The 2007 Indiana General Assembly has entered its final week as leaders of both houses and parties struggle to finalize a budget; and, address unresolved issues such as property tax reform, privatization of the Indiana lottery, slots at the horse racing tracks, and health care for the uninsured. While attention is focused on these huge budgetary issues, conference committees are meeting on bills that passed both the House and the Senate but in different forms. The following provides a summary of what is happening on bills of interest to HOPE members.

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### HB 1001 - The Budget:

The House proposed no increases for Medicaid in its version of the budget, while the Senate proposed a 5% increase. HOPE strongly supports the 5% increase. The amount of increase is one of the issues highlighted in the report.

### The State of Aging and Health in America 2007

The Centers for Disease Control and Prevention (CDC), in partnership with The Merck Company Foundation, recently released The State of Aging and Health in America 2007 report. The report provides an overview of our nation’s progress in promoting the health and well-being of older adults and in reducing the prevalence of behaviors and conditions that contribute to premature death and disability.

Highlighted in the report are “Calls to Action” that address critical public health issues impacting older adults. This feature is intended to stimulate health and aging services professionals, communities, and the public, to take steps on critical issues for older adults. The report provides guidance on implementing innovative programs designed to improve the health and well-being of older Americans. In addition, the report includes a spotlight section on falls, which are the leading cause of injuries and injury-related deaths among older adults. An electronic, interactive version allows easy access to national and state-based data searchable by state, health indicator and other variables. You may read the report at [http://www.cdc.gov/aging/](http://www.cdc.gov/aging/).

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Provider Groups Meeting with Division on Aging Regarding Waiver Rules

HOPE joined IAHSA, IALFA, IHCA, and the Indiana Home and Hospice Care Association at a meeting with representatives of the Division on Aging (DoA) regarding quality surveys and required incident reporting for Waiver Providers licensed by the Indiana State Department of Health. The Division has told licensed providers that participate in the Medicaid Waiver programs (such as licensed residential care facilities and home health agencies) that EDS will conduct quality assurance surveys on all Waiver Providers and that these organizations must comply with FSSA incident reporting requirements. The provider groups believe that the waiver rules specifically exempts licensed providers from these requirements. No decisions were made at the meeting but DoA staff indicated that they would bring our concerns to Division Director Steve Smith. We will keep our waiver providers informed as this issue unfolds.

Five Dollars to Be Reinstated in Nursing Home Rates

In response to an expected shortfall in the Medicaid nursing home budget for the FY 06-07 biennial budget, the three nursing home associations, including HOPE, agreed to a temporary $5/day rate reduction through the end of FY 07 (June 30, 2007). The three associations have had numerous discussions with FSSA officials about the FY 07-08 budget over the last six months. Steve Smith, Director of the Division on Aging, had proposed that the $5 would be returned to the rates but that the FY 07 – 08 rates would be limited to a 5% increase because nursing home expenditures were projected to increase significantly during this period.

The provider associations and DoA continue to discuss the best methodology for achieving the 5% growth limit objective.

Health Facility Administrator Board Update

At the April 5 meeting of the board, a number of items were discussed. The board recognized John “Woody” Woodford for his 8+ years of service. He has now become a licensed Health Facility Administrator (HFA) and can no longer serve as a consumer advocate representative. The board currently has two open seats.

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The board is reviewing proposed rules including:

- The establishment of an inactive license category;
- Requirements for the reactivation of an inactive license;
- College credit maximums for CEUs; and
- Limiting the number of CEUs HFA Board Members may receive for participating on the board.

There is a long list of back-logged complaints against HFAs that the Attorney General’s Office has yet to clear. Most of those are not pursued after review.

The board also adopted an amendment to 840 IAC 1-1-6 (concerning the licensure exam). The amendment allows applicants to take the nursing home administrators licensing examination two additional times, if the applicant fails the first time.

The annual membership meeting of Hoosier Owners and Providers for the Elderly will be held at 3:00pm Wednesday, May 16, 2007 at Ruth’s Chris Steak House. The main business to be transacted at the annual meeting will be the election of Directors of the Association for 2-year terms. HOPE directors are elected for 2-year terms. The terms are staggered so that one-half (½) are elected each year. The following Directors have submitted their names for re-election: Jim Burkhart, Gary Ott, Stuart Reed and Eric Walts. If you are interested in submitting your name as a candidate, please contact Bob Decker no later than May 14, 2007. However, nominations may be made from the floor at the Annual Meeting. All members are invited to attend the annual meeting. However, only credentialed Regular Members may vote. The Annual Meeting of the Board of Directors will follow the annual membership meeting. All Board of Directors meetings are open to members.

Tax Revenue Forecast Cut by $130 million

According to a new fiscal forecast released on April 16th, lawmakers will take in about $130 million less in tax revenue to spend on the two-year budget they are drafting than was projected earlier – $23 million less than projected, meaning lawmakers actually would have $150 million less to spend over the next two years. A forecast in December projected that lawmakers would have about $1.5 billion in new money to spend in the next budget.

Wage Survey

Hard to believe, but it is time for the annual HOPE/IAHSA Wage/Salary Survey to be distributed. We have invested in the building of a new, more user friendly document that will improve the data entry process and significantly reduce entry error. For those of you that have participated in the past, it will not look significantly different, yet it will have directions and instructions along the way to assist you. Once again, results will be mailed approximately 90 days after the participation cut-off date. Participants will receive a free copy of the results if you are a non-participating member or purchase $10.00. Watch for the log-in and password to be mailed to each facility administrator. If you have questions, please give Becky Carter a call at 317-733-2380.

Ethical and Legal Marketing Issues with Hospice

As competition increases in the home health and hospice markets, providers look for additional ways to generate referrals, develop new referral relationships, and further strengthen old relationships. Unfortunately, there are federal fraud and abuse laws that may be broken in the diligent quest for increased market share. The Indiana Association for Home & Hospice Care (IAHHC) has responded to the increasing number of complaints about this by developing a newsletter just on that subject. The newsletter has been posted on the HOPE website – look under ‘Current Issues’. We offer thanks to IAHHC for this timely information.

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Long Term Care Nurse Management Class Announced

HOPE is pleased to present a four-day course designed to prepare nurse managers to understand and address regulatory issues related to long-term care. The course is a joint association training program sponsored by HOPE, IAHSA, and IHCA.

The course will take place at the Marten House Hotel – Hope Lodge in Indianapolis on June 12, 13, 19 & 20, 2007. This year the course will be taught by Becky Bartle, HOPE; Linda Woolley, IAHSA; and Faith Laird from IHCA. This course always sells out, so be sure to register early – space is limited to 40 attendees. Look for the flyer enclosed with this newsletter.

For more information contact Becky Bartle at bbartle@HoosierOwnersandProviders.org, or Emilie Perkins at (317) 733-2380.
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The exam must be successfully completed within one year of sitting for the original exam (instead of only one year from notification of failure of the original exam). If the applicant remains unsuccessful, he or she is responsible for submitting proof of additional requirements met (no change in those requirements).

Finally, the board was informed of the legislative passage of SB 333. That bill gives the HFA board the authority to proceed with the development of the Residential Care Administrator license program. HOPE, IHCA, IAHSA and IALFA were asked to bring forward a proposal.

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HOPE members have access to information at www.iahsa.com: Log-in: hope Password: 2002
General Assembly Heats Up as Session Nears End

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Medicare to Provide Health Insurance Counseling

Medicare will provide funding for health insurance counseling in every state, the Centers for Medicare & Medicaid Services (CMS) announced last week. Each state will receive a share of $30 million in grant funds so state agencies can bring personalized assistance to people with Medicare at the local level. Under the State Health Insurance Assistance Programs (SHIPs), CMS provides funding to 54 SHIPs, including all 50 states, and the District of Columbia, Puerto Rico, Guam and the Virgin Islands. In Indiana, the SHIP is the Senior Health Insurance Assistance Program or SHIP (http://www.in.gov/idoi/ship/ship.html) which helps educate beneficiaries about health insurance coverage, including Medigap, Medicare Advantage options, Medicare prescription drug coverage, and long-term care financing.

SHIPs are intended to serve beneficiaries who want information, counseling, and assistance beyond what is available through other CMS channels, including 1-800-MEDICARE and http://www.medicare.gov. CMS will continue to provide training for SHIP counselors and full access to computer programs and other support tools, such as the Plan Finder tool and Tip Sheets, developed by CMS to help SHIPs with outreach and other functions.

(Look for more CMS News on the Regulatory Updates page.)

OIG OKs Nursing Homes’ Use of Credit Card Affinity Awards

The U.S. Office of the Inspector General (OIG) recently ruled that if a nursing home receives affinity rewards using a credit card to buy items reimbursable by Medicare or Medicaid, the organization can use the rewards to purchase additional items or services or as performance-based compensation for employees. The OIG’s opinion concludes that this arrangement does not violate federal anti-kickback laws. The opinion is found at http://oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07-03.pdf.

AARP Says It Will Become Major Medicare Insurer

AARP, the lobby for older Americans, announced April 16th that it would become a major participant in the nation’s health insurance market, offering a health maintenance organization to Medicare recipients and several other products to people 50 to 64 years old. The products for people under 65 include a managed care plan, known as a preferred provider organization, and a high-deductible insurance policy that could be used with a health savings account. When the new coverage becomes available next year, AARP will be the largest provider of private insurance to Medicare recipients. In addition to the new H.M.O., AARP will continue providing prescription drug coverage and policies to supplement Medicare, known as Medigap coverage. The group also said it would use its leverage to reshape the health insurance market. The organization has 38 million members, and Mr. Novelli said it hoped to have 50 million by 2011. The new Medicare product will be marketed with UnitedHealth Group. Policies for people under 65 will carry the AARP name and will be marketed with Aetna.

Revenues and royalties from the sale of goods and services have, for many years, accounted for a substantial part of AARP’s income. AARP officials insisted that its financial interests do not affect the positions it takes on Medicare, Medicaid, Social Security and dozens of other issues on which it lobbies and litigates. Judith A. Stein, director of the Center for Medicare Advocacy, a nonprofit group that counsels people on Medicare, said, “The new arrangements with insurance companies create a tremendous number of potential conflicts for AARP, which is a powerhouse, perceived as the most important voice for older people.”

The role of private insurers in Medicare is one of the most hotly debated issues in American health policy. In general, Republicans want to expand the role of private insurers like UnitedHealth and Aetna, while Democrats want to limit the role of private entities. “AARP will not be perceived as a truly independent advocate on Medicare if it’s making hefty profits by selling insurance products that provide Medicare coverage,” Ms. Stein said. “AARP’s role in this market could give a big boost to the privatization of Medicare.”

Payments to UnitedHealth and Aetna will be linked to their performance in improving the health of subscribers, including members of minorities, Mr. Novelli said. The new plans will coordinate care for people with chronic conditions and will develop special programs to treat people with depression. AARP will measure how frequently the companies deliver recommended treatments to people with diabetes, hip fractures and other conditions. (New York Times, 4-16-07)
Bill Would Narrow Labor's Definition of 'Supervisor'

More nurses would be eligible for union membership under new legislation introduced in the Senate. The bill (S.B. 969) would strip two terms from the National Labor Relations Act definition of supervisor: "assign" and "responsibility to direct."

The measure comes on the heels of a highly touted National Labor Relations Board decision in October that ruled some hospital charge nurses were supervisors but also found that some nursing home charge nurses were not. While most of the publicity focused on the acute-care side of the ruling, long-term care observers predicted it would not have much of an impact on their business.

The new bill, "The Re-empowerment of Skilled and Professional Employees and Construction Tradeworkers Act," however, could have a significant impact on LTC union-member eligibility. It stipulates that an employee would have to meet the act's supervisor status criteria for "a majority of the individual's work time" to be exempt from union organizing efforts. The bill was introduced by three Democratic Senators: Richard Durbin (IL), Edward Kennedy (MA) and Christopher Dodd (CT). Reps. Rob Andrews (D-NJ) and Rosa DeLauro (D-CT) have already unveiled a companion bill in the House. (McKnightsonline.com, 3-27-07)

New York Times Investigates Denials of Long-Term Care Insurance Claims

The New York Times recently examined how, although tens of thousands of elderly U.S. residents have "received life-prolonging care as a result of their long-term care policies," thousands of policyholders "say they have received only excuses about why insurers will not pay." The Times reviewed more than 400 grievances and lawsuits filed against long-term care insurers and found "some long-term care insurers have developed procedures that make it difficult -- if not impossible -- for policyholders to get paid."

According to the Times, the issue has not received much attention because long-term care insurers settle many lawsuits with the requirement that documents and depositions remain confidential. In addition, "few states have conducted meaningful investigation" into the issue, the Times reports. Glenn Kantor, a California attorney who represents long-term care insurance policyholders, said, "These companies have essentially turned their bureaucracies into profit centers."

Mary Beth Senkewicz, who resigned in 2006 as a senior executive at the National Association of Insurance Commissioners, said, "The bottom line is that insurance companies make money when they don't pay claims." She added, "They'll do anything to avoid paying, because if they wait long enough, they know the policyholders will die." However, long-term care insurers maintain that the criticisms are unfair. In a statement, officials for Conseco, which markets long-term care insurance policies, said that the company "is committed to the highest standards for ethics, fairness and accountability, and strives to pay all claims in accordance with policy contracts." (Kaisernetwork.org, 3-26-07)

Supreme Court: False Claims Cases Must Stem From Original Sources

The Supreme Court this week laid down strict rules regarding information sources in False Claims lawsuits. A private individual who sues under the False Claims Act must be an original source of the allegations in the complaint, the Supreme Court ruled in a 6-2 decision. Providers, including the American Health Care Association, last fall filed an amicus brief calling for strict rules when private individuals bring False Claims cases based on public information.

Information held in the public domain cannot make up the basis of the allegations in the complaint, the high court ruled. When a complaint is based on public information no jurisdiction exists for the court to hear the case, the court said. The decision stemmed from the case, Rockwell v. United States. The court questioned whether the source of information in the lawsuit was a former employee who had first-hand knowledge of fraud because the information also was available in the public domain. Beginning January 1, 2007, healthcare providers who receive Medicaid payments totaling $5 million or more per year have been required to provide information to their staff on the federal False Claims Act and its whistleblower protections, according to the CMS guidance. (McKnightsonline.com, 3-29-07)

Healthcare Providers Have Unique ADA Challenges, EEOC Finds

Nursing home employees and other healthcare workers pose unique disability challenges for their employers because of "societal misperceptions" that healthcare providers be free from any physical or mental impairment, according to a new fact sheet from the U.S. Equal Employment Opportunity Commission. The fact sheet focuses on the application of the Americans with Disabilities Act as it relates to job applicants and employees with occupational or non-occupational illness or injury in the healthcare industry, which includes nursing homes and other long-term care providers.

The fact that many facilities providing healthcare operate seven days a week, 24 hours per day and rely on shift work, presents unique disability issues for nursing homes and their employees, according to the EEOC. Also, the nature of work offers a special set of challenges. For example, a healthcare worker with a degenerative eye condition could be regarded as an individual with a disability because she is misperceived to be substantially limited in working with medical records, the EEOC said. The document is available at http://www.eeoc.gov/facts/health_care_workers.html. (McKnightsonline, 4-3-07)
Tai Chi Helps Combat Shingles in Elderly

The traditional Chinese exercise of Tai Chi has been found to help improve balance and reduce falls in the elderly. Now researchers say it boosts the immune system in older adults, particularly against the virus that causes shingles. Tai Chi may increase older adults' immunity to varicella-zoster virus, which causes both chicken pox and shingles, according to a new study by researchers at the University of California at Los Angeles, the University of California at San Diego and the San Diego Veterans Affairs Healthcare System.

Researchers found that Tai Chi alone increased study participants' immunity to varicella as much as the varicella vaccine typically produces in middle-aged adults. Tai Chi in combination with the vaccine produced about a 40% increase in immunity levels over that produced by the vaccine alone, according to the study. The study is published in the Journal of the American Geriatrics Society. (McKnight's Online)

Embrace Technology and Live Longer

Staying current on technology, spiritual activities, eating right and just plain being happy topped the list when 100 people 99 or older were recently asked about their "secrets" to a long life. "They very much paid attention to both technology and current events," said Dr. John Mach, the head of Evercare which conducted the poll. Mach said one of the most surprising findings was the extent to which technology had entered the centenarians' lives. Nearly one-fourth had bought CDs, nearly one-third had watched reality television shows and almost one in six had played video games. Six of the respondents had used the Internet while four had listened to music on an iPod.

"Certainly we know that social interactions make a difference over a lifetime, so maintaining those social interactions ... in e-mails, the Internet and being able to converse about current events, that does contribute to the overall social well-being of people which we know contributes to successful aging," Mach noted. There are nearly 80,000 centenarians living in the United States, according to the U.S. Census Bureau, which predicts the number could reach 580,000 by 2040. (McKnight's Online)

Researchers: Visualization Exercises Help Stroke Victims

Mentally practicing tasks as part of a therapy regimen significantly improves outcomes of chronic stroke patients, according to a new report in the journal Stroke. "Mental practice increases motor-skill learning and performance in rehabilitative settings," said Dr. Stephen J. Page and research colleagues from the University of Cincinnati Academic Medical Center, Ohio. "The same neural and muscular structures are activated when movements are mentally practiced as during physical practice of the same skills."

Researchers tested arm rehabilitation in two test groups. One received traditional therapy that emphasized activities of daily living in 30-minute sessions twice a week over six weeks. The other group added 30-minute mental practice sessions involving activities of daily living. The latter group noted remarkably better improvement and function in their arms. (McKnight's Online)

Bill Would Fund Fall Prevention Research for Seniors

Two senators recently introduced a bill that would expand research and education into fall prevention for seniors, including those who reside in long-term care facilities. The measure, S.B. 845, directs the secretary of the Department of Health and Human Services to expand and intensify research and education programs. It asks for $25 million annually over three years starting in fiscal year 2008. One of the bill's research goals is to evaluate the most effective approaches to reducing falls among high-risk adults living in long-term care and other communities. Sens. Michael Enzi (R-WY) and Barbara Mikulski (D-MD) introduced the bill.

Nursing Home 'Worker' Headed for White House?

One presidential candidate did morning nursing-home rounds recently. That's right. John Edwards, a Democrat who ran for vice president in 2004 and is running for the top spot in 2008, helped deliver breakfast and perform personal care duties for residents at the Sarah Neuman Nursing Home outside New York City. Edwards was participating in "Work a Day in My Shoes," a program sponsored by the Service Employees International Union. The program introduces presidential candidates to the daily life of frontline workers to understand the challenges of the jobs. "I think all politicians should take a page from his book," said Elaine Ellis, a certified nursing assistant who escorted Edwards on her early morning rounds. (McKnight's Online)

Advancing Excellence in America's Nursing Homes Announces Early Registration Recognition

"Trailblazers" will be recognized for leadership in the Advancing Excellence campaign. Nursing homes that register for the Advancing Excellence in America's Nursing Homes campaign by May 14, 2007 will receive "Advancing Excellence Trailblazers" recognition and publicity as early registrants. Signing up is an important way for nursing homes to demonstrate that quality of life for nursing home residents and staff is a top priority. To be designated a "Trailblazer," a facility must register for Advancing Excellence no later than May 14, 2007. The significance of this May date is that May 13 to 19 is National Nursing Home Week and the month of May is Older Americans Month. After May 14th, the campaign will distribute information publicizing listing each state's "Trialblazers." If you have not yet registered, you may do so at www.nhqualitycampaign.org.

H.O.P.E. advances the interest of Hoosier owned and operated providers of health care, housing, and assistance services for the elderly.
The Mandate for Restraint Reduction

It has come to our attention that some of you have been asked by survey staff why you are working to reduce restraints. Here are some facts about CMS expectations for restraint reduction.

The Government Performance Rating Act (GPRA) is the federal government’s commitment to hold federal agencies accountable. In the GPRA, the Department of Health and Human Service (DHHS), which includes the Centers for Medicare & Medicaid Services (CMS), has established numerous goals for measuring and improving long-term care. One of these goals is "Decrease the Prevalence of Restraints in Nursing Homes." This is a goal for Indiana State Department of Health Surveyors. Attempts to dissuade you from restraint reduction by state surveyors should be reported to the survey agency.

The method for reduction was assigned to the State Survey and Certification Program through the Guidance for Surveyors. From Fiscal Year (FY) 1996 (which was the baseline year) through 2002, rates steadily improved from 17.2 to 9.6 percent. http://www.cms.hhs.gov/GPRA/Downloads/PerformancePlan.pdf Pages 9, 60, and 203 through 204.

In the FY 2008 CMS plan, the goal for FY 2008 is 6.1 percent. "The reduction in the use of physical restraints is an accepted indicator of quality of care and may be considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves." http://www.cms.hhs.gov/GPRA/Downloads/FY2008CMSCJ.pdf Pages 109 through 110 and 222.


The section begins - 483.13(a) Restraints "The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms." Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident’s safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psycho social well-being. "'Medical Symptom’ is defined as an indication or characteristic of a physical or psychological condition. "Medical symptoms that warrant the use of restraints must be documented in the resident’s medical record, ongoing assessments, and care plans. "The physician’s order alone is not sufficient to warrant the use of the restraint. It is further expected, for those residents whose care plans indicate the need for restraints, that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities)."

Consideration of Treatment Plan - "Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g., strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. "...the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative’s request or approval."

The Mandate for Restraint Reduction

Assessment and Care Planning for Restraint Use - "The facility must design its interventions not only to minimize or eliminate the medical symptom, but also to identify and address any underlying problems causing the medical symptom."

Procedures - "Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential for a decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression or inappropriate use of restraints."

Probes - "1. What are the medical symptoms that led to the considerations of the use of restraints? 3. Can the cause(s) of the medical symptoms be eliminated or reduced? 8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained resident' strength and mobility?"

Additionally, CMS added responsibility to the Medicare QIO program to work with nursing homes to reduce restraint use. Goals for the QIOs vary depending on the prevalence rates within the nursing homes in the Identified Participant Group (IPG). In Indiana, the IPG group baseline was in the range requiring a 35% relative improvement. Currently the group stands at approximately 17% relative improvement at the end of Quarter 3 of 2006. The state figures are not as good.

The newest national initiative for improving nursing home care is "Advancing Excellence in America’s Nursing Homes." This is a voluntary effort to bring together nursing homes, agencies, organizations, and individuals to support improvement. Indiana currently has 98 nursing homes signed up for this two-year initiative. Of those 98, restraint reduction was ranked as the fifth highest goal set. http://www.nhqualitycampaign.org/.

**April 2007**

**CMS Warns of New Interpretive Guidance for 2 F-tags**

CMS announced that it will unveil revisions to two F-tags after previously stating that fiscal year 2007 would not see any changes. In June, facilities should expect to see new survey guidance on Feeding Assistants. Then, as early as July, revisions to F324 - Accidents and Supervision will emerge. These will be the only changes to F-tags released in the upcoming fiscal year, according to CMS officials. The fiscal year for CMS ends September 30th. We have no word on what guidance might be released from October 1 to December 31, 2007.

**March 2007 Revisions to the MDS 2.0**


**Phase 4: National Nursing Home Testing & Final Revisions - National Validation and Performance Testing**

The national validation and evaluation of the minimum data set, version 3.0 (MDS 3.0) includes approximately 70 community nursing homes and 2800 residents, regionally distributed throughout the United States. The Veterans Administration (VA) sample includes 20 nursing homes (NHs) regionally distributed. To view the document, go to http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS30Phase4.pdf.

**CMS Revisits User Fee**

Officials from the Centers for Medicaid & Medicare Services (CMS) recently gave notification that they are working on regulations to impose user fees on all survey revisits, except those required for initial certification. The revisits for which a fee would be imposed include on a standard survey, for an abbreviated survey and for a substantiated complaint. Potentially, the fee could be imposed for on-site revisits and telephone and written verifications that a facility is back in compliance. Facilities will have to pay the fee even if cited deficiencies are overturned; and, the fee will be imposed in addition to whatever penalties are assessed against nursing homes for deficiencies. The fees were authorized under the spending bill that funds most federal programs through the end of September; now is the time to halt these fees and prevent their renewal.

**More on Supportive Documentation Guidelines**

Since the comments about the Supportive Documentation Guidelines appeared in our last newsletter there was an update to the guidelines sent by way of an IHCP Banner page. To see the Banner Page that includes the change go to http://www.indianamedicaid.com/ihcp/Banners/BR200711.pdf.

**Providers to Get Help with ID Transition**

The Centers for Medicare & Medicaid Services is offering assistance for providers transitioning to National Provider Identifier. "Good faith" operators who cannot convert to NPI use by May 23 without incurring problems can receive up to 12 more months to make the transition, the government announced. The shift is mandated by the Health Insurance Portability and Accountability Act. The NPI replaces various older identifiers, including Medicaid provider IDs and various PIN designations.

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CMS Change Avoids Confusion with Provider Name Change

In order to avoid confusing the National Provider Identifier (NPI) with the Medicare/Medicaid Provider Number, CMS changed the name of the latter to the CMS Certification Number (CCN). The purpose of this name change is to distinguish between the two roles each play. Effective immediately, CMS states that the CCN will serve its same purpose as the former Medicare/Medicaid provider number and continue to be issued to certified providers and suppliers and to verify Medicare and Medicaid certification on all survey and certification and resident assessment transactions, according to CMS. SNFs should continue to use their NPIs for claims, remittance advice, eligibility inquiries, prior authorization and referral, and claim status. (CLTC Weekly, 3-21-07)

CMS Updates Minimums for Medicare Legal Challenges

The initial minimum amount for hearings before an administrative law judge was set at $100 in 2005. It increased to $110 on Jan. 1, 2006. CMS's decision is to retain the $110 minimum for calendar year 2007. The initial amount for federal district court appeals was set at $1,000 in 2005, and it increased to $1,090 on Jan. 1, 2006. For 2007, the amount increases once more, to $1,130. These minimums apply to providers, physicians, and suppliers who submit claims to a wide variety of Medicare contractors. These contactors include fiscal intermediaries, carriers, regional home health intermediaries, Part A/B Medicare administrative contractors, and others. (MHHA Monday Mailing, 4-16-07)

Payment Details about the Herpes Zoster, Other Vaccines

The FDA approved a Herpes Zoster vaccine in May 2006 for adults over 60. The law provides for the vaccine, called Zostavax, to be covered by Medicare Part D prescription drug plans; however, physicians are not in Part D. Therefore, the Indiana State Medical Association (ISMA) advises physicians contact the patient's Part D carrier to identify the appropriate way to handle requests for this vaccine.

Also, the Tax Relief and Health Care Act of 2006 passed by Congress provided that Medicare Part B pay for administration of vaccines covered by Part D at the same rate physicians receive for administering flu and pneumonia vaccine.

A new code — G0377 — was established for administration of HZ and other Part D vaccines. You can submit claims with the G0377 code to Part B carriers in 2007 even though patients submit claims for Part D vaccines to their Part D plans.
Respecting Others' Personal Space: Guidelines You Need to Follow

Have you ever been in a situation when someone invaded your personal space? Perhaps someone has stood too close to you as you converse, or maybe you've been the recipient of an unwanted hug. These situations most likely cause anxiety or just make you feel plain uncomfortable. Furthermore, you probably find it extremely difficult to concentrate and contribute to the conversation. However, in most cases the personal space offender has no idea that he/she has made you feel this way. This is because everyone has different boundaries for personal space. Some prefer conversations from afar while some like to express themselves more physically and at a closer range.

Proxemics: A guide to personal space

American anthropologist Edward T. Hall developed a field known as "Proxemics," which is the study of a person's behavioral use of space. He has assigned and titled areas of personal space into four distinct zones:

The Intimate Zone
This zone would be considered for whispering and embracing and would encompass 18 inches around your body.

The Personal Zone
This zone would be used for conversing with close friends and would encompass a zone between 18 inches to 4 feet.

The Social Zone
This zone would encompass space of 4 to 10 feet around your body. It would be used for conversing with acquaintances.

The Public Zone
The public zone is used for interacting with strangers. This zone encompasses between 10 to 25 feet.

Knowing these basics of personal space can help you deal with co-workers, your social life, and family. If an acquaintance has moved into the intimate zone, it is completely acceptable to take a step or two back; the other person will most likely get the point. If he or she doesn't, it's time to say something like, "I can hear you just fine from here, there's no need to get closer."

Furthermore, by using this guide, you may be quicker to realize that a co-worker is feeling uncomfortable with you. You can then adjust your proximity to help make your conversations more effective. The ability to know when to "stay away" or "come closer" ultimately helps us adjust to new situations and become better communicators. (Clint Maun, www.clintmaun.com and www.maunlemke.com)
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