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 Region 5 CY 2016 LTC Provider Meeting Summary**

On December 13-14, 2016, CMS Region 5 held their annual LTC Provider Meeting in Chicago. The meeting was represented by all the states in Region 5 including their survey agencies, Ombudsman programs and LTC Provider Associations. The following is a summary of the meeting along with handouts provided by CMS.

- Dr. Rob Furno, Chief Medical Officer for Region 5 presented the Quality Payment Program. Dr. Furno explained what a quality payment program is, gave an introduction to merit-based incentive payment systems and provided a list of resources for further review and guidance.

- The next session dealt with the new ROPs. Evan Shulman, Deputy Director of the Division of Nursing and Nursing Homes in the Central CMS Offices in Baltimore conducted a phone presentation. The issues he addressed were:
  
  o **Abuse** – all alleged violations are to be reported in a timely fashion. Alleged abuse with injuries is to be reported immediately (soon as possible) but no later than 2 hours after the event. Alleged abuse with no injury – no later than 24 hours. Facility should have documentation regarding the reporting process and timelines. A report of alleged abuse is also required to be reported to the administrator without delay and this should also be documented.
  
  o **Reporting of a crime** – is a Phase 2 requirement and will be explained in detail in the new Interpretive Guidelines, which will be out this summer.
  
  o **Willful** – this term as used in the definition of abuse was determined based on several legal cases.
  
  o **Exploitation** – this term will be further defined in the new Interpretive Guidelines.
  
  o **Phase 1** requirements under the new ROPs were aligned with the current F-tags with no additional changes to the current Interpretive Guidelines. CMS stated that there is a ‘reasonable expectation’ with regard to the new Phase 1 rules without any new Interpretive Guidelines. Please see [click here](#) to review how CMS is training surveyors to review the new requirements under the current F-tags. This document tells surveyors what to look for (key points) under the current F-tags that incorporate the new requirements under Phase 1 of the new ROPs.
  
  o CMS stated that the new Draft Interpretive Guidelines for Phase 2 will be out this summer for review and finalization. CMS also stated that the new F-tags will be completely different in number from the current F-tags.
  
  o The new survey process, which will be implemented in Phase 2 (November 28, 2017), will combine both the traditional and QIS survey processes. The new survey process will be computer based and take the best components from the two current survey processes. All states will use the same survey process.
• The Payroll Based Journal (PBJ) will EVENTUALLY replace the CMS-671 form. BUT, this won’t occur until the PBJ data is complete and tested. In the first reporting timeframe, 90 percent of the LTC facilities required to report, did. CMS also stated that they will release the PBJ data first to the LTC facilities for review prior to reporting the information on Nursing Home Compare. This release could possible happen in the 2nd half of 2017.

• Guidance on QAPI, behavioral health, infection control, antibiotic protocols, and all other new ROPs that are to be implemented in Phase 2 and Phase 3, will be further defined and clarified in the new Interpretive Guidelines.

• With regard to the Special Focus Surveys:
  - **Adverse Event** – no action at this time. These surveys have been ‘put on hold’ for the present time.
  - **Dementia Care** – surveys are ongoing and being done by CMS contractors not state survey agencies. CMS is picking ‘outlier’ facilities based on their data for these surveys.
  - **MDS** – surveys are ongoing and being conducted by state survey agencies. See S&C 17-06 for a summary of MDS survey results. See also a summary of Region 5’s most common deficiencies from the MDS surveys later in this report.

• With regard to discharge notices to the Ombudsman, discharges to the hospital or for therapeutic reasons with an expectation of a return to the LTC facility do not need to be reported to the Ombudsman. Only transfers/discharges with the expectation of the person not returning to the LTC facility need to be reported to the Ombudsman.

• Dr. Daniel Schwartz, Chief Medical Officer with the Survey and Certification Group at the CMS Central Office conducted a phone presentation on the new Infection Control Pilot Project. This project is summarized in S&C 17-09. This is a 3-year pilot and involves a total of 40 hospitals around the U.S. and one related LTC facility per hospital. The purpose of the pilot is to improve assessment of infection control and coordination of care between the hospital and related LTC facility. The surveys are educational and no citations will be issued – unless there is an IJ situation. HHS has contractors to do the surveys and they will be unannounced. The pilot is just starting the second year and the transition surveys just started. The worksheets the surveyors are using are available and can be used by LTC facilities as a training or assessment tool. After the pilot is finished, HHS will determine what if any changes need to be made to the infection control regulations.

• Ray Swisher, Consortium for Medicare Health Plans operations in Region 5 made a presentation on Medicare Advantage Update.

• Marilyn Hirsch, Manager of the Survey and Certification Branch in Region 5, presented on several 2016 survey data trends:
  - Calculating IJ CMP Amounts
  - Top Ten Citations Cited by Region 5 States and Nation on Standard and Complaint Surveys
  - Top Citations on Top 10 Report for Region 5 and Nation on Standard and Complaint Surveys – Description
  - Average Number of Deficiencies Cited Per Survey by Region 5 States and Nation on Standard and Complaint Surveys
  - Total Deficiencies Cited by Region 5 States and Nation by Severity Level on Standard and Complaint Surveys
  - IJ Actual Harm Trends on Standard and Complaint Surveys for Region 5 and Nation
  - Remedies in Effect in Region 5 States and Nation
  - Number and Percentage of Enforcement Cases Transferred to the RO by Type of Sanction and State

• **2012 Life Safety Code (LSC)**
  - Implemented new surveys under 2012 LSC on 11-1-16.
  - 7-5-16 is the cut-off date for construction, prior is under 2000 LSC, after is under 2012 LSC.
CMS will not conduct a webinar or other training for the 2012 LSC. CMS released the training program (click here) for surveyors to LTC providers and they feel that is adequate.

CMS is preparing a Q&A document with regard to the new 2012 LSC. It should be out soon and we will bring it to your attention when available.

The 2012 LSC required that the 2013 FSES be used. There are differences with the old FSES and the new that could cause problems. CMS is investigating this.

CMS strongly suggests that whomever in the LTC facility is responsible for the physical plant/life safety code review the above course and be familiar with the new requirements.

The Region 5 and Nation LSC Deficiency Count and Top Ten

Enforcement

CMS is still reviewing the request that they share the IDR explanation for a denial.

Any CHOW after November 28, 2016 – if new provider does not accept the current certification number for that facility, the new owner would have to meet new requirements for LSC.

Involuntary Discharge Project

CMS is reviewing involuntary discharges vs. improper/wrongful discharges.

CMS believes this is a growing problem and they are reviewing this issue and plan on providing further guidance in this area.

F202 specifically requires that the reason for the transfer/discharge is clearly documented and that certain information is given to the receiving facility.

Any facility deficiencies for F201 through F206 that are at a ‘D’ level or above are to the sent by the State Survey Agency to the CMS Regional Office for review.

Various Survey Issues

Captain Gregory Hann presented on the new Emergency Preparedness Requirements, effective 11-15-17.

- Interpretive Guidelines for implementation of the new emergency preparedness requirements should be out later this spring.
- CMS is also preparing a Q&A document with regard to emergency preparedness.
- LTC facilities will be required to carry out one table top exercise and one full scale exercise per year.
- Questions were raised with regard to the generator requirement and what the generator must provide power for. CMS is reviewing.
- There will be a requirement that all staff, residents and others must be trained with respect to the facility’s emergency preparedness plan.

Exit Conferences

- CMS and State Agency surveyors are prohibited from giving F-tags at the exit conference. However, surveyors should provide enough information to allow the facility to understand the deficiency and be able to develop an acceptable plan of correction. The LTC facility should be allowed to ask questions and provide additional information prior to the surveyors leaving the building.

Social Media Policy

- Facility policy required on this pursuant to S&C 16-15.
- For the first year/full survey after the release of this S&C, surveyors will ask to see and review this specific policy.
- After the first year, surveyors will only ask to see/review this policy if it is raised as an issue (i.e. complaint).

Dementia Focused Surveys – Common Deficiencies

- F309 – provide care and services for highest wellbeing (dementia care)
- F329 – free from unnecessary drugs
- F241 – dignity and respect for individuality
- F323 – free of accident hazards/adequate supervision
- F353 – sufficient staffing to meet the resident needs as determined by care plan
- F248 – activities meet needs/interests of residents
- F279/280 – care planning
- F365 – food in form to meet the individual needs/choices
- F278 – MDS accuracy
- F495 – nurse aide training

**MDS Focused Surveys – Common Deficiencies**
- F278 – MDS accuracy
- F279/280 – care plan development/revision
- F274 – significant change assessment
- F272 – comprehensive assessments
- F312 – provision of ADL care to dependent residents
- F311 – ADL decline
- F317 – range of motion
- F353 – sufficient staffing

### Clinical Care Documentation that Survives Auditing

Medicare claims set the stage for reimbursements – they're the cast. Backstage, however, documentation comprises the crew, supporting the claim and determining whether or not the show – the outcome of an audit – goes off without a hitch. Nailing down documentation best practices has become more and more important each year, as the Centers for Medicare & Medicaid Services put long term care and skilled-nursing claims under increased scrutiny.

Long term care organizations have always been held accountable to compliance requirements when it comes to documentation. Now, as a condition for participation in federal healthcare payment programs, they must develop and implement an effective compliance plan to ensure they either are prepared for an audit or can avoid one altogether.

The CMS Office of the Inspector General also recently set its sights on skilled nursing facilities. Its 2015 Work Plan identified how skilled nursing facilities are increasingly billed for the highest level of therapy – despite patient characteristics remaining unchanged from previous years when they'd billed for lower acuities – and they will be investigating what caused the uptick in billing.

### MACs, ADRs and RUGs

If a Medicare audit contractor cannot make a coverage or coding determination from the information provided on a claim, then providers might need to submit additional documentation and receive an Additional Development Request. The MAC requests records related to the claim(s) being reviewed, and may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition.

ADRs give facilities a chance to supplement existing documentation before CMS determines overpayment has been made. At this point, CMS or other federal agencies are saying that they want their money back – unless you can provide better proof of services at the facility level. Providers must prove those services through proper documentation. If the provider cannot offer sufficient proof, the government will recoup the money. These stem from federal government and programs put in place by CMS.

CMS looks at claims with high Resource Utilization Group scores and are asking providers if they are performing the minimum services to justify high RUG categories. It's incumbent upon the business side of an organization to engage with physicians and nurses to prevent erroneous claims. High RUG utilization is a focus area for new audits; providers should focus on documentation to make the case for claims.
**Tips for building audit-friendly documentation**

How can providers survive the audits that federal agencies have said will increase during the coming years?

The answer: By creating detailed, correct care documentation. The goal of documentation is to substantiate daily skilled care. It must be complete, accurate, readily accessible and systematically organized to allow medical reviewers to determine the appropriateness of the billed services.

Documentation that stands up to audits begins with neatness. It counts. More importantly, completeness rules the day.

Here are a few best practices that providers should implement if they haven't already:

- Write entries legibly and have them signed with credentials.
- Put events in chronological order; never chart before giving care.
- Be truthful.
- Make sure documentation in keeping with acceptable nursing practice.
- Practitioners should only document what they are qualified to do and what is in their scope of practice, including clinical issues, rehab and treatments.
- Date and time all entries, using “a.m.” and “p.m.,” unless using military time.
- Avoid red flag language, such as “accidentally,” “by mistake,” or “I think”.
- Nurses must be sure to document – at a minimum – a complete assessment every 24 hours. We recommend doing this at least twice a day, as each person on duty is going to see something a little bit differently; this will allow for a more complete picture of the resident.

Clinical decision making also plays a role in documentation. A provider should be able to communicate how it has met residents' needs. Documentation must also reflect that a practitioner performed a clinical assessment on the resident, which required a higher-level evaluation that precipitated a call for skilled services later on, all of which appeared on the claim.

- Document objectively, not to a particular RUG requirement.

There are specific items to confirm exists in the documentation before submitting claims:

- The need for skilled service – rehab or medical diagnosis – make sure to show an auditor that was the reason for the patient's services.
- All appropriately billed services.
- All comorbidities, not just issues a resident is there for.
- Rehab and treatments.
- ADLs and all functional areas.
- Cognition and mood – that can help with facility's overall case mix index.

The best defense is a good offense. Handling documentation will protect the organization and its staff from audit problems down the road. It will help prove that patient need, instead of payment incentives, is driving the provision of services.

Creating accurate documentation to justify claims will eliminate fear if a provider is selected for an audit. It will proof the documentation and claims processes, and will confirm the provider is on the right path – especially if it can provide ADRs to satisfy auditors' needs. How can a provider really know it has provided a successful audit response? When the government doesn't take money away in the end.

This article was reprinted out of McKnight’s and authored by Jayne Warwick, RN, HBScN, is the Director of Industry Insight at PointClickCare.
**Trending Statistics**

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

**U.S. Life Expectancy Declines for the First Time Since 1993**

For the first time in more than two decades, life expectancy for Americans declined last year — a troubling development linked to a panoply of worsening health problems in the United States.

Rising fatalities from heart disease and stroke, diabetes, drug overdoses, accidents and other conditions caused the lower life expectancy revealed in a report released Thursday by the National Center for Health Statistics. In all, death rates rose for eight of the top 10 leading causes of death.

© CDC/NCHS/HHS/NVSS Life expectancy at selected ages, by sex

“I think we should be very concerned,” said Princeton economist Anne Case, who called for thorough research on the increase in deaths from heart disease, the No. 1 killer in the United States. “This is singular. This doesn’t happen.”

A year ago, research by Case and Angus Deaton, also an economist at Princeton, brought worldwide attention to the unexpected jump in mortality rates among white middle-aged Americans. That trend was blamed on what are sometimes called diseases of despair: overdoses, alcoholism and suicide. The new report raises the possibility that major illnesses may be eroding prospects for an even wider group of Americans.

Its findings show increases in “virtually every cause of death. It’s all ages,” said David Weir, director of the health and retirement study at the Institute for Social Research at the University of Michigan. Over the past five years, he noted, improvements in death rates were among the smallest of the past four decades. “There’s this just across-the-board [phenomenon] of not doing very well in the United States.”

Overall, life expectancy fell by one-tenth of a year, from 78.9 in 2014 to 78.8 in 2015, according to the latest data. The last time U.S. life expectancy at birth declined was in 1993, when it dropped from 75.6 to 75.4, according to World Bank data.

The overall death rate rose 1.2 percent in 2015, its first uptick since 1999. More than 2.7 million people died, about 45 percent of them from heart disease or cancer.
Experts cautioned against interpreting too much from a single year of data; the numbers could reverse themselves next year, they said.

“This is unusual, and we don’t know what happened,” said Jiaquan Xu, an epidemiologist and lead author of the study. “So many leading causes of death increased.”

The report’s lone bright spot was a drop in the death rate from cancer, probably because fewer people are smoking, the disease is being detected earlier and new treatments have been developed recently, experts said.

The largest rate jump for any cause of death was for Alzheimer’s disease, which went from 25.4 to 29.4 deaths per 100,000 people. But several experts attributed that to greater reporting of the disease as a cause of death, not by any huge growth in the number of people who died.

Death rates rose for white men, white women and black men. They stayed essentially even for black women and Hispanic men and women. “It’s just confirming this deterioration in survival for certain groups,” said Ellen Meara, a professor at the Dartmouth Institute for Health Policy and Clinical Practice. She wonders what factors might be protecting Hispanic men and women from the negative trend.
According to the new report, males could expect to live 76.3 years at birth last year, down from 76.5 in 2014. Females could expect to live to 81.2 years, down from 81.3 the previous year.

Life expectancy at age 65 did not fall, another indication that the diseases behind the lower life expectancy occur in middle age or younger. At 65, men can expect to live 18 more years, while women survive an average of 20.6 more years, the data shows. Infant mortality rose slightly, according to the report, but the difference was not considered statistically significant.

Heart disease was responsible for more than 633,000 deaths in 2015, up from a little more than 614,000 the previous year. Cancer killed more than 595,000 people.

“We’re seeing the ramifications of the increase in obesity,” said Tom Frieden, director of the Centers for Disease Control and Prevention. “And we’re seeing that in an increase in heart disease.”

The number of unintentional injuries — which include overdoses from drugs, alcohol and other chemicals, as well as motor vehicle crashes and other accidents — climbed to more than 146,000 in 2015 from slightly more than 136,000 in 2014. Public health authorities have been grappling with an epidemic of overdoses from prescription narcotics, heroin and fentanyl in recent years. Xu said overdose statistics were not yet ready to be released to the public.

Deaths from suicide, the 10th-leading cause of death in the United States, rose to 44,193 from 42,773 in 2014.

Several experts pointed out that other Western nations are not seeing similar rises in mortality, suggesting an urgency to determine what is unique about health, health care and socioeconomic conditions in the United States.

“Mortality rates in middle age have totally flatlined in the U.S. for people in their 30s and 40s and 50s, or have been increasing,” Case said. “What we really need to do is find out why we have stopped making progress against heart disease. And I don’t have the answer to that.”

Meara noted that more people need better health care but that “the health-care system is only a part of health.” Income inequality, nutrition differences and lingering unemployment all need to be addressed, she said.

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**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 17-13 – Transplant** - Transplant Centers: Citation for Outcome Requirements. This policy memorandum supersedes policy memorandums S&C: 10-16-Transplant and S&C 08-17-Transplant. Background: Certain Medicare-approved organ transplant center programs must maintain one-year patient and graft survival rates consistent with the Standard: Outcome requirements within the Transplant Center Conditions of Participation (CoP) at 42 CFR §482.82. CMS uses risk-adjusted statistical reports, released semi-annually by the Scientific Registry of Transplant Recipients (SRTR), to measure and determine program compliance. Enforcement of the Outcomes Requirement: Beginning with the January 2017 SRTR center-specific reports, CMS will identify those transplant programs who cross CMS’ thresholds for one-year patient and/or graft survival rates, in accordance with 42 CFR §482.82(c). Simultaneously, CMS will review more recent SRTR data to determine whether the program’s one year patient/graft survival rate is improving, static or declining. If the program is out of compliance upon the release of the next SRTR report and is not showing improvement in more recent data, CMS will consider the program to be non-compliant at a Condition level and may conduct an on-site survey to determine whether there are deficiencies with other requirements.
2) Federal HHS/CMS released the following notices/announcements:

- **S&C 17-14 – LSC** - Clarification of Automatic Fire Sprinkler System Installation Requirements in Attic Spaces in Long-Term Care (LTC) Facilities. Sprinkler Requirement for Long Term Care Facilities: On May 4, 2016, CMS published the final rule Medicare and Medicaid Programs: Fire Safety Requirements for Certain Health Care Facilities (81 FR 26872). This regulation adopted the 2012 Life Safety Code (LSC), and the 2012 Health Care Facilities Code (HCFC). The 2012 LSC requires all existing and newly constructed health care facilities including long term care facilities to be equipped with a supervised automatic sprinkler system. This regulation requires compliance with the 2010 edition of National Fire Protection Association (NFPA) 13, Installation of Sprinkler Systems. Sprinkler Installation Requirements for Attics containing Fire Retardant Treated Wood (FRTW): The use of FRTW is allowed to be installed in a facility in concealed or attic space without the installation of an automatic sprinkler system, provided that it meets certain conditions related to access, construction type, storage and fuel fired equipment. This is a change, because FRTW was not discussed clearly with regards to concealed spaces in the 2000 edition of the LSC or the 1999 edition of NFPA 13.

- **S&C 17-15 – LSC** - Use of the Fire Safety Evaluation System (FSES), National Fire Protection Association (NFPA) 101A, Guide on Alternative Approaches to Life Safety, 2013 Edition by Health Care Occupancies and Board and Care Occupancies. Fire Safety Requirements: CMS has adopted the 2012 Life Safety Code (LSC) and the 2012 Health Care Facilities Code (HCFC) through regulation (see 81 FR 26872, 5/4/16), effective July 5, 2016. FSES Edition to be Used To Meet Fire Safety Requirements: If the FSES is being used to demonstrate compliance with the fire safety requirements, the version of the FSES for Health Care Occupancies and Board and Care Occupancies found in the 2013 edition of the Guide on Alternative Approaches to Life Safety, NFPA 101A must be used. A facility that achieves a passing score on the 2013 edition of the FSES will be considered to meet the fire safety requirements for certification and recertification with the Medicare and Medicaid programs. Survey Start Date: CMS began surveying for compliance with the 2012 LSC and HCFC on November 1, 2016. Facilities may now use the 2013 edition of the FSES. Time Limited Waiver for Corrective Action: Long Term Care (LTC) facilities using the FSES may be granted a time limited waiver to correct certain deficiencies.

- **S&C 17-16 – ESRD** - Notice of Interim Final Rule (IFR) Third Party Payment and Information on Implementation Plan. CMS has published an IFR on third party payment requirements in the Federal Register on December 14, 2016. This rule implements new requirements for Medicare-certified dialysis facilities that make financial contributions to patients in order to support enrollment in individual market health plans either directly or indirectly through a parent organization or third party. The IFR establishes new standards under the End Stage Renal Disease (ESRD) Conditions for Coverage (CfC) 42 CFR 494.70 Patient Rights (c) Standard: Right to be informed of health insurance options and 42 CFR 494.180 Governance (k) Standard: Disclosure of financial assistance to insurers. The requirements of the IFR apply to any dialysis facility offering financial contributions in the form of premium assistance to support enrollment in individual market health plans. The requirements will be effective 30 days from the date of publication with the exception of one portion of 42 CFR 494.180(k) which may be delayed to July 1, 2017 if there is a potential for a coverage gap for the beneficiary. A survey tool has been developed to assess compliance with the new standards pending completion of Interpretive Guidance.
- **Improve cardiac care**: Three new payment models will support clinicians in providing care to patients who receive treatment for heart attacks, heart surgery to bypass blocked coronary arteries or cardiac rehabilitation following a heart attack or heart surgery.

- **Improve orthopedic care**: One new payment model will support clinicians in providing care to patients who receive surgery after a hip fracture, other than hip replacement. In addition, CMS is finalizing updates to the Comprehensive Care for Joint Replacement Model, which began in April 2016.

- **Provide an Accountable Care Organization opportunity for small practices**: The new Medicare ACO Track 1+ Model will have more limited downside risk than Tracks 2 or 3 of the Medicare Shared Savings Program in order to encourage more practices, especially small practices, to advance to performance-based risk.

- **Hospice Quality Measure Reports Available**: Two new reports for hospices are available in the Certification and Survey Provider Enhanced Reporting (CASPER) application:
  - Confidential Provider Feedback Reports – Hospice-Level Quality Measure (QM) Report
  - Hospice Patient Stay-Level QM Report

  These QM reports allow you to specify a reporting period and view your quality data at both the hospice level and patient-stay level. View the [Getting Started with Hospice CASPER QM Reports](#) Fact Sheet and the [Requirements and Best Practices](#) webpage for more information.

- **Dementia Care and QAPI Call: Audio Recording and Transcript** — New. An [audio recording](#) and [transcript](#) are available for the December 6 call on the National Partnership to Improve Dementia Care and Quality Assurance and Performance Improvement (QAPI). Learn about the reform of requirements for long term care facilities, highlighting the Behavioral Health Services & Pharmacy Services sections. A Tennessee nursing home also discussed innovative approaches to dramatically reduce the use of antipsychotic medications.


- **Medicare Billing: 837P and Form CMS-1500 Fact Sheet** — Revised. A revised [Medicare Billing: 837P and Form CMS-1500](#) Fact Sheet is available. Learn about:
  - Medicare institutional claims submission and coding
  - When Medicare will accept a hard copy claim form
  - Timely filing

- **Continuing Education Credits for Web-Based Training Courses**. Busy clinicians often find it difficult to fit in their required Continuing Medical Education (CME) credits. CMS can help. CMS is accredited by the Accreditation Council for Continuing Medical Education to offer AMA PRA Category 1 Credit™. AMA PRA credit is recognized and accepted by hospital credentialing bodies, state medical licensure boards and medical specialty certifying boards, as well as other organizations. Medicare Learning Network web-based training courses carrying CME credit cover a wide variety of topics of interest to clinicians, including:
  - Infection control
  - ICD-10 coding
  - Certificate of medical necessity
  - Provider compliance programs

Visit the [WBT](#) webpage for a list of courses offered through the Learning Management and Product Ordering System.
• **Hospice Quality Reporting Program Provider Training — January 18.** Wednesday, January 18 from 8:30 am to 4:30 p.m. ET CMS is hosting a 1-day training, in-person event on the Hospice Quality Reporting Program (HQRP) in Baltimore, MD. This training will discuss:
  o Upcoming data collection instructions 
  o Updates associated with the changes in the Hospice Item Set (HIS), which will become effective on April 1, 2017 
  o Two new HIS-based quality measures that will be incorporated into the HQRP in 2017

Visit the [Hospice Quality Reporting Training webpage](#) for more information and to [register](#).

• **Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents — Payment Reform MLN Matters® Article — New.** An MLN Matters Special Edition Article on [The Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents — Payment Reform](#) is available. Learn about a new payment model for nursing facilities and practitioners to incent early identification of changes in condition, treatment of specific conditions in a nursing facility without a hospital transfer, and improved care planning.

• **Medicare Overpayments Fact Sheet — Revised.** A revised [Medicare Overpayments Fact Sheet](#) is available. Learn about:
  o The definition of an overpayment 
  o Overview of the overpayment collection process 
  o Timeframes for the debt collection process

• **PECOS for Provider and Supplier Organizations Fact Sheet — Revised.** A revised [PECOS for Provider and Supplier Organizations Fact Sheet](#) is available. Learn about:
  o Provider Enrollment, Chain and Ownership System (PECOS) provider and supplier organizations 
  o Disregarded entities 
  o Medicare enrollment application submission options

• **Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet — Reminder.** The [Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants Booklet](#) is available. Learn about required qualifications, coverage criteria, billing, and payment for services furnished by advanced practice registered nurses, anesthesiologist assistants, and physician assistants.

• The latest copy of the CMS [Midwest Division Provider Update](#) is available.

3) The [Centers for Disease Control and Prevention (CDC) U.S. Influenza Surveillance Report](#).

4) The [Agency for Healthcare Research and Quality (AHRQ) released the following reports:](#)

• **Journal Supplement Focuses on Tools and Methods for Preventing Blood Clots -** A new *Journal of Hospital Medicine* supplement, “Preventing Hospital-Acquired Venous Thromboembolism: Lessons from the Field,” includes articles that demonstrate the benefit of hospital wide reminders and alerts used to evaluate risks for blood clots and ensure all people at risk receive effective preventive measures. The supplement, funded by the Centers for Disease Control and Prevention, includes an [editorial](#) co-authored by two experts from AHRQ’s Center for Quality Improvement and Patient Safety, center Director P. Jeffrey Brady, M.D., M.P.H., and Medical Officer Barbara Bartman, M.D., M.P.H. Articles in the supplement show that several hospitals were able to prevent venous thromboembolisms (VTEs) by engaging teams of health care experts, informing patients and providers about the need for and benefits of VTE prevention, and using technology (such as electronic risk assessment and clinical decision support tools and alerts) to ensure all patients were assessed for their VTE risk and bleeding. AHRQ offers a [toolkit](#) that health care providers can use to ensure they are following best practices in VTE prevention.
• **AHRQ Develops New Safety Program for Healing Pressure Ulcers** - A new [training guide](#) has been added to AHRQ's online resources for helping nursing homes manage pressure ulcers. The guide, part of AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Healing, includes videos and exercises for training facilitators to show nursing home staff how on-time reports can track pressure ulcers that are healing too slowly or are at risk for slow healing. Other online resources include an overview of on-time pressure ulcer healing, sample on-time reports and an assessment tool for report implementation.

• **AHRQ Offers Continuing Education Resources** - AHRQ offers continuing education videos and articles on a range of health care topics, including patient safety and patient-centered outcomes research findings. The continuing education activities summarize reviews of evidence on the effectiveness and safety of treatments and strategies for improving patient care. These resources provide health care providers with skills and information to support individual decision-making and patient management. Access [activities available](#) at no cost and obtain continuing education credit.

5) The U.S. Department of Health and Human Services – Food and Drug Administration (FDA) released the following reports:

• **Post-market Management of Cybersecurity in Medical Devices** – Draft that contains nonbinding recommendations [click here](#).

• **Banned Devices; Powdered Surgeon’s Gloves, Powdered Patient Examination Gloves, and Absorbable Powder for Lubricating a Surgeon’s Glove** [click here](#). The Food and Drug Administration (FDA or Agency) has determined that Powdered Surgeon's Gloves, Powdered Patient Examination Gloves and Absorbable Powder for Lubricating a Surgeon's Glove present an unreasonable and substantial risk of illness or injury and that the risk cannot be corrected or eliminated by labeling or a change in labeling. Consequently, FDA is banning these devices.

6) The U.S. Government Accountability Office (GAO) released the following report:


7) The U.S. Department of Labor – Occupational Safety and Health Administration (OSHA) issued final rules [click here](#) clarifying the ongoing obligation to make and maintain accurate records of work-related injuries and illnesses.

8) The Illinois Department of Healthcare and Family Services (HFS) posted the following notices since the last issue of Regulatory Beat:

• HFS posted a new provider notice regarding **Prevention of Spousal Impoverishment Standards for 2017**. You may view the notice [here](#).

• HFS posted **Public Notice – Medication Assisted Treatment Services**. You may view the notice [here](#).

• HFS posted a new provider notice regarding **Pharmacy Benefit Management System (PBMS) Updates – New Payor Sheet and Prescriber Enrollment Requirement**. You may view the notice [here](#).

• HFS posted a new provider notice regarding **Pharmacy Claim Submissions with Incorrect Prescribing Provider Information**. You may view the notice [here](#).

• HFS posted a new provider notice regarding **Fee-For-Service Reimbursement for Licensed Clinical Psychologist (LCP) or a Licensed Clinical Social Worker (LCSW)**. You may view the notice [here](#).
• HFS has released an email to alert you to a change effective December 21, 2016 in the 271, Electronic Health Care Eligibility Benefit Response, Loop 2110C, MSG01 segment. An update to the Chapter 300 Companion Guide will be made at a later date. Providers are encouraged to pass this information on to their software vendors. There are now four characters displayed in this segment. Previously, there were only two. The first two characters following the SEE COMPANION GUIDE MESSAGE designate the co-payment message number and the second set of two characters designate the participant’s Title information. For example: MSG*SEE COMPANION GUIDE MESSAGE – 10 19. In the above example, the first two characters, 10, designate the message number and the following two characters, 19, designate Title 19. The first two characters still correspond to the Special Messages listed in the 270/271 Standard Companion Guide Section 4.3. The range of options for the second two characters that may display are 19 for Title 19, 21 for Title 21 and SF for State Funded.

9) The American Health Care Association (AHCA) released the following news items:

• National Correct Coding Initiative edits tables: Early last month, CMS released their quarterly NCCI edits tables. These tables apply to Medicare part B and some state Medicaid agency claims for the period of January 1 through March 31, 2017. However, an alert AHCA member noticed that there appeared to be errors in the edits that will apply to the new physical therapy and occupational therapy evaluation code combinations 97162/97165, 97163/97165, and 97165/97164. AHCA submitted a request to CMS to review the published CCI edits tables and provide corrections where needed. CMS responded favorably in two letters (click here and here to view) and also provided instructions to state Medicaid agencies that apply NCCI edits to outpatient therapy CPT codes. If you have any questions, you may contact Dan Ciolek, Associate Vice President, Therapy Advocacy for AHCA.

• Members of AHCA staff met with the Health transition team last week and went over AHCA’s asks for the White House, agencies and Congress. Click here to view the letter to President-elect Trump and his administration from AHCA/NCAL. AHCA will focus heavily on regulatory relief and ensure Medicaid is not fundamentally changed. The president-elect outlines both of these projects in his contract with the American voter (click here).

• AHCA noted that CMS issued the final rule implementing the Advancing Care Coordination through Episode Payment Models mandatory bundled payment program. (The CMS Fact Sheet on the rule can be found online here. View the final rule in the Federal Register here.) This impacts the areas of Chicago, Naperville, Elgin in northern Illinois; Springfield in central Illinois and Cape Girardeau on both the Illinois and Missouri sides. This rule implements three new mandatory episodic payment models (EPMs): coronary artery bypass graft (CABG); acute myocardial infarction (AMI); and surgical hip/femur fracture treatment (SHFFT). The two cardiac episodes will be tested in 98 Metropolitan Statistical Areas (MSAs) across the country. The SHFFT episode will be tested in the 67 MSAs currently participating in the Comprehensive Care for Joint Replacement (CJR) demonstration. Under the program, hospitals will be held accountable for total Medicare Parts A and B spending, as well as performance on certain quality measures, during 90-day episodes of AMI, CABG and SHFFT, depending on where the hospital is located. Hospitals may share in risk and in savings with other provider types, including SNFs, but they are not required to do so. The EPMs will begin on July 1, 2017, and will run for almost five years, through 2021. Almost all of the new EPM policies mirror those in the CJR demonstration. All available CMS materials on these new EPMs are accessible online.

• AHCA amended Trend Tracker to add four new measures for assisted living members. Assisted Living members will now be able to track hospital admissions, hospital readmissions, off-label use of antipsychotic medications and occupancy rates all in the AHCA online member tool.

10) Telligen reports:

• The latest Telligen events/announcements can be found at https://www.telligenqingio.com/.
• Don’t be Left behind: Join Telligen’s Nursing Home Quality Care Collaborative! The Illinois Health Care Association endorses our member’s participation with this CMS initiative aimed at improving Quality for both post-acute and long term care. Telligen is the Medicare-contracted Quality Innovation Network-Quality Improvement Organization (QIN-QIO) in Illinois, Iowa, and Colorado. Their work aligns with Illinois Health Care Association’s 2017 Quality goals and plans to prepare our members for the CMS Final Rule for Long Term Care, released in September 2016.

By partnering with Telligen, you will have free resources and technical support to help you implement the required QAPI Plan due in 2017, learn how to deploy and document PIP Teams, improve or sustain five star quality measure ratings (including the newest measures) and reduce avoidable hospitalizations. Working with Telligen will keep you current with CMS changes and support compliance with the new survey requirements including: Infection prevention, Antibiotic stewardship and Person Centered Care. You can customize your participation as Telligen offers free scheduled webinars/teleconferences, recorded webinar events, scheduled sharing calls, group learning using affinity groups and individualized technical assistance.

Don’t be left behind. Click here to download the participation agreement. Please email the completed participation agreement to nell.griffin@area-d.hcquis.org or fax to 630-928-5865 by January 30th 2017. If you have questions, call 630-928-5800 and ask to speak with a Telligen QIN-QIO nursing home quality improvement facilitator.

11) PBS To Air Special on Alzheimer’s Disease - PBS will air a special on Alzheimer’s disease, “Alzheimer’s: Every Minute Counts,” January 25, 2017, focusing on the social and economic challenges the United States may face if advancements in finding a cure are stalled. The one-hour documentary “will be accompanied by community engagement, education, and social media initiatives that will extend its reach and impact far beyond broadcast – to educate the public about the crisis as well as provide on-the-ground support to help those who already have Alzheimer’s,” according to the PBS website.

12) Medical News Today reports on What Things Are Best to Drink for People with Acid Reflux. Managing the symptoms of acid reflux mainly involves learning what triggers the symptoms and then avoiding them. Certain foods are much more likely to cause acid reflux. As the symptoms occur quite soon after eating the offending food, it is usually quite easy to narrow down what may be causing the symptoms. It is also important for a person with acid reflux to consider what they are drinking. This is often overlooked when evaluating eating habits. Certain beverages are the worst offenders when it comes to triggering acid reflux.

13) Argentum Encourages Participation in National Study of Long-Term Care Providers. The Centers for Disease Control’s National Center for Health Statistics has launched the third wave of the National Study of Long-Term Care Providers (NSLTCP), a biennial national study of the major sectors of paid, regulated providers of long-term care services.

14) Bloomberg News reports that No Regulatory Mess for Next Administration: Shelanski. The new Trump administration will find a steadily moving and proper regulatory review process in place, not a lot of messy, badly done leftovers for them to deal with, said Howard Shelanski, administrator of the Office of Information and Regulatory Affairs.

15) The Scientific American reports that Women Make Up Nearly Two-Thirds of the More Than Five Million Americans Living with Alzheimer’s. In the Scientific American "MIND Guest Blog," Heather M. Snyder writes that "women make up nearly two-thirds of the more than five million Americans living with Alzheimer’s today." New research indicates "there may be distinct biological and genetic factors shaping how the disease develops and progresses in women." According to Snyder, "Understanding these differences will be of key importance in devising new, more effective strategies for treating, preventing and diagnosing Alzheimer’s."

16) The Long-Term Living Magazine reports on AARP Report Finds Seniors are Disproportionately Impacted by Rising Drug Costs. Long-Term Living Magazine reports seniors "are disproportionately impacted by skyrocketing prescription drug costs" and are paying more to stay healthy, "according to a new report from the AARP Public Policy Institute." The
report found that one of the biggest health care cost increases for seniors are "maintenance drugs" that are used to manage "chronic conditions, including high blood pressure, high cholesterol, diabetes, COPD, arthritis and acid reflux."

17) U.S. News & World Report reports on the Number of Seniors Needing Long-Term Care Expected to Grow in U.S. and the World. U.S. News & World Report reports 8 million people in the US, mainly seniors, require long term care services, according to the Centers for Disease Control and Prevention, and that number is expected to grow as the population continues to age. The number of seniors is also expected to grow globally to around one in six people by 2030, according to the UN, so the number of people in need of long-term care services is also expected to grow around the world.

18) Healio reports on Antipsychotic Use may be Associated with Increased Mortality Risk Among Individuals with Alzheimer’s, Study Indicates. Healio reports, "Antipsychotic use was associated with increased risk for mortality among individuals with Alzheimer’s disease and remained increased two years after initiation," researchers found after analyzing "data from a nationwide register-based study for 70,718 community dwelling individuals diagnosed with Alzheimer’s disease in Finland from 2005 to 2011." The findings were published online December 5 in the Journal of Alzheimer’s Disease.

19) The Washington Post reports that Medicare Patients Who See Female Physicians May be Less Likely to Die or be Readmitted in Following Month than Those Who See Male Physicians, Study Suggests. The Washington Post "Wonkblog" reports Medicare patients who saw female physicians were slightly less likely to die or be readmitted to the hospital in the month following their visits compared to Medicare patients who saw male physicians, according to a study published in JAMA Internal Medicine. Researchers worked to "rule out other explanations" by comparing physicians who worked in the same settings and comparing the patient groups as well.

20) NPR reports that Opioid Epidemic Affecting Seniors as Well. On its website, the NPR "Shots" blog reports the opioid epidemic is affecting seniors as well as younger adults. The article points out that in recent decades, "physicians have increasingly prescribed older patients medication to address chronic pain from arthritis, cancer, neurological diseases and other illnesses that become more common in later life" and that "sometimes those opioids hurt more than they help."

21) Modern Healthcare reports that CMS Will Not Enforce Ban on Arbitration Agreements with Nursing Homes Unless Injunction Lifted. ModernHealthcare reports the Centers for Medicare and Medicaid Services sent a memo to states and Medicare contractors last month announcing that the agency will not enforce the ban on binding arbitration agreements between nursing homes and their residents unless an injunction against the ban is lifted. The article explains that a US District Court judge in Mississippi granted a request for an injunction against the ban that was made by the American Health Care Association and several other groups.

22) Healthcare IT News reports:

- Health Care Data Breaches Increased by 60 Percent From October to November, Report Finds. HealthcareITNews reports there was a 60 percent increase in health care data breach incidents in November compared to October, according to the Protenus Breach Barometer report released on December 15. The report found that the majority of incidents were caused by employees, or "insiders," and that it took on average 135 days for entities to report the breaches to the Department of Health and Human Services.

23) Kaiser reports that the Federal Government May Change “Hands-Off” Approach Towards Hospitals Providing Objective Information About Nursing Homes. Kaiser Health News reports that many case managers at hospitals "do not share objective information or their own knowledge about nursing home quality." According to Kaiser Health News, the Federal government "may change this hands-off approach by requiring hospitals to provide guidance and quality data to patients while still respecting a patient’s preferences." Such a rule "would apply to information not only about nursing homes but also about home health agencies, rehabilitation hospitals and other facilities and services that patients may need after a hospital stay."
24) *Medline Plus* reports [Antipsychotic Drugs May Up Risk of Early Death in Alzheimer’s Patients](http://www.medlineplus.gov/ency/article/001215.htm). Taking antipsychotic drugs significantly increases the risk of premature death among Alzheimer's patients, a new study indicates. Slightly more than a quarter of the Alzheimer's patients took antipsychotic drugs. The study found they had a 60 percent higher risk of death than those who didn't take the drugs. The risk of death was highest when patients first started taking antipsychotics, but the increased risk persisted with long-term use of the drugs.

25) *McKnight’s* reports:

- **CMS Issues Guidance for HCBS for Individuals with Dementia.** *McKnight’s Senior Living* reports that CMS issued guidance concerning home- and community-based services for individuals with dementia. Under the guidance, "a person-centered care plan must be developed for each individual served, with input from the person with dementia as well as his or her representatives, as appropriate." The guidance adds that in settings "in which egress is controlled," the "individual’s choices about, need for and understanding of safety measures" should be documented.

- **Staffing Regulations Among Five Biggest Issues in Senior Housing in 2016.** *McKnight’s Senior Living* reviews five themes found in seniors housing coverage in 2016: staffing, regulations, fraud, intergenerational programs and transportation. The article examines approaches taken by seniors housing providers to address staffing issues, such as tuition reimbursement to attract nurses. Regulatory changes affecting the industry occurred in almost half the states, including requirements for camera installations in Utah assisted living units and increases in allowable duties for some aides in Tennessee and New York. Arbitration agreements came under fire in 2016 through a CMS rule, though "a federal court granted the American Health Care Association’s motion to stop the ban from beginning in late November."

- **Study Shows Medicare’s Bundled Payments Cut PAC Costs by 27 Percent.** *McKnight’s Long Term Care News* reports new research has shown that "Medicare’s bundled payment program for hip and knee replacements succeeded in cutting costs, largely due to reduced spending on post-acute care." The study by researchers at the University of Pennsylvania found that the bundled payment model "cut total spending in each joint replacement episode by more than 20 percent, resulting in savings of more than $5,500 per beneficiary," and determined that "average spending on post-acute care dropped 27 percent, or more than $2,400 per beneficiary."

- **Opinion: Clinical Care Documentation Becoming More Important as CMS Putting LTC Under Increased Scrutiny.** In a piece for *McKnight’s Long Term Care News* Jayne Warwick, RN, HBScN, the Director of Industry Insight at PointClickCare, writes that "nailing down documentation best practices has become more and more important each year, as the Centers for Medicare & Medicaid Services put long-term care and skilled-nursing claims under increased scrutiny." Warwick adds that better handling of documentation "will protect" organizations "from audit problems," and "help prove that patient need, instead of payment incentives, is driving the provision of services." Creating "accurate documentation to justify claims will eliminate fear if a provider is selected for an audit," will "proof the documentation and claims processes, and will confirm the provider is on the right path."

- **Report: Up to 12.5 Percent of SNFs Likely Inflate Self-Reported Measures.** Between 6 percent and 12.5 percent of skilled nursing providers are believed to inflate their self-reported staffing and quality measures, causing inaccuracies in their overall ratings, according to a report published recently. Researchers from the [Brookings Institution](http://www.brookings.edu/) and the University of Connecticut School of Business identified a trend of facilities' self-reported staffing and quality measures shifting to higher star ratings between 2009 and 2013. During that same time period, the distribution of on-site inspection ratings between the star levels remained unchanged.

- **Nurses Rank as Most Trusted Profession for 15th Straight Year.** Health care providers have taken the top three spots on a poll rating honesty and ethical standards among different professions. The results of Gallup's annual honesty and ethical standards poll show nurses clinching the top spot for the 15th year in a row, with 84 percent of respondents saying they rate nurses' ethical standards and honest as very high or high. Nurses have topped the list every year since 1999 except for one — firefighters took the top spot in 2001 after the 9/11 terrorist attacks.
• **OIG: Two-Midnight Policy Led to Limited Access to Skilled Nursing Care.** The implementation of the Centers for Medicare & Medicaid Services’ controversial two-midnight rule has left some “vulnerabilities” in its wake, according to a federal report. They include an increasing number of Medicare beneficiaries in outpatient stays who had more limited access to skilled nursing services than they would have, had they been qualified as an inpatient stay, according to a report from the Department of Health and Human Services' Office of Inspector General. Investigators analyzed Medicare hospital claims from fiscal years 2013 and 2014 assess the impact of the policy, which was implemented in fiscal 2014.

26) **Interesting Fact:** For a very brief moment of time, you were the youngest person on the earth.