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!

Emergency Preparedness Update – Are You Ready For The New CMS Emergency Preparedness Requirements?
The federal Centers for Medicare and Medicaid Services (CMS) has adopted a final rule (click here) establishing national emergency preparedness requirements for Medicare and Medicaid participating providers and suppliers to plan adequately for both natural and man-made disasters, and coordinate with federal, state, tribal, regional and local emergency preparedness systems. It will also assist providers and suppliers to adequately prepare to meet the needs of patients, residents, clients and participants during disasters and emergency situations. Despite some variations, the CMS regulations will provide consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare and Medicaid participating facilities, and establish a more coordinated and defined response to natural and man-made disasters. The effective date of these regulations was November 15, 2016 and the implementation date is November 15, 2017. This gives providers 1 year to prepare and be in compliance with the new regulations. Interpretive Guidelines to further explain these new rules are expected to be released in late spring or early summer 2017.

CMS reviewed existing Medicare emergency regulatory preparedness requirements for both providers and suppliers. They found that many providers and suppliers have emergency preparedness requirements, but those requirements do not go far enough in ensuring that these providers and suppliers are equipped and prepared to help protect those they serve during emergencies and disasters. CMS believes that the existing emergency preparedness requirements are generally insufficient in the face of the needs of the patients, staff and communities, and do not address inconsistency in the level of emergency preparedness amongst health care providers.

CMS issued emergency preparedness requirements that will be consistent and enforceable for all affected Medicare and Medicaid providers and suppliers (referred to collectively as “facilities,” throughout the remainder of this final rule where applicable). This final rule addresses the three key essentials we believe are necessary for maintaining access to health care services during emergencies: safeguarding human resources, maintaining business continuity and protecting physical resources. Current regulations for Medicare and Medicaid providers and suppliers do not adequately address these key elements. Based on our research and consultation with stakeholders, we have identified four core elements that are central to an effective and comprehensive framework of emergency preparedness requirements for the various Medicare and Medicaid participating providers and suppliers. The four elements of the emergency preparedness program are as follows:

- Risk Assessment and Emergency Planning
- Policies and Procedures
- Communication Plan
- Training and Testing

See the October 11, 2016 edition of Regulatory Beat (click here) for a summary of the new emergency preparedness rules.
WHAT EVENTS DO I NEED TO PREPARE FOR?

An LTC facility must be prepared to meet the full spectrum of emergencies or disasters that the facility is susceptible to. As used in the rule, the terms “emergency” and “disaster” do not refer exclusively to an event resulting in an official public declaration of a state of emergency. Even an event confined within a single facility, such as a localized power failure, a cybersecurity event or even an elopement, falls under the rule’s scope. These could be natural disasters (such as severe weather events, fires flooding, etc.) or man-made disasters (such as chemical spills, train derailments, active shooter, etc.). Power outages are the most prevalent emergencies that LTC facilities deal with.

WHAT DO I NEED TO KNOW?

Emergency/disaster planning is all in the details. What is the emergency plan for your facility? Your emergency/disaster plan needs to be based on and include a facility AND community-based Risk Assessment. This plan needs to be customized to the specifics of your facility – one size does not fit all. The Risk Assessment must include:

- High probability and impact events
- Address facility population at risk because of their residents’ unique needs
- Identification of services that must be provided in the emergency
- Continuity of operations/delegation of authority
- Process of cooperation with community response
- All Hazards Approach
- Reviewed and updated annually

“All Hazards Approach” means an integrated approach to emergency preparedness planning that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters. Contact your local emergency management agency to discuss facility/community issues and concerns. The approach must be community based and facility specific. This approach is specific to the location of the facility and considers the particular types of hazards most likely to occur in their area. The Threat and Hazard Identification Risk Assessment is a four step process:

1. Identify Threats and Hazards of Concern – Based on a combination of experience, forecasting, subject matter expertise and other available resources. Identify a list of the threats and hazards of primary concern to the facility/community.
2. Give the Threats and Hazards Context – Describe the threats and hazards of concern, allowing how they may affect the facility/community.
3. Establish Capacity Targets – Assess each threat and hazard in context to develop a specific capacity target for each core capability identified in the National Preparedness Goal. He capacity target defines success for the capability.
4. Apply the Results – For each core capability, estimate the resources required to achieve the capability targets through the use of facility/community assets and mutual aid, while also considering preparedness activities, including mitigation opportunities.

Integrated response planning includes:

- A process for ensuring cooperation and collaboration with local, state and federal emergency preparedness officials to maintain an integrated response during a disaster or emergency.
- Documentation of the LTC facility’s efforts to contact such officials and when applicable of its participation in collaborative/cooperative planning.
- Include contact information in the facility’s emergency plan for emergency officials you should be contacting during emergencies.

POLICIES AND PROCEDURES ON RISK ASSESSMENT

Emergency/Disaster policies and procedures must be reviewed and updated annually and address at a minimum:

- Provision of subsistence needs for staff and residents, whether evacuation or shelter in place
- Food, water, medical and pharmaceutical supplies
Federal CMS has clarified that this does not mean that facilities would necessarily need to store provisions themselves. Local, state and regional agencies and organizations often participate with facilities in addressing subsistence needs, emergency shelter, etc. CMS does not specify the amount of subsistence that must be provided, but the general rule of thumb is 5 days. In an emergency, a facility cannot over-depend on resupply. Medical supplies and pharmaceuticals need special attention. Also, in an evacuation, a facility needs to plan what to take en route and what will be needed at the evacuation site.

When sheltering-in-place during an emergency/disaster, consideration and planning must address alternate sources of energy. **The new federal emergency preparedness requirements will now require SNFs and NFs to have generators** (DD/IID facilities are not required to have a generator unless needed to meet temperature, lighting, etc. requirements). The generator must provide for:

- Temperatures to protect residents health and safety and safe storage of provisions
- Emergency lighting
- Fire detection, extinguishing and alarm systems
- Sewage and waste disposal (provisions for maintaining the necessary services)

CMS encourages facilities to establish policies and procedures in their emergency preparedness plans that would address providing auxiliary electrical power to power dependent residents during an emergency or evacuation of such residents to alternate facilities.

In the case of a facility evacuation, the facility’s policies and procedures must address:

- Care and treatment of residents
- Staff responsibilities
- Transportation
- Evacuation locations
- **Primary and alternate** means for communication with external sources of assistance

The development of arrangements in collaboration with other facilities to receive residents is necessary in order to provide the continued needed care and treatment for all residents.

In an evacuation, provisions must also be made with regard to medical documentation that preserves information, protects confidentiality and maintains the availability of records. The facility must also develop policies and procedures for the proper use of volunteers. Health care volunteers would be allowed to perform services within their scope of practice and training and non-medical volunteers would only perform non-medical tasks.

**COMMUNICATION PLAN**

The facility’s communication plan (under their facility emergency plan) must be updated **annually**, and include:

- Names and contact information for staff
- Contact information for entities providing services to the facility
- Contact information for the residents’ physicians
- Contact information for other LTC facilities in the area
- Contact information for facility volunteers
- Contact information for the local emergency management agency
- Contact information for the hospitals in the area
- Contact information for the IDPH Regional and Central Office
- Contact information for the local Ombudsman and their office
- Contact information for other sources of assistance

The facility must also have a communication plan that provides a **primary and alternate** means for communication with facility staff and local emergency contacts. **In some emergencies, cell phones may not work or circuits will be overwhelmed. A facility must plan for this and have an alternate plan for essential communication.**

As stated earlier, a facility must develop a method for sharing information and medical documentation, as necessary:
• With other health care providers to maintain continuity of care
• Means to release medical information in event of resident transfers and/or evacuation as permitted under HIPPA
• Means of providing information about the general condition and locations of residents
• And regarding the occupancy, needs and ability to provide assistance to authority having jurisdiction or incident commander

The facility must also establish a method of sharing information from the emergency plan with residents and their families/representatives

• Expectation is that this information precedes the emergency event
• Consider at orientation, post-admission and annually
• Could be a great trust builder with families and an way to get them to cooperate and communicate in accordance with the emergency plan during an event

TRAINING AND TESTING
The facility’s emergency preparedness training program must do all of the following:

• Initial training in emergency preparation to all new staff upon hiring and for existing staff
• Individual(s) providing services under a contractual arrangement or other arrangement
• Volunteers consistent with their role
• Provide training at least annually
• Maintain documentation of training
• Ensure that staff can demonstrate knowledge on implementation of the emergency plan and their role

Note: Current CMS direction is that both training exercise requirements must be met by November 15, 2017 to be in compliance.

With regard to testing, the facility must:

• Participate in a full-scale exercise that is community-based at least annually
• If a full-scale community exercise is not available, conduct a facility-based full-scale exercise
• Conduct a second formal exercise that can be a table top exercise at least annually involving a narrated clinically relevant emergency scenario and questions/problems to challenge the plan
• Document the training exercises and the results
• Analyze response to exercise and table top and make necessary changes/revisions to the facility’s emergency plan

Special note for integrated health care systems:
• If a facility is part of a health care system/corporation with multiple facilities, they can elect to have a unified and integrated emergency preparedness program
• Must document and demonstrate that each facility participated in the development of the emergency plan
• Must reflect each facility’s unique circumstances, population and services based on their facility-specific assessment
• Have integrated policies and procedures for coordinated communication plan, testing and training

Where Do I Start?
• The American Health Care Association - California affiliate (California Association of Health Facilities) has developed and implemented a very thorough emergency plan protocol and tools for their LTC facilities. Visit http://www.cahfdisasterprep.com/Home.aspx for a plethora of information, guidelines, tools and forms that can be used to guide a facility in their emergency preparation planning.
• New federal interpretive guidelines on the emergency preparedness requirements will be available sometime later this spring or summer.
• Every facility should reach out to their local emergency management agency to get acquainted and begin discussion on community emergency planning involving their LTC facility.
• The AHCA website also has emergency preparedness guidance materials available.
• See the October 11, 2016 edition of Regulatory Beat (click here) for a summary of the new emergency preparedness rules.

As more information/guidance becomes available, we will get it to our members.

**Medicare Outpatient Observation Notice (MOON)**

The Medicare Outpatient Observation Notice (MOON) was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services, and are not an inpatient of the hospital or Critical Access Hospital (CAH). The MOON is mandated by the Federal Notice for Care Eligibility Act (NOTICE Act), passed on August 6, 2015.

The statute does not require hospitals and CAHs to deliver the MOON to all beneficiaries who receive outpatient services. The MOON is intended to inform beneficiaries who receive observational services for more than 24 hours that they are outpatients receiving observation services and not inpatients, the reasons for such status, and it must be delivered no later than 36 hours after observation services begin. However, there is flexibility to deliver the MOON any time up to, but no later than, 36 hours after observation services begin, which allows hospitals and CAHs to spread out the delivery of the notice and other hospital paperwork in an effort to avoid overwhelming and confusing beneficiaries. **The Effective Date for the MOON was February 21, 2017.**

A copy of the MOON and instructions for completion, including if a beneficiary refuses to sign the MOON can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf.

Medicare Outpatient Observation Notice and accompanying form instructions are available in “Downloads” below. All hospitals and CAHs are required to provide the MOON, per CMS guidance, beginning no later than **March 8, 2017.**

**Downloads**

- CMS-10611 (MOON) [ZIP, 141KB]
- MOON FAQs [DOCX, 29KB]
- CR9935 MOON Instructions [PDF, 63KB]

**NEW IDPH Incident Reporting Form, Instructions, and Processing Options**

The Illinois Department of Public Health (IDPH) requires that all of the various LTC and ID/DD facilities notify the Department of any serious incident or accident (for example click here). For the purposes of reporting, “serious” means any incident or accident that causes physical harm or injury to a resident. To assist facilities in reporting, IDPH has developed a new Serious Injury Incident Report form (click here) for providers to use. This form is **NOT mandatory**, but is an option for facilities to use that contains all of the information that IDPH requires.

IDPH has also developed instructions for use of their new serious incident reporting form:

1. Download the Serious Injury Incident Report form (click here).
2. Fill out the form **completely**.
3. If this is an initial report, be sure to include the following:
   - Name of the alleged perpetrator of abuse (if known)
   - Name of the resident and/or staff involved
   - Allegation category and injury (if any)
4. **Fax** or **email** the completed form to your Regional IDPH Office.
5. After receipt of your final report, the facility will be notified if additional documentation is required.

For those LTC facilities choosing to **email** incident forms to the Regional Office, the following addresses may be used:
All ICF/IID incidents and SMHRF reports (regardless of the Region) may be emailed to - dph.incidentreports@illinois.gov. If you choose to fax them, you may continue to fax to the Region.

If you have any questions regarding this new form and process, contact your IDPH Regional Office.

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**Trending Statistics**

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

**Portrait of a Modern Nurse Survey Finds Half of Nurses Consider Leaving the Profession**

*A departure of nurses would add to the growing nursing shortage in the U.S.*

To better understand the life of a modern nurse, RNnetwork surveyed nurses about their workload, work/life balance, the national nursing shortage and how respected they feel at work.

Half of the nurses surveyed have considered leaving nursing. The number one reason for wanting to leave is feeling overworked (27 percent), followed by not enjoying their job anymore (16 percent) and spending too much time on paperwork (15 percent).

To find out more about these reasons, [click here](#) to view the report.
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:

   - **HHS, CMS Leaders Promise Medicaid Collaboration with States.** The CMS administrator Seema Verma and HHS Secretary Price sent a letter to governors encouraging states to innovate and break with federal standards by receiving "waivers" from government rules.

   - **Inpatient Skilled Nursing Facility Denials.** According to the 2015 Comprehensive Error Rate Testing (CERT) Report, the denial rate for Skilled Nursing Facilities (SNFs) increased from 6.9 percent in 2014 to 11 percent in 2015 due to missing or incomplete certification/recertification:
     - Statement must contain need for skilled services that can only be provided in SNF/swing-bed on a daily basis for a condition patient was treated for in prior hospital stay
     - Must include physician's dated signature (printed name if signature is illegible)
     - In addition, recertifications should include:
       - Expected length of stay
       - Explanation if continued need for services is for a condition that arose after SNF admission
       - Any plans for home care
     - Resources:
       - CERT: SNF Certifications and Recertifications MLN Matters® Special Edition Article
       - SNF Billing Reference Fact Sheet
       - Medicare Fee-For-Service 2014 Improper Payments Report, page 19
       - Medicare Fee-For-Service 2015 Improper Payments Report, page 18

   - **Social Security Number Removal Initiative: New Details.** Updated Social Security Number Removal Initiative Home and Provider webpages will help you prepare to transition to Medicare Beneficiary Identifiers next year. Find new information including:
     - How to identify railroad retirement board beneficiaries
     - Coordination of benefits with other payers
     - Where to direct your patients to correct their addresses so they receive new Medicare cards

   - **Hospice Quality Reporting Program: Rerun Your Quality Measure Reports.** An issue was identified and corrected with calculations for the following reports with implementation dates of December 18, 2016 through February 26, 2017:
     - Hospice-Level Quality Measure Report
     - Hospice Patient Stay-Level Quality Measure Report

     Providers should rerun any reports during this date range. Visit the HIS Technical Information webpage for more information.

   - **LTCHs: Exceptions to Moratorium on Increasing Beds.** Congress recently provided exceptions to the moratorium on increasing beds in existing Long Term Care Hospitals (LTCHs) and LTCH satellite facilities. The requirements and procedures for an exception to this moratorium are the same as those for new facilities, as explained in Change Request 9025 in 2015 (see Establishment and Classification of a LTCH or LTCH Satellite). If an LTCH or LTCH satellite facility increases beds under one of the exceptions, there may be an effect on other Medicare payment policies.

   - **IMPACT Act: Standardized Patient Assessment Data Activities Call — Wednesday, March 29, 12:30 - 2 p.m. CST.** To register or for more information, visit MLN Connects Event Registration. During this call, find out about efforts to develop, implement and maintain standardized Post-Acute Care (PAC) patient assessment data, including pilot testing results and plans for the upcoming national field test. CMS is working toward implementing the IMPACT Act, which requires changes to the MDS. They are hosting a Medicare Learning Network session on the NEW RAND
Standardized Patient Assessment to replace sections of the MDS. The RAND team under contract to CMS will be working with SNFs in 14 Chicago Metropolitan areas this Fall to test NEW sections for the MDS. We highly encourage you to participate in the webinar to see if you can help! Topics:

- Goal of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
- Timeline of activities
- Alpha 1 results
- Alpha 2 progress
- Plans for beta test
- How to get involved

The IMPACT Act requires the reporting of standardized patient assessment data by PAC providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. Visit the Data Standardization & Cross Setting Measures website for more information.

- Medicare Enrollment Resources Educational Tool — New. A new Medicare Enrollment Resources Educational Tool is available. Learn about:
  - How to enroll
  - What to do if you run into problems
  - Where to locate enrollment forms

- Chronic Care Management Services Call: Audio Recording and Transcript — New. An audio recording, transcript and post-call clarification are available for the February 21 call on Understanding and Promoting the Value of Chronic Care Management (CCM) Services. During this call, CMS experts discuss the benefits of providing CCM services and changes for CCM in the Physician Fee Schedule final rule.

- IMPACT Act Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the February 23 call on Looking Ahead: The Improving Medicare Post-Acute Care Transformation of 2014 (IMPACT Act) in 2017. During this call, CMS experts discuss goals, requirements, progress to date, and key milestones for 2017.

- Advance Care Planning Fact Sheet — Reminder. The Advance Care Planning Fact Sheet is available. Learn about:
  - Beneficiary eligibility
  - Provider and location eligibility
  - Diagnosis requirements

- Revision to State Operations Manual (SOM) Appendix PP - Incorporate revised Requirements of Participation for Medicare and Medicaid certified nursing facilities. 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. Transmittal 167 dated February 10, 2017, is being rescinded and replaced by Transmittal 168, March 8, 2017 to correct the following tags: F203, F205, F221, F223, F224, F225, F246, F247, F252, F309, F319, F320, F329, F333, F455, F456, F457, F458, F459, F460, F461, F462, F463, F464, F465, F466, F467, F468, and F469. In addition, the Effective and Implementation dates were also changed to reflect the current re-issue date. All other information remains the same.

- CMS Final Rule on Medicaid Pass-Through Payments. You may have seen stories in the trade press concerning CMS’ new final rule on the states’ use of pass-through payments in Medicaid managed care and wondered what this is all about. LTC Pharmacy News has put together an informative overview of the issue and its potential impact on hospitals and nursing homes.


- Prevention of Health Care Associated Infections – Webinar – Friday, March 24, 2017, 12-1 p.m. CST. Register to join us today! CMS is inviting you to join the Office of Disease Prevention and Health Promotion, PFCC partners,
Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, and Centers for Medicare and Medicaid Services for a webinar about health care-associated infections (HAIs). HAIs are infections that people get while receiving care for another condition. HAIs are a significant cause of illness and death, affecting about 1 in 25 Americans who receive hospital care. In October 2016, the U.S. Department of Health and Human Services (HHS) announced new targets for the national acute care hospital metrics outlined in the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination (HAI Action Plan). During this webinar, we’ll share:

- A patient perspective on HAIs and their consequences
- An in-depth look at the new acute care hospital targets and measures
- Updates on HAI Action Plan data sources
- How federal health agencies are working together to improve patient safety in acute care hospitals

- Payroll Based Journal (PBJ). PBJ 2.2.0 was released on January 22 and includes minor updates to the PBJ and CASPER reporting systems. You may also want to review the PBJ Providers User’s Guide. The due date for the reporting period of January 1, 2017 through March 31, 2017 is May 15, 2017. AHCA is available to help as well, just submit any of your PBJ questions to them at staffdatacollection@ahca.org.

- CMS’ Opioid Misuse Strategy 2016. CMS has made attacking this devastating epidemic a top priority and is providing help and resources to clinicians, beneficiaries and families. This is an ongoing CMS strategy, as part of the HHS Opioid Initiative launched in March 2015, to combat misuse and promote programs that support treatment and recovery support services. The CMS effort includes four priority areas:
  1. Implement more effective person-centered and population-based strategies to reduce the risk of opioid use disorders, overdoses, inappropriate prescribing, and drug diversion;
  2. Expand naloxone use, distribution, and access, when clinically appropriate;
  3. Expand screening, diagnosis, and treatment of opioid use disorders, with an emphasis on increasing access to medication-assisted treatment; and
  4. Increase the use of evidence-based practices for acute and chronic pain management.

The success of this strategy depends upon CMS effectively communicating to everyone who interacts with Medicare and Medicaid. We are working with people with Medicare and Medicaid benefits, their physicians, health insurance plans, and states to improve how opioids are prescribed by physicians and used by patients, how opioid use disorder is identified, how patients are connected to treatment, and how alternative approaches to pain management could be promoted.

3) The U.S. Government Accountability Office (GAO) recently released the following reports:

- Antibiotics: FDA Has Encouraged Development, but Needs to Clarify the Role of Draft Guidance and Develop Qualified Infectious Disease Product Guidance. Each year, over 2 million Americans get sick from bacterial infections that are resistant to antibiotics, and at least 23,000 die as a result. There has also been a steady decline in the development of new antibiotics since the 1980s—raising concerns that there may not be enough new antibiotics to replace those that have become ineffective. See Report

- Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings. Many patients who leave hospitals receive continuing care from places like rehab facilities (called post-acute care settings). When patients leave the hospitals and move to post-acute care settings, electronic health records can help providers know what the patient needs and better coordinate care. However, we found that issues like increased costs and a lack of access to technology deter the use of electronic health records in these settings. See Report


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

- **Electronic Prescribing Tied to Reduction in Adverse Drug Events.** Electronic prescribing (e-prescribing), which is intended to ensure that accurate, error-free and understandable prescriptions are sent directly to pharmacies, was found to lower the risks among diabetes patients of experiencing adverse drug events that required emergency department visits or hospitalizations. In an AHRQ-supported article, researchers examined 2011–2013 data for 3.1 million Medicare Part D beneficiaries who were 66 or older and had taken anti-diabetes medications for at least 90 days. Their analysis, published in *Medical Care*, showed 21 adverse drug events per 1,000 beneficiaries who had at least 75 percent of their medications e-prescribed. Beneficiaries with less e-prescribing, meanwhile, had more adverse drug events—with the highest rate, 44 events per 1,000 diabetes patients, occurring for those patients who had 0.1 percent to 24.9 percent of their prescriptions handled electronically. Access the abstract.

- **AHRQ Toolkit Designed To Reduce Urinary Tract Infections in Long Term Care.** A new evidence-based toolkit from AHRQ can help long term care facilities reduce catheter-associated urinary tract infections (CAUTIs). The toolkit uses strategies from AHRQ’s Comprehensive Unit-based Safety Program (CUSP), which has reduced CAUTI as well as central line-associated bloodstream infections in hospitals. The toolkit is based on the experiences of more than 450 long term care facilities nationwide and resulted in a significant reduction of CAUTI rates. Toolkit modules, which are customizable to local needs, include Using the Comprehensive Long Term Care Safety Toolkit; Senior Leader Engagement; Staff Empowerment; Teamwork and Communication; Resident and Family Engagement; and Sustainability. Access the toolkit and a new AHRQ Views blog, “Help for Nursing Homes in Fighting HAIs.”

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

- HFS posted new information regarding **Ambulatory Procedures Listing for 01/01/17.** You may view the new information here.

- Will your Illinois Medicaid claims continue to process? Go-Live for the Department’s new **PBMS** is March 26 at 5 p.m. Are you ready? If not, your claims will not process and you will not receive reimbursement. Have you made the changes to accommodate the new payer sheets for the Pharmacy Benefits Management System (PBMS) implementation? These changes include a change from COB1 to COB3, in addition to other required fields for all transactions. More information about this implementation is available on the Illinois Rx website: [https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/illinoisrx/Pages/default.aspx](https://www.illinois.gov/hfs/MedicalProviders/Pharmacy/illinoisrx/Pages/default.aspx).

- 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 **Institutional Paper Claims Technical Guidelines.** You may view the notice here.

- HFS posted a new provider notice regarding **Point of Sale (POS) System Outage and New POS Payor Sheet.** You may view the notice here.

- The state would like to learn about difficulties the **ABE user** community may be experiencing when uploading client proof documents in ABE. If you encountered problems uploading documents using the ABE website, please complete this brief survey by April 1, 2017. If you have not encountered problems, please do not complete the survey. [https://surveynuts.com/surveys/take?id=128637&c=2438957537JTRR](https://surveynuts.com/surveys/take?id=128637&c=2438957537JTRR).

- Additional **Technical Assistance calls for the new billing process** have been scheduled for March 24, 2017 and April 28, 2017. Call in information for the March 24 Technical Assistance call has been posted on the LTC Direct Billing webpage [https://www.illinois.gov/hfs/MedicalProviders/Ltss/Pages/LongTermCareDirectBilling.aspx](https://www.illinois.gov/hfs/MedicalProviders/Ltss/Pages/LongTermCareDirectBilling.aspx). The TA call will predominately be a Q&A format to discuss issues providers are having with the submission of their monthly
The Department will provide updates on any system issues affecting claim submission and pricing, as well as common billing mistakes.

8) **News items form the American Health Care Association (AHCA):**

- **House Introduces Repeal and Replace – It Includes Fundamental Changes to Medicaid – The Changes Pose a Serious Threat to LTC Funding.** This is the biggest threat we have faced to Medicaid perhaps in the history of the sector. It comes at a particularly bad time for the sector and our residents. It's not acceptable, but it's also not inevitable. We can create the outcome we need over the next four weeks, but that is only possible if we all get involved.

- **Observation Stays Legislation Re-Introduces and Helpful Materials.** The observation stays legislation, the Improving Access to Medicare Coverage Act of 2017 (S. 568/ H.R. 1421), was re-introduced on March 8. You will find some helpful materials in the website noted above for your advocacy efforts on the legislation.

- **AHCA’s letter to Secretary Price, detailing our regulatory asks for HHS and CMS (click here).**

- **AHCA’s new Issue Brief on the survey/CMP issue.** The issue brief will also be available on the AHCA homepage (click here).

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

10) **UTHealth Study Paves the Way for Clostridium Difficile Treatment in Pill Form.** Frozen and freeze-dried products for Fecal Microbiota Transplantation (FMT) are nearly as effective as fresh product at treating patients with Clostridium difficile (C-diff) infection, according to researchers at The University of Texas Health Science Center at Houston (UTHealth) School of Public Health and Kelsey Research Foundation. A new study, which proves that a pill form of treatment could be effective and more convenient for patients and physicians, was published in the most recent issue of *Alimentary Pharmacology & Therapeutics*.

11) **Modern Healthcare** reports that **HHS Says It Can’t Clear Medicare Appeals Backlog by 2021 Deadline.** HHS officials say they don’t have the money or resources to wipe out their pending Medicare billing appeals by a court-imposed 2021 deadline. In a report to a U.S. District Court in the District of Columbia, HHS said it hasn’t been able to effectively reduce its Medicare billing appeals backlog, and it has even more pending appeals than previously anticipated. The court last year ordered the federal agency to fully clear all pending Medicare appeals from hospitals by January 1, 2021, resolving a long-standing dispute with the American Hospital Association. The group sued HHS in 2012, alleging it took far longer than the 90-day limit for a hospital to dispute a denied claim by Medicare recovery audit contractors. HHS must also follow a gradual elimination process and file reports to the court every 90 days on its progress.

12) **RawStory** reports that **Scientists Identify First Sign of Alzheimer’s Disease.** Memory loss and cognitive decline are commonly thought to be the earliest signs of the neurodegenerative disorder Alzheimer’s, but a new study has found declines in glucose levels in the brain come even sooner — before the first symptoms appear. Even better? The same team also believes they have figured out a way to stop these levels from falling in the first place, a finding that could potentially prevent Alzheimer’s.

13) **Forbes** reports that **Alzheimer’s Staggering $259B Cost Could Break Medicare.** The cost of providing care for Americans with Alzheimer’s disease has hit $259 billion—more than a quarter of a trillion dollars—as costs mount to treat more aging baby boomers entering long term care facilities, according to a new report. The annual cost estimate for the deadly disease from the Alzheimer’s Association comes as Congress and the White House once again have health care reform and funding for entitlement programs like Medicaid for poor Americans and Medicare for the elderly on their agenda.

14) **Health in Aging** reports **Longer Hospital Stays Might Reduce Readmissions From Post-Acute Care Facilities.** More than 25 percent of Medicare beneficiaries who are admitted to the hospital are sent to a post-acute care facility (a health facility
like a rehabilitation or skilled nursing center used instead of a hospital) after being discharged. However, more than 23 percent of these older adults face readmission to the hospital within 30 days, and often within the first week.

15) **ScienceDaily** reports that [Tailored Preventive Oral Health Intervention Improves Dental Health Among Elderly](https://www.sciencedaily.com/releases/2018/08/180816173016.htm). A tailored preventive oral health intervention significantly improved the cleanliness of teeth and dentures among elderly home care clients. In addition, functional ability and cognitive function were strongly associated with better oral hygiene, according to a new study.

16) **Kaiser Health News** reports that [For Some Hospice Patients, A 911 Call Saves a Trip to the ER](https://www.kaiserhealthnews.org/health-at-a-distance/2018/03/13/a-911-call-saves-a-trip-to-the-er/). On average, 18 percent of hospice patients go to the emergency room at least once before their death, according to an analysis of Medicare data published last year in the journal *Medical Care*. Melissa Aldridge, the study’s lead researcher and an associate professor at New York City’s Icahn School of Medicine at Mount Sinai, describes paramedic-hospice partnerships such as Fort Worth’s as “forward-thinking” in promoting better patient care.

17) **Luc Bourne Science Blog** reports that [Nursing Homes Rarely Use Isolation Precautions Against Multi-Drug Resistant Infections](https://lucbourne.com/2018/04/08/nursing-homes-rarely-use-isolation-precautions-against-multi-drug-resistant-infections/). Nursing homes may be infrequently applying isolation precautions to prevent the spread of infections caused by multi-drug resistant organisms (MDRO), a recent study suggests. They found that, of the 138,294 residents included in the sample who had developed MDRO infections, only 12.8 percent reported that an isolation precaution had taken place. Furthermore, 69 percent of the 11,773 nursing homes had not reported using any isolation for infected residents.

18) **Medical News Today** reports that [Vaccination May Reduce Cases of Serious Shingles Complications in Seniors](https://www.medicalnewstoday.com/articles/321479). Immunization can significantly lower the risk of serious complications from shingles among older adults, suggest findings from a new study published in *Clinical Infectious Diseases* and available online. Drawing on data from approximately 2 million Medicare beneficiaries from 2007 to 2014, the retrospective cohort study evaluated the effectiveness and durability of the currently available, but under-utilized, vaccine.

19) **Bloomberg News** reports that [Privacy and Security Audits May Be Moving From Education To Enforcement](https://www.bloomberg.com/news/articles/2018-04-05/privacy-and-security-audits-may-be-moving-from-education-to-enforcement). Ongoing privacy and security health care audits may be moving from education to enforcement, and providers need to ensure that their compliance and operational teams are working together to detect vulnerabilities. The second round of Health Insurance Portability and Accountability Act audits began in March 2016, and the Health and Human Services Office for Civil Rights has repeatedly said they are intended to be educational. However, a shift to an enforcement mode is likely.

20) **Healthcare IT News** reports that the [GAO Recommends HHS Increase HER Use for Post-Acute Care](https://www.healthcareitnews.com/news/gao-recommends-hhs-increase-her-use-post-acute-care). GAO found HHS currently "lacks a comprehensive plan" to establish increasing standards of electronic communications to exchange health information for post-acute care providers. According to GAO, "Exchange of accurate and timely health information is particularly important in these transitions, and technology like EHRs could help to improve quality and reduce costs."

21) **Medpage Today** reports that [Hospice Care May Reduce Health Care Spending in Certain High-Cost Regions](https://www.medpagetoday.com/news/ob/18743). *MedPage Today* carried a HealthLeaders Media story reporting that research suggests that "to reduce health care spending, areas of the" U.S. "with relatively high medical service costs would benefit most from increased utilization of hospice care." The findings were published in *Health Affairs*.

22) **MedlinePlus** reports on:

- **Exercise Beats Weight Loss at Helping Senior’s Hearts**. Seniors who want to give their hearts a healthy boost may want to focus on exercise first, a new study suggests. The research found that getting active may do more for cardiovascular health in older adults than losing weight does.

- **Older Bones Benefit From Dairy Plus Vitamin D**. A combination of vitamin D supplements and certain dairy foods may protect against age-related bone loss, a new study indicates. Consumption of milk, yogurt and cheese was associated with higher bone mineral density in the spine and less bone loss in the hip among older adults -- but only
if they also took vitamin D supplements, researchers said. Vitamin D stimulates calcium absorption, which aids in bone building and prevention of bone loss.

- **Annual Death Toll From Alzheimer’s Nearly Doubles in 15 Years.** Alzheimer’s disease claims nearly twice as many American lives annually as it did just 15 years ago, a new report shows. The report also found that more than 5 million American seniors aged 65 and older now live with the memory-rob­bing disease. That represents approximately 10 percent of all the nation’s seniors, and that number is projected to jump to nearly 14 million by 2050. In fact, nearly half a million seniors are expected to develop the disease in 2017 alone. Another 200,000 Americans under the age of 65 also struggle with the disease, the report found.

23) **Provider Magazine** reports:

- **Opinion: Physicians Can Improve Care by Improving Communication.** V. Tellis-Nayak, PhD, a senior research adviser at NRC Health in Lincoln, NE, writes in an opinion piece in Provider Magazine that many physicians have lost "the art of relating" to patients. Nayak argues that miscommunication is a common cause of many problems in medicine, then outlines several ways that physicians could improve communication with patients.

- **OIG To Focus On Nursing Home Rehospitalizations In 2017.** Provider Magazine reported that "rehospitalizations will be under increased scrutiny," according to the Office of Inspector General 2017 work plan. The focus is a response to "a 2014 OIG study on adverse events in nursing centers, which found that in just one month Medicare spent nearly $2.8 million on hospital treatments for harm caused by poor nursing care." The agency will review "skilled nursing care centers with high rates of patient transfers to hospitals for potentially preventable condi­tions," which the CMS has identified.

- **Opinion: Technology Adoption Can Improve Employee and Resident Retention.** Patrick Hart, the vice president of senior living solutions for MatrixCare, writes in an opinion piece in Provider Magazine that technology adoption can improve employee and resident retention. Hart outlines how new technologies can help improve retention among residents by improving care workflow and also can also help improve employee retention, especially among Millennial employees who grew up with technology.

24) **McKnight’s** reports:

- **ACA Replacement Could Worsen Health Care Worker Shortage, Report Suggests.** McKnight’s Long Term Care News reports the Republicans’ ACA replacement "may complicate the increasing shortage of health care workers," according to a "brief published by the Paraprofessional Health Care Institute." The brief indicates that "the ACA contributed to a 26 percent reduction in the uninsured rate among health care workers." In an accompanying statement, PHI VP of policy Robert Espinoza explains, "Policies that undermine the progress made by the Affordable Care Act, or that reform Medicaid’s financing structure, will make it increasingly difficult to attract sufficient numbers of workers to meet our nation’s caregiving needs."

- **MedPAC Indicates New PAC Reimbursement System May Be Implemented By 2021.** McKnight’s Long Term Care News reports the Medicare Payment Advisory Commission indicated that "a new reimbursement system for post-acute care providers could be implemented" as early as 2021. Commissioners said "the reimbursement shakeup was required as part of the Improving Medicare Post-Acute Care Transformation Act," and most "seemed to favor a three-year transition timeline that would include two years where reimbursement rates would be set by combining the current and proposed systems."

- **CMS’ Enhanced Care and Coordination Provider Models Reduced Hospitalizations, Study Finds.** McKnight’s Long Term Care News reports that an evaluation of "seven Enhanced Care and Coordination Provider models tested as part of CMS’ Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents" found "reductions between 2.2 and 9.3 percentage points in the likelihood of an all-cause hospitalization among residents participating" in the models, as well as a "drop of 1.4 to 7.2 percentage points in probability of a potentially avoidable hospitalization." The study also found a decrease in per-resident Medicare costs "between $60 and
$2,248 for all-cause hospitalizations, and $98 to $577 for potentially avoidable hospitalizations." The findings were published in *Health Affairs*.

- **OIG Report Shows Medicaid Fraud Control Units Delivered $1.9 Billion In Recoveries Last Year.** *McKnight’s Long Term Care News* reports data released by the Office of Inspector General show "Medicaid Fraud Control Units delivered nearly $1.9 billion in recoveries in fiscal year 2016." The units conducted 18,730 investigations last year, "with the majority (15,509) focused on Medicaid fraud," and about 3,000 dealing with abuse or neglect. See also 5) above for the OIG Statistical Report.

- **Opioid Abuse Becoming An Increasing Problem Among Long Term Care Provider Employees.** *McKnight’s Long Term Care News* reports that "prescription drug abuse" among employees is becoming an increasing problem for long term care providers. A survey of "just over 500 human resources workers" by the National Safety Council found "more than 70 percent...felt the impact of opioid abuse in their workplaces," and 40 percent "had seen employees taking prescription pain medications at work." The NSC advises employers to recognize the problem, "put ‘strong’ policies in place, expand drug testing panels to include opioids, and train staff to spot signs of drug misuse."

- **Report: SNF Occupancy Rates Hit Lowest Level On Record.** *McKnight’s Long Term Care News* reports, "Skilled nursing occupancy rates hit their lowest level on record in the fourth quarter of 2016, according to the National Investment Center for Seniors Housing & Care’s Skilled Nursing Data Report. The report "shows the national occupancy rate fell from 82.6 percent to 81.8 percent."

- **MedPAC: Officials Could Have Saved Up To $11 Billion By Implementing MedPAC Post-Acute Payment Updates.** *McKnight’s Long Term Care News* reports, "Federal officials may have missed out on saving as much as $11 billion over the past seven years by not implementing the Medicare Payment Advisory Commission’s recommended post-acute payment updates, the group said on Wednesday." The numbers were outlined in the group’s most recent report to Congress.

### 25) Interesting Fact: 1 in 4 U.S. Adults Disabled by Arthritis.

Arthritis is expanding its grip on Americans, with 24 million adults limited in their everyday activities because of the debilitating joint disease, U.S. health officials say. Overall, 54 million adults -- or one in four -- report an arthritis diagnosis. And the number of people disabled by it has jumped 20 percent since 2002, the U.S. Centers for Disease Control and Prevention reported recently.

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If you have any questions or comments on any of the information contained in this publication, or to suggest content for future editions, please don’t hesitate to contact Bill Bell. If you’d like to be removed from this mailing list, simply reply to let us know. And as always, we welcome your feedback!

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