Feature Focus

Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

CMS Requirements of Participation - Important Dates for Educational Sessions

On Wednesday, September 28, 2016, CMS released a final rule entitled ‘Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities.’ The final rule was published in the Federal Register on October 4, 2016. It reaffirms some existing requirements, such as existing resident rights, and finalizes a wide range of new requirements, from comprehensive person-centered care planning to compliance and ethics.

The regulations are effective on November 28, 2016. However, in response to comments by AHCA and our members, CMS is implementing the regulations using a phased approach. The phases are as follows:

- Phase 1: The regulations included in Phase 1 must be implemented by November 28, 2016.
- Phase 2: The regulations included in Phase 2 must be implemented by November 28, 2017.
- Phase 3: The regulations included in Phase 3 must be implemented by November 28, 2019.

Some regulatory sections are divided among more than one phase, and some of the more extensive new requirements have been placed in later phases to allow facilities time to successfully prepare to achieve compliance.

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities (RoP) was published and S&C 16-42-NH RoP was released. AHCA has developed a summary, just visit Required on ahcancalED and click on Summary-Final Rule. The summary is free to all members, but you must log in to view it (using the same username and password as you use to access members-only pages on the AHCA website). AHCA will also be providing additional guidance in the form of a ‘playbook,’ checklists and other useful resources for the new ROPs. To help you navigate through this rule, IHCA will have monthly member conference calls starting October 27, 2016 at 2 p.m. (central). Bill Bell and Dr. David Gifford with AHCA will lead this initial call. The one-hour call will concentrate on the priorities needed so you can be ready for this rule to go into effect on November 28, and will also feature a Q&A session. Please call in to 866-754-8248 using passcode 7906945265 at 2 p.m. on October 27. Going forward, we will have these member calls on the fourth Thursday of the month, unless there are conflicts and we will reschedule as necessary.

Also, on November 10, 2016, IHCA will be hosting an intensive web seminar given by Bill Bell titled, “Requirements of Participation Phase I: What You Need to Know to Comply.” For more information and to register click here.

IDPH Office of Health Care Regulation – Quarterly LTC Association Meeting

On October 12, 2016, The Illinois Department of Public Health’s Office of Health Care Regulation hosted the Quarterly LTC Association Meeting. These meetings are an opportunity for the various Illinois LTC Associations and the key
management staff of OHCR to sit down, face-to-face and discuss issues/items of concern. The following is a summary of this most recent meeting.

1) Questions related to generators and the new Emergency Preparedness Requirements.
   - Are generators required in all NF and SNF facilities (because of the new Emergency Preparedness requirements – effective in November of 2017)? IDPH stated that they have contacted federal CMS to get clarification on this and have not yet received a definitive answer. The way the new emergency preparedness requirements are written, it implies the answer is yes, but the requirements don’t come right out and say such. IDPH and IHCA are trying to get a definitive response from federal CMS and will pass this information along as soon as we get it.
   - What must the generator provide power to...AC/Heating? This is another question that there is no definitive answer as of yet. If the requirement is that the generator must support both heating and air conditioning, many facilities will have to upgrade their generator to a much bigger size to handle that load. Again, as soon as we get clarification from federal CMS, we will pass the information along to our members.
   - Different panels for different systems? Even if a facility has a generator large enough to handle all electrical operations, they still need to have a separate panel/branch for life safety and one for critical care functions (see K-145).
   - Battery power for certain items even if a facility is fully covered by generator? IDPH stated that there must be a battery powered light at the generator location and power (battery or otherwise) to the emergency egress passages and the facility’s common areas, in case of power failure and/or generator loss.
   - Will there be training on the new NFPA 2012 Life Safety Code? IDPH is working with their contacts on providing some in-person training courses on the 2012 LSC changes. However, IHCA believes not enough providers will be able to attend, so IHCA has an inquiry into federal CMS to see if a 2012 LSC webinar can be arranged. We will keep you informed on this request.
   - The new 2012 LSC will require federal CMS to rewrite/redo the K-Tags. Is there a date for this release? IDPH stated that they have seen a draft of the new K-Tags but haven’t heard a date for their final release. Possibly November?
   - What is the possibility of the Assisted Living program moving to the 2012 LSC, currently at the 2000 LSC? IDPH is considering this, but has not made a decision yet. They would have to propose this change as proposed rulemaking for comment.

2) Section 483.12a)3) of the new ROPs. New HCWBC language seems to not allow waivers? IHCA noted this issue in our initial reading of the new ROPs. IDPH was not aware of this and will inquire with IDPH Legal and federal CMS as to how this issue will be handled.

3) Updated status of:
   - LTC Electronic Incident Report Form – The form is done and IDPH just waiting for it to be put on the IDPH website. When this happens, we will alert our members about the form and new procedure for transmitting incident reports.
   - Subpart S Rulemaking – Rule is being worked on between IDPH and Governor’s Office.
   - Distressed Facility Rulemaking – Rule still being developed.
   - Informed Consent Rulemaking – Rule still being developed.
   - Behavioral Health Unit Rulemaking – Rule still being developed.
   - Electronic POCs – IDPH stated that they will move this issue up their priority list and see if they can make this work. In order for this to work properly, each facility will need to have a FACILITY EMAIL ADDRESS that will not change when there is an Administrator change. The facility email address must remain constant. Please consider setting this up if you haven’t already.

4) Any progress of information regarding rulemaking or guidance with regard to electronic monitoring devices and medical marijuana? No IDPH movement on either of these two issues.
5) Any movement with regard to explanations for denial of certification IDRs similar to licensure IDRs? Also difference in what IMPRO vs MAXIMUS provides? IDPH is still considering this, but has not yet implemented it. IDPH did verify that federal CMS stated that it is not required, but is also not disallowed either. IHCA stressed the desire for this and IDPH will review the request and report at the next Quarterly meeting.

6) Discussion/clarification on the term “serious injury” with regard to incident reporting. IDPH clarified that ‘serious’ in the reporting of a serious injury means that the injury required outside services, meaning an ambulance, visit to the hospital, non-regular physician visit, etc.

7) Discussion/clarification on reporting of incidents with an “injury of unknown cause”…only if suspicious in nature or every one? IDPH stated that reporting should occur if a ‘serious’ incident or if during the facility investigation, there appears to be suspicion of abuse/neglect.

8) Follow-up of questions from last meeting with regard to the Identified Offender Program. My recollection/summary issues were:

- One of the questions raised was with regard to repeat background checks of residents. Unlike the background checks for employees, that are only done once and the background check follows the employee to different facilities, the background check for residents must be completed each time a resident moves from one facility to another. We asked IDPH to research this issue and see if there could be some exceptions or allowances for not repeating background checks on residents similar to what is done for employees. IDPH stated they understood the concern of the increased cost and the stress this put on residents and their families and agreed to discuss this internally and see if there are options to address the problem.

- Another issue raised had to do with residents guilty of sex offences. There are situations where a person has been found guilty of a sex offense, but they are not listed on any of the Sex Offender Registries. This is a quirk in the system due to older convictions and the reporting systems at that time. They are still considered sex offenders and some facilities have got caught admitting such individuals not knowing of the conviction until after the entire background check is completed. The question is then how does a facility respond to this situation and if they cannot meet the resident’s needs, how is the person properly discharged? The new IOP Guideline will provide guidance on this.

- We believe that the IOP statute only requires sex offences and felonies to be reported. We have heard of instances where the Illinois State Police (ISP) have made visits to LTC facilities and have stated that misdemeanors along with felonies have to be reported. IDPH agreed to discuss this with their legal staff and with ISP and bring this issue back for further discussion at our next quarterly meeting.

Someone from the IDPH Identified Offender Program was to be at this Quarterly Meeting to address the above questions/concerns, but they were not able to make the meeting. Someone from the IO Program will hopefully be at the next meeting.

9) Discussion on abuse/strict liability. IDPH in discussion with federal CMS agreed that there is strict liability and the LTC facility is responsible for everything that goes on within the facility, even things beyond their control. Not fair, but…….

10) Discussion on Imposed Plans of Correction. Under what circumstances does OHCR impose a plan of correction? Shouldn’t a facility be given the opportunity to provide a POC before one is imposed? Doesn’t an imposed POC open the door for IDPH liability? The IDPH OHCR management staff forwarded this series of questions regarding imposed POCs to the IDPH Legal unit for a response and had not yet received one. IHCA will continue to follow-up on this issue.
11) Any information from CMS to the state(s) with regard to the new ROPs and implementation strategies? IDPH has heard nothing from federal CMS on training or how to implement the new ROPs. They stated they will keep us in the loop and let us know when they receive any guidance/information on the new ROPs.

12) Does IDPH believe that PA 99-0822, Alzheimer’s Disease and Related Dementias Services Act, applies to all LTC facilities regardless as to whether or not they have a designated Alzheimer’s Unit? IDPH OHCR is waiting for IDPH Legal to respond to this question, but IDPH OHCR believes that the new law and requirements apply to any facility that has Alzheimer/dementia residents. We will notify our members as soon as IDPH Legal confirms one way or the other.

13) Nurse Aide shortage and availability of classes. It appears that more and more of the nurse aide classes are being filled with future nurses and regular nurse aides are finding it hard to get into a class and we are starting to see nurse aide shortages in certain areas of the state. IDPH will address this issue at the next Nurse Aide Workgroup meeting in November. IHCA asked that the possibility of more online training be considered. AHCA offers an online nurse aide program that might be one solution for this occurring and serious future issue. Facilities that have a nurse aide training program and have lost it due to a survey issue, should consider the waiver option.

14) Even though the survey processing requirements are the same for LTC and ICF/IID, why are the actual processes different? What providers get after a survey is different between the two programs. Is there a reason for this? It appears to us that the ICF/IID process most closely follows the statute/rules. Examples were provided and IDPH stated that they will review their processes and make the necessary changes to make them the same and in conformance with the statute and corresponding rules.

15) Is IDPH doing ‘special’ involuntary discharge surveys? IDPH stated no, but they are responding to complaints with regard to involuntary discharges.

16) Has IDPH surveyors received any training on the new MDS requirements? They have a draft training protocol and expect that to be finalized in the near future and then surveyor training will occur. IHCA asked if the training material could be shared with us and they stated they will check but believe they can share. As soon as we receive the IDPH training document, we will share it with our members.

**AHCA Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcome Series – Part 12 of 13**

This is part of a series featuring one element of the Building Prevention Into Every Day Practice: Framework for Successful Clinical Outcomes.

Success in achieving positive resident/patient outcomes is even more critical now than ever before. The link between quality and payment in long term and post-acute care is growing stronger, as evidenced by the SNF Value Based Purchasing Program (VBP), Improving Post-Acute Care Transformation (IMPACT) Act, SNF Quality Reporting Program (QRP) and more.

In addition, regulatory activity is intensifying through focused surveys on adverse events, dementia care and MDS. The Five-Star Rating system and Nursing Home Compare have been revised and will add items in the future as it broadens public reporting and transparency. Most importantly, consumers expect and deserve high quality care.

The entire framework outlines key elements from both an organizational and clinical nature that are critical to successful clinical and organizational outcomes. Positively, these elements reflect common denominators that cross multiple care situations. Therefore, instead of being yet another initiative or single focused project to achieve just one outcome, it is a way of acting, thinking and being that will benefit multiple areas across an organization. Each element is addressed in detail throughout the framework.

This week we will feature the element of *Clinical Foundation: Timely Provision of Necessary Care*
Key Takeaways: Timely Provision of Necessary Care

✓ Timely availability of resources is essential for the staff and practitioners to be able to deliver timely and effective care.
✓ Our centers can improve the timeliness of care by scrutinizing existing systems and processes to make them more efficient.
✓ Commit to a culture of safety.

Probing Questions for Team Reflection and Discussion:

1. Do we have the right resources available at the right time? How do we know?
2. How do we prevent unnecessary delays from occurring?
3. How do we know what is necessary and/or desired care for each individual?
4. How do our staff that are not involved in direct care help the staff providing care in every way possible to be more efficient and effective?

Visit the AHCA Clinical Practice website to learn more about the element of “Clinical Foundation: Timely Provision of Necessary Care.”

What does this mean?
“Timeliness” is another of the six key criteria for quality in the Institute of Medicine (IOM) report Crossing the Quality Chasm.

It is defined as reducing harmful delays both for those who give care and those who receive it.

Commission (providing care in an incomplete or substandard way) and omission (missing care or not providing it in a needed time frame) increases the risk for adverse events.

Why is this important?
The February 2014 OIG report on Adverse Events in Skilled Nursing Facilities identified that many of the adverse events and temporary harm events came from care-related commissions and omissions. This means that care was provided but at a substandard level or not provided at all.

Timely provision of necessary care helps attain desired results and prevents adverse events.

Timely availability of resources (including discharge and other important information about the individual, medications, necessary equipment and supplies) is essential for the staff and practitioners to be able to deliver timely and effective care.

What are some examples?
• The patient is admitted from the hospital with special equipment needs. The equipment is available immediately on admission due to adequate communication and is planned between the hospital and center prior to transition.
• Timely administration of the first dose of antibiotics prevents worsening of an infection.
• Medications required 30 minutes prior to the meal are given as directed, preventing issues affecting absorption or altering the medication’s effectiveness.
• Review of a patient’s advance directives or current orders for life-sustaining treatments in a timely fashion results in necessary or desired care versus an avoidable return to the hospital.

What is my part (as an individual employee, manager or practitioner)?
As a manager, commit to improving the efficiency of staff and being flexible enough to allow them to do their job in a timely fashion.

Staff that are not involved in direct care should do everything possible to support the direct care staff; for example, by making sure equipment and supplies are available, organizing medical records and getting new charts to the staff promptly for new admissions, repairing malfunctioning equipment promptly and helping direct care staff communicate with hospitals, pharmacies, and other outside ancillaries. Even when staffing is challenged, it is possible to help existing staff be more efficient throughout each day.

As a practitioner, make sure the items ordered fit within the scope and training of the staff and are necessary for patient care; for example, monitoring blood sugars, blood pressures, and pulse oximetry.

Provide “just-in-time” training when indicated for unexpected issues.

What can my organization do?

- Scrutinize existing systems and processes to make them more efficient.
- Hold everyone accountable to doing their jobs, so that the system runs smoothly and does not waste staff time.
- Commit to a culture of safety.
- Review and address issues affecting timeliness of care as part of the QAPI program.
- Commit to staff training and coaching about task performance and use the information to improve systems and individual performance.

Resources/Tools:
AHRQ Improving Patient Safety in Long Term Care
AHRQ's Safety Program for Nursing Homes: On-Time Prevention

Start somewhere, pick one element and work through it with your team.

Enjoy the journey through the framework!

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Trending Statistics

Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.

New Data: 49 States Plus DC Reduce Avoidable Hospital Readmissions
CMS recently published news of the reduction in potentially avoidable hospital readmissions that occur within 30 days of a patient’s initial discharge. The effort to provide Better Care and Lower Costs appears to be on the path to success as national data shows an 8 percent reduction. The blog, authored by Patrick Conway and Tim Gronniger, which includes a state by state breakdown can be reviewed here.

The unfortunate experience of having to return to the hospital after recently being treated—or watching the same thing happen to a friend or family member—is all too common. Potentially avoidable hospital readmissions that occur within 30 days of a patient’s initial discharge are estimated to account for more than $17 billion in Medicare expenditures annually.[1] Not only are readmissions costly, but they are often a sign of poor quality care. Many readmissions can be avoided through improvements in care, such as making sure that patients leave the hospital with appropriate medications, instructions for follow-up care, and follow-up appointments scheduled to make sure their recovery stays on track.

To address the problem of avoidable readmissions, the Affordable Care Act created the Hospital Readmissions Reduction Program, which adjusts payments for hospitals with higher than expected 30-day readmission rates for targeted clinical conditions such as heart attacks, heart failure, and pneumonia. The Centers for Medicare & Medicaid Services has also
undertaken other major quality improvement initiatives, such as the Partnership for Patients, which aim to make hospital care safer and improve the quality of care for individuals as they move from one health care setting to another.

The data show that these efforts are working. As described below, between 2010 and 2015, readmission rates fell by 8 percent nationally. CMS is releasing new data showing how these improvements are helping Medicare patients across all 50 states and the District of Columbia.

The data show that since 2010:
- All states but one have seen Medicare 30-day readmission rates fall.[2]
- In 43 states, readmission rates fell by more than 5 percent.
- In 11 states, readmission rates fell by more than 10 percent.

Across states, Medicare beneficiaries avoided approximately 100,000 readmissions in 2015 alone, compared to if readmission rates had stayed constant at 2010 levels. That means Medicare beneficiaries collectively avoided nearly 100,000 unnecessary return trips to the hospital. Cumulatively since 2010, the HHS Assistant Secretary for Planning and Evaluation estimates that Medicare beneficiaries have avoided 565,000 readmissions.

The Hospital Readmissions Reduction Program is just one part of the Administration’s broader strategy to reform the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. Other initiatives include Accountable Care Organizations, as well as efforts by Quality Improvement Organizations and Hospital Engagement Networks, which fund quality improvement expert consultants to work with provider and hospital communities to improve care. The goal of all of these efforts is to spend our health care dollars more wisely to promote better care for Medicare beneficiaries and other Americans across the country.
Important Regulations, Notices & News Items of Interest

1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 17-01 – Hospice** - Impact of Nursing Shortage on Hospice Care. Extraordinary Circumstances due to Nursing Shortage: The period of time has been extended for a hospice agency to elect an exemption to allow for the contracting of nurses pursuant to “extraordinary circumstance” as noted at 42 CFR 418.64 when it believes that the nursing shortage has affected its ability to directly hire sufficient numbers of nurses. Extension: This policy is effective through September 30, 2018.

2) Federal HHS/CMS released the following notices/announcements:

- **CMS/Hospice Cost Data:** They published the [Hospice Utilization and Payment Public Use File](https://www.cms.gov) last week. It breaks down hospice costs and usage data by geographic location, beneficiary demographics, costs and individual provider characteristics. In 2014 alone, 1.3 million Medicare beneficiaries received a total of 92.3 million hospice care days, with each stay averaging about $11,393 per beneficiary. CMS says that releasing the state and individual provider data will help improve data transparency and help providers make informed decisions about their location and the patients they serve.

- **CMS/QAPI:** CMS recently released a [Volume 2 QAPI Brief](https://www.cms.gov), which focuses on adverse events for the first time since 2013. It includes a list of potentially preventable adverse events and a medication related adverse events case study. The next QAPI brief is expected to be on care and infection related adverse events.

- **SECTION GG:** Beginning October 1, 2016 skilled nursing centers are required to report information to CMS for the [SNF Quality Reporting Program](https://www.cms.gov) required under IMPACT (Improving Medicare Post-Acute Care Transformation) Act of 2014. **Section GG** (self-care and mobility) will be added to MDS 3.0 and required to complete on the PPS 5 day and PPS Part a Discharge Assessments. Information from Section GG will be used to calculate the [standardized measure](https://www.cms.gov) of Percent of Residents With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function” (NQF #2631). This measure reports the percentage of residents with both an Admission and a Discharge functional assessment and an activity (self-care or mobility) goal that addresses function. Section GG items focus on admission performance, discharge goals and discharge performance. CMS has not specified who should complete Section GG, but has emphasized the importance of collaboration among members of the interdisciplinary team. Final direction and guidance on coding Section GG has not been released yet from CMS, however AHCA has developed a [two-page introduction](https://www.cms.gov) with a section on what you can do to prepare for Section GG. For more information and resources, visit the AHCA website [here](https://www.cms.gov).

- **PBJ:** The deadline for nursing centers to gather and submit Payroll-Based Journal (PBJ) data for the first mandatory quarter is November 14, 2016. As you get ready, it’s important to remember that the system requires the reporting of hours per day and per employee that are worked. It’s also important to keep in mind that the employee must be paid for all of the hours reported. Click [here](https://www.cms.gov) and [here](https://www.cms.gov) for more resources, including webinars and list of vendors offering PBJ solutions! Here are a few other things to keep in mind:

  Are facilities required to report hours paid or hours worked?
  - Facilities (SNF/NF) will report hours paid for services performed onsite for the residents of the facility, with the exception of paid time off (e.g., vacation, sick leave, lunch, etc.). For example, if a salaried employee works 10 hours but is only paid for 8 hours, only 8 hours should be reported.
  - I know that only the hours paid for a salaried employee shall be submitted. Can you clarify if I can submit the hours for an extra shift that my salaried employee works, if I pay them a bonus for these additional hours?
The hours may be reported under the following conditions: The payment must be directly correlated to the hours worked and must be distinguishable from other payments. (e.g., cannot be a performance-based or holiday bonus). Additionally, the bonus payment must be reasonable compensation for the services provided.

When considering reporting, realize that you can report fractions of time as follows.

- Fractions of time should be reported under the following protocol that converts from minutes to tenths of an hour:
  - 1 to 6 Minutes = 0.1
  - 7 to 12 Minutes = 0.2
  - 13 to 18 Minutes = 0.3
  - 19 to 24 Minutes = 0.4
  - 25 to 30 Minutes = 0.5
  - 31 to 36 Minutes = 0.6
  - 37 to 42 Minutes = 0.7
  - 43 to 48 Minutes = 0.8
  - 49 to 54 Minutes = 0.9
  - 55 to 60 Minutes = 1.0

As always, consult the PBJ Policy Manual, FAQs, etc., for more information. Questions can always be sent to staffdatacollection@ahca.org.

- **Importance of Documentation:** Include proper medical record documentation for correct payment of your Medicare claims. Watch a brief video on the Importance of Documentation from the Office of the Inspector General (OIG) to learn how proper documentation protects the provider, patient, and Medicare program integrity. This video is part of the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative to prevent fraud, waste, and abuse. The video originally aired in 2012, but the information is current.

- **Long Term Care Facilities: Reform of Requirements Call — October 27 - Thursday, October 27 from 1:30 to 3 pm ET.** To register or for more information, visit MLN Connects® Event Registration. Space may be limited, register early. During this call, learn about the final rule to reform the requirements for long term care facilities. These requirements are the federal health and safety standards that long-term care facilities must meet in order to participate in the Medicare or Medicaid programs. Find out about the changes included in the final rule; implementation and survey process; and provider training and resources. A question and answer session will follow the presentation. Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders.

- **Emergency Preparedness Requirements Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the October 5 call on Emergency Preparedness Requirements. During this call, CMS discussed the new requirements in the final rule, as well as how to plan for both natural and man-made disasters, while coordinating with other emergency preparedness systems.

- **Hospice Payment System Booklet — Revised.** A revised Hospice Payment System Booklet is available. Learn about:
  - Medicare hospice benefit
  - Payments
  - Option for Medicare Advantage enrollees
  - Hospice Quality Reporting Program

- **Provider Compliance Fact Sheets — Revised.** Revised Provider Compliance Fact Sheet are available with tips for:
  - Computed Tomography (CT Scans)
  - Diabetic Test Strips
• **Entering Nutrition Pumps**

- **Continuing Education Credits for Web-Based Training Courses.** Are you looking for Continuing Education (CE) credits? Most Medicare Learning Network Web-Based Training (WBT) courses offer CE credits accepted by professional associations, state agencies, and accrediting bodies. CMS is:
  - Accredited by the Accreditation Council for Continuing Medical Education (ACCME) to offer AMA PRA Category 1 Credit™
  - Approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET) to provide Continuing Education Units (CEUs)

Visit the [WBT](https://www.cms.gov) webpage for a list of courses offered through the Learning Management and Product Ordering System. After you complete a WBT, you will receive an official CMS certificate.

- **New Data to Increase Transparency on Medicare Hospice Payments.** On October 6, CMS released a privacy-protected public data set, the Hospice Utilization and Payment Public Use File (Hospice PUF), which provides information on services provided to Medicare beneficiaries by hospice providers. CMS also released an update to the Market Saturation and Utilization Data Tool. The Hospice PUF contains information on utilization, payments, submitted charges, diagnoses, and hospice beneficiary demographics organized by provider and state. The Hospice PUF covers CY 2014 and includes information on 4,025 hospice providers, over 1.3 million hospice beneficiaries, and over $15 billion in Medicare payments. The third release of the Market Saturation and Utilization Data Tool includes interactive maps and supporting data sets that show national, state and county-level provider services and utilization data for three reference periods and the following health service areas: Home health, ambulance, independent diagnostic testing facilities, skilled nursing facilities, and hospice. For More Information:
  - [Medicare Hospice Transparency Data](https://www.cms.gov) Fact Sheet
  - [Medicare Provider Utilization and Payment Data: Hospice Providers](https://www.cms.gov) webpage
  - [Market Saturation and Utilization Data Tool](https://www.cms.gov) webpage

See the full text of this excerpted [CMS press release](https://www.cms.gov) (issued October 6).

- **SNF Value-Based Purchasing Program: Confidential Feedback Reports Available.** Confidential quality feedback reports are now available for Skilled Nursing Facilities (SNFs) through the Certification and Survey Provider Enhanced Reports (CASPER) system. If your SNF does not have access to CASPER, contact help@qtso.com. Visit the [SNF Value-Based Purchasing Program](https://www.cms.gov) webpage for more information.

- **Protect Your Patients from Influenza this Season.** The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months of age and older receive an influenza vaccine every year. Influenza is a serious health threat, especially to vulnerable populations like people 65 and older who are at high risk for hospitalization and complications. Vaccinate by the end of October, if possible – to protect your patients, your staff, and yourself. Medicare Part B covers one influenza vaccination and its administration each influenza season for Medicare beneficiaries. Medicare may cover additional seasonal influenza vaccinations if medically necessary. The CDC recommends use of the Inactivated Influenza Vaccine (IIV) and the Recombinant Influenza Vaccine (RIV). The nasal spray vaccine or Live Attenuated Influenza Vaccine (LAIV) should not be used during 2016-2017.

For More Information:
  - [Preventive Services](https://www.cms.gov) Educational Tool
  - [Influenza Resources for Health Care Professionals](https://www.cms.gov) MLN Matters® Article
  - [Influenza Vaccine Payment Allowances](https://www.cms.gov) MLN Matters Article
  - [CDC Influenza](https://www.cdc.gov) website
Visit the HealthMap Vaccine Finder to find locations in your area that offer the recommended vaccines

- **Reporting Fraud to the Office of the Inspector General.** Do you suspect someone is submitting fraudulent claims to Medicare? Watch a brief video on How to Report Fraud to the OIG and learn how you can report these activities anonymously to The Office of the Inspector General (OIG). Help protect the Medicare Program and your patients. This video is part of the OIG Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training initiative to prevent fraud, waste, and abuse. The video originally aired in 2011, but the information is current.

- **SNF Value-Based Purchasing Program Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the September 28 call on the Skilled Nursing Facility (SNF) Value-Based Purchasing Program. Learn how the implementation of the program will affect your Medicare payment.

- **CMS Finalizes the New Medicare Quality Payment Program.** On October 14, HHS finalized its policy implementing the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) incentive payment provisions in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), collectively referred to as the Quality Payment Program. The new Quality Payment Program will gradually transform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care system. The final rule with comment period offers a fresh start for Medicare by centering payments around the care that is best for the patients, providing more options to clinicians for innovative care and payment approaches, and reducing administrative burden to give clinicians more time to spend with their patients, instead of on paperwork. Accompanying the announcement is a new Quality Payment Program website, which will explain the new program and help clinicians easily identify the measures most meaningful to their practice or specialty.

For More Information:
- Final Rule and Executive Summary
- Press Release
- Fact Sheet
- Quality Payment Program website

3) The **Occupational Safety and Health Administration (OSHA)** has recently updated the Guidelines for Safety and Health Programs (click here) it first released 30 years ago, to reflect changes in the economy, workplaces and evolving safety and health issues. The new Recommended Practices have been well received by a wide variety of stakeholders and are designed to be used in a wide variety of small and medium-sized business settings. The Recommended Practices present a step-by-step approach to implementing a safety and health program, built around seven core elements that make up a successful program.

The main goal of safety and health programs is to prevent workplace injuries, illnesses and deaths, as well as the suffering and financial hardship these events can cause for workers, their families and employers. The recommended practices use a proactive approach to managing workplace safety and health. Traditional approaches are often reactive – that is, problems are addressed only after a worker is injured or becomes sick, a new standard or regulation is published, or an outside inspection finds a problem that must be fixed. These recommended practices recognize that finding and fixing hazards before they cause injury or illness is a far more effective approach.

The idea is to begin with a basic program and simple goals and grow from there. If you focus on achieving goals, monitoring performance, and evaluating outcomes, your workplace can progress along the path to higher levels of safety and health achievement.

Employers will find that implementing these recommended practices also brings other benefits. Safety and health programs help businesses:
- Prevent workplace injuries and illnesses
- Improve compliance with laws and regulations
- Reduce costs, including significant reductions in workers’ compensation premiums
- Engage workers
- Enhance their social responsibility goals
- Increase productivity and enhance overall business operations

4) Illinois Submits Medicaid Waiver to Improve Delivery of Behavioral Healthcare (click here to view). This waiver will allow Illinois to care for our most vulnerable citizens earlier and more efficiently. Governor Rauner joined state agency directors, local officials and stakeholders to announce Illinois has officially submitted the 1115 Medicaid waiver proposal to the federal government. This waiver will allow Illinois to use innovative health strategies for better coordination and integrated care, and will address behavioral health and substance abuse treatment for some of our most vulnerable residents. This waiver, if approved, will transform the way Illinois provides behavioral and mental health care services to our residents.

5) Cook County/Paid Sick Leave: The Cook County Board of Commissioners enacted an ordinance (Click here to view) that will require employers throughout Cook County, Illinois to provide paid sick leave to employees. It adopts the same terms set as forth in the Chicago Paid Sick Leave Ordinance, which was passed by the Chicago City Council in June, and goes into effect on the same day: July 1, 2017. Once the ordinances take effect, employees throughout Cook County will accrue 1 hour of paid sick leave for every 40 hours worked. Employees will be able to accrue up to 5 days of paid sick leave per year, unless the employer’s policies provide for a greater benefit. Employers throughout Cook County should update their sick leave policies prior to July 1, 2017.

6) The Illinois Department of Healthcare and Family Services (HFS) posted the following notices and information:

- HFS posted a new provider notice regarding the Service Definition and Reimbursement Guide (SDRG), Reissue. You may view the notice here.

- HFS posted a new provider notice regarding the Monthly Occupied Bed Provider Assessment Due Date Extension. You may view the provider notice here.

- A video presentation of the Direct Data Entry (DDE) claim submittal process has been posted to the LTC Direct Billing webpage (click here).

- HFS issued a provider notice regarding the Handbook for Providers of Practitioners Rendering Medical Services – Reissue. You may view the notice here.

- HFS posted a new provider notice regarding the Requirement for Long Term Care Providers to Submit Monthly Billing for Reimbursement Purposes – Delayed Implementation. You may view the notice here.

7) The Illinois Department of Public Health (IDPH) posted the following information:

- The remaining 2016 IDPH Town Hall regional meetings dates are below. They are very informal and an excellent opportunity to ask questions. Please have staff from each facility attend one of these Town Hall Meetings. All reservations should be made via email to Lisa.Reynolds@illinois.gov. Please include the words “Town Hall Reservation” in the subject line.

- IDPH Flu Guidelines: Check out this year’s guidance from IDPH regarding Influenza outbreaks, as well as the CDC’s Tool Kit on the issue... click here.

- IDPH State Fines: Click here to view the IHCA fine data as the 3rd quarter fine amounts were recently released by IDPH.
The American Health Care Association/ National Center for Assisted Living (AHCA/NCAL) posted the following:

- **AHCA Sues CMS Over Nursing Home Arbitration Regulation** - CEO Mark Parkinson said in statement, "AHCA is extremely disappointed that CMS included in the final rule a provision banning all pre-dispute arbitration agreements. That provision clearly exceeds CMS’ statutory authority and is wholly unnecessary to protect residents’ health and safety." AHCA says the FAA mandate that arbitration agreements be enforced can only be changed by Congress. "Over and over since 2008, Congress has thoroughly and repeatedly refused to regulate or prohibit the use of arbitration agreements between skilled nursing care centers and their residents," says Parkinson. He also said AHCA has "a strong legal case. That’s why we’re asking the courts to have this rule overturned."

- **NCAL Adds Four Measures To TLC Trend Tracker** - the National Center for Assisted Living recently announced it will add four new assisted living measures to its online data collection tool TLC Trend Tracker: hospital admissions, hospital readmissions, the off-label use of antipsychotic medications, and occupancy rates. LTC Trend Tracker now has six measures for assisted living providers. Sunday’s announcement also means "that NCAL member organizations now have the ability to track their progress on all of the NCAL Quality Initiative goals within one tool." NCAL Executive Director Scott Tittle said, "NCAL is proud to grow our assisted living footprint in LTC Trend Tracker to help providers better understand how they’re doing, share that with other health care partners and consumers and, hopefully, get recognized for their amazing work."

- **NCAL Writes Letter To CMS Calling For Agency To Clarify Final Rule About Home- And Community-Based Settings** - the National Center for Assisted Living wrote a letter to the Centers for Medicare & Medicaid Services calling for the agency to clarify "a final rule defining home- and community-based settings through the Medicaid waiver program." The letter says the final rule fails "to distinguish between the needs and preferences of people with disabilities and of seniors." Scott Tittle, the executive director of NCAL, said, "We want to work alongside CMS to protect the wants and needs of vulnerable individuals who benefit from assisted living. While we agree about the importance of ensuring that home- and community-based settings offer resident-centered services that are integrated into the community, it’s also critical to ensure that the settings analysis takes into account what community integration means for seniors."

**9) POLST Survey:** IHCA and the POLST Illinois Taskforce is aware of a lack of consistency across the state in use and understanding of the POLST. Below you will find a link to a ten-minute survey that will help us assess POLST use and identify potential educational needs. Only aggregate non-identified data will be reported. Please click on the following to take the survey: [https://www.surveymonkey.com/r/B3KGGRF](https://www.surveymonkey.com/r/B3KGGRF).

**10) The latest Telligen events/announcements can be found at [https://www.telligeninqio.com/](https://www.telligeninqio.com/).**

**11) The Washington Post reports Researchers Estimate Economic Cost of American Adults Falling Ill From the FLU in 2015 to be $5.8 Billion.** "American adults sick with flu cost about $5.8 billion last year in medical visits, medication and lost productivity, according to a new study published in Health Affairs." Researchers also found that the total economic costs of adults falling ill from all diseases that can be prevented by vaccines collectively cost about $9 billion in 2015," and $7.1 billion of that "was caused by people who skipped vaccines, for diseases including influenza and HPV." The study’s authors also point out that the majority of adults were not vaccinated last flu season, according to the CDC.

**12) The Los Angeles Times reports Advances in Predictive Health Care Technology Raise Patient Privacy Concerns.** Advances in predictive analytics, technologies that could predict patients’ future medical conditions, are raising concerns about patient privacy. The article points out that Northrop Grumman is building a computer system for the Centers for Medicare & Medicaid Services to better detect health care fraud, but in the future it could be used to predict people’s medical needs by analyzing their health records. The article quotes Dr. Shantanu Agrawal, the director of Medicare’s Center for Program Integrity, who said, "The use of data in health care is absolutely critical. Having it be predictive of various issues is extremely important."
13) *Medicalxpress* reports that a **New Version of Ibuprofen May be Superior for Pain Relief Than the Current Version**. Move over aspirin, a new formulation of ibuprofen might prove to be a "wonder drug." In a research report published online in *The FASEB Journal*, scientists used mice and rats to show that ibuprofen arginate may allow people to take higher doses without the cardiovascular side effects that are associated with current formulations found in over the counter products. In addition to being better tolerated, ibuprofen arginate also is released into the bloodstream more rapidly than the current formulations, likely providing faster pain relief.

14) *HealthDay* reports:

- *HealthDay* reports **Pulmonary Embolism May be the Cause of Fainting in Some Elderly Adults**. Research suggests "when elderly adults suffer a fainting spell, a blood clot in the lungs may be the culprit more often than" physicians "have realized." Investigators "found that among 560 patients hospitalized for a first-time fainting episode, one in six had a pulmonary embolism." The findings "do not mean that everyone who faints needs to be evaluated for pulmonary embolism," stressed Dr. Lisa Moores," who is "with the American College of Chest Physicians." However, "the condition should be on doctors' radar with certain patients, according to" Dr. Moores, who was not involved in the research. The findings were published in the New England Journal of Medicine.

- *HealthDay* reports **Exercise May Benefit Older People Who Have Memory Thinking Problems**. Research suggests "older people who have memory and thinking problems may get a slight benefit from exercise." Investigators found that "people who exercised showed some improvement on a test of thinking and memory skills compared with those who didn't exercise." The study involved 70 people.

15) *Provider Magazine* reports **Online Courses Expanding Opportunities for Health Care Workers**. Health care workers are using online courses to complete certification requirements, receive training, or brush up on old topics. The article points out that the American Health Care Association authorized technology vendor Academic Platforms and the Bethel University nursing department to utilize the AHCA's "How to be a Nurse Assistant" curriculum as part of "an online education initiative," and now "AHCA is offering it to providers who want an online training course for their CNAs." The article quotes Jon-Patrick Ewing, the senior director of marketing at AHCA, several times explaining the benefits and limitations of online courses.

16) *MedlinePlus* reports **Better Way to Treat Seniors’ Ankle Fractures?** A new type of plaster cast might help older adults avoid surgery for unstable ankle fractures, researchers say. "Older adults -- those over 60 -- are suffering an increasing number of ankle fractures from leading more active lifestyles and the rising prevalence of osteoporosis," said study author Keith Willett. Currently, two techniques are used to treat unstable ankle fractures: surgery to set and fix the bones using plates and screws; or a traditional plaster cast. "Each technique has drawbacks," Willett said in a university news release. "Traditional plaster casts are associated with misaligned bones, poor healing and plaster sores. Surgery, especially in older people, is often complicated by poor implant fixation, wound healing problems and infection." Willett and his colleagues assessed the use of a new plaster cast technique called "close contact casting." This uses less padding than a traditional cast and sets the bones by being a close anatomical fit. The cast is applied by a surgeon while the patient is under anesthetic.

17) *McKnight’s* reports:

- *McKnight’s Senior Living* editorializes that the **Distinction Between Nursing Homes and Assisted Living Communities is "Narrowing," but that "fundamental differences remain" primarily funding and federal regulation. The editorial argues that assisted living is becoming increasingly "clinical" like skilled care as evidenced by the new measures added to NCAL’s LTC Trend Tracker, while many nursing homes are adopting a "social conscience" making them more like assisted living. The editorial quotes NCAL Board Chairman Chris Mason, who said about assisted living, "What began as a social model with a medical conscience in many states is now a medical model with a social conscience." The editorial also says "anyone at this week’s American Health
Care Association/National Center for Assisted Living annual meeting in Nashville, TN, might be forgiven for concluding that both are kind of the same thing."

- *McKnight’s Long Term Care News* reports, "*Managing Therapy Minutes May Soon be Replaced by Payment Models that Focus on Patient Characteristics.*" Dan Ciolek, associate vice president for therapy advocacy at AHCA, warned at the association’s annual convention in Nashville. "Massive" changes may be "on the horizon as the Centers for Medicare & Medicaid Services adopts more alternative payment models, and groups such as the Office of Inspector General and the press place more scrutiny on therapy billing."

- **Section GG: Collaboration With Rehab.** Now that the much-anticipated October 1 implementation of MDS Section GG has come and gone, a number of questions regarding best practices for collaboration among skilled nursing interdisciplinary teams have emerged. Common work among departments always can be tricky, and this instance is no exception. On the positive side, however, the need for interdisciplinary partnerships has led to increased communication, collaboration and awareness related to the functional abilities and desired functional outcomes for the individuals we serve.

- **Antidepressant Interrupt Seniors’ Sleep, May Raise Dementia Risk.** Antidepressants may significantly disrupt older adults' sleep patterns and cause a disorder that can contribute to dementia, according to new research. Investigators at SUNY Upstate Medical University analyzed 10 studies published within the last five years to determine how antidepressants, especially selective serotonin reuptake inhibitors, affect sleep.

- **GAO: Lack of ‘Meaningful’ Quality Measures Hurting Providers.** A “misalignment” of healthcare quality measures may place a burden on providers and jeopardize the success of value-based payment methods, according to a new federal report. This misalignment — found in quality measures used in skilled nursing facilities, hospitals and physician offices — is primarily driven by variation in data collection and reporting systems, decision making gaps between public and private payers, and few meaningful measures, the Government Accountability Office said in its Thursday report. While quality measures can be used successfully to encourage improvement in healthcare quality, those discrepancies can cause burdens for the providers they're meant to benefit.

18) **Interesting Fact:** The average person in the West eats 50 tons of food and drinks 50,000 liters (11,000 gallons) of liquid during his life.