October 31, 2017 Edition

Feature Focus

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

IDPH Bureau of Long Term Care Quarterly LTC Provider Association Meeting

On Wednesday, October 11, 2017, the IDPH Bureau of Long Term Care held their Quarterly LTC Provider Association meeting. A summary of the issues discussed is as follows:

1) Updated status of:

- Subpart S Rulemaking – Still under internal discussion within IDPH – no timetable for publication as proposed rulemaking.
- Distressed Facility Rulemaking – This item will be on the next Long Term Care Advisory Board Meeting (November 16, 2017) agenda for discussion.
- Informed Consent Rulemaking – Still under internal discussion within IDPH – workgroup being formed within the LTC Advisory Board to develop draft rules and forms.
- Behavioral Health Unit Rulemaking – IDPH wants to develop a workgroup to develop this issue – possibly just incorporate new federal CMS rules/guidelines into IDPH rules.
- Electronic POCs – LSC using now? – IDPH will pursue this if we can get a facility specific email address for each facility that will not change.
- PA 99-822 New Dementia Requirements – Effective 9-1-17 – This legislation passed with a time frame allowed for IDPH development of regulations to implement. However, IDPH has not promulgated rulemaking on this. IDPH stated they are working on this but it is still under development. This is problematic since there are no rules to implement an active statute. Concerns will have to be handled on a case-by-case basis until the rules are finalized.

2) Any progress of information regarding rulemaking or guidance with regard to electronic monitoring devices and medical marijuana? There is currently no rulemaking by IDPH for either of these two statutes. IHCA and others believe that rulemaking is necessary to fully implement and provide guidance for both of these programs with respect to LTC facilities. We will continue to press for this. Any issues that come up with regard to either of these two programs will have to be handled on a case-by-case basis. Contact IHCA if you have any problems or questions in these two areas.

3) IDPH Legal review of Section 483.12a)3) of the new federal ROPs? Rule seems to prohibit waivers? Status report? This is still in IDPH Legal review and they have not issued any guidance on this issue at the present time.

4) Based on your earlier note that someone from the Identified Offender Program was going to be available at this meeting, here are our outstanding issues:
• Status of Revised/Draft Guidelines? The new IDPH Identified Offender Program Guidelines are still in review within IDPH. They hope to have the new guidelines out sometime before the end of the year.

• One of the questions raised was with regard to repeat background checks of residents. Unlike the background checks for employees, that are only done once and the background check follows the employee to different facilities, the background check for residents must be completed each time a resident moves from one facility to another. We asked IDPH to research this issue and see if there could be some exceptions or allowances for not repeating background checks on residents similar to what is done for employees. IDPH stated they understood the concern of the increased cost and the stress this put on residents and their families and agreed to discuss this internally and see if there are options to address the problem. IHCA pressed IDPH on this issue and stated that if a background check could be done once and follow the LTC employee wherever they go, why can’t the same be done for residents? IDPH stated that they are aware of our concern and the concern for the residents and their families, but have not reached a solution on this issue. IDPH is in discussion with the Illinois State Police to try to address this concern/problem.

• Another issue raised had to do with residents guilty of sex offences. There are situations where a person has been found guilty of a sex offense, but they are not listed on any of the Sex Offender Registries. This is a quirk in the system due to older convictions and the reporting systems at that time. They are still considered sex offenders and some facilities have gotten caught admitting such individuals not knowing of the conviction until after the entire background check is completed. The question is then how does a facility respond to this situation and if they cannot meet the resident’s needs, how is the person properly discharged? The new IOP Guideline will provide guidance on this. IDPH is aware of this problem and does not have a solution for it. There are sex offenses that do not show up on the various sex offender websites. This puts an LTC facility in a dangerous situation when they review all of the various sex offender websites and get a negative hit, go ahead and admit the resident and then find out, after the fact when the background check is done, that the resident has a sex offense. There is currently no known solution to this “quirk” in the system.

• We believe that the IOP statute only requires sex offences and felonies to be reported. We have heard of instances where the Illinois State Police (ISP) have made visits to LTC facilities and have stated that misdemeanors along with felonies have to be reported. IDPH agreed to discuss this with their legal staff and with ISP and bring this issue back for further discussion at our next quarterly meeting. The definition for an “Identified Offender” in the Nursing Home Care Act only requires the reporting of certain felonies and all sex offenses to the Illinois State Police. State Police officers have told facilities that all crimes are to be reported. That is not what the statute states. IDPH will discuss this with ISP and report back.

• I am concerned about verification that we checked and I was hoping for printing purposes that there would be a method of printing a results screen. I do not want to do printed screen shots as it is not always easy to do so. I would like to use a signed and dated form that we checked the applicable web lists but in the past the IDPH inspectors informed us that a signed sheet was not satisfactory. Can the Department give us guidance on what we need to keep on file for verification that we checked these websites? I am hoping that they will officially allow a signed form to save us from the difficulty of printing these lists. IDPH reported that there is a screen shot option and that it can be used to show proof of checking the website. No need to print out the entire website. IDPH is also working on a new automated system and will report back on their pilot at the next meeting.

5) Could we get a status/update on the issue of requests for Social Security numbers, home addresses and home phone numbers? The questions of why they are required, their availability to the general public and obvious safety concerns. IDPH is in the process of correcting the various ownership forms to remove personal information that is not required in statute. IDPH is reviewing all of their various documents and forms to remove unnecessary information that is beyond statutory requirements. The forms on the website are also in process of being revised and updated to reflect these changes.
6) How is IDPH going to conduct the emergency preparedness survey? Part of annual? Part of health or LSC survey or both? The new Emergency Preparedness requirements (effective 11-15-17) will be reviewed during the facility’s annual survey. The E-Tags will be divided up between the nurse surveyors and the life safety surveyors with the majority done by the nurse surveyors. They expect the emergency preparedness survey activities to take no more than an hour to conduct. IDPH stated that they will be looking to see that the facility is in general compliance with the regulations. However, deficiencies can/will be written and scope and severity will guide the enforcement decision.

7) LTC providers need some clarification on the arbitration agreement issue. The question IHCA and its members have is whether or not the arbitration agreement can be in the facility contract, or does it have to be a stand-alone document? We need to know what IDPH surveyors will expect so that we can tell our members and have them be in compliance. IDPH is still studying this issue and will let us know their decision as soon as it is available.

8) Governor Rauner has issued Exec Order (EO) 2017-04 regarding Administrative Hearings (click here). Will this have an impact on IDPH Hearings and if so how? There has been no impact on the IDPH legal/hearing process at this point. This could change in the future, but IDPH has not heard anything from the Governor’s Office on this to date.

9) Illinois has a limitation on C2 controlled substances in emergency medication boxes. These are mostly used for pain. These limitations place NF patients at risk for preventable pain. We received a waiver in 2011, however the waiver mistakenly indicated it needs to be renewed every year. We haven't had an issue with the 2011 waiver until this year. Surveyors stopped honoring this waiver in the last few months. We have re-requested the waiver but haven't received the outcome despite being told the waiver was reviewed and a letter will be sent. This limitation has a potential negative effect for all NFs. Anything that can be done with regard to this and not have it be a waiver? Again, IDPH is reviewing this and will provide an answer at a later time.

10) PA 100-0217 regarding nursing waivers became effective on 8-18-17. We understand rulemaking is necessary to fully implement, but how do we proceed with this new law that is in effect now? Here again, IDPH believes that they need to do rulemaking before the waivers can be used. IHCA disagrees because legislation trumps rulemaking and this law was effective 8-18-17. If a facility is requesting a waiver pursuant to PA 100-0217, we suggest you contact IHCA and we will assist you with the request.

11) With regard to new Emergency Preparedness requirements:
   • Alternate source of power – anything other than generator?
   • Is it acceptable to heat/cool just a part of the facility in an emergency?
   • Any CMS discussion with regard to a hold harmless for the new provisions similar to what CMS is doing with the Phase 2 requirements under the RoPs?
   • How will the two (2) exercise requirement be reviewed? Full scale/table top?

IDPH stated that they are planning a teleconference on the Emergency Preparedness requirements and will answer these and other questions at that time.

12) With regard to the new RoPs:
   • Does the 48-hour base-line care plan have to be given to the resident/resident representative in writing? The summary must be in writing and in a language the resident/resident representative understands. The written summary is to be given to the resident/resident representative as soon as it is completed and prior to the development of the full care plan.
   • Issue of Discharge Planning being driven by what the resident’s goals are—great idea, but it is in direct conflict with MCOs saying they will only pay for a certain amount of days. How will this be reviewed/handled by IDPH? IDPH’s response to this issue was only that the facility should do their discharge planning as soon as possible.
   • Added duties of the consultant pharmacist. They must now review the entire medical record, not just the MAR and create a separate, written report of any irregularities and send that to the medical director, DON and attending physicians. Facilities are seeing some push back and some companies are increasing their consultant
fees as a result of the added duties. IDPH sympathized with us on this, but stated there was not anything they could do with this – a federal requirement outside their control.

- Attending physicians also not happy that they have to respond, in writing, to these irregularities. Same answer as above – beyond their control.
- The hold harmless for the Phase 2 requirements—is it for all Phase 2 requirements or just some? Any information? IDPH stated that federal CMS has not notified them of the final decision on this.
- Will IDPH surveyors be ready for the new RoP survey process? All be trained? IDPH stated that they would be, but expect a lot of questions and some confusion on the front end.

Other issues address during the discussion on the RoPs:

- Surveyors will be using the critical element pathways to guide them through the survey process.
- The IDPH surveyors will monitoring/observing the first meal upon entrance.
- Mixing crushed meds is prohibited. You can crush one med at a time and add it to food, but you cannot crush multiple meds and add them altogether to food.
- Providers will be asked to immediately fill out the matrix for the residents admitted within the last 30 days. A second Matrix form will need to be filled out for all other residents within 4 hours of survey entrance.
- Surveyors will want a copy of the Facility Assessment and QAPI Plan for review at the entrance conference.
- Facilities should become familiar with the Entrance Conference Worksheet so that they know the documents and timeframes for producing certain documents.
- IDPH is planning on having a Field Supervisor on each annual survey to be able to act as the “go between” for the surveyors and the provider to help manage the new survey process and to resolve any issues. The Regional Supervisor and Connie Jensen are also available to resolve any issues.

13) Could we get a status/update on the issuance of survey documents for the ID/DD facilities versus the LTC facilities? Why the difference? Shouldn’t they all be the same? LTC gets some documents that the ID/DD facilities do not? IDPH stated they will review this issue and report back at the next meeting.

14) Any other information/guidance from IDPH/CMS to be passed on to our members? IDPH stated that they are also planning a teleconference to discuss the RoP process and answer related questions.

A Lesson in Disaster Preparedness for LTC Facilities – Technology Issues/Concerns

As healthcare entities throughout Texas and Florida work tirelessly to put back the pieces following hurricanes Harvey and Irma, reflection is likely top of mind. These devastating storms and resulting widespread power outages are a true test of just how far healthcare technology has come. They are also a strong reminder of the importance of disaster preparedness to ensure continuity of care.

Natural disasters happen. Hurricanes, snow storms, earth quakes; no business or person is immune. Independent of natural disasters, widespread power outages can occur any time. For those who don’t account for the possibility, the impact can be substantial. Continuity of care and patient satisfaction will be negatively impacted, and a facility's reputation potentially damaged.

To ensure continuity of care, everyone involved in patient care must be aware of each resident's complete medical history at all times. This information is essential to avoid duplication of medications and miscommunication on the resident's plan of care. With patient health information in hand, existing medical conditions and current treatments can be viewed regardless of where a patient is physically located or what natural disasters may occur.
Technology such as electronic medical record systems and clinical software systems are increasingly utilized in long-term care facilities to help streamline day-to-day processes and workflow. These same systems can (and should) be used to ensure continuity of care during an emergency.

While most long-term care facilities have disaster preparedness plans in place, many of these plans don’t incorporate the use of technology. Equally as alarming, those plans that do take technology into consideration are rarely (if ever) tested by facility staff prior to an actual event. It is only when a disaster happens that many discover the plan they have is inadequate, no one knows how to use it, and/or it simply doesn't work. When this happens PHI is inaccessible and staff are left scrambling. If a mock drill is not conducted in advance of an event, there is no way to know if the processes outlined within your plan will work.

Disaster preparedness is much more than some steps printed on paper and stuck in a folder, binder or policy book. It is developing a plan and testing that plan, step by step, to make sure it works and that everyone is familiar with their role. It also requires getting your EMR vendor involved.

Power outages and lost internet connection should not render PHI inaccessible. There are various ways to access information regardless of the situation. It's important to work with your EMR vendor, before a disaster strikes, to determine which approach is right for your facility and your budget.

Many long-term care facilities have a generator back-up (red outlet). These generators can be wired to power your server and your printer. For example, using transactional log shipping your EMR vendor can set up a minimal SQL database on a computer that is connected to outlets at your facility that run off of a backup generator. This allows information to be accessed directly from your laptop. Staff accessing information on the laptop can either share or hook the laptop up to the printer to print information.

If an Internet connection is required, your vendor can work with you to set up a dedicated laptop with its own ISP Verizon, Sprint or other provider’s data card that connects to 4G Internet. You simply register with a hosted service/EMR provider and set the laptop aside in a safe place in the event of a disaster. In either scenario, if a long-term outage and/or resident transfers are necessary, PHI can be saved from your laptop to an electronic file for easy handover.

In an event of a disaster, when there is no internet and no electricity, it is essential that long-term care facilities have a tested plan in place that allows PHI to be accessed and shared.

How do you do this? Talk to your EMR vendor — they have solutions. Your EMR vendor should play a key role in deciphering the needs of your facility and work closely with you to design (and test) a disaster recovery plan that actually works. Maintaining continuity of care during a disaster doesn’t have to cost a fortune. It doesn’t require special interfaces nor a lot of ground work. However, it does require a partnership with your EMR vendor.

*Article authored by LeRoy Boan and reprinted out of McKnight’s.*

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**Trending Statistics**

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

**National Partnership to Improve Dementia Care Achieves Goals to Reduce Unnecessary Antipsychotic Medications in Nursing Homes**

On October 2, the National Partnership to Improve Dementia Care announced that it met its goal of reducing the national prevalence of antipsychotic use in long-stay nursing home residents by 30 percent by the end of 2016. It also announced a new goal of a 15 percent reduction by the end of 2019 for long-stay residents in those homes with currently limited reduction rates. Nursing homes with low rates of antipsychotic medication use are encouraged to continue their efforts and maintain their success.
For Illinois, the numbers are not so great. The current national average is 15.7 percent, and for Illinois, the current number is 19.1 percent. This ranks Illinois at 49th in the nation. We have to do better. With a national goal of 15 percent by the end of 2019 and potential penalties for states that do not meet that goal, Illinois needs to address this issue and make drastic changes with our use of antipsychotic medications.

For More Information:
- Fact Sheet
- National Partnership to Improve Dementia Care in Nursing Homes webpage

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

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

- **S&C 18-01 – NH** – Revised Policies regarding the Immediate Imposition of Federal Remedies - FOR ACTION. This policy memo replaces S&C: 16-31-NH released July 22, 2016 and the revision on July 29, 2016. Revisions to Chapter 7 of the State Operations Manual (SOM): CMS has revised guidance relating to the Immediate Imposition of Federal Remedies. Other sections of Chapter 7 have been revised to ensure consistency with these revisions. Major revisions include: We specify that when the current survey identifies Immediate Jeopardy (IJ) that does not result in serious injury, harm, impairment or death, the CMS Regions may determine the most appropriate remedy; We clarified that Past Noncompliance deficiencies as described in §7510.1 of this chapter, are not included in the criteria for Immediate Imposition of Remedies; For Special Focus Facilities (SFFs), we now exclude any S/S level “F” citations under tags F812, F813 or F814 from the tags that require immediate imposition of remedies. *This memo is being released in draft. We seek comment on this policy by December 1, 2017.*

- **S&C 18-02 – NH** – Clarification regarding Nurse Aide Training and Competency Evaluation Program (NATCEP/CEP) Waiver and Appeal Requirements. Existing Waiver and Appeal Authorities: CMS is providing clarification regarding existing statutory and regulatory authority regarding waivers and appeals of NATCEP/CEP prohibition or loss.

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

- **SNF Quality Reporting Program Confidential Feedback Reports for Claims-Based Measures.** Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Confidential Feedback Reports are available via the CASPER Reporting System. These reports contain information for the following Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) claims-based quality measures:
  - Total Estimated Medicare Spending Per Beneficiary Measure
  - Discharge to Community-Post Acute Care—SNF QRP
  - Potentially Preventable 30-Day Post Discharge Readmission Measure
  - The full Confidential Feedback Reports containing all SNF QRP quality measures (claims and assessment-based) will be released later this year

  For More Information:
  - Review the September 28 presentation and audio and transcript
  - Contact the SNF QRP Help Desk at SNFQualityQuestions@cms.hhs.gov

- **SNF Review and Correct Report Update.** Skilled Nursing Facility (SNF) Review and Correct reports are available in the SNF Quality Reporting Program (QRP) report category in the CASPER Reporting application. Request your report to view updated measure results; the updated report should replace previous versions.
  - Submission deadline for third quarter 2017 data is changed to May 15, 2018
- Report is updated to reflect that both first and second quarter 2017 are “open”
- Data for all measures for first quarter 2017 are recalculated for any assessment records that were received since the original first quarter 2017 submission deadline of August 15, 2017

For More Information:
- SNF QRP Spotlights and Announcements webpage
- SNF QRP Data Submission Deadlines webpage for previous updates
- Contact the QTSO Help Desk at help@qtso.com or 800-339-9313

- **Post-Acute Care Quality Reporting Programs FY 2018 APU: Successful Facilities.** CMS published lists of hospice providers, Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs) who successfully met the reporting requirements to avoid the FY 2018 Annual Payment Update (APU). View the lists on the following webpages:
  - HQRP Requirements and Best Practices
  - IRF Quality Reporting Data Submission Deadlines
  - LTCH Quality Reporting Data Submission Deadlines

- **New CMS Legionella Requirement for Hospitals, Critical Access Hospitals and Nursing Homes.** Learn to control the growth and spread of Legionella and other waterborne pathogens; review information from the Centers for Disease Control and Prevention and the new surveyor Legionella training webinar. Act now to protect your patients and be in compliance with new CMS requirements.

For More Information:
- Water management fact sheet
- Legionella fact sheet
- Frequently Asked Questions
- From Plumbing to Patients webpage
- Surveyor training video

**PROVIDER ALERT** — IHCA has received some phone calls from members regarding a company called Legionella Watch. They are advertising for a water testing of Legionella program that they are charging for and their advertising makes it appear that the testing program is required or authorized by CMS. Please keep in mind that if you receive one of these notices, investigate it thoroughly to determine if this is a service you need or want for your facility.

- **Coudé Tip Catheters CMS Provider Minute Video — Reminder.** 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.

- **New Medicare Card Project Special Open Door Forum — Thursday, November 9 from 1 to 2 pm CST.** This call will educate State Medicaid Agencies, Medicaid providers, Managed Care Organizations, Medicaid partners, and other Medicaid stakeholders about the change from Social Security Number-based Health Insurance Claim Numbers to new Medicare Beneficiary Identifiers (MBIs). A question and answer session follows the presentation. CMS discusses:
  - Background and implementation
  - MBI format
  - Timeline and milestones, including the transition period
  - Beneficiary outreach and education
To participate:
  - Dial-In Number: 800-837-1935; conference ID #: 49255212
  - TTY services dial 7-1-1 or 800-855-2880

For more information, visit the [New Medicare Project](#) website and [Transcripts](#) webpage.

- **SNF Value-Based Purchasing Program FY 2018 Final Rule Call** — Thursday, November 16, 12:30 - 2 pm CST. [Register](#) for Medicare Learning Network events. Learn how the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program will affect Medicare’s payments to your SNF beginning October 1, 2018, as well as details on how CMS will translate SNF performance scores into value-based incentive payments. CMS will also discuss policies finalized in the FY 2018 [final rule](#). A question and answer session follows the presentation; however attendees may email questions in advance to [SNFVBPInquiries@cms.hhs.gov](mailto:SNFVBPInquiries@cms.hhs.gov) with “SNF VBP November NPC” in the subject line. These questions may be addressed during the call or used for other materials following the call.

- **Medicare Quarterly Provider Compliance Newsletter Educational Tool** — New. A new [Medicare Quarterly Provider Compliance Newsletter](#) Educational Tool is available. Learn about:
  - How to avoid common billing errors and other erroneous activities
  - How to address and avoid the top issues this quarter.

- **New Medicare Numbers/Cards: Coordination of Benefits.** CMS notified supplemental insurers (e.g., Medigap plans, employer retiree plans, TRICARE for Life, FEHBP plans) and State Medicaid Agencies about the transition from Social Security Number based Health Insurance Claim Numbers (HICNs) to new numbers (known as Medicare Beneficiary Identifiers (MBIs)) on several occasions, including two calls on January 17 about the impact of the New Medicare Card: One for [Medicare secondary payer stakeholders](#) and another on the [Coordination of Benefits Agreement claim crossover process](#). During the [transition period](#), we will process and transmit Medicare crossover claims with either the HICN or MBI, based on what you include on the incoming claim to minimize changes for all stakeholders and assure a smooth transition. Visit the [Provider](#) webpage for the latest information or refer to the [Transition to New Medicare Numbers and Cards](#) Medicare Learning Network Fact Sheet.

- **Reporting Changes in Ownership** — Reminder. A 2016 Office of the Inspector General (OIG) report noted that providers may not be informing CMS of ownership changes. Providers must update their enrollment information to reflect changes in ownership within 30 days. Owners are individuals or corporations with a 5 percent or more ownership or controlling interest. Failure to comply could result in revocation of your Medicare billing privileges. Resources:
  - [Timely Reporting of Provider Enrollment Information Changes](#) MLN Matters® Article
  - [42 CFR 424.516](#)
  - [Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure](#) OIG Report
  - [PECOS Enrollment Tutorial - Change of Information for an Individual Provider](#)
  - [PECOS Enrollment Tutorial - Change of Information for an Organization/Supplier](#)
  - [Updated Manual Guidelines for Electronic Funds Transfer Payments and Change of Ownership](#) MLN Matters Article

- **Preventive Care and Health Screenings for Persons with Disabilities Webinar** — Thursday, November 2, 3:30 - 4:30 pm ET. Part of the Disability Competent Care series, this webinar explores the challenges health plans and providers experience providing preventive care and screenings for persons with disabilities. Find out about promising practices to address identified barriers and challenges. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available. See the [announcement](#) to register and for more information.
• **Comparative Billing Report on Emergency Department Services Webinar — Wednesday, December 13, 3 - 4 pm ET.** Join us for a discussion of the comparative billing report on Emergency Department Services (CBR201709), an educational tool for providers of all specialties who submit claims for emergency department services using Current Procedural Terminology® codes 99281 through 99285. During the webinar, interact directly with content specialists and submit questions about the report. See the announcement for more information and find out how to participate.

• **HHA Star Rating Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the October 10 call on Home Health Agencies (HHAs): Quality of Patient Care Star Rating Algorithm. Learn about modifications and proposed changes to the way the star rating is calculated, including the removal of the influenza measure.

• **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program MLN Matters Article — Revised.** An MLN Matters Special Edition Article on Prohibition on Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program is available, including these revisions: Provider Remittance Advice and Medicare Summary Notices identify QMB status of beneficiaries and exemption from cost-sharing for Part A and B claims processed on or after October 2, 2017. Recommendations on how providers can use these and other upcoming system changes to promote compliance with QMB billing requirements.

• **General Equivalence Mappings FAQs Booklet — Revised.** A revised General Equivalence Mappings FAQs Booklet is available. Learn about:
  - Use of external cause and unspecified codes in ICD-10-CM
  - Background and FAQs on the conversion of ICD-9-CM codes to ICD-10-CM/PCS and ICD-10-CM/PCS codes back to ICD-9-CM

• **Medicare Fraud & Abuse: Prevention, Detection, and Reporting Web-Based Training Course — Reminder.** With Continuing Education Credit. A Medicare Fraud & Abuse: Prevention, Detection and Reporting Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  - Fraud and abuse in healthcare
  - Laws governing fraud and abuse activities
  - Government partnerships fighting fraud and abuse
  - Where to report suspected fraud and abuse

3) The federal Agency for Healthcare Research and Quality (AHRQ) reported on:

• **While Hospital Admissions Decline, Observation Stays and Emergency Department Visits on the Rise.** Trends showing fewer hospital admissions and more treat-and-release observation stays or emergency department (ED) visits have occurred among patients across all insurance categories, according to a recent AHRQ-funded study. “The Shifting Landscape in Utilization of Inpatient, Observation, and Emergency Department Services Across Payers,” published in the *Journal of Hospital Medicine*, showed hospital admissions decreased while observation and ED visits increased from 2009 to 2013 among patients who were uninsured or covered by Medicare, Medicaid or private insurance. Among Medicare patients, for example, admissions fell by 17 percent while observation stays increased by 33 percent. The study analyzed data from AHRQ’s Healthcare Cost and Utilization Project for 10 common conditions in four states. Access the abstract.

• **Evaluation of the association between Nursing Home Survey on Patient Safety culture measures and catheter-associated urinary tract infections: results of a national collaborative.**

• **High-Alert Medication Safety Self-Assessment Launched.** A new online patient safety tool is available to help hospitals, long-term care facilities and outpatient facilities evaluate their best practices related to high-alert medications, identify opportunities for improvement and track their experiences over time. Developed by the Institute for Safe Medication Practices (ISMP), the ISMP Medication Safety Self Assessment® for High-Alert Medications focuses on general high-alert medications and 11 specific medication categories including opioids,
insulin, neuromuscular blocking agents, chemotherapy and moderate and minimal sedation. Participants who submit assessment findings to ISMP anonymously via a secure Internet portal can obtain weighted scores to compare with demographically similar organizations. Participation also can help organizations meet requirements for managing high-alert medications from regulatory and accrediting agencies, such as the Centers for Medicare & Medicaid Services and The Joint Commission. Access more information.

- New Training Program Helps Hospitals Prevent Pressure Ulcers. Hospital quality improvement (QI) staff, patient safety officers and others now have a new resource to help reduce the number of pressure ulcers, also known as pressure injuries, in hospitals. AHRQ’s Pressure Injury Prevention in Hospitals Training Program can help prevent pressure ulcers. Data provided by hospitals that implemented the program showed a decrease in the average number of pressure ulcers that was sustained for one year. The program is designed for those who want to launch an evidence-based, structured pressure injury prevention initiative based on QI principles. Access the training program and implementation guide.

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

- HFS posted a new provider notice regarding Utilization Review Update Effective December 1, 2017. You may view the notice here.

- HFS posted a new provider notice regarding Update to the Crisis and Referral Entry Service (CARES) Transition to the Integrated Eligibility System (IES). You may view the notice here.

- HFS posted a new provider notice regarding Managed Care Program Update. You may view the notice here.

- HFS posted a new provider notice regarding Succeeding in the New Managed Care Program Series (#1-4): Four key ways the new managed care will mean less work for providers. You may view the notices here.

5) The Illinois Department of Public Health (IDPH) reports:

- 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.
  - November 30, 1-3 PM | Dupage Convalescent Center | 400 North County Road, Wheaton IL 60817

- The Life Safety Code Division (LSC) within IDPH is alerting providers to two sections of the 2012 LSC that require inspections. They are:
  - Exit Signage Inspection (7.10.9.1)(K293) Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. Need to document this for surveyor review.
  - Electrical Receptacles (6.3.3.1.4)(K914) Electrical receptacles not listed as hospital-grade at patient bed locations are to be tested at intervals not exceeding 12 months. It is not intended that each receptacle in each resident room be tested. It is intended that compliance be demonstrated and documented through random testing in each resident room. The 10% random testing in each resident room should include a mixture of both normal and emergency receptacles. The intent is to have at least one receptacle tested in each resident room.

6) The American Health Care Association (AHCA) recently published The Quality Initiative Quarterly Update (click here).
7) The latest Telligent events/announcements can be found at [https://www.telligenqinqio.com/](https://www.telligenqinqio.com/).

8) The Hill reports Opioid Epidemic Also Hitting Older Adults. As America grapples with an opioid epidemic, senior citizens are often overlooked. Yet, older adults are highly susceptible to chronic pain and the prescription painkiller addiction is hitting this population. Roughly one in three beneficiaries in Medicare’s prescription drug program received a prescription for opioids in 2016. About half a million received high amounts of opioids. And nearly 90,000 are at “serious risk” of opioid misuse or overdose, according to a July report by the inspector general of the Department of Health and Human Services (HHS).

9) Medical News Today reports Could Alzheimer’s be Prevented With a Vaccine? Scientists have devised a vaccine that has shown promise in the treatment of psoriasis and cat allergies, as well as in the prevention of Alzheimer’s disease. The new research was a collaborative effort among universities in the United Kingdom and Switzerland, and the findings were published in the journal Nature Vaccines.

10) Medscape reports FDA Clears Shingles Vaccine Shingrix for Adults 50 and Older. GlaxoSmithKline’s recombinant zoster vaccine (adjuvanted) (Shingrix) has been approved in the United States for the prevention of herpes zoster (shingles) in adults aged 50 years and older. The approval follows a unanimous vote last month by the Vaccines and Related Biological Products Advisory Committee of the US Food and Drug Administration (FDA) that the vaccine is effective and safe for adults aged 50 years and older. Shingrix combines an antigen, glycoprotein E, and an adjuvant system, AS01B, intended to generate a strong and long-lasting immune response that can help overcome the decline in immunity as people age, the company explained in a news release. Shingrix is given in two doses, with a 2- to 6-month interval between doses.

11) ThinkAdvisor reports that Trump Signs Elder Fraud Bill Into Law. President Donald Trump signed into law legislation that cracks down on elder abuse and fraud, specifically the use of telemarketing and email fraud designed to induce investment or financial profit. The bill also adds health care fraud to the list of fraud offenses subject to enhanced penalties. The Elder Abuse Prevention and Prosecution Act, S. 178, establishes certain requirements for the Department of Justice with respect to investigating and prosecuting elder abuse crimes.

12) Healio reports Frail Elderly Patients Comprise 44 Percent of Potentially Preventable Medicare Spending. High-cost frail elderly individuals accounted for 44 percent of total potentially preventable Medicare spending, despite only comprising 4 percent of the Medicare population, according to findings published in Annals of Internal Medicine.

13) The Washington Post reports that Social Security Checks to Rise 2 Percent in 2018, the Biggest Increase in Years. Social Security checks are going up 2 percent in 2018, the U.S. government announced recently. It's the first substantial raise in years. More than 66 million Americans receive Social Security payments. Most recipients are seniors over age 65, but some payments also go to the severely disabled and orphans. The average check is currently $1,377 a month, meaning next year's increase will raise the typical payment by $27 a month.

14) MedlinePlus reports that Nearly 4 in 10 U.S. Adults Now Obese. Almost forty percent adults in the United States are now obese, continuing an ever-expanding epidemic of obesity that's expected to lead to sicker Americans and higher health care costs. Almost four out of 10 adults and 18.5 percent of kids aged 2 to 19 now meet the clinical definition of obesity, according to a new report from the U.S. Centers for Disease Control and Prevention. That's up from 30.5 percent of adults and 13.9 percent of children in 1999-2000, the CDC report noted. Public health experts are concerned that the continuing rise in obesity will lead to greater numbers of people suffering from diabetes, heart disease and other chronic illnesses.

15) Kaiser Health News reports that Seeking Additional Medicaid Funding, Hospitals Increasingly Purchase Nursing Homes. Kaiser Health News recently reported on the trend of hospitals buying nursing homes, which helps them collect "significantly higher reimbursement rates from Medicaid." According to advocates, the process helps hospitals maintain financial stability at a time when many rural facilities face economic hardship. Meanwhile, critics say the funding does not improve nursing home quality and that it incentivizes patients to enter nursing homes rather than seek lower-cost alternatives. Citing the cases of hospitals in Indiana, the Indiana Health Care Association president Zach Cattell "noted
the number of nursing homes in the state earning Medicare’s top, five-star rating has increased 9 percentage points since 2011,” saying the percentage of high-risk residents with conditions such as pressure ulcers and patients who are physically restrained have dropped.

16) STAT reports that Benefits of Implementing Value-Based Care in Question. According to STAT, "the implementation of value-based care is a flop so far," as "costs have continued to skyrocket," Medicare "has lost money on accountable care organizations," and "forecasted quality gains have not materialized." The article explains that CMS Director Seema Verma "began soliciting new ideas last month for changing how care is delivered and paid for by the government." According to STAT, Verma’s request "charted a new course for the agency’s innovation center, saying it wants to cut red tape, empower consumers, and ‘allow physicians and other providers to focus on providing high-quality health care to their patients.’"

17) Bloomberg News reports that Data Show Americans Retiring Later, Dying Sooner and in Poorer Health. According to Bloomberg News, data released last week suggests that Americans are retiring later, dying sooner and suffering from more serious health problems in their late 50s. The data by the Society of Actuaries show that nearly one-third of those age 65 to 69 are still working and age-adjusted mortality rates rose 1.2 percent from 2014-2015. By the age of 58 to 60, a quarter of Americans rated their health as "poor" or "fair." The article mentions several potential causes for why Americans’ health appears to be getting worse, including a suicide epidemic, drug and alcohol abuse, and higher obesity rates.

18) TIME reports that Investigation Finds Patients, Families Experience Poor Quality Hospice Care. In a 3,202-word story TIME spotlights one family’s chaotic experience with one of the nation’s 4,000-plus hospice agencies, "which pledge to be on call around the clock to tend to a dying person’s physical, emotional and spiritual needs." It is a "thriving business" that served about 1.4 million Medicare patients in 2015, but "families across the country, from Appalachia to Alaska, have called for help in times of crisis and been met with delays, no-shows and unanswered calls, a Kaiser Health News investigation published in cooperation with TIME shows." The investigation "analyzed 20,000 government inspection records," revealing that missed visits and neglect are common for patients dying at home. "Families or caregivers have filed over 3,200 complaints with state officials in the past five years," leading inspectors to identify problems in 759, but "only in rare cases were hospices punished for providing poor care, the investigation showed." Hospice enrollment has more than doubled since 2000 but 21 percent of hospices failed to provide crisis care in 2015, and 8.1 percent didn’t provide a single skilled visit, according to CMS.

19) ModernHealthcare reports that CMS Initiative Decreases Hospital Visits for Nursing Home Residents. ModernHealthcare recently reported on CMS’ three-year Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, which released results showing $50 million in savings and a 17 percent reduction in potentially-avoidable hospitalizations from the 143 participating nursing homes. The experiment involved "third-party organizations known as enhanced care and coordination providers, or ECCPs, hired nurses to provide education and clinical support to nursing home staff and help keep residents out of the hospital." Initiative participants will move on to the second phase of the program which pays nursing homes at higher rates – what hospitals are paid under Medicare -- when they treat patients in-house for common conditions that lead to 80 percent of hospitalizations: pneumonia, dehydration, congestive heart failure, urinary tract infections, skin ulcers and asthma.

20) Skilled Nursing News reports:

- SNFs Can Reduce Inappropriate Medication Use Through 3MR Intervention. Skilled Nursing News reports on a study published in the Annals of Internal Medicine that found that SNFs seeking to lower the use of potentially inappropriate medications (PIMs) could experience success "through implementing Multidisciplinary Multistep Medication Review (3MR) intervention." Researchers followed "426 nursing home residents from 59 Dutch nursing home wards, randomly assigning them to either a control group or the 3MR intervention," and found that in the intervention group, "39.1 percent of participants discontinued use of at least one inappropriate medication, compared with 29.5 percent in the control group." According to the article, "the findings could have significant impact for skilled nursing facilities (SNFs) stateside, given ongoing efforts by the Centers for Medicare & Medicaid Services (CMS) to reduce unnecessary drug use." The study is accompanied by an editorial.
• **SNF Advocates Press CMS to Change Three-Day Stay Rule.** *Skilled Nursing News* reports that the American Health Care Association is among a group of SNF operators and industry advocates called the Observation Stays Coalition urging CMS to change its "three-day stay rule, which requires patients to undergo a three-day hospital stay as an inpatient before Medicare will pay for subsequent SNF care." Dana Halvorson, a senior director at AHCA, said the rule is out of date, adding that patients "could really be in for a shock if they did not have...inpatient days." She said that "sometimes [patients are] filling out so many forms in the hospital...you might not even know what you’re signing and still have that surprise after." The AHCA also has implored "CMS and the U.S. Department of Health and Human Services (HHS) to allow observation stays to count toward the three-day stay rule," although, the piece says, with HSS Secretary Tom Price’s resignation "and ongoing the uncertainty surrounding who might replace him, a quick fix may not come any time soon."

21) **McKnight’s reports:**

• **LTC Should Consider Staff Turnover When Making Flu Management Plans.** *McKnight’s Long Term Care News* reports that a research review published in the *Annals of Long-Term Care* found long term care providers should consider staff turnover rates while considering efforts to increase employee flu vaccination rates. Department of Veterans Affairs and the University of California-Los Angeles researchers "stressed that all staff members should be involved with flu season preparation," although they noted that employee compliance "can often be a challenge." A release from the CDC "found long term care had a vaccination rate of just 68 percent, compared to hospitals (92 percent) and ambulatory care settings (76 percent)."

• **State Telemedicine Laws Can Lead to Confusion for Providers.** *McKnight’s Long Term Care News* reports that legal experts commenting on state telemedicine laws say the policies could lead to billing confusion for providers concerning which services are covered, noting primarily how state legislators draft the laws based on different requirements for insurance coverage and payment parity. According to one legal expert, the discrepancies leave legislation unable to "accomplish what a lot of health care providers believe they do," and some lead to a process that "simply confuses and frustrates health care providers because they don’t actually offer meaningful coverage or payment parity."

• **States Considering Wage Increases to Mitigate Long Term Care Workforce Turnover, Shortages.** *McKnight’s Long Term Care News* reports that the Kaiser Family Foundation released its 50-state Medicaid budget survey recently, finding that for fiscal years 2017 and 2018 "shortages and turnover among the long term services and supports workforce" poses "an issue to watch in coming years." Seventeen of the states surveyed said they were developing strategies during that time period to address those issues, "with 11 responding that they were looking at wage increases as a possible solution."

• **Data Analysis Remains Critical for SNF Providers to Ensure Higher Quality Services.** James M. Spencer, CPA, MBA, a manager at Senior Living Services Consulting Group, writes in a contributor piece for *McKnight’s Long Term Care News* that SNF administrators should rely on data collection and analysis to develop solutions to issues such as declining residency. Spencer says analysis of data can help SNF administrators "not only to understand outcomes of residents once they are discharged from the SNF, but also to leverage the information for talking points with hospitals when seeking preferred provider relationships or bundled payment arrangements." Doing so, he says, "can set an SNF apart from the competition and will help keep those coveted Medicare resident beds full." Spencer recommends providers consult data available on CMS’ Home Health Compare website.

• **Some Long Term Care Nurses Feel Isolated From Other Health Care Professionals.** *McKnight’s Long Term Care News* reports that a study published in the *Journal of Clinical Nursing* found that some nurses "in the long-term care sector may feel isolated or excluded from other workers in the health care industry." In the study on nurses’ "work identities," respondents from seven nursing homes in England "shared that their work caring for ‘residents’ differs from the way other nurses care for ‘patients.’"
• Nursing Workforce Becoming More Educated, Diverse. More men and people of color are entering the nursing profession, and more nurses are pursuing additional education than ever before, according to a new analysis. The results, published in Nursing Outlook, found that more men have joined the workforce in recent years, jumping to 13.6 percent of those surveyed in 2015. The percentage of white nurses dropped from almost 79 percent in 2008 to 73.8 percent in 2015.

• Communicating With Family While Respecting Resident Privacy. In this day and age of constantly evolving technology, everyone seems to have a cell phone in their hand at all times. People want to be constantly updated on the world around them. Accessing the knowledge of a loved one's status is no exception. Family members often have high expectations, and they want an immediate response to their calls and questions. However, if staff members are not aware of the proper guidelines on what information can and cannot be shared, there could easily be a breach of that resident's privacy.

• Readmission Prevention: The Role of Post-Acute Providers. Long term care providers have an opportunity to thrive with value-based care, escape cynicism and join the growing wave successful at avoiding readmissions. Unlike fee-for-service care, which compensates providers for each procedure, value-based care pays for the episode of care, making it essential to coordinate between providers and to avoid unnecessary medical utilization. Efforts to avert hospitalization and readmission are paramount.

• Post-ACUTE Providers Putting Billions Into Regulatory Compliance. The healthcare industry spends roughly $39 billion annually on regulatory compliance efforts, with post-acute care providers bearing the brunt, a new report shows.

22) Interesting Fact: More than 179 million Americans will celebrate Halloween this year, with seven out of ten consumers planning to hand out candy. Total spending in 2017 will reach $9.1 billion, with the average consumer planning to spend $86.13 on decorations, candy, costumes and more.