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

**CMS Push for More Federal Funding for Survey Draws Industry Support**

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma released a blog post this week offering more details on quality and safety measures for skilled nursing facilities (SNFs), including a request for additional federal money to bolster the survey process and State Survey Agencies (SSAs).

The post, titled, “Ensuring Safety and Quality in Nursing Homes: Five-Part Strategy Deep Dive,” picked up where CMS left off in April when Verma announced a five-part approach to the issue, which entails efforts to: Strengthen Oversight, Enhance Enforcement, Increase Transparency, Improve Quality and Put Patients over Paperwork.

The new blog entry is the first in a series on each of the five categories and covered oversight matters.

After describing the steps CMS has taken to modernize and improve the survey process, Verma said the agency is not alone in this effort, and needed help from Congress, too.

Currently, she said CMS (through SSAs) is required by law to annually inspect each SNF that participates in Medicare and Medicaid, a total of approximately 15,000 facilities. Additionally, SSAs inspect SNFs upon receipt of complaints or facility-reported incidents. Combined, these surveys total roughly 70,000 inspections each year.

“This is a monumental task. The mandated annual survey cycle is costly to SSAs and requires us to use precious resources to survey each facility, regardless of their quality performance,” Verma said.

As a result, she said in President Trump’s Fiscal Year (FY) 2020 budget proposal, “we’ve asked Congress for the authority to transition to a risk-based survey model for nursing homes so we can target low-performing nursing homes with more frequent surveys.”

CMS proposes to survey top-performing facilities every 30 months, with no more than 36 months between surveys of any single facility. “We would reinvest the savings to strengthen our oversight and quality improvement efforts for facilities that are low performers,” Verma said.

“We would also continue to inspect facilities in response to complaints, which can occur at both low- and high-performing facilities, giving providers incentive to continuously monitor quality.”

Verma said the president’s budget proposal asks for $442.2 million in FY 2020 for the CMS Survey and Certification budget, an increase of $44.9 million above what Congress enacted in 2019.
In response, the American Health Care Association (AHCA) offered its backing of the push for more funding.

“AHCA supports the request for more funding to strengthen the survey process and to support State Survey Agencies and their work,” says David Gifford, MD, senior vice president of quality and regulatory affairs. “The consistency and timeliness of the survey process is important, and we support CMS’ work to address those issues. We share the CMS commitment to improving the lives of every resident in nursing homes across the country.”

Verma also said more needs to be done in making sure the survey process is standardized across the country, not dependent on geography for how the system works.

“Our nation is vast, and the states vary widely with regard to culture, geography, and climate. But high-quality health care should be the same, no matter the location,” she said. “This means that all SSAs must fairly and consistently apply CMS rules. Unfortunately, in recent years CMS has found variation across states in terms of the issues SSAs identify in nursing homes’ compliance with our requirements.”

See the entire blog post at www.cms.gov.

**How Your Facility Can Prepare for USP**

We are less than three months away from Dec. 1—the day that USP<800> will go into effect. Created by the United States Pharmacopeia (USP), USP<800> is designed to educate and enforce the safe handling of hazardous drugs to protect healthcare workers and patients. It is an important set of standards, as unsafe exposure to hazardous drugs poses health risks, ranging from short-term reactions (e.g., nausea or skin rashes) to long-term effects (e.g., infertility or cancer).

Whereas past standards like USP<797> only covered sterile preparations in facilities where compounding occurs, USP<800> will encompass the end-to-end handling process: receiving, transport, storage, compounding, dispensing, administration, patient care, cleaning, disposal and waste management. Therefore, practically all types of medical practices handling and dispensing hazardous drugs will need to meet compliance.

**Does USP<800> matter to skilled nursing and long-term care?**

In skilled nursing and long-term care, common drugs like warfarin and oxytocin are administered to patients regularly. These too are considered hazardous by the Centers for Disease Control and Prevention and National Institute for Occupational Safety and Health.

Further, it is common practice to crush or split medication tablets in long-term care and assisted living facilities for convenience and to assist residents with swallowing. For drugs which are hazardous if altered by crushing, breaking, splitting, or other manipulation from their intended dosage form, you need to consider potential exposure, surface contamination and medication errors. In fact, it is estimated that 10 percent of all medication is not suitable for splitting or crushing.

**Where will enforcement of these standards come from?**

Enforcement of USP<800> will initially come from the state boards of pharmacy. The Food and Drug Administration (FDA) may also carry out enforcement through the 2013 Drug Quality and Safety Act. The Joint Commission can enforce the standards during accreditation surveys. Further, the Occupational Safety and Health Administration (OSHA) already has authority wherever worker safety is concerned. It is up to each skilled nursing and long-term care facility to ensure they have the proper policies and procedures in place ahead of Dec. 1.

**How can you prepare your facility for USP<800>?**

USP<800> outlines guidelines to mitigate risks from exposure, including personnel responsibilities for hazardous drug handling, the use of protective equipment, decontamination and cleaning for spills, and safe disposal. It may seem daunting at first, but there are proactive steps that you can take to prepare and meet compliance:
• Review NIOSH’s list of hazardous drugs

Since 2004, NIOSH has continued to update the “NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.” NIOSH has made the list available online so healthcare workers always have access to the most current list. Before Dec. 1, facilities should review this document to see if they handle any of the listed drugs. Nurses and other staff members should also plan to download the <800> HazRx™ Mobile App. Released by USP itself, the app enables you to select any drug, your activity and access handling instructions in accordance with USP<800> standards to minimize on-the-job risk.

• Appoint a compliance leader

Given the vast number of USP <800> requirements, it is a good idea to appoint one experienced individual to serve as a compliance leader. They may be an on-site pharmacist, nurse, or administrative staff member. The compliance leader should know all USP <800> guidelines so that they can serve as a single point of contact for accountability and dissemination of information.

• Perform an initial risk assessment

An initial risk assessment helps to identify areas of potential exposure within your facility so that you can revise current policies and procedures. An assessment should include documentation of all hazardous drugs by type and dosage, and analysis of how they are packaged, stored, manipulated and moved throughout a facility. Due to the frequency of splitting and crushing medications in long-term care and assisted living facilities, the assessment should include a review of whether certain drugs can be split or crushed, as well as if equipment and safeguards are in place or need to be.

The assessment should also include a list of all staff members who may encounter hazardous drugs while performing their job duties—even non-medical staff, such as those in shipping and receiving and housekeeping.

• Invest in online tools and education

USP <800> mandates that everyone handling hazardous drugs must understand the requirements and how to properly perform their job function. For instance, a housekeeper will need to know how to recognize a dangerous spill and the appropriate steps for escalation so that the issue is contained. The level of competency across a facility should be assessed every 12 months, as well as when a new hazardous drug is introduced. Online toolkits are now available to help facilities and employees with compliance.

These toolkits include resources for risk assessments, up-to-date hazardous drug lists, customizable safety data sheets and policy templates. Policy templates are particularly beneficial as they enable you to custom create electronic policy manuals, detailing everything from floor plans and diagrams for how drugs move throughout the facility, to instructions for equipment use and maintenance. By making policy manuals available in a digital format, it is easier to track who has received them and ensure everyone has the most up-to-date information.

Online training courses can help to educate staff on the hazardous drug handling guidelines. Online education provides the added benefit of being able to monitor and report on who has completed the required training. Moreover, staff members can take the courses on their own time so they don’t have to take time out of their schedule for lengthy seminars. External resources for toolkits and training can simplify compliance greatly for skilled nursing and long-term care facilities, in the days leading up to December and thereafter.

*This article was authored by Brian Williams and reprinted out of McKnight’s.*

Focus F-Tag – F580 – Notify of Changes (Injury/Decline/Room Etc.)

This Regulatory Beat’s Focus F-Tag is F580 Notify of Changes, which is part of the Residents Rights regulatory group. This requirement is relatively straightforward as far as requirements go, however, it is widely cited across the country, including at the more severe levels of Scope and Severity, including Actual Harm and Immediate Jeopardy. The
regulation at F580 requires that facilities provide immediate notification of several things to the resident, consult with the resident’s physician and notify the resident representative (as required). These include:

- When a resident has an accident that results in injury and may require physician intervention (including, per the Interpretive Guidance (IG), chest pain, loss of consciousness and other signs/symptoms of a heart attack or stroke).
- When the resident experiences a significant change in status (physical/mental/psychosocial).
- When there a significant change in treatment required.
- When the resident will be transferred or discharged from the facility. The facility needs to provide the appropriate documentation (required under F622) is available for the physician to review. This include the documentation in the medical record.
- When the resident will be admitted to a composite distinct part of the facility.

Notification to the resident and resident representative must promptly be made when there is a change to the resident’s room or roommate or a change to the resident’s rights. The facility is also responsible for ensuring that it records and periodically updates contact information for the resident representative (phone/mailing address/email). The Interpretive Guidance (IG) states that even if a resident is competent, the resident representative should be notified of significant changes in health status because the resident may not be able to notify them themselves. Likewise, even if the facility notifies the resident representative because the resident does not have decision-making capacity, the facility is responsible for telling the resident what is happening to him/her.

How It’s Being Cited
Some frequently cited issues that have been cited as either Actual Harm or Immediate Jeopardy level deficiencies include:

- Failure to notify the physician after a resident experienced:
  - Respiratory distress
  - Change in condition – vital signs, abnormal lab values
  - Significant weight loss
  - Pain
  - Meds not administered due to unavailability
- Failure to notify licensed staff after resident experienced:
  - Fall with injury
  - Pain during wound care
  - Food/liquid intake reduced

This is, from many perspectives, a “gotcha” deficiency. We simply fail to communicate in a timely and effective manner with the representative or the physician. A facility should consider developing a list of changes/concerns/criteria for which physician and representative notification should be conducted and it should be comprehensive. There also needs to be a clear understanding by all staff of what is considered an acceptable timeframe for carrying out the notification. Pick up that phone and make those notification calls and document this contact in the medical record.

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**Trending Statistics**

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

**Final Death Data for 2017 – CDC National Vital Statistics Report**

The Centers for Disease Control and Prevention (CDC) recently release the final death data for 2017 ([click here](#)). In 2017, a total of 2,813,503 deaths were reported in the United States. The age-adjusted death rate was 731.9 deaths per
100,000 U.S. standard population, an increase of 0.4 percent from the 2016 rate. Life expectancy at birth was 78.6 years, a decrease of 0.1 year from the 2016 rate.

The 15 leading causes of death in 2017 were:
1. Diseases of heart (heart disease)
2. Malignant neoplasms (cancer)
3. Accidents (unintentional injuries)
4. Chronic lower respiratory diseases
5. Cerebrovascular diseases (stroke)
6. Alzheimer disease
7. Diabetes mellitus (diabetes)
8. Influenza and pneumonia
9. Nephritis, nephrotic syndrome and nephrosis (kidney disease)
10. Intentional self-harm (suicide)
11. Chronic liver disease and cirrhosis
12. Septicemia
13. Essential hypertension and hypertensive renal disease (hypertension)
14. Parkinson disease
15. Pneumonitis due to solids and liquids

Important Regulations, Notices & News Items of Interest

1. There were two 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 19-19 – NH - Updates to Civil Money Penalty (CMP) Reinvestment Resource Materials. CMS has updated and added CMP reinvestment resources on the CMP Reinvestment Resource Web Page, available here. Updated resources include the following: CMP reinvestment application resources; CMP reinvestment state plan resources; State CMP reinvestment projects funded in calendar years (CY) 2017 and 2018; Examples of CMP funded projects as well as non-allowable uses of CMP funding.

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

   - CMS Releases Final RAI Manual for PDPM Kick-Off. Twelve days before the Oct. 1 transition to the Patient-Driven Payment Model (PDPM) for Medicare payments to skilled nursing facilities, CMS released the final version of the MDS 3.0 RAI Manual (version 1.17.1). Skilled nursing centers had identified this latest update as the final piece of regulatory guidance they were waiting for before the PDPM rollover in less than two weeks. The final update includes new guidance on swing-bed providers, coding items, and group therapy payment clarifications. See the CMS release here.

   - 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 (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
- Implementation of the SNF PDPM MLN Matters Article
- New Medicare Webpage on PDPM MLN Matters Article

• **New Medicare Card: Why Use the MBI?** Use Medicare Beneficiary Identifiers (MBIs) now to protect your patients’ identities. 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 Health Insurance Claim Number (HICN).

Starting January 1, 2020, you must use MBIs regardless of the date of service:
- We will reject claims you submit with HICNs with a few exceptions
- We will reject all eligibility transactions you submit with HICNs

For more information:
- MLN Matters Article
- September 11 ODF Presentation

• **New Medicare Card: Do You Refer Patients?** When you refer a patient for a service, such as a laboratory test or medical supplies, be sure to coordinate with the entity providing the service. All providers must use the Medicare Beneficiary Identifier (MBI) when billing Medicare. Starting January 1, 2020:
  - We will reject claims submitted with Health Insurance Claim Numbers (HICNs) with a few exceptions
  - We will reject all eligibility transactions submitted with HICNs

For more information, see the MLN Matters Article.

• **Health Care Supply Chain, Provider Self-Care, and Emergency Preparedness Resources.** The most recent Express and webinar from the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) highlight recently developed resources, including:
  - Partnering with the Health Care Supply Chain during Disasters: Emergency planning and response considerations for supply chain owners, operators, end users, and health care coalitions
  - Disaster Behavioral Health Self Care for Health Care Workers Modules: Use prior to a disaster to recognize and reduce your stress levels and maintain resilience during recovery
  - Emergency Preparedness Information Modules for Nurses in Acute Care Settings: Addresses perceived gaps in emergency preparedness and response knowledge for nurses
For More Information:
  o  [ASPR TRACIE](#) Fact Sheet
  o  [ASPR TRACIE](#) website

- **New Enforcement Authorities to Reduce Criminal Behavior in Medicare, Medicaid, and CHIP.** CMS issued a final rule, effective November 4, 2019, that strengthens the agency’s ability to stop fraud before it happens by keeping unscrupulous providers out of our federal health insurance programs. This first-of-its-kind action – stopping fraudsters before they get paid – marks a critical step forward in our longstanding fight to end “pay and chase” in federal health care fraud efforts and replace it with smart, effective and proactive measures.

The final rule creates several new revocation and denial authorities to bolster our efforts to stop waste, fraud and abuse. A new authority in the rule allows CMS to identify individuals and organizations that pose an undue risk based on their relationships with other previously sanctioned entities.

The rule also includes other authorities that will effectively improve our fraud-fighting capabilities. Similar to the affiliations component, these authorities provide a basis for administrative action to revoke or deny, as applicable, Medicare enrollment if a provider or supplier:
  o  Circumvents program rules by coming back into the program, or attempting to come back in, under a different name
  o  Bills for services/items from non-compliant locations
  o  Exhibits a pattern or practice of abusive ordering or certifying of Medicare Part A or Part B items, services, or drugs
  o  Has an outstanding debt to CMS from an overpayment that was referred to the Treasury Department

The new rule also gives CMS the ability to prevent applicants from enrolling in the program for up to 3 years if a provider or supplier is found to have submitted false or misleading information in its initial enrollment application. Furthermore, the new rule expands the reenrollment bar that prevents fraudulent or otherwise problematic providers from re-entering the Medicare program. CMS can now block providers and suppliers who are revoked from re-entering the Medicare program for up to 10 years. Additionally, if a provider or supplier is revoked from Medicare for a second time, CMS can now block that provider or supplier from re-entering the program for up to 20 years.

To learn more, visit the Center for Program Integrity Spotlight webpage. See the full text of this excerpted CMS Press Release (issued September 5).

- **LTCH Provider Preview Reports – Now Available.** Long-Term Care Hospital (LTCH) Provider Preview Reports have been updated and are now available. The data contained within the Preview Reports is based on quality data submitted by LTCHs between Quarter 2 – 2018 and Quarter 1 – 2019, and reflects what will be published on LTCH Compare during the December 2019 refresh of the website. Providers have 30 days (9/11/19 to 10/11/19) to review their performance data. Corrections to the underlying data will not be permitted during this time; however, providers can request CMS review of their data during the preview period if they believe the quality measure scores that are displayed within their Preview Reports are inaccurate.

As a reminder, data for the quality measure Percent of Residents or Patients that have New or Worsened Pressure Ulcers (short stay), will continue to reflect data collected between Quarter 3 2017 – Quarter 2 2018. This data will continue to be publicly displayed until such time as the new Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, is publicly displayed in fall 2020, as finalized in the FY 2018 IPPS/LTCH PPS Final Rule.

As of the December 2019 refresh, CMS will no longer publicly display the National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia outcome measure, as finalized in the FY 2019 IPPS/LTCH PPS Final Rule. This change is reflected in your preview reports.
LTCHs can access their preview report by logging in to iQIES at https://iqies.cms.gov/. At the main screen, select Reports; then ‘My Reports’. For more information: LTCH Quality Public Reporting webpage and LTCH Compare.

- **Hospice Provider Preview Reports Now Available.** Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® provider preview reports have been updated and are now available. These two separate reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from Quarter 1, 2018 to Quarter 4, 2018 and their facility-level CAHPS® survey results from Quarter 1, 2017 to Quarter 4, 2018.

  Providers have 30-days to review their HIS and CAHPS® results (September 11, 2019 through October 11, 2019) prior to the November 2019 Hospice Compare site refresh, during which this data will be publicly displayed.

  Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data webpage and the Public Reporting: CAHPS® Preview Reports and Requests for CMS Review of CAHPS® Data webpage. For more information on how to access these reports, view the HIS Preview Report Access Instructions and the Hospice CAHPS® Provider Preview Reports Access Instructions.

- **Hospices: Call for Panel on Assessment Instrument and Quality Measures — Nominations due September 30.**
  Nominations are due September 30 for a Technical Expert Panel (TEP) to provide input on a hospice assessment instrument and corresponding set of quality measures in support of the Hospice Quality Reporting Program. For more information, visit the TEP webpage.

- **Important Updates on the Hospice Quality Reporting Program (HQRP).** CORMAC sends informational messages to hospices related to the Quality Reporting Program (QRP) on a quarterly basis. Their latest outreach communication can be found on the HQRP Requirements and Best Practices webpage. If you want to receive CORMAC’s quarterly emails, then add or update the email addresses to which these messages are sent by sending an email to QRPHelp@cormac-corp.com. Be sure to include your facility name and CMS Certification Number (CCN) along with any requested updates.

- **Presentation for the September 2019 HQRP Special Open Door Forum Available.** CCSQ will host a Special Open Door Forum (SODF) in September to allow hospices and other interested parties to ask questions on the development of the Hospice Outcomes & Patient Evaluation (HOPE). This SODF is part of a series of regular SODF’s CMS plans to host on this patient assessment tool and other key topics related to the Hospice Quality Reporting Program. The presentation for this event is now available in the Downloads section of the HOPE page.

- **Pain Management: CDC Conversation Starters for Patients and Their Doctors.** The Centers for Disease Control and Prevention (CDC) released four new fact sheets that encourage patients and doctors to discuss pain management options and the potential risks of opioid medication. Information includes:
  - What patients can expect if they are taking opioids
  - Guidance on safer use
  - Prompts for a doctor-patient discussion of treatment goals and plans
  - Non-pharmacologic and non-opioid medication options for pain management.

  The fact sheets cover the important questions and information you should cover when you talk to your patients about:
  - Acute pain
  - Chronic pain
  - Prescription opioids
  - Reducing risk of opioid addiction
Chiropractic Services: Comply with Medicare Billing Requirements. In a recent report, the Office of Inspector General (OIG) determined that payments for chiropractic services did not comply with Medicare billing requirements. Overall, medical record documentation did not support medical necessity or corrective treatment. CMS developed the Medicare Documentation Job Aid for Doctors of Chiropractic Educational Tool to help you bill correctly. Additional resources:
- Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits MLN Matters Article
- Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449) MLN Matters Article
- Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article
- Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services OIG Report
- Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12, Section 220


Refresher Webinars on Reporting Healthcare Personnel Influenza Vaccination Summary Data. The Centers for Disease Control (CDC) invites staff from inpatient rehabilitation facilities (IRFs) and long-term acute care hospitals (LTACHs or LTCHs) to participate in live training webinars. The webinars will cover reporting healthcare personnel (HCP) influenza vaccination summary data to the National Healthcare Safety Network (NHSN).

These are refresher trainings, as the reporting requirements have not changed from last year’s influenza season. The trainings will review topics such as requirements for collecting HCP influenza vaccination summary data and entering data into NHSN. The webinars will be presented at the dates and times listed below:

Training Webinars for Inpatient Rehabilitation Facilities
- Tuesday, October 1, 2019 from 2-3 PM ET
- Wednesday, October 9, 2019 from 11:30 AM-12:30 PM ET

Training Webinar for Long-term Acute Care Hospitals
- Thursday, October 3, 2019 from 12:30 PM-1:30 PM ET

Facilities can register for a webinar using this link: https://www2.cdc.gov/vaccines/ed/nhsn/registration/.

For questions on HCP influenza vaccination summary data reporting, please send an e-mail to: NHSN@cdc.gov and include “HPS Flu Summary” and your facility type in the subject line.

2019-2020 Influenza (Flu) Resources for Health Care Professionals. A new MLN Matters Article SE19022 on 2019-2020 Influenza (Flu) Resources for Health Care Professionals is available. Learn about payment and coverage for the influenza vaccine.


- Who can submit reports
Steps

Benefits

• **Medicare Billing: CMS Form CMS-1500 and the 837 Professional — Revised.** A revised Medicare Billing: CMS Form CMS-1500 and the 837 Professional Medicare Learning Network Booklet is available. Learn:
  o When Medicare will accept a hard copy claim form
  o Filing requirements
  o How to submit and code claims

• **Medicare Secondary Payer — Revised.** A revised Medicare Secondary Payer Medicare Learning Network Booklet is available. Learn:
  o When Medicare pays first
  o How to gather accurate data from the beneficiary
  o What happens if you fail to file correct and accurate claims

• **Roadmap to Behavioral Health — Updated.** CMS and the Substance Abuse and Mental Health Services Administration updated the Roadmap to Behavioral Health. This guide includes information about mental health and substance use disorder services, finding a behavioral health provider, defining behavioral health terms, receiving services, and following up on care. To learn more, visit the From Coverage to Care webpage or email CoverageToCare@cms.hhs.gov.

• **Home Health Call: Audio Recording and Transcript.** An audio recording, transcript, revised presentation and clarification are available for the August 21 Medicare Learning Network call on the Home Health Patient-Driven Groupings Model (PDGM): Operational Issues. Learn information to help your agency prepare to implement billing changes for the PDGM on January 1, 2020.

• **SNF Value-Based Purchasing Call: Audio Recording and Transcript.** An audio recording and transcript are available for the August 27 Medicare Learning Network call on Understanding Your Skilled Nursing Facility (SNF) Value-Based Purchasing Program Performance Score Report. CMS experts present a high-level summary of the program and highlight payment year one results.

• **Medicare Secondary Payer Provisions Web-Based Training Course — Revised - With Continuing Education Credit.** A revised Medicare Secondary Payer Provisions Web-Based Training (WBT) course is available through the Medicare Learning Network Learning Management System. Learn about:
  o Identifying provisions
  o Recognizing when Medicare is primary and secondary
  o Filing accurate claims

• **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:
  o Integrated Coding & PDPM Case Study – Run time: 58 mins

For more information, visit the PDPM webpage.

• **Medicare Enrollment for Institutional Providers — Reminder.** The Medicare Enrollment for Institutional Providers Medicare Learning Network Booklet is available. Learn:
  o Who are institutional providers
  o How to obtain a National Provider Identifier
  o How to respond to Medicare Administrative Contractor requests
• Medicare Enrollment Resources Educational Tool — Reminder. The Medicare Enrollment Resources Medicare Learning Network Educational Tool is available. Learn:
  o How to enroll
  o What to do if you encounter enrollment problems
  o Where to find enrollment forms

• PECOS FAQs Booklet — Reminder. The PECOS FAQs Medicare Learning Network Booklet is available. Learn about:
  o Getting started with the Provider Enrollment, Chain, and Ownership System (PECOS)
  o Enrollment application
  o Application fee
  o Supporting documentation

• PECOS Technical Assistance Contact Information Fact Sheet — Reminder. The PECOS Technical Assistance Contact Information Medicare Learning Network Fact Sheet is available. Learn who to contact when you need technical support for the Provider Enrollment, Chain, and Ownership System (PECOS).

3. The Agency for Healthcare Research and Quality (AHRQ) announced a free AHRQ Webinar on the Role of Health IT to Improve Care Transitions. On September 26, 1 to 2:30 p.m. CST, discussion on how health IT can improve care transitions for patients with complex conditions. Presenters will discuss their work on smartphone-based applications to improve care coordination, an interactive patient-centered discharge toolkit to promote self-management and the role of clinical decision support in improving care transitions for patients with multiple chronic diseases. This webinar is ideal for healthcare researchers, physicians, physician assistants, nurses, pharmacists and other health care professionals, health IT researchers and vendors. Registration Information.

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

  • HFS’ Supportive Living Program has published a new Approved Dementia Care Settings Directory. You may view the new Directory here.

  • HFS posted a new Provider Notice: ABE Partner Portal Report of Birth is Live! You may view it here.

  • HFS posted a new Provider Notice regarding the Williams Consent Decree. You may view the new notice here.

  • HFS posted a new Provider Notice regarding Update: Long Term Care Rejected Admission Transaction Review Project. You may view the new notice here.

  • HFS posted a Podiatry Fee Schedule Update. You may view the new Fee Schedule here.

  • HFS posted a new Practitioner Fee Schedule, updated 09/11/2019. You may view the new Fee Schedule here.


  • HFS posted an updated Taxonomy for 837I. You may view the updated document here.

  • HFS’ Bureau of Rate Development and Analysis, has posted the Distribution of Fiscal Year 2020 Disproportionate Share Hospital (DSH) Determination for Hospitals. You may view the letters here.

  • HFS posted a new Provider Notice regarding Webinar Trainings for the Family Support Program (FSP) and the Specialized Family Support Program (SFSP). You may view the new notice here.
• HFS posted a new Provider Notice regarding Transportation Billing Reminders. You may view it here.

• HFS posted a new Provider Notice regarding Required Staffing Plan for Nursing Facilities. You may view it here.

• HFS posted a new Provider Notice regarding Ordering/Referring/Prescribing Provider Enrollment and Provider Directory. You may view the new notice here.

• HFS posted a new Provider Notice regarding Attending Provider NPI Requirements Delay to November 1, 2019. You may view the new notice here.

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

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

• The Power Point Presentation for the Colbert Consent Decree Webinar (affecting Cook Count only) can be found here.

• In the Friday (9-20-19) Illinois Register, there was one proposed rulemaking by the Illinois Department of Public Health (IDPH) of interest: This proposed rulemaking implements federal regulations for long term care assistants and aides training programs to include requirements consistent with current federal regulations for instructors who train nurse aides. This rulemaking includes several new Sections to provide the Department direct oversight of requirements for an Advanced Nursing Assistant Training Program (ANATP) and provides updates to the requirements for a Basic Nursing Assistant Training Program (BNATP.) The proposed rulemaking seeks to update state rules to be consistent with current federal regulations, addresses federal mandate for states to create a “career ladder” for advanced nurse aide training, and to implement best practices in nurse aide training programs as suggested by nursing professionals and IDPH professional staff.

6. 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.

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

• Preparing for PDPM – October 1, 2019. Are you ready for the Patient-Driven Payment Model (PDPM) to start on October 1? The American Health Care Association (AHCA) has many resources to help you prepare. AHCA members have access to free resources including:
  o PDPM Academy, which you can register for here and includes helpful PDPM Frequently Asked Questions.
  o Check out our other PDPM resources available to members on ahcancalED.
Be sure to take advantage of everything so you are ready for October 1. Please email pdpm@ahca.org with any questions.

- **PDPM Transition Preparation.** As we approach implementation of the new Patient-Driven Payment Model (PDPM), I want to make sure you have last minute tips and resources to be successful and **ensure facilities are correctly and adequately reimbursed**. You will receive a weekly email with important information on critical areas of PDPM as we head into October 1 and post-implementation. I hope you find this information helpful.

With only a few days until PDPM goes live, skilled nursing facilities (SNFs) should be assessing, testing, and making improvements in frontline staff preparedness and systems readiness using real time drills on a variety of PDPM-critical functions. Over the next three weeks, I'll be highlighting key action steps you should have underway.

**Beta Test Information Technology Functions.** PDPM is a complex system which requires a far more detailed collection of patient clinical information and diagnoses than under the soon-to-end Resource Utilization Group (RUG IV) system.

1. SNFs should have requested patient classification simulations and compared those simulations with the outcomes from manual classifications conducted on the same patients but by clinicians.
2. SNFs should assess medical information storage and how new PDPM clinical information is collected and used to keep the care plan current.
3. Assessing how Minimum Data Set (MDS) information flows to billing offices is critical. With 188 MDS items driving payment, and several requiring ICD-10 codes, communication between clinical systems and billing systems is essential.

**Review PDPM Transitional Interim Payment Assessments (IPA) Capacity.** In October, SNFs must convert all Part A fee-for-service (FFS) patients to PDPM using a Transitional IPA. Converting all Part A patients to PDPM on one day, or handful of days, will likely be overwhelming and result in errors and payment problems. **SNFs should have a plan to gather information on all September admissions as if they are PDPM admissions.**

1. Starting to conduct September admissions as if they were PDPM admissions is both good practice for admissions and interdisciplinary team staff and will reduce burden in October.
2. Use the September "dress rehearsals" to assess your Return to Provider rate and implement strategies to reduce the rate if it is high.
3. SNFs should also have a schedule for Transitional IPAs so the assessments are not all clustered around a handful of days.

Please email pdpm@ahca.org with any questions.

- **Preparing for the PDPM.** Are you ready for the Patient-Driven Payment Model (PDPM) to start on October 1? The American Health Care Association (AHCA) has many resources to help you prepare. What can you do to prepare?

  1. If you haven't logged into Long Term Care (LTC) Trend Tracker, now is the time. AHCA offers a quarterly Top-Line report that highlights your center's progress on Five-Star, the AHCA/NCAL Quality Initiative, rehospitalization rates, and your current progress and eligibility to apply for Quality Awards. It also helps you understand your survey ratings.
  2. Access your facility's personal Top-Line PDPM report [here](#). This report is a snapshot of previous coding practices for ICD-Coding on MDS assessments. Use this [step-by-step guide](#) to access your reports.
  3. Make sure you know as much as possible about ICD-10 coding under PDPM. Check out our [training sessions](#). One is an in-depth course for coders, and the other offers basic knowledge for non-coders. Both courses provide key information that will support a successful PDPM implementation.

Please email help@ltctrendtracker.com if you need assistance.

- **New Resource: AHCA Grouper Tool.** The AHCA Grouper Tool was developed to help AHCA members with PDPM implementation and to directionally understand the financial impact of PDPM. Please note the AHCA Grouper
Tool is not a substitute for the forthcoming CMS GROUPER tool. Rather, it is intended to help members simulate PDPM payments and probable PDPM performance. The user guide explains how to use the AHCA Grouper Tool, along with important model and data considerations. The tool allows the user to input patient-level data and derive estimated PDPM payments for non-interrupted patient stays. The user will be able to use this tool to understand the difference between reimbursement under RUG-IV and PDPM at a patient and facility level.

- AHCA PDPM Grouper Tool Guide
- AHCA PDPM Grouper Tool

Please e-mail educate@ahca.org for assistance.

- CMS Releases Additional PDPM Resources. On August 30, the Centers for Medicare and Medicaid Services (CMS) updated an array of subregulatory PDPM materials including:
  - PDPM FAQs – Changes in terminology such as 5-Day Assessment now called the Initial Medicare Assessment;
  - Patient Classification – Updates Case Mix Indices based on the Final Rule;
  - Interrupted Stay – Updates the Interrupted Stay Example;
  - Therapy Group and Concurrent – Updates the Definition of Group to 2 – 6 Residents; and
  - PDPM ICD-10 Mapping – Updates following the Final Rule Changes.

These materials can be viewed here. Please note that the documents which have been updated have an 8/30/2019 date stamp next to them.

Be Prepared
AHCA has resources to help you be prepared for the October 1 implementation of PDPM.

- Visit ahcancalED to find all our online resources to help you be ready for PDPM on October 1.
- PDPM training will be a major focus at the 70th AHCA/NCAL Convention and Expo, October 13-16 in Orlando, FL. Education sessions will focus on a variety of topics, including PDPM and the Future of SNF Payment and Organizational Success Under PDPM. Be sure to register today.

Please feel free to email the AHCA PDPM team with any questions, suggestions, or concerns.


- AHCA/NCAL Social Media Update.

- AHCA PDPM Academy Update: September 20.

  - New Toolkit Available: CMS PDPM HIPPS Coding Webpage Resource (posted 9/20/19). This webpage contains information related to the use and maintenance of the Health Insurance Prospective Payment System (HIPPS) codeset. CMS is named in the ASC X12 837 Institutional Claim Implementation Guide as the code source for HIPPS codes. The following files contain specific details regarding the SNF PPS PDPM HIPPS code construction as well as a master list of all valid HIPPS codes applicable to PDPM.
    - Definition and Uses of HIPPS Codes
    - HIPPS Code Master List - an Excel spreadsheet that provides a complete list of all valid HIPPS codes, with their effective dates, payment settings, and code definitions.

  - Archive Recording of 9/19 webinar:
    - Using Organizational Change Management to Drive & Maintain Optimal PDPM Performance
    - Suggested Organizational Change Management Resources handout

  - Save The Date. Upcoming PDPM Webinars to assist members after the PDPM transition are available here:
October 24, 3-4:00 PM ET  
October 31, 3-4:00 PM ET  
November 7, 3-4:00 PM ET  
November 14, 3-4:00 PM ET  

November 21, 3-4:00 PM ET  
December 5, 3-4:00 PM ET  
December 19, 3-4:00 PM ET  

- An Update from the AHCA Chair – September 2019

- Nominations for 2020/2021 AHCA Committees. Starting September 17 through October 21, you have the opportunity to nominate yourself or another member to serve on one or more of the following committees: Business Management, Clinical Practice, Constitution and Bylaws, Credentialing, Customer Experience, Emergency Preparedness, Independent Owner Council, Intellectual and Developmental Disabilities (ID/DD) Residential Services, Legal, Life Safety, Not for Profit Council, Political Action and Involvement (PAIC), Quality Improvement, Regional Multifacility Council, Reimbursement, Survey/Regulatory and Workforce.

AHCA Facility Member Nominations:  
All AHCA members are highly encouraged to participate in this process. In an effort to create diverse and widespread representation, appointments to specific committees may be limited to one participant per state and company. To assist in the process, individuals should be nominated for up to three committees and rank their selections in order of preference. To submit your nominations, please complete the Online Form.

State Affiliate Executives and Staff:  
The leadership of the Affiliated State Health Care Association Executives (ASHCAE), representing the state executives from AHCA’s 49 state affiliates and the District of Columbia, appoint state executives and state affiliate staff to the AHCA committees. State affiliate staff and state executives can submit their nominations through the Survey Monkey.

Non-Provider Members/Associate Business Member (ABM) Nominations:  
As a benefit of membership, only Gold Associate Business Members of AHCA/NCAL (national office) may serve on committees. To submit nominations and committee selection, please complete the Online Form. For further information regarding the nomination of a vendor representative, please contact Allison Frenkel.

We appreciate your willingness to serve in any capacity and are committed to do everything we can to honor your committee selections.

All 2020/2021 committee appointments will be for a two-year term. Appointments are finalized by the AHCA Board of Governors Chair. In order to keep committee sizes at optimal levels, applicants are likely to be assigned to just one committee. Please visit the AHCA website for a list of committee descriptions.

Please note the following items regarding this process:
1. User Name and Password: If you have not done so already, please obtain an AHCA website user name and password on the website here. This is necessary to access the nomination materials on the AHCA website.
2. Current Committee Members: All current committee members who wish to be re-appointed for 2018/2019 must nominate themselves or have another member nominate them.

If you have any questions regarding this process, please contact Christy Herle.
We hope you will take this opportunity to be an active member!

8. The New York Times reports Health Experts Say Skilled Nursing Facilities Vulnerable to Candid Auris Spread. The New York Times reported that "public health officials from cities, states and the federal government say that skilled nursing facilities" are impacting the spread of "Candida auris, a highly contagious, drug-resistant fungus that has infected nearly 800 people since it arrived in the United States four years ago, with half of patients dying within 90 days." Public health experts "say that nursing facilities, and long-term hospitals, are a dangerously weak link in the health care system...continuously cycling infected patients, or those who carry the germ, into hospitals and back again."
9. **MedPage Today** reports that **Ordinary Medical Masks May Offer Adequate Protection from Acute Respiratory Illness.** *MedPage Today* reports researchers found that "ordinary medical masks were as effective as N95 respirators for protecting health care personnel against acute respiratory illness, including the flu." The findings were published in *JAMA*. In an accompanying *editorial*, "Thomas Talbot, MD, of Vanderbilt University in Nashville, and Hilary Babcock, MD, of Washington University School of Medicine in St. Louis," wrote, "The pragmatic design of the ResPECT study reflects the conditions that many hospital epidemiologists are accustomed to: HCPs may or may not wear the PPE [personal protective equipment] they are supposed to, may or may not wear it correctly if they do wear it, and may self-report higher levels of adherence to hand hygiene and PPE use than noted by independent observers."

10. **Medscape** reports **Blood Test for Alzheimer’s 94% Accurate.** Medscape reports on a blood test that highly correlates with a diagnosis of Alzheimer’s disease, offering hope for a tool for early diagnosis and treatment. [Medscape](https://medscape.com).

11. An article in **LTC Pharmacy News**, authored by Elise Smith, entitled **Elise Unpacks the Proposed Rule for SNF PPS can be found here.**

12. **Modern Healthcare** reports **CMS Quality Measures Might Not Be Indicative of Actual Patient Care, GAO Report Says.** *ModernHealthcare* reported that, "CMS quality measures might not indicate the actual care patients receive, according to a new Government Accountability Office report." The GAO "found that the CMS doesn’t have processes to make sure that the indicators actually measure what the agency says it cares about in its strategic objectives."

13. **Provider Magazine** reports:

   - **New Arbitration Regulations Released by CMS Now in Effect.** *Provider Magazine* reports, "The long term and post-acute care profession is reminding providers that new arbitration regulations released earlier in the summer by CMS have gone into effect as of Sept. 16, stressing that separate legal actions concerning arbitration issues do not impact the implementation process." American Health Care Association (AHCA) sources "tell Provider that despite some erroneous media coverage of the arbitration implementation date, the Sept. 16 start date has not been impacted." Only the "specific providers involved in arbitration rule lawsuits are affected by the court order, not all skilled nursing facilities (SNFs), they say." The article lists additional matters implemented by the regulation. Regarding the final regulation’s release, AHCA President and CEO Mark Parkinson "said the skilled nursing profession is ‘concerned about CMS adding any conditions or administrative requirements when Congress has spoken on the subject.’"

   - **Article Outlines What Will Not Change for SNF Under PDPM.** In an article in *Provider Magazine*, RN Jane Belt writes that as skilled nursing facilities (SNFs) "prepare for the transition to the new Medicare Part A reimbursement system, Patient-Driven Payment Model (PDPM), understanding what is not changing may be as important to appropriate care and reimbursement success as insight into the new requirements." In the article, Belt lays out a list of elements she says will remain unchanged.

   - **Analysis Indicates States Increasingly Utilizing Telehealth in Rural Areas.** *Provider Magazine* reports, an analysis "examines how states are increasingly turning to telehealth options as they look for avenues to improve access and health outcomes for their underserved, rural, or homebound populations." Avalere Health, a consulting firm that conducted the analysis, "said even as the Centers for Medicare & Medicaid Services has made regulatory efforts to expand access to telehealth, like through its final rule in April to increase telehealth benefits for Medicare Advantage plans, it is the states that are playing a critical role in the coverage and reimbursement environment for telehealth services." For example, "in the 2019 legislative sessions, state legislators introduced more than 80 bills that would increase cross-state licensing for telehealth providers, an important development that could spur additional access to clinical care."

   - **AHCA Offers Support, Suggestions for Proposed Changes To The Requirements Of Participation.** *Provider Magazine* reports, "In a letter and comments to the Centers for Medicare & Medicaid Services (CMS), the American Health Care Association (AHCA) offers broad support for proposed changes to the Requirements of
Participation (RoP) that the agency released in July, but does offer suggestions to clarify language and to streamline rules to an even greater degree." AHCA "said it received more than 600 comments from its members on the proposed rule, and its submission to CMS reflects their views." AHCA "chief medical officer and senior vice president of quality and regulatory affairs" David Gifford, MD said, "[CMS] has proposed changes that would eliminate unnecessary paperwork and allow long term care facilities and caregivers to devote more of their time and resources to resident care. ... We are pleased that in proposing these changes, CMS preserved important advances in these regulations such as those addressing infection prevention and control, resident rights, and person-centered care. ... At the same time, many of the changes in the proposed rule will allow caregivers to devote more time to resident care instead of completing paperwork that does not help keep residents safe and healthy."

- Medicare Part A Patients Whose Care Overlap with PDPM Implementation Subject to PDPM On October 1, 2019. Provider Magazine reports in its September issue that skilled nursing facilities providing care under Medicare Part A "should consider assessment and payment logistics related to residents whose Medicare Part A stay begins prior to Oct. 1 and remain on Part A" when the new Patient-Driven Payment Model (PDPM) takes effect. The article notes, "Any Part A stay started before Oct. 1 and continuing into October will be subject to RUG-IV assessment schedules and per diem payment policy up to and including Sept. 30 and be subject to PDPM policy for dates of service beginning Oct. 1." Moreover, "special consideration should be given to resident stays that start during this date range because the shortened assessment reference period may impact the RUG-IV classification and rates for the late September dates of service."

14. McKnight’s reports:

- CMS Final Rule Confirms 2.4 Percent Pay Hike for SNF Providers, Adds PDPM Guidance. McKnight’s Long Term Care News reports that CMS published a final rule confirming SNF providers will see a 2.4 percent market basket increase, in the amount of $851 million, for fiscal year 2020. Mark Parkinson, AHCA president and CEO, said, "The 2.4 percent market basket increase is critical, especially as members are actively preparing for implementation of the new Patient-Driven Payment Model on October 1. Skilled nursing facilities are coping with devastating closures, particularly in rural areas. This increase doesn’t solve this problem, but it does provide some much needed help." McKnight’s Long Term Care News reports CMS included additional guidance on the Patient-Driven Payment Model in the final rule. For example, "the rule institutes an expected sub-regulatory process for classification of diseases and corresponding ICD-10 codes, such as when a prior code is split into two new codes." Furthermore, "the group therapy definition for skilled nursing will soon follow the inpatient rehabilitation facility norm and cover sessions with groups of two to six patients."

- AHCA’s Parkinson Says it Will Take Several Weeks to Know Effects of PDPM. McKnight’s Long Term Care News reports AHCA/NCAL President and CEO Mark Parkinson told attendees at the fall meeting of the National Investment Center for Seniors Housing & Care in Chicago that it would take “five or six weeks” to understand the ramifications of the overhauled Medicare reimbursement system that goes into effect Oct. 1. Parkinson said, "We’re going to know on the therapy stuff right away because people have to report on their therapy in five days ... On the revenue side, by the end of November, we’ll have a pretty decent feel for it." Parkinson said AHCA analysts remained “cautiously optimistic” about the Patient-Driven Payment System’s potential effects. Parkinson also “added with a smile” that “every [skilled nursing provider] is going to have the best October they ever had” because under the new system, reimbursements start very high for the first three days before falling off incrementally.

- Column: How to Create Job Satisfaction for CNAs. In a Guest Column for McKnight’s Long Term Care News, Centers Health Care’s Chief Nursing Officer Heidi Hendrix, RN writes about creating job satisfaction for certified nursing assistants "in long-term care." Hendrix describes several approaches employers can take to improve the working environment for CNAs, such as promoting purpose and congruency. Hendrix concludes, "Providers must build an environment of support and encouragement. A CNA can get a job in almost any location, but they will be fulfilled in this job when the employer constructs an ecosystem of value, gratitude and purpose."
MedPAC Proposes Post-Acute Payments Based on Quality Measures. *McKnight’s Long Term Care News* reports that Medicare payments for post-acute care providers "would be determined based on a small number of risk-adjusted, claims based quality measures under a recent proposal by the Medicare Payment Advisory Commission." MedPAC "revealed that it’s drafting a value-based payment proposal that would pay providers based on their quality of care during a commission meeting last week, Bloomberg Law reported. The proposal would apply to four types of post-acute care providers: nursing homes, in-home care, inpatient rehab facilities and long-term acute care hospitals."

**Intensive Blood Pressure Treatment May Prevent Dizziness, Falls.** Intensive blood pressure treatment makes it less likely that older adults will experience drastic blood pressure drops, become dizzy and fall, according to preliminary research presented at an American Heart Association conference. Optimal blood pressure helps reduce the risk for heart attacks and strokes, but aggressive blood pressure treatment in older adults has long been thought to be dangerous. The idea is that it contributes to falls by increasing the risk of sudden drops in blood pressure, called orthostatic hypertension.

**Twice-Weekly Strength-Based Activity Can Help Delay Muscle Decline.** Engaging in strength-based activity twice a week helps older adults delay the muscle decline that sets in after age 50 and supports functional independence, according to new British health guidelines. The recommendations draw on up-to-date scientific evidence and emphasize the importance of building strength and balance. They also encourage cardiovascular exercise.

**Experts Suggest Taking Wait-And-See Approach on Contract Therapy Under PDPM.** In his Daily Editors’ Notes column in *McKnight’s Long Term Care News*, Executive Editor James M. Berklan writes about the issue of whether skilled nursing facilities are likely to move away from contract therapy after Medicare’s Patient-Driven Payment System goes into effect on Oct. 1. Berklan writes that panelists at a recent educational session concluded: "No. Or at least not right away, was the answer." Berklan reports that American Health Care Association President and CEO Mark Parkinson suggested providers should wait six months before making any decisions.

**CMS Works to Improve Investigation, Reporting of Elder Abuse in Long-Term Care.** *McKnight’s Senior Living* reports that CMS "is working to address numerous recommendations from federal agencies to improve reporting, investigation and law enforcement notification of elder abuse, the Government Accountability Office said in report released Wednesday." The report "highlights the differences in requirements for assisted living communities versus nursing homes." A spokesperson for the American Health Care Association / National Center for Assisted Living "told McKnight’s Senior Living that the organizations ‘take allegations of abuse very seriously and are focused on preventing these rare incidents’.”

15. **Interesting Fact:** Researchers have found that lack of vitamin D reduces fat breakdown and triggers fat storage. So, the lack of sunlight has more to do with the extra gain than all the pumpkin spice lattes. Well, at least some of it.

*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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