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!

CMS Proposes Rule Intended to Ease Some of the Current RoP Requirements and Upcoming Phase 3 Requirements

Federal CMS filed a proposed rulemaking (click here) with a 60-day comment period intended to ease some of the pressures of the Requirements of Participation (RoPs) and delay implementation of certain Phase 3 requirements due to go into effect on November 28, 2019. The proposed rule includes changes to the current long term care (LTC) requirements of participation and survey process designed to reduce excessively burdensome and overly prescriptive regulations while allowing LTC facilities to focus on providing high-quality care. The following is a summary of the proposed changes:

Proposed Delay of Some Phase 3 Requirements

- CMS has proposed to delay implementation of some Phase 3 requirements for one year after the effective date of finalization of the rule. The requirements included in the proposed delay are:
  - Elements of the Quality Assurance and Performance Improvement (QAPI) program including program design and scope; program feedback, data systems and monitoring; program systematic analysis and systematic action; program activities; governance and leadership; quality assessment and assurance; and required QAPI staff training.
  - Compliance and ethics program requirements as well as required compliance and ethics staff training.

- CMS has not proposed to delay implementation of the Phase 3 Infection Preventionist requirements nor the Phase 3 requirements for culturally competent and trauma-informed care or the requirements for a call system from the residents' bedsides.

- Because this is a proposed rule, the delay itself is also proposed and does not go into effect until CMS issues a final rule. We are seeking clarification on how CMS intends to manage implementation of the proposed delay given their stated intent in the proposed rule “to avoid unnecessary work, confusion and burden associated with implementing provisions, which may then change in a final rule shortly thereafter.” Until we know more, members should continue to prepare for Phase 3 implementation this November.

Resident Rights (§483.10)

- Grievances: CMS proposes to clarify the difference between resident feedback and a grievance, to remove specific duties required of the grievance official, remove some of the specificity required in the written grievance decisions and to reduce the period of time that nursing homes must maintain evidence demonstrating the results of all grievances from 3 years down to 18 months.
• Choice of attending physician: CMS proposes that nursing homes must inform residents of their primary care physician’s information at admission, with change of such information and upon resident request, rather than the current requirement that residents remain notified of each of their specialty physicians and other primary care professionals.

Admission, Transfer, and Discharge Rights (§483.15)
• Notification of Ombudsman and of Resident’s Discharge or Transfer: CMS proposes to only require copies of discharge notices to the Office of the LTC Ombudsman in situations of involuntary discharge initiated by the facility and clarifies that transfers to an acute care facility when return is anticipated are not considered an involuntary discharge. They propose to define involuntary discharger or transfer to mean those that the resident did not object to and that did not originate through the resident’s request or that are inconsistent with the resident’s goals and discharge plan.

Quality of Care (§483.25)
• Bed side rails: CMS Proposed to remove references to the “installation” of bed rails and focus on appropriate "use" of bed rails, which will help when side rails cannot be removed due to bed design. Other bed rail assessment requirements remain in place. This change will provide clarity and address concerns regarding the purchase of beds with bed rails already in place with no practical means of removal.

Nursing Services (§483.35)
• Posting of nurse staffing: CMS proposed to reduce the timeframe that facilities are required to retain posted daily nursing staffing data from 18 months to 15 months, or as required by state law.

Behavioral Health (§483.40)
• Duplicative requirements: CMS proposes to remove behavioral health language that is duplicative of the specialized rehabilitative services requirement and where nursing services requirements and behavioral health services requirements overlap.

Pharmacy Services (§483.45)
• PRN orders for psychotropic drugs: CMS proposes to allow renewal of PRN orders for psychotropic and antipsychotic medications as long as the physician’s or prescriber’s rationale is provided in the medical record and the facility develops a policy on PRN prescribing with required elements and notifications. This change will make it easier for physicians to prescribe PRN medications when appropriate and provide better guidance to nursing on when to use PRN medications. This change will help address physician/prescriber access concerns for rural and other underserved providers regarding timely access to appropriate medications.

Food and Nutrition Services (§483.60)
• Staff roles and training: CMS proposes to remove the requirement that if the facility does not employ a dietitian full time, the director of food and nutrition services must be a certified dietary manager (CDM)—instead, CMS proposes that in these situations the director of food and nutrition services must have two or more years of experience in the position of director of food and nutrition services or have completed a minimum course of study in food safety that includes topics integral to managing dietary operations such as, but not limited to, foodborne illness, sanitation procedures and food purchasing/receiving. The director of food and nutrition services must continue to receive frequently scheduled consultation from a qualified dietitian or other clinically qualified nutrition professional. This change will address workforce concerns and make it easier for facilities to fill the important CDM role with qualified individuals, including those who have worked in the facility for years prior.

Administration (§483.70)
• Facility Assessment: CMS is proposing to revise the minimum timeframe for updating the facility assessment from annually to biennially (every two years). To avoid duplication, CMS is explicitly stating that the data collected for the facility assessment can be used to meet the requirement in the other areas, such as nursing services and QAPI. This is an attempt to reduce burden on facility staff.
Quality Assurance and Performance Improvement (§483.75)

- QAPI program: CMS proposed to revise requirements to allow providers greater flexibility in tailoring their QAPI program to the specific needs of their individual center and simplify many of the more detailed and prescriptive requirements related to program design and scope, data systems and monitoring and systematic analysis and action. The proposed change requires facilities to establish and implement policies and procedures to meet these requirements, including feedback, data collection and monitoring, including adverse events monitoring, but removes many of the prescriptive details micromanaging how a facility must do so. CMS notes that review of QAPI-related documents should only occur at the end of the survey after investigations into all other requirements are complete. These changes will reduce administrative and paperwork burden and eliminate overly prescriptive requirements that prevent facilities from develop a QAPI program tailored to their specific needs and systems.

Infection Control (483.80)

- Infection preventionist: CMS proposes to change the requirement that the infection preventionist be a part-time employee of the facility to instead be a person who has “sufficient time at the facility to achieve the objectives” of the infection prevention and control program. This change will address workforce concerns by making it easier for facilities to meet the IP requirements.

Compliance and Ethics Program (§483.85)

- Program requirements: CMS proposes to remove some of the compliance and ethics program requirements that were not explicitly required as part of the Affordable Care Act. For all nursing centers, CMS proposes to change from a required annual review to a periodic review of the compliance and ethics program, as well as to remove the requirement for a designated contact person for reporting suspected violations. For operating organizations that operate five or more facilities, CMS would remove the requirements for a designated compliance officer, compliance liaison at each facility and that training be conducted annually, though larger organizations are expected to have a program of appropriate complexity. All nursing centers would still be required to assign high level personnel to oversee the compliance and ethics program, as well as have a training program or other practical way to explain the program requirements. These changes will remove administrative burden for all facilities as well as larger operating organizations and eliminate inconsistencies between the LTC facility requirements for compliance and ethics and existing statute.

Physical Environment (§483.90)

- Life Safety Code and FSES Scoring: CMS proposes to allow facilities that were Medicare- or Medicaid-certified before July 5, 2016, that have previously used the FSES to determine equivalent fire protection levels, to continue to use the 2001 FSES mandatory values when determining compliance for containment, extinguishment and people movement requirements.

- Resident rooms: CMS proposes that the new resident room requirements apply only to newly constructed facilities and newly-certified facilities that have never previously been a long term care facility.

- These changes provide significant relief for existing facilities. This proposed change, if enacted, will permit the use of the mandatory values of the 2001 edition of NFPA 101A for existing facilities that previously passed that edition of the FSES. It will obviate the need for extensions of Time Limited Waivers (TLWs) obtained for construction type deficiencies thereby providing much needed relief to LTC facilities.

Survey, Certification, and Enforcement Procedures

- Informal Dispute Resolution (§488.331): CMS proposes that Informal Dispute Resolution (IDR) processes be completed in the same timeframe as required for Independent Informal Dispute Resolution (IIDR) processes (60 days). CMS also proposes that results of survey should not be uploaded into the survey and certification database or Nursing Home Compare until the IDR or IIDR process is complete.

- Civil Money Penalty Imposed by CMS and IIDR (§488.431): CMS proposes written notification with the rationale for the independent reviewer’s recommendation and final decision be provided for IIDR decisions. CMS would
also clarify that the approved independent entity reviewing the IIDR must have a specific understanding of Medicare and Medicaid Program requirements, including when that reviewer is a component of an umbrella state agency separate from the agency.

- Civil Money Penalties Imposed by the State (§488.432); Civil Money Penalties: Waiver of Hearing, Reduction of Penalty Amount (§488.436); and Civil Money Penalties: Due Date for Payment of Penalty (§488.442): CMS proposes to eliminate the requirement to file a written waiver of hearing rights when a CMP is levied. Instead, through a constructive waiver a nursing center would be deemed to have waived its rights if 60 days elapses and CMS has not received a timely request for a hearing. After the 60 days elapse, the state would initiate collection. There is no change in the reduction of the penalty (35 percent). Nursing centers that wish to request a hearing would continue to follow the existing appeals process requirements. The CMP would be due 75 days after the notice of the penalty and a hearing request was not received in specified circumstances.

It is important to submit public comments in support of this proposed change. Public comments on the proposed rule are due by 5 p.m. on September 16, 2019 and may be submitted electronically to [http://www.regulations.gov](http://www.regulations.gov) or by mail, following the instructions provided in the Federal Register (website noted above).

**CMS Final Rule on Arbitration Agreements**

The Centers for Medicare and Medicaid Services (CMS) issued the [final rule](http://www.regulations.gov) that reverses the Obama-era ban on the use of arbitration agreements. This rule makes it very clear that LTC facilities have the ability to use pre-dispute agreements, while at the same time adding provisions intended to make sure that residents and/or their representatives understand the agreements into which they are entering. Additionally, the rule prevents a facility from making the signing of an agreement a precondition of admission.

In October of 2016, CMS published a rule prohibiting LTC facilities from entering into pre-dispute arbitration agreements. AHCA and others filed a complaint in the U.S. District Court seeking a permanent injunction enjoining CMS enforcement of the prohibition on pre-dispute. The court decided in December 2016 that CMS could not enforce the pre-dispute, binding arbitration provisions. In June of 2017, CMS proposed rules to remove the prohibition prohibiting pre-dispute, binding arbitration agreements and to strengthen requirements regarding transparency of arbitration agreements in LTC facilities.

CMS has adopted a final rulemaking (effective September 16, 2019) that allows for the use of pre-dispute, binding arbitration agreements. The rule also adds several requirements with regard to the use of binding arbitration agreements in LTC facilities. In summary, the final rule states:

- The facility must not require any resident or their representative to sign a binding arbitration agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. The facility must inform the resident/resident representative that they do not have to sign the agreement as a condition of admission or to continue to receive care at the facility. The agreement is strictly voluntary on the part of the resident.

- The facility must ensure that:
  - The agreement is explained to the resident/resident representative in a form and manner that they understand, including in a language that they understand;
  - That the resident/resident representative acknowledge that they understand the agreement;
  - The agreement provides for the selection of a neutral arbitrator agreed upon by both parties;
  - The agreement provides for a selection of a venue that is convenient to both parties;
  - The agreement must explicitly grant the resident/resident representative the right to rescind the agreement within 30 calendar days of signing it;
  - The agreement must explicitly state that neither the resident or their representative is required to sign the agreement as a condition to admission or to continue to receive care;
  - The agreement does not contain any language that prohibits the resident/resident representative or anyone else from communicating with federal, state or local officials; and
When the facility and resident/resident representative resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator’s final decision must be retained by the facility for 5 years after the resolution of that dispute and be available for inspection by request of CMS or its designee.

Focus F-Tag – F600 – Free From Abuse and Neglect (Part 2 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.

In the July 17, 2019 issue of Regulatory Beat, in our Part 1 of 4 review of F600 Free from Abuse and Neglect, we provided an overview of the types of abuse. We are continuing our review of F600 (Part 2 of 4) by looking at some different types of abuse situations outlined in the regulation.

Staff to Resident Abuse (Any Type)
The Interpretive Guidance (IG) very clearly spells out some important information related to these situations, so even if you plan to skim the rest of the post, read these bullets:

- When a facility accepts a resident, it assumes responsibility for ensuring the safety and well-being of the resident. Thus, it is the facility’s responsibility to ensure that staff are appropriately trained and understand how to respond to a resident’s exhibited behavior. The Facility Assessment provides a guide to the variety of resident conditions that a facility states it is capable of caring for. Remember, there should be related staff competencies to validate that the staff is competent in managing behaviors and ensuring that the resident population remains free of abuse.

- Staff are expected to control their own behavior and the Centers for Medicare & Medicaid Services (CMS) does not consider striking a resident who is being combative to be acceptable under any circumstances. The Agency also does not accept that a staff member’s action was unintentional or reflexive and not intended to cause harm.

- Any retaliation by a staff member towards a resident is considered abuse and will be cited as such.

- A nursing facility cannot disown the acts of its staff members since the facility relies on its staff to provide care in a safe environment.

Visitor to Resident Abuse (Any Type)
Facilities also need to ensure they have procedures in place to ensure residents are safe when they are with visitors, whether they are family members or otherwise. Surveyors are instructed to look at a resident’s social history to the extent possible, to see if there are issues or concerns that have been identified related to the resident’s relationship with a spouse, family members or visitors who are not part of the resident’s immediate family to see if the facility identified and implemented interventions to keep the resident free from abuse. Facilities need to have P&Ps in place related to visitor access, including safety restrictions if issues have been identified related to a visitor.

Resident to Resident Abuse (Any Type)
The regulatory guidance at F600 states that resident-resident incidents should be investigated as potential abuse, even if one or both residents have a cognitive impairment/mental disorder. The definition of abuse, as we mentioned in our last post, includes the concept of “willful,” which means that the person acted deliberately. The IG notes that just the fact that a resident may have a cognitive impairment or mental disorder does not mean that he/she is unable to take deliberate actions. If the surveyor determines that an action was not willful, then the surveyor needs to investigate whether the facility is in compliance with the requirement for adequate supervision at F689. The facility is responsible for ensuring that it has effective interventions in place to prevent resident-resident incidents and if needed, provide immediate interventions to ensure the residents are safe from abuse. This includes monitoring for any aggressive behaviors by one resident that may provoke another. These interventions need to be included in the care plan and updated based on effectiveness. Those residents who are at risk to harm others as well as those who are at risk to be
victimized need to be on the radar screen not only of the caregivers but administration as well. There is an administrative responsibility to have sound systems in place to prevent abuse as well as a mechanism to monitor compliance with established protocols.

Stay tuned for Part 3 of 4 in our review of F600, Free From Abuse and Neglect in the next issue of *Regulatory Beat*.

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**Trending Statistics**

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

**Characteristics of 30-Day All-Cause Hospital Readmissions, 2010-2016**

Hospital readmissions serve as a key measure for the quality of patient care in U.S. hospitals. National initiatives such as the Centers for Medicare & Medicaid Services Hospital Readmissions Reduction Program (HRRP) and the Partnership for Patients (PfP) are focused on decreasing preventable readmissions. HRRP incentivizes hospitals to reduce readmissions by linking payment with readmission measures. PfP has built a collaborative network of health care stakeholders that is focused on improving practices related to transitions of care and lowering readmissions.

In a previous Healthcare Cost and Utilization Project (HCUP) Statistical Brief, statistics on 30-day all-cause readmissions among patients aged 1 year and older by expected payer and patient age group were presented from 2009 through 2013. To understand how readmission rates have changed since the implementation of such national initiatives as HRRP and PfP, it is important to continue to track changes in readmissions over time.

This HCUP Statistical Brief presents statistics on 30-day all-cause readmissions among patients aged 1 year and older using the 2010-2016 Nationwide Readmissions Database (NRD). Trends in readmissions by expected payer are provided from 2010 through 2016. Changes in readmission rates between 2010 and 2016 are presented by expected payer. The rate of readmissions and a comparison of costs for the index admission (the initial inpatient stay) and the readmission in 2016 is provided by the type of principal diagnosis. Both the expected payer and the principal diagnosis are determined based on the index admission.

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

1) There was one new Federal [CMS Quality, Safety and Oversight Letters](https://www.cms.gov/Regulations-and-Guidance/Legislation/Survey-Certification-Letters) (formerly known as Survey and Certification (S&C) Letters) released since the last issue of *Regulatory Beat*:

   - **QSO 19-09 – All – Revisions to Appendix Q, Guidance on Immediate Jeopardy.** Appendix Q has been revised to reinsert language referring criminal acts to local law enforcement.

2) [Federal HHS/CMS](https://www.hhs.gov/about/news/index.html) released the following notices/announcements:

   - **SNF: FY 2020 Payment and Policy Changes.** On July 30, CMS issued a final rule for FY 2020 Medicare payment rates and quality programs for Skilled Nursing Facilities (SNFs). CMS projects aggregate payments to SNFs will increase by $851 million, or 2.4 percent, for FY 2020 compared to FY 2019. This estimated increase is attributable to a 2.8 percent market basket increase factor with a 0.4 percentage point reduction for the multifactor productivity adjustment. The final rule also includes:
     - Payment policy
     - Sub-regulatory process for ICD-10 code revisions
     - Align group therapy definitions with other post-acute care settings
- SNF Value-Based Purchasing (VBP) Program policy changes
- SNF Quality Reporting Program (QRP)

For More Information:
- Final Rule
- SNF PPS website
- SNF QRP Measures and Technical Information webpage
- SNF VBP Program website

See the full text of this excerpted CMS Fact Sheet (Issued July 30).

- Nursing Homes: Updating Requirements for Arbitration Agreements and New Regulations. On July 16, CMS announced two Medicare and Medicaid rules – one proposed and one final – that emphasize the agency’s commitment to ensuring safety and quality in nursing homes. In addition to protecting patients and reducing burdens, the rule helps nursing homes focus their resources on their residents by saving them $616 million in administrative costs annually that can be reinvested in patient care.

The proposed rule allows long-term care facility providers to devote more of their time and resources to their residents – instead of unnecessary paperwork – by eliminating obsolete or excessively burdensome regulations. The proposed rule would eliminate prescriptive requirements and allow commonsense flexibilities.

“The Trump administration is helping nursing homes provide high-quality care by allowing them to focus their time and resources on residents – not unnecessary process and outdated regulations,” said CMS Administrator Seema Verma. “We know our regulations work best when they are smart, targeted, and patient-focused, so we have taken a close look at our rules with patients and burden in mind. We’ve identified opportunities for reducing provider burden while maintaining high quality resident care.”

In addition, CMS proposes revisions to certain requirements included in the third phase of our comprehensive 2016 regulatory overhaul, which are scheduled to be implemented in November 2019. To avoid confusion and promote transparency, CMS proposes to allow one year following the effective date of the final rule for implementation.

In a related effort to protect nursing home residents’ right to make informed choices, CMS issued a final rule updating the requirements nursing homes must meet to use binding arbitration agreements. The CMS proposal supports patients and their caregivers by removing the ban on binding arbitration agreements while requiring nursing homes to ensure residents have the ability to choose the method of dispute resolution they want. CMS is allowing binding arbitration agreements, but will prohibit nursing homes from requiring residents to sign binding arbitration agreements as a condition for receiving care, and will require nursing homes to inform residents or their representatives that they are not required to sign a binding arbitration agreement. Finally, CMS is prohibiting nursing home arbitration agreements from including language preventing residents or anyone else from communication with federal, state, or local officials.

For More Information:
- Arbitration Agreements: final rule and fact sheet
- Regulatory Provisions: proposed rule and fact sheet

See the full text of this excerpted CMS Press Release (issued July 16).

- PDPM Calculation Worksheets for SNFs. The purpose of this Patient-Driven Payment Model (PDPM) calculation worksheet is to illustrate how a resident is classified for payment purposes and how per diem payment is calculated under PDPM. This document is a draft worksheet that is intended to aid stakeholders in their review of the FY 2019 SNF PPS Notice of Proposed Rulemaking (CMS-1696-P) (NPRM) and in the development of
comments on the NPRM. We have carefully reviewed the worksheet to ensure that it represents the resident classification logic presented in the NPRM and accompanying Technical Report.

- **IRF/LTCH/SNF QRP August 15, 2019 Submission Deadline Reminder.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH) and Skilled Nursing Facility (SNF) Quality Reporting Programs is approaching. IRF-PAI and LTCH CARE Data Set assessment data and data submitted to CMS via the Center for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) for January 1 – March 31 (Q1) of calendar year (CY) 2019 are due with this submission deadline.

MDS data for January 1 – March 31 (Q1) of calendar year (CY) 2019 are due with this submission deadline.

**All data must be submitted no later than 11:59 p.m. Pacific Standard Time on August 15, 2019.**

The list of measures required for this deadline is found on the CMS QRP websites:

- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines
- SNF Quality Reporting Program Data Submission Deadlines

As a reminder, it is recommended that providers run applicable CASPER/iQIES/NHSN analysis reports prior to each quarterly reporting deadline, in order to ensure that all required data has been submitted.

CORMAC sends informational messages to IRFs, LTCHs and SNFs that are not meeting APU thresholds on a quarterly basis ahead of each submission deadlines. If you need to add or change the email addresses to which these messages are sent, please email QRPHelp@cormac-corp.com and be sure to include your facility name and CMS Certification Number (CCN) along with any requested email updates.

- The next **CMS Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum** is scheduled for Thursday, August 8, 2019, 1pm – 2pm CST. *Please dial-in at least 15 minutes before call start time.* The agenda items include:
  - Opening Remarks
  - Announcements & Updates
    - Payment Policies
    - Quality Reporting Program
    - Value-Based Purchasing Program
  - PBJ Update
    - Open Q&A

Policy Questions should be sent to: NHStaffing@cms.hhs.gov

Technical Issues/Questions should be sent to: NursingHomePBJTechIssues@cms.hhs.gov


- **Hospice: FY 2020 Hospice Payment Rate Final Rule.** On July 31, CMS issued a final rule that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices. For FY 2020, hospice payment rates are updated by 2.6 percent ($520 million increase in their payments). The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The aggregate cap limits the overall payments per patient made to a hospice annually. This Rule Finalizes:
  - Rebasing to more accurately align Medicare payments with the costs of providing care
**Modifications to the election statement beginning in FY 2021,** increasing coverage transparency for beneficiaries under a hospice election

**Hospice Quality Reporting Program updates,** including developing a hospice assessment tool for real-time patient assessments

For More Information:
- Final Rule
- Hospice Center webpage
- Hospice Quality Reporting webpage

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

- **Protect Your Patients’ Identities: Use the MBI Now.** Protect your patients’ identities by using the Medicare Beneficiary Identifier (MBI) now. 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.

Will your claims be paid in 2020? Starting January 1, you must use the MBI. We will reject claims you submit with the Health Insurance Claim Number (HICN), with a few exceptions, and reject all eligibility transactions.

- **Is Your Vendor/Clearinghouse Submitting Your Claims with the MBI?** If you send the Medicare Beneficiary Identifier (MBI) to your vendor/clearinghouse on your Medicare claim for payment, but you see both the Health Insurance Claim Number (HICN) and the MBI on your remittance advice, your vendor/clearinghouse is not using the MBI to submit your claims. Contact your vendor/clearinghouse today and ask about their process to submit Medicare claims.

Starting January 1, 2020, Medicare will reject claims with the HICN, with a few exceptions. Make sure your vendor/clearinghouse is submitting your claims with the MBI, or they will be rejected. For more information, see the MLN Matters Article.

- **CMS Advances MyHealthEData with New Pilot to Support Clinicians.** On July 30, CMS announced changes that further protect and strengthen Medicare by unleashing the power of data and placing it firmly where it belongs, in the hands of patients and the clinicians who treat them. CMS is accelerating the transformation of the nation’s health care system to one that is based on value by increasing patient and provider access to the data needed through a new pilot program for clinicians called Data at the Point of Care (DPC). DPC is based on an industry-standard application programming interface and is part of the MyHealthEData Administration-wide initiative.

The DPC pilot program will leverage Medicare’s Blue Button data to provide clinicians with access to claims data. The claims data will fill in information gaps for clinicians, giving them a more structured and complete patient history with information like previous diagnoses, past procedures, and medication lists. Clinicians will be able to access the DPC pilot data directly within their workflow, without needing to log into another application. This will reduce burden in the exam room and give clinicians more time to deliver high quality care for their patients. DPC is one of many critical steps CMS is taking to build on our actions to make a truly interoperable health care system. If you are interested in participating in the DPC pilot program, sign up by visiting the Data at the Point of Care website. Beneficiaries who wish to opt out of data sharing can do so by calling 1-800-Medicare.

See the full text of this excerpted CMS Press Release (Issued July 30).
• **Reducing Administrative Burden: Comment by August 12.** In June, CMS issued a [Request for Information](https://www.cms.gov) (RFI) seeking your ideas on how to continue the progress of the Patients over Paperwork initiative. Since launching in fall 2017, Patients over Paperwork has streamlined regulations to significantly cut the “red tape” that weighs down our health care system and takes clinicians away from their primary mission—caring for patients. As of January, CMS estimates that through regulatory reform alone, the health care system will save an estimated 40 million hours and $5.7 billion through 2021. These estimated savings come from both final and proposed rules. The RFI provides an opportunity for you to recommend further changes to rules, policies, and procedures that would shift more of your time and our health care system’s resources from needless paperwork to high-quality care that improves patient health. We seek ways to improve:
  - Reporting and documentation requirements
  - Coding and documentation requirements for Medicare or Medicaid payment
  - Prior authorization procedures
  - Policies and requirements for rural providers, clinicians, and beneficiaries
  - Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
  - Beneficiary enrollment and eligibility determination
  - CMS processes for issuing regulations and policies

For more information, including how to submit comments, read the [RFI](https://www.cms.gov). Submit comments by August 12.

• **Medicare Coverage for Treatment Services Furnished by Opioid Treatment Programs.** CMS proposed policies to implement Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ([SUPPORT Act](https://www.cms.gov)), which established a new Medicare Part B benefit for opioid use disorder treatment services, including medications for medication-assisted treatment, furnished by Opioid Treatment Programs (OTPs). Comments on the proposed OTP policies are due via the official comment submission process by September 27. For More Information:
  - [Proposed Rule](https://www.cms.gov) see section II.G
  - [OTP](https://www.cms.gov) webpage

• **Open Payments Program Expansion.** The [SUPPORT Act](https://www.cms.gov) impacts Open Payments by expanding the definition of a covered recipient to include five additional provider types: Physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. For more information, visit the [Open Payments](https://www.cms.gov) website.

• **Improve Accessibility of Care for People with Disabilities: New Resources.** In recognition of the anniversary of the Americans with Disabilities Act, CMS offers new resources for people with disabilities and their care providers to improve access to high quality health care and support independent living. Adults with disabilities are almost twice as likely as other adults to report unmet health care needs due to problems accessing a doctor’s office or clinic.
  - [Getting the Care You Need: A Guide for Individuals with Disabilities](https://www.cms.gov)
  - [Modernizing Health Care to Improve Physical Accessibility: Resources Inventory](https://www.cms.gov)
  - [How Does Disability Affect Access to Health Care for Dual Eligible Beneficiaries?](https://www.cms.gov)

Learn about the experiences of people that use wheelchairs and how you can be a better advocate; watch the Navigating Health Care with a Disability videos:
  - [Our Stories, a Focus on People with Disabilities](https://www.cms.gov)
  - [Our Stories, a Focus on the Provider](https://www.cms.gov)

For more information visit the [CMS Office of Minority Health](https://www.cms.gov) website.

• **Part A Providers: Formal Telephone Discussion Demonstration.** CMS expanded the Qualified Independent Contractor Formal Telephone Discussion Demonstration to include Part A appeals on May 1. If you submit Part A claims to the following Medicare Administrative Contractors you are eligible to participate:
- All Part A appeals: JH, JJ, JK, JL, JM, and JN
- Home health and hospice (HHH) appeals in J6 and J15

Participation in the Demonstration remains voluntary. All Part A claim types are eligible, except:
- Reconsiderations for service termination
- Hospital discharge reviews
- Claims or providers that are already involved in another CMS initiative (e.g., the Settlement Conference Facilitation)

Benefits of participating in a telephone discussion:
- Direct interaction with the reconsideration decision maker
- Ability to discuss the facts of the case and provide verbal testimony
- Opportunity to receive education regarding applicable CMS policies
- Improvement of future claim submissions

Current Demonstration activities conducted within DME MAC Jurisdictions will continue. Visit the Original Medicare Appeals webpage for more information.

- **July – September Quarterly Provider Update.** The July – September Quarterly Provider Update is available, including issuances and regulations. Find out about:
  - Regulations and major policies currently under development during this quarter
  - Regulations and major policies completed or cancelled
  - New or revised manual instructions

- **Disaster Preparedness Resources.** The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center and Information Exchange (TRACIE) released several new resources:
  - Health Care Coalition Surge Estimator Tool and Data Collection Form
  - Topic Collection updates: Mental Health/Behavioral Health, Responder Safety and Health and Viral Hemorrhagic Fever/Ebola
  - Federal Recovery Programs for Health Care Organizations Fact Sheet
  - Medical Surge and the Role of Accountable Care Organizations

For More Information:
- ASPR TRACIE Fact Sheet
- ASPR TRACIE website

- **Vaccines Are Not Just for Kids.** National Immunization Awareness Month (NIAM) is an annual observance to highlight the importance of vaccinations. Protect your Medicare patients:
  - Assess their vaccination status
  - Educate and counsel on recommended vaccines
  - Vaccinate at the same visit or refer the patient to a vaccinating provider
  - Document receipt of the vaccine

For More Information:
- Medicare Preventive Services Educational Tool
- Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Educational Tool
- Mass Immunizers and Roster Billing: Simplified Billing for Influenza Virus and Pneumococcal Vaccinations Booklet
- Medicare Part D Vaccines and Vaccine Administration Fact Sheet
- NIAM website, Centers for Disease Control and Prevention (CDC)
- Adult Vaccination Information webpage, CDC
Visit the Preventive Services website to learn more about Medicare-covered services.

- **PEPPERS for HHAs, PHPs.** Fourth quarter CY 2018 Program for Evaluating Payment Patterns Electronic Reports (PEPPERS) are available for Home Health Agencies (HHAs) and Partial Hospitalization Programs (PHPs). These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Use your data to support internal auditing and monitoring activities.
  - HHAs and free-standing PHPs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide
  - PHP units of hospitals or inpatient psychiatric facilities or inpatient rehabilitation facilities: PEPPER was distributed via the QualityNet secure portal

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

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

Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:
- Use Medicare 270/271 HIPAA Eligibility Transaction System (HETS) data; see MLN Matters® Article SE1128
- Check your Medicare Remittance Advices (RAs); see MLN Matters Article MM10433
- Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing and issuance of Medicaid RAs for payment of Medicare cost-sharing. Check with the states where your beneficiaries reside to determine the enrollment requirements.

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

For More Information:
- QMB Program webpage
- Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article
- QMB Program Billing Requirements FAQs
- Materials from 2018 Medicare Learning Network call
- Dual Eligible Beneficiaries under the Medicare and Medicaid Programs Booklet

- **Mass Casualty Triage White Paper and June Express.** The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) released Mass Casualty Trauma Triage Paradigms and Pitfalls, which highlights the differences between “conventional” mass casualty incidents and mass violence incidents. This white paper includes key differences between these events when:
  - The scene is dynamic
  - The number of patients far exceeds usual resources
  - Usual triage and treatment paradigms may fail
The June issue of The Express includes:
- Medical Surge and the Role of Home Health and Hospice Agencies
- Pediatric Surge Annex Template
- Pediatric Topic Collection
- Upcoming events

For More Information:
- ASPR TRACIE Fact Sheet
- ASPR TRACIE website

• **Looking for Educational Materials?** Visit the Medicare Learning Network and see how we can support your educational needs. Learn about publications; calls and webcasts; continuing education credits; web-based training; newsletters; and other resources.

• **ESRD and DMEPOS CY 2020 Proposed Rule.** On July 29, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also:
  - Proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI
  - Proposes changes to the ESRD Quality Incentive Program
  - Includes requests for information on data collection resulting from the ESRD PPS technical expert panel, on possible updates and improvements to the ESRD PPS wage index, and on new rules for the competitive bidding of diabetic testing strips.

  In addition, this rule proposes a methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts. This rule would also:
  - Make amendments to revise existing policies related to the competitive bidding program for DMEPOS
  - Streamline the requirements for ordering DMEPOS items, and create one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements

The proposed CY 2020 ESRD PPS base rate is $240.27, an increase of $5.00 to the current base rate of $235.27. This proposed amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.7 percent) and application of the wage index budget-neutrality adjustment factor (1.004180).

The proposed rule also includes:
- Annual update to the wage index
- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of Payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA
- New and innovative renal dialysis equipment and supplies
- Discontinuing the application of the erythropoiesis-stimulating agent monitoring policy
- Impact analysis

For More Information:
- Proposed Rule: Public comments due by September 27
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 29). [PDF]
• **SNF Quality Reporting Program Spotlights and Announcements** – *What’s New With Skilled Nursing Facilities.*

• **HHS awards $20 Million to 27 Organizations to Increase the Rural Workforce Through the Creation of New Rural Residency Programs.** The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA) awarded approximately $20 million in Rural Residency Planning and Development Program (RRPD) grants. Recipients across 21 states will receive up to $750,000 over a three-year period to develop new rural residency programs while achieving accreditation through the Accreditation Council for Graduate Medical Education.

“Promoting the health of rural America is one of the Trump Administration’s healthcare priorities,” said HHS Secretary Alex Azar. “Supporting the training of healthcare providers in rural areas through grants like these is a key way to help expand rural access to care, and is part of an overall effort to support rural healthcare in sustainable, innovative, and flexible ways.”

• **Hospice Web-Based Courses Available** - Courses Provide an Overview of the Hospice Quality Reporting Program. Links to the following new courses can be found on the:
  - Hospice Quality Reporting Training—Training and Education Library webpage
  - Introduction to the Hospice Quality Reporting Program (HQRP)
  - HQRP Data Submission Requirements and Reports

• **Important Reminder on Reconsideration Requests.** Facilities that will be submitting reconsideration requests to CMS for the FY 2020 Annual Payment Update (APU) for Hospice, SNF and LTCH or Annual Increase Factor (AIF) for IRF Quality Reporting Programs (QRP) are reminded that **any documentation submitted for review that includes protected health information (PHI) will not be accepted, nor reviewed for reconsideration.** Please redact any PHI prior to sending by completely removing all PHI from supporting documentation. If any of the documents included in a reconsideration request contain PHI, the entire request will be rejected and your reconsideration will not be reviewed. Facilities are encouraged to carefully review all supporting materials to ensure all PHI has been removed. For more information visit:
  - Hospice Reconsideration Requests webpage
  - IRF Quality Reporting Reconsideration and Exception & Extension webpage
  - LTCH Quality Reporting Reconsideration and Exception & Extension webpage
  - SNF Quality Reporting Reconsideration and Exception & Extension webpage

• **Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines.** A new MLN Matters Article SE19011 on **Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines** is available. Learn about the risk, key issues, and practices to reduce co-prescribing.

• **Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program.** A new MLN Matters Article SE19001 on **Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program** is available. Learn about this new Medicare-covered service, benefits for your patients, and the referral process.

• **Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019.** A new MLN Matters Article MM11357 on **Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019** is available. Learn about updates related to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual.

• **Provider Compliance Tips for Respiratory Assistive Devices — Revised.** A revised **Provider Compliance Tips for Respiratory Assistive Devices** Fact Sheet is available. Learn:
  - Reasons for claim denials
  - How to prevent denials
  - Requirements for orders
• Provider Compliance Tips for Enteral Nutrition — Revised. A revised Provider Compliance Tips for Enteral Nutrition Fact Sheet is available. Learn:
  o Reasons for denials
  o How to prevent denials
  o Coverage and billing requirements for therapy

• Post-Acute Care Call: Audio Recording and Transcript. An audio recording and transcript are available for the June 5 Medicare Learning Network call on the post-acute care quality reporting programs. Learn about reporting requirements and resources for inpatient rehabilitation facilities, long-term care hospitals and skilled nursing facilities.

• Importance of Proper Documentation: Provider Minute Video. Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payment and medical review in the Provider Minute: The Importance of Proper Documentation video. Learn about:
  o Top five documentation errors
  o How to submit documentation for a Comprehensive Error Rate Testing review
  o How your Medicare Administrative Contractor can help

• Home Health Patient-Driven Groupings Model: Operational Issues Call — Wednesday, August 21, 12:30 – 2 pm CST. Register for Medicare Learning Network events. During this call, learn information to help your agency prepare to implement billing changes for the Patient-Driven Groupings Model (PDGM) on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:
  o Billing and claims processing overview
  o How Outcome and Assessment Information Set (OASIS) data will be used in the claims system
  o Reporting new occurrence codes
  o Period timing and admission source scenarios
  o Transition scenarios

A question and answer session will follow the presentation. For more information, visit the Home Health Prospective Payment System website, and review MLN Matters Articles MM11081 and MM11272.

• Medicare Plans to Modernize Payment Grouping and Code Editor Software. An MLN Matters Article SE19013 on Medicare Plans to Modernize Payment Grouping and Code Editor Software is available. Learn about the proposed schedule to convert this software to Java.

• Medicare DMEPOS Improper Inpatient Payments. A new Medicare DMEPOS Improper Inpatient Payments Medicare Learning Network Fact Sheet is available. Learn about:
  o Federal regulations and guidance
  o Deliveries before discharge

• Medicare Part D Vaccines — Revised. A revised Medicare Part D Vaccines Medicare Learning Network Fact Sheet is available. Learn about:
  o Administration coverage
  o Reimbursement in a prescriber’s office
  o Patient access

• Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session — Monday, August 12, 12:00 – 1:30 pm CST. Register for Medicare Learning Network events. Proposed changes to the CY 2020 Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spend taking care of patients, removing unnecessary measures and making it easier for clinicians to be on the path towards value-based care. During this listening session, CMS experts briefly cover three provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission:
• Increasing value of Evaluation and Management (E/M) payments
• Continuing to improve the Quality Payment Program by streamlining the program’s requirements in order to reduce clinician burden
• Creating the new Opioid Treatment Program benefit in response to the opioid epidemic

We encourage you to review the following materials prior to the call:
  o Proposed rule
  o Press release
  o Physician Fee Schedule proposed rule fact sheet
  o Quality Payment Program Proposed Rule Fact Sheet

Note: feedback received during this listening session is not a substitute for your formal comments on the rule. See the proposed rule for information on submitting these comments by September 27.

• **ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call** — Tuesday, August 20, 1 – 2 pm CST. Register for Medicare Learning Network events. During this call, learn about proposals for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) in the CY 2020 ESRD Prospective Payment System (PPS) proposed rule. Topics include:
  o ESRD QIP legislative framework
  o Overview of the proposed rule
  o Methods for reviewing and commenting on the proposed rule

• **Home Health Patient-Driven Groupings Model: Operational Issues Call** — Wednesday, August 21 from 12:30 to 2 pm CST. Register for Medicare Learning Network events. During this call, learn information to help your agency prepare to implement billing changes for the Patient-Driven Groupings Model (PDGM) on January 1, 2020. CMS will use the PDGM to reimburse home health agencies for providing home health services under Medicare fee-for-service. Topics include:
  o Billing and claims processing overview
  o How Outcome and Assessment Information Set (OASIS) data will be used in the claims system
  o Reporting new occurrence codes
  o Period timing and admission source scenarios
  o Transition scenarios

• **Understanding Your SNF VBP Program Performance Score Report Call** — Tuesday, August 27, 12:30 – 2 pm CST. Register for Medicare Learning Network events. During this call, learn about your Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program Performance Score Report. CMS experts present a high-level summary of the program and highlight the payment year 1 results (FY 2019 program year). A question and answer session will follow the presentation; however, attendees may email questions in advance to SNFVBP@rti.org with "SNF VBP Aug 27 NPC" in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, visit the SNF VBP website.

• **New Waived Tests.** A new MLN Matters Article MM11354 on New Waived Tests is available. Learn about new Clinical Laboratory Improvement Amendments of 1988 waived tests approved by the Food and Drug Administration.

• **Skilled Nursing Facility 3-Day Rule Billing.** A new Skilled Nursing Facility 3-Day Rule Billing Medicare Learning Network Fact Sheet is available. Learn about:
  o Communication of coverage
  o Claims processing edits
  o Financial responsibility
• **Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies — Revised.** A revised Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies Fact Sheet is available. Learn:
  o Reasons for claim denials
  o How to prevent denials

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

• **Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings.** Measles is most commonly acquired from persons in the household or community, but spread of measles can also occur in healthcare settings.

• **Influenza Planning and Response.** Influenza poses one of the world’s greatest infectious disease challenges. CDC programs protect the United States from seasonal influenza and pandemic influenza, when a new flu virus emerges that can infect people and spread globally.

4) The federal Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE) released their [July 2019 edition](#) of The Express.

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

• HFS posted a new Provider Notice regarding **Correction - Hospital Outpatient Claims Referring Provider Requirements for October 1, 2019.** You may view the notice [here](#).

• HFS posted a new Provider Notice regarding **Referring Provider NPI Usage on Outpatient Claims.** You may view the new notice [here](#).

• HFS posted a new Provider Notice regarding **Attending Provider NPI Requirements for October 1, 2019.** You may view the notice [here](#).

• HFS posted two new **Transportation Physician Certification Statement Quarterly Reports.** You may view the reports [here](#).

• HFS posted Provider Notice: **Update: New Section Published under the Comprehensive Billing Guide for Medicaid Managed Care.** To view, [click here](#).

• HFS posted the meeting agenda for the July 31, 2019 **Dental Policy Review Committee.** You may view the agenda [here](#).

• HFS posted the **2019 DME Fee Schedule.** To view, [click here](#).

• HFS posted “Provider Notice: **REMINDER – Statewide HealthChoice Illinois Managed Long Term Services and Supports (MLTSS) Implementation.**” To view, [click here](#).

• HFS posted “Provider Notice: **Fiscal Year 2020 Long Term Care Provider Assessment.**” To view, [click here](#).

• The Illinois Department of Healthcare and Family Services has posted “**Provider Notice: Fiscal Year 2020 Hospital Inpatient and Outpatient Assessment Programs.**” To view, [click here](#).

• HFS posted **Provider Notice: Facility Compliance in Completing the HFS 2270, Physician Certification Statement for Non-Emergency Transportation.** To view, [click here](#).
• HFS posted the Excel Version of the Downloadable Cost Report, as well as the Downloadable Cost Report Instructions. You may view both documents here.

• HFS posted a new Provider Notice regarding UPDATE: New Section Published under the Comprehensive Billing Guide for Medicaid Managed Care Services. You may view the new notice here.

• HFS posted a new Provider Notice regarding Adult Coverage of Current Dental Terminology (CDT) D4910 - Periodontal Maintenance Procedure. You may view the new notice here.

• HFS calculated Nursing Facility Rates for the July 1, 2019 Quarter and will be posting to the HFS website soon. In addition, the facility specific rate sheets and case mix information will be made available to download from MEDI. The July 1, 2019 rates are still pending federal approval and will not be loaded into the Department’s payment system until approval is received. July service claims billed in August will initially be paid at the facility rate in effect on June 30, 2019. Once federal approval is received, rates will be entered into the payment system and claims will be repriced automatically by the Department. Hospice providers will need to void any claims paid at the June 30, 2019 rate and re bill to get reimbursed at the newly approved rate. It is anticipated that the effective date of the rate increase will be July 1, 2019.

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

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

• The IDPH 2019 LTC Annual Report

• Letter from Debra Bryars (deputy Director of the IDPH Office of Health Care Regulation) regarding the Colbert v. Quinn Consent Decree and its Impact on Cook County LTC Providers

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:

• AHCA Summary of 2020 Skilled Nursing Prospective Payment System Final Rule. CMS issued a final rule outlining the proposed Fiscal Year (FY) 2020 Medicare prospective payment system rate update and quality reporting requirements for skilled nursing facilities (SNFs). The FY20 final rule establishes a market basket increase of 2.4 percent, a figure statutorily mandated by Congress, and will start October 1, 2019. Mike Cheek and the AHCA team have put together a summary of the final rule and important changes. To view the final unadjusted Case Mix Group Rates click here.

• Is Your ICD-10 Coding Ready? Accurate ICD-10 coding and documentation are important to the success of your PDPM implementation. Have you taken steps to evaluate your team’s coding proficiency? AHCA and AHIMA
have joined forces to make sure you have access to ICD-10 training that will get your team implementation ready. Register now and be ready for PDPM on October 1.

- **Coder** version
- **Non-coder** version

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

- **AHCA Webinar Recording on CMS Requirements of Participation Proposed Rule Now Available.** AHCA hosted a webinar summarizing the new CMS Requirements of Participation proposed rule. For those who were unable to participate, the recording of the webinar is now available for viewing [here](https://educate.ahcancal.org/RoP). Visit [educate.ahcancal.org/RoP](https://educate.ahcancal.org/RoP) to find resources to help you navigate the new requirements. AHCA will continue to add and update these resources as more information becomes available. As a reminder, you can view AHCA's detailed summary of the proposed rule [here](https://educate.ahcancal.org/RoP). If you have additional questions, please email regulatory@ahca.org.

- **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

- **The Latest Your Top-Line Publication for Skilled Nursing Centers in Your State are Now Available.** Log into [LTC Trend Tracker](https://tc.ahcancal.org) to view.

- **AHCA/NCAL Social Media Update – July 22 – 29**

- **AHCA PDPM Academy Weekly Update – August 1**

- **Now Available – 2020 AHCA/NCAL National Quality Award Applications.** The National Quality Award Program is pleased to announce that the 2020 application packets are [now available online](https://tc.ahcancal.org). In addition, the 2020 program calendar and submission checklist have been posted to each award level page. We hope you'll consider applying for this prestigious award. Participating in the program has many benefits:
  - It provides a proven framework that organizations can use to make improvements in any clinical, quality or other operational issue (i.e. staff engagement, customer satisfaction, hospital readmissions).
  - It prepares organizations to meet regulatory requirements and navigate a changing market.
  - It serves as a team building activity to engage staff across all levels of the organization.
  - Organizations gain national recognition and external validation for their care and services.
  - It serves as a marketing resource for consumers, referral sources and other key stakeholders.
  - Participants receive customized feedback with their top strengths and improvement areas.

  Please visit the Bronze, Silver or Gold application pages to download your respective award level application materials to learn how your center should begin preparing.

  If you're interested in other ways to get involved, consider becoming an [Examiner for the 2020 program cycle](https://tc.ahcancal.org). Examiners play a significant role in reviewing Quality Award applications and impacting quality improvement in organizations across the country.

  Get started today by visiting [ahcancal.org/qualityaward](https://ahcancal.org/qualityaward)! For questions, email qualityaward@ahca.org.
• AHCA Webinar on CMS’ Final Arbitration Rule. AHCA will host a webinar on CMS’ final arbitration rule on Thursday, August 29 at 1 pm CST. As a reminder, last month CMS issued the final rule that reverses the Obama-era ban on the use of arbitration agreements. This rule makes it very clear that we have the ability to use pre-dispute agreements, while at the same time adding provisions intended to make sure that residents and/or their representatives understand the agreements into which they are entering. Additionally, the rule prevents a facility from making the signing of an agreement a precondition of admission.

Click here to register for the webinar. If you are a new member, click here to create a new account and email educate@ahca.org for any additional assistance needed.

Webinar Details
Title: "Tips and Tools for Implementing CMS' Recent Final Rule on Arbitration"
Date: Thursday, August 29
Time: 1:00 - 2:00 pm CST
Speakers: Mark Reagan, Managing Shareholder, Hooper, Lundy & Bookman, PC and James Segroves, Partner, Reed Smith LLP
Registration Link: https://educate.ahcancal.org/p/190829

9) The Clinical Advisor reports that High-Dose Influenza Vaccine More Effective for Older Adults. High-dose influenza vaccination had higher relative vaccine effectiveness compared with standard-dose vaccination in Medicare beneficiaries aged ≥65 years, and was more effective across all seasons for adults aged ≥85 years, according to study results published in the Journal of Infectious Diseases.

10) Kaiser Health News reports that Anticholinergic Drugs Might Pose Dementia Risk for Seniors. Kaiser Health News recently reported on the risks of anticholinergic drugs for seniors. For example, the article highlights a case of an older woman who was taking so many anticholinergic drugs that she was suspected of having dementia, but her physician suspected the combination of drugs might be having a negative impact so the patient was gradually switched over to alternative medications and her dementia-like symptoms resolved. The article also mentions that studies have found links between anticholinergic drugs and dementia.

11) Skilled Nursing News reports that Respiratory Therapy May Pose Opportunities Under PDPM. Skilled Nursing News reported on the opportunity for SNFs to capture a new revenue source under the impending PDPM model with respiratory therapy. Melissa Sabo of Gravity Health care Consulting explained, "Everybody's interested in it, because once you start going through the numbers, the reimbursements are just unbelievable." For example, "ventilator and tracheostomy care, two types of respiratory services, automatically put residents in the highest reimbursement case-mix groups for the Nursing component of PDPM, Sabo noted, with other respiratory modalities also boosting a resident’s overall payment score in the Non-Therapy Ancillaries category." Moreover, "Sabo said, it has a much greater chance of capturing all 100 days of Medicare eligibility for skilled nursing coverage, as not all operators in a given market typically can accept such patients."

12) MD Magazine reports on Substantial Costs, Increased Hospital Stays may be Associated with Hospital-Acquired C. Difficile Infections. MD Magazine has reported, "A new look at Clostridioides difficile infections...shows substantial costs, as well as increased hospital stays when the infection is acquired in the hospital," researchers concluded after using "three different forms of data – linked clinical, administrative, and microcosting data – in a retrospective, population-based, propensity-score-matched cohort study to determine the attributable cost and length of stays for patients with hospital-acquired Clostridioides difficile infections." The findings were published online in Infection Control & Hospital Epidemiology.

13) The AP reports:

• New Standards Seek to Optimize Surgery for Elderly Patients. The AP reported that the American College of Surgeons "launched a program Friday to encourage hospitals around the country to adopt 30 new standards to optimize surgery on patients who are 75 and older – information seniors and their families eventually will be
able to use in choosing where to get care." The newly suggested standards "stress team-based care and better communication about surgical risks and quality of life, to help patients choose their treatment." Seniors "must be evaluated for vulnerabilities" and standards after surgery "run the gamut from geriatric-friendly hospital rooms...to preventing post-surgery complications."

- **HHS Unveils Drug-Importation Plan.** The AP reports the Trump Administration announced today that it will "create a way for Americans to legally and safely import lower-cost prescription drugs from Canada for the first time, reversing years of refusals by health authorities amid a public outcry over high prices for life-sustaining medications." The AP adds that "it’s unclear how soon consumers will see benefits, as the plan has to go through time-consuming regulatory approval and later could face court challenges from drug-makers."

14) **McKnight’s reports:**

- **Nurses, Cleaning Professionals Should be Aware of Study on Hospital Infections.** In an advisory piece for *McKnight’s Long Term Care News*, contributor Robert Kravitz writes that "both nurses and cleaning professionals should be aware of a study published in the *Journal of Hospital Infections* in July 2018." While the study "did not focus on health care acquired infection (HAI) prevention," it did "point out new ways HAI s and other diseases can spread in a LTCF or similar facility."

- **Heat-Activated Would Dressing Has Potential to Heal Chronic Wounds, Pressure Sores.** Biomedical engineers said they have created a new wound dressing that contracts in response to body heat, is stretchy, adhesive, antimicrobial and helps to speed healing. The material, called active adhesive dressing, closes wounds “significantly faster” than other commonly used materials and prevents bacterial growth without the need for additional apparatus, the engineers reported.

15) **Interesting Fact:** August was named in honor of Augustus Caesar. It has 31 days because Augustus wanted as many days as Julius Caesar’s month of July had. They took the extra day from February.