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!

The Healthy Adult Opportunity (HAO)

CMS announced on January 30, 2020 a new opportunity to support states with greater flexibility to improve the health of their Medicaid populations. The Healthy Adult Opportunity (HAO) emphasizes the concept of value-based care while granting states with extensive flexibility to administer and design their programs within a defined budget. This state opportunity will enhance the Medicaid program’s integrity through its focus on accountability for results and quality improvement, making the Medicaid program stronger for states and beneficiaries.

Beneficiary Protections

HAO is available to all states, with a focus on a limited population – adults under age 65 who are not eligible for Medicaid on the basis of disability or their need for long term care services and supports, and who are not eligible under a state plan. Other very low-income parents, children, pregnant women, elderly adults, and people eligible on the basis of a disability will not be directly affected – except from the improvements that result from states reinvesting savings into strengthening their overall programs. Under HAO, beneficiaries will maintain all of the federal due process and civil rights they have today, and HAO demonstrations will be expected to provide minimum benefit standards, eligibility protections, and limits on out of pocket expenses. Specifically, the guidance articulates the key beneficiary protections that states will be required to adhere to, and standards that states will be expected to meet, including:

- Following all federal disability and civil rights laws,
- Following a public and beneficiary notice process, and providing for fair hearing rights,
- Providing regular and ongoing reporting on key performance metrics,
- Providing key statutory protections for tribal beneficiaries,
- Maintaining benefits that at a minimum meet the Essential Health Benefits (EHB) standard,
- Ensuring access to medications for people with HIV or behavioral health needs; and
- Ensuring that the aggregate limit on premiums and cost sharing does not exceed 5% of family income.

Flexibilities Available Under the Healthy Adult Opportunity

The HAO will involve the use of section 1115(a)(2) authority to provide coverage to adults not eligible for benefits under the state’s Medicaid state plan, while affording states significant flexibility in the administration of benefits for such individuals. For the first time, CMS is offering flexibilities currently available to states in a comprehensive suite of pre-packaged waiver authorities. This will give states, if they choose it, the opportunity to propose commonly requested authority for participating populations, including the ability to:
• Adjust cost-sharing requirements to incentivize high value care,
• Align benefits more closely to what is available through a commercial insurance benefit package,
• Improve negotiating power to lower drug costs by adopting a closed formulary similar to those provided in the commercial market (see section below for more detail),
• Make timely programmatic adjustments without additional federal approval,
• Apply additional conditions of eligibility which support the objectives of the program,
• Deliver care through innovative delivery systems, and
• Waiving retroactive coverage and hospital presumptive eligibility requirements.

Eligibility and Enrollment Processes
HAO is available to all states, with a focus on a limited population – adults under age 65 who are not eligible for Medicaid on the basis of disability or on their need for long term care services and supports, and who are not eligible under a state plan. States choosing to apply for an HAO demonstration will have flexibility to propose to set the income standard for eligibility under an HAO, as well as to change the standard over the course of the demonstration, consistent with approved terms and conditions. States may also propose to target coverage to a defined subset of high need individuals, such as individuals with severe mental illness, individuals needing treatment for substance use disorder, or individuals with HIV/AIDS.

However, consistent with current policy, an income standard of at least 133 percent FPL and eligibility for all individuals described in the adult group is required in order for states to be eligible for the enhanced FMAP available for this population under the statute. States will still have the flexibilities to propose additional conditions of eligibility, such as community engagement requirements, that are consistent with the objectives of the Medicaid program. Additional flexibilities available for states to propose include, but are not limited to, the ability to not provide retroactive coverage or hospital presumptive eligibility.

As part of this demonstration, states may develop eligibility and enrollment policies, which will improve upon the administrative efficiency of these processes, e.g., by periodically checking electronic data sources between regular eligibility renewals; however, the federal requirements governing these fundamental components of states’ eligibility and enrollment systems will apply to coverage under an HAO.

Benefit Design and Drug Coverage
States have the opportunity to design a benefit package that aligns with private coverage. At a minimum, proposed benefit design under an HAO should include Essential Health Benefits (EHB), defined using the requirements that apply under the law to the individual health insurance market, or benefits that meet larger health reform and Medicaid objectives. The EHB approach promotes coverage of important services such as mental health and substance use services and a minimum level of prevention services that are otherwise optional in traditional Medicaid.

States will have the opportunity to design Federally Qualified Health Center (FQHC) coverage and payment in order to facilitate the use of value-based payment design among safety-net providers.

In order to provide states with greater negotiating power to lower drug spending and promote value in the program, states will have the opportunity to design formularies under an HAO consistent with those provided in Exchange coverage in the commercial health insurance markets. That is, coverage would be at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the benefit package the state is using to define Essential Health Benefits (EHBs).

In addition, states will be expected to apply certain beneficiary protections for people with HIV and behavioral health conditions. These include: coverage of (1) substantially all drugs for mental health (that is, antipsychotics and antidepressants) consistent with Medicare Part D coverage; (2) substantially all antiretroviral drugs (including PrEP) consistent with Medicare Part D coverage, and (3) all forms, formulations, and delivery mechanisms for drugs approved by the Food and Drug Administration (FDA) to treat Opioid Use Disorders (OUDs) for which there are rebate agreements in place with the manufacturers.
**Managed Care and Delivery Systems**

CMS encourages states applying for this demonstration to implement evidence-based payment and delivery system reforms in order to achieve compliance with the quality and cost goals. In general, states will be able to use any combination of fee-for-service and managed care delivery systems and will have flexibility to alter these arrangements over the course of the demonstration, as long as certain guidelines are met. As part of the application, states will need to explain the payment or delivery system reforms they plan to use under the HAO.

States will be given the option in the application for an HAO demonstration to elect one of two options to measure and monitor access and availability of Medicaid services in a managed care delivery system. States generally will be expected to meet specified managed care statutory requirements that provide beneficiary protections, facilitate beneficiary decision making, support access to services, monitor program administration, and measure the quality of the delivery system. For example, states will be expected to certify that their managed care plans have the capacity to meet the state’s standards for access to care and availability of services. However, states will have flexibility under this demonstration to propose alternative approaches to ensure network adequacy, access to care, and availability of services to those required in current federal regulations. The state would need to develop and propose alternative standards subject to CMS approval and provide reasonable evidence of enrollee access to care and satisfaction. Regardless of the approach elected, all states participating in the HAO will be required to submit routine data reports described in the Monitoring and Evaluation section of the guidance.

You can access the full announcement [here](#).

**Skilled Nursing Facilities and Senior Living Providers Oppose MFAR Rule**

The *Skilled Nursing News* reported that the skilled nursing industry’s opposition to a plan that could slash supplemental Medicaid programs for nursing homes began to ramp up over the last week, and as the fight moves into its next phase, SNF operators are finding allies in the senior living world.

The comment period on the Medicaid Fiscal Accountability Rule (MFAR) came to a close this past Saturday, leaving operators and advocates to play the waiting game until the Centers for Medicare & Medicaid Services (CMS) announces a move to finalize, amend, or scrap the rule entirely.

The rule would most directly affect skilled nursing providers that have come to rely on supplemental Medicaid payments — gained through such mechanisms as intergovernmental transfers (IGTs) and provider taxes — to supplement per-day rates for long-term care residents. In Indiana alone, for example, nursing facilities pull down more than $1 billion in supplemental payments, representing about 37% of total Medicaid payments for institutional long-term care services in the state.

All told, the MFAR rule could potentially slash $50 billion in available Medicaid funding for nursing facilities, prompting industry leaders to ask the federal government to abandon the effort.

“The bleak reality is that Medicaid funding is already inadequate,” American Health Care Association CEO Mark Parkinson said in a joint statement with American Hospital Association CEO Rick Pollack. “Enacting this proposed rule would cut up to $50 billion nationally from the Medicaid program annually, further crippling Medicaid financing in many states and jeopardizing access to care for the 75 million Americans who rely on the program as their primary source of health coverage.”

But the rule could also have a knock-on effect on the wider senior living continuum, with LeadingAge — a trade group that represents non-profit senior living and care providers — warning that MFAR’s focus on provider taxes could end up harming continuing care retirement communities (CCRCs).

“Most CCRCs would not be able to absorb new taxes without cutting services, passing the new costs along to their residents or closing their nursing homes entirely,” the organization wrote in a statement calling on CMS to withdraw the rule. “In other words, older adults in CCRCs would likely bear the brunt of the proposed MFAR if finalized.”
Provider assessments, or provider taxes, benefit skilled nursing operators because the revenue can be used for the non-federal portion of Medicaid funding. But because CCRCs and other senior living facilities generally do not rely on Medicaid-reimbursed services — instead receiving most of their revenue from private-pay residents — many states with provider taxes have instituted waivers that exempt these properties from having to pay into a program from which they do not benefit.

MFAR would prevent states from picking and choosing which senior housing and care facilities can be subject to a provider tax, a restriction that would present lawmakers with two options: scrap the tax entirely and remove the funding source for nursing homes, or pass a new tax that includes CCRCs.

“The proposed MFAR poses a serious threat to CCRCs in states with SNF provider tax waivers that exempt these communities from the tax or assess them at a discounted rate,” LeadingAge concluded.

In fact, many of the comments on the rule — which totaled 2,841 as of 5 p.m. ET on Friday — came directly from residents at CCRCs across the country.

You can access the full article here.

Focus F-Tag – F603 Free from Involuntary Seclusion
This Regulatory Beat’s Focus F-Tag is F603 Free from Involuntary Seclusion. The regulation at F603, part of the Freedom from Abuse, Neglect and Exploitation regulatory group, states that Residents have the right to be free from involuntary seclusion, which is when a resident is separated from other residents, from his or her room, or confined to his or her room or in another area against the resident or resident representative’s will. Involuntary seclusion can occur related to secured/locked units if a resident is placed on this unit without meeting the clinical criteria for such placement. There are many circumstances that can constitute involuntary seclusion.

Transmission-Based Precautions and Involuntary Seclusion
In some cases, isolating a resident cannot be prevented, and if transmission-based precautions are warranted and used appropriately, this will not be considered involuntary seclusion. Per the IG, the resident’s medical record must include the rationale for the selected precautions, and facilities must have in place policies that:

- Identify the type and duration of required transmission-based precautions
- Ensure the precautions put in place are the least restrictive for the resident based on the clinical situation

It is important to ensure thorough communication when residents have been isolated in these situations. A facility was cited for not knowing that a resident’s antibiotic therapy had ended two months prior to a surveyor inquiry after the resident was interviewed and said she was only out of her room for treatments and appointments and could not attend activities she liked. Staff were not aware as to why the resident had been isolated for so long. Precautions must be the least restrictive, and the plan of care should include interventions to ensure the resident can still participate in room-based activities that are of interest to him/her.

Secured/Locked Units and Involuntary Seclusion
The IG at F603 provides criteria for ensuring that a resident in a secured or locked unit is not considered to be involuntarily secluded. These include:

- Identifying the clinical criteria for placing the resident in a secured or locked area. Many facilities have been cited during survey for having residents reside on secured units or dementia units who do not have appropriate clinical indications that this type of restrictive environment is needed. For instance, a facility was cited for having a cognitively intact resident reside on a secured unit. The resident told surveyors that he often has to go to appointments outside the facility and needs to wait for staff to let him come in and out of the unit. The resident’s clinical record did not include any documentation that the resident needed to reside on a secured unit.
• **Using a resident’s diagnosis as the sole basis for determining placement.** Determination for placement in a secured area must be made on an individualized basis to ensure the safety of the resident. Residents, particularly those living with dementia, should be allowed to reside in the least restrictive environment possible, while ensuring they remain safe.

• **Ensuring that placement is not based on request from a resident representative/family member when there is no clinical justification.** In one citation reviewed at F603, a resident was found to be the only resident living in a secured unit. Interviews and record review found that the resident did not meet the clinical criteria for placement and that she was only on the unit due to the family’s preference.

• **Ensuring that placement is not for staff convenience or disciplinary purposes.** A facility was cited for placing multiple residents living with dementia on a secured unit when they did not meet the clinical criteria for placement in a secured unit. This was put in place due to staffing issues since the facility had issues with turnover for positions that required 1:1 supervision. There was also a lack of appropriate programming in place for the residents on other units, so they were taken to the secured unit.

Do not forget that if a resident experiences an escalation in behavior and requires immediate interventions to ensure the safety of the resident and/or others, that the staff must consult with the resident’s physician regarding the behavioral symptoms. The resident’s representative should also be contacted. Any necessary supervision required to protect the resident or others should be put into place, but isolating the resident in a manner such as placing the resident in an area secluded from staff or other residents as punishment or to avoid having to deal with the resident is considered involuntary seclusion. Residents who exhibit behavioral symptoms should have strong, individualized care plans in place with nonpharmacological interventions that staff can attempt for de-escalation purposes. In many of the citations reviewed for F603, staff did not appear to have a good understanding of the residents’ needs or how to assist them with feeling better. Remember, your staff should be provided with the necessary information and tools, including training and education, to help them prevent abuse, neglect and mistreatment in the workplace while ensuring residents do not have negative outcomes.

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**Trending Statistics**

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

**Turnover and Hiring Concerns in Senior Care Drive: Increased Focus on Employee Perks and Programs**

In fall 2019, OnShift conducted a survey to better understand the critical workforce issues in senior care. Nearly 1,500 industry professionals shared their perspectives on top workforce challenges facing the industry today, including the impact, outlook and potential solutions. Across all demographics, respondents report employee turnover as the top workforce challenge (72 percent) impacting their organization today. The challenge was most greatly felt by HR professionals, with 84 percent citing this issue as their biggest struggle.

**Outlook & Impact**

When asked to rate the outlook of these workforce challenges over the next three years, the vast majority of respondents believe issues of retaining employees (63 percent), finding qualified employees (73 percent) and managing labor costs (69 percent) will remain the same or worsen. The devastating organizational impact of these challenges is far-reaching. When asked how employee turnover impacts their organization, respondents note an increase in employee burnout (70 percent) and labor costs (47 percent) due to an increased reliance on overtime (62 percent). However, the negative impact of employee turnover not only affects an organization’s employees and bottom line, but their residents as well. Respondents cite that employee turnover correlates to a decrease in continuity of care (68 percent) and resident satisfaction (44 percent).
Competition for Talent Is Expanding
These challenges are further magnified by growing competitive threats for talent both in and outside the industry. While the majority of those surveyed indicated other senior care organizations as their biggest threat for talent (91 percent), they also recognize that home health agencies (58 percent) and hospitals and health systems (69 percent) are largely competing for the same pool of talent. However other, healthcare providers are not the only concern. Nearly 66 percent of all respondents indicated they also regularly compete for talent outside the healthcare industry, i.e. hotels, restaurants, retail and growing “gig economy” services such as Uber, Lyft and Instacart. Competition for talent outside the industry was more predominately felt by senior living organizations (70 percent) than skilled nursing providers (42 percent).

Employee Struggles Widely Recognized
Employee work-life balance is the top issue facing the senior care workforce today. Respondents reported that the most critical challenge their staff face is working multiple jobs (69 percent), lacking reliable childcare (59 percent) and having additional family responsibilities (50 percent). A lack of financial savings (59 percent) was also cited as a top personal challenge facing employees. When asked how these personal struggles impact work performance, respondents reported more frequent call-offs and absenteeism (80 percent), lower motivation and satisfaction (59 percent) and an inability to work when needed (59 percent). Additionally, 41 percent of HR respondents cited that these personal struggles often lead to strained employee-manager relationships.

Perks & Benefits Are A Main Focus
Recognizing the issues facing employees, respondents indicated their organization offers or plans to offer additional perks and benefits to help ease their employees’ stresses. The top perk senior care organizations are focused on implementing is an employee rewards and recognition program (62 percent) to help ensure their employees feel recognized and rewarded for their contributions at work. To help accommodate their employees' additional work and family responsibilities, respondents offer or plan to offer more flexible scheduling (50 percent) for better employee work-life balance. Additionally, respondents said their organization offers or plans to offer employee tuition assistance (50 percent) to help advance careers. In addition, organizations indicated they offer or plan to offer meal and/or consumer discounts (37 percent) and access to earned wages between paychecks (34 percent) to further ease the financial burden many of their employees’ face.

Technology as A Retention Tool
Respondents recognize that technology is vital to better meeting the needs of today’s workforce. And while 58 percent of those surveyed feel that, overall, they have the right technologies in place to meet the needs of today’s workforce, 42 percent indicated they are not fully confident in every area of their technology stack. Knowing the high value today’s workforce places on work-life balance, 61 percent of those surveyed indicated they have an above average employee scheduling software in place. However, respondents are less confident in the software they are using to meet staffing compliance requirements (40 percent) and to train and develop employees (48 percent). When it comes to engaging employees through technology, respondents are also feeling confident. 36 percent of all respondents indicated their technology for employee engagement and retention was above average. Solutions to enhance employee communication and feedback (38 percent), as well as employee satisfaction surveys were also reported as above average (38 percent).

Key Takeaways
The workforce crisis facing senior care providers is expected to get worse and can critically impact an organization’s viability. To remain competitive, senior care executives should pay close attention to the needs of their employees and look to redefine the employee experience by implementing programs and technologies designed to reduce turnover and create a pipeline of qualified candidates. Doing so will create an engaged workforce that dramatically reduces turnover rates, decreases costs and improves the quality and continuity of care.

You can access the full study here.
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 Expands Coverage of NGS as Diagnostic Tool for Patients with Breast and Ovarian Cancer.** On January 27, CMS took action to cover Food and Drug Administration approved or cleared laboratory diagnostic tests using Next Generation Sequencing (NGS) for patients with germline (inherited) ovarian or breast cancer.

  NGS tests provide the most comprehensive genetic analysis of a patient’s cancer because they enable simultaneous detection of multiple types of genetic alterations. Medicare first began covering laboratory diagnostic tests using NGS in March 2018 for Medicare patients with advanced cancer that met specific criteria. As a result of today’s decision, more Medicare patients will have access to NGS in managing other types of inherited cancers to reduce mortality and improve health outcomes.

  Using genetic tests gives patients a more complete profile of their cancer cells and may help identify proven, targeted treatments. Patients who use NGS tests may also find they are good candidates for cancer clinical trials.

  We want to ensure that patients have ready access to this diagnostic test when appropriate. Therefore, we provided Medicare’s Administrative Contractors with discretion over whether to cover certain other indications. Read the **Decision Memo**.

  See the full text of this excerpted **CMS Press Release** (issued January 27).

- **Nursing Home Quality Initiative: Draft MDS 3.0 Item Set Change History.** A new draft version of the **MDS 3.0 Item Set Change History (PDF)** for October 2020 (v1.18.0) is available. Visit the **MDS 3.0 Technical Information** webpage for more information.

- **Nursing Homes: Use Updated Infection Control Worksheet.** The November 2019 **State Survey Agency Directors Memorandum (PDF)** includes infection control information and basic practices to improve resident safety and quality in nursing homes. Read the memo and log in to the **Quality, Safety & Education Portal**, which replaced the Integrated Surveyor Training website, to find these resources:

  - Updated Nursing Home Infection Control Worksheet: Self-assessment tool includes requirements and best practices to improve infection control programs, including new questions about facility water management to reduce the risks to residents of Legionella infections
  - Technical resources, especially when new organisms appear or there is an outbreak in your area
  - Antibiotic Stewardship Program for Nursing Home Providers: Training and resources on requirements to improve appropriate antibiotic usage

  Note: CMS encourages use of alcohol-based handrub, instead of soap and water, in all clinical situations except when hands are visibly soiled (e.g., blood, body fluids) or after caring for a resident with known or suspected C. difficile or norovirus infection during an outbreak; in these circumstances, use soap and water.

- **Glaucoma Awareness Month: Make a Resolution for Healthy Vision.** Encourage people with a higher risk for glaucoma to make healthy vision a priority this New Year. Recommend an annual screening if appropriate; Medicare provides glaucoma screening coverage for beneficiaries in at least one high risk group:

  - Individuals with diabetes mellitus
  - Individuals with a family history of glaucoma
  - African-Americans aged 50 and older
  - Hispanic-Americans aged 65 and older
For More Information:

- Medicare Preventive Services Educational Tool
- Medicare Vision Services (PDF) Fact Sheet
- Initial Preventive Physical Examination (PDF) Booklet
- Annual Wellness Visit (PDF) Booklet
- National Eye Institute website
- Visit the Preventive Services website to learn more about Medicare-covered services.

- **Hospice Care: Safeguards for Medicare Patients.** In a two-part report series, the Office of Inspector General (OIG) focused on hospice:
  
  - Quality of care and common deficiencies
  - Instances of beneficiary harm and vulnerabilities

CMS released the Safeguards for Medicare Patients in Hospice Care (PDF) Fact Sheet to help you recognize and address deficiencies in care and protect your patients from harm. Additional resources:

  - Hospice Deficiencies Pose Risks to Medicare Beneficiaries OIG Report
  - Safeguards Must Be Strengthened To Protect Medicare Hospice Patients From Harm OIG Report
  - Medicare Claims Processing Manual, Chapter 11 (PDF), Section 30.1
  - Eldercare Locator website
  - Contact Information For Filing a Complaint with the State Survey Agency (PDF)

- **OPPS Pricer File: January 2020.** CMS posted the first quarter 2020 Pricer text file and outpatient provider data on the Outpatient Prospective Payment System (OPPS) Pricer webpage.

- **Ground Ambulance Organizations: Reporting Staff and Labor Costs Open Door Forum — February 6.**

  Thursday, February 6 from 2 to 3:30 pm ET

  During this Ambulance Open Door Forum, learn how to report required staff and labor costs in the new Ground Ambulance Data Collection system. The webinar will review Section 7 of the data collection instrument (PDF) and walk through illustrative examples with time at the end for questions and answers.

  Participation Instructions:

  - Conference call only; you do not need to RSVP
  - Dial: 888-455-1397 and reference conference passcode 9375124
  - For TTY services dial 7-1-1 or 800-855-2880; a relay communications assistant will help
  - Visit the Ambulance Open Door Forum webpage for more information

  Target Audience: All ground ambulance organizations that use volunteer labor and ambulance stakeholders are welcome to attend; however, we strongly encourage the participation of all ground ambulance organizations selected to report the first year.

- **Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20.** Thursday, February 20 from 2 to 3 pm ET. Register for Medicare Learning Network events.

  During this call, learn how to report volunteer labor in the new Ground Ambulance Data Collection system.

  A question and answer session follows the presentation; however, you may email questions in advance to AmbulanceDataCollection@cms.hhs.gov with “February 20 Call” in the subject line. These questions may be
addressed during the call or used for other materials following the call. For more information, including ground ambulance organizations selected for the first round of reporting, see the Ambulances Services Center webpage, CY 2020 Physician Fee Schedule final rule, and Bipartisan Budget Act of 2018.

Target Audience: Ground ambulance organizations that use volunteer labor and ambulance stakeholders.

- **CMS Quality Conference — February 25-27.** Tuesday, February 25 through Thursday, February 27. [Register](#) for this conference.

Each year CMS brings together over 3,000 leaders across the health care spectrum, to explore how patients, advocates, providers, researchers, and champions in health care quality improvement can develop and spread solutions to address America’s most pervasive health system challenges.

- **Medicare Learning Network Celebrates 20 Years.** The Medicare Learning Network® (MLN) is celebrating 20 years of producing free, high quality educational resources for health care providers and professionals.

Visit the [MLN Homepage](#) to learn about CMS programs, policies, and initiatives. Find educational materials in a variety of formats, including:

  - MLN Matters Articles
  - Calls & Webcasts
  - Web-Based Training
  - Publications
  - Multimedia
  - Social Media

- **CMS Updates Open Payments Data.** CMS updated the [Open Payments Data Set](#) to reflect changes to the data that took place since the last publication in June 2019. The refresh includes:

  - Record updates: Changes to non-disputed records that were made on or before November 15 are published.
  - Disputed records: Dispute resolutions completed on or before December 31 are displayed with the updated information. Records with active disputes that remained unresolved as of December 31 are displayed as disputed.
  - Record deletions: Records deleted before December 31 were removed from the Open Payments database. Records deleted after December 31 remained in the database, but will be removed during the next data publication in June 2020.

CMS updates the Data Set at least once annually to include updates from disputes and other data corrections made since the initial publication of the data.

For More Information:

  - Open Payments website
  - Resources webpage
  - Submit questions to openpayments@cms.hhs.gov or call 855-326-8366 (TTY: 844-649-2766)

- **Open Payments Search Tool: New Features.** The updated Open Payments [search tool](#) has the following features:

  Entity Profile:
The profile pages for companies, physicians, and teaching hospitals are redesigned to present the payment data in a dashboard format.

Apply filters to update the data sections: Sort the data by year, payment type, entity making or receiving payment, and nature of payment.

Advanced Search:

- Open Payments website
- Resources webpage
- Submit questions to openpayments@cms.hhs.gov or call 855-326-8366 (TTY: 844-649-2766)

- **Shoulder Arthroscopy: Comparative Billing Report in January.** In late January, CMS will issue a Comparative Billing Report (CBR) on Shoulder Arthroscopy, focusing on providers who submit Medicare Part B claims. These reports contain data-driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.

  CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com to access your report. Update your contact email address in the Provider Enrollment, Chain, and Ownership System to ensure accurate delivery. Visit the CBR website for more information.

- **Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier.** Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk eligible Medicare beneficiaries:
  - Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
  - Up to 2 years of sessions delivered to groups of eligible beneficiaries

  Find out how to become a Medicare enrolled MDPP supplier:

  - Obtain CDC preliminary or full recognition - Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition: See the Supplier Fact Sheet and CDC website
  - Prepare for Medicare enrollment: See the Enrollment Fact Sheet and Checklist
  - Apply (PDF) to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll): See the Enrollment Webinar Recording and Enrollment Tutorial Video
  - Furnish MDPP service: See the Session Journey Map
  - Submit claims to Medicare: See the Billing and Claims Webinar Recording, Billing and Claims Fact Sheet, and Billing and Payment Quick Reference Guide

  For More Information:

  - MDPP Expanded Model (PDF) Booklet
  - Materials from Medicare Learning Network call on June 20, 2018
  - MDPP webpage
  - CDC - CMS Roles Fact Sheet
  - Contact mdpp@cms.hhs.gov

- **Continue Seasonal Influenza Vaccination through January and Beyond.** Vaccinate as long as influenza activity continues, even in January or later. People 65 years and older are at high risk of developing serious complications from seasonal influenza. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older – to help protect your patients, your staff, and yourself.
Medicare Part B covers:

- Influenza virus vaccine once per influenza season
- Additional influenza vaccines if medically necessary

For More Information:

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

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

  CMS developed the Medicare DMEPOS Improper Inpatient Payments Fact Sheet (PDF) to help you bill correctly.

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

- **Medicare Diabetes Prevention Program: Valid Claims.** For a claim to be valid under the Medicare Diabetes Prevention Program (MDPP), you must have both:
  
  - Centers for Disease Control and Prevention (CDC) preliminary or full recognition; see the Supplier Fact Sheet and CDC website for more information
  - Separate Medicare enrollment as an MDPP supplier (Specialty D1); see the Enrollment Fact Sheet and Checklist

  Important: If you do not have a separate Medicare enrollment as an MDPP supplier and you submit a claim for MDPP services, your claim will be rejected.

  Medicare enrolled MDPP suppliers: See the Quick Reference Guide to Payment and Billing and the Billing and Claims Fact Sheet for information on valid claims:
  
  - MDPP Medicare beneficiary eligibility data is returned via the HIPAA Eligibility Transaction System (HETS) on the 271 response; use this data to determine if a beneficiary meets the criteria to receive MDPP services
  - Submit claims when a performance goal is met, and report codes only once per eligible beneficiary (except G9890 and G9891)
List each HCPCS code with the corresponding session date of service and the coach’s National Provider Identifier.

List all HCPCS codes associated with a performance payment (including non-payable codes) on the same claim.

Include Demo code 82 in block 19 (Loop 2300 segment REF01 (P4) and segment REF02 (82)) to identify MDPP services.

Do not include codes for other, non-MDPP services on the same claim.

For More Information:

- MDPP Expanded Model (PDF) Booklet
- MDPP webpage
- For trouble with MDPP billing and claims, contact your Medicare Administrative Contractor

- **Highly Pathogenic Infectious Disease Training and Exercise Resources Webinar — March 5.** Thursday, March 5, from 1:30 to 3 pm ET. Register for this webinar.

Join the Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) and the National Ebola Training and Education Center to learn about new online courses and exercise templates. See the announcement for more information.

- **Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised.** A revised MLN Matters Article MM11598 on Calendar Year (CY) 2020 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment (PDF) is available. Learn about the delay until January 2021.


- **January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS).** A new MLN Matters Article MM11605 on January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) (PDF) is available. Learn about changes and billing instructions.

- **Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020.** A new MLN Matters Article MM11628 on Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.1, Effective April 1, 2020 (PDF) is available. Learn about availability of the final file on or about February 14.


- **Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens.** A new MLN Matters Article MM11641 on Clinical Laboratory Fee Schedule – Medicare Travel Allowance Fees for Collection of Specimens (PDF) is available. Learn about payment of travel allowances for HCPCS codes P9603 and P9604.

- **Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder.** A new MLN Matters Article MM11623 on Update to the International Classification of
Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder (PDF) is available. Learn about the addition of a new code effective April 1.

- **Safeguards for Medicare Patients in Hospice Care.** A new Safeguards for Medicare Patients in Hospice Care Fact Sheet is available. Learn about:
  - Your responsibilities to protect patients from abuse and neglect
  - Survey and certification
  - Reporting abuse

- **Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B — Revised.** A revised Medicare Part B Immunization Billing: Seasonal Influenza Virus, Pneumococcal, and Hepatitis B Medicare Learning Network Educational Tool is available. Learn about:
  - Administration and codes
  - Billing
  - FAQs

- **Skilled Nursing Facility Prospective Payment System — Revised.** A revised Skilled Nursing Facility Prospective Payment System Medicare Learning Network Booklet is available. Learn about:
  - Payment rates
  - Quality Reporting Program
  - Value-Based Purchasing Program

- **Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation — Revised.** A revised MLN Matters Article MM11081 on Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation (PDF) is available. Learn about the corrected request for anticipated payment percentage.

- **Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System — Revised.** A revised MLN Matters Article MM11003 on Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System (PDF) is available. Learn about the February 3 effective date.

- **Quality Payment Program: 2020 Resources.** CMS posted new Quality Payment Program (QPP) resources to help you understand how to participate in the 2020 performance period:

  Merit-based Incentive Payment System (MIPS) Quick Start Guides:
  - Overview
  - Eligibility and Participation
  - Part B Claims Reporting
  - Quality Performance Category
  - Promoting Interoperability Performance Category
  - Improvement Activities Performance Category
  - Cost Performance Category

  Other resources:
  - MIPS Data Validation Criteria
  - Quality Benchmarks
  - Shared Savings Program and QPP Interactions Guide
  - Scores for MIPS Alternative Payment Models (APMs) Improvement Activities
  - Comprehensive List of APMs
  - Qualified Registries Qualified Posting
  - Qualified Clinical Data Registries Qualified Posting
For More Information:
  o Resource Library webpage
  o 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)

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 19 – January 25), influenza activity in the United has remained high, and, after falling during the first two weeks of the year, increased over the last two weeks. Indicators that track severity (hospitalizations and deaths) 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 Integrated Health Homes Town Hall Meetings. You may view the new notice here.
   
   • The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Retroactive Enrollment Date to be Discontinued. 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 Monday, 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.

   • The Department will be hosting a Public Hearing on Monday, February 24, 2020 from 1:00 p.m. to 3:00 p.m. The hearing will be held in Springfield, IL regarding to informed consent and enforcement of staffing ratio (44 Ill. Reg. 435).

       You can find the notice 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/NCAL Social Media Update.**

8) **Provider Daily Magazine** reports:

- **New Medicaid Block Grant Policy Under AHCA Review.** *Provider Magazine* (1/31, Connole, 151K) reported "a block grant initiative unveiled by the Centers for Medicare & Medicaid Services (CMS) would allow states to seek a waiver to cap Medicaid funding for low-income adults brought into the program under the Affordable Care Act." Although "long term and post-acute care (LT/PAC) providers will not be directly impacted by the plan, the profession is alert to the possibilities that any changes to Medicaid could filter throughout the program." In response to the new initiative, called the Healthy Adult Opportunity (HAO), "Mike Cheek, senior vice president of reimbursement policy at the American Health Care Association and National Center for Assisted Living (AHCA/NCAL), said AHCA is reviewing the CMS block grant letter." Cheek said, "While the new initiative does not directly impact long term care services, this is an important issue because most people who reside in nursing centers rely on Medicaid, as well as tens of thousands of seniors in America’s assisted living communities, because any changes to Medicaid financing is critical. Medicaid is the primary funding source for all long term care services." He added, "We will continue to work with our members, CMS, and other stakeholders to ensure that we can provide the quality care on which our nation’s most vulnerable residents rely via stable and predictable Medicaid funding."

- **Differences Between PDGM, PDPM Highlighted.** *Skilled Nursing News* (2/2, Flynn) reports on the differences between the PDGM and PDPM. Only "three months after the nursing home world saw a new Medicare payment model take effect, the home health industry dealt with its own sea change: the Patient-Driven Groupings Model." They article says "the Patient-Driven Payment Model for SNFs made the resident condition the primary driver of Medicare reimbursement; under the old Resource Utilization Group, Version 4 (RUG-IV), SNFs were paid based on the level of therapy provided to patients." Meanwhile, "PDGM is a comprehensive overhaul of case-mix groupings, and like PDPM, it takes aim at therapy – particularly to remove incentives to over-provide such services."

- **Health Care Providers Question Use of CPR In Certain Elderly Patients.** *The New York Times* (1/31, Span, 18.61M) reported on CPR and attempts to revive elderly patients who are "already near death." Whether to start CPR for certain patients is "a question arising with greater frequency as more people live to advanced ages, when the odds of surviving an out-of-hospital cardiac arrest after CPR are grim, and the chances of avoiding significant neurological disability are worse." For example, a study published in the Journal of the American Geriatrics Society asked clinicians about "their most recent patients over 80 who had undergone CPR," and discovered although "only 2 percent of these patients survived long enough to leave the hospital," over "half the health care professionals thought CPR was appropriate in those cases."

- **SNF Providers May Choose to Create, Join IPA To Gain Negotiating Power.** *Skilled Nursing News* (2/2, Yamshon) reports "creating or joining an independent practice association (IPA) empowers providers to negotiate managed care plan services and rates, a potential game-changer for nursing home owners amidst Medicare Advantage headaches – pains that include shorter lengths of stay, or the elimination of skilled nursing stays altogether in favor of home care." Providers may choose to "opt into an IPA network if they’re willing put in the time and effort – and adhere to agreed-upon clinical and administrative parameters that the legal model requires." However, "with so many evolving payment models and a fairly stringent approval process, it remains to be seen whether more operators in the sector will explore this very state-specific trend, or if the industry will
remain cautious about entering into a complex system while already burdened by so many other regulatory changes."

- **Researchers Developing System To Use Machine, Deep Learning Techniques To Detect Risk Of Dementia, Alzheimer's.** The AP (2/1, Casey) reported "an effort to use voice-assistant devices like Amazon’s Alexa to detect signs of memory problems in people has gotten a boost with a grant from the federal government." Researchers from the University of Massachusetts Boston and Dartmouth-Hitchcock "will get a four-year $1.2 million grant from the National Institute on Aging." The research "team hopes to develop a system that would use machine and deep learning techniques to detect changes in speech patterns to determine if someone is a risk of developing dementia or Alzheimer’s."

- **NIC Report Examines Rent Growth Between 2015 Q3 and 2019 Q3.** Senior Housing News (1/30, Regan) reported on a new report from the National Investment Center for Seniors Housing & Care (NIC) that "examined same-store annual asking rent growth for 31 primary markets between the third quarter of 2015 and the third quarter of 2019." According to the report, "in the 31 primary markets that NIC tracks, average annual asking rent growth was 2.3% in the third quarter of 2019, and 2.5% in 4Q19." The markets that showed the "highest average assisted living rent growth rates and highest average occupancy rates for the past four years were San Jose, Portland, Sacramento, New York City, Los Angeles, San Francisco, Baltimore, Seattle and San Diego."

- **Researchers Suggest Improving State Websites’ Information About Assisted Living Communities May Help Residents, Families Find Communities That Best Meet Needs.** McKnight’s Senior Living (1/31, Bowers) reported "improving the information available about assisted living communities on state websites could help steer prospective residents and their families to communities that best meet their needs and minimize move-outs, say the authors of a study recently published by The Gerontologist." In the study, "almost all of the state websites provided basic information about assisted living communities, such as number of units, addresses and telephone numbers, and about 75% of the states listed ownership information and license numbers." The study also found "more than two-thirds of state websites provided access to routine survey results and statements of deficiencies for communities, but less than half of them posted plans of correction, and only three states displayed whether a community had been fined, the authors said."

- **Threat to Funding, Access to Care.** Provider Magazine (1/30, Connole, 151K) reports "health care provider groups and the National Governors Association (NGA) said on Thursday that a funding proposal by the Centers for Medicare & Medicaid Services (CMS) would have severe negative consequences for the nearly 75 million Americans who rely on the program." Mark Parkinson, president and chief executive officer (CEO) at the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), and Rick Pollack, president and CEO at the American Hospital Association (AHA), issued a statement that "said the proposed Medicaid Fiscal Accountability Regulation (MFAR) [CMS–2393-P] threatens funding and access to care." Parkinson and Pollack "said entire communities could lose access to care under the CMS proposal, notably in rural areas where 15 percent of hospital revenue and nearly two-thirds of nursing facility revenue nationwide depend on Medicaid funding." Moreover, in comments on the rule to CMS AHCA "said the proposed changes do not look at total provider payments when figuring the impact of the plan, and lastly, the proposed implementation time frames are likely to result in serious challenges at the state level." The Nashville (TN) Medical News (1/30) reports the statement from Parkinson and Pollack said, in part, "Enacting this proposed rule would cut up to $50 billion nationally from the Medicaid program annually, further crippling Medicaid financing in many states and jeopardizing access to care for the 75 million Americans who rely on the program as their primary source of health coverage." The statement added, "CMS has provided little to no analysis to justify these policy changes, nor has the agency assessed the impact on providers and the patients they serve. Many of the proposed changes would also violate federal laws, including the current Medicaid statute. The AHA and AHCA request that the agency withdraw the proposed rule in its entirety."

- **Contributor Writes About Personal Experience with PDPM’s Impact on Therapy.** Next Avenue Contributor John Gilman writes in Forbes (1/29, 9.71M) about the Patient-Driven Payment Model, and his personal experience with how "dramatic" the changes may be for those who need therapy. He provides advice for those who are dealing with therapy impacted by PDPM, and concludes, "The vast majority of therapists have their patients’
best interests at heart and will do the right thing if allowed. Just understand that there are new pressures on
them with P.D.P.M. and it may take a bit of work on your part to make sure you or your loved one receives
appropriate therapy."

- **Trump Administration Announces Medicaid Block Grant Policy Impacting Medicaid Expansion Beneficiaries.**
The [New York Times](https://www.nytimes.com) (1/30, Goodnough, 18.61M) reports the Trump Administration announced on Thursday its Medicaid block grant program, "Healthy Adult Opportunity." Under the policy, states would be allowed "to cap Medicaid spending for many poor adults, a major shift long sought by conservatives that gives states the option of reducing health benefits for millions who gained coverage through the program under the Affordable Care Act." The [Wall Street Journal](https://www.wsj.com) (1/30, Armour, Subscription Publication, 7.57M) reports that under the new policy, states would be able to convert their current Medicaid funding from the federal government into block grants. The policy enables states to impose prescription drug limits and eligibility requirements. [The Hill](https://thehill.com) (1/30, Weixel, 2.98M) reports legal backlash is likely as "Democrats have been arguing the administration doesn’t have the authority to approve such drastic changes."

- **Expert: New Technologies, Drugs for Alzheimer’s Care, Treatment Being Developed In 2020.** Health law
attorney Neville M. Bilimoria writes in [McKnight’s Long Term Care News](https://mcknights.com) (1/30) about the potential breakthroughs in Alzheimer’s treatment and care that may happen in 2020. For example, more "apps or touch screen applications can help Alzheimer’s patients by providing reminders, music, videos and connections to caregivers and doctors," while other technologies "include life-like robotic companion pets, robots used to help patients remember to complete a task, GPS tracking tools to help wanderers, and even virtual reality systems that can transport Alzheimer’s patients to other parts of the world or decades to ease agitation and confusion." In addition to new technology, Bilimoria writes "2020 may also see new drug therapies for Alzheimer’s disease," like the new Chinese drug, Oligomannate, which starts clinical trials this year.

- **AD Patients Prescribed Antipsychotic Medications Showed Increased Risk Of Head Injuries, TBI, Study Reports**
[Neurology Today](https://neurologytoday.com) (1/30, Talan) reports "Alzheimer’s disease (AD) patients who were prescribed antipsychotic medications had an increased risk of head injuries and traumatic brain injury (TBI), according to a large retrospective Finnish study published in the January 7 online edition of the Journal of the American Geriatrics Society." In the "findings, the researchers reported that those taking antipsychotics had a 29 percent higher risk of head injuries: 1.65 per 100 people over a one-year period compared with 1.26 per hundred in non-users." The researchers "also compared the risk in patients taking several different antipsychotic medications and found that those prescribed quetiapine had a 60 percent higher risk of TBI compared with those who took risperidone."

- **Many Seniors in Independent Living Facilities Have Moderate to Severe Levels of Loneliness, Study Finds**
The [Concord (NH) Monitor](https://monitor.boston.com) (1/30, Wilkens, 50K) reports that a small study by researchers at University of California, San Diego’s medical school "assessed residents of an independent living facility in San Diego County and found 85% have moderate to severe levels of loneliness, a complex condition that mounting evidence links to higher risks for heart disease, dementia, elevated blood pressure, depression and premature death." The findings were published online in Aging and Mental Health.

- **Health Care Workers May Not Be Using Hand Sanitizer In The Proper Manner, Study Indicates.** [Reuters](https://www.reuters.com) (1/30, Rapaport) reports, "Health care workers may not be using the right amount of hand sanitizer or letting it dry on their hands long enough to achieve maximum protection against the spread of germs," investigators concluded after performing laboratory "tests to see how long different amounts of gel and foam versions of alcohol-based hand sanitizer took to dry on nine volunteers' hands." Researchers found that "in the test of 0.75-milliliter, 1.5ml, 2.25ml and 3ml dollops, smaller amounts of sanitizer sometimes dried within the 20-30 second time frame recommended by the World Health Organization for optimal effectiveness, but none of the products dried that fast when the largest amounts were used." The findings were published online in the American Journal of Infection Control.
• CMS Encourages States to Move to Block-Grant Funding for Medicaid While Bracing for Inevitable Court Battle. Kaiser Health News (1/31) reports, CMS Administrator Seema Verma and the Trump administration rolled out the new plan on Thursday that would allow states to cap Medicaid spending for adults who were enrolled in the program under the health law expansion. The idea has been a long-held goal for Republicans, but critics say the change would jeopardize medical access and care for some of the poorest Americans.

• Kaiser Health News: 5 Things to Know About Trump’s Medicaid Block Grant Plan. Kaiser Health News (1/31, Pradhan and Galewitz) reports, The Trump administration unveiled a plan Thursday that would dramatically revamp Medicaid by allowing states to opt out of part of the current federal funding program and instead seek a fixed payment each year in exchange for gaining unprecedented flexibility over the program. Medicaid, a federal-state health program that covers 1 in 5 Americans, has been an open-ended entitlement since its beginning in 1965. That means the amount of money provided by the federal government grows with a rise in enrollment and health costs.

10) Skilled Nursing News reports:
• CMS Medicaid Crackdown Could Slash Funding By $50B Per Year, But SNFs Escape Direct Hit on Block Grants. Skilled Nursing News (1/30, Spanko) reports, A federal push to reform programs that nursing home operators use to boost Medicaid rates could lead to a $50 billion cut in total annual funding — but a separate Medicaid crackdown appears to have spared the long-term care industry for now.

• Blueprint’s $8.5M Ohio Sale; JLL Closes on Chicago Nursing Home & Shelter. Skilled Nursing News (1/30, Yamshon) reports, Blueprint helps a longtime operator exit the business in the Buckeye State, Cambridge pulls off a HUD refinance in California, and more.

• Lawsuit: CMS Using Unvetted Claims in Star Rating Formula, Hurting Nursing Home Finances. Skilled Nursing News (1/29, Flynn) reports, A lawsuit filed last week accuses CMS of using unreviewed deficiencies in its star rating system for nursing homes — a practice that providers claim puts them at risk for a variety of financial hardships.

11) Interesting Fact: On this day in 1971, Apollo 14 commander Alan B. Shepard Jr. became the fifth human to walk on the moon with astronaut Edgar D. Mitchell.