Medicaid Proposes Restructuring
IGT Payment Distributions

A growing number of Indiana nursing homes are participating in the Intergovernment Transfer payment (IGT) program for Non-state Governmental Owned or Operated (NSGO) facilities. Facility owners lease their nursing homes to a county hospital which then becomes the licensee. Typically, the current owner becomes the manager of the facility.

The purpose of this arrangement is to obtain additional reimbursement “supplemental payments” from the federal government without the State paying its match. The additional reimbursement is the difference between the rate Medicare would pay, if the residents were covered, less the Medicaid rate (minus items not covered by Medicaid such as prescription drugs). The proxy Medicare rate is the “Upper Payment Limit” (UPL).

The NSGO writes the State a check in the amount of the State share of the additional reimbursement. This is the IGT. The State then pays the hospital the full amount of the additional reimbursement using the IGT and the federal match. Under the current methodology, the payment calculations for all participating facilities in the state are pooled and then distributed to NGSOs based on their proportion of total Medicaid days in the pool.

The Office of Medicaid Policy and Planning (OMPP) is proposing a change in this distribution approach. Under the proposed methodology, a supplemental payment for each participating facility will be calculated as the difference between each facility’s specific Medicaid per diem and the reasonable estimate of what would have been paid to the facility using Medicare principles, times the number of Medicaid days for that facility. In other words, a facility’s payments would be based on its circumstances and not on the average for the total pool.

This proposed change has not been publically released. When it is, comments can be made to Medicaid. The proposal will be posted at http://in.mslc.com.
New Medicaid Audit/Compliance Procedures for Inadequate Records

The new state plan amendment implementing the changes in the Quality Assessment (QA) resulting from the 2011 legislation maximizing the QA included a change in the penalties for not providing adequate records or documentation during a cost report audit. Facilities will have 30 days to produce the information and will be provided a 30 day extension. If the information is not provided in this time frame, the facility’s rates will be reduced by 10% starting the next month until the information is provided.

Medicaid shared a procedures overview for this new process which can be viewed at the HOPE website, www.hoosierownersandproviders.org.

OMPP Approves LTC RAC Audits

The Office of Medicaid Policy and Planning (OMPP) has authorized Health Management Systems (HMS), the Recovery Audit Contractor (RAC) vendor, to perform a comprehensive review of financial activity for each Medicaid-enrolled resident in an Indiana Health Coverage Program (IHCP) nursing facility. The audits will cover a three-year review period adjusted by a one-year look-back period from the date when each audit commences. Because claims filed within the most recent 12 months are excluded (due to timely filing allowances), audited claims can date back four years.

The HMS audits will focus on, but are not limited to:

- Payments made for dates of service after date of discharge
- Duplicate Medicaid payments
- Appropriateness of reporting Medicare or other third-party payments
- Errors related to patient liability application or collection

HMS expects to review all nursing facilities on a two-year cycle. Audits are expected to begin in September 2012.

Recent ISDH Provider Meeting

At the recent meeting with provider associations, the Indiana State Department of Health (ISDH) stated that they were informed on a call with CMS that surveyors are now supposed to ask facilities, when they are surveying, the following two questions:

- What is the facility doing regarding Dementia care?
- What is your facility doing to reduce antipsychotic medications?

This is to help raise facility awareness regarding CMS’s focus on Reducing Inappropriate Use of Antipsychotic and improving Dementia Care in Nursing Homes.

There have been no changes to the Regulations regarding this initiative; however there is a new focus in this area by surveyors.

2012 IHCP Annual Provider Seminar

The Office of Medicaid Policy and Planning (OMPP) and HP Enterprise Services invite Indiana Health Coverage Programs (IHCP) providers to attend the IHCP Annual Provider Seminar October 23-25, 2012, in Indianapolis. There is no cost for the seminar.

The seminar features three full days of important information, including program overviews and billing guidelines for specific programs, as well as sessions on Medicaid Recovery Audit Contractor (RAC) audits and member eligibility. HP, ADVANTAGE Health Solutions, Anthem, Managed Health Services (MHS), MDwise, MAXIMUS, and the Division of Family Resources will lead sessions – see the seminar lineup on the website to select your “can’t-miss” sessions.
New to the Association, Integrity Care, LLC, is based in West Lafayette. Integrity provides 24 hour non-emergency medical transportation services and homemarker, companion and attendant care services. It is Medicaid certified for transportation and waiver services. Integrity emphasizes good character and integrity in all it does; showing compassion, love and kindness. It is motivated by the simple fact that everybody is entitled to the highest quality of care. It is driven by the need to give people opportunity to stay in their home environment to get care as long as their health conditions permit it. Contact information for Integrity: Ranti Ladapo, 765-463-7111, integritycarewl@gmail.com, website www.integritycarewl.com.

Preferred Podiatry Group (PPG) is a long-standing associate member of HOPE. PPG was founded by Dr. Sanford Mason in 1972. The following year PPG began to work with physicians and nursing home administrations to provide the most comprehensive and reliable foot care program available. Today, PPG’s "Managed Foot Care Plan" has become the standard in the podiatric industry.

PPG currently has a large staff of highly qualified podiatrists complimented by an excellent administrative support team. The doctors follow all OSHA and OBRA guidelines and adhere to the company’s Quality Assurance/Infection Control Protocol. PPG’s quality assurance program is governed by our Medical Directors. All podiatrists at PPG are periodically and randomly reviewed. Long-term care facilities are chosen to participate in the quality assurance review. The Medical Director reviews charts, treatments and patient billings of the podiatrist. Follow-up interviews are made with the doctors and in-house staff. Outcome reports are logged and filed. Preferred Podiatry Group’s Quality Assurance/Infection Control programs are documented and available to the long-term care facilities upon request.

In 1999 PPG was appointed to the Provider Communications (PCOM) Advisory Group, which provides a forum for a group of key Medicare Part B providers to communicate with National Government Services Part B Provider Relations staff. This involvement is based on our continuing desire to stay at the leading edge of long-term care.

PPG is currently serving long-term care facilities throughout Illinois, Indiana, Wisconsin, Missouri, Texas, Kentucky, and Arkansas.

Mission Statement
To remain the premier provider of comprehensive podiatric services to the long-term care community by:

- Enhancing the quality of life of the residents
- Providing exceptional patient foot care
- Improving access to care
- Assisting the facilities with compliance regulations
- Exceeding the expectations of the nursing homes we serve

Philosophy
Preferred Podiatry Group (PPG) is committed to creating and maintaining excellence in all programs. We strive to offer new and improved programs and services to benefit the residents and facilities we serve. We maintain professional staff and physician relationships with integrity, compassion and ethical conduct.

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Use the Provider Education Quick Link in the right navigation panel of the provider home page for easy access. The registration page provides instructions, including the Workshop Registration Tool Quick Reference. If you register online, you will receive immediate confirmation. All registration is on a first-come, first-served basis, so sign up early for the best selection.

(continued on the back)
Walk-in registrations will be allowed; however, it is not recommended. The most popular sessions fill up well before the start of the seminar, and walk-in registrants will be allowed to attend sessions only as space is available.

**Governor’s Representatives Update Legislators on Implementation of ACA**

Governor Daniel’s health care team in charge of heading up Indiana’s response to the Affordable Care Act made a presentation to the members of the Health Finance Commission and the insurance committees on the current status of implementation of the ACA in Indiana and issues to be resolved. The following article from the Indiana Business Journal provides a summary of the meeting: http://www.ibj.com/daniels--health-care-team-says-answers-pending/PARAMS/article/36787

**Indiana Compensation and Benefit Survey**

The 2012 HOPE/LeadingAge Indiana Compensation and Benefit Survey has been released! Forty-six participant organizations were sent a copy of the results of the survey. The report is significantly revised and updated from prior years. The results are broken out by provider type, size and region.

Members who did not participate may purchase a copy of the 136-page report for $150. Please call the LeadingAge Indiana office at 317-733-2380 for more information.

**Upcoming Education Opportunities**

October 30—MDS Basics  
October 31—MDS Beyond the Basics  
November 6—Medicare Beyond the Basics  
November 7—MDS for Non-Nursing  
November 8—Assisted Living Compliance (AM)  
November 8—Quarterly Compliance (PM)  
November 13—Leadership Training  
November 14—HFA Preceptor Certification Course

(Brochures enclosed with this newsletter.)
Federal Update
Congress made a brief appearance before adjourning on September 21st until after the November elections.

Medicare/Medicaid: Nursing homes are due to receive a payment update October 1 which will average 1.8%. The actual update for individual facilities will vary according to their case mix and geographic location.

The major issue potentially affecting Medicare and Medicaid is sequestration, the automatic spending cuts due to take effect on January 1. If sequestration goes into effect on January 1, all health care providers will get a 2% cut in Medicare reimbursement. Housing programs would likely get approximately an 8% cut in funding.

Before the election, there is virtually no chance that Congress will pass an alternative to the automatic spending cuts. There has been speculation about whether the lame duck Congress could pass a budget measure that would avert sequestration. An added incentive is that the national debt limit will have to be raised again in late December/early January.

Republican leaders in Congress have indicated some willingness to “kick the can” farther down the road at the end of this year by passing short-term bills to keep the government in operation into the spring of 2013. This is a particularly likely development if Republicans gain a majority in the Senate in the next Congress and/or if Governor Romney wins the presidential race. At that point, Republicans would want to defer action on budget issues until the new Congress when they would control the agenda.

If as a result of the outcome of the election, control of the White House and/or Senate shifts, each party may perceive an advantage to delaying work on a spending bill until new party members come in in January, or conversely getting a spending bill done in December while the party still retains a majority.

Stakeholders are urging legislators in both parties to take a balanced approach to deficit reduction that does not disproportionately burden programs serving elders, particularly those with low to moderate incomes.

Medicare observation days: Provider groups continue to advocate for the Improving Access to Medicare Coverage Act, S. 818 in the U.S. Senate and H.R. 1543 in the U.S. House of Representatives.

The bill would specify that a Medicare beneficiary hospitalized under observation for more than 24 hours would be deemed to have been an inpatient and would be considered to have been discharged upon leaving the hospital. Under these circumstances, the beneficiary would be eligible for Medicare Part A coverage of post-acute care. The legislation would correct the present situation under which lengthy hospital stays have been deemed, sometimes retroactively, as being for observation rather than inpatient stays, making the beneficiary ineligible for Medicare coverage of any subsequent skilled nursing facility stay.

Congress will have to pass the annual Medicare bill in December to prevent a big reimbursement cut for physicians. Many hope to attach the provisions of the Improving Access to Medicare Coverage Act to the end-of-the-year Medicare bill. (See a related article in the CMS News insert with this newsletter.)

Fiscal 2013 stopgap spending bill: Congress has passed H.J. Res. 117. The continuing resolution keeps federal agencies in operation through March 27, 2013.

(continued on the back)
Funding is provided at fiscal 2012 levels plus a 0.06% increase for programs subject to appropriations. Those programs include Section 202 housing and Older Americans Act home- and community-based services funding.

Medicare reimbursement is not subject to appropriations. CMS has indicated that nursing homes will get a payment update averaging 1.8% beginning on October 1. The actual payment update will vary according to case mix and geographic location. Medicaid funding to the states is not subject to appropriations and will go to the states under the existing formula.

Administrative funding for Medicare and Medicaid is subject to appropriations. Under the terms of the CR, administrative funding for activities like nursing home surveys will be at the 2012 level plus a 0.06% increase.

Obama Administration report on sequestration: [http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf](http://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/stareport.pdf)

On Friday, September 14, the White House finally issued the report on the potential impact of automatic spending cuts ordered by the Budget Control Act of 2011, as mandated by the Sequestration Transparency Act which Congress passed in August.

The automatic spending cuts (sequestration) will hit both defense and domestic programs. Medicaid is one of a handful of programs that will not be affected. Medicare reimbursement to health care providers will be cut by 2%. These cuts will amount to an $11 billion cut in Medicare spending.

The report estimates the cut in Section 202 housing funding at 8.2%, amounting to $31 million (p. 111). Section 811 housing for people with disabilities would get an 8.2% cut, amounting to $14 million (p. 111). The report notes that Older Americans Act programs under the Administration on Aging are subject to sequestration but does not provide a figure on the amount of the cuts.

If Congress allows the automatic spending cuts to go into effect, the funding cuts will be applied to the amounts the programs received under the continuing resolution. So the 0.06% increase in funding for Section 202 and Section 811 housing and the Medicare payment update will disappear as of January 1 and spending for the remainder of the year will be lower.

Congress will take no action before the election to head off sequestration. Any hope of averting the automatic cuts lies in the post-election lame duck session.

There are three potential scenarios:

- In the lame duck session, Congress could adopt a budget plan for fiscal 2013 that would provide for the amount of deficit reduction called for in the Budget Control Act;
- Congress could vote in the lame duck session to delay sequestration (which many folks think is the most likely possibility); or
- Congress could let the spending cuts take effect and let the new Congress figure out how to modify or cancel. Some analysts have pointed out that funds already in the pipeline for federal agency activities and projects could prevent the automatic spending cuts from being felt immediately on January 2.
**Flu Season 2012-2013**

With the end of summer, it is time to begin planning for the 2012 - 2013 flu season. The U.S. Centers for Disease Control and Prevention (CDC) has released information and resources about the upcoming flu season. The CDC Web site provides information about vaccines and what individuals should know about the flu. The information is available at [http://www.cdc.gov/flu/about/season/upcoming.htm](http://www.cdc.gov/flu/about/season/upcoming.htm).

The Indiana State Department of Health (ISDH) has information about the flu located at [http://www.in.gov/isdh/25462.htm](http://www.in.gov/isdh/25462.htm).

The National Council on Aging (NCOA) provides free resources to help educate older adults about the seriousness of influenza, the importance of annual influenza immunization, and available vaccine options. A toolkit for professionals is available at [http://www.ncoa.org/improve-health/community-education/flu-you/flu-you-resources-for.html](http://www.ncoa.org/improve-health/community-education/flu-you/flu-you-resources-for.html).

**Effects of Delirium are Found to Linger**

For years, people thought of it as a transient condition: Patients, especially older ones, grow confused and irrational and sometimes even violent during hospital stays—then in a few days, the delirium passes and people return to themselves. Evidence increasingly shows that the mental effects of delirium linger. In Archives of Internal Medicine it indicates that it takes a terrible long-term toll on those who can least afford to lose cognitive ground: people with Alzheimer’s disease.

In the study deterioration as measured by memory and concentration tests, proceeded at more than twice the rate of those who hadn’t experienced delirium. “This study stands a stark warning of the potential long-term dangers of hospitalization, regardless of whether people have dementia,” states Dr. Alden Gross. Most of the time, the condition goes unnoticed by doctors and nurses, Dr. Gross said.

The task of preventing delirium not only falls to the medical pros, but to family members. Seemingly small efforts—having large clocks and calendars in a hospital room, keeping the environment dark at night and bright during the day to reduce sleep disruption, bringing familiar belongs from home—have been shown to help keep patients oriented.

The evidence of prolonged impairment raised the issue of hospitalization itself. We still tend to think of the hospital as the safest place for older people to be when things go wrong. Yet research increasingly points to its dangers, of which delirium is only one. For old people, heading for a hospital should never be a casual decision. “You don’t want to withhold hospitalization, but it’s useful to keep in mind that it’s not always a great thing,” Dr Gross said. “Be smart about it.” (Paula Span, *The New York Times*)

**Minding MDS Accuracy**

Build a strong MDS Team. To mitigate the loss of payment, it is critical for the administrators to support solid teamwork and strong systems within the MDS department so that common scheduling pitfalls can be avoided.

The following are some strategies for success in this area:

- Daily stand-up meeting. Improves communication between therapists and the MDS nurses. They do this by using the resident roster to review the resident’s Medicare information.
- The team needs to use the allotted time to cross-check accuracy of the MDS, while corrections can be made without penalty, before the record is submitted. To minimize errors, CMS recommends that the MDS team utilize the 14-day coding period and the 7-day encoding period allowable by federal regulation.
- Have more than one schedule for MDS assessments. It is critical that both the therapy department and the MDS scheduler keep track of the assessment schedule. They can then compare their separate schedules at the daily meetings to ensure that End of Therapy, Change of therapy, and other assessments are not missed and that their schedules match.
- Have a trained back-up person. Errors occur because the MDS scheduler does not have a trained back-up. The MDS scheduling system should be well-defined, and multiple team members should be able to use it.

(Judi Kulus, NHA, RN, *Provider September 2012*)

**Five Reasons to Educate Residents About Their Illnesses**

Residents often enter long-term care with little knowledge about their conditions, whether they have a recent diagnosis or have been living with an illness for many years. The lack of information isn’t good for residents, families or facility staff.

(continued on the back)
Here are 5 reasons why we should teach our residents about the illnesses they live with:

1. **Education leads to more active resident involvement in care.** When residents have information about their illnesses, they are more able to accurately report their symptoms to the medical team and to provide the type of information that improves treatment. A resident without knowledge is a passive recipient of medication and care; a resident with knowledge can partner with his or her medical team to address needs and find effective solutions.

2. **Knowledge increases compliance.** Uneducated individuals are less likely to comply with treatment recommendations or may reject medications due to side effects without fully considering potential benefits. Individuals who understand why particular medications are given and how to cope with potential side effects are more likely to comply with treatment. They’re also more likely to have reasonable informed objections for foregoing a particular course of treatment—reasons that can be readily understood and documented.

3. **Information reduces anxiety.** When faced with an information vacuum, people often assume the worse.

4. **Information helps residents fulfill their roles as educators.** Residents are no different than others with illnesses who find themselves in the role of having to explain their disease to others around them. Residents may need to describe to aides why their osteoarthritis makes it so difficult to get out of bed, or to their family members why their diabetes makes it dangerous for them to eat the birthday cake. Providing residents with information about their illnesses and about how others handle similar conditions can reduce their stress and improve the ability to communicate with those around them.

5. **We need to prepare ourselves for the boomers.** While the current cohort of nursing home residents tend to view the medical team as the decision-makers, the upcoming baby boomers are likely to demand a more active role in their healthcare. They will expect information about their diagnoses and treatment and to have educated discussions with their physicians and other team members. LTC facilities looking to appeal to the coming boomers will benefit from determining now which resident education techniques work best for their facilities.

(Eleanor Ferdman Barbera, PhD, Long-Term Living Magazine, August 21, 2012)

**Long-Term Care Providers to be Studied by CDC**

CDC is releasing the National Healthcare Safety Network (NHSN) as a tool for the identification, reporting and analysis of healthcare associated infections. This will allow nursing homes and other long-term care facilities to monitor healthcare-associated infections. The new NHSN will allow facilities to track *Clostridium difficile*, drug-resistant infections such as methicillin-resistant *Staphylococcus aureus* (MRSA), urinary tract infections and healthcare worker adherence to basic infection control procedures including hand hygiene and glove and gown use. NHSN’s component is ideal for use by nursing homes, skilled nursing facilities, chronic care facilities and assisted living and residential care facilities. To access or enroll your facility in NHSN’s long-term care component, see CDC’s website, [http://www.cdc.gov/nhsn/LTC/index.html](http://www.cdc.gov/nhsn/LTC/index.html). (CDC)

**How Nursing Homes can Cut Hospital Readmissions**

By some estimates as many as 60% of re-hospitalizations are preventable. Nursing facilities and their partner hospitals are taking steps to cut these readmissions. Some of this is being driven by new Medicare rules. Among them: On Oct 1, Medicare will begin cutting payments to hospitals where too many patients are readmitted within 30 days of discharge. While the initial penalties are modest and for only 3 conditions—heart failure, pneumonia, and heart attacks—they will gradually stiffen.

Hospitals are improving discharges and keeping a close eye on patients after they leave. Many are putting transition programs in place—often using care managers, social workers, or nurses—to assist patients who are discharged to home. They are beginning to work more closely with nursing facilities to reduce readmissions.

The best nursing facilities are making big changes of their own. They include:

- Increasing staff and improving training for nurses and aides to help them identify and treat situations that can lead to hospitalizations. These steps often prevent a crisis before it occurs.
- Working with primary doctors to encourage them to allow the nursing facility to treat many acute episodes rather than ordering patients back to the hospital.
- Asking patients, residents and their families whether they want to be hospitalized.

Steps such as these are important since more patients are receiving post-acute and post-surgical care in skilled nursing facilities rather than in hospitals themselves.

It is important to keep in mind that reducing hospitalizations is not the goal: The real goal is improving the quality of care for these patients, many of whom need both medical care and personal assistance. Sometimes, they should be hospitalized. But often, they can receive the best care by staying where they are. (Howard Gleckman, Forbes)
CMS SNF ODF
On August 23 CMS held a SNF Open Door Forum (ODF):

Announcements:
- FY 2013 SNF PPS Update Notice Published on August 22; 1.8 percent increase for FY13.
- MDS Manual Update: CMS is “diligently putting together next update for fall, 2012.” May not be ready by October 1, but definitely this fall.
- MDS User’s Manual Version 6.0 will be published in September [includes specs for the QMs].
- Antipsychotic Quality Measures (QMs) are now on Nursing Home Compare; previous indicators have been taken down. QMs are based on MDS data; “up-to-date and current.”
- Partnership to Improve Dementia Care in NHs: ‘Up to ears” in contacting states regarding development of state-based coalitions to support/implement this initiative; CMS has contacted 48 States to date. Included in the calls are e.g., State Survey Agencies; State Medicaid Agencies; QIOs; various other State-based Aging Organizations. The goal is to develop an action plan to help facilities start this initiative; have developed some provider resources and tools that can disseminate to providers to help get started. CMS has also been receiving follow-up from coalitions where the initiative has already started; hearing a lot of success stories, i.e., that information is trending in right direction already. CMS has an email address dedicated to this initiative: dnh_behavioralhealth@cms.hhs.gov.
- MDS 3.0 frequency report: The web page has been taken down. CMS found issues identified with the calculation of percentages and is currently recalculating. Once done, by the end of October is the goal, will repost the reports.

Q & A:
- Is there going to be change to the resident interview section of the 6.0? Nothing official/definitive at this point.
- Phase-in project of comparing MDS’ with claims; when will SNFs be phased into that process? No one available that can answer this question; please mail to ODF mailbox.
- Missed assessments; Part A; 3 required change of therapy assessments, but not done; still on Part A. What does facility have to do to cover? Can’t allow submission of assessment with duplicate ARD; mail in question with specific scenario and CMS will respond.
- Info on establishing the ARD promptly after admission; what happens when don’t set; facility liability? July 12 Open Door Forum Encore is no longer available; send in & will send transcript directly.
- How long do validation reports need to be maintained at facilities after MDS submission? No mandated timeframes, but do recommend they be printed; have to check with medical review, but believe in neighborhood of 5 years.
- Is there a date to release of revised 671/802 to vendors/providers? No date at this point – will look into further; send question in & will respond.
- RAI 3.0 manual due out this fall? – When will the changes targeted for 10/1 go into place? When the manual is posted, not before.
- When will the Hand-to-Hand Video be available? Late September; notice will be sent out.
- Dementia-care Initiative: Will CMS have a website with all of the tools, actions being collected from all of the states? Not looking at a website at this point, but have been partnering with Advancing Excellence; has a link that lists a lot of the resources identified to date; will also link to tools when available. Will also develop a resource on AE re: the emails / Q and A’s received.
- NH Compare: Under the previous system, facilities with less than 100 beds were assigned the state average if not enough assessments; still the same? Can’t answer; please email to ODF.

The next Open Door call will be on October 4, 2012.

CMS: Therapy Cap Exception Pre-Approval Process
The therapy cap ($1800 for physical therapy and speech language pathology services combined and $1800 for occupational therapy) has been around for many years, and several years ago Congress implemented an exceptions process to pay for medically necessary services beyond the cap.

Congress typically extends the exceptions process when it over-rides the scheduled cuts in the physician fee schedule. There is also an upper threshold for 2012 ($3700 for PT and SLP and $3700 for OT), and this year providers will be required to submit a pre-approval request for an exception that exceeds the upper thresholds.

Once a beneficiary reaches the $3700 threshold, there will be no automatic exception based solely on the specific diagnoses and the KX modifier on the claim. Instead, certain providers must submit a request for pre-approval to its Medicare Administrative Contractor in advance of providing the therapy services above the $3700 threshold.

Provider Phases: CMS has divided providers into three phases that cover specific periods of time, as follows:
- Phase I October 1, 2012, to December 31, 2012
- Phase II November 1, 2012, to December 31, 2012
- Phase III December 1, 2012, to December 31, 2012

Providers may go to the link below to determine which Phase they have been assigned (you are in Phase III if not listed in Phase I or II). https://data.cms.gov/dataset/Therapy-Provider-Phase-Information/ucun-6i4t

Providers are required to submit pre-approval exception requests in advance of furnishing therapy services above the $3700 threshold if the planned therapy service date will occur in the provider’s phase.
Stay Dilemma

For years, nursing home providers and Medicare beneficiaries seeking skilled nursing facility (SNF) care have complained that hospitals are treating what once were considered inpatient stays as observation stays. On paper, that may be look like a question of semantics, especially since the care provided is the same regardless of the setting, but the real world application has been tremendously costly for many.

Under current Medicare rules, CMS pays more for Medicare Part A inpatient stays than it pays for Part B observation stays. However, if a Medicare auditor determines that a hospital inpatient stay should have been classified as an observation stay, the hospital generally loses the full Medicare payment for that stay. To be safe, many hospitals appear to be erring on the side of caution by classifying stays that otherwise would be considered inpatient as observation stays in order to avoid losing the full Medicare payment.

The dilemma lies in the fact that Medicare only will pay for a SNF stay if the resident in question has had a prior inpatient hospitalization stay of at least three days. In other words, those who are hospitalized under the “observation” patient classification are not eligible for Medicare reimbursement for their SNF stay.

The problem is exacerbated in many instances because the first time a patient is informed his/her hospital stay was an observation stay rather than an inpatient stay is when they are told Medicare will not cover their SNF stay.

A recent study conducted by Brown University appears to confirm the problem is a real one. Among the findings in that study were the following: 1) Observation stays increased by 34%, while inpatient admissions declined; 2) The average length of stay in observation increased by more than 7%, from 26.2 hours in 2007 to 28.2 hours in 2009; 3) More than 10% of the Medicare beneficiaries, or approximately 100,000 individuals, were placed on observation status for more than 48 hours, despite the fact the Medicare Manual suggests that observation generally should not exceed 24 hours and only in “rare and exceptional cases” should exceed 48 hours; and 4) The number of Medicare beneficiaries with observation stays exceeding 72 hours increased from 23,841 in 2007 to 44,843 in 2009, an 88% increase.

The Center for Medicare Advocacy in November 2011 filed litigation on behalf of 14 Medicare beneficiaries challenging this use of observation status (Bagnall v. Sibelius) as a violation of the Medicare statute, the Freedom of Information Act, the Administrative Procedure Act, and the Due Process Clause of the 5th Amendment to the Constitution.

Under the CMS pilot program, 380 participating hospitals will be given the opportunity to rebill Medicare for observation services if claims for inpatient care were rejected. The hospitals would receive 90% of the allowable Medicare payment for these services but would be required to give up their right of appeal to the American Hospital Association argues the pilot doesn’t go far enough; the Center for Medicare Advocacy states the pilot should be scrapped because it won’t help observation patients. The question for HOPE members is: Will the pilot in any way help address the problem of SNF admissions by prospective residents who find out at the 11th hour (or later) that their hospital stay was classified as observation?

The observation day situation also is being addressed in Congress. Representative Joe Courtney (D-CT) has introduced H.R. 1543, the Improving Access to Medicare Coverage Act of 2011, which would count a period of receipt of outpatient observation services in a hospital toward satisfying the 3-day inpatient hospital requirement for coverage of SNF services under Medicare. A companion bill (S. 818), authored by Senator John Kerry (D-MA), has been introduced in the Senate. Unfortunately, www.GovTrack.us gives these bills only a 1% chance of being enacted, primarily because the 112th Congress is operating under electoral inertia and the bill’s House author is a member of the minority party.

CMS Partnership to Improve Dementia Care

In 2012, CMS launched the Partnership to Improve Dementia Care in Nursing Homes to promote comprehensive dementia care and therapeutic interventions for nursing home residents with dementia-related behaviors. The goals of this initiative include a focus on person-centered care and the reduction of unnecessary antipsychotic medication use in nursing homes and eventually other care settings as well. CMS is using several approaches to successfully implement this initiative. CMS is developing and conducting trainings for nursing home providers, surveyors, and consumers. CMS is conducting research, raising public awareness, using regulatory oversight, and public reporting to increase transparency.

In addition, CMS has partnered with national organizations to encourage communication among the national organizations and their members. The American Medical Directors Association (AMDA) and the American Health Care Association (AHCA) and LeadingAge have sent letters to their membership or State affiliates this summer. The National Consumer Voice for Quality Long-Term Care (Consumer Voice) sent a press release to their membership indicating their support for the initiative.

AMDA’s letter sought to educate members about the issues to achieve the goals of the Partnership and encourages nursing home medical directors to join with AMDA and CMS in reducing the unnecessary use of antipsychotic agents by refocusing the interdisciplinary team on a better understanding of the root cause of dementia-related behaviors. The letter further provides medical directors with the tools and resources they might use to achieve this goal. The letter is located on the AMDA website at http://www.amda.com/advocacy/antipsychotic_msg.pdf.

The Consumer Voice has advocated for the appropriate care for residents with dementia, which is important to residents, their families, and advocates. In meeting with former CMS Administrator Don Berwick, MD, and current Administrator Marilyn Tavenner, Consumer Voice advocated for strong leadership from CMS to end the misuse of antipsychotic drugs in nursing homes.

If you have questions about CMS’ Partnership to Improve Dementia Care in Nursing Homes, please contact Kathleen Wilson at (410) 786-1507 or Kathleen.Wilson@cms.hhs.gov.
H.O.P.E. advances the interest of Hoosier owned and operated providers of health care, housing, and assistance services for the elderly.

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