The Academy Weekly

News & Information for LTC Providers

The Academy of Senior Health Sciences, Inc.
www.seniorhealthsciences.org

Week of 26 May 2019

Ohio News

National News

Ohio News

ODM proposes new LOC determination notice

The Ohio Department of Medicaid has proposed a new form for LOC determinations. From ODM: "In an effort to streamline processes, ODM is proposing a new form, ODM 10240. [Click here to download a draft of the form.] Previously the Notice of PASSPORT Administrative Agency (PAA) Determination letter was issued by the HENS system any time a level of care determination was made for a nursing home stay. State hearing language was not included as the county DJFS would issue hearing rights along with the eligibility determination. However, this process does not cover every scenario and the modification is to allow for notification of the level of care determination and provide state hearing rights on that determination. The form was modified in collaboration with the Ohio Department of Aging (ODA) and regional PAAs and will be sent to the individual, the individual's authorized representative and the facility who requested the level of care

determination." ODM is seeking feedback on this proposed form. Please send any comments, questions or suggestions to The Academy before June 11, 2019. Please note that ODM cannot change any of the standard state hearing notification language included on pages 2, 3 and 4. (Back to top.)

Cost report rules open for five-year rule review

The Ohio Department of Medicaid has proposed changes to the cost report rules as part of the five-year rule review process. The changes incorporate current statute, remove ICF-IID references, and reorganize the language. You can view the proposed changes by clicking here. If you have any questions, concerns or recommended changes, please contact The Academy by June 6. (Back to top.)

Need Residents' Rights Booklets? Order online!

Order your Residents' Rights Booklets online - click here! It is easy, secure, and fast. Click here to get started today! (Back to top.)

Is more Medicaid money tied to quality a growing trend?

Oklahoma may soon be the next state to up the ante when it comes to paying skilled nursing facilities more based on how the facility performs on certain quality metrics (QMs). (See: State to reward providers who meet quality metrics with bigger share of 'landmark' 15% increase, McKnight's Long Term Care News, 28 May 2019.) The Oklahoma pay for performance ties about $5 a day to those providers over the statewide average in the QMs or improve by 5 percent or more. Nebraska is another state that is moving in that direction with a plan to introduce a pay for performance into their Medicaid rates. (Click here for more information on the Nebraska plan.) Ohio currently has $1.79 of its Medicaid rate tied to performance on QMs; however, the current budget bill, H.B. 166, could increase that to an average of over $11.00 per day. This push towards states spending more on quality mirrors efforts at the federal level, where 2% of Medicare payments are now under pay for performance. While it is uncertain if the amount of Medicaid dollars going towards pay for performance is increasing - it probably is - there is evidence to suggest that states are paying more attention to QMs and are looking for ways to incentivize providers to improve quality. (Back to top.)

National News

CMS makes rule changes for PACE program

From CMS: The Centers for Medicare & Medicaid Services (CMS) finalized a rule today to update and modernize requirements for the Programs of All-Inclusive Care for the Elderly (PACE).

The final rule removes redundancies and eliminates outdated information, which will reduce administrative burden on PACE organizations, and allow clinicians and other care providers to focus more of their time on patients and less time on paperwork. This rule also finalizes several operational flexibilities for PACE organizations that will improve care and access for individuals enrolled in PACE. For example, PACE interdisciplinary teams that provide coordinated care to patients will be able to participate in more aspects of their patients' care, including allowing certain non-physician primary care providers to provide some services in the place of primary care physicians. This will allow PACE organizations to operate with greater efficiency, while ensuring they continue to meet the specific needs and preferences of their patients.

The rule also finalizes important patient protections, including:

- Clarifying that PACE organizations offering qualified prescription drug coverage must comply with Medicare Part D prescription drug program requirements unless the requirement has been waived;
- Implementing changes related to PACE enforcement actions, including sanctions and civil money penalties, to strengthen CMS' ability to hold PACE organizations accountable and protect individuals enrolled in PACE from harm;
- Increasing transparency and simplifying the regulations for PACE organizations – changes that will help clarify enrollment policies and requirements for quality improvement; and
- Adding language to help ensure that individuals with a conviction for a criminal offence relating to physical, sexual or drug or alcohol abuse or use will not be employed by a PACE organization in any capacity where their contact with patients would pose a potential risk.

To view the final rule (CMS-4168-F), please visit: https://www.federalregister.gov/documents/2019/06/03/2019-11087/medicare-and-medicaid-programs-programs-of-all-inclusive-care-for-the-elderly

For a fact sheet on the final rule, please visit: https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f

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CMS MLN Connects

News

- New Medicare Card Flyer for Your Patients
- Programs of All-Inclusive Care for the Elderly Final Rule
- Hospice Compare Refresh
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Compliance

- Chiropractic Services: Comply with Medicare Billing Requirements

Claims, Pricers & Codes

- HETS Includes Medicare Diabetes Prevention Program Information

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series — Updated Schedule
- Prior Authorization of Pressure Reducing Support Surfaces Special Open Door Forum — June 4
- Post-Acute Care QRPs: Reporting Requirements and Resources Call — June 5
- Delivering Dementia Capable Care within Health Plans: Why & How? Webinar — June 19
- Practices for Supporting Dually Eligible Older Adults with Complex Pain Needs Webinar — June 27

MLN Matters® Articles

- Additional Processing Instructions to Update the Standard Paper Remit (SPR)
- Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions — Revised

Publications

- Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

View this edition as a PDF [PDF, 298KB]

View this edition as a webpage.

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ODDS AND ENDS

HW&Co to host cybersecurity webinar

HW&Co. is hosting a free webinar on June 20 from 11 AM to Noon titled: The Top 5 Cybersecurity Threats in Healthcare: How to Identify, Mitigate, and Mange Them. Many healthcare organizations have failed to implement cybersecurity safeguards to protect their confidential business information. Additionally, HIPAA requirements are often missing or incomplete. This webinar will review and outline strategies for handling confidential information, electronic health records (including data stored on mobile devices,) and how to document compliance with the complicated HIPAA requirements. Click here to register.

From CGS: Billing Reminder: Claim Change Reason (Condition) Code D9

A claim change reason code is submitted when adjusting or canceling a claim. Each of the claim change reason codes are used to describe a specific reason for adjusting or canceling a claim. Only one code can be submitted on the adjustment or cancel claim. Providers should choose the one claim change reason code that best describes the adjustment request. Please click here to read more.

CMS ODF: Developing a Hospice Assessment Tool - Status Update

CMS will be hosting a special open door forum call to provide an update on the Hospice Assessment Tool. The call is June 12 at 2 PM. Participant Dial-In Number: 1-800-837-1935 Conference ID #: 9490006

You can learn about the hospice assessment tool by going to: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HEART.html

CMS to host webinar on ACOs, other training workshops

CMS National Training Program will host its Monthly Update Webinar on June 4 from 2:30 to 3:30 PM. The webinar will feature overviews of Accountable Care Organizations and 2019

NOTABLE DATES OR EVENTS

9401 Transition for PAAs 7, 8, 9
June 6 at 9 AM
Webinar

Livanta BFCC-QIO
Effective June 8

NAB 2019 Annual Meeting
June 12 and 14
Charleston, SC

9401 Transition PAAs 7, 8, 9 Make-up Session
June 13 at 1 PM
Webinar

9401 Transition PAAs 7, 8, 9 Q&A
June 27 at 9 AM
Webinar

HOME Choice changes
Effective July 1

9401 Transition for PAAs 7, 8, 9
Effective July 1

NELS 2019 Summit
July 16-18
Washington, D.C.

PDPM Implementation
Effective October 1

ASHS/OANAC Fall Conference
November 19 and 20
Columbus, OH

Click here to view CGS training events

National Training Program Workshops. Registration is required. Click here to learn more.

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Membership.

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