Summary of the Revisions to the Emergency Preparedness Requirements

The Emergency Preparedness Final Rule was published in the Federal Register on September 16, 2016, with an effective date of November 15, 2016. Health care providers and suppliers affected by this rule were given until November 15, 2017 to come into compliance and implement the new CMS emergency preparedness regulations.

This final rule established national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to plan adequately for both natural and man-made disasters, and to coordinate with federal, state, tribal, regional and local emergency preparedness systems. It also assists providers and suppliers to adequately prepare to meet the needs of patients, residents, clients and participants during disasters and emergency situations. Despite some variations, the CMS regulations will provide consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities, and establish a more coordinated and defined response to natural and man-made disasters.

On February 1, 2019, federal CMS released QSO 19-06, which updates Appendix Z of the State Operations Manual to add emerging infectious diseases to the definition of all-hazards approach and to add clarifications under alternate source power and emergency standby systems.

The major changes to the Emergency Preparedness Requirements pursuant to QSO 19-06 include:

- Under the definition of All-Hazards Approach, CMS is adding that “Planning for using an all-hazard approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others.” These EIDs may require modifications to facility protocols to protect the health and safety of residents, such as isolation and personal protective equipment (PPE) measures.

- Since the release of the Emergency Preparedness Requirements, there has been a lot of confusion with regard to alternate sources of power and the use of both permanently installed and mobile/portable generators. CMS has added new guidance under Tag E0015 and Tag E0042. Facilities should use the most appropriate energy source or electrical system based on their review of their individual facility’s all-hazards risk assessment and as required by existing regulations or state requirements. Regardless of the alternate sources of energy a facility chooses to utilize, it must be in accordance with local and state laws, manufacturer requirements, as well as applicable Life Safety Code (LSC) requirements. Revisions include:
Facilities are not required to upgrade their alternate energy source or electrical systems, but after review of their risk assessment may find it prudent to make modifications.

Facilities are not required to heat and cool the entire building evenly, but must ensure safe temperatures are maintained in those areas deemed necessary to protect residents, other people who are in the facility, and for provisions stored in the facility during the course of an emergency, as determined by the facility risk assessment.

If unable to meet the temperature needs, a facility should have a relocation/evacuation plan (that may include internal relocation, relocation to other buildings on the campus or full evacuation). The relocation/evacuation should take place in a timely manner so as not to expose residents to unsafe temperatures.

LTC facilities certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F.

If a facility risk assessment determines that the best way to maintain temperatures, emergency lighting, fire detection and extinguishing systems and sewage and waste disposal would be through the use of a portable and mobile generator, rather than a permanent generator, then the LSC provisions such as generator testing, maintenance, etc. outlined under the NFPA guidelines requirements would not be applicable, except for NFPA 70 - National Electrical Code. Per NFPA 70, portable and mobile generators should:

- Have all wiring to each unit installed in accordance with the requirements of any of the wiring methods in Chapter 3.
- Be designed and located so as to minimize the hazards that might cause complete failure due to flooding, fires, icing, and vandalism.
- Be located so that adequate ventilation is provided.
- Be located or protected so that sparks cannot reach adjacent combustible material.
- Be operated, tested and maintained in accordance with manufacturer, local and/or state requirements.

If LTC facility determines that the use of a portable and mobile generator would be the best way to accommodate for additional electrical loads necessary to meet subsistence needs required by emergency preparedness plans, policies and procedures, then NFPA requirements on emergency and standby power systems such as generator installation, location, inspection and testing and fuel would not be applicable to the portable generator and associated distribution system, except for NFPA 70 - National Electrical Code.

For requirements regarding permanently installed generators, refer to existing LSC and NFPA guidance.

Extension cords or other temporary wiring devices may not be used to connect electrical devices in the facility to a portable and mobile generator due to the potential for shock, fire and tripping hazards when using such devices.

The type of protection needed for the fuel stored by the facility for use by the portable and mobile generator will depend on the amount of fuel stored and the location of the storage, as per the appropriate NFPA standard.

If a facility has a permanent generator to maintain emergency power, LSC and NFPA 110 provisions such as generator location, testing, fuel storage and maintenance, etc. will apply and the facility may be subject to LSC surveys to ensure compliance is met. Please also refer to Tag E0041 Emergency and Standby Power Systems for additional requirements for LTC facilities, CAHs and Hospitals.
Facilities may contract with individuals providing services who also provide services in multiple surrounding areas. For instance, an ICF/IID may contract a nutritionist who also provides services in other locations. Given that these contracted individuals may provide services at multiple facilities, it may not be feasible for them to receive formal training for each of the facilities for emergency preparedness programs. The expectation is that each individual knows the facility’s emergency program and their role during emergencies; however, the delivery of such training is left to the facility to determine. Facilities in which these individuals provide services may develop some type of training documentation – i.e. the facility’s emergency plan, important contact information and the facility’s expectation for those individuals during an emergency, which documents that the individual received the information/training, etc. Furthermore, if a surveyor asks one of these individuals what their role is during a disaster, or any relevant questions, then the expectation is that the individual can describe the emergency plans/their role.

An actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the annual exercise requirement and exempts the facility for engaging in a community-based full-scale exercise or individual, facility-based mock disaster drill for one year following the actual event; and facilities must be able to demonstrate this through written documentation. If a facility activates its emergency plan twice in one year, then the facility would be exempt from both exercises (community-based full-scale exercise and the secondary exercise – individual, facility-based mock disaster drill, table top exercise) for one year following the actual events.

Please review OSO 19-06 for all of the CMS changes.

High-Dose Flu Vaccine More Effective Than Standard Vaccines in Older Adults

Compared with standard-dose influenza vaccines, the high-dose vaccine is more effective in preventing influenza- or pneumonia-associated hospitalizations, cardiopulmonary hospitalizations, and all-cause hospitalizations among adults aged 65 and older, data from around 1.7 million patients showed.

“This long-term analysis across five flu seasons — 2010-2011 through 2014-2015 — provides a succinct appraisal of the high-dose vaccine’s effectiveness over the standard-dose vaccine,” Yinong Young-Xu, ScD, director of the clinical epidemiology program at the VA Medical Center in White River Junction, Vermont, told Infectious Disease News.

During the 2017-2018 season, 48.8 million illnesses, 22.7 million medical visits, 959,000 hospitalizations and 79,400 deaths were caused by influenza, according to the CDC. This season has been less severe. However, the vaccine has demonstrated just 24% effectiveness in adults aged 50 or older.

Recently reported study results showed that vaccination halves the risk for influenza-related hospitalization among adults, and many other studies have shown the benefits of influenza vaccination in older adults. Adding to this body of literature, Young-Xu and colleagues’ study assessed the relative vaccine effectiveness of the high-dose influenza vaccine compared with the standard dose in preventing hospitalizations among Veterans Health Administration (VHA)-enrolled veterans aged 65 years or older.

According to the study, the researchers collected electronic medical record databases in the VHA and Medicare administration files for five influenza seasons from 2010-2011 to 2014-2015. The analysis included 3,638,924 person–influenza seasons of observation. Of these, 4% were among individuals who received the high-dose vaccine and 96% were among those who received the standard-dose vaccine.

A longitudinal analysis of all five seasons revealed that the high-dose vaccine had an estimated 10% (95% CI, 8%-12%) instrumental variable-adjusted relative vaccine effectiveness — or additional reduction — in all-cause hospitalization compared with the standard dose. The high-dose vaccine also demonstrated 18% (95% CI, 15%-21%) and 14% (95% CI,
6%–22%) relative vaccine effectiveness against cardiorespiratory-associated hospitalization and influenza/pneumonia-associated hospitalization, respectively, according to the results.

The researchers observed similar findings when they assessed the vaccine effectiveness by season.

“Overall, the high-dose vaccine was found to be more effective than standard-dose vaccines in preventing hospitalizations caused by the flu, pneumonia, cardiorespiratory conditions and all-cause hospitalizations,” Young-Xu said. “The high-dose flu vaccine can help protect adults 65 years of age and older from serious illness and complications related to the flu.

**Focus F-Tag – F883 Influenza and Pneumococcal Vaccinations**

This *Regulatory Beat*’s Focus F-Tag is *F883 Influenza and Pneumococcal Vaccinations*, which is part of the Infection Prevention and Control regulatory group. F883 is a relatively straight-forward regulation, but where facilities are vulnerable is in not having a strong system around thorough documentation. During survey, five residents who may have been included in the sample for other reasons will be reviewed for the administration of these vaccinations. Surveyors will conduct record review and will be looking for the following information.

For both influenza and pneumococcal immunizations, facilities are required to do several things. First, residents/resident representatives must be provided with education on both the benefits and potential side effects risk of the immunization. The resident/representative must be provided with the opportunity to refuse. For influenza, residents must be offered the immunization between October 1 and March 31 on an annual basis unless the resident has already been immunized during that time frame or it is medically contraindicated. The regulatory guidance notes that the Centers for Disease Control (CDC) recommends administering the influenza vaccine when it becomes available rather than on a specific date. Regarding Pneumococcal immunizations, facilities are expected to follow CDC and ACIP (Advisory Committee on Immunization Practices) recommendations. This means facilities need to have a protocol in place for the administration of PPSV23 and PCV13.

What is also required is the following documentation the medical record:

- Documentation that education was provided on benefits/side effects
- Resident either:
  - Received the immunization – The resident’s medical record should show that a vaccine was administered unless there is documentation of one of the following:
    - Did not receive it based on contraindication
    - Resident or representative refused
    - Resident has already been immunized
    - Decision has been made to delay vaccination for a resident on precautions
    - Resident is end-stage and receiving palliative/comfort care and has refused

The Interpretive Guidance (IG) notes that having an effective immunization program in place requires collaboration with the Medical Director on developing policies for immunizations that reflect current standards of practice. This includes the development and implementation of physician-approved orders for vaccines, include a review of the resident’s medical record for immunization status and possible medical contraindications, information on how education and information will be provided to the resident/representative and a vaccination schedule that includes recording and monitoring of administration that meets acceptable national recommendations.

Remember, the focus of this regulation is to minimize each resident’s risk of acquiring, transmitting or experience complications for either influenza or pneumococcal disease. Lowering your resident population’s risk lowers your staff’s risk, too.
**Opioid-Related Hospital Care for Seniors**

Opioid misuse in older adults is an underappreciated and growing problem. Although opioid misuse overall is lower among older than among younger Americans, the rate of opioid misuse among older adults nearly doubled between 2002 and 2014. In 2016, a third of the more than 40 million Americans enrolled in Medicare Part D received prescription opioids and a substantial number received higher doses than recommended for prolonged periods of time, putting them at increased risk of misuse. Between 2005 and 2014, the rate of opioid-related hospitalizations increased fastest among patients aged 65 years and older compared with all other age groups.

From 2010 to 2015, the rate of opioid-related hospital stays increased between 27 and 39 percent among patients age 65 and older, depending on the age group. Non-opioid-related hospital stays decreased 17 percent for patients age 65 and older during the same period.

Eighty percent of U.S. adults aged 65 years and older have multiple chronic conditions (e.g., heart disease, diabetes, arthritis and depression) compared with less than 20 percent of adults aged 18-44 years. Chronic pain is common among older adults, and more than one-third of older Americans are living with a disability, making this population more likely than younger adults to receive an opioid prescription. In addition, complex social needs and mental health issues including depression, substance abuse, cognitive decline and dementia often go unrecognized and/or complicate clinical management. Compounded by the physiologic changes associated with aging, these conditions place older adults using opioid medications at increased risk for adverse events including injurious falls and delirium, which may result in ED visits or hospital admissions.

Additionally, older adults are more likely than younger adults to take prescription medications, which increases the likelihood of drug interactions and adverse effects associated with the use of opioids. In the period from 2011-2014, more than 90 percent of Americans aged 65 years and older reported use of a prescription drug in the past 30 days, with over 40 percent reporting use of five or more prescription drugs in the prior 30 days (compared with less than 5 percent of adults aged 18-44 years). This represents a substantial increase in the proportion of adults aged 65 years and older who used prescription medications compared with 20 years earlier (1988-1994: one prescription medication, 74 percent; five or more prescription medications, 14 percent). [Click here](#) for the full report.

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

1) The following Federal [CMS Quality, Safety and Oversight Letters](https://cms.gov) (formerly known as [Survey and Certification (S&C) Letters](https://www.cms.gov)) were released since the last issue of *Regulatory Beat*:

- **QSO 19–07 - NH** – Enhanced Oversight and Enforcement of Non-Improving Late Adopters. The National Partnership & Identification of Late Adopters – Since 2011, the CMS has seen a reduction of 38.9 percent in long-stay nursing home residents who were receiving an antipsychotic medication. Despite the success of the National Partnership, CMS identified approximately 1,500 facilities that had not improved their antipsychotic medication utilization rates for long-stay nursing home residents, referred to as late adopters. In December 2017, CMS notified these facilities of this identification. Enforcement for A Segment of Non-Improving Late Adopters with Multiple Citations - As of January 2019, there are 235 late adopter nursing homes that have been cited for noncompliance with federal regulations related to unnecessary medications or psychotropic medications two or more times since January 1, 2016, and who have not shown improvement in their long-stay antipsychotic medication rates. If these facilities are determined not to be in substantial compliance with
requirements for Chemical Restraints, Dementia Care, or Psychotropic Medications during a survey, they will be subject to enforcement remedies for such noncompliance. Corporate Engagement - CMS is also looking for opportunities to engage with corporate chains that have significant numbers of nursing homes identified as late adopters.

- **QSO 19-08 NH - April 2019 Improvements to Nursing Home Compare and the Five-Star Rating System.** Ending the Freeze on Health Inspection Star Ratings - In April 2019, the CMS will end the freeze on the health inspection domain of the Five-Star Quality Rating System. CMS will resume the traditional method of calculating health inspection scores by using three cycles of inspections. Inspections occurring on or after November 28, 2017, will be included in each facility’s star rating. Quality Measure (QM) Domain Improvements – CMS is introducing separate ratings for short- and long-stay measures to reflect the level of quality provided for these two sub-populations in nursing homes. They are also revising the thresholds for ratings, adding a system for regular updates to thresholds every six months, and weighting and scoring individual QMs differently. Additionally, they are adding the long-stay hospitalization measure and a measure of long-stay emergency department (ED) transfers to the rating system. Two measures from the Skilled Nursing Facility Quality Reporting Program (QRP) will be adopted to replace duplicative existing measures. Staffing Domain Improvements – CMS is adjusting the thresholds for staffing ratings. Also, the threshold for the ‘number of days without a registered nurse (RN) onsite’ that triggers an automatic downgrade to one star will be reduced from seven to four days.

- **QSO 19-09 All - Revisions to Appendix Q, Guidance on Immediate Jeopardy.** Core Appendix Q and Subparts - Appendix Q to the State Operations Manual (SOM), which provides guidance for identifying immediate jeopardy, has been revised. The revision creates a Core Appendix Q that will be used by surveyors of all provider and supplier types in determining when to cite immediate jeopardy. CMS has drafted subparts to Appendix Q that focus on immediate jeopardy concerns occurring in nursing homes and clinical laboratories since those provider types have specific policies related to immediate jeopardy. Key Components of Immediate Jeopardy – To cite immediate jeopardy, surveyors determine that (1) noncompliance (2) caused or created a likelihood that serious injury, harm, impairment or death to one or more recipients would occur or recur; and (3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment or death to one or more recipients. Immediate Jeopardy Template – A template has been developed to assist surveyors in documenting the information necessary to establish each of the key components of immediate jeopardy. Survey teams must use the immediate jeopardy template attached to Appendix Q to document evidence of each component of immediate jeopardy and use the template to convey information to the surveyed entity.

- **QSO 19-10 – NH - Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting is Now Available.** CMS and the Centers for Disease Control and Prevention (CDC) collaborated on the development of a free on-line training course in infection prevention and control for nursing home staff in the long term care setting. The training provides approximately 19 hours of continuing education credits as well as a certificate of completion. The "Nursing Home Infection Preventionist Training Course" is located on CDC’s TRAIN website (click here). This memo supersedes memo Quality, Safety & Oversight policy memorandum QSO 18-15-NH.

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

- **CMS is updating the Quality Improvement and Evaluation System.** Starting in March, the Quality Improvement and Evaluation System (QIES), Certification and Survey Provider Enhanced Reports (CASPER) and Automated Survey Processing Environment (ASPEN) will undergo a series of modernizing enhancements. Once updated, the system will be called the Internet Quality Improvement and Evaluation System (iQIES). The iQIES system will not change how providers currently submit data to CMS.

The new enhancements in iQIES are based on user research and testing and feature a human-centered design and agile development practices. CMS is phasing in the iQIES system beginning with long term care hospitals (LTCH). Several updates to the QIES- Assessment Submission and Processing (ASAP) system are also planned. The Cloud-based solutions will also make it easier for users to receive support and use the system.
iQIES Details:
  - Users will no longer need a virtual private network (VPN) or CMSNet to access the system. iQIES is Internet-facing and maintains the latest system architecture and security standards.
  - System enhancements support flexible and user-friendly data reports for providers, allowing them to use real-time data for care planning as well as quality monitoring and improvement.
  - Users can access important information for work anywhere, at any time, on mobile devices, laptops, and tablets.

CMS will be sharing more information about iQIES such as onboarding, stakeholder engagement opportunities, training, and general updates soon!

If you have questions, please contact our service desk at: help@qtso.com or by phone: 800-339-9313.

- **Updated MDS 3.0 RAI Manual Errata.** The PDF file labeled “MDS-3.0-RAI-Manual-v1.16R-Errata-v1.1-February-13-2019”, available in the Downloads section of the MDS 3.0 RAI Manual page, contains revisions to pages in Chapter 3, Section J, of the MDS 3.0 RAI Manual v1.16R, that (1) address coding item J0200 when the resident interview should have been conducted but was not conducted within the look-back period of the ARD and (2) amend the criteria for major surgery and correct the associated examples.

  Changed manual pages are marked with the footer “October 2018 (R).”

  The errata document begins with a table that lists all identified revisions and the pages to which they have been applied. Following the table are the actual corrected replacement pages for insertion into the printed manual.

- **Reducing Opioid Misuse Letter.** CMS, through the Medicare Administrative Contractors (MACs), recently mailed letters to all Medicare fee-for-service providers about our work to reduce opioid misuse by people with Medicare, including:
  - Providing guidance on co-prescribing Naloxone
  - Implementing new Medicare Part D opioid policies
  - Promoting a range of safe and effective pain treatments

  They are committed to exploring and offering viable options to address the opioid crisis, sharing information on the data they collect with other agencies and organizations, and protecting beneficiaries and communities affected by the crisis. Together, we can make progress in addressing many aspects of the opioid epidemic.

- **New Medicare Card: Need an MBI?** All providers (hospitals and other facilities, group practices, labs, etc.) can use their Medicare Administrative Contractor’s (MAC’s) secure portal Medicare Beneficiary Identifier (MBI) look-up tool. Even if your patient is in a Medicare Advantage Plan, you can look up the MBI to bill for things like indirect medical education. If you do not have access to the tool, sign up.

  Your patient’s Social Security Number (SSN) is required for the search and may differ from their Health Insurance Claim Number (HICN), which uses the SSN of the primary wage earner. If your Medicare patients do not want to give their SSN, they can log into mymedicare.gov to get the MBI.

  If the look-up tool does not return an MBI, be sure you are using the full last name, including any suffix, such as Jr, Sr, or III.

- **CMS Improving Nursing Home Compare in April.** On March 5, CMS announced updates coming next month to Nursing Home Compare and the Five-Star Quality Rating System to strengthen this tool for consumers to compare quality between nursing homes.

  “CMS is committed to safeguarding the health and safety of nursing home residents by ensuring they are receiving the highest quality of care possible,” said CMS Administrator Seema Verma. “Our updates to Nursing
Home Compare reflect more transparent and meaningful information about the quality of care that each nursing home is giving its residents. Our goal is to drive quality improvements across the industry and empower consumers to make decisions, with more confidence, for their loved ones.”

The April 2019 changes include:
- Revisions to the inspection process, enhancement of staffing information, and implementation of new quality measures
- Lifting of the ‘freeze’ on the health inspection ratings instituted in February 2018
- Setting higher thresholds and evidence-based standards for nursing homes’ staffing
- Adding measures of long-stay hospitalizations and emergency room transfers
- Removing duplicative and less meaningful measures
- Establishing separate quality ratings for short-stay and long-stay residents
- Revising the rating thresholds to better identify the differences in quality among nursing homes

See the full text of this excerpted CMS Press Release (issued March 5).

- **Hospice Provider Preview Reports: Review Your Data by March 31.** Two reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder:
  - Hospice provider preview report: Review Hospice Item Set (HIS) quality measure results from the third quarter of 2017 to the second quarter of 2018
  - Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey provider preview report: Review facility-level CAHPS survey results from the third quarter of 2016 to the second quarter of 2018

Review your HIS and CAHPS results by March 31. If you believe the denominator or other HIS quality metric is inaccurate or if there are errors in the results from the CAHPS survey data, request a CMS review:

- HIS Preview Reports and Requests for CMS Review webpage
- CAHPS Preview Reports and Requests for CMS Review webpage

Access Instructions:
- Hospice Provider Preview Report
- Hospice CAHPS Provider Preview Reports

- **LTCH Provider Preview Reports: Review Your Data by April 3.** Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with third quarter 2017 to second quarter 2018 data. Review your performance data on quality measures by April 3, prior to public display on LTCH Compare in June 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate. For More Information:
  - LTCH Quality Public Reporting webpage
  - Preview Report Access Instructions

- **Interoperability and Patient Access to Health Data: Comments on New Proposals due May 3.** CMS proposed policy changes supporting the MyHealthEData initiative to improve patient access and advance electronic data exchange and care coordination throughout the health care system. The Interoperability and Patient Access Proposed Rule outlines opportunities to make patient data more useful and transferable through open, secure, standardized, and machine-readable formats while reducing restrictive burdens on health care providers. In addition to the policy proposals, CMS released two requests for information to obtain feedback on:
  - Interoperability and health information technology adoption in post-acute care settings
  - The role of patient matching in interoperability and improved patient care

Proposed Changes and Updates:
- Patient access through Application Programming Interfaces (APIs)
- Health information exchange and care coordination across payers
- API access to published provider directory data
- Care coordination through trusted exchange networks
- Improving the dual eligible experience by increasing frequency of federal-state data exchanges
- Public reporting and prevention of information blocking
- Provider digital contact information
- Revisions to the conditions of participation for hospitals and critical access hospitals
- Advancing interoperability in innovative models

For More Information:
- Proposed Rule: CMS will accept comments until May 3
- All Your Health Records in One Place from Fortune Magazine
- See the full text of this excerpted CMS Fact Sheet

**SNF Provider Threshold Report.** The FY 2020 and 2021 Skilled Nursing Facility (SNF) Provider Threshold Report is available in the Certification and Survey Provider Enhanced Reports (CASPER) application. Check the status of your compliance threshold for the SNF Quality Reporting Program. For More Information:
- Nursing Home/Swing Bed Providers webpage
- CASPER Reporting User’s Guide, Section 13

**Medicare Beneficiaries at a Glance Infographic.** CMS published a Medicare Beneficiaries at a Glance infographic with summarized CY 2016 information, including coverage, utilization, average cost, top chronic conditions, satisfaction, access to care and source of care.

**Help Your Patients Make Informed Food Choices.** March is National Nutrition Month®. Choosing nutritious foods and getting enough physical activity can make a real difference in someone’s health. Talk to your patients about making informed choices to help prevent or reduce nutrition-related health conditions, including diabetes, chronic kidney disease and obesity. Encourage your patients to take advantage of appropriate Medicare-covered preventive services:
- Medical Nutrition Therapy
- Diabetes Screening
- Diabetes Self-Management Training
- Intensive Behavioral Therapy for Obesity
- Intensive Behavioral Therapy for Cardiovascular Disease
- Annual Wellness Visit

For More Information:
- Medicare Preventive Services Educational Tool
- National Nutrition Month website
- National Diabetes Education Program website
- National Kidney Disease Education Program website
- Million Hearts® website
- Find a Registered Dietitian/Nutritional Professional

Visit the Preventive Services website to learn more about Medicare-covered services.

**Opioid Prescribing Mapping Tool Improved with Medicaid and Rural Data.** On February 22, CMS released an expanded version of the Opioid Prescribing Mapping Tool, ensuring that you have the most complete and current data to effectively address the opioid epidemic across the country. This update further demonstrates the agency’s commitment to opioid data transparency and using data to better inform local prevention and treatment efforts, particularly in rural communities hard hit by the opioid crisis. For the first time, the tool includes data for opioid prescribing in the Medicaid program. Additionally, users can now make geographic comparisons of Medicare Part D opioid prescribing rates over time for urban and rural communities. See the full text of this excerpted CMS Press Release (issued February 22).
• **Hospice Compare Refresh.** The February 2019 Hospice Compare refresh is available. Visit [Hospice Compare](#) to view the data. For more information, visit the [Hospice Quality Public Reporting](#) webpage.

• **Data on Geographic Variation in the Medicare Program.** CMS posted the annual release of the [Geographic Variation Public Use File](#) (PUF) with data for 2007 to 2017. This PUF is a series of downloadable tables and reports with demographic, spending, utilization, and quality indicators for the Medicare fee-for-service population. It presents data at the state, hospital referral region, and county level.

• **2017 CMS Program Statistics.** CMS released 2017 program statistics, including detailed summary information on Medicare populations, utilization, expenditures and certified providers. Visit the [CMS Program Statistics](#) webpage for more information.

• **Laboratory Blood Counts: Provider Compliance Tips — Reminder.** In 2017, the Medicare fee-for-service improper payment rate for blood counts was 19.2 percent with projected inaccurate payments of $56.6 million. Improper payments resulted from:
  - Insufficient documentation - 89 percent
  - Incorrect coding - 8.3 percent
  - No documentation - 2.7 percent

Prevent denials by reviewing the [Provider Compliance Tips for Laboratory Tests – Blood Counts](#) Fact Sheet, which details coverage and documentation requirements.

• **Average Sales Price Files: April 2019.** CMS posted the April 2019 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the [2019 ASP Drug Pricing Files](#) webpage.

• **Data Interoperability across the Continuum: CMS Data Element Library Call — Tuesday, March 19 from 12:30 to 2 pm CST.** Register for Medicare Learning Network events. During this call, learn about the recently released [CMS Data Element Library](#) (DEL), a database of post-acute care patient assessment content mapped to nationally accepted health IT standards to support interoperable health information exchange between providers and with patients. A question and answer session will follow the presentation, including an opportunity to provide feedback on the DEL.

  Topics:
  - The patient story: Use cases for health information exchange and care coordination
  - The Improving Medicare Post-Acute Care Transformation Act and the DEL
  - Data interoperability: Benefits and challenges
  - DEL next steps: FHIR®

• **SNF Value-Based Purchasing Program: Phase One Review and Corrections Call — Wednesday, March 20 from 12:30 to 2 pm CST.** Register for Medicare Learning Network events. During this call, participants learn about the Skilled Nursing Facility (SNF) Value-Based Purchasing (VBP) Program Review and Corrections process and get answers to frequently asked questions about Phase One of the process. During the Review and Corrections period, SNFs have an opportunity to review and submit correction requests to quality measure information. Deadline for correction submission is April 1, 2019. For more information: visit the [SNF VBP Program](#) webpage.

  A question and answer session will follow the presentation; however, attendees may email questions in advance to [SNFVBPlInquiries@cms.hhs.gov](mailto:SNFVBPlInquiries@cms.hhs.gov) with “SNF VBP Mar 20 NPC” in the subject line. These questions may be addressed during the call or used for other materials following the call.

• **Submitting Your Medicare Part A Cost Report Electronically Webcast — Thursday, March 28 from 12 to 1:30 pm CST.** Register for Medicare Learning Network events. Medicare Part A providers: Learn how to use the new Medicare Cost Report e-Filing (MCReF) system. Use MCReF to submit cost reports with fiscal years ending on or after December 31, 2017. You have the option to electronically transmit your cost report through MCReF or mail
or hand deliver it to your Medicare Administrative Contractor. You must use MCReF if you choose electronic submission of your cost report. Note: This content was presented in prior webcasts on May 1 and October 15, 2018.

Topics:
  o How to access the system
  o Detailed overview
  o Frequently asked questions

A question and answer session will follow the presentation; however, attendees may email questions in advance to OFMDPAOQuestions@cms.hhs.gov with “Medicare Cost Report e-Filing System Webcast” in the subject line. These questions may be addressed during the webcast or used for other materials following the webcast. For more information, see the MCReF MLN Matters Article and MCReF webpage.

CMS will use webcast technology for this event with audio streamed through your computer. If you are unable to stream audio, phone lines are available.

• Home Health Call: Audio Recording and Transcript — New. An audio recording and transcript are available for the February 12 call on the Home Health Patient-Driven Groupings Model (PDGM) that will be implemented on January 1, 2020. CMS will use the PDGM to reimburse home health agencies.

• AWV, IPPE, and Routine Physical – Know the Differences Educational Tool — Reminder. The AWV, IPPE, and Routine Physical – Know the Differences Educational Tool is available. Learn about what is covered.

• Diabetes Self-Management Training Accrediting Organizations Fact Sheet — Reminder. The Diabetes Self-Management Training Accrediting Organizations Fact Sheet is available. Learn about:
  o Programs to prevent and manage diabetes
  o How to become an accredited provider

• Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course — Reminder - With Continuing Education Credit. The Diagnosis Coding: Using the ICD-10-CM Web-Based Training (WBT) course is available through the Learning Management System. Learn:
  o How to recognize features
  o Find correct codes
  o Identify structure and format

• Dual Eligible Beneficiaries under Medicare and Medicaid Booklet — Reminder. The Dual Eligible Beneficiaries under Medicare and Medicaid Booklet is available. Learn about:
  o Assistance with Medicare premiums or cost sharing through a Medicare Savings Program, including the Qualified Medicare Beneficiary Program
  o Benefits and qualifications

• Procedure Coding: Using the ICD-10-PCS Web-Based Training — Reminder - With Continuing Education Credit. The Procedure Coding: Using the ICD-10-PCS Web-Based Training (WBT) course is available through the Learning Management System. Learn:
  o How to recognize guidelines
  o Find correct codes
  o Identify structure and format

• DMEPOS Fee Schedule: April 2019 Update MLN Matters Article — New. A new MLN Matters Article MM11179 on April Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule is available. Learn about amounts for new codes.
• **NCCI: Modification of MCS Logic for Modifiers Involving PTP MLN Matters Article — New.** A new MLN Matters Article MM11168 on [Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes](https://www.cms.gov/MLNSurveys/mm11168.html) is available. Learn about modifiers on column one and column two codes bypassing the edit.

• **Home Health PDGM MLN Matters Article — Revised.** A revised MLN Matters Article MM11081 on [Home Health Patient-Driven Groupings Model (PDGM) - Split Implementation](https://www.cms.gov/MLNSurveys/mm11081.html) is available. Learn about the payment reform requirements.

• **Medical Documentation: Exchanging the List of eMDR via esMD MLN Matters Article — Revised.** A revised MLN Matters Article MM11003 on [Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System](https://www.cms.gov/MLNSurveys/mm11003.html) is available. Learn about changes required to send Additional Documentation Request letters.

• **How to Use the Medicare Coverage Database Booklet — Revised.** A revised [How to Use The Medicare Coverage Database](https://www.cms.gov/MLNSurveys/mm11003.html) Booklet is available. Learn about:
  o Navigating the database
  o Searching indexes
  o Downloading reports

• **SNF Billing Reference Booklet — Revised.** A revised [SNF Billing Reference](https://www.cms.gov/MLNSurveys/mm11003.html) Booklet is available. Learn about:
  o Coverage rules
  o Payment information
  o Billing requirements

• **Clinical Laboratory Fee Schedule Fact Sheet — Revised.** A revised [Clinical Laboratory Fee Schedule](https://www.cms.gov/MLNSurveys/mm11003.html) Fact Sheet is available. Learn about:
  o Coverage requirements
  o How payments rates are set
  o Updates

3) The federal [Centers for Disease Control and Prevention (CDC)](https://www.cdc.gov) reports on:

• **Weekly U.S. Influenza Surveillance Report**

• **CDC Updates Report on Assisted Living Community Characteristics.** A new report from the Centers for Disease Control and Prevention’s National Center for Health Statistics sheds light on the characteristics of the 28,900 assisted living and similar residential care communities that were providing long term care services as of 2016. The report, titled “Long-Term Care Providers and Services Users in the United States: 2015-2016”, is “intended to inform policy makers, providers, researchers, consumer advocates, the media, foundations, and others to inform planning for long-term care services,” according to the authors.


5) The federal [Agency for Healthcare Research and Quality (AHRQ)](https://www.ahrq.gov) reports:

• **AHRQ Study Updates Picture of U.S. HIV Positive Nursing Home Patients.** Nearly 80 percent of nursing home residents with HIV are prescribed antiretroviral treatments, according to an AHRQ study that provides an updated snapshot of HIV positive nursing home patients for the first time in nearly 15 years. Researchers reviewed a nationwide database of Medicare claims linked to nursing home health assessments and prescription
dispensing databases, comparing data from 2011-2013 and 1998-2000. Compared with statistics from 1998-2000, researchers found that patients with HIV are entering nursing homes at an average age of 60, as opposed to 44. New admissions had a higher prevalence of viral hepatitis (about 16 percent vs. 8 percent) and anemia (about 31 percent vs. 25 percent), but less pneumonia (about 11 percent vs. 14 percent) and dementia (about 9 percent vs. 21 percent). This population is expected to increase in the coming years as HIV treatments improve. Researchers believe these updated statistics will allow nursing homes to better anticipate the future health care needs of people living with HIV. Access the abstract to the study, published in the Journal of the Association of Nurses in AIDS Care.

- **Analysis Concludes Medicare Drug Plans Should Eliminate Barriers to Opioid Use Disorder Treatment.** Eliminating Medicare Part D coverage restrictions on the medication buprenorphine would immediately improve patients’ access to opioid use disorder treatment, according to a research letter in *JAMA*. About 300,000, or 12 percent, of Americans diagnosed with opioid use disorder in 2013 were Medicare beneficiaries. Buprenorphine, which may cause less dependence and fewer withdrawal symptoms than other opioids, is often used to treat the disorder. AHRQ-funded researchers who analyzed drug formularies found that Part D coverage for buprenorphine was relatively high. In 2018, generic buprenorphine tablets were covered by all plans. And about three-fourths of plans covered brand-name and generic versions of buprenorphine-naloxone, which is another opioid medication. Access to both brand-name and generic formulations was often delayed, however, by prior authorization requirements. For example, prescriptions for generic buprenorphine tablets, despite having the lowest cost (about $80), required prior authorization by 66 percent of Part D plans. Access the abstract.

- **AHRQ Nursing Home Survey on Patient Safety Culture: 2019 User Comparative Database Report.** The Agency for Healthcare Research and Quality developed the Nursing Home Survey on Patient Safety Culture to assess safety culture in long term care facilities. This report summarizes survey data from nearly 10,500 staff working in 191 nursing homes. Respondents reported positive perceptions of resident safety and feedback and communication about incidents. Areas needing improvement included comfort with speaking up about safety concerns and sufficient staffing. As in prior studies of safety culture, managers reported higher safety culture scores compared to frontline staff. Most respondents reported that they would recommend the facility where they worked to friends and family. A past PSNet interview explored unique issues surrounding patient safety in the nursing home population.

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

- HFS posted a new Provider Notice regarding Due Date for Payment of the Monthly Occupied Bed Provider Assessment. You may view the notice [here](https://www.illinois.gov/hfs/MedicaidReimbursement/Pages/Practitioner.asp).

- HFS posted a new Public Notice regarding Proposed changes in methods and standards for establishing medical assistance payment rates. You may view the notice [here](https://www.illinois.gov/hfs/MedicaidReimbursement/Pages/Practitioner.asp).

- HFS posted a new Provider Notice regarding Hospital Cost Report Forms and Instructions. You may view the notice [here](https://www.illinois.gov/hfs/MedicaidReimbursement/Pages/Practitioner.asp).

- HFS posted an Updated Practitioner Fee Schedule. You may view the updated fee schedule from the link: [https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.asp](https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/Practitioner.asp).


- HFS posted Licensed Clinical Psychologists and Licensed Social Workers Fee Schedule Updates. You may view the updated fee schedules [here](https://www.illinois.gov/hfs/MedicaidReimbursement/Pages/Practitioner.asp).
The Illinois Department of Public Health (IDPH) reports:

- Schedule for IDPH Town Hall Meetings will be out shortly.

- The Building Resilience Against Climate Effects (BRACE-Illinois) team at the UIC School of Public Health developed maps to identify health care facilities in or near floodplains. A pre-survey was previously sent out and subsequently the actual mapping tool with an instructional video on how to navigate the map. For those who participated in the baseline survey, thank you. In order to obtain a follow-up understanding of what tools and resources emergency preparedness professionals currently use for planning for flood disasters, please complete the survey below.

  Link to the survey: https://uic.ca1.qualtrics.com/jfe/form/SV_6xH9GXRtr22ABSJ

Participation in the online survey will take about 5 minutes to complete, is voluntary, and answers will be confidential. As of September 4, 2018, the University of Illinois at Chicago’s Office for the Protection of Research Subjects granted the “Flood preparedness among Illinois healthcare facilities” research project exempt from the federal regulations for the protection of human subjects. However, our project will adhere to the ethical conduct of research and protection of participants’ information.

Building Resilience Against Climate Effects (BRACE-Illinois) is a CDC-funded project at the University of Illinois at Chicago (UIC). A goal of BRACE is to improve preparedness for the health effects of climate change and extreme weather events. More information about BRACE-Illinois can be found here: https://braceillinois.uic.edu/. BRACE-Illinois works directly with and on behalf of the Illinois Department of Public Health (IDPH).

If you have any questions, please feel free to reach out to Elena Grossman at egross5@uic.edu or 312-996-2085.

- IDPH Memorandum on Use of Alcohol-Based Hand Rubs for Hand Hygiene in Long Term Care Facilities. The purposes of this memorandum are to:
  - Remind facilities that alcohol-based hand rubs are the preferred method of hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids; and
  - Recommend that all long term care facilities incorporate alcohol-based hand rub into hand hygiene programs in accordance with the Centers for Disease Control and Prevention (CDC) recommendations.

Hand hygiene is essential for preventing the spread of infectious organisms in health care settings. The CDC and Illinois Department of Public Health recommend the routine use of alcohol-based hand rubs over soap and water due to improved adherence, effectiveness and accessibility, except in situations where soap/water handwashing is specifically recommended.

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

- New Report Ready or Not: Protecting the Public’s Health from Diseases, Disasters and Bioterrorism. Trust for America's Health has tracked public health emergency preparedness in the United States since 2003 and documented the nation's level of preparedness as well as those areas still in need of improvement. This 2019 report finds that states have made progress in key areas, including public health funding and participation in provider compacts and coalitions, with a majority of states making preparations to expand capabilities in an emergency, often through collaboration.

  Emergencies start at the local level and many of the events our providers have experienced in the last couple of years needed to have coordination with local and state officials. The report examines the country's level of public health emergency preparedness on a state-by-state basis using 10 priority indicators. It also outlines major public health incidents, actions, research findings, meetings, and federal hearings across three domains: disease outbreaks; severe weather and natural disasters; and biological, chemical, radiological and nuclear
terrorism. Trust for America's Health (TFAH) is a nonprofit, nonpartisan public health policy, research, and advocacy organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority.

- **New Resource Available: Emergency Planning Toolkit for the Aging and Disability Networks.** A new Capacity-Building Toolkit for Including Aging and Disability Networks in Emergency Planning is now available from the National Association of County & City Health Officials and the Association of State and Territorial Health Officials, in partnership with the Office of the Assistant Secretary for Preparedness and Response and the Administration for Community Living. Organizations that are new to emergency planning can use this toolkit as an orientation to emergency planning. Those with established emergency preparedness programs can use it as a resource to enhance their capabilities.

This resource guides aging and disability networks to increase their ability to plan for and respond to public health emergencies and disasters. This toolkit helps programs that support older adults and people with disabilities, through the emergency planning process of preparedness, response, recovery, and mitigation activities.

- **President's Budget 2020 Summary.** Every year in late winter, the President releases a proposed budget request. The President's Proposed Budget is a blueprint for the upcoming federal fiscal year (FY) containing an array of provisions, which may or may not be implemented. Some of the provisions require legislation. Legislative proposals in the President's Budget follow the same process as all legislation - a Congressional sponsor must be found, hearings are required, it must receive a price tag (or score) from the Congressional Budget Office, and it must be voted upon. Other provisions are proposed as administrative initiatives. Administrative proposals may be implemented using regulation or sub-regulatory authority such as State Medicaid Directors' Letters.

Of note in the President's FY20 Budget Proposal is an array of legislative proposals:

- Medicaid Block Grant & Per Capita Caps (proposed last year);
- Further reduction in Medicare Bad Debt;
- Unified Post-Acute Care Prospective Payment System (proposed last year);
- Changes in how states may structure Medicaid payments relative to the Upper Payment Limit;
- Expansion of Medicaid Fraud Control Unit Review to Additional Care Settings including non-institutional settings; and
- Permanent authority to operate Medicaid Managed Care Programs (new).

Administrative proposals of note to the membership include:

- Adoption of Innovative Technologies through Medicare Bundled Payment Efforts - specifically calls out post-acute care providers as targeted providers; and
- Medicaid and CHIP (MAC) Scorecard aimed at providing more state Medicaid program transparency.

AHCA/NCAL's summary is available [here](https://www.ahca.org/budget/). To view the President's complete budget proposal, click [here](https://whitehouse.gov/2020-budget), and to view the U.S. Department of Health and Human Services budget proposal, click [here](https://www.hhs.gov/budget/). We hope you find this information useful.

9) **Telligen** reports on:

- **Opioid Use Disorders Training Opportunities.** Training in Medication Assisted Treatment (MAT), which is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole patient approach" to the treatment of substance use disorders, is available for practitioners in Colorado, Illinois, Iowa and online. Telligen is here to support your efforts - [learn more](https://telligen.org/)

- **This Month at Telligen**
10) The UCLA Newsroom reports, Study Finds a Lack of Adequate Hydration Among the Elderly. Dehydration accounts for a five percent increase in preventable emergency room visits between 2008 and 2012, and adults older than 65 have the highest hospital admission rates for dehydration, according to the Agency for Healthcare Research and Quality.

11) Skilled Nursing News reports:

- Providers Performing Well Under RUG Will Fare Worse Under PDPM. Skilled Nursing News reports that an analysis by Plante Moran suggests skilled nursing providers that "have mastered the current Resource Utilization Group (RUG) system tend to be those projected to see reimbursement declines under the new Patient-Driven Payment Model...while the so-called PDPM 'winners' generally have lower RUG hauls." The analysis indicates the "average RUG per diem rate for PDPM 'losers' nationally is $558.38" but "under PDPM, their rate will drop to $529.59." Meanwhile, winners "have an average RUG rate of $489.50 at present; under PDPM, their average rate will jump to $524.46." Plante Moran also highlighted rate drivers for reimbursement, which include "how well ICD-10 diagnosis codes will be captured after PDPM, and the tapering of the PT and OT rates."

- Nurses to Play Critical Role in Managing Documentation Burdens Under PDPM. Skilled Nursing News reports on comments made by Zimmet Health care Services Group President Marc Zimmet at the eCap Health care Summit near Miami, Florida, last month, where he discussed how the implementation of the Patient-Driven Payment Model (PDPM) "will place increasing pressure on nursing facilities to justify each resident's need for Medicare-reimbursed skilled care." Zimmet said that when the program is implemented, the "pressure in this system really falls to the nurses: a lot of the responsibilities and the pressures of maintaining strong documentation that supports skilled care." Zimmet "also joined the chorus of industry watchers who note that while knowledge of ICD-10 coding will help providers under PDPM, it's not a vital cure-all."

12) Business Insider reports on Nursing Home Costs in US States Listed. Business Insider features a list of "the median monthly cost of a private nursing home room in every state, according to survey data collected by Genworth, an insurance company that provides long-term care insurance." The data found that Delaware was "among the most expensive states, at $10,950 per month," as well as New Hampshire, North Dakota, and West Virginia. Alaska is "the most expensive state for a nursing home stay at $27,573 a month. The state has 82,580 residents 65 and older."

13) Provider Magazine reports:

- Long Term, Post-Acute Providers Eyeing Technology to Improve Performance, Care Quality. In its March cover story, Provider Magazine highlights the methods long term and post-acute care (LT/PAC) providers are using to integrate technology into their caregiving practices. Providers are using technology to understand how "new ways of processing data, populating electronic health records (EHRs), moving to mobile devices for clinical charting and other nurse functions, monitoring for falls, or EHR connecting devices actually improve care and operations, and importantly in this era of tight to nonexistent margins, show a return on investment." The piece cites leaders in the industry who share the steps they have taken to integrate technology into company operations and the challenges of using the technologies to meet consumer, regulatory and investor demands.

- Start Preparing Communication Strategies Now for Coming PDPM Changes. In its March 2019 issue, Provider Magazine carries a piece by AHCA senior VP of reimbursement policy Mike Cheek, who explains some of the upcoming changes that will impact how skilled nursing providers structure patient care. The transition to the Patient-Driven Payment Model (PDPM) eliminates therapy minutes as a metric for Medicare reimbursement and replaces it with policies that emphasize a "holistic" approach to care. Cheek explains this transition means providers will need to improve staff communication, which he says is currently "not well structured and generally not sufficient...[to] meet CMS expectations for holistic care" in many skilled nursing facilities. Cheek concludes that providers should "should open discussions, now, with their nursing and therapy staff to assess how they currently communicate and operate compared with what is needed under PDPM."

14) USA Today reports, Experts Emphasize Need for Financial Planning Prior to Entering Nursing Home. USA Today reported that according to industry leaders and planning experts, the cost of nursing home care can be a financial
burden to many people, making appropriate budgeting a critical part of the planning process. The article says that "56 percent of Americans between 57 and 61" will spend time in a nursing home at some point in their lives, according to a 2017 study by the Rand Corp; but for many, "the costs can be prohibitive." Indeed, the "median cost of a semi-private room in a nursing home was $7,441 per month in 2018," a survey by long term care insurance company Genworth Financial revealed.

15) McKnight’s reports on:

- **Nursing Home Occupancy Falling but Trend Should Reverse as Population Ages.** McKnight’s Long Term Care News reports that a new analysis of nursing home trends between 2013 and 2017, conducted by Marcum LLP, indicates the overall occupancy percentages for nursing homes "declined from 83.07% at the beginning of the study down to 80.24% in 2017." Additionally, the report found, nearly "all U.S. regions experienced decreases in patient days, driven partially by patients turning to other care options, such as home health and assisted living." Matthew Bavolack, national health care services leader at Marcum, said "the shrinking reimbursement and lower occupancy levels have really caused the non-chain or the smaller nursing home groups" to question why they "can’t compete in the marketplace anymore." However, the report indicates that current population trends could help reverse the "lull in nursing home census numbers."

- **Nursing Homes with Higher Medicaid Populations Have Poorer Quality Outcomes.** McKnight’s Long Term Care News reports, a new study conducted by the American Health Care Association indicates nursing homes that care for "a larger proportion of Medicaid beneficiaries have lower quality ratings." Based on data collected from "a sample of more than 13,600 SNFs," AHCA concluded that "Medicaid census and quality are inversely related," results that AHCA senior research analyst Marsida Domi said strengthens the association’s call to improve reimbursement rates. Domi stated, "State Medicaid agencies need to develop a payment system that recognizes facilities with a high percentage of Medicaid beneficiaries to help achieve the same quality levels as facilities with a lower percentage of Medicaid beneficiaries."

- **Survey Examines Perspectives on Use of “Granny Cams” in Nursing Homes.** McKnight’s Long Term Care News reports that in a new "survey of 2733 long-term care professionals across 39 states and the District of Columbia," researchers found 75 percent of respondents believe there is "at least one potential disadvantage" to surveillance cameras – or "granny cams" – being installed in nursing home rooms. More than 50 percent of respondents "noted at least one advantage," but many complained of a lack of privacy, "undermining the home-like experience of a nursing home, and potential negative effects on staffers." The findings were published in AJOB Empirical Bioethics.

16) **Interesting Fact:** Saint Patrick himself would have to deal with pinching on his feast day. His color was “Saint Patrick’s blue,” a light shade. The color green only became associated with the big day after it was linked to the Irish independence movement in the late 18th century.