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!


Legionnaires’ disease is a serious type of pneumonia caused by bacteria, called Legionella, that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Unfortunately, Legionnaires’ disease is on the rise in the United States. To reverse this trend, we are asking for your help to manage the risk of exposure to Legionella from water in your building.

CMS expects Medicare certified long term care facilities to have water management policies and procedures (See the revised Survey and Certification Letter [QSO 17-30](#)) to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. An industry standard calling for the development and implementation of water management programs in large or complex building water systems to reduce the risk of legionellosis was published in 2015 by American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE). In 2016, the CDC and its partners developed a toolkit to facilitate implementation of this ASHRAE Standard ([click here](#)). Environmental, clinical and epidemiologic considerations for health care facilities are described in this toolkit.

Surveyors will review policies, procedures and reports to ensure that facilities have water management plans and documentation that, at a minimum, ensure that each facility:

- Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria and fungi) could grow and spread in the facility water system.
- Implements a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing for pathogens.
- Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.

Health care facilities are expected to comply with CMS requirements to protect the health and safety of its patients. Those facilities unable to demonstrate measures to minimize the risk of LD are at risk of citation for non-compliance with the CMS requirements.
Your building will need a water management program to reduce the risk for Legionnaires’ disease associated with your building water system and devices. This water management program should identify areas or devices in your building where Legionella might grow or spread to people so that you can reduce that risk. Legionella water management programs are now an industry standard for large buildings in the United States (ASHRAE 188: Legionellosis: Risk Management for Building Water Systems June 26, 2015. ASHRAE: Atlanta).

CMS does not require water cultures for Legionella or other opportunistic water borne pathogens. Testing protocols are at the discretion of the provider.

LTC surveyors will expect that a water management plan (which includes a facility risk assessment and testing protocols) is available for review but will not cite the facility based on the specific risk assessment or testing protocols in use.

The above noted toolkit will help you develop and implement a water management program to reduce your building’s risk for growing and spreading Legionella. If you already have a program, this toolkit will help you assess and strengthen it. Included are practical resources to help you ensure that your water management program is comprehensive, effective and in line with industry standards. This toolkit also highlights special considerations for health care facilities.

Because building water systems vary in their design and complexity, examples in this toolkit are only meant to help you understand the process. You should develop a water management program to reduce Legionella growth and spread that is specific to your building.

For additional information about Legionnaires’ disease, visit www.cdc.gov/legionella. For questions or concerns regarding QSO 17-30, contact NHSurveyDevelopment@cms.hhs.gov.

**Shingles Vaccination Guidelines**

Maybe you’ve heard or maybe you haven’t – there’s a new shingles vaccine approved by the FDA, and studies show it’s more effective at preventing the disease. In fact, the CDC recommends that all healthy adults 50 years and older get two doses of the vaccine, called Shingrix.

**One of the Recommended Vaccines by Disease**

Shingles vaccination is the only way to protect against shingles and postherpetic neuralgia (PHN), the most common complication from shingles. CDC recommends that healthy adults 50 years and older get two doses of the shingles vaccine called Shingrix (recombinant zoster vaccine), separated by 2 to 6 months, to prevent shingles and the complications from the disease. Your doctor or pharmacist can give you Shingrix as a shot in your upper arm.

Shingrix provides strong protection against shingles and PHN. Two doses of Shingrix is more than 90% effective at preventing shingles and PHN. Protection stays above 85% for at least the first four years after you get vaccinated. Shingrix is the preferred vaccine, over Zostavax® (zoster vaccine live), a shingles vaccine in use since 2006. Zostavax may still be used to prevent shingles in healthy adults 60 years and older. For example, you could use Zostavax if a person is allergic to Shingrix, prefers Zostavax, or requests immediate vaccination and Shingrix is unavailable.

**Who Should Get Shingrix?**

Healthy adults 50 years and older should get two doses of Shingrix, separated by 2 to 6 months. You should get Shingrix even if in the past you:

- had shingles
- received Zostavax
- are not sure if you had chickenpox

There is no maximum age for getting Shingrix.
If you have had shingles in the past, you can get Shingrix to help prevent future occurrences of the disease. There is no specific length of time that you need to wait after having shingles before you can receive Shingrix, but generally you should make sure the shingles rash has gone away before getting vaccinated.

You can get Shingrix whether or not you remember having had chickenpox in the past. Studies show that more than 99 percent of Americans 40 years and older have had chickenpox, even if they don’t remember having the disease. Chickenpox and shingles are related because they are caused by the same virus (varicella zoster virus). After a person recovers from chickenpox, the virus stays dormant (inactive) in the body. It can reactivate years later and cause shingles.

If you had Zostavax in the recent past, you should wait at least eight weeks before getting Shingrix. Talk to your health care provider to determine the best time to get Shingrix.

Shingrix is available in doctor’s offices and pharmacies. To find doctor’s offices or pharmacies near you that offer the vaccine, visit HealthMap Vaccine Finder. If you have questions about Shingrix, talk with your health care provider.

Who Should Not Get Shingrix?
You should not get Shingrix if you:

- have ever had a severe allergic reaction to any component of the vaccine or after a dose of Shingrix
- tested negative for immunity to varicella zoster virus; if you test negative, you should get chickenpox vaccine
- currently have shingles
- are currently pregnant or breastfeeding; women who are pregnant or breastfeeding should wait to get Shingrix

If you have a minor acute (starts suddenly) illness, such as a cold, you may get Shingrix. But if you have a moderate or severe acute illness, you should usually wait until you recover before getting the vaccine. This includes anyone with a temperature of 101.3°F or higher.

How Well Does Shingrix Work?
Getting two doses of Shingrix provides strong protection against shingles and postherpetic neuralgia (PHN), the most common complication of shingles.

- In adults 50 to 69 years old who got two doses, Shingrix was 97 percent effective in preventing shingles; among adults 70 years and older, Shingrix was 91 percent effective.
- In adults 50 to 69 years old who got two doses, Shingrix was 91 percent effective in preventing PHN; among adults 70 years and older, Shingrix was 89 percent effective.

Shingrix protection remained high (more than 85 percent) in people 70 years and older throughout the four years following vaccination. Since your risk of shingles and PHN increases as you get older, it is important to have strong protection against shingles in your older years.

What Are the Possible Side Effects of Shingrix?
Studies show that Shingrix is safe. The vaccine helps your body create a strong defense against shingles. As a result, you are likely to have temporary side effects from getting the shots. The side effects may affect your ability to do normal daily activities for 2 to 3 days.

Most people got a sore arm with mild or moderate pain after getting Shingrix, and some also had redness and swelling where they got the shot. Some people felt tired, had muscle pain, a headache, shivering, fever, stomach pain or nausea. About 1 out of 6 people who got Shingrix experienced side effects that prevented them from doing regular activities. Symptoms went away on their own in about 2 to 3 days. Side effects were more common in younger people.

You might have a reaction to the first or second dose of Shingrix, or both doses. If you experience side effects, you may choose to take over-the-counter pain medicine such as ibuprofen or acetaminophen.
If you experience side effects from Shingrix, you should report them to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS website, or by calling 1-800-822-7967.

If you have any questions about side effects from Shingrix, talk with your doctor.

The shingles vaccine does not contain thimerosal (a preservative containing mercury).

**When Should I See a Doctor Because of the Side Effects I Experience From Shingrix?**

In clinical trials, Shingrix was not associated with serious adverse events. In fact, serious side effects from vaccines are extremely rare. For example, for every 1 million doses of a vaccine given, only one or two people may have a severe allergic reaction. Signs of an allergic reaction happen within minutes or hours after vaccination and include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness or weakness. If you experience these or any other life-threatening symptoms, see a doctor right away.

Shingrix causes a strong response in your immune system, so it may produce short-term side effects more intense than you are used to from other vaccines. These side effects can be uncomfortable, but they are expected and usually go away on their own in 2 or 3 days.

**How Can I Pay For Shingrix?**

There are several ways shingles vaccine may be paid for:

* **Medicare**
  - Medicare Part D plans cover the shingles vaccine, but there may be a cost to you depending on your plan. There may be a copay for the vaccine, or you may need to pay in full then get reimbursed for a certain amount.
  - Medicare Part B does **not** cover the shingles vaccine.

* **Medicaid**
  - Medicaid may or may not cover the vaccine. Contact your insurer to find out.

* **Private health insurance**
  - Many private health insurance plans will cover the vaccine, but there may be a cost to you depending on your plan. Contact your insurer to find out.

* **Vaccine assistance programs**
  - Some pharmaceutical companies provide vaccines to eligible adults who cannot afford them. You may want to check with the vaccine manufacturer, GlaxoSmithKline, about Shingrix.

To find doctor’s offices or pharmacies near you that offer the vaccine, visit HealthMap Vaccine Finder.

**Focus F-tag – F809 Frequency of Meals/Snacks at Bedtime**

This Regulatory Beat’s Focus F-tag is **F809 Frequency of Meals/Snacks at Bedtime**, which is part of the Food and Nutrition Services regulatory group. The basic requirements of this regulation have stayed the same, but emphasis on resident choice has been added.

First, the regulation states that residents must receive, and the facility must provide, at least three meals per day. These meals must be served “at regular times” based on normal mealtimes in the community, or, adding in the person-centered focus, may also be served in accordance with resident needs, preferences, requests and plan of care. The second section of the regulation has remained the same, requiring that no more than 14 hours pass between a “substantial evening meal” and breakfast the next morning, except when a nourishing snack is served at bedtime. If a nourishing snack, which is comprised of an item or items from the basic food groups, is served, then 16 hours may separate the meals so long as a resident group has agreed to this meal plan.

What’s new, however, is the requirement that “suitable, nourishing alternative meals and snacks,” – meals/snacks that are of similar nutritive value as the meal/snack that is offered during normally scheduled meals and consistent
with the resident’s plan of care – must be provided to residents who prefer to eat at non-traditional times or outside of scheduled meal times, so long as this is consistent with the care plan. The IG notes that this does not mean nursing facilities have to provide food service 24 hours per day and that it is acceptable to prepare suitable alternatives in advance that can be “appropriately served by appropriately trained facility staff” at non-traditional times. With the strong emphasis in the RoPs on person-centered care and autonomy, you can expect that surveyors will be interviewing residents to ask them if they like their meal schedules and what input they provide regarding their choices to eat at non-traditional times. Let’s remember what also leads to survey concerns being identified on interview related to snacks; residents can be asked if they are offered snacks at bedtime and if a snack is not offered, would they want one. What do you think that answer is most likely to be?

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### Trending Statistics

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

**Number of Opioid Prescriptions Falls for Fifth Year in a Row**

The number of opioid prescriptions issued nationwide has dropped by 22 percent between 2013 and 2017, which a doctors group touted as progress in fighting the epidemic of opioid addiction.

The report from the American Medical Association (AMA) finds there were 55 million fewer prescriptions over that time period and the number of prescriptions has dropped for five years in a row.

“While this progress report shows physician leadership and action to help reverse the epidemic, such progress is tempered by the fact that every day, more than 115 people in the United States die from an opioid-related overdose,” said Dr. Patrice Harris, chairwoman of the AMA’s Opioid Task Force.

“What is needed now is a concerted effort to greatly expand access to high-quality care for pain and for substance use disorders. Unless and until we do that, this epidemic will not end.”

The report also finds there was a 121 percent increase between 2016 and 2017 in doctors accessing electronic databases that track opioid prescribing and can help identify abuse.

As of May, there were 50,000 doctors certified to provide buprenorphine, a drug to treat opioid addiction, a 42 percent increase in the last 12 months, the report found. A shortage of doctors certified to provide that treatment has been an ongoing problem.

Some policymakers have proposed limits on how long opioid prescriptions can last, such as a three-day limit, but the AMA has opposed those efforts, saying that would interfere with doctors’ decision making.

The AMA instead calls for reducing barriers to treatment drugs and enforcing laws to ensure that insurance plans provide adequate coverage of addiction care.

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

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

2) Federal HHS/CMS released the following notices/announcements:
- **New Medicare Card Mailing Update – Wave 4 Begins, Wave 2 Ends.** CMS started mailing new Medicare cards to people with Medicare who live in Wave 4 states: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island and Vermont. They continue to mail new cards to people who live in Wave 3 states, as well as nationwide to people who are new to Medicare. They have finished mailing cards to people with Medicare who live in Wave 1 and Wave 2 states and territories (Alaska, American Samoa, California, Delaware, District of Columbia, Guam, Hawaii, Maryland, Northern Mariana Islands, Pennsylvania, Oregon, Virginia and West Virginia). If someone with Medicare says they did not get a card, print and give them the “Still Waiting for Your New Card?” handout (in English or Spanish) or instruct them to:
  - Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They need to create an account if they do not already have one
  - Call 1-800-MEDICARE (1-800-633-4227). There might be something that needs to be corrected, such as updating their mailing address.

To ensure that people with Medicare continue to get care, health care providers and suppliers can use either the former Social Security number-based Health Insurance Claim Number or the new alpha-numeric Medicare Beneficiary Identifier (MBI) for all Medicare transactions through December 31, 2019.

Check the mailing strategy as the mailings progress. Continue to direct people with Medicare to Medicare.gov/NewCard for information about the mailings and to sign up to get email about the status of card mailings in their state.

CMS is committed to mailing new cards to all people with Medicare by April 2019.

Information on the transition to the new MBI:
  - **New MBI Get It, Use It** MLN Matters® Article (Updated 7/11/18)
  - **Transition to New Medicare Numbers and Cards** MLN Fact Sheet
  - **New Medicare Card information** website

- **Qualified Medicare Beneficiary: Learn about State Medicaid Agency Requirements.** Medicare providers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiary (QMB) program for Medicare Parts A and B deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs. Check with the states where your beneficiaries reside to determine the billing processes that apply.
  - For fee-for-service Medicare claims, nearly all states have electronic crossover processes through the Medicare Benefits Coordination and Recovery Center to automatically receive Medicare-adjudicated claims. Different processes may apply for Medicare Advantage services.
  - If a claim is crossed over to Medicaid, it is noted on the Medicare Remittance Advice (RA).
  - States require providers to enroll in their Medicaid system for claims review, processing and issuance of Medicaid RAs. Contact the State Medicaid Agency for information on enrollment.

For More Information:
  - Contact your State Medicaid Agency; see Medicaid.gov for state contacts
  - **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program** MLN Matters® Article
  - **QMB Program** webpage

- **SNF QRP Non-Compliance Letters: Request for Reconsideration by August 7.** CMS provided notifications to facilities that were determined to be out of compliance with Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) requirements for CY 2017. This will affect your FY 2019 Annual Payment Update. Non-compliance notifications were mailed by Medicare Administrative Contractors and placed into QIES CASPER folders on July 9.
If you receive a letter of non-compliance, you may submit a request for reconsideration to CMS via email no later than 11:59 pm PT on August 7. See the instructions in your notification letter and on the SNF Quality Reporting Reconsideration and Exception & Extension webpage.

- **HQRP Non-Compliance Letters: Request for Reconsideration by August 7.** CMS provided notifications to hospices that were determined to be out of compliance with Hospice Quality Reporting Program (HQRP) requirements for CY 2017. This will affect your FY 2019 Annual Payment Update. Non-compliance notifications were mailed by Medicare Administrative Contractors and placed into QIES CASPER folders on July 9. If you receive a letter of non-compliance, you may submit a request for reconsideration to CMS via email no later than 11:59 pm PT on August 7. See the instructions in your notification and on the Reconsideration Requests webpage.

- **CMS Proposes Historic Changes to Modernize Medicare and Restore the Doctor-Patient Relationship.** Proposed changes to the Medicare Physician Fee Schedule and Quality Payment Program would streamline clinician billing and expand access to high-quality care. On July 12, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare. The proposed rules would fundamentally improve the nation’s health care system and help restore the doctor-patient relationship by empowering clinicians to use their Electronic Health Records (EHRs) to document clinically meaningful information, instead of information that is only for billing purposes. Public comments on the proposed rules are due by September 10. For More Information:
  - Proposed Rule
  - Proposed Policy, Payment, and Quality Provisions Changes to the Medicare PFS for CY 2019 Fact Sheet
  - Proposed Rule for the QPP Year 3 Fact Sheet
  - MA Qualifying Payment Arrangement Incentive Demonstration Fact Sheet

- **New CMS Proposals to Modernize and Drive Innovation in DME and ESRD Programs.** Combined actions would increase access to durable medical equipment, reduce administrative burden and encourage development of innovative therapies for beneficiaries on dialysis. On July 11, CMS proposed innovative changes to the payment rules for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) and the End-Stage Renal Disease (ESRD) program. The DME proposals in the proposed rule aim to increase access to items for patients and simplify Medicare’s DMEPOS Competitive Bidding Program (CBP) to drive competition and increase affordability. The rule also includes ESRD proposals, including a proposal to address new renal dialysis drug and biological costs and foster innovations in treatment by incentivizing new therapies for patients on dialysis and a proposal to reduce facility-related documentation burden. For More Information:
  - Proposed Rule
  - Fact Sheet

See the full text of this excerpted CMS Press Release (issued July 11).

- **A Letter to Doctors From CMS Administrator Seema Verma.** America’s physicians are spending too much time as data entry clerks focused on “burdensome and often mindless” administrative tasks that are distracting them from direct patient care, a serious problem in healthcare that the Centers for Medicare and Medicaid Services is taking steps to address.

- **CMS Provides Additional KEPRO Resources** (KEPRO is the Beneficiary and Family Centered Care QIO (BFCC-QIO).
  - Frequently Asked Questions: Notice of Medicare Non-Coverage
  - KEPRO’s Patient Navigation Program
  - Patient Navigation Process
  - Skilled Nursing Facility Service Termination Review Compliance
  - Patient Navigation FAQs
REGISTRATION OPEN – Upcoming Home Health QRP Webinars (August 28, and September 5, 2018) Related to Changes Associated with the Scheduled January 1, 2019, Implementation of the OASIS-D. The first webinar will occur on Tuesday, August 28, from 2:00 to 4:00 p.m. and provide a high level overview of changes to the OASIS-D related to the Home Health QRP. The second webinar will occur on Wednesday, September 5, from 2:00 to 4:00 p.m. and focus on new quality measures and data collection items specifically associated with Section GG: Functional Abilities and Goals.

Registration for these webinars is limited to 1,500 attendees per event on a first-come, first-served basis. Please register only if you know you will be able to attend the webinar, as space is limited. If you would like your name placed on a list to receive an email notification when the recorded version of the webinar is available, please email PACTraining@econometricainc.com and ask to be placed on a notification list.

CLICK HERE to register for the Introduction to the OASIS-D Webinar on Tuesday, August 28, 2018, from 2:00 to 4:00 p.m.

CLICK HERE to register for the Introduction to the Section GG: Functional Abilities and Goals Webinar on Wednesday, September 5, 2018, from 2:00 to 4:00 p.m.

PEPPERs for Home Health Agencies, Partial Hospitalization Programs. Fourth quarter CY 2017 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) are available for Home Health Agencies (HHAs) and Partial Hospitalization Programs (PHPs). These reports summarize provider-specific data statistics for Medicare services that may be at risk for improper payments. Providers can use the data to support internal auditing and monitoring activities. HHAs and Community Mental Health Center PHPs: For instructions on obtaining your PEPPER, see the Secure PEPPER Access Guide. PHPs operated by short-term acute care hospitals or inpatient psychiatric facilities: Your PEPPER was distributed via the QualityNet secure portal. For More Information:

- Attend a WebEx training session: July 25 for HHAs or August 2 for PHPs
- Visit the PEPPER Resources website for user guides, recorded training sessions, information about QualityNet accounts, frequently asked questions, and examples of how other providers are using the reports
- Visit the Help Desk if you have questions or need help obtaining your report
- Send us your feedback or suggestions

July Quarterly Provider Update. The July Quarterly Provider Update is available. Find out about:
- Regulations and major policies currently under development during this quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

Meeting the Behavioral Health Needs of the Dually Eligible Webinar — Thursday, August 2, 1 - 2 pm CST. Register for this webinar. This interactive webinar discusses common behavioral health conditions and related challenges among dually eligible older adults, identifies best practices for treatment options and care coordination, and demonstrates practical strategies for meeting beneficiary needs. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

ESRD Quality Incentive Program: CY 2019 ESRD PPS Proposed Rule Call — Tuesday, August 14, 1 - 2 pm CST. Register for Medicare Learning Network events. During this call, learn about proposals for the End Stage Renal Disease Quality Incentive Program (ESRD QIP) in the CY 2019 ESRD Prospective Payment System (PPS) proposed rule. Topics include:
- ESRD QIP legislative framework
- Proposed updates to ESRD QIP measures, domain structure, and weights
Proposed modifications to data submission requirements and the National Healthcare Safety Network Validation Study

Methods for reviewing and commenting on the proposed rule

Please note: This call will not include a question and answer session.

- **Medicare Part A SNF PPS Pricer Update MLN Matters Article — New.** A new MLN Matters Article on Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update is available. Learn about the SNF payment increase factor for FY 2019.

- **Medicare Preventive Services Educational Tool — Revised.** A revised Medicare Preventive Services Educational Tool is available. Learn about:
  - HCPCS/CPT and ICD-10 Codes
  - Who is covered
  - Frequency
  - What the beneficiary pays

- **Behavioral Health Integration Services Fact Sheet — Reminder.** The Behavioral Health Integration Services Fact Sheet is available. Learn about:
  - Who can bill for services
  - New CPT codes
  - Integrating behavioral health with primary care services
  - Psychiatric Collaborative Care Model

- **Chronic Care Management Services: Changes for 2017 Fact Sheet — Reminder.** The Chronic Care Management Services Changes for 2017 Fact Sheet is available. Learn about:
  - 2017 coding changes
  - Included services
  - Key improvements reducing requirements associated with initiating care

- **Chronic Care Management Services Fact Sheet — Reminder.** The Chronic Care Management Services Fact Sheet is available. Learn about:
  - Separately payable services for non-face-to-face coordinated care for beneficiaries with multiple chronic conditions
  - Physician Fee Schedule billing requirements
  - Practitioner and patient eligibility
  - Service elements

- **Hospice Quick Reference Guides.** A Quick Reference Guide for the Hospice QRP for FY2020 is now available on the HQRP reconsiderations page. The guide includes frequently asked questions, information on QRP help desks, and helpful links to additional resources for the Hospice QRP.

- **HHA Star Ratings Call: Audio Recording and Transcript — New.** An audio recording and transcript are available for the June 27 call on Home Health Agencies: Quality of Patient Care Star Ratings Algorithm. CMS presents the rationale, proposed timing, and impact of changes.

- **Ambulance Services Listening Session: Audio Recording and Transcript — New.** An audio recording and transcript are available for the June 28 listening session on the Ground Ambulance Data Collection System.
Section 50203(b) of the Bipartisan Budget Act of 2018 requires the development of a system to collect cost, revenue, utilization and other information on providers and suppliers of ground ambulance services.


- **Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Revised.** A revised [Dual Eligible Beneficiaries under Medicare and Medicaid](#) Booklet is available. Learn about:
  
  - Assistance with Medicare premiums or cost sharing through a Medicare Savings Program, including the Qualified Medicare Beneficiary Program
  - Benefits and qualifications

- **Medicare Vision Services Fact Sheet — Revised.** A revised [Medicare Vision Services](#) Fact Sheet is available. Learn about:
  
  - Billing for cataract removal of intraocular lenses
  - Glaucoma screening
  - Other eye-related Medicare-covered services

- **SNF Consolidated Billing Web-Based Training Course — Revised.** With Continuing Education Credit. A revised SNF Consolidated Billing Web-Based Training course is available through the [Learning Management System](#). Learn about:
  
  - Skilled Nursing Facility (SNF) coverage and payment guidelines
  - Bundled prospective payments
  - Services excluded from SNF consolidated billing

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov) released **New Tools to Aid in Antibiotic Stewardship.** The CDC rolled out the second installment of its four-part [online training course](https://www.cdc.gov) tied to antibiotic stewardship. Two more segments are set to follow later this year. This latest release focuses on, among other topics: outpatient antibiotic use in the United States, along with inappropriate antibiotic use, and communicating with patients when these medicines are unnecessary. Participation in the online courses also qualifies participants for continuing education credit. Antibiotic resistant infections are a key concern for nursing home operators. [One study](https://www.ncbi.nlm.nih.gov) earlier this year found that treatment costs tied to those infections have doubled since 2002, up to more than $2 billion annually. CMS’ revised Final Rules of Participation require all federally supported skilled nursing facilities to have a trained infection preventionist on staff by November 2019.

4) The federal [HHS Office of the Inspector General](https://oig.hhs.gov) issued a report: **MCOs Should Improve Fraud Identification Efforts.** Managed care organizations, which oversee 80 percent of all Medicaid enrollees, are weak in fighting fraud and abuse, the Health and Human Services Inspector General said. MCOs often missed identifying fraudulent overpayments and referred few cases of suspected fraud in 2015, [the July report](https://oig.hhs.gov) from Inspector General Daniel R. Levinson states. Not all organizations used analysis for fraud identification and when they took action against potentially fraudulent providers, they did not generally tell the state, he wrote. The fates of Medicaid and the long term care industry are thickly intertwined, with the former providing about two-thirds of the funding for the latter.

5) The federal [Agency for Healthcare Research and Quality (AHRQ)](https://www.ahrq.gov) noted, **AHRQ Recruiting Long Term Care Facilities for Antibiotic Stewardship Project.** AHRQ is seeking long term care facilities to join a national project that aims to reduce harms related to inappropriate use of antibiotics while preserving antibiotics’ effectiveness for future generations. The 12-month project is offered at no charge, and will begin in December. Continuing education credits are available. For more details, register to attend one of the following one-hour webinars:

  * **July 26, 2:30 p.m. ET**
6) The federal HHS Office of the Assistant Secretary for Preparedness and Response (ASPR TRACIE) released their July edition of The Express. This issue of The Express highlights a newly released webinar, new ASPR TRACIE resources, upcoming events and domain updates.

7) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:
   - HFS posted a new provider notice regarding New BHC Fee Schedule. You may view the notice here.
   - HFS posted the updated SLP Cost Reports for 2018. You may view the updated reports here.
   - HFS posted a new public notice regarding Integrated Assessment and Treatment Planning. You may view this notice here.
   - HFS posted a new provider notice regarding Chapter L-200, Handbook for Providers of Laboratory Services Correction Regarding Global Laboratory Billing in the Hospital Outpatient Setting and Hospital Use of Modifier “90” for Reference Laboratory Services. You may view the notice here.
   - HFS posted a new public notice regarding “Mobile Crisis Response Services.” You may view the notice here.
   - HFS posted a new provider notice regarding LTC Monthly Occupied Bed Provider Assessment. You may view the notice here.

8) The Illinois Department of Public Health (IDPH) recently announced:
   - 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:
     - 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
   - 2017 Statistical Report on Complaints
     - LTC Complaints
     - DD/ID Complaints

9) The Illinois Department on Aging announced:
   - The LTC Ombudsmen will be focusing on Resident Councils this year during their facility visits.
   - Provided Process Evaluation of the Long-Term Care Ombudsman Program.

10) The American Health Care Association (AHCA) recently reported on AHCA Mid-Year Update.

11) The latest Telligen events/announcements can be found here.

12) Provider Magazine reports that Receptive Music Therapy Effective at Lowering Older Dementia Patients’ Aggression. Provider Magazine recently reported, receptive music therapy "is more effective in reducing agitation,
behavioral problems, and anxiety in older individuals with dementia," researchers concluded in a study in *JAMDA*. Investigators "reviewed 38 trials involving the use of music therapy for 1,418 participants with dementia," concluding that "participants involved with receptive music therapy had significant decreases in agitation and behavioral problems, compared with 'usual care' without this therapy." Holly Harmon, RN, associate vice president of quality and clinical affairs at the American Health Care Association, told Provider that music therapy "is an opportunity to get to know each person living in the center on a deeper level through music. ... Become informed by what types of music bring each person peace or happiness, and use that learning to enhance their life wherever possible."

13) **RPA, a Jensen Hughes Company** reports that they [Updated the CMS Emergency Preparedness Crosswalk to Reference E-Tags](https://www.rpajvm.com). RPA has moved forward and added E-tag references to the updated Emergency Preparedness Program (EPP) Best Practice Guidebook for Long Term Care. This crosswalk relates CMS Emergency Preparedness requirements directly to the Guide content. This updated tool should be helpful to anyone who has purchased the EPP Customizable Plan for LTC (sold by AHCA/NCAL: [click to purchase from AHCA](https://www.ahca.org)). The updated EPP Best Practice Guidebook contains additional information addressing 1135 Waivers and how they relate to disaster/emergency declarations under the Stafford Act or National Emergencies Act. This information will be beneficial to both surveyors and providers, as there has been a good deal of confusion regarding the CMS regulation and how providers should be addressing 1135 Waivers in their policies and procedures. To download our EPP Best Practice Guide.Template Compliance Crosswalk, [click here](https://www.rpajvm.com).

14) **Medscape** reports that *Quality of Care at End of Life Has Improved in US Since 2000*. Medscape reports that research indicates "the quality of care at the end of life has improved in the United States since 2000, with fewer deaths occurring in acute care hospitals and more occurring at home or in hospice." Medscape adds, "Fewer end-of-life patients are being transferred to hospitals for ‘burdensome care’ for things like dehydration and infections, the study found, and use of the intensive care unit (ICU) in the last month of life, which had increased until 2009, has stabilized." The research was published online in the *Journal of the American Medical Association*. In an accompanying editorial, "Ezekiel J. Emanuel, MD, PhD, from Perelman School of Medicine, University of Pennsylvania, Philadelphia, says the findings are good news."

15) **Skilled Nursing News** reports:

- **Skilled Nursing Providers Cheer New CMS Telehealth Proposal.** *Skilled Nursing News* reports that skilled nursing providers have reacted positively to CMS’ new proposed telehealth guidelines that "would expand physician coverage to include remote check-ins on patients...while also covering a wider swath of preventative telehealth interventions." While the guidelines "don’t represent broad-based coverage for skilled nursing facilities," they "have drawn praise from providers and groups." CMS said of the proposals, "Innovative technology that enables remote services can expand access to care and create more opportunities for patients to access personalized care management as well as connect with their physicians quickly."

- **CMS to Survey SNFs About Opioid Use At Facilities.** *Skilled Nursing News* reports, CMS has proposed surveying "1,200 nursing home administrators or directors of nursing, community-based pharmacists, and physicians to evaluate its medication safety and adverse drug event prevention programs – with a focus on opioid overuse and overdose." Regulators will examine "how well a variety of initiatives – including the National Action Plan for Adverse Drug Prevention and its Quality Improvement Organizations – have worked in helping to curb the use of certain drugs, while also assessing the impact on health care providers."

16) **Health News Illinois** reports:

- **Report: Illinois Policies ‘Moderately’ Support Telemedicine.** Illinois state laws and Medicaid policies "moderately" support the use of telemedicine services, according to a recent nationwide survey. Manatt Health conducted a 50-state survey related to telemedicine and analyzed areas including practice standards and licensure, coverage and reimbursement, eligible patient settings, eligible provider types, eligible technologies and service limitations. They classified each state’s policies as restrictive (may inhibit the use of telemedicine),
moderate (may moderately support it) or progressive (enable and incentivize it). Illinois was categorized as moderate, with areas receiving mixed reviews:

- **Restrictive** - practice standards and licensure, Medicaid-eligible provider settings
- **Moderate** - Medicaid-eligible patient settings
- **Progressive** - Medicaid coverage and reimbursement, Medicaid-eligible technologies and Medicaid service limitations

Including Illinois, 19 states were classified as moderate, 12 as restrictive and 20 as progressive. Read more.

- **Rauner Signs Bill Aimed at Boosting Physician Assistants.** Gov. Bruce Rauner signed legislation that supporters say will increase the number of physician assistants in the state. The **law** increases how many physician assistants can enter into a collaborative agreement with doctors from five to seven, and eliminates the ratio in certain areas that the federal government determines have a shortage of health professionals. Nearly half of the state’s counties meet that designation, according to the Illinois Academy of Physician Assistants, who says physician assistants have lost out on jobs because of the ratio. “This bill will ease the way for medical practices in Southern Illinois, rural Illinois and in underserved areas to improve access to high quality healthcare,” Jennifer Orozco, legislative chair of the academy and an assistant professor at Rush University Medical Center in Chicago, said in a statement late last month.

- **Report: 2.9 Million in Illinois Enrolled in Medicaid, CHIP.** Approximately 2.9 million individuals in Illinois were enrolled in Medicaid and the Children’s Health Insurance Program as of April 2018, CMS found in a recent report. That’s a 10.5 percent increase since mid-2013, before the first Affordable Care Act open enrollment period and Medicaid program changes. Nationwide, 73.8 million people were enrolled in the programs in April, with 67.3 million in Medicaid and 6.5 million in CHIP.

- **State Fines 36 Nursing Homes Nearly $1 Million During Second Quarter.** The state cited 36 nursing homes for violations during the second quarter of the year, issuing nearly $1 million in fines.

- **A state audit issued Thursday found systemic failures in Illinois’ licensing and oversight of thousands of taxpayer-funded group homes for adults with disabilities, reported the Chicago Tribune.**

17) McKnight’s reports:

- **Palliative Care Enhances Providers’ Re-hospitalization Reduction Efforts.** In a guest column, Cyndi Seiwert, Chief Operating Officer of Turn-Key Health, wrote for McKnight’s Long Term Care News that the American Health Care Association has updated its National Quality Initiative to encourage providers to "achieve quantitative results in key areas by March 2021," including objectives such as reducing hospitalizations. Seiwert wrote that reducing hospital readmissions is a goal shared by CMS, and that since the launch of the AHCA program in 2012, "AHCA reports that their SNF members have safely prevented more than 142,000 individuals from returning to the hospital – a 12% reduction since 2011." Seiwert recommended that providers emphasize the role of palliative care to reduce readmission rates, noting that it "draws upon clinician expertise in conducting sensitive conversations that better align treatment options with personal goals of care."

- **CMS Exploring Reimbursement of Telehealth Services.** McKnight’s Long Term Care News reports that CMS officials proposed "allowing reimbursement for video chats or check-ins" amid the agency’s "move to start paying for virtual visits, beyond rural areas of the country," which advocates have applauded. Officials "also say CMS will cover doctors who evaluate patient-submitted photos or monitoring chronic conditions via smartphone." CMS Administrator Seema Verma said, "This is a big issue for the elderly and disabled population for which transportation can be a barrier to care. ... We’re not intending to replace office visits but rather to augment them and create new access points for patients."

- **CMS Streamlines Medicare Application Process for Providers.** McKnight’s Long Term Care News reports, CMS announced last week that it plans "to make it easier for providers to apply for eligibility" by amending the
provider Medicare enrollment application to "to make the flow of questions more logical," remove duplicate fields, and add "new specialty codes for providers to choose from." Providers "have criticized the enrollment process as inconsistent"; but the new process "will create a single document for application, experts said, speeding up the ability to process new providers."

- **Average Survival Time For Dementia Patients Runs Six Years, Research Suggests.** *McKnight’s Long Term Care News* reports that new research at the Alzheimer’s Association’s 2018 International Conference in Chicago suggests that the survival time for dementia patients "is short, regardless of the age at onset." The study suggests that the "median survival time, across all age groups, was six years" for early-onset dementia patients. At the conference, which also featured additional research, the association announced "that it is establishing the first-ever Dementia Care Provider Roundtable" which "will meet for the first time Thursday, the last day of the five-day conference."

- **Judge Approves Verbal Instructions For Nursing Home Arbitration Contracts.** *McKnight’s Long Term Care News* reports Mississippi judge Michael P. Mills recently "struck down one woman’s attempt to take her dispute" with the nursing home Golden Living Center Ripley "to trial, arguing the verbal consent for an arbitration agreement was sufficient." The woman, who sued for neglect, "had argued that the arbitration agreement she had signed on behalf of her mother," now deceased, "was invalid...because [she] only gave verbal consent to sign her admission forms, with no formal document establishing their relationship." However, the judge ruled that "verbal instructions may be sufficient to create an agency to sign an arbitration contract on behalf of a nursing home resident," and that "no formal written document is required in this regard."

18) **Interesting Fact:** July 2018 is the only time you will see this in your lifetime. The month of July this year will have 5 Sundays, 5 Mondays and 5 Tuesdays. This happens once every 823 years.

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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!*