April 17, 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!

Update on Payroll Based Journal (PBJ) Staffing Measures and Its Impact on Five-Star Rollout

On April 6, 2018, the Center for Clinical Standards and Quality/Quality, Safety and Oversight Group at the Centers for Medicare & Medicaid Services (CMS) issued a memorandum, “Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five-Star Quality Rating System.” A summary of the information is provided below.

Beginning in April 2018, CMS will utilize PBJ data to calculate the staffing measure rating for the Five-Star Quality Rating System. While CMS has not published an exact date of release of the measures, we anticipate that they will be included in the updates to Five-Star that are generally posted in the last week of the month.

The measures will be calculated based on the fourth calendar quarter of 2017 (data submitted by February 14, 2018). Hours per resident per day (HPRPD) will be posted for nursing staff and physical therapy staff. This HPRPD is calculated by summing the number of hours for the relevant job categories submitted for each day of the quarter, and dividing by the sum of each day’s census within the same quarter. Note that resident census is calculated based on MDS submissions.

The staffing measure rating is calculated by adjusting the HPRPD based on the expected level of staff needed given the number and acuity of the residents in the facility. CMS will move to using RUG-IV vs. RUG-III to calculate the adjusted staffing levels. The measure will be calculated by combining a total nursing staff rating (registered nurse (RN), licensed practical nurse and nurse aide) with an RN rating. CMS will establish new rating thresholds (cut points) to keep the number of facilities in each rating category (distribution) approximately the same. Further details on the technical specifications can be found in the Technical User’s Guide on or before May 1, 2018.

Penalties
Providers whose audits show significant inaccuracies between hours reported and verified or those who fail to submit data by the PBJ reporting deadlines will have a one-star rating on the staffing domain, which will result in a drop by one star in their overall Five-Star rating.

Similarly, those facilities that report seven or more days in a quarter with no RN hours will have a one-star rating on the staffing domain, which will result in a drop by one star in their overall Five-Star rating. This enforcement will start in July 2018, after the May 15, 2018 submission deadline for the first calendar quarter of 2018. Prior to the July date, facilities that report seven or more days in a quarter with no RN hours will have an icon placed next to their name on Nursing Home Compare.
If you are not already doing so, we strongly recommend that providers submit PBJ data early and review the CASPER based PBJ reports to identify issues and correct them before the reporting deadlines to avoid any penalties.

**Staffing Data Audits**

CMS and its contractor have begun conducting audits aimed at verifying that the staffing hours submitted by facilities are aligned with the hours staff were paid to work over the same timeframe. CMS has found that facilities are submitting their data in good faith, and they appreciate facilities’ efforts to submit accurate data. As with many new programs, CMS expects to find areas that are more prone to errors than others. Below are common errors identified through the audits. CMS encourages facilities to review these items, and adjust their submissions as necessary to ensure accuracy.

- Per the PBJ Policy Manual, providers are required to exclude meal times for each employee’s daily hours.
- Providers must assign a unique identifier for each employee.
- For accurate census calculations, providers must submit timely and accurate MDS assessments for every resident in the facility.
- Providers must exclude time from the reporting that staff spend providing care to individuals that are non-certified.
- If a provider receives an audit, they must promptly respond to it.

**Requirement for RN Staffing**

Since facilities are required to submit the number of hours staff are paid to work each day, the PBJ data show whether or not facilities have an RN onsite each day. CMS also notes that facilities are required to have an RN onsite at least 8 consecutive hours a day, 7 days a week under sections 1819(b)(4)(C) and 1919(b)(4)(C) of the Act and 42 CFR §483.35(b)). While the majority of nursing homes are reporting an RN onsite each day, submitted staffing data show that there are some facilities that don’t.

CMS believes the presence of an RN onsite every day is extremely important to improving the health and safety of nursing home residents. CMS is also concerned about the risks that the absence of an RN introduces. Therefore, facilities reporting 7 or more days in a quarter with no RN hours will receive a one-star staffing rating, which will drop their overall (composite) rating by one star. This action will be implemented in July 2018, after the May 15, 2018 submission deadline for 2018 Calendar Quarter 1, 2018 (January – March, 2018) data. CMS will work with facilities to evaluate RN waiver requests while continuing to focus on protecting resident health and safety.

**Technical Assistance for Nursing Homes**

CMS will continue to provide technical assistance to nursing homes to improve their staffing and data submissions. Facilities should review their monthly Provider Preview in their Certification and Survey Provider Enhanced Reports (CASPER) folder for feedback on their most recent submission. CMS also encourages nursing homes to run CASPER reports (1700D Employee Report, 1702D Individual Daily Staffing Report and/or 1702S Staffing Summary Report) prior to their submission before the quarterly deadline to review their data, and ensure accuracy.

Facilities should be familiar with the policies described in the PBJ policy manual on the PBJ website (noted below). CMS will continue to provide information related to updates or guidance through stakeholder calls (e.g., Skilled Nursing Facility Open Door Forum) and memoranda. Nursing homes can also use the contact information at the bottom of this memo for more questions, technical support, or if they believe the information posted about their facility is incorrect.

**Future Actions**

**CMS-671 form:** Beginning on June 1, 2018, facilities will no longer be required to complete the staffing portion of the CMS-671 form found on page 2. All other information requested on the CMS-671 unrelated to facility staffing (e.g., address, ownership type, etc.) will still be required. The form will ultimately be revised; however, legacy forms may still be in the field. As of June 1, 2018, surveyors using CMS-671forms with staffing fields (page 2) don’t need to have facilities complete these fields.
Public use files: CMS has posted public use files which include facility level data from quarterly submissions. To date, these files have included nursing hours and resident census data. CMS intends to add other data elements to these files in future quarters (e.g., hours for therapy staff). These files are available here.

Other staffing measures: The measures for nursing and physical therapy staff are the first measures to be posted on Nursing Home Compare using PBJ data. However, CMS plans to develop additional measures like staff turnover and also post them on Nursing Home Compare. The CMS goal is to post information that stakeholders can use to understand the type of care and quality a nursing home may provide, and that can also be used to improve quality and outcomes.

Informational Resources

- For questions on this memorandum, please email: NHStaffing@cms.hhs.gov.
- Technical questions from vendors or software developers related to the data submission specifications should be sent to: NursingHomePBJTechIssues@cms.hhs.gov.
- Please contact the AHCA PBJ team here with any questions
- Slide Set for the 4-11-18 AHCA Webinar (click here).
- Staffdatacollection@ahca.org
- For talking points visit AHCA’s PBJ Resources.

CMS Releases Clarifications on Door Inspections

In a move that will benefit all health care settings, CMS recently released guidance clarifying fire door inspection criteria. CMS is indicating that the only doors required to be included in annual fire door testing/inspection programs are fire doors located within required fire-resistance rated barriers or enclosures. The requirement for such barriers is derived from the Life Safety Code® (2012 Edition). CMS stressed the need to maintain accurate Life Safety Drawings indicating the locations of rated fire barriers and enclosures.

Previously, CMS had indicated that smoke barrier doors were not required to be included in the annual door testing/inspection program. However, recognizing that smoke barrier doors play a crucial role in an organization’s fire and evacuation procedures, they realized that including such doors in the testing/inspection program would make sense, and should be included in a facility’s maintenance program.

If there are smoke barrier doors in your inventory, you can continue to consider them smoke doors even though they may contain a fire-protection label on the doors. They do not need to be inspected, tested and maintained as a fire-rated door assembly if they truly only serve in a smoke barrier wall. As such, protective plates of unlimited height are permitted to remain attached to smoke barrier doors and any listed product, such as rubber gasketing and brush gasketing, may be used to reduce excessive gaps on smoke barrier doors. While positive latching is not required for smoke barrier doors, if the doors are equipped with positive latching hardware, it must function properly.

Any other doors that may have a fire-protection label but are not part of a required fire-rated barrier or enclosure may be omitted from the organization’s required fire door inspection/testing program. Best practice would include ensuring all corridor doors are part of a door maintenance program.
Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.

**AHRQ Stats: Decline in Hospitalizations**

While the rate of hospitalizations (excluding pregnancies and newborns) declined for all age groups from 2000 to 2015, the biggest drop -- 25 percent -- occurred among patients 65 and older. (Source: AHRQ, Healthcare Cost and Utilization Project Statistical Brief #235: *Trends in Hospital Inpatient Stays by Age and Payer, 2000-2015*.)

**Figure 5. National trends in primary payer among non-neonatal, non-maternal inpatient stays for patients aged 65 years and over 2000-2015**

Note: Shares of "Missing" and "Other" payers are not presented.


Line graph that shows the share of each payer among stays for patients aged 65 years and over from 2000 to 2015. Medicaid: fluctuated between 1.3% and 1.8% between 2000 and 2015, starting at 1.5% in 2000 and ending at 1.4% in 2015; net change -7%. Private insurance: decreased from 8.2% in 2000 and 2001 to 6.2% in 2003; increased to 7.3% in 2004; decreased to 6.5% in 2005; increased steadily to 8.9% in 2008; decreased steadily to 7.1% in 2012; increased steadily to 7.6% in 2014; decreased to 7.5% in 2015; net change -9%. Uninsured: fluctuated between 0.4% and 0.7% between 2000 and 2015, starting and ending at 0.6%; net change -3%. Medicare: decreased from 88.6% in 2000 to 88.5% in 2001; increased steadily to 90.9% in 2003; decreased to 89.7% in 2004; increased to 90.9% in 2005; decreased steadily to 87.7% in 2008; increased to 88.1 in 2009; decreased to 88.0% in 2010; increased steadily to 89.8% in 2012; decreased steadily to 89.1% in 2014 and 2015; net change +1%.

Medicare and private insurance accounted for about 97 percent of non-neonatal and non-maternal inpatient stays among patients aged 65 years and over.

Among patients aged 65 years and over, the share of inpatient stays covered by Medicare fluctuated between 88 and 91 percent during the 2000-2015 period; at the same time, the share of stays covered by private insurance fluctuated between 6 and 9 percent. These two payers together consistently covered about 97 percent of the inpatient stays within this age group during the 16-year period. Within this age group, the share of stays covered by Medicaid remained under 2 percent, and the share of stays that were uninsured remained under 0.8 percent.
1) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 18-16 - ICF/IID** - Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Survey Protocol – State Operations Manual (SOM) Appendix J Revised. CMS has revised the survey protocol in Part I of Appendix J of the SOM. The survey process will refocus the surveyor’s time on increased observation time and more effective use of interviews and client record reviews. The fundamental survey is revised to be a focused fundamental survey accomplished through the concept of key standards and corresponding standards within the Conditions of Participation (CoPs). The survey procedures for tasks one, two and three are revised.

- **S&C 18-17 - NH** - Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five Star Quality Rating System. See First Article. Transition to Payroll-Based Journal (PBJ) Data – Starting in April, 2018, CMS will use PBJ data to determine each facility’s staffing measure on the Nursing Home Compare tool on Medicare.gov website and calculate the staffing rating used in the Nursing Home Five-Star Quality Rating System. Staffing data audits - We are providing lessons-learned from audits conducted, and guidance to facilities for improving their accuracy. Nursing homes whose audit identifies significant inaccuracies between the hours reported and the hours verified, or facilities who fail to submit any data by the required deadline will be presumed to have low levels of staff. This will result in a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter. Requirement for registered nurse (RN) staffing – We are reminding nursing homes of the importance of RN staffing and the requirement to have an RN onsite 8 hours a day, 7 days a week. Nursing homes reporting 7 or more days in a quarter with no RN hours will receive a one-star rating in the staffing domain, which will drop their overall (composite) star rating by one star for a quarter. This action will be implemented in July 2018, after the May 15, 2018 submission deadline for data for 2018 Calendar Quarter 1, 2018 (January – March, 2018) data. Technical assistance – CMS is continuing its efforts to help nursing homes submit accurate data, and there are a variety of ways described below in which facilities can seek support. Future Actions – As of June 1, 2018, we will no longer collect facility staffing data through the CMS-671 form, and we will announce other future activities.

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

- **CMS issues Final Rule and Call Letter for 2019.** CMS has announced the Final payment rates and Call Letter for calendar year 2019 as well as the Final Rule on Policy and Technical Changes for 2019. Among the highlights:
  - Transition supply fills for LTC residents will be reduced from 90 days to one month supply.
  - Health plans will be required to make contract terms and conditions available to pharmacies by September 15 and will establish deadlines for plan response for pharmacies wishing to be included in networks.
  - CMS has codified that LTC residents will not be subject to pharmacy drug utilization management for drugs with abuse potential.
  - CMS will allow plans to include generics on formularies without a waiting period.
  - CMS decided to take no action on requiring discounts and rebates applied at point of sale.

- **NIC Releases Q4 2017 Skilled Nursing Data Report.** The National Investment Center for Seniors Housing & Care (NIC) has published its latest survey of skilled nursing facility occupancy and payer trends. It seems the recent trends continue, with occupancy falling to 81.9 percent, while managed care payments continue their slide and Medicaid continues to account for an increasing percentage of SNF revenue.

- **Register Now: CMS Quality Payment Program Year 2 Webinar: May 1, 2018.** The Philadelphia Regional Office of the CMS will host a national webinar on Year 2 (2018) of the Quality Payment Program (QPP) on Tuesday, May 1, 2018, from 12 Noon until 1:30 PM EDT. Click here to register.
• **Health and Human Services and the Department of Justice Return $2.6 Billion in Taxpayer Savings from Efforts to Fight Healthcare Fraud.** Health and Human Services Secretary Alex Azar and Attorney General Jeff Sessions today released a fiscal year (FY) 2017 Health Care Fraud and Abuse Control Program report showing that for every dollar the federal government spent on health care related fraud and abuse investigations in the last three years, the government recovered $4. Additionally, the report shows that the departments’ FY 2017 Takedown event was the single largest health care fraud enforcement operation in history.

• **HHS Releases a New Resource to Help Individuals Access and Use Their Health Information.** The US Department of Health and Human Services’ Office of the National Coordinator for Health Information Technology (ONC) released the [ONC Guide to Getting and Using your Health Records](https://www.hhs.gov/health IT/guides/), a new online resource for individuals, patients and caregivers. This new resource supports both the 21st Century Cures Act goal of empowering patients and improving patients’ access to their electronic health information and the recently announced MyHealthEData initiative. The new initiative, led by the White House Office of American Innovation and supported by ONC, empowers patients by giving them control of their healthcare information. Other participants in the effort include CMS, National Institutes of Health and the Department of Veterans Affairs. Individuals’ ability to access and use their health information electronically is a measure of interoperability and a cornerstone of ONC’s efforts to increase patient engagement, improve health outcomes, and advance person-centered health. In fact, a new [ONC data brief](https://www.hhs.gov/health IT/news-events/2017/august/healthcaredata1.html) shows that in 2017, half of Americans reported they were offered access to an online medical record by a provider or insurer. This is up from 42 percent in 2014. Over half of individuals who were offered online access viewed their record with the past year. Eight in 10 of the individuals who viewed their information rated their online medical records as both easy to understand and useful for monitoring their health. These positive perceptions may be attributed to individuals’ varied use of online medical records, including viewing test results; managing their health needs with greater convenience; communicating with their health care provider; self-management and treatment decision-making; and contributing information to and correcting errors in their medical record.

• **New Medicare Card Project – Important Updates.** CMS started mailing newly-designed Medicare cards with the new Medicare Beneficiary Identifier (MBI), or Medicare Number. People enrolling in Medicare for the first time will be among the first to get the new cards, no matter where they live. Current Medicare beneficiaries will get their new cards on a rolling basis over the coming months. We'll continue to accept the Health Insurance Claim Number (HICN) through the transition period. During planning, they have continuously adjusted and improved their mailing strategy to make sure they’re:
  - Mailing the new cards to accurate addresses.
  - Protecting current Medicare beneficiaries and their personal information in every way possible.

CMS is working on making their processes even better so they’re using the highest levels of fraud protection when they mail new cards to current Medicare beneficiaries. Over the next few weeks, they’ll be done with this additional work so they can mail new cards to current Medicare beneficiaries.

They’re committed to mailing new cards to all Medicare beneficiaries over the next year.

• **CMS Lowers Cost of Prescription Drugs for Medicare Beneficiaries.** CMS finalized polices for Medicare health and drug plans for 2019 that will save Medicare beneficiaries money on prescription drugs while offering additional plan choices. “The Trump Administration is taking steps for seniors with Medicare to save money on prescription drugs,” said CMS Administrator Seema Verma. “The steps we are taking will drive more competition among plans and pharmacies to meet the needs of seniors and lower costs.” The [final policies](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugs/downloads/2019-policies.pdf) further the Trump Administration’s commitment to lowering drug prices. CMS is finalizing a reduction in the maximum amount that low-income beneficiaries pay for certain innovative medicines known as “biosimilars.” Other actions that CMS is finalizing to lower the cost of prescription drugs include:
  - Allowing for certain low-cost generic drugs to be substituted onto plan formularies at any point during the year, so beneficiaries immediately benefit and have lower cost sharing.
  - Increasing competition among plans by removing the requirement that certain Part D plans have to “meaningfully differ” from each other, making more plan options available.
Increasing competition among pharmacies by clarifying the “any willing provider” requirement, to increase the number of pharmacy options that beneficiaries have.

The final policies also advance the “Patients Over Paperwork” initiative – an effort aimed at removing regulatory obstacles and empowering patients to make informed healthcare decisions; developing innovative approaches to improving quality, accessibility, and affordability; and improving beneficiaries’ customer experience. Specifically, the final policies will:

- Authorize CMS to permit plans to use notice of electronic posting (and provision of copies upon request) to satisfy disclosure requirements for certain bulky documents to Medicare beneficiaries.
- Improve transparency of the Star Ratings that give beneficiaries information about each Medicare Advantage and Part D plan’s quality rating. The changes put patients first by increasing the weight given to patient experience and access measures.
- Streamline government review and approval of marketing materials Medicare health and drug plan use.

For a fact sheet on the 2019 Rate Announcement and Final Call Letter, click here.

For a fact sheet on the final rule (CMS-4182-F), click here.

The 2019 Rate Announcement and Call Letter may be viewed by clicking on this link https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html and selecting “2019 Announcement.”

The final rule can be downloaded here.

- **CMS Issues Changes to the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN).** On March 30, 2018, CMS issued Transmittal 4011, with CMS Medicare Claims Processing Manual changes revising the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), Form CMS-10055. With this revision, CMS is discontinuing the 5 SNF Denial Letters and the Notice of Exclusion from Medicare Benefits (NEMB-SNF), Form CMS-20014; the revised SNF ABN replaces the formerly used SNF ABN, the 5 SNF Denial Letters and the NEMB. SNFs must use the revised SNF ABN to inform beneficiaries of their potential liability for Part A items or services that may be denied effective April 30, 2018, however SNFs can implement use of the new form prior to that date. For instructions on use of Form CMS-10055, see here. SNFs will continue to use the ABN, Form CMS-R-131, for items or services that may be denied by Medicare paid under Medicare Part B to inform beneficiaries of their potential liability. These changes are effective April 30, 2018. Note that use of the revised SNF ABN is addressed in the requirements and interpretive guidance under F-582, Medicare/Medicaid Coverage/Liability Notice, which can be found here. The transmittal is available here.

- **Bipartisan Budget Act: CMS Reprocessing Impacted Claims.** On February 9, Congress passed the Bipartisan Budget Act of 2018, which contains provisions that extend certain Medicare Fee-For-Service (FFS) policies. Provisions include:
  - Ambulance add-on payment
  - Work Geographic Practice Cost Index Floor
  - Three percent Home Health Rural Add-on Payment

Due to the retroactive effective dates of these provisions, your Medicare Administrative Contractor (MAC) will reprocess Medicare FFS claims impacted by this legislation. You do not need to take any action. MACs are reprocessing CY 2018 outpatient therapy cap claims, which contain the KX modifier for services in excess of the prior cap amounts. Learn more in MLN Matters® Article #10531.

- **Reducing Provider Burden: Send us Your Feedback.** Medicare is simplifying claims documentation requirements so that you spend less time on paperwork, allowing you to focus more on your patients. Visit the Provider Compliance Group’s Simplifying Documentation Requirements and Reducing Provider Burden web pages to learn about our recent initiatives, including:
  - Documentation Requirements Simplification Initiative
Simplifying medical review with Targeted Probe and Educate

Where should we focus next? Send feedback and suggestions to ReducingProviderBurden@cms.hhs.gov.

- **IMPACT Act Transfer of Health measures: Public Comment Period - Ends May 3.** CMS has contracted with RTI International and Abt Associates to develop cross-setting post-acute care transfer of health information and care preferences quality measures in alignment with the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). As part of its measure development process, CMS requests interested parties to submit comments on two draft measure specifications:
  1. Medication Profile Transferred to Provider
  2. Medication Profile Transferred to Patient

The call for public comment period closes on May 3, 2018. View the public comment web page for more information.

- **Medicare Diabetes Prevention Program: New Resources.** New resources are available on the Medicare Diabetes Prevention Program Expanded Model website:
  - Orientation Video: 5-minute overview, including introductory information on enrollment and services
  - Enrollment Process Timeline: Steps CMS will take to process your enrollment application, how the Medicare Administrative Contractors are involved and actions to take in this process
  - Supplier Requirements Checklist: Requirements you must comply with to maintain enrollment in Medicare

Overview of MDPP:
  - Overview Fact Sheet
  - CDC - CMS Roles Fact Sheet: Roles of the Centers for Disease Control and Prevention (CDC) and CMS in the implementation of MDPP
  - Medicare Learning Network Call on the Final Rule: Overview of the regulations

MDPP Supplier Enrollment:
  - List of eligible organizations
  - Road Map: Understand the supplier journey
  - Orientation Webinar: Requirements to enroll as a supplier, furnish services and submit claims (registration required to view webinar)
  - Enrollment Fact Sheet and Checklist: Find out what you need to do to enroll in Medicare
  - Enrollment Application: Submit though PECOS or use the paper form

For more information, email MDPP@cms.hhs.gov.

- **Administrative Simplification: Electronic Transactions.** Did you know that Administrative Simplification standards can help you streamline your paperwork and reduce costs? By adopting CMS standards for electronic transactions, you can reduce the time your practice spends on insurance and billing tasks. For More Information:
  - Visit the Administrative Simplification web page
  - Check out the video, infographic and fact sheet

- **Opioids: CDC Online Training Series.** More than 40 people die every day from prescription opioid-involved overdose. The Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain provides recommendations for safer and more effective prescribing of opioids for chronic pain in patients 18 and older in outpatient settings outside of active cancer treatment, palliative care and end-of-life care. This online training series will help you apply CDC’s recommendations in your clinical setting through interactive patient scenarios, videos, knowledge checks, tips and resources.
  - Applying CDC’s Guideline for Prescribing Opioids
  - Treating Chronic Pain without Opioids
  - Communicating with Patients
- **Reducing the Risks of Opioids – New**

- **Reduce the Risk of Falls in Elderly Patients.** Falls are not an inevitable part of aging, yet one in four adults over age 65 falls every year. Reduce your patients’ chances of falling by being proactive. Ask:
  - Have you fallen in the past year?
  - Do you feel unsteady when standing or walking?
  - Do you worry about falling?

Learn to screen, assess and intervene. Visit the Centers for Disease Control and Prevention Older Adult Fall Prevention web page, and read their pocket guide.

- **Hospice Election Statements Lack Required Information or Have Other Vulnerabilities — Reminder.** After a stratified random sample review of hospice election statements and certifications of terminal illness, the Office of the Inspector General (OIG) reports that more than one-third of hospice General Inpatient (GIP) stays lack required information or had other vulnerabilities.
  - Hospice election statements did not always mention – as required – that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative.
  - In 14 percent of GIP stays, the physician did not meet requirements when certifying that the beneficiary was terminally ill and appeared to have limited involvement in determining that the beneficiary’s condition was appropriate for hospice care.

Hospices should improve their election statements and ensure that physicians meet requirements when certifying beneficiaries for hospice care. Resources:
  - [Hospices Should Improve Their Election Statements and Certifications of Illness OIG Report](#)
  - [Hospice Payment System Booklet](#): Includes a section on the hospice election statement
  - [Documentation Requirements for the Hospice Physician Certification/Recertification MLN Matters Article](#)
  - [Sample Hospice Election Statement MLN Matters Special Edition Article](#)

- **Home Health Utilization and Payment Data**
  - CMS posted the [home health agency Public Use File (PUF)](#) with data for 2015, including utilization, payment, submitted charges and condition indicators. The PUF has information for 10,526 home health agencies, over 6 million claims, and $18 billion in Medicare payments.
  - Visit the [Provider Utilization and Payment Data web page](#) for more information, including updated PUFs for 2013 and 2014.

- **Medicare Cost Report e-Filing System Webcast — Tuesday, May 1, 12 - 1:30 pm CST.** Register for Medicare Learning Network events. During this webcast, learn how to use the Medicare Cost Report e-Filing (MCreF) system. Beginning May 1, Medicare Part A providers can use MCreF to submit cost reports with fiscal years ending on or after December 31, 2017. You will have the option to electronically transmit your cost report through MCreF or mail or hand deliver it to your Medicare Administrative Contractor. Starting July 2, you must use MCreF if you choose electronic submission of your cost report. Access to MCreF will be controlled by the CMS Enterprise Identity Management (EIDM) system. Security Officials (SOs) and Backup SOs registered in EIDM for access to the Provider Statistical and Reimbursement (PS&R) system will have access to MCreF through their existing account. Providers that are not registered in EIDM as PS&R users must register and assign an SO for their organization.

A question and answer session follows the presentation; however, attendees may email questions in advance to [OFMDPAOQuestions@cms.hhs.gov](mailto:OFMDPAOQuestions@cms.hhs.gov) with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio through your computer, phone lines are available.
• **Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities MLN Matters Article — New.** A new MLN Matters Article on Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities is available. Learn about payment reductions applied to both the base rate and the mileage reimbursement.

• **New Waived Tests MLN Matters Article — New.** A new MLN Matters Article on New Waived Tests is available. Learn about the latest tests approved by the Food and Drug Administration under Clinical Laboratory Improvement Amendments.

• **Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 MLN Matters Article — Revised.** A revised MLN Matters Article on Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018 is available. Learn about Medicare fee-for-service claims reprocessing requirements and timeframes.

• **Revised and New Modifiers for Oxygen Flow Rate MLN Matters Article — Revised.** A revised MLN Matters Article on Revised and New Modifiers for Oxygen Flow Rate is available. Learn about adjustments to the monthly payment amounts for oxygen and oxygen equipment based on the patient’s prescribed oxygen flow rate.

• **April 2018 MLN Catalog – Revised.** A revised April 2018 MLN Catalog is available. Learn about:
  - Products and services that can be downloaded for free
  - Web-based training courses; some offer continuing education credits
  - Helpful links, tools, and tips

• **Medicare Home Health Benefit Booklet — Revised.** A revised Medicare Home Health Benefit Booklet is available. Learn about:
  - Qualifying for services
  - Consolidated billing
  - Therapy services
  - Physician billing and payment

• **HCPCS Code Set Modifications.** The April update of the HCPCS code set is available on the HCPCS Quarterly Update web page. Changes are effective on the date indicated in the update.

• **Safe and Effective Use of Medications in Older Adults Webinar — Wednesday, April 18, 11 - 12:30 pm CST.** Register for this webinar. Part of the Geriatric Competent Care series, this interactive webinar describes the need for management and coordination for older adults as they manage multiple medications. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

• **Managing Older Adults with Substance Use Disorders Webinar — Wednesday, May 16, 12 - 1:30 pm ET.** Register for this webinar. Part of the Geriatric Competent Care series, this webinar describes Substance Use Disorder (SUD), how to diagnose SUD, and available treatment resources. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

• **SNF ABN MLN Matters Article — New.** A new MLN Matters Article on Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) is available. Learn about the discontinuation of the five SNF denial letters and the Notice of Exclusion from Medicare Benefits, Form CMS-20014.

• **SNF Value-Based Purchasing Program Updated MLN Matters Article — New.** A new MLN Matters Special Edition Article on Skilled Nursing Facility Value-Based Purchasing Program Updated is available. Learn about scoring and operational policies affecting payment determination in FY 2019 and the exchange function approach to implement incentive payment adjustments.

• **Dementia Care Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the March 20 call on Dementia Care: Person-Centered Care Planning and Practice Recommendations. Gain
insight on the phase two changes for person-centered care planning and discharge planning, and learn about the new Alzheimer’s Association Dementia Care Practice Recommendations.

- **2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training Course — Revised.** With Continuing Education Credit. A revised 2018 Medicare Part C and Part D Reporting Requirements and Data Validation Web-Based Training (WBT) course is available through the Learning Management System. Learn about:
  - Planning and performing data validation activities
  - Analyzing results and submission of findings
  - Completing the post-data validation activities

- **Medicare Parts A & B Appeals Process Booklet — Reminder.** A revised Medicare Parts A & B Appeals Process Booklet is available. Learn about:
  - Five levels of claim appeals
  - New option for a level three on-the-record review
  - Forms and helpful tips for filing an appeal


4) The federal HHS Office of the Inspector General (OIG) posted the:

- **Health Care Fraud and Abuse Control Program Report FY 2017.** Efforts to combat fraud were consolidated and strengthened under Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Act established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS) acting through the Department’s Inspector General (HHS/OIG). The HCFAC program is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. The Act requires HHS and Department of Justice (DOJ) detail in an Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits.

- **Medicaid Fraud Control Units Fiscal Year 2017 Annual Report.** Medicaid Fraud Control Units (MFCUs or Units) investigate and prosecute Medicaid provider fraud and patient abuse or neglect. They operate in 49 States and the District of Columbia. The Department of Health and Human Services Office of Inspector General is the designated Federal agency that oversees and annually approves Federal funding for MFCUs through a recertification process. For this report we analyzed the annual statistical data on case outcomes—such as convictions; civil settlements and judgments; and recoveries—that the 50 MFCUs submitted for fiscal year 2017.

5) The federal HHS Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE) posts their April 2018 Express Updates. This issue of The Express includes links to newly-released webinars, information on recent and updated ASPR TRACIE documents, and domain updates.

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

- HFS posted a new public notice regarding HCBS Waiver for Persons with HIV or AIDS - Managed Care. You may view the notice here.
- HFS posted a new public notice regarding HCBS Waiver for Persons with Disabilities – Managed Care. You may view the notice here.
- HFS posted a new provider notice regarding Hospital Cost Report Forms and Instructions. You may view the notice here.
- HFS posted a revised 276/277 Health Care Claim Response form. You may view this item here.
- HFS posted a new provider notice regarding Continuity of Care Requirements for HealthChoice Illinois Managed Care Health Plans. You may view the notice here.
- HFS posted a new Public Notice regarding a revised TBI Waiver. You may view the notice here.
7) The Illinois Department of Public Health (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

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

- **MCO Web Seminars for IHCA Members.** IHCA will be hosting free web seminars with MCOs involved in HealthChoice Illinois. As Illinois' Medicaid program moves completely into Managed Care, you will need to learn how each organization operates and what is expected of you as providers. In these web seminars you will learn each plan's procedures on billing coding, prior authorizations, a step-by-step process of the claims process, what triggers rejects and how they are handled and more.
  
  - **BCBS - April 20 - 10 a.m.** | Pre-registration required to receive log in information.
  - **BCBS - April 24 - 10 a.m.** | Pre-registration required to receive log in information.

Below are links to presentation materials from our webinars last week with Meridian and Molina:

- Meridian Presentation
- Meridian Prior Authorization Form
- Molina Presentation

- **AHCA Congressional Briefing.** Registration is now open for the 2018 AHCA/NCAL Congressional Briefing—June 4 – 5, 2018 in Washington, DC. Join your colleagues from across the country as we gather for two full days of exciting advocacy efforts, updates and discussions. This year's Opening Keynote is Carl Bernstein, legendary Pulitzer Prize-winning journalist, author, and political analyst. [Click here](#) for more information.

- **Submit Your Data - 2018 Aon Benchmark Study on Professional and General Liability for LTC Providers.** With AHCA/NCAL's support, Aon is again soliciting your help to assemble the facility-specific data necessary to conduct its annual Aon Benchmark Study on Professional Liability (PL) and General Liability (GL) costs in the Long Term Care (LTC) Provider industry. The 2018 Benchmark marks the 16th annual edition of the Aon Professional and General Liability Benchmark for Long Term Care Providers. To participate in the 2018 Benchmark, access the Long Term Care Provider Data Call [web page](#) to download the consent form, instructions and data template. Similar to last year, Aon is asking for data to be submitted by CMS Provider Number so that they can examine liability costs by Five-Star Quality Rating. The deadline for participation in the Aon Study is **Monday, April 30, 2018.**

- **Introducing the New LTC Trend Tracker SNF VBP Predictor Tool.** AHCA/NCAL is pleased to launch the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Predictor Tool, available exclusively to skilled nursing center members through [LTC Trend Tracker](#), to help organizations determine the financial impact of the [CMS SNF VBP Program](#) on their facility. Data collected for the first year of the SNF VBP program will impact reimbursement for skilled nursing care centers beginning **October 1, 2018.** The [SNF VBP Predictor Tool](#) provides valuable insights about your center's performance for the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM), and enables you to plan for future Medicare Part A disbursement based on this performance to quickly establish benchmarks and set targets to guide performance improvement.

The archived recording of The AHCA Quality Initiative 2018-2021: What’s New & What it Means for You is now ready for you to view at your convenience.

2. Once the page opens, click on the “View Archived Recording” button on the right hand side of the page. The presentation will open in a new window for you to view and hear the program.
3. Click on the Handout tab to download your copy of the handouts and other available materials.

For questions or support, please email ahca@commpartners.com.

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

10) Careinfo.org reports on New Guidelines for Recognizing and Assessing Pain in Older Adults. New recommendations to help healthcare professionals recognize and assess levels of pain in older people have been published in the scientific journal Age and Ageing. The Age and Ageing paper ‘Pain Assessment in the Older Population – where are we now?’ can be viewed here.

11) Becker’s Hospital Review reports on CBO: Medicare Spending to Climb 7% Each Year After 2018 – With Nearly 5 Percentage Points Reflecting Cost Growth. The Congressional Budget Office projects Medicare spending will grow to $1.2 trillion by 2028, according to its Budget and Economic Outlook: 2018 to 2028. This year, CBO estimates Medicare spending will grow by 3 percent, which is much slower than previous years. CBO attributes the slow growth to higher premium revenue, and anticipates Medicare enrollment to increase by 2.7 percent this year, compared to 2.6 percent last year. However, that won't be the case from 2019 to 2028, CBO said. The office anticipates Medicare spending to climb an average of 7 percent each year during the time period. The change is "driven by the rising per-beneficiary costs of medical care," CBO said. Specifically, cost growth reflects nearly 5 percentage points of the increase. Growing enrollment only accounts for the remainder. Medicaid is also expected to cost the government more due mostly to increasing per capita costs. After this year, CBO projects Medicaid spending will grow at an average rate of 5.5 percent per year. Just 1 percent of the spending reflects an uptick in enrollment, while nearly 5 percent is due to cost.

12) Newsweek reports that Researchers Successfully Change Alzheimer’s Associated Protein into More Harmless Form. Newsweek reports researchers from the Gladstone Institutes in San Francisco "successfully changed a protein associated with Alzheimer’s disease into a more harmless form, allowing them to erase brain cell damage." While "the results are promising, especially since they were seen in human cells and not an animal model," the piece reports that "researchers are now working to translate this finding into a compound that can be used on an industrial level so that eventual human trials will be possible." The findings were published in Nature Medicine.

13) Forbes reports that Elder Care Settings Should Consider ‘Required Hospitality’ Approach for Helping Customers. Micah Solomon, customer service consultant, writes for Forbes about strategies to offer exemplary customer service in assisted living, home health care and health care settings. Solomon examines the distinctions between "classic customer service" in retail and the "required hospitality" necessary for these settings, saying "the customer isn’t coming to you out of desire...but out of need." He also cites recommendations from Springpoint Senior Living on fostering high-quality customer service.

14) Bloomberg News reports, CMS to Increase Medicare Advantage Payments by 3.4% in 2019. Bloomberg News recently reported that CMS "said it will increase payments to privately run health plans for the elderly by an average of 3.4 percent next year, almost double the amount it had previously estimated." The article says this will "be a boon for insurers such as UnitedHealth Group Inc. and Humana Inc. that have big businesses selling the private plans, known as Medicare Advantage."

15) Medical News Today reports on:

- Alzheimer's: Scientists Find the Cause of Evening Agitation. A new study has uncovered a biological clock circuit that may explain why people with Alzheimer's disease or other forms of dementia can become more agitated or...
aggressive in the early evening. The researchers hope that their findings will lead to new treatments that help to calm the aggressiveness and agitation that individuals with Alzheimer’s and other neurodegenerative diseases commonly experience as part of a condition known as "sundowning."

- **Diabetes Skin Patch Could Abolish Finger-Prick Tests.** Finger-prick tests for blood glucose monitoring may soon be a thing of the past, thanks to scientists who have developed an adhesive skin patch that measures glucose levels every 10–15 minutes. Created by researchers from the University of Bath in the United Kingdom, the novel patch has proven to be a feasible noninvasive strategy for blood glucose monitoring in tests of both pig and human skin.

16) **Skilled Nursing News** reports on:

- **Gaps Persist in LT/PAC Performance Measures.** Skilled Nursing News reports an analysis from the non-partisan National Quality Forum’s (NQF) Measure Applications Partnership (MAP) suggests that there are disparities between "performance measures for post-acute care (PAC) and long-term care (LTC), particularly with regard to care coordination and information exchanges." The analysis found that CMS’ Meaningful Measures framework suggests "critical" gaps in the performance measures remain. It further said "MAP emphasized the importance of care coordination in post-acute and long-term care" and "recommended that measure developers focus on care coordination measures."

- **ACOs Cost Medicare $384 Million Instead of Saving $2 Billion.** Skilled Nursing News reports Avalere Health found in a recent analysis that accountable care organizations (ACOs) "may be doing more harm than good," considering that the "Medicare Shared Savings Program (MSSP) increased federal spending by $384 million between 2013 and 2016," compared to "a 2010 estimate from the Congressional Budget Office that the program would save $1.7 billion over that time period." The article says the findings contrast research by the Department of Health and Human Services last year, which "found that ACOs saved $1 billion between 2013 and 2015."

- **Providers Increasingly Transitioning Into Insurers to Mitigate Medicare Advantage Shift.** Skilled Nursing News reports that as Medicare Advantage gains momentum among a greater proportion of seniors, some providers are becoming insurers by seeking "institutional special needs plans (I-SNPs), a special type of Medicare Advantage program that covers beneficiaries in need of in-home nursing care or confined to an institution," as "a useful tool in a period of low occupancy and evolving payment models." According to David Gifford, senior vice president for quality and regulatory affairs at the American Health Care Association, "We’re seeing more and more of our members pursue I-SNPs. ... I think in general the [accountable care organizations] and the bundled payment models have been disappointing from the SNF side."

17) **Provider Magazine** reports on:

- **Rural Areas Seeing More Pronounced Drop in Occupancy Than Urban Locations.** Provider Magazine reported a new analysis from the National Investment Center for Seniors Housing & Care (NIC) suggests that in 2017, "rural skilled nursing facilities (SNFs) experienced a more pronounced decline in occupancy than urban-centered buildings, but the average occupancy for all SNFs regardless of location fell ‘significantly’ in the fourth quarter." The NIC found SNF occupancy during the fourth quarter "declined to 81.9 percent, down 66 basis points from the previous quarter and 159 basis points year-over-year," and rural occupancy fell "381 basis points from December 2016 to December 2017, while urban occupancy experienced a 148 basis point decline."

- **Many Providers are Excited by Prospects of CMS’ MA Rate, Policy Changes.** Provider Magazine reports that many long term and post-acute care (LT/PAC) providers "say they are encouraged by new coverage and reimbursement policies" in CMS’ final Medicare Advantage (MA) and Part D 2019 Rate Announcement and Call Letter. CMS has issued new reimbursement rates that "would be 3.4 percent, a large increase from the 1.84 percent raise proposed in a February draft," and "also relaxed a previous standard that said MA plans could not cover ‘daily maintenance’ types of care." The article says many providers "say they see some significant opportunities from the changes."
**OIG Audit Uncovers Office-Based Therapy Overpayments Not Linked to SNFs.** *Provider Magazine* reports a recent Department of Health and Human Services Office of Inspector General (OIG) audit on Medicare reimbursement for outpatient physical therapy services determined that overpayments reached $367 million over a six-month period, which CMS has "disputed." The alleged overpayments "were not tied to" SNF therapy services, "but only involved PT provided in an office setting." The article says, "long term and post-acute care payment experts at the American Health Care Association" believe SNFs "should be aware of where OIG and CMS are focusing their audit efforts since the same coverage and coding requirements apply to all outpatient therapy providers." AHCA associate vice president of therapy advocacy Daniel Ciolek explained, "We believe that the OIG audit findings should be considered in the appropriate context. ... For example, while outpatient PT services are furnished in a variety of office- and facility-based settings, the OIG audit only included claims from office-based PTs in private practice." He added, "The significant disagreement between OIG and CMS...just serves to highlight the challenges providers have in complying with myriad and complex policies."

**Providers Must Begin Preparing to Address Trauma in Residents.** In its cover story for April, *Provider Magazine* reports on the damage trauma causes individuals, citing expert advice on recognizing the signs of trauma in patients and determining treatment options. The article says that in November 2019, long term and post-acute care providers will face new Medicare and Medicaid Requirements of Participation regulations focusing on trauma. For providers to be prepared, experts recommend they begin assessing their needs and formulating strategies now. The article includes recommendations and spotlights providers who have implemented them.

18) **McKnight’s reports on:**

- **Nursing Home Occupancy May be Down, but Facilities Have More Residents in Need of Higher Levels of Care.** *McKnight’s Long Term Care News* reports on a new study from the Kaiser Family Foundation indicates that although nursing home occupancy rates fell between 2009 and 2016, residents’ need "have grown considerably," which has placed "more demands on sometimes unprepared nursing staff." The report found that in 2016, "nearly half of nursing home residents had a dementia diagnosis, and just under one-third had other psychiatric conditions such as schizophrenia, mood disorders or other diagnoses." Additionally, "the report found nearly two-thirds of residents received psychoactive medications, including anti-depressants, anti-anxiety drugs, sedatives, hypnotics and antipsychotics."

- **Op-Ed Advises Providers on Methods to Determine Sources of Dementia Patients’ Pain.** Renee Kinder, MS, CCC-SLP, RAC-CT, director of Clinical Education for Encore Rehabilitation, writes for *McKnight’s Long Term Care News* that caring for ill dementia patients can be challenging because often they are unable to articulate the causes of their pain. She points out strategies for providers to help them determine sources of pain, citing methods from the Alzheimer’s Association’s Campaign for Quality Residential Care, which advocates for routine assessment measures.

- **Medicare Advantage Revisions Increase Payments to Plans, Aim to Spur Drug Savings.** *McKnight’s Long Term Care News* reports that CMS’ 2019 final rate notice and call letter show Medicare Advantage plans will receive an increase of 3.4 percent in federal payments next year. The revisions also finalize "several new policies designed to reduce drug costs," allowing plans to "add generic drugs to their formularies at any time during the year, and increase the number of plan options available." However, "missing from the rule...is a decision on whether the discounts pharmacy benefit managers get for drugs should go toward lowering the actual price a patient pays."

- **CMS Begins Implementation of Medicare Diabetes Prevention Program.** *McKnight’s Long Term Care News* reports that CMS has begun its diabetes prevention program that could save "as much as $182 million over 10 years by linking with community partners." Health care settings including SNFs can offer the program, "which accepts Medicare beneficiaries with high body-mass indexes or other risk factors for developing diabetes." CMS plans to incorporate nutritionists, dietitians, and "lifestyle coaches who work in non-clinical settings" into the program, which offers reimbursement to providers under a pay-for-performance model "based on patient attendance and weight loss benchmarks."
• **Federal Initiatives Will Help Providers Address Opioid Crisis.** McKnight’s Long Term Care News reports new federal measures could help providers as they work to address the impact of the opioid crisis, saying that the National Institutes of Health announced on Wednesday "that it is doubling funding," with Director Dr. Francis Collins saying, "NIH has been deeply invested in efforts to counter this crisis through research, but we are determined to do even more." Also, the US Surgeon General issued an advisory, "the first from that office since 2005, urging family and friends to carry the overdose-reversing drug Naloxone." The piece adds that opioids present "a critical issue for skilled nursing," noting that the Substance Abuse and Mental Health Administration estimates that the population of older adults who abuse opioids will double.

• **Nursing Home Assistants Have Workplace Injury Rate three Times Higher than Other Workers.** McKnight’s Long Term Care News says new media reports this week show certified nursing assistants "are injured three times more often than the average worker," according to new research. They experience a rate of injury "similar to the rate among construction workers, police and firefighters, according to 2016 data from the U.S. Bureau of Labor Statistics." The article notes that "privately-owned skilled facilities and those operated by local governments fare better than state-run homes, with injury rates of 6.5 and 6.1 per 100, respectively, compared to 13.7 at state-owned facilities."

• **How to Make the Resident Move-In Process as Easy as Possible.** Moving is not fun. It's stressful and exhausting, and when everything is finally into your new place, you're left with a world of cardboard, furniture placement that needs adjusting, and an endless to-do list to make the place habitable, much less comfortable. Fortunately, long-term and senior care providers are increasingly focusing on making this process as simple and enjoyable as possible for new residents.

• **Members of Congress Ratchet Up Pressure on Nursing Homes.** Four influential Republican Congressmen recently sent a letter to federal regulators, requesting sweeping answers about CMS’ oversight of nursing homes. It is part of the House Energy and Commerce Committee’s official inquiry into how well the agency oversees skilled nursing providers nationwide.

19) **Interesting Fact:** If a human being’s DNA were uncoiled, it would stretch 10 billion miles, from Earth to Pluto and back

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