HOPE
Hoosier Owners & Providers for the Elderly

NewsBriefs

Independent IDR

Resulting from the Patient Protection and Affordable Care Act (PPACA), CMS recently provided guidance to state survey agencies regarding independent informal dispute resolution (IIDR). As part of the Act, states will be required to provide independent informal dispute resolution to nursing homes as part of the certification process.

The ISDH has had an independent informal dispute resolution process since 2004. The current process allows for providers to request independent informal dispute resolution. The ISDH approved MPRO to conduct the independent reviews. Under the existing system, the providers pay for the costs of the independent informal dispute resolution.

Effective January 1, 2012, state survey agencies will be required to provide the option of an independent informal dispute resolution. The primary change will be that the cost of the independent informal dispute resolution will be paid by the state survey agencies through its CMS budget.

In preparation for this transition, the ISDH is terminating its existing independent informal dispute resolution option through MPRO effective immediately. Any requests for the provider-paid MPRO review already in process will be completed through that process. No new requests for independent informal dispute resolution will be accepted until a new system is in place. During this interim period, the only available informal dispute resolution process available to nursing homes will be the traditional ISDH IDR process with ISDH staff.

The ISDH is developing a new independent informal dispute resolution system consistent with the federal guidance. Details on the new process will be provided once they are completed. Because of the payment component, the ISDH will need to contract with a qualified entity to provide the independent process. The ISDH expects the contract process to take a couple of months. The ISDH hopes to have a new independent informal dispute resolution process in place early in 2012.

Other ISDH News

Long Term Care Bed and Personnel Tracking System: The system is progressing towards completion. It is expected that the system will be ready around November 1. Once completed, the ISDH will release an advisory letter informing providers of the tracking system and how to submit updates. The advisory letter

(continued inside)

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Inserts in this Issue

Mission

H.O.P.E. advances the interest of Hoosier owned and operated providers of healthcare, housing, and assistance services for the elderly.

will be sent out in the ISDH LTC Newsletter and to provider associations.

AHFSA Award: The Association of Health Facility Survey Agencies held its annual meeting the week of October 3. This is an Association of State Survey Agencies and CMS staff related to the licensing and certification of state health facilities. At the Annual Meeting, Kim Rhoades, on behalf of the ISDH, was presented with a Best Practices Award for the ISDH's survey report system that allows for online survey reports, plans of correction, and posting of survey reports.

Regulatory Committee Continues Evaluation of the Health Facility Administrators

The Regulatory Occupations Evaluation Committee (ROEC) was formed due to a law passed by the Indiana General Assembly in 2010 that required an evaluation of the need for and function of every professional licensing agency administered by the State of Indiana. They met a few times in 2011 to evaluate the Health Facility Administrators Board (HFAB), which issues professional licenses to Indiana Health Facility and Residential Care Administrators.

At their most recent meeting, the committee received testimony and recommendations from the Chair of the HFAB, Shelley Rauch, who also is a licensed administrator. The ROEC was interested in hearing about the process by which the HFAB evaluates administrators' performance via CEU audits and examination of Immediate Jeopardy/Sub-standard Quality Care findings from state and federal facility surveys.

Mrs. Rauch made several recommendations to the ROEC to improve the HFAB's oversight of Indiana's administrators. The recommendations included:

- **Designate a compliance officer** to the HFAB who would identify and act upon issues identified in state and federal facility surveys;
- **Create a compliance fund**, funded by an add-on to the HFA licensure fee, in order to provide the HFAB additional resources to provide education, licensee retraining and to fund the recommended compliance officer. The HFAB is only allocated $15,143 per year to operate even though it generates nearly $80,000 in licensure fees each year;
- **Require all administrators to report** any change of employment to the HFAB in order to monitor excessive employment changes which may indicate poor performance;
- **Study the regulatory structure** regarding the Administrator in Training (AIT) program to remove barriers of entry into the profession.

One of the issues regarding the AIT program is the requests for reduction in hours in certain categories of the AIT by experienced applicants. HOPE, with input from IAHSA, IHCA and INALA, drafted a set of proposed guidelines to assist the HFA board in its decision-making process for granting a waiver for experience. Those recommendations will be considered by the HFA board.

State Revenues Up in September

Indiana's September revenue report shows collections for the month were $31 million more than projected and approximately $164 million above collections for the same period last year. The State Budget Agency says actual revenues at the end of the first quarter were $67 million ahead of the monthly targets.

Total revenue collections were $1,326 million, $31 million more than projected by the revenue forecast updated on April 15, 2011. Total collections were $164 million above collections for the same period last year (+14.1%). Sales tax collections totaled $554 million for the month, $42 million (+8.1%) above collections for the same period last year. Individual income tax collections totaled $447 million for the month, $55 million (+13.9%) above collections for the same period last year. Payroll withholdings increased 5.2% compared to the same period last year.

Through the first quarter of FY 2012, actual revenues lead the most recent forecast (April 15, 2011) by $66.8 million. Sales tax collections increased 7.6% in the first quarter compared to the same period last year. Individual income tax collections increased 12.0% in the first quarter compared to the same period last year. Payroll withholding, the largest component of individual income tax collections, increased 4.0% in the first quarter compared to the same period last year.

Corporate income tax collections exceeded the monthly target by $49 million, and have increased 36.5% in the first quarter compared to the same period last year.

The official revenue forecast will be updated in December. Although actual revenues are $67 million ahead of the monthly targets at the end of the first

quarter, the current economic forecasts from Global Insight are considerably more pessimistic about future growth in the national economy than those used in the April forecast. *(Indiana Department of Revenue Press Release)*

Indiana Medical Directors Association Sponsors Education Program

IMDA November Educational update for 2011 will be held on November 10 (5:30-8pm) at St. Vincent's Seton Specialty Hospital located at 8050 Township Line Road, Indianapolis, IN 46260. This is a free dinner meeting that will require prior registration. You can register by emailing anazir@iupui.edu OR klieb1@iuhealth.org

This meeting will feature Drs. Diane and Pat Healy, well-known, local experts in the long-term care arena. They will present on perils of inappropriate antibiotic use for asymptomatic bacteriuria. In this interdisciplinary discussion, you will have the opportunity to share your experiences and solutions with the group and to learn from others.

Indiana Rates Poorly in AARP Report on HCBS

AARP's Public Policy Institute released the report, *Raising Expectations: A State Scorecard on Long-Term Services and Supports*, which shows some states excel in the delivery of long-term services and supports (LTSS) for older adults and people with disabilities.

The report looks at four key aspects of state LTSS system performance: affordability and access; choice of setting and provider; quality of life and quality of care; and support for family caregivers. Indiana rated 47th in the nation overall and was in the bottom quartile in all four of these systems measures. Only West Virginia, Oklahoma, Alabama, and Mississippi rated lower. The report notes that all of the states in the bottom quartile have among the lowest median incomes and highest rates of both poverty and disability in the nation, including Indiana.

The tables show that while Indiana ranks relatively well on state systems in place to support and promote home and community based services, it consistently ranks poorly on utilization, access, and affordability. To view the report, go to http://assets.aarp.org/rgcenter/ppi/ltc/ltss_scorecard.pdf.

Statewide Nursing Organization Unveiled

Indiana nursing leaders have formed a new organization to assure the future of the nursing workforce and promote Indiana as a magnet state for nursing practice. The Indiana Center for Nursing (ICN), a nonprofit 501(c)(3), incorporates Nursing 2000, Nursing 2000 North, and the Indiana Nursing Workforce Development Coalition under one organization to join the best practices and functions of all three organizations. ICN creates an entity that will serve to expand and enhance current services and secures the future of Indiana's licensed nursing workforce.

ICN is aimed at strengthening the voice of the nursing profession throughout the state. As a state-wide membership organization, ICN is working to expand service capacity and geographical scope of the recruitment and retention of nurses within Indiana's workforce, increase the opportunity to develop innovative educational and practice programming responsive to the needs of the nursing workforce in Indiana, optimize the strategic utilization of Indiana's nursing leadership in seeking solutions to the challenges the nursing workforce in Indiana will face in the future, and increase options for creating and sustaining financial viability by broadening base funding opportunities.

Kimberly Harper, MS, RN, has been appointed executive director of the Indiana Center for Nursing. Harper has 35 years of healthcare experience in Indiana in roles that include nursing education, nursing practice, communications and philanthropy. Most recently she has served as interim executive director for Nursing 2000.

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Myers & Stauffer Website Contains a Wealth of Data

HOPE receives many inquiries from members about statewide average staffing, expenses, CMIs, quarterly RUGs information, etc. Our staff is more than happy to answer all your questions; however, you may be able to obtain the information you want more quickly by visiting the Myers & Stauffer website: http://in.mslc.com/Resources/Documents.aspx . Select the Nursing Facility folder under Long-Term Care.

The site contains both aggregate and individual facility information. The source of the data is the annual Nursing Facility Cost Report, so the data is only as current as the last cost reports. But it is the best information we have and very reliable.

Please look for the Reimbursement Update insert with important Indiana news in this newsletter.

(Continued from page 3)

ICN is a co-lead in the Indiana Action Coalition: Transforming Healthcare and has been nationally appointed by the Center to Champion Nursing in America to implement the national recommendations resulting from the Institute of Medicine (IOM) Report on the Future of Nursing. Outcomes from this work will result in the improvement of healthcare across Indiana. The Action Coalition, in partnership with Indiana Area Health Education Centers (IN AHEC), has, in only six months, gained national recognition for its ability to organize state-wide in a manner that moves Indiana forward in identifying and implementing innovative education and practice reform initiatives in the areas of interprofessional education and practice, patient safety, nursing education and nursing practice.

Plans call for ICN to become one of Indiana's premier centers for philanthropic support of nursing education at the undergraduate and graduate level. Historically the organizations which have joined to form the ICN have already collectively provided well over $1 Million in nursing scholarships in Indiana. *(Center for Nursing press release)*

IU Research on How Technology Can Help Underserved Elders Age in Place

Older adults living in rural areas and underprivileged urban neighborhoods will be the main beneficiaries of new research on aging in place being conducted at Indiana University (IU) in Bloomington. Using a $500,000 grant from the National Science Foundation (NSF), the researchers will focus on understanding how technology can help keep underserved rural and urban-dwelling older adults at home even as their needs for long-term services and supports increases.

Residents of rural areas make up one-fifth of the elderly population and are more likely than other older adults to require long-term services and supports, according to Kay Connelly and Kelly Caine, the co-directors of IU's Pervasive Health Information Technology lab. Similarly, older adults living in economically challenged urban neighborhoods experience higher rates of functional loss and poorer overall health outcomes than other elders.

Through the NSF-funded project, Connelly and Caine will develop guidelines on how community members, service providers and government agencies can use technology to promote aging in place. Once the guidelines are established, the researchers will assemble a suite of technologies that is customized for the specific needs of rural and urban older adults with low socioeconomic status. The researchers will then be able to assess how these older adults use and adjust to the technologies, and how the technologies may improve their ability to age in place.

Upcoming Education Opportunities

November 8 ~ MDS 3.0 Update with Jane Belt, Plante Moran~ 9:00 am to 4:00 pm ~ The Marten House Hotel ~ *brochure enclosed with this newsletter*

November 11 ~ Webinar *Preparing for the ICD-10* ~ 11:30 am to 12:30 pm

November 17 ~ Assisted Living Compliance Update with Sharon Kennell ~ 9:30 am ~The Marten House Hotel

November 17 ~ Quarterly Compliance Update with Becky Bartle ~ 12:30 pm ~The Marten House Hotel

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Reimbursement Update

Medicaid Submits the State Plan Amendment for Nursing Home Reimbursement Changes

Indiana Medicaid submitted the state plan amendment for the nursing home reimbursement changes related to the Quality Assessment maximization passed by the General Assembly this year and to incorporate the 5% rate cut. As has been described in this newsletter previously, the QA will increase to the federal maximum and the additional funding will be provided primarily through a significant increase in the Quality Add-On. This is based currently on a facility's survey report card score but will be based on a variety of criteria, including staffing levels, turnover, and satisfaction, starting in July 2012. In addition, funding will be added to the administrative component, which will be available to all providers.

CMS must approve these changes before they can be implemented. The changes will be retroactive to October 1, 2011.

Nursing Home Report Card Scores Trend

Although the average nursing home survey report card score rose slightly during the third quarter of 2011, the trend for the past 3 years has been down. In data prepared by HOPE, the median score increased slightly from 134 in the second quarter to 138 in the third quarter. This is still considerably lower than where it was for the third quarter of 2008 when the median was 161. (See chart below.)

The current Quality Add-On for Indiana's Case Mix Reimbursement system is based on a facility's survey report card score. A facility with a score of 82 or below receives the full Add-On and facilities with scores of 266 or above receive no Add-On. For facilities with report card scores in the 83 – 265 range, the amount of the Add-On is reduced ratably for each point greater than 82. The 266 limit represents the 75th percentile (4th quartile) of report card scores (those with the highest scores), when the Add-On was established. The 75th percentile is currently 223. The amount of the maximum Add-On will increase to $14.30 when the state plan amendment is approved (see previous article).

Division of Aging - Reportable Incident Guidelines

The FSSA Division of Aging recently distributed their new guidelines regarding the reporting of Reportable Incidents. These requirements are for any community that actually provides the waiver and/or Money Follows the Person services. This would apply to any residential care community that is a provider of these services. The form is available at http://ialfa.createsend3.com/t/r/l/tulizy/mudjlltiu/k/.

Age & Disabled Waiver Update

The Division of Aging has shared that in Fiscal Year 2011 (ended June 30, 2011) there were 11,802 Aged & Disabled slots approved by CMS. An additional 1,126 slots were approved for Fiscal Year 2012. The number of waiver slots actually allocated in Fiscal Year 2011 was not shared. The Division anticipates releasing 200 slots per month through December.

Enhanced Social Services System Debuts in Central Indiana

Indiana Family and Social Services Administration (FSSA) has announced expansion of its Indiana Eligibility Modernization Project – commonly referred to as Hybrid – to 19 central Indiana counties. Beginning October 24th, people eligible for state public assistance in the Tippecanoe Region: Tippecanoe, Montgomery, Clinton, Boone, Hamilton, Hendricks, Morgan, and Johnson Counties; and the Wayne Region: Wayne, Henry, Hancock, Shelby, Rush, Fayette, Union, Brown, Bartholomew, Decatur and Franklin Counties will use the enhanced

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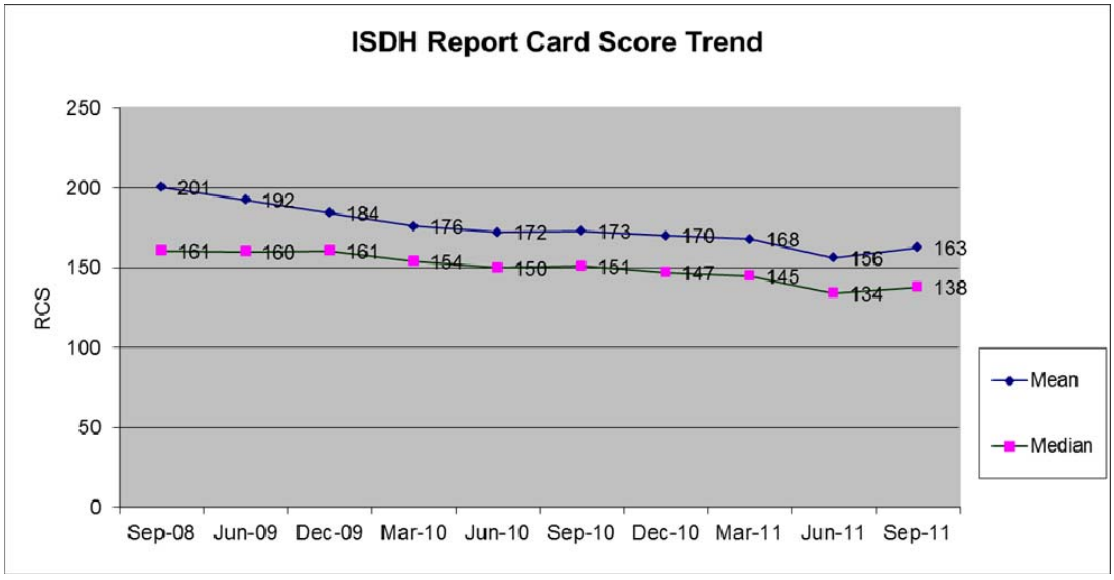

system to apply for and maintain benefits including Medicaid, Supplemental Nutritional Assistance Program (SNAP - formerly known as food stamps), Temporary Assistance for Needy People (TANF), Healthy Indiana Plan (HIP), Hoosier Health Wise (HHW), and Indiana Manpower and Comprehensive Training (IMPACT).

The Hybrid system employs technology, greater flexibility, and more accessibility to provide client support via in-office, telephone and Internet service options. Clients may apply for benefits and report changes to their cases (such as a new phone number, address or job) in the following ways:

- **In-office:** For those who prefer face-to-face support, **visit a local FSSA Division of Family Resources office**. These local offices are available to assist clients during regular business hours – 8:00 A.M. to 4:30 P.M. (local time). Clients can walk in without an appointment to their local office to discuss a case, submit applications and have required documents scanned.
- **Telephone:** Beginning October 24th, **clients in the Tippecanoe and Wayne Regions (excluding Marion County) should call toll free 1-800-403-0864**. During business hours of 8:00 A.M. – 4:30 P.M. (local time) calls are routed to a team member who will best meet their needs. Clients also have 24 hours a day, seven days a week access to the voice response system to check the status of benefits. Individuals needing assistance through October 21st should call their local office directly.
- **Online: Go to** http://www.in.gov/fssa/dfr/2999.htm. Clients may complete an application via the Internet using an electronic signature. Additionally, active clients can log in to check their case status.

Some Division of Family Resources (DFR) offices in the Tippecanoe and Wayne Regions have been relocated.

Tippecanoe Region
DFR – Old address – 11 No. 4th St., Lafayette, Ind.
DFR – New address (with Arbor) – 3847 State Rd. 26 E., Lafayette, Ind.
Wayne Region
DFR – Old address – 1340 N. Cherry St., Rushville, Ind.
DFR – New address – 144 E. U.S. 52, Rushville, Ind.

For additional information about office locations, call 1-800-403-0864, or go online to http://www.in.gov/fssa/dfr/2999.htm. Implementation of the Hybrid system began in Vanderburgh Region January 18, 2010 followed by Vigo Region June 21, 2010; Clark Region September 20, 2010; Allen and Grant Regions February 14, 2011; and Lake and St. Joseph Regions June 20, 2011.

The IHCP to Adopt New Provider Enrollment and Screening Requirements

Effective January 1, 2012, the Indiana Health Coverage Programs (IHCP) will adopt new provider enrollment and screening requirements mandated by the *Affordable Care Act (ACA*). Providers can expect to see details of the new requirements in several upcoming communications, including Web content on indianamedicaid.com. An introduction to and over-view of the major changes follows:

- **Provider types are categorized by risk level** – **high, moderate, or limited**. This categorization is established by the Centers for Medicare & Medicaid Services (CMS), based on an assessment of potential for fraud, waste, and abuse for each provider type.
- **Providers are screened according to the assigned risk level**. The attached table shows the assigned risk levels for most IHCP provider types and outlines the general screening activities associated with each risk category. A full list of provider types by risk level will soon be available on indianamedicaid.com for your reference.
- **Certain providers are subject to an application fee of $505**. CMS sets the application fee amount, which may be adjusted annually. The fee is assessed at the point of initial enrollment and at enrollment revalidation, and is charged individually and in full for each service location. If a provider pays an application fee to Medicare or to another state Medicaid agency for a service location, the provider is not required to pay an additional application fee for that location to the IHCP. The application fee applies to "institutional" providers, as defined by CMS, including, but not limited to, the following provider types:
    - Clinical laboratories
    - Community mental health centers (CMHCs)
    - Durable medical equipment (DME) providers
    - Federally Qualified Health Centers (FQHCs)
    - Hospice providers
    - Hospitals
    - Nursing facilities
    - Outpatient physical therapy clinics
    - Occupational therapy groups
    - Pharmacies
    - Speech/hearing therapy groups

  Generally, application fees do not apply to individual professionals, such as physicians. A full list of providers, by type and specialty, that are subject to application fees will soon be available on indianamedicaid.com for your reference.
- **Enrollment forms will collect additional information**. Updated IHCP enrollment forms will require additional information for all disclosed individuals, including those with ownership interest of 5% or greater and those with operational or managerial control of the applying entity. New information includes dates of birth and Social Security numbers.
- **All enrolled providers must be revalidated at least every five years**. Under current policy, providers have not been required to re-enroll on a regular basis. Providers enrolling on or after January 1, 2012, however, will be required to revalidate their enrollment with the IHCP at five-year intervals. A more frequent three-year revalidation requirement applies to DME providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers enrolled before January 1, 2012, must also revalidate their enrollments under ACA criteria. Beginning in the spring of 2012, the IHCP plans to revalidate existing providers in phases, with completion scheduled for December 31, 2014.

As the IHCP prepares to implement an ACA-compliant enrollment and screening process effective January 1, 2012, please look for additional guidance in upcoming bulletins and banner pages, and on indianamedicaid.com. You can also learn more about the ACA provider screening and enrollment criteria in the *Federal Register, Volume 76, No. 22, Pg. 5862,* published Wednesday, February 2, 2011.

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National News

HHS Halts CLASS Implementation; Supporters Urge Further Work

On October 14th, Health and Human Services Secretary Kathleen Sebelius said the administration would not proceed with the Community Living Assistance Services and Supports (CLASS) program because she has been unable to find a way to make the program financially solvent. "For 19 months, experts inside and outside of government have examined how HHS might implement a financially sustainable, voluntary, and self-financed long-term care insurance program under the law that meets the needs of those seeking protection for the near term and those planning for the future," she said in a letter to Congress. "But despite our best analytical efforts, I do not see a viable path forward for CLASS implementation at this time."

CLASS was part of the Affordable Care Act or health care reform. The idea behind CLASS was to help older Americans better cope with the cost of care at nursing homes or in community- or home-based settings. The voluntary long term care program was to have the added potential benefit of reducing demands on Medicaid to pay for such services in the future.

The problem that HHS has identified for CLASS was adverse selection. Since the program is purely voluntary, the fear is that only those with health issues or disabilities would apply and that premiums would become very high and benefits would make the program insolvent. Language in the act required that it be solvent for 75 years and not rely on government funding.

At a presentation at the LeadingAge conference on October 17th, Bob Yee, an HHS actuary who was deeply involved in the CLASS deliberations, listed a few options, such as increasing benefits and premiums over time on a fixed schedule, or barring benefits for 15 years for care related to medical conditions that existed when a person enrolled. He noted that there were several ways forward but was not sure if they could all be pursued without legislative modifications.

Republican Congressional leaders have called for a repeal of the CLASS provisions. "The Obama administration today acknowledged what they refused to admit when they passed their partisan health bill: The CLASS Act was a budget gimmick that might enhance the numbers on a Washington bureaucrat's spreadsheet," Senate Minority Leader Mitch McConnell said in a statement.

The Congressional Budget Office said on October 17th that since the administration is not going ahead with CLASS, a repeal bill doesn't need offsetting savings. Instead, the CBO will raise its estimate of the deficit. That ruling removed a major obstacle for repeal, and Republicans vowed to press ahead.

The administration announced that they would oppose repeal. "We do not support repeal," White House spokesman Nick Papas said. "Repealing the CLASS Act isn't necessary or productive. What we should be doing is working together to address the long-term care challenges we face in this country."

Congressional Update

Social Security COLA for 2012: The Social Security Administration has announced that the cost-of-living adjustment in Social Security and Supplemental Security Income (SSI) benefits will be 3.6% for fiscal 2012. This will be the first cost-of-living increase since 2009. Read the announcement: http://www.ssa.gov/pressoffice/pr/2012cola-pr.html

Accountable Care Organizations: The Administration announced the final rule on ACOs on October 20th. They have posted a fact sheet: http://www.healthcare.gov/news/factsheets/2011/10/accountable-care10202011a.html.

NLRB Postpones Implementation of Notice-Posting Rule

The National Labor Relations Board (NLRB) has issued a final rule requiring employers to post notices informing employees of their rights under the National Labor Relations Act. It also has released 2 decisions that have the potential to greatly affect members. The NLRB has posted a Fact Sheet with additional details about the notice requirements of the rule at http://nlrb.gov/news-media/fact-sheets/final-rule-notification-employee-rights.

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The final rule was set to become effective on November 14, 2011, but it has been postponed until January 31, 2012. The rule requires employers to post an employee rights notice in places where other workplace notices are typically posted, as well as on an internet or intranet site if employers also typically use these sites to post notices to employees regarding personnel rules or policies.

The NLRB poster is now available for download from the NLRB website. The poster is required to be 11" x 17" under the rule. The NLRB website has two versions--one that is 11" x 17," and one that is two pages 8-1/2" by 11." NLRB says you can tape the two smaller ones together to comply. Here is the link to the NLRB posters: https://www.nlrb.gov/poster . The poster can be in color or black and white.
The NLRB has a Frequently Asked Questions document available at https://www.nlrb.gov/news/nlrb-poster-employee-rights-now-available-download.

There is a question about whether this rule applies to all small businesses, and the answer is that the NLRB's jurisdiction depends on the amount of gross revenue and the type of business. For nursing homes, the threshold is $100,000 revenue per year. For hospitals, it is $250,000. For residential apartments, condominiums, cooperatives, and hotels, it is $500,000. Consequently, it appears that relatively small senior housing organizations may be exempt from this rule.

Another question pertains to translations. If more than 20 percent of your employees speak a different language than English, you will also need a translation. The NLRB will provide the translation. If they are not able to do so, you will not be held liable. For more information, go to www.nlrb.gov.

New Analysis Examines 2012 Medicare Part D Drug Plan Choices

For 2012, Medicare beneficiaries will have, on average, 31 stand-alone Medicare Part D prescription drug plans to choose from, a new Kaiser analysis finds. Average premiums would increase by 4 percent from 2011 to 2012 if beneficiaries remain with their current plans during the open enrollment period, which begins October 15 and ends December 7 of this year. That represents the lowest projected annual increase since the program began in 2006.

The analysis, *Medicare Part D: A First Look at Part D Plan Offerings in 2012*, is the first in a series of planned reports examining the private plan choices available to Medicare beneficiaries. In addition, a separate fact sheet contains 2012 state-specific summary data about available Medicare drug benefit options. Go to http://www.kff.org/medicare/7426.cfm

RESOURCES

Resources Available for Health Information Technology Implementation

The Office of the National Coordinator for Health Information Technology (ONC) has recently launched a new website, www.HealthIT.gov, designed to become the leading national resource on health information technology for both consumers and health care professionals.

The ONC is a national resource to the entire health system to support the adoption of health information technology and the promotion of nationwide health information exchange to improve health care.

The new website contains information on:

- Why adopting electronic health records (EHRs) matters;
- How to start your own transition to EHRs;
- Access to EHR implementation support;
- Financial incentives; and
- Resources to help select an EHR system.

Indiana Alzheimer's Association Professional Training this Fall

Including: The Dementia Seminar Series, Person Centered Care and Dementia Care, Activity Based Alzheimer's Care, and Dementia Professional Certification training.

Check out the catalog at http://www.alz.org/indiana/documents/Alz_Program_Guide_%281%29.pdf

Free Alzheimer's & Dementia Tool Kit

The Tool Kit is free and available at www.nccdp.org. The Tool Kit includes many free PowerPoint in-services for download beginning November 15th 2011 to March 1st 2012. Each in-service is designed to be taught in 30 minutes to health care professionals and front line staff.

The Tool Kit and the declaration by the NCCDP Alzheimer's and Dementia Education Week February 14th to the 21st was developed to bring national and international awareness to the importance of providing comprehensive dementia education by means of face to face

interactive classroom environment to all healthcare professionals and line staff and to go above and beyond the minimum state requirements regarding dementia education. Visit their website at www.nccdp.org.

The Pioneer Network Food and Dining Clinical Standards

The Pioneer Network Food and Dining Clinical Standards Task Force recently released its 62-page *New Dining Practice Standards. T*he New Dining Practice Standards document reflects evidence-based research available to date as well as current thinking and consensus. To view, go to

http://www.pioneernetwork.net/Providers/DiningPracticeStandards/

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Nurse's Notes

QIS- Will Process Lead to Better Surveys?

By Andy Kramer MD, *Provider Magazine*, October 2011

The results of long-term care facility study strongly suggest that both facilities that are struggling with quality of care and high-performing facilities can improve using a Quality Assurance and Performance Improvement (QAPI) system based on Quality Indicator Survey (QIS) methods.

The study also showed that improvement takes a commitment to the continued use of these methods to improve resident care, rather than the "Mock Survey" approach during a survey window.

Study results also showed it took more comprehensive QAPI to achieve additional quality improvements in already high-performing facilities. It took more than simply conducting the Stage I assessments to have an impact. Organizations that used the root-cause analysis and investigation methods included in the system to conduct their QAPI process were most successful.

It appears that nursing facilities have the tools available to them to improve survey results; the challenge is to have staff committed to consistent adherence to a QAPI program.

Increasing Job Satisfaction, Benefits Keep CNAs

From: *McKnight's* at http://www.mcknights.com/increasing-job-satisfaction-benefits-among-ways-to-keep-cnas/article/214798/?DCMP=EMC-MCK_Daily

A study by Jules Rosen MD that was first published in *The Gerontologist* states that job satisfaction, emotional well-being and benefits are key issues in retention of CNAs. Previous studies have demonstrated the high rate of turnover of CNAs; Rosen team sought to understand why people leave. The study found that benefits, especially health insurance, made a difference in whether a CNA stayed at the facility, and whether they felt there were opportunities for promotion or were happy at work.

While providers may be motivated to hire part-time CNAs in order to save on benefit costs, this can backfire when the CNA has to be replaced. Rosen said the cost of one CNA turnover is about $3,500 and the rate of full-time CNAs leaving is far lower than part-timers.

Long-Term Institutionalization after Hospital Stay a Risk for Medicare Patients

From: *Medical News Today*

A national study has shown that being hospitalized for an acute event, such as a stroke of a hip fracture, can lead to long-term institutionalization in a nursing home. Researchers found that direct discharge to a skilled nursing facility-a practice designed to reduce hospital stays- put patients at "extremely high risk" of needing nursing home care.

Findings from research at the University of Texas Medical Branch, suggested that programs aimed at helping older patients recuperate successfully at home instead of in an institutional setting could greatly improve their health outcomes and reduce healthcare costs.

"Hospitalization is a tipping point for older patients, often reducing their ability to live as independently as before," states author James S. Good-

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win MD. Goodwin also noted that certain factors common among the elderly - cognition problems, frailty, lack of social support-increase the risk of nursing home institutionalization.

Being transferred to a skilled nursing facility on discharge was the primary risk factor leading to substantial long-term care. The study found that nearly 65% of patients in nursing homes six months after hospitalization had first been transferred to a skilled nursing facility. This was up from 50% in 1996.

Goodwin recommended that hospitals consider alternatives to skilled nursing facilities post hospitalization, such as community–based facilities, assisted living facilities and at-home care. Goodwin said "We do know that most people fervently wish to remain in home and it is our responsibility to help avoid preventable nursing home admissions."

Report Shows SNF Care Has Improved

From: *Long-Term Living*

According to a new quality of care report, skilled nursing care has improved and survey citations are declining.

The Alliance for Quality Nursing Home Care and the American Health Care Association issued a report that presents data from Centers for Medicare & Medicaid Services (CMS). This report shows positive quality trends in a majority of quality measures and quality indicators. SNF in the past year, have improved in all short-stay measures, which include delirium, pain and pressure ulcers and a majority of long-stay measures including improvements in activities of daily living (ADL), high-risk pressure ulcer, resident mobility and pain.

Report contributors found that current quality measures reflect the traditional roll of nursing homes and do not allow for proper measurement of rehabilitation services for short-stay Medicare patient, and that change is needed in nursing facility quality measures. "Post-acute care has gravitated to a system of multiple transfers to different levels of care. With this, it is critical that measures of rehabilitation quality follow patients across these transitions over fixed time intervals rather than during individual stays," stated Andrew Kramer, MD, a report contributor.

Prescription Dementia Drugs Delay Nursing Home Admission

From: *McKnight's* at http://www.mcknights.com/prescription-dementia-drugs-delay-nursing-home-admission-by-one-year-new-study-shows/article/214138/

New British research suggests dementia–fighting drugs could delay admission of individuals with dementia to nursing homes by up to a year.

Researchers noted a delay in nursing home placement by a median of 12 months in patients who took anti-dementia drugs. Lead author Emad Salib, MD stated "Treatment daily with drugs like Aricept would cost $3.13 a day, so in a year it will cost about $1,095. A year in a nursing home will cost $39,118 so if I delay admission to a nursing home by using drugs, this means enormous savings, not just in money but in emotions and stress."

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Health Care Excel News

Health Care Excel to Collaborate with Providers in New Ways to Spark Rapid-Cycle, Wide-Scale Change

Between now and July 2014, CMS is launching a series of projects led by the Quality Improvement Organization (QIO) Program. Health Care Excel, the Medicare QIO for Indiana, is focusing on three aims for Hoosier seniors: better individual patient care, better population health, and lower health care costs by improvement through the following efforts.

- *Fulfilling CMS' obligation to protect the rights of Medicare beneficiaries by reviewing quality of care concerns and appeals and denial or discontinuation of health care services.* The QIO advocates for beneficiaries and their families to be meaningfully involved in QIO improvement and prevention activities.
- *Working with hospitals to achieve as much as 50% reductions in health care-associated infections (HAI) that will contribute to as much as a 50% reduction in national HAI rates.* The initiative will reduce central line-associated blood stream and catheter-associated urinary tract infections by implementing the Comprehensive Unit-Based Safety Program (CUSP), Clostridium difficile, and surgical site infections.
- *Contributing to a 40% national reduction in health care-acquired conditions (HAC), such as catheter-associated urinary tract infections (CAUTI) and falls.* The QIO also is working with nursing homes to improve pressure ulcer prevention and reduce physical restraint use.
- *Improving the quality of care for high-risk Medicare patients by working with clinical pharmacists, primary care clinics, and other providers that care for older patients with multiple chronic conditions to reduce adverse drug events (ADEs).* The initiative focuses on increasing patient self-management skills, reducing unnecessary hospital readmissions, and forming community relationships to ensure community-wide adoption of improved practices.
- *Assisting physician practices that want to use their electronic health record system to coordinate preventive services like flu and pneumococcal immunizations, and colorectal and breast cancer screenings*. The QIO is partnering with local Health Information Technology Regional Extension Centers (REC) to promote health information technology integration into clinical practice.
- *Collaborating with hospitals, nursing homes, home health agencies, dialysis facilities, physician practices, patient advocacy organizations, and other stakeholders to reduce hospital readmissions.* The QIO will assist in the goal of reducing hospital readmissions within 30 days of discharge by 20% over three years by changing processes of care at the community level.

New Ways to Work Together

New models for accelerating and spreading change have shaped Health Care Excel's approach to working with health care providers and partners. Providers and partners have more and different ways to be a part of QIO initiatives. Health Care Excel is convening a statewide Learning and Action Network (LAN) that recognizes everyone's knowledge and contribution to better health care. Through an "all teach all learn" large-scale LAN approach, the QIO will accelerate the pace of change and rapidly spread best practices. Improvement initiatives include collaborative projects, online interaction, and peer-to-peer education.

By participating in the LAN, health care providers and partners can join a community for addressing common challenges, connect with a peer facility for mentoring, and be the first to know about improvement breakthroughs—and how to replicate them in their own facility or practice.

Beginning in 2013, Health Care Excel will launch a statewide LAN for nursing homes that will address catheter-associated urinary tract infections, falls, and other HACs. Learning and Action Network participants can learn from local and national peers, obtain evidence-based tools and resources, and participate in an improvement collaborative. Focusing on ADEs, providers and partners can expect to benefit from participation in a statewide LAN by accessing evidence-based tools for assessing pharmacy processes and implementing safer practices, support for rapid-cycle improvement, and strategies for spreading success within their community.

Learn More and Become Involved

The QIO Program invites all health care providers, Medicare beneficiaries, family members, caregivers, and other health quality stakeholders and partners to be part of these new improvement initiatives. More information about the QIO Program is available online at www.hce.org, or by calling 812-234-1499.

To attend Health Care Excel's November 9, 2011, LAN meeting at the Indianapolis Marriott East, go to Health Care Excel's LAN meeting, or contact Amy Tooley, Administrative Assistant, at atooley@inqio.sdps.org, or call 812-234-1499, extension 269.

The QIO Program is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy to transform America's health care system. The CMS administers the program through a national network of 53 independent QIO contractors located in each of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands. It serves as the largest federal program dedicated specifically to improving health care quality at the community level.

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CMS to Host Provider Call on RUG IV and MDS 3.0 Policies and Clarifications

The Centers for Medicare & Medicaid Services (CMS) will host a National Provider Call on "Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Minimum Data Set (MDS) 3.0 and Resource Utilization Group-Version 4 (RUG-IV) Policies and Clarifications." CMS subject matter experts will provide a brief overview of the policies, along with clarifications on the SNF PPS FY2012 policies related to the MDS 3.0. A question and answer session will follow the presentations.

The provider call will be on **Thursday, November 3 from 12:30 - 2 p.m. Central Time**. The call is for SNF providers, facility Resident Assessment Instrument (RAI) coordinators, state RAI coordinators, rehabilitation therapists, Recovery Audit Contractors and Medicare Administrative Contractors.

The agenda will include:

- Allocation of group therapy
- Changes to the MDS Assessment Schedule
- End of Therapy (EOT) Other Medicare Required Assessment (OMRA) Clarifications
- End Of Therapy with Resumption (EOT-R)
- Change of Therapy (COT) OMRA

In order to receive the call-in information, you must register for the call. Registration will close at 12 p.m. ET on Thursday, November 3 or when available space has been filled. No exceptions will be made. Please register early.

For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Common LSC Violations Webinar by NFPA

The National Fire Protection Agency (NFPA) has announced that it will present a free 90-minute webinar covering the most common citations issued by Centers for Medicare and Medicaid Services (CMS) inspectors (and the Joint Commission for hospitals). The webinar will also review helpful provisions in more recent editions of the Life Safety Code (NFPA 101), including some provisions of the new 2012 edition. The NFPA accepted four major recommendations from the Pioneer Network, so this webinar may help explain these changes.

The webinar will be broadcast on **November 29, 2011, from 11:30 a.m. - 1 p.m. CT.** Members may register for the webinar at: https://www2.gotomeeting.com/register/790382050.

CMS Issues Clarification on Leave of Absence Policies

CMS has updated its transition guidelines on the SNF PPS FY 2012 Final Rule, effective October 1, 2011, regarding the effect of Leave of Absence (LOA) days on scheduled and unscheduled PPS assessments. The following LOA policy was recently added to the transition guidelines.

For scheduled assessments, pursuant to the policy outlined in Chapter 2, page 2-64, of the MDS 3.0 RAI Manual, the Medicare assessment schedule is adjusted to exclude the LOA when determining the appropriate ARD for a given assessment. For example, if a resident leaves a SNF at 6:00 p.m. on Wednesday, which is Day 27 of the resident's stay, and returns to the SNF on Thursday at 9:00 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay. Therefore, a facility that would choose Day 27 for the ARD of their 30-day assessment would select Thursday as the ARD date rather than Wednesday, as Wednesday is no longer a billable Medicare Part A day.

However, in the case of unscheduled PPS assessments, the ARD of the relevant assessment is not affected by the LOA because the ARDs for unscheduled assessments are not tied directly to the Medicare assessment calendar or to a particular day of the resident's stay. Specifically, in the case of an EOT OMRA, an EOT OMRA must be performed if a resident does not receive therapy for three consecutive calendar days, which may include days during which the resident experienced a LOA. For example, if a resident were to miss therapy on Monday and Tuesday, go to the emergency room at 9:00 p.m. on Wednesday, return to the facility on Thursday at 10:00 a.m. and receive therapy on Thursday, then an EOT OMRA would be required with an ARD set for Monday, Tuesday, or Wednesday. With regard to payment, the EOT OMRA would control payment for those Medicare-billable days during which the resident did not receive therapy, while those non-Medicare billable days would remain non-billable to Medicare. We would note that, in the example above, the provider could complete the Resumption of Therapy items to resume therapy after the patient's return, assuming the resumption was completed consistent with existing policies governing the definition of a resumption of therapy.

In the case of a COT OMRA, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. For example, if the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00 p.m. on November 9, returning at 2:00 p.m. on November 10, Day 7 of the COT observation period would remain November 14. With regard to payment, consistent with current policies related to the COT OMRA, the COT OMRA would set payment for those Medicare billable days beginning on Day 1 of the COT observation period and forward until the next scheduled or unscheduled assessment. Any days during which the resident was out on the LOA would remain non-billable to Medicare.

It should be noted that while these rules cover general cases of how the LOA policy would affect unscheduled assessments, specific cases may vary as to the which assessment is most appropriate given a specific LOA. Particularly in cases where a resident experi-

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ences frequent and/or extended LOAs, providers are encouraged to consider the causes for the LOAs and if these causes might have some impact on the patient's care plan, the assessments appropriate to that resident, and the extent to which the resident requires the level of care necessary for the resident to qualify for the Part A SNF benefit.

A beneficiary's ability to have frequent or prolonged absences from the facility may raise a question as to whether the beneficiary, as a practical matter, can only receive the care that he or she needs on an inpatient basis in the SNF. However, this is not the case when a beneficiary is capable of having only occasional, brief absences from the facility.

The CMS transition guidelines for the SNF PPS 2012 final rule are available at http://www.cms.gov/SNFPPS/Downloads/Provider_Call_FollowUp082311.pdf

Health and Human Services Announces Medicaid Recovery Audit Program

Final rules were published on September 14 that announced the formation of the Medicaid Recovery Audit Program, which will help states identify and recover improper Medicaid payments. It will be largely self-funded, paying independent auditors a contingency fee out of any improper payments they recover that took place in the previous three years. HHS predicts $2 billion in savings with $900 million to be returned to the states. The final rule also directs States to assure that adequate appeal processes are in place for providers. Lastly, the rule directs States to coordinate with other contractors, auditing entities and with State and Federal law enforcement agencies.

For more information on this announcement, visit http://www.healthcare.gov/news/factsheets/2011/09/fraud09142011a.html

CMS Provides Clarifications to the 2012 SNF PPS Final Rule-- MDS 3.0 Changes

The Skilled Nursing Facility (SNF) Prospective Payment System (PPS) FY2012 Final Rule outlined several policy changes relating to Minimum Data Set (MDS) 3.0 scheduling and completion changes effective October 1, 2011. These changes include: a revised MDS assessment schedule, the Change of Therapy (COT) Other Medicare Required Assessment (OMRA), a resumption of therapy option for the End-of-Therapy OMRA, the allocation of group therapy time, and a revised student supervision policy.

CMS has issued a new memo which describes the transition guidelines for these policies and also includes the questions-and-answers discussed during the August 23rd and September 1st national provider calls. The CMS clarification memo is available at: www.cms.gov/SNFPPS/Downloads/Provider_Call_FollowUp082311.pdf.

Nursing Home Physicians Could Be Exempt from e-Prescribing Penalties

Physicians who practice part-time in a nursing home or another long-term care facility and have limited electronic prescribing (e-prescribing) opportunities will not be penalized for their failure to adopt e-prescribing in their practices, according to the final rule for the 2011 Medicare Electronic Prescribing Incentive Program. The Centers for Medicare and Medicaid Services (CMS) issued the rule in early September.

The e-prescribing incentive program was authorized by the Medicare Improvements for Patients and Providers Act of 2008. Through the program, physicians who use a qualified e-prescribing system are eligible for an additional 1% in Medicare Part B payments in 2011 and 2012, and a 0.5% increase in 2013. Providers who fail to meet minimum e-prescribing requirements will receive a 1% cut in Medicare reimbursements in 2012, a 1.5% cut in 2013 and a 2% cut in 2014.

According to the final rule, physicians are exempt from the payment adjustments if they:

- See very few patients.
- Practice in rural areas without sufficient high-speed Internet access.
- Have insufficient access to pharmacies.
- Have had limited prescribing activity during a 6-month time frame.
- Reside in an area where regulations hinder e-prescribing.
- Are registered to participate in the Medicare or Medicaid Electronic Health Record Incentive Program.

Version 5010 Testing Transactions

All covered entities under the Health Insurance Portability and Accountability Act (HIPAA) must be ready to implement the Version 5010 electronic transaction standards used to send administrative transactions on January 1, 2012. A critical step to reaching this milestone is testing Version 5010 transactions prior to going live. Providers are encouraged to conduct (external) Level II testing. CMS has posted a new fact sheet at http://www.cms.gov/ICD10/Downloads/Versions5010TestingReadinessFactSheet.pdf

External testing with business partners in the new Version 5010 format will ensure compliant transactions occur prior to the deadline.

CMS Suggestions:

- Identify the partners with whom you currently conduct transactions
- Create a schedule and timeline for external testing with each partner
- Identify priority partners to conduct testing with if you trade with a large number of business partners

CMS has also established a webpage for ICD-10 and the Version 5010 for electronic claims at: http://www.cms.gov/icd10/. The Version 5010 will be required for electronic transactions as of Jan. 1, 2012. Version 5010 will accommodate the ICD-10 codes, which are significantly expanded from the ICD-9 codes.

CMS Issues J8 MAC Contractor Awards through Competitive Process

The Centers for Medicare & Medicaid Services (CMS) announced that Wisconsin Physicians Service Insurance Corporation (WPS) has been awarded the Jurisdiction 8 A/B MAC contract for the administration of the Part A and Part B Medicare fee-for-service claims in the states of Indiana and Michigan. When the contract is fully implemented, the Jurisdiction 8 A/B MAC contractor will serve over 2.2 million beneficiaries in Indiana and Michigan.

In addition to processing Medicare claims in Jurisdiction 8, WPS will perform other critical Medicare operational functions, including enrolling, educating, and auditing Medicare providers. NGS currently holds the Part A contract in Indiana. Over the next several months, CMS will oversee the transfer of Medicare work from the incumbent contractors to the Jurisdiction 8 A/B MAC.

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