Regulatory beat

November 6, 2019 Edition

Feature Focus

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

IDPH Quarterly Provider Association Meeting
The following is a summary of the issues discussed at the October, 23 2019 IDPH Quarterly Provider Association Meeting:

1) Updated status of:
   - Distressed Facility Rulemaking and Legislation- The LTC Associations have suggested legislative changes to this Section to make it more workable. Last year during session legislation was stalled in committee. We will attempt to bring it back to life this spring. Certain advocates are pressuring IDPH to move forward with distressed facility language. Whatever language is decided upon must go through the LTC Advisory Board and the rulemaking process.
   - Status of the Implementation of SB 1814 – Still in internal IDPH review

2) Discussion on new federal changes to Nursing Home Compare (abuse icon) with regard to abuse, neglect and exploitation cites. Action against facility vs. action against staff - The LTC Associations have suggested potential solutions and discussed the impact of the abuse icon with IDPH. The Department will review internally and provide more information in the next meeting.

3) Identified Offender – Reporting of Felonies [210 ILCS 45/1-114.01]. Request ISP, Sergeant Jones, to attend to explain why the ISP believes all crimes must be reported to ISP. - We were informed that Sergeant Jones has been relocated to another post at this time. New ISP representative will be Lieutenant Daniel Carter. IDPH stated they will invite Lieutenant Daniel Carter to come to next meeting. The statute clearly states that only felonies are required to be forwarded to ISP. Previously, persons within the management of ISP have stated that they want all crimes Feature Focus (misdemeanors) reported. Lieutenant Daniel Carter will provide clarification at next meeting.

4) Request an IDPH ALJ to attend to discuss Involuntary Discharges. Issues include:
   - ALJ’s refusing to rule when the discharge is for Non-Payment due to a Medicaid Pending, even though the Pending has exceeded the 45-day limit;
   - ALJ’s allowing multiple re-filing of Medicaid Apps to delay am Involuntary Discharge; and

   -IDPH invited Kevin Stroud, Interim Chief of the ALJ. He stated we should not have to refile Involuntary Discharge Notice for Non-Payment. The judges have been informed to hold until the status for 30 to 45 days to wait for HFS approval/denial determination in order to have a hearing. If this becomes an issue,
ALJ asked for us to bring to his attention. Hearing should be held within 10 days after the determination is made. ALJ encouraged providers' lawyers to contact ALJ once a determination is made. ALJ does not receive a notice form HFS of their determination, typically notified by facility or resident.

- ALJ’s refusing to rule on "the safety of individuals in this facility is endangered", when the discharge also includes Non-Payment

- ALJ told the judges they can move on this as a 2\(^{nd}\) count complaint. He stated they can proceed on the 2\(^{nd}\) count (safety) without a ruling on Medicaid.

5) Facility License Renewal Applications – IDPH is working with DoIT to get applications listed electronically at this time.

6) Issue of relocation assistance. What will IDPH provide if requested?

- For Resident/Family
  - Mandated for IDPH to provide support in the instances of Involuntary Discharge and Facility Closure for the resident only.

- For Facility
  - IDPH will invite Ombudsman to attend next meeting to clarify. IDPH has an obligation to help the facility enforce a resident to move locations. Will discuss further at next meeting.

7) Any progress of information regarding rulemaking or guidance with regard to electronic monitoring devices and medical marijuana? The issue of medical marijuana in LTC facilities is beginning to ramp up and many facilities are being approached about this. Questions also regarding privacy issues related to smart speaker devices like Amazon Echo and Google Home that residents have or want in their rooms. IDPH perspective on this? Removal of marijuana convictions and how this will be handled by the HCWBC program?

- Electronic Monitoring – No IDPH guidance/rules to date. Can LTC facilities use the same process and consent form for these type of devices like we are to use for specific electronic monitoring devices spelled out in the statute? There have been articles written that the Echo/Home devices are possibly recording. HIPAA issues? Use of these types of devices draw upon the facilities internet and could slow down regular operations

- Medical Marijuana – Not just medical marijuana due to new law allowing recreational use of marijuana. Rules for use in LTC facilities – IDPH has not provided any guidance for this How is the new marijuana law allowing for the expungement of certain marijuana convictions going to be handled with regard to the Health Care Worker Background Check program? Need to address how the liability issue is going to be handled/resolved with regard to LTC facilities. No new guidance from federal CMS, marijuana is still against the law federally.

8) Status of the ID/DD Statement of Deficiencies conforming with the LTC Statement of Deficiencies? There are differences in how IDPH processes Statements between the ID/DD facilities and the LTC facilities. The statute/process is the same for both. IDPH stated that they are internally reviewing this issue and agreed to address and correct discrepancy in the near future – Status? – Will discuss with IDPH at next meeting

9) How to address CNAs walking out during their shift – resident abandonment – action that can be taken by IDPH? At the last meeting, IDPH stated they would review this issue with Legal and get back to us- This issue also needs to be in the discussion of the new BIMP language. Can abandonment be considered neglect? How can this best be reported to the Nurse Aide Registry? Previously, we asked that George Logan from the Registry Section be at the next meeting to discuss options. Will discuss with IDPH further at the next meeting.

10) IDPH Fine Reduction IDPH takes the position that any State fines can’t be reduced to 25% until the Federal fine has been paid. They rely on the word “paid” in the statute. This to the LTC Industry is another example of IDPH taking an unreasonable position. The timing of a provider paying the federal fine shouldn’t dictate whether we are entitled to the 75% reduction. What if we waive the State fine and pay 65%? Is there a mechanism to get
back the money from IDPH once we’ve paid the corresponding federal fine? To us, IDPH should just accept that the federal fine is going get paid at some point and just let us pay the 25%. IDPH LTC understands the issue and will discuss with IDPH Legal for possible solutions and report back at the next Quarterly meeting. – This item is still in IDPH Legal Review

11) What can a family paid caregiver do in a LTC facility? Is the facility liable for anything the paid caregiver does? Can a family give a waiver and will CMS/IDPH accept it should something go wrong? Is strict liability in place?
   • IDPH stated that a facility is liable for what the family paid caregiver does because it is related to the patients care plan. Will discuss further in the next meeting.

12) With regard to PA 100-0754 (Eff 8/10/18) (DSP Credentialing Pilot Program), Does this mean that a CNA, who is also a DSP, can use their active role/duties as a DSP, to show they are actively “performing nursing or nursing-related services”, to prevent losing their CNA Certification? – IDPH answered yes. Does this allow CNA’s to work in ICFDD/ID’s without becoming DSPs? - IDPH stated no because they are separate criteria.

13) Personal Update within BLTC - No update from IPDH at this time.

14) How is F919 being implemented? The reg doesn’t state it but we have heard that CMS is requiring that there must be two-way communication between resident and facility staff? - Holding until Bill Bell returns to clarify question for IDPH.

15) Personnel Update
   • Sandra Brand, Associate Deputy Director of Transitional Care
   • Felicia Gray, Senior Colbert Administrator (Cook Co. only)
   • Kevin Stroud, Interim Chief of the ALJ

Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule for CY 2020

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) finalized policies that aims to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud and abuse to protect seniors and taxpayers will be effective on or after January 1, 2020.

The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

The CY 2020 OPPS/ASC Payment System final rule with comment period further advances the agency’s commitment to strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider burden, and strengthening program integrity so that hospitals and ambulatory surgical centers can operate with better flexibility and patients have what they need to become active healthcare consumers.

This fact sheet discusses the major provisions of the final rule with comment period (CMS-1717-FC), which can be downloaded from the Federal Register.

Focus F-Tag – F602 Free from Misappropriation/ Exploitation

This Regulatory Beat’s Focus F-Tag is F602 Free from Misappropriation/ Exploitation which is part of the Freedom of Abuse, Neglect, and Exploitation regulatory group. The regulation at F602 states that residents have the right to be free from misappropriation of their property and free from exploitation. The Interpretive Guidance (IG) for this regulation
was greatly expanded when the Requirements of Participation (RoPs) were updated and include a detailed protocol for surveyors to follow when investigating allegations of misappropriation or exploitation.

Misappropriation
The State Operations Manual Appendix PP defines misappropriation as the deliberate misplacement/ exploitation or wrongful temporary/permanent use of a resident’s belongings or money without the resident’s consent. This includes, per the Interpretive Guidance, money, clothing, jewelry, electronics, and also the personal information of residents including credit card information, bank account information and Social Security cards. This has been cited on survey related to:

- Residents’ wallets/cash/gift cards going missing. In some cases, staff were identified on facility surveillance going into the rooms where items were reported missing, and in other cases even on the surveillance cameras of stores using the stolen items, such as ATM cards or gift cards.
- A CNA “traded” $20 bills with a resident because the one he/she had did not work in the vending machine. The resident gave the CNA a different $20 and it was later identified that the $20 the CNA had provided was a counterfeit bill (S/S: D)

Another area of resident property that should not be forgotten is resident medications, especially controlled substances, through diversion. Many of the citations reviewed for this post were related to controlled substance diversion, including:

- One facility reported it had identified diversion of controlled substances and was put into Immediate Jeopardy (S/S: K). Another facility in the same area employed the suspected RN who was a float nurse, and they received a visit from the local authorities who ultimately interviewed the RN and arrested her. That facility was also put into Immediate Jeopardy (S/S: K). Neither facility had conducted the necessary background checks on the employee.
- A facility was contacted by another nursing facility and was provided with social media messages showing that an LPN was selling controlled substances. Observation of the staff member showed that he/she spent most of the shift in the medication room and did not provide medications to residents as ordered. Checks of the controlled substances found missing medications (S/S: D)

Exploitation
Exploitation is defined in the SOM as taking advantage of a resident for personal gain through manipulation, intimidation, threatening the resident or through coercion. Residents may perceive staff as in a more powerful position than them, which may allow staff to unfairly manipulate the resident. This includes asking residents to borrow money or personal items or gaining access to resident’s personal holdings through persuasion, coercion or solicitation. Residents who consent due to intimidation, fear or coercion are not considered to have provided valid consent. Here are some examples of how facilities have been cited for exploitation:

- A resident loaned the Director of Social Services $1000 for personal use. The resident stated he felt uncomfortable saying no to the employee. The Social Services Director initially denied the allegation, but later admitted it. (S/S: D)
- One resident’s relative who managed her money withdrew nearly all of the money in the resident’s personal funds account and the facility did not intervene on her behalf to address the withholding of funds through exploitation of a vulnerable adult. (S/S: D)

Facilities need to have comprehensive policies and procedures in place to prevent misappropriation of resident property as well as exploitation. These topics need to be covered as part of the facility’s mandatory abuse training that should be in place as part of the Requirements of Participation.

When an allegation of exploitation or misappropriation of property is being investigate, do you think about and follow-up on identified changes in the victim’s mood and demeanor from the time the alleged exploitation/misappropriation was first noted? Are we looking for a change in the level of trust, fear of being touched/near others or is the person trembling or cowering (sure signs of fear), altered sleep patterns or new behaviors such as angry outbursts or agitation? Misappropriation and exploitation can have a profound negative affect on a resident, so we need to do our utmost to prevent misappropriation and exploitation through a strong prevention system that includes staff education and monitoring of the effectiveness of the system.
Fear of Falling

Falls remain the leading cause of fatal and nonfatal injuries for older Americans according to the National Council on Aging. Hospitals face financial penalties when they occur. Nurses and aides get blamed or reprimanded if a patient under their supervision hits the ground. But hospitals have become so overzealous in fall prevention that they are producing an “epidemic of immobility,” experts say. To ensure that patients will never fall, hospitalized patients who could benefit from activity are told not to get up on their own — their bedbound state reinforced by bed alarms and a lack of staff to help them move.

“Older patients face staggering rates of disability after hospitalizations,” said Dr. Kenneth Covinsky, a geriatrician and researcher at the University of California-San Francisco. His research found that one-third of patients age 70 and older leave the hospital more disabled than when they arrived.

The first penalties took effect in 2008, when the Centers for Medicare & Medicaid Services declared that falls in hospitals should never happen. Those penalties are not severe: If a patient gets hurt in a hospital fall, CMS still pays for the patient’s care but no longer bumps up payment to a higher tier to cover treatment of fall-related conditions. Still, Covinsky said that policy has created “a climate of fear of falling,” where nurses “feel that if somebody falls on their watch, they’ll be blamed for it.” The result, he said, is “patients are told not to move,” and they don’t get the help they need. To make matters worse, he added, when patients grow weaker, they are more likely to get hurt if they fall.

Congress introduced stiffer penalties with the Affordable Care Act, and CMS began to reduce federal payments by 1% for the quartile of hospitals with the highest rates of falls and other hospital-acquired conditions. That’s substantial because nearly a third of U.S. hospitals have negative operating margins, according to the American Hospital Association. Nancy Foster, the AHA’s vice president of quality and patient safety policy, said these policy changes sent “a strong signal to the hospital field about things CMS expected us to be paying attention to.” Limiting patient mobility “certainly is a potential unintended consequence,” she said. “It might have happened, but it’s not what I’m hearing on the front line. They’re getting people up and moving.”

Access the full Kaiser Health News article here.

Important Regulations, Notices & News Items of Interest

1) There were no 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.

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

- Medicare Hospital OPPS and ASC Payment System Final Rule for CY 2020. On November 1, CMS finalized policies that aim to increase choices, encourage medical innovation, empower patients, and eliminate waste, fraud, and abuse to protect seniors and taxpayers. The changes build on existing efforts to increase patient choice by making Medicare payment available for more services in different sites of services and adopting policy
changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.6 percent. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for Multi-Factor Productivity (MFP).

Using the hospital market basket, CMS is finalizing an update to the ASC rates for CY 2020 equal to 2.6 percent. The update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for MFP. This change will also help to promote site-neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The final rule with comment period includes:

- Increasing choices and encouraging site neutrality
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the inpatient only list
- ASC covered procedures list
- Payment for procedures involving skin substitutes
- Rethinking rural health
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Addressing wage index disparities
- Unleashing innovation
- Device pass-through applications
- Protecting taxpayer dollars
- Meaningful Measures/Patients Over Paperwork
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program (PHP) rate setting
- Update to PHP per diem rates
- Revision to the organ procurement organization conditions for certification

For More Information:

- Final Rule
- Register for November 6 Call
- See the full text of this excerpted CMS Fact Sheet (Issued November 1).

**Success with the Hospice Quality Reporting Program Webinar — November 14.** Thursday, November 14 from 2 to 3 pm ET

Register for this webinar.

Find out how to put the pieces together to meet compliance. CMS experts provide an overview of Hospice Quality Reporting Program (HQR) requirements. Topics:

- Hospice Item Set (HIS) reporting requirements
- HQR compliance cycle
- How to achieve hospice compliance
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey requirements
- How to switch CAHPS survey research vendors
• Target Audience: Medicare-certified hospice providers.

• **IRF/LTCH/SNF QRP November 15, 2019 Submission Deadline Extended.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) has been extended to November 18, 2019. Assessment data for IRFs, LTCHs, and SNFs, and CDC data for IRFs and LTCHs submitted April 1 – June 30 (Q2) of calendar year (CY) 2019 are due with this deadline.

All data must be submitted no later than 11:59 p.m. on November 18, 2019.

**The lists of measures required for this deadline are found on the CMS QRP websites:**

- IRF Quality Reporting Data Submission Deadlines
- LTCH Quality Reporting Data Submission Deadlines
- SNF Quality Reporting Program Data Submission Deadlines

As a reminder, it is recommended that providers run applicable CASPER/iQIES/NHSN analysis reports prior to each quarterly reporting deadline, in order to ensure that all required data has been submitted.

Swingtech sends informational messages to IRFs, LTCHs, and SNFs that are not meeting APU thresholds on a quarterly basis ahead of each submission deadlines. If you need to add or change the email addresses to which these messages are sent, please email QRPHelp@swingtech.com and be sure to include your facility name and CMS Certification Number (CCN) along with any requested email updates.

• **New Medicare Card: Claim Reject Codes After January 1.** Starting January 1, 2020, you must use Medicare Beneficiary Identifiers (MBIs) 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
  - If you do not use MBIs on claims after January 1, you will get:

    Electronic claims reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity’s contract/member number), and an Entity Code of IL (subscriber)

    Paper claims notices: Claim Adjustment Reason Code (CARC) 16 “Claim/service lacks information or has submission/billing error(s)” and Remittance Advice Remark Code (RARC) N382 “Missing/incomplete/invalid patient identifier”

    Do not wait. Protect your patients’ identities by using MBIs now for all Medicare transactions. Need 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.

• **Take Medicare Fraud, Waste and Abuse Fighting Further, Through Innovation.** CMS is looking for innovative program integrity solutions to meet the challenges of the new Medicare landscape. We live in a more complex
world today than we did when the Medicare program was created. As the Medicare program has evolved, so have our efforts to combat fraud, waste and abuse to ensure we “pay it right.” What new solutions can we implement? What does the future of program integrity look like? You tell us.

On October 21, we announced two Requests for Information (RFIs), open until November 20:

- **Future of Program Integrity RFI** seeks information on how we can better align our initiatives with the changing health care environment. How can we modernize program integrity strategies for value-based programs, improve prior authorization for Medicare fee-for-service, and improve provider education with innovative solutions?

- **Advanced Technology in Program Integrity RFI** asks: How can we use the latest technology such as artificial intelligence to ensure proper claims payment, reduce provider burden, and maximize efficiency? We want to hear your ideas on technology that could be applied to provider enrollment, electronic health records, and data and analytics systems.

Hear from Administrator Seema Verma on [why we are asking for your help](#).

- **Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier.** Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk Medicare beneficiaries:
  - Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum. Up to 2 years of sessions delivered to groups of eligible beneficiaries.
  - Find out how to become a Medicare enrolled MDPP supplier:
    - Obtain CDC preliminary or full recognition: Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition; see the [Supplier Fact Sheet](#) and [CDC website](#) for more information.
    - Prepare for Medicare enrollment; see the [Enrollment Fact Sheet](#) and Checklist. Apply to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll), See the [Enrollment Webinar Recording](#) and [Enrollment Tutorial Video](#).
    - Furnish MDPP services; see the [Session Journey Map](#)
    - Submit claims to Medicare; view the [Billing and Claims Webinar Recording](#); see the [Billing and Claims Fact Sheet](#) and [Billing and Payment Quick Reference Guide](#)

For More Information:
- [MDPP Expanded Model](#) Booklet
- [Materials](#) from Medicare Learning Network call on June 20, 2018
- [MDPP](#) webpage
- [CDC - CMS Roles Fact Sheet](#)
- Contact the MDPP Help Desk at [mdpp@cms.hhs.gov](mailto:mdpp@cms.hhs.gov)

- **Proper Coding for Specimen Validity Testing Billed in Combination with Urine Drug Testing.** In a February 2018 report, the Office of the Inspector General (OIG) determined that Medicare payments to clinical laboratories and providers for specimen validity tests did not comply with Medicare billing requirements. A recent [MLN Matters Special Edition Article](#) reminds laboratories and other providers about proper billing for specimen validity testing done in conjunction with drug testing; this article contains no policy changes.

  Current coding for testing for drugs of abuse relies on a structure of presumptive and definitive testing that identifies the specific drug and quantity in the patient. This article includes descriptors for:
Presumptive drug testing codes
- Definitive drug testing codes

Use the following resources to bill correctly and avoid overpayment recoveries:

- National Correct Coding Initiative Policy Manual
- Contact your Medicare Administrative Contractor
- Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests OIG Report

- **ICD-10 Vaping Coding Guidance.** A supplement to the ICD-10-CM Official Coding Guidelines is available for encounters related to e-cigarette, or vaping, product use. Visit the [2020 ICD-10-CM](#) webpage for more information.

- **Clinical Diagnostic Laboratory Test Payment System: Data Reporting Call — November 14.** Thursday, November 14 from 2 to 3 pm ET

  Register for Medicare Learning Network events.

  During this call, learn how to report data required by the Clinical Diagnostic Test Payment System final rule. CMS demonstrates how to register in the system and submit then certify data. Laboratories, including physician offices laboratories and hospital outreach laboratories that bill using a 14X TOB are required to report laboratory test HCPCS codes, associated private payor rates, and volume data if they:

  o Have more than $12,500 in Medicare revenues from laboratory services on the Clinical Laboratory Fee Schedule (CLFS), and
  
  o Receive more than 50 percent of their Medicare revenues from CLFS and physician fee schedule services during a data collection period
  
  o CMS will use this data to set Medicare payment rates effective January 1, 2021. For more information, visit the [PAMA Regulations](#) webpage.

  A question and answer session follows the presentation; however, you may email questions in advance to CLFS_Inquiries@cms.hhs.gov with “November 14 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call.

  Target Audience: Clinical diagnostic laboratories, including physician offices and hospital outreach laboratories.

- **Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates.** A new MLN Matters Article MM11455 on Updating Calendar Year (CY) 2020 Medicare Diabetes Prevention Program (MDPP) Payment Rates is available. Learn about HCPCS G-codes and payment amounts for 2020.

- **CDC Opioids Training Module for Nurses.** The Centers for Disease Control and Prevention (CDC) released a new module, A Nurse’s Call to Action for Safer Opioid Prescribing Practices in the interactive online training series, Applying CDC’s Guideline for Prescribing Opioids. In this module, nurses learn how they can support the implementation of the CDC Guideline to address the opioid overdose epidemic.

  Each module offers free continuing education and includes clinical scenarios, knowledge feedback prompts, and a resource library to enhance learning.
• **Quality Payment Program: APMs Web-Based Training.** CMS posted five Continuing Medical Education (CME) modules on Alternative Payment Models (APMs). Access them by logging into the Medicare Learning Network Learning Management System. Modules include:
  - Quality Payment Program 2019 Overview: Information on the origin and objectives of the program, the Merit-based Incentive Payment System (MIPS), and Advanced APMs
  - Transitioning to an Advanced APM: 2019 Update: Benefits and features of Advanced APM participation, how to prepare to join an Advanced APM, and resources to help with the transition
  - Quality Payment Program for MIPS APMs in 2019: Overview, benefits of participation, and reporting criteria
  - Quality Payment Program for Advanced APMs in 2019: Identifies the different Advanced APMs, participation and reporting requirements, and information on achieving Qualifying APM Participant (QP) status
  - Quality Payment Program: All-Payer Combination Option in 2019: Explains the option, criteria for Other Payer Advanced APM participation, and QP determinations

For More Information:
  - [Resource Library webpage](#)
  - Contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

• **Protect Your Patients’ Identities: Use the MBI Now.** Protect your patients’ identities by using the Medicare Beneficiary Identifier (MBI) now. Don’t have an MBI?

Ask your patients for their card. If they did not get a new card, give them the Get Your New Medicare Card flyer in [English](#) or [Spanish](#).

Use your Medicare Administrative Contractor’s look-up tool. [Sign up](#) for the Portal to use the tool.

Check the remittance advice. We return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number (HICN).

Will your claims be paid in 2020? Starting January 1, you must use MBIs when billing Medicare regardless of the date of service:
  - We will reject claims submitted with HICNs with a few exceptions
  - We will reject all eligibility transactions submitted with HICNs

For more information, see the [MLN Matters Article](#).

• **Hospital Value-Based Purchasing Program Results for FY 2020.** The Hospital Value-Based Purchasing (VBP) Program works by adjusting what Medicare pays hospitals under the Inpatient Prospective Payment System based on the quality and cost of inpatient care the hospitals provide to patients. In FY 2020, more hospitals will receive positive payment adjustments than will receive negative payment adjustments. In total, more than 1,500 hospitals (over 55 percent) will receive higher Medicare payments.

For FY 2020, the law requires that 2 percent of the payments for all participating hospitals be withheld and redistributed to the hospitals based on their performance on a previously announced set of quality and cost measures. We estimate that the total amount available for value-based incentive payments in FY 2020 will be approximately $1.9 billion.

The Total Performance Score for each hospital is based upon hospital performance scores in each of four measurement domains. Each domain contributes 25 percent to the total score. The measurement domains for FY 2020 are:
  - Clinical Outcomes
  - Safety
Person and Community Engagement
Efficiency and Cost Reduction

We posted the Hospital VBP Program incentive payment adjustment factors for each participating hospital for FY 2020 in Table 16B. Hospitals’ payments will depend on the following:

- How they performed—compared to their peers—on important health care quality and cost measures during a performance period.
- How much they have improved the quality of care provided to patients over time.

For FY 2020, almost 60 percent of hospitals will see a small change (between -0.5 and 0.5 percent) in their Medicare payments. The average net payment adjustment is 0.16 percent. The average net increase in payment adjustments is 0.60 percent, and the average net decrease in payment adjustments is -0.39 percent. Due to the Hospital VBP Program, the highest performing hospital in FY 2020 will receive a net increase in payments of 2.93 percent, and the lowest performing hospital will incur a net decrease in payments of -1.72 percent.

For More Information:

- Hospital VBP Program webpage
- QualityNet website

See the full text of this excerpted CMS Fact Sheet (issued October 29), including information on computing the Hospital VBP score.

**IRF/LTCH/SNF Quality Reporting Program Submission Deadline: November 15.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Programs is November 15 for second quarter 2019 data:

IRF- Patient Assessment Instrument (PAI) and LTCH Continuity Assessment Record and Evaluation (CARE) assessment data and data submitted to CMS via the Center for Disease Control and Prevention National Healthcare Safety Network

Minimum Data Set (MDS) data

**List of Measures:**

- IRF Quality Reporting Data Submission Deadlines webpage
- LTCH Quality Reporting Data Submission Deadlines webpage
- SNF Quality Reporting Program Data Submission Deadlines webpage

CMS recommends that you run analysis reports prior to each quarterly reporting deadline to make sure all required data is submitted.

**Nursing Home Compare Refresh.** The October 2019 Nursing Home Compare refresh is available, including quality measure results based on Skilled Nursing Facility (SNF) Quality Reporting Program data. Visit the Nursing Home Compare website to view the data.

For More Information:

- SNF Quality Public Reporting webpage
- Discharge to Community measure Fact Sheet and FAQ
- Potentially Preventable Readmission measure Fact Sheet and FAQ
• **Influenza Vaccination: Protect Your Patients 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

• **DMEPOS: Bill Correctly for Items Provided During Inpatient Stays.** In a recent report, the Office of Inspector General (OIG) determined that Medicare improperly paid suppliers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items provided during inpatient stays. Medicare should not pay a supplier for items furnished to a beneficiary when the beneficiary is still an inpatient.

CMS developed the Medicare DMEPOS Improper Inpatient Payments Fact Sheet to help you bill correctly. Additional resources:

- Medicare Quarterly Provider Compliance Newsletter, Volume 9, Issue 2
- Medicare Claims Processing Manual, Chapter 20, Section 10
- Medicare Claims Processing Manual, Chapter 30, Section 130.1
- Medicare Improperly Paid Suppliers for DMEPOS Provided to Beneficiaries During Inpatient Stays OIG Report
- Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities OIG Report
- Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays OIG Report
- Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay OIG Report

• **Liver Transplant Claims: Possible Overpayment.** Inpatient Part A claims for liver transplants processed after January 1, 2017, and before November 18, 2019, may be overpaid because Medicare Administrative Contractors (MACs) did not request medical records due to a system error. MACs will adjust these claims and request medical records.

Hospitals: It is important to provide the records. If records are not received, the claim will be considered overpaid, and the overpayment will be recovered.

• **Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N.** A new MLN Matters Article SE19024 on Billing Instructions for Beneficiaries Enrolled in Medicare Advantage (MA) Plans for Services Covered by Decision Memo CAG-00451N is available. Learn about coverage of Chimeric Antigen Receptor (CAR) T-cell therapy for cancer.
• **Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model — Revised.** A revised MLN Matters Article SE1514 on [Overview of the Repetitive, Scheduled Non-emergent Ambulance Prior Authorization Model](https://www.cms.gov/Medicare/Provider-Participation/MLNMattersArticles/MLNMattersArticleSE1514.html) is available. Learn about extension of the model for an additional year.

• **What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight — Revised.** A revised MLN Matters Article SE19005 on [What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight](https://www.cms.gov/Medicare/Provider-Participation/MLNMattersArticles/MLNMattersArticleSE19005.html) is available. Learn who will be affected and when CMS started to place new HHAs into a provisional period.

• **Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training Course.** With Continuing Education Credit

  A new Medicare Fraud & Abuse: Prevent, Detect, and Report Web-Based Training (WBT) Course is available through the Medicare Learning Network [Learning Management System](https://medlearn.medicare.gov). Learn about:

  - Provisions and penalties
  - Prevention methods
  - How to report

• **Quality Payment Program: MIPS 2019 Web-Based Training Courses.** CMS posted six Continuing Medical Education (CME) modules on the Merit-based Incentive Payment System (MIPS). Access them by logging into the Medicare Learning Network [Learning Management System](https://medlearn.medicare.gov). Modules include:

  - Quality Payment Program 2019 Overview: Information on the origin and objectives of the program, MIPS, and Advanced Alternative Payment Models
  - Quality Payment Program Merit-based Incentive Payment System (MIPS): Participation in 2019: Eligibility, participation options, and reporting
  - Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019: Requirements, data submission and collection types, and scoring
  - Quality Payment Program Merit-based Incentive Payment System (MIPS): Promoting Interoperability Performance Category in 2019: Reporting requirements, measures, and reweighting
  - Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019: Requirements, reporting steps, and scoring
  - Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019: New measures, attribution, and scoring

For More Information:

- [Web-Based Training webpage](https://medlearn.medicare.gov#web-based-training)
- [Resource Library webpage](https://medlearn.medicare.gov#resource-library)
- Contact [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov) or 866-288-8292 (TTY: 877-715-6222)

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov) reports on:

• **Weekly U.S. Influenza Surveillance Report.** CDC's Influenza Division produces a weekly influenza surveillance report. According to this week’s report (Oct 26 - Nov 5), influenza activity is occurring in the United States has increased slightly, but still remains low.

• **CDC Podcast Series: Aging and Health Matters.** This new podcast and recent blogs ([Part 1](https://www.cdc.gov) and [Part 2](https://www.cdc.gov)) describe how living a healthy lifestyle may help reduce your risk for Alzheimer’s disease—the most common form of
dementia. Genes may not be your destiny after all. Find out what CDC expert, Scott Bowen, has to say about your genes and the studies.

4) 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 Attending Provider NPI Requirements Delay to January 1, 2020. You may view the new notice here.
   - The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding Ordering/Referring/Prescribing Provider – Delay to January 1, 2020. You may view the new notice here.
   - The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding Quality of Life Enhancement Add-on Payment for Single Occupancy Rooms. You may view the new notice here.

5) The Illinois Department of Public Health (IDPH) reports:
   - IDPH has decided to postpone the IDPH Town Hall Meetings until CY 2020.

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.

7) 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/NCAL Social Media Update.
   - Quality Award Program: Intent to Apply Deadline November 7th.

8) Provider Editor Daily Magazine reports:
   - ProMedica HCR ManorCare To Roll Out Meals-To-Go Program Nationally, President Says. Provider Magazine (10/31, Connole, 151K) reports, "David Parker, president, ProMedica HCR ManorCare, tells Provider that the organization’s Meals-to-Go program to ensure patients who are discharged to home from skilled nursing facilities (SNFs) have enough food to eat has been such a success that it will go national at all of the company’s SNFs by the end of next year. Parker stated, "It is such an amazing program, and the feedback has been so phenomenal that we will be rolling it out nationally."
• CMS Finalizes Home Health Pay Increase, Creates Home Infusion Therapy Benefit. ModernHealthcare (10/31, Livingston, Subscription Publication, 214K) reports that the Trump Administration on Thursday "finalized a 1.3% pay bump next year for home health agencies and created a new home infusion therapy benefit." The rule "also included a controversial new policy to pay infusion drug suppliers only for days when a skilled provider is present to administer the therapies to patients." While CMS "touted the home infusion benefit as allowing patients to choose where they receive care, experts say the policy may force more patients into hospitals."

• Columns Discuss High Costs Of Long-Term Care. In the Washington Post (10/31, Singletary, 14.2M), columnist Michelle Singletary discusses the high costs of long-term care for the families of elderly patients. She explains that the "Community Living Assistance Services and Supports (CLASS) Act was supposed to be an insurance program administered by the federal government that would cover long-term care," but it was ultimately abandoned over "concern that the people who most needed the insurance would pay but that others without health issues would opt out," meaning "premiums would be too high" and the government would be compelled to bail out a financially unstable program. Singletary contends that "until there is a national fix for how to pay for long-term care, the cost will still largely be covered by individuals and their caregivers." In a financial planning column in the Wall Street Journal (10/31, Subscription Publication, 7.57M), Glenn Ruffenach provides readers with several calculators to help them estimate what long-term care will cost.

• Quality Indicators Identified By Long-Term Care Residents May Not Be Great At Predicting How Well A Facility Will Perform During Inspections, Research Indicates. McKnight’s Long-Term Care News (10/31, Brown) reports, "Quality indicators identified by long-term care residents aren’t great at predicting how well a facility will perform during inspections," research indicated. After looking at "inspection report data from 594 long-term care homes throughout Ontario from 2017 to 2018," researchers from Canada "found a ‘weak relationship’ between quality indicators identified by residents and inspection performance for long-term care facilities." The findings were published online in the Journal of Post-Acute and Long-Term Care Medicine.

• Wearable Devices Using Machine Learning May Accurately Detect, Rate Parkinson’s Disease Tremors, Research Indicates. McKnight’s Long-Term Care News (10/30, Lasek) reported, "Wearable devices using machine learning can accurately detect and rate Parkinson’s disease tremors as people go about their normal activities," research indicated. People taking part in the study "wore sensors on the wrist or ankle," and data were "collected while they performed a variety of activities such as walking, resting, eating and getting dressed." What’s more, in the majority of "cases, results from the machine learning test matched results of the standard assessment currently used by neurologists."

9) The Wall Street Journal reports:

• Lifestyle Interventions May Stop Cognitive Decline and Improve Cognition In People At Risk For Alzheimer’s Disease, Study Indicates. The Wall Street Journal (10/30, Reddy, Subscription Publication, 7.57M) reports a study published in Alzheimer’s & Dementia suggests that lifestyle changes can improve cognition and possibly reduce the risk of Alzheimer’s disease. The study found that even people who already had memory problems could have cognitive improvement if they made changes in nutrition and exercise. On its website, CNN (10/30, LaMotte, 83.16M) reports the study indicates that "personalized lifestyle interventions not only stopped cognitive decline in people at risk for Alzheimer’s, but actually increased their memory and thinking skills within 18 months."

10) Kaiser Health News reports:

• Some California Nursing Home Residents Being Cut Off from Long-Term Care Payments. Kaiser Health News (10/30, Wiener) reports that some of California’s "most vulnerable nursing home residents, many of whom have nowhere else to go, are receiving letters from their health care plans saying they are no longer eligible for long-term care." In one notable example, "three dozen nursing home residents in San Luis Obispo County were informed on the same day that their Medi-Cal managed care plan was cutting off payment for nursing home care, said Karen Jones, the county’s long-term care ombudsman." The California Department of Health Care
Services, "which administers Medi-Cal, the state’s Medicaid program for low-income people, said the terminations by the managed care plan, CenCal Health, were isolated, a perspective some long-term care advocates share."

11) McKnight’s reports:

- **Medicare SNF Co-Payment Policy Contributes To Premature Discharge, Worse Patient Outcomes, Study Suggests.** [McKnight’s Long Term Care News](10/30) reports a study by the University of Pennsylvania suggests "Medicare’s skilled nursing facility copayment policy could be causing residents to be discharged too soon from facilities, producing worse patient outcomes." The [study](https://www.healthservicesresearch.com/) published in Health Services Research "found that 33.2% of all SNF admissions were discharged by day 20 of the benefit period," and "beneficiaries also had a 36.7% readmission rate within 30 days of a SNF [discharge], and a 43.1% readmission rate within 90 days." Moreover, "staying one day longer in a SNF...was linked to lower readmissions within 30 and 90 days of hospital and SNF discharges."

- **Survey Indicates Older Adults, Caregivers Believe Quality Of Life Decline Inevitable With Age.** [McKnight’s Long Term Care News](10/30) reports a survey conducted by WebMD and the John A. Hartford Foundation indicates "most older adults and caregivers mistakenly believe that sharp declines in quality of life are inevitable with age." The study showed that "the majority of seniors think that depression, dementia and lack of mobility can’t be helped. And three in four older adults surveyed were not aware that they have the right to ask for and receive health care tailored especially to their needs and wants."

12) **Interesting Fact:** PEZ Candy was invented in Vienna, Austria by Eduard Haas III as an alternative to smoking. The name PEZ comes from the German word for peppermint, “Pfefferminz” taking the P from the first letter, E from the middle and Z from the last letter to form the word PEZ. In 1952, PEZ came to the United States.