ROPs – Phase 2 – What is on the Horizon?

Most LTC providers are still wrestling with implementation of the Phase 1 requirements under the new CMS Requirements of Participation (ROPs). Many have not even had an annual survey yet under the new Phase 1 requirements. To make it even more challenging, CMS has yet to release any draft Interpretive Guidelines with respect to Phase 1. However, unless AHCA and other LTC provider associations/organizations are able to convince CMS to either eliminate some of the new requirements or at least gain an extended timeframe to implement, Phase 2 requirements will be effective on November 28, 2017.

What can we expect under Phase 2?

With the implementation of Phase 2, CMS has decided to totally reorganize the current F-tags, draft new Interpretive Guidelines and implement a new survey process. The current F-tags will be renumbered under a new coding system beginning with F-540+. New Interpretive Guidelines will be generated to include all of the new ROP requirements under Phases 1 and 2. A new survey process will be instated that incorporates the ‘best’ out of the traditional survey process (currently used in Illinois) and the Quality Indicator Survey (QIS) process (currently used in half of the states). This new survey process will be computer-based and will hopefully promote consistency throughout the US. CMS has yet to release any drafts of new F-tags, new Interpretive Guidelines or the new survey process. As soon as they become available we will be sure to get them out to our members along with any training materials that will be developed to help with implementation.

What are the new requirements under Phase 2?

Section 483.10 – Resident Rights

- 483.10(g) Information and communication (4)(ii) through (v) – Providing contact information for State and local advocacy organizations, Medicare and Medicaid eligibility information, Aging and Disability Resources Center and Medicaid Fraud Control Unit. The facility must furnish a written description of legal rights, including a list of and contact information for all pertinent State regulatory and informational agencies and advocacy groups.

Section 483.12 – Freedom From Abuse, Neglect and Exploitation

- 483.12(b)(5) Reporting of Crimes/1150B - CMS is requiring that facilities establish policies and procedures to ensure reporting of crimes in accordance with section 1150B of the Act. The policies and procedures have to include, at a minimum, annual notification of covered individuals, posting a conspicuous notice of employee rights, and prohibiting and preventing retaliation.
Section 483.15 – Admission, Transfer and Discharge Rights

- **483.15(c)(2) – Transfer/Discharge Documentation** - When the facility transfers or discharges a resident under any of the circumstances specified in the rule, the facility must ensure that the transfer or discharge is documented in the resident’s medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the resident’s medical record must include:
  - demographic information, including but not limited to name, sex, date of birth, race, ethnicity, and preferred language;
  - resident representative information including contact information;
  - advanced directive information;
  - history of present illness/reason for transfer, including primary care team contact information, past medical/surgical history, including procedures, active diagnoses/current problem list;
  - laboratory tests and the results of pertinent laboratory and other diagnostic testing;
  - functional status;
  - psychosocial assessment including cognitive status, social supports;
  - behavioral health issues;
  - medications, allergies including medication allergies, immunizations;
  - smoking status;
  - vital signs;
  - unique identifier(s) for a resident’s implantable device(s), if any;
  - comprehensive care plan including health concerns, assessment and plan, goals, resident preferences, other interventions, efforts to meet resident needs; and
  - resident status.

CMS did not prescribe a form for this information and did not establish a time frame for this communication, as this may vary based on circumstances surrounding the transfer; however CMS expects the communication to occur shortly before or as close as possible to the actual time of transfer.

Section 483.21 – Comprehensive Person-Centered Care Planning

- **483.21(a) – Baseline Care Plans** – Each LTC facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

CMS is requiring facilities to develop and implement a baseline care plan for each resident, within 48 hours of their admission, which includes the instructions needed to provide effective and person-centered care that meets professional standards of quality care. The information required to complete the baseline care plan includes: initial goals based on admission orders; physician orders; dietary orders; therapy services; social services; and PASARR recommendations as appropriate. This would be the type of information that would be necessary to provide appropriate immediate care for a resident. However, since care plans are developed specifically for each resident, a facility could decide to include additional information as appropriate.

The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-- (i) Is developed within 48 hours of the resident’s admission; (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident; (ii) A summary of the resident’s medications and dietary instructions; (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; (iv) Any updated information based on the details of the comprehensive care plan, as necessary.
Section 483.35 – Nursing Services

- **483.35 - Nurse Staffing** - Specific usage of the Facility Assessment at 483.70(e) in the determination of sufficient number and competencies for staff. Each LTC facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at 483.70(e).

Section 483.40 – Behavioral Health Services

- **483.40 – Behavioral Health Care** – New section mostly being implemented in Phase 2.
- CMS is adding a new section that focuses on the requirement to provide the necessary behavioral health care and services to residents, in accordance with their comprehensive assessment and plan of care.
- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident’s whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
- The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with §483.70(e).

Section 483.45 – Pharmacy Services

- **483.45(c)(2) – Medical Chart Review** - CMS is requiring that a pharmacist review a resident’s medical chart during each monthly drug regimen review.
- **483.45(e) – Psychotropic Drugs and PRN Orders** – Based on a comprehensive assessment of a resident, the facility must ensure:
  - Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;
  - residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
  - residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and
  - PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.
- PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

Section 483.55 – Dental Services

- **483.55(a)(3) and (a)(5) - Loss or Damage of Dentures and Policy for Referral**. We are prohibiting SNFs and NFs from charging a Medicare resident for the loss or damage of dentures determined in accordance with facility
policy to be the facility’s responsibility. CMS is requiring that the facility have a policy identifying those instances when the loss or damage of dentures is the facility’s responsibility.

- 483.55(b)(3) and (b)(4) – Referral for Dental Services Regarding Loss or Damaged Dentures. CMS is clarifying that with regard to a referral for lost or damaged dentures “promptly” means that the referral must be made within 3 business days unless there is documentation of extenuating circumstances. If the referral doesn’t happen within 3 business days, facilities must document what they did to ensure the resident could eat and drink adequately while awaiting dental services, as well as the extenuating services leading to the delay.

Section 438.60 – Food and Nutrition Services

- 483.60(a) – Staffing - The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at § 483.70(e).

Section 483.70 – Administration

- 483.70(e) – Facility Assessment - CMS is requiring facilities to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Facilities are required to address in the facility assessment the facility’s resident population (that is, number of residents, overall types of care and staff competencies required by the residents, and cultural aspects), resources (for example, equipment, and overall personnel), and a facility-based and community-based risk assessment.

Section 483.75 – Quality Assurance and Performance Improvement (QAPI)

- 483.75(a)(2) – QAPI Plan - Each facility must present its QAPI plan to the IDPH surveyors at the time of an inspection on or after November 28, 2017. Documentation and demonstrative evidence of the facility’s ongoing QAPI program will be required on or after November 28, 2019.

Section 483.80 – Infection Control

- 483.80(a) – Facility Assessment - The Infection Prevention and Control Program (IPCP) must follow accepted national standards, be based upon the facility assessment conducted according to §483.70(e) and include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement.

- 483.80(a)(3) – Antibiotic Stewardship – An antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use.

We expect that the new Interpretive Guidelines to fill in a lot of the holes/gaps to better explain the requirements and how they will be interpreted by state and federal surveyors. As soon as information is made available, you’ll be the first to hear and receive.

Emergency Preparedness – Training and Testing Program

The Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule became effective on November 15, 2016 with an implementation date of November 15, 2017. This means that as of November 15, 2017, all LTC providers must meet all of the applicable requirements of the rule. For additional background information, LTC providers may reference policy memorandum SC-17-05 Information on the Implementation Plans for the Emergency Preparedness Regulation published, on October 28, 2016.
Many LTC providers have asked whether they will be expected to have completed the two required “exercises” per the training and testing requirements in each standard (d) of the Final Rule (click here to view), by the implementation date. Because the Final Rule has an implementation date of November 15, 2017, one year following the effective date, providers and suppliers are expected to meet the requirements of the training and testing program by the implementation date.

This means that all LTC facilities are expected to have completed the following staff training requirements by 11/15/2017:

- Initial training with the facility specific emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
- Provide the emergency preparedness training at least annually.
- Maintain documentation of the training.
- Demonstrate staff knowledge of emergency procedures.

The Emergency Preparedness requirements require that LTC facilities complete TWO training exercises BEFORE 11/15/2017:

- LTC facilities are urged to participate in a full-scale exercise that is community-based with their local and/or state emergency agencies and other health care coalitions. If this type of exercise is not accessible/available, the LTC facility must complete an individual facility-based exercise and document the circumstances as to why a full-scale community-based exercise was not completed. The documentation should include what emergency agencies and/or other health care coalitions the LTC facility contacted to partner with in a full-scale community exercise and the specific reason(s) why a full-scale exercise was not possible.
- Also, each LTC facility is required to complete a second exercise that is either:
  - A second full-scale exercise this is individual, facility based; or
  - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge the facility’s emergency plan.

In order to meet these requirements, we strongly encourage our LTC facility provider members to seek out and participate in a full-scale, community-based exercise with their local and/or state emergency agencies and health care coalitions and to have completed a tabletop exercise by the implementation date. We realize that some providers are waiting for the release of the interpretive guidance to begin planning these exercises, but that is not necessary nor is it advised. LTC providers that are found to have not completed these exercises, or any other requirements of the Final Rule upon their survey, will be cited for non-compliance.

Training and Testing Program Definitions

- **Facility-Based:** When discussing the terms “all-hazards approach” and facility-based risk assessments, we consider the term “facility-based” to mean that the emergency preparedness program is specific to the facility. Facility-based includes, but is not limited to, hazards specific to a facility based on the geographic location; Patient/Resident/Client population; facility type and potential surrounding community assets (i.e. rural area versus a large metropolitan area).

- **Full-Scale Exercise:** A full scale exercise is a multi-agency, multi-jurisdictional, multi-discipline exercise involving functional (for example, joint field office, emergency operation centers, etc.) and/or “boots on the ground” response (for example, firefighters decontaminating mock victims).
**Table-top Exercise (TTX):** A table-top exercise is a group discussion led by a facilitator, using narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It involves key personnel discussing simulated scenarios, including computer-simulated exercises, in an informal setting. TTXs can be used to assess plans, policies, and procedures. The training and exercise requirements of the regulation call for individual-facility and/or full-scale community-based exercises, the below are some examples of exercise considerations:

- Earthquakes
- Tornados
- Hurricanes
- Flooding
- Fires
- Cyber Security Attack
- Single-Facility Disaster (power-outage)
- Medical Surge (i.e. community disaster leading to influx of patients)
- Infectious Disease Outbreak
- Active Shooter

While the scenarios are important, the most important thing to consider when developing an exercise is what part of the plan or participant skill is to be tested and evaluated. Identifying those objectives first will make the exercise more successful and beneficial to participants. The scenario that drives to those objectives can be determined later in development.

If the facility experienced an emergency and had to activate its emergency plan between November 15, 2016 and November 15, 2017, that would satisfy one of the annual testing requirements and would exempt the facility from engaging in a community or facility based exercise for one year following the date of the actual emergency event. The “annual” testing requirement will not be measured on a calendar year basis which is January 1 through December 31. The annual requirement will be measured from the date of the last actual emergency event or the date the exercise/testing took place.

**Resources**
To assist providers and suppliers in meeting the requirements of the new Final Rule, CMS has developed a website that contains various resources such as checklists, links to emergency preparedness agencies, planning templates and many other valuable resources. The information can be found at our website at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html). For questions regarding the EP Rule, please contact SCGEmergencyPrep@cms.hhs.gov. AHCA also has several resources available on the AHCA website ([https://www.ahcancal.org/Pages/Default.aspx](https://www.ahcancal.org/Pages/Default.aspx)) under ahcancalED.

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**Trending Statistics**

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

**Opioid Use Soars Among Middle Aged and Elderly**
The epidemic of opioid abuse sweeping the U.S. might seem like a distant phenomenon to the average middle-aged patient who is getting a joint replacement, visiting an emergency room or seeking help with persistent pain from a primary-care physician.
But according to the Centers for Disease Control and Prevention, Americans age 45 to 64 accounted for about 44% of deaths from overdoses in 2013 and 2014. And the proportion of adults 50 and older seeking treatment for opioid addiction has increased dramatically in recent decades.

While many deaths and overdoses are linked to illicit street drugs, the CDC reported in December that there is a continuing problem with prescription opioids, a class of narcotic painkillers that can be highly addictive and deadly when misused. Experts say many doctors are uninformed about the risks of opioids and are insufficiently trained in how to prescribe them.

Hair trigger

“Even one prescription can be a trigger for long-term use,” says Michael Barnett, assistant professor of health policy and management at the Harvard T.H. Chan School of Public Health. “We have to figure out how to encourage safe prescribing without undertreating pain.”

Last year, the CDC issued new guidelines for primary-care providers, who write 50% of the prescriptions for opioids. The new regimen discourages use of opioids for chronic pain—defined as lasting more than three months—other than for cancer patients and those at the end of life. For acute pain, following surgery or injury, CDC says, “start low and go slow,” urging doctors to prescribe the lowest effective dose in no greater quantity than needed for the duration of pain severe enough to require a narcotic.

If an opioid is prescribed, CDC recommends faster-acting medication with a short duration of pain relief, rather than slower-acting, extended-release drugs with a longer duration.

The CDC released data last month showing that those who started out on long-acting drugs had the highest probabilities of long-term use. An unexpected finding was that the short-acting drug tramaadol, considered less of a risk for abuse than other opioids, had the next-highest probability of long-term use. And 1 in 7 people who got any refill or second opioid prescription authorized were on the drugs a year later.

It can be a challenge to get doctors to change prescribing habits, as most were trained to treat pain aggressively. “The traditional approach was to give a prescription for 30 or even 90 days, but this has turned into a tremendous problem,” says Howard Marcus, an internal-medicine physician in Austin, Texas, and chairman of the Texas Physician Advisory Board for malpractice insurers the Doctors Co.

The insurer recently examined trends from 272 malpractice claims closed between 2007 and 2015 in which opioids resulted in patient harm, including errors in patient monitoring, insufficient warnings to patients about the risk of narcotic painkillers, and failing to assess patients for psychiatric issues or a history of drug abuse. Doctors also sometimes failed to communicate with one another about drugs prescribed to a patient and didn’t check to see whether patients were taking other drugs that could interact dangerously with opioids such as antianxiety medication or prescription sleep aids.

The Doctors Co. is now offering a course to help physicians apply the new CDC guidelines in their practice and help patients manage pain safely with other approaches including the over-the-counter painkiller Tylenol and physical therapy. “I have found patients are actually really happy to know they can take something else,” Dr. Marcus says.

Dr. Marcus advises patients to strictly follow instructions on opioid labels, never take an extra dose, avoid alcohol and inform the doctor of all medications they are taking. Patients should consider alternatives to opioids whenever possible,
he suggests, such as controlling daytime pain after surgery with a non-opioid medication and using an opioid only at bedtime.

Harvard’s Dr. Barnett, who is also a hospitalist at Brigham and Women’s Hospital in Boston, says older patients “have the most to lose from getting the wrong opioid prescription or dose.” They are especially vulnerable to falls, fractures and respiratory arrest when using prescription narcotics—and often they are taking other medications that magnify the risks.

Rating prescribers
A study of a large sample of Medicare patients, co-written by Dr. Barnett, and published in February in the New England Journal of Medicine, found wide variations in the rates of opioid prescribing among doctors practicing in the same emergency department. Medicare patients who had not previously had the drugs and were treated by one of the “high-intensity” prescribers had higher rates of long-term use of opioids, likely because outpatient doctors continued providing previous prescriptions. The study suggests that for every 48 patients prescribed a new opioid in the ER who might not otherwise use the drugs, one will become a long-term user.

Patients should speak up about any concerns with an opioid prescription, even in an emergency setting, says Dr. Barnett. “It is OK to say, ‘I’ve heard these drugs have a lot of side effects, can I get something else or a lower dose?’”

A study of which medical specialists are prescribing medications to patients who die of prescription-drug abuse in San Diego County, published in the American Journal of Emergency Medicine in 2015, found that some doctors tended to prescribe more pills per bottle. Emergency-room doctors wrote about 5% of all prescriptions, giving patients an average of 23 pills per bottle. By contrast, surgeons wrote 7% of prescriptions for opioids, but gave an average of 123 pills per bottle.

Opioids are risky even if taken exactly as prescribed, Dr. Lev says. Of the 254 people whose records were used in the study, the majority were not following directions, and mixed with drugs, alcohol, or additional medications, but 16.5% died using the medication in the prescribed doses and intervals and weren’t combining their medication with other drugs or alcohol.

Emergency departments in San Diego and Imperial counties are participating in a safe-prescribing project led by Dr. Lev, with posters in emergency rooms warning that doctors there will only prescribe lesser amounts of medication and don’t prescribe long-acting pain medicines.

“Patients in pain can and should be able to obtain relief, and this often requires an opioid,” Dr. Lev says. “But when they are misused, unintentionally or otherwise, they can be a prescription for death.”

**Article authored by Laura Landro in the Wall Street Journal.**

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**Important Regulations, Notices & News Items of Interest**

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

- **S&C 17-26 – NH** - Notice of Proposed Regulation Changes to Requirements Related to Survey Team Composition and Investigation of Complaints. Notice of Proposed Rule Making (NPRM): CMS published a proposed regulation Medicare Program; FY 2018 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule, which displayed on the Federal Register on April 27, 2017. CMS proposed four changes to the Survey Team Composition within the NPRM, which include revision of the definitions of “complaint survey” and “abbreviated standard survey,” relocation of requirements related to complaint surveys, and revision of

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

- **CMS released an Informational Bulletin extending the timeline for compliance with the home and community-based settings (HCBS) rule.** CMS indicates that states should continue progress with their statewide transition plan to be approved by March 17, 2019, but the agency is extending the transition period for states to demonstrate compliance with the settings criteria by 3 years to March 17, 2022.

- The latest edition of the **CMS Midwest Division Provider Update** can be found here. The update discusses the Elder Justice Act Posting Requirements, recent Federal Register announcements, recently released S&C Letters, Fire Watch Policies, an ASPR TRQACIE Webinar and an FDA Recall.

- **Hospice Item Set V2.00.0 Receives OMB Approval.** The Office of Management and Budget (OMB) approved the Hospice Item Set (HIS) V2.00.0, effective April 1, 2017. The HIS Manual V2.00 and the HIS V2.00.0 forms are now final and posted in the downloads section of the HIS webpage. No changes were made to the HIS or the HIS Manual as part of OMB approval.

- **New PEPPERs Available for Hospices, SNFs, IRFs, IPFs, CAHs, LTCHs.** Fourth quarter FY 2016 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for hospices, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), Inpatient Psychiatric Facilities (IPFs), Critical Access Hospitals (CAHs) and Long-Term Care Hospitals (LTCHs). PEPPERs are distributed by TMF Health Quality Institute under contract with CMS. These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities.
  - Hospices, LTCHs and free-standing SNFs and IRFs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide
  - CAHs, IPFs, and SNF and IRF units of hospitals: PEPPER was distributed via the QualityNet secure portal

For more information, including guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other hospitals are using PEPPER, visit PEPPERresources.org. If you have questions or need help obtaining your report, visit the Help Desk. Send us your feedback or suggestions.

- **Requesting Appeal Redeterminations.** You now have the option to submit requests for appeal redeterminations with electronic, digital and/or digitized signatures by mail or fax. You may also continue to submit via a CMS-approved secure Internet portal/application.

- **CMS Provider Minute Video: Coudé Tip Catheters.** Avoid delays. Bill it right the first time. The CMS Provider Minute: Coudé Tip Catheters video includes pointers on how to provide the correct documentation when submitting claims for this item. Learn about:
  - Importance of documenting medical necessity
  - Requirement of providing the KX modifier

This video is part of a series to help providers of all types improve in areas identified with a high degree of noncompliance.

- **Emergency Preparedness Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the April 27 call on Emergency Preparedness Requirements Final Rule Training. During this call, learn about implementation of the final rule, including an overview of the regulation and training and testing requirements.
• **Resources for Medicare Beneficiaries Booklet — Revised.** A revised [Resources for Medicare Beneficiaries Booklet](#) is available. Learn about:
  - Medicare, Medicare supplements and other insurance
  - Medical expenses and basic needs
  - Long-term care
  - Informed decisions; rights and protections; notices; and forms
  - Fraud, waste, and abuse
  - Caregiving

• **SNF Billing Reference Booklet — Revised.** A revised [SNF Billing Reference Booklet](#) is available. Learn about:
  - Medicare-covered Skilled Nursing Facility (SNF) stays
  - SNF payment and billing requirements

• **Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised.** A revised [Dual Eligible Beneficiaries under Medicare and Medicaid Booklet](#) is available. Learn about:
  - Medicare and Medicaid Programs
  - Dual eligible beneficiaries
  - Prohibited billing of Qualified Medicare Beneficiaries and Medicare assignment

• **Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Revised.** With Continuing Education Credit - A revised Medicare Fraud & Abuse: Prevention, Detection and Reporting Web-Based Training (WBT) course is available through the [MLN LMS](#). Learn about:
  - Fraud and abuse in health care
  - Laws governing fraud and abuse activities
  - Government partnerships fighting fraud and abuse
  - Where to report suspected fraud and abuse

• **Looking for the Latest National Medicare Policy Information?** Visit the [MLN Matters® Articles webpage](#). Learn about coverage, billing, and payment rules for specific provider types.

3) The federal Agency for Healthcare Research and Quality (AHRQ) reports on [New Persistent Opioid Use After Minor and Major Surgical Procedures in U.S. Adults](#). Opioid medication use represents a significant safety problem in the United States. Overprescribing by providers is one factor contributing to the widespread use of opioids. Reducing inappropriate prescribing may help improve patient safety. Using claims data for 36,177 patients, investigators sought to better characterize new and persistent opioid use after surgery, defined as filling an opioid prescription between 90 and 180 days postoperatively. Although there was no major difference in persistent opioid use between those who underwent minor surgical procedures and those who underwent major surgical procedures, results demonstrated that opioid use persisted in greater frequency after surgery among patients with behavioral, pain and substance use disorders. A recent [PSNet perspective](#) discussed patient safety with regard to opioid medications.

4) The U.S. Government Accountability Office (GAO) recently published a report entitled, [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. [We recommended](#) that the Department of Health and Human Services comprehensively plan its efforts to increase the electronic exchange of health information in these settings, and evaluate these efforts.

5) The Occupational Safety and Health Administration (OSHA) reports [Clarification of Employer's Continuing Obligation to Make and Maintain an Accurate Record of Each Recordable Injury and Illness](#). Under the Congressional Review Act, Congress has passed, and the President has signed, Public Law 115-21, a resolution of disapproval of OSHA's final rule titled, "Clarification of Employer's Continuing Obligation to Make and Maintain an Accurate Record of each Recordable
Injury and Illness." OSHA published the rule, which contained various amendments to OSHA's recordkeeping regulations, on December 19, 2016. The amendments became effective on January 18, 2017. Because Public Law 115-21 invalidates the amendments to OSHA's recordkeeping regulations contained in the rule promulgated on December 19, 2016, OSHA is hereby removing those amendments from the Code of Federal Regulations.

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

- HFS posted a new provider notice regarding an Extension in Due Date for Payment of the Monthly Occupied Bed Provider Assessment. You may view the notice here.
- HFS posted a new provider notice regarding Department of Human Services Medical Field Operations Changes. You may view the notice here.

7) The Illinois Department of Public Health (IDPH) released the 2017 IDPH Town Hall Meeting schedule. Letters will be sent to the individual facilities in the regions prior to each meeting. Instructions for responding (will be included in the letter) or you can RSVP (at least three days before the scheduled meeting) to Lisa Reynolds via email at: lisa.reynolds@illinois.gov. Please include the date and location of the meeting in the Subject Line.
- May 23, 10 AM-Noon | Norridge Healthcare & Rehab Center | 7001 West Collum, Norridge IL, 60706
- June 13, 1-3 PM | Marion Regional Office | 2309 W. Main St., Marion, IL 62959
- July 13, 1-3 PM | CCNH/Brookens Building-Champaign | 500 South Art Bartell Drive, Urbana, IL 61802
- August 30, 1-3 PM | Willows Health Center | 4054 Albright Lane, Rockford IL 61103
- September 19 or September 21 (PENDING) | Friendship Village | 350 W. Schaumburg Road, Schaumburg, IL 60194
- September 28, 1-3 PM | Washington County Hospital | 705 South Grand Ave, Nashville, IL
- October 24, 1-3 PM | Knox County Nursing Home
- November 30, 1-3 PM | Dupage Convalescent Center | 400 North County Road, Wheaton IL 60817

8) The American Health Care Association (AHCA) recently reported:

- Emergency Preparedness Final Rule AHCA Webinar Series. Due to CMS scheduling an emergency preparedness training call on April 27 at the same time as our EP webinar, we will need to reschedule the second AHCA webinar to May 17 at 2:30 p.m. EST. Members that have already registered will not need to register again. The product will update to the new date and time. An email update has been sent to all members that are currently registered. Members are encouraged to register for the April CMS call, for more information please visit: www.cms.gov/Outreach-and-Education/Outreach/NPC/...
- Repeal and Replace Bill Passes in the House. An amended version of the bill passed the House 217-213. While the legislation has been modified from when it was initially introduced on March 6, there are no material changes in regards to how it will affect AHCA/NCAL constituencies. The substantial reforms to Medicaid funding still exist in the bill and will seriously affect AHCA/NCAL membership if it becomes law. The bill will now go to the Senate, where a final vote could be made on the current legislation, or the bill will be sent back to the House floor for additional changes. This memo will reiterate components of the bill relevant to our members, summarize our concerns, and discuss how you can help ensure our success.
- Help Your Staff to Give Even Better Dementia Care. The affordable CARES Dementia Specialist curriculum consists of 32 hours of online video-based person-centered dementia care education. Once activated, staff members will have 10-day access to each of the five professional caregiver courses and 30-day access to the CARES Dementia Care for Families program. Those who earn this credential will be placed on an international registry. In addition, each will receive an official recognition package that includes a lapel pin, a CARES card and a frameable certificate. Take advantage of this terrific bargain today, and remember to use discount code AHCA10 to receive 10% off the $199.95 program price.
9) The Illinois Health Care Association (IHCA) is offering a MDS Basics & Advanced Training program on May 23 and 24, 2017 in Springfield. The brochure and registration information can be found here.

10) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

11) The BBC News reports on a NI-Designed Dementia Tool Aims to Deepen Understanding. A new assessment tool has been developed to help evaluate people diagnosed with dementia. The model, called Look At All of Me, has been designed by Frances Duffy, a clinical psychologist in the Northern Health Trust. It aims to equip care home staff with information so they can understand and assess behaviour, particularly when it is most challenging. Dr Duffy said the new model can meet a patient's specific needs. "What is so important is that we remember that the patient is still a person and we look at the person's entire behaviour and not just as someone who has been labelled with dementia," she said.

12) The Neurology Advisor reports that Benzodiazepine Use in Alzheimer’s: Weighing the Risks and Benefits. An observational study published in the Canadian Medical Association Journal showed that patients with Alzheimer’s disease who were receiving benzodiazepines had a risk for pneumonia 30 percent greater than that of matched control patients. Patients were at highest risk within the first 30 days of benzodiazepine initiation.

13) ProPublica reports Nursing Homes Toss 740 Tons of Unused Drugs. Every year nursing homes nationwide flush, burn or throw out tons of valuable prescription drugs. If you want to know why the nation’s health care costs are among the highest in the world, a good place to start is with what we throw away. Across the country, nursing homes routinely toss large quantities of perfectly good prescription medication: tablets for diabetes, syringes of blood thinners, pricey pills for psychosis and seizures. "It would not surprise me if as much as 20 percent of the medications we receive we end up having to destroy," said Mark Coggins, who oversees the pharmacy services for Diversicare, a chain of more than 70 nursing homes in 10 states. “It’s very discouraging throwing away all those drugs when you know it can benefit somebody.”

14) MedlinePlus reports Nearly a Third of Drugs Hit by Safety Issues After FDA Approval. Safety problems emerge with nearly one in three prescription drugs after they’ve been approved by the U.S. Food and Drug Administration, a new study reveals. Researchers examined data on drugs approved by the FDA between 2001 and 2010, with follow-up through 2017. The investigators found that 32 percent of the drugs had safety issues after approval. "That is very rarely a drug withdrawal, but more commonly a black-box warning or drug safety communication issued by the FDA to let physicians and patients know that new safety information has been determined," said study leader Dr. Joseph Ross. He is an associate professor of medicine and public health at Yale University. Of 222 drugs approved by the agency during the study period, three were withdrawn, 61 received boxed warnings and 59 prompted safety communications, the findings showed. Drugs most likely to have post-approval safety concerns included biologics, psychiatric drugs and medicines approved through the FDA's accelerated approval process.

15) MedicalXpress reports that Personalized Music May Help Nursing Home Residents With Dementia. A new study suggests that personalized music has important psychiatric benefits for people with dementia living in nursing homes. Across the country, nursing home employees and families are trying personalized music playlists to help seniors cope with the disorienting, anxious experience of living with Alzheimer's disease and related dementias. Now they can look to the results of the first national study to compare key outcomes in homes that implemented an individualized music program called MUSIC & MEMORY with similar homes that did not adopt the program. The Brown University evaluation found that after homes adopted the program, residents with dementia became significantly more likely to discontinue antipsychotic and antianxiety medications and significantly less likely to engage in disruptive behaviors, compared to those residing in homes used for comparison. But the study of more than 25,000 residents in 196 nursing homes did not identify a significant improvement in mood.

16) CNN reports Common Painkillers Linked to Increased Risk of Health Attack. Taking even over-the-counter doses of common painkillers known as NSAIDs -- nonsteroidal anti-inflammatory drugs -- has been linked to an increased risk of heart attack in a new study. The likelihood of experiencing a heart attack was calculated to increase by an average of 20 percent to 50 percent, compared with someone not taking the drugs, regardless of the dosage and amount of time the medications are taken.
17) **Healio** reports on an [APA, AAN Update Dementia Management Guidance](https://www.healio.com). The American Psychiatric Association and American Academy of Neurology recently released an updated dementia management quality measurement set, which included three new measures, removed measures and modified measures. “The consequential nature of dementia cannot be underestimated. Although not often conceptualized as such, dementia is a terminal disorder. According to the 2015 annual statistics available from the Alzheimer’s Association, one in nine Americans aged 65 and older has Alzheimer’s disease and one in three older adults who dies in a given year has been diagnosed with Alzheimer’s disease or another dementing disorder,” Amy E. Sanders, MD, MS, of SUNY Upstate Medical University, Syracuse, and colleagues wrote. “It is estimated that 14.7% of people older than 70 in the United States have dementia. Alzheimer’s disease is listed officially as the sixth leading cause of death in the United States.” Further, dementia costs in the U.S. range from $159 billion to $215 billion annually, making it more expensive than heart disease or cancer, according to researchers.

18) **NPR** reports that the US Spends More Money Treating Elderly, Poor Countries Spend More Treating Children. NPR reports in its “Goats and Soda” section that the US spends more money treating the elderly than the young, evidenced by CMS data showing that in 2010, “each person 65 and older received $18,424 in health care services...five times more than the $3,628 in spending per child under 18, and three times more than the $6,125 per working-age adult." In contrast, research appearing in the journal Health Affairs Centers analyzing "the $36.4 billion spent on health assistance from development agencies and nonprofit donors to low- and middle-income countries" found that 90 percent "is spent on people under the age of 60," mostly to children. The report is said to have fueled the debate about age discrimination and the best allocation of resources in health care.

19) **Medical Daily** reports that Certain Medications Prescribed For PTSD May Risk for Dementia Later in Life. Medical Daily reports that certain medications prescribed for post-traumatic stress disorder (PTSD) "may raise the risk for dementia later in life," research suggests. The study of some "3,139,780 veterans aged 56 and older" revealed "evidence to suggest that certain medications used to treat PTSD, such as antidepressants, tranquilizers, sedatives, or antipsychotic medications significantly increased an individual’s risk for developing dementia, compared to the risks for individuals who didn’t take these medications." The findings were published online March 17 in the Journal of the American Geriatrics Society.

20) The **New York Times** reports that Unmarried Senior Cohabitation Increased 75 Percent Over the Last Decade. The New York Times reports that “the number of people over 50 who cohabit with an unmarried partner" increased by 75 percent to 4 million between 2007 and 2016, according to a study by the Pew Research Center published in April. The increase coincides with a doubling in the over-50 divorce rate since the 1990s, as baby boomers enter their senior years. The article goes on the detail the economic, social, and health benefits of such an arrangement.

21) **Medscape** reports that Later-Career Physicians More Likely to Overprescribe Antibiotics to Elderly Patients. Medscape reports that according to a study published online in the Annals of Internal Medicine, 46.2 percent "of elderly patients with nonbacterial acute upper respiratory infections (AURIs) received an antibiotic prescription," and "later-career physicians and those from high-volume practices were more inclined to prescribe them." Additionally, antibiotic prescribing rates were lower among those "physicians with a hospital affiliation, as well as those who had received their medical training in Canada or the United States compared with those physicians who had trained abroad."

22) **MedPage Today** reports that Older individuals Who Do Not Achieve Blood Pressure Control May Face Increased Risk of Developing Dementia, Alzheimer’s Disease. According to MedPage Today, research indicated "older individuals who failed to achieve blood pressure control seemed to be at an increased risk of developing dementia and/or Alzheimer’s disease." Investigators found that "the mid-to-late life trajectory risk of developing dementia was nearly twice as great among individuals who had persistently elevated blood pressure (BP) after age 55 and those people whose blood pressure was less than 140 mm Hg systolic and 90 mm Hg diastolic." The findings were presented at the American Academy of Neurology annual meeting.

23) **Kaiser Health News** reports that Home Health Worker Shortage Robs Thousands of Proper Care. Kaiser Health News' Judith Graham considered how "acute shortages of home health aides and nursing assistants are cropping up across the country," impacting "care for people with serious disabilities and vulnerable older adults." Graham quoted Dr.
David Gifford, senior vice president of quality and regulatory affairs for the American Health Care Association, as saying, "If we don’t turn this around, things are only going to get worse."

24) **USA Today** reports that Half of Americans Age 62 and Older Experience Some Degree of Loneliness. In a piece focused on loneliness, **USA Today** reported that nearly "half of Americans age 62 and up experience some degree of loneliness, according to a new AARP Foundation survey," while "two in 10 say their loneliness is frequent." Just "last week, the U.S. Senate Special Committee on Aging held a hearing on the effect of isolation and loneliness." At that hearing, Sen. Susan Collins, R-ME, "said, 'The consequences of isolation and loneliness are severe – negative health outcomes, higher health care costs and even death.'"

25) **HealthDay** reports:

- **Seniors Need Help in Managing Drugs.** **HealthDay** reports on a Dutch study, published in the *Journal of the American Geriatrics Society*, which suggests that more than a third of seniors aged 85 and older need help in managing their medications. Among seniors aged 65-69 the percentage is still approximately 10 percent.

- **Quality of an Older Person’s Relationships With Adult Children May be Linked to Dementia Risk.** **HealthDay** reports that "the quality of" an older person’s "relationships with" his or her "adult children and spouse" may be linked to dementia risk. Investigators looked at data on approximately 10,000 men and women who were at least 50 years old. The investigators "observed that those who had received positive support from their adult children faced a reduced risk of dementia." However, "for every one-point increase in an individual’s overall negative social support ‘score’ – the risk for dementia went up by 31 percent...said" study author Mizanur Khondoker. The findings were published in the *Journal of Alzheimer’s Disease*.

26) **Provider Magazine** reports:

- **Resident Assessment Instrument Section GG Compliance Explained.** Vice president of curriculum development for the American Association of Nurse Assessment Coordination Judi Kulus writes in **Provider Magazine** that noncompliance with section GG of the Resident Assessment Instrument (RAI) User’s Manual could reduce a skilled nursing facility’s Medicare Part A payment rates significantly, and provides advice to providers on how to avoid problems. She explains, "state surveyors may check section GG accuracy," which clinicians often do not prioritize, and details when section GG is required. She adds that discharge goals should be "clinically appropriate and based on the individual resident’s baseline and desired outcomes," because "penalties are assessed only when the admission or discharge performance items are dashed or if all of the discharge goals are dashed."

- **Whitehurst: Advice for Minimizing Litigation Risks in Skilled Nursing Care.** In a piece for **Provider Magazine**, Kevin Whitehurst, senior vice president of skilled nursing solutions for MatrixCare, offers advice for skilled nursing care providers about how to minimize the risk of litigation and to prioritize risk management in order "to avoid lawsuits related to injuries, accidents, or fatalities that could otherwise be prevented." Whitehurst emphasizes the importance of automating workflow, and outlines "three critical activities to support the development of" such: (1) defining accountable clinical processes, (2) taking advantage of training opportunities, and (3) accessing and understanding data. According to Whitehurst, minimizing the risk of "litigation in skilled nursing centers requires a focus on well-defined processes and effective technology," and "combining the two takes collaboration and engagement of facility staff."

- **Long Term Care Employee Shortage Continues, Expected to Grow.** **Provider Magazine** reports on the growing shortage of long term and post-acute caregivers. Patti Cullen, president of Care Providers of Minnesota, explains that the shortage is due in part to a recovering economy, putting providers "in competition wage-wise and benefit-wise with every other entry-level employer for starting-level positions," as well as other health care providers. What’s more, experts say "shortages will become even greater over the next several decades," as the "population of people 65 and older from 48 million now to 88 million in 2050." The piece goes on to detail recruitment and retention efforts, including partnerships with schools and reaching out to people "unfamiliar
with the field.” However, industry experts say that legislative action will be needed to “bring stability to the workforce rather than continuing to pay for this revolving door and this high turnover,” and suggest that increasing the minimum wage or increasing provider reimbursement rates may be a possible solution.

27) McKnight’s reports:

- **Review Suggests “Comprehensive” Intervention Program is Most Effective at Reducing Nursing Home UTI Rates.** *McKnight’s Long Term Care News* reports that a review by University of Michigan researchers suggests that “a ‘bundled’ intervention approach has shown success in combating urinary tract infections in nursing homes.” In fact, researchers found that only a "comprehensive program" that included microbial use, hand hygiene and precautionary steps for residents with catheters resulted in a "significant reduction of catheter-associated UTIs." The findings were published in the *Journal of Hospital Medicine*.

- **Missing PBJ Deadlines Will Lead to “Suppressed” Star Ratings, CMS Officials Warn.** *McKnight’s Long Term Care News* reports, "Skilled nursing providers who miss two Payroll Based Journaling deadlines in a row will face ‘suppressed’ Five Star ratings, Centers for Medicare & Medicaid Services officials said Thursday" at the SNF Open Door Forum, "less than two weeks before the May 15 submission deadline for data from the second fiscal quarter." Those officials urged "providers to submit staffing data throughout the quarter, not wait until the last minute before a deadline," reminding them that "PBJ data must be submitted successfully in order to be considered on time."

- **Medicare Advantage Beneficiaries Less Likely to Use Post-Acute Care Than Traditional Patients, Analysis Finds.** *McKnight’s Long Term Care News* reports, "More Medicare Advantage beneficiaries are being discharged from the hospital directly to their homes...than traditional fee-for-service patients, according to a new analysis from Avalere." According to *McKnight’s*, "the study found 77 percent of Medicare Advantage patients are sent home directly from the hospital, without home health care services or other forms of post-acute care," as "compared to 63 percent of traditional Medicare beneficiaries." Fred Bentley, vice president at Avalere, said, "Our research demonstrates that MA plans are using post-acute care differently. MA plans are incented to actively manage patients, and they may keep patients in hospital settings longer to facilitate less intensive care for a patient following a hospitalization when appropriate."

- **Expert Warns That CMS Opioid Strategy Could Block Best Treatment Options for Palliative Care Patients.** *McKnight’s Long Term Care News* reports that according to Academy of Integrative Pain Management executive director Bob Twillman, the Centers for Medicare & Medicaid Services’ plan to combat opioid addiction released in January could harm patients who require the drugs for end-of-life care. He explained that some patients "need opioids to achieve the best possible outcomes," and warned that the new plan could prevent some patients from getting "the therapy they need." He added, "CMS could help us tremendously by increasing coverage for non-pharmacological treatments under Medicare and Medicaid."

- **Group Advocates for Non-Criminal Treatment of Nurse Substance Abuse.** *McKnight’s Long Term Care News* reports a new policy statement from the International Nurses Society on Addictions suggests an "alternative-to-discipline" approach to treat nursing staff with substance abuse disorders. Programs "should focus on the goals of rehabilitation, retention and re-entry into ‘safe, professional practice,’ instead of” criminal punishments, the group said, adding that treating substance abuse as a "a chronic medical illness...can result in lasting benefits."

28) **Interesting Fact:** A recent study reported that 60 percent of seniors talked on the phone while driving, researchers found in a "survey of almost 400 adults, aged 65 and older." What’s more, "27 percent of respondents drove with children younger than age 11" in the car, and 42 percent of those talked on the phone while driving. Dr. Linda Hill explained that "older adults are driving distracted less than their younger counterparts, but are still engaging in this dangerous behavior," and noted concerns that "adding distraction to the reduced skills of some older adults will increase these crash rates even further."
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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