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!

**How the New Hazardous Waste Pharmaceuticals Rule Will Impact LTC**

In the last few years, we’ve seen legislation for the disposal of pharmaceuticals on the state and federal level grow due to our nation’s opioid crisis. One of the most recent rules we’ve seen is the Management Standards for Hazardous Waste Pharmaceuticals. In February 2019, the Environmental Protection Agency published the long-awaited rule in the Federal Register, which will help establish cost-saving, streamlined standards for handling hazardous waste pharmaceuticals.

Not only will these new standards help how the healthcare sector operates, but it will better protect the health of individuals and the environment. Annually, it’s estimated up to 2,300 tons of pharmaceuticals are disposed of down the drain. The EPA predicts that by enacting this new rule, it will reduce the amount of hazardous waste pharmaceuticals entering our waterways. This new rule will prohibit long-term care facilities from dumping pharmaceuticals down the drain, making our drinking and surface water safer and healthier.

This new rule will significantly change how the healthcare sector manages their hazardous waste pharmaceuticals, eliminating existing regulations that have been in place for decades. Not only is it important for facility managers to be aware of these changes, but to also understand what it means for their long-term care or healthcare business. Failure to do so could be a costly mistake, as well as a risk the public’s health and environment.

**What is considered hazardous waste?**

The EPA defines hazardous waste as “waste with properties that make it dangerous or capable of having a harmful effect on human health or the environment.” Once an item containing hazardous properties is no longer usable, it is deemed hazardous waste.

The EPA regulates hazardous waste under the Resource Conservation & Recovery Act to ensure these wastes are managed in a compliant manner. RCRA mandates that generators of hazardous waste, such as long-term care and other healthcare facilities, are responsible for waste from the time of generation to the final destruction. RCRA also sees that these wastes are managed in ways that protect human health and the environment. Generators of hazardous waste are regulated based on the amount of hazardous waste they generate in a calendar month, not the size of their business or facility.

Hazardous waste items have ignitable, corrosive, reactive or toxic characteristics. To determine whether a product is considered hazardous waste, review its safety data sheet, manufacturer information, label and ingredients. Specific guidelines provided by hazardous management service providers can also be referenced.
Common types of hazardous waste pharmaceuticals found in long-term care and nursing homes include, but aren’t limited to:

- Aerosols
- Insulin
- Multivitamins
- Some blood thinner medications
- Some Drug Enforcement Administration (DEA) controlled substances

**What are the changes?**

One of the biggest changes from the final rule is that it mandates long-term care facilities to follow the requirements set out by RCRA. These requirements regard the generation, management, storage, treatment and disposal of hazardous wastes. While the final rule does not increase the number of pharmaceuticals considered to be hazardous waste, it does include many changes that will impact long-term care and healthcare facilities. Some of these changes include the following:

- **Eliminates “sewering” of hazardous waste pharmaceuticals.** Reducing intentional sewer disposal is one mechanism to help reduce the environmental loading of pharmaceuticals into our nation’s waters.
- **Provides regulatory clarity on how pharmaceuticals must be managed.** These new regulations eliminate the dual regulation of RCRA hazardous waste pharmaceuticals that are also DEA controlled substances. The new rules also maintain the household hazardous waste exemption for pharmaceuticals collected during pharmaceutical take back programs and events, while ensuring their proper disposal.
- **Offers regulatory relief to healthcare facilities for management of hazardous waste pharmaceuticals.** The rule outlines that hazardous waste pharmaceuticals do not count toward generator status, eases labeling and manifesting and clarifies what wastes should be shipped to reverse distributors.
- **Amends the listing of nicotine patches, gums and lozenges.** These items no longer have to be managed as hazardous waste.

**What happens I don’t comply?**

There are many repercussions for improperly handling hazardous waste pharmaceuticals at any given time. Facilities that do not understand federal, state and local regulations can face environmental, health and safety risks, including water contamination. In addition, non-compliance fines levied against the healthcare sector have risen in recent years, making facilities today face the risk of significant monetary penalties for non-compliance. While the financial burden of non-compliance is significant, the negative impact these public fines have on brand perception can be even more damaging.

**What’s the bottom line?**

State-by-state adoption of the Management Standards of Hazardous Waste Pharmaceuticals will be a long process with varying timelines and outcomes as states have the ability to be more stringent. The rule will go into effect in Alaska, Iowa and Puerto Rico on Aug. 21, 2019. Other states will have until 2021 or 2022 to adopt the new rule. This is because each state has their own version of the EPA and can adapt the rule accordingly.

Management personnel are encouraged to seek help from a third-party vendor to not only help dispose of hazardous waste pharmaceuticals, but to also serve as a compliance expert. Using a vendor can help make sure facilities are up-to-date in regulatory changes and its deadlines.

While there might be some time to adapt to the new rule, it’s important to be aware of these upcoming changes and even start implementing it sooner rather than later. Putting best practices in place now can help eliminate waste streams and better ensure the safety of patients, employees, the environment and the facility’s overall brand.

*Article authored by Wade Scheel and reprinted out of McKnight’s*

**5 Myths SNF Administrators Should Know About PDPM**

There’s a great deal of conversation about the Patient Driven Payment Model and the role it plays in reimbursement and care delivery. But, while everyone is focused on conjecture and what-ifs, it’s easy to lose sight of the facts.
Below are five myths and misconceptions about PDPM to ensure your facility and staff are prepared when the new payment model goes into effect on October 1, 2019.

- **Myth: PDPM is the same as value-based care.** While PDPM and the term “value-based care” stem from a similar spirit, they are two distinct concepts:
  
  - Value-based care refers to the general practice of delivering holistic, personalized treatments to optimize resident or patient outcomes. PDPM fits under the topical umbrella of value-based care, but not all value-based care aligns with PDPM.
  
  - PDPM is a specific Centers for Medicare & Medicaid Services-led reimbursement model that only applies to skilled nursing facilities.
  
  - The ideology behind value-based care is that resident outcomes should determine reimbursements for facilities. Under PDPM, resident results will influence, but not define, reimbursements. Despite PDPM’s shift away from the existing RUG IV model, services themselves will still factor into payment rates for each care episode. This point leads us to an alternative view on PDPM. Industry expert Steven Littlehale makes a hard distinction between PDPM and value-based purchasing by claiming that PDPM is still “really all about volume.” He also challenges the sentiment that PDPM itself is the coming of a new era, positioning it as a blip on the long-term radar of reform. PDPM is just one progress point, he implies, along the IMPACT Act’s journey to achieve a “unified post-acute care payment system (U-PAC).”

- **Myth: PDPM will automatically cause most SNFs to lose money.** This myth presupposes that the RUG-IV model was ideal for SNFs. But even if facilities adopted the practice of augmenting therapy to increase reimbursements, that doesn’t mean it was their best option. It is possible that SNFs have been heavily documenting residents’ supposed therapy requirements while still providing, but not fastidiously recording, clinically complex care delivery. In this case, PDPM will boost reimbursement rates for SNFs – as long as providers understand how to code for and classify residents’ needs under the new payment paradigm.

- **Myth: PDPM deprioritizes therapy.** PDPM does aim to discourage SNFs from using higher therapy RUG levels just to reap financial rewards. However, if a resident genuinely requires treatments like PT, OT, or SLP, then CMS will still reimburse SNFs accordingly. **Section O**, an addition to the MDS per PDPM, will require SNFs to track the cumulative therapy minutes for each resident’s stay. A significant drop here in therapy utilization may raise a red flag to CMS, which could result in reduced payments.

- **Myth: SNFs should max out group and concurrent therapies under PDPM.** On one hand, PDPM promotes more individualized treatments for residents, which could necessitate outside-of-the-box therapy modes. But even though therapy minutes won’t define payment classifications under PDPM, the new regulation caps group and concurrent therapy allowances at 25%. Anything over that could result in penalties. This proposed limit intends to discourage SNFs from inappropriately using group/concurrent therapies as a cost cutter.

- **Myth: The MDS coordinator role will lose importance.** Some have predicted that PDPM’s lighter assessment requirements will stamp out the MDS coordinator role, but this isn’t the case. It is true that PDPM reduces the number of required MDS assessments from five to two (with a third optional one), but in turn, the proper execution of these assessments will get more difficult. **Where subpar coding could sometimes slide under the RUG-IV model, it won’t under PDPM.**

MDS coordinators will play an integral role in conducting hands-on assessments and documenting the details that spur reimbursements. Instead of disappearing, the MDS coordinator role will evolve into a more dynamic job function which requires collaboration to corral and record key data points.

*Article authored by Tad Druart and reprinted out of McKnight’s.*

**Focus F-Tag – F600 – Free From Abuse and Neglect (Part 1 of 4)**

This Regulatory Beat’s Focus F-Tag is F600 Free From Abuse and Neglect, which is part of the Freedom from Abuse, Neglect and Exploitation regulatory group of the Requirements of Participation (RoPs) for nursing homes. Under the RoPs, the Interpretive Guidance (IG) for F600 has been expanded to such a length that we will be reviewing this F-Tag over the next few issues.
The regulation at F600 states that residents have the right to be free from abuse, neglect, exploitation and misappropriation of resident property (F602). This includes the right to be free from corporal punishment, involuntary seclusion (F603) and from physical (F604) and/or chemical restraints (F605). The facility, per the regulation, is prohibited from using verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion of a resident.

**Abuse – Defined**

F600 defines “abuse” as the willful infliction of injury, unreasonable confinement, intimidation, or punishment that results in physical harm, pain or mental anguish to the resident. Deprivation of good services by a caretaker that are necessary to maintain the resident’s well-being is also considered a form of abuse. The regulation clearly states that irrespective of any mental or physical condition, abuse of residents causes physical harm, pain or mental anguish. Forms of abuse include verbal abuse, sexual abuse, physical abuse and mental abuse – including abuse facilitated by technology (i.e. social media).

**Key Points**

The IG notes that there are some facility characteristics that can increase the likelihood for abuse that administration needs to be on the lookout for:

- Chronic staffing issues, staff burnout and stressful working conditions
- Staff attitudes toward residents that are unsympathetic or negative
- Inadequate training/preparation to fulfill caregiving duties
- Deficiencies in providing a safe resident environment
- Policies that are not resident-centered and “operate in the interests of the institution”
- Lack of administrative oversight

**Deprivation of Good and Services by Staff**

If staff have the knowledge and ability to provide the necessary care and services to ensure a resident attains/maintains the highest well-being, but chooses not to, this is considered abuse. It is also considered abuse if a staff member does not acknowledge a request for assistance that results in a care deficit.

**Physical Abuse**

Physical abuse, per the IG, includes actions such as hitting, biting and slapping, as well as corporal punishment. Corporal punishment is meant to correct or control the behavior of a resident and involves someone taking an action such as pinching, flicking, slapping hands or hitting with an object.

**Mental and Verbal Abuse**

The IG notes that mental abuse includes both verbal and nonverbal actions which cause – or have the potential to cause – a resident to experience intimidation or fear, shame, humiliation, degradation or agitation. Verbal abuse, which includes oral, written or gestured communication or sounds, can also be considered mental abuse when used within hearing distance of residents.

Keeping or distributing photographs or recordings of a resident that demeans or humiliates the resident can be considered abuse. Even if the resident has provided consent, and regardless of whether he/she is cognitively intact, surveyors are instructed to investigate if there is non-compliance related to abuse at F600. Depending on the content of the documentation/materials reviewed, physical and/or sexual abuse may also be identified.

If a surveyor identifies mental abuse, he/she must cite F600 at a scope/severity level that considers any psychosocial harm that residents may have experienced as a result of the mental abuse. Staff should be familiar with the Psychosocial Harm Severity Scale.

**Sexual Abuse**

Sexual abuse, per the IG, is any non-consensual sexual contact with a resident. Sexual contact is considered to be non-consensual under several circumstances, including if a resident appears to want the contact but is unable to consent, if the resident does not want the contact to occur, and if the resident is sedated/unconscious/in a coma.

Stay tuned for Part 2 of our review of F600 Free from Abuse and Neglect in the next issue of *Regulatory Beat*. 
Hospitalizations for Mental and Substance Use Disorders

Nearly 10 million hospital stays in 2016 involved a mental and substance use disorder (MSUD). Six percent of all U.S. hospitalizations involved a principal diagnosis of MSUD (2.2 million stays) while 22 percent had a secondary diagnosis (7.7 million stays). This information is based on the AHRQ, Healthcare Cost and Utilization Project Statistical Brief #249: Inpatient Stays Involving Mental and Substance Use Disorders, 2016.

Mental and substance use disorders are common in the United States. In 2016, over 55 million people aged 18 years and over (more than one in five adults) suffered from mental and/or substance use disorders (MSUDs). Of these adults, nearly 45 million had a mental disorder alone, 11 million had a substance use disorder alone, and 8 million had both a mental disorder and a substance use disorder.

Not only do mental and substance use disorders co-occur, they also are linked to other physical conditions such as diabetes, heart disease, and asthma. Disorders such as depression, anxiety, and substance use disorder are associated with significant distress and impairment, including complications with multiple chronic conditions, disability, inability to function in society, and substantial economic costs. The treatment costs of mental disorders alone totaled $201 billion in 2013. Taking into account additional costs associated with lost work productivity and disability payments, the total cost of mental and substance use disorders to society is estimated to be more than twice that amount.

Highlights

- In 2016, nearly 10 million inpatient stays had a principal (2.2 million) or secondary (7.7 million) MSUD diagnosis, constituting 6.1 and 21.7 percent of all inpatient stays, respectively.
- In total, stays principally for MSUDs cost $15.3 billion (3.6 percent of total hospital costs). On average, stays for MSUDs cost $7,100 and were 6.4 days.
- The rate of stays principally for MSUDs was highest among adults aged 18-64 years.
- Nearly 60 percent of MSUD stays for patients aged less than 65 years were billed to public payers.
- One in four stays principally for MSUDs were for depressive disorders. Alcohol-related disorders and schizophrenia each constituted nearly one in five MSUD stays.
- Although uncommon, stays for eating disorders were the costliest ($19,400 per stay) and the longest (14 days, on average) type of MSUD stay. Inpatient stays for schizophrenia were the second costliest ($8,900 per stay) and second longest (11 days on average) MSUD stay.
- The most common reason for MSUD stays among males aged 45-64 years was alcohol-related disorders. Schizophrenia was the most common reason for MSUD stays for males aged 18-44 years.

Important Regulations, Notices & News Items of Interest

1) There was one 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:

- QSO 19-15 – EMTALA – Frequently Asked Questions on the Emergency Medical Treatment and Labor Act (EMTALA) requirements. EMTALA and Psychiatric Hospitals: Medicare-participating psychiatric hospitals are required to comply with EMTALA requirements. Frequently Asked Questions: CMS is providing the attached
2) **Federal HHS/CMS** released the following notices/announcements:

- **HHS Announces Quality Summit to Streamline and Improve Quality Programs across Government.** The U.S. Department of Health and Human Services (HHS) Deputy Secretary Eric Hargan announced the formation of the [Quality Summit (QS)](https://www.qualitysummit.org), which will bring together key industry stakeholders and government leaders to discuss how current quality programs administered by HHS can be further evaluated, adapted and ultimately streamlined to deliver a value-based care model focused on improving outcomes for American patients. On June 24, President Trump signed the Improving Price and Quality Transparency in American Healthcare to Put Patients First Executive Order, directing federal agencies to develop a Health Quality Roadmap that aims to align and improve reporting on data and quality measures across federal health programs.

- **Medicaid Program Integrity: A Shared and Urgent Responsibility.** The Medicaid program has grown from $456 billion in 2013 to an estimated $576 billion in 2016, largely fueled by a mostly federally financed expansion of the program to more than 15 million new working age adults. For these adults, the estimated cost per enrollee grew about 7 percent from FY2017 to 2018, compared to about 0.9 percent for other enrollees. With this historic growth comes a commensurate and urgent responsibility by CMS on behalf of the American taxpayers to ensure sound stewardship and oversight of our program resources. Read [CMS Blog Post](https://www.cms.gov/blog/2018/06/medicaid-program-integrity-shared-and-urgent-responsibility/).

- **HHS Launches President Trump’s ‘Advancing American Kidney Health’ Initiative.** President Donald Trump signed an Executive Order to launch [Advancing American Kidney Health](https://www.cms.gov/End-Stage-Renal-Disease/End-Stage-Renal-Disease-Information/Advancing-American-Kidney-Health), a bold new initiative to improve the lives of Americans suffering from kidney disease, expand options for American patients, and reduce healthcare costs. The initiative provides specific solutions to deliver on three goals: fewer patients developing kidney failure, fewer Americans receiving dialysis in dialysis centers, and more kidneys available for transplant.

- **Advancing Excellence in America’s Nursing Homes Campaign.** In September 2016, CMS and its contractors continued the work of the Advancing Excellence in America’s Nursing Homes Campaign to make nursing homes better places to live, work and visit by promoting quality and performance improvement in nursing homes through individualized, person centered care. Subsequently, the campaign continued and was renamed the National Nursing Home Quality Improvement Campaign. The campaign was operated by Telligen through a contract with CMS. Telligen’s contract will end on July 17, 2019, and unfortunately, Telligen will no longer be able to operate the campaign after that date.

Many of the NNHQI Campaign tools and resources will continue to be available at the QIO Program website, [https://qioprogram.org/nursing-home-resources](https://qioprogram.org/nursing-home-resources). If you are using a Campaign Tracking Tool, you may continue to use that Tracking Tool, but you will not be able to use the campaign website to trend your goal data over time.

After **Wednesday, July 17**, there will not be any way to access your website account or view goal data that you have entered on the Campaign website, so we strongly recommend that long-term care providers download any goal data that they have entered on the Campaign website by July 17:

1. Log in to your account at [https://www.nhqualitycampaign.org/](https://www.nhqualitycampaign.org/). (If you have any trouble accessing your account, please email help@nhQualityCampaign.org on or before July 17, 2019.)
2. Click the ‘View My Progress’ icon and select the goal for which you want to download data.
3. Update the options to get data for the desired measure.
4. Under the Data Display option, select ‘Table’ and then click ‘Refresh Table.’
5. Click the ‘Export: XLS’ button to save the data in an Excel file.

If you have a data share arrangement with the campaign that allows you to access campaign data for participating providers in your region, we recommend downloading the data for your providers by logging into the Campaign website, going to the ‘Signed in as’ menu in the upper right corner and selecting ‘Raw File
Downloads’ under ‘Data Share Group Reports,’ and downloading the data for each goal for which you collect data.

If you have any questions about this change, please contact help@nhQualityCampaign.org.

- **SNF Quality Reporting Program: Non-Compliance Letters.** CMS is providing notifications to facilities that were determined to be out of compliance with the quality reporting requirements for the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), which will affect their FY 2020 Annual Payment Update (APU). Non-compliance notifications are in the process of being sent by the Medicare Administrative Contractors (MACs) and will be placed into facilities’ CASPER folders in QIES on July 16, 2019. Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 pm PST, August 15, 2019. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the [SNF Quality Reporting Reconsideration and Exception & Extension webpage](#).

- **New Medicare Card: Transition Period Ends in Less Than 6 Months.** Starting January 1, 2020, you must use the Medicare Beneficiary Identifier (MBI). They will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions and reject all eligibility transactions. Many providers are using the MBI for Medicare transactions. For the week ending July 5, providers submitted 76 percent of fee-for-service claims with the MBI. Protect your patients’ identities by using MBIs now for all Medicare transactions. Don’t have an MBI? Ask your patients for their card. If they did not get a new card, give them the Get Your New Medicare Card flyer in [English](#) or [Spanish](#). Use your Medicare Administrative Contractor’s look up tool. [Sign up](#) for the Portal to use the tool. Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN. For more information, see the [MLN Matters Article](#).

- **CMS Expands Coverage of Ambulatory Blood Pressure Monitoring.** On July 2, CMS finalized its national coverage policy for Ambulatory Blood Pressure Monitoring (ABPM). ABPM is a non-invasive diagnostic test that uses a device to track blood pressure over 24-hour cycles, allowing a doctor to assess a patient’s blood pressure during routine daily living. ABPM may measure blood pressure more accurately and lead to the diagnosis of high blood pressure in patients who would not otherwise have been identified as having the condition.

  “CMS is dedicated to improving cardiovascular health in the Medicare population,” said CMS Administrator Seema Verma. “Today’s decision reflects CMS’ commitment to continually updating our policies to ensure that more Medicare beneficiaries have access to the latest technology and appropriate evidence-based health care. We believe stakeholders will appreciate the policy being expanded to include diagnostic uses recommended by the multi-society task force blood pressure practice guidelines.”

  In addition, this decision lowers the blood pressure threshold for hypertension from the current policy of 140/90 down to 130/80 to align with the latest society recommendations regarding the diagnostic criteria. This will allow more patients to use ABPM and receive appropriate treatment if needed.

  For more information, read the [Decision Memo](#). See the full text of this excerpted [CMS Press Release](#) (issued July 2).

- **SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1.** On October 1, the new Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has resources to help you prepare:
  - PDPM webpage, including [fact sheets, FAQs, presentation](#) and [coding crosswalks/classification logic](#)
  - [Materials](#) from the Medicare Learning Network call in December
  - [New Medicare Webpage on PDPM](#) MLN Matters Article
  - [Implementation of the SNF PDPM](#) MLN Matters Article

REGISTRATION OPEN – SNF QRP Provider In-Person Training Event, August 13 and 14, 2019. CMS will be hosting a 2-day Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) in-person ‘Train the Trainer’ event for providers on August 13 and 14, 2019, at the Four Seasons Hotel, 200 International Drive, Baltimore, MD 21202. This event will be open to all SNF providers, associations and organizations.

Like the May 2019 SNF QRP Provider Training, the primary focus of this ‘Train-the-Trainer’ event will be to provide those responsible for training staff at SNFs with information about:

- The transition to the Patient Driven Payment Model (PDPM) which becomes effective on October 1, 2019.
- A review of SNF QRP changes and updates to the Minimum Data Set (MDS) 3.0 Version 1.16.0, which became effective October 1, 2018.
- An overview of the eleven SNF QRP Quality Measures.
- An interactive session on the use of reports to identify opportunities for process improvement and utilize information contained in reports available via the Certification And Survey Provider Enhanced Reports (CASPER) system to develop quality improvement plans.

During this event, presenters will incorporate additional information into their presentations based on questions received from participants during the May training. A full agenda can be accessed here.

Training will start at 8:00 a.m. EDT and end at 5:15 p.m. EDT on Tuesday, August 13. On Wednesday, August 14, training will start at 8:30 a.m. EDT and end at 3:30 p.m. EDT. Following the training on August 14, there will be an optional “We Want to Hear From You” session from 3:30 to 4:30 p.m. EDT.

Registration for this in-person training is limited to 250 people on a first-come, first-serve basis. CMS has negotiated a discounted room rate of $149 per night with the hotel for a limited number of rooms. To receive the room discount, you must reserve your sleeping room with the hotel no later than 6:00 p.m. EDT on July 22, 2019. Instructions to reserve a hotel room at the discounted rate will be sent to you in a confirmation email once you register for the training.

When registering, please enter your name as you would like it to appear on your name tag and Completion of Certificate.

For those not able to attend in person, a URL to access the webcast will be provided prior to the event Whether you participate in-person or via the webcast, we ask that you register for this event. CLICK HERE to register.

**Requests for reasonable accommodations must be received at least 5 business days prior to the beginning of the event (no later than Tuesday, August 6, 2019) and can be emailed to Chandler Bishop at PACTraining@EconometricaInc.com with a copy to Stacy.Cole@cms.hhs.gov.**

If you have questions or need additional information regarding the logistics of this training session, please email the PAC Training mailbox at PACTraining@econometricainc.com

HQRP Quarterly Update for 2nd Quarter of 2019 is Available. The Hospice Quarterly Update for the second quarter of 2019 is now available. This update includes Hospice Quality Reporting Program highlights from this past quarter (May-June 2019), events and engagement opportunities planned for this coming quarter (July-September 2019) and selected questions and answers from the Hospice Quality Help Desk. Please navigate to the HQRP Requirements and Best Practices page to download this document.
• **Public Reporting: Key Dates for Hospice Providers.** Key dates are important for Public Reporting. When data are updated affects when the data are displayed on Hospice Compare. The data shown on your Preview Reports are the data that will be displayed on the next Hospice Compare refresh. For example, the June 2019 Preview Reports (available in the CASPER folder 05/30/2019) will be the data displayed on the August 2019 refresh of Hospice Compare. For more information about the freeze date, preview reports, and key public reporting dates for providers, please see the [Public Reporting: Key Dates for Providers](#) webpage.

• **Hospice Quality Reporting Program: Non-Compliance Letters.** CMS is providing notifications to hospices that were determined to be out of compliance with Hospice Quality Reporting Program (HQRP) requirements for CY 2018, which will affect their FY 2020 Annual Payment Update (APU). Non-compliance notifications are in the process of being mailed by the Medicare Administrative Contractors (MACs) and will be placed into hospices' CASPER folders in QIES on July 16, 2019. Hospices that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 pm PST, August 15, 2019. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification and on the [Reconsideration Requests webpage](#).

• **Home Health Payment and Policy Changes.** On July 11, CMS issued a proposed rule [CMS-1711-P] that proposes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule will also include:
  - Proposal to modify the payment regulations pertaining to the content of the home health plan of care
  - Proposal to allow therapist assistants to furnish maintenance therapy
  - Proposal related to the split percentage payment approach under the Home Health Prospective Payment System (PPS)
  - Proposals related to the implementation of the permanent home infusion therapy benefit in 2021

This proposed rule sets forth implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology, and a 30-day unit of payment as mandated by the Bipartisan Budget Act of 2018 (BBA of 2018). CMS projects that Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase in aggregate by 1.3 percent, or $250 million, based on proposed policies. The increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase) mandated by BBA of 2018. It also reflects a 0.2 percent decrease in aggregate payments due to reductions made by the new rural add-on policy mandated by the BBA of 2018 for CY 2020 (i.e., an estimated $40 million decrease in rural add-on payments). The rate updates also include adjustments for anticipated changes with implementation of the PDGM and a change to a 30-day unit of payment, the use of updated wage index data for the home health wage index, and updates to the fixed-dollar loss ratio to determine outlier payments.

In addition, the proposed rule includes:
  - Proposed payment rate changes for home infusion therapy temporary transitional payments for CY 2020
  - Payment proposals for new home infusion therapy benefit for CY 2021
  - Regulatory burden reduction – Patients over paperwork and enhance and modernize program integrity
  - Paraprofessional roles – Improving access to care
  - Home Health Quality Reporting Program – Support MyHealthEData Initiative
  - Home Health Value-Based Purchasing model

For More Information:
  - [Proposed Rule](#)
  - [Press Release](#)
  - [Home Health PPS website](#)
  - [Home Health Quality Reporting Requirements webpage](#)
  - [Home Health Value-Based Purchasing Model](#)

See the full text of this excerpted [CMS Fact Sbheet](#) (issued July 11).
• **LTCH QRP Review and Correct Reports Now Available.** The enhanced Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) review and correct reports are now available on demand in iQIES. In addition to enhanced sorting functionality, this report now includes patient level data. Providers will have the option to download the report in PDF or CSV format. Providers can access these reports by selecting the ‘Find Report Type’ from the Reports menu. Type ‘Review and Correct’ in the report keyword box or use the filter options to locate the report from the report options.

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

• **LTCH Quality Reporting Program: Non-Compliance Letters.** CMS is providing notifications to facilities that were determined to be out of compliance with the quality reporting requirements for the Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), which will affect their FY 2020 Annual Payment Update (APU). Non-compliance notifications are in the process of being sent by the Medicare Administrative Contractors (MACs) and will be placed into facilities’ My Reports folders in iQIES on July 16, 2019. Facilities that receive a letter of non-compliance may submit a request for reconsideration to CMS via email no later than 11:59 pm PST, August 15, 2019. If you receive a notice of non-compliance and would like to request a reconsideration, see the instructions in your notification letter and on the [LTCH Quality Reporting Reconsideration and Exception & Extension webpage](#).

3) The federal [HHS Office of the Inspector General](#) released **Two Reports on Hospice Care.** The Department of Health and Human Services Office of Inspector General has released two reports which found that from 2012 through 2016, the majority of U.S. hospices that participated in Medicare had one or more deficiencies in the quality of care they provided to their patients. Some Medicare beneficiaries were seriously harmed when hospices provided poor care or failed to take action in cases of abuse. OIG made several recommendations in both reports to strengthen safeguards to protect Medicare hospice beneficiaries from harm and to ensure hospices are held accountable for deficiencies in their programs.

• Read [Media Materials](#)
• Read [Hospice Deficiencies Pose Risks to Medicare Beneficiaries (OEI-02-17-00020)](#)
• Read [Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm (OEI-02-17-00021)](#)

4) 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 **REVISED Proposed ID/DD and MC/DD Reimbursement Rate Increase.** You may view the notice [here](#).

• HFS posted a new Public Notice regarding **Home and Community Based Services Persons Who are Elderly Waiver.** You may view the new notice [here](#).

• HFS published an updated **Practitioner Fee Schedule.** You may view the new Fee Schedule [here](#).

• HFS posted a new Provider Notice regarding **Chapter K-200, Handbook for Hospice Agencies Hospice Billing Changes Regarding Service Line Date and Occurrence Code Requirements Effective with Dates of Service on and after August 1, 2019.** You may view the new notice [here](#).

• HFS posted a new Provider Notice regarding **Updated Pricing Calculators.** You may view the new notice [here](#).
• HFS posted a new Provider Notice regarding **Hospital Rate Sheets Effective July 1, 2019**. You may view the notice [here](#).

• HFS posted “**Preferred Drug List Illinois Medicaid July 1, 2019**”. To view, click [here](#).

• HFS posted a new Provider Notice regarding **Due Dates for FY 2020 Hospital Assessment Program**. You may view the new notice [here](#).

• **LTC Advance Payment Plan Agreements.** The following information was posted as an Announcement on the LTC Exchange site. We are sending this listserv in case providers are not set up to receive automatic alerts when Announcements are posted. In addition, HFS is uploading a file to the LTC Exchange Shared Documents folder that demonstrates how to sign up for automatic alerts when Announcements are posted.

  HFS began uploading Advance Payment Plan agreements on July 10, 2019 to the LTC Exchange site, and will continue to do so as more are approved. The agreements list the total amount approved for payment as well as the monthly amounts that will need to be repaid over the course of calendar year 2020.

  Please access the agreement in your Advance Payment folder, print out, sign and date and upload to the same folder on the LTC Exchange site. When signing, please include Name, Date, Provider Name and Title in the lower right-hand corner of the agreement.

  When uploading the signed agreement, please choose the document type "Signed Advance Payment Plan Agreement".

  HFS will not entertain any amendments to the agreement.

  Once HFS receives the signed agreement, HFS will sign and upload the final agreement. In addition, HFS will begin the process of generating the Advance Payment. This process should take at least a week before funds are available to the provider.

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

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

6) 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](#).

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

• **AHCA PDPM Academy Weekly Update: July 11.** Important resources concerning the June 25 webinar, PDPM Updates to the MDS RAI Manual and the Potential Impact on CMS PDPM Quality Monitoring, are available for you to view at your convenience.
• **AHCA PDPM Academy Compliance Toolkit**
  o **Q&A Document** for June 25 AHCA PDPM Academy Monthly Webinar

  1. Click [here](#) to log in using your AHCA username and password. If you have forgotten your password and need help signing in, please click [here](#).
  2. 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.
  3. Click on the **Handout tab** to download your copy of the presentation slides and the Q&A Document.

For questions or support, please e-mail educate@ahca.org

• **AHCA Update on Release Rules and Congressional Hearing.** AHCA President & CEO Mark Parkinson sent out an update today regarding updates to released rules and a Congressional Hearing that impact our sector ([click here](#) to view). First, CMS issued the **final rule** that reverses the Obama-era ban on the use of arbitration agreements. Second, CMS issued the proposed rule that is intended to ease some of the pressures of the Requirements of Participation (RoPs) and delays implementation of Phase 3 by a year: *Medicare and Medicaid Programs: Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency*. Finally, Chairman Grassley of the Senate Finance Committee has scheduled another hearing related to our sector. The title of the hearing is "Promoting Elder Justice: A Call for Reform." It will take place on Tuesday, July 23 at 10:15 AM in the Dirksen Senate Office Building. The topic of the hearing is still developing, but we are told it will center around a forthcoming GAO report. We are still learning about the subject of the GAO report, but we think it will examine CMS oversight of abuse and neglect claims.

• **Important CMS MDS Section GG Training Resources Have Been Recently Updated.** The SNF PPS Patient Driven Payment Model (PDPM) relies on accurate coding of several MDS Section GG mobility and self-care items that impact the PT, OT, and Nursing component per-diem case-mix payment rates. This toolkit contains a collection of Section GG training materials that the Centers for Medicare and Medicaid Services (CMS) has provided on their website that may be useful for provider PDPM training of nurses, certified nursing assistants, and therapists. Click [here](#) to access the June 26, 2019 updated materials.

• **AHCA/NCAL Social Media Update.**

  8) **Telligen** reports:

  • **Pause in Telligen QIN-QIO Services Begins Wednesday, July 17, 2019.** As you may have read in Monday's *Weekly Digest*, Telligen wanted to let you know about some important news that will affect the quality improvement support that they provide to your organization as a Quality Innovation Network-Quality Improvement Organization (QIN-QIO).

    As you may know, Telligen has been preparing for a new project cycle to continue to serve you as quality improvement partner. We learned that the CMS has delayed the start of this project cycle until the fall of 2019. **This delay affects all QIN-QIOs - not just Telligen - and will impact the work we can do for you after July 17, 2019.**

    Here's what we know right now:

    o The QIN-QIO project is one of many projects Telligen runs for federal, state and local governments. We want to reassure you that Telligen remains your trusted source for quality improvement resources and consulting.
    o **We fully expect to resume the QIN-QIO project in the fall.** CMS projects that this could be between September and November 2019.
    o It's possible that **Telligen may serve different states** during the next CMS project cycle. If that happens, please be assured that you will still enjoy QIN-QIO support like that you have received from Telligen.
    o When it begins, the next project cycle will allow us to work with organizations like yours on **new facets of healthcare quality improvement**. This will likely include resources to support nursing homes adapting
to new federal regulations. Other areas of emphasis will address opioid misuse and other behavioral health disorders, as well as ways to better identify and manage chronic conditions like diabetes and heart disease.

Once CMS makes project assignments in the fall we will share more.

In the meantime, here’s what you can expect from Telligen:

- **The current QIN-QIO project ends on Wednesday, July 17, 2019.** The project will restart once CMS makes its QIN-QIO assignments in the fall.
- **Our staff will keep its commitments for any speaking engagements at conferences made through the summer. Other assignments, such as serving as representatives for community coalitions or leading task forces, will likely resume in the fall once CMS starts the next QIN-QIO project.** This includes the Telligen Weekly Digest newsletter and any other regular QIN-QIO communications you have been receiving.
- **You can still talk to us! Our team** is here to take your calls and answer your questions. We are committed to share updates with you as they become available.

Please feel free to contact your quality improvement advisor or call us at 515-440-8600 with any questions or concerns and we will do our best to get the answers you need. Many thanks for your patience during this transition.

- **Telligen Weekly Digest – July 1, 2019**
- **Telligen Weekly Digest – July 8, 2019**
- **Telligen Weekly Digest – July 15, 2019**

9) **Crain’s Chicago Business** reports that **Illinois to Hire Hundreds of Workers to Resolve Medicaid Backlog.** *Crain’s Chicago Business (IL)* recently reported, "Illinois is hiring hundreds of frontline workers to resolve major delays of its Medicaid application and renewal processes." The Illinois Department of Health care and Family Services, which oversees Medicaid, and the Illinois Department of Human Services "are working together to fill the vacancies, the departments said in a statement today." The first vacant positions "are expected to be filled this week."

10) **McKnight’s** reports, Researchers Suggest Patients in HCBS Settings May Have Worse Outcomes Than Those in LTC Settings. *McKnight’s Long Term Care News* reports that researchers from the University of Chicago found in a study that "elderly, dual-eligible Medicaid beneficiaries in long-term care settings aren’t more likely to be hospitalized than those receiving community-based care, even though long-term care residents tend to be older and have more chronic conditions." The investigators "noted that care intensity and duration are more likely to suffer at the hands of untrained caregivers in non-facility settings." The study also showed "that among people with dementia, home- and community-based service users actually had higher rates of hospitalizations than nursing home residents." The research suggests Medicaid’s focus on HCBS "may actually be detrimental to patients." The *study* was published in *Health Affairs.*

11) **Reuters** reports that **Footwear Needs Change As People Age, Research Suggests.** *Reuters* reported on a medical literature review published in Maturitas which found that shoes which fit when a person is young "may become uncomfortable and unsafe in [their] senior years." Footwear which is safe for older adults "should have a proper anatomical fit, a well-fitted toe box, a low heel height, a broad enough heel, a snug fit, and be easy to get on and off, researchers note."

12) **Healio** reports that **Delaying Vaccination Until October 1 in Seniors May Be Harmful, Study Indicates.** *Healio* recently reported that researchers at the Centers for Disease Control and Prevention "estimated that delaying vaccination until October 1 in adults aged 65 years or older would increase influenza-associated hospitalizations if a certain proportion of those who usually get vaccinated earlier failed to get vaccinated." The *findings* were published in *Clinical Infectious Diseases.*
13) The Washington Post reports that President Trump Withdraws Plan to End Drug Rebates. The Washington Post recently published an article reporting that the Trump Administration withdrew "one of its key proposals to lower drug prices by eliminating industry rebates in Medicare." The article points out that "the rule is the second major drug pricing effort to collapse this week, revealing the internal conflicts surrounding the question of how to lower prescription drug costs." The article adds that Secretary of Health and Human Services Alex Azar and several "top White House policy advisers...disagreed over the merits of the rule."

14) NBC News reports that C. Diff Spores Appear to Survive Appropriate Cleaning Procedures, Researchers Say. The NBC News website reported that Clostridiodes difficile (C. diff) bacteria "have been shown to survive on disposable hospital gowns and stainless steel surfaces – even after they’re scrubbed clean." While keeping hospitals or long term care facilities clean is important, "new research, published" online "in the journal Applied and Environmental Microbiology, shows how difficult that can be." In laboratory studies, investigators "found that C. diff spread easily from disposable gowns often employed in surgery or infection control to stainless steel and vinyl surfaces." The bacteria also did not "die when the researchers tried to kill them with concentrated chlorine disinfectant."

15) The New York Times reports that Urinary Tract Infections Increasingly Resistant to Antibiotics. There is growing evidence that urinary tract infections, "which afflict millions of Americans a year, mostly women, are increasingly resistant" to antibiotics, The New York Times reported on its front page, "turning a once-routine diagnosis into one that is leading to more hospitalizations, graver illnesses and prolonged discomfort from the excruciating burning sensation that the infection brings." In fact, the New York City Department of Health "has become so concerned about drug-resistant U.T.I.s, as they are widely known, that it introduced a new mobile phone app this month that gives doctors and nurses access to a list of strains of urinary tract infections and which drugs they are resistant to." The department’s research "found that a third of uncomplicated urinary tract infections caused by E. coli – the most common type now – were resistant to Bactrim [sulfamethoxazole trimethoprim], one of the most widely used drugs, and at least one fifth of them were resistant to five other common treatments."

16) Modern Healthcare reports:

- Study Shows Self-Reported Staffing Levels Higher Than Payroll-Based Data in Some Nursing Homes. Modern Healthcare reports that research shows "nursing home staffing levels are often lower than what facilities report." The study, published in Health Affairs, "said self-reported direct staffing time per resident was higher than the CMS’ payroll-based metrics 70% of the time," and "staffing levels were significantly lower during the weekends, particularly for registered nurses." Researchers "found that more than half of the facilities analyzed met the expected staffing level less than 20% of the time." The results also "show that the numbers were most stark for RNs, where 91% of the organizations met expectations less than 60% of the time." Courtney Krier Bishnoi, vice president of quality and programs at American Health Care Association, said, "While staffing is one of many important metrics in quality care, judging the quality of a nursing home based solely on staffing is misguided. Health outcomes, customer satisfaction and visiting a center in person can help give an accurate picture of the care provided."

- Expansion of CMS’ Readmissions Penalty Program to Hip, Knee Replacements Did Not Lead to Significant Reductions in 30-Day Return Rates, Study Indicates. Modern Healthcare reports, "The expansion of the CMS’ long-standing readmissions penalty program to hip and knee replacement procedures didn’t lead to significant reductions in 30-day return rates to hospitals, a new study finds." The study, published in Health Affairs, "said while readmission rates have declined for total hip and knee replacement surgeries, the most dramatic improvements happened before providers even knew the procedures were included in the Hospital Readmissions Reduction Program." The study found that reductions in 30-day readmission rates for the surgeries nearly doubled from 2010 to 2013 but then returned to pre-2010 reduction rates after the program was expanded to those procedures."

17) Provider Magazine reports:

- Contributor Gives Advice on When to Offer Residents POLST Forms. In its July issue, Provider Magazine carries a piece by Karl Steinberg, MD, CMD, HMDC, chief medical officer for Mariner Health Care and vice president of
AMDA – The Society for Post-Acute and Long-Term Care, who writes about the Physician Orders for Life-Sustaining Treatment (POLST) Paradigm. He writes that "the National POLST Paradigm is working toward reducing variation among POLST forms and processes, helping eliminate reciprocity concerns and building consensus among how the POLST Paradigm should be integrated into technology, such as electronic medical records, health information exchanges, and registries so these orders may be easily accessed by first responders and other health care providers." However, Steinberg cautions against using POLST forms for residents "who are not seriously ill, frail, or nearing the end of life." Instead, these residents should be offered "an internal form (such as Preferred Intensity of Treatment)," Steinberg writes, "Even though it may be inconvenient as far as workflow for a nursing center to have two different pathways to document code status (or end-of-life wishes)."

- **Study Finds HD Flu Vaccines Greatly Reduce Hospitalization Risk for SNF Residents.** *Provider Magazine* reported that a study found "that while influenza is a leading cause of avoidable and costly hospital admissions for long-stay skilled nursing facility (SNF) residents, the risk of an individual being sent to the hospital for this reason can be greatly reduced with the use of high-dose (HD) vaccines versus the standard-dose (SD) variety." The report said, "Even considering that HD vaccines cost $20 more than SD, there was a net financial savings to Medicare of $526 for patients who received the higher dose." The study was published in *JAMDA.*

**18) Interesting Fact:** Only 3.6% of people over 65 years old are in nursing homes. Elderly men are likely to live with a spouse while elderly women are more likely to live alone.