January 22, 2020 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!

PDPM is Running Above Budget-Neutral, But Clawbacks Aren’t Inevitable

Skilled Nursing News reports early analyses of the new Medicare payment model for nursing homes indicate that operators may be pulling in more money than the federal government intended — leading to widespread speculation that adjustments could be coming sometime in 2020.

American Health Care Association (AHCA) president and CEO Mark Parkinson agrees with the idea that the Patient-Driven Payment Model (PDPM) is currently running slightly above the budget-neutral baseline. But he also says the size of the gains will likely play into the Centers for Medicare & Medicaid Services’ (CMS) clawback calculus — and that he doesn’t see the same level of pain that the industry weathered during the last major payment shift ahead.

“My view is that if the increase that we see is just a few percent above budget-neutral, I don’t think that CMS will react in a 2021 payment rule, which will be proposed around May 1 of this year,” Parkinson told SNN in an interview this week. “I think that they would view that as possibly statistical noise, and more time would need to pass before there would be significant adjustments.” In a wide-ranging interview, Parkinson also expressed serious concerns about CMS’s proposed crackdown on state-level supplemental Medicaid payment programs for nursing homes: “I don’t think there’s an adjective that you could use that would over-exaggerate the impact this rule would have on providers in those three states.”

In your view, what are the biggest skilled nursing challenges and opportunities for 2020? On the challenge side, we have two big issues that we’re looking at right now — one of which is also an opportunity. Those two are PDPM, and how the rollout is going, and what — if any — changes will be made as a result of the rollout. And then the second big issue, which is a challenge, is the CMS Medicaid rule that would dramatically reduce the ability to have provider assessments and other intergovernmental transfers. Those are the two challenges that we have in 2020.

On the opportunity side, I think PDPM is both a challenge and an opportunity, as we get more familiar with the new payment model. And then we continue to talk about Institutional Special Needs Plans — I-SNPs — and other risk-bearing arrangements that providers are really adopting, and what I think is the most exciting development in the sector.

Let’s start with PDPM. We’ve had leaders predict that clawbacks or other adjustments will be coming over the next year, as it may not be budget-neutral. What’s your sense of if — and when — PDPM changes will happen?
On the “how is it going” side, we continue to believe it’s too early to tell. We’ve just finished three months. It will be another couple of months before we have good data on the cost and revenue side. It’ll be a few more months after that before we have patient outcome data, which is the most important thing. I think it would be a huge mistake for CMS to make dramatic changes in PDPM until we really have the ability to figure out how the patients are doing under it. If the patients are having fantastic outcomes, it doesn’t make a lot of sense to make dramatic changes. If there’s areas where we’re finding shortcomings in patient care, then CMS is going to need to adapt PDPM to adjust to those types of realizations as well — and it’s just going to take some time.

Having said all that, the anecdotal information that we have after three months is that the system is working pretty well. On the patient outcome side — again, it’s anecdotal, but we’re hearing stories that residents are being taken care of; providers are getting good outcomes. And we’re really anxious to see a full data set to see if that’s true across the country. On the business side of it — again, we don’t know for sure, but what we’re hearing from a smattering of providers is that they’re doing well on the revenue side. My view is that the current reimbursement is probably a little bit above budget-neutral.

I don’t think it’s anything like 2011, where there was a 12% increase in rates that had to be adjusted very dramatically. If there’s an increase, I think it’s going to be much more modest than that. We’ll have our first real data on that when the publicly traded companies start reporting — which will be here in just a few weeks. In early February, we’ll start to hear first-quarter data. I think we’ll have a really good idea then as to: Where did CMS end relative to the budget neutrality situation? My view is that if the increase that we see is just a few percent above budget-neutral, I don’t think that CMS will react in a 2021 payment rule, which will be proposed around May 1 of this year. I think that they would view that as possibly statistical noise, and more time would need to pass before there would be significant adjustments.

On the other hand, if there’s an increase that showed, say, more than 4% or 5% above budget-neutral, I think it’s very likely that CMS will do what it did in 2011 and make an adjustment that would go into effect on October 1 of 2020. There is also the possibility that CMS will wait a couple of quarters, really try to get more data on exactly what’s happening, and then issue an interim payment rule — which they could do at any time. They wouldn’t have to wait for the normal rule-making process where the new rates go into effect on October 1. They may want to say, “Hey, let’s wait six or nine months and get into the summer of 2020, see exactly how this is going — and if it looks like there’s a more-than-modest increase above budget-neutral, we’ll issue a rule then that will pare this back.”

So I would say that the range of outcomes would be all the way from CMS not doing anything, because the increase is not material; to it making some changes in the May 1 rule that would go into effect on October 1; or then possibly waiting until after May 1 to get more data and then releasing something in, let’s say, the late summer, early fall.

Correct me if I’m wrong, but it seems like this rule is progressing relatively quickly; CMS extended the comment deadline, but only by about two weeks. Do you have a sense of when CMS might introduce any changes or a final rule?

I think you’re right. I don’t think CMS did this intentionally, but by issuing the rule on November 17, they issued at a time where it’s been hard to galvanize the long-term care community into responding by the time of the comment period, which initially was going to end on January 17. They’ve now extended it to February 1, which has been really helpful. I think we have had time to get the hundreds of buildings, and scores of interest groups that should care about this, to notice the rule and to submit comments. We do anticipate that, by the time February 1 rolls around, there will be hundreds, maybe even bleeding into the low thousands, of thoughtful comments to CMS about why this idea isn’t a good one.

In terms of when CMS would actually finalize this rule, it’s hard to say. Typically, there is at least a 60-day period after comments are submitted before a rule is finalized. But in this case, this rule is so complicated and so far-reaching, impacting not just skilled nursing but impacting, in a very significant way, many other health care providers — particularly hospitals — that CMS is going to hear from a lot of people. I would be surprised if this rule was finalized quickly. My hope would be that CMS would step back, take a deep breath, thoughtfully think about the impact of this
rule, and take its time and not finalize it for a good period of time. But that’s something that we really don’t know. It could be as early as the spring that it’s finalized; it could be as late as never, and probably somewhere in between.

You can access the full interview here.

**OIG Audit: CMS’s Controls Over Assigning Medicare Beneficiary Identifiers and Mailing New Medicare Cards Were Generally Effective but Could Be Improved in Some Areas**

From the beginning of the Medicare program, beneficiaries’ Medicare cards displayed Social Security numbers (SSNs), which increased beneficiaries’ vulnerability to identity theft. To meet the requirements of a 2015 Federal law, the Centers for Medicare & Medicaid Services (CMS) generated new randomized insurance numbers, called Medicare Beneficiary Identifiers (MBIs), to replace SSNs on Medicare cards; assigned the MBIs to beneficiaries; and mailed new Medicare cards. Because deficiencies in assigning MBIs and mailing new Medicare cards could have resulted in unintended consequences, such as claim processing errors and inappropriate release of personally identifiable information, OIG evaluated CMS’s internal controls over implementation of the new MBIs.

Their objective was to assess CMS’s internal controls over assigning MBIs and mailing new Medicare cards to beneficiaries.

**How OIG Audit Was Conducted**

OIG reviewed policies, procedures, and system controls; Medicare Enrollment Database (EDB) records; Medicare card mailing data (e.g., beneficiary names, MBIs, and mailing addresses); and Medicare payments from January 2018 through March 2019. Specifically, we identified beneficiaries with multiple MBIs, new Medicare cards mailed to deceased beneficiaries, and payments for claims with service dates after beneficiaries’ dates of death.

**What OIG Found**

CMS’s controls were generally effective in ensuring that (1) beneficiaries were properly assigned MBIs, (2) deceased beneficiaries were not mailed new Medicare cards, and (3) payments were not made on behalf of deceased beneficiaries. However, in a small percentage of cases, CMS’s controls did not prevent multiple MBIs from being assigned to beneficiaries or prevent mailing of new Medicare cards to deceased beneficiaries. In addition, CMS made improper payments of $2.3 million on claims for deceased beneficiaries. Specifically, OIG found that CMS assigned to 22,662 beneficiaries 2 or more MBIs associated with multiple enrollment records that contained the same SSN and date of birth because CMS’s system controls did not always identify and merge multiple enrollment records before assigning the MBIs. (The MBIs represented 0.02 percent of the MBIs assigned to Medicare beneficiaries.) In addition, CMS mailed 58,420 new Medicare cards after the beneficiaries’ dates of death, of which 2,222 were mailed after the EDB was already updated with the dates of death because CMS’s system controls did not always check the EDB’s date-of-death information in a timely manner before card mailing data were sent to the print/mail contractor. (The 58,420 Medicare cards represented 0.09 percent of the total cards mailed.) Finally, CMS made improper payments for claims with dates of service after the beneficiaries’ dates of death even though it had policies, procedures, and system controls to ensure that payments were not made for Medicare services on behalf of deceased beneficiaries. By improving its controls, CMS can limit unintended consequences, such as claim processing errors and inappropriate release of personally identifiable information.

**OIG Recommendations and CMS Comments**

OIG recommends that CMS improve its system controls by checking the EDB’s date-of-death information as close as reasonably possible to the date that card mailing data are sent to the print/mail contractor to ensure that Medicare cards are not mailed to deceased beneficiaries. They also make two more recommendations, which are shown in the full report. CMS concurred with their recommendations and provided information on actions that it planned to take to address OIG recommendations.

You can access the full report here.
Focus F-Tag – F560 Right to Refuse Certain Transfers

This Regulatory Beat’s Focus F-Tag is F560 Right to Refuse Certain Transfers. The regulation at F560 states that a resident has the right to refuse transfer to another room within the facility under three general situations. Per the regulation, if a resident exercises the right to refuse a transfer, it does not impact the resident’s eligibility or entitlement to Medicare/Medicaid benefits. F560 requires that:

SNF Residents
First, if the intention is to relocate a SNF resident from a distinct part of the facility that is a SNF to a part that is not a SNF, the resident may decline that relocation for the purpose of obtaining Medicare or Medicaid eligibility. The Interpretative Guidance (IG) notes that the facility is responsible for notifying the resident/representative about any changes in eligibility for covered services and if the resident may have a financial responsibility. If the resident cannot pay for the services, and after being given a discharge notice the resident can be transferred or discharged under the provision of F621, Equal Access to Quality Care.

NF Residents
Second, if a resident who is residing in a NF distinct part of a facility (Medicaid only), he/she cannot be forced to move from the NF part of the facility to another part of the overall campus, such as a hospital, just to ensure the resident is eligible for Medicare payments. The IG states that these moves can only be made at the request of the resident.

Transfers for Staff Convenience
Finally, residents have the right to refuse a transfer if it is solely for the convenience of staff. There is a potential for psychosocial harm when residents are moved, so it is important to minimize the potential for negative outcomes when planning room changes. The majority of the issues cited under F560 are related to these types of transfers, as you can see from the following examples:

- A resident who was admitted to a subacute room was transferred to a long-term care unit. The resident was upset and crying and the transfer continued anyway, resulting in actual harm to the resident due to her psychological distress (S/S: G)
- A cognitively impaired resident was not informed of her room change from one floor to another until staff started moving her belongings. The resident’s son was made aware of the room change, but was not offered the option to refuse the transfer (S/S: E)
- Female residents of a facility were moved from the general residential area of the nursing home to the secure female unit because the facility needed their rooms so they could admit male residents to the facility. Residents and their representatives were informed but were not given any choice about the move, and documentation showed the residents were very upset after the move (S/S: E)

It is important to remember that residents need to be offered the option to refuse transfers such as these, and that emotional prep is included as part of the process when a resident is being prepared for a room change. In each of these deficiencies, the residents were visibly upset or crying, but psychosocial services were not provided to alleviate their distress. As with so many situations, documentation is crucial – it needs to be evident that the resident was given an opportunity to refuse a transfer. Obviously, residents not being given the opportunity to refuse a transfer is looked at closely, but remember, when determining compliance with this regulation, a surveyor will also be assessing compliance with such areas as notification of roommate change and Medicare/Medicaid coverage.
Prior Authorization Model for Non-Emergent Hyperbaric Oxygen (HBO) Therapy

In 2015, the Centers for Medicare & Medicaid Services (CMS) launched a three-year prior authorization model for hyperbaric oxygen (HBO) therapy in selected states that were found to have high improper payment rates compared to other states. Prior authorization is a utilization management strategy intended to reduce improper payments by requiring claims for services to be reviewed by a health care payer for compliance with coding, billing, and coverage rules (including medical necessity) before services are rendered to beneficiaries and claims are submitted for payment. Thus, prior authorization promotes both general cost containment and control of waste, fraud, and abuse.

The purpose of the model was to test whether prior authorization could lower Medicare expenditures by reducing the provision of non-covered outpatient HBO therapy without adversely affecting access to or quality of care for beneficiaries. Non-emergent HBO provides a therapeutic dose of oxygen by exposing a patient’s entire body to pure oxygen under increased atmospheric pressure. The resulting higher oxygen concentration in the bloodstream has the potential to improve wound healing—for example, for wounds from diabetic neuropathy or for soft tissue damage from radiation treatment. HBO therapy is a covered service under Medicare Part B if the receiving beneficiary meets specified criteria. However, past audits of Medicare claims and medical records revealed a high improper payment rate for HBO therapy.

Implementation of the model began in April 2015 in Michigan, followed by Illinois and New Jersey in August 2015. The model concluded in February 2018.

The Evaluation Process

- **Utilization and expenditures.** How does the HBO prior authorization model affect Medicare service utilization and expenditures? Does the model realize savings on fee-for-service (FFS) expenditures for the Medicare program?
- **Quality of care.** How does the HBO prior authorization model affect the quality of care for Medicare beneficiaries? Are there any adverse outcomes associated with the model?
- **Claim denials.** Does HBO prior authorization affect the rate of claim denials?
- **Model operations.** How was the HBO prior authorization model operationalized by the Medicare Administrative Contractors (MACs)? Were opportunities for improvement identified?

Participants

Outpatient HBO providers located in the three model states submitted prior authorization requests before the start of HBO treatment for five targeted conditions. These include wound or other tissue damage conditions such as diabetic wounds of the lower extremities and osteoradionecrosis (a complication of radiation therapy involving bone death). Generally, the documentation submitted should provide evidence that more conventional treatments were tried and were ineffective before the patient receives HBO therapy.

The evaluation examined costs and quality of care in all patients with one or more of the five targeted conditions, including both beneficiaries who did and did not receive HBO therapy. HBO use was relatively rare; 5.5 percent of the analytic sample received HBO during the study period. To enable us to observe whether long-term health outcomes were affected by the prior authorization model, we followed beneficiaries from the date of their diagnosis until they died, left the state, or left fee-for-service Medicare.

HBO Utilization and Expenditures
While HBO utilization and expenditures declined in all states during the study period, the model states saw larger decreases following the start of the prior authorization model.

Quality
Overall, the prior authorization model did not appear to reduce the quality of care received by beneficiaries or increase adverse events.
- There were no impacts on unplanned hospitalizations or mortality.
- They found a small (0.03 percentage point) increase in probability of emergency department utilization for diabetic lower extremity wounds.

Key Takeaways
The prior authorization model decreased HBO therapy utilization and quarterly expenditures, but did not have a significant impact on total Medicare expenditures. During the period of model operation examined in the final report, the HBO prior authorization model reduced HBO quarterly expenditures by 32.2%, resulting in a reduction of approximately $307 million in HBO service expenditures for beneficiaries with included conditions. In general, the model did not appear to decrease quality of care or increase the probability of adverse events overall.

You can access the full study 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:
   - CMS Reduces Psychiatric Hospital Burden with New Survey Process. On January 13, CMS announced a streamlined survey and certification process for psychiatric hospitals, delivering on the Agency’s Patients Over Paperwork initiative. This new process will ensure safety and quality through more holistic and efficient hospital inspections that protect patients, while reducing burden for providers. Currently, psychiatric hospitals surveyed by State Survey Agencies are subject to two separate onsite compliance surveys conducted by:
     - State Survey Agency (SSA) for compliance with the hospital requirements
Outside contractor selected by the SSA for compliance with two additional psychiatric hospital standards

Beginning in March 2020, CMS will implement a streamlined process in which psychiatric hospitals will receive one comprehensive hospital survey performed by the SSA to review compliance with both hospital and psychiatric hospital participation requirements:

- Allow inspectors to take a broader view of a psychiatric hospital’s operations and better identify systemic quality issues
- Benefit patients by ensuring psychiatric hospital services are evaluated in the context of the overall hospital survey program, making it easier for surveyors and the provider to identify and correct systemic quality issues that impact patient care
- Reduce the regulatory burden currently imposed on psychiatric hospitals because a single team will conduct the survey, and only one report will be issued documenting any survey findings, instead of two

CMS is notifying hospitals, SSAs and psychiatric hospital stakeholders of this upcoming change through a memorandum. This change does not affect accreditation organizations’ current methodologies for approving hospitals or psychiatric hospitals, or CMS’s criteria for approving accreditation organizations to survey such facilities. To ensure states are appropriately prepared to begin conducting these surveys in March 2020, CMS is developing an online training that will be released soon.

See the full text of this excerpted CMS Fact Sheet (issued January 13).

- **Quality Payment Program: MIPS 2020 Payment Adjustments.** CY 2020 Merit-based Incentive Payment System (MIPS) payment adjustments are applied to payments made for Part B covered professional services payable under the Physician Fee Schedule. Payment adjustments are determined by your 2018 MIPS final score. 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.

  For More Information:

  - 2020 MIPS Payment Adjustment Fact Sheet
  - Resource Library webpage
  - Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Quality Payment Program: New MIPS Participation Framework for 2021 Performance Period.** CMS is implementing a new participation framework for the Merit-based Incentive Payment System (MIPS) starting with the 2021 performance period, MIPS Value Pathways (MVPs). The goal of this new framework is to move away from siloed performance category measures and activities and toward an aligned set of measures and activities that are more meaningful to clinicians and patient care.

  We will not immediately eliminate the current MIPS framework. We intend to develop MVPs for 2021 and beyond in collaboration with stakeholders, and we will provide opportunities for dialogue and additional feedback.

  For More Information:

  - MVPs webpage
  - MVPs: The Future of MIPS video
  - Overview Fact Sheet
  - Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)
Part A Providers: Talk to a QIC Adjudicator About Your Appeal. Do you file second level Medicare Part A claims appeals (reconsiderations) to the Part A East Qualified Independent Contractor (QIC), C2C Innovative Solutions, Inc. (C2C)? If so, you may be eligible to participate in the QIC Telephone and Reopening Process Demonstration, which includes:

- Telephone Discussion of your second level appeal with the appeals adjudicator at the QIC prior to their decision
- Reopening Process: C2C reviews appeals that are pending at the Office of Medicare Hearings and Appeals (OMHA) for potential reopening and faster resolution

How to participate:

- Look for a letter from C2C to participate in a call to discuss your appeal or for a letter requesting documentation to support favorable resolution of your appeal pending at OMHA
- Email ADemoFeedback@c2cinc.com if you want to discuss your appeal or C2C to review appeals pending at OMHA for potential reopening

Participation does not affect your future appeal rights. Telephone Discussion participants are experiencing higher favorability rates than non-participants.

For More Information:

- C2C Appeals Demonstration website
- Original Medicare (Fee-for-service) Appeals website

Comparative Billing Reports: Access via CBR Portal. Comparative Billing Reports (CBRs) are distributed electronically via the secure CBR portal. Is a CBR available for you? Look for an email or fax notification with your unique access code, or contact the CBR Help Desk to find out.

CBRs are provider-specific reports that compare your billing and payment patterns to those of your peers in your state and across the nation. For more information, visit the CBR website.

Quality Payment Program: 2018 Performance Data. CMS released the final 2018 performance data for the Quality Payment Program. Additional data elements show significant success and participation in both the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Model (APM) paths. Performance highlights:

- 98% of eligible clinicians participated in MIPS in 2018 — up from 95% in 2017
- 98% of eligible clinicians exceeded the performance threshold score of 15 points to receive a positive payment adjustment — up from 93% in 2017
- 356,353 clinicians participated in MIPS through APMs — up from 341,220 in 2017

For More Information:

- Blog
- Infographic
- Quality Payment Program website
- Find no-cost technical assistance for Small, Underserved, and Rural Practices
- Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

Quality Payment Program APM Incentive Payment: Verify Banking Information. If you are a qualified Alternative Payment Model (APM) participant based on your 2017 performance, you are eligible for a 5%
incentive payment for 2019. CMS is unable to pay the incentive to a number of clinicians because we cannot verify their banking information. If you are on our list, contact us so we can send your 2019 payment.

For More Information:

- 2019 Quality APM Participants Notice for APM Incentive Payment
- Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Quality Payment Program: Participation Status Tool Includes Third Snapshot of Data.** CMS updated the Quality Payment Program Participation Status Lookup Tool based on the third snapshot of data from Alternative Payment Model (APM) entities. The third snapshot includes data from Medicare Part B claims with dates of service between January 1 and August 31, 2019. The tool includes 2019 Qualifying APM Participant (QP) and Merit-based Incentive Payment System APM participation status.

For More Information:

- 2019 QP Methodology Resources
- APM Overview webpage.
- Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Quality Payment Program: Recheck Your Final 2019 MIPS Eligibility.** After releasing final 2019 Merit-based Incentive Payment System (MIPS) eligibility data in December, CMS discovered and corrected inconsistencies. Use the Quality Payment Program Participation Status Tool to re-check and confirm your final 2019 MIPS eligibility.

For More Information:

- MIPS Participation webpage
- Participation Infographic
- Participation and Eligibility Fact Sheet and User Guide
- Opt-In and Voluntary Reporting Fact Sheet and Election Toolkit
- Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Quality Payment Program: Check Your Initial 2020 MIPS Eligibility.** Use the Quality Payment Program Participation Status Tool to check on your initial 2020 eligibility for the Merit-based Incentive Payment System (MIPS). Just enter your national provider identifier to find out whether you need to participate.

For More Information:

- How MIPS Eligibility is Determined webpage
- Final Rule Overview Fact Sheet
- Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Quality Payment Program: Qualified Registries and QCDRs for CY 2020.** CMS posted the CY 2020 approved Qualified Registries and Qualified Clinical Data Registries (QCDRs) qualified postings. These entities collect clinical data from individual Merit-based Incentive Payment System (MIPS)-eligible clinicians, groups, and/or virtual groups and submit data to CMS.
• **January is Cervical Health Awareness Month.** Cervical cancer often be prevented with regular screening tests and follow-up care. Talk with your patients about cervical health and encourage them to take advantage of Medicare-coverage preventive services, including the screening Pap test and screening pelvic examination.

For More Information:

- [Centers for Disease Control and Prevention Cervical Cancer webpage](#)
- Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

• **Hospice Provider Preview Reports: Review Your Data by January 15.** Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:

  - Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the second quarter of 2018 to the first quarter of 2019
  - Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) provider preview report: Review facility-level CAHPS survey results from the second quarter of 2017 to the first quarter of 2019

Review your results by January 15. If you believe the denominator or other HIS quality metric is inaccurate or if there are errors in the results from the CAHPS survey data, request a CMS review.

For More Information:

- [HIS Preview Reports and Requests for CMS Review](#)
- [CAHPS Preview Reports and Requests for CMS Review](#)

• **Feedback on Scope of Practice: Send Recommendations by January 17.** CMS is seeking additional input and recommendations regarding elimination of specific Medicare regulations that require more stringent supervision than existing state scope of practice laws, or that limit health professionals from practicing at the top of their license.

  We are seeking additional feedback in response to part of the President’s Executive Order (EO) #13890 on Protecting and Improving Medicare for Our Nation’s Seniors. The EO specifically directs HHS to propose a number of reforms to the Medicare program, including ones that eliminate supervision and licensure requirements of the Medicare program that are more stringent than other applicable federal or state laws. These burdensome requirements ultimately limit healthcare professionals, including Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs), from practicing at the top of their professional license.

  In response to suggestions we have already received regarding supervision, scope of practice, and licensure requirements, CMS has made a number of regulatory changes in several payment rules, including the CY 2020 Physician Fee Schedule, Home Health, and Outpatient Prospective Payment System final rules. These changes include, but are not limited to: redefining physician supervision for services furnished by PAs, allowing therapist assistants to perform maintenance therapy under the Medicare home health benefit and reducing the minimum level of physician supervision required for all hospital outpatient therapeutic services.
We are proud of the work accomplished, and now we need your help in identifying additional Medicare regulations which contain more restrictive supervision requirements than existing state scope of practice laws, or which limit health professionals from practicing at the top of their license. If you submitted comments on these topics to our 2019 Request for Information on Reducing Administrative Burden to Put Patients over Paperwork, thank you! We are reviewing those submissions.

We welcome any additional recommendations. Please send your recommendations to PatientsOverPaperwork@cms.hhs.gov with the phrase “Scope of Practice” in the subject line by January 17, 2020.

We also continue to welcome your input on ways in which we can reduce unnecessary burden, increase efficiencies and improve the beneficiary experience, and request that input on such topics only be sent to this email address with the phrase “Scope of Practice” in the subject line if they relate to the specific areas in regulation which restrict non-physician providers from practicing to the full extent of their education and training.

- **Bill Correctly for Polysomnography Services.** In a recent report, the Office of Inspector General (OIG) determined that CMS improperly paid practitioners for some claims associated with polysomnography services that did not meet Medicare requirements. We revised the Provider Compliance Tips for Polysomnography (Sleep Studies) (PDF) Fact Sheet to help you bill correctly. Additional resources:
  - Medicare Claims Processing Manual, Chapter 15 (PDF), Section 70
  - Questionable Billing for Polysomnography Services OIG Report
  - Medicare Payments to Providers for Polysomnography Services Did Not Always Meet Medicare Billing Requirements OIG Report

- **Listening Sessions on MAC Opportunities to Enhance Provider Experience — January 22 or 29.** Wednesday, January 22 or 29 from 2 to 3 pm ET

  Register for one of these Medicare Learning Network events.

As part of our 2020 priorities, we are holding a series of listening sessions to gather feedback and improve your experience with the Medicare Fee-For-Service (FFS) program. Through competitive cost-plus award-fee contract procurements, CMS encourages Medicare Administrative Contractors (MACs) to innovate and respond to provider, practitioner, and supplier expectations in their jurisdictions.

We invite you to participate in a MAC listening session. CMS wants to hear your feedback to improve processes and enhance interactions with your MAC related to operations, technology, and business functions. We are particularly interested in hearing provider, practitioner, and supplier ideas about actions we could take to improve the overall beneficiary quality of care and customer service experience they may have with the MACs. CMS Administrator, Seema Verma will open these calls.

You can email comments or questions in advance of the listening session to CMSListens@cms.hhs.gov with “MAC Provider Experience” in the subject line. We may address them during the listening session or use them to develop other resources following the session.

Target Audience: Medicare FFS providers, practitioners, suppliers, their representative associations, and any interested stakeholders.

- **Quality Payment Program: MIPS for 2020 Performance Period Webinar — January 22.** Wednesday, January 22 from 2:30 to 4 pm ET

  Register for this webinar.
This webinar provides a basic overview of the Merit-based Incentive Payment System (MIPS) for the 2020 performance period. Topics:

- Eligibility
- Reporting options
- Basic requirement for the MIPS performance categories
- Help and support

Target Audience: Clinicians, care teams, and practice support staff

- **Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2.** The deadline to submit your 2019 registration and attestation information for the Medicare Promoting Interoperability Program is March 2:
  - Medicare eligible hospitals and Critical Access Hospitals (CAHs): Attest through the [QualityNet Secure Portal](#)
  - Medicaid eligible professionals, eligible hospitals, and CAHs: Follow the requirements of your State Medicaid agency
  - Dual-eligible hospitals and CAHs: Attest through the QualityNet Secure Portal (not your State Medicaid agency)

  For More Information:
  - [Eligible Hospital Information](#) webpage
  - [Registration and Attestation](#) webpage
  - [QualityNet Secure Portal Enrollment and Login User Guide (PDF)](#)
  - Contact the QualityNet help desk at 866-288-8912 or qnetsupport@hcqs.org

- **Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31.** The data submission period is open for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2019 performance period of the Quality Payment Program. Submit and update your data until 8 pm ET on March 31. Note: The data submission period for accountable care organizations and pre-registered groups and virtual groups also closes on March 31.

  For More Information:
  - [Resource Library](#) webpage
  - [Introduction and Overview of 2019 Data Submission](#) Video
  - [File Upload and Quality Scoring](#) Video
  - [Manual Attestation of Improvement Activities](#) Video
  - [Support for Small, Underserved, and Rural Practices](#) webpage
  - Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Hospitals: New Beneficiary Notices (IM, DND, and MOON) Required April 1.** The Office of Management and Budget renewed the following notices:
  - Important Message from Medicare (IM) ([CMS-10065 (ZIP)](#)): Revised; new CMS form number (formerly CMS-R-193)
  - Detailed Notice of Discharge (DND) ([CMS-10066 (ZIP)](#)): Revised
  - Medicare Outpatient Observation Notice (MOON) ([CMS-10611 (ZIP)](#)): Unchanged; only the expiration date is different

  English and Spanish versions are included in each zip file. Hospitals are required to use the new notices beginning April 1. Both the previous and new versions of the notices are acceptable for use through March 31.

  For More Information:
Hospital Discharge Appeal Notices webpage for information on IM and DND
MOON webpage

• Hospital Outpatient Departments: Prior Authorization Process Begins July 1. For dates of service beginning July 1, you must request prior authorization for the following outpatient department services. Medical necessity documentation requirements remain the same.
  o Blepharoplasty
  o Botulinum toxin injections
  o Panniculectomy
  o Rhinoplasty
  o Vein ablation

For More Information:
  o Hospital Outpatient Prospective Payment System Final Rule: See section XIX, beginning on page 61446 and the full list of HCPCS codes on page 61464
  o We will provide additional details before July 1

• Home Health Compare: Preview Reports for April Refresh. Certification and Survey Provider Enhanced Reports (CASPER) reports preview data that will be displayed on the Home Health Compare website in April:
  o Provider Preview Report
  o Quality of Patient Care Star Rating Preview Report

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

• Clinical Laboratory Data Reporting Delayed. For Clinical Diagnostic Laboratory Tests (CDLTs) that are not Advanced Diagnostic Laboratory Tests (ADLTs), private payor data reporting is delayed by one year. CDLT data that was supposed to be reported between January 1, 2020, and March 31, 2020, must now be reported between January 1, 2021, and March 31, 2021. Labs must report data from the original data collection period of January 1, 2019, through June 30, 2019. Data reporting for these tests will resume on a three-year cycle, beginning in 2024. (Section 105(a)(1) of the Further Consolidated Appropriations Act of 2020 (FCAA)).

In addition, the statutory phase-in provisions are updated. For 2020, the rates for CDLTs that are not ADLTs or new CLDTs may not be reduced by more than 10% of the rates for 2019. There will be a 15% reduction cap for each of 2021, 2022, and 2023. (Section 105(a)(2) of FCAA). The reduction cap for CDLT rates:

  o 2020: 10% based on the January 1, 2017 – May 30, 2017 reporting period
  o 2011: 15% based on the January 1, 2017 – May 30, 2017 reporting period
  o 2022: 15% based on the January 1, 2021 – March 31, 2021 reporting period
  o 2023: 15% based on the January 1, 2021 – March 31, 2021 reporting period

For more information, see the PAMA Regulations webpage. Disregard any messaging, such as remittance advice messages or prior MLN Connects messages, indicating the previous reporting end date of March 31, 2020.

• ICD-10-CM Browser Tool. Use the new National Center for Health Statistics ICD-10-CM Browser Tool to:
  o Search for ICD-10-CM codes
  o Understand how to use the codes
  o Access multiple fiscal year version sets with comprehensive results
• **Provider Enrollment Application Fee Amount for CY 2020.** On November 12, CMS issued a notice: Provider Enrollment Application Fee Amount for Calendar Year 2020 [CMS–6089–N](https://www.cms.gov/files/document/cms-6089-n.pdf). Effective January 1, 2020, the application fee is $595 for institutional providers that are:

  - Initially enrolling in the Medicare or Medicaid program or the Children’s Health Insurance Program (CHIP)
  - Revalidating their Medicare, Medicaid, or CHIP enrollment
  - Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2020.

• **Nursing Home Quality Initiative: Draft 2020 MDS Item Sets.** Draft 2020 Minimum Data Set (MDS) item sets (v1.18.0) [ZIP](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EndStageRenalDisease/2020-MDS-Item-Sets.html) are available and scheduled to become effective October 1, 2020. For more information, visit the [MDS 3.0 Technical Information](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EndStageRenalDisease) webpage.

• **Hospice Quality Reporting Program News.** View the December Hospice Quality Reporting Program (HQRP) [outreach email](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLNProductsOutreachEmails.html) for information on:

  - Reporting for CY 2020
  - Quarterly update for the third quarter of 2019
  - November Hospice Compare refresh
  - Hospice Outcomes & Patient Evaluation (HOPE) tool

For more information, visit the [HQRP Requirements and Best Practices](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) webpage.

• **Qualified Medicare Beneficiary Billing Requirements.** Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing. Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions.

Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:

  - Use Medicare 270/271 [HIPAA Eligibility Transaction System](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLNProductsEligibilityAndRemittanceAdvice.html) (HETS) data; see [MLN Matters Article SE1128](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Medicare-Claims/MLN-Matters-Articles.html)
  - Check your Medicare Remittance Advices (RAs); see [MLN Matters Article MM10433](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Medicare-Claims/MLN-Matters-Articles.html)
  - Check state automated Medicaid eligibility-verification systems

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing, and issuance of Medicaid RAs for payment of Medicare cost-sharing. [Check with the states](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies), and refund the invalid charges they paid.

For More Information:

  - [QMB Program](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) webpage
  - [Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) (PDF) MLN Matters Article
  - [QMB Program Billing Requirements FAQs](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) (PDF)
  - [Materials](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) from 2018 Medicare Learning Network call
  - [Dual Eligible Beneficiaries under the Medicare and Medicaid Programs](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/hqrp/HQRP-Requirements-and-Best-Practices.html) Booklet
Get Your Patients Off to a Healthy Start in 2020. Get your patients off to a healthy start this year by recommending the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV). Medicare covers these preventive services at no cost to your patients.

- IPPE or the “Welcome to Medicare” preventive visit is a one-time service for newly-enrolled beneficiaries: Review medical and social health history and discuss preventive services
- AWV is a yearly office visit that focuses on preventive health: Develop or update a personalized prevention plan and perform a health risk assessment

For More Information:
- Medicare Preventive Services Educational Tool
- AWV, IPPE, and Routine Physical - Know the Differences (PDF) Educational Tool

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

Chiropractic Services: Comply with Medicare Billing Requirements. In a recent report, the Office of Inspector General (OIG) determined that payments for chiropractic services did not comply with Medicare billing requirements. Overall, medical record documentation did not support medical necessity or corrective treatment. CMS developed the Medicare Documentation Job Aid for Doctors of Chiropractic (PDF) Educational Tool to help you bill correctly.

Additional resources:
- Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits (PDF) MLN Matters Article
- Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449) (PDF) MLN Matters Article
- Educational Resources to Assist Chiropractors with Medicare Billing (PDF) MLN Matters Article
- Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services OIG Report
- Medicare Benefit Policy Manual, Chapter 15 (PDF), Sections 30.5 and 240
- Medicare Claims Processing Manual, Chapter 12 (PDF), Section 220

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Encounters. A new MLN Matters Article SE20002 on Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Encounters (PDF) is available. Learn about using the K3 segment to report line level ordering professionals’ information on these claims.

CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule — Revised. A revised MLN Matters Article MM 11570 on CY 2020 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule (PDF) is available. Learn about the corrected CY 2020 maintenance and servicing fee for certain oxygen equipment.

Medicare Fee-for-Service (FFS) Response to the 2020 Commonwealth of Puerto Rico Earthquakes. The HHS Secretary declared a Public Health Emergency in the Commonwealth of Puerto Rico, which allows for CMS programmatic waivers based on Section 1135 of the Social Security Act. An MLN Matters Special Edition Article SE20003 on Medicare Fee-for-Service (FFS) Response to the 2020 Commonwealth of Puerto Rico Earthquakes
(PDF) is available. Learn about blanket waivers issued by CMS. These waivers prevent gaps in access to care for beneficiaries impacted by the emergency.

- **January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0.** A new MLN Matters Article MM11564 on *January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 (PDF)* is available. Learn about modifications and effective dates.

- **Quality Payment Program and MIPS Resources.** Quality Payment Program — [Access User Guide](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram) (updated): Process of obtaining a user ID and password; connecting to an organization; and managing your access to view, submit, and update your data.

  Merit-based Incentive Payment System (MIPS) 2020 Performance Period:
  - [Quality Measures List](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/medicare-quality-measures-list): Includes descriptions, collection types, and applicable specialty measure sets
  - [Medicare Part B Claims Measure Specifications and Supporting Documents](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/medicare-part-b-claims-measure-specifications-and-supporting-documents): Descriptions of the measures for the Quality performance category
  - [Clinical Quality Measure Specifications and Supporting Documents](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/clinical-quality-measure-specifications-and-supporting-documents): Descriptions of the measures for the Quality performance category
  - [CMS Web Interface Measure Specifications and Supporting Documents](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/cms-web-interface-measure-specifications-and-supporting-documents): Descriptions of the measures for the Quality performance category
  - [Qualified Clinical Data Registry Measure Specifications](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/qualified-clinical-data-registry-measure-specifications): Measures and corresponding calculations
  - [Improvement Activities Inventory](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/improvement-activities-inventory): Descriptions of activities for the performance category objectives and measures
  - [Cost Measure Information Forms](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/cost-measure-information-forms): Measure methodology for each of the episode-based cost measures
  - [Cost Measure Code Lists](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/cost-measure-code-lists): Lists for each of the episode-based cost measures
  - [Summary of Cost Measures](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/summary-of-cost-measures)

  MIPS 2019 Performance Period:
  - [Automatic Extreme and Uncontrollable Circumstances Policy Fact Sheet](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/automatic-extreme-and-uncontrollable-circumstances-policy-fact-sheet): Explains how the policy works and answers frequently asked questions
  - [Data Validation Execution Report Template](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/data-validation-execution-report-template)


  For More Information:
  - [Resource Library](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/resource-library) webpage
  - Contact [gpp@cms.hhs.gov](mailto:gpp@cms.hhs.gov) or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

- **Diabetes Resources.** Tailoring diabetes treatment options and resources to meet individual needs can help improve outcomes. CMS released two new resources for health care providers and patient advocates:
  - [Diabetes Medication Management: Directory of Provider Resources (PDF)](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/diabetes-medication-management-directory-of-provider-resources): For primary care teams, particularly providers working with Medicare beneficiaries and vulnerable populations
  - [Culturally and Linguistically Tailored Type 2 Diabetes Resources Inventory (PDF)](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/culturally-and-linguistically-tailored-type-2-diabetes-resources-inventory): Catalog of prevention resources tailored to various audiences, including racial and ethnic minorities, LGBTQ communities, people with disabilities, and people with limited English proficiency

  For More Information:
  - [Connected Care: Chronic Care Management Resources](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/connected-care-chronic-care-management-resources)
  - [CMS Office of Minority Health](https://www.cms.gov/Medicare/MediQoL-CoordinationQual/QualityPaymentProgram/cms-office-of-minority-health) website
  - Email [OMH@cms.hhs.gov](mailto:OMH@cms.hhs.gov)
- **Hospice Payment System — Revised.** A revised Hospice Payment System Medicare Learning Network Booklet is available. Learn about:
  - Coverage and certification requirements
  - Election periods and statements
  - Caps on payments

- **Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring.** A new MLN Matters Article MM11577 on Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring (PDF) is available. Learn about updates to chapter 7 of the Medicare Benefit Policy Manual.

- **Medicare Diabetes Prevention and Diabetes Self-Management Training — Revised.** A revised Medicare Diabetes Prevention and Diabetes Self-Management Training Medicare Learning Network Fact Sheet is available. Learn how to become a Medicare Diabetes Prevention Program supplier and an accredited Diabetes Self-Management Training provider.

- **Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS — Revised.** A revised MLN Matters Article MM11335 on Add Dates of Service (DOS) for Pneumococcal Pneumonia Vaccination (PPV) Health Care Procedure Code System (HCPCS) Codes (90670, 90732), and Remove Next Eligible Dates for PPV HCPCS (PDF) is available. Learn about contractor integration testing.

- **Provider Compliance Tips for Hospital Based Hospice — Revised.** A revised Provider Compliance Tips for Hospital Based Hospice Medicare Learning Network Fact Sheet is available. Learn about:
  - Certification requirements for billing
  - Face to face encounters
  - How to avoid claim denials

- **Provider Compliance Tips for Polysomnography (Sleep Studies) — Revised.** A revised Provider Compliance Tips for Polysomnography (Sleep Studies) Medicare Learning Network Fact Sheet is available. Learn about:
  - Common reasons for claim denials
  - Coverage criteria
  - How to prevent denials

- **Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM).** A revised MLN Matters Article MM 11513 on Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) (PDF) is available. Learn about updates to handle Veterans Administration demonstration claims.

- **MLN Catalog – January 2020 Edition.** The January 2020 Edition of the MLN Catalog (PDF) is available. Learn about:
  - Products and services you can download for free
  - Web-based training courses; some offer continuing education credits
  - Helpful links, tools, and tips

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 (January 4 – January 11), influenza activity in the United has declined slightly but remain high. Indicators that track severity are not high at this point in the season.
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 Gender-affirming Services. You may view the new notice [here](#).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Prevention of Spousal Impoverishment Standards for 2020. You may view the new notice [here](#).

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Advance Payment Recoupments – 3 Month Extension to April 15, 2020. You may view the new notice [here](#).

5) The Illinois Department of Public Health (IDPH) reports:

- There was a notice of a change for long term care facilities ONLY located in the Chicago/Bellwood Region in regards to long term care facility incident reports. Effective immediately, all incident reports for these facilities are to be faxed to the following number: 708-544-9250. (No changes for submission of reports for IID, MC/DD or SMHRF facilities.) If there are questions regarding this change, please contact Janette Williams-Smith at Janette.Williams-smith@Illinois.gov or Kimberly Hollowell at Kimberly.Hollowell@illinois.gov.

- The Office of Policy, Planning & Statistics, Division of Patient Safety and Quality announced a series of educational webinars with a focus of healthcare associated infections (HAIs). You can find the flyer [here](#).

- The Department filed the proposed rule on January 10th that addressed changes to informed consent and enforcement of staffing ratios from legislation passed last Spring. It also includes guidance on RN staffing waivers that the association passed a few years ago. IHCA will be submitting a request for a public hearing on the draft rules as well as providing comments to the Department and would strongly encourage membership to submit their own comments. Comments must be submitted before **February 24, 2020** to Erin Conley, Rules Coordinator in the Division of Legal Services. This is the first comment period that is open to the public.

You can find the IDPH Proposed Rule Dot Points [here](#). Also, you can find the full rule [here](#).

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.** Thursday, January 23: Application Deadline for AHCA/NCAL National Quality Award Program

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

- **IHCA VCast 1/16/20.** CMS Medicaid Fiscal Accountability Regulation with Matt Werner and Ashley Snavely
ACO Participation in MSSP Will Remain Steady In 2020, According To NAACOS. Provider Magazine (1/16, Connelle, 151K) reports "new data show that the Medicare Shared Savings Program (MSSP) will see participation remain steady for 2020 with 517 accountable care organizations (ACOs) taking part this year, down one from last year but off from the high-water mark of 561 ACOs two years ago, according to the National Association of ACOs (NAACOS)." The "report comes at a time when an increasing number of long term and post-acute care providers are exploring value-based care options, be they via ACO membership or starting health insurance plans under the Medicare Advantage program, among other alternatives." However, "the outlook for ACOs in the MSSP is clouded by the fact that in 2020 just 35 Shared Savings Program ACOs will enter into their first contract with the Centers for Medicare & Medicaid Services (CMS)," whereas, "between 2012 and 2018, the program averaged 107 new ACOs annually."

Facilities in Indiana, Illinois Receive AHCA/NCAL Recognition. The Greater Fort Wayne (IN) Business Weekly (1/16) reports "The Laurels of DeKalb, a skilled nursing and rehabilitation center operated by Laurel Health Care Company, has been recognized as Tier 4 Achiever" in "the American Health Care Association and National Center for Assisted Living’s Quality Initiative Program for its work to improve the quality of care for short-term and long-term residents." With this recognition, "The Laurels of DeKalb was one of only 624 skilled nursing facilities nationwide to meet four or more goals and receive top recognition through the Quality Initiative Program." Laurel VP of operations Cathy Chiovaro stated, "We thank AHCA/NCAL for this tremendous recognition. It is an excellent endorsement that the Laurel Way of Caring makes a difference!" The Canton (IL) Daily Ledger (1/16, Schrodt, 15K) reports members of the Fulton County Board "learned that the American Health Care Association has awarded the Clayberg with a Certificate of Achievement for receiving Tier 1 recognition in the following areas: hospitalizations, antipsychotics, customer satisfaction and functional outcomes."

Facilities Across the Country Receive AHCA/NCAL Recognition. The Hampshire (WV) Review (1/15, Staff) reports "Hampshire Center, at Sunrise Summit, and Dawn View Center in Fort Ashby have been honored by the American Health Care Association and National Center for Assisted Living for meeting all 4 goals the group sets out." The Murray (KY) Ledger & Times (1/15, Ledger, 20K) report "Henry County Health Care Center & Plumley Rehab was recognized by the American Health Care Association and National Center for Assisted Living (AHCA/NCAL) for its achievements in the quality of care they provide." The facility "has been recognized as a Tier 3 skilled nursing care facility in the 2020 AHCA/NCAL Quality Initiative Recognition Program for meeting three of the four goals related to hospitalization, customer satisfaction, antipsychotics, and functional outcomes." This program "is a national effort through AHCA/NCAL that builds upon the existing work of the long term and post-acute care profession by setting specific, measurable targets to further improve quality of care in America’s skilled nursing centers and assisted living communities." Effingham Radio (1/14) reports Willowbrook in Effingham was recognized for achieving "Tier One of four national goals in areas including Staff Stability, Customer Satisfaction, Hospital Readmissions and Antipsychotics use." The Quality Initiative of AHCA/NCAL "aims to further improve quality of care in skilled nursing centers and assisted living communities by challenging member facilities to meet measurable goals in areas such as hospital readmissions, off-label use of antipsychotics, and customer satisfaction."

Nearly Half of Health Care Organizations Are Just in Pilot Stages of Value-Based Care Implementation, Or Have Not Started at All, Survey Indicates. McKnight’s Long Term Care News (1/15, Brown) reports "nearly half of health care organizations have either not started or are in the pilot stages of implementing value-based care even though more than 45% of executives said they understand the pay model, a new survey by health care technology company Innovaccer revealed." The survey found "about 20% of providers have yet to start their journey toward value-based care, while about 25% are still in the pilot stages toward implementation." The survey results also indicate "a little more than 23% have begun successful pilots; less than 20% have rolled out a program and achieved financial success; and about 18% have rolled out the program but are still working toward financial success."

Some Senior Living Residents Receiving Unsolicited Calls to Transfer Prescriptions. McKnight’s Senior Living (1/16, Bowers) reports "some assisted living and independent living residents are receiving unsolicited calls to
move their prescriptions from their independent pharmacies to Amazon’s PillPack, according to a media report, which describes it as a ‘growing practice.’" Claims about "this alleged practice began almost immediately after Amazon bought PillPack’ in 2019, Pharmacy Times reported, citing a CNBC report." Pharmacists speaking "with the publication said the calls confuse residents, who think they are coming from their current pharmacies or insurance companies." However, "a PillPack spokeswoman said that the company only requests prescription transfers with the customer’s explicit and documented consent."

- **Experts Warn US Unprepared to Meet the Needs of Aging Baby Boomers.** Kaiser Health News (1/16, Graham) reports that as baby boomers age, experts are warning that the US is not prepared to handle the "unprecedented demographic shift." For example, data from the Genworth Cost of Care Study found that "while the median household income for older adults was just $43,696 in 2019, the annual median cost for a private room in a nursing home was $102,204; $48,612 for assisted living; and $35,880 for 30 hours of home care a week."

- **Study Suggests Copper-Surfaced Fixtures May Reduce Risk of Hand-Transmitted Infection Outbreaks in Long-Term Care Facilities.** McKnight’s Long Term Care News (1/16, Lasek) reports "copper-surfaced fixtures can reduce the risk of hand-transmitted infection outbreaks in eldercare facilities, a new study has found." The research, published in JAMDA, included investigation of "four documented outbreaks in a nursing home with two distinct wings," where "one wing was equipped with copper fixtures such as support bars, doorknobs and railings, and the other was not." The study found "residents who lived in the wing with copper fixtures had a significantly lower risk of contracting hand-transmitted disease (eye infection and diarrhea) when compared to their peers in the other wing." Antipsychotics May Cause Increased Risk of Death or Cardiopulmonary Arrest in Older Adults, Study Indicates.

- **Antipsychotic Medications May Raise Risk of Head Injury, TBI In People with Alzheimer’s, Study Indicates.** Medscape (1/16, Brooks, Subscription Publication, 277K) reports, "Antipsychotic medications raise the risk of head injury and traumatic brain injury (TBI) in people with Alzheimer’s disease," researchers concluded after matching data on "21,795 individuals who started taking an antipsychotic medication with 21,795 who did not." The findings were published online Jan. 7 in the Journal of the American Geriatrics Society.

- **Headphone-Based Hearing Aid Alternative May Improve Understanding, Engagement, Study Suggests.** McKnight’s Long Term Care News (1/15, Lasek) reports "a headphone-based audio technology received high marks from residents, improving understanding and engagement during a recent case study, say researchers." The Eversound "over-the-ear, wireless listening system" is said to be "an alternative to traditional hearing aids," and was recently tested by the Front Porch Center for Innovation and Technology. The testing indicates "more than 77% of participants, including long-term care residents, were found to be more engaged in group activity when using the technology," while "care staff in skilled nursing and memory care settings observed positive changes in mood and behavior among residents when listening with the headphones."

- **Health Care Administrator Suggests Ways for SNFs To Reduce Short-Term Rehab Stays.** McKnight’s Long Term Care News (1/15, Adams) publishes a blog post by the health care administrator of Presbyterian Village at Holidaysburg in Pennsylvania, who writes, "While short-term rehabilitation is effective in addressing the acute medical issue that landed a senior there, there is a constant struggle to ensure they receive the support needed after they return home – because that support means the difference between staying home or returning to the hospital." The author adds that Presbyterian Village "can be a model for other SNFs looking to reduce short-term rehabilitation stays, as we have reduced short-term stays for Medicare patients by 45%, while also reducing seniors with private plan’s stays by 55%." She concludes, "We know that collaborative communication, a data-based approach and prioritizing quality care over long-term stays go a long way to improving the short-term rehabilitation experience for older adults, their families, caregivers and medical professionals."

- **Higher Employment May Facilitate Spread of Influenza During Flu Season, Study Indicates.** On its website, CBS News (1/15, Picchi, 3.68M) reports that higher employment may facilitate the spread of influenza during flu season. The article cites a study published in Economics & Human Biology that concluded each 1% increase in employment is tied to a 16% increase in influenza-related medical visits. The article quotes Erik Nesson, an
economics professor at Ball State University and one of the study’s authors, who said employers should consider implementing more generous sick leave policies to stop the spread of flu, “Since a person may be infectious while experiencing mild symptoms, this greatly increases the probability that the virus will spread to other workers in the firm. This implies that firms should consider more generous sick day policies, particularly during the flu season."

- **CDC Predicts Influenza Season Will Not Slow Down for Weeks.** Medscape (1/15, Brown, Subscription Publication, 277K) reports that "influenza is still going strong in the United States and isn’t expected to slow down for at least several more weeks, according to a report from the" CDC. The article says that while "levels of outpatient visits for influenza-like illness (ILI) remain elevated, hospitalization rates and the percentage of deaths resulting from pneumonia and influenza remain low." The article outlines the level of flu activity in different regions and states across the US.

- **Review Study Suggests Sleep Troubles May Increase Risk for Cognitive Problems or Dementia.** Reuters (1/15, Rapaport) reports a review study published in the Journal of Neurology, Neurosurgery, & Psychiatry suggests that "people who have trouble falling asleep may be at increased risk of developing cognitive problems or dementia than their counterparts who sleep well." The study’s authors analyzed data from "51 previously published studies that followed middle-aged and older people in North America, Europe and East Asia for at least several years to see if sleep issues were associated with cognitive health over time."

9) **Interesting Fact:** Today is National Polka Dot and Hot Sauce Day!