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

**CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met**

**What OIG Found**
CMS improperly paid 65 of the 99 SNF claims we sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled $481,034. On the basis of our sample results, we estimated that CMS improperly paid $84 million for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

We attribute the improper payments to the absence of a coordinated notification mechanism among the hospitals, beneficiaries, and SNFs to ensure compliance with the 3-day rule. We noted that hospitals did not always provide correct inpatient stay information to SNFs, and SNFs knowingly or unknowingly reported erroneous hospital stay information on their Medicare claims to meet the 3-day rule. We determined that the SNFs used a combination of inpatient and non-inpatient hospital days to determine whether the 3-day rule was met. In addition, because CMS allowed SNF claims to bypass the CWF qualifying stay edit during our audit period, these SNF claims were not matched with the associated hospital claims that reported inpatient stays of less than 3 days.

**What OIG Recommends and CMS Comments**
CMS should ensure that the CWF qualifying inpatient hospital stay edit for SNF claims is enabled when SNF claims are processed for payment. In addition, CMS should require hospitals to provide beneficiaries a written notification of the number of inpatient days of care provided during the hospital stay and whether the hospital stay qualifies subsequent SNF care for Medicare reimbursement so that beneficiaries are aware of their potential financial responsibility before consenting to receive SNF services. CMS should require SNFs to obtain a written notification from the hospital and retain it as a condition of payment for their claims. Further, CMS should educate both hospitals and SNFs about verifying and documenting the 3-day inpatient hospital stay relative to supporting a Medicare claim for SNF reimbursement. CMS concurred with our recommendations concerning the CWF qualifying inpatient hospital stay edit and educating hospitals and SNFs but did not concur with the remaining recommendations related to a coordinated notification mechanism among hospitals, beneficiaries, and SNFs. After reviewing CMS’s comments, we maintain that our findings and recommendations are valid. Without a coordinated notification mechanism, CMS will continue to make improper payments when the 3-day rule is not met.

The full report can be found [here](#).
On November 12, the Centers for Medicare & Medicaid Services (CMS) released a preprint version of the Medicaid Fiscal Accountability (MFAR) Proposed Rule (CMS-2393-P). The proposed regulation was set to publish in the Federal Register on November 18, 2018. CMS provides that the goal of the Proposed Rule is to “strengthen overall fiscal integrity of the Medicaid program” and “promote transparency” by establishing new reporting requirements.

The Proposed Rule identifies and addresses the following topic areas:

- Medicaid fee-for-service (FFS) provider payments;
- Disproportionate share hospital (DSH) payments;
- Medicaid program financing;
- Supplemental payments; and
- Health care-related taxes and provider-related donations.

McKnight’s Long-Term Care News reports a new proposal aimed at clamping down on “impermissible financing arrangements” under Medicaid could hurt supplemental payments providers currently receive. The announcement caused ripples of concern throughout the provider community Tuesday.

The Centers for Medicare & Medicaid Services announced the Medicaid Fiscal Accountability Rule that aims to add transparency to Medicaid payment processes and eliminate suspect practices.

“We have seen a proliferation of payment arrangements that mask or circumvent the rules where shady recycling schemes drive up taxpayer costs and pervert the system,” CMS administrator Seema Verma said in announcing the new proposal.

The rule would establish new requirements for states to report provider-level information on Medicaid supplemental payments. It also would clarify Medicaid financing definitions by proposing new regulatory definitions for Medicaid base and supplemental payments.

The American Health Care Association stressed the importance of supplemental payments to long-term care providers in response to the announcement.

“Provider taxes and supplemental payment arrangements both have become very important financing sources for long-term care providers,” Mark Parkinson, AHCA president and CEO, said in a statement.

“We welcome discussions with CMS on balancing adequate Medicaid base rates with the potentially devastating effects of any changes in Medicaid financing. This includes the vital need to protect provider taxes and supplemental payments, which are often used to offset inadequate base rates,” he said.

Parkinson added that “underfunding is a challenge that must be addressed in order to ensure continued access to quality long-term services and supports for the millions who depend on them.”

Added Brendan Flinn, director of home and community-based services for LeadingAge: “Supplemental payments are an important part of Medicaid financing, particularly given that Medicaid rates in most states are inadequate compared to the actual cost of care.”

“Generally speaking, changes that would restrict the state’s ability to make supplemental payments would jeopardize access to these important services,” Flinn said.

LeadingAge added that it plans to continue reviewing the proposed rule and assessing its impact on aging services providers, particularly nursing homes.

The full proposed rule can be found [here](#).
Focus F-Tag – F551 Rights Exercised by Representative

This Regulatory Beat’s Focus F-Tag is **F551 Rights Exercised by Representative**, which is part of the Resident Rights regulatory group. This regulation addresses the resident’s right to designate a representative and this depends on the resident’s competency to consent or not.

**Residents with Competency to Designate a Representative**
Residents who have not been legally adjudged incompetent in a state court in accordance with state laws have the right to designate a representative to exercise the resident’s rights for him/her. The resident has the right to choose the extent that the representative may exercise those rights. Facilities are expected to ensure that the resident representative does not make decisions on behalf of the resident that exceed the rights set out by the resident. Since the facility must treat the resident representative’s decisions as though they are decisions of the resident, it is important to ensure that there is a sound system in place to know who the designated representative is and the scope of his/her decision-making authority. Per the Interpretive Guidance at F551, facilities must ensure that there is documentation in place that shows that the representative has the necessary authority to make decisions.

In addition to not allowing the resident representative to overstep the limits on his/her decision-making capabilities, the facility also needs to ensure the resident remains involved in the decision-making process. The resident retains the right to exercise rights that were not delegated, including the right to revoke the representative’s right, unless state law does not permit this. Facilities should not “go around” competent residents to speak with their representatives in lieu of allowing the resident to retain decision-making rights as long as he or she is able to competently do so. Additionally, in cases where the facility believes that the representative may be making decisions that are not in the best interests of the resident, the facility needs to report the identified concerns as required under State law.

**Residents without Competency to Designate a Representative**
Residents who are not competent to designate a representative have a resident representative appointed for them in accordance with state laws. Court-appointed representatives exercise the resident’s rights to the extent that has been judged necessary. In these cases, the resident retains rights that are outside of the court-appointed representative’s decision-making authority. Facilities are expected to ensure that the resident is provided opportunities to participate in the care planning process (to the extent possible), and that the resident’s wishes and preferences are considered when the resident representative is exercising the resident’s rights. Per the IG, if a resident understands the risks, benefits and alternatives of a treatment and expresses a preference, then this should be considered to the extent possible.

The resident representative for residents who have been adjudged incompetent to designate a representative may be appointed several different types of representative. These include a person who has been authorized by state or federal law to act on behalf of a resident to assist with decision-making, provide financial management assistance, receive notifications or access medical/social/personal resident information. The representative may be a legal representative or a court-appointed guardian or conservator, depending on the circumstances and state laws. Facilities are responsible for verifying that court-appointed representatives have the necessary authority to make decisions based on the court’s decision.

**Thinking About Survey**
F551 has not been cited that frequently on survey in 2019, but surveyors have been provided with significant guidance in Appendix PP to help them identify problematic situations regarding the resident representative. Surveyors are expected to confirm that a resident’s rights have been delegated, and if so, if staff have been appropriately following the resident’s delegation of rights. This includes reviewing the resident record to verify that appropriate documentation is in place, which in many cases, is not. In reviewing what has been cited on survey, there are many instances where a resident who has been deemed incompetent has been the person who signed paperwork, or the paperwork that has been signed does not give authority to an individual who has been making decisions on behalf of the resident.
Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.

**Nurse Staffing Shortage Expected to get Worse**

*Mcknight’s* report that a survey of registered nurses found about 20% are planning to retire within the next five years indicating that staffing shortages could worsen.

The findings were published in the 2019 AMN Survey of Registered Nurses. It includes input from more than 20,000 RNs who work multiple settings, including post-acute and acute care.

The survey revealed 27% of nurses believe it’s unlikely they’ll remain at their current job in one year.

Increasing wages and offering additional benefits could be key in how well providers retain nurses. Thirty-one percent said compensation and benefits are the biggest influences on whether they’ll stay at their current organization.

Workplace violence is also a key concern for nurses, with 41% saying they have been victims of bullying, incivility or other forms of workplace violence. Another 27% said they have witnessed workplace violence. Sixty-three percent of respondents said their organization did not address the situation well at all, while just 10% said their organization addressed the situation extremely well or very well.

A [proposed federal bill](#) would require the Secretary of Labor to issue a final rule requiring healthcare and social services employers to develop and implement a comprehensive plan for protecting workers and other personnel from workplace violence.

If passed, skilled nursing facilities and hospitals would be required to comply with it as a condition of partaking in the Medicare program. The bill, however, could cost providers billions, a Congressional Budget Office report estimated.

On the brighter side, 81% of nurses said they’re satisfied with their career choice, and 70% said they would encourage others to become nurses.

Forty-four percent, however, said they often feel like resigning from their jobs. The same amount of nurses also said they usually don’t have enough time to spend with their patients.

Full survey results are available for download [here](#).

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**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:

   - **Hospital Price Transparency Requirements.** CY 2020 Hospital Outpatient Prospective Payment System Policy Changes. On November 15, CMS finalized policies that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

     The policies in the final rule will further advance the agency’s commitment to increasing price transparency. It includes requirements that would apply to each hospital operating in the United States. In response to
comments, CMS is extending the effective date to January 1, 2021 to ensure hospital compliance with these regulations.

The final rule includes:

- Definitions of “hospital,” “standard charges,” and “items and services”
- Requirements for making public all standard charges for all items and services in a machine-readable format
- Requirements for displaying shoppable services in a consumer-friendly manner
- Monitoring and enforcement

For More Information:

**View the final rule (CMS-1717-F2)**: This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the [Federal Register](https://www.federalregister.gov/) is the official HHS-approved document.

- [Press Release](https://www.cms.gov/about/news-releases/2021/12/2021-12-3-call.html)
- [Registration opening soon](https://www.cms.gov/about/news-releases/2021/12/2021-12-3-call.html) for December 3 Call

See the full text of this excerpted [CMS Fact Sheet](https://www.cms.gov/about/news-releases/2021/12/2021-12-3-call.html) (Issued November 15).

- **New Medicare Card: If an MBI Changes.** Medicare beneficiaries or their authorized representatives can ask to change their Medicare Beneficiary Identifiers (MBIs); for example, if the MBI is compromised. CMS can also change an MBI. It is possible for your patient to seek care before getting a new card with the new MBI.

  If you get an eligibility transaction error code (AAA 72) of “invalid member ID,” your patient’s MBI may have changed.

  - Do a historic eligibility search to get the termination date of the old MBI.
  - Get the new MBI from your Medicare Administrative Contractor’s secure MBI look-up tool. [Sign up](https://www.cms.gov/about/news-releases/2021/12/2021-12-3-call.html) for the Portal to use the tool.

Reminders about using the old or new MBIs:

**Fee-For-Service (FFS) claims submissions with:**

- Dates of service before the MBI change date – use old or new MBIs
- Span-date claims with a “From Date” before the MBI change date – use old or new MBIs
- Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs

**FFS eligibility transactions when the:**

- Inquiry uses new MBI – we will return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we will return all eligibility data. We will also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we will return an error code (AAA 72) of “invalid member ID.”

See the [MLN Matters Article](https://www.cms.gov/about/news-releases/2021/12/2021-12-3-call.html) for more information on how to get and use MBIs.
• **Person-Centered Planning: Comment on Performance Measurement by December 2.** CMS and the HHS Administration for Community Living are working with the National Quality Forum (NQF) to design a foundation for measuring performance of person-centered planning across community-based and institutional settings, including:
  - Definition for person-centered planning
  - Core competencies for facilitators
  - Optimal systems characteristics

NQF is accepting comments on the [draft interim report](#) through December 2:
  - [Registration](#) is required for submitting comments
  - Contact pcplanning@qualityforum.org with questions

• **Emergency Preparedness Resources.** The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) released:
  - [Issue 9 of The Exchange](#): Planning, response, and lessons learned specific to chemical incidents
  - [CMS Emergency Preparedness Rule Resource](#) webpage: Updated facility-specific requirement overviews to reflect the CMS Omnibus Burden Reduction (Conditions of Participation) [Final Rule](#)

For More Information:
  - [ASPR TRACIE](#) Fact Sheet
  - [ASPR TRACIE](#) website

• **Medicare Shared Savings Program: Application Deadlines for January 1, 2021, Start Date.** CMS announced Notice of Intent to Apply (NOIA) and application submission dates for a January 1, 2021, start date for the Medicare Shared Savings Program. Beginning April 20, 2020, CMS will start accepting NOIAs via the [Accountable Care Organization (ACO) Management System](#). You must submit a NOIA if you intend to apply to the Medicare Shared Savings Program for a January 1, 2021 start date.

NOIA submissions are due no later than May 8, 2020, at noon ET. A NOIA submission does not bind your organization to submit an application; however, you must submit a NOIA to be eligible to apply. Each ACO must submit only one NOIA.

The application submission period will be open from May 14 through June 11, 2020, at noon ET.

The NOIA and application submission dates are earlier in the year than they were in the past in order to give applicants more time to make application changes. Please consider these earlier submission deadlines when planning your application for a January 1, 2021, agreement period start date.

For More Information:
  - [Shared Savings Program](#) website
  - [Application Types and Timeline](#) webpage
  - [Application Toolkit](#) webpage
  - For questions email SharedSavingsProgram@cms.hhs.gov

• **Drug Units in Excess of MUE: Comparative Billing Report in November.** In late November, CMS will issue a Comparative Billing Report (CBR) on Drug Units in Excess of Medically Unlikely Edits (MUE), focusing on providers who submit Medicare Part B claims. These reports contain data-driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.
CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com to access your report. Update your contact email address in the Provider Enrollment, Chain, and Ownership System to ensure accurate delivery. Visit the CBR website for more information.

- **Raising Awareness of Diabetes in November.** National Diabetes Month, Diabetic Eye Disease Month, and World Diabetes Day on November 14 promote diabetes awareness and the impact of diabetes on public health. Talk to your patients about their risk factors and recommend appropriate Medicare preventive services for detection and treatment.

  The Medicare Diabetes Prevention Program (MDPP) is a new Medicare-covered service. Read the Pre-Diabetes Services: Referring Patients to the MDPP MLN Matters Article to learn more.

  For More Information:
  - Medicare Vision Services Fact Sheet
  - MDPP Expanded Model Booklet
  - National Diabetes Month webpage
  - World Diabetes Day website

  Visit the Preventive Services website to learn more about Medicare-covered services.

- **Recognizing Lung Cancer Awareness Month and the Great American Smokeout.** November is Lung Cancer Awareness Month, and November 15 is the Great American Smokeout. Tobacco use is the leading cause of preventable illness and death in the United States. Many smokers want to quit but have difficulty succeeding.

  - Talk to your patients about quitting
  - Recommend appropriate Medicare-covered preventative services, including counseling to prevent tobacco use, lung cancer screening counseling, and annual screening for lung cancer with low dose computed tomography

  For More Information:
  - Medicare Preventive Services Educational Tool
  - Lung Cancer Awareness website, Centers for Disease Control and Prevention
  - Great American Smokeout webpage, American Cancer Society

  Visit the Preventive Services website to learn more about Medicare-covered services.

- **IRF/LTCH/SNF Quality Reporting Program: Submission Deadline Extended to November 18.** The submission deadline for the Inpatient Rehabilitation Facility (IRF), Long-Term Care Hospital (LTCH), and Skilled Nursing Facility (SNF) Quality Reporting Programs is November 18 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.

- **2020 Quality Payment Program Final Rule Webinar — November 19.** Tuesday, November 19 from 2 to 3:30 pm ET
  
  Register for this webinar.

  CMS provides information about the final rule for the 2020 Performance Period of the Quality Payment Program. Topics include:
  - Overview of the Quality Payment Program, Merit-based Incentive Payment System (MIPS), and Advanced Alternative Payment Models (Advanced APMs)
  - MIPS and Advanced APM policy changes
  - Key differences between 2019 and 2020 requirements
  - MIPS Value Pathways, a new participation framework starting in 2021
  - Ways to connect to no-cost technical assistance and identify additional resources

- **Kidney Care Choices Model Webinars — November 22.** CMS is hosting a series of webinars to introduce the Kidney Care First and Comprehensive Kidney Care Contracting Model options and review the application process:
  
  - Register for the Kidney Care First Webinar: Friday, November 15 from noon to 1 pm ET
  - Register for the Comprehensive Kidney Care Contracting Finance Webinar: Friday, November 22 from noon to 1 pm ET

  For More Information:
  - Kidney Care Choices Model webpage
  - Webinars & Forums webpage: Presentation materials from the sessions
  - Contact the Model team at KCF-CKCC-CMMI@cms.hhs.gov.

- **MIPS Heart Failure Measure: Call for Public Comment Closes November 27.** CMS is developing a measure of acute cardiovascular-related admissions for patients with heart failure for the Merit-based Incentive Payment System (MIPS). Visit the Public Comment webpage for more information, and find out how to submit your comments.

- **CAHs: Hardship Exception Application Deadline December 2.** CMS requires that all Critical Access Hospitals (CAHs) use either the 2014 or 2015 Edition Certified Electronic Health Record Technology (CEHRT) to meet the reporting requirements of the Medicare Promoting Interoperability Program and successfully demonstrate meaningful use. CAHs may avoid the Medicare downward payment adjustments if they can show that meeting these requirements would result in a significant hardship. To be considered for an exception, you must complete a hardship exception application by December 2 and select the reason for the hardship.

  For More Information:
  - Scoring, Payment Adjustment, and Hardship Information webpage
  - Submit electronically
  - Submit your application over the phone by calling the QualityNet Help Desk at 866-288-8912

- **Drug Units in Excess of MUE: Comparative Billing Report Webinar — December 4.** Wednesday December 4 from 3 to 4 pm ET
  
  Register for this webinar.
Join us for a discussion of the Comparative Billing Report (CBR) on Drug Units in Excess of Medically Unlikely Edits (MUE), an educational tool for providers who submit Medicare Part B claims. Visit the [CBR website](https://www.cms.gov) for more information.

- **Ground Ambulance Organizations: Data Collection System Call — December 5.** Thursday, December 5 from 1:30 to 3 pm ET. [Register](https://www.medicare.gov) for Medicare Learning Network events.

  During this call, get an overview of the new Ground Ambulance Data Collection system, including:
  - Background
  - Selection of organizations required to report
  - Detailed discussion of the Data Collection Instrument

  A question and answer session follows the presentation; however, you may email questions in advance to AmbulanceDataCollection@cms.hhs.gov with “December 5 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call. For more Information, including providers selected for the first round of reporting, see the [Ambulance Services Center](https://www.cms.gov) webpage, CY 2020 Physician Fee Schedule [final rule](https://www.cms.gov), and [Bipartisan Budget Act of 2018](https://www.cms.gov).

  Target Audience: Ground ambulance organizations and ambulance stakeholders.

- **DMEPOS Competitive Bidding Surveys: Comment by December 20.** CMS is soliciting comments on:
  - Questions to ask in surveys of key stakeholders (e.g., beneficiaries, contract suppliers, and referral agents) to help us further strengthen the monitoring, outreach, and enforcement of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program
  - Effective methods for contacting referral agents, as they play a critical role in helping beneficiaries obtain competitively bid DMEPOS items

  We will accept comments through December 20. For more information, see the [Public Comments on Competitive Bidding Surveys](https://www.cms.gov) webpage.

- **MIPS: Virtual Group Election Period Open Through December 31.** To form a virtual group for the 2020 Merit-based Incentive Payment System (MIPS) performance year, you must follow an election process and submit your election to CMS via email by December 31.

  For More Information:
  - [2020 Virtual Groups Toolkit](https://www.cms.gov)
  - Contact QPP@cms.hhs.gov or 866-288-829 (TTY: 877-715-6222)

- **Medicare Ground Ambulance Data Collection System: Starts January 1, 2020.** Beginning January 1, CMS requires selected ground ambulance organizations to collect and report cost, revenue, utilization, and other information through a Ground Ambulance Data Collection System. The data will be analyzed to assess the adequacy of Medicare payment rates for ground ambulance services.

  More than 2,600 randomly selected Medicare rural health ground ambulance organizations make up the initial group. Other randomly selected Medicare ground ambulance organizations will be selected each year from 2020-2024.

  For More Information:
- Ambulances Services Center website: List of selected organizations, webinars, and other resources
- Register for Medicare Learning Network call on December 5

- **Home Health Agency: Final OASIS D-1 Data Submission Specifications.** Final Outcome and Assessment Information Set (OASIS) D-1 data submission specifications are available on the Data Specifications webpage, including required changes to support transition to the Patient-Driven Groupings Model. The new version, V2.31.0, is effective for assessments with a completion date of January 1, 2020 or later.

- **MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers.** The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the establishment and use of Patient Relationship Categories (PRCs) and codes. When tested, the PRCs will be incorporated into the claims-based cost measures, which assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during eight episodes of care. Read [MLN Matters Article MM11259](#), and learn how to report HCPCS Level II modifiers.

- **MACRA Patient Relationship Categories and Codes: Learn More.** MACRA Patient Relationship Categories (PRCs) and codes facilitate the attribution of patients and care episodes to clinicians who serve patients in different roles as part of the assessment of the cost of care. When tested, the PRCs may be incorporated into the claims-based cost measures, which assess the beneficiary's total cost of care during the year, or during a hospital stay, and/or during eight episodes of care. CMS finalized five patient relationship categories for use in a voluntary reporting period, which began January 1, 2018. Read the FAQ document to learn more.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the establishment and use of patient relationship categories and codes.

- **Recommend Influenza Vaccination: Each Office Visit is an Opportunity.** People 65 years and older are at high risk of developing serious influenza-related complications. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. Your strong vaccine recommendation is a critical factor that affects whether your patients get an influenza vaccine. Take time to recommend and vaccinate 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:
- [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

- **Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy.** A new MLN Matters Article MM11508 on Addition of Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy is available. Learn about the addition of MS-DRGs 319 and 320.

- **Health Professional Shortage Area (HPSA) Bonus Payments for All Mental Health Specialties.** A new MLN Matters Article MM11327 on Health Professional Shortage Area (HPSA) Bonus Payments for All Mental Health Specialties is available. Learn about psychiatric specialties eligible to receive the mental health bonus.

• April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised. A revised MLN Matters Article MM11216 on April 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS) is available. Learn about revisions related to Chimeric Antigen Receptor (CAR) T-Cell Therapy.

• Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised. A revised MLN Matters Article MM11003 on Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System is available. Learn about eMDR registration and enrollment.

• 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. Learn about:
  o Provisions and penalties
  o Prevention methods
  o How to report

• Opioid Treatment Programs (OTPs) Medicare Enrollment. A new Opioid Treatment Programs (OTPs) Medicare Enrollment Medicare Learning Network Fact Sheet is available. Learn about:
  o Pre-enrollment steps
  o How to submit your application
  o What to expect after you submit your application
  o Enrollment process checklist

• Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised. A revised Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Medicare Learning Network Educational Tool is available. Learn about:
  o Billing information
  o Frequently asked questions
  o Codes
  o Descriptors

• Medicare Telehealth Services Video. A new Medicare Telehealth Services Medicare Learning Network Video is available. Learn about:
  o Who can furnish services
  o Qualifications for an originating site
  o Covered services
  o Billing and payment

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

• Weekly U.S. Influenza Surveillance Report. CDC's Influenza Division produces a weekly influenza surveillance report. According to this week's report (Nov 5 - Nov 9), influenza activity is occurring in the United States is increasing.
• **New Report Details Antibiotic Resistance Threats in the United States.** Published this week, CDC’s *Antibiotic Resistance Threats in the United States, 2019* includes the latest national death and infection estimates that underscore the continued threat of antibiotic resistance in the United States. CDC estimates that more than 2.8 million antibiotic-resistant infections occur in the United States each year, and more than 35,000 people die as a result. *Campylobacter* and *Salmonella*, commonly spread through food, cause an estimated 660,900 resistant infections each year. Data show that resistance to antibiotics recommended to treat *Campylobacter* and *Salmonella* infections is increasing.

Read the report and get CDC advice on preventing foodborne illness (food poisoning).

• **Revised Guidelines for Outbreak Responses Open for Public Comment.** The Council to Improve Foodborne Outbreak Response (CIFOR) invites public comment on the third edition of its Guidelines for Foodborne Disease Outbreak Response. Download the draft documents on the [CIFOR website](http://cifor.org) and submit comments online through Dec. 1.

CIFOR also has published a new reference guide of governmental programs that detect, investigate, control, or prevent foodborne illness in the United States. The [Food Safety Programs Reference Guide](http://cifor.org) also has tips for information sharing, surveillance networks, connecting with partners, and more.

Download it free. CIFOR is a collaboration of state, local and federal public health agencies who work to reduce foodborne illness. Members include experts in epidemiology, environmental health, and laboratory work.

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 [HFS 2270 Physician Certification Statement and Transportation Provider Complaint Portal](http://dfs.hfs.state.il.us). You may view the new notice here.

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding [UPDATE: New Sections Published under the Comprehensive Billing Guide for Medicaid Managed Care Services](http://dfs.hfs.state.il.us). You may view the new notice here.

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice regarding [LTC Monthly Occupied Bed Provider Assessment](http://dfs.hfs.state.il.us). 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](http://consumerchoice.aging.state.il.us). 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. As CMS has undertaken the implementation of the Patient Driven Payment Model (PDPM), they are holding a limited number of Skilled Nursing Facility (SNF) claims while they make further refinements to their claims processing system.

AHCA/NCAL Social Media Update.

Email Update on the potential impact of the Centers for Medicare and Medicaid Services (CMS) issued a proposed Medicaid Fiscal Accountability Regulation.

Theme Announced for the 2020 National Skilled Nursing Care Week (NSNCW).

Deadline to Submit your Quality Initiative data in LTC Trend Tracker is November 21, 2019.

Provider Daily Magazine reports:

Federal Hearing Addresses Quality of Care in Skilled Nursing Facilities. McKnight’s Long Term Care News (11/14) reports a federal hearing on Thursday addressed quality of care in skilled nursing facilities. AHCA President and CEO Mark Parkinson "noted that quality of care in skilled nursing facilities has 'improved dramatically' over the last seven years." He "also said the number of residents receiving antipsychotic medications has declined significantly since 2011." Parkinson is quoted saying, "Without question, abuse and neglect have no place in a nursing home or in any health care setting. One instance of abuse or neglect is one too many, but the facts show that such instances are rare and the vast majority of nursing home staff provide high-quality resident care." He added, "AHCA has made several recommendations to Congress for measures that can continue to improve care and prevent abuse and neglect. We look forward to continuing our work with lawmakers, regulators and other stakeholders to advance these recommendations, including policies that help facilities retain more high-quality staff, bring more clarity and transparency to abuse and neglect reporting, and provide consumers additional information to help them make informed decisions."

AHCA’s Population Health Management Summit Gives Providers Insight into Developing SNPs, MA Plans For Residents. Provider Magazine (11/7, Connole, 151K) reports in December AHCA/NCAL will host the Population Health Management Summit for Long Term and Post-Acute Leaders where providers can get "information and the strategic know-how to launch specialized Medicare Advantage (MA) plans, or Special Needs Plans (SNPs), for their long-stay residents." Jill Sumner, vice president, population health management, AHCA, explains the summit was created "in consultation with Mark Parkinson, president and chief executive officer of AHCA/NCAL" because, "Every population health management conference that comes up seems to focus on how hospitals, health systems, or physicians can manage the post-acute care stay. These conferences are never about the PAC provider taking the lead." Sumner adds, "We are trying to set the overall tone as providers taking a leading role on working within the system and not trying to push against it."

LTC Providers Reportedly Prepare for Future With PDPM. McKnight’s Long Term Care News (11/6, Berklan) reports on how long-term care providers are preparing for the Patient Driven Payment Model (PDPM). The article says that AHCA President and CEO Mark Parkinson has reiterated that documentation is key "if there are swings in the amounts or modes of therapy."

Report Says Salaries in Long-Term Care Industry Increasing. McKnight’s Long Term Care News (11/14) reports the "longest bull market in United States history has turned up the pressure for employees up and down the long-term care chain – from CNAs to the C-suite – according to experts who commented on compensation data in the 2019–20 ‘Nursing Home Salary & Benefits Report,’ the largest annual survey of long-term care professionals." The report was supported by the American Health Care Association. Among facilities "that also participated in the survey last year, administrators’ salaries increased by a robust 4.35% to $127,967 in 2019. Directors of nursing saw a slightly more modest 3% salary increase to $103,343 using the same comparison method, which analysts typically use as a better method of comparison."
- CMS Issues Final Rule on Payments Under Medicare Physician Fee Schedule for Next Year. Provider Magazine (11/6, Connole, 151K) reports CMS "issued a final rule that includes updates to payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) effective Jan. 1, 2020." The agency "said these policies affect care for residents at skilled nursing facilities (SNFs) and assisted living communities in several ways, including services furnished by physicians, therapists, and other suppliers of Medicare Part B services."

- BMI-Adjusted Waist Circumference May Be Positively Associated with Incidence of Dementia in Older Adults, Research Indicates. Endocrinology Advisor (11/14, Akirov) reports, "In older adults, body mass index (BMI)-adjusted waist circumference is positively associated with the incidence of dementia," research indicated. The findings were published online in the journal Obesity.

- People Who Cannot Read or Write May Be Three Times as Likely To Develop Dementia, Study Indicates. Newsweek (11/14, Moyler, 1.53M) reports, "People who cannot read or write may be three times as likely to eventually develop dementia," researchers concluded in a 983-participant analysis. The findings were published online in the journal Neurology.

- Experts Say Seniors Should Receive High-Dose Flu Vaccine for Best Protection. USA Today (11/14, Rodriguez, 10.31M) reports seniors are the "most vulnerable" to the flu accounting for the majority of flu-related deaths, and that the FDA has approved two high-dose vaccines for use in seniors. The article says that James Steckelberg of the Mayo Clinic recommends that seniors receive high-dose flu vaccine to prevent infections. Meanwhile, Dr. William Schaffner, an infectious disease specialist at Vanderbilt University Medical Center, said research shows that high-dose flu vaccines provide "more protection for older people."

- GAO Audit Questions Care Provided to Medicare Patients By For-Profit Hospices. Bloomberg Law (11/14, Pugh, Subscription Publication, 4K) reports, "For-profit hospice providers were more likely to discharge Medicare beneficiaries prior to their death and were less likely to visit these patients in the last three days of life." These findings stem from an audit conducted by the Government Accountability Office, and they "suggest a continuation of problems identified in previous reports on hospice care, which aims to improve the quality of life for patients with advanced incurable diseases." The article says, "Medicare payment to hospices jumped from $2.8 billion in fiscal year 2000 to roughly $17.7 billion in FY 2017." The GAO recommended that CMS "require state hospice inspections to incorporate more information about the providers’ performance on federal quality measures."

- OIG Report Says Several Hospitals Billed Improperly for Post-Acute Care Transfers. McKnight’s Long Term Care News (11/6, Brown) reports that "several acute-care hospitals will likely have to pay back $54.4 million to Medicare after an investigation found that the program wrongly billed inpatient claims subject to the post-acute care transfer policy." The article says that a report from OIG found that "the hospitals improperly billed the claims by using incorrect patient discharge status codes."

- CMS Announces New Project That Aims to Expand Access To Behavioral Health Treatments For Medicaid Beneficiaries. McKnight’s Long Term Care News (11/6, Brown) reports the CMS announced a "first-of-its-kind" project that aims "to expand access to behavioral health treatment for Medicaid beneficiaries." The article says that the "project waives a longstanding payment exclusion for state Medicaid programs and allows them to now
treat residents with serious mental illness and/or emotional disturbance in settings that qualify as institutions for mental disease."

9) The Provider Editor reports:

- **SNF Advocates Cite Dramatically Improved Care in Response to House Hearing.** Following a congressional hearing on Nov. 14, AHCA said the long term and post-acute care profession has improved quality of care significantly and stands ready to explore new ways to make care even better.

- **Pair of New Studies Point to Holes in Medicare Coverage.** Two new studies said Medicare beneficiaries with a serious illness are finding it difficult to pay their medical bills even with support from the government-funded program.

- **AHCA/NCAL Population Health Summit Targets Providers.** As interest continues to grow among LT/PAC providers in the I-SNP sector, so does the need for information geared specifically to skilled nursing and assisted living operators.

10) Kasier Family Foundation reports:

- **Millions of Medicare Part D Enrollees Face Increases in Premiums and Other Costs in 2020 if They Do Not Switch Plans During Open Enrollment.** Millions of current enrollees in stand-alone Medicare Part D prescription drug plans will face premium and other cost increases next year unless they switch to lower-cost plans during the open enrollment period that began Oct. 15 and ends on Dec. 7, a [new KFF analysis](#) finds.

11) McKnight’s reports:

- **McKnight’s Senior Living** (11/13) reports Bill would permanently block rule allowing providers to deny care based on religious beliefs. Three members of Congress planned to introduce a bill Tuesday that would permanently block a federal rule that allows healthcare workers and organizations to decline to provide care that conflicts with their religious and moral beliefs or mission.

12) **Interesting Fact:** Jeannette Rankin was an American politician and women's rights advocate, and the first woman to hold federal office in the United States. She was elected to the U.S. House of Representatives as a Republican from Montana in 1916, four years before the 19th Amendment was ratified, and again in 1940.

*If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!*

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