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!

Summary of the CMS Region 5 LTC Provider Association
On December 11 and 12, federal CMS hosted their annual Region 5 LTC Provider Association Meeting in Chicago. CMS invites state Surveyor Agency representatives, state LTC Provider Association representatives and state LTC Ombudsmen of each of the six Region 5 states to this meeting. The organization uses this meeting to give updates on various programs/issues and allows for question and answers. Each LTC Provider Association is limited to two representatives. Attending for IHCA were Fred Benjamin, Lexington Health Network and Bill Bell, IHCA. The following are key highlights and other important information from the meeting:

- CMS provided several summary report handouts:
  - Midwest DSC Involuntary Discharge Initiative
  - Temporary Enforcement Moratorium for Certain Phase 2 F-_tags
  - QIO Program-Area 4-Contract Year 3 Report
  - Civil Money Penalty Reinvestment Program
  - CMS Questions-Revised Regulations
  - Medicaid Managed Care
  - Overview of the New Long Term Care Survey Process
  - FY 2016 Timeliness of Nursing Home Surveys by Five Measures
  - Average Number of Deficiencies Cited Per Survey
  - FY 2017 Remedy Percentages
  - FY 2017 Total Deficiencies by Severity Level
  - FY 2017 Top Ten Citations
  - FY 2017 Top Ten Citations by Region V and Nation
  - JJ Citation Trends
  - KEPRO-Outreach Presentation
  - Medicare Advantage Update
  - QIO Person and Family Engagement
  - FY 2017 Remedies in Effect

- CMS is releasing information related to the new QCOR website in an overarching initiative for increased transparency. The QCOR website launch replaces the previously known Survey and Certification Providing Data Quickly (S&C PDQ) system. S&C PDQ provided summarized survey and certification data, including results of on-site inspections of providers and suppliers. The old PDQ system was only available to CMS and the State Survey Agencies, but the new QCOR makes the same information available to providers and the public. The system imports data from a variety of data platforms, such as the Certification and Surveyor Provider Enhanced Reporting (CASPER) national database. However, S&C PDQ's functionality and ease of access of information to providers and suppliers was limited, therefore CMS removed the requirements for username and passwords for accessing the data on the new site. The QCOR website can be accessed at https://qcor.cms.gov or the previous
PDQ link (https://pdq.cms.hhs.gov/main.jsp), which will redirect to QCOR. This website provides access to the results of CMS survey and certification activity over the last 10 years.

- CMS made special note that with regard to F-Tag 655 – Baseline Care Plans – admission orders are not enough. The Baseline Care Plan must include the minimum health care information necessary to properly care for a resident, including, but not limited to:
  - initial goals based on admission orders
  - physician orders
  - dietary orders
  - therapy services
  - social services
  - PASSAR recommendations, if applicable

The Baseline Care Plan will remain in effect and be operational until the Comprehensive Care Plan is developed. Also remember a summary of the Baseline Care Plan must be given to the resident and the resident representative that includes, but is not limited to:
  - the initial goals of the resident
  - a summary of the resident’s medications and dietary instructions
  - any services and treatments administered by the facility or persons acting on behalf of the facility
  - any updated information based on the details of the Comprehensive Care Plan, as necessary

- **F692 – Dehydration** - While food intake may be considered, ensuring a resident receives the fluids they require can more easily be overlooked. Individuals who do not receive adequate fluids are more susceptible to urinary tract infections, pneumonia, pressure injuries, skin infections, confusion and disorientation. While there is no reliable calculation to determine an individual’s fluid needs, an assessment should take into account those characteristics pertinent to the resident, such as age, medical diagnoses, activity level, etc. On the Matrix form, make sure to include any resident on IVs and anyone on fluid restrictions.

- **F758 – Unnecessary Drugs** – With regard to the 14 day limit on the PRN requirement for psychotropic drugs, 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 must document their rationale in the resident’s medical record and limit the new PRN order to a maximum of 14 more days. This added 14-day extension limit is a new CMS guideline.

- **F758 – Unnecessary Drugs** – With regard to the reduction of medication requirement, CMS stated that attempts to reduce medications must be continuous and attempted periodically. The intent of the regulation is to hopefully stop medications and find alternatives to address the resident’s care/behavior issues.

- **F812/813 – Food Safety** – With regard to food brought into the facility by visitors, the facility needs to have a policy (that is shared with residents and visitors) on food brought into the facility to make sure the facility is aware of the fact and that the food is handled and stored appropriately.

- **F604/689 – Resident Position Change Alarms** – CMS is instructing surveyors to do an in-depth review regarding the use of these types of alarms. Surveyors will be reviewing these alarms to evaluate if they are being used as a restraint and/or for staff convenience and to determine if they inhibit freedom of movement and are an irritant or nuisance to the resident. Personal position alarms are allowable, but the facility is going to have to fully justify their use and show a benefit to the resident.

- **F620 – Admission Policy** – CMS reiterated that facilities must disclose and provide to a resident or potential resident prior to the time of admission, notice of special characteristics or service limitations of the facility – what care services you do provide or cannot/do not provide.

- **F661 – Discharge Summary** – The Discharge Summary refers to the resident’s most recent comprehensive MDS assessment as being part of the information that must be given to the resident/resident representative. Does
this mean that you have to give the resident/resident representative a complete copy of the comprehensive MDS assessment? CMS stated that it is not required that you give a copy of the complete comprehensive assessment. The facility can develop their own form for the discharge summary that contains all the required components.

- **F741 – Behavioral Health Staff Competencies** – CMS stated that there are no formalized training requirements at this point in time. They will be developed and made available to facilities prior to the implementation of Phase 3 requirements.

- **F760 – Combining of Crushed Medications** - In response to those concerns, CMS is revising the interpretive guidance to convey that best practice would be to separately crush and administer each medication with food to address concerns with physical and chemical incompatibility of crushed medications and ensure complete dosaging of each medication. However, they will add new guidance that separating crushed medications may not be appropriate for all residents and should not be counted as a medication error unless there are instructions not to crush the medication(s). Facilities should use a person-centered, individualized approach to administering all medications. If a surveyor identifies concerns related to crushing and combining oral medications, the surveyor should evaluate whether facility staff have worked with the resident/representative and appropriate clinicians (e.g., the consultant pharmacist, attending physician, medical director) to determine the most appropriate method for administering medications which considers each resident’s safety, needs, medication schedule, preferences and functional ability. Interpretive guidance related to crushed medications administered via feeding tube will remain unchanged. CMS has revised the facility task/pathway for Medication Administration Observation, CMS 20056, to reflect this change.

- **F865 – QAPI Plan** – CMS stated that they have instructed surveyors to ascertain that a facility is aware of the QAPI requirement, that they are working on developing a QAPI program and that the facility is beginning (if they haven’t already) implementing a QAPI process.

- CMS discussed Survey and Certification Letter 18-04 [click here]. This S&C Letter discusses:
  - The temporary moratorium on imposing certain enforcement remedies for specific Phase 2 requirements – CMS will provide an 18-month moratorium on the imposition of certain enforcement remedies for specific Phase 2 requirements. This 18-month period will be used to educate facilities about specific new Phase 2 standards. The temporary moratorium includes F-tags:
    - F655 (Baseline Care Plan); §483.21(a)(1)-(a)(3)
    - F740 (Behavioral Health Services); §483.40
    - F741 (Sufficient/Competent Direct Care/Access Staff-Behavioral Health); §483.40(a)(1)-(a)(2)
    - F758 (Psychotropic Medications) related to PRN Limitations §483.45(e)(3)-(e)(5)
    - F838 (Facility Assessment); §483.70(e)
    - F881 (Antibiotic Stewardship Program); §483.80(a)(3)
    - F865 (QAPI Program and Plan) related to the development of the QAPI Plan; §483.75(a)(2) and,
    - F926 (Smoking Policies). §483.90(i)(5)
  - For surveys identifying noncompliance of both Phase 1 and the Phase 2 tags specified above, the CMS Regional Office (RO) will follow standard enforcement procedures related to the Phase 1 tag if the Phase 1 tag(s) necessitates the imposition of remedies. For example, if a survey conducted during the moratorium period cites deficiencies both for infection control practices at tag F880 and antibiotic stewardship at tag F881 and the RO determines enforcement remedies are warranted, the RO may impose appropriate remedies as it relates to F880; however, only a Directed Plan of Correction (DPOC) and/or Directed In-Service training (DIST) remedy could be imposed for the findings related to tag F881. Once the temporary moratorium period is over, enforcement for all cited tags will return to the normal enforcement policies.
CMS implemented a freeze on the Health Inspection 5-Star Ratings. Following the implementation of the new LTC survey process on November 28, 2017, CMS will hold constant the current health inspection star ratings on the Nursing Home Compare (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018. This is due to the differing standards and processes between those facilities surveyed under the new survey process compared to prior surveys. The “freezing” of the health inspection star rating also includes complaint investigations conducted on or after November 28, 2017. We expect this freeze to begin in early 2018, and last approximately one year. Note that recent health surveys and complaint investigations conducted before November 28, 2017, will continue to be calculated in a facility’s star rating, including any revisit or changes based on informal dispute resolutions (IDR) or independent IDR. Additionally, the health inspection star rating will no longer use information of the third (oldest) cycle of health inspection survey and complaint investigation data as a part of a nursing home’s health inspection score. The weighted health inspection score and star rating for all nursing homes will then be based on the two most recent cycles of survey data. This change is to account for the fact that the data would have been dropped from the health inspection score because of its age, as part of the normal update process. This change will also occur in early 2018 for all facilities. At that time, the most recent cycle of data will be weighted at 60 percent and the prior cycle of data will receive a 40 percent weighting. CMS will be updating the Five-Star Quality Rating System Technical User’s Guide to reflect these changes.

CMS is also implementing other adjustments to ensure transparency. CMS plans to provide summaries of a facility’s most recent survey findings, such as the total number of deficiencies cited and the highest scope and severity level cited, on NHC. This also includes identifying nursing homes with deficiency-free surveys. CMS will also post the full report of each survey (Form CMS-2567), which provides more details about the survey findings. They expect to implement these changes in early 2018, concurrent with the changes to the Five-Star Quality Rating System. The survey findings of facilities surveyed under the new LTC survey process will be published on NHC, but will not be incorporated into calculations for the Five-Star Quality Rating System for 12 months. CMS will add indicators to NHC that summarize survey findings.

CMS gave an update on the Payroll Based Journal (see also S&C 17-45). They began posting Payroll-Based Journal public use files, which were accessible at https://data.cms.gov/, on November 1, 2017. NHC indicates whether providers have submitted data by the required deadline, and if providers have submitted complete, incomplete or inaccurate data. CMS is updating the data submission specifications to give providers the ability to link employee IDs for an employee that has changed employee IDs within a facility. They posted an updated PBJ policy manual and related information on October 1, 2017 (click here). CMS also stated that once they believe the PBJ data is complete and accurate, they will discontinue the CMS 671 and 672 forms, possibly in early 2018. Additional Quality Measures based on the PBJ data will probably be implemented in 2018.

CMS did not have any update or guidance related to the use of Medical Marijuana. CMS has received no guidance from the Administration. They are aware that many states have adopted laws allowing for the use of medical marijuana, but the Administration, to date, has not made any comment or taken any action. Illinois law now allows for the use of medical marijuana, but IDPH has not proposed any regulations for the use of medical marijuana in health care facilities. There are serious liability issues for facilities with medical marijuana use. Until IDPH outlines the guidelines for use of medical marijuana in health care facilities, facilities considering allowance of medical marijuana should fully discuss this with their legal counsel.

Status of the CMS Special Focus Surveys:
- MDS Special Focus Surveys are discontinued and have been incorporated into the new LTC survey process.
- Dementia Care Special Focus Surveys are continuing through a CMS contract agency.
- Adverse Medication Event Special Focus Surveys are discontinued and are now part of the new LTC survey process.
- Schizophrenia Special Focus Surveys are new and being conducted based off of evidence based diagnosis through a CMS contract agency.

- CMS reiterated that there is no enforcement delay for the Emergency Preparedness requirements. E-tag deficiencies, if warranted, will be cited during the annual survey on a separate 2567. However, except in very rare cases, E-tag deficiencies will be cited mostly at Level 1 or 2.

- Several questions have come into CMS with regard to the Facility Assessment requirement. CMS stated that if facilities use or follow their template (found here), facilities should not have any survey issues. CMS also stated that the Facility Assessment tag should not be cited by surveyors unless there are systemic problems. The bottom line is that the facility must match their staff numbers and competencies to the types of residents they admit and care for.

- CMS stated they are aware of CNA staffing issues and the NATCEP/CEP prohibition or loss. CMS recently issued S&C 18-02 and stated that they are working to find/allow as much flexibility as the law allows. Facilities affected by the NATCEP/CEP prohibition or loss provision, should contact IDPH and work with them through the waiver process.

- CMS also discussed various Medicaid issues. Most of the discussion was on state problems with 'pendings' and they did note that Illinois has a very serious backlog and that CMS was in close contact with Illinois HFS to try to help resolve this huge problem. No action other than discussions was noted.

- There was discussion on the issue of ‘Multiple Citations’. CMS stated that they have instructed State Survey Agencies that multiple citations for the same incident/problem are acceptable. However, CMS also stated that there can be 'no cut and paste'; each multiple deficiency must be specific to the F-tag citation and each citation must be able to stand on its own. Scope and severity of each multiple citation must be assigned individually, specific to the citation.

- There was discussion on Past Noncompliance, but there were more questions/confusion than answers/guidance, so we will discuss this further with CMS and we will do a separate article on this issue in Reg Beat in the near future.

- CMS and some of the ombudsmen at the meeting conducted a session on Involuntary Discharge, including Improper/Wrongful Discharge. CMS, and especially the ombudsmen, believe there is a very serious problem with improper involuntary discharges across the country. Everyone agrees that involuntary discharges are not illegal if the requirements in the law and corresponding regulations are met. The bigger issue is the number of improper involuntary discharges CMS and the ombudsmen believe are occurring. Since July of 2016, CMS has had an ongoing Midwest Involuntary Discharge Initiative. This initiative was divided into two tracks – an enforcement track and a surveyor oversight track. The State Survey Agencies are required to send all transfer/discharge cases/survey findings to the Chicago Region 5 Offices for review and possible imposition of federal enforcement remedies. These would include any deficiencies at tags F622-F626 at a scope and severity of ‘D’ or above. CMS stated that they do a case-by-case review and then take the necessary/appropriate action. For involuntary transfers or discharges, facilities need to make sure there is physician agreement, sign-off and documentation as to why the transfer/discharge is occurring. All other discharge requirements noted in the law and regulations must be followed and thoroughly documented. There is also the new requirement that all notices of involuntary transfer/discharge must be given to the resident, resident representative and ombudsman immediately or as soon as practicable. Also, notices of resident initiated transfer/discharge, therapeutic visits and transfers to the hospital where it is expected that the resident will return to the facility, must be given to the ombudsman at least monthly. CMS also noted that residents who are transferred to the hospital or take therapeutic visits must be informed of the facility’s bed-hold policy.

- CMS discussed the Civil Money Penalty Reinvestment Program. The Social Security Act provides that collected CMP funds may be used to support activities that directly benefit nursing home residents. State Survey Agencies
may contract with, or grant CMP funds to any entity provided that the funds are used for CMS approved projects to protect and improve nursing home services for residents. The CMS resource page for CMP Grants can be found here. The State Survey Agency contact for Illinois is Darlene Harney at DPH.HCR.CMPGRANT@illinois.gov. IHCA is currently working on an initiative for a grant.

- CMS made note of the CMS website that includes all of the information on the New Survey Process (click here). They also reiterated that on their training website (click here), providers can see the same training that the surveyors received with regard to the new survey process.

- CMS introduced a new Beneficiary and Family Centered Care Quality Improvement Organization named KEPRO. KEPRO is a federal contractor for CMS. Each state also has a Quality Innovation Network Quality Improvement Organization (QIN-QIO). KEPRO provides the following services for Medicare beneficiaries:
  - Discharge Appeals and Service Terminations,
  - Beneficiary Complaints, and
  - Immediate Advocacy.

  More information on KEPRO can be found at (https://www.keproqio.com/).

- Enforcement. CMS spent some time going over S&C 18-01 and other related enforcement issues. CMS reiterated that they try to select the most appropriate remedy that will bring about compliance quickly and help maintain continued compliance. CMS did state that they try to consider the extent to which the noncompliance is a one-time mistake or accident, the result of larger systemic concerns, or a more intentional action or disregard for resident health and safety. We argued about fines and the amount of fines and how they could negatively impact resident care, but CMS feels very strong about fines being an appropriate remedy. CMS stated that CHOWs do not make any difference in an enforcement case, the new owner not only buys the operation, they buy the history. CMS stated that providers should use financial hardship, if warranted. It is a tool that facilities can use. The State Association also raised concerns with regard to revisit timeframes. Since penalties are running, revisits in a timely manner are extremely important. CMS agreed and stated they will monitor this and the State Survey Agencies more closely with regard to revisit timelines.

- Life Safety Code and Emergency Preparedness. Eric Mangahis is the new federal CMS Life Safety Code surveyor for Illinois. The LSC team started to discuss the new 2012 LSC survey process and common findings, but was interrupted early on by Capt. Greg Hahn and discussion around the new Emergency Preparedness requirements, and then ran out of time. The only LSC issue they were able to discuss prior to moving into the EP issues dealt with the fire safety plan and the new requirement that the facility must make a phone call to the Fire Department even though they may have direct signaling. We are hopeful that the LSC Section will forward their Top Ten Deficiencies and any other relevant LSC guidance. With regard to the new EP requirements, the Top 5 citations have been:
  - #5 – E36 – Training and Testing – The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan.
  - #4 – E15 – Policies and Procedures – The facility must develop and implement emergency preparedness policies and procedures based on the emergency plan.
  - #3 – E1 – The facility must comply with all applicable federal, state and local emergency preparedness requirements and must establish and maintain a comprehensive emergency preparedness program.
  - #2 – E39 – Testing – The facility must conduct exercises to test the emergency plan at least annually.
  - #1 – E41 – Emergency and Standby Power Systems – The facility must implement emergency and standby power systems based on the emergency plan.

  CMS stated that even if the facility’s emergency plan is to evacuate, the facility must still have an alternate power supply to:
  - Maintain temperatures to protect resident health and safety;
  - Sanitary storage of provisions;
  - Emergency lighting;
Surveyors will look back 12 months at the time of the annual survey to see if the facility has conducted the required exercises. In Illinois, the nurse surveyors will be conducting most of the EP review, with the LSC surveyors reviewing the generator issues.

EP training is available on the federal CMS website (https://surveyortraining.cms.hhs.gov/).

Contact us with any questions.

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**Trending Statistics**

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

**Hospital Stays for Hepatitis C Increase Most Among Baby Boomers**

Hospital stays involving hepatitis C increased 67 percent among “Baby Boomer” patients (ages 52–72) between 2005 and 2014, more than any other age group, according to a new AHRQ statistical brief. During the same period, hepatitis C hospital stays increased 15 percent among people 18 to 51 and 12 percent among people older than 72. The hepatitis C virus is the most common chronic bloodborne pathogen in the United States. Hospital stays involving hepatitis C nearly tripled from 2010 through 2015, likely due to increased needle use associated with the nation's opioid epidemic, the authors noted. AHRQ’s analysis, based on data from the agency’s Healthcare Cost and Utilization Project, quantified trends for adults 18 years and older, including those with and without key co-occurring diagnoses for hepatitis B, HIV and alcoholic liver disease. Access the [statistical brief](https://www.ncbi.nlm.nih.gov/books/NBK289504/).

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

1) The following federal [Survey and Certification (S&C) Letters](https://www.cms.gov/Regulations-and-Guidance/Laws-and-Rules/Survey-and-Certification-Letters) were released since the last issue of *Regulatory Beat*:

- **S&C 18-06** – Hospitals – Clarification of Ligature Risk Policy. Ligature Risks Compromise Psychiatric Patients’ Right to Receive Care in a Safe Setting: The care and safety of psychiatric patients and the staff that provide that care are our primary concerns. CMS is in the process of drafting comprehensive ligature risk interpretive guidance to provide direction and clarity for Regional offices (RO), State Survey Agencies (SAs) and accrediting organizations (AOs).

- **S&C 18-07** – CLIA – CLIA Proficiency Testing (PT) Referral Categories. The final regulations implementing the Taking Essential Steps for Testing Act (“TEST Act”) include three categories for PT Referral, which are based on severity and extent of the violation.

- **S&C 18-08** – NH – An Initiative to Address Facility Initiated Discharges that Violate Federal Regulations. Federal regulations allow facilities to initiate discharges of residents only in specific instances. Despite these protections, discharges which violate Federal regulations continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs. CMS has begun an initiative to examine and mitigate facility-initiated discharges that violate federal regulations. CMS is examining State survey agency’s intake and triage practices for these type of discharge complaints, developing examples of inappropriate and appropriate discharges for surveyors, identifying best practices for nursing homes, developing training and evaluating enforcement options for these types violations. Civil Money Penalty (CMP) Reinvestment Projects Assistance.
CMS is encouraging States to pursue CMP-funded projects that may help prevent facility initiated discharges that violate federal regulations.


- **S&C 18-10** – All – Texting of Patient Information Among Healthcare Providers. Texting patient information among members of the health care team is permissible if accomplished through a secure platform. Texting of patient orders is prohibited regardless of the platform utilized. Computerized Provider Order Entry (CPOE) is the preferred method of order entry by a provider.

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

- **SNF QRP - Full Confidential Feedback Reports - Now Available.** The Skilled Nursing Facility Quality Reporting Program (SNF QRP) Confidential Feedback Reports/Quality Measure Reports containing the assessment and claims-based IMPACT Act measures are now available via the Certification and Survey provider Enhanced Reports (CASPER) Reporting System. For more information on these reports, please refer to the December 6, 2017 [presentation](#) and [audio and transcript](#) on the [SNF QRP Training](#) website.

  **Assessment-based quality measures:**
  - Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)
  - Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function
  - Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)

  **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

**Please note** – CMS has discovered an error in some of the MSPB measure calculations contained in the SNF October 2017 Confidential Feedback/QM reports. The error affects the risk adjustment of the measure. CMS has corrected this issue and the data has been loaded into the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. These facility level quality measures reports are on-demand, user-requested reports in your CASPER folder in QIES. Providers should request an updated version of the report to review the corrected MSPB measure calculation.

If you have questions about the information contained in your report, please contact the SNF QRP Help Desk at **SNFQualityQuestions@cms.hhs.gov**.

- **Home Health QRP:** Transcript and Audio from Removal of Influenza Vaccination Measure from Quality of Patient Care Star Rating Webinar Available. An [audio recording and transcript](#) is now posted on the [Home Health Quality Reporting Training](#) webpage for the December 14, 2017 webinar on Removal of Influenza Vaccination Measure from Quality of Patient Care Star Rating.

- **New Medicare Card: Less Than Four Months until Transition Begins.** On April 1, 2018, CMS will start mailing Medicare cards with new Medicare Beneficiary Identifiers (MBIs) to everyone with Medicare. The MBI will replace the Social Security Number (SSN)-based Health Insurance Claim Number for transactions like billing, eligibility status and claim status after a **transition period.** You must be ready to accept the MBI beginning April 1. People new to Medicare after April 1 will only get a card with the MBI.
  - Get ready to use the new **MBI Format.** Ask your billing and office staff if your system(s) will be ready to accept the 11 digit alpha numeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready.
Consider automatically accepting the new MBI from the remittance advice (835) transaction.

Prepare to process Railroad Retirement Board (RRB) claims: Ensure your staff can identify the RRB Medicare card; program your system to send these patients’ claims to the Specialty Medicare Administrative Contractor (the MBI itself will not indicate it is an RRB beneficiary).

Make and internally test changes to your practice management systems and business processes before April 2018.

Sign up for your Medicare Administrative Contractor’s portal now, so you can use the provider MBI look-up tool starting in June 2018.

Subscribe to the weekly MLN Connects newsletter for updates and new information.

Attend our quarterly calls to learn more. We will let you know when calls are scheduled in MLN Connects.

For More Information:
- Fact Sheet
- Overview webpage
- Provider webpage

**Provider Enrollment Application Fee Amount for CY 2018.** On December 4, CMS issued a notice: Provider Enrollment Application Fee Amount for CY 2018 [CMS–6075–N]. Effective January 1, 2018, the CY 2018 application fee is $569 for institutional providers that are:
  - Initially enrolling in the Medicare or Medicaid program or the Children's Health Insurance Program (CHIP)
  - Revalidating their Medicare, Medicaid, or CHIP enrollment
  - Adding a new Medicare practice location

This fee is required with any enrollment application submitted from January 1 through December 31, 2018.

**If You Submit Paper Claims: Avoid Crossover Issues.** If you submit paper Part B claims (including DMEPOS claims) to Medicare, do not add data or stray marks in item 13 of the CMS-1500 to indicate the beneficiary has not assigned benefits to you. If “no,” “none,” or stray marks appear in item 13, supplemental payers will incorrectly reimburse you instead of your patient.

**Quality Payment Program Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the November 30 call on the Quality Payment Program. During this call, learn about the Year 2 provisions in the final rule with comment and interim final rule with comment.

**December 2017 Catalog — Revised.** A revised December 2017 MLN Catalog is available. Learn about:
  - Products and services you can downloaded for free
  - Web-based training courses; some offer continuing education credits
  - Helpful links, tools, and tips

**Medical Privacy of Protected Health Information Fact Sheet — Reminder.** The Medical Privacy of Protected Health Information Fact Sheet is available. Learn about:
  - Privacy rule
  - How the rule applies to customary health care practices
  - Tips for securing health information when using a mobile device
  - HIPAA resources

**Behavioral Health Integration Services Fact Sheet — Reminder.** The Behavioral Health Integration Services Fact Sheet is available. Learn about:
  - Integrating behavioral health with primary care services
  - Psychiatric Collaborative Care Model
  - How to bill for behavioral health integration services
• **Medicare Basics: Commonly Used Acronyms Educational Tool — Reminder.** The Medicare Basics: Commonly Used Acronyms Educational Tool is available. Learn about:
  - Acronyms frequently used in Medicare publications
  - Webpage references for certain acronyms
  - Creating a personalized list of the acronyms you use

• **Evaluation and Management Services Web-Based Training Course — Reminder.** With Continuing Education Credit. The Evaluation and Management Services Web-Based Training course is available through the Learning Management System. Learn about:
  - Medical record documentation
  - Billing and coding considerations
  - 1995 and 1997 documentation guidelines

• **Physician Compare: 2016 Performance Information Available.** CMS recently added PY 2016 performance information to Physician Compare. For the first time, CMS publicly reported a small subset of 2016 Physician Quality Reporting System (PQRS) group-level measures on Physician Compare profile pages as star ratings. The updated 2016 measures CMS released on the Physician Compare public-facing profile pages include:
  - Fifteen 2016 PQRS measures for groups as star ratings
  - 2016 Consumer Assessment of Healthcare Providers and Systems for PQRS patient experience measures for groups as top-box scores
  - 2016 non-PQRS Qualified Clinical Data Registry measures with performance rates expressed as percentages for clinicians and groups
  - 2016 Accountable Care Organization measures

Data are also available via the Physician Compare Downloadable Database on data.medicare.gov. The 2016 performance information is anticipated to be made publicly available for download in late spring/early summer 2018. While the profile pages are intended for patients and caregivers, the Downloadable Database is a resource for clinicians and group representatives as well as third-party data users.

For More Information:
  - Fact Sheet
  - Physician Compare Initiative website

• **Hospice Payment System Booklet — Revised.** A revised Hospice Payment System Booklet is available. Learn about:
  - Coverage
  - Certification requirements
  - Election periods and statements
  - Payments
  - Option for Medicare Advantage enrollees
  - Hospice Quality Reporting Program

• **Ambulance Fee Schedule Fact Sheet — Revised.** A revised Ambulance Fee Schedule Fact Sheet is available. Learn about:
  - Ambulance transport benefit
  - Providers and suppliers
  - Advance Beneficiary Notice of Noncoverage
  - Payments and payment rates
  - Updates to the Ambulance Fee Schedule

• **Medicare Overpayments Fact Sheet — Revised.** A revised Medicare Overpayments Fact Sheet is available. Learn about:
  - Collection process, tools, and payment options
- Timeframes for the debt collection process

- **PAC QRP – Section GG Web-Based Training Modules Now Available.** CMS is offering a web-based training modules to address questions submitted by providers during training’s between November 2015 and August 2016 related to Section GG across the Skilled Nursing Facility (SNF), Long-Term Care Hospital (LTCH), Inpatient Rehabilitation Facility (IRF) and Home Health (HH) care settings. For details and to view the training specific to each care setting, click on one of the following links:
  - Home Health Quality Reporting Training
  - IRF Quality Reporting Training
  - LTCH Quality Reporting Training
  - SNF Quality Reporting Training

- **Hospice Compare Updates - New Guidance on How to Update Demographic Data.** The demographic data displayed on the Provider Preview Reports and on Hospice Compare is generated from information stored in the Automated Survey Processing Environment (ASPEN) system. If inaccurate demographic data is included on the Preview Report or on Hospice Compare, Hospices need to contact their Medicare Administrative Contractor (MAC) for assistance. When requesting updates to your demographic data, it is important to specify that you want your data within the ASPEN system updated, instead of referring to your data on the Hospice Compare site. View the How to Update Demographic Data 12-21-17 PDF for further information. Please note-updates to Hospice Provider demographic information do not happen in real time and can take up to 6-months to appear on Hospice Compare.

Hospice Compare Tip Sheets. CMS is working to make users experiences finding and comparing hospices more accurate in the following ways:
  - They’re working to improve the data used to power the search over the next several months, and
  - Since hospices report the data on the Compare website, they’re working with hospice agencies to ensure that the data they’re reporting to CMS is accurate and current.

View the tip sheets for users and providers when searching on Hospice Compare. View the Hospice Quality Public Reporting: Background and Announcements webpage for more information.

- **Proposed Phase Four of the National Action Plan to Prevent Health Care-Associated Infections.** ODPHP and the Federal Steering Committee for the Prevention of Health Care-Associated Infections (HAIs) have written a new phase of the National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination (HAI Action Plan). The first 3 phases of the HAI Action Plan meaningfully enhanced coordination of federal efforts to address HAIs by establishing a structure to regularly share best practices, resources and lessons learned among federal partners...

- **National Partnership to Improve Dementia Care and QAPI Call.** This call occurred on December 14, 2017. A copy of the presentation materials can be found at:
  - Presentation [PDF, 2MB]
  - Audio Recording [ZIP, 18MB]
  - Transcript [PDF, 242KB]

3) The Federal HHS Office of the Inspector General reports on an OIG Advisory Opinion No. 17-08. An OIG advisory opinion regarding your proposal to develop a state-wide network of nursing facilities that would provide discounts on the daily rates they charge to private long term care insurers and the insurers’ policyholders (the “Proposed Arrangement”). Specifically, you have inquired whether the Proposed Arrangement would constitute grounds for the imposition of sanctions under the civil monetary penalty provision prohibiting inducements to beneficiaries, section 1128A(a)(5) of the Social Security Act (the “Act”), or under the exclusion authority at section 1128(b)(7) of the Act, or the civil monetary penalty provision at section 1128A(a)(7) of the Act, as those sections relate to the commission of acts described in section 1128B(b) of the Act, the Federal anti-kickback statute.

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

- HFS has provided an Update to the Taxonomy Table for 837p’s. You may view the update here.
- HFS posted a new provider notice regarding Reporting an Admission to Long Term Care Facilities and Supportive Living Program Participants with Current Medicaid Eligibility in the Community. You may view the notice here.
- HFS posted a new provider notice regarding HFS Urges Providers to Sign HealthChoice Illinois Contracts Now. You may view the notice here.
- HFS posted a new provider notice regarding Updates to Hospital Reimbursement Components Effective January 1, 2018. You may view the notice here.
- HFS posted a new provider notice regarding Expansion of Abortion Reimbursement Effective January 1, 2018. You may view the notice here.
- HFS has posted a new provider notice regarding LTC Monthly Occupied Bed Provider Assessment. You may view the notice here.
- The provider notice titled “The Medical Electronic Data Interchange (MEDI) System - Dual Eligible Beneficiaries Enrolled in Medicaid Managed Long Term Services and Supports (MLTSS) and Medicare” issued on December 8, 2017 has been updated to include language in the “special information” section under the MCO segment in MEDI clarifying that DD waiver services are not billed to MLTSS health plans.”

6) The Illinois Department on Aging – Office of the State Long-Term Care Ombudsman reported that they recently sent out a 2nd Notice regarding the Consumer Choice Website (click here). The Consumer Choice website has been developed and meets the requirements of the Illinois Act on the Aging 20 ILCS 105/1 (from Ch. 23, par. 6101) (c-5). Facilities licensed under the Nursing Home Care Act (210 ILCS 45/2-214), the MC/DD Act (210 ILCS 46/2-214), and the ID/DD Community Care Act (210 ILCS 47/2-214) are all mandated to complete the electronic questionnaire provided by the Office of the State Long-Term Care Ombudsman. As of this date, your facility has not complied with the request for an e-mail address which will begin the process of compliance.

7) The American Health Care Association (AHCA) and The Illinois Health Care Association recently reported on:

- 2017 AHCA-NCAL Annual Report and 2018 Focus Areas. AHCA/NCAL President and CEO Mark Parkinson and SVP of Quality and Regulatory Affairs David Gifford would like to share some highlights from 2017 and areas to focus on in the new year. Take a few minutes to watch and share their video.
- A Message from Mark Parkinson. We know that 2017 was one of the toughest years in the history of the profession to operate buildings. The occupancy data speaks for itself with multi-year lows for both skilled nursing facilities (SNF) and assisted living (AL). The reason for the occupancy drop on the SNF side is particularly painful. It is due to reduced length of stay in Medicare stays, which remains the only payor that provides us a positive margin. The Medicare resident days we lost in 2017 are the days we could afford to lose the least. On top of that, the regulatory burden is challenging, maddening, and frustrating. But 2017 also had bright spots. We faced the biggest threat to Medicaid in the history of the profession. Congress came close to approving cuts that
would have been lights-out for most of us. The cuts were in the hundreds of thousands of dollars per building in a profession that is just scraping by right now. But we fought - and we fought hard. And we won. Each of us should be proud of the effort of this profession in refusing to quit and prevailed over this incredible challenge. There were also some bright spots on the regulatory side. The new administration didn’t give us everything we wanted, but it gave us some victories and provides us hope that more will come in 2018. I’m going to provide a summary of where each of our key issues for 2017 ended up and where this is likely headed next year.

- **Impact of Congressional Delay on Medicare Extenders Including Part B Therapy Caps Starting January 1, 2018** *(click here)*. AHCA/NCAL is providing the following in a frequently asked questions (FAQ) format, based on currently available knowledge. You may wish to specifically share questions 1-4 with your billers and therapy clinicians. We have also reached out to CMS for updated guidance, as its Therapy Services webpage does not currently address 2018 therapy cap coverage policy.

- **Pendings Victory. IHCA Member Alert**: There is finally some good news to report on pendings. Last spring IHCA worked with Leading Age of Illinois and the Affordable Assisted Living Coalition on legislation with Representative Norine Hammond to expedite the application and admission process that has led to the pending crisis. The administration informed us that they would change policy to reduce the financial documentation necessary when applying for long term and services and supports for those currently on Medicaid for the previous six months. No details were provided at that time.

Today we had a meeting with the administration about implementation of this new policy. Starting January 1, 2018 the new policy is as follows:

“Upon receipt of admit packets state caseworkers will identify cases of clients who have had active community Medicaid for at least six months immediately prior to seeking LTC services.

- Clients who meet the above criteria will continue be sent the resource transfer and review form (3654) as part of the post eligibility process. However, if their response to the relevant resource and transfer questions is "no", they will be informed that they do not have to return the form. If any questions are answered with a "yes", the form must be signed and returned as the current process dictates. If caseworkers do not receive the returned 3654 form with any "yes" responses from this group of Medicaid enrolled clients within the 10-day deadline CW's will
  - assess client contribution (group care credit) for their care
  - approve the client for LTC services.”

We are going to continue to push for greater administrative action and legislation to address the pending crisis, but this delayed benefit from our spring advocacy is welcomed. We will provide updates as more information becomes available.

- **Duane Morris** provided the following information:

  - **Unclaimed Property Changes**: Click here to read an article authored by our friends at Duane Morris (Stan Kaminski and Maureen McClusky) on the changes coming 1/1/18 with the Unclaimed Property Act. This Act replaces the old one and stipulates:
    1. Property not reportable under the old Act for the last five years is now required to be reported under this new act.
    2. Creates specific exceptions for a new three-year general abandonment period, which will require you to change accounting of unclaimed property.
    3. Creates an unlimited statute of limitations against those businesses that fail to file reports.
    4. It allows the state to contract with third-party auditors using a contingent-fee arrangement.
    5. Expands the state’s jurisdiction to take custody of unclaimed property.
8) The latest Telligen events/announcements can be found at https://www.telligenqinqio.com/.

9) CBS Boston reports MIT Researchers Make Potentially Groundbreaking Alzheimer’s Discovery. CBS Boston recently reported that Massachusetts Institute of Technology (MIT) researchers at the Picower Institute for Learning and Memory have found a way to reverse memory loss in mice. Dr. Jay Penney and his team focused on one enzyme that has been proven to cause memory loss in people with Alzheimer’s. “What we’ve done is found a new way to basically prevent this negative effect of this enzyme,” essentially by turning it off, he says. This did not just stop the memory loss in the lab mice, it actually reversed it. Penney remarks, “We seem to have been able to pinpoint its role in memory processes quite specifically.” If it does the same thing for human beings with Alzheimer’s, the hope is to one day develop a drug to treat the disease. This marks the first time scientists have been able to switch the enzyme off without causing other kinds of problems. Testing on people, though, is many years away.

10) National Pain Report writes that Researchers Focusing on Pain Management in Elderly. Elderly people present a unique series of challenges to health providers with respect to managing pain. “Pain is prevalent and often undertreated among older adults,” said Robert Gatchel, UTA Distinguished Professor of Psychology, Nancy P. and John G. Penson Endowed Professor of Clinical Health Psychology and director of UTA’s Center of Excellence in Health & Chronic Illness. “With 20 percent of Americans expected to be 65 or older by 2030, the development of new and effective pain management strategies is a necessity, especially given that 75 percent of people in this age group have two or more chronic conditions such as heart disease, arthritis or diabetes, which complicate the taking of pain medications,” he added.

11) Today’s Geriatric Medicine reports Mini-Strokes Can be an Ominous Prelude to Catastrophic Strokes. Each year, more than 200,000 Americans experience mini-strokes known as transient ischemic attacks (TIAs). Patients suffer stroke-like symptoms such as paralysis on one side or difficulty speaking. While symptoms typically disappear in less than a few minutes and there's no brain damage, TIAs often are followed by severe strokes. TIAs are an “ominous prelude to an impending cerebrovascular catastrophe, but also the opportunity to prevent a disabling event,” Loyola Medicine neurologists Camilo R. Gomez, MD; Michael J. Schneck, MD; and José Biller, MD, report in the journal F1000Research. However, the Illinois neurologists add that rapid evaluation and treatment can reduce the risk of stroke by about 80 percent during the dangerous first week following a TIA. Most strokes are ischemic, meaning they are caused by blood clots that block blood flow to a part of the brain. TIAs also are caused by blood clots, but the clots quickly dissolve or are dislodged. However, there’s a 5 percent to 10 percent risk of suffering a stroke during the 30 days following a TIA, and 15 percent to 20 percent of ischemic stroke patients report having experienced an earlier TIA. Full story.

12) Eurekalert reports that Screening Could Prevent a Quarter of Hip Fractures in Older Women. Community screening for osteoporosis could prevent more than a quarter of hip fractures in older women, according to new research. A new study, published in The Lancet, has shown that a simple questionnaire, combined with bone mineral density measurements for some, would help identify those at risk of hip fracture. The research, involving more than 12,000 older women and carried out in collaboration between the universities of Birmingham, East Anglia, Bristol, Leicester, York and Sheffield, found that screening through GP practices allowed patients to be targeted for treatment. In women agreeing to participate, this led to a 28 per cent reduction in hip fractures over five years.

13) News Medical reports that One in Two Older Adults Has Suboptimal Vitamin D Levels. One in two persons aged 65 and above has suboptimal levels of vitamin D in the blood. This is the conclusion of an investigation conducted by researchers at the Helmholtz Zentrum München, as part of the population-based KORA-Age study in the region of Augsburg. Moreover, as the authors of the study report in the peer-reviewed journal ‘Nutrients’, one in four older adults has suboptimal vitamin B12 levels.

14) MedlinePlus reports, New Cancer Drug Shows Promise Against Wide Range of Tumors. A new drug that targets a genetic flaw common to most cancer cells is showing potency against many tumor types. The preliminary trial of a drug
called  ulixertinib was conducted with 135 patients who had already failed treatments for one of a variety of advanced, solid tumors.

15) Managed Health Care Connect reports on Distinguishing Early Dementia From Normal Aging. A new model of normal cognitive decline that takes age and education into account can be used to identify patients in the early stages of dementia, according to a new report in CMAJ. “Being able to screen these patients early, when they are only starting to fall off the curve, that’s really where you can intervene and have an impact,” Dr. Robert Laforce Jr. of the Universite Laval in Quebec, one of the study’s authors, told Reuters Health in a telephone interview. Similar to the growth charts used in pediatricians’ offices, these predictive curves allow clinicians to track patients’ cognitive function over time, Dr. Laforce and his colleagues explain in their December 4 report. Their model is called QuoCo (cognitive quotient) and incorporates age, Mini Mental State Examination (MMSE) score, and education.

16) HealthLeaders Media reports on CMS Proposes Patient Questionnaire Led by AHCA for SNFs in 2018. HealthLeaders Media reported that CMS recently released its List of Measures under Consideration for 2018 pre-rule making. Among the components of the measures is the "CoreQ: Short Stay Discharge Measure," led by the AHCA, which "will include a four-item patient questionnaire intended to gauge the individual’s satisfaction with their stay."

17) Provider Magazine reports, SNF Occupancy Falls to Five-Year Low. Provider Magazine says the Skilled Nursing Data Report published by the National Investment Center for Seniors Housing & Care (NIC) found occupancy at SNFs nationwide "declined to 81.6 percent in the third quarter of 2017, a slight decrease from the previous quarter and a sharper fall-off from year-ago levels." The rates were down 29 basis points from the second quarter and "down 167 basis points from the same quarter of 2016." The report also found "third-quarter Medicare patient-day mix declined 58 basis points from the second quarter and 84 basis points from year-earlier levels."

18) The Washington Post reports that Loneliness May Increase Risk of Getting Sick. The Washington Post reports new research indicates people who are lonely "are more likely to get sick." Researchers are investigating what causes this relationship, with three speaking at the Aspen Ideas Festival on how loneliness impacts the body, such as leading to inflammation and neurological changes, as well as how health care providers are reacting. The piece adds that "research presented to the American Psychological Association this summer...posited that loneliness is a bigger public health risk than obesity."

19) The Hill reports that Medicaid to Face Tests in 2018. According to The Hill, "Medicaid could face crucial tests in 2018 at both the federal and state levels." GOP efforts to cut it at the federal level are expected, with House Speaker Paul Ryan saying in December that "health-care entitlements such as Medicare and Medicaid are the big drivers of debt." However, "any entitlement cuts from Ryan will likely face pushback from members of his own party." Meanwhile, "advocates worry that unprecedented flexibilities offered by the Trump administration will allow states to completely change the nature of Medicaid." Administration officials have said they will allow "work requirements, time limits and lockout periods for people who can’t pay their premiums on time." However, advocates say such provisions cast Medicaid as "a welfare program, instead of health insurance."

20) The New York Times reports:

- Research on Loneliness and Social Isolation indicates it can Lead to Cognitive Impairment. The New York Times reports on the state of research into the "potentially harmful effects of loneliness and social isolation on health and longevity," including work regarding "who is likely to be most seriously affected, and what kinds of interventions may reduce the associated risks." Julianne Holt-Lunstad and Timothy B. Smith, both at Brigham Young University, explained that "loneliness and social isolation don’t necessarily go hand-in-hand," because, "isolation denotes few social connections or interactions, whereas loneliness involves the subjective perception of isolation." Holt-Lunstad has found that "loneliness peaks in adolescents and young adults, then again in the oldest old." Loneliness has also been suggested as "a preclinical sign for Alzheimer’s disease." The Times cites several studies finding that loneliness, but to a much greater degree depression, appears to lead to cognitive impairment.
- **Trump Administration Moves to Reduce Use of Fines Against Nursing Homes.** *The New York Times* reported that the Trump Administration has moved to scale back the use of fines against nursing homes which have injured residents or have put them "in grave risk of injury," a shift which "was requested by the nursing home industry" – notably the American Health Care Association, which "has complained that...federal inspectors focused excessively on catching wrongdoing rather than helping nursing homes improve." AHCA President and CEO Mark Parkinson wrote in a letter to President Trump in December 2016, "It is critical that we have relief." David Gifford, the AHCA's senior vice president for quality, "said daily fines were intended to prompt quick remedies but were pointless when applied to past errors that had already been fixed by the time inspectors discovered them," adding that providers "were seeing massive fines accumulating because they were applying them on a per-day basis retrospectively." The piece also quotes CMS Administrator Seema Verma as saying after the agency rescinded a rule banning nursing homes from requiring arbitration agreements that the "nearly 11,000 pages of regulation" CMS publishes each year is "taking doctors away from what matters most: patients."

21) **Skilled Nursing News** reports:

- **Reducing Avoidable Hospitalizations Requires SNFs to Add More Advanced Practice Nurses.** *Skilled Nursing News* reports that CMS recently released an analysis showing its initiative to "reduce avoidable hospitalizations among nursing facility residents" as part of the Missouri Quality Initiative for Nursing Homes (MOQI) met its goal, finding that if nursing homes want to reduce hospitalizations, they must have more nursing personnel. A parallel program in Indiana, also supported by CMS, similarly "found embedding nurses and nurse practitioners could significantly reduce potentially avoidable hospitalizations through its OPTIMISTIC program." The article says the Missouri program "reduced hospitalizations from all causes by 33 percent and potentially avoidable hospitalizations by 48 percent."

- **CMS Seeks Suggestions From SNFs on New Data Assessment Rules.** *Skilled Nursing News* recently reported that CMS has joined the RAND Corporation to set and institute "a standard post-acute patient assessment data plan" as part of the IMPACT Act of 2014, although they are "behind their target number of Medicare-eligible SNF participants, officials indicated on an Open Door Forum call held Tuesday afternoon." CMS and RAND had recruited 172 of the 210 facilities for inclusion in the testing process by late November, and of the groups, SNF participation is the lowest, with 67 of 84 operators agreeing to participate. CMS will lead another round of training for interested operators on January 31 and February 1.

22) **FierceHealthcare** reports that **CMS Adds New Quality Measures to Long-Term Care, Inpatient Rehabilitation Comparison Websites.** *FierceHealthcare* reports CMS added new quality measures to its websites showing patient data on long term care and inpatient rehabilitation facilities. The new measures focus on vaccination and infection rates.

23) **HealthDay** reports that **Almost 75 Percent of Older Americans Believe Nursing Home Employees Should be Vaccinated Against the Flu Each Year.** *HealthDay* reports a recent poll from the University of Michigan and AARP found "almost three-quarters of Americans over the age of 50 think all nursing home employees should get a flu vaccine every year." The study included responses from more than "2,000 men and women between the ages of 50 and 80," and indicated that more than 60 percent of respondents believe all patients at nursing homes and assisted living facilities also should be vaccinated. The piece adds that CDC data show "less than seven in 10 long-term care workers routinely get vaccinated against the flu."

24) **Modern Healthcare** reports:

- **Reduced Hospitalizations Do Not Drive ACO Savings.** *Modern Healthcare* reports that researchers at Harvard Medical School found that hospitalizations did not decline for patients in the Medicare Shared Savings program over a three-year period, according to a study published in *Health Affairs*. As a result, the "net savings from Medicare’s accountable care organizations weren’t driven by reductions in hospitalizations despite the program’s emphasis on tackling costly inpatient stays." The article adds that the "authors suggest the ACO payment policy be retooled to give greater consideration to how the model improves patient experience and clinical outcomes as opposed to utilization measures like number of hospitalizations or readmissions."
Survey Finds 60 Percent of Medical Practices’ Medicare Revenue Expected to be Risk-Based by 2019. ModernHealthcare reports, a new survey released recently found that by 2019, 59 percent of “medical practices’ Medicare revenue will come from pay models that require the providers to take downside risk.” The survey of AMGA members forecasted that "if Medicare Advantage, bundled payments and Medicare accountable care organizations are factored together, alternatives to Medicare fee-for-service, or FFS, are predicted to account for 59 percent of AMGA member’s revenue by 2019, compared to 53 percent in 2017." Medicare FFS is expected to decline by 17 percent by 2019 and commercial FFS may decline by 11 percent.

CMS Unveils Retooled Hospital Star Ratings Formula. ModernHealthcare reports, "CMS announced Thursday it has added updated star ratings to its Hospital Compare site using a new methodology after a five-month delay." The article explains that CMS "had postponed the release of the star ratings since July as it worked to change the methodology and gather stakeholder feedback." The new methodology "slightly flattens the usual bell-curve of hospitals that receive stars on a scale of 1 to 5," and "the number of hospitals with 1 or 5 stars has risen."

Kaiser Health News reports:

Complaints About Allegedly Wrongful Nursing Home Evictions Rising. Kaiser Health News reports on the rising number of complaints from nursing home residents about "allegedly improper evictions and discharges." The piece says that in California, a state which government data show has had a significant rise in the number of complaints, allegations "have jumped 70 percent in five years, reaching 1,504 last year," and nationwide, "ombudsmen say many patients...end up with no permanent housing or regular medical care after being discharged," adding that when discharges are considered legal, often they are "unethical." The piece adds that senior care advocates argue that even when they win the appeal process, patients do not always benefit, and that although CMS "advised California on two occasions...that it must enforce decisions from appeals hearings," advocates worry patients do not receive their rights.

Analysis: Infection Control Lapses “Rampant” in Nursing Homes, but CMS Penalties are “Rare.” Kaiser Health News reports that "a Kaiser Health News analysis of four years of federal inspection records shows 74 percent of nursing homes have been cited for lapses in infection control – more than for any other type of health violation." However, "disciplinary action such as fines is rare: Nationwide, only 1 of 75 homes found deficient in those four years has received a high-level citation that can result in a financial penalty, the analysis found." American Health Care Association senior director of clinical services Holly Harmon "said the industry has made strides in combating infections through better training and encouragement for staff members to look for gaps in infection control and to speak up about them." She added, "Infection prevention control is a priority. The path really is focused on continuous improvement."

New Federal Rules Will Require Home Health Agencies to do Much More for Patients. Home health agencies will be required to become more responsive to patients and their caregivers under the first major overhaul of rules governing these organizations in almost 30 years. The federal regulations, published last month, specify the conditions under which 12,600 home health agencies can participate in Medicare and Medicaid, serving more than 5 million seniors and younger adults with disabilities through these government programs. They strengthen patients’ rights considerably and call for caregivers to be informed and engaged in plans for patients’ care. These are “real improvements,” said Rhonda Richards, a senior legislative representative at AARP. Home health agencies also will be expected to coordinate all the services that patients receive and ensure that treatment regimens are explained clearly and in a timely fashion. The new rules are set to go into effect in July, but they may be delayed as President Donald Trump’s administration reviews regulations that have been drafted or finalized but not yet implemented. The estimated cost of implementation, which home health agencies will shoulder: $293 million the first year and $234 million a year thereafter.

McKnight’s reports:

MEDPAC Members Unanimously Supported Incremental Transition to New Pay Model. McKnight’s Long Term Care News reports that members of the Medicare Payment Advisory Commission (MedPAC) "expressed
unanimous support for a plan to transition to a new post-acute payment system beginning in 2019 at a meeting last week,” suggesting a two-year, “incremental transition plan last month that would ‘blend’ the current payment rates with those in the group’s recommended unified post-acute payment system.” Members said the gentler transition into the new rates could promote more time to adjust to the new method. The pay rates "would be blended in 2019 and 2020, with a complete move to the new system slated for 2021," and the group "is expected to vote on the transition plan during its January meeting."

- **Penalizing Hospitals to Reduce Readmissions May Lead to Compromises in Patient Care.** *McKnight’s Long Term Care News* reports a recent study found that after financial penalties were implemented, hospital readmission rates decreased; however, an analysis by STAT indicates skeptics are uncertain whether the reduction in readmissions means patients have better health or whether "hospitals are taking shortcuts." University of Michigan researchers, who conducted the study, "found a large percentage of the reduction in readmissions following the Hospital Readmission Reduction Program has been attributable to changes in the way hospitals are describing their patients in claims data." When hospitals describe patients as being sicker, they "can increase their risk adjustments and reduce financial penalties."

- **Nearly Six Percent of Nursing Homes Inflate Self-Assessments to Improve Ratings.** *McKnight’s Long Term Care News* reports that a new study published by the National Institute for Health Care Management Foundation found "at least 6 percent of nursing homes inflate their self-reported measures – ‘most often the larger and for-profit facilities that stand to gain most financially by improving their scores.’” Researchers collected data from 1,200 California nursing homes from between 2009 and 2013 and reviewed measures such as facilities’ Five-Star ratings. The piece adds that the American Health Care Association advises to "always use multiple resources to determine a facility’s quality." Beth Martino, AHCA’s senior vice president of public affairs, said, "Nursing Home Compare, and the information it contains, is just one source that people can use to get an understanding of the care a facility provides. ... Visiting facilities in person and spending time there is one of the best ways people can obtain firsthand information (about) the care provided."

- **More Than 20 Percent of Adults Aged 85 and Older Require ADL Assistance.** *McKnight’s Senior Living* reports that recent data released by the CDC’s National Center for Health Statistics show that 21.7 percent of adults aged 85 and older "needed help with activities of daily living in the first half of the year." The January-to-June National Health Interview Survey found "adults in that age range are more than twice as likely as those aged 75 to 84 (8.5 percent) and more than six times as likely as adults aged 65 to 74 (3.4 percent) to need ADL assistance." The piece adds that seven percent of adults aged 65 or older "need help [with] personal care such as eating, bathing, dressing and walking."

- **Managed Care Organizations Accused of Withholding Medicaid Payments From SNFs.** *McKnight’s Long Term Care News* reports several managed care organizations offering Medicaid coverage in Illinois have been “accused in federal court of taking too long to get payments to skilled nursing facilities.” A group of nine organizations filed a complaint in US District Court against the organizations whose state contracts obligate them to have beneficiaries in need of treatment, alleging "Aetna Better Health Inc., Meridian Health Plan, Humana Inc., and Molina Health care of Illinois Inc. violated federal law because they didn’t process and pay bills in a timely manner."

- **SNF Cost Comparison Report Reveals ‘Paralyzing’ Data Divide.** With fewer hospitalizations and fewer referrals, it’s more important than ever that skilled nursing facilities know where their patients come from and how they can best serve them. But an annual report designed to help long term care operators see how they stack up against the competition shows that many are struggling to transform data into actionable information. “We have noted that SNFs either don’t have the data necessary to make decisions, or they have adequate data but lack the understanding to interpret it,” wrote the authors of CliftonLarsonAllen’s 32nd Edition of the Skilled Nursing Facility Cost Comparison Report. “In extreme cases, SNFs are paralyzed by the overabundance of information available.”
Providers Awaiting Decision From Congress on Therapy Caps. McKnight’s Long Term Care News reports providers are concerned about the future of therapy caps, which Congress could eliminate this year. An exception to the cap limit allowing Medicare Part B patients “to receive medically necessary treatment above the standard caps set by CMS” was effective until December 31, “meaning the cap is back in effect for all rehab settings including nursing homes.” Cynthia Morton, executive vice president of the National Association for the Support of Long Term Care, observed, "As we get into late January and into February, patients will begin to hit" CY 2018 therapy caps, which underscores the need for providers to "communicate this to patients and help them understand the state of their benefits."

Interesting Fact: WIND CHILL IS CALCULATED USING A PRECISE FORMULA. When the weatherman reports a “real feel” temperature of -10 degrees outside, it may sound like he’s coming up with that number on the spot. But wind chill is actually calculated using a complicated equation devised by meteorologists. For math nerds who’d like to test it at home, the formula reads: Wind Chill = 35.74 + 0.6215T – 35.75(V^0.16) + 0.4275T(V^0.16).