The New Alzheimer’s Disease and Related Dementias Services Code

Public Act 99-822, created the Alzheimer’s Disease and Related Dementias Services Act (410 ILCS 406) and PA 100-1074, (trailer legislation) amended the original Act based on negotiations between the Illinois Department of Public Health (IDPH) and the Alzheimer’s Association. IDPH drafted regulations to implement the above Act and the rules became effective on May 23, 2019.

These new rules apply to all LTC facilities, Assisted Living and Shared Housing facilities, Home Health, Home Services, Home Nursing Agencies and Hospice programs. LTC facilities, regardless of whether or not they have a designated Alzheimer’s Special Care unit, are required to follow these new regulations if they care for any resident who has Alzheimer’s or related dementias.

Facilities that have residents with Alzheimer’s or related dementias must have a care plan that is implemented in accordance with nationally recognized standards of care or guidelines for Alzheimer’s disease or related dementias. Materials defining the philosophy of the services, specific services offered and behavior management tactics and drug therapies employed shall be provided to a resident or the resident's representative upon admission or enrollment to an entity, or earlier upon request, including a disclaimer that the services are not certified under the Alzheimer's Disease and Related Dementias Special Care Disclosure Act.

The regulations also spell out staffing and staff training requirements, which include:

- An Alzheimer's services supervisor working in an entity licensed under 77 Ill. Adm. Code 295 or 300 shall complete at least 12 hours of continuing education annually, especially related to the care of residents or clients with Alzheimer’s disease or other related dementias and shall have documented course work in dementia care and ability-centered care. An Alzheimer’s services supervisor shall also meet at least one of the following requirements:

  1) Have an associate’s or bachelor's degree or be a registered nurse and have at least one year of experience working with persons with Alzheimer's disease and other related dementias and have completed training in ability-centered care (see 77 Ill. Adm. Code 300.7030); or

  2) Have a minimum of five years of experience working with persons with Alzheimer's disease and other related dementias, at least two years of which are management experience working with
persons with Alzheimer's disease and other related dementias and have completed ability centered care training.

- Staff with direct access to clients with Alzheimer's disease or a related dementia hired after June 2, 2019 shall complete a minimum of 6 hours of initial training in the first 60 days of employment using an Alzheimer's disease and related dementias services curriculum.

- The new rules also establish a minimum Alzheimer’s and related dementias services training curriculum.

- As of June 2, 2019, staff with direct access to clients with dementia shall receive 3 hours of advanced training on caring for individuals with Alzheimer's disease and related dementias each year.

- As of June 2, 2019, Alzheimer’s disease and related dementias services employers shall maintain training records and make them available to the Department on request.

**New Drug Disposal Regulations Implemented**

A new federal rule will go into effect next week prohibiting healthcare organizations from flushing hazardous waste pharmaceuticals into the sewer system, which will cause some providers, distributors and pharmacies to change their protocol and processes.

*Starting August 21, 2019*, drugs like opioids and chemotherapies will need to be disposed of through proper channels rather than down the drain, which will cost healthcare facilities time and money if they need to get up to speed. But the Environmental Protection Agency's final rule will also clear up conflicting regulations and ease some requirements, which health systems are applauding.

"I have talked to a lot of hospitals and other healthcare facilities that are still flushing hazardous waste pharmaceuticals; there has been no effort to minimize that practice," said Elise Paefgen, an attorney in Alston & Bird's environment, land use and natural resources group. "Now they have a hard stop next week that applies across the country. It's definitely a big change for a lot of facilities."

Under the presiding Resource Conservation and Recovery Act, flushing hazardous drugs down the drain or toilet has been permitted, despite the growing awareness of the damage that could cause to the environment. The final rule will immediately stop that, as well as outline a host of changes such as calculating how much waste a facility generates, among others, that will be implemented over time.

Certain states will adopt the federal rules in their entirety, while others will take a more stringent approach applied over the next two years. What's left will be a patchwork of state laws that health systems will have to navigate if they operate or dispose waste in multiple states.

"The regulations need to catch up—you shouldn't be flushing chemotherapies and narcotics down the drain," he said, adding, "Even though it is a good thing, healthcare costs keep rising and reimbursement isn't going to go up, which makes it tough."

The maximum fine will be more than $70,000 dollars per day per violation, although it will be difficult to police, said Delphine O'Rourke, a partner at Duane Morris.

"The fines are significant," she said. "The burden will be on the facility to train and monitor staff."

As for the new federal rule, O'Brien said he was appreciative that it streamlined conflicting controlled substance regulations from the Food and Drug Administration, the EPA and the Drug Enforcement Agency. Healthcare organizations will also treat all hazardous waste alike, rather than differentiate by product.
Another potential benefit to healthcare facilities involves empty pharmaceutical containers, Paeffgen said. Triple rinsing containers with acute waste is no longer required. Also, duplicative reporting requirements have been eliminated and container storage mandates are less onerous, she said.

"As far as the management of pharmaceuticals that are sent to the reverse distributor, most of the requirements will be easier after the final rule is implemented," Paeffgen said. "But for a lot of healthcare facilities that weren't focused on waste management, it will feel like a lot."

*Article authored by Alex Kacik and reprinted out of Modern Healthcare.*

**Focus F-Tag – F600 – Free From Abuse and Neglect (Part 4 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. We are wrapping up our review of F600 (Part 4 of 4) by discussing the regulation as it relates to the right to be free from Neglect. The definition of Neglect, per Appendix PP, is failure by the facility or facility employees/service providers to provide necessary goods and services to a resident to avoid physical harm or pain, mental anguish or emotional distress. The Interpretive Guidance (IG) notes that failure to provide the necessary care and services to a resident may not only have a negative physical outcome, but could result in a negative psychosocial outcome for the resident as well.

Neglect can be identified when a facility does not provide “required structures and processes” to meet the needs of its residents, which includes things like ensuring there is sufficient staffing, staff supervision and resident care policies in place. Neglect can also occur when staff are aware of, or should be aware of, residents’ care needs but do not meet those needs based on factors such as inability to perform an intervention due to lack of training, sufficient supplies, or lack of knowledge about the resident. The IG notes that if a facility admits a resident, it should have determined that it has the ability to take care of that resident and provide the goods and services that he or she needs. To ensure it can meet each individual resident’s needs, the facility needs to have in place structures such as:

- Sufficient numbers of qualified, competent staff based on the facility’s assessment of the residents’ needs
- Resident care P&Ps that ensure that facility provides care based on current standards of practice, provide clinical/technical direction for provision of care and services and address each diagnosis of a resident.
- A safe, sanitary environment.
- Sufficient provisions of items such as clean linens and food.

Facilities cannot disavow the actions of the staff that have been hired to care for their residents. This makes it important to ensure that staff are following the individualized care plan for each resident to avoid negative outcomes.

**Office of the Inspector General Reports**

The Office of the Inspector General released two reports this week that discuss how potential incidents of abuse and neglect in nursing homes were not always thoroughly reported and how CMS could use Medicare data to identify potential situations of abuse and neglect. You can view CMSCG’s blog posts on these OIG reports here and here.

**Final Thoughts on Abuse & Neglect**

We all have a responsibility no matter what health care setting we work in as well as in our daily lives to understand that our tolerance level for abuse and neglect should be ZERO. And, once again in regulation, we are shown another instance of the importance that should be placed on the Facility Assessment and using this assessment as a guide for staffing levels, educational/training programs needed and ensuring that we meet each resident’s needs based on their individualized plan of care.
**Most Nursing Facilities Failing in CMS Requirements Around RN Staffing, Analysis Finds**

Investing in registered nurses may help curb abuse and neglect rates in nursing homes, experts suggested in a recent analysis.

In a study of more than 15,000 facilities, Harvard University researchers found 54% of facilities met expected staffing levels less than 20% of the time. Despite the Centers for Medicare & Medicaid Services listing expected staffing levels for RNs, 91% of facilities met those levels less than 60% of the time.

Scrutiny has been on skilled nursing’s abuse rate, with a recent report by the Government Accountability Office noting the number of incidents reported over four years had nearly doubled.

While CMS requires at least one registered nurse on duty for eight straight hours per day, more experts are calling for minimum staffing requirements at facilities, Bloomberg Law reported Thursday.

“Federal standards in this area are lacking unless we call on Congress to establish and enforce minimum requirements for numbers of direct-care staff, including the presence of registered nurses on site 24 hours per day,” Lori Smetanka, executive director of the National Consumer Voice for Quality Long-Term Care, told the Senate Finance Committee.

Other experts believe larger facilities with “more complex patients” may benefit from having minimum staffing requirements, but that type of approach may not work for smaller, rural or long-term care facilities.

“The broad differences in the types of residents and the way the facilities care for them, I don’t think means that you need to have it for everyone,” David Gifford, MD, senior vice president of quality and regulatory affairs at the American Health Care Association, told Bloomberg. “It sounds nice to say something the data supports, but to make everyone do it all the time? With no exceptions? That doesn’t make sense.”

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**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 19-17 – AO/CLIA** - FY 2018 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program. Annual Report to Congress: The 2018 annual RTC details the review, validation, and oversight of the FY 2017 activities of the approved AOs Medicare accreditation programs as well as the CLIA Validation Program. Section 1875(b) of the Social Security Act (the Act) requires the CMS to submit an annual report to Congress on its oversight of national AOs and their CMS-approved accreditation programs. Section 353(e)(3) of the Public Health Service Act (PHSA) requires CMS to submit an annual report of the CLIA validation program results.

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

   - **SNF Provider Preview Reports:** Review Your Data by September 16. Skilled Nursing Facility (SNF) Provider Preview Reports are available. Review your performance data by September 16, prior to public display.
on [Nursing Home Compare](http://www.NursingHomeCompare) in October. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe your data is inaccurate. For More Information:

- [SNF Quality Public Reporting](http://www.snfqualitypublicreporting) webpage
- [Access Instructions](http://www.accessinstructions)

**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](http://www.presentation) (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](http://www.factsheets), [FAQs](http://www.faq), [presentation](http://www.presentation) and [coding crosswalks/classification logic](http://www.codingcrosswalks)
- [Materials](http://www.materials) from the Medicare Learning Network call in December
- [Implementation of the SNF PDPM](http://www.implementationofSNFPDPM) MLN Matters Article
- [New Medicare Webpage on PDPM](http://www.newmedicarewebpage) MLN Matters Article

**Overall Hospital Quality Star Ratings: Upcoming Enhancement.** CMS plans to update the quality measurement methodology of the Overall Hospital Quality Star Ratings located on CMS’ popular [Hospital Compare](http://www.hospitalcompare) website in 2021. In the interim, CMS will refresh the Star Ratings using the current methodology in early 2020, ensuring patients have timely access to the most up-to-date hospital quality information while a new methodology is being finalized.

On August 19, CMS posted a [summary of comments](http://www.summaryofcomments) received on potential technical changes received during a [public comment period](http://www.publiccommentperiod) that ended March 29. This public feedback is a critical part of ongoing efforts, along with comments submitted during future rulemaking that will help shape improvements to the Star Ratings targeted for early 2021. CMS plans more public outreach to shape potential changes including a [public listening session](http://www.publiclisteningsession) in Baltimore on September 19 that will include a call-in option.

See the full text of this excerpted [CMS Press Release](http://www.cmspressrelease) (issued August 19).

**Pneumococcal Vaccine Eligibility Data Issue.** Medicare covers pneumococcal conjugate vaccine (PCV13) and pneumococcal polysaccharide vaccine (PPSV23). Original (Fee-For-Service (FFS)) Medicare gives beneficiary eligibility information on those services in various ways, including through vendors and clearinghouses. There is a data issue with FFS beneficiary eligibility information for both Pneumococcal Vaccines (PVs):

- When a provider administers only one vaccine, in some cases the FFS beneficiary eligibility response reflects both vaccines have been administered
- When FFS beneficiary eligibility data indicates your patient got both vaccines, please talk with your patient about prior vaccination status (Medicare Benefit Policy Manual, [Chapter 15, Section 50.4.4.2.A.2](http://www.chapter15section50.4.4.2.A.2)) until we resolve this issue in early 2020
The eligibility issue does not affect FFS claims processing for PV.

When the FFS beneficiary eligibility response indicates the beneficiary is enrolled in a Medicare Advantage Plan (Part C), check with the plan for beneficiary eligibility information. The FFS beneficiary eligibility transactions give you plan names and contact information so you can get Medicare Advantage Plan benefit information, including PV services your patient received under plan coverage.

- **Hospice Compare Refresh.** The August 2019 Hospice Compare refresh is available. Visit [Hospice Compare](#) to view the data. This refresh includes performance scores for the Hospice Visits when Death is Imminent three-day measure. CMS decided not to publish Measure 2, the seven-day measure, and will conduct further testing. For More Information:
  - Hospice Quality Public Reporting webpage
  - Visits when Death is Imminent Fact Sheet and Q & A

- **Ambulance Fee Schedule and Medicare Transports.** In a recent report, the Office of Inspector General (OIG) determined that Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to skilled nursing facilities as part of consolidated billing requirements. CMS developed the [Ambulance Fee Schedule and Medicare Transports](#) Booklet to help you bill correctly. Additional resources:
  - Ambulance Fee Schedule webpage
  - Sections 1861(e)(1) or 1861(j)(1) of the Social Security Act
  - Medicare Benefit Policy Manual, Chapter 10, Section 10.3.3
  - Medicare Claims Processing Manual, Chapter 15
  - Medicare Claims Processing Manual, Chapter 30, Section 50
  - Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements OIG Report

- **Beneficiary Notices Initiative Mailbox Portal.** Send your beneficiary notices and related policy questions to the new CMS Beneficiary Notices Initiative (BNI) mailbox portal, which includes links to a variety of resources. Note: This portal replaces the BNI mailbox. See the announcement for more information.

- **DMEPOS: Nationwide Expansion of Required PA of Pressure Reducing Support Surfaces.** A Federal Register Notice (84 FR 16616) added five Pressure Reducing Support Surfaces codes to the Required Prior Authorization (PA) List. Effective October 21, all Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers in all states are required to obtain prior authorization for these items:
  - E0193 - Powered air flotation bed (low air loss therapy)
  - E0277 - Powered pressure-reducing air mattress
  - E0371 - Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
  - E0372 - Powered air overlay for mattress, standard mattress length and width
  - E0373 - Non-powered advanced pressure reducing mattress

Visit the [Prior Authorization Process for Certain DMEPOS Items](#) webpage for more information, including the June 4, 2019 [Open Door Forum Slides](#) and [PA Operational Guide](#).

- **Dementia Care: Supporting Comfort and Resident Preferences Call — National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement - Tuesday, September 10, 12:30 - 2 pm CST.** 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.
• **New Medicare Card: Open Door Forum — Wednesday, September 11, 1 - 2 pm CST.** Join us for this Open Door Forum to learn about the status of new Medicare cards and Medicare Beneficiary Identifiers (MBIs). Are you ready for the end of the transition period on December 31? Starting January 1, 2020, you must use the MBI:
  - We will reject Claims you submit with Health Insurance Claim Numbers (HICNs) with a few exceptions
  - We will reject all eligibility transactions you submit with HICNs

Updated Alert Code – An updated alert Remittance Advice Remark Code now appears on remittance advices. Make sure your billing staff is aware of this change and uses the MBI:
  - N793: ALERT - Starting January 1, 2020, Medicare will ONLY accept claims submitted with the Medicare Beneficiary Identifier (MBI). Medicare will reject any claims submitted with the Health Insurance Claim Number (HICN) with a few exceptions.

Don’t have an MBI?
  - Ask your patients for their cards. 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.

• **Hospice Outcomes & Patient Evaluation Tool ODF — Thursday, September 12, 1 - 2 pm CST.** This Special Open Door Forum (SODF) is part of a series on a patient assessment tool, now called the Hospice Outcomes & Patient Evaluation (HOPE) Tool, and other key topics related to the Hospice Quality Reporting Program. During this SODF, get a status update and ask questions about the development of the tool. See the announcement for more information.

• **Opioids: What’s an “Outlier Prescriber”? Listening Session — Tuesday, September 17, 3:30 - 5 pm CST.** Register for Medicare Learning Network events. Are you a physician, nurse practitioner, other advanced practice nurse, or physician assistant who prescribes opioids? CMS wants your input on how best to implement Section 6065 of the SUPPORT Act.

Signed into law in October 2018, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) outlines national strategies to help address opioid misuse. As part of Section 6065 of the SUPPORT Act, CMS is required to notify opioid prescribers with prescription patterns identified as “outliers” compared to their peers and encourage them to reference established opioid prescribing guidelines. The purpose of this listening session is to get feedback on the following topics:
  - Methodology to establish outlier prescriber thresholds
  - Tone and content of feedback reports to clinicians
  - How to best identify a “medical specialty” from the National Provider Identifier framework
  - How to define geographic areas for analysis
  - Recommendations on opioid prescribing guidelines to include with the notification

You are encouraged to review the following materials before the call:
  - SUPPORT Act
  - Centers for Disease Control and Prevention (CDC) Guideline 2016
  - CDC Advisory
  - Food and Drug Administration Safety Alert
• **New Documentation Requirements for Filing Medicare Cost Reports.** A new MLN Matters Article SE19015 on [New Documentation Requirements for Filing Medicare Cost Reports](#) is available. Learn about causes for cost report rejection.

• **Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020.** A new MLN Matters Article MM11411 on [Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020](#) is available. Learn about changes effective October 1, 2019.

• **Claim Status Category and Claim Status Codes Update.** A new MLN Matters Article MM11393 on [Claim Status Category and Claim Status Codes Update](#) is available. Learn about updated code sets.

• **Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions.** A new MLN Matters Article MM11395 on [Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions](#) is available. Learn about the HH PDGM Grouper program and how we will process claims starting in CY 2020.

• **Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update.** A new MLN Matters Article MM11418 on [Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update](#) is available. Learn about changes to the code set including the addition of a new code and addition of definitions to existing codes.

• **Physician Fee Schedule Listening Session: Audio Recording and Transcript.** An [audio recording](#) and [transcript](#) are available for the August 12 Medicare Learning Network listening session on the Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics. CMS experts briefly cover provisions from the proposed rule and address your clarifying questions to help you formulate your written comments for formal submission.

• **ESRD QIP Call: Audio Recording and Transcript.** An [audio recording](#) and [transcript](#) are available for the August 20 Medicare Learning Network call on the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP): CY 2020 ESRD PPS (Prospective Payment System) Proposed Rule Call. Learn about the legislative framework, the proposed rule and methods for reviewing and commenting on the rule.

• **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.

• **New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued.** A reissued MLN Matters Article SE18006 on [New Medicare Beneficiary Identifier (MBI) Get It, Use It — Reissued](#) is available. Learn the latest information about the MBI including why to use it and how to handle special situations.

• **Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management.** A new MLN Matters Article SE19008 on [Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management](#) is available. Learn about National and Local Coverage Determinations and Chronic Care Management services for patients with chronic pain.

• **Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual.** A new MLN Matters Article MM11403 on [Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual](#) is available. Learn about current influenza codes and payment rates.

• **Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update.** A new MLN Matters Article MM11422 on [Quarterly Healthcare Common Procedure Coding](#)
System (HCPCS) Drug/Biological Code Changes - October 2019 Update is available. Learn about 44 new HCPCS codes, effective for claims with dates of service on or after October 1, 2019.

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

- **Ambulance Fee Schedule and Medicare Transports.** A new Ambulance Fee Schedule and Medicare Transports Booklet is available. Learn about coverage, billing and payment for ground and air ambulance transport benefits.

- **Getting Started with Hospice CASPER Review and Correct Reports.** Read Getting Started Review and Correct Reports for an overview of the Hospice Certification and Survey Provider Enhancement Reports (CASPER) Review and Correct Reports for Hospice Item Set data. Learn about the reports and how to use them. For more information visit the Hospice Quality Reporting Program Requirements and Best Practices webpage.

- **Behavioral Health Integration — Revised.** A revised Behavioral Health Integration Medicare Learning Network Booklet is available. Learn about:
  - Who can bill for services
  - CPT codes
  - Primary care services
  - Psychiatric Collaborative Care Model

- **Swing Bed Services — Revised.** A revised Swing Bed Services Medicare Learning Network Fact Sheet is available. Learn about:
  - Requirements that apply to hospitals and Critical Access Hospitals
  - Payments

- **Screening Pap Tests and Pelvic Examinations Booklet — Revised.** A revised Screening Pap Tests and Pelvic Examinations Booklet is available. Learn about:
  - Coverage
  - Documentation and coding
  - Billing and payment

- **Hospices: CASPER QM Fact Sheet — Updated.** CMS updated the Certification and Survey Provider Enhanced Reporting (CASPER) Quality Measure (QM) Reports Fact Sheet. It states that we added the Hospice When Death Is Imminent Measure Pair to both the Hospice-Level and Patient Stay-Level CASPER QM Reports. For more information, see the Hospice Quality Reporting Program Requirements and Best Practices webpage.

3. The federal Centers for Disease Control and Prevention (CDC) announces:

- **2018 Update – Antibiotic Use in the United States – Progress and Opportunities.** This 2018 update highlights new antibiotic stewardship data, programs and resources since the July 2017 report. CDC continues to work to improve antibiotic prescribing and use through data for action, implementation, innovation and education.

- **2019-2020 Flu Season Vaccine Recommendations.** CDC published the annual MMWR Recommendations & Reports on the use of influenza vaccine for the 2019-2020 season. This report updates the 2018–2019 recommendations of the Advisory Committee on Immunization Practices (ACIP) regarding the use of seasonal flu vaccines. Routine annual flu vaccination is recommended for all persons aged ≥6 months who do not have contraindications, using a licensed, recommended and age-appropriate vaccine.
4. The federal Office of the Assistant Secretary for Preparedness and Response (ASPR) released their August 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 Fiscal Year 2020 Provider Assessment Program. You may view the new notice [here](#).
   - HFS posted a new Provider Notice regarding Pharmacy Reimbursement Methodology. You may view the new notice [here](#).
   - HFS posted the 2018 Long Term Care Cost Reports. You may view the cost reports [here](#).
   - **This notice** is to inform you of the proposed settlement of a class action lawsuit (*O.B. v. Eagleson*, Case No. 15 C 10463) set forth in a proposed Consent Decree with the Director of the Illinois Department of Healthcare and Family Services regarding Medicaid services for children in Illinois under the age of 21 who receive in-home shift nursing. The Consent Decree requires the Department to take certain actions to enhance the abilities of class members to receive in-home shift nursing services at the levels approved by the Department in compliance with the law. The Court will hold a Fairness Hearing regarding the fairness, reasonableness, and adequacy of the proposed Consent Decree on November 5, 2019.
   - HFS posted a new Provider Bulletin regarding Chapter 100 – Handbook for Providers of Medical Services, General Policy and Procedures Elimination of Title XIX Copayments Effective September 1, 2019. You may view the new Provider Bulletin [here](#).
   - HFS posted a new Public Notice regarding Home and Community Based Services Waiver for Supportive Living. You may view the new notice [here](#).
   - HFS posted a new Provider Notice regarding LTC Monthly Occupied Bed Provider Assessment. You may view the new notice [here](#).

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

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

7. 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**

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

- **IHCA Member Alert – Staffing Rate Increase Update.** Yesterday IHCA and other stakeholders met with the Department of Healthcare and Family Services to discuss the staffing component of the skilled nursing rate increases, as well as the staffing plans that will be required to continue to capture that funding. IHCA was pleased to hear the approach the Department is taking when reviewing the provider’s staffing plan is broad and takes a more outcome-based approach. Of course, the devil can always be in the details, but the Department’s goal is seemingly to make this as simple, data driven, and outcome based as possible. Below are a few key points that we were able to clarify with the Department.

  - HFS will have a template for the new required annual staffing plan done by the end of September. They will also provide broad guidelines on what is acceptable and unacceptable within these plans.
  - They expect to have providers complete and submit a plan by mid-October.
  - The Oct-Dec quarter will be the first quarter monitored. HFS will have a template for that too.
  - HFS does not intend to audit how providers spend every penny of the $4.55; HFS wants providers to set acceptable targets on staffing and make progress toward the target and hit it by the end of the year.
  - HFS will NOT recoup the money. They will enforce prospectively so if you miss a target in a quarter, then next quarter you will not receive the $4.55 add on. If you get back on track with your plan the following quarter, you get the $4.55 again.
  - Revenues from the $4.55 for July -Sept 2019 the provider will keep and no plan is needed for approval during this quarter. The Oct-Dec 2019 revenues will be kept as well, but that quarter will be monitored based upon the provider’s plan. The Jan-March 2020 quarter is the first quarter providers could get their $4.55 reduced to zero.
  - HFS is working with IDPH to have a consistent plan on monitoring staffing so the Medicaid rate add-on and the new IDPH fines are harmonious with each other.

Bottom-line – once HFS begins paying the new rates providers will not need to segregate these funds or account for them in any special manner. The $4.55 funding will not be recouped. The penalty for not complying with the staffing plan will be a loss of the $4.55 in the next quarter.

**Important note.** HFS has an agreement with the Medicaid MCOs that they will begin to pay the new rates prospectively around October 1, even if federal CMS has not approved. Within an estimated 45 days after that, they expect the MCOs to make adjustments to claims prior to Oct 1 back to July 1. Providers will not be required to resubmit these claims. HFS FFS payments will not start until federal approval is received.

If you have further questions, please do not hesitate to reach out to Ashley Snavely or Matt Hartman.

- **Strengthen Your ICD-10 Coding.** Facilities that have piloted PDPM implementation have identified that a lack of understanding of the MDS and inaccurate ICD-10 coding and documentation are roadblocks to a successful PDPM implementation. With four weeks to go, you want your team to get the coding data correct. Now is the time to strengthen your ICD-10 coding. Register now for the online, self-paced AHCA/AHIMA ICD-10 trainings.
  - **Coder version**
  - **Non-coder version**
9. **The New York Times** reports *Long-Term Care Insurers Increasing Rates “Significantly” Causing Problems for Consumers.* *The New York Times* recently reported that insurers that offer long-term care coverage "have been imposing significant rate increases for nearly a decade, and the problem has the attention of the regulators in each state, who must approve premium increases." The article said, "The regulators’ national group created a task force earlier this year to address the issue, although the effort probably won’t provide much relief to" some people. The piece added that premiums are rising for several reasons, "but two of the more serious problems involved the predictions insurers made roughly two decades ago. Not only did they underestimate how long policyholders would live, they overestimated how many people would drop their policies, which meant insurers would not have to pay claims." At present, only a few companies are selling long-term care policies, "down from more than 100 in the market’s heyday."

10. **Skilled Nursing News** reported that **Tech Companies Providing Potential Solutions for Skilled Nursing Facilities.** *Skilled Nursing News* reports, "Data continues to be the watchword in a skilled nursing marketplace where hospitals and other referral partners demand increasingly concrete information about post-acute outcomes." In response to the demand, "numerous tech companies have stepped into the fray to provide potential solutions – from data analytics tools that can identify serious health issues before they escalate to a hospitalization, to tracking software that alerts SNFs when one of their former residents shows up at a hospital." However, this technology "doesn’t mean much if the frontline employees at a SNF don’t actually use it."

11. **McKnight’s** reports:

   - **Researchers Develop Model to Assess Readmission Risk of Surgical Patients Discharged to a SNF.** *McKnight’s Long Term Care News* reported, "A new model may let providers predict how likely it is for a skilled nursing facility post-surgical patient to be readmitted to the hospital." Researchers "developed their model to assess the readmission risk of surgical patients discharged to a SNF." Through a "study of 2,405 surgical patients who were discharged to 110 SNFs, researchers found that 519 of them experienced readmission within 30 days." The study, published in the *Journal of Post-Acute and Long-Term Care Medicine,* found that the "length of hospital stay, number of hospitalizations and surgery riskiness were associated with all of those readmissions."

   - **Exercise of any Intensity Cuts Early Mortality Risk in Older Adults.** Whether light, moderate or intense, any level of regular exercise lowers early mortality risk in middle-aged and older adults, new research from the University of Oslo has found.

   - **New Program Reduces Pain Intensity in Nursing Home Residents.** *McKnight’s Long Term Care News* reports that a new study published in the *Journal of the American Geriatrics Society* found that "nurses may be able to reduce pain for nursing home residents thanks to a new pain management program." The investigation "evaluated the effectiveness of a newly implemented pain management program within nursing homes."

12. **Interesting Fact:** The first U.S. Labor Day was celebrated on Tuesday, September 5, 1882 in New York City, planned by the Central Labor Union. The Labor Day parade of about 10,000 workers took unpaid leave and marched from City Hall past Union Square uptown to 42nd street, and ended in Wendel’s Elm Park at 92nd Street and 9th Avenue for a concert, speeches, and a picnic.
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!