Contract Year 2021 and 2022 Medicare Advantage and Part D Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) proposed a rule on Tuesday regarding Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. The proposed rule is another step in lowering drug costs for seniors, increasing competition, and further advancing the agency’s efforts to strengthen and modernize the popular MA and Part D programs.

The proposed rule implements several changes stemming from federal laws related to the Part C and D programs—including the Bipartisan Budget Act of 2018 (BBA of 2018), the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act), and the 21st Century Cures Act (the Cures Act). The proposed rule also addresses the opioid epidemic across CMS programs and continues CMS’s Patients Over Paperwork initiative to reduce “red tape” that depletes resources from our healthcare system. If finalized, the proposed changes would result in an estimated $4.4 billion savings to the federal government over ten years, largely arising from proposed refinements to the MA and Part D Quality Star Rating system. CMS expect some savings will also be passed onto beneficiaries in the form of increased benefit offerings and reduced premiums or cost sharing.

As part of the Patients Over Paperwork initiative to reduce unnecessary burden to increase efficiencies and the beneficiary experience, CMS is seeking comment from the public on proposals to codify many longstanding policies on the MA and Part D programs that have been previously adopted through sub-regulatory guidance such as the annual Call Letter and other guidance documents. CMS will not publish a Call Letter for 2021. They believe that codifying the policies in regulation provides additional transparency and program stability, and allows MA organizations and Part D plan sponsors to develop more innovative plan designs. In addition, CMS will issue HPMS memoranda to communicate instructions, such as those around bidding, in advance of the bid deadline. Through this regulation, the final Rate Announcement, the bid pricing tool materials and bidding instruction memoranda, plans will have all of the information needed to prepare Part C and D bids for 2021.

Medicare Advantage (MA) and Part D Prescription Drug Program Quality Rating System

The Part C and D Star Ratings support CMS efforts to improve the level of accountability for the care provided by health and drug plans, physicians, hospitals, and other Medicare providers. In addition to routine measure updates and technical clarifications to the Star Ratings, CMS proposes to further increase the predictability and stability in the Star Ratings by directly reducing the influence of outliers on cut points. They also propose to further increase measure
weights for patient experience/complaints and access measures from 2 to 4, reflecting CMS’s commitment to put patients first and to empower patients to work with their doctors to make healthcare decisions that are best for them.

**Permitting a Second, “Preferred”, Specialty Tier in Part D**
Part D sponsors and pharmacy benefit managers have requested a second specialty tier option, suggesting this would encourage the use of more preferred, less expensive agents, reduce enrollee cost sharing, and reduce costs to CMS. In response, with a proposed effective date of January 1, 2021, we propose to: allow Part D sponsors to establish a second, “preferred” specialty tier with lower cost sharing than the current specialty tier; codify the methodology that determines and increases the specialty tier cost threshold; require sponsors to permit tiering exceptions between the two specialty tiers; and permit sponsors to determine which drugs go on either tier subject to the proposed cost threshold. This proposal supports the agency’s commitment to lowering drug prices for the Medicare population.

**Beneficiary Real Time Benefit Tool (RTBT)**
CMS proposes that each Part D plan implement a beneficiary RTBT that will allow enrollees to view plan-provided, patient-specific, real-time formulary and benefit information by January 1, 2022. Plans would be able to use existing secure patient portals, develop a new portal, or use a computer application to fulfill this requirement. Plans would be required to also make this information available to enrollees who call the plan’s customer service call center. In order to encourage enrollees to use the beneficiary RTBT, they also propose to allow plans to offer rewards and incentives to their enrollees who log onto the beneficiary RTBT or seek to access this information via the plan’s customer service call center.

**Establishing Pharmacy Performance Measure Reporting Requirements**
Under the Part D program, plans currently do not have to disclose to CMS the measures they use to evaluate pharmacy performance in their network agreements. The measures used by plans potentially impact pharmacy reimbursements. Therefore, CMS proposes to require Part D plans to disclose such information to enable CMS to track how plans are measuring and applying pharmacy performance measures. CMS will also be able to report this information publicly to increase transparency on the process and to inform industry in their recent efforts to develop a standard set of pharmacy performance measures. CMS is also seeking comment on the Part D pharmacy performance measures more broadly, including recommendations for potential Part D Star Ratings metrics to incentivize the uptake of a standard set of measures.

**Medical Loss Ratio (MLR)**
CMS proposes to amend the MA MLR regulations to allow MA organizations to include in the MLR numerator as “incurred claims” all amounts paid for covered services, including amounts paid to individuals or entities that do not meet the definition of “provider” as defined at §422.2, in alignment with changes to MA supplemental benefits in recent years. In addition, CMS proposes to add a deductible-based adjustment to the MLR calculation for MA medical savings account (MSA) contracts receiving a credibility adjustment. The proposed adjustment would remove a potential deterrent to the offering of MSAs by MA organizations that may be concerned about their inability to meet the MLR requirement as a result of random variations in claims experience, the risk of which is greater under health insurance policies with higher deductibles. This proposal aligns with President Trump’s Executive Order on Protecting and Improving Medicare for Our Nation’s Seniors for the Department of Health and Human Services to propose regulatory changes that reduce barriers to obtaining MSAs.

**Implementing Several Opioid Provisions of the SUPPORT Act**
Continuing the fight against the opioid epidemic, the proposed rule implements several provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that require Part D plans to educate beneficiaries on opioid risks, alternate pain treatments, and safe disposal of opioids. The proposed rule also expands drug management programs and medication therapy management programs, through which Part D plans review with providers opioid utilization trends that may put beneficiaries at-risk and provide beneficiary-centric interventions. These provisions will help prevent and treat opioid overuse.
Codifying Existing Part C and D Program Policy
CMS proposes to strengthen network adequacy rules for MA plans by codifying our existing network adequacy methodology, but we are also proposing new policies to improve access in rural areas and encourage the use of telehealth in all areas. In rural areas, we are proposing to reduce the required percentage of beneficiaries that must reside within the maximum time and distance standards from 90% to 85% and inviting comment regarding additional changes to improve MA access in rural areas. To encourage and account for telehealth providers in contracted networks, we are proposing that MA plans receive a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for Dermatology, Psychiatry, Cardiology, Otolaryngology, and Neurology. We are soliciting comment regarding whether to expand this credit to other specialty provider types.

Special Election Periods (SEPs) for Exceptional Conditions
CMS is proposing to codify a number of SEPs that we have adopted and implemented through sub-regulatory guidance as exceptional circumstances SEPs. Among the proposed SEPs are the SEP for Individuals Affected by a FEMA-Declared Weather-Related Emergency or Major Disaster, the SEP for Employer/Union Group Health Plan elections, and the SEP for Individuals Who Disenroll in Connection with a CMS Sanction. Two SEPs that do not currently exist in guidance are also being proposed: the SEP for Individuals Enrolled in a Plan that has been identified by CMS as a Consistent Poor Performer and the SEP for Individuals Enrolled in a Plan Placed in Receivership. Codifying their current policy for these SEPs will provide transparency and stability for stakeholders about the MA and Part D programs and about the nature and scope of these SEPs by ensuring that the SEPs are changed only through additional rulemaking.

Implementing Certain BBA of 2018 Provisions
CMS is proposing a minor policy modification to SSBCI. Previously, CMS limited the chronic conditions an enrollee must have to be eligible under SSBCI to those conditions outlined in the Medicare Managed Care Manual (Chapter 16b). However, the agency recognizes that there may be other chronic conditions that may meet the statutory definition of a chronic condition, but are not included in Chapter 16b. Therefore, beginning in contract year 2021, CMS is proposing that plans be allowed to target other chronic conditions.

“Look-Alike” Dual Eligible Special Needs Plans
CMS proposes to limit MA plans that are Dual Eligible Special Needs Plan (D-SNP) “look-alikes.” These “look-alike” plans, which have similar levels of dual eligible enrollment as D-SNPs but are not subject to the federal regulatory and state contracting requirements applicable to D-SNPs, circumvent federal regulatory and state contracting requirements that otherwise apply to D-SNP products. The Medicare Prescription Drug, Improvement, and Modernization Act created D-SNPs to allow for Medicare Advantage (MA) products that exclusively serve individuals dually eligible for Medicare and Medicaid. D-SNPs must meet a number of additional requirements, relative to non-SNP MA plans, related to health risk assessments, models of care, and Medicaid integration. Most recently, the Bipartisan Budget Act (BBA) of 2018 required CMS to establish additional requirements related to Medicaid integration for D-SNPs. The “look-alike” D-SNPs impede the ability of states and CMS to meaningfully implement existing and new statutory requirements for D-SNPs that Congress created in the BBA by allowing plans that fail to meet the requirement to create look-alikes instead.

Under the proposed rule, CMS proposes to not enter into or renew a contract for an MA plan that is a non-SNP plan that either:
- Projects in its bid that 80 percent or more of the plan’s total enrollment are enrollees entitled to medical assistance under a state plan under Title XIX, or
- Has actual enrollment, as determined by CMS using the January enrollment of the current year, consisting of 80 percent or more of enrollees who are entitled to medical assistance under a state plan under Title XIX, unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals at the time of such determination.
Under the proposed rule, MA plans exceeding this threshold would be able to transition their membership into a D-SNP or another zero-premium plan offered by the MA organization.

**Proposed Changes to the Programs of All-Inclusive Care for the Elderly (PACE)**

CMS proposes to reduce the administrative burden for PACE organizations by proposing to allow service delivery requests be approved in full by an interdisciplinary team (IDT) member at the time the request is made. This proposal eliminates the requirement that the IDT conduct a reassessment of the participant for service delivery requests that can be approved. They are also proposing to enhance participant protections by improving the participant appeals process, adding additional participant rights, increasing requirements related to the provision of services, and ensuring PACE organizations appropriately document care in the medical record while maintaining original communications from caregivers and others. CMS is also proposing to bolster CMS’s ability to access records, improve the regulatory framework relating to required services in PACE, and set out appeal processes for PACE organizations following certain enforcement actions.

You can access the proposed rule [here](#).

**OIG Audit: The Majority of Providers Reviewed Used Medicare Part D Eligibility Verification Transactions for Potentially Inappropriate Purposes**

The Centers for Medicare and Medicaid Services (CMS) requested that OIG audit a mail-order pharmacy's Medicare Part D Eligibility Verification Transactions (E1 transactions). To address CMS's request, we conducted this audit of E1 transactions, which included the requested provider's transactions. During our audit, we discovered that providers were taking advantage of gaps in CMS's program integrity in E1 transactions. Because E1 transactions contain beneficiary protected health information (PHI), we wanted to verify that the providers were appropriately using E1 transactions for their intended purposes.

**How OIG Did This Audit**

The OIG judgmentally selected 30 providers that submitted 3.9 million E1 transactions. We selected these 30 providers because they submitted a large volume of E1 transactions relative to the number of prescriptions processed. They matched E1 transactions to prescriptions within 90 days of an E1 transaction. The result was 2.6 million E1 transactions not matched to a prescription. OIG reviewed supporting documentation to determine whether providers used E1 transactions for appropriate purposes.

**What OIG Found**

The majority of providers (25 of 30) used E1 transactions for some purpose other than to bill for a prescription or determine drug coverage billing order. On average, 98 percent of these 25 providers’ E1 transactions were not associated with a prescription. We did not contact 10 providers because they were closed, under investigation, or both. Fifteen providers submitted or hired other entities to submit E1 transactions for inappropriate purposes, which involved using a beneficiary's PHI. After the audit period, CMS took additional steps to monitor use of the eligibility verification system and take appropriate enforcement action when abuse is identified. The deficiencies we identified occurred because CMS had not yet (1) fully implemented controls to monitor providers submitting a high number of E1 transactions relative to prescriptions processed until after our audit period, (2) published clear guidance that E1 transactions are not to be used for marketing purposes, and (3) limited non-pharmacy access.

**What OIG Recommends**

We recommend that CMS (1) continue to monitor providers submitting a high number of E1 transactions relative to prescriptions processed, (2) issue guidance that clearly states that E1 transactions should not be used for marketing purposes, (3) ensure that only pharmacies and other authorized entities submit E1 transactions, and (4) take appropriate enforcement action when abuse is identified. CMS concurred with our recommendations and described actions that it had taken or planned to take to address our recommendations.
Focus F-Tag – F842 Resident Records – Identifiable Information

This Regulatory Beat’s Focus F-Tag is F842 Resident Records – Identifiable Information. The regulation F842 is part of the Administration regulatory group. There are multiple requirements under this regulation, of which the following are included:

- **Requirements for the release of resident-identifiable information** – Facilities are prohibited from releasing information to the public that is resident-identifiable. Information of this type may only be released when a contract is in place where the agent agrees that the information will not be used or disclosed in a manner that is greater than the facility itself is permitted to disclose/use.

- **Protection and retention of medical records** – The facility is responsible for protecting the residents’ medical records from loss, destruction or unauthorized use. The records must be retained for the period required by applicable state law. If there is no state law, then the information must be retained for five years from the date of discharge (or for three years after a minor reaches the state’s legal age if the resident was a minor). Facilities have been cited for records being unavailable to surveyors upon request for this information.

**Medical Records**

Much of this regulation addresses requirements for the Medical Record. Providers are required to maintain medical records for each resident, in accordance with accepted professional standards/practices, that are complete, accurate, systematically organized and readily accessible. Medical records must contain sufficient information to identify the resident, include a record of the resident’s assessments and the comprehensive plan of care and services provided. It should also include progress notes from physicians, nurses and other licensed professionals to reflect how the plan of care is being implemented and should include lab, radiology and other diagnostic service reports in addition to results of pre-admission screening/evaluations required by the state. If surveyors request this information and cannot find the associated documentation, the facility is likely to be cited under F842 for failure to have a complete and accurate medical record.

The Interpretive Guidance (IG) at F842 states that staff are required to document residents’ medical and non-medical status when there is a change in condition, whether positive or negative, in addition to documenting periodic reassessments and annual comprehensive assessments. The goal is to ensure there is sufficient information about each resident’s condition, plan of care and services being provided so that the Interdisciplinary team has sufficient information for decision-making and to facilitate communication between disciplines.

Due to the sensitive nature of this information, facilities are required to keep all information in the medical record confidential except under a few allowable circumstances as permitted by regulation:

- Release to the resident (or resident representative where permitted by law)
- For the purposes of public health activities or health oversight activities
- For the purpose of reporting abuse, neglect or domestic violence
- For release required by law, for law enforcement purposes and judicial or administrative proceedings
- For the purposes of averting a serious threat to health or safety
- For payment purposes
- For treatment or health care operations
- For organ donation or research purposes
- Release to medical examiners, coroners and/or funeral directors

**Electronic Health Records**

The Interpretive Guidance also discusses the use of Electronic Health Records (EHR) in facilities. Facilities using electronic documentation formats are required to be compliant with HIPAA rules, as well as ensuring the data is backed up and kept secure. With the growing number of ransomware attacks on the rise that have impacted healthcare entities, these are valid concerns that should be considered when selecting a vendor if a facility is transitioning to an EHR. When a facility is in survey, it is required to give access to the EHR to the survey team before the end of the first day of survey.

The Long-Term Care Survey Process information includes a form for ensuring surveyors have access, know how to access
information, and have a staff member available to assist them if needed. Prolonged delays in providing access to the survey team can result in a survey deficiency. It is also important to note that surveyors are instructed to observe if computer screens are left unattended and open, allowing unauthorized access to patient health information, which can result in a deficiency.

The amount of information that may need to be captured for an individual resident can be cumbersome, particularly if there are a lot of consults or diagnostic tests being done. The information that is included in the medical records needs to be sufficient for staff to have access to the necessary and relevant information to implement the plan of care and recognize the resident’s status, but this need should be balanced with periodic thinning of the medical record (the infamous paper chart) to archive older documentation while still ensuring availability of these documents for review. Staff also need to know where to look for information, so having a sound system in place to ensure consistency in where and how notes and documents are kept is essential to maintaining a useful, well-organized record.

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**Trending Statistics**

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

**A Whole New World: 15% Growth in Post-Acute Care Among 30-year Nursing Home Industry Changes**

*Mcknight’s Long Term Care News* reports the population of residents served by nursing homes has undergone dramatic changes in the past 30 years – including a 15% increase in post-hospital admissions.

That’s a takeaway from a recent study that highlights trends since the 1987 passage of the Omnibus Reconciliation Act, which called for an overhaul to the nursing home quality assurance system.

The industry has lost 400 facilities since that time, with more operators becoming Medicare and Medicaid certified, linking up with chain operators and embracing not-for-profit care models, the researchers say. Facilities have meanwhile transformed their care to support growing populations, including:

- Residents who are racial or ethnic minorities
- Residents admitted for rehabilitative/post-acute care
- Residents with complex conditions who require assistance with activities of daily living
- Residents primarily supported by Medicare (the number of those primarily supported by Medicaid has decreased)
- Residents diagnosed with dementia and psychiatric conditions such as schizophrenia

Quality improvements have accompanied these shifts, the authors added. This includes a dramatic drop in the number of residents who are physically restrained (from 19% to 1%), and a decrease in inappropriate antipsychotic use (from 16% in 2000 to 12% in 2015). However, there’s been little change in the proportion of facilities cited for medication errors.

Operators are performing admirably in a complex clinical landscape, concluded Shekinah A. Fashaw, MSPH, and colleagues from Brown University. “[I]t is important to note that despite an increasingly vulnerable and higher-need population, we still observe quality gains among nursing homes during this time period,” the authors said.

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

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**Important Regulations, Notices & News Items of Interest**
1) The following Federal **CMS Quality, Safety and Oversight Letter** (formerly known as Survey and Certification (S&C) Letters) released since the last issue of *Regulatory Beat*.

- **QSO 20-11-NH** - *Release of Additional Toolkits to Ensure Safety and Quality in Nursing Homes*. CMS announced the release of two toolkits that align with the CMS strategic initiative to Ensure Safety and Quality in Nursing Homes. Developing a Restful Environment Action Manual (DREAM) Toolkit – CMS has created a toolkit that offers education and person-centered, practical interventions that nursing home administrators, directors of nursing, and bedside staff can implement to promote high-quality sleep for residents living with dementia. Head-to-Toe Infection Prevention (H2T) Toolkit – CMS has created a toolkit that offers educational materials and practical interventions for bedside staff designed to prevent common infections by improving activities of daily living (ADL) care.

- **QSO 20-10-CLIA** - *Notification to Surveyors of the Authorization for Emergency Use of the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Assay and Guidance for Authorized Laboratories*. The Centers for Medicare & Medicaid Services (CMS) is providing guidance to surveyors in regards to the authorization for emergency use of the Centers for Disease Control (CDC)’s 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel assay and the deployment into CDC qualified, and, certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to perform high complexity tests). Assays that have been issued an Emergency Use Authorization (EUA) by the United States Food and Drug Administration (FDA) remain subject CLIA regulations. The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel assay and the corresponding protocols have been developed by the CDC for use by CDC qualified laboratories and the assay has been issued an EUA from the FDA. Upon receipt of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel assay and corresponding Manufacturer’s Instructions (MI), CDC qualified laboratories will verify assay performance specifications in their laboratory per the manufacturer’s instructions. CMS is also providing guidance for surveyors to notify their CMS Location if they discover a laboratory using an assay without an EUA that is testing for the same agent for which the emergency has been declared, or a modified EUA assay. The CMS Location will notify CMS Baltimore.

- **QSO 20-09-ALL** - *Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness.* Information Regarding Patients with Possible Coronavirus Illness: the U.S. Centers for Disease Control and Prevention (CDC) has issued information on the respiratory illness caused by the 2019 Novel Coronavirus (2019-nCoV). Links to these documents are provided. Healthcare Facility Expectations: CMS strongly urges the review of CDC’s guidance and encourages facilities to review their own infection prevention and control policies and practices to prevent the spread of infection.

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

- **DMEPOS Items Subject to Prior Authorization**. CMS will begin requiring prior authorization as a condition of payment for several types of lower limb prosthetics (LLPs). Prior authorization of these LLPs will occur in two phases:
  - Phase I begins May 11 in California, Michigan, Pennsylvania, and Texas
  - Phase II begins October 8 for all remaining states and territories

The following HCPCS codes were added to the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) *Required Prior Authorization List (PDF)*: L5856, L5857, L5858, L5973, L5980, and L5987.

For More Information:
- [DMEPOS Prior Authorization webpage](#)
- [Federal Register Notice](#)

- **Influenza Activity Continues: Are Your Patients Protected?** People over 65 are at a greater 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. As long as influenza viruses are circulating, it is not too late to get vaccinated – 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

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

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

Use the following resources to bill correctly and avoid overpayment recoveries:
- National Correct Coding Initiative Policy Manual
- Contact your Medicare Administrative Contractor
- Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination with Urine Drug Tests OIG Report

- **Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20.** Thursday, February 20 from 2 to 3pm 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.

- **Dementia Care: CMS Toolkits Call — March 3.** National Partnership to Improve Dementia Care and Quality Assurance Performance Improvement. Tuesday, March 3 from 1:30 to 3 pm ET. Register for Medicare Learning Network events.

During this call, learn about new CMS toolkits for nursing homes:
Head-to-Toe Infection Prevention: Easy to access best practices for direct care staff to prevent infections before they occur

Developing a Restful Environment Action Manual: Non-pharmacological approach to improve the quality of life and quality of care for residents living with dementia

Staffing Toolkits: Staff Competency Assessment, Employee Satisfaction Survey, and Guide to Improving Employee Satisfaction

Additionally, CMS provides updates on the progress of the **National Partnership to Improve Dementia Care in Nursing Homes**. A question and answer session follows the presentations.

Speakers: Cathleen Lawrence, Michele Laughman, Sheila Hanns, and Dara Graham from CMS.

Target Audience: Consumer and advocacy groups; nursing home providers; surveyor community; prescribers; professional associations; and other interested stakeholders.

- **Hospice Item Set Data Submission Requirements Webinar — March 3.** Tuesday, March 3 from 2 to 3:30 pm ET. [Register](#) for this webinar.

  This webinar provides a general overview of the Hospice Item Set and associated submission requirements. See the [Hospice Quality Reporting Training: Announcements and Registration](#) webpage for details.

- **Part A Providers: QIC Appeals Demonstration Call — March 5.** Thursday, March 5 from 1 to 2 pm ET. [Register](#) for Medicare Learning Network events.

  During this call, learn about the May 2019 expansion of the Qualified Independent Contractor (QIC) Telephone Discussion and Reopening Process Demonstration. It now includes Part A providers that submit second level claim appeals (reconsiderations) to C2C Innovative Solutions Inc., the Part A East QIC. Topics:

  - Benefits
  - Who can participate
  - How to participate

  A question and answer session follows the presentation; however attendees may email questions in advance to MedicareFFSappeals@cms.hhs.gov with "Appeals Demonstration" in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, visit the [Original Medicare Appeals](#) webpage.

  Target Audience: Part A providers located in these areas may participate in the demonstration; however, any Part A provider may attend.

- **Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12.** Thursday, March 12 from 1 to 2 pm ET. [Register](#) for Medicare Learning Network events.

  During this call, ground ambulance organizations that also provide fire, police, and other public safety services learn how to collect information for reporting to 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 “March 12 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 also provide fire, police, or other public safety services.

- **Open Payments Registration.** Reporting entities are currently submitting Program Year 2019 data. In order to participate in upcoming Open Payments program activities, physicians and teaching hospitals must be registered in the [Open Payments system](https://openpaymentsdata.cms.gov):
  
  - If you registered last year, you do not need to register again
  - If it has been over 180 days since you logged in, your account is deactivated for security purposes.
  - Contact the Open Payments Help Desk.

  The review and dispute period is targeted to begin in April 2020.

  For More Information:
  - [Open Payments](https://openpaymentsdata.cms.gov) website
  - [Resources](https://www.cms.gov/OpenPayments/Resources) webpage
  - Contact the Help Desk at openpayments@cms.hhs.gov or 855-326-8366 (TTY: 844-649-2766)

- **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](https://qnn.hcpr.gov/)
  - 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](https://qnn.hcpr.gov/) webpage
  - [Registration and Attestation](https://qnn.hcpr.gov/) webpage
  - Contact the QualityNet help desk at 866-288-8912 or qnetsupport@hcqis.org

- **Quality Payment Program: Updated Explore Measures Tool.** CMS updated the [Explore Measures Tool](https://qualitypaymentprogram.cms.gov/ExploreMeasuresTool) for the 2020 performance period. The tool now includes 2020 Merit-based Incentive Payment System (MIPS) measures and activities for the four performance categories:
  
  - Quality
  - Cost
  - Improvement Activities
  - Promoting Interoperability

  Note: The tool is only for informational and estimation purposes. It cannot be used to submit or attest to measure and activities. 2020 MIPS resources, including January technical updates:

  - [Summary of Cost Measures](https://qnn.hcpr.gov/QualityMeasures/QualitySummary)
  - [Cost Measure Information Forms](https://qnn.hcpr.gov/QualityMeasures/QualityMeasureInformationForms)
  - [Cost Measure Code Lists](https://qnn.hcpr.gov/QualityMeasures/QualityMeasureCodes)
  - [Improvement Activities Inventory](https://qnn.hcpr.gov/QualityMeasures/ImprovementInventory)
  - [Promoting Interoperability Measure Specifications](https://qnn.hcpr.gov/QualityMeasures/InteroperabilitySpecifications)
• **Quality Payment Program: MIPS 2020 Call for Measures and Activities.** CMS encourages you to submit measures and activities for consideration for future years of the Merit-based Incentive Payment System (MIPS). Currently, we are accepting submissions for:
  - Promoting Interoperability performance category: Submission period closes July 1 for 2022 measures
  - Improvement Activities performance category: Submission period closes July 1 for 2022 activities

In March, we will provide information on submissions for the Quality performance category. For more information, see the Call for Measures and Activities Overview Fact Sheet in the toolkit.

• **Medicare Promoting Interoperability Program: Requirements for 2020.** In the FY 2020 Medicare Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-term Care Hospital Prospective Payment System final rule, CMS finalized changes to the Medicare Promoting Interoperability Program for eligible hospitals, critical access hospitals, and dual-eligible hospitals attesting to CMS. Visit the 2020 Program Requirements webpage to learn about the changes.

• **SNF Quality Reporting Program: FY 2022 APU Table.** CMS published the FY 2022 Skilled Nursing Facility (SNF) Annual Payment Update (APU) table (PDF). This table indicates the data elements we will use for Quality Reporting Program APU determinations. Visit the Measures and Technical Information webpage for more information.

• **Reassignment of Medicare Benefits: Revised CMS-855R Required May 1.** Physicians and non-physician practitioners: Use the revised CMS-855R (Reassignment of Benefits) application once it is posted on the CMS Forms List in early February 2020. Medicare Administrative Contractors will accept current and revised versions of the form through April 30, 2020. Starting May 1, 2020, you must use the revised form. Form updates:
  - Can select Change of Reassignment Information as submission reason
  - Option to identify a secondary practice address

Visit the Medicare Provider-Supplier Enrollment webpage for more information about Medicare enrollment.

• **February is American Heart Month.** Heart disease can often be prevented by identifying risk factors and making healthy lifestyle choices. Help your Medicare patients reduce their risk. Recommend appropriate preventive services, including cardiovascular disease screening tests and intensive behavioral therapy for cardiovascular disease.

For More Information:
Medicare Preventive Services Educational Tool

Million Hearts®: An HHS initiative to prevent a million heart attacks and strokes

Centers for Disease Control and Prevention Heart Disease website

American Heart Month webpage

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

- **Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements.** In a recent report, the Office of Inspector General (OIG) determined that payments for physical therapy services did not comply with Medicare billing requirements. CMS developed the [Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements (PDF)](#) Booklet to help you bill correctly, reduce common errors, and avoid overpayments.

Additional Resources:

- [Updated Editing of Always Therapy Services - MCS (PDF)](#) MLN Matters Article
- [Update to Editing of Therapy Services to Reflect Coding Changes (PDF)](#) MLN Matters Article
- [Outpatient Therapy Functional Reporting Requirements (PDF)](#) MLN Matters Article
- [Medicare Benefit Policy Manual, Chapter 12 (PDF)](#)
- [Medicare Benefit Policy Manual, Chapter 15 (PDF), Sections 220 and 230](#)
- [Medicare Claims Processing Manual, Chapter 5](#)
- [Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5 (PDF)](#)
- [Medicare Program Integrity Manual Chapter 3 (PDF)](#)
- [Medicare Program Integrity Manual Chapter 13 (PDF)](#)
- [Comprehensive Error Rate Testing Program](#) webpage
- [Functional Reporting](#) webpage
- [Local Coverage Determinations State Index Tool](#)
- [Social Security Act § 1128J (d)](#)
- [Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements](#) OIG Report

- **Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder.** A new MLN Matters Article MM11656 on [Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder (PDF)](#) is available. Learn about diagnosis code U07.0.

- **Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy.** A new MLN Matters Article MM11559 on [Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy (PDF)](#) is available. Learn about policy from chapters 3 and 4 of the Medicare Claims Processing Manual.

- **Update to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for Vaping Related Disorder — Revised.** A revised 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.

- **January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) — Revised.** A revised 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.

- **Provider Enrollment Appeals Procedure.** A new MLN Matters Article MM11210 on [Provider Enrollment Appeals Procedure (PDF)](#) is available. Learn about corrective action plans, reconsideration requests, and updates to model letters.
• **Quarterly Influenza Virus Vaccine Code Update - July 2020.** A new MLN Matters Article MM11603 on [Quarterly Influenza Virus Vaccine Code Update - July 2020](https://www.cms.gov/mm11603) is available. Learn about updates to new or existing codes.

• **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](https://www.cms.gov/mm11623) is available. Learn about the addition of a new code effective April 1.

• **2020 Annual Update to the Therapy Code List — Revised.** A revised MLN Matters Article MM11501 on [2020 Annual Update to the Therapy Code List](https://www.cms.gov/mm11501) is available. Learn how the two new biofeedback codes are paid.


• **Medicare Mental Health.** A new [Medicare Mental Health](https://www.cms.gov/mm11503) Booklet is available. Learn about:
  - Covered services
  - Eligible professionals
  - Coding and billing

• **Medicare Provider Enrollment.** A new [Medicare Provider Enrollment](https://www.cms.gov/mm11504) Educational Tool is available. Learn about:
  - Eligibility and process
  - Application fee for institutional providers
  - Revalidation
  - Provider Enrollment, Chain and Ownership System (PECOS)

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

• **Weekly U.S. Influenza Surveillance Report.** CDC's Influenza Division produces a weekly influenza surveillance report. According to this week's report (February 2–February 8), influenza activity in the United States has remained high, and, after falling during the first two weeks of the year, increased over the last four weeks. Indicators that track severity (hospitalizations and deaths) are not high at this point in the season.

• **February is Heart Health Month.** CDC’s Coronary Heart Disease, Myocardial Infarction and Stroke Data Brief. The brief provides public health professionals with the most recent, practical, and useful data available on coronary heart disease, blood pressure, and stroke for adults aged 45 years or older.

4) The [Illinois Department of Healthcare and Family Services (HFS)](https://www.hfs.illinois.gov) 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 [Client Eligibility for Temporary Medical Cards](https://www.hfs.illinois.gov/mm11603). You may view the new notice here.

• The Illinois Department of Healthcare and Family Services has posted a new Provider [ABE Partner Portal — Instructions for Creating Accounts and Uploading Documents](https://www.hfs.illinois.gov/mm11623). You may view the new notice here.

• The Illinois Department of Healthcare and Family Services has posted a new Provider Notice [Request for Primary Agency Security Administrator (ASA) Approval to Access the ABE Partner Portal](https://www.hfs.illinois.gov/mm11501). You may view the new notice here.
The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Nursing Facility Rate Changes Affecting Hospice Patient Room and Board Payment. You may view the new notice here.

The Illinois Department of Healthcare and Family Services has posted a new Provider Notice LTC Monthly Occupied Bed Provider Assessment. 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 Email Update. Update on 2020 Medicare physician fee schedule (PFS) policies.

- AHCA/NCAL Email Update. New AHCA Board Chair, Debbie Meade.

- AHCA/NCAL Email Update. Update on FY 2021 President’s Proposed Budget.
8) Provider Daily Magazine reports:

- **More, Brighter Lighting May Help Nurses Prevent Medication Errors, Thesis Suggests.** McKnight’s Long Term Care News (2/18, Lasek) reports, "More, and brighter lighting may help nurses prevent medication errors, according to a recent thesis from the Netherlands." The research found "nurses who had either nearsightedness or the normal visual changes of aging were less likely to misread small print on medication labels when lighting conditions were optimized for brightness." Although "the impact of lighting was minor for nurses with perfect vision," those "with the farsightedness that starts roughly at age 35 encountered problems under suboptimal lighting conditions," according to the study’s lead investigator.

- **Wisconsin Has Short Supply of Long-Term Caregivers, Recent Survey Shows.** Wisconsin Public Radio (2/18, Mills, 3K) reports, "Nursing homes are having a harder time finding workers than in the past, according to a new report on long-term care providers." Caregiver vacancies "increased with nearly 1 in 4 openings going unfilled, according to the new survey from Wisconsin’s long-term care providers." Long-term care facilities heavily rely on federal and state funding for their operations, with two-thirds of residents "on Medicaid, which does not fully reimburse for costs, [President and CEO of the Wisconsin Health Care Association and the Wisconsin Center for Assisted Living John] Vander Meer said."

- **More Than One-Third of Eldercare Facility Residents Aged 65 And Older Remain on Statins, Despite Having Life-Limiting Illnesses, Research Shows.** McKnight’s Long Term Care News (2/17) reported, "Despite having life-limiting illnesses, more than one-third of eldercare facility residents aged 65 and older remain on statins – with some on high-intensity doses, finds a new national study" published in the Journal of the American Geriatrics Society. In the study, "the researchers followed more than 420,000 Medicare fee-for-service beneficiaries with life-limiting illnesses," and "among residents expected to live less than six months, 23% ages 65 to 75 and 12% of people older than age 75 were on statins, the researchers found." Furthermore, "the more non-statin medications a resident was prescribed, the more likely they were to be on statins."

- **Early Improvements of Individual Symptoms May Impact Later Treatment Response in Patients with Alzheimer’s Receiving Antipsychotics for Neuropsychiatric Symptoms, Study Indicates.** Healio (2/18, Gramigna, 28K) reports, "Early improvements of individual symptoms might contribute to later treatment response among patients with Alzheimer’s disease receiving antipsychotics for neuropsychiatric symptoms," researchers concluded after analyzing "data from the Clinical Antipsychotic Trials of Intervention Effectiveness-Alzheimer’s Disease," which "included data from 421 patients with DSM-IV Alzheimer’s Disease receiving antipsychotics for neuropsychiatric symptoms." The findings of the "re-analysis study" were published online in the Journal of Clinical Psychiatry.

- **VA Program to Help Vets Pay for Long-Term Care Said to be Long, Complicated.** Texas Public Radio (2/18, Colombini) reports, "The VA Aid and Attendance benefit can help some vets and spouses pay for nursing homes, assisted living facilities, and home health care," although "the application process is often long and complicated." The program "is designed for war veterans and their surviving spouses who are unable to care for themselves." Although an application may "take many months to get approved...the VA typically expedites claims for applicants who are very old or terminally ill."

- **Expert Highlights Potential Considerations for Those Investing in Senior Living Communities.** In an article for McKnight’s Senior Living (2/18), Patrick McCormick, CPA, writes that dated buildings with sweeping staircases are just "one example of the pitfalls of investing in senior living communities that don’t show up on a spreadsheet." McCormick lists a variety considerations to be made when people think about investing in senior
living facilities, including "whether a building has the characteristics that will enable it to be transformed into a viable asset long-term." Additionally, McCormick says "investors also need to understand the type and mix of residents they have," along with paying close attention to staffing, and understanding "the funding model they're getting into."

- **Opinion: Getting Health Care in The Right Setting Is "Crucial" For Older Patients.** Dr. Cameron Gettel, a practicing emergency medicine physician at Yale University School of Medicine, writes for The Hill (2/18, Gettel, 2.98M) "obtaining health care in the appropriate setting is crucial" for seniors. Dr. Gettel explains, "If a patient is not going to benefit from hospitalization, then efforts should be made to get them the necessary attention" at the skilled nursing facility.

- **Bipartisan Coalition Sends CMS Letter Urging Repeal Of MFAR.** McKnight’s Senior Living (2/14, Bowers) reported, "A bipartisan coalition of 27 members of the House of Representatives is asking the Centers for Medicare and Medicaid Services to withdraw its proposed Medicaid Fiscal Accountability Regulation" in an effort that "aligns with sentiments of...the American Health Care Association / National Center for Assisted Living." The January 30th letter to CMS Administrator Seema Verma said, "Under the MFAR rule, states will have to repeal the exemptions from the nursing home provider bed tax that currently applies to continuing care retirement communities (CCRCs). ... CCRCs are likely to lose their exemption and be assessed additional state taxes, the costs of which could be passed on to CCRC residents, limiting access to and reducing the affordability of these communities." The letter also suggested CMS "include language in any final rulemaking that makes clear that state provider tax exemptions and discounts for CCRCs comply with the final rule" as an alternative to withdrawal.

- **New PDGM Changes May Discourage Home Health Agencies from Providing Therapy Services to Patients.** Forbes (2/14, 9.71M) reported on PDGM, and how it is "making it much harder for some patients living at home to receive occupational, physical, and speech therapy." Some "published reports suggest that many home health agencies, afraid that Medicare no longer covers most home-based therapy at all, are responding by stopping the services entirely for many patients." The PDGM "changes appear to be increasing incentives for Medicare home care agencies to focus on the post-acute care of patients discharged from hospitals but they are discouraging them from providing longer-term therapy for, say, people with degenerative disease."

- **Nursing Care Industry Has Greater Diversity, Acuity in Today’s Centers Than at Time OBRA ‘87 Passed, Study Demonstrates.** Provider Magazine (2/14, Connole, 151K) reported, "A new study in JAMDA takes a look at how skilled nursing facilities have changed over the past decades since passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87), with the most marked differences being the greater diversity and higher acuity in today’s centers as well as the new ways in which care for residents has evolved over time." The "researchers found that in the past 30 years, the nursing care industry has decreased in size from 19,068 facilities to 15,686, with an increase in the number of nonprofit (25 percent to 31 percent), dually certified (33 percent to 97 percent), and chain facilities (51 percent to 57 percent), as well as those with an Alzheimer’s special care unit (11 percent to 15 percent)." The study said, "The number of residents with Medicaid as a primary payer has decreased, while the percentage of those mostly supported by Medicare has risen."

- **Florida Legislation Would Reduce Inspections at Certain Nursing Homes.** The Naples (FL) Daily News (2/14, Mills, 185K) reports, "Two bills making their way through the Florida Legislature...would reduce inspections" at some nursing homes. Under the terms of the legislation, Florida’s Agency for Health Care Administration (AHCA) "would be required to do only one additional inspection at nursing homes after the agency cites them with a Class 1 or multiple Class 2 violations. The loosened mandate would apply to every nursing home in the state, from the highest rated to the lowest." In addition, "AHCA’s inspection fine would be cut in half from $6,000 to $3,000." Meanwhile, "other parts of the legislation would give AHCA leeway to extend inspection deadlines at highly rated assisted living facilities and exempt ‘low-risk providers’...with excellent regulatory histories from regular inspections."

- **Researchers Say Mediterranean Diet Can Alter Microbiome of Elderly People Improving Brain Function.** CNN (2/17, LaMotte, 83.16M) reports a study published in the journal Gut indicates that adhering to "the
Mediterranean diet for just one year altered the microbiome of elderly people in ways that improved brain function and would aid in longevity." The researchers also found that the Mediterranean diet "can inhibit production of inflammatory chemicals that can lead to loss of cognitive function, and prevent the development of chronic diseases such as diabetes, cancer and atherosclerosis." Newsweek (2/17, Gander, 1.53M) reports, "The study involved 612 people aged between 65 to 79 years old from five European countries – the U.K., France, the Netherlands, Italy, and Poland – who either were or were not frail, or were on the cusp of this condition." The article says, "Switching to the diet usually means people eat more fibers and vitamins, in vegetables and fruits; carbohydrates from wholegrains; plant proteins from legumes, and polyunsaturated fats from fish, which in moderation are thought to improve blood cholesterol levels, according to the AMA."

**Expert: Outbreak of Coronavirus Presents Long-Term Care Facilities Opportunity to Review Infection Control Procedures.** Provider Magazine (2/13, Conolle, 151K) reports "amidst a worldwide health alert over the deadly Chinese-born coronavirus outbreak, officials in the United States have taken steps in recent weeks to review and improve infection control measures at any number of government-run facilities, and seek compliance with Medicare rules and regulations on control procedures for those providers in the program." Post-acute and long-term care sources "said these precautionary steps taken by federal and state authorities mark a good time for skilled nursing and assisted living facilities to become proactive in order to reduce the chances for the spread of what is now known as the 2019-Novel Coronavirus (2019-nCoV)." Senior manager, clinical and regulatory services, for the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), Pamela Truscott "tells Provider that even though there is currently a low risk of exposure to the virus for the vast majority of Americans, the outbreak is an opportunity to prepare just in case," and she "says through the AHCA/NCAL Infection Prevention Control Officer (IPCO) training course, individuals will be specially trained to effectively implement and manage an infection prevention and control program in their nursing center or assisted living community."

**Proposed Federal Legislation Endorsed by AHCA Aims to Improve Transparency At Intermediate-Care Facilities.** The Arizona Republic (2/13, Innes, 869K) reports "a proposed federal law set to be introduced Thursday in" the House is aimed "to improve transparency by giving the public easily accessible information about quality problems and substantiated complaints at" care facilities. The bill’s measures include a provision allowing "intermediate-care facilities to run national background checks through the National Practitioner Data Bank – an online repository created by Congress designed to prevent health practitioners with records from harming patients by moving state-to-state to get jobs." The American Health Care Association has already endorsed the bill. It is expected that companion legislation will also be introduced in the Senate.

**CMS Administrator Verma Says Proposed Supplemental Payment Rule "Not Intended to Reduce Medicaid Payments".** McKnight’s Long Term Care News (2/12, Brown) reports "a Centers for Medicare & Medicaid Services’ proposed rule that targets supplemental payments is ‘not intended to reduce Medicaid payments’ for providers but rather increase transparency, Administrator Seema Verma argued in a blog post Wednesday." Currently, the agency is "reviewing more than 4,000 comments submitted on the proposed Medicaid Fiscal Accountability Regulation, which has faced heavy criticism from long-term care providers." The American Health Care Association has "called on CMS to withdraw the proposed rule."

**Opinion: Signing Days for Students Pursuing Careers in Long-Term Care Nursing Are "Beyond Clever".** John M. Berklan writes a Daily Editor’s Note in McKnight’s Long Term Care News (2/12), in which he refers to a photo and announcement he received from John Matson, communications director of the Alabama Nursing Home Association, featuring six Southern Union State Community College students on their "signing day," where they commit to pursue careers in long-term care nursing. Berklan commends the partnership between the Alabama Nursing Home Association and the Alabama Community College System, where "member nursing facilities can hire nursing students, dole out scholarships and provide other assistance, ultimately leading to full-time positions after graduation." According to Berklan, in comparison to "signing days" for high school athletes about to embark on their college athletic career, "the idea that we might celebrate and publicize who’s going to take care of Grandma and Grandpa when they're frail and in need of daily assistance is beyond clever."
• **Firms Who Represent Nursing Homes May Not Sue Illinois, Medicaid Managed Care Organizations for Outstanding Bills for Beneficiaries, Appeals Court Rules.** McKnight’s Long Term Care News (2/12) reports "firms representing nursing homes don’t have the authority to sue the state of Illinois and Medicaid managed care organizations for outstanding bills for beneficiaries, an appeals court has ruled." The firms had been "appointed by Medicaid beneficiaries who alleged that Aetna, Cigna, Humana and Molina Health care of Illinois Inc. haven’t ‘timely processed’ claims for services." Although "the firms had argued that Medicaid regulations allow beneficiaries to appoint representatives to handle various matters with the agency, which includes filing a lawsuit, according to the report," the court held "that the regulation only allows a representative to be designated only for the purposes of eligibility applications and determinations."

• **Wyoming Lawmakers Consider Bill Involving Nursing Home Hot Water, Staff Licensing Requirements.** The AP (2/12) reports "Wyoming lawmakers are considering a bill that would change licensing requirements for staff at nursing homes while also requiring those facilities to provide hot water to all residents." In addition, "the measure would reduce training requirements for staff at facilities for people with Alzheimer’s disease and other forms of dementia," and "facilities would no longer need to be staffed by advanced-practice nurses, which [bill co-sponsor Sen. Charlie Scott] says isn’t necessary." The bill "cleared introduction in the state Senate on a 20-9 vote," and "now heads to the Senate Labor, Health and Social Services Committee for consideration."

• **Frail Adults May Be at High Risk for Poor One-Year Outcomes Following Emergency Surgery, Research Demonstrates.** McKnight’s Long Term Care News (2/13, Lasek) reports "frail adults should be consulted about their care preferences after emergency surgery, as they are at high risk for poor one-year outcomes, according to surgeon-researchers." Researchers have "linked frailty to a higher risk for death, likelihood of long-term care admissions and poorer health in the year following abdominal surgery." The research findings were published in the Journal of the American Geriatrics Society.

• **Suggestions for Fire Prevention, Management at Senior Care Facilities Highlighted.** iAdvance Senior Care (2/13, Howley) reports "fire remains an ongoing risk in facilities where oxygen tanks may be in abundance and older adults may be less able to react quickly to a fire." The article lists simple tools all facilities "should have to help prevent and manage fires," which include fire alarms, extinguishers, and "kitchen systems." The article also provides a variety of other suggestions on fire preparedness planning in senior care facilities, such as having a written evacuation plan and staff training.

• **Shingles Vaccine May Reduce Risk of Stroke By 16 Percent, Study Indicates.** McKnight’s Long Term Care News (2/13, Lasek) reports a shingles vaccine may reduce "stroke risk by up to 16%, a new study finds." In adults who live to 85 years, "fully half" either "have had or will get shingles, and they are at a higher risk for stroke, according to the Centers for Disease Control and Prevention." In the recent study, researchers found "the vaccine’s protection was strongest for people ages 66 to 79 years," and in those "younger than 80, the vaccine reduced the risk of stroke by nearly 20%." 

• **Study Examines Benefits of Tai Chi for Older Adults.** McKnight’s Long Term Care News (2/13, Lasek) reports "tai chi practice helps to improve health and functioning in older adults, studies show." A recent "feasibility study aimed at improving chronic lower back pain" involved "participants 65 years of age and older who took 12 weeks of tai chi classes plus 24 weeks of maintenance classes." The research published in the Journal of Alternative and Complementary Medicine found "the program had an excellent safety record," and "at 52 weeks, 70% of tai chi practitioners reported having practiced the week before."

• **Nursing Home Quality Has Improved, Resident Population Has Become More Diverse Since OBRA ‘87 Was Passed, Study Shows.** McKnight’s Long Term Care News (2/12, Brown) reports "nursing homes are admitting more patients from hospitals 30 years after the passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA ‘87), according to new research" published the Journal of Post-Acute and Long-Term Care Medicine. And, "during that time...nursing home quality has improved and the resident population has become more diverse, the study revealed." Moreover, the study found "the number of residents receiving antipsychotics has dropped, while the use of physical restraint also dropped significantly." In a separate article, McKnight’s Long Term Care
News (2/12, Lasek) reports the study found "a 15% increase in post-hospital admissions." Facility "operators are performing admirably in a complex clinical landscape, concluded" study authors, adding, "It is important to note that despite an increasingly vulnerable and higher-need population, we still observe quality gains among nursing homes during this time period."

- **Expert: Fast-Growing Assisted Living Facilities in Massachusetts Have Had $5 Billion Economic Impact In Commonwealth.** An Associated Press article published in U.S. News & World Report (2/11, 2.4M) reports that there are 263 assisted living facilities listed "on the Commonwealth of Massachusetts website." To reside in a Massachusetts-based living facility costs $5,463 a month, according to SeniorLiving.org, which is "well above the national average of about $4,000, according to a recent report by the National Center for Assisted Living." According to Massachusetts Assisted Living Association President Brian Doherty, "Assisted living has been a fast-growing alternative for older adults in continuing of care and has grown to have a direct and indirect economic impact of about $5 billion in the commonwealth."

- **Opinion: President Trump Broke His Promise Not to Cut Medicaid.** Brendan Williams, president/CEO of the New Hampshire Health Care Association, writes in the Concord (NH) Monitor (2/12, 50K) that while he was running for office, President Trump promised not to cut Medicaid. Since he took "office, Trump has repeatedly tried to cut Medicaid, and not just the expansion that occurred under the Affordable Care Act." The President "has also gone after traditional Medicaid that serves over 62% of nursing home residents."

- **Op-Ed: Legislation to Increase Number of CNAs In State’s Nursing Centers Must Aim for Best Possible Access, Quality Outcomes for Residents and Caregivers.** In an Op-Ed in The Newark (NJ) Star-Ledger (2/11, 2.15M), president and CEO of the Health Care Association of New Jersey Jon Dolan writes about "legislation to increase the number of certified nursing assistants or CNAs in the state’s nursing centers" in New Jersey. Although much has been written on the topic, Dolan argues "there are several significant challenges and unintended consequences existing with some iterations of this legislation," and "the Health Care Association of New Jersey (HCANJ) has had the solemn responsibility to take the most realistic approach for the best interests of all parties." According to Dolan, "legislation or stakeholder groups failing to recognize the need to in some way address the workforce shortage and necessary funding, guarantee failure of our common goals and ensure that even the best centers will face insurmountable operational challenges." He concludes, "our goal must be the best possible access and quality outcomes for residents and their caregivers."

- **Higher Optimism Levels in Survivors of Stroke May Be Associated with Reduced Stroke Severity, Less Physical Disability, And Lower Inflammation Levels After Three Months, Study Demonstrates.** CNN (2/12, Lamotte, 83.16M) reports "higher levels of optimism in stroke survivors was associated with reduced stroke severity, less physical disability and lower levels of inflammation at the end of three months, according to preliminary research presented at the American Stroke Association’s 2020 International Stroke Conference on Wednesday." In "the small study of 49 stroke patients," researchers "found stroke severity and levels of interleukin-6 decreased as optimism levels climbed." Also, "C-reactive protein, a sign of inflammation in the body, also fell as optimism rose."

- **Risk of Premature Death in Older Adults May Be Lowered by Playing Golf At Least Once A Month, Study Suggests.** CNN (2/12, Rogers, 83.16M) reports new research has "found that playing golf at least once a month can lower older adults’ risk of premature death." In the study, "when comparing death rates among golfers and non-golfers, researchers found that golfers had a more than 8% lower death rate (from all causes) than non-golfers." Although "playing golf hasn’t been shown to reduce risk of heart attack and stroke, golf as a protective factor against early death risk is a suitable activity option for older adults due to its low impact and relaxed nature, the authors said." HealthDay (2/12, Mckiski, 17K) reports the study may be "the first of its kind to evaluate the long-term health benefits of golf," according to the study’s lead author. The findings will be presented in Los Angeles at the American Stroke Association’s International Stroke Conference.

- **President Trump Releases $4.8 Trillion Budget Plan with Proposed Cuts To Medicaid And Other Domestic Programs.** The New York Times (2/10, A1, Tankersley, Sanger-Katz, Rappeport, Cochrane, 18.61M) reports
"President Trump released a $4.8 trillion budget proposal on Monday that includes a familiar list of deep cuts to student loan assistance, affordable housing efforts, food stamps and Medicaid." McKnight’s Senior Living (2/11, Bowers) reports "the Department of Health and Human Services would see a 10% funding cut, and the Department of Housing and Urban Development would see a 15% funding cut, under the" proposed budget. Senior vice president of reimbursement policy at AHCA / NCAL Mike Cheek "said the organization was still reviewing the proposal, ‘but we’re concerned about any changes to Medicaid that would threaten funding and access to long-term care.’" About "16.5% of assisted living residents rely on Medicaid to pay for their daily services, according to NCAL." The president’s "proposed budget would cut $700 billion from Medicaid over the next decade, although not all of those cuts would be directly to programs for older adults."

- **Lawmakers Express Concern Over Proposal That Would Cut 8% From Medicare Payments for Physical, Occupational Therapy Services.** McKnight’s Long Term Care News (2/10, Brown) reports that last week, nearly 100 US lawmakers sent a letter to CMS Administrator Seema Verma, expressing "concerns regarding a proposal that would slice 8% from Medicare payments for physical and occupational therapy services." According to the story, "The letter asks CMS to explain the agency’s methodology and data used to calculate the estimated impact the coding change would have on each specialty. It also asks the agency what additional information it would consider before preparing the final 2021 fee schedule, and if it contemplated how the changes may impact beneficiary access to the specialty services."

- **Nursing Home Industry Adds Jobs In January, Report Shows.** Skilled Nursing News (2/10, Spanko) reports, "After several consecutive months of declines, the nursing home industry actually added jobs in January, the first month of employment growth since the implementation of a new Medicare payment system last October. The nation’s nursing care facilities brought on 2,400 workers in the first month of 2020, according to the regular monthly employment report from the federal Bureau of Labor Statistics."

- **Older Adults Taking Blood Thinners For A-fib Should Be Investigated for Bowel Cancer If Gastrointestinal Bleeding Is Reported, Danish Researchers Say.** McKnight’s Long Term Care News (2/10, Lasek) reports, "Older adults taking blood-thinning drugs for irregular heartbeat should always be investigated for bowel cancer if they report gastrointestinal bleeding," according to "Danish researchers who found a high risk of colorectal cancer among 125,000 study participants who fit this profile." The article adds, "Between 4% and 8% of all adult study participants who took blood thinners for A-fib were diagnosed with bowel cancer within a year after bleeding was detected," compared to "less than 1% of their peers who didn’t report any bleeding." The study was published in the European Heart Journal.

9) **Interesting Fact:** The term “jazz” was coined in Chicago in 1914 by Benny Goodman and Gene Krupa.