CMS Announces Changes to Five-Star Quality Rating System and to Nursing Home Compare with Regard to Abuse

Five-Star Quality Measure Changes
On October 23, the Centers for Medicare & Medicaid Services (CMS) will make several changes to the Nursing Home Compare website and the Five-Star Quality Rating System. These changes will affect the health inspection and quality measure (QM) domains for skilled nursing centers.

CMS announced that they will be adding an alert icon on Nursing Home Compare to centers that have been cited for abuse and neglect. We estimate approximately 750 facilities will receive this icon. For more information, read yesterday's member email here.

CMS published updates to the Five-Star Technical Users’ Guide stating that centers that receive the abuse icon will have their health inspection rating on Nursing Home Compare capped at a maximum of two stars. Due to the methodology used to calculate the overall rating, the best overall quality rating a facility flagged for abuse can have is four stars.

In addition, CMS will be removing two quality measures from the Five-Star Quality Rating System. These measures are:

1. Percentage of short-stay residents who report moderate to severe pain.
2. Percentage of long-stay residents who report moderate to severe pain.

As a result of dropping these two measures, the cut-points for the long-stay, short-stay, and overall QM ratings will change starting later this month. These changes will overall maintain the same distribution of short-stay and long-stay QM ratings that were posted on Nursing Home Compare in July 2019. The new cut-points are shown in the table below.

<table>
<thead>
<tr>
<th>QM Rating</th>
<th>Long-Stay QM Rating Thresholds</th>
<th>Short-Stay QM Rating Thresholds</th>
<th>Overall QM Rating Thresholds</th>
</tr>
</thead>
<tbody>
<tr>
<td>★</td>
<td>155–469</td>
<td>144–473</td>
<td>299–943</td>
</tr>
<tr>
<td>★★</td>
<td>470–566</td>
<td>474–567</td>
<td>944–1,132</td>
</tr>
<tr>
<td>★★★</td>
<td>565–644</td>
<td>568–653</td>
<td>1,133–1,298</td>
</tr>
<tr>
<td>★★★★</td>
<td>645–734</td>
<td>654–739</td>
<td>1,299–1,474</td>
</tr>
<tr>
<td>★★★★★</td>
<td>735–1,150</td>
<td>740–1,150</td>
<td>1,475–2,300</td>
</tr>
</tbody>
</table>

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1,150/800 to the unadjusted scores).
IHCA and AHCA will keep you informed on any further developments. If you have any questions, please contact the AHCA Regulatory team at regulatory@ahca.org.

**Nursing Home Compare Changes with Regard to Abuse, Neglect, Exploitation**

The Centers for Medicare and Medicaid Services (CMS) announced it will use a special icon to identify nursing homes that have been cited for abuse and neglect. According to CMS, adding the icon to Nursing Home Compare, the federal government website, is designed to improve the transparency of consumer information as part of its five-point plan to improve nursing home quality and safety. CMS’s action follows two hearings on nursing home abuse and neglect held earlier this year by the US Senate Finance Committee.

**How the icon will work**

The icon, which CMS is calling a consumer alert icon, will be a circle with a red hand in the middle signifying “stop.” Beginning October 23, 2019, it will indicate nursing homes that meet the following criteria:

1. Have been cited for one or more of the following deficiencies related to abuse, neglect, or exploitation:
   - F600 (Protect each resident from all types of abuse, such as physical, mental, sexual abuse, physical punishment, and neglect by anybody);
   - F602 (Protect each resident from the wrongful use of the resident’s belongings or money);
   - F603 (Protect each resident from separation from other residents, his/her room, or confinement to his/her room);
   - 223 (Protect each resident from all abuse, physical punishment, and involuntary separation from others); and
   - F224 (Protect each resident from mistreatment, neglect, and misappropriation of personal property).

2. The cited deficiency:
   - a) has harmed a resident within the past year (a scope and severity level of G or higher); and/or
   - b) potentially could have harmed a resident within each of the past two years (a scope and severity level of D, E or F).

The icon will be removed after the facility has corrected the deficiency and has gone a full cycle (about 1 year) with no abuse citations on any survey (standard or complaint). For instance, if a facility receives an icon based on a finding of abuse during a standard (annual) survey and then has no abuse findings on the next standard survey and on complaint investigations, the icon will be taken off.

In addition, nursing homes that receive the abuse icon will have their health inspection rating capped at a maximum of two stars. Due to the methodology used to calculate the overall rating, the best overall quality rating a facility that has received the abuse icon can have is four stars (see the Five Star Technical Users’ Guide).

Nursing Home Compare will be updated monthly.

**Hazardous Areas...Ensuring They Comply**

The Life Safety Code® has long required special protections for “hazardous areas.” Locations commonly considered under this designation are storage rooms, soiled utility rooms, boiler rooms, laboratories and bulk laundry areas. For existing hazardous areas (in place prior to May 2016), the requirements include:

- Enclosure of the space with 1-hour fire resistance rated construction (if the room is provided with sprinkler protection, the enclosure is not required to be rated but should limit the passage of smoke)
- Doors shall be self-closing and positive latching. In rooms constructed or transformed into hazardous areas after May of 2016, the requirements are similar. However, the 1-hour enclosure of the room or space is required and cannot be offset with sprinkler protection unless it is a storage space less than 100 square feet.

Prior to the adoption of the 2012 edition of the Life Safety Code®, organizations often found themselves in trouble if they converted an existing office, sleeping room, or other space into a storage room. The conversion changed the use of the room and therefore triggered the provisions for “new” construction in the Life Safety Code®. However, such rooms usually did not have 1-hour rated enclosures. If identified during survey, it was often a surprise to learn that a simple reallocation of space would lead to a survey deficiency.

The adoption of the 2012 edition of the Life Safety Code® provided potential relief to organizations who are converting existing spaces into storage areas. The 2012 edition includes a new chapter (Chapter 43 – Building Rehabilitation) that clarifies the requirements applicable when implementing repairs, renovations, changes of use, or even changes in occupancy type. In particular, Section 43.7.1.2(2) provides guidance on the requirements around converting existing spaces into newly designated hazardous areas. Essentially, a 1-hour enclosure of the newly created hazardous area is not necessary if the following criteria are met:

- The area is not greater than 250 square feet
- The room in being converted to a location used for storage (including repair shops)
- The building is fully sprinklered

This provision in Chapter 43 provides much more flexibility when reallocating space and developing additional storage locations, a common practice in buildings where storage space is scarce. All door provisions for hazardous areas still apply.

As always, knowledge of the applicable codes and standards is your best tool for ensuring compliance. You can purchase a copy of the Life Safety Code® (NFPA 101) online at www.nfpa.org.

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

Focus F-Tag – F921 Safe/Functional/Sanitary/Comfortable Environment

This Regulatory Beat’s Focus F-Tag is the final F-Tag that is part of the Physical Environment Regulatory group, F921 Safe/Functional/Sanitary/Comfortable Environment. The Centers for Medicare & Medicaid Services (CMS) must have felt that the title of the F-Tag was sufficient to explain the regulatory requirement to providers, as the regulation is only one sentence long and is void of any Interpretive Guidance. The regulation for “other” environmental conditions states that the facility must provide an environment for residents, staff and the public that is safe, functional, sanitary and comfortable. F921 is referenced under the Interpretive Guidance at F584 Safe/Clean/Comfortable/Homelike Environment (which has a very similar name) as a potential F-Tag for surveyors to consider as well. Specifically, the IG states that surveyors should consider citing F912 for issues related to cleanliness of staff-only areas of the facility or areas only used by the public. This includes areas such as break rooms, the kitchen (despite there being an F-Tag for that as well at F812), and facility parking lots that may be used by visitors or others.

F921 has been cited infrequently, and mostly on Complaint Surveys, however, when it has been cited, it has been predominantly at an Immediate Jeopardy level. Areas where issues with compliance were identified include:

- Ceilings on hallways and resident rooms with water damage and mold (Recertification Survey S/S: L)
- Fire alarm system did not notify fire department or law enforcement if activated and water was leaking from the ceiling into the therapy hallway (Complaint S/S: L)
- Water in excess of 120F observed running during survey, and residents were queried about why the water was on everywhere, they told the surveyor that it was to keep the pipes from freezing (Complaint S/S: K)
• Dirty, stained grout in shower stalls with stained, worn shower chairs and worn shower curtains observed on survey (S/S: F)

As you can see from these actual citations, there is a bit of variation as to what is cited under F921, and all of it is not necessarily related to staff/public use areas. These citations could have been easily avoided through routine Environmental Rounds by the Housekeeping and Maintenance staff and follow-up with any third-party vendors, such as the fire alarm company, to ensure that maintenance and repairs were completed as required. CMSCG is hoping that looking at all of the Physical Environment F-Tags through the microscope that a surveyor can use makes you realize that the expectation is that residents who live in your facility have an environment that you would like to live in.

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**Trending Statistics**

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

**Hospitalizations for Depressive Disorders**

In 2016, one in four hospitalizations for mental and substance use disorders was for depressive disorders. (Source: AHRQ, Healthcare Cost and Utilization Project Statistical Brief #249: *Inpatient Stays Involving Mental and Substance Use Disorders, 2016*.)

Mental and substance use disorders are common in the United States. In 2016, over 55 million people aged 18 years and over (more than one in five adults) suffered from mental and/or substance use disorders (MSUDs). Of these adults, nearly 45 million had a mental disorder alone, 11 million had a substance use disorder alone, and 8 million had both a mental disorder and a substance use disorder.

Not only do mental and substance use disorders co-occur, they also are linked to other physical conditions such as diabetes, heart disease, and asthma. Disorders such as depression, anxiety, and substance use disorder are associated with significant distress and impairment, including complications with multiple chronic conditions, disability, inability to function in society, and substantial economic costs. The treatment costs of mental disorders alone totaled $201 billion in 2013. Taking into account additional costs associated with lost work productivity and disability payments, the total cost of mental and substance use disorders to society is estimated to be more than twice that amount.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents statistics from the 2016 National Inpatient Sample (NIS) on inpatient stays involving MSUDs at community hospitals among patients aged 5 years or older. First, MSUD-related inpatient stay characteristics, including costs, length of stay, discharge status, patient demographics, primary expected payer, and hospital location are shown. Inpatient stays for MSUDs (i.e., those with a principal MSUD diagnosis) are shown separately from those with a principal diagnosis of a physical condition and a secondary MSUD condition. Stays with no MSUD diagnosis are shown as a point of comparison. Second, the frequency, costs, and length of stay for specific MSUDs are shown. Because of the large sample size of the HCUP NIS, small differences can be statistically significant. Thus, only percentage differences between groups greater than or equal to 10 percent are noted in the text. For further information on the methodology, see the Data Source and Definitions sections at the end of this Statistical Brief.

**Highlights**

- In 2016, nearly 10 million inpatient stays had a principal (2.2 million) or secondary (7.7 million) MSUD diagnosis, constituting 6.1 and 21.7 percent of all inpatient stays, respectively.
- In total, stays principally for MSUDs cost $15.3 billion (3.6 percent of total hospital costs). On average, stays for MSUDs cost $7,100 and were 6.4 days.
- The rate of stays principally for MSUDs was highest among adults aged 18-64 years.
- Nearly 60 percent of MSUD stays for patients aged less than 65 years were billed to public payers.
One in four stays principally for MSUDs were for depressive disorders. Alcohol-related disorders and schizophrenia each constituted nearly one in five MSUD stays. Although uncommon, stays for eating disorders were the costliest ($19,400 per stay) and the longest (14 days, on average) type of MSUD stay. Inpatient stays for schizophrenia were the second costliest ($8,900 per stay) and second longest (11 days on average) MSUD stay. The most common reason for MSUD stays among males aged 45-64 years was alcohol-related disorders. Schizophrenia was the most common reason for MSUD stays for males aged 18-44 years.

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

1. There were no new Federal [CMS Quality, Safety and Oversight Letter](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/SurveyCertification-Letters/index.html) (formerly known as Survey and Certification (S&C) Letters) released since the last issue of Regulatory Beat.

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

   - **Nursing Homes: Enhancing Transparency about Abuse and Neglect.** On October 7, CMS announced a major enhancement of the information available to nursing home residents, families, and caregivers on our [Nursing Home Compare](https://www.medicare.gov/nursinghomecompare) website. Beginning October 23, we will display a consumer alert icon next to nursing homes that have been cited for incidents of abuse, neglect, or exploitation. By making this information accessible and understandable, we are empowering consumers to make the right decisions for themselves and their loved ones.

      “The Trump Administration and CMS are committed to ensuring that nursing home residents are safe from abuse and neglect. Through the “transparency” pillar of our five-part strategy to ensure safety and quality in nursing homes, we are giving residents and families the ability to make informed choices,” said Administrator Seema Verma. “With today’s action, the Trump Administration is putting critical information at consumers’ fingertips, empowering them and incentivizing nursing homes to compete on cost and quality.”

      The new alert icon will be added for facilities cited on inspection reports for one or both of the following:

      - Abuse that led to harm of a resident within the past year
      - Abuse that could have potentially led to harm of a resident in each of the last two years

      The icon will be updated monthly, at the same time CMS inspection results are updated. This icon will supplement existing information, including the Nursing Home [Five-Star Ratings](https://www.medicare.gov/nursinghomecompare), helping consumers develop a more complete understanding of a facility’s quality.


   - **PEPPER 2019.** The RELI Group, along with its partners TMF Health Quality Institute and CGS, is contracted with the Centers for Medicare & Medicaid Services to develop, produce and disseminate provider-specific comparative data reports, referred to as the Program for Evaluating Payment Patterns Electronic Report, or PEPPER. PEPPER summarizes one provider’s Medicare claims data statistics for areas that have been identified as at higher risk for improper Medicare payments. Providers can use the PEPPER to identify where they may be at higher risk for improper payments so they can consider their statistics and whether they should take any action, such as reviewing a sample of records to ensure care provided was necessary and that documentation supports the diagnosis codes and services billed. We encourage providers to access this free comparative billing report and utilize it as a tool to support their auditing and monitoring efforts. More on PEPPER can be seen [HERE](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Performance-Improvement-Eval/Program-for-Evaluating-Payment-Patterns-cbir-2019.html).
Modernizing and Clarifying the Physician Self-Referral Regulations Proposed Rule. On October 9, CMS issued a proposed rule to modernize and clarify the regulations that interpret the Medicare physician self-referral law (often called the “Stark Law”), which has not been significantly updated since it was enacted in 1989. The proposed rule supports the CMS “Patients over Paperwork” initiative by reducing unnecessary regulatory burden on physicians and other health care providers while reinforcing the Stark Law’s goal of protecting patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician’s financial self-interest. Through the Patients over Paperwork initiative, the proposed rule opens additional avenues for physicians and other health care providers to coordinate the care of the patients they serve – allowing providers across different health care settings to work together to ensure patients receive the highest quality of care. For More information:

- Proposed Rule: Public comments due by December 31
- Press Release

See the full text of this excerpted CMS Fact Sheet (Issued October 9).

View this edition as PDF [PDF, 117KB].

New Medicare Card: 80% of Claims Submitted with MBI. Many providers are using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions. For the week ending September 27, providers submitted 80% of fee-for-service claims with the MBI. Help protect your patient’s personal identity by using MBIs for Medicare business, including claims submission and eligibility transactions. Claims with MBIs by provider type:

- Institutional: 83%
- Professional: 80%
- Durable Medical Equipment: 74%

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

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 or the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

For more information, see the MLN Matters Article.

New Medicare Card: MBI Transition Ends in Less Than 10 Weeks. The 21 month Medicare Beneficiary Identifier (MBI) transition period ends on December 31, 2019. Are you ready? Starting January 1, 2020, you 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
Many providers are using the MBI for Medicare transactions. For the week ending October 4, providers submitted 80% of fee-for-service claims with MBIs. Protect your patients' identities by using MBIs now for all Medicare transactions. Don’t have an MBI?

- Ask your patients for their cards. If they did not get a new card, give them the Get Your New Medicare Card flyer in English or Spanish.
- Use your Medicare Administrative Contractor’s look-up tool. Sign up for the Portal to use the tool.
- Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active HICN.

For more information, see the MLN Matters Article.

- **Guide for Appropriate Tapering or Discontinuation of Long-Term Opioid Use.** On October 10, HHS published a new Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. Prescription opioids benefit the patient only when the benefit of using opioids outweighs the risks. But once a patient is on opioids for a prolonged duration, any abrupt change in the patient’s regimen may put the patient at risk of harm and should include a thorough case review and discussion with the patient. HHS does not recommend tapering opioids rapidly or discontinuing suddenly due to the significant risks of opioid withdrawal, unless there is a life-threatening issue confronting the individual patient. The HHS guide provides advice to clinicians who are contemplating or initiating a change in opioid dosage. See the full text of this excerpted HHS Press Release (issued October 10).

- **ICD-10 Coordination and Maintenance: Deadline for Comments November 8.** Proposed new codes and revisions were discussed at the September ICD-10 Coordination and Maintenance Committee meeting for implementation on October 1, 2020. The deadline for comments on these proposals is November 8. Visit the Meeting Materials webpage to watch videos from the meeting. Procedure code topics:
  - Visit the Meeting Materials webpage for the agenda and handouts
  - Send comments to ICDProcedureCodeRequest@cms.hhs.gov

  Diagnosis code topics:
  - Visit the National Center for Health Statistics webpage for the agenda and handouts
  - Send comments to nchsicd10cm@cdc.gov

- **Protect Your Patients from Influenza this Season.** The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. Influenza is a serious health threat, especially to vulnerable populations like people 65 and older, who are at high risk for hospitalization and developing serious complications. Vaccinate by the end of October – to help protect your patients, your staff, and yourself.

  Medicare Part B covers:
  - Influenza virus vaccine once per influenza season
  - Additional influenza vaccines if medically necessary

  For More Information:
  - Medicare Preventive Services Educational Tool
  - Influenza Resources for Health Care Professionals MLN Matters Article
  - Influenza Vaccine Payment Allowances MLN Matters Article
CDC Influenza website
CDC Information for Health Professionals webpage
CDC Fight Flu Toolkit webpage
CDC Make a Strong Flu Vaccine Recommendation webpage

- Submitting Your Medicare Part A Cost Report Electronically Webcast — Tuesday, November 5 from 12 to 1:30 pm CST. Register for Medicare Learning Network events. Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCReF) system. Use MCReF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCReF or mail or hand deliver it to your Medicare Administrative Contractor. You must use MCReF if you choose electronic submission of your cost report. Note: This content was presented in prior webcasts on May 1 and October 15, 2018 and March 28, 2019. Topics:
  - How to access the system
  - Detailed overview
  - Frequently asked questions

A question and answer session follows the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast. For more information, see the MCReF Medicare Learning Network Booklet, MCReF MLN Matters Article, and MCReF webpage.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

- Provider Compliance Focus Group Meeting — Tuesday, November 12 from 11am to 3 pm CST. Dial-in/Webex or in person at CMS Central Office, Baltimore, MD. Register for this meeting. Join us for an interactive session on Medicare Fee-For-Service (FFS) compliance. CMS want to make it easier for you to submit claims accurately and manage the audit process, while ensuring that we pay claims appropriately.

- Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS. A new MLN Matters Article MM11335 on Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS is available. Learn about additional detail in eligibility transactions on PPV vaccines.

- Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes. A new MLN Matters Article MM11361 on Fiscal Year (FY) 2020 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes is available. Learn about changes effective for hospital discharges occurring on or after October 1.

- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised. A revised MLN Matters Article MM11152 on Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) is available. Learn about the required changes.

- Provider Enrollment Rebuttal Process. A new MLN Matters Article MM10978 on Provider Enrollment Rebuttal Process is available. Learn about your rights and how to file.

- Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) — Revised. A revised MLN Matters Article MM11152 on Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) is available. Learn about the required changes.
- **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 is available. Learn about new and revised codes for NCDs.

- **Medicare Preventive Services — Revised.** A revised Medicare Preventive Services Medicare Learning Network Educational Tool is available. Learn about:
  - Codes
  - Coverage information

- **Medicare Fraud & Abuse Poster — Reminder.** The Medicare Fraud & Abuse Poster Medicare Learning Network Educational Tool is available. Learn:
  - Ways to avoid fraudulent activities
  - How to contact the Office of the Inspector General Hotline

- **Medicare Fraud & Abuse: Prevent, Detect, Report — Reminder.** The Medicare Fraud & Abuse: Prevent, Detect, Report Medicare Learning Network Booklet is available. Learn:
  - Fraud and abuse definitions and laws
  - How to report suspected fraud
  - Physician business relationships that may raise concerns

- **Medicare Overpayments — Reminder.** The Medicare Overpayments Medicare Learning Network Fact Sheet is available. Learn about:
  - Definition of an overpayment
  - Payment options
  - Collection tools and processes

- **PECOS for Provider and Supplier Organizations — Reminder.** The Provider Enrollment, Chain, and Ownership System (PECOS) for Provider and Supplier Organizations Medicare Learning Network Booklet is available. Learn how to:
  - Authenticate credentials
  - Register a surrogate
  - Respond to Medicare Administrative Contractor requests

- **Opioid Treatment Program Listening Session: Audio Recording and Transcript.** An audio recording and transcript are available for the September 24 Medicare Learning Network listening session on Opioid Treatment Programs (OTPs): New Medicare Benefit. Under the CY 2020 Physician Fee Schedule proposed rule, CMS plans to pay 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.

- **Roster Billing for Mass Immunizers — Revised.** A revised Roster Billing for Mass Immunizers Medicare Learning Network Booklet is available. Learn about:
  - Coverage requirements
  - Billing requirements
• Hospice Payment System— Reminder. The Hospice Payment System Medicare Learning Network Booklet is available. Learn about:
  
  o Coverage and certification requirements
  o Election periods and statements
  o Caps on payments

• Long-Term Care Hospital Prospective Payment System— Reminder. The Long-Term Care Hospital Prospective Payment System Medicare Learning Network Booklet is available. Learn about:
  
  o Certification elements
  o Patient classification
  o Payment adjustments

• Telehealth Services — Reminder. The Telehealth Services Medicare Learning Network Booklet is available. Learn about:
  
  o Requirements
  o Distant site practitioners
  o Billing and payment for the originating site facility

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

• Weekly U.S. Influenza Surveillance Report. FluView has been updated! The first report of the 2019-2020 is now available. CDC’s Influenza Division produces a weekly influenza surveillance report. According to this week’s report (Sept 29 - Oct 5), low level influenza activity is occurring in the United States at this time.

• MMWR: Summer Flu Activity in the U.S. and Composition of the 2020 Southern Hemisphere Flu Vaccine. Summer flu activity was low in the U.S. with cocirculation of influenza A and B viruses. In the Southern Hemisphere, flu viruses circulated widely, with influenza A(H3) predominating in many regions; however, influenza A(H1N1)pdm09 and B viruses were pre-dominant in some countries. It’s too early to know which viruses will predominate in the U.S. this season. Now is a good time to get a flu vaccine.

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

• Urinary Antigen Testing Can Help Improve Antibiotic Stewardship. Only 15.5 percent of adult patients with pneumonia received pneumococcal urinary antigen testing (UAT), a useful tool that, when it yields positive findings, can help physicians reduce the time that patients in stable condition need to take broad-spectrum antibiotics, according to an AHRQ study published in Clinical Infectious Diseases. The researchers used data from a national discharge hospital database over a five-year period, from 2010 to 2015. Although UAT is fast, accurate and inexpensive, its utilization remains low. The authors suggest that increased use of UAT can improve antibiotic stewardship efforts. Access the abstract.

• AHRQ Report Provides Comprehensive Definition of “Omissions of Care” in Nursing Homes. An AHRQ-funded team of experts has developed a comprehensive definition of omissions of care for nursing homes. Preventing adverse events and poor health outcomes for nursing home residents is an ongoing challenge for residents and staff. Residents’ complex needs, along with challenging working conditions for staff, increase the chance of residents experiencing harmful, yet avoidable, adverse events. While omissions of care have been cited frequently for contributing to subpar care, a comprehensive definition has not existed. The new definition, intended as a meaningful and actionable reference for researchers, nursing home residents and caregivers, states: “Omissions of care in nursing homes encompass situations when care—either clinical or nonclinical—is not provided for a resident and results in additional monitoring or intervention or increases the risk of an undesirable or adverse physical, emotional, or psychosocial outcome for the resident.” The definition was
designed to guide quality improvement efforts, training and education for care providers and additional research. Access Understanding Omissions of Care in Nursing Homes.

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

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding Admission Transaction Submission Guidelines. You may view the new notice here.

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

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

7. The Illinois Department on Aging reports:

- **Consumer Choice Website.** The Illinois Department on Aging and the Office of the State Long-Term Care Ombudsman Program have developed a website for consumers to use when seeking a long-term care facility. The website meets the requirement of the Illinois Act on the Aging 20 ILCS 105/1) (from Ch. 23, par. 6101) (c-5). The intent of the website is to provide consumers with information about facilities in their preferred area regarding medical care, services and treatment, special services and amenities, staffing, facility statistics and demographics, ownership and administration, safety and security, meals, nutrition, rooms, furnishings, and equipment as well as family, volunteer and visitation provisions. The consumer will be able to filter their search based on location, needs, and preferences.

   Facilities licensed under the Nursing Home Care Act (210 ILCS 45/2-214), the MC/DD Act (210 ILCS 46/2-214), and the ID/DD Community Care Act (210 ILCS 47/2-214) are all mandated to complete the electronic questionnaire provided by the Office of the State Long-Term Care Ombudsman. The questionnaire must be updated annually or when changes occur within the facility. The Questionnaire and the Facility Letter the Ombudsman are handing to facilities are included.

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

- **Weekly PDPM Update.** Since the Skilled Nursing Facility (SNF) Prospective Payment System officially migrated to the Patient-Driven Payment Model (PDPM) on Tuesday, October 1, there have been some bumps in the road.

- **AHCA Urges CMS to Change New Nursing Home Abuse Alert Icon for Consumers.** Today, the American Health Care Association (AHCA) submitted a letter urging Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma to change the new nursing home abuse alert icon on Nursing Home Compare that was announced this week. AHCA believes these suggested changes will improve the accuracy of information consumers access on Nursing Home Compare. The AHCA letter also reiterates the call for CMS to create a standard and rational definition of both abuse and neglect. Click here to read the full letter.

- **New Top Line – Q4.** Your Top-Line is a LTC Trend Tracker℠ publication that includes metrics and graphics outlining skilled nursing center’s progress on Five Star performance, the AHCA/NCAL Quality Initiative, their journey through the Quality Awards program, and other necessary data to help skilled nursing centers achieve their desired goals.

- **AHCA/NCAL Social Media Update.**

9. Reuters reports **Non-Drug Therapies May be More Effective at Easing Dementia-Associated Agitation.** Reuters reports an analysis by Canadian researchers at Li Ka Shing Knowledge Institute within Unity Health Toronto of over 163 studies involving nearly 25,000 patients suggests that “symptoms of aggression and agitation in dementia
patients may respond better to non-drug therapies such as massage, touch therapy and outdoor activities." Investigators "found that outdoor activities were more effective than antipsychotic medications for treating physically aggressive patients." Also, in terms of "verbal aggression, massage and touch therapy were more effective than the patients' usual care." The findings were published in the Annals of Internal Medicine.

10. **Senior Housing News** reports **Five Trends of Hospice Utilization in Assisted Living Highlighted**: Senior Housing News reports that the utilization of hospice "is rising in the U.S., particularly in assisted living." As an increasing number of "senior living operators explore hospice, what they are finding is a barrage of trends, statistics and use cases that highlight the unique value hospice has within senior living." The article then lists the five largest trends regarding hospice among assisted living facilities.

11. **Skilled Nursing News** reports:

- **AHCA Official Says Therapy Cuts Under PDPM Were "Inevitable," But SNFs Should Be Ready to Use It to Gain Efficiencies**: Skilled Nursing News reports that according to the American Health Care Association, "the cuts to therapy were baked into the system of the Patient-Driven Payment Model (PDPM)." AHCA Senior Vice President for Government Relations Clifton Porter said, "Lots of press has been going on about cuts in therapy. ... That was inevitable as it relates to how the system’s structured, because [PDPM] is structured based on clinical conditions, and that being the driver. There’s clearly going to be shifts." Porter made the comments during the AHCA/NCAL expo and convention in Orlando. What will eventually happen "in therapy, according to Porter, will be related to efficiencies." The new model "allows for a great deal of flexibility in terms of providing group and concurrent therapy, and SNFs should be ready to use it as part of their work to gain efficiencies and reduce expenses, he said – and there are no subsequent differences in terms of outcomes in delivering those modalities, according to Porter."

- **Hospitals Clarifying Discharge Policies in Light of New Skilled Nursing Data Guidelines**: Skilled Nursing News reports, "The new federal guidelines mandating that hospitals offer patients detailed information about available post-acute providers is prompting their acute-care counterparts to solidify and deepen their discharge policies." The rule "calls for hospitals to provide information about residents’ SNF options – with detailed data on quality measures – to help patients make the most informed decision possible during the vulnerable transfer period." In response to the new rules, "hospitals around the country are working to clarify their communication procedures when connecting patients with SNFs to ensure they are in the right place – and that they know what they can expect in terms of quality measures – in accordance with the new regulations."

12. **McKnight's** reports:

- **Parkinson Says Positive Provider Stories Are the Antidote to Criticism Of Long-Term Care Industry**: McKnight’s Senior Living reports, "Positive provider stories are the antidote to the criticism that the long-term care industry continues to hear from lawmakers and others despite making great strides in measures of quality, American Health Care Association / National Center for Assisted Living President and CEO Mark Parkinson said Monday to those attending the opening session of the organizations’ 70th Annual Convention and Expo." Parkinson said, "By any objective standard, quality has improved in assisted living buildings and SNFs all over the country. ... Our residents are experiencing less pain. Thousands more are returning to the community. Tens of thousands are not going back to hospitals, and hundreds of thousands have been taken off the antipsychotic medication. What has been accomplished is truly remarkable." Parkinson added, "Instead, we have been subjected to more criticism, more congressional hearings, more OIG reports than ever before. In fact, there was data that shows that people care more about individual stories than they do about data." The article also highlights NCAL Executive Director Scott Tittle, who "said NCAL members must go beyond working to improve quality and tracking data to chart their own course by asking one question: Will this make our residents’ lives better? ‘It’s simple but powerful,’ he said."

- **Three Ways to Reduce Burnout Among Nurses Highlighted**: McKnight’s Long Term Care News reports, "The perfect recipe for optimizing employee and patient satisfaction at long-term care and skilled nursing facilities includes two key elements: a well-staffed facility and a team of nursing professionals who feel appreciated and..."
engaged." The article then provides "three tips to improve nursing professionals’ lives, the lives of your patients and the rest of your staff," therefore reducing the risk of burnout. The three tips include investing "in nurses' mental health," praising and encouraging the team, and "addressing staffing needs head-on."

- **Analysis Finds SNFs Median Operating Margin Fell Below Zero for First Time.** [McKnight’s Long Term Care News](https://www.mcknightslongtermcare.com) reports, "A declining median operating margin means more skilled nursing facilities – particularly poor performers – are entering an economic danger zone, according to the latest [analysis](https://www.mcknightslongtermcare.com) from CliftonLarsonAllen." The analysis "found that SNFs’ median operating margin, which compares net income to revenues, dipped below zero for the first time in the report’s history." The article adds, "In 2018, SNFs that received an overall star rating of three stars or higher experienced an operating margin above the national median, according to the report." The facilities "that received an overall star rating of one or two stars, however, experienced operating margins below -1% for 2018."

13. **Interesting Fact:** The state of Illinois is the country's largest producer of pumpkins, second-largest producer of corn, and leading producer of arguments about whether or not ketchup is an acceptable condiment for a hot dog.