



Posted: 11-23-2009

It's Another Victory For The CLASS Act

Thanks to the hard work and difference-making advocacy of our members, the CLASS Act will be included in the Senate health care reform bill.

Last Wednesday evening, Senate Majority Leader Harry Reid, D-Nevada unveiled the Senate's health care reform bill, called the Patient Protection and Affordable Care act at

<http://www.agingservicesmn.org/inc/data/senatebillhr3590.pdf>. The bill is similar to the House health care reform bill, with some key differences that can be found here

<http://www.nytimes.com/interactive/2009/11/19/us/politics/1119-plan-differences.html>.

A vote to allow debate on the bill was held on Saturday, with 60 votes in favor of bringing the legislation to the floor.

The long-term care insurance industry is mounting a full-court press in opposition to the CLASS Act provision and in support of removing it from the bill. Please take a moment to e-mail your Senator asking for their support to keep the CLASS Act in the bill at

http://www.agingservicesmn.org/index/Become_Active.

The CLASS program is a voluntary insurance program that is similar in design to Social Security. An individual pays a premium into an account via a payroll deduction, and receives a cash benefit to pay for supports and services that will enable him or her to remain independent in the community. Eligibility is determined by the number of activities of daily living (ADLs) with which an individual needs assistance or the level of an individual's cognitive impairment. Eligibility also requires a five-year vesting period for premiums.

Individuals also eligible for Medicaid can receive the cash benefit. However, depending on the program in which the individual is enrolled, at least half of the benefit goes to the LTC facility or state to contribute to the cost of care. This leaves Medicaid as the secondary payor.

Additional aging services-related provisions in the Senate's health care reform bill include:

- SNFs get full payment update in 2010 and 2011. Productivity adjustment, which would likely be market basket minus 1 percent, begins thereafter.
- Pilot program on Medicare bundling to be established by 2013; recommendations to Congress by 2016
- One-year extension of Medicare therapy caps exceptions process, thru end of 2010 (House bill extended through end of 2011)
- Allows special needs plans operating in CCRCs to continue, which is also in the House bill
- Section on disclosure of nursing home ownership similar to House bill, including a required description of organization's governing body.
- Similar provisions to House on requiring ethics and compliance programs in nursing homes and increased

information reporting on Nursing Home Compare

- Separate reporting of staffing expenditures on Medicare cost reports, which we support.
- Requires GAO report on 5-star
- Civil Money Penalty (CMPs) - allows 50 percent discount for self-reported deficiencies. Escrow applies only to CMPs assessed for actual harm and immediate jeopardy, and maximum escrow period is 90 days (during which there would be informal dispute resolution). No increase in CMP amounts. These provisions are a big improvement over the House bill.
- Similar provisions to House on development of independent monitor for nursing home chains
- Similar provisions to House establishing a nationwide requirement for criminal background checks on potential employees with direct access to patients
- Community First Choice Option for Medicaid
- Removal of barriers to providing HCBS covered by Medicaid
- Improvements to the Money Follows the Person demonstration
- Spousal impoverishment protection for Medicaid coverage of home and community-based services
- Additional funding for aging and disability resource centers
- Independence at Home pilot program for care coordination for people with chronic conditions
- Establishment of the Center for Medicare and Medicaid integration.

For Further Information:

Contact Jen McNertney at jmcnertney@agingervicesmn.org.

Star Tribune Publishes Responses to Falls Series

In response to the series on falls, the *Minneapolis Star Tribune* published a commentary on Saturday co-authored by Aging Services President and CEO Gayle Kvenvold.

In addition, the *Star Tribune* also published a commentary by **Barb Rode**, the president and Chief Executive Officer of **St. Therese Home** in New Hope.

The article co-authored by Kvenvold stated the recent three-part series in the *Star Tribune* failed to share the full story and provide readers with the appropriate context regarding nursing home care in Minnesota. Statistics clearly shows that our population is aging, but she pointed out there also are several relevant issues related to our aging population where data only tell part of the story.

Rode talked from the perspective of someone who has spent her entire career in nursing homes. She wrote about the challenges of caring for our elderly and the pain of losing a parent to a fall in a nursing home.

To read both commentaries, visit:

http://www.startribune.com/opinion/commentary/70662492.html?elr=KArksc8P:Pc:Ug8P:Pc:UiD3aPc:_Yyc:aUUr and
http://www.startribune.com/opinion/commentary/70663437.html?elr=KArksc8P:Pc:Ug8P:Pc:UiD3aPc:_Yyc:aUUr

For Further Information:

Contact Bill Floyd at bfloyd@agingervicesmn.org.

Photo Is Silhouette Of Empty Wheelchair Parked in Hospital Hallway

Eric Schubert, the vice president of Communications and Public Affairs for **Ecumen** voiced concerns over the page design and the front page photo used last Sunday in the first installment of the *Star Tribune* falls series.

What most readers won't know, according to Schubert, is that the *Star Tribune* didn't shoot this photo. It's from [Istockphoto.com](http://www.istockphoto.com), an online stock photography databank. And the description says it's a hospital, not a nursing

home.

To read more of Shubert's reaction, visit:

<http://www.minnpost.com/braublog/2009/11/19/13646>

/should_a_polish_photo_grace_a_minnesota_investigation#comments_section.

Transition Rate for CL Clients is Announced by DHS

Last Wednesday, Aging Services received a notice from the Department of Human Services that DHS will implement a "transition rate" for Elderly Waiver Customized Living (CL) clients who are re-assessed between Jan. 1 and May 31, 2010, and do not have a change in Case Mix category as a result of the re-assessment.

For these clients, the transition rate will be 50 percent of the difference between the most recently authorized rate (e.g., the pre-tool rate) and the new rate calculated using the CL tool. This transition rate will then be deducted or added to the rate calculated by the CL tool so that the change in rate will be cut in half for the transition rate period.

The transition rate will be effective Jan. 1-June 30, 2010, and will affect both rate increases and decreases as calculated by the CL tool. As of July 1, the affected clients will apparently see their CL rate go to the actual rate as determined by the CL tool.

Following is an example showing how we understand the transition rate will work:

- Client's Previous CL rate (pre-tool): \$2,600 per month
- Client's CL rate calculated with the CL tool: \$2,300 per month
- Transition rate: $(\$2,600 - \$2,300) \times .5 = \$150$ per month
- Client's rate during the transition period from Jan-May, 2010 = $\$2,300 + \$150 = \$2,450$
- Client's rate after the transition period ends on July 1, 2010 = \$2,300

Although this will somewhat mitigate some of the rate reductions that providers may experience in the first half of 2010, it's unclear how significant the transition rate will be since it will not affect any new CL clients or any current clients whose re-assessment results in a change in their Case Mix classification.

In other news on the CL tool, DHS has announced that the client's printed CL plan, which is shared with the CL provider, will include the assessment scores related to items on the CL plan. These scores come from the Long-Term Care Consultation assessments made using DHS form 3428A, but not all of the assessment scores will be available on the CL Plan.

Although some of the assessment scores will now be available to CL providers, DHS has now decided that the printed CL plans will no longer include the clients' Case Mix classification or their community budget caps. The clients' Case Mix and community budget cap limits were included on all previous versions of the CL plan, and it came as a surprise that that DHS would remove this helpful information from the printed CL plan at this late date.

DHS previously announced its decision on the meal preparation rates, which has a single rate for each meal without adjustment for the number of meals prepared. The DHS meal preparation rates would reimburse a provider offering residents three daily meals plus snacks about \$393/month, which is well below the costs reported by most housing-with-services providers.

Although DHS had considered adding to the CL tool an "economies of scale" rate reduction, this proposal has been dropped from the most recent version of the tool, which is found at http://www.agingservicesmn.org/inc/data/EW_CL_Workbook.xls.

In addition to DHS' planned evaluation of the CL tool, Aging Services of Minnesota will be asking members to provide data on clients' pre-tool and post-tool CL rates. Aging Services will also seek feedback on members'

activities to manage their Elderly Waiver Customized Living programs to deal with rate cuts resulting from the 2009 legislation and implementation of the CL tool.

These latest changes to the CL tool, as well as many important operational considerations in managing your Elderly Waiver Customized Living program, were explored in an Aging Services' webinar, "Minnesota's Customized Living Tool: Practical and Operational Approaches," on Monday afternoon.

Presenters were Mark Anderson, housing director, Walker Plaza, Anoka; Barbara Blumer, attorney, Barb Blumer Law PA; Annette Greely, director of assisted living, Guardian Angels by the Lake, Elk River; and Mary Youle, VP of housing and community services for Aging Services.

The webinar will be archived and available for later viewing. Watch future Monday Mailings for more details.

For Further Information:

Contact Mary Youle at myoule@agingservicesmn.org.

Final Electronic Billing Deadline Approaching

Effective Tuesday, Dec. 15, all health care providers and payers, including care centers and home health care providers, will be required by Minnesota state law to exchange remittance advice electronically.

This requirement was passed into law in 2007 and is the third of three requirements going into effect this year (electronic eligibility transactions went into effect on Jan. 15 and electronic claims were required as of July 15).

With the remittance advice deadline approaching quickly, both providers and payers are working to be prepared by that date. Payers have notified many members regarding the billing clearinghouses that will be used to distribute electronic remittance advice.

In some cases, members are concerned that those networks do not include the billing services that they are currently using. Aging Services is tracking this issue and will provide an update on it prior to the Dec. 15 deadline, but we are hopeful that most of these issues will be resolved by that time as payers see the wisdom in providing their electronic remittance advice through a broad spectrum of billing vendors.

Some members who use ClearConnect for their billing have contacted us with their concern that at this point ClearConnect has only arranged to handle electronic remittance advice from Blue Cross of MN. Members who are faced with situations where payers are not planning to use their clearinghouse are encouraged to let us know so that we can work on these issues through the AUC.

Providers should also contact both the payer and their clearinghouse to encourage them to work together on exchanging electronic remittance advice. In cases where a clearinghouse will not be processing remittance advice from a particular payer, that remittance advice is usually available electronically on the payer's web site, but looking it up that way is a more cumbersome process for the provider.

Members who do their billing using the ORBIT tool have been wondering about whether that tool will accommodate electronic remittance advice, and the good news is that ORBIT will be offering electronic remittance advice from numerous payers beginning today.

For further information on that process:

Visit the ORBIT web site at <http://www.mneconnect.com/>

For Further Information:

Contact Jeff Bostic at jbostic@agingservicesmn.org or Lori Meyer at lmeyer@agingservicesmn.org.

Applications For Position on BENHA Board Due Tuesday

Applications for a manager of a non-profit nursing home position on the Board of Examiners for Nursing Home Administrators (BENHA) are due tomorrow (Tuesday, Nov. 24).

The vacancy was announced by the Secretary of State's Office. The position is appointed by Gov. Tim

Pawlenty and receives a \$55 per diem. For an application form click here http://www.sos.state.mn.us/index.aspx?page=18&dc_id=37.

BENHA licenses administrators of nursing homes, conducts studies of nursing home administration; approves continuing education programs for administrators; investigates complaints and allegations of rule violations.

Membership includes: four owners or managers of nursing homes, one doctor, one nurse, and three public members. Representatives of the Department of Health and the Department of Human Services are ex-officio members. Quarterly meetings of the board are held at the board offices in St. Paul.

For Further Information:

Contact Lori Meyer at lmeyer@agingservicesmn.org.

Rate Setting Methodologies Work Group holds Meeting

Last Thursday, the Rate Setting Methodologies Expanded Work Group of the Home and Community-based Services (HCBS) Expert Panel met to discuss the work of the Rate Setting Methodologies Intensive Work Group.

Aging Services is a member of the Expanded Work Group and the HCBS Expert Panel.

The goal of the groups is to create a new per person/per day rate for general residential services in disability HCBS waivers. There is to be a shared rate in each residential program, with an additional amount reflecting each client's individual rate.

The Expanded Work Group reviewed the Intensive Work Group's recommendations on: what data sources to use when creating the new rate framework for disability HCBS waivers; as well as what is to be included in the rate framework for group residential services.

Data Sources

The Intensive Work Group identifies seven data sources to use for the rate framework. These include sources that will track wages, such the Bureau of Labor Statistics; current medical insurance data to look at claims and costs; specialized costs like transportation; a cost survey; and client assessment data.

Expanded Work Group discussion focused on gathering medical insurance data, noting that information cannot come from MMIS alone but must also come from managed care plans -- and that information is not easy to come by. The Expanded Working Group was also informed that any new rates would be compared with paid claims data to make sure the rates are budget-neutral within the waivers.

Framework for Group Residential Services

The Intensive Work Group made the following recommendations for what to include in the framework for group residential services:

- Direct care staffing
- Employment related expenses
- Transportation
- Client programming and supports
- Monitoring technology
- General and administrative costs
- And other rate factors

Each of these items garnered Expanded Work Group discussion, particularly direct care staffing, transportation, and general and administrative costs.

The next meeting of the Expanded Work Group is Wednesday, Dec. 16. Aging Services' members wishing to provide feedback on any of the above information should do so by emailing Jen McNertney at

jmcnertney@agingservicesmn.org by Tuesday, Dec. 1.

Background

DHS is charged with establishing statewide rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The rate-setting methodologies must:

- abide by the principles of transparency and equitability across the state.
- involve a uniform process of structuring rates for each services and must promote quality and participant.

Rate setting methodologies are to be based on:

- Components in each waiver service
- Individual's assessed need for particular components
- Standardized value of components
- Other cost variations due to factors like administrative costs and demographic differences.

Finally, web-based technology will be used to calculate rates for services based on standardized costs for service components and store rate data, making it accessible for reporting.

Although these rate setting methodologies apply only to disability waivers (CAC, CADI, TBI, DD), it is important to remember that HWS is included in these waivers, and providers who serve these clients may be impacted by any changes made as a result of the group's work.

More information on the Rate Setting Methodologies Work Groups can be found online at

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_144651#.

For Further Information:

Contact Jen McNertney at jmcnertney@agingervicesmn.org.

November Five-Star Ratings Available

The Centers for Medicare & Medicaid Services last week announced that the five-star provider preview reports are currently available.

Providers can access the report from the Minimum Data Set (MDS) State Welcome pages available at the State servers for submission of Minimum Data Set data.

To access these reports, select the Certification and Survey Provider Enhanced Reports (CASPER) Reporting link located at the bottom of the login page. Once in the CASPER reporting system, click on the 'Folders' button and access the Five-Star Report in your 'st LTC facid' folder, where "st" is the 2-digit postal code of the state in which your facility is located, and "Facid" is the state-assigned facility identification number for your facility.

BetterCare@cms.hhs.gov is available to address any questions and concerns about the November data. The helpline will reopen in January 2010. Nursing Home Compare will update with November's five-star data on Wednesday, Nov. 25.

Members should note a couple of recent changes. First, your inspections (survey) rating will be held constant unless new health inspection data (e.g. a new health inspection survey, new complaint information or a 2nd, 3rd or 4th revisit) become available. Your inspections rating will not change from month to month without new survey information from the facility, regardless of changes in the state-wide distribution due to new surveys in other facilities. This change addresses a complaint from providers whose rating changed even though there had been no change in their survey data.

Second, the quality measures on Nursing Home Compare will now be an average of three quarters, not the most recent quarter's results. This change matches the Nursing Home Compare data to those on the five-star rating system. CMS's technical guide justifies averaging three quarters of data by stating that it increases the number of

assessments available for calculating the quality measure rating, thereby increasing the stability of estimates and reducing the amount of missing data. It does not mention that this approach has the effect of preventing consumers and providers from seeing the most recent data on quality measures.

Members who wish to examine the most recent edition of CMS's technical guide can find it at this link:

<http://www.cms.hhs.gov/CertificationandCompliance/Downloads/usersguide.pdf>.

For Further Information:

Contact Darrell Shreve at dshreve@agingservicesmn.org.

Medicare Amounts Released for 2010

The Centers for Medicare and Medicaid Services has released the Medicare amounts for beneficiary deductibles, personal needs allowance, copayments, and coinsurance for 2010.

These amounts apply to services delivered during the calendar year.

The SNF coinsurance amount will be \$137.50. The SNF coinsurance increases by \$4 per day because it's currently \$133.50. By law, this is set at one-eighth of the hospital deductible, which will be \$1,100.00. The SNF coinsurance applies to days 21-100 of a Part A stay for a particular spell of illness (or benefit period).

Each year on Jan. 1, the personal needs allowance for Medical Assistance recipients in MA-certified nursing facilities is increased to keep pace with inflation. The inflation adjustment is the same as that used for social security benefits, which for 2010 calls for no increase. As a result, the personal needs allowance for 2010 will be the same as in 2009 - \$89 per month.

The Part B coinsurance remains at 20 percent. The annual Part B deductible is \$155.00, and the monthly Part B premium is \$110.50. When Part B pays for a service, Part B pays 80 percent, and the beneficiary (or other third-party payer) is responsible for the 20 percent coinsurance.

For Further Information:

Contact Darrell Shreve at dshreve@agingservicesmn.org or Jeff Bostic at jbostic@agingservicesmn.org.

MDH to Develop Some Home Care Proposals for 2010 Legislation

The Minnesota Department of Health announced last week that it would draft proposed 2010 legislative language for home care changes before its next Care Regulatory Framework Planning Group meeting on Thursday, Dec. 17.

MDH staff has previously indicated that it is looking for some additional enforcement language, but no specifics have been described.

At last week's meeting of the planning group, Susan Winkelmann, Assistant Division Director, MDH Compliance Monitoring Division, again reviewed the preliminary plans to move the survey responsibility for Class A licensed-only and Class F home care providers back to the MDH licensing and certification division directed by Mary Absolon. In preparation for this change, Case Mix Review (CMR) staff was asked for feedback on the Class A and Class F surveys.

The CMR staff identified a number of problem issues, including difficulty in finding some providers, providers without basic knowledge of home care or how to run a business, cultural and language barriers, concerns about inadequate RN staffing by licensees, med errors, and safety of the surveyors when they go into private homes.

MDH is considering some additional requirements for new license applicants based, in part, on the CMR staff feedback. MDH staff indicated that the department has the authority to require new applicants to submit additional information with their license applications, such as copies of some key policies and procedures.

Following this discussion by Winkelmann, the various subgroups reported back on their recent discussions and recommendations. At this point, most of the subgroups have worked through their assigned sections of the

preliminary draft home care requirements. They have been asked to send their specific proposals to MDH staff that will incorporate the recommendations into a second draft of the home care requirements.

Many recommendations are still somewhat general and many big questions - such as whether home care tasks that do not involve nursing or delegating nursing tasks should be licensed at all have yet to be discussed thoroughly and resolved. Thus, much work remains for the Planning Group to accomplish in 2010. Aging Services will re-convene a meeting of its interested home care members when a revised set of home care requirements is available for review, probably early next year.

Beckie Conway, Executive Director of Home Care and Hospice, **Presbyterian Homes Management Services**, represents Aging Services on the Planning Group and is the convener for the medication subgroup.

In addition, many Aging Services members are active participants on the various subgroups. Aging Services appreciates the time members have devoted to this major revision of the home care requirements.

More information about the Planning Group, along with minutes from the meetings, is posted at:
<http://www.health.state.mn.us/divs/fpc/profinfo/hcwg/>

For Further Information:

Contact Mary Youle at myoule@agingservicesmn.org.

DHS Holds Long-term Care Consultation Videoconference

Last Thursday, the Department of Human Services (DHS) held a videoconference on the new Long-term Care Consultation (LTCC) assessment forms.

The following forms were discussed and can be downloaded at

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000100

3428 (assessment)

3428B (case mix)

3428C (supplemental form for children)

3427 (LTC Screening Document)

3426 (OBRA Level I)

3361 (NF Level of Care Criteria)

In addition, two handouts are available at (PLEASE LINK TO "HANDOUT-LTCC ASSESSMENT" and "HANDOUT DEAFBLIND" in folder).

The new assessment form includes the new Case Mix L, which is for former Case Mix A clients who have no ADLs or only one of the following ADLs: dressing, grooming, bathing, or eating with a score of 2 or lower.

In addition, there are two English versions of the LTCC assessment: 3428, which is created for use by one assessor, usually a social worker or a public health nurse; and 3428A, which is created for use by two assessors, usually a social worker and a public health nurse. The content of the two versions is the same, with different lay-outs.

Some upcoming dates to take note of regarding LTCC assessments:

- Changes in the nursing home level of care eligibility will begin Jan. 1, 2011. These changes will impact all re-assessments and new clients for nursing homes and home and community-based services waivers. DHS training on these changes will begin Oct. 2010.
- LTC assessors must be certified starting Jan. 1, 2011. This certification will begin April 2010.

For Further Information:

Contact Jen McNertney at jmcnertney@agingservicesmn.org.

VA Able to Contract with External Organizations to Provide Services

The Veterans Administration (VA) is initiating demonstration programs for "patient-centered alternatives to institutional extended care."

While the program funding will go to VA facilities, AAHSA is reporting these facilities may contract with outside organizations to provide the services, such as adult day services. Adult day programs serving a significant number of veterans are encouraged to reach out to the VA medical center in their area and suggest they apply for these funds.

The VA will be seeking innovative clinical demonstration pilots that hold promise for efficacy, sustained success, and subsequent dissemination and are integrated and coordinated with other initiatives, such as patient-centered medical home (PCMH).

VA facilities must submit applications by Monday, Dec. 7.

For Further Information:

Contact: Peter Notarstefano, AAHSA, at pnotarstefano@aahsa.org.

Stratis Health's Work with Care Centers Pays Off

Under its current scope of work, Stratis Health (Minnesota's Quality Improvement Organization, or QIO) has been working with 43 care centers on pressure ulcers and physical restraints.

The care centers, who volunteered for this arrangement, were among those identified by the Centers for Medicare & Medicaid Services as having relatively high rates of pressure ulcers or physical restraints. The goal of the arrangement is to use the resources available through Stratis Health to assist the care centers in making improvements.

At the quarterly meeting of Stratis Health's care center and home health stakeholder meeting last Thursday, Stratis Health released two sets of preliminary data. In both sets, the participating care centers showed an improvement of 1.5 percentage points more than the statewide average exclusive of the participants.

On a monthly measure of the Quality Indicator pressure ulcer rates, the 43 participants showed a decline from 11 percent in January 2008 to slightly over 9 percent in June 2009. By contrast, all care centers not participating in this effort showed a much smaller decline, from 8.5 percent to just below 8 percent.

The participating care centers also improved more than the rest of the care centers in the area of the physical restraints Quality Indicator. The participants' improved from 5.2 percent to 3.3 percent, compared to the non-participants improvement from 2.0 to 1.6 percent.

For Further Information:

Contact Darrell Shreve at dhsreve@agingervicesmn.org.

Stakeholders Meet to Discuss Observation Days

Last week a group of stakeholders met to discuss issues related to the increased use of observation days by hospitals.

The issues relate to observation stays longer than 48 hours. The participants included staff from Aging Services, the Long Term Care and Home Care Ombudsman offices, the Medicare Revenue Enhancement Project, Noridian Administrative Services, and Stratis Health.

The consensus of the meeting was that some hospitals appeared to be using extended observation stays as a preventive measure related to the RACs (Recovery Audit Contractors), the new mechanism created by CMS to recover inappropriate Medicare payments. In the RAC demonstration project, CMS found that some hospitals inappropriately considered some days as inpatient days when they should have been outpatient observation days. (See Issues Update Number 130, July 13, 2009, for further information about the RACs and what SNFs can do to protect themselves financially.)

Because observation days are outpatient days, they do not count toward the three-day inpatient days that create the SNF Part A benefit for beneficiaries. Additionally, if the beneficiary was never admitted on an inpatient basis, the individual will face the Part B coinsurance of 20 percent for the observation stay and other services that would have been bundled into the DRG payment for an inpatient stay, plus the total cost of the drugs (which also would have been bundled).

Stratis Health reported that QIOs around the country have received calls about this issue. They have not found any Medicare requirement that hospitals must tell the beneficiary that they are admitted to an outpatient observation stay, rather than an inpatient stay, even though observation services are covered by Medicare only when ordered by a physician (or other person authorized by state licensure laws and hospital staff bylaws).

Stratis Health also reported that CMS has given inconsistent direction to QIOs. In some cases, QIOs are handling beneficiary appeals, but in other cases CMS has prohibited this practice. Stratis Health is not aware of any appeal mechanism they have with respect to coverage on outpatient observation days, and they refer beneficiaries to 1-800-MEDICARE.

Noridian staff indicated that there are some constraints that apply to hospitals. If a beneficiary starts in an observation stay and then is admitted as an inpatient, the hospital cannot discharge the patient back to an observation stay. The hospital can change the status from outpatient to inpatient, but a second change is not permitted. They also indicated that once the patient is discharged, the hospital cannot change the person's status in either direction, other than to correct for clerical errors.

Minnesota Hospital Association staff agreed with others that there is no definitive, required notice statement. They indicated a willingness to help develop one and to distribute it to their members.

The Medicare Benefits Policy Manual, Chapter 30, Section 20.5, defines outpatient observation services and indicates that it involves assessment to determine whether the beneficiary will require further treatment as an inpatient in the hospital or can be discharged from the hospital. The manual states that the assessment can usually be made in less than 24 hours and that Medicare will pay for outpatient observation services for longer than 48 hours only in the "rare and exceptional cases" where "reasonable and necessary outpatient observation services span more than 48 hours."

The Medicare Benefits Policy Manual also states that if a hospital intends to place or retain a beneficiary in observation for a non-covered service, it must give the beneficiary "proper written advance notice of noncoverage under limitation of liability procedures." If the hospital fails to give this notice, it would appear that the hospital cannot charge the individual for subsequent observation services.

Members should note two situations in which beneficiaries might have successful appeal rights or strategies. The first involves situations in which there are one or two inpatient days and at least one observation day. The beneficiary has the right to request a demand bill to challenge the determination that the beneficiary is not eligible for a Part A stay. The demand bill would go to the fiscal intermediary, and it does not pose any financial risk to the facility.

The second situation involves an extended outpatient observation stay for which the hospital does not bill all observation days to Part B. In this situation, the hospital cannot bill the beneficiary for the noncovered days unless the hospital gave appropriate written notice. Although CMS has not produced a specific, required notice, the requirement for the notice is in the Medicare manual. In this case, the beneficiary can simply refuse to pay the bill and force the hospital to produce proof that it gave the beneficiary the required written notice.

The stakeholders agreed to work together to produce materials to address the issues and problems. The first will be an educational brochure that will be designed to educate beneficiaries, care centers, and hospitals. A second product may be a sample notice that could be distributed to and used by hospitals on a voluntary basis.

Aging Services will provide further information as it becomes available.

For Further Information:

Contact Darrell Shreve at dshreve@agingservicesmn.org.

Nasal Spray Recall Announced

Procter & Gamble and the Food and Drug Administration have released information about a voluntary recall of three lots of a Vicks Sinex Nasal Spray in the United States, Germany and the United Kingdom.

The bacteria *B. cepacia* was found in a small amount of product made at its plant in Gross Gerau, Germany. There have been no reports of illness. However, the bacteria could cause serious infections for individuals with a compromised immune system, or those with chronic lung conditions, such as cystic fibrosis.

In the United States, the recall affects Vicks Sinex Vapospray 12-Hour Decongestant Ultra Fine Mist, 15 ml., Nasal Spray. The lot number is 9239028831.

Consumers should simply discard the affected product as they would any over the counter medicine. Customers who have the affected lots can call Procter & Gamble for a replacement coupon or refund.

Anyone who has this specific lot of this product can call 1-877-876-7881 between 8 a.m. and 5 p.m., Monday through Friday, or 8 a.m. to 3 p.m., Saturday and Sunday. The recall notice is at: <http://www.fda.gov/Safety/Recalls/ucm191416.htm>.

ALFA Hero Award Nominations Being Sought

ALFA (Assisted Living Federation of America) members are alerted to the fact that nominations for the 2010 Hero Awards are currently being accepted online at <http://www.alfa.org/heronomination>.

The nomination process will be open until Jan. 15, 2010. Categories for the award include Executive Director, Staff Member, Nurse, Caregiver and Volunteer. Winners will be honored during ALFA's 2010 Conference & Expo in Phoenix, Arizona, May 25-27, 2010, in conjunction with the organization's 20th anniversary.

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Feb. 10-12, 2010 (Minneapolis)

Member Types: All

Audience: All

Training Mode: Live Training - Conference & Expo

CEUs: All

Questions or Comments? Contact us at education@agingservicesmn.org.

Aging Services of Minnesota

2550 University Avenue West, Suite 350S, St. Paul, MN 55114-1900
Phone: 651.645.4545 Toll Free: 800.462.5368 Fax: 651.645.0002

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