March 20, 2018 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!

Survey Tools

This edition of Regulatory Beat includes two tools that facilities can use to help insure compliance with various aspects of the new survey process. This first is a tool for the NFPA 99 Risk Assessment and the other is a tool for the Emergency Preparedness program. IDPH and/or federal surveyors will be looking for compliance for both provisions/areas noted below.

NFPA 99 Facility Risk Assessment Tool
(click here to download form for facility use)

NFPA 99 Risk Assessment

This risk assessment has been developed to comply with NFPA 99 (2012 Edition) risk-based process. NFPA 99 (2012) requires facilities to be designed to meet system risk categories 1 through 4 as described in the code. Based on a facility’s risk assessment being competed the facility would follow the requirements of each chapter. Each chapter is also divided into the four risk categories based on either New or EXISTING and instructs facility of the requirements.

Risk Assessment Instructions
NFPA 99 (2012)

Attached are two risk assessment tools that may be used to implement the requirements of NFPA 99:

- Facility Systems
- Electrical Equipment and Gas Equipment

The Facility Systems Risk Assessment includes determination of risk for the following: Gas and Vacuum Systems (Chapter 5), Electrical Systems (Chapter 6), and HVAC (Chapter 7).

The Electrical Equipment and Gas Equipment Risk Assessment addresses the risk determination for Electrical Equipment (Chapter 10) and Portable Patient Gas Equipment (Chapter 11).

The assessments are designed to aide facilities to determine risk as outlined in NFPA 99 and the steps to meet compliance. These risk assessments should be kept for review and updated periodically as facility systems/equipment change. CMS has established compliance requirements (K Tag) for the risk assessment and its completion.
The K tag is:

| K901 | Fundamentals – Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) |

Completion of Risk Assessments:
Enter the risk category (number 1 through 4) of for each room identified item set (room or equipment) based on the risk categories summarized below and as outline in NFPA 99 Chapter 4. Facilities should assess the risk for equipment for “appliances and equipment used in patient care rooms of health care facilities.”

Facilities need to develop a risk team that is familiar with the requirements of NFPA 99 as well as the facility’s systems including Electrical, HVAC, Medical Gases, resident care and environmental operations. Risk teams need to also understand the risk categories and how systems/equipment operations affect resident safety.

The risk categories are below:

<table>
<thead>
<tr>
<th></th>
<th>Facility systems in which failure of such equipment or systems is likely to cause major injury or death of residents or staff is designated category 1 requirements as defined by the NFPA 99-2012 edition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Facility systems in which failure of such equipment or systems is likely to cause minor injury of residents or staff is designated category 2 requirements as defined by the NFPA 99- 2012 edition</td>
</tr>
<tr>
<td>2</td>
<td>Facility systems in which failure of such equipment or systems is not likely to injury of residents or staff but can cause discomfort to residents is designated category 3 requirements as defined by the NFPA 99- 2012 edition</td>
</tr>
<tr>
<td>3</td>
<td>Facility systems in which failure of such equipment or systems would have no impact on residents or staff is designated category 4 requirements as defined by the NFPA 99- 2012 edition</td>
</tr>
<tr>
<td>Room</td>
<td>Type</td>
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<td>-----------------------</td>
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<tr>
<td>Resident Rooms</td>
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<tr>
<td>Rehabilitation</td>
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<tr>
<td>Custodial Care</td>
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<tr>
<td>Dementia/ Alzheimer's</td>
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<tr>
<td>Respiratory/ Ventilator</td>
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<td>Wound</td>
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<tr>
<td>Behavior/ Mental Health</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Therapy</td>
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<tr>
<td>Physical Therapy</td>
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<tr>
<td>Occupational Therapy</td>
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<tr>
<td>Speech Therapy</td>
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<tr>
<td>Respiratory Therapy</td>
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<td>Other:</td>
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<tr>
<td>Nursing</td>
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<td>Nursing Stations</td>
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<td>Medication Room</td>
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<td>Clean Utility</td>
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<td>Central Supply</td>
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<td>Oxygen Storage</td>
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<td>Soiled Utility/ Trash</td>
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<td>Other:</td>
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<tr>
<td>Other</td>
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<tr>
<td>Offices</td>
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<td>Kitchen</td>
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<td>Dining Room(s)</td>
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<tr>
<td>Staff Break Room(s)</td>
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<td>Laundry</td>
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<tr>
<td>Lobby/ Louges</td>
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<td>Public Rest Rooms</td>
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<tr>
<td>Activities</td>
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<tr>
<td>Beauty Shop</td>
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<tr>
<td>Medical Records</td>
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<td>Other:</td>
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<tr>
<td>Maintenance</td>
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<tr>
<td>Boiler Room</td>
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<tr>
<td>Generator/ Electrical</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>
Facilities should assess the risk for equipment for “appliances and equipment used in patient care rooms of health care facilities.”

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Item#</th>
<th>Risk</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BiPap/ Cpap</td>
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<tr>
<td>Bladder Scanner</td>
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<tr>
<td>Bone Stimulator</td>
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<tr>
<td>Cell Phone w/charger</td>
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<tr>
<td>CPM</td>
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<tr>
<td>Defibrillator</td>
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<tr>
<td>DVD</td>
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<tr>
<td>DVT Pump</td>
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<tr>
<td>E Stem machine</td>
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<td>ECG Machine</td>
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<tr>
<td>EKG Machine</td>
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<tr>
<td>Electric Bed</td>
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<tr>
<td>Electric Wheel Chair w/charger</td>
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<tr>
<td>Game System Player</td>
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<td>IV Pump</td>
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<tr>
<td>Lamp</td>
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<tr>
<td>Laptop/w charger</td>
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<td>Lift Chair</td>
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<td>Low-air Loss Mattress</td>
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<tr>
<td>Oxygen Concentrator</td>
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<td>Oxygen Regulator</td>
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<td>Pulse Oximeter</td>
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<td>Scale</td>
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<tr>
<td>Suction Equipment</td>
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<td>Task Lighting/ Lamps</td>
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<tr>
<td>Television</td>
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<td>Tube Feed Pump</td>
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<tr>
<td>Ultrasound machine</td>
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<tr>
<td>Ventilator</td>
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<tr>
<td>Vital sign monitor</td>
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<tr>
<td>Wheel Chair Battery Charger</td>
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<tr>
<td>Wound Vac</td>
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<tr>
<td>Oxygen Storage (Tank)</td>
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<td>Oxygen Storage (Liquid)</td>
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<tr>
<td>Oxygen Concentrator</td>
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<td>Other:</td>
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</table>

Special thanks to Frank Caruso for sharing this tool.
Emergency Preparedness Tool

The IDPH surveyors (both Life Safety and Health) will be using a similar survey document to verify compliance with the new CMS Emergency Preparedness (EP) requirements. Facilities (both LTC and ICF/IID) can use this tool to evaluate their compliance with the required Emergency Preparedness regulatory provisions.

E-0001 – Establishment of the Emergency Program – The facility must comply with all applicable Federal, State, and local Emergency Preparedness (EP) requirements. The facility must establish and maintain a comprehensive EP program that meets the requirements of this section. The EP program must include, but not be limited to, the development of an EP program that describes a facility’s comprehensive approach to meeting the health, safety, and security needs of their staff and residents during an emergency or disaster situation. The EP program must also address how the facility would coordinate with other healthcare facilities as well as the whole community during an emergency or disaster. MET NOT MET

E-0004 – Develop and Maintain EP Program – The facility must develop and maintain an EP plan that must be reviewed and updated at least annually. MET NOT MET

E-0006 – Maintain and Update EP Plan Annually – The EP plan must be based on and include a documented, facility based and community based risk assessment, utilizing an all-hazards approach, including missing residents. The EP plan must also include strategies for addressing emergency events identified by the risk assessment. MET NOT MET

E-0007 – EP Program/Resident Population – The EP plan must address resident population, including, but not limited to, persons at-risk, the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plan. MET NOT MET

E-0009 – Process for EP Collaboration – The EP plan must include a process for cooperation and collaboration with local, regional, State and federal EP officials’ efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. MET NOT MET

E-0013 – Development of EP Policies and Procedures – Facilities must develop and implement EP policies and procedures, based on the emergency plan, risk assessment and the communication plan. The policies and procedures must be reviewed and updated at least annually. MET NOT MET

E-0015 – Subsistence Needs for Staff and Residents – At a minimum, the policies and procedures must address the following: (1) the provision of subsistence needs for staff and residents whether they evacuate or shelter in place including food, water, medical and pharmaceutical supplies; and (2) an alternate source of power to maintain temperatures to protect resident health and safety, safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems and sewage and waste disposal. MET NOT MET

E-0018 – Procedures for Tracking of Staff and Residents – A system to track the location of on-duty staff and residents in the facility’s care during an emergency, both if sheltering in place or evacuation and relocation of residents. The LTC facility must document the specific name and location of the receiving facility or other location in an evacuation/relocation. MET NOT MET

E-0020 – Policies and Procedures for an Evacuation – Safe evacuation from the facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities, transportation, identification of evacuation locations(s); and primary and alternate means of communication with external sources of assistance. MET NOT MET

E-0022 – Policies and Procedures for Sheltering in Place – The facility must have a means to shelter in place for residents, staff and volunteers who remain in the facility during an emergency situation. MET NOT MET

E-0023 – Policies and Procedures for Medical Documentation – The facility must have a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains availability of records. MET NOT MET
E-0024 – Policies and Procedures for Volunteers – The facility must plan for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and federal designated health care professionals to address surge needs during an emergency. MET NOT MET

E-0025 – Arrangement with Other Facilities – The facility must develop arrangements with other facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. MET NOT MET

E-0026 – Roles Under a 1135 Waiver Declared by the Secretary of HHS – The role of the facility under a waiver declared by the HHS Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. MET NOT MET

E-0029 – Development of a Communication Plan – The facility must develop and maintain an EP communication plan that complies with federal, State and local laws. This communication plan must be reviewed and updated at least annually. MET NOT MET

E-0030 – Communication Plan, Names and Contact Information – The communication plan must include names and contact information for staff, resident’s physicians, other facilities and volunteers. MET NOT MET

E-0031 – Communication Plan, Emergency Officials Contact Information – The communication plan must include contact information for federal, State, regional and local emergency preparedness staff; the State Licensing and Certification agency (IDPH); the Office of the State Long-Term Care Ombudsman; an any other identified sources of assistance. MET NOT MET

E-0032 – Primary/Alternate Means for Communication – The facility must have primary and alternate means for communicating with the facility’s staff and federal, State, regional and local emergency management agencies. MET NOT MET

E-0033 – Methods for Sharing Information – The facility must develop a method for sharing information and medical documentation for residents under the facility’s care, as necessary, with other health providers to maintain the continuity of care. MET NOT MET

E-0034 – Sharing Information of Occupancy/Needs – The facility must have a method for providing information about the facility’s occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. MET NOT MET

E-0035 – LTC and ICF/IID Family Notifications – The facility must have a method for sharing information form the emergency plan, that the facility has determined is appropriate, with the residents and their families or representatives. MET NOT MET

E-0036 – Emergency Preparation Training and Testing – The facility must develop and maintain an EP training and testing program that is based on the facility’s emergency plan, risk assessment, policies and procedures and communication plan. The training and testing program must be reviewed and updated at least annually. MET NOT MET

E-0037 – Emergency Preparation Training Program – The facility must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement/contracts, and volunteers consistent with their respective roles; provide EP training at least annually; maintain documentation of the training; and demonstrate staff knowledge of emergency procedures. MET NOT MET

E-0039 – Emergency Preparation Testing Requirements – The facility must conduct 2 exercises to test the emergency plan at least annually, including unannounced drills using emergency procedures. The facility must participate in (1) a
full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility based exercise. If the facility experiences an actual natural or man-made emergency that requires activation for the facility emergency plan, the facility is exempt from engaging in a community-based or individual facility based exercise for 1 year following the onset of the actual event; and (2) conduct an additional exercise that is either community-based or individual facility based that could also be a tabletop exercise. A tabletop exercise is one that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. The facility must analyze its response to and maintain documentation of all drills, tabletop exercises and emergency events, and revise the facility’s emergency plan as needed. MET NOT MET

E-0041 – LTC Emergency Power (ICF/IID facilities are exempt from this requirement) - LTC facilities must implement emergency and standby power systems (generators) based on the emergency plan. The generator must be located according to NFPA requirements. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in NFPA. The LTC facility must maintain an onsite fuel source to power emergency generators and must have a plan for how it will keep emergency power systems operational during an emergency, unless or until it evacuates. MET NOT MET

E-0042 – Integrated Healthcare Systems – If a facility is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the facility may choose to participate in the healthcare’s coordinated emergency preparedness program. If elected, the unified and integrated EP program must do the following: (1) demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated EP program; (2) be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered; (3) demonstrate that each individual certified facility is capable of actively using the unified and integrated EP program and is in compliance with the program; (4) the unified and integrated emergency plan must be based on both a documented community-based risk assessment and a documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach; and (5) include integrated policies and procedures, coordinated communication plan, and training and testing programs that meet all of the above requirements. MET NOT MET

NOTE: The IDPH Life Safety Code surveyors will review tags E-0015, E-0022 and E-0041. The IDPH health surveyors will review all of the other EP requirements.

For a complete copy of the new CMS Emergency Preparedness requirements, interpretive guidelines and survey procedures, click here.

Trending Statistics

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

How Many Seniors Are Living in Poverty?

National and State Estimates Under the Official and Supplemental Poverty Measures in 2016

Payments from Social Security and Supplemental Security Income have played a critical role in enhancing economic security and reducing poverty rates among people ages 65 and older. Yet many older adults live on limited incomes and have modest savings. In 2016, half of all people on Medicare had incomes less than $26,200. This analysis provides current data on poverty rates among the 49.3 million seniors in the U.S. in 2016, as context for understanding the implications of potential changes to federal and state programs that help to bolster financial security among older adults.

The U.S. Census Bureau currently reports two different measures of poverty: the official poverty measure and the Supplemental Poverty Measure (SPM). Unlike the official poverty measure, the SPM reflects available financial
resources and liabilities, including taxes, the value of in-kind benefits (e.g., food stamps), and out-of-pocket medical spending (generally higher among older adults), and geographic variations in housing costs. This analysis presents national and state estimates of poverty under both measures for adults ages 65 and older. Current estimates of poverty based on the SPM indicate that the share (and number) of older adults who are struggling financially is larger than is conveyed by the official poverty measure.

Key Findings
- Under the SPM, 7.1 million adults ages 65 and older lived in poverty in 2016 (14.5%), compared to 4.6 million (9.3%) under the official poverty measure (Figure 1).
- Nearly 21 million people ages 65 and older had incomes below 200% of poverty under the SPM in 2016 (42.4%), compared to 15 million (30.4%) under the official measure.
- Under both the official measure and the SPM, the poverty rate among people ages 65 and older increased with age and was higher for women, blacks and Hispanics, and people in relatively poor health.
- Under the SPM, 4.4 million older women lived in poverty in 2016, 1.5 million more than under the official measure; 2.8 million older men lived in poverty under the SPM, 1.1 million more than under the official measure.
- Under the SPM, at least 15% of people ages 65 and older lived in poverty in 10 states (CA, FL, GA, HI, IN, LA, NJ, NM, TX and VA) plus Washington, D.C. in 2016; under the official poverty measure, only D.C. had a poverty rate above 15% for older adults in 2016.

![Figure 1](image)

More than 7 million people ages 65 and older had incomes below poverty in 2016, based on the Supplemental Poverty Measure, 2.6 million more than under the official poverty measure

<table>
<thead>
<tr>
<th>Official Poverty Measure</th>
<th>Supplemental Poverty Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.3 million (69.6%)</td>
<td>28.4 million (57.6%)</td>
</tr>
<tr>
<td>10.4 million (21.2%)</td>
<td>13.7 million (27.9%)</td>
</tr>
<tr>
<td>4.6 million (9.3%)</td>
<td>7.1 million (14.5%)</td>
</tr>
</tbody>
</table>

Total Number of People Ages 65 and Older, 2016: 49.3 million


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

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

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

- CMS Therapy Claim Changes. Click here to see the new CMS guidance clarifying instructions for conducting medical review of therapy claims in the case of intensive services. The notice, which sets a start date of March 23 for the new interpretation, means Medicare contractors can no longer deny a claim solely because the three-hour threshold is missed. Instead, they'll have to take into consideration a patient’s overall needs and treatment
plan. Until now, Medicare has paid for therapy if beneficiaries get at least three hours of direct care daily. That’s a problem when claims have been denied when they missed the threshold by mere minutes, even if that time was made up on subsequent days.

- **CMS Adjusting for Hospital Readmissions.** CMS said they will adjust Medicare payments to providers based on how well they manage hospital readmissions performance through its SNF Value Based Purchasing (VBP) program starting on October 1, 2018. The calendar year 2017 performance window used to measure the SNF VBP Readmission Measure (RM) rates for the first year of the program has now passed. While the data has already been collected, the SNF RM rates have not been finalized. **Providers have until the end of the month, March 31, to review their CMS Quarterly Confidential Feedback reports, identify any issues related to their SNF RM rates and request corrections from CMS by emailing SNFVBPinquiries@cms.hhs.gov.** Details on how to access your Quarterly Feedback reports via the Quality Improvement Evaluation System (QIES) and the CASPER reporting application can be found [here](#). For more information on the SNF VBP program and to access tools and resources on ahcancalED and other sites visit AHCA's VBP website [here](#).

- **CMS RCS-1.** As you should be aware, CMS is exploring a Medicare SNF payment system, which would replace RUGs IV with a new concept called the Resident Classification System, Version 1 (RCS-1). They [announced](#) last week during the March 8 Skilled Nursing Facility Open Door Forum that they will be taking a slower, more deliberate pace with the development of the system. AHCA believes that it is very unlikely that CMS will formally propose the system in the FY19 Notice of Proposed Rule Making.

However, we still believe members should begin to educate themselves about the core elements of RCS-1. Want to learn more? Then join AHCA’s Mike Cheek on **March 29, 2:00-3:30 p.m. CST,** as he will lead a free webinar *(for AHCA member facilities only!)* designed to help you better understand RCS-1 and possible implementation timelines. Learning Objectives:

- Understand CMS' goals and overarching RCS-1 construct
- Learn about each component and associated patient characteristics
- Learn about member expert preliminary analyses and steps to assess RCS-1 impacts
- Review the possible implementation and transition from RUGS IV to RCS-1

The 90-minute webinar will include a Question and Answer session and will be recorded. Online registration deadline: March 27, 2018. Registration Link: [https://educate.ahcancal.org/p/180329](https://educate.ahcancal.org/p/180329).

- **CMS Quality Grants Announced:** CMS is allotting $30 million for SNFs and other providers to help develop better quality measures. They said they want to work hand-in-hand with SNFs, docs, hospitals and patients to flesh out new measures. Applications are due by May 2, 2018 with awards being issued by August 3, 2018. [Click here](#) for further details.

- **CMS PBJ Staffing Update:** In April, CMS plans to post new PBJ staffing measures on Nursing Home Compare and use them in Five-Star rating calculations. CMS recently published PBJ data for the third quarter of calendar year 2017 through files posted [here](#) and plans to continue to do so quarterly moving forward. CMS will post two staffing measures: RN hours per resident day (HPRD) and Total Nursing Staff (RN, LPN & Aide) HPRD, which will replace the measures currently used from the form “CMS-671” completed during the annual survey. They will also post a Physical Therapy HPRD but do not plan to use this metric in Five-Star right away.

After analyzing the PBJ data, the AHCA research team has identified several staffing patterns that may hurt a center’s Five-Star staffing ratings, such as:

- Failing to submit timely MDS discharge assessments.
  - CMS uses the discharge assessment to determine your daily census, which is used to determine the hours per resident day. Failure to complete an MDS discharge assessment will make your average daily census look higher than actual and will cause your HPRD to be lower than actual.
- Reporting daily RN hours of 0.
  - It is a regulatory requirement to have at least 8 hours of RN each calendar day. CMS plans to force the Staffing Component of Five-Star to ONE star when you have >7 days in the quarter with 0 RN hours in a calendar day.

- Reporting outlier Aide and Total HPRD values.
  - When data on a given day looks out of range, which most often happens at the low range, suggesting incomplete data submission, this causes your center’s HPRD to be lower than actual.

- **Home Health QRP: Revised Logic for the Timely Initiation of Care Measure.** The Medicare Conditions of Participation (CoPs) for home health agencies that became effective January 13, 2018 included a change regarding resumption of care (ROC) dates for patients returning to home health following an inpatient stay. Specifically, the revised guidance allows for a physician ROC date as an alternative to the fixed 48-hour timeframe for the post-hospital reassessment. To align with this CoP change, a technical document on the updated logic for the Timely Initiation of Care process measure has been posted to the [Home Health Quality Measures](#) web page.

- **Low Volume Appeals Settlement Process.** On February 5, CMS started accepting Expressions of Interest for the Low Volume Appeals (LVA) settlement process. The LVA settlement option is for providers, physicians, and suppliers (appellants) with:
  - Fewer than 500 appeals pending at the Office of Medicare Hearing and Appeals and the Medicare Appeals Council at the Departmental Appeals Board, combined, as of November 3, 2017
  - A total billed amount of $9,000 or less per appeal

  If you are interested in participating in LVA to address your pending appeals, visit the [Low Volume Appeals Initiative](#) web page.

- **Hospice Provider Preview Reports – Review Your Data.** Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® provider preview reports are available. These are two separate reports available in your Certification and Survey Provider Enhanced Reports (CASPER) folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from Quarter 3-2016 to Quarter 2-2017 and their facility-level CAHPS® survey results from Quarter 3, 2015 to Quarter 2, 2017. Providers have 30-days to review their HIS and CAHPS® results (March 1, 2018 through March 30, 2018). Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the [Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data](#) web page and the [Public Reporting: CAHPS® Preview Reports and Requests for CMS Review of CAHPS® Data](#) web page. For more information on how to access these reports, view the [HIS Preview Report Access Instructions](#) and the [Hospice CAHPS® Provider Preview Reports Access Instructions](#).

- **MyHealthEData Initiative Puts Patients at the Center of the US Health Care System.** On March 6, CMS Administrator Seema Verma announced a new Trump Administration initiative – MyHealthEData – to empower patients by giving them control of their health care data and allowing it to follow them through their health care journey. MyHealthEData will help to break down the barriers that prevent patients from having electronic access and true control of their own health records. Patients will be able to choose the provider that best meets their needs and then give that provider secure access to their data, leading to greater competition and reducing costs. In an address at the Healthcare Information and Management Systems Society (HIMSS) Annual Conference in Las Vegas, Administrator Verma also announced the launch of Medicare’s Blue Button 2.0 – a new and secure way for Medicare beneficiaries to access and share their personal health data in a universal digital format. This enables patients who participate in the traditional Medicare program to connect their claims data to the secure applications, providers, services, and research programs they trust. Additionally, CMS intends to overhaul the Electronic Health Record Incentive Programs to refocus the programs on interoperability and reduce the time and cost required of providers to comply with the programs’ requirements. The Administrator also highlighted other CMS plans to empower patients with data:
- Require providers to update their systems to ensure data sharing
- Require that a patient’s data follow them after they are discharged from the hospital
- Streamline documentation and billing requirements for providers to allow doctors to spend more time with their patients
- Reduce the incidence of unnecessary and duplicative testing which occurs as a result of providers not sharing data

For More Information:
- Fact Sheet: Trump Administration Announces MyHealthEData Initiative at HIMSS18
- Speech: Remarks by CMS Administrator Seema Verma at the HIMSS18 Conference

See the full text of this excerpted CMS Press Release (issued March 6).

**New Medicare Card Transition Begins In Less Than a Month.** CMS will begin mailing new Medicare cards with the Medicare Beneficiary Identifier (MBI) on April 1. Start using the MBI as soon as your patients get their new cards. The MBI on the new card is effective immediately unless the patient is new to Medicare, in which case refer to the “coverage starts” date on the card. People new to Medicare will only have a Medicare card with an MBI.

1. **How can I get the MBI?**
   - From your patient’s new Medicare card: From April 2018 through December 31, 2019, if you submit a HICN on the 270 eligibility transaction request, we will tell you in the message field of the 271 response when we mailed a new Medicare card to each individual with Fee-For-Service Medicare. (Mailing schedule)
   - From your Medicare Administrative Contractor’s (MAC) portal if your patient can’t provide the card: Starting in June 2018, use the look-up tool on your MAC’s portal. If you don’t have access, sign up.
   - From the Remittance Advice (RA): From October 2018 through December 31, 2019, we will include the MBI on the RA if you submit a HICN on the claim. (Examples)
   - People with Medicare enrolled in Medicare Advantage and/or Part D plans will continue to use the cards from those plans when they get health care and/or prescriptions.

Questions? Attend the next Open Door Forum devoted to answering provider questions. Details will be provided in a future MLN Connects.

For More Information:
- Fact Sheet
- Overview web page
- Provider web page

CMS will host a Special Open Door Forum on Tuesday, March 20 from 1 to 2 pm CST to give providers an opportunity to ask questions about the New Medicare Card Project. Use this call to get answers to your questions, so you are ready to accept the new Medicare Beneficiary Identifier starting April 1, 2018. For more information, visit the New Medicare Card website. Send feedback and questions to NewMedicareCardSSNRemoval@cms.hhs.gov. Participation Instructions:
   - Participant Dial-In Number: 800-837-1935; Conference ID #: 4588156
   - TTY Communications Relay Services are available for the Hearing Impaired; dial 7-1-1 or 800-855-2880

A transcript and audio recording will be posted to the Podcasts and Transcripts web page.

**Antipsychotic Drug Use in Nursing Homes: Trend Update.** CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who receive antipsychotic medication, excluding residents diagnosed with schizophrenia, Huntington's disease or Tourette’s syndrome. In the fourth quarter of 2011, 23.9 percent of residents received an antipsychotic medication; since then there has been a decrease of 35.4 percent to a national prevalence of 15.4 percent in the third quarter of 2017. Success
varies by state and CMS region; some states and regions have a reduction greater than 35 percent. A four-quarter average of this measure is posted on the Nursing Home Compare website.

For More Information:
- Visit the Partnership web page
- Send correspondence to dnh_behavioralhealth@cms.hhs.gov
- Register for the Medicare Learning Network call on March 20

- **Interdisciplinary Team Building, Management, and Communication Webinar — Wednesday, March 21, 1 - 2 pm CST.** Register for this webinar. Part of the Disability Competent Care series, this webinar explores the value of the interdisciplinary team in supporting and empowering participants with disabilities. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

- **Hospice Quality Reporting Program Webinar — Tuesday, March 27, 12:30 - 2 pm CST.** Register for this webinar. During this webinar, learn about updated coding guidance for the Hospice Item Set and how to navigate the Hospice Quality Reporting Program websites. Subject matter experts also provide an update on Hospice CAHPS®. For more information, visit the Hospice Quality Reporting Training: Announcements and Registration web page.

- **IMPACT Act and Improving Care Coordination Special Open Door Forum — Wednesday, March 28, 1 - 2 pm CST.** This Special Open Door Forum provides information and solicits feedback on development and testing of standardized patient assessment data elements mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Learn about the national field test, ongoing stakeholder engagement activities, and ways to remain engaged and informed during the upcoming year. See the announcement for more information.

- **Managing Transitions with Adults with Disabilities Webinar — Wednesday, March 28, 1 - 2 pm CST.** Register for this webinar. Part of the Disability Competent Care series, this webinar describes the challenges participants with disabilities experience as they face care settings transitions and steps that providers can take to help empower participants to make informed decisions and improve care outcomes during these transitions. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

- **Provider Compliance Tips for Glucose Monitors Fact Sheet — New.** A new Provider Compliance Tips for Glucose Monitors Fact Sheet is available. Learn about:
  - Improper payment rates for glucose monitors
  - How to prevent claim denials
  - Type of order needed to submit a claim

- **Provider Compliance Tips for Manual Wheelchairs Fact Sheet — New.** A new Provider Compliance Tips for Manual Wheelchairs Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Coverage requirements

- **Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet — New.** A new Provider Compliance Tips for Ordering Lower Limb Prostheses Fact Sheet is available. Learn about:
  - Reasons for denial
  - How to prevent claim denials
  - Medical necessity determinations

- **Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet — New.** A new Provider Compliance Tips for Laboratory Tests – Bacterial Cultures Fact Sheet is available. Learn about
  - Reasons for denial
  - How to prevent claim denials
Acceptable methods to communicate and order

- **Provider Compliance Tips for Wheelchair Options/Accessories Fact Sheet — New.** A new Provider Compliance Tip for Wheelchair Options/Accessories Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Types of options/accessories

- **Provider Compliance Tips for Ostomy Supplies Fact Sheet — New.** A new Provider Compliance Tip for Ostomy Supplies Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Coverage requirement

- **Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet — New.** A new Provider Compliance Tips for Ordering Oxygen Supplies and Equipment Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Qualifying criteria for oxygen saturation results

- **Provider Compliance Tips for Enteral Nutrition Fact Sheet — New.** A new Provider Compliance Tips for Enteral Nutrition Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Coverage requirements

- **Provider Compliance Tips for Walkers Fact Sheet — New.** A new Provider Compliance Tips for Walkers Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Clinical criteria for mobile assistive equipment coverage

- **Provider Compliance Tips for Home Health Services Fact Sheet — New.** A new Provider Compliance Tips for Home Health Services (Part A non DRG) Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Required elements of the plan of care

- **Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet— New.** A new Provider Compliance Tips for Respiratory Assistive Devices Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Acceptable formats for orders

- **ICD-10 and Other Coding Revisions to NCDs MLN Matters Article — Revised.** A revised MLN Matters Article on ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) is available. Learn about the maintenance update of the ICD-10 conversions and other coding updates.

- **Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet — New.** A new Provider Compliance Tips for Negative Pressure Wound Therapy Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
- **Provider Compliance Tips for Surgical Dressings Fact Sheet — New.** A new Provider Compliance Tips for Surgical Dressings Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Code specific requirements

- **Provider Compliance Tips for Urological Supplies Fact Sheet — New.** A new Provider Compliance Tips for Urological Supplies Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Specific criteria that must be met to qualify for payment

- **Low Volume Appeals Settlement Call: Video Presentation — New.** A video presentation is available for the February 13 call on the Low Volume Appeals Settlement Option. Learn how the settlement process works, how to identify whether you are eligible and which of your pending appeals may be settled.

- **ESRD QIP Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the February 22 call on the End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP). Learn about provisions in the CY 2018 ESRD Prospective Payment System final rule, including plans for the ESRD QIP in Payment Years 2019 through 2021.


- **Provider Compliance Tips for Laboratory Tests: Other Fact Sheet — Revised.** A revised Provider Compliance Tips for Laboratory Tests – Other (Non-Medicare Fee Schedule) Fact Sheet is available. Learn about:
  - Reasons for denial
  - How to prevent claim denials
  - Acceptable forms for submitting orders

- **Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet — Revised.** A revised Provider Compliance Tips for Skilled Nursing Facility Services Fact Sheet is available. Learn about:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements

- **Provider Compliance Tips for Enteral Nutrition Therapy Pumps Fact Sheet — Revised.** A revised Provider Compliance Tips for Enteral Nutrition Therapy Fact Sheet is available. Learn about:
  - Reasons for claim denials
  - How to prevent denials
  - Medical necessity criteria

- **Medicare Ambulance Transports Booklet — Revised.** A revised Medicare Ambulance Transports Booklet is available. Learn about:
  - Ground and air ambulance providers, vehicles, and personnel requirements
  - Documentation requirements
  - Coverage, billing, and payments
  - Advance Beneficiary Notice of Noncoverage
Medicare Provider-Supplier Enrollment National Educational Products Listing — Revised. A revised Medicare Provider-Supplier Enrollment National Educational Products Listing is available. Learn about:
  o Requirements
  o Resources


4) The federal Agency for Healthcare Research and Quality (AHRQ) reports on New AHRQ Views Blog Post: Waging the Battle Against Adverse Drug Events. A new AHRQ Views blog post from Jeffrey Brady, M.D., director of AHRQ’s Center for Quality Improvement and Patient Safety, highlights successes and challenges for hospitals and patients in reducing adverse drug events (ADEs). According to data from a recent AHRQ statistical brief, the rate of patients who experienced an ADE while in the hospital fell by 24 percent between 2010 and 2014. Improvements were uneven, however, as patients arriving at the hospital with an ADE for treatment increased by 16 percent during the same time frame. Access the blog post to learn more about AHRQ’s evidence-based tools to prevent ADEs.

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

- State continues work on 1115 waiver, despite questioning letter from feds. The Department of Healthcare and Family Services is moving forward with its 1115 behavioral health waiver after a January letter from the federal government poked a pair of holes in the process. The state is seeking to overhaul how behavioral health is delivered through its Medicaid program. The waiver would, among other things, increase integration with primary care, shift more treatment to community-based settings and promote value-based payments. However, in a letter dated January 18, CMS said the state’s proposal would not achieve budget neutrality, a key requirement for the waiver. It also dismissed a sizable pot of funding the state was relying on for its share of spending for the program. CMS said the state couldn’t count $130 million in savings for a new adult group because it hadn’t been around long enough. “Expenditures for the new adult group are considered ‘hypothetical’ for purposes of calculating budget neutrality in the demonstration, due to the limited experience and lack of historical data,” CMS wrote. CMS also said the state couldn’t use $996 million it’s spending on designated state health programs as its contribution for the demonstration project. CMS provided Medicaid money for designated state health programs under previous 1115 waivers, but in December put a halt to that practice, saying it wasn’t a good investment. CMS also asked the state for more information on $406 million it had identified in interagency agreements and an intergovernmental transfer. HFS spokesman John Hoffman declined to provide any specifics to Health News Illinois on whether the state would be able to fill the gaps or if it was still confident the waiver would be approved. “We continue to work closely with CMS on any outstanding issues to better serve those facing behavioral health challenges,” he said in an emailed statement.

- HFS posted a new Public Notice regarding the Home Community Based Waiver - SLF Amendment. You may view this notice here.

- HFS posted a new Public Notice regarding HCBS Elderly Waiver Expansion of Managed Care. You may view this notice here.

- HFS posted a new provider notice regarding Submittal of Medicaid Eligibility Redetermination Form. You may view the notice here.

- HFS posted a new public notice regarding Integrated Assessment and Treatment Planning Services. You may view the notice here.

- HFS posted a revised Preferred Drug List, effective 03/09/18. You may view the revised list here.

6) The Illinois Department of Public Health reported:

- IDPH recently announced the list of Town Hall Meetings for 2018. Notices are being sent to the individual providers prior to the meeting in their location. Reservation information is included in that letter. The dates and locations are:
  - April 26, Washington County Hospital, Nashville 1-3pm
  - May 15, Pine Crest Manor, Mt. Morris 1-3pm
  - June 12, Hope Creek, East Moline 1-3pm
  - July 10, DuPage County 1-3pm
  - August 14, Brookens Bldg, Urbana 1-3pm
  - September 11, Abington of Glenview 1-3pm
  - October 16, Pekin Manor 1-3pm
  - November 14, Oak Trace, Downers Grove 1-3pm

- IDPH Reminder on Penalties for Significant Harm (SNF): They sent a memo making sure you are aware of the CMS guidance on Denial of Payment for New Admissions (DDPNA) along with S&C Memo 16-31, Revised 7/22/16. With nursing home surveys issued on or after March 1, 2018, IDPH will use the remedy, Discretionary Denial of Payment for New Admissions (DDPNA), for enforcement cases consistent with CMS S&C 16-31 when an immediate imposition of remedy is required. Click here.

CMS is implementing a national policy that requires the use of federal enforcement remedies when one or more residents suffer significant harm. CMS’ policy about when facilities with deficiencies are given an opportunity to correct them before remedies are imposed can be found in Chapter 7 of the SOM. Chapter 7 is revised to define new mandatory criteria for the deficiency cited at a Scope and Severity (S/S) level of J or higher (II level) will require the immediate imposition of a CMP against that facility, in addition to any other remedy or remedies imposed.

- The Health Facilities Services Review Board (HFSRB) has sent out their annual Nursing Home LTC Facility Questionnaire 2017 (Annual LTC Questionnaire Form). They sent a separate (slightly different) questionnaire to the ID/DD facilities.

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

- At last week’s AHCA/NCAL National Quality Summit, they announced new goals as part of its multi-year initiative to further improve quality in long term and post-acute care. Basically, the want providers to meet measurable targets in four areas by March 2021. The goals for SNFs are aligned with top priorities for CMS and federal mandates that link financial outcomes to quality performance. Learn more about the skilled nursing goals at qualityinitiative.ahcancal.org. They are:
  - Safely reduce long-stay and short-stay hospitalizations by improving 10 percent—or maintain a rate of 10 percent or less;
  - Improve functional outcomes (self-care and mobility) by 15 percent;
  - Improve long-stay and short-stay satisfaction by 10 percent—or achieve a rate of 90 percent or greater; and
  - Safely reduce the off-label use of antipsychotics by 10 percent—or maintain a rate of 8 percent or less in long-stay residents, and maintain a rate of 1 percent or less in short-stay residents.

The three-year goals for assisted living communities are:
  - Reduce turnover among direct care staff to a rate of 50 percent or less;
  - At least 90 percent of customers (residents and/or families) are satisfied with their experience;
  - Safely reduce hospital readmissions within 30 days of hospital discharges to a rate of 20 percent or less; and
  - Safely reduce the off-label use of antipsychotics to a rate of 15 percent or less.
Since the launch of the Quality Initiative in 2012, skilled nursing members have achieved reductions in the use of antipsychotics and in re-hospitalizations. Specifically, over half (57 percent) of skilled nursing member organizations safely reduced the off-label use of antipsychotic medications by 30 percent in the third quarter of 2017. For hospital readmissions, skilled nursing members have safely prevented more than 142,000 individuals from returning to the hospital — a 12 percent reduction since 2011.

To monitor progress among skilled nursing centers, AHCA will use CMS measures to track progress on antipsychotic usage, and measures endorsed by the independent rating organization National Quality Forum (NQF) to track progress on re-hospitalizations, functional outcomes and customer satisfaction. The assisted living goals will use measures developed by AHCA/NCAL. Members can view their progress using AHCA/NCAL’s LTC Trend TrackerSM.

- **Infection Preventionist Training (IPCO):** Check out AHCA’s Infection Preventionist Specialized Training (IPCO) program, which is an online, self-study course with 23 hours of training that meets the educational requirements outlined by CMS. It includes online lectures, case studies and interactive components taught by subject matter experts who have real life experience working in long term/post-acute care.

Now for the not so good news. The most frequently cited F-Tag in standard nursing facility health inspection surveys under the new survey process is F880 – Infection Prevention & Control. Since November 2017 when the new survey process began, more than one-third of surveys conducted across the nation have included a F880 Infection Prevention & Control citation. The IPCO online training program is a great and timely tool to help skilled nursing centers avoid the F880 tag. To access ahcancaled and the IPCO course, members will need to login with their AHCA/NCAL usernames and passwords. For assistance obtaining AHCA/NCAL usernames and passwords, please e-mail update@ahca.org with your name and facility contact information.

- **Five-Star Survey Rating Methodology Change.** The Centers for Medicare & Medicaid Services (CMS) changed the survey domain methodology of the Five-Star rating system. In the previous methodology, CMS used a center’s most recent three survey cycles in calculating the survey rating. In the updated methodology, CMS will use the most recent two survey cycles in calculating the survey rating. Moving forward, citations from the first cycle will contribute 60% toward a center’s survey rating and will include the most recent standard survey prior to November 28, 2017, as well as any complaint surveys from November 28, 2016, to November 27, 2017. Citations from the second cycle will contribute 40% and will include the previous standard survey, as well as any complaint surveys from November 28, 2015, to November 27, 2016.

- **SNF VBP: Corrections to Feedback Reports due March 31, 2018.** CMS will adjust Medicare payments to providers based on how well they manage hospital readmissions performance through its SNF Value Based Purchasing (VBP) program starting on October 1, 2018. The calendar year 2017 performance window used to measure the SNF VBP Readmission Measure (RM) rates for the first year of the program has now passed.

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

9) **Health News Illinois** reports on **Illinois Emergency Departments See 66 Percent Increase in Opioid Overdoses.** Illinois emergency departments saw suspected opioid overdoses increase by 66 percent between July 2016 and last September, according to new data released by the Centers for Disease Control and Prevention. The data show that the opioid epidemic hit the Midwest hardest among the country’s regions during that period. The Midwest experienced a 70 percent increase in opioid overdose emergency department visits, according to an analysis that covered 60 percent of emergency department visits in the United States. The average was 30 percent nationwide. “This fast-moving epidemic does not distinguish age, sex or state or county lines, and it’s still increasing in every region of the United States,” CDC Acting Director Dr. Anne Schuchat told reporters on a press call. The CDC took a more in-depth look at 16 states, including Illinois.

10) **The Washington Post** reports that **An Exercise Pill May be in the Future for Those Incapable of Working Out.** Not everyone can exercise. People with muscle-wasting diseases and movement disorders, the frail, the very obese and postsurgical patients are among those who face a significant challenge when it comes to working out. This can be frustrating,
considering the well-established benefits of exercise. But what if a drug could stimulate the body into producing some of the same effects of exercise — more endurance and weight control, for example — without the need to run a single step? Such a pill may be on the way. Several scientists are testing compounds that apparently can do this — and people wouldn’t even have to move at all to benefit.

11) Modern Healthcare reports that New CMS Policy Would Prevent Denial of Medicare Rehab Claims Based Solely on Time Requirement. According to a recent ModernHealthcare article, Medicare reimburses providers for daily inpatient rehabilitation therapy "if beneficiaries participate at least three hours a day." However, "Post Acute Medical, a long-term acute-care facility operator, sees Medicare deny 20% to 25% of its inpatient rehab claims when patients miss that threshold by just minutes." The article says this "denial trend should change soon, thanks to a recent CMS policy move." CMS "has issued a notice that starting March 23, Medicare contractors can no longer deny a claim solely because the three-hour threshold is missed."

12) Time reports Strong Association May Exist Between Low-Level Nighttime Light Exposure, Depressive Symptoms Among Elderly Adults. TIME recently reported there may be "a strong association between even low-level nighttime light exposure and depressive symptoms among elderly adults," researchers concluded in a study including "863 elderly Japanese adults." The findings were published in the March issue of the American Journal of Epidemiology.

13) HealthDay reports that Falls Among Older Americans Cost $50 Billion Annually. HealthDay reports a new study published in the Journal of the American Geriatrics Society suggests that the cost of falls among elder Americans totals $50 billion annually. The report indicates that in 2015, "payments for nonfatal falls cost Medicare nearly $29 billion and Medicaid $8.7 billion, while private and other payers laid out $12 billion." Lead researcher Curtis Florence, health economist at the US Centers for Disease Control and Prevention, explained, "If we don’t prevent older adult falls now, we can expect the already large economic burden to increase."

14) Provider Magazine reports Expert Lists Top Four Cybersecurity Threats to LTC PAC Providers in 2017. Bradley J. Sayles, Counsel in the law office Nelson Mullins Riley & Scarborough, writes in the March issue of Provider Magazine about the four leading cybersecurity threats to long term and post-acute care (LT/PAC) providers this year. He points to "vendor failure to protect data," the interconnection of medical devices, "mobile device vulnerabilities and use," and ransomware. Sayles also points out that with regard to threats to medical device interconnectivity, the US Department of Homeland Security issued a warning about cybersecurity vulnerabilities in 2013, which "spurred the U.S. Food and Drug Administration to issue recalls and, in 2016, to issue cybersecurity guidance for medical devices."

15) Skilled Nursing News reports:

- PAC Expert Advises on How Providers Can Be Proactive in Preparing for BPCI Advanced. Skilled Nursing News reports post-acute providers impacted by CMS' new bundled payments program do not "need to sit on the sidelines," but rather can be proactive as they "position themselves for success in the world of Bundled Payments for Care Improvement Advanced (BPCI Advanced), according to Brian Ellsworth, director of payment transformation at the Minneapolis-based consulting firm Health Dimensions Group." Ellsworth recommended providers "get a seat at the table right as this program is being designed, right now as the bundlers are completing their application," adding that it would behoove them to become risk-sharing partners with bundlers, among other steps to ease the transition.

- Skilled Nursing Experts Predict How Number of Medicare Advantage Beneficiaries Will Rise. Skilled Nursing News reports industry leaders and experts are making predictions about how use of managed Medicare Advantage plans will grow. While the "Congressional Budget Office has predicted growth in MA plans by about 4% per year," Avalere Health president Dan Mendelson "says his company projects the pace at closer to 6% or 7% per year." Meanwhile, the Health Care Cost Institute "thinks that the proportion of Medicare beneficiaries in MA plans will reach 50% faster than other prognosticators believe."

- Providers Turning to In-House Insurance Plans Amid Industry Uncertainty. Skilled Nursing News reports on the rise of in-house insurance plans among skilled nursing providers, which many have found to be a solution to the "record-low skilled nursing occupancy and rapidly shifting payment models." Providers are able to "create their own institutional special needs plans (I-SNPs)." Stakeholders commenting on the trend suggest "that creating an
I-SNP can help skilled nursing and other senior living providers direct the overall pattern of care, while also integrating financing and moving the business away from the ‘heads-in-beds’ model.

16) *McKnight’s* reports:

- **Hospitals Should Work Directly With Nursing Homes to Reduce Infections.** *McKnight’s Long Term Care News* reports University of Michigan Medical School researchers wrote in an opinion piece for JAMA that hospitals have been working more diligently to reduce infection rates than their peers in the long-term care sector, and should work alongside them to impart their strategies and best practices to address the issue. The authors pointed to a lack of sharing of electronic medical records an impediment to progress, and advised direct contact between care providers.

- **Importance of Zinc for Elderly Touted.** Attorney Joy Stephenson-Laws, the founder of Proactive Health Lab, in an op-ed in *McKnight’s Long Term Care News*, writes, "according to a study published in The American Journal of Clinical Nutrition, a simple solution to reducing the rates of infection may be administering zinc supplementation to the elderly in nursing homes who need it." She recommends making sure patients in nursing home facilities "get a comprehensive nutrient test at least annually," have "a balanced gut," and consider whether their medications are depleting the body of essential nutrients.

- **National Quality Forum Releases ‘Playbook’ for Opioid Prescribing Practices.** *McKnight’s Long Term Care News* reports the National Quality Forum on Thursday released its "National Quality Partners Playbook," its "comprehensive guide to support safe and appropriate opioid prescribing practices and help manage patients’ pain." The guide "offers a path for long-term care providers and all health care organizations and clinicians to better assess, diagnose, and treat pain using safe and appropriate patient-centered strategies that may or may not include medications," according to organization president and CEO Shantanu Agrawal, MD, MPhil.

17) **Interesting Fact:** Census Bureau predicts that U.S. Elderly over age 65 will outnumber children by 2035, a first in U.S. history.