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 Extends Comment Period on Medicaid Fiscal Accountability Regulation

Skilled Nursing News reports the federal government extended the deadline for providers — both acute and post-acute — to comment on a proposed rule that would crack down on supplemental payment programs under Medicaid.

The new comment period deadline will be extended by 15 calendar days to February 1, 2020 in response to public feedback and in consideration of the holiday season.

The Centers for Medicare & Medicaid Services (CMS) in November 2019 proposed a rule that would clarify crucial definitions for Medicaid supplemental payment programs, and set up new reporting requirements for the states that make use of such supplements.

In multiple states, the additional payments help bolster Medicaid rates for skilled nursing facilities through a variety of mechanisms. Multiple providers, including the SNF and senior living trade associations LeadingAge and the American Health Care Association (AHCA), requested an extension. Both LeadingAge and AHCA had requested that the deadline be moved March 17 to allow for more thorough comment and to allow state Legislatures to be consulted.

“We are concerned about the limited timeframe available to stakeholders to offer meaningful, data-driven comments given the magnitude of CMS’ proposals,” AHCA president and CEO Mark Parkinson wrote in his December 2 comment letter. “Given the complexity of these arrangements, both states and stakeholders will need time to fully assess the impact of the proposed changes and the degree to which these changes will impact both their Medicaid and overall state budgets.”

Because the federal rule would affect state-level budgets, Parkinson and Ruth Katz, senior vice president for policy at LeadingAge, argued that state legislatures should have a say in the process. The oversight of the programs has been a long-standing issue for CMS and for other federal agencies — particularly because of how the programs have evolved over time, Andrea Maresca, senior vice president at the consulting firm Thorn Run Partners, noted in a presentation at AHCA’s annual convention and expo in Florida in 2019.

“All of this is driving work in the agency to come up with a regulation that will put more parameters about how supplemental payment programs would work in the future,” she said at the October conference. “The agency is also
concerned about the lack of a clear link between how payments are made to providers, and whether these are made based on services delivered or somehow tied to quality and outcomes.”

The proposed rule would include definitions for multiple terms related to the supplemental Medicaid payments, such as base payment, non-state government provider, private provider, state government provider, and supplemental payment. It would also limit approval for any Medicaid supplemental payments to a period of three years at most, and require states to monitor a supplemental payment program during the terms of its approval.

Multiple SNF providers have already sent in public comments warning officials about the proposed rule’s adverse effects, if it is implemented.

Louis Grimmel, of Lorien Health Services in Ellicott City, Md., argued in a comment letter dated December 23 that the supplemental payment funding mechanism lets SNFs increase staffing, wages, and quality, while also making capital improvements and investing in new technologies. “Further, the proposed rule would also have a broad negative impact on Maryland’s Medicaid budget which, in turn, would adversely impact all of the state’s nursing providers and beneficiaries,” Grimmel wrote.

Operators in Texas, another state that has made use of different funding transfers to make up Medicaid shortfalls, could be affected as well. Under Texas’s Quality Incentive Payment Program (QIPP), providers can earn Medicaid payment increases by launching quality-improvement initiatives.

Josh Bates, vice president and owner of Transition Health Services, noted in multiple letters that his SNFs benefit from the program.

At Transition’s SNFs, QIPP has allowed for an attendee bonus plan for certified nurse aides and the addition of a “quality assurance nurse,” Bates wrote in letters on behalf of Briarcliff Health Center, Chandler Nursing Center, and Havencare Nursing & Rehab. According to Bates — and another letter from Matt Fowers, administrator at Legend Oaks Healthcare and Rehabilitation — the rule would have a “significant impact on Texas’ largest pay-for-performance program.”

The both argued that CMS should consider a five-year transition period for all regulatory changes proposed in the rule, “given the tight timeframe CMS is proposing for states to come into compliance with the proposed changes.”

“As the only supplemental payment program currently available for the nursing home sector in Texas caring for over 60,000 Medicaid recipients daily, QIPP demonstrates the importance the state places on improving quality outcomes for the frail and elderly of Texas,” the authors wrote in their different letters. “Having shown its effectiveness through actual improvement in measured outcomes, efforts to expand the program should be considered.”

You can access the proposed rule here.

**CMS Extends Comment Period for Transparency in Coverage Proposed Rule**

CMS stated they have extended the comment period for the previously released Transparency in Coverage Proposed Rule (CMS 9915-P) published on November 27, 2019 by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. This proposed rule delivers on President Trump’s Executive Order on Improving Price and Quality Transparency.

The new comment period deadline will be extended by 15 calendar days to January 29, 2020 in response to public feedback and in consideration of the holiday season.

This proposed rule is a historic step toward putting health care price information in the hands of consumers, advancing the Administration’s goal to ensure consumers are empowered with the information they need to make informed health care decisions. The proposals in this rule build on actions the Administration has taken to increase price transparency through hospitals by giving patients tools to access pricing information through their health plans. The Administration has finalized requirements for hospitals to disclose their standard charges, including negotiated rates with third-party payers. The proposals in this rule would bring greater transparency across the health care industry.
You can access the proposed rule here.

**Focus F-Tag – F840 Use of Outside Resources**

This *Regulatory Beat’s* Focus F-Tag is **F840 Use of Outside Resources**, which is part of the Administration regulatory group. F840 requires that:

- If a facility does not employ a qualified professional to furnish a service to be provided by that facility, it must have an arrangement in place to ensure that service is furnished to residents by an outside resource.
- The arrangements made must specify that the facility is responsible for obtaining these services and that the services meet the professional standards and principles that are practiced by employees of the facility.
- The arrangements must also specify that the facility is responsible for the timeliness of services. “Timeliness” in this regard, is when services are completed and results are provided within timeframes specified in facility policies, by medical orders, or by professional standards of practice. The facility is also responsible for ensuring that the resident’s physician (or PA/NP), dentist or clinical nurse specialist are notified as directed in the medical order.

These citations point to system “holes” that can happen in many facilities. All staff need to receive proper orientation in order to be able to follow facility policies. The use of agency staff is often a band-aid to fill staffing gaps, but there is an expectation that all staff understand the facility’s policies and procedures and follow them. Since we all know this is the case, it is more a matter of ensuring proper coordination between the agency and the facility so agency staff receive orientation prior to starting. Likewise, for the citations related to lack of dentures and lack of order follow up, these show the difficulty in having a sound system in place to ensure orders from outside professionals are followed up on in the same manner and timeframes that orders from professionals within the facility are.

Finally, the last citation regarding outside mental health services should provide a good reminder that facilities are responsible for coordinating the necessary behavioral health services for their residents. This includes ensuring there is documentation in place of outside support resources that cannot be provided within the facility. The Phase 3 Interpretive Guidance may not be fully available yet, but there is an increased emphasis on meeting behavioral health needs going forward, and even not having an agreement for services in place for residents that require certain services that can only be provided by an outside resource can point to a lack of a system to appropriately meet your residents’ needs.

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**Trending Statistics**

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

**US on Track for One of the Worst Flu Seasons in Decades**

*CNN* reports that the flu season is shaping up to be one of the worst in decades, according to the United States' top infectious disease doctor. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, said while it's impossible to predict how the flu will play out, the season so far is on track to be as severe as the 2017-2018 flu season, which was the deadliest in more than four decades, according to the US Centers for Disease Control and Prevention.

So far this flu season, at least 2,900 people in the US are estimated to have died of the flu, according to data released Friday by the CDC. That's 800 more deaths than estimated the previous week. Flu cases and hospitalizations because of the flu have also risen sharply since the season began in October. CDC estimates there have been at least 6.4 million flu illnesses and 55,000 hospitalizations.
Fauci said it's possible this steep rise in flu activity could reverse itself soon, in which case the season wouldn't end up being so severe. "Hopefully this turns around and comes down, but if it continues on the trajectory it's on, it's not going to be good," he said. Fauci pointed out a [CDC graph](https://www.cdc.gov/flu/weekly/fluactivity-graph.htm) to compare the current flu season to two of the most severe in recent decades. In the graph below, designed by CNN based on the CDC data, the red line indicates flu activity from September 29 through December 28. The other lines show the 2014-2015 and 2017-2018 flu seasons, two of the worst in recent decades.

So far this season, flu activity has surpassed the peak for 2014-2015, and is climbing toward the peak for the particularly deadly 2017-2018 season. "We don't want it to keep going up and up and up like in 2017-2018," he said. "Hopefully it won't, but if it continues to go straight up, this could really be a bad year. "The only thing predictable about flu is that it's unpredictable." This season so far has been particularly deadly for children, with 27 deaths reported through December 28. That's the highest number of deaths at this point in the season since the CDC started keeping track 17 years ago.


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


2) [Federal HHS/CMS](https://www.hhs.gov) released the following notices/announcements:

- **DMEPOS: Changes to Conditions of Payment Reduce Burden.** The [Final Payment Rule](https://www.cms.gov/Regulatory-Compliance/Survey-and-Certification/Conditions-of-Payment/conditions-of-payment-reimbursement.html) (Section VI, beginning on p. 60742) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) included several provisions to reduce burden. Effective January 1:
  
  - Standard order/prescription requirement for all DMEPOS items
  - One Master List of DMEPOS items, which may be selected to require a face-to-face encounter and written order prior to delivery and/or prior authorization
  - Items require face-to-face encounter and written order prior to delivery only after selection announced in Federal Register notice
  - Prior authorization submission process for DMEPOS is unchanged

- **LTCH Provider Preview Reports: Review Your Data by January 9.** Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with third quarter 2018 second quarter 2019 data. Review your performance data on quality measures by January 9, prior to public display on [LTCH Compare](https://ltchcompare.cms.gov) in March 2020. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.
Access your report by logging into the Internet Quality Improvement and Evaluation System (iQIES). At the main screen, select “Reports;” then “My Reports.” For more information, visit the LTCH Quality Public Reporting webpage.

- **IRF Provider Preview Reports: Review Your Data by January 9.** Inpatient Rehabilitation Facility (IRF) Provider Preview Reports are now available with third quarter 2018 to second quarter 2019 data. Review your performance data on quality measures by January 9, prior to public display on IRF Compare in March 2020. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

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

- **Reminder for MDPP Suppliers: Crosswalk Submission Due on January 15, 2020.** MDPP suppliers that have offered MDPP services for at least 6 months are required to submit a crosswalk file at each quarterly due date. Therefore, if your organization furnished MDPP services on or before June 30, 2019, you are required to submit a crosswalk file on January 15. Still unsure if your organization needs to submit a Crosswalk? Take a look at our Flow Chart for more direction.

If your organization began to furnish MDPP services on or after July 1, 2019 or your organization has not yet begun to furnish MDPP services, your organization is not required to submit a crosswalk file on January 15.

As a reminder, the crosswalk file lists beneficiary identifiers used for the Centers for Disease Control and Prevention (CDC) performance data submissions and the corresponding Medicare identifiers for each beneficiary who receives MDPP. This requirement is essential for the evaluation of the MDPP expanded model. Submission of the crosswalk file is an MDPP supplier standard, which means that MDPP suppliers must comply with this requirement in order to maintain their enrollment in Medicare as an MDPP supplier.

If your organization must submit a crosswalk on January 15, you must do so using the CMS-provided crosswalk template and the secure website described below. If you have not previously gained access to the website or downloaded the template, please register at the link below.

After you register, login information will be sent to your organization with instructions on how to download the crosswalk template and how to submit it using a secure FTP server by the January 15, 2020 deadline. If you do not need to submit a crosswalk on January 15, 2020, please go ahead and register so that you may gain access to the MDPP crosswalk file template and begin entering your data prior to your first crosswalk file submission date. If you are unsure if you need to submit a crosswalk file, please see the above flowchart.

Registration link: [https://goo.gl/forms/mVEr0l7B9J12dhjg2](https://goo.gl/forms/mVEr0l7B9J12dhjg2)

- Please view our Crosswalk Submission webinar. To download the slides and audio, please visit our website and scroll down to Past Events. The first bullet is the Crosswalk Guidance Webinar.
- For additional details concerning the data that must be included in your crosswalk data submission, please visit here.
- MDPP Crosswalk Frequently Asked Questions can be found on the MDPP FAQ page here.
- For any additional questions, please contact RTIsuppliercrosswalkhelp@rti.org

- **Quality Payment Program: Check Your Final 2019 MIPS Eligibility Status.** Your eligibility status may have changed for the Merit-based Incentive Payment System (MIPS). Check the Quality Payment Program Participation Status Tool to view your final 2019 eligibility status:
Your initial eligibility status was based on review of Medicare Part B claims and Provider Enrollment, Chain and Ownership System (PECOS) data from October 1, 2017, to September 30, 2018.

CMS has updated your status based on a second review of Medicare Part B claims and PECOS data from October 1, 2018, to September 30, 2019.

For More Information:

- **MIPS Participation webpage**
- **Participation Infographic**
- **Participation and Eligibility Fact Sheet**
- **Participation and Eligibility User Guide**
- **Contact QPP@cms.hhs.gov** or 866-288-8292 (TTY: 877-715-6222)

### Quality Payment Program: MIPS Low-Volume Threshold Criteria for 2019

CMS added a third low-volume threshold criterion for determining Merit-based Incentive Payment System (MIPS) eligibility for 2019. Clinicians and groups are excluded from MIPS if they:

- Billed $90,000 or less in Medicare Part B allowed charges for covered professional services during either of the two determination periods (October 1, 2017 – September 30, 2018, or October 1, 2018 – September 30, 2019)
- Provided care to 200 or fewer Part B-enrolled patients during either of the two determination periods.
- New for 2019: Provided 200 or fewer covered professional services under the Physician Fee Schedule during either of the two determination periods

In order to be eligible for MIPS, a clinician or group must exceed all three criteria listed above. Check the Quality Payment Program Participation Status Tool to view your final 2019 eligibility status for MIPS.

Clinicians and groups who are not eligible for MIPS can still choose to report data to MIPS through the opt-in or voluntary reporting options.

For More Information:

- **Reporting Options Overview Webpage**
- **2019 MIPS Opt-In Reporting and Election Process Toolkit**
- **Contact QPP@cms.hhs.gov** or 866-288-8292 (TTY: 877-715-6222)

### New Medicare Card Transition End in 2 Weeks; Use MBIs Now to Get Paid January 1

The 21-month Medicare Beneficiary identifier (MBI) transition period ends in two weeks. Update your patients’ records and use MBIs now. Starting January 1, you must use MBIs to bill Medicare regardless of the date of service:

- We will reject claims submitted with Health Insurance Claims Numbers (HICNs) with a few exceptions
- We will reject all eligibility transactions submitted with HICNs

**Need the MBI?**

We encourage people with Medicare to carry their cards with them since we removed the Social Security Number-based numbers; if your patients do not bring their Medicare cards with them:

- Give them the Get Your New Medicare Card flyer in [English](https://www.cms.gov/Medicare/Provider-Participation/Medical-Beneficiary-Identifiers/QPP/Patient-Handouts/GetYourNewMedicareCard.pdf) or [Spanish](https://www.cms.gov/Medicare/Provider-Participation/Medical-Beneficiary-Identifiers/QPP/Patient-Handouts/GetYourNewMedicareCard-Spanish.pdf).
- Use your Medicare Administrative Contractor’s look-up tool. [Sign up](https://www.medicare.gov) for the Portal to use the tool.
- Check the remittance advice. Until December 31, we return the MBI on the remittance advice for every claim with a valid and active HICN.

**MBI on a Patient’s Card Doesn’t work?**
Medicare beneficiaries, their authorized representatives, or CMS can ask to change MBIs; for example, if the number is compromised. It is possible your patient will 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 look-up tool. Sign up (PDF) for the Portal to use the tool.

See the MLN Matters Article (PDF) for answers to your questions on using MBIs.

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments. The American Hospital Association challenged CMS’s use of its authority under Subsection (t)(2)(F) of the Medicare statute to pay for certain outpatient clinic visit services provided at excepted off-campus Provider-Based Departments (PBDs) at the same rate that CMS uses to pay non-excepted off-campus PBDs for those services under the separate Physician Fee Schedule as finalized with Final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).

The United States District Court for the District of Columbia issued instructions for CMS to immediately cease the clinic visit provided at excepted off-campus PBDs payment reduction for CY 2019 implemented with final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).

CMS installed a revised Hospital Outpatient Prospective Payment System Pricer to update the rates being applied to claim lines. The revised Pricer went into production on November 4, 2019, and applies to claims with a line item date of service of January 1, 2019, and after. Starting January 1, 2020, and over the next few months, the Medicare Administrative Contactors will automatically reprocess claims paid at the reduced rate; no provider action needed.

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Final Rule Call — January 14. Tuesday, January 14 from 2 to 3 pm ET.

Register for Medicare Learning Network events.

During this call, learn about the finalized proposals for the End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) in the CY 2020 ESRD Prospective Payment System (PPS) Final Rule. Topics include:

- ESRD QIP legislative framework
- Overview of the final rule

A question and answer session follows the presentation.

Target Audience: Dialysis clinics and organizations; nephrologists; hospitals with dialysis units; billers/coders; quality improvement experts; and other stakeholders.

- 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 NOIA as 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](mailto:SharedSavingsProgram@cms.hhs.gov)

- **Register for the January 16 Webinar to Learn About Changes to the Medicare Promoting Interoperability Program in 2020.** The Centers for Medicare & Medicaid Services (CMS) is hosting a webinar on **Thursday, January 16** to discuss changes to the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals participating in 2020.

  This presentation will provide information on electronic health record (EHR) reporting requirements, 2015 Edition certified EHR technology requirements, scoring details, and more information for 2020.

  Attendees will have an opportunity to ask questions during a Q&A session following the presentation.

  **Webinar Details:**
  - **Title:** 2020 Medicare Promoting Interoperability Program Webinar
  - **Date:** Thursday, January 16
  - **Time:** 1:00 - 2:00 p.m. ET
  - **Registration link**

  For more information please visit the [Promoting Interoperability Programs website](#).

- **Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment.** A new MLN Matters Article SE19029 on [Medicare Part B Home Infusion Therapy Services with the Use of Durable Medical Equipment](#) is available. Learn about the accreditation process to become a qualified supplier.

- **CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule.** A new MLN Matters M11570 on [CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule](#) is available. Learn about new codes, data files, and update factors.

- **Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List.** A new MLN Matters Article MM11560 on [Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List](#) is available.
Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List (PDF) is available. Learn about changes to Medicare Part B payment for services furnished in CY 2020.

- **Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35.** A new MLN Matters Article MM10882 on [Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35 (PDF)](PDF) is available. Learn about new sections on global billing and separate technical component and professional component billing instructions.

- **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements — Revised.** A revised MLN Matters Article MM11268 on [Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements (PDF)](PDF) is available. Learn about the removal of codes that are not available for 2020.

- **Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 — Revised.** A revised MLN Matters Article MM11536 on [Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2020 (PDF)](PDF) is available. Learn about corrected low-utilization payment adjustment add-on factors.

- **Opioid Treatment Programs (OTPs) Medicare Billing & Payment.** A [Opioid Treatment Programs (OTPs) Medicare Billing & Payment](Medicare Learning Network Fact Sheet) Medicare Learning Network Fact Sheet is available. Learn about:
  - Covered opioid use disorder treatment services
  - Coding and submitting claims for OTP services
  - Payment and remittance advice

- **Hospice Comprehensive Assessment Measure.** CMS posted an [infographic (PDF)](PDF) with key information about the Hospice Comprehensive Assessment Measure. See how the seven Hospice Item Set measures contribute to the Comprehensive Assessment Measure and how to stay on target by completing all measures for each patient. Visit the [Current Measures](Current Measures) webpage for more information.

3) The federal [Centers for Disease Control and Prevention (CDC)](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 (December 23 – December 28), influenza activity in the United States is high and continues to increase. The activity has been elevated for eight weeks.

4) The [Illinois Department of Healthcare and Family Services (HFS)](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 [Managed Care Organization Grandfathering Clause for Certain Drugs](Managed Care Organization Grandfathering Clause for Certain Drugs). You may view the new notice [here](here).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice [Cost of Living Adjustment (COLA) File Download through the Medical Electronic Data Interchange (MEDI) System](Cost of Living Adjustment (COLA) File Download through the Medical Electronic Data Interchange (MEDI) System). You may view the new notice [here](here).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice [Gender-affirming Services](Gender-affirming Services). You may view the new notice [here](here).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice [Nursing Facility Rates Effective July 1, 2019](Nursing Facility Rates Effective July 1, 2019). You may view the new notice [here](here).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice [January 1, 2020 Requirement for Ordering/Referring/Prescribing Provider Enrollment and Managed Care Plan Adoption of HFS Preferred Drug List](January 1, 2020 Requirement for Ordering/Referring/Prescribing Provider Enrollment and Managed Care Plan Adoption of HFS Preferred Drug List). You may view the new notice [here](here).
• The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Health Insurance Claim Number Transition to Medicare Beneficiary Identifier January 1, 2020 Handbook Supplement Update. You may view the new notice here.

• The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Illinois Medicare-Medicaid Alignment Initiative Statewide Expansion Effective January 1, 2021. You may view the new notice here.

• The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Update: Patient Credit File Download through the Medical Electronic Data Interchange (MEDI) System. 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:

• AHCA Email Update, 2019 Wrap Up and 2020 Focus Areas from Mark Parkinson, President & CEO of AHCA

• AHCA Email Update. Centers for Medicare and Medicaid Services (CMS) published the Calendar Year 2020 Physician Fee Schedule Payment Final Rule. This is effective as of January 1, 2020.

• AHCA/NCAL Social Media Update.

• AHCA/NCAL Quality Aware Program Email Update. Deadline for 2020 AHCA/NCAL National Quality Award Program is Thursday, January 23rd at 8:00 p.m. ET.

8) Provider Daily Magazine reports:

• Ohio Managed Medicaid Plan Scales Back in Wake of Financial Losses. Skilled Nursing News (1/7) reports, " Paramount Health Care, the managed Medicaid arm of major health system and skilled nursing operator ProMedica, this week announced a move to substantially scale back its footprint in the wake of serious financial losses for the plan." Paramount, based in Toledo, Ohio, "will exit the central and southeast regions of Ohio, cutting its overall enrollment by about 31,000 beneficiaries; the plan will continue to cover 184,000 managed Medicaid enrollees in the western and northeastern parts of the Buckeye State, according to the company."

• Expert Details Plan to Provide Long-Term Care Protection. Forbes (1/7, 9.71M) publishes an article by Brand Contributor Bryant Monson through Impact Partners BrandVoice on the costs of long-term care and potential impacts on retirement. The author argues, "Long-term care could be one of the most financially devastating
events a senior faces today." He discusses the plan he helped a client develop in terms of long-term care coverage, which included a long-term care policy, guaranteed life insurance policy, and a fixed annuity.

- **Commentary Warns of Unexpected Health Risks from Cannabis Edibles.** Reuters (1/7, Carroll) reports a commentary piece published in CMAJ warns about unexpected health risks associated with cannabis edibles. The article says, "Risks include inadvertent overdose, because it takes much longer for edible cannabis to take effect, accidental consumption by children and unexpected potency in the elderly."

  McKnight’s Long Term Care News (1/7, Lasek) reports, "Older people who consume edible cannabis products may be inviting health risks, write the authors of" the commentary. When patients ask questions "about medical cannabis, physicians should routinely ask questions about intended use, wrote" the authors of the commentary. The top concerns related to cannabis consumption include things such as over-consumption, longer impairment time, naiveté, and drug interactions.

- **Study Indicates Lifestyle Changes May Slow Progression of Frontotemporal Dementia.** CNN (1/8, Lamotte, 83.16M) reports on its website, "Frontotemporal dementia strikes early, typically in the 50s, sometimes as young as age 45." A study "suggests that lifestyle changes may help slow the disease progression." Researchers with the Memory and Aging Center at the University of California, San Francisco "followed the activity levels of 105 people with the inherited form of the disease, the first study to do so in this population," and "found people who ranked highest in levels of mental and physical activity slowed their functional decline from the disease by half."

- **Antipsychotics May Cause Increased Risk of Death or Cardiopulmonary Arrest in Older Adults, Study Indicates.** MD Magazine (1/7, Walter) reports researchers "evaluated the risk of death or nonfatal cardiopulmonary arrest in hospitalized adults exposed to antipsychotics at a large academic medical center." Included in the study were "data from 150,948 hospitalizations...with 691 total events – 515 deaths and 176 cardiopulmonary arrests." The study revealed that for patients who were 65 years old and older, "both typical and atypical antipsychotics were associated with increased risk of death or cardiopulmonary arrest." The findings were published online Nov. 19 in the Journal of the American Geriatrics Society.

- **Federal Government Challenges Decision Forcing Health Care Workers to Provide Care Despite Conflicts with Religious, Moral Beliefs.** McKnight’s Long Term Care News (1/7, Brown) reports, "The federal government is challenging a decision that would force health care workers to provide care, even if it conflicts with their religious and moral beliefs." According to McKnight’s, "The decision blocks a federal rule that would allow workers to deny care based on religious and moral grounds." A notice of appeal was filed by the Trump Administration "in the U.S. District Court for the Southern District of New York Friday after the court vacated the ‘conscience rule’ in early November, Bloomberg Law reported." SNFs "and other long-term care facilities that accept federal funding were among the providers that could have been affected by the rule."

- **AHCA/NCAL Awards Elkins Rehabilitation & Care Center Certificate of Achievement.** Elkins (WV) Intermountain (1/6, 30K) reports, "The American Health Care Association/National Center for Assisted Living’s Quality Initiative Recognition Program has awarded [Elkins Rehabilitation & Care Center (ERCC)] its Certificate of Achievement, according to Tara Shaver, ERCC administrator." Shaver stated, "This is a testament to our staff’s dedication and work." In a letter to ERCC, Dr. David Gifford, senior vice president of quality and regulatory affairs for AHCA/NCAL, said, "The AHCA/NCAL commends you and your staff’s proven commitment to quality."

- **Researchers Assess Impact of Medicare’s Bundled-Payment Programs on Costs and Quality.** ModernHealthcare (1/6, Meyer, Subscription Publication, 214K) reports a study published in Health Affairs suggests that "Medicare’s voluntary bundled-payment program for hip and knee replacements reduced spending by 1.6% from 2013 to 2016 – less than previously estimated – with no overall change in quality." In another study published in Health Affairs, researchers conducted a meta-analysis and concluded that "lower
extremity joint replacement is the only type of clinical episode in Medicare bundled-payment programs that has produced savings so far."

- **Researchers Testing Whether Retinal Screening Tests Can Detect Alzheimer’s Disease Years Before Symptoms Appear.** The *Providence (RI) Journal* (1/6, Miller, 259K) reports researchers in Rhode Island and Florida are preparing to conduct a clinical trial testing whether retinal screening tests can "detect Alzheimer’s disease many years before severe clinical symptoms appear." If successful, the tests may be administered by eye physicians "at considerably less cost than today’s PET scans, which can detect the buildup of amyloid plaque in the brain associated with Alzheimer’s before symptoms appear."

9) **Interesting Fact:** 51% of Americans fear snakes, most than another other thing in the world.

*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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