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!

New IDPH Proposed and Emergency Regulations Regarding the Health Care Employee Vaccination Code

Effective September 18, 2018, the Illinois Department of Public Health (IDPH) issued a Notice of both Proposed and Emergency rulemaking with regard to the Health Care Employee Vaccination Code (77 Ill. Adm. Code 956). See the Illinois Register (click here) pages 17545 (proposed) and Page 17942 (emergency) for a full copy of the regulation and revised Sample Declination Form. Since these rules were published as EMERGENCY rulemaking, they are in effect now.

IDPH stated that these emergency rules are part of the Illinois Department of Public Health's efforts to combat influenza. The emergency rules implement PA 100-1029, which amended the Department of Public Health Powers and Duties Law to modify the instances in which a health care employee may decline an influenza vaccine offer made by a facility licensed by the Department. The offer program ensures that health care personnel are offered the opportunity to be vaccinated against seasonal influenza and other novel/pandemic influenza viruses as vaccines become available. The emergency rules will provide health care settings the ability to implement vaccination programs consistent with the statute for the 2018-2019 influenza season. Seasonal influenza places a great demand on the health care delivery system by making many people ill over a short period of time, so that every available health care worker may be necessary to provide care. Health care personnel who do not provide direct care must also be protected from influenza, because their work is essential to the efficient and effective delivery of health care. In addition, exposed personnel themselves can transmit the disease. Many professional organizations, such as the Centers for Disease Control and Prevention (CDC), the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) and the National Foundation for Infectious Diseases, endorse the universal, annual vaccination of health care personnel. The purpose of these emergency rules is to increase vaccination rates, to reduce the incidence of illness among health care personnel, and to reduce transmission rates in the population of the state.

Section 5-45 of the Illinois Administrative Procedure Act [5 ILCS 100/5-45] defines "emergency" as "the existence of any situation that any agency finds reasonably constitutes a threat to the public interest, safety, or welfare." In addition, the emergency must require adoption of a rule upon fewer days than is required by the regular rulemaking process. The situation that the Department faces in regard to influenza vaccination of health care personnel meets these criteria. The prospect of thousands of health care personnel becoming infected with influenza poses a threat to the public interest, safety and welfare, in regard to both their own health and the health of the population of the state whose care is entrusted to them. In addition, health care personnel who have been exposed to influenza in a work environment can expose others outside of that environment with whom they come in contact. Voluntary vaccination of health care personnel is an important step in controlling the spread of influenza and protecting the health of the population. Using the regular rulemaking process to adopt these rules would preclude their effectiveness at the time when they are most needed, which is during the influenza season. Health care personnel need to be vaccinated before they are called upon to care for individuals who have influenza. Adoption of these emergency rules will help to fulfill the Department's goal of
taking proactive steps to prevent the spread of disease. The Department is also publishing identical proposed rules, which were approved by the State Board of Health on September 13, 2018.

In summary, the proposed and emergency rulemaking:

- Adds/modifies definitions for
  - MC/DD facility;
  - Specialized Mental Health Rehabilitation facility
- Adds a new definition for ‘Medically Contraindicated’;
- Adds some reference cites;
- Changes the Section on ‘Declination of Vaccine’ to **remove** the exemption for general philosophical or moral reluctance to influenza vaccines;
- Now makes a declination statement mandatory and to be handled confidentially.

Therefore, the **only** time an employee can decline the offer of a vaccination is if:

- The vaccine is medically contraindicated;
- The vaccination is against the employee’s religious belief; or
- The employee has already been vaccinated.

There is a **revised Sample Declination Form** attached to the rulemaking for facilities to use. The revised form has an error on it under #4. ‘My philosophical’ is an error and should only state ‘religious beliefs’. The employee only need to initial that they have a religious belief that prohibits vaccination or they have a medical contraindication to receiving the vaccine. **Nothing in the current emergency rulemaking requires any documentation of either reason for declination.** This may change in the final rulemaking, but we will have to wait and see. IHCA will be sending in comments to the proposed rulemaking to address this. You (and we urge you to do this) also can send into IDPH any comments/concerns you have. Where to send your comments is in the notice/introductory part of the rulemaking.

As this rule evolves, we at IHCA will keep you informed. Please contact Bill Bell with any questions.

**Medication Administration Observation (Part 4 in the Series – Mandatory LTC Survey Pathways)**

During the Annual LTC survey, surveyors will make random medication observations of several staff over different shifts and units, multiple routes of administration -- oral, enteral, intravenous (IV), intramuscular (IM), subcutaneous (SQ), topical, ophthalmic, and a minimum (not maximum) of 25 medication opportunities. The surveyors will not preselect residents for observation. They will observe and document all of the resident’s medications for each observed medication administration (this does not mean all of the medications for that resident on different shifts or times). Additionally, if possible, they will observe medications for a sampled resident whose medication regimen is being reviewed. Otherwise, they will observe medications for any resident to whom the nurse is ready to administer medications.

**NOTE:** There may be times when the surveyor should intervene before the person administering the medication makes a potential medication error. If a surveyor intervenes to prevent a medication error from occurring, each potential medication error would be counted toward the facility’s medication error rate.

Under **General Medication Administration**, surveyors will review for:

- Hand hygiene was performed prior to handling medication(s) and after administering medication(s) if resident contact was necessary.
- The correct medication was administered to the resident.
- The correct medication dose was administered to the resident.
- Medications administered with a physician’s order. Medications administered as ordered (e.g., before, after, or with food such as antacids).
- Medications administered before the expiration date on the label.
- Medications administered to the resident via the correct route.
- Medication held and physician notified in the presence of an adverse effect, such as signs of bleeding or abnormal lab results with anticoagulants.
• Checked pulse and/or blood pressure prior to administering medications when indicated/ordered.
• Staff ensured medications were administered to the resident (e.g., left medications at bedside).
• Resident was properly positioned to receive medications (e.g., head of the bed is elevated at an angle of 30-45°).
• Resident was properly informed of the medications being administered.
• Medication cart was locked if left unattended in resident care area.
• If a controlled medication was administered, made sure the count in the cart matches the count in the facility’s reconciled records.
• Insulin suspensions – "mix" or “roll” the suspension without creating air bubbles.
• Shake a drug product that is labeled "shake well," such as Dilantin Elixir.
• Nutritional and dietary supplements are given as ordered and documented by staff but not counted in the medication observation except for vitamins and minerals. Administration of vitamins and minerals are part of medication administration observation and errors with vitamins and minerals are counted in the error rate calculation.

Under **Oral or Nasogastric Tube Administration**, surveyors will review for:

• The administration of medications with adequate fluid as manufacturer specifies such as bulk laxatives, non-steroidal anti-inflammatory drugs and potassium supplements.
• Staff did not crush tablets or capsules that manufacturer states “do not crush,” such as enteric coated or time-released medications.
• Staff did not crush and combine medications and then give medications all at once either orally (e.g., in pudding or other similar food) or via feeding tube.
• Prior to medication administration, nasogastric or gastrostomy tube placement is confirmed (NOTE: If the placement of the tube is not confirmed, this is not a medication error. For concerns related to care of a resident with a feeding tube, refer to guidance at 483.25(g)(4)-(5), F693 Enteral Nutrition.
• Nasogastric or gastrostomy tube flushed with the required amount of water before and after each medication unless physician orders indicate a different flush schedule due to the resident’s clinical condition.
• Staff separated the administration of enteral nutrition formula and phenytoin (Dilantin) to minimize interaction. Simultaneous administration of enteral nutrition formula and phenytoin is considered a medication error.

Under **Injection Practices and Sharps Safety (Medications and Infusates)**, surveyors will review for:

• Injections are prepared using clean (aseptic) technique in an area that has been cleaned and is free of contamination (e.g., visible blood or body fluids).
• Needles, cannulas and syringes are used for one resident.
• Medication vials (labeled single dose) are used for one resident.
• Bags of IV solutions and medication administration are used for one resident.
• Mixed the suspension (e.g., insulin) without creating air bubbles. Multi-dose vials used for more than one resident are kept in a centralized medication area and do not enter the immediate resident treatment area (e.g., resident room). If multi-dose vials enter the immediate resident treatment area they are dedicated for single-resident use only.
• Multi-dose vials that have been opened or accessed (e.g., needle-punctured) are dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for the opened vial.
• Multi-dose vials that are not opened or accessed (e.g., needle-punctured) should be discarded according to the manufacturer’s expiration date.
• Insulin pens containing multiple doses of insulin are meant for single-resident use only, and must never be used for more than one person even when the needle is changed.
• Insulin pens must be clearly labeled with the resident’s name and other identifier(s) to verify that the correct pen is used on the correct resident.
• Insulin pens should be stored in a sanitary manner to prevent cross-contamination.
• The rubber septum on any medication vial, whether unopened or previously accessed, is disinfected with alcohol prior to piercing.
• Proper technique used for IV/IM/SQ injection.
• Sharps containers are readily accessible in resident care areas.
• Sharps are disposed of in puncture-resistant sharps containers.
• Sharps containers are replaced when the fill line is reached.
• Sharps containers are disposed of appropriately as medical waste.
• IM/SQ injection sites are rotated.
• Insulin pens used for one resident.
• Observe for the safe use of point of care devices (e.g., blood glucose meter, International Normalized Ratio (INR) monitor).
• Finger stick devices (both lancet and lancet-holding devices) are used for one resident.
• If used for more than one resident, the point-of-care testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to manufacturer’s instructions. If manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for more than one resident.
• IV pumps are clean and a protocol exists for cleaning between residents.

Under **Topical, Ophthalmic and Inhalation Medications**, surveyors will review for:

• Transdermal patch sites are rotated.
• Transdermal patch is dated and timed.
• Used transdermal patches are disposed of properly.
• Multiple eye drops administered with adequate time sequence between drops.
• Inhaler medication administered, handled or stored according to physician’s orders and/or manufacturer’s instructions.
• Single-dose vials for aerosolized medications used for one resident.
• Metered dose inhalers administered per manufacturer instructions.
• Sterile solutions (e.g., water or saline) are used for nebulization.
• Jet nebulizers used for single resident or cleaned and stored as per facility policy (e.g., rinsed with sterile water and air-dried between treatments on the same resident).
• Gloves worn when in contact with respiratory secretions and changed before contact with another resident, object or environmental surface.

**Calculations for Team’s Combined Medication Administration Observations:**

• Step 1. Combine all surveyor observations into one overall calculation for the facility. Record the Total Number of Errors. Record the number of Opportunities for Errors (doses given plus doses ordered but not given).
• Step 2. Medication Administration Error Rate (%) = Number of Errors divided by Opportunities for Errors (doses given plus doses ordered but not given) multiplied by 100.
• Step 3. After the overall error rate is determined, the team will determine whether a facility citation is appropriate during the team meetings. If the Medication Administration Error Rate is 5 percent or greater, cite F759. If any one medication error is determined to be significant, cite F760.
• Total Number of Errors divided by the Opportunities for Errors times 100 equals the Medication Administration Error Rate by percent.

The tag numbers the surveyors will focus on are:

• Does the facility ensure that it is free of medication error rates of five percent or greater? (F759)
• Does the facility ensure that residents are free of any significant medication errors? (F760)
• Did the facility provide medications and/or biologicals and pharmaceutical services to meet the needs of the resident? (F755)
• Did the facility appropriately label and store drugs and biologicals in accordance with currently accepted professional principles? (F761)
• Did the facility implement appropriate infection prevention and control practices during medication administration including hand hygiene, injection safety and point-of-care testing? (F880)
• Did the facility meet professional standards of quality? Note: If F658 is cited, an associated tag should be cited. (F658).
Focus F-Tag – F645 PASARR Screening for Mental Disorder/Intellectual Disability

This Regulatory Beat’s Focus F-tag is F645 PASSAR Screening for Mental Disorder/Intellectual Disability, which is part of the Resident Assessments regulatory group. This F-tag outlines a nursing facility’s requirements for not admitting new residents with a mental disorder or intellectual disability except where certain criteria have been met.

What Conditions Meet the Criteria?

First, let’s look at some of the definitions:

- **Mental Disorder (MD)** – Per the RoPs, “An individual is considered to have a serious mental illness if the individual meets the following requirements on diagnosis, level of impairment and duration of illness.”
  - The *diagnosis* must be a major mental disorder that is diagnosable under DSM-3. This includes: schizophrenic, mood, paranoid, panic/other severe anxiety disorder, somatoform disorder, personality disorder or other psychotic disorder or another mental disorder that may lead to a chronic disability. This excludes a primary diagnosis of dementia or a non-primary diagnosis of dementia unless a major mental disorder is one of the primary mental disorders listed prior.
  - The *level of impairment* requires that the mental disorder results in functional limitations in major life activities that are appropriate for the individual’s life stage for the past 3-6 months. This includes issues with interpersonal functioning, concentration/persistence/pace and/or adaptation to change.
  - The *recent treatment* requirement is based on a person’s treatment history that shows the person had at least one of the following occur: (a) psychiatric treatment more than once in the past 2 years that is more intensive than outpatient care, such as partial or inpatient hospitalization and/or (b) within the past 2 years, due to the mental disorder, the person has “experienced an episode of significant disruption to the normal living situation.” This disruption required support services to allow the individual to maintain functioning at home/residential treatment environment or resulted in “intervention by housing or law enforcement.”
  - **Intellectual Disability (ID)** – Per the RoPs, “an individual is considered to have intellectual disability (ID) if he or she has (i) a level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual’s Disability Manual on Classification in Intellectual Disability (1983)” or a related condition.
  - **Persons with Related Conditions** – Per the RoPs, persons with related conditions means individuals who have a severe, chronic disability that meets all of the following conditions: (a) is attributable to cerebral palsy, epilepsy or any other condition (other than mental illness) that is found to be closely related to ID, (b) manifested before the person reached age 22, (c) is likely to continue indefinitely, (d) results in substantial functional limitations in three or more areas of major life activity. These areas include self-care, understanding/use of language, learning, mobility, self-direction and/or capacity for independent living.

Understanding PASARR

All applicants for Medicaid-certified nursing facilities are required to be screened for possible serious mental disorders, intellectual disabilities and related conditions through the PASARR process. This is because the intent of F645 is to ensure that each resident in a nursing facility with one of these conditions is screened prior to admission and that those people who are identified to have MD/ID are evaluated and receive the care and services that they need in the most appropriate integrated setting. The initial screening is appropriately named “Level I Identification of individuals with MD or ID” and its purpose is to identify the individuals who would require a PASARR Level II evaluation and determination, which is an in-depth evaluation by a state-designated authority, which also occurs prior to admission.

The Level II assists with determining the appropriate setting for the person, as well as if any specialized services and/or rehabilitative services would be needed, so this cannot be conducted by the nursing facility. Each State Medicaid Agency has its own processes for Level I and Level II Screens, so it’s important to review your state-specific requirements if you have questions. The state is responsible for providing or arranging for specialized services for residents, and the facility is responsible for providing all the other care/services that are appropriate to the resident’s condition. Specialized services that the state could arrange for are those which would normally exceed the NF per diem rate, such as hiring additional staff that are qualified mental health/intellectual disability professionals. Rehabilitative services for MD/ID are those which nursing facility staff could provide and are considered necessary whether or not they are specified in the PASARR Level II or if the resident does or does not require additional services provided by the state. This means that your staff
need to understand how to work with the residents that you admit to your building and have an understanding of their underlying conditions.

Exceptions

As with many cases, there are several exceptions to this requirement, including:

- Readmission to a nursing facility for a resident who was transferred to a hospital and then back to the nursing facility.
- If a state chooses to not apply the preadmission screening process to an individual:
  - Who is admitted to the facility directly from a hospital after receiving acute inpatient care there;
  - Who requires nursing facility services for the condition that the person was treated for in the hospital;
  - Whose attending physician has certified, before admission to the facility that the person is likely to require less than 30 days of nursing facility services. If this exception is permitted and the person remains in the facility longer than 30 days, the facility must screen the person using the state’s Level I screening process and refer the resident who may have MD/ID/related condition to the appropriate state-designated authority for a Level II screening.

PASAAR document review is an important part of a facility’s admission decision process and should not downplayed. If you choose to admit a person who required a Level II screen, remember you need to incorporate the evaluation letter’s recommendations into the plan of care.

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**Trending Statistics**

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

**More Clinicians Should Get Flu Vaccination, CDC Says**

Yearly influenza vaccination is a standard recommendation for all health care professionals (HCPs) to protect themselves and their patients, but new data from the Centers for Disease Control and Prevention (CDC) show that rates of flu vaccination among HCPs have stalled at about 74 percent since 2014.

The vaccination rate was particularly low among those working in long term care settings (67.4 percent) and settings where vaccination was not required, not promoted or not offered on-site (47.6 percent), report Carla L. Black, PhD, and colleagues in today’s issue of *Morbidity and Mortality Weekly Report*.

The researchers note that vaccination rates are highest in workplaces with vaccination requirements (94.8 percent) and that rates can be improved by offering worksite vaccination at low or no cost for 1 day (70.4 percent) or by actively promoting vaccination (75.1 percent).

"Influenza vaccination coverage among health care personnel working in long term care settings, the majority of whom work as assistants and aides, continues to be consistently lower than that among health care personnel working in all other health care settings. Influenza vaccination among health care personnel in long term care settings is especially important because influenza vaccine efficacy is generally lowest among the elderly, who are at increased risk for severe disease," the authors write.

"In contrast to health care personnel working in hospitals, a much lower proportion of survey respondents working in long term care settings reported having a requirement for vaccination, and 23.5 percent reported that their employer did not require, make available on-site at no cost, or promote vaccination in any way."

The analysis was based on an opt-in Internet panel survey of 2265 US HCPs conducted between March 27, 2018 and April 17, 2018.
Vaccination coverage varied by work setting and profession. Vaccination rates were 91.9 percent for those working in hospitals, 75.1 percent for those working in ambulatory care, 74.9 percent for those working in other clinical settings, and 67.4 percent for those working in long term care.

The overall vaccination rate of 74.8 percent among HCPs was 15-points higher than during the 2010-2011 season but was not significantly different from the past 4 years, the authors write.

Physicians had the highest influenza vaccination coverage (96.1 percent), followed by pharmacists (92.2 percent), nurses (90.5 percent), nurse practitioners/physician assistants (87.8 percent), other clinical personnel (80.9 percent), assistants and aides (71.1 percent) and nonclinical HCPs (72.8 percent).

The authors note that the majority of HCPs in long term care settings are assistants and aides. They suggest that implementing workplace vaccination programs that have been successful in increasing coverage in hospital settings, such as vaccination requirements.

They also suggest that use of the CDC's digital campaign and long term care employer toolkits could increase influenza vaccine coverage among HCPs.

The authors emphasize that the CDC, Advisory Committee on Immunization Practices, and Healthcare Infection Control Practices Advisory Committee recommend that all healthcare workers get the annual flu vaccine.

*Reprinted out of Medscape.

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

1) No new federal **CMS Quality, Safety and Oversight Letters** (formerly known as Survey and Certification (S&C) Letters) were released since the last issue of *Regulatory Beat*.

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

   - **2019 Medicare Parts A and B Premiums and Deductibles**. On October 12, 2018, CMS released the 2019 premiums, deductibles and coinsurance amounts for the Medicare Part A and Part B programs.

   - **The Payroll Based Journal (PBJ) Deadline for the Quarter Ending September 30, 2018**, is **November 14, 2018**. Facilities need to enter their staffing data before that date and they can check their submitted data for accuracy and completeness on CASPER (Certification and Survey Provider Enhanced Reporting).

   - **Hand in Hand: A Training Series for Nursing Homes**. Do you need in-service training on dementia management and resident abuse prevention? Hand in Hand: A Training Series for Nursing Homes focuses on caring for residents with dementia and preventing abuse. This training is updated and available in two formats:
     - **Self-Paced Online Training**
     - **Downloadable Materials for Instructor-Led Training**

     For help with registration and technical issues, contact the Helpdesk at cmstraininghelp@hendall.com.

   - **New Medicare Card: Destroy the Old Card**. Remind your Medicare patients that when they get their new Medicare cards, they should destroy the old red, white, and blue Medicare cards but not their Social Security, Medicare Advantage plan, or drug plan cards. If they belong to a Medicare Advantage plan or a Medicare drug plan (Part D), they should continue to use these cards when they get health care services or fill a prescription.
Important New Medicare Card Mailing Update — Wave 7 Begins, Wave 5 Ends. CMS has started mailing new Medicare cards to people with Medicare who live in Wave 7 states and territories including: Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee and the Virgin Islands.

They have finished mailing cards to people with Medicare who live in states within Waves 1 through 4 and now Wave 5. If someone with Medicare who lives in one of these states says they did not get a card, you should instruct them to:

- Sign into MyMedicare.gov to see if we mailed their card. If so, they can print an official card. They will need to create an account if they do not already have one.
- Call 1-800-MEDICARE (1-800-633-4227) where we can verify their identity, check their address and help them get their new card.

You can also print out and give them a copy of Still Waiting for Your New Card?, or you can order copies to hand out.

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

Participants in New Value-Based Bundled Payment Model. On October 9, CMS announced that 1,299 entities have signed agreements with the agency to participate in the Administration’s Bundled Payments for Care Improvement (BPCI) – Advanced Model. The participating entities will receive bundled payments for certain episodes of care as an alternative to fee-for-service payments that reward only the volume of care delivered. The Model participants include 832 Acute Care Hospitals and 715 Physician Group Practices – a total of 1,547 Medicare providers and suppliers, located in 49 states plus Washington, D.C. and Puerto Rico.

“To accelerate the value-based transformation of America’s health care system, we must offer a range of new payment models so providers can choose the approach that works best for them,” said CMS Administrator Seema Verma. “The Bundled Payments for Care Improvement – Advanced model was the Trump Administration’s first Advanced Alternative Payment Model, and today we are proud to announce robust participation. We look forward to launching additional models that will provide an off-ramp to the inefficient fee-for-service system and improve quality and reduce costs for our beneficiaries.”

Under the traditional fee-for-service payment system, Medicare pays providers and suppliers for each individual service they perform. However, under this new episode payment model, participants can earn an additional payment if all expenditures for a beneficiary’s episode of care are less than a spending target, which factors in measures of quality. Conversely, if the expenditures exceed the target price, the participant must repay money to Medicare.

The BPCI Advanced Model was publicly announced in January 2018, and runs from October 1, 2018, through December 31, 2023. It builds on the BPCI Initiative, which ended on September 30, 2018. BPCI Advanced will initially include 32 bundled clinical episodes - 29 inpatient and 3 outpatient. Currently, the top three clinical episodes selected by participants are: Major joint replacement of the lower extremity, congestive heart failure, and sepsis. For More Information:

- BPCI Advanced webpage

See the full text of this excerpted CMS Press Release (issued October 9).

Medicare Diabetes Prevention Program: New Covered Service. The 2019 Medicare & You Handbook includes information on the Medicare Diabetes Prevention Program (MDPP), a new Medicare-covered service. Help your patients prevent or delay Type 2 diabetes and understand their treatment options. For More Information:

- Review materials from the September 26 Medicare Learning Network call
• Become familiar with beneficiary eligibility criteria and coverage; screen at-risk patients for eligibility
• Access the MDPP Supplier Map or view a list of all current MDPP suppliers; refer eligible patients to a nearby MDPP supplier
• Visit the MDPP Expanded Model webpage

MDPP is a new program that is still ramping up. If you do not see an organization that offers services in your community, keep checking the list. New MDPP suppliers are added to the list on a regular basis.

• Part A Providers: MCReF System Enhancement. On May 1, CMS implemented the new Medicare Cost Report e-Filing (MCReF) system; over 2,000 cost reports were submitted through the system in the first month. For FYs ending on or after December 31, 2017, you can electronically submit your cost report package to your Medicare Administrative Contractor through MCReF. You must use MCReF to submit your cost report electronically; you may also continue to mail or hand deliver them.

An enhancement on September 10 allows contractor users to submit MCReF role requests to multiple organizations at the same time without waiting for each request to be approved before submitting another. Users that represent multiple organizations can obtain timely approval. For More Information:
  o Register for the October 15 Medicare Learning Network webcast
  o How to Request a User Role
  o FAQs
  o User Manual
  o MCReF MLN Matters® Article
  o MCReF webpage

For questions, contact the External User Services helpdesk at eussupport@cgi.com or 866-484-8049 (TTY/TDD: 866-523-4759).

• Protect Your Patients from Influenza this Season. The Centers for Disease Control and Prevention (CDC) recommends annual influenza vaccination for everyone 6 months and older. Influenza is a serious health threat, especially to vulnerable populations like people 65 and older, who are at high risk for hospitalization and complications. Vaccinate before the end of October – to help protect your patients, your staff and yourself. Medicare Part B covers the influenza virus vaccine once per influenza season. Medicare covers additional influenza vaccines if medically necessary. You may also want to recommend the pneumococcal vaccine during the same visit. Medicare covers:
  o An initial pneumococcal vaccine for Medicare beneficiaries who never received the vaccine under Medicare Part B
  o A different, second pneumococcal vaccine 1 year after the first vaccine was administered

For More Information:
  o Preventive Services Educational Tool
  o Influenza Resources for Health Care Professionals MLN Matters Article
  o Influenza Vaccine Payment Allowances MLN Matters Article
  o CDC Influenza website
  o CDC Information for Health Professionals webpage
  o CDC Tools to Prepare Your Practice for Flu Season webpage
  o CDC Make a Strong Flu Vaccine Recommendation webpage

• 2019 MS-DRG Definitions Manual and Software. The 2019 Medicare Severity Diagnosis Related Group (MS-DRG) definitions manual and software is available on the MS-DRG Classifications and Software webpage:
  o Definition of Medicare Code Edits v36: Description of each coding edit with the corresponding code lists, effective FY 2019 (PDF and text file)
  o Errata and ICD-10 MS-DRG Definitions Manual Files v36 R1: Complete documentation of the ICD-10 MS-DRG Grouper logic (text version, updated October 9, 2018)
CMS Issues Proposed Rule to Reduce Burden, Improve Efficiency and Transparency. CMS issued a proposed rule on September 20, 2018 entitled: Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency and Burden Reduction. According to CMS, the proposed rule is to reform Medicare regulations that are identified as unnecessary, obsolete or excessively burdensome on health care providers and suppliers. This proposed rule would increase the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or that divert resources away from furnishing high-quality patient care. The proposed changes fall into one of three categories:

1) proposals that simplify and streamline processes;
2) proposals that reduce the frequency of activities and revise timelines; and
3) proposals that are obsolete, duplicative or that contain unnecessary requirements.

This proposed rule impacts regulations for 12 different types of health care providers and providers and suppliers that must comply with the CMS requirements related to Emergency Preparedness. The following are the Emergency Preparedness provisions of the proposed rule that will impact nursing centers:

- There is no longer a need to document efforts to contact local, tribal, regional, state and federal emergency preparedness officials, related to their participation in collaborative and cooperative planning efforts.
- A training program for the emergency plan must be provided biennially (every 2 years), rather than annually, after the initial training for the emergency program. Additional training must occur when the plan is significantly updated.
- The types of acceptable testing exercises that may be conducted is expended so one of the two annually required testing exercises may be an exercise of the provider's choice and may include one community-based full-scale exercise, if available, an individual facility-based functional exercise, a drill, or a tabletop exercise or workshop that includes a group discussion led by a facilitator.
- Providers must review their emergency plan, policies and procedures, communication plan, and training and testing at least every two years (rather than annually).

Other Changes Proposed
There are changes made proposed to the Hospice regulations when operating in a nursing center or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) staff that relate to providing orientation to the nursing center and ICF/IID staff about the hospice philosophy and its approach to care. Further, there are changes proposed to Long Term Care Hospitals and Critical Access Hospital Providers of Long-Term Care Services (“Swing Beds”).

Home Health Star Ratings Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the October 3 call on Final Modifications to the Quality of Patient Care Star Rating Algorithm. CMS presented the rationale, timing and impact of planned modifications to the Home Health Quality of Patient Care star ratings.

Annual Wellness Visit Booklet — Revised. The revised Annual Wellness Visit Booklet is available. Learn about:

- Health risk assessment
- Initial and subsequent components
- Coding, diagnosis, and billing

Initial Preventive Physical Examination Educational Tool — Revised. The revised Initial Preventive Physical Examination Educational Tool is available. Learn about:

- Components
• **Systematic Validation Edits for OPPS Providers MLN Matters® Article — New.** A new MLN Matters Article SE18023 on *Activation of Systematic Validation Edits for Outpatient Prospective Payment System (OPPS) Providers with Multiple Service Locations* is available. Learn about requirements previously discussed in MLN Matter Articles 9613 and 9907.

• **IPPS and LTCH PPS: FY 2019 Changes MLN Matters Article — New.** A new MLN Matters Article MM10869 on *Fiscal Year (FY) 2019 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment Schedule (PPS) Changes* is available. Learn about policy changes.

• **Annual Wellness Visit Booklet — Revised.** The revised *Annual Wellness Visit* Booklet is available. Learn about:
  - Health risk assessment
  - Initial and subsequent components
  - Coding, diagnosis, and billing

• **Initial Preventive Physical Examination Educational Tool — Revised.** The revised *Initial Preventive Physical Examination* Educational Tool is available. Learn about:
  - Components
  - Coding, diagnosis, and billing

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov) provides updates on the 2018-2019 Flu Season:

• **Weekly U.S. Influenza Surveillance Report.** CDC’s Influenza Division produces a weekly influenza surveillance report, FluView. According to this report (Oct 7-13), seasonal influenza activity is at levels below baseline in the United States.

• **Who Should and Should Not Get Vaccinated.** Everyone 6 months and older is recommended for annual flu vaccination, with rare exceptions. Vaccination is particularly important for people who are at high risk for serious complications from influenza. Talk to your doctor or nurse if you have any questions regarding which influenza vaccines are best for you and your family.

4) **Social Security Announces 2.8 Percent Benefit Increase for 2019.** Social Security and Supplemental Security Income (SSI) benefits for more than 67 million Americans will increase 2.8 percent in 2019, the Social Security Administration announced. The 2.8 percent cost-of-living adjustment (COLA) will begin with benefits payable to more than 62 million Social Security beneficiaries in January 2019. Increased payments to more than 8 million SSI beneficiaries will begin on December 31, 2018. (Note: some people receive both Social Security and SSI benefits). The Social Security Act ties the annual COLA to the increase in the Consumer Price Index as determined by the Department of Labor’s Bureau of Labor Statistics.

5) The federal [U.S. Department of Health & Human Services, Office of the Assistant Secretary for Preparedness & Response](https://www.hhs.gov) released their [October 2018 The Express](https://www.hhs.gov). This issue of The Express highlights a recently scheduled webinar, new ASPR TRACIE resources, upcoming events and domain updates.

6) The [Illinois Department of Healthcare and Family Services (HFS)](https://www.dhs.state.il.us) released the following notices since the last issue of *Regulatory Beat*:

• HFS posted an updated [Preferred Drug List for Illinois Medicaid](https://www.dhs.state.il.us), effective October 1, 2018. You may view the updated list [here](https://www.dhs.state.il.us).

• HFS posted a new public notice regarding a [Settlement Agreement in M.A. V. Bellock - In-Home Shift Nursing Services](https://www.dhs.state.il.us). You may view the notice [here](https://www.dhs.state.il.us).

• HFS posted a new provider notice regarding Extension in Due Date for Payment of the Monthly Occupied Bed Provider Assessment. You may view the notice here.

• HFS posted a new provider notice regarding Better Care Illinois Behavioral Health Initiative: Residential/Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot. You may view the notice here.

• HFS posted a new provider notice regarding Extension in Due Date for Payment of the October 2018 Hospital Assessment. You may view the notice here.

• HFS posted a new provider notice regarding Posting of Admission Transaction Audit Numbers (TANs) and Status Codes. You may view the notice here.

7) The Illinois Department of Public Health (IDPH) continues with its 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 final date and location is:

• November 14, 2018 – Oak Trace in Downers Grove 1-3pm

8) The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) note that:

• The Department of Labor has published a Notice of Proposed Rulemaking to allow trained 16- and 17-year-olds to independently operate power-driven patient lifts. This would be an expansion of the current non-enforcement policy, where they are technically prohibited but DOL will not prosecute if 16- and 17-year-olds assist with power lifts in specified circumstances.

   To inform our comments supporting this change, we are asking for members and affiliates to send us the following:
   1. Recent examples about the danger of injury using manual lifts as opposed to a power-driven lifts
   2. Recent examples of how the current policy has created barriers to workforce entry or training for these youths

   Our 2011 advocacy was instrumental in the creation of the non-enforcement policy, and now in the NPRM the DOL quotes prior examples from AHCA/NCAL. Thank you in advance for anything you can provide that we could include to make our comments more concrete and impactful. You can email me at LHummel@ncal.org.

9) Telligen reports:

• Telligen Happy Health Fall 2018 Newsletter.

• The latest Telligen report can be found here.

10) U.S. News and World Report reports, Number of Americans With Alzheimer’s Disease Could Reach 13 Million by 2060. U.S. News & World Report recently reported that the number of Americans with Alzheimer’s disease or a related dementia is expected to increase significantly by 2060, according to a report from the Centers for Disease Control and Prevention. The report estimates that the number will increase from five million in 2014 to 13.9 million by 2060, which would then be around 3.3 percent of the US population.
11) **HealthDay** reports on Fall Prevention Program Reduces Falls Among At-Risk Adults. **HealthDay** reports that new research indicates that a fall prevention initiative led by the US Centers for Disease Control and Prevention that screened "older people who are at risk of falling...found that at-risk adults who received the intervention had similar odds for falling as adults who weren’t at risk of a fall, and 40 percent lower odds than those at risk without a fall prevention plan." Researchers separated "more than 12,000 older adults into three fall-risk groups," including an "at-risk" group which received the "Fall Plan of Care" intervention. The **findings** appear in The **Gerontologist**.

12) **Skilled Nursing News** reports, Employee Satisfaction Directly Impacts Bottom Line in Skilled Nursing Facilities. **Skilled Nursing News** reports that the Great Place to Work survey of senior care workplaces "found a strong correlation between employee satisfaction and resident engagement." The survey found that the "top half of 79 communities cited in the data had an 83 percent trust index score," and had an occupancy rate of 91 percent. By comparison, the "bottom half had a score of 70 percent" and occupancy rates of 89 percent. Todd Schmiedeler of Trilogy Health Services discussed the findings Wednesday at the National Investment Center for Seniors Housing & Care (NIC) Fall Conference in Chicago, concluding, "The happier the employees, the happier the residents, the better the money."

13) **McKnight’s** reports on:

- **Researchers Identify Factors For LTC Patients’ Chances Of Readmission To Hospital.** **McKnight’s Long Term Care News** reports that researchers from the University of Alberta recently determined in a new study that "care setting, before and after the hospital episode, is a key predictor of rehospitalization within 30 days." They determined that "those returning to long term care had a greater risk of readmission, while those newly admitted to long term care had a lower risk." Researchers reached these conclusions after examining "data from more than 700,000 patients, at a mean age of 78."

- **CMS’ Proposed Fines For Elder Abuse Would Unfairly Target Nursing Homes, AHCA VP Says.** **McKnight’s Long Term Care News** reports long term care industry leaders "blasted" CMS’ new proposed "regulation that would allow civil money penalties of up to $200,000 against skilled nursing home staff who fail to report reasonable suspicion of crimes." AHCA Vice President David Gifford, MD, stated AHCA/NCAL "members fully support thoughtful, proactive measures" to combat abuse and neglect; however, he added, "this kind of penalty will do nothing to proactively prevent abuse." Rather, he told McKnight’s, "it singles out nursing home staff and sends a chilling effect through the profession, making it more challenging to hire and retain qualified staff. This kind of regulation will prevent skilled and passionate individuals from working in nursing homes."

- **Assisted Living Communities Three Times Less Likely To Receive Negative Reviews Than Nursing Homes.** **McKnight’s Senior Living** reports that according to an assessment of reviews by consumers research firm FamilyAssets, assisted living communities "garner far fewer negative reviews than do nursing homes." The report shows eight percent of "assisted living communities received one-star reviews on the site, compared with 25.7 percent of nursing homes." The piece adds that the firm "attributed the difference to payer source," being that 62 percent of nursing home residents cover their costs with Medicare.

- **Adjuvanted Flu Shot May Better Prevent Hospitalization Of Nursing Home Residents Than Non-Adjuvanted Trivalent Vaccine.** **McKnight’s Long Term Care News** reports that according to new research presented at the ID Week conference last week in San Francisco, long-stay SNF residents "who receive an adjuvanted trivalent influenza vaccine (aTIV) may be at a lower risk for hospitalization compared to a non-adjuvanted trivalent influenza vaccine." Brown University researcher Stefan Gravenstein, MD, and colleagues examined "more than 800 nursing homes to determine whether a standard, seasonal flu shot was as effective as the aTIV," finding "there were around 400 fewer hospitalizations in the aTIV group."

- **AMDA Analysis Identifies Methods To Improve Primary Care Quality In Nursing Homes.** **McKnight’s Long Term Care News** reports that the Society for Post-Acute and Long-Term Care recently concluded in an analysis that quality measures for primary care in nursing homes "focus on facility processes and characteristics," and are "not crafted specifically to evaluate a physician’s role in delivering care at a nursing home." To close the gap, AMDA "identified and adapted quality indicators...and had them reviewed by 11 experts," who established a list
of 95 indicators found to be "valid." The findings were published in the Journal of Post-Acute and Long-Term Care Medicine.

- **LTC Providers Will See 6 Percent Increase In Liability Claims Next Year, AHCA Analysis Suggests.** McKnight’s Long Term Care News reports, an analysis released by the American Health Care Association and professional services firm Aon suggests nursing homes “should expect to see a 6 percent increase in liability claims next year,” based on a survey of about 30 LTC providers and "more than 18,000 claims." The data suggest "operators should expect to see a 3 percent uptick in total claims frequency, coupled with another 3 percent climb in the average size of each claim." Mark Parkinson, President and CEO of the AHCA, said, "Liability costs are an ongoing problem for our providers. Despite the fact that quality of care has improved, this report confirms that long term care providers are still absorbing high liability costs. ... Arbitration agreements and other reform efforts can help ensure that residents and providers have a way to effectively and efficiently resolve disputes."

- **OSHA Launches Program to Identify Facilities With High Injury Rates.** McKnight’s Long Term Care News reports that this week, the Occupational Safety and Health Administration "launched its Site-Specific Targeting Program" which aims to "pinpoint high-injury rate establishments, such as skilled nursing facilities, for inspection." OSHA said inspections will target "employers that it believes should have, but did not, submit injury data for 2016," and that nursing facilities are among the "establishments classified as having a historically high rate of occupational injuries and illness."

14) **Interesting Fact:** Halloween is more Irish than St. Patrick’s Day. Halloween’s origins come from a Celtic festival for the dead called “Samhain.” Celts believed the ghosts of the dead roamed Earth on this holiday, so people would dress in costumes and leave “treats” out on their front doors to appease the roaming spirits.