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[NEW 2012 education program coming in March! How to survive the new quality add-ons](#) – The Academy of Senior Health Sciences knows how critical a thorough understanding of the new quality add-ons is to your facility's bottom line. **The Academy is finalizing an education program for the first week in March that will give you the tools you need to ensure success in this new environment.** This program will feature industry experts that will help you navigate the maze of new regulations. Watch your email and *The Weekly* for more information. ([Back to top](#)).

[Possible convention? Let us know!](#) – The Academy is considering having a small convention this fall in Columbus. We need YOUR input on this event to determine topics, social events and length. This is your opportunity to shape your event, so take advantage! Please take a few minutes to complete a short survey by going to <http://www.surveymonkey.com/s/N3TSBJY>. ([Back to top](#)).

[ODJFS continues work on billing issues](#) – The Ohio Department of Job and Family Services (ODJFS) said they continue to work on billing issues related to MITS and 5010 at the latest Medicaid Initiative meeting this week:

- HIPPA Version 5010 billing changes: The delayed release of information on how to bill dates of service and reporting patient liability under HIPPA Version 5010 may have caused error in vendor payments. The instructions were released in January and many billing companies may not have calculated claims correctly especially as it relates to patient liability. Providers may be overpaid and should monitor their Medicaid payments.
- Waiver recipients and leave days: ODJFS said they are reviewing the policy on leave days and waiver recipients. Current rule exempts waiver recipients that are in a NF for respite care from leave days. ODJFS is not sure if that is correct interpretation of the rule and is reviewing the rules and policies before making changes to the MITS system.
- COLA adjustment and 9401s: ODJFS agreed to review the Cost of Living Adjustment (COLA) report provided by the county to see if it would suffice for patient liability calculations instead of requiring a new 9401 for each resident. Many counties do not have the resources to redo the 9401s which are required for audit purposes.
- Part-B co-insurance for therapy: ODJFS agrees that providers should be paid the Part-B co-

insurance for outpatient therapy. They are not aware of any problems with how the billing system is set-up for the crossover payment; however, ODJFS encourages providers with problems to contact ODJFS with the ICNs that are not paying properly.

- Other issues: ODJFS continues to work on other MITS issues raised by the Medicaid Initiative. ODJFS noted that they meet monthly with the contractor (HP) to get the status on current fixes and prioritize the list.

For more information, please contact [Chris Murray](#). ([Back to top](#)).

Timeline for training outlined by ODJFS – The Ohio Department of Job and Family Services outlined the timeline for creating training materials for county case workers at the latest Medicaid Initiative meeting. They anticipate have a rough draft of the materials done by the end of March. The materials are to be reviewed by stakeholders in April and then prepare for training activities in May. ODJFS did provide an outline of the material to be covered: Application Processing, Non-Financial, Financial, Resources, MPAP/Buy-In, Post Eligibility, and Waiver. For more information, please contact [Chris Murray](#). ([Back to top](#)).

Providers to report MSS issues to DODD – The Ohio Department of Developmental Disabilities (DODD) notified providers this week that they are aware of the issues regarding the slowness of the MSS system especially when in the DRA area or the application. DODD appreciates your cooperation while they research and attempt to fix the various reasons behind these performance issues. If users continue to have problems with the system timing out, kicking them out of a website, or not completing a request, they ask that users report this to the MSSSupport@dodd.ohio.gov email with a brief description of what you were attempting to do and if possible a screen shot of what the system displayed. ([Back to top](#)).

Update from CMS – The Centers for Medicare & Medicaid Services (CMS) recently released the following information of interest to long-term care providers:

- **Next SNF Open Door Forum**

The next Skilled Nursing Facility (SNF)/Long Term Care (LTC) Open Door Forum is scheduled for Thursday, March 1 from 2 to 3 p.m. This forum is an audio only streaming web forum. Registration for audio only streaming web forum will open on February 23. [Click here](#) for the full announcement.

- **All Medicare and Supplier Payments to be Made by Electronic Funds Transfer**

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official. For more information about provider enrollment revalidation, review the Medicare Learning Network's [Special Edition Article #SE1126](#), titled "Further Details on the Revalidation of Provider Enrollment Information."

- **From the MLN**

- The new "[Preventive Services Educational Resources for Health Care Professionals](#)" MLN Matters® Special Edition Article (#SE1142) is designed to provide education on available educational resources related to Medicare-covered preventive services. It includes a list of MLN products that can help Medicare FFS providers understand coverage, coding, reimbursement, and billing requirements related to these services.
- The new "[Advanced Payment Accountable Care Organization Model](#)" fact sheet (ICN 907403) is designed to provide education on the advance payment model for Accountable Care Organizations (ACOs). It includes a summary of the Advance Payment ACO Model, background, and information on the structure of payments, recoupment of advance payments, eligibility, and the application process.
- The new "[Summary of Final Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program](#)" fact sheet (ICN 907404) is designed to provide education on the provisions of the final rule that implements the Medicare Shared Savings Program with ACOs. It includes background, information on how ACOs impact beneficiaries, eligibility requirements to form an ACO, and information on monitoring and tying payment to improved care at lower costs.
- The new "[Improving Quality of Care for Medicare Patients: Accountable Care Organizations](#)"

fact sheet (ICN 907407) is designed to provide education on improving quality of care under ACOs. It includes a table of quality measures under the program.

- The new "[Medicare Shared Savings Program and Rural Providers](#)" fact sheet (ICN 907408) is designed to provide education on how the Medicare Shared Savings Program impacts rural providers. It includes information on federally qualified health centers, rural health clinics, critical access hospitals, and how this program impacts them.

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Stakeholders discuss single waiver concept paper – The Ohio Office of Health Transformation (OHT) recently released a [concept paper](#) on the creation of one waiver for non-developmental disability waivers. The waiver separates the assessment and case management services into two different contracts to avoid conflict of interests. As proposed, the state would award one contract for each region. The regions have yet to be determined. Many topics were discussed at a stakeholder meeting to discuss the concept paper. In most cases, the administration was not able to provide answers, only that these issues will be discussed further as they develop the policies necessary to implement the single waiver. Topics discussed included:

- How the single waiver and Integrated Care Delivery System (ICDS) will interact. A lot depends on how the ICDS for dual eligibles is rolled out. The transition will be as seamless as possible for consumers.
- Who will be doing the eligibility determinations, including patient liability, pending eligibility, etc...?
- Who is responsible for assessment after the initial assessment? Does the case manager have the ability to make an assessment for significant changes in services?
- What are the advantages/disadvantages of providing respite, adult day care, enhanced community living, meals, nutrition counseling, and social work services under the single waiver?
- Will there be public reporting of quality measures?

The administration said they plan on posting the comments and questions they receive regarding the concept paper in a question and answer format. People can comment on the proposal until mid February. For more information, please contact [Chris Murray](#). [\(Back to top\).](#)

Website enhancements roll out in early February – The Academy will unveil several website enhancements in early February. Scheduled to make its debut is the **ASHS Marketplace**, our new virtual tradeshow. "Exhibitors" will have the opportunity to showcase their products and services to the long-term care community, making it the "one stop shop" for providers' needs. Need to order **Residents' Rights booklets**? One click and you're there, either by hard copy or online. How about **online CEUs**? The Academy will provide two options for your online education needs. Finally, if you like earning your credit card points, then **pay your dues online**. It's quick and easy! Don't forget to join the conversation—we're on Facebook and Twitter! For more information on our online information, contact [Victoria Gresh](#). [\(Back to top\).](#)

CMS clarifies provider termination criteria – The Centers for Medicare & Medicaid Services has clarified the terms under which states can terminate a provider's participation in state Medicaid programs. The Affordable Care Act stipulates that Medicaid terminate any individual or entity that has been terminated under Medicare or any other state Medicaid program, according to a bulletin issued by CMS. As defined by CMS, termination occurs when an action has been taken to revoke a provider's billing privileges. Providers can only be terminated in cases where a provider's billing privileges have been revoked "for cause." Examples of "for cause" decisions would be a provider terminated for fraud or abuse of billing privileges, the agency stated. [Click here](#) to read the advisory. (Source: [McKnight's Long-Term Care News & Assisted Living](#), 1/24/12) [\(Back to top\).](#)

Targeting hospital readmissions gives skilled nursing facilities opportunities, expert says – Skilled nursing facilities should know their track record and be able to spread the word about it well if they want to thrive and help reduce rehospitalizations, a policy expert said Tuesday. Hospitals will face penalties for patients who are unexpectedly readmitted for acute myocardial infarction, heart failure and pneumonia starting in fiscal year 2013, with the list broadening in 2015. Long-term care providers should be able to show what they are doing to keep a resident from going back into a hospital, said Anne Tumlinson, senior vice president at Avalere Health. "Post-acute care providers will have to understand how they perform relative to their peers," Tumlinson said

in the Avalere Health webinar, “Hospital Readmissions: Opportunity or Threat?” on Tuesday. “The more information they have about their own performance, the greater the ability will be to form referrals.” Hospitals can now give families performance data about post-acute facilities upon a loved one's discharge, noted Erik Johnson of Avalere. The work on reducing rehospitalizations has to be multipronged, with SNFs communicating interventions to potential problems to staff, and then communicating external successes with referring partners. “Observe and collect information that shows risks of rehospitalization and target as efficiently as possible,” Tumlinson said.

(Source: [McKnight's Long-Term Care News & Assisted Living](#), 1/24/12)

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