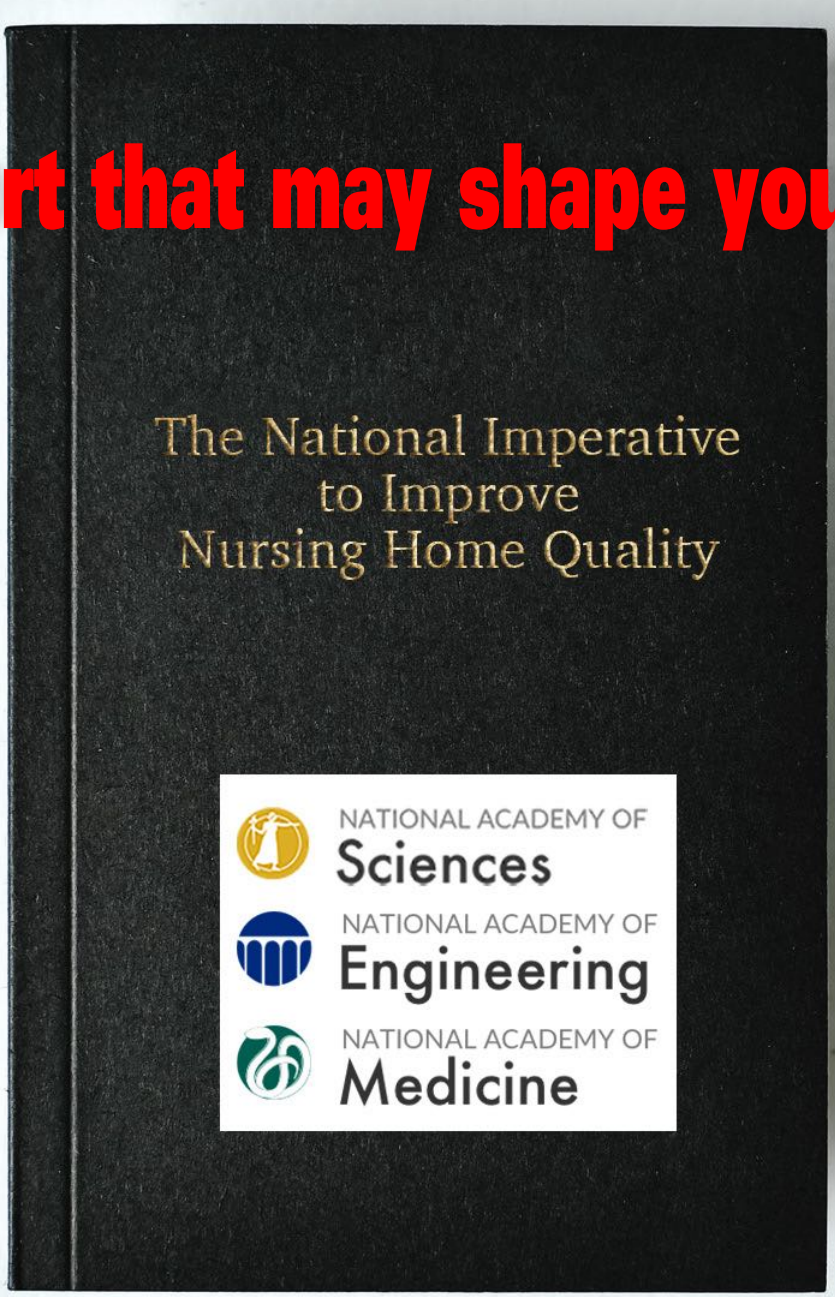
New England
ADMINISTRATOR

September
2022

"The older I get the more I remember things that never happened."
-Mark Twain

District One
ACHCA
American College of
Health Care Administrators

The report that may shape your future



ALSO IN THIS ISSUE:

Pioneer Richards Merry Bradley • Stress reduction and aging
The C.A.R.E.S. Expert • The Marketing Guru • Talking Dirty

Harmony Healthcare INTERNATIONAL

GSA

Harmony Healthcare International, Inc. (HHI)
Contract # 47QRAA22D00BZ

C.A.R.E.S.™
HHI C.A.R.E.S. About Care
Compliance | Analysis | Audit | Regulatory | Rehabilitation
Reimbursement | Education | Efficiency | Survey

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Capability Statement

HHI C.A.R.E.S. Platform

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Analysis
Audit
Regulatory
Rehabilitation
Reimbursement
Education
Efficiency
Survey

Compliance

Auditing and Monitoring
Compliance Officer Services
Compliance Plan Development
Compliance Program Hotline
Compliance Program Review
Education and Training
HIPAA
Policy and Procedure Development
QAPI Program Development and Oversight
Response, Reporting and Prevention Guidance
Risk Analysis
Risk Management Analysis

Analysis

CASPER Report Analysis
Clinically Anticipated Stay (CAS) Analysis
Compliance Analysis (Off-Site)
Five-Star Quality Rating System Analysis
Medicaid Revenue and Risk Analysis
Medicare Part A PDPM Revenue and Risk Analysis
Medicare Part B Revenue and Risk Analysis
PEPPER Revenue and Risk Analysis
Quality Measures Analysis
Staffing Analysis

Corporate Overview

Harmony Healthcare International, Inc. (HHI) founded in 2001, is a Woman-Owned Small Business (WOSB) certified by the National Women Business Owners Corporation (NWBOC). Headquartered in Boston, MA, Harmony Healthcare International, Inc. (HHI) services Skilled Nursing Facilities and other health organizations in the area of Compliance, Analysis, Audit, Regulatory, Rehabilitation, Reimbursement, Education, Efficiency and Survey.

The HHI Team is composed of on staff, accomplished professionals who serve as HHI Consultants to for-profit, not-for-profit, stand-alone and multi-facility chains across the country. Historically, Harmony Healthcare International, Inc. (HHI) has ranked among the top 5,000 fastest-growing private companies in the U.S. for three consecutive years by Inc. Magazine.

Harmony Healthcare International, Inc. (HHI) is one of the nation's leading healthcare consulting companies, helping thousands of nursing facilities and healthcare organizations, from Northern Maine to Hawaii, with providing guidance, implementing systems and assisting with oversight to ensure residents and patients receive person-centered care. All the while, safeguarding that these clients receive the support they need to stay in business.

NWBOC
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Speaking Engagements

Kris is a nationally recognized keynote speaker in the Post-Acute and Long-Term Care (PALTC) continuum specializing in nursing homes, with more than 28 years of experience in the Health Care industry. Kris began as an Occupational Therapist with a degree from Tufts University followed by a Master's in Business Administration from Salem State University coupled with a Nursing Home Administrator's License. All of which afford Kris an in-depth perspective into the clinical, financial, and operational components critical for business success. Kris works collaboratively with industry experts to create continuing education and professional development courses for clinical professionals including Occupational Therapists, Physical Therapists, Speech Language Pathologists, Nurses, and Nursing Home Administrators.

National Affiliations

AHCA American Health Care Association
NCAL National Center for Assisted Living
ACHCA American College of Health Care Administrators
NASL National Association for the Support of Long Term Care
National Association of State Veterans Homes
LeadingAge
NADONA National Association of Directors of Nursing Administration in LTC

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NAB National Association of Long Term Care Administrator Boards
ANA American Nurses Association
ANCC American Nurses Credentialing Center

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Capability Statement

Audit

Appeals and Denied Claims Management
Billing and Coding On-Site Mentoring
Compliance Auditing and Monitoring
Five-Star Quality Rating Audits and Improvement Methods
Home Care
Integrity (Therapy, MDS, etc.) Auditing and Monitoring
Managed Care Auditing and Monitoring
Managed Medicare Auditing and Monitoring
MDS Systems Assessment
Medicaid (Case Mix States) Auditing and Monitoring
Medicare Auditing and Monitoring
Medicare Part A Auditing and Monitoring
Medicare Part B Auditing and Monitoring
Mock MDS Focused Survey (Two Days)
Mock RAC (Recovery Audit Contractor) (Two Day)
Mock RAC (Recovery Audit Contractor) Therapy and MDS
Mock Regulatory Survey (Three Days)
Mock Survey Level IV
Mock Zone Program Integrity Contractor (ZPIC)
QAPI
Quality Measure Auditing and Monitoring
Skilled Therapy Documentation Review Auditing and Monitoring
Therapy Systems Assessment Auditing and Monitoring

Regulatory

Clinical Consulting (Wounds, Incontinence, Falls, Restraints, Quality Measures, etc.)
MDS Accuracy
MDS Completion
MDS Transmission
Plan of Care Monitoring
Policies and Procedures

Rehabilitation

Clinical, Financial and Operational Consulting
Program Development
Therapy Staffing

Reimbursement

Accountable Care Organization
Billing
Bundled Payment
Comprehensive Joint Replacement (CJR)
Consolidated Billing
Cost Reporting
Managed Care
Medicaid
Medicare Part A and Part B
Pre and Post Pay Claims Review and Preparation (PREP)
Revenue Cycle Management
Value-Based Purchasing

Education (live, remote, public and private)

Certification and Competency Programs
Seminars
Symposium

Efficiency

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Interim Harmony HHI Specialist
Mentoring/Coaching
Placement: Interim and Permanent
Retention Program Development
Staff Talent Enrichment

Survey

Accident and Incident Investigation
Adverse Events Focused Survey
Expert Witness Services
Facility Assessment
Five Star Quality Rating System
IDR (Informal Dispute Resolution)
IIDR (Independent Informal Dispute Resolution)
Infection Control
Mock Dementia Focused Survey (Two Days)
Mock MDS Focused Survey (Two Days – Five Days)
Mock Regulatory Survey
Plan of Correction Development
Policy and Procedure Review and Development

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THE C.A.R.E.S. EXPERT

Isolation: documentation and MDS coding

by Kris Mastrangelo, OTR/L, MBA, LNHA

The topic of isolation has produced a significant amount of confusion in the long-term care industry. The reason for the nationwide misunderstanding is because there are different definitions of the term isolation. So, before you engage in a discussion about isolation, pause and be sure to identify the context of the isolation definition subject matter.

In other words, distinguish between one of two situations. Are you and the facility team discussing Isolation in general terms or Isolation related to coding on the MDS?

Isolation in General Terms

Clinically, the CDC and CMS allows for placing two patients with the same infectious disease in the same room to "isolate" the patient from other patients and contain the threat of spread. Unfortunately, in the realm of long-term care, this scenario would not allow for the coding of isolation on the MDS. In other words, cohorting patients is clinically acceptable, but does not constitute the coding of isolation on the MDS.

Isolation MDS Coding

If you have ever experienced this misperception, most likely it is when you understood a patient to be receiving isolation, but then, out of the blue the MDS Coordinator states, "I cannot code that isolation on the MDS," and your brain cannot comprehend why this is the case. The reason is that the MDS has rules of coding, and one cannot code isolation if the patient is co-horted.

The HHI Isolation Documentation and MDS Coding Summary Sheet provides a 2-page synopsis of the requirements necessary to code isolation for each scenario.

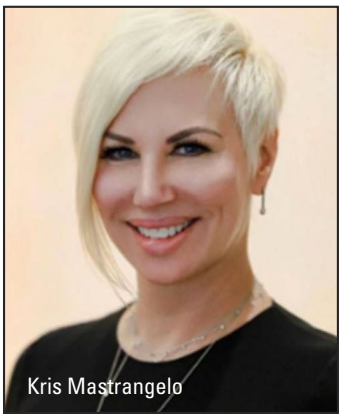
- Page 1: Isolation in general terms.
- Page 2: Isolation on MDS.

Prior to referencing the summary sheet, HHI suggests you familiarize yourself with terminology used in infection control situations. According to the CDC, isolation is for people who are ill, while quarantine applies to people who have been in the presence of a disease but have not necessarily become sick themselves. "Isolation separates sick people with a contagious disease from people who are not sick." Furthermore, "Isolation is for patients with symptoms and or positive tests," while "Quarantine is for patients exposed but exhibits no symptoms."

Using the terms "quarantine," "precautions," or "isolation" do not independently support coding isolation on the MDS, nor do they unilaterally define a clinical situation of isolation. In both situations, Isolation in general terms and Isolation related to coding on the MDS, the facility must meet five requirements:

1.) Diagnosis
2.) Physician Order
3.) Bed Placement
4.) Plan of Care
5.) Documentation

To see the differences, please reference the following HHI Isolation Documentation and MDS Coding Summary Sheet.


Kris Mastrangelo

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Isolation in General

Diagnosis:

- The resident has an active diagnosis.
- For a condition requiring transmission-based precations
- Supported in the medical record

The Physician's Order for isolation includes:

- Type of transmission-based precautions
  "Isolation with (Contact, Droplet, or Airborne) precautions related to (Diagnosis)"
- A parameter statement:
  "All services to be provided in patient room secondary to isolation precautions related to (Diagnosis)."
- An active diagnosis
- The term Isolation in the order
- A sign off confirming compliance for every shift when the resident is without a roommate

Bed Placement:

- The resident is placed in:
  - A room by themselves, or
  - With a roommate with the same diagnosis.
- Patients can co-hort, i.e., two patients with same diagnosis, in the same room. However, cannot code isolation on the MDS when patient co-horting.

Continued on page 21

Revenue, staffing and regulation: The trifecta of pain for SNFs

by Irving L. Stackpole, RRT, MEd

Long-term care operators, especially skilled nursing have endured the trifecta of pain for the past 30 months:

1. Loss of revenue
2. Staffing constraints
3. Regulation deluge

Anyone of these would be stressful, but together they are enough to make any operator asked, "Why am I in this business?" For a mission driven organization, the answer is easy; "Because they need us." However, with almost 2/3 of the operations being for-profit, the question has a very real, and sharp point. To wit, REITs are pruning SNFs from their portfolios.[1] Here is a brief review of each source, and what the segment might do now to ease the pain.

1. Top Line, Bottom Line or Flat-Line

Loss of revenue is the result of the declining utilization in the SNF sector. Occupancies had been headed downward for many years, due to both demographics and intermediaries' interventions. When the

Irving L. Stackpole

1 Loss of revenue

2 Staffing constraints

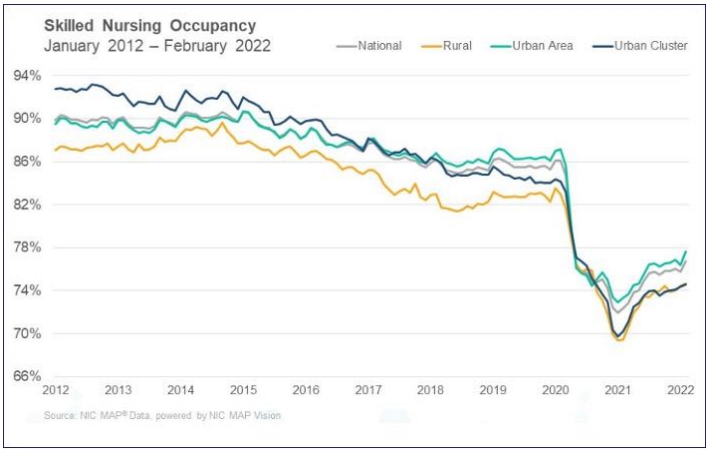
3 Regulation deluge

pandemic hit, the bottom fell out, literally. Occupancies & utilization plummeted and have only just begun to crawl back.[2] Other segments, like independent living centers and assisted living residences are recovering better than SNFs.

The "nursing home" brand took a real beating during the pandemic and will take time to recover. In addition, the relatively small, short-term rehabilitation market, which had cross-subsidized the very large Medicaid SNF market has dried up and has not returned to prior levels.

What to do?

In a declining market, the textbook response is to: 1. Protect your current market share; think "last one standing"; 2. Differentiate; what makes your operation distinct and how can you communicate these differences to the medical referral sources who are important to restoring/renewing your higher revenue consumers; 3. Increase efficiency; this doesn't mean cutting staff (more about this later) it means making sure that the right people are doing the right job at the right time. It also means using your staff resources creatively and measuring things you've never measured before, and; 4. Innovate; closely linked to number 2 (differentiation) how can you meet a distinct need in the marketplace area? What penalties are your local hospitals receiving for inappropriate readmissions, or what types of patients are your local ER's having difficulty triaging?



(NOTE: The NIC data cited here is skewed to the high side due to their sampling method; the actual averages are certainly lower.)

2. The People Who Care

Staffing constraints have been existential for many SNF operators, preventing admissions of what would be high-paying consumers because staff isn't available to care for them. Reliable estimates are that over 440,000 individuals have left long-term care, and a significant number of them from nursing homes.

The current unemployment rate is 3.6%, and the workforce participation rate is also very high. And the demographics are not in the SNFs favor either. Older, female workers, many of whom were black and/or immigrants, are among those who are still on the sidelines not working, and so far,

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What the NASEM report means for you

by Richard Gamache, MS, FACHCA

When the National Academy of Sciences, Engineering, and Medicine (NASEM) released a 600-page report on April 6th of this year, entitled, "The National Imperative to Improve Nursing Home Quality," some administrators could not be blamed if they shrugged their shoulders and said, "Just ignore it. Eventually, it will go away." After all, how many times have outside agencies and consultant groups submitted their own formulas to remedy what ails long-term care? Almost invariably, their reports end up in a three-ring binder collecting dust on a bookcase.

But this time is different.

NASEM is comprised of private, nonprofit organizations that provide expert advice on some of the most pressing challenges facing the nation and world. NASEM reports are evidence-based research and consensus-driven recommendations from experts in a wide-range of fields. Their reports inform public opinion, influence government, and shape policy. To paraphrase an old tagline from a finance company, when NASEM speaks, people listen.

"The National Imperative to Improve Nursing Home Quality," was written in the wake of the COVID-19 pandemic that saw more than 200,000 nursing home residents and staff pass away from the disease in the past two-plus years. The coronavirus exposed the flaws of our broken system for all the world to see. There has never been a more appropriate time than now to redesign long-term care.

The NASEM report concludes with the following paragraph:

"The COVID-19 pandemic provided powerful evidence of the deleterious impact of inaction and inattention to long-standing nursing home quality concerns. At the same time, the pandemic can serve as a potent catalyst to drive urgently needed innovations to improve the quality of nursing home care. Implementing the committee's integrated set of recommendations will move the nation closer to making high-quality, person-centered, and equitable care a reality for all nursing home residents, their chosen families, and the nursing home workforce."

The report reached seven overarching conclusions:

1. The way in which the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable.
2. Immediate action to initiate fundamental change is necessary.
3. Stakeholders need to make clear a shared commitment to the care of nursing home residents.
4. Ensure that quality improvement initiatives are implemented using strategies that do not exacerbate disparities in resource allocation, quality of care, or resident outcomes.
5. High-quality research is needed to advance the quality of care in nursing homes.
6. The nursing home sector has suffered for many decades from both underinvestment in ensuring the quality of care and a lack of accountability for how resources are allocated.
7. All relevant federal agencies need to be granted the authority and resources from the U.S. Congress to implement the recommendations of this report.

To address these seven areas, NASEM established seven goals:

1: DELIVER COMPREHENSIVE, PERSON-CENTERED, EQUITABLE CARE THAT ENSURES THE HEALTH, QUALITY OF LIFE, AND SAFETY OF NURSING HOME RESIDENTS; PROMOTES RESIDENT AUTONOMY; AND MANAGES RISKS

2: ENSURE A WELL-PREPARED, EMPOWERED, AND APPROPRIATELY COMPENSATED WORKFORCE

3: INCREASE TRANSPARENCY AND ACCOUNTABILITY OF FINANCES, OPERATIONS, AND OWNERSHIP

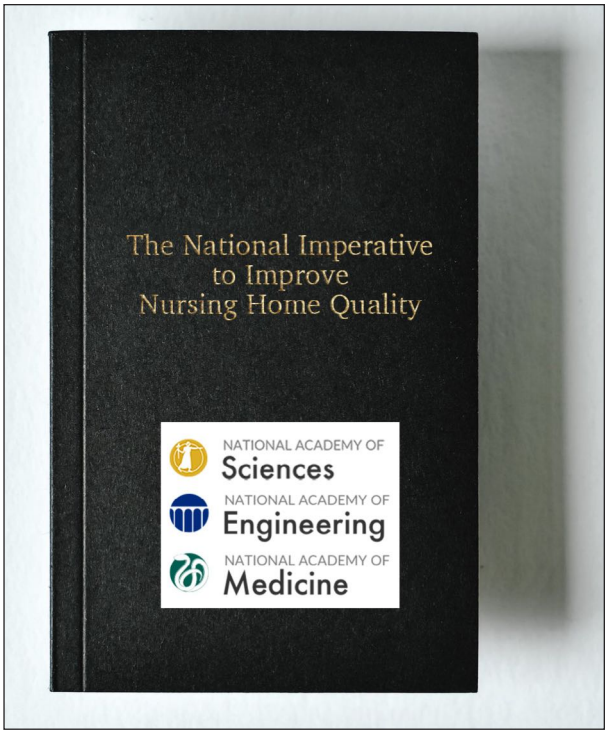
4: CREATE A MORE RATIONAL AND ROBUST FINANCING SYSTEM

5: DESIGN A MORE EFFECTIVE AND RESPONSIVE SYSTEM OF QUALITY ASSURANCE

6: EXPAND AND ENHANCE QUALITY MEASUREMENT AND CONTINUOUS QUALITY IMPROVEMENT

7: ADOPT HEALTH INFORMATION TECHNOLOGY IN ALL NURSING HOMES

The John A. Hartford Foundation is funding a two-year Leading Age initiative to extract actionable items from each of the seven goals and create plans to achieve them. Seven "Action Coalitions" were formed in August, made up of stakeholders that represent government, private ownership, faith-based, not-for-profits, consumer advocates, unions, trade associations, staff, residents, and families. The effort will be led by Dr. Alice Bonner, a geriatric nurse practitioner, Senior Advisor for Aging at the Institute for Healthcare Improvement (IHI), and former director of the CMS Division of Nursing Homes.



For decades now, course corrections in long-term care have been driven by advocacy groups, usually in response to a catastrophic event. The results of those efforts are predictable: more regulations, more inspections, and more fines. Meanwhile, costs continue to rise, and budget cuts keep occurring, with no correlations made between the reimbursement system and the regulatory system.

The NASEM report contends that all components of long-term care, including the survey process and the payment system, are interdependent on each other to attain a level of quality that is worthy of the people we serve. The piecemeal and punitive fixes that have characterized government's response to issues in long-term care have left us with some 130,000 pages of regulations, more than any other business sector and profession (including nuclear power). This "Groundhog Day" approach does not work

Continued on page 18

PIONEERS & ROGUES: Richards Merry Bradley

We regularly feature a New England individual whose accomplishments –good or bad–helped to shape our profession. In this issue, we instead highlight Richards Merry Bradley of Vermont, an influential Thomas Thompson trustee. The information is from a review of the Sophia Smith Collection Archive

by Dane Rank

IN THE SMALL STATE OF VERMONT, THE GENEROSITY AND DEDICATION OF ONE INDIVIDUAL INTRODUCED IMPORTANT SERVICES FOR CHILDREN, ADULTS, AND SENIORS.

Upon her death in 1899 after a years-long battle with "paralytic shock," Elizabeth Rowell Thompson passed away in Littleton, New Hampshire. Shortly following, Thomas Thompson's will, including his and Elizabeth Rowell Thompson's kind and kindred plans for the people of Brattleboro, Vermont and Rhinebeck, NY, took effect. A Boston attorney, Mr. Minot, and a Mr. Bradley, a local Brattleboro businessman with a real estate office in Boston became the first two trustees of this fortune. Its original designation from Thomas Thompson being for the benefit of the "shop girls and seamstresses of Brattleboro, Vermont and Rhinebeck, New York" needed consideration, as Brattleboro had changed in the time since the Thompsons took stock of the needs of the town.

Richards M. Bradley focused on the provisions of Thomas Thompson and Elizabeth Rowell Thompson to eliminate the causes of suffering. Towards this end, in 1904 the Thompson Trust funded the building of the Hemlocks (later named Brattleboro Memorial Hospital) without charging a cent to the people of Brattleboro. Richards was heard to say: "at the heart of a great town is a hospital."

In 1907, the plight of the local poor became overwhelmingly apparent to Richards, and child mortality rates were climbing, so the call went out for the local church women and townspeople to form a board from which to administer funds to maintain a local nursing health service, and later, to offer a hospital and in home care insurance prior to the establishment of Medicaid. The association began training licensed practical nurses, providing in-home care, and well-baby education and services. The Thompson School of Nursing was established and would operate as the longest running nursing program in North America until 1992, when it was transferred to Vermont Technical College due to regulation changes for institutions of higher education and the education of nurses.

By 1914 the association was providing school nursing services to local preschools and public schools, often providing clothing and food to students who couldn't come without them. By 1935 the association regularly provided diphtheria services, immunization clinics, and free dental work for all school-aged children in Brattleboro and the surrounding towns. They were so busy that by October of that year, the association had conducted 357 preschool visits, 130 chronic care visits, and delivered 16 babies.

Brattleboro Memorial Hospital, circa 1912

Richards was invited to Washington by President Roosevelt in 1938 to represent the region and as part of the "group of 100" who would inform the president on the establishment of the National Health Service that would come to be known as Medicaid. Also in that year, Thompson House closed its maternity home for lack of need, as in-home nursing services furthered both health, and education into maintaining health, of the children for the new parents in the community. They continued to offer new-baby and maternity services in half of the building. On January 1st, 1939, Thompson House first opened its doors to the chronically ill and infirm, serving these clients where the maternity home had been previously. These essential services to Brattleboro made it an example to the rest of the country in how to serve the kind and kindred needs of the community.

In a meeting of the founders held October 13, 1937, Bradley said, "When we started 30 years ago, we were looked upon as a sort of heresy. The Mutual Aid now has a daughter in Boston, and our principles instead of being condemned are now being approved and carried out."

The following is from Richard's obituary: "An Apostle of Public Health"

February 13th, 1943

"In the death of Richards M. Bradley, a native of Brattleboro and for many years its active and influential friend, this town loses a part-time resident whose work in behalf of the cause of public health was nationally recognized and whose efforts along this line as reflected in his trusteeship of the Thompson fund had marked effect not only in Brattleboro itself but throughout the entire county.

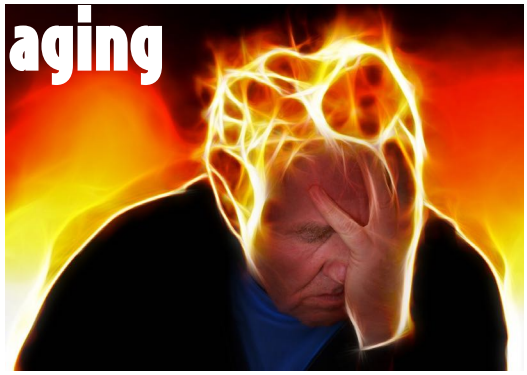
Brattleboro Memorial Hospital as well as its system of insurance, the Mutual Aid Association, the various dental and child-health clinics started in towns in this region–all these came about as the result of Mr. Bradley's foresight. And in the case of the Mutual Aid and the insurance plan their successful operation here served as examples which led many other towns to adopt them.

Throughout his long crusade for public health improvement, R. M. Bradley held steadfastly to certain definite ideals. And it is a fair tribute to his vision to say that many who once disagreed with him later came to his point of view. While he distrusted socialized medicine as a government-administered activity he was realist enough to know that only a larger sense of their responsibilities on the part of the medical and nursing professions would prevent it. And he spent quantities of his time trying to get this point over.

Those who knew him personally respected his wide and intelligent grasp of the national health problem and admired the constant zest with which he approached it. Up to the end he was as enthusiastic about the future as if he were always to be an active participant in it."

Dane Rank is the administrator at Thompson House Nursing Home in Brattleboro, Vermont.

Stress reduction and aging



by Sheldon Ornstein Ed.D, RN, LNHA

The aged frequently experience a decrease in their ability to cope with the multiple stressors of life that can result in a waning of their capacity to adapt. The following is a review of several themes that are recommended by the researchers and that offer practical suggestions for those who are dealing with the excessiveness of life's stressors.

Theme I
Progressive relaxation

This is a method for stress reduction that is achieved through tensing and relaxing of specific muscles or muscle groups and through imagery or recall of pleasant events or experiences.

Theme II – Meditation

Meditation is a form of relaxation and a means of coping with stress. Two that are found in our western culture, Zen and transcendental meditation, are designed to induce a state of relaxation. However, it has also been suggested that to quiet the mind, practice and perseverance are necessary.

Theme III
Arranging one's environment

This is, according to one researcher, a means for reducing the potential for stress by taking advantage of a quiet environment, a place where one can take a momentary break to contemplate or to re-energize.

Stress arises not only from worry, anger, expectations and demands, but also from loneliness, noise, or lighting. Occasionally, getting lost in some creative pursuit is an excellent way for dealing with stress. For some it can be knitting, whereas others may find painting a pastoral scene as a way of lowering stress. Also, stroking and petting the family's pet or simply watching fish with assorted exotic colors and shapes in an aquarium can serve as a unique form of stress reduction.

Theme IV
Environmental sensitivity

The physical components of environmental sensitivity are air, water, and land mass. These are but three examples in which the elderly individual's health and wellness can either be enhanced or limited. The researcher, States, declares, "These environmental components that the elderly may rely on are (1) the security of their home and concern for their belongings, and (2) a familiarity with neighborhood and friendly others. However, if there is a 'crush' on destruction of any one of these levels, it can with time, determine the older individual's response to either wellness or illness."

Theme V – Personal space

According to the researcher, Brighton, "Personal space refers to the aged person who may either be living in the community or an institution and is unaware of the concept of personal space that can reinforce a state of wellness." The following are several examples of personal space:

- A sunlit porch with comfortable seating and a moment of stillness;
- Relaxing before a wintry fireplace and perhaps with a glass of wine;
- Finding a secluded reading corner or nook at home;
- Engaging in conversation with a friend or relative of a similar generation;
- Enjoying the natural occurrence of a rainbow after a storm and contemplating its significance.

Instead of watching the aged individual languish, it becomes the caregiver's role to aid the person and advise him about the opportunities that afford a better and healthier environment.

One example of this philosophy is when a nursing facility encourages the prospective resident to bring with them meaningful items to their new home as a way of recreating a familiar home environment for their mental and physical comfort.

Theme VI
Energy and conservation

The researcher, Robles, suggests that "Energy conservation is an important environmental issue that may well influence the health and continued wellness of an admitted resident, thereby reducing nagging stress issues." For example, body heat and the comfort it offers can be adequately maintained by donning several layers of clothing with additional use of blankets at night. However, the aged individual who resides in a facility can have difficulty tolerating a sharp temperature drop. And if that drop continues, it can quickly cause bodily discomfort, progressive stress, and complaints to a family member.

The following is a case study about Sally, an 85-year-old woman who has been attempting to understand about several age-related changes she's been experiencing which were causing her extreme stress and anxiety. Here are her musings about her stress:

"Strange how these things creep up on you. I was really surprised and upset when I first realized it was not the headlights on my car that were growing dim but rather my aging night vision. Then I remembered how other bits of awareness became clear and forced me to recognize that I, that 16-year-old in me, was now experiencing those normal changes that go along with getting old."

Quotable Quote
"Avoid adopting other people's negative views."

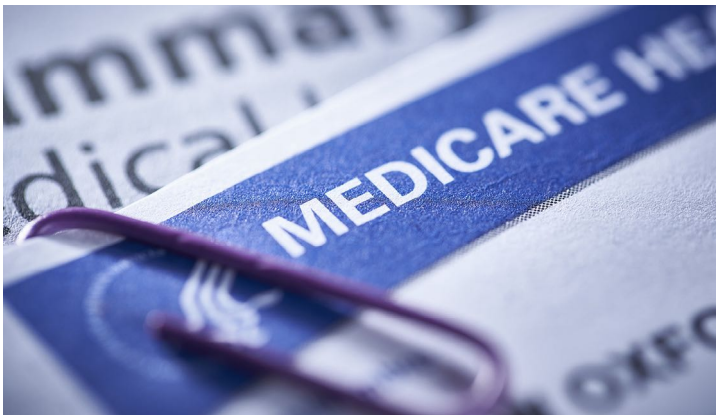
In 1959 Dr. Sheldon Ornstein received his nursing diploma from the Mills-Bellevue Schools of Nursing becoming a registered professional nurse. He continued to earn several degrees including a Post Masters Certificate in Gerontology from Yeshiva University in 1979 and a Doctor of Education in Nursing Organization from Columbia University in 1997. He began his clinical career as head nurse on a rehabilitation unit, and nurse educator providing in-service education and clinical instruction for Nursing students and colleagues alike. He taught at several colleges and was an adjunct professor at Hunter College. Over the course of a 50+ year career, he held the position of Director of Nursing Services in long term care facilities before retiring in September of 2010 as Distinguished Lecturer/Associate Professor in the Department of Nursing at Lehman College, CUNY in the Bronx.

Profitability dwindling, compliance risk rising as managed care rolls in

by Maureen McCarthy

Medicare replacement and Medicare Advantage insurers have been diligently working to attract beneficiaries to their products. In 2021, more than 40% of Medicare beneficiaries were enrolled in managed care plans1 and the Congressional Budget Office (CBO) estimated this total will increase to more than 50% by 2030.[1 2] Advertising targets potential new beneficiaries and touts additional services such as vision, dental, and prescription benefits.

However, managed care plans aren't as all-inclusive as they may seem. Managed care organizations operate under a capitated payment model and receive a fixed rate per beneficiary regardless of services provided. Capitated payment models may incentivize managed care insurers to deny coverage payments to increase profits. These plans have higher than average coverage denial rates; as a result, many beneficiaries are left with costly bills for necessary care. An internal or external case manager decides if a beneficiary is allowed to access their inpatient benefits. Ultimately, beneficiaries who require medically necessary daily skilled services may be unable to access their benefits. Periodically, beneficiaries themselves pay out of pocket for the additional care needed, which would have been covered under a traditional Medicare fee-for-service benefit.



The U.S. Department of Health and Human Services, Office of Inspector General (OIG) recognized that findings from the Centers for Medicare and Medicaid Services' (CMS) annual audits of Medicare Advantage Organizations (MAOs)"highlighted widespread and persistent problems related to inappropriate denials of services and payment." The OIG reviewed denials of prior authorization requests and payment denials from one week in June 2019 and determined "MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules."

The OIG found that an estimated 18% of payment denials in the sample met Medicare coverage rules and should have been approved. To put this in context, if the MAOs in this review denied the same number of payment requests for the remainder of the year (2019), they would have denied 1.5 million payment requests that met Medicare coverage and MAO billing rules.

Post-acute care in skilled nursing and inpatient rehabilitation facilities were among the most prominent service types denied by MAOs. The OIG determined that post-acute services in those care settings are significantly more expensive than home health services, leading to increased scrutiny from MAOs looking to reduce their costs. [3]

The appeal process

CMS drafted the Medicare Benefit Policy Manual, the Medicare Claims Processing Manual, and the Medicare Managed Care Manual. Each publication clearly defines the rules and regulations skilled nursing providers must conform to when providing Medicare-covered services, as well as what information must be submitted on a claim to receive timely payment. Insurers must follow Medicare coverage rules and make determinations based on the medical necessity of plan-covered services, "coverage criteria no more restrictive than original Medicare's national and local coverage policies, and the beneficiary's medical history."[4]

Traditional fee-for-service, Medicare-certified providers abide by these rules and regulations daily to continue participating in the Medicare program. If payment or services are denied by Medicare, there is a five-step appeal process available to both beneficiaries and providers who disagree with Medicare's decision: redetermination by a Medicare administrative contractor (MAC), reconsideration by a qualified independent contractor (QIC), hearing before an administrative law judge (ALJ), review by the Medicare Appeals Council, and judicial review in a U.S. district court.

The process of appealing services or payments denied by managed care insurers looks a bit different for providers and beneficiaries. In a three-level appeal process, the provider or beneficiary appeals their denied services or payments directly with the denying insurer. In the first level, the staff member that initially denied the claim reconsiders their decision. After filing another appeal, providers and beneficiaries can proceed the second level and a different staff member representing the denying insurer will review the case. In the third level of the appeal process, the case is peer-reviewed by a physician trained by the insurer to understand their interpretation of skilled services, acceptable documentation, and claims requirements.

Providers are often frustrated by the appeal process for managed care products because there is no clear path to get these cases reviewed by an independent party not associated with the denying insurer. As a result, providers are left with uncompensated care costs and no way to recoup their losses.

While some providers are publicly vocal about their annoyance with managed care insurers' denial practices and appeals process, many are reluctant to file appeals. Providers are concerned that expressing grievances may threaten ongoing business and existing contractual obligations with managed care insurers.

When providers choose to appeal payment denials, they often drop out before reaching the third level, feeling that time spent arguing with managed care insurers is wasted. However, industry experts recommend providers complete all three levels of the appeal process. If the denying insurer has not reversed the decision after the three-level appeal process, providers can attempt to file a formal complaint with CMS.

When appealing their case, it is important that billing department staff in skilled nursing facilities have a precise understanding of their managed care contracts and the regulations defined in the Medicare Managed Care manual. In addition, staff members who package records to return to the denying insurer must ensure the records are received prior to the due date, as late submissions cannot be appealed.

Dwindling rates

Not only have many managed care insurers overlooked basic coverage guidelines, but rates paid to contracted providers have dwindled over the last decade. The average Medicare Advantage rate is now hovering

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EDITORIAL

Might reform be for real this time?

by Bruce Glass, MBA, FACHCA

We've heard it before. OBRA. MDS. But we're still in the same mess. Covid. Spotty quality. Awful reimbursement. Numerous investigations.

And today senior care has never been in worse shape.

But, maybe. Just maybe. There is a possibility of true reform. The kind that will correct decades of neglect.

If you don't read anything else (although I certainly hope you will read ALL of the fine articles in this issue), please read Rick Gamache's article on the NASEM study.

This 600-page report offers some reason for optimism. It does not paper over the reality of where we are today, but proposes significant changes that are desperately needed by an industry overwhelmed by Covid, staff shortage, poor design, hostile regulation, and financial peril.

This is your future being discussed. Pay attention.

Bruce Glass, MBA, FACHCA, is licensed for both nursing homes and assisted living in several New England states. He is currently principal of BruJan Management, an independent consulting firm. He can be reached at bruceglass@rocketmail.com.

FROM THE PRESIDENT/CEO

Greetings to all! As we end the month of August, we're now eight months and counting to our next Convocation and Expo, scheduled for April 24 to 27, 2023 in Baltimore! While eight months may seem like a long time, my experience with our New Orleans Convocation reminds me the time passes quickly, so make sure to get these dates on your calendar! In Baltimore, we're going to change things up a bit, with no formal Academy Fundraiser scheduled, which will enable our business partners and chapters to enjoy a "free" night to network, host receptions, attend the Orioles baseball game, etc. This change was made from feedback received from New Orleans, and we're pleased to be able to accommodate.

Some other items of interest include the revitalization of our certification program! The new and improved version is slated to be available in early 2023, hopefully before Convocation, so stay tuned.

We are working with several vendor partners to develop several webinar series focusing on various topics. These will be exclusive to the vendor and will allow them to fully cover a topic without being "rushed" by only having 60 to 90 minutes. More details on this to come.

We just completed our third round of my Listening sessions, and I want to thank those of you who joined one of our calls the week of 8/25. The next round of these will occur in November, so watch for more information!

Continued on page 22

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CALL LIGHTS WERE BLINKING. A RESIDENT AT THE FAR END OF THE HALL WAS YELLING, "IS ANYONE GOING TO HELP ME?"

In the distance a phone was ringing. The morning food trucks, which had been delivered on time 20 minutes ago, were still where they had been left, next to the elevators. The residents who had been helped out of bed before the commotion, roamed around the halls in wheelchairs. A few of the more mobile residents stood in their doorways, looking around. Everyone was waiting.

Tammy, the 11-to-7 charge nurse was leaning against the nurse's station with a set of keys in one hand and a cell phone in the other. She was staring off into space with a look of disbelief, frustration, and exhaustion.

Ninety-minutes earlier, the administrator called and asked her to stay through breakfast. Kim, the day nurse and her relief, had just called out.

Tammy protested at first. She had been working short-staffed every night for weeks, and she was exhausted. The administrator promised her the world. A $50 gift card. Guaranteed days off, and of course, that this would be the last time he asked her to stay late to cover for a callout.

Tammy pulled the phone away from her ear, leaned back against the nurse's station and tried to breathe. She wanted to say no. She wanted to throw the phone against the wall and watch it shatter into a million pieces. She wanted to scream. But she didn't.

Instead, she went back to work, trying her best to do the bare minimum of AM care.

Knock. "Good morning."

Toilet.

Back to bed or into a wheelchair.

Wash face and hands.

Promise coffee and breakfast are coming soon.

Next resident: repeat.

At some point she realized she was alone. She looked at her phone. It was 7:35 a.m. Everyone should have been there by now. At least the CNAs. She finished helping a resident get situated in bed and then walked to the nurse's station. To her surprise, two CNAs were sitting at the desk, their eyeballs glued to their phones.

Tammy watched them for a full minute in disbelief. Call lights were blinking in all directions. A resident was literally yelling for

Continued on page 22

Pennsylvania facilities get $500+ million in reimbursement

by K.R. Kaffenberger, PhD, MPH

In July, Governor Thomas Wolfe of Pennsylvania held a press conference to announce a roughly 20% increase in Medicaid rates for nursing homes. The press release announced that "the money should increase workers salaries, staffing levels and retention while stabilizing facilities' finances and improving quality of care." The amount of state funds was around $3 million. With federal matches it is estimated to be worth $515 million in additional financial support to residential long-term care ($35/patient day).

Zach Shamberg, the president of PHCA credited the support of the entire long-term care community as well as state leaders with this positive outcome. Supporters included nursing homes, personal care homes, and assisted living communities. Residents, families, ownership, professional associations (PHCA and Leading Age) and unions (SEIU Healthcare Pennsylvania) all cooperated in advocacy and a major rally to demand better financial support for care facilities through Medicaid according to Skilled Nursing News. The positive outcome was especially notable since no substantial increase in Medicaid rates for Nursing Homes (including SNFs) had occurred since 2014. The advocates, who often disagree, had apparently applied the idea that cooperating around the 80% of policy they agreed upon was better than skirmishing with each other about the 20% about which they do not agree.

The need in Pennsylvania was well documented over the years and was highlighted in several reports. The authors of some reports were those you might expect. Clifton Larson Allen (CLA), the well-known accounting firm with a specialization in long term care, published its annual "State of Skilled Nursing Facility Industry Report". This report was cited in arguments made for increased funding. Another national firm, Health Management Associates (HMA), provided "The Staffing Crisis in Pennsylvania Nursing Facilities https://www.phca.org/wp-content/uploads/2022/05/HMA-Analysis-Pennsylvanias-Nursing-Facility-Staffing-Crisis.pdf", a human resources analysis. This report also provided useful information and was used for advocacy.

Each of these reports had some weaknesses when used for advocacy. The CLA report did not focus on Pennsylvania but is a national report. While HMA is a national organization its report focused on Pennsylvania. But it also focused narrowly on staffing issues with some demographic component. Both organizations are well known vendors and supporters of long-term care organizations in Pennsylvania and around the United States.

Jewish Healthcare Foundation of Pennsylvania (JHF) has been an organization with interests around aging, and by extension, long term services and supports for more than 30 years. Like their partners they had been advocating for increased rates for Nursing Homes and other LTSS activities for many years. They feel that staffing and payment are key elements to improve quality and assure adequate care for the burgeoning aging population of Pennsylvania.

The COVID 19 crisis caused vilification and eventually additional learning about the situation of nursing homes and other residential long term care providers in the United States and in Pennsylvania. In 2020 JHF produced a video intended to help the public learn more about Covid-19 and about nursing homes. It is entitled "What Covid-19 Exposed in Long Term Care https://www.jhf.org/publications-videos/pub-and-vids/ltc-documentary." When talking about the advocacy effort to improve nursing homes through additional funding, JHF staff refer to this thoughtful and compelling video documentary. Many notable figures appear in the production. They include staff and leadership of nursing homes, family members, television news figures, and Ashish Jha then of Brown University, now the President's advisor. Central arguments were presented by Marc Cohen, Director of he Leading Age LTSS Center at University of Massachusetts Boston.

As the campaign to improve funding for staff and facilities in Pennsylvania continued JHF contracted the LTSS Center at UMB to provide a report explaining the problems faced in Pennsylvania and the necessary solutions. The result was "The Case for Funding: What is Happening to Pennsylvania Nursing Homes https://www.jhf.org/publications-videos/pub-and-vids/research-papers/407-the-case-for-funding-what-is-happening-to-pennsylvania-s-nursing-homes-leadingage-ltss-center-report/file". This 42-page report uses compelling, publicly available data, and intuitively accessible graphs together with a well written narrative to describe the issues which have led to the current difficult situation in Pennsylvania. It is designed to be helpful for lay persons and professionals alike.

This report makes points that are well known to those working in and studying nursing homes. More beds are needed; residents are older and sicker; residents are poorer and more diverse; workforce levels are slightly reduced; real wages have declined, quality metrics have declined; length of stay has declined, residents may enter sicker and may die sooner; and reimbursement is inadequate and has been for some time.

Edward Miller was one of the authors of the report. In our conversation he made several important points. While many advocates have this information, the report presents it in a detailed manner from very strong sources. The fact that a third party, independent, academic, institution presented the report is important.

The information not only comes from trusted sources that are well documented, the report presents the information in a thoroughly explanatory way. Both the words and the graphs were carefully developed to make it easy for lay persons to fully understand the arguments.

Providers see the importance of reimbursement and reimbursement methodologies. Providers know that the methodology used to determine reimbursement is a function of policy. Consumer advocates do not always understand this.

This leads to the situation in which a 4 to 1 staffing ratio is seen as a real plus by consumer advocates. However, they are unconcerned about reimbursement. So as one professional advocate said of these standards – "we are expected to hire unicorns without money". This means that no staff are available to hire and if they were facilities would not have the funds to pay them.

According to Miller getting state officials to act is key. Because Medicaid is the single largest payer for residential long term care services, only the states can make the necessary difference. Case populations are becoming tougher in many ways and they may be-

Continued on page 22

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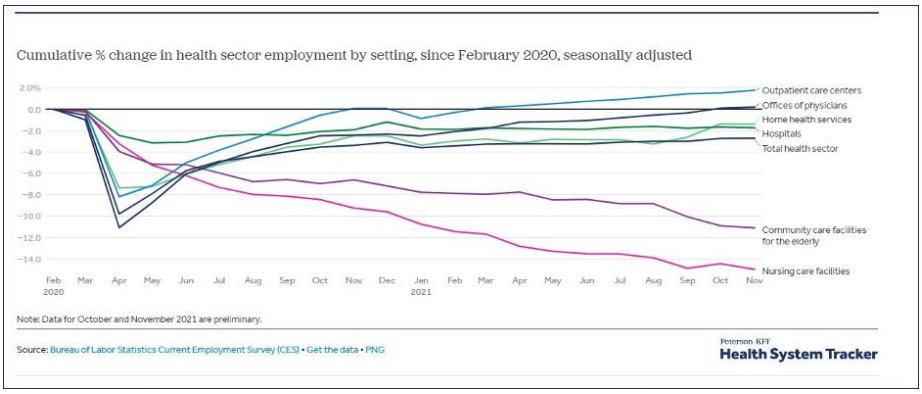
The Marketing Guru: The trifecta of pain for SNFs



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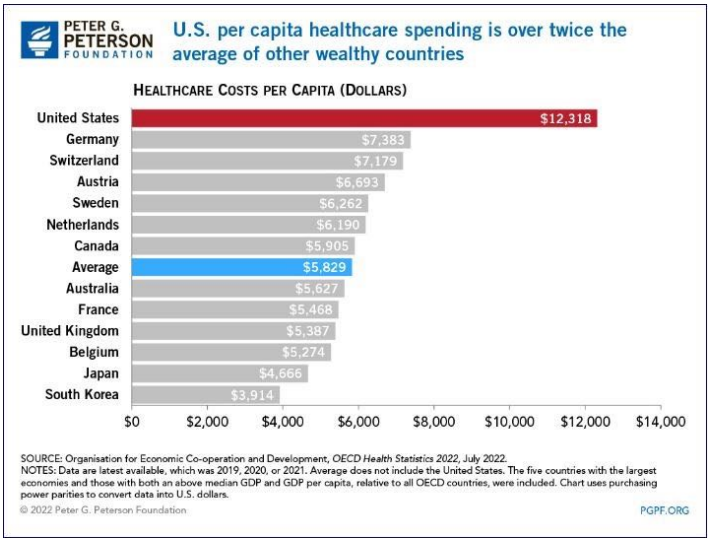
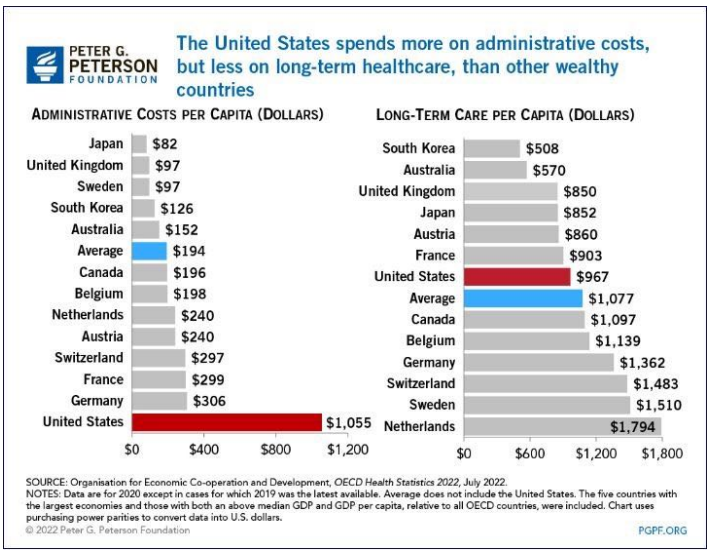
have not been inclined to return to work. With the unemployment rate as low as it is, and "Help-Wanted" signs everywhere, very few will pass up other opportunities, which often offer more flexible shifts, better pay, benefits and easier work.

What to do?

The first step in this staffing crisis for skilled nursing centers is to do a better job of retention.[3] Take a completely new look at the culture within your organization – what are the relationships between and among leadership, supervisors and staff? People stay because of relationships, and they leave because of relationships. Why aren't SNFs doing a better job measuring and taking care of them? (Spoiler alert – because we haven't had to before!)

The second thing to do is to recruit differently than what we've done in the past. Investments needed to both retain and recruit more effectively include innovative human resources information systems (HRIS). One of the dimensions we know is important to staff working in SNFs is flexibility in scheduling. Yet, when we interview human resources managers at skilled nursing centers, we discover that they are completely daunted by rigid, outdated scheduling procedures, and even when they do have an HRIS in place it often doesn't allow for the kind of flexibility that employees today need and want. Finally, and extremely important is training. Virtually every skilled nursing center we've worked with since 1991 has offered the same kinds of training to the same categories of staff. Does that sound right?





Uncle, or "UNCLE!"

Turning to Uncle Sam, or a local version thereof, we find only very thin balm for the wounds that have been endured. Nursing home regulations have progressed since the 1987 Nursing Home Reform Act, the first comprehensive Federal and state regulations, and now there is not a more heavily regulated segment in the healthcare system.[4] The White House Fact Sheet on nursing homes offered 21 suggestions, the majority of which were focused on greater levels of control or oversight.[5] The policy initiatives break down into #3 categories: Staffing, Performance and Transparency.[6] Notably, there was no new funding called for or suggested. CMS has recently announced increase payments for skilled nursing which will amount to slightly more than 2.5%. While this will certainly help, the level is almost laughable in the face of occupancy which continues 20% below pre-pandemic levels, increased labor costs, looming staffing requirements, restricted occupancy due to room utilization and a host of other Uncle-imposed requirements.

It's enough to make operators say, "Uncle!" Oh wait, they are! More nursing homes are closing, and more beds are being taken off-line than ever before. When the leading edge of the Baby Boom generation hits 85 in 2031, supply shortages will create a national "scandal", a fully predictable train-wreck.

What to do?

The long-term care sector, and nursing homes in particular should not be patting themselves on the back for their representation of their membership in Washington DC. The scale of what needs to be done requires fiscal and policy solutions.

Skilled nursing centers in particular are the very poorest stepchild of the healthcare system in the United States. (It has been argued that there is no "system" in long-term care in the United States; this author agrees.[7]) The US spends less than other developed economies on long term care,

Continued on page 17

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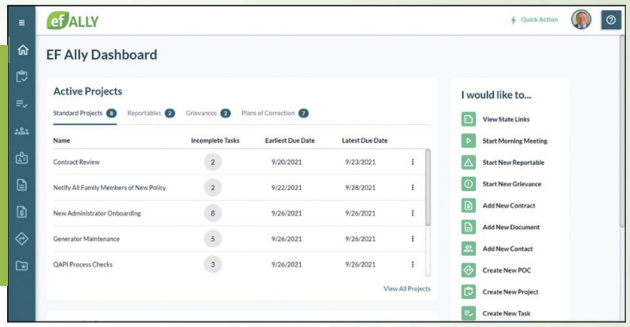
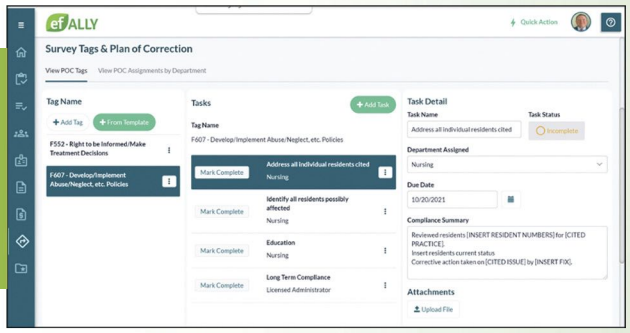


Prepare and Monitor Plans of Correction, Reportables and Grievances



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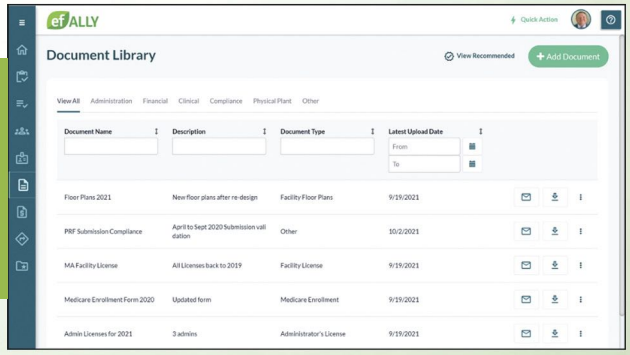

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The Marketing Guru

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but we spend over 100% more on healthcare overall. (What does THAT say?)

It is time to expect more from membership organizations and associations, which are so fragmented that even those of us in the field can't keep them all straight. Healthcare in the United States is a $3.7 trillion enterprise and has the largest congressional lobby in Washington DC.[8] But long-term care spends an immeasurably small percentage on lobbying. According to Open Secrets, the combined healthcare lobbies will spend $304 billion in 2022, ~24% of the $1.24 trillion total; long term care represents ~ 0.08 – 0.12% of the total, and 0.5% of the healthcare lobby spend.

If LTC is unable to spend more to bend legislators' ears, we must flagrantly use the court of public opinion, and embarrass legislators to act. The facts about long term care are elitist, sexist, and ageist. These are our weapons. Many state legislators want to help; we must coalesce this interest into narratives that help the people we serve by enabling needed providers to stay in business.

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[8]See: Open Secrets. https://www.opensecrets.org/federal-lobbying/industries

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NASEM Report

Continued from page 7

when we are chronically underfunded, in the midst of an unprecedented labor shortage, and facing the greatest imbalance of supply/demand issues any health care sector has ever experienced.

In the long and painful history of long-term care, we, the leadership, are often painted as a significant part of the problem. Yet, we are here, giving it our all, along with our dedicated staff, every day during COVID. We know why COVID spread throughout nursing homes, and it is not because we failed to learn how to properly don and doff PPE or correctly wash our hands.

Faced with the pandemic, nursing homes never had a chance because this system is so poorly designed. COVID advanced like wildfire because of a perfect storm: Frail, compromised elders must share living quarters and bathrooms, and staff members must work multiple jobs to make ends meet because woefully inadequate Medicaid reimbursement handcuffs our ability to pay them what they deserve. It was a surefire way for infections to spread from person to person and building to building.

In 1986, the Institute of Medicine issued a scathing report on the state of nursing homes in America which eventually led to OBRA '87, AKA The Nursing Home Reform Act. The rollout of OBRA, well-intended as it might have been, was a failure. Certainly, there were successes because of the legislation, such as the paradigm shift in the use of physical and chemical restraints, which resulted in dramatic and necessary reductions in both. However, CMS missed an opportunity to build a regulatory process that would foster innovation and reward best practice, reimbursement was not aligned to keep pace with increased mandates, and person-centered care, which was the intention of OBRA, failed to catch on due to lack of understanding from surveyors and lack of input from providers.

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Now, in 2022, we have an opportunity to reimagine the system. This time, we need to make it work. If only one positive comes out of the dark chapter of the pandemic, let it be that we transform the dysfunctional long-term care system in this country. As leaders, we need to familiarize ourselves with the recommendations (To read the full report, please visit https://www.nationalacademies.org/nursing-homes) and even if we do not agree with all the findings, we need to recognize that the NASEM report represents a moment in time that can forever change the delivery of long-term care in America. I urge you to get involved through your associations to help guide and influence the process.

Richard Gamache, MS, FACHCA, is CEO of Aldersbridge Communities in RI, and teaches Long Term Care Administration at RI College. He is also an item writer for the NAB exam and the assistant editor of New England Administrator.

Managed care rolls in

Continued from page 10

around $453 per day while traditional Medicare rates are approximately $573 per day for the same beneficiary with the same conditions.

Bad debt may create obstacles for compliance

Managed care payment denials increase a provider's uncollectable debt, known as "bad debt." Decreased revenue during a time when provider expenses have never been higher has a trickle-down effect and can impact staffing in a facility.

Labor is the biggest expense for a skilled nursing facility and decreased revenue often forces a provider to cut labor budgets, lay off staff, and offer less competitive wages. These actions can contribute to a lower quality of care and increased risk for errors and compliance issues. Staff may unintentionally fail to conform with regulations for care, documentation, and billing of skilled services.

Case managers pressure providers to falsify records

There is a particularly concerning trend within the long-term care industry that places providers' conformance with regulatory requirements at risk. Nurses in long-term care facilities that provide skilled care utilize a tool called the Minimum Data Set (MDS) 3.0 assessment to determine payment levels. Some case managers have reportedly requested that nurses manipulate or falsify the information to meet the insurer's pre-determined payment levels. Both the facility nurse and case manager must attest to the accuracy of the information encoded in the MDS assessment, and this practice puts both in danger of penalties from government agencies. The False Claims Act penalty is $11,803 to $23,607 per violation, and there is also a statutory penalty of three times the damages the government sustains due to the violation.[5] If CMS begins to uncover instances of case managers choosing Patient Driven Payment Model (PDPM) scores and requiring MDS coordinators to falsify coding to match their PDPM score, experts anticipate CMS will audit more managed care MDSs.

Providers that suspect this is happening should file a grievance with the insurer. If the provider does not receive a timely response, it should file a complaint with the regional CMS office to call attention to the unethical behavior.

It is best practice for a provider to require clinical staff to report requests to modify MDS assessments to facility management. Management can then prepare data and trends to report to CMS.

Managed care insurers are "playing games"

Managed care insurers have adapted techniques that allow them to issue denials (many unfounded) for coverage and payment. By misinterpreting guidelines defined in the MDS 3.0 Resident Assessment Instrument (RAI) Manual, these insurers have been known to deny coding, assessment types, assessment reference dates (ARDs), completion dates, and submission dates.

Some insurers use a strategy that involves changing who is responsible for issuing denial notices to beneficiaries. When an insurer denies services, it is required to notify the beneficiary that the insurer will no longer pay for their care. In 2015, CMS audited several managed care insurers and noted a higher than normal rate of inappropriately denied cases, citing 56% of audited managed care contracts for making inappropriate denials. Further, "CMS cited 63 of the 140 audited MAO contracts (45 percent) for sending denial letters that did not contain important required information." In its review, CMS found that some denial letters "did not clearly explain why a request was denied, contained incorrect or incomplete information, did not use approved language, and/or were written in a manner not easily understandable to beneficiaries." In response to 2015 audit findings, CMS issued $1.9 million in civil money penalties to nine managed care insurers.[6]

The newest game insurers have been playing is misinterpreting federal regulations for their own benefit.

As a result of audit findings, managed care insurers got creative. They handed the responsibility of drafting or issuing denial notices to the provider. This is cause for concern, as the provider is liable for the accuracy and validity of the denial notice. If a notice is invalid, the provider is responsible for the cost of care.

Experts want to empower skilled nursing providers to challenge managed care insurers providers and avoid this provider liability scenario. Providers have options when a managed care insurer determines it will deny coverage of services for a beneficiary; for example, the provider can reject the responsibility to draft or issue the notice, or it can request that the insurer issue the notice and the provider will deliver on behalf of the insurer.

Case managers have allegedly misinterpreted requirements to complete an accurate MDS assessment, further diluting the reimbursement providers receive from managed care insurers. If the documentation submitted for review does not include the additional items to support the misinterpreted regulations, providers will be held to a lowered payment rate.

The newest game insurers have been playing is misinterpreting federal regulations for their own benefit in an effort to deny entire stays or reduce already insufficient payments for services provided. Many times, this includes denying care retroactive to the date of admission.

The insurer assigns case managers to monitor care provided to the beneficiary. Case managers may also speak with the SNF team about the resident and their current skilled needs; attend facility meetings; and participate in care conferences. During this process there are many opportunities for case managers to notify providers of concerns regarding the plan and level of care provided. That allows the provider to change, add to, or otherwise alter the plan of care to meet the insurer's requirements for full payment.

However, some case managers have not communicated concerns about skilled criteria, leading the insurer to deny entire stays after the resident is discharged and the provider has billed for care.

A difficult decision for providers

Recent practices by managed care insurers have put providers in a tough position: there aren't enough traditional fee-for-service Medicare beneficiaries in the country to avoid admitting managed care beneficiaries and. turning down that population would result in a drop in providers' census'.

This has led providers to examine the true cost of doing business with managed care insurers. Providers receive lower reimbursement rates from managed care insurers and managed care beneficiaries are becoming high accounts receivable problems for many providers. Some of the larger care chains are hiring staff just to address these issues and manage the growing receivable balances, along with fighting the denied claims through the current appeals process.

To entice providers, managed care insurers promise to fill providers' beds with managed care residents. However, many providers need every penny to offset staffing and equipment costs that skyrock-

Continued on next page

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Richard Gamache
CEO, Aldersbridge Communities

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Patricia@PatriciaRaskin.com

Managed care

Continued from previous page

eted during the pandemic. As a result some providers are reconsidering their participation with managed care insurers and questioning why they would admit a managed care beneficiary, with a higher-than-average denial rate and declining daily rate, when they could admit a resident with a guaranteed state or federal payer.

What Does the Future Hold for Managed Care Insurers and Skilled Nursing Providers?

Skilled nursing providers are unlikely to see much change from managed care providers until CMS places stronger constraints on their actions.

The OIG recommended that CMS issue new guidance for using managed care clinical criteria in medical necessity reviews, update its audit protocols to focus on issues identified, and direct managed care insurers to address vulnerabilities. CMS agreed with the recommendations3; however, experts have not yet seen evidence of progress beyond these recommendations.

Ultimately, the relationship between skilled nursing providers and managed care insurers is not doomed. As many managed care insurers' practices take a toll on providers' receivables and pose risks to their compliance with regulations, experts believe providers will learn which insurers follow the guidelines dictated in the Medicare Managed Care manual. Billing department staff can help identify those organizations by documenting billing/coverage challenges and denial rates for MAOs they are contracted with. Ultimately, providers will be able to determine, based on their own metrics, which insurers are problematic and choose not to engage with them.

Endnotes:

1Freed, Meredith, Jeannie Fuglesten Biniek, Tricia Neuman, and Anthony Damico. "Medicare Advantage in 2021: Enrollment Update and Key Trends." KFF. Kaiser Family Foundation, June 21, 2021. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

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[6]Office of Inspector General, and Daniel R. Levinson, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials § (2018). https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

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Maureen McCarthy is the President and CEO of Celtic Consulting. Celtic is a post-acute care advisory firm concentrated in clinical operations and regulatory compliance. Founded in Connecticut, it serves hundreds of clients nationwide as Regulatory and Operational subject matter experts and is recognized by National, Regional, and State Professional Associations as innovative thought leaders.

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The C.A.R.E.S. Expert

Continued from page 4

Isolation in General (continued)

The Plan of Care specifies:

- Type of transmission precautions: Contact, Droplet, or Airborne.
- All services must be provided in the room during isolation.
- Isolation related to active diagnosis.
- Explanation of why the infective agent cannot be contained:
  "Isolation is necessary because the infectious organism cannot be contained due to incontinence, resident cannot be properly educated for containment due to dementia/cognition, highly exuding wound, etc."
- The terms "quarantine" and "precautions" do not support coding isolation on the MDS.

Documentation:

- Notes from therapy and nursing include that:
  - *"All services were provided in the resident room,"*
  - *"The resident is the sole occupant of the room or the resident co-horted the room."*

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Isolation for MDS Coding

Diagnosis:

- The resident has an active diagnosis.
- For a condition requiring transmission-based precautions.
- Supported in the medical record.
- During the ARD lookback period.

The Physician's Order for isolation includes:

- Type of transmission-based precautions
  "Isolation with (Contact, Droplet, or Airborne) precautions related to (Diagnosis)"
- A parameter statement:
  "All services to be provided in patient room secondary to isolation precautions related to (Diagnosis)."
- An active diagnosis.
- The term Isolation in the order.
- A sign off confirming compliance for every shift during at least one 24-hour period when the resident without a roommate.

Bed Placement:

- The resident is placed in:
  - A room by themselves i.e., no roommate
  - For at least 24 hours
  - During the ARD lookback period
- Patient cannot co-hort: i.e., two patients with same diagnosis, in the same room
  - Cannot code isolation on the MDS when patient co-horting

The Plan of Care specifies:

- Type of transmission precautions: Contact, Droplet, or Airborne.
- All services must be provided in the room during isolation.
- Isolation related to active diagnosis.
- Explanation of why the infective agent cannot be contained:
  "Isolation is necessary because the infectious organism cannot be contained due to incontinence, resident cannot be properly educated for containment due to dementia/cognition, highly exuding wound, etc."

Documentation:

- Notes from therapy and nursing include that:
  - *"All services were provided in the resident room,"*
  - *"The resident is the sole occupant of the room."*
  - *"All services provided in room" supported in the medical record:*
    - *By every shift,*
    - *For at least one 24-hour period,*
    - *During the ARD lookback period, and*
    - *When the resident has no roommate.*

Kris Mastrangelo, OTR, MBA, NHA, is president and CEO of Harmony Healthcare International and is a nationally-recognized authority of Medicare issues. She is a regular contributer to the New England Administrator.
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Talking dirty

Continued from page 12

help down the hall, a phone was ringing in an office right behind them and here they were, sitting there scrolling through social media, without a care in the world.

"What are you guys doing?" Tammy said, trying her best to not scream but clearly angry. The CNAs, without looking up from their phone said they were waiting for help.

"Help?" Tammy said. "This is it babe. It's just us. Now let's go. We have a lot of work to do." The CNAs looked at Tammy and then each other and started to shake their heads.

"I'm not taking care of 20 residents by myself," one of the CNAs said.

"Me neither," the other agreed. "That's ridiculous. I don't get paid enough to do the work of three CNAs."

Tammy shrugged in disbelief. "We don't have a choice," she said. "We are the only one's here!"

The two CNAs looked at each other and got up. "You may not have a choice," they said. "But we do, and we are not doing it. Not anymore." Then without another word, they left.

Tammy pulled out her phone and her keys and thought seriously about following them out the door. She leaned against the nurse's station and tried to breathe.

A resident in a wheelchair came around the corner with a look of concern on his face. "Ma'am," he said, breaking her trance. Tammy looked down. Although he needed a wheelchair for long distances, he was ambulatory and had gotten himself up. He smiled.

He was wearing a black t-shirt with a heart on it. Inside the heart were the words, "Start here."

"I like your shirt," Tammy said. He looked down at it and smiled.

"If you show me what to do, I can help," he said.

"Oh yeah," she said. "You think you can help me get everyone up, use the bathroom, and fed?"

He shrugged. "I can do what I can," he said.

"Me too," a lady said from her door a few feet away.

"I can help too," another women said from a wheelchair.

Tammy laughed out loud and said, "Why not!" and they did.

As always, I hope this made you think and smile.

Ralph Peterson is a three-time best-selling author and a leading expert in management development in the long-term care industry. Ralph@ralphpeterson.com

President/CEO

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ACHCA is YOUR professional association, and we exist to help you become a better leader. Your professional development is important, so if you have an idea or suggestion, please shoot me an email at bob@achca.org . Thanks for being a member, and thanks for the opportunity to participate in this great newsletter!

Collegially,

Bob Lane

Pennsylvania funds

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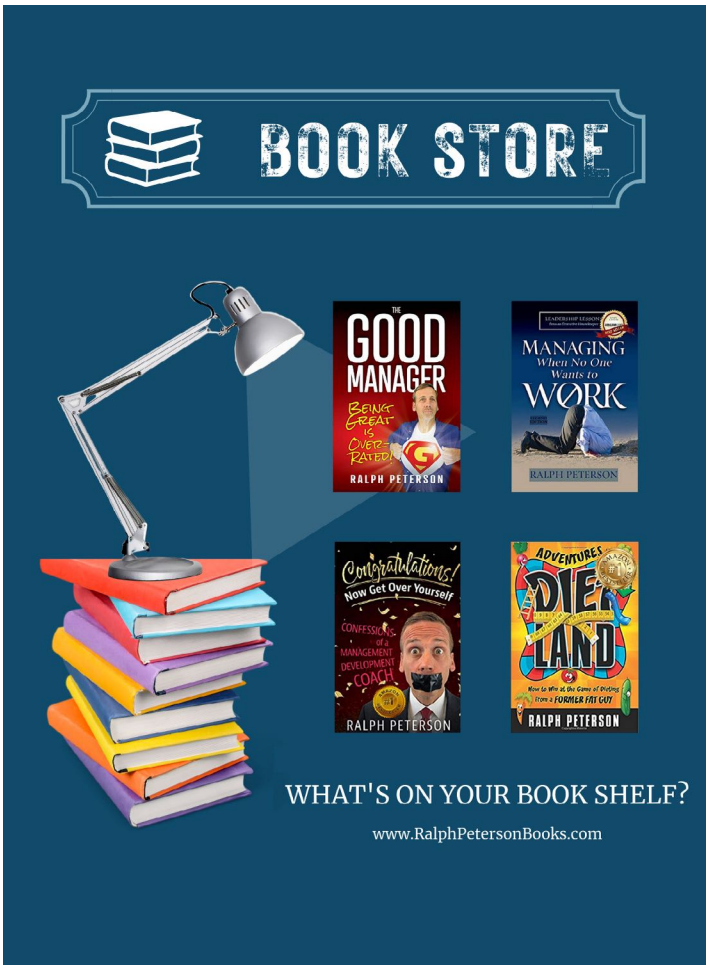
come more numerous. Action is needed sooner than later.

Now is the time. The iron is hot. The Covid crisis has brought the attention of voters and elected officials to the dire circumstances facilities and health systems face. Policy issues emerge and recede.

In the Pennsylvania case the most important thing was the willingness of disparate parties to come together for enhanced reimbursements. The presentation of an unbiased, easily understood, independent, and factual report also helped.

Residential long-term care is at the forefront of policy discussions. Now is the time.

KR Kaffenberger, Ph.D., M.P.H. is a fellow of the Gerontology Institute at UMass Boston and a former nursing home administrator.



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