***PLEASE NOTE: If You Wish to Keep Receiving this Publication - Update Your Communications Preferences Today!!

For the past several months, IHCA has been asking our members to log into the new member portal and update their communications preferences. In order to continue receiving this publication, and other IHCA publications, you must log in to the Member Portal and update your communications preferences by selecting which ones you want to receive. If you have not done this by Friday, March 3, 2017 you will no longer receive IHCA publications via email—even if you have previously requested to be added to an email list.

Starting in March IHCA will no longer use our previous email lists -- we will instead be using our database to create up-to-date lists periodically. To update your preferences, log into the member portal and scroll to the bottom of your contact profile. There select which electronic publications you wish to receive. If you need help logging in, check out the Member Portal Fact Sheet. If you have any questions, or need assistance, please contact Ashley Caldwell.

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!

The Motion Picture Licensing Corporation (MPLC)

Do you know that if you are playing motion pictures and other audiovisual programs in your facility (other than in a private room for personal use), you are violating the law?

Motion pictures and other audiovisual programs have long been a great way to entertain and educate. But what you might not be aware of is that unless you’re viewing them for personal, private use, legal authorization is needed to avoid copyright infringement.

Many organizations unknowingly expose themselves to penalties when they play audiovisual programs, whether it is movies, TV programs or any other type of entertainment video, for seemingly innocent purposes. Now, with an Umbrella License® from the MPLC, you can show audiovisual programs without violating the United States Copyright Act. Title 17 of the U.S. Copyright Act gives copyright owners control over the use of their works. Civil penalties for unauthorized exhibitions start at $750 for each inadvertent infringement and go as high as $150,000 for each egregious violation.

The MPLC Umbrella License grants organizations permission to show legally obtained audiovisual programs without the need to report titles, dates or times of exhibition.

The Motion Picture Licensing Corporation (MPLC) is the worldwide leader in motion picture copyright compliance, supporting legal access across five continents and more than 30 countries. They represent over 1,000 producers and distributors from major Hollywood studios to independent and foreign producers.
The MPLC was started over 30 years ago by motion picture studio executives and copyright experts. Their goal was to develop a process to help the public leverage the work of the creative community without infringing on copyright. The MPLC has unequalled access to Hollywood studios, as well as independent film makers, and has skillfully negotiated preferred rates for corporate and organizational use.

MPLC's mission is to provide a comprehensive copyright compliance solution for motion pictures and other audiovisual programs that is simple and affordable. The MPLC works closely with a variety of institutions, associations and antipiracy groups to educate and promote the intellectual property rights of the creative community and to ensure copyright compliance. The MPLC licenses over 500,000 locations worldwide, including, but not limited to: multinational companies, child care programs, non-profit organizations, federal, state and local government, private clubs, health care facilities, waiting rooms, campgrounds and libraries.

MPLC represents over 1,000 Hollywood, independent, faith-based, television, special interest and international motion picture studios and producers to ensure a comprehensive copyright compliance solution. Motion picture studios and producers represented under the Umbrella License vary according to the intended use and facility type. Contact MPLC for a complete list of motion picture studios and producers included in your Umbrella License. Click to read about the Umbrella License®.

The American Health Care Association/National Center for Assisted Living, and all other leading industry associations, have partnered with MPLC to secure a discount on the Umbrella License and better educate members on the need for copyright compliance when motion pictures and other audiovisual programs are shown in senior living and health care communities. Click here for information and the brochure/application for motion picture licensing. The brochure also includes a helpful list of Frequently Asked Questions (FAQs).

Deadline Notice - For AHCA/NCAL members, MPLC has agreed to provide a special Umbrella License rate of only $2 per room/unit for assisted living, nursing and rehabilitation facilities. This 40 percent cost savings is only available if a signed application or agreement with a retroactive start date of January 1, 2017 is received on or before March 15, 2017. Current association member Umbrella License holders receive this reduced rate upon renewal. Please note that while closed circuit television connections, independent living and low income rooms/units, and adult day centers are not eligible for the $2 rate, they also require a license and can take advantage of other member discounts.

If your community is part of a larger corporation, let them know you are interested in a single Umbrella License Agreement to ensure copyright compliance across all facilities. If your corporate office secures licensing for multiple facilities, there could be an economies of scale discount for certain qualifying rooms/units.

What are the Stages of Alzheimer's Disease?
Part 3 of a 3 part series on Dementia/Alzheimer’s that can be shared with staff and residents/families as educational materials.

Alzheimer's disease is a progressive degenerative disorder that becomes worse over time. It involves a gradual loss of memory, as well as changes in behavior, thinking and language skills. Alzheimer's disease is the most common form of dementia. It affects more than 5 million people in the United States. Although every person experiences Alzheimer's differently, the way in which the disease progresses can be grouped into a series of stages. It is important to make sure that someone with dementia lives well with the condition and that their needs are met, rather than focusing on what stage they might be in.

- Contents of this article:
  - How quickly does Alzheimer's disease progress?
  - Stages of Alzheimer's disease
  - Outlook
How Quickly does Alzheimer's Disease Progress?

Alzheimer's disease seems to develop slowly compared to other types of dementia, but the rate of progression varies between individuals. The average life expectancy for a person with this disease is \textbf{8-10 years} after diagnosis, but people can live with Alzheimer's for 20 years or more. Several factors can affect disease progression. These include:

- **Age**: People with Alzheimer's symptoms that develop before age 65 years may have faster progression.
- **Genes**: A person's genes may affect progression rate.
- **Physical Health**: People with poorly managed heart conditions or diabetes, who have had several strokes or have repeated infections, may deteriorate more quickly.

Keeping active, being involved in activities and getting regular exercise may help the individual to maintain their abilities for longer. Other important factors include:

- Maintaining a healthy diet.
- Getting enough sleep.
- Taking all prescribed medication correctly.
- Quitting smoking.
- Not drinking too much alcohol.
- Going to regular checkups.

If a person with Alzheimer's disease experiences a sudden change in abilities or behavior, they could have another health problem or an infection. It is important to seek advice from a doctor as soon as possible.

Stages of Alzheimer's Disease

Looking at Alzheimer's in stages can give a clearer idea of the changes that could occur. Stages are a rough guide. The symptoms a person has, and when they appear, will vary. There are several different ways of mapping Alzheimer's disease. Some people refer to seven stages, while others refer to just three. This article, however, will look at five stages of Alzheimer's disease:

- **Preclinical Alzheimer's disease**
- **Mild cognitive impairment due to Alzheimer's disease**
- **Mild dementia due to Alzheimer's disease**
- **Moderate dementia due to Alzheimer's disease**
- **Severe dementia due to Alzheimer's disease**

The dementia noted in stages 3 to 5 describes the set of symptoms that affect memory, thinking, problem-solving or language, and they are severe enough to affect daily life. The average time between the onset of Alzheimer's symptoms and reaching a diagnosis is \textbf{approximately 2.8 years}.

**Stage 1: Preclinical Alzheimer's Disease**

The functional changes that are associated with Alzheimer's are thought to begin years, or even decades, before diagnosis. This long phase is known as the preclinical stage of Alzheimer's disease. During this stage, there will not be any noticeable clinical symptoms. Although there are no noticeable symptoms in the preclinical stage, imaging technologies can spot deposits of a protein called amyloid beta. In people with Alzheimer's disease, this protein clumps together and forms plaques. These protein clumps may block cell-to-cell signaling and activate immune system cells that trigger inflammation and destroy disabled cells. There are \textbf{other biological markers}, or biomarkers, that show an increased risk of disease, as well as genetic tests that can detect if a person does have an increased risk. Using imaging technology to locate amyloid beta clumps, biomarker detection and genetic testing could all be important in the future as new Alzheimer's treatments are developed. Researchers are studying this preclinical stage to work out which factors can predict the risk of progression from normal cognition to stage 2 of Alzheimer's progression, which involves mild cognitive impairment. Researchers are also hoping that their studies will help people with Alzheimer's get treated at a much earlier stage. Disease-modifying therapies may be most effective in the more initial stages of Alzheimer disease, and they could slow disease progression.
**Stage 2: Mild Cognitive Impairment Due to Alzheimer's Disease**

Mild cognitive impairment occurs between the cognitive decline that is expected as a normal part of aging, and the most severe decline of dementia. A person with mild cognitive impairment may notice subtle changes in their thinking and their ability to remember things. They may exhibit memory lapses when it comes to recent conversations they have had, recent events or appointments they have been to. However, changes to memory and thinking at this stage are not serious enough to cause problems with day-to-day life or usual activities. As people age, it is normal for forgetfulness to increase slightly, or for individuals to take longer to think of a word or remember a name. If the problem is more severe, it could be a sign of mild cognitive impairment. Symptoms of mild cognitive impairment include:

- Forgetting things more often
- Forgetting appointments, conversations or recent events
- Inability to make decisions or feeling overwhelmed when doing so
- Becoming increasingly unable to judge the time or sequence of steps to complete a task
- Being more impulsive or showing increasingly poor judgment
- Friends and family noticing the above changes

People with mild cognitive impairment might also experience depression, irritability, aggression, apathy and anxiety. Not everyone with mild cognitive impairment will develop dementia. Research suggests that around 10-15 percent of older adults with mild cognitive impairment will develop dementia each year. There are currently no drugs or therapies specifically approved that are able to treat mild cognitive impairment. However, studies are underway to identify treatments that may help to improve symptoms, or prevent or delay their progression to dementia.

**Stage 3: Mild Dementia Due to Alzheimer's Disease**

The mild dementia stage is the typical point at which doctors would diagnose Alzheimer's disease. In addition to friends and family noticing that the person is having problems with their memory and thinking, these problems may also begin to affect daily life. Symptoms of mild dementia due to Alzheimer's disease include:

- Difficulty remembering newly learned information
- Asking the same question repeatedly
- Trouble problem-solving and completing tasks
- Reduced motivation to complete tasks
- Experiencing a lapse in judgment
- Becoming withdrawn or uncharacteristically irritable or angry
- Having difficulty finding the correct words to describe an object or idea
- Getting lost or misplacing items

**Stage 4: Moderate Dementia Due to Alzheimer's Disease**

During the stage of moderate dementia due to Alzheimer's disease, the person becomes increasingly confused and forgetful. They may need help with daily tasks and assistance with looking after themselves. Symptoms of moderate dementia due to Alzheimer's disease include:

- Losing track of location and forgetting the way, even in familiar places
- Wandering in search of surroundings that feel more familiar
- Failing to recall the day of the week or season
- Confusing family members and close friends, or mistaking strangers for family
- Forgetting personal information such as address, phone number, what schools they went to
- Repeating favorite memories or making up stories to fill in the gaps they have in their memory
- Needing help with making decisions of what to wear for the weather or season
- Needing assistance with bathing and grooming
- Occasionally losing control of bladder or bowel
- Becoming unduly suspicious of friends and family
- Seeing or hearing things that are not there
- Becoming restless or agitated
Displaying aggressive or physical outbursts

**Stage 5: Severe Dementia Due to Alzheimer’s Disease**

During this stage, the person's mental functioning continues to decline. Movement and physical capabilities can worsen significantly. Symptoms of severe dementia due to Alzheimer's disease include:

- Inability to speak and communicate coherently
- Needing complete assistance with personal care, eating, dressing and using the bathroom
- Failure to walk without help, unable to sit or hold head up
- Rigid muscles and abnormal reflexes
- Loss of the ability to swallow, inability to control bladder and bowel movements

A person with severe Alzheimer's disease has a high chance of dying from pneumonia. Pneumonia is a common cause of death in those with Alzheimer's because as the person loses the ability to swallow, food and beverages can enter the lungs and cause infection. Other common causes of death among people with Alzheimer's disease can include dehydration, malnutrition and other infections.

**Outlook**

Alzheimer's disease is currently the sixth leading cause of death in the U.S. Around 1 in every 3 seniors die from Alzheimer's or another type of dementia. It kills more people than breast cancer and prostate cancer combined. Life expectancy for individuals with Alzheimer's disease varies depending on many factors. If a person's symptoms appear when they are in their 60s or 70s, they are likely to live for 7-10 years. However, if a person's symptoms start in their 90s, they are likely to live for around another 3 years. Among the top 10 leading causes of death in the U.S., Alzheimer's is the only disease that cannot be slowed down, cured or prevented. As the cause of Alzheimer's is unknown, there is no known way to prevent the disease. Research is ongoing. Medications to treat the disease can help for a while with memory symptoms and other such cognitive changes. Actions that may contribute to the reduction of dementia risk - or possibly delay its onset - include quitting smoking, cutting down on alcohol, eating a healthy diet, maintaining a healthy weight and staying physically fit and mentally active.

**Re-written based off an article written by Hannah Nichols for Medical News Today.**

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**Trending Statistics**

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

**End-of-Life Care Measures – National Healthcare Quality and Disparities Report**

In 2014, hospice patients who were age 65 and older reported receiving care consistent with their end-of-life wishes about 95 percent of the time. (Source: Agency for Healthcare Research and Quality, [2015 National Healthcare Quality and Disparities Report Chartbook on Person- and Family-Centered Care](https://www.hsrc.org/ncqr/cp/2015/).)

- Hospice care is generally delivered at the end of life to patients with a terminal illness or condition who want palliative medical care.
- Hospice care also includes practical, psychosocial, and spiritual support for the patient and family.
- The goal of end-of-life care is to achieve a “good death,” defined by the Institute of Medicine as:
  - ...free from avoidable distress and suffering for patients, families, and caregivers; in general accord with the patients’ and families’ wishes; and reasonably consistent with clinical, cultural, and ethical standards ([Field & Cassell, 1997](https://www.journals.uchicago.edu/doi/abs/10.1086/258756)).
Hospice Patients Who Received Care Consistent With Their Stated End-of-Life Wishes

_Hospice patients who received care consistent with their stated end-of-life wishes, by age and ethnicity, 2008-2014_


Note: White and Black are non-Hispanic. Hispanic includes all races.

Overall Rate: In 2014, nearly all (94.8%) of hospice patients received care consistent with their stated end-of-life wishes.

Trends:
- From 2008 to 2014, the percentage of hospice patients age 65 and over who received care consistent with their stated end-of-life wishes improved from 94.4% to 95.1%. There were no statistically significant changes for those age 18-44 and ages 45-64.
- From 2008 to 2014, the percentage of White hospice patients who received care consistent with their stated end-of-life wishes improved from 94.7% to 95.7%. There were no statistically significant changes among Blacks and Hispanics.

Groups With Disparities:
- In 2014, hospice patients age 65 and over were significantly more likely than patients ages 18-44 to receive care consistent with their stated end-of-life wishes.
- In 2014, Black and Hispanic hospice patients were significantly less likely than White patients to receive care consistent with their stated end-of-life wishes.

Hospice Patients Who Received the Right Amount of Help for Feelings of Anxiety or Sadness

_Hospice patients who received the right amount of help for feelings of anxiety or sadness, by ethnicity and race, 2008-2014_
Key: AI/AN = American Indian or Alaska Native; API = Asian or Pacific Islander.


Trends: From 2008 to 2014, there were no statistically significant changes by ethnicity or race in the percentage of hospice patients who received the right amount of help for feelings of anxiety or sadness.

Groups With Disparities:
- In 2014, Hispanics and non-Hispanic Blacks were significantly less likely than non-Hispanic Whites to receive the right amount of help for feelings of anxiety or sadness.
- Also in 2014, Blacks, Asians and Other Pacific Islanders, and AI/ANs were significantly less likely than Whites to receive the right amount of help for feelings of anxiety or sadness.

Important Regulations, Notices & News Items of Interest

1) No new federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat.

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

- **CMS Reiterates: No Pass-Through Payments for Medicaid Managed Care Rates for Hospitals, Nursing Homes, and Physicians.** Through a series of tortuous proposed and final rules it is now, perhaps, clear that pass-through payments cannot be used in the development of Medicaid managed care rates. What does this mean? It means that the policies and tools used under Fee For Service (FFS) to augment reimbursement to certain Medicaid provider groups cannot be transferred into the calculation of Medicaid managed care rates. This prohibition applies to Medicaid managed care rates for hospitals, physician and nursing facilities. As to providers, the overall policy of prohibiting pass-throughs has been, understandably, met with concern and dismay. CMS provided transition periods to ease the pain. In short, on January 18, 2017, CMS issued the final rule, Medicaid Program: The Use of New or Increased Pass-Through Payments in Medicaid Managed Care Delivery Systems, 82 CFR 5415. This rule finalized changes to the pass-through payment transition periods. The January 18, 2017 final rule follows a series of proposed and final rules, starting with the mega Proposed Rule on June 1, 2015, that have addressed Medicaid managed care.

- **Medicare Quarterly Provider Compliance Newsletter.** A new Medicare Quarterly Provider Compliance Newsletter [Volume 7, Issue 2] Educational Tool is available. Learn about:
  - How to avoid common billing errors and other erroneous activities
  - How to address and avoid the top issues this quarter

- **Looking Ahead: The IMPACT Act in 2017 Call —** Thursday, February 23 from 1:30 to 3 pm ET. To register or for more information, visit MLN Connects Event Registration. The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. During this call, CMS experts discuss goals, requirements, progress to date, and key milestones for 2017. A question and answer session follows the presentation.

- **CMS releases manual updated with new requirements of participation.** Revisions were made to the regulation language per the final rule for Long Term Care facilities that was published October 4, 2016. Only regulation text was revised.

3) The U.S. Government Accountability Office (GAO) recently released a report entitled, Medicaid: CMS Has Taken Steps, but Further Efforts are Needed to Control Improper Payments. Medicaid is a joint federal-state health care program for low income and medically needy people, with an estimated $36 billion in improper payments in fiscal year 2016. The GAO identified some ways to reduce these errors, such as by confirming that Medicaid’s participants and health care providers meet eligibility requirements, effectively overseeing managed care organizations, and ensuring
that participants don’t have duplicate coverage through private health insurance. CMS has taken steps to address some of these issues, but more work is needed—at both the state and federal levels.

4) The federal Centers for Disease Control and Prevention (CDC) reports on:

- **Weekly U.S. Influenza Surveillance Report.** The CDC Influenza Division collects, compiles and analyzes information on influenza activity year-round in the US and produces FluView, a weekly influenza surveillance report. During week 5, ending February 4, influenza activity increased in the United States with widespread influenza activity reported in 43 states and Puerto Rico.

- **Recommended Immunization Schedules for Adults.** Each year, the Advisory Committee on Immunization Practices (ACIP) approves immunization schedules recommended for persons living in the United States. The adult immunization schedule provides a summary of ACIP recommendations on the use of licensed vaccines routinely recommended for adults aged 19 years or older. The adult immunization schedule is also approved by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Nurse-Midwives (ACNM).

5) The federal Agency for Healthcare Research and Quality (AHRQ) reports on:

- **Prospect of Financial Penalty Appears To Reduce Hospital Readmission Rates: JAMA Study.** An AHRQ-funded study found that the prospect of financial penalties led hospitals to take steps that reduced patient readmissions. The study, published in December in *JAMA*, examined hospital readmission rates for heart attack, heart failure and pneumonia among Medicare fee-for-service beneficiaries before and after implementation of the CMS Hospital Readmission Reduction Program. The program, a part of the Affordable Care Act, started imposing financial penalties in October 2012 on hospitals with higher-than-expected readmissions. Before the program was announced, researchers found, readmission rates were mostly stable. After the program announcement in March 2010, however, hospitals subject to financial penalties reported significantly faster declines in readmissions than non-penalized hospitals. Access the abstract.

- **AHRQ-Funded Articles Propose Strategies for Increasing Shared Decision-Making.** The January issue of *Patient Education & Counseling* includes six AHRQ-funded articles and an editorial that discuss using evidence to facilitate shared decision-making between clinicians and patients. Articles in the journal offer strategies for reducing barriers to shared decision-making, which may include low health literacy, patients’ tendencies to defer decision-making to clinicians, inadequate skills among clinicians to communicate evidence to patients, and clinical environments that do not support patient involvement in making treatment choices. According to an editorial by Monique D. Cohen, Ph.D., M.P.H., health science administrator at AHRQ, the potential benefits of shared decision-making will not be realized unless policies and programs are enacted to increase participation among patients and families.

- **New AHRQ Publications Summarize Evidence on the Management of Gout.** New evidence-based publications from AHRQ can help clinicians and patients make informed decisions about managing gout, a common form of arthritis that results from excessive uric acid in the blood and causes severe pain, swelling, redness and joint stiffness. *Diagnosis and Management of Gout: Current State of the Evidence* is a publication for clinicians that summarizes findings of two AHRQ-funded systematic reviews that examined the evidence about the accuracy and safety of diagnostic tests and the effectiveness of treatments for patients with acute gout attacks. The clinician publication cites a strong body of evidence supporting the effectiveness of several treatments and therapies for gout, but emphasizes the importance of clinicians and patients working together to decide which approach might be best. Also available is a continuing education module based on the evidence review, as well as a plain-language publication for patients, *Managing Gout – A Review of the Research for Adults*. Call (800) 358-9295 or email AHRQPubs@ahrq.hhs.gov for printed copies of the patient publication.

- **AHRQ Training Modules Available For Improving Informed Consent.** Two new training modules developed by AHRQ are available to help hospital executives and other health care professionals improve the informed
consent process. The modules aim to support better communication with patients, who often do not understand the risks, benefits and alternatives of their treatments even after signing consent forms. The Joint Commission is offering free continuing education credits (continuing education and continuing medical education) for taking AHRQ’s Making Informed Consent an Informed Choice modules. Learn more about the modules and how organizations that do not participate in Joint Commission accreditation may obtain them from AHRQ, and access a guide to implementing the modules.

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

- HFS posted an update to the Practitioners Fee Schedule. You may view this information here.
- The calculations and amounts for the hospital ACA Access Payments for the period of February 2017 through April 2017 have been posted to the Department’s web site and can be viewed here.
- HFS posted a new provider notice regarding Pharmacy Pilot Testing of Pharmacy Benefits Management System (PBMS). You may view the notice here.
- This is to inform providers that the Department of Healthcare and Family Services (HFS) has launched a secure electronic web-based portal to assist providers statewide in resolving issues with Illinois Medicaid Managed Care Organizations (MCOs).

HFS recognizes the importance of providers having a mechanism for reporting and resolving issues encountered with an individual Medicaid MCO when these issues cannot be resolved using existing processes designated by the MCO. A major goal of the new MCO provider complaint portal is to facilitate prompt and fair resolution of disputes between MCOs and providers. Issues impacting immediate access to care will be expedited.

The new MCO provider complaint portal does not replace issue reporting and escalation processes already in place between providers and an MCO. Prior to submitting a complaint through the new online portal, issues must already have been submitted to and reviewed by the MCO in question. If HFS determines a complaint was submitted to the Department prior to the MCO being afforded an opportunity to resolve it directly with the provider, the complaint will be immediately closed.

Providers should carefully identify which representatives within their provider organizations will be designated to use this complaint system for unresolved issues. The name of the provider representative submitting the complaint will be shared with the MCO, and outcomes will be reported only to the provider representative whose email is entered into the system with the complaint. HFS will collect and publically report the volume of complaints received and resolved by provider type, MCO, and other categories.

HFS staff will follow Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy procedures when using this secured site and providers must do so as well as a condition of use. Providers are able to upload protected health information to the secure provider complaint portal. If the complaint relates to a specific individual or claim, or group of related claims, providers must share the relevant member name(s), HFS 9-digit Recipient Identification Number(s), and date(s) of service. Each complaint should be for a single topic for a single MCO; please do not combine several issues or designate more than one MCO on the same complaint.

The link to the complaint portal may be found on HFS’ Care Coordination Webpage, or may be accessed directly from the HFS Managed Care Provider Complaints webpage. The portal is available for immediate use.

Please note that this new system is designed specifically for issues enrolled providers have with Illinois Medicaid MCOs. Provider complaints regarding the resolution of Medicaid Fee-for-Service issues should continue to be directed to HFS at 877-782-5565.
HFS posted a new provider notice regarding Pharmacy Benefits Management System (PBMS) Registration for Pharmacy Pilot Testing. You may view the notice here.

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

HFS posted a new provider notice regarding a new Managed Care Organization (MCO) Provider Portal. You may view the notice here.

HFS posted a new provider notice regarding New Web-based Medical Record submission process for retrospective Pre-Payment and Post-Payment Utilization Review. You may view the notice here.

HFS released new information regarding pilot testing for the new Point of Sale pharmacy claims processing system. You may view the information here.

HFS released two new public notices regarding Adult DD Waiver Documents. You may view the notices from the links below:
   - https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx
   - https://www.illinois.gov/hfs/medicalclients/hcbs/Pages/default.aspx

HFS posted a new provider notice regarding Hospital Cost Report Forms and Instructions. You may view the notice here.

HFS posted a new public notice regarding the Persons with Traumatic Brain Injury Waiver. You may view the public notice and the waiver from the links below:
   - https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx
   - https://www.illinois.gov/hfs/medicalclients/hcbs/Pages/default.aspx

7) The Illinois Department of Public Health (IDPH) updates include:

The IDPH Division of Life Safety and Construction is offering a 3-day seminar on the NFPA – Life Safety Code – 2012 edition on March 14-16, 2017. The seminar will be at the Crowne Plaza Hotel and Resorts, 3000 North Dirksen Parkway, Springfield, Illinois. Registration Form is available on the Division's web page at http://lists.illinois.gov/t/928197/87403671/1851/4/. Completed forms should be sent pdf to dph.design.standards@illinois.gov or may be faxed to 217-782-0382. This seminar is open to healthcare facilities licensed in the State of Illinois and those that are part of the Plan Review Process and Fee requirements. For questions, contact the Division of Life Safety and Construction at 217-785-4247.

The IDPH Long-Term Care Advisory Board met on February 16, 2017. The Board:
   - Approved proposed rulemaking to remove the requirement for Social Security Numbers (SSN) of persons who have a financial interest in the operation and ownership of the facility.
   - Approved proposed rulemaking to increase the student-to-instructor ratio for the CNA laboratory training from 15 to 16 students.
   - IDPH proposed rulemaking that would add new language and procedures regarding distressed facilities. Several of the Board members had significant problems with the proposed draft regulations. The Board voted to table the distressed facility proposal and provide comments to IDPH for discussion at the next meeting.
   - IDPH proposed an Informed Consent form for review and discussion. All of the Board members had concerns with the draft form. Lengthy discussion occurred and IDPH asked that anyone interested should submit comments to make the form workable. IDPH must also develop rulemaking to develop the protocols for the form. This will be discussed again at the next meeting.
8) The American Health Care Association (AHCA) released a summary regarding a **Favorable Court Decision Regarding “Skilled Maintenance” Nursing and Therapy Services (Jimmo v. Sebelius).** The U.S. District Court made a favorable decision last week pertaining to the *Jimmo v. Sebelius* class action lawsuit, which AHCA/NCAL has been actively engaged in supporting over the past several years. This decision will help assure that Medicare beneficiaries with chronic and progressive conditions residing in AHCA and NCAL member centers will have access to necessary nursing and therapy services to help maintain their health and function. Specifically, during this follow-up *Jimmo v. Burwell* class action, the Court found that CMS had violated part of the terms of the 2013 *Jimmo* settlement agreement and has ordered CMS to perform very specific education activities by September 4, 2017. These educational activities are intended to assure that providers, medical reviewers, and beneficiaries clearly understand that a "maintenance coverage standard" does exist under Medicare Parts A & B and Medicare Advantage (MA), and that skilled nursing and therapy services cannot be arbitrarily denied due to a lack of improvement. More details about the Court decision can be found in the above website.

9) The latest copy of the **Illinois Health Care Association (IHCA) Education Access** can be found [here](https://www.tellenginqiqo.com/).

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

11) The February 2017 **LTC Pharmacy News** reports on their view of the **Nursing Home Policy Priorities in 2017.** As the long term care pharmacy industry looks forward to 2017, we take some time to consider the issue priorities of our host community—the nursing home industry. As we talk with our partners, it will be important to keep in mind the environment in which they operate and how it affects their ability to care for their residents. The overarching issue area for SNF/NFs is the alleged “reform” of both Medicare and Medicaid payment systems. According to the Medicare Payment Advisory Commission (MedPAC), in 2016, Medicare spending for SNF patients was $30 billion. Medicare makes up about 12 percent of total facility days but 21 percent of revenue. Medicaid accounts for more than 65 percent of days but a disproportionately small percentage of revenue. However, Medicaid reimbursement has for some years now been very low and research indicates that while a few states – apparently very few – have reasonable levels of reimbursement, overall the funding gap between costs and reimbursement is huge. Items discussed include Medicare Funding, Medicaid Funding, Provider Taxes, Medicaid Managed Care, Block Grants and Per Capita Caps, Observation Stays, Quality Measures and Arbitration.

12) **ScienceDaily** reports that **Routinely Prescribed Antibiotic May Not be Best for Treating Severe C. Diff Infections.** Over the past two decades there has been a sharp rise in the number and severity of infections caused by the bacteria *Clostridium difficile* often shortened to *C. diff* now the most common hospital acquired infection in the United States. But a new study suggests that the most routinely prescribed antibiotic is not the best treatment for severe cases. Scientists at the VA Salt Lake City Health Care System and University of Utah report that patients with a severe *C. diff* infection (CDI) were less likely to die when treated with the antibiotic vancomycin compared to the standard treatment of metronidazole.

13) **Medical News Today** reports on **How to Break a Fever: Treatment Tips for Various Ages.** Fevers themselves do not cause the damage; it is the underlying disease that causes the biggest problem. Myths about brain injuries due to fevers have convinced many people that all fevers need treatment but that is not the case. In people that do not have any health issues, fevers do not necessarily need to be treated. In fact, treating a fever to enable a person to get back to their usual activities is unwise. Doing so can slow the body's ability to fight the infection.

14) The **Gerontological Society of America** reports on **New Data Reveal Aging Experiences of the LGBT Americans.** A new supplemental issue of the journal *The Gerontologist* presents the findings of the largest national survey to date focused on the health and well-being of lesbian, gay, bisexual, and transgender (LGBT) older adults. The issue, titled “*Aging with Pride: National Health, Aging, and Sexuality/Gender Study (NHAS),*” provides cutting edge research, drawing upon the 2014 wave of data from the first national, longitudinal study of more than 2,400 diverse LGBT adults aged 50 to 100. This research was supported by a grant from the National Institute on Aging.

15) **Medscape** reports on **Why Physicians and Nurses Should be Texting.** Not many understand why the joint commission doesn't [embrace or encourage order texting](https://www.medscape.com/viewarticle/878558). Ask any nurse who has waited for a return call while
tachycardia rages, blood pressure continues to plummet, or bleeding persists. They are grateful for the fastest recommendation possible to stabilize a patient. Device-savvy physicians, nurses, and pharmacists have embraced the convenience and expediency of texting. If we can rely on a texted description of a scenario to make a decision, we should be able to text an order that addresses it. Furthermore, cutting response time in a critical situation makes sense. We know what happens when we wisely utilize every minute of the golden hour of trauma or decrease the door-to-balloon time for a PCI. It stands to reason that reducing delays in time to action for critically ill inpatients will improve their outcomes as well.

16) Futurity reports that Caregivers Need Help Dealing With Depression. There are more than 34 million people in the US who care for terminally ill loved ones, but few resources are available to help them navigate the challenges they encounter. A new study published in the Journal of Palliative Medicine finds that nearly one-quarter of caregivers are moderately or severely depressed and nearly one-third have moderate or severe anxiety. Researchers recommend that health providers remember to treat the whole family, providing ongoing screening to caregivers to identify early signs of depression and anxiety.

17) The Knowledge Science Report reports on How Therapy Animals Help Those Living With Dementia. When I worked in long-term care facilities with those on their dementia journey, I saw the benefits of animal-assisted pet therapy firsthand. People living with dementia often feel isolated, depressed and without purpose. Yet my coworkers and I saw the residents experience so much joy simply by having animals around — to pet, to groom, to feed or to share a lap. Some residents saw reduced stress and anxiety or improved social skills. Others were able to reduce their medications as a result of the happiness brought on by the pets that either lived in or visited our facilities.

18) MedicalXpress reports on Examining Different Accountable Care Organization Payment Models. Two new studies published online by JAMA Internal Medicine take a look at different accountable care organization (ACO) payment models.

19) Health Affairs reports on How Can We Increase the Use of Palliative Care in Medicare? Medicare will cover some elements of palliative care, but payments are generally less than the cost of delivering the service because Medicare’s approach to reimbursement values procedures over time spent with patients and families. Hospitals have begun investing in palliative care teams because of the acute disease burden their patients experience near the end of life, but the availability of such care varies widely. Increasing the system-wide use of palliative care will require a new payment approach for Medicare, the insurer for over eight in 10 decedents annually in the United States.

20) The JAMA Network reports on Trends in Central Nervous System – Active Polypharmacy Among Older Adults Seen in Outpatient Care in the United States. With each new revision of the Beers Criteria, the list of psychotropic medications considered potentially inappropriate in the elderly has grown. Opioids have recently been included in a Beers measure of central nervous system (CNS) polypharmacy. Prescribing related drug combinations also received increased regulatory attention when the US Food and Drug Administration recently ordered a black-box warning to alert patients of serious risks, including death, caused by opioids co-prescribed with CNS depressants. While evidence builds concerning harms of CNS polypharmacy, little is known about the trends in relevant prescribing practices.

21) Modern Healthcare reports on GAO Report: Health Plans May be Underpaid for Managed Long-Term Care Services. ModernHealthcare reports the Government Accountability Office believes "Health plans could lose money if the CMS doesn’t increase its oversight over managed long-term supports and services programs." The GAO continues, "Without strong data, states and the federal government risk paying rates that are too low, which could result in quality and access concerns for beneficiaries, or rates that are too high, which diverts limited Medicaid dollars to [plan] profit and away from needed care."

22) HealthDay reports that Obese People May be Less Likely to Receive Hospice Care, Research Suggests. HealthDay reports research suggests that obese people are less likely receive hospice care "and more likely to die at home." The study authors "tracked the experiences of almost 5,700 Medicare beneficiaries who died between 1998 and 2012." The investigators "looked at weight levels and whether or not someone died in hospice care." Overall, about "35 percent of those in the study received hospice care, but just 23 percent of the severely obese did. In addition, the severely obese
spent four fewer days in hospice care than those with a BMI of 20." The findings were published online February 6 in *Annals of Internal Medicine*.

23) **The New York Times** reports:

- **Number of Retirement-Age Americans Taking At Least Three Psychiatric Medications More Than Doubled Between 2004 And 2013, Researchers Say.** The *New York Times* reports, "The number of retirement-age Americans taking at least three psychiatric medications "more than doubled between 2004 and 2013, even though almost half of them had no mental health diagnosis on record, researchers" found after analyzing "data from annual government surveys of office-based" physicians. In particular, investigators "focused on office visits by people 65 or older that resulted in the prescribing of at least three of a list of psychiatric, sleep and pain medications." The findings were published online February 13 in a research letter in *JAMA Internal Medicine*.

- **C. Difficile Cases Dropping In Some Areas Of The US.** In "The New Old Age," the *New York Times* reported on advances in preventing and treating *Clostridium difficile* (C. Difficile) infections. Six years ago, "an analysis by the Centers for Disease Control and Prevention estimated there were 453,000 cases a year and 29,300 deaths from the infection." In 2013, the CDC even "categorized C. diff as an 'urgent threat.'" Now, however, cases have dropped in various areas of the country, perhaps as a result of "stewardship programs to track and control" the use of antibiotics in both nursing homes and hospitals. Meanwhile, researchers are "testing innovative treatments, and three pharmaceutical companies plan to roll out large-scale vaccine trials."

24) **Provider magazine** reports that the Annual Flu Vaccine is Vitally Important for Older Adults in Nursing, Assisted Living Centers, William Schaffner, MD, medical director at the National Foundation for Infectious Diseases, writes in *Provider magazine* that the annual influenza vaccine is "vitally important" for "every older adult in a nursing, assisted living, or any other type of long term or post-acute care center," due to the disproportionate burden of flu on older adults. Dr. Schaffner also suggests the importance that "everyone who works in these environments be vaccinated annually to further reduce the spread of influenza." He explains that the "aging" immune system "leaves the body less prepared to fight infections."

25) **Medline Plus** reports:

- **Opioids and Alcohol a Dangerous Cocktail.** Drinking alcohol while taking powerful opioid painkillers can trigger a potentially deadly respiratory problem, particularly in seniors, a new study warns. "Unfortunately, we're seeing more fatalities and people in emergency rooms after having misused or abused legally prescribed opioids, like oxycodone, while having consumed alcohol," said study author Dr. Albert Dahan. "Respiratory depression [where breathing becomes very shallow or stops temporarily] is a potentially fatal complication of opioid use. We found alcohol exacerbated the already harmful respiratory effects of opioids," Dahan said.

- **Sticking With One Doctor May Help Keep Seniors Out of the Hospital.** Seeing the same doctor for a long time may help keep older people out of the hospital, a new British study suggests. Researchers from the Health Foundation in London analyzed about two years' worth of medical records for more than 230,000 patients, aged 62 to 82, in England. They looked at how often the patients saw the same general practitioner (continuity of care) and how that affected their risk of hospitalization. Compared to those with low continuity of care, rates of hospital admissions were 9 percent lower among those with medium continuity of care. Admission rates were 12 percent lower in those with high continuity of care, wrote study author Creina Lilburne and colleagues.

26) **Kaiser** reports:

- **Humor Is Important For Patients Nearing End Of Life, Author Says.** *Kaiser Health News* reports on the importance of maintaining high spirits after facing devastating news on a terminal illness. "Laughter is the best medicine," says Mary Kay Morrison, president of the Association for Applied and Therapeutic Humor, "unless you have diarrhea." Morrison stresses the importance of humor particularly for people near the end of life. Her group "has some loose guidelines for the use of humor among the dying. Most critically: Make certain that you
know the ailing person very well before using humor with them." Additionally, the National Cancer Institute urges patients, on its website, "to build humor into their day-to-day lives, in ways as small as buying a funny desk calendar and watching comic films and TV shows."


27) *McKnight’s reports:*

- **Skilled Nursing, Assisted Living Occupancy Low In Fourth Quarter Of 2016, Data Show.** *McKnight’s Long Term Care News* reports the occupancy rate "remained at 86.8 percent in skilled nursing" during the fourth quarter of 2016, according to data from the National Investment Center for Seniors Housing & Care. The skilled nursing facility "inventory growth rate also remained steady for the quarter – at virtually 0 percent," alongside "the slowest rent growth since at least 2006." In addition, "assisted living occupancy rates fell 0.3 percentage points from the third quarter, leaving the sector at its lowest level of occupancy since early 2010."

- **CMS Data Used In Medicaid Often Incomplete, Inaccurate, And Late, GAO Report Finds.** *McKnight’s Long Term Care News* reports the Government Accountability Office published a report Monday questioning "the accuracy of data in the CMS-64, a system used to calculate matching Medicaid funds for states, and the Medicaid Statistical Information System, or MSIS, which reports on individual beneficiary claims." The report says there are "issues with completeness, accuracy, and timeliness" in the systems, and that CMS' "continued reliance" on the systems prevents "effective oversight" and is "inconsistent with federal internal control standards." The report urged CMS to take immediate action to remedy the problems.

- **Court Ruling Clears Way for Debate Over Inpatient Stays, SNF Coverage.** *McKnight’s Long Term Care News* reports, "Debate over Medicare beneficiaries’ hospital stays being classified as inpatient — a designation crucial to receive skilled nursing coverage — will continue, thanks to a court’s order last week" which will allow Alexander v. Cochran to proceed. The US District Court for the District of Connecticut made the ruling on February 8, "citing ongoing disputes over whether the Centers for Medicare & Medicaid Services criteria or a physician’s judgment is the best way to designate a stay as inpatient or outpatient."

- **Lower the Risk and Deter Elopement.** The single most cited F-tag in a Centers for Medicare & Medicaid Services survey is F-323 in regards to resident safety and supervision. This alone should lead organizations to stand up and pay attention to the risks inherent with a lack of adequate resident supervision. Elopement occurs when a resident leaves a health care facility without staff knowledge of their departure. These events can be an area of both claim frequency and severity in the senior living residential care setting. Adults with a history of Alzheimer’s disease and/or dementia are at risk for wandering and elopement. Since this could result in an injury or a fatality, it is advisable to consider evaluating existing organizational protocols and strategies for elopement prevention.

- **Bundled Payment Programs Curbed Unnecessary Care Costs, Over 4-Year Period, Report Asserts.** Value-based care models, including bundled payments for hip and knee replacements, reduce costs and unnecessary care, according to a new analysis. The *Altarum Institute’s Center for Payment Innovation* authors — which include Patrick Conway, M.D., Deputy Administrator for Innovation & Quality and the Chief Medical Officer at the Centers for Medicare & Medicaid Services — examined Medicare Part A Claims and hospitals participating in the Bundled Payment for Care Improvement program from 2011 to 2015. Their research indicates bundled payments had increased quality metrics and lowered the costs without increasing the volume of episodes, they wrote.

- **Medical Marijuana Company Looking to Nursing Homes as Potential Customers.** A New York company that grows and sells medical marijuana is attempting to tap into the skilled nursing industry to find new customers.
The state launched its medical marijuana program over a year ago, the *New York Daily News* reported, but the market has been tough since few patients and doctors are willing to complete the registration process.

28) Interesting Fact: An average human body has 60,000 miles of blood vessels. They would stretch the entire earth if you laid them out end to end.