U.S. Department of Labor Expands Eligibility for Overtime
The Department of Labor (Department) is updating and revising the regulations issued under the Fair Labor Standards Act (FLSA) to allow 1.3 million workers to become newly entitled to overtime by updating the earnings thresholds necessary to exempt executive, administrative or professional employees from the FLSA’s minimum wage and overtime pay requirements. This requirement is effective on January 1, 2020.

The Department is updating both the minimum weekly standard salary level and the total annual compensation requirement for “highly compensated employees” to reflect growth in wages and salaries. The new thresholds account for growth in employee earnings since the currently enforced thresholds were set in 2004. The Department believes that the update to the standard salary level will maintain the traditional purposes of the salary level test and will help employers more readily identify exempt employees. The Department is also revising the special salary levels for employees in U.S. territories and the special base rate for employees in the motion picture producing industry. The Department estimates that as a result of the final rule 1.3 million currently exempt employees will become nonexempt.

Key Provisions of the Final Rule
The final rule updates the salary and compensation levels needed for workers to be exempt in the final rule:

1. raising the “standard salary level” from the currently enforced level of $455 to $684 per week (equivalent to $35,568 per year for a full-year worker);
2. raising the total annual compensation level for “highly compensated employees (HCEs)” from the currently-enforced level of $100,000 to $107,432 per year;
3. allowing employers to use nondiscretionary bonuses and incentive payments (including commissions) that are paid at least annually to satisfy up to 10 percent of the standard salary level, in recognition of evolving pay practices; and
4. revising the special salary levels for workers in U.S. territories and in the motion picture industry.

Additionally, the Department intends to update the standard salary and HCEs total annual compensation levels more regularly in the future through notice-and-comment rulemaking.

Standard Salary Level
The Department is setting the standard salary level at $684 per week ($35,568 for a full-year worker). The salary amount accounts for wage growth since the 2004 rulemaking by using the most current data available at the time the Department drafted the final rule. The Department is updating the standard salary level set in 2004 by applying to
current data the same method and long-standing calculations used to set that level in 2004—i.e., by looking at the 20th percentile of earnings of full-time salaried workers in the lowest-wage census region (then and now the South), and/or in the retail sector nationwide.

HCE Total Annual Compensation Requirement
The Department is setting the total annual compensation requirement for HCEs at $107,432 per year. This compensation level equals the earnings of the 80th percentile of full-time salaried workers nationally. To be exempt as an HCE, an employee must also receive at least the new standard salary amount of $684 per week on a salary or fee basis (without regard to the payment of nondiscretionary bonuses and incentive payments).

Treatment of Nondiscretionary Bonuses and Incentive Payments
In the final rule, in recognition of evolving pay practices, the Department also permits employers to use nondiscretionary bonuses and incentive payments to satisfy up to 10 percent of the standard salary level. For employers to credit nondiscretionary bonuses and incentive payments toward a portion of the standard salary level test, they must make such payments on an annual or more frequent basis. If an employee does not earn enough in nondiscretionary bonus or incentive payments in a given year (52-week period) to retain his or her exempt status, the Department permits the employer to make a “catch-up” payment within one pay period of the end of the 52-week period. This payment may be up to 10 percent of the total standard salary level for the preceding 52-week period. Any such catch-up payment will count only toward the prior year’s salary amount and not toward the salary amount in the year in which it is paid.

Updating
Experience has shown that fixed earning thresholds become substantially less effective over time. Additionally, lengthy delays between updates necessitate disruptively large increases when overdue updates finally occur. Accordingly, in the final rule the Department reaffirms its intent to update the earnings thresholds more regularly in the future through notice-and-comment rulemaking.

The Department’s final rule is available at http://www.dol.gov/whd/overtime2019.

New Portable Fire Extinguisher Guidelines - Do You Have the Right Kind of Fire Extinguisher for the Right Area of Your Facility? RPA Offers Updated Guidance
Every facility contains a certain degree of fire hazard, and health care facilities are not exempt. Due to the multitude of services and activities that take place within a health care setting, fires can occur at any time. Fire extinguishers therefore serve a vital role in supplementing the other fire protection features commonly found in a health care facility. This article, in conjunction with the corresponding document created by RPA, a Jensen Hughes Company, entitled Portable Fire Extinguishers Summary, will provide guidance on selecting extinguishers per each area within a health care facility.

To begin, it should be noted that there are very specific requirements for the selection, placement and use of fire extinguishers – not only in health care facilities, but in any occupancy type. Furthermore, there are limitations on the use of fire extinguishers as they should only be used by trained personnel to control small, incipient-stage fires. To that end, NFPA 10, Standard for Portable Fire Extinguishers, is the main standard that must be referenced when managing the various aspects of fire extinguishers. Since health care facilities are governed by the Centers for Medicare & Medicaid Services (CMS), the 2010 edition of NFPA 10 is adopted and enforceable since this edition is referenced within the 2012 Life Safety Code.

As depicted in the attached Portable Fire Extinguishers Summary, the selection of fire extinguishers begins with identifying the potential fire hazard(s) present in a space using the following classification system per NFPA 10:

- Class A (fires involving ordinary combustibles)
- Class B (fires involving flammable liquids)
- Class C (fires involving energized electrical equipment)
• Class K (fires involving combustible cooking materials)

Once the fire hazard class is decided, an extinguisher listed for use on fires of that same class must be selected. Common extinguishing agents used to control each class of fire are listed below. (It should be noted that Class ABC extinguishers are available, and are, by far, the type most widely used in health care facilities.)

Class A:
• Water type
• Halogenated agent type
• Multipurpose dry chemical type
• Wet chemical type

Class B:
• Aqueous film-forming foam (AFFF)
• Film-forming fluoroprotein foam (FFFP)
• Carbon dioxide
• Dry chemical type
• Halogenated agent type

Class C hazards shall be selected from types specifically listed for use on Class C hazards.

Class K hazards shall be selected from either a wet chemical type or dry chemical type.

Selecting the proper extinguisher in surgery areas is one of the most challenging decisions to make within a health care facility since it is important to maintain the sterile surgical field as much as possible while controlling a fire. As shown in the attached Portable Fire Extinguishers Summary, RPA, a Jensen Hughes Company, recommends a carbon dioxide (CO2) extinguisher be used in the operating room; this recommendation is supported by later editions of NFPA 99, as well as by the Emergency Care Research Institute (ECRI) and Association of Operative Registered Nurses (AORN).

For additional detailed guidance on the selection of fire extinguishers, please reference the Portable Fire Extinguishers Summary.

This article provided by RPA (A Jensen Hughes Company).

Focus F-Tag – F920 - Requirements for Dining and Activity Rooms
This Regulatory Beat’s Focus F-Tag is part of the Physical Environment regulatory group, F920 Requirements for Dining and Activity Rooms. This regulation requires that facilities provide one or more rooms that are designated for resident dining and resident activities. The rooms must:

• Be well-lit – By definition, illuminated sufficiently to allow residents to perform tasks.
• Be well-ventilated – By definition, good air circulation, avoidance of floor-level drafts and adequate odor and smoke exhaust removal capabilities.
• Be adequately furnished – For dining areas, adequate furnishings refers to the ability to accommodate residents’ different physical and social needs. For activities areas, this refers to ensuring that the area has furnishings to accommodate the needs, interests and preferences of the residents.
• Have sufficient space to accommodate all activities and be adaptable to multiple uses and to meet residents’ needs.

Surveyors can query residents as to whether they feel the furnishings and areas are adequate for their needs. They can also visually observe whether the space is adequate for resident activities, if there is crowding, and if resident access to space is limited. Let’s see how F920 has been cited under the LTCSP. Here are some actual citations:
• During meal observation, there was limited space between dining room tables and residents' wheelchairs, and residents were unable to enter and exit the dining room independently due to crowding. Surveyors noted that for one resident to leave the dining room, four residents in wheelchairs had to be moved to create space.
• The majority of residents in one facility were observed eating dinner in their rooms. Surveyors identified a small area that had one table for dining and were informed that the previous dining room was converted into resident rooms and thereby reduced the amount of space available for residents to dine together in a common area.
• During survey, residents were noted to be lined up along a hallway wall eating their lunches on bedside tables since there was not enough seating in the dining room. One resident stated to the surveyor, “This is a cover up; why am I sitting out here in this hallway? I never sit out here, I always eat in my room.” Another stated that she normally ate in her bedroom and did not want to sit in the doorway. Staff told surveyors that the residents in the hallways were all choking risks and needed to be observed so that is why they were there, however, upon record review, the residents that the surveyors spoke with did not have swallowing concerns.

While the intent of this regulation is to ensure the comfort of the residents during dining and activities, it’s also important to think about the potential implications in the event of an emergency. If you needed to quickly evacuate your dining room or activity area, how easily could it be done with a tangle of wheelchairs and no room to maneuver them? If there is insufficient room to have your residents all dining at the same time, consider serving meals in two seatings. The dining experience is meant to be a dignified one, not one where residents are routinely expected to eat in the hallway, which most residents complain about, or, worse yet, have to wait to exit the dining room until everyone is finished because of overcrowding and egress being blocked. It is also worth taking a look at what it looks like during those popular Bingo sessions and monthly birthday celebrations.

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**Trending Statistics**

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

**CMS Penalizes 2,583 Hospitals for High Readmissions: 5 Things to Know**

In fiscal year 2020, CMS will penalize 2,583 hospitals for having too many Medicare patients readmitted within 30 days, according to federal data released Sept. 30 cited in a [Kaiser Health News](https://www.kaiserhealthnews.org/) report.

This is the eighth year of the Hospital Readmissions Reduction Program. To determine penalties for fiscal 2020, CMS examined hospitals’ 30-day readmission rates for patients who had originally been treated for the following conditions: heart failure, heart attack, pneumonia, chronic lung disease, hip and knee replacement or coronary artery bypass graft surgery. Scheduled readmissions were not counted.

CMS used patient data from July 2015 through June 2018 to determine the penalties. The agency compared each hospital's reported readmission rate to national averages for each of the conditions to determine the penalties.

Here are five takeaways from the [Kaiser Health News](https://www.kaiserhealthnews.org/) analysis:

1. Eighty-three percent of the 3,129 hospitals evaluated received a penalty.
2. CMS will cut payments to the penalized hospitals by as much as 3 percent for each Medicare case during fiscal 2020, which runs Oct. 1 through September 2020.
3. Fifty-six hospitals were hit with the maximum penalty. The average penalty will be a 0.71 percent payment cut for each Medicare patient.
4. Though 64 hospitals received the same penalty as the year prior, 1,177 hospitals received a higher penalty and 1,148 hospitals received a lower penalty.
5. In fiscal 2020, CMS will withhold an estimated $563 million in Medicare payments to hospitals under the Hospital Readmissions Reduction Program.

Access the full [Kaiser Health News](https://www.kaiserhealthnews.org/) article [here](https://www.kaiserhealthnews.org/).
1. There was one new Federal CMS Quality, Safety and Oversight Letter (formerly known as Survey and Certification (S&C) Letters) released since the last issue of Regulatory Beat:

- **QSO 19-20 – CLIA** - Revisions to State Operations Manual (SOM), Chapter 6 – Special Procedures for Laboratories. The Centers for Medicare & Medicaid Services (CMS) is issuing a revised State Operations Manual (SOM), Chapter 6 “Special Procedures for Laboratories” which includes a comprehensive revision to establish quality laboratory policies and procedures to ensure accurate and reliable test results to protect patients and improve the quality of health care. All sections of the SOM Chapter 6 have been aligned with the information within the SOM Chapter 6 Appendix C – Interpretive Guidelines.

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

- **The Centers for Medicare and Medicaid Services (CMS) this week issued three important manual updates for PDPM implementation.**
  
  1. The **Medicare General Information, Eligibility, and Entitlement** Manual PDPM update contains minor updates to certification guidance.
  2. The **Medicare Benefit Policy** Manual PDPM update contains minor updates to the SNF benefit period and benefit days sections in chapter 3, as well as major changes to the SNF PPS guidance in Chapter 8.
  3. The **Medicare Claims Processing** Manual PDPM update provides substantial updates to the chapter 6 SNF PPS claims processing instructions.

AHCA has conducted a preliminary review of these updates and will share key observations in tomorrow's PDPM weekly update. And make plans to join us for the upcoming "**Week 2 of PDPM Implementation Status Update**“ all-member webinar on Friday, October 11, 2019 from 3-4 PM Eastern. You may register for the webinar [here](#).

Please contact [pdpm@ahca.org](mailto:pdpm@ahca.org) with any questions or concerns.

- **SNF PDPM Assessments and Grouper Update.** CMS is aware of issues with the latest PDPM DLL Package (V1.0002 FINAL). We are targeting to release an updated version on **Monday, October 7, 2019**, which corrects the identified grouper discrepancies. SNF providers should continue to follow the Resident Assessment Instrument (RAI) requirements which include, but are not limited to, establishing assessment reference dates for OBRA or PPS assessments that are required/scheduled, including the PDPM Transitional Interim Payment Assessments, assessing residents, and coding the applicable MDS assessments. As per the RAI requirements, assessments should be completed within 14 days and recorded in Z0500. Late submission payment penalties do not apply under the SNF PPS. We will work with providers to ensure that timely payments are made. We will continue to share updates as they become available. In the meantime, providers should not hesitate to contact us. For questions regarding PDPM please send inquiries to [pdpm@cms.hhs.gov](mailto:pdpm@cms.hhs.gov), and for information technology questions please send emails to [MDSTechIssues@cms.hhs.gov](mailto:MDSTechIssues@cms.hhs.gov). Please contact your state Medicaid agency for questions related to the Other State Assessment (OSA) and Medicaid payment.

- **Omnibus Burden Reduction (Conditions of Participation) Final Rule.** On September 26, CMS took action at President Trump’s direction to “cut the red tape,” by reducing unnecessary burden for American’s health care providers allowing them to focus on their priority – patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost.
This rule advances the Patients over Paperwork initiative by saving providers an estimated 4.4 million hours of time previously spent on paperwork with an overall total projected savings to providers of $800 million annually.

This rule finalizes the provisions of three proposed rules:

- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (“Omnibus Burden reduction”), published September 20, 2018
- Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, published June 16, 2016

For More Information:
- Final Rule
- Press Release

Press release See the full text of this excerpted CMS Fact Sheet (Issued September 26).

- **Emergency Preparedness Changes Pursuant to the Omnibus Burden Reduction (Conditions of Participation) Final Rule** (noted above). Below is a quick summary of the final rule regarding emergency preparedness. AHCA was supportive of the proposed changes however, some of the proposed changes will not apply to SNFs.

  - **Emergency program:** We have decreased the requirements for facilities to conduct an annual review of their emergency program to a biennial review. However, based on industry feedback, long term care (LTC) facilities will continue to review their emergency program annually.
  - **Emergency plan:** Eliminating the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, State, and federal emergency preparedness officials and a facility’s participation in collaborative and cooperative planning efforts;
  - **Training:** Decreasing the training requirement from annually to every two years. Nursing homes will still be required to provide annual training.
  - **Testing (for inpatient providers/suppliers):** Increasing the flexibility for the testing requirement so that one of the two annually-required testing exercises may be an exercise of the facility’s choice; and
  - **Testing (for outpatient providers/suppliers):** Decreasing the requirement for facilities to conduct two testing exercises to one testing exercise annually.

- **Discharge Planning Rule Supports Interoperability and Patient Preferences.** On September 26, CMS issued a final rule that empowers patients preparing to move from acute care into Post-Acute Care (PAC), a process called discharge planning. The rule puts patients in the driver’s seat of their care transitions and improves quality by requiring hospitals to provide patients access to information about PAC provider choices, including performance on important quality measures and resource-use measures, including:

  - Number of pressure ulcers
  - Proportion of falls that lead to injury
  - Number of readmissions back to the hospital

The rule also:

- Advances CMS’s interoperability efforts by requiring the seamless exchange of patient information between health care settings, and ensuring that a patient’s health care information follows them after discharge from a hospital or PAC provider.
- Revises the discharge planning requirements that hospitals (including long-term care hospitals, Critical Access Hospitals (CAHs) psychiatric hospitals, children’s hospitals, and cancer hospitals), inpatient rehabilitation facilities, and home health agencies must meet to participate in Medicare and Medicaid
programs. It requires the discharge planning process to focus on a patient’s goals and treatment preferences. Hospitals are mandated to ensure each patient’s right to access their medical records in an electronic format.

- Implements requirements from the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) that includes how facilities will account for and document a patient’s goals of care and treatment preferences.

Hospitals and CAHs are already conducting most of the revised discharge planning requirements, with the exception of the discharge planning requirements of the IMPACT Act.

For More Information:
- Fact Sheet
- Final Rule

See the full text of this excerpted CMS Press Release (Issued September 26).

- **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

- **CMS - Ensuring Safety and Quality in Nursing Homes: Five Part Strategy Deep Dive.** In April, CMS was proud to announce the five-part approach the Centers for Medicare & Medicaid Services (CMS) is using to guide our work as we ensure safety and quality in America’s nursing homes. We at CMS bear the responsibility to develop and enforce quality and safety standards across the nation’s health care system, and we are deeply committed to that job. Every nursing home resident deserves to be treated with dignity and respect, and all of our nursing home work at CMS is predicated upon that single goal.

Our five-part approach announcement only scratches the surface of our efforts, and there’s a lot more to share. So, in an effort to be transparent with Americans about what CMS is doing to ensure safety and quality in America’s nursing homes, CMS will publish a blog on each part of our five-part approach, digging into what CMS is doing – and what we hope to do – in this critically important area. As a reminder, our approach is:
- Strengthen Oversight
- Enhance Enforcement
- Increase Transparency
CMS is excited to share the details of our work to ensure safety and quality in nursing homes. I hope you’ll come away from this series with a more thorough understanding of CMS’s work in this area.

- **New Medicare Card: More Questions about Using the MBI?** Questions about the Medicare Beneficiary Identifier (MBI)? Read MLN Matters Article New MBI: Get It, Use It for answers, including:
  - Why I should use the MBI now
  - Starting January 1, 2020, even for services provided before this date, you must use MBIs
  - It is 0 not O
  - How I know my patient is eligible through the railroad board
  - What to do if an MBI changes

Protect your patients’ identities, and use the MBI now. Starting January 1, 2020, you must use MBIs regardless of the date of service:
- 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

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.

- **New Medicare Card: Do You Refer Patients?** When you write an order or refer a patient for a service or treatment, use your discretion and share the Medicare Beneficiary Identifier (MBI) with:
  - Lab or diagnostic facilities, especially when they do not see the patient
  - Skilled nursing facilities for transfers between facilities
  - Ambulance transport providers when arranging patient transport

Starting January 1, 2020, all providers must use the MBI when billing Medicare regardless of the date of service:
- 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.

- **Opioid Treatment Programs: Get Ready to Participate in the New Benefit.** Starting January 1, 2020, under the CY 2020 Physician Fee Schedule proposed rule, CMS plans to pay Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder treatment services for people with Medicare Part B, including medication-assisted treatment medications, toxicology testing, and counseling.

Get ready to participate in the new benefit:
- Obtain full OTP certification from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Enroll in Medicare starting in early November
- Subscribe to MLN Connects for the latest news and updates

For More Information:
- Fact Sheet
- OTP webpage
• **Home Health Preview Reports for January 2020 Refresh.** Download home health preview reports from your Certification and Survey Provider Enhanced Reports (CASPER) folder. These reports preview data that will be displayed on Home Health Compare in January 2020. Save your reports for reference:
  - Home Health Compare Provider Preview Reports: Available for 60 days
  - Quality of Patient Care Star Ratings Provider Preview Reports: Available for 90 days

For More Information:
  - Home Health Quality Reporting Data Submission Deadlines webpage
  - Home Health Star Ratings webpage

• **LTCH Provider Preview Reports: Review Your Data by October 11.** Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with second quarter 2018 to first quarter 2019 data. Review your performance data on quality measures by October 11, prior to public display on LTCH Compare in December 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

Access your report by logging into the Internet Quality Improvement and Evaluation System (iQIES). At the main screen, select “Reports;” then “My Reports.” For more information, visit the LTCH Quality Public Reporting webpage.

• **LTCH Compare Refresh.** The September 2019 quarterly Long-term Care Hospital (LTCH) Compare refresh is available, including updated quality measure results, as well as an annual update to the LTCH claims-based quality measures. Visit LTCH Compare to view the data. For more information, visit the LTCH Quality Public Reporting webpage.

• **Hospice Provider Preview Reports: Review Your Data by October 11.** Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:
  - Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the first quarter of 2018 to the fourth quarter of 2018
  - Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) provider preview report: Review facility-level CAHPS survey results from the first quarter of 2017 to the fourth quarter of 2018

Access Instructions:
  - Hospice Provider Preview Report
  - Hospice CAHPS Provider Preview Report

• **Post-Acute Care and Hospice Utilization and Payment Public Use Files.** CMS posted the first annual release of the Post-Acute Care (PAC) and hospice utilization and payment Public Use Files (PUFs) with data for 2017. These PUFs replace the home health, hospice, and Skilled Nursing Facilities (SNFs) utilization and payment PUFs released in past years. Improvements include:
  - Data for Inpatient rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs)
  - New metrics
  - Standardized metrics across all PAC and hospice settings

These PUFs include:
  - Summarized information on services provided to Medicare beneficiaries by 9,701 home health agencies, 4,254 hospices, 15,036 SNFs, 1,119 IRFs, and 410 LTCHs
  - Summarized information on nearly 16 million claims and over $74 billion in Medicare payments
  - Demographic and clinical characteristics of beneficiaries served; professional and paraprofessional service utilization; submitted charges; and payments at the provider, state, and national levels
  - Payment information at the payment system level for home health agencies, SNFs, and IRFs
• **Hospice Quality Reporting Program Quarterly Updates.** Sign up for quarterly email updates about the Hospice Quality Reporting Program (HQRP): Send your facility name, CMS Certification Number, and any new or updated email addresses to QRPHelp@cormac-corp.com.
  - View the **September Update**
  - Find past issues on the **HQRP Requirements and Best Practices webpage**

• **Important Updates on the Hospice Quality Reporting Program (HQR).** 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.

• **Qualified Medicare Beneficiary Billing Requirements.** Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:
  - Use Medicare 270/271 **HIPAA Eligibility Transaction System** (HETS) data; see **MLN Matters Article SE1128**
  - Check your Medicare Remittance Advices (RAs); see **MLN Matters Article MM10433**
  - Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing, and issuance of Medicaid RAs for payment of Medicare cost-sharing. **Check with the states** where your beneficiaries reside to determine the enrollment requirements. Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies), and refund the invalid charges they paid.

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

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

• **DME Proof of Delivery Documentation Requirements.** CMS simplified and clarified documentation requirements for proof of delivery of Durable Medical Equipment (DME) and related services. If you are a physician, provider, or supplier who bills a DME Medicare Administrative Contractor, read the MLN Matters Article on **Proof of Delivery Documentation Requirements** for details. Learn about updates to support compliance and the impact on your payment.

More resources to help you bill correctly and avoid overpayment recoveries:
  - **Medicare Program Integrity Manual, Chapter 4**, Section 26
  - **42 CFR Section 424.57(c)(12)**

• **Quality Payment Program: Resources for Clinicians New to the Program in 2019.** New clinician types became eligible to participate in the Quality Payment Program this year, including clinical psychologists, physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, and registered dieticians and nutrition professionals CMS posted resources on the [Resource Library](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medicare-Quality-Payment-Program.html) webpage to help you understand how to successfully participate in the Merit-based Incentive Payment System (MIPS) in 2019:
  - Participation and Eligibility Fact Sheet: Overview of the eligibility criteria
  - Participating in QPP Infographic: How to check your participation status, basic requirements for participation, and key dates
  - MIPS Eligibility Decision Tree: A series of questions to help you determine if you are eligible
  - Quick Start Guide: Eligibility requirements, low-volume threshold criteria, exclusions, and timeline
  - Specialty Measures Guides for [clinical psychologists](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medical-Specialty-Measures-MIPS.html), [physical therapists and occupational therapists](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medical-Specialty-Measures-MIPS.html), [speech-language pathologists and audiologists](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medical-Specialty-Measures-MIPS.html), and [registered dietitian and nutrition professionals](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medical-Specialty-Measures-MIPS.html): A sample of performance year measures and activities

For More Information:
  - [Quality Payment Program](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/QualityPaymentProgram/Medicare-Quality-Payment-Program.html) website
  - Contact the Quality Payment Program at 866-288-8292 (TTY: 877-715-6222) or [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)

  - Who are part B suppliers
  - What it means to be a participating provider

  - Coding
  - Coverage requirements
  - Patient cost-sharing for each service

  - How to use the Provider Enrollment, Chain, and Ownership System (PECOS)
  - Privacy tips
  - How to keep, review, and protect enrollment information


• **International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update — Revised.** A revised MLN Matters Article MM11392 on [International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update](https://www.cms.gov/Medicare/Coverage/National-Coverage-Determination/ICD-10-and-Other-Coding-Revisions-to-National-Coverage-Determination-ICD-10-and-Other-Coding-Revisions-to-National-Coverage-Determination.html) is available. Learn about new and revised codes for NCDs.
• Reducing Opioid Misuse Listening Session: Audio Recording and Transcript. An audio recording and transcript are available for the September 17 Medicare Learning Network listening session on Opioids: What’s an “Outlier Prescriber”? 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.

• 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.

3. The federal Centers for Disease Control and Prevention (CDC) reports on:
   • National Press Conference Kicks Off 2019-2020 Flu Vaccination Campaign. On Thursday, September 26, 2019, CDC and partners kicked off the 2019-2020 seasonal flu vaccination campaign at the NFID news conference, where experts stressed the importance of getting an annual flu vaccine. HHS Secretary Alex Azar II reported CDC flu vaccination coverage estimates for 2018-2019 that showed 45% of American adults got a flu vaccine last season while nearly 63% of children were vaccinated.

   • Flu Vaccination Recommendations for the 2019-2020 Season. Although influenza seasons vary in severity, influenza can cause millions of illnesses, hundreds of thousands of hospitalizations, and tens of thousands of deaths worldwide each season. Dr. Lisa Grohskopf, a medical officer in CDC’s Influenza Division, discusses the 2019-2020 influenza vaccine recommendations in a recently published CDC Medscape expert commentary.

   • Benefits of Flu Vaccination. Getting a flu vaccine is the best thing you can do to prevent flu to protect yourself and those around you, including those who are more vulnerable to serious flu illness. While some people who get vaccinated do still get sick, there is a growing amount of data showing that flu vaccination makes flu illness less severe, helping to prevent serious outcomes.

4. The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:
   • HFS has posted a new Provider Notice regarding Federal Fiscal Year 2020 Safety Net Determination. You may view the new notice from the following link here.
   • HFS has posted a new Provider Notice regarding Nursing Facility Resident Assessment Instrument Effective October 1, 2019. You may view the new notice from the following link here.
   • HFS has posted a new Provider Notice regarding Chapter K-200, Handbook for Hospice Agencies Hospice Billing Change Regarding CBSA Code 14 Effective with Dates of Service on and after November 1, 2019. You may view the new notice from the following link here.
   • HFS has posted a new Provider Notice regarding Annual Rate Changes Effective October 1, 2019. You may view the new notice from the following link here.
   • HFS has posted a new Public Notice regarding Home and Community Based Waivers for Persons with HIV or AIDS. You may view the new notice from the following link here.
   • HFS has posted a new Public Notice regarding Home and Community Based Waivers for Persons with Brain Injury. You may view the new notice from the following link here.
• HFS has posted a new Public Notice regarding **Home and Community Based Waivers for Persons with Disabilities**. You may view the new notice from the following link [here](#).

• HFS has posted new **Webinar Material - MEDI LTC Change in income instructions, Required Staffing Plans, HFS LTC Billing Guidelines July 30, 2019.** You may view the new material from the following link [here](#).

• HFS has posted a new Provider Notice regarding **LTC Monthly Occupied Bed Provider Assessment.** You may view the new notice from the following link [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. The [Questionnaire](#) and the [Facility Letter the Ombudsman](#) are handing to facilities are included.

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

• **PDPM is Here! Share Your Feedback & Available Resources.** **October 1st, the Patient-Driven Payment Model (PDPM) became the Medicare Part A fee-for-service payment system for Skilled Nursing Facilities. PDPM replaces the Resource Utilization Group IV (RUG IV) payment system in its entirety with no transition period. If you have not done so already, now is the time to make sure your contracts are up-to-date and appropriate with all payers impacted by PDPM, including Medicaid, Medicare Advantage, the U.S. Department of Veterans Affairs (VA), and TRICARE. It is important that your legal counsel also reads any contracts closely before entering into them, particularly with the VA.**
Important – New CMS PDPM Bugs Identified. We are working hard to keep you updated on important changes and challenges that arise as we approach PDPM implementation tomorrow, October 1. AHCA was informed today that CMS has identified and is working to fix a new bug with the system.

Here's what you need to know:
- Last Friday, the Centers for Medicare and Medicaid Services (CMS) issued updates to the PDPM DLL Package (V 1.0002 FINAL). This is the software code that SNF software vendors use as part of the PDPM classification Grouper programs within the MDS software packages to generate the PDPM billing case mix codes (physical therapy, occupational therapy, speech-language pathology, non-therapy ancillary, and nursing).
- This past weekend, software vendors identified problems with the released DLL package. CMS has privately acknowledged that additional updates are needed to make the PDPM Grouper operate correctly.
- The date for the corrected software code fix is still to be determined.

AHCA is in communication with CMS to seek further guidance for providers. The PDPM DLL software is necessary to properly classify a resident under PDPM, and CMS is working to fix the problem. We have also been made aware that some vendors are instructing SNFs to delay marking a PDPM MDS Assessment (5-Day or IPA) with a reference date beginning October 1 and beyond as complete until this data issue can be resolved.

We will share updates as they become available. In the meantime, please do not hesitate to contact pdpm@ahca.org with any questions.

AHCA/NCAL Social Media Update.

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.

New Quality Initiative Progress. Your Quality Initiative Progress is a LTC Trend Tracker℠ publication that includes metrics and graphics outlining individual center's progress through the four goals of both the AHCA and NCAL Quality Initiative. Distributed semi-annually, the report also includes links to member resources that help with specific goals.

PDPM Update. As you know, the SNF Prospective Payment System officially migrated to PDPM on Tuesday, October 1. As an update to Monday's email about the MDS software grouper errors, the Centers for Medicare & Medicaid Services (CMS) is aware of the problems and AHCA is in regular contact with CMS at all levels as well as with our sister associations. We have encouraged CMS to work with SNF providers and information technology vendors to correct the problems as soon as possible, and we will provide updates as they become available.

AHCA PDPM Academy Weekly Update – October 4.

CMS Announces Changes to Nursing Home Compare. The Centers for Medicare & Medicaid Services (CMS) announced today that starting October 23, 2019, Nursing Home Compare (NHC) will flag skilled nursing centers that have been cited for abuse, neglect and exploitation. A nursing center will receive an alert icon on NHC if it falls under one of two categories:
1. If a nursing center has been cited for abuse that led to harm (G or above) in the last year for one of three abuse F-tags; or
2. If a nursing center has been cited for abuse with the potential for harm (D and above) in each of the last two years.

The three abuse and neglect citations that will result in an icon are as follows:
1. F600: Free from abuse and neglect
2. F602: Free from misappropriation/exploitation
3. F603: Free from involuntary seclusion

After a nursing center has been free from any of these three citations (at any level) for a full year or inspection cycle, the icon will be removed. The NHC website will be updated with new information on a monthly basis.

Nursing Homes that receive the abuse icon will have their health inspection rating capped at a maximum of two stars.

- The Quality Initiative Quarterly Update. The Quality Initiative Recognition Program is back to honor member skilled nursing centers and assisted living communities for their work in achieving the goals of the AHCA/NCAL Quality Initiative.

- PDPM Resources at Your Fingertips. Resources to help you tackle all of your PDPM implementation, coding, billing, and documentation concerns.

8. ModernHealthcare reports Medicare Care Choices Model for Hospice Care Examined. ModernHealthcare reports, "Despite limited participation among terminally ill seniors, health care professionals are hopeful that a new payment model will get more people to use and benefit from hospice care." The changes come as "advocates have called for reforms to the way the CMS pays for hospice care because less than half of eligible Medicare beneficiaries use it" while among those who do, "half of them are admitted within the last two weeks of life" – "far less than the six months allowed under the existing Medicare Hospice Benefit." Consequently, "the CMS is experimenting with alternative payment models for hospice and other post-acute settings in its pursuit to increase clinical integration throughout the care continuum." ModernHealthcare adds that in 2016, a "five-year trial that began in January 2016, the Medicare Care Choices Model (MCCM), allows beneficiaries to enroll in hospice care while continuing to receive curative care for their terminal illness such as chemotherapy or dialysis." Results suggest that about "4 out of 5 beneficiaries in the MCCM chose the Medicare Hospice Benefit after an average of two months in the program and spent one month in hospice, which is double the length of the typical hospice stay."

9. Skilled Nursing News reports PDPM Drives Reductions in Therapy Staff, Giver Greater Leeway for Customized Care. Skilled Nursing News reports Medicare’s new Patient-Driven Payment Model (PDPM) for nursing homes "took effect this week with a bang, as therapists across the nation criticized a wave of staffing reductions in the immediate wake of the October 1 start date." But those types of changes "also belie another side of PDPM: Individual therapists and rehab teams have greater leeway to customize care for residents, without the pressure to meet certain minute-based thresholds." No matter the strategy, "the eventual resident outcomes will serve as the final arbiter of PDPM prep success, according to American Health Care Association president and CEO Mark Parkinson."

10. Newsweek reports Alzheimer’s Research Gets Major Funding From Public, Private Sources. Newsweek reports it "has been a big week for Alzheimer’s research with large grants being awarded to multiple organizations, and a private donation of $50 million going to the University of Washington Medicine." Among the grants were a National Institutes of Health award of $36 million to the Indiana University School of Medicine "that’s expected to launch a drug discovery center to accelerate the development of promising treatments for Alzheimer’s disease, which is also a partnership with the Purdue Institute for Drug Discovery." And a $50 million gift "was given to University of Washington Medicine by Lynn and Mike Garvey this week, which will eventually become the Garvey Institute for Brain Health Solutions."

11. Provider Magazine reports AHCA Supports Five-Star Changes, But Says CMS Should Add Customer Satisfaction Data. Provider Magazine reports the American Health Care Association "is commending a change to the Five-Star Quality Rating System and urging improvements," in response to an announcement from CMS "that beginning Oct. 23, 2019, Nursing Home Compare will display a consumer alert icon next to skilled nursing centers that have been cited for incidents of abuse, neglect, or exploitation." AHCA President and CEO Mark Parkinson said, "We support transparency so that potential residents and their families can make an informed decision on care. We appreciate CMS’ efforts to improve Nursing Home Compare, but as we have previously suggested, we believe that CMS should
create a standard and rational definition of both abuse and neglect and then report them separately. That would help provide consumers with the information that they need." Moreover, he said, "In addition, CMS should add customer satisfaction to Nursing Home Compare because that is the best way for consumers to select facilities. It’s surprising that we can look for customer reviews of restaurants and hotels that we select, but that information isn’t available for nursing homes."

12. McKnight’s reports:

- **PDPM Could Increase SNF’s Focus on Clinical Competency, Partnerships.** In her "Rehab Realities" blog for McKnight’s Long Term Care News, Renee Kinder MS, CCC-SLP, RAC-CT, "advisor to the American Medical Association’s Relative Value Update Committee (RUC) Health Care Professionals Advisory Committee (HCPAC)," addressed advantages and effects of the Patient-Driven Payment Model. Kinder highlighted the potential impacts of the model on facilities "who choose to take advantage of PDPM’s flexibility and reduce traditional therapy" and the impacts on care among skilled nursing facilities (SNFs). Kinder concludes that the PDPM will create an advantage, "hopefully in the best of ways, thereby allowing us to take advantage of the opportunity to refine care, take advantage of working alongside care teams with increased focus on clinical competency and partnership, and in the end leave the advantage to those we serve – our patients."

- **Strategies to Prevent Falls Among Seniors Highlighted.** McKnight’s Senior Living reports, "September is nationally recognized as Falls Prevention Awareness Month," during which "a special focus is placed on raising awareness about ways that seniors – and those who care for them – can prevent falls, the most common accident experienced by older adults." The article adds, "According to the Center for Disease Control and Prevention, more than one-fifth of assisted living residents are injured in falls every year." The article then highlights prevention strategies that "can go a long way toward keeping older adults safe in their living spaces," as well as discussing the role of artificial intelligence.

- **Researchers Say Unique Walking Patterns Help Differentiate Between Two Types Of Dementia.** McKnight’s Long Term Care News reports, "People with Lewy body dementia and Alzheimer’s disease do not walk the same way. In fact, their unique walking patterns may help clinicians differentiate between the two conditions and improve disease-specific care, say researchers." In a study of 110 people, participants with Lewy body dementia "varied their step time and length, and moved asymmetrically, meaning their left and right footsteps looked different from each other. People with Alzheimer’s disease, in contrast, rarely changed their walking patterns." The "findings could be a significant step toward using gait as a marker of dementia, said Ríona McArdle, Ph.D." The gait study "was funded by the Alzheimer’s Foundation," and the results were published "in the organization’s journal, Alzheimer’s & Dementia."

- **Increase In Social Services Helps Decrease Wandering, Reduce Antipsychotic Use In Nursing Homes, Researchers Find.** McKnight’s Long Term Care News reports researchers "are calling for skilled nursing providers to invest more in social services after a study found that facilities with more qualified social workers helped improve behavioral symptoms, like wandering, in residents." The findings were published Friday in the Journal of Post-Acute and Long-Term Care Medicine.

- **CMS Should Ensure Quality Measures Actually Match Strategic Objectives, OIG Report Asserts.** A federal watchdog wants the Centers for Medicare & Medicaid Services to get better at ensuring its quality measures actually match its strategic objectives aimed at improving care quality and reducing “unnecessary” burdens for providers. The recommendation was made in a new report by the Government Accountability Office that reviewed how the agency develops and uses quality measures used to assess the care of Medicare providers and funds quality measurement activities. The report also found that CMS should maintain more complete information on how it funds its quality measurement activities, and develop and use performance indicators to evaluate the agency’s progress in achieving its objectives. The Department of Health and Human Services agreed with each of the recommendations.

- **Delivering a Paperless Clinical Environment for Improved Care.** We spend more than $3 trillion dollars a year on healthcare in America and generate more data than ever before. Yet some of the most meaningful data – data
to unlock potential improvements in patient outcomes is fragmented, inaccessible or incomplete,” says James Madara, CEO of the American Medical Association. While the clinical hard chart is essentially a relic in the acute care setting, digital transformation outside the walls of the hospital setting is the next frontier. A paperless clinical environment is closer than you think. Read more [here].

- **CMS TO Release Corrected PDPM Grouper Package.** [McKnight’s Long Term Care News](https://www.mcknights.com) reports the Centers for Medicare & Medicaid Services announced plans to release "a corrected version of the latest PDPM DLL Package (V1.0002 FINAL)." The new version "corrects the identified grouper discrepancies." CMS stated, "We will work with providers to ensure that timely payments are made. We will continue to share updates as they become available. In the meantime, providers should not hesitate to contact us."

- **NCAL: Regulations Over Assisted Living Providers Likely to Grow.** [McKnight’s Senior Living](https://www.mcknights.com) reports in the "Assisted Living State Regulatory Review," NCAL executives predicted that regulations governing assisted living will continue to proliferate. According to the report, "twenty-seven states updated their assisted living-related regulations, statutes and policies from June 2018 to June 2019," and "since 2015, 84% of states have reported changes that affect assisted living." NCAL Senior Policy Director Lilly Hummel, report author, said, "Changes each year can vary from big to small, but it is evident that state regulations are increasing in assisted living. Each state is determining how to enhance assisted living for their specific resident population, and we anticipate this trend to continue."

13. **Interesting Fact:** The name of the month of October comes from the Latin “octō”, meaning “eight”, because in the Roman calendar October was the eight month of the year. With the adding of January and February at the beginning of the calendar after the Julian calendar reform, October became the tenth month of the year, as we know it today.

*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](mailto:billbell@ihca.com). If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*