August 21, 2019 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

Summary of the August 15, 2019 LTC Advisory Board Meeting
On Thursday, May 16, 2019, the Illinois Department of Public Health (IDPH) conducted the Long Term Care Advisory Board Meeting. A summary of the issues discussed is as follows:

- Discussion of LTC issues that need rulemaking:
  - Marijuana Use in LTC Facilities
    - Not just medical marijuana due to new law allowing recreational use of marijuana
    - Rules for use in LTC facilities – IDPH has not provided any guidance for this
    - How is the new marijuana law allowing for the expungement of certain marijuana convictions going to be handled with regard to the Health Care Worker Background Check program?
    - Need to address how the liability issue is going to be handled/resolved with regard to LTC facilities
    - No new guidance from federal CMS, marijuana is still against the law federally
  - Electronic Monitoring Devices such as Google Home or Amazon Echo
    - No IDPH guidance/rules to date
    - Can LTC facilities use the same process and consent form for these type of devices like we are to use for specific electronic monitoring devices spelled out in the statute?
    - There have been articles written that the Echo/Home devices are possibly recording. HIPAA issues?
    - Use of these types of devices draw upon the facilities internet and could slow down regular operations

- Update of LTC rulemaking in process or already published:
  - There were several sets of rules approved at the May LTC Advisory Board Meeting that are being readied for First Notice in the Illinois Register for public comment. They include revisions to:
    - Section 300.660 - Nursing Assistants
    - Section 300.661 - Health Care Worker Background Check (also HCWBC Code definition addition needed)
    - Section 300.663 - Registry of Certified Nursing Assistants
    - Section 300 - National Fire Protection Association (NFPA) revisions/update to the 2012 LSC
    - Section 300.120 - Application for Licensure (facility specific email address)
The above proposed changes are going to be combined with another general cleanup rulemaking that was discussed at the August LTC Advisory Board Meeting. Expect these changes to be published in the Illinois Register for public comment some time near the end of the year. As soon as this proposed rulemaking is published, we will let our members know.

- Part 395 - LTC Assistants and Aides Training Program Code
  - This proposed rulemaking sets up the parameters for an advanced nurse aide category of staffing
  - This proposed rulemaking was approved at the May LTC Advisory Board and is in the process of being readied for First Notice in the Illinois Register
  - There will be a 45-day public comment period once the proposed rule appears in the Illinois Register
  - IHCA will alert our members (once published) for their review and comments

- Rules to implement new legislation with regard to Informed Consent and Staffing
  - IDPH provided a DRAFT set of regulations to implement the new legislation with regard to informed consent and new staffing requirements (click here). This is a working DRAFT.
  - IHCA is actively involved with all interested parties to best put this new DRAFT language into workable requirements.
  - As soon as there is a final DRAFT of the proposed regulations, we will share it with our members.

The next meeting of the LTC Advisory Board is scheduled for November 21, 2019.

**What SNF Providers Should Know About Arbitration**

The Centers for Medicare & Medicaid Services Final Rule, released July 18, revised arbitration agreements for long-term care facilities.

The new rule amends the requirements of a 2016 rule titled “Reform of Requirements for Long-Term Care Facilities.” The 2016 rule prohibited LTC facilities from entering into pre-dispute binding arbitration agreements with any resident or from requiring residents to sign an arbitration agreement as a condition of admission to the LTC facility.

Advocates of the 2016 rule argued that it was an important step towards protecting vulnerable nursing home residents who may not understand the implications of signing binding pre-dispute arbitration agreements. Many providers disagreed, arguing it created too much burden on LTC providers who were already struggling under onerous regulatory requirements that strained their available resources.

The 2019 Final Rule appears to be a compromise between proponents of the 2016 rule (who did not want it modified whatsoever) and the opponents who wanted it rescinded completely. The 2019 Final Rule repeals the prohibition on the use of pre-dispute binding arbitration agreements, while strengthening the transparency of arbitration agreements.

The new rule includes provisions that “establish substantial protections for residents and their representatives and ensure transparency in the arbitration process” and “protects residents’ rights to make informed choices about their healthcare by ensuring that residents or their representatives have the right to understand what the arbitration agreement says and the consequences of signing the agreement.”

**2019 Final Rule Revisions to Arbitration Requirements**

Under the 2019 Final Rule, an LTC facility must comply with the following criteria:

- Not require a resident or his or her representative sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at the facility.
- Ensure that the agreement is explained to the resident or his or her representative in a form, manner and language that he or she understands. The resident or his or her representative must acknowledge that he or she understands the agreement.
- Ensure that the agreement provides for the selection of a neutral arbitrator agreed upon by both parties and a venue that is convenient to both parties.
- Ensure that the agreement does not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state or local officials.
- Retain copies of the signed agreement for binding arbitration and the arbitrator’s final decision for five years after the resolution of any dispute resolved through arbitration with residents. These documents must be available for inspection upon request by CMS or its designee.
- Grant residents a 30-calendar day period during which they may rescind their agreement to arbitrate.

What this means for SNFs
The 2019 Final Rule becomes effective on September 16, 2019. This means that any valid arbitration agreements that have already been signed by current LTC residents will remain valid, although CMS encourages “LTC facilities to offer current residents who have signed arbitration agreements the opportunity to rescind those agreements and proceed with a new agreement that conforms to these regulations.”

To be compliant with the 2019 Final Rule, all LTC providers should consider the following next-steps:

- Amend any pre-dispute arbitration agreement templates as necessary to comply with the 2019 Final Rule.
- Update record-retention policies and procedures to ensure that arbitration agreements and final decisions are maintained in accordance with the 2019 Final Rule.
- Update policies and procedures to ensure that prospective residents are informed of the nature and existence of pre-dispute arbitration agreements as required by the 2019 Final Rule.
- Provide training to relevant employees regarding all updated policies and procedures.

Article authored by Dana Petrillo and reprinted out of McKnight’s.

Focus F-Tag – F600 – Free From Abuse and Neglect (Part 3 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 have been reviewing it over the last several issues of Regulatory Beat. The final piece of this F-Tag in the next issue.

Under the updated Requirements of Participation (RoPs), CMS greatly expanded the Interpretive Guidance related to abuse at F600 Free from Abuse and Neglect. In our prior two Regulatory Beat’s, we looked at types of abuse and abuse scenarios related to different involved parties, whether it is staff members or residents or visitors. While we provided an overview on the types of abuse in Part 1, this week’s post is going to focus on sexual abuse, which is a topic with significantly expanded IG to consider and be aware of.

The Importance of Consent
In recent years, many nursing homes have taken significant strides to ensure that their residents are free to express themselves sexually in a safe manner. The IG at F600 provides detailed information on determining consent, stating that any investigation of an allegation of resident sexual abuse must first determine whether the resident consented to the sexual activity.

- A resident cannot consent to engage in sexual activity if he/she does not have the capacity to consent or if the consent is obtained via intimidation/coercion/fear.
- If sexual activity is forced/coerced/extorted, no matter what the circumstances of the relationship, CMS considers this sexual abuse.
The facility is responsible for investigating when there is non-consensual sexual activity and protecting the resident at any time the facility suspects that the resident does not wish to participate in sexual activity or if that resident does not have the capacity to consent. If the facility suspects that a resident may not have the capacity to consent, then it must conduct a capacity evaluation, because residents who do not have the capacity to consent to sexual activity may not engage in this type of activity.

The Interpretive Guidance provides reference information on determining consent, including that capacity to consent to one thing does not mean capacity for all things. Specifically, it states: “Capacity at its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation. Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with state law, if applicable.” This means that the facility’s P&Ps need to identify all of the details about how capacity will be determined, by whom and when.

Residents with a Designated/Legal Representative
Some residents may have legally appointed representatives with varying amounts of decision-making power. The IG states that it is the facility’s responsibility to determine what types of decisions this representative may make on behalf of the resident, including those related to consent for sexual activity. This can become tricky for the facility, because if a resident has the capacity to consent to sexual activity and the representative disagrees, this can create an uncomfortable scenario. However, the IG notes that the facility is expected to honor the resident’s wishes unless the resident’s representative has legal authority that addresses decision-making in this area, at which point the facility must respect the representative’s decision.

Indicators of Potential Sexual Abuse
The Interpretive Guidance includes a list of potential physical indicators of physical abuse, but clearly states that “the most prevalent psychosocial outcomes of abuse are depression, anxiety and posttraumatic disorder,” as well as sudden/unexpected changes in usual behavior patterns or activities.

Allegations of Sexual Abuse
If there is an allegation of sexual abuse, the facility is required to take several steps. First, the facility must report the allegation to the appropriate authorities and implement safeguards to prevent any further potential abuse. Then the facility is also required to thoroughly investigate the allegation of abuse and document and report the outcome of the investigation. It is essential to keep the resident safe during the course of the investigation.

Allegations of Staff to Resident Sexual Abuse
- Staff must recognize that engaging in a sexual relationship with a resident is inconsistent with the person’s role as a caregiver, and is considered to be an abuse of power, even if the relationship is seemingly consensual.
- If the staff member had a pre-existing sexual relationship with a resident who is then admitted to the nursing facility, then this may not be considered sexual abuse unless there are concerns about whether the activity is consensual or not.

Allegations of Resident to Resident Sexual Abuse
- Any allegation regarding a resident who did not wish to engage in sexual activity with another resident or who may not have the capacity to consent requires that the facility responds as though the activity is an alleged violation of sexual abuse.

Allegations of Visitor to Resident Sexual Abuse
- If a resident and visitor had a pre-existing sexual relationship before the resident entered the facility, this type of sexual activity may not be considered sexual abuse. This would require that the resident has the capacity and ability to consent and that the resident wishes to continue this type of activity. If there is an allegation/suspicion that a visitor is engaging in improper sexual behavior with a nursing home resident, the facility must immediately act.
Response to Alleged Violations of Sexual Abuse
As mentioned above, if there is an allegation of sexual abuse, the facility must immediately protect the resident from any further potential abuse. The alleged violation needs to be reported to the administrator and any authorities and investigated. The IG notes that while the investigation is underway, the facility needs to ensure that any potential evidence, such as bed linens or clothing, is not tampered with, which would impede the investigation.

In our next Focus F-Tag (Part 4 of 4), we will look at the second component of F600 regarding the resident’s right to be free from Neglect.

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

Antipsychotic Drug Use in Nursing Homes: Trend Update
CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease, or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent of residents received an antipsychotic medication; since then there has been a decrease of 39 percent to a national prevalence of 14.6 percent in the fourth quarter of 2018:
- Illinois is ranked 48th with a 2018 Q4 percentage of 18.6%. The Goal is less than 15%.
- Success varies by state and CMS region; some states and regions have a reduction greater than 45 percent.
- A four-quarter average of this measure is posted on the Nursing Home Compare website

For More Information:
- Visit the Partnership webpage
- Register for the September 10 Medicare Learning Network call
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov

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 19-16 – CAH – Critical Access Hospitals (CAHs) Adding a Provider-Based Location. Updates to the State Operations Manual (SOM) Chapter 2: CMS updated the SOM Chapter 2 for CAHs adding a provider-based location: SOM Chapter 2 Section 2004 - Provider-Based Determinations: A sentence has been added to the end of the section instructing “For Critical Access Hospitals (CAHs) adding a provider-based location - also see SOM Chapter 2 Section 2256H - Off-Campus CAH Facilities – Process Requirements.” SOM Chapter 2 Section 2256H - Off-Campus CAH Facilities: This section has been updated to clarify the process for CAHs adding a provider-based location to ensure the inclusion of verifying the CAH’s continued compliance with the distance requirements at 42 CFR 485.610(e)(2).
2. Federal HHS/CMS released the following notices/announcements:
   - SNF Provider Preview Reports – Now Available. Skilled Nursing Facility (SNF) Provider Preview Reports have been updated and are now available. The data contained within the Preview Reports is based on quality data
submitted by SNFs between Quarter 1-2018 and Quarter 4-2018 for assessment-based quality measures, and between Quarter 4 -2016 to Quarter 3 -2018 for claims-based quality measures. Providers have until September 16, 2019 to review their performance data prior to the October 2019 Nursing Home Compare site refresh, during which this data will be publicly displayed. Corrections to the underlying data will not be permitted during this time; however, providers can request CMS review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate.

CMS will be posting quality measure scores for the SNF QRP Potentially Preventable Readmissions measure for the first time during this refresh. In addition to this, CMS has updated the methodology for assigning providers to performance categories for the publicly displayed SNF QRP Discharge to Community measure for the October 2019 refresh of NH Compare and beyond.

- For additional information on the SNF QRP Potentially Preventable Readmissions (PPR) measure, we invite you to view the SNF QRP PPR Fact Sheet and FAQ documents.
- For additional information on the change in methodology related to the SNF QRP Discharge to Community (DTC) measure, we invite you to view the SNF QRP DTC Fact Sheet and FAQ documents.
- For additional information on accessing your facility’s preview report, please review the Preview Report Access Instructions.

- **New Medicare Card: Transition Period Ends in Less Than 5 Months.** Starting January 1, 2020, you must use the Medicare Beneficiary Identifier (MBI). We 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 August 2, providers submitted 77% 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 patient 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.

- **Securing Access to Life-Saving Antimicrobial Drugs for American Seniors.** Antimicrobial Resistance (AMR) represents an urgent clinical and economic crisis for the American health care system. Each year, more than 2 million Americans are infected by bacteria that are resistant to existing antibiotic drugs, resulting in thousands of deaths annually. CMS is committed to removing regulatory restraints on innovators and modernizing payment systems to secure access to medications for Medicare beneficiaries and all Americans.

As part of the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS has finalized an alternative pathway for the New Technology Add-On Payment (NTAP) for drugs designated by the Food and Drug Administration as Qualified Infectious Disease Products (QIDPs), under which these drugs would not have to meet the substantial clinical improvement criterion. Additionally, CMS is increasing the NTAP for QIDPs from 50% to 75%. Limiting access to the current upper band of NTAP to only QIDP drugs reflects the agency’s awareness of the public health imperative for novel antibiotics.

Additionally, within IPPS, CMS finalized a change in the severity level designation for 18 ICD-10 codes for antimicrobial drug resistance from ‘non-CC’ to ‘CC’ (complications or comorbidities). This change to CC recognizes the added clinical complexity and cost of treating patients with drug resistance, and ensures physicians are appropriately incentivized to use the correct (and sometimes, more expensive) drugs needed to manage patients with AMR. By increasing payments for inpatient cases with drug resistance, we are removing financial disincentives to antibiotic innovation and thus increasing beneficiaries’ access to these drugs. CMS will also seek further feedback about additional changes to the Diagnosis-Related Group system, such as any additional payment adjustments for antimicrobial resistance based on the relative hospital resources used in these cases, allowing us to receive feedback from stakeholders on this topic. This will help inform our thinking beyond IPPS on how to implement additional reforms to the government’s current payment methodologies and pave the road for new antimicrobial drug innovations in the long-term.
CMS – based on significant stakeholder feedback from academia, professional societies, non-profits, and innovators – is also exploring implementing Centers for Disease Control and Prevention-recommended guidelines for hospital-based Antibiotic Stewardship Programs into the regulations that govern hospitals’ Conditions of Participation in Medicare. This potential policy change will help slow AMR, and improve the safety and quality of inpatient care.

See the full text of this excerpted CMS Blog (Issued August 6).

- **Hospice Compare Quarterly Refresh Available.** The August 2019 quarterly Hospice Compare refresh of quality data is now available. It is based on Hospice Item Set (HIS) quality measure results from data collected Q4 2017-Q3 2018 and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® results reported Q4 2016 – Q3 2018.

Beginning with the August 2019 refresh, Hospice Compare will include hospice provider performance scores on the *Hospice Visits when Death is Imminent* three-day measure, which assesses the percentage of patients who receive at least one visit from a registered nurse, physician, nurse practitioner or physician assistant in the last three days of life. CMS has decided not to publish Measure 2, the seven-day measure, at this time to allow further testing to determine if changes to the measure or how it would be displayed on Hospice Compare are needed. Additional testing will help ensure the measure’s accuracy and reliability as an indicator of provider quality. CMS will not post data for this measure, including each hospice’s performance as well as the national rate, while conducting more testing. The decision not to publicly report the seven-day measure at this time has no impact on other Hospice Quality Reporting Program (HQR) measures.

We invite you to visit [Hospice Compare](https://www.cms.gov) to view the data.

For additional information on the Hospice Visits when Death is Imminent measures, we invite you to view the associated [Fact Sheet](https://www.cms.gov) and [Q & A](https://www.cms.gov) documents.

- **Hospice Patient Assessment Instrument Focus Groups: Respond by August 26.** CMS is recruiting experienced hospice providers and clinicians to participate in focus groups to discuss and provide input as we develop a hospice patient assessment tool:
  - Interested participants will be considered based on their hospice role, knowledge and experience with the Hospice Quality Reporting Program (QRP) or completing patient assessments
  - Selection will take into account hospice type and location to ensure a nationally balanced representation of diverse hospices

For More Information:
  - [Announcement and Application](https://www.cms.gov): Deadline August 26
  - [Hospice QRP Provider Engagement Opportunities](https://www.cms.gov) webpage

- **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 (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). PDPM improves the accuracy and appropriateness of payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing administrative burden.

  *Changes to the Assessment:*
  Both RUG-IV and PDPM use the Minimum Data Set (MDS) 3.0 as the basis for patient assessment and classification, but the assessment schedule under PDPM is more streamlined and less burdensome on providers. See the [presentation](https://www.cms.gov) (starting on slide 52) to find out how your assessments will change.
Billing for Services:
Use the Health Insurance Prospective Payment System (HIPPS) code generated from assessments with an assessment reference date on or after October 1, 2019, to bill under the PDPM.

Changes to Payment:
Under the PDPM, clinically relevant factors and patient characteristics are used to assign patients into case-mix groups across the payment components to derive payment. Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.

CMS has resources to help you prepare:
- PDPM webpage, including fact sheets, FAQs, presentation and coding crosswalks/classification logic
- Videos: PDPM: What Is Changing (and What Is Not) and Integrated Coding & PDPM Case Study
- 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

- Skilled Nursing Facility 3-Day Rule Billing. In a recent report, the Office of Inspector General (OIG) determined that Medicare improperly paid for Skilled Nursing Facility (SNF) services when the Medicare 3-Day inpatient hospital stay requirement was not met. CMS developed the Skilled Nursing Facility 3-Day Rule Billing Fact Sheet to help you bill correctly. Additional resources:
  - Reminder of the Required Three-day Hospital Stay for SNF Admissions, MLN Matters Special Edition Article
  - SNF Billing Reference Medicare Learning Network Booklet
  - Title 42 of the Code of Federal Regulations (CFR) § 411.400
  - Medicare Benefit Policy Manual, Chapter 8
  - Medicare Claims Billing Manual, Chapter 6
  - Medicare Claims Billing Manual, Chapter 30
  - Medicare Financial Management Manual, Chapter 3, 70.3(C), 90, 100
  - CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met OIG Report

- Getting Started with Hospice CASPER Review and Correct Reports is Available. Getting Started with Hospice CASPER Review and Correct Reports is now available for download. This document is intended to help providers understand what the Review and Correct Reports are and how to use them. To download the Getting Started with Review and Correct Report, please refer to the “Downloads” section of the HQRP Requirements and Best Practices page.

- New Version of CASPER Quality Measure Reports Fact Sheet now available. An updated version of the CASPER Quality Measure (QM) Reports Fact Sheet is now available in the Downloads section of the HQRP Requirements and Best Practices page. This updated version reflects the addition of the Hospice When Death Is Imminent Measure Pair to both the Hospice-Level and Patient Stay-Level CASPER QM Reports.

- 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 follows 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.

- Dementia Care: Supporting Comfort and Resident Preferences Call — National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement — Tuesday, September 10, 1:30 – 3 pm ET. Register for Medicare Learning Network events. During this call, gain insight on approaches to care for residents.
living with dementia that focus on resident preferences, maintaining comfort and assisting with unmet needs. Additionally, CMS provides updates on the progress of the National Partnership to Improve Dementia Care in Nursing Homes. A question and answer session will follow the presentations.

- **International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update.** A new MLN Matters Article MM11392 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update is available. Learn about new and revised codes for NCDs.

- **Chronic Care Management Services — Revised.** A revised Chronic Care Management Services Medicare Learning Network Booklet is available. Learn about:
  - Separately payable services for beneficiaries with multiple chronic conditions
  - Physician Fee Schedule billing requirements
  - Practitioner and patient eligibility
  - Service elements

- **ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets — Revised.** A revised ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Medicare Learning Network Fact Sheet is available. Learn:
  - Definition and details for each code set
  - Payment information

- **SNF PPS: Patient Driven Payment Model Videos.** On October 1, the new Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has videos to help you prepare:
  - Integrated Coding & PDPM Case Study – Run time: 58 mins

  For more information, visit the PDPM webpage.

- **Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates’ Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims.** A new MLN Matters Article MM11290 on Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates’ Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims is available. Learn about submitting demonstration code 77 to attest that a claim meets the eligibility requirements for the SNF 3-Day Rule Waiver.

- **October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement.** A new MLN Matters Article MM11381 on October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement is available. Learn about updates to HCPCS codes subject to SNF consolidated billing and three incorrectly categorized CPT codes.

- **Oxygen Policy Update.** A new MLN Matters Article MM10837 on Oxygen Policy Update is available. Learn about new oxygen payment classes and HCPCS code for portable liquid oxygen.

- **CMS: Beyond the Policy Podcast: Nursing Home Strategy Part 1 – Strengthening Oversight.** CMS released the latest episode of our podcast, CMS: Beyond the Policy. This edition focuses on the first of our 5-pronged strategy on strengthening oversight in nursing homes. You can also listen to the podcast on Google Play and iTunes.

3. The U.S. Department of Homeland Security recently released a draft guidance document entitled Planning Considerations: Evacuation and Shelter-In-Place – Guidance for State, Local, Tribal and Territorial Partners. Evacuation and shelter-in-place protective actions are prompted by a variety of threats and hazards. Incident-specific circumstances drive the relevant protective actions based on a community’s demographics, infrastructure,
resources, authorities and decision-making process. Determining that evacuation needs to take place is not an all-or-nothing approach. Lessons learned from disasters, such as hurricanes Harvey, Irma, Katrina and Maria, have highlighted the value of enacting a zone-phased approach to evacuation and shelter-in-place, enabling jurisdictions to move as few people as necessary. Sheltering-in-place populations that are not directly in harm's way, rather than having them evacuate, helps jurisdictions reduce costs, resource requirements and the negative impacts of evacuations, while promoting improved response and quicker re-entry and recovery.

4. The U.S. Centers for Disease Control and Prevention (CDC) reports on:

- **Study Shows Hospitalization Rates and Risk of Death from Flu Increase with Age.** While flu seasons can vary in severity, during most seasons, people 65 years and older bear the greatest burden of severe flu disease. A CDC co-authored study published in the journal *Open Forum Infectious Diseases* reports that people 85 years and older are much more likely to be hospitalized and die from flu than adults 65 to 74 years old.

- **People at High Risk for Flu Complications.** Most people who get sick with flu will have mild illness, will not need medical care or antiviral drugs and will recover in less than two weeks. Some people, however, are more likely to get flu complications that can result in hospitalization and sometimes death. Flu also can make chronic health problems worse.

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

- **No Difference in Outcomes for Patients with Complex Medical Needs Across Medicare ACOs.** Accountable care organization (ACO)-reported care management and coordination activities were not associated with improved outcomes among patients who were frail or had multiple chronic conditions, according to an AHRQ-funded study in *JAMA Network Open*. ACOs give health organizations and providers financial incentives to improve care coordination. Researchers who reviewed survey responses from 244 ACOs with claims data from 1.4 million Medicare patients found patients in the best-performing ACOs for care management and coordination activities did not have different outcomes as measured by hospital readmissions, hospital or emergency department visits, visits for evaluation and management services in outpatient settings, or healthcare spending compared with patients in lower-performing ACOs. Study findings suggest that health organizations should consider the effectiveness of investing heavily in care coordination activities that are difficult to implement, according to researchers. Access the abstract to the study, which was part of AHRQ’s Comparative Health System Performance Initiative.

- **Adverse Events in Long Term Care Residents Transitioning from Hospital Back to Nursing Home.** Transitions from hospitals to long term care facilities are associated with safety hazards. This prospective cohort study identified adverse events in the 45 days following acute hospitalization among 555 nursing home residents, which included 762 discharges during the study period. Investigators found that adverse events occurred after approximately half of discharges. Common adverse events included falls, pressure ulcers, health care–associated infections, and adverse drug events. Most adverse events were deemed preventable or ameliorable. The authors conclude that improved communication and coordination between discharging hospitals and receiving long term care facilities are urgently needed to address this patient safety gap. A previous WebM&M commentary discussed challenges of nursing home care that may contribute to adverse events.

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

- HFS posted an updated Renal Dialysis Injectable Drug Table. You may view the new table here.

- HFS posted a new Provider Notice regarding Medication Synchronization. You may view the new notice here.

- HFS posted a new Provider Notice regarding Publicly Owned Transportation Providers – Supplemental Payments. You may view the new notice here.
HFS posted a new Provider Notice regarding **Changes to Vaccination Billing Requirements Effective with Dates of Service Beginning September 1, 2019**. You may view the new notice [here](#).

HFS posted a new Public Notice regarding **Elimination of Cost Sharing for Title XIX**. You may view the new notice [here](#).

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

- IDPH has decided to **postpone** the **IDPH Town Hall Meetings** until CY 2020.

- 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

8. The **Illinois Department on Aging** reports:

- **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](#).

  - There are no registration fees for the conference. Snacks will be provided each day, but hotel, meal, and parking costs will be up to each attendee.
  - Please attend even if you are not available for all three days—when registering you will be asked which days you are attending.
  - [Hotel Information](#)
  - [Draft Matrix of Meetings](#)

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

- **IHCA Member Alert – Rate Calculations Breakdown & Staffing Component**. IHCA sent out the following alert last week. As a reminder, please review the information below. IHCA would like to inform members about the rate calculation break down and one of the pieces that has the most unanswered questions at this time, the staffing component. As mentioned in other IHCA publications, the rate increase consisted of a support rate increase and money allocated to use for staffing. The July 1, 2019 rates that HFS posted last week included both, here is the breakdown:

  **Staffing**
  - A $4.55 per diem add-on to your direct care per diem rate based off of a weighted formula of Medicaid bed days. *It is important to note that this portion of the increase was legislated for the purpose of*
addressing a facility's staffing needs through a provider initiated, annually approved, staff spending plan.*

IHCA is currently working with the Department on obtaining details of what the staffing plan requires as well as clarification on how a facility may spend the money. Until we have answers, we strongly advise facilities to carefully track any dollars spent on staffing issues, including recruitment and media. The following are questions to consider and posed to HFS:

- Once the new money is placed into the rate can a facility begin to spend it on staffing?
- Do providers need to set this money aside until an approved plan is received back from HFS, then move forward with their plan?
- If a provider does not meet the specifics in their staffing plan in a certain timeframe (asking for timeframe), what will recoupment look like?

**Support Rate**

- Each facility's support rate in effect on June 30, 2019 was updated using the latest cost report on file March 31, 2015, which in most cases is the 2014 cost report.
- The newly calculated support rate was then capped at 90.8% to spend 80% of the $170 million annually.
- After applying the cap, if a facility's rate was less than what was in effect on June 30, their rate was restored to that June 30 rate.
- Once the above calculations were complete, each facility's rate was increased by 3.45%.

To have a more detailed explanation of the rate calculations, click here to view the rate calculation handbook. If you have yet to receive your support rate calculation you may contact Nancy.Becker@illinois.gov and send her your provider ID and fax number. Click here to see the Medicaid Rate List for Nursing Facilities as of July 1, 2019. Facilities will continue to be paid their old rate until the newest rate increase is approved by CMS. Once approved, facilities will see the increase backdated to July 1, 2019 under fee-for-service and managed care.

We will continue to keep members updated as the Department releases clarification on the above items.

- **Your Resident Profile in LTC Trend Tracker is Available.** Your Resident Profile is an LTC Trend Tracker℠ publication that provides the information the skilled nursing centers in your state need to begin the resident profile portions of Components 1 and 2 of the annual Facility Assessment, required under the CMS requirements of Participation. Distributed semi-annually, this report allows you to review the resident populations for the centers in your state to help determine the resources they require to provide person-centered care and help establish the services their residents need in both day-to-day operations and emergencies.

- **AHCA PDPM Academy FAQ Spotlight**

- **Appendix Q Update on Referring Crimes to Law Enforcement**

- **Take Action Now! Submit Your RoP Comments to CMS**

- **D.C. Update: Good Year So Far, More To Do**

- **AHCA Webinar on CMS' Final Arbitration Rule** (click here). AHCA will host a webinar on the 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.
• **AHCA/NCAL Social Media Update**

• **AHCA PDPM Academy Weekly Update – August 16**

10. **ModernHealthcare** reports:

- CMS Issues Guidance on Tracking Medicaid Opioid Use. *ModernHealthcare* reports, "The CMS on Monday issued new guidance for states and Medicaid managed care programs to change up their Medicaid drug utilization review programs by the end of this year." ModernHealthcare adds, "The CMS’ new mandates, which include setting opioid prescription limits and monitoring Medicaid patients for potential abuse, apply equally to state Medicaid fee for service programs and private managed care companies." Meanwhile, "states have until Dec. 31 to outline their state plan amendments to overhaul the way they approach opioid use by their Medicaid populations." States "will have to set their own limits on opioid prescriptions and refills while also tracking patients who are at risk of overusing" analgesics, "or who may be concurrently taking multiple prescribed opioids and benzodiazepines and antipsychotics."

- Medicare to Lower Rates for Home Health Care Services. *ModernHealthcare* reports, "After pushing more medical care out of hospitals and into patients’ homes, the federal government wants to pay less for home health care." The article adds, "Impending changes in Medicare’s home health payment system would dramatically alter how agencies are reimbursed for services, cutting payments by 8 percent. Lower rates would squeeze profit margins in what has been a reasonably lucrative business."

11. The **Washington Post** reports **Risks of Surgery Reportedly Not Always Made Clear to Older Adults.** According to the *Washington Post*, a common complaint is that "surgeons don’t help older adults and their families understand the impact of surgery in terms people can understand, even though older patients face a higher risk of complications after surgery." In addition, they fail to "routinely engage in ‘shared decision-making,’ which involves finding out what’s most important to patients and discussing surgery’s potential effect on their lives before setting a course for treatment." According to newly released standards for surgery in this population, "all older patients should have the opportunity to discuss their health goals and goals for the procedure, as well as their expectations for their recovery and their quality of life after surgery."

12. **MedPage Today** reports that **Many Patients Receive Antibiotics for UTIs Without Microbiological Testing.** MedPage Today reports researchers found that "almost 86% of patients received antibiotics for a UTI on the day they were diagnosed, and 83% of those had no evidence of collecting a urine sample for microbiological testing." In addition, "urine sampling was performed within 10 days of presentation in just 25% of patients." The findings were published in *EClinicalMedicine*.

13. **Provider Magazine** reports:

- **Frailty’s Importance Discussed as PDPM Approaches.** Provider Magazine reports that "frailty is common among older people," and a new study published in *JAMA Network Open*, "suggests the value of assessing and addressing frailty to prevent surprises and minimize its negative consequences." The study found "the incidence varied according to the measurement methods used...and by the income level in the region/country." The authors suggested that "preventing, predicting, and addressing frailty calls for an understanding of its risk factors." Steven Buslovich, MD, MSHCPM, chief executive officer of Patient Pattern and a New York-based geriatrician, "agrees and further suggests that assessing frailty is key to capturing revenue and accurately predicting costs of care in the world of the Patient-Driven Payment Model (PDPM), as the components affecting reimbursement – cognitive, psychosocial, and functional domains – all involve frailty."

- **PDPM Means it is Time to Use New MDS-RAI Manuals to Prevent Revenue Loss.** Provider Magazine reported in its August 2019 issue that starting on October 1, 2019, the CMS will implement "the new skilled nursing facility Medicare Part A prospective payment system, known as the patient-driven payment model (PDPM)." Provider added that in order "to implement PDPM, and to standardize the reporting of many resident assessment items
across post-acute provider settings, CMS introduced major changes to the" minimum data set resident assessment instrument (MDS-RAI) manual "that providers should review and retrain staff on prior to Oct. 1." Moreover, "providers that do not rely on dusty obsolete versions of the MDS-RAI manual and are diligent in keeping MDS coders and clinical staff up to date with these important changes will be better prepared for finding the right road to success under both the PDPM and SNF QRP programs."

14. McKnight's reports:

- **Study Shows RAFT Model Reduced Nursing Home Hospitalizations by 31 Percent.** [McKnight’s Long Term Care News](https://www.mcknights.com) reports, "The Reducing Avoidable Facility Transfers (RAFT) model reduced emergency department transfers and hospitalizations among skilled nursing facility residents by more than a third, according to a study in the August issue of the Journal of the American Medical Directors Association (JAMDA)." The RAFT model "involves actively asking nursing home residents about their preferences, especially around end-of-life care, as well as increased engagement of the primary provider during an acute-care event." In an 18-month study of "three rural SNFs," the number of average "monthly ED transfers and hospitalizations decreased by 35.8% and 30.5% respectively."

- **Patients with Dementia May Fare Better in Residential Care of Nursing Home Than at Home.** [McKnight’s Senior Living](https://www.mcknights.com) reports the study "examined the differences between residents with moderately severe dementia who live in residential care settings, such as retirement communities and assisted living, and those who live in nursing homes or at home." Researchers "used data from the National Health and Aging Trends Study to compare the medical characteristics of 728 adults aged 65 or more across the three settings; 126 of them lived in residential care settings." According to lead author Krista Lyn Harrison, Ph.D., an assistant professor at the University of California, San Francisco, the most important message that those in senior living can take away from the study is that "[o]ptimally supporting the quality of life of people with dementia requires attending to all three domains of wellbeing: social, functional, and medical."

- **Healthy Heart Guidelines Can Also Lower Dementia Risk.** Following the American Heart Association’s guidelines for good cardiovascular health may also help participants reduce dementia risks, French researchers have found.

- **Sepsis Watch Needed Post-Hospital Stays: 1 in 3 Face Death Risk.** Residents who exit the hospital after a bout with sepsis aren’t out of the woods for up to a year and require special post-acute vigilance, researchers say. One in three are likely to face death months after discharge, mostly due to heart disease and stroke, findings indicate. Many sepsis patients retain inflammation levels twice as high as healthy individuals months after leaving the hospital. This inflammation may be a key reason sepsis is associated with so many cardiovascular problems, reported researcher Sachin Yende, M.D. of the University of Pittsburgh’s School of Medicine.

- **Illinois Governor Signs Bill to Prohibit Discrimination Based on Sexual Orientation, Gender Identity in Assisted Living.** [McKnight’s Senior Living](https://www.mcknights.com) reports Illinois Gov. J.B. Pritzker (D) has signed legislation that "amends the Assisted Living and Shared Housing Act to prohibit discrimination based on the protected categories in the Illinois Human Rights Act, including race, color, religion, national origin, ancestry, age, sex, disability, sexual orientation and gender identity." The law "applies to discrimination by ‘any owner, licensee, administrator, employee or agent of an assisted living establishment.’"

- **HHS Office of Inspector General Announces Report Focusing on Assisted Living Providers Serving Medicaid Beneficiaries.** [McKnight’s Senior Living](https://www.mcknights.com) reported, "Assisted living providers who serve Medicaid beneficiaries will be the focus of a report released by the Department of Health and Human Services Office of Inspector General between Oct. 1, 2019, and Sept. 30, 2020, the office said in releasing updates to its work plan." The OIG said, "We will determine whether assisted living providers are meeting quality-of-care requirements for Medicaid beneficiaries residing in assisted living facilities and whether the providers properly claimed Medicaid reimbursement for services in accordance with Federal and State requirements." The timing of the release "aligns with the federal 2020 fiscal year."
15. **Interesting Fact:** More than half your bones are located in your hands and feet. We are born with approximately 300 bones and cartilage which eventually fuse together by the time we reach adulthood. The adult human body consists of 206 bones. Of these bones, 106 of them are located in our hands and feet. Bones in the arms are among the most commonly broken bones and account for almost half of all adults’ bone injuries.

*If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*

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