Proposed CMS Rulemaking – Part 7

The October 14, 2015 deadline for comments to the CMS proposed rulemaking, which significantly revises the entire set of requirements for Long-Term Care Facilities, has passed. CMS received over 9000+ comments to these proposed rules. CMS will now be required to review all of the comments and decide what changes need to be made before they can adopt the rules as a final rulemaking to be published in the Federal Register. CMS has three years from the date of proposed rulemaking to finalize and adopt rules. After final adoption, CMS will then need to revise the Interpretive Guidelines to clarify the final rulemaking.

Over the remaining 2015 issues of Regulatory Beat, I will continue with my section by section review of the CMS proposed regulations. It is important that you are aware and review the proposed regulations before they are adopted. CMS believes these proposed changes are necessary to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. These proposals are also an integral part of CMS’s efforts to achieve broad-based improvements both in the quality of health care furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

This segment will focus on Food and Nutrition Services (483.60), Specialized Rehabilitative Services (483.65) and Outpatient Rehabilitation Services (483.67).

P. Food and Nutrition Services (483.60)

Dietary standards for residents of LTC facilities are critical to both quality of care and quality of life. CMS states that it is not enough to ensure that residents have choices in what they eat. Many residents have other barriers to eating, including dental issues, medical issues, medication-related issues, physical limitations and the need for proper positioning and assistance at mealtimes. Adequate nutrition requires both an understanding of the facility’s population as a whole and an interdisciplinary approach for each resident. CMS believes their revisions to this section include person-centered requirements that are outcome focused and intended to ensure each resident is provided, in a dignified manner, the nutritional and dietary care and services needed to meet the statutory goal of attaining or maintaining his or her highest practicable mental, physical and psychosocial well-being.

CMS is designating Food and Nutrition Services as a new section combining all of the dietary related issues. They are revising the introductory language to include taking resident preferences into consideration.

a) Revise to require that the facility employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population.
a)(1) CMS will retain the requirement that a facility employ a qualified dietician on a full-time, part-time or consultant basis, but update the requirements to be considered a qualified dietician. CMS is proposing to allow five years after the effective date of the revised regulations to come into full compliance with the new qualified dietician qualifications.

a)(2) CMS is proposing to require that the director of food and nutrition services, if hired or designated after the effective date of these regulations, must be a certified dietary manager or certified food service manager as evidenced by meeting national certification standards for a certified dietary manager or a certified food manager. If already serving as a director of food and nutrition service on the effective date without one of these certifications, the individual must obtain a certification no later than five years after the effective date of this rulemaking.

a)(4) New requirement that the facility must provide sufficient support personnel with appropriate competencies and skill sets to carry out the functions of the food and nutrition service.

b) New requirement that a member of the food and nutrition service staff must participate on the interdisciplinary team (IDT).

c)(1) Revise terminology from “Recommended Dietary Allowances” to “established national guidelines or industry standards.”

c)(4) New requirement that menus reflect the religious, cultural and ethnic needs of the residents, as well as input received from residents or resident groups. CMS wants to ensure that appropriate options are available to residents under most circumstances.

d) Revised to incorporate the addition of drinks, to clarify that “proper” means both safe and appetizing, to include consideration of allergies, intolerances and preferences in preparing food, and to ensure that water and other dietary liquids are available to residents and provided, consistent with resident needs and preferences. CMS believes it is critical to specifically include water and dietary liquids in their regulations pertaining to food and nutrition services.

e)(2) New requirement that allows the attending physician to delegate to a qualified dietician or other clinically qualified nutrition professional the task of prescribing a resident’s diet, including a therapeutic diet, to the extent allowed by state law.

f)(1) Revised requirement that a facility must provide residents with three meals per day at regular times served in accordance with the resident needs, preferences, requests and plan of care; deletes the 14 hour requirement.

f)(2) New requirement that a facility provide suitable, nourishing meals and snacks for each resident who wants to eat at non-traditional times or outside the facility’s scheduled meal service times, in accordance with their respective plans of care.

g) Revised requirement that a facility not only provide adaptive eating equipment and utensils for residents who need these devices, but also provide appropriate staff assistance to ensure that these residents can use the assistive devices when consuming meals and snacks.

h) Revised guidelines with respect to paid feeding assistants. Eliminates the reference to the resident call system; a feeding assistant should be able to call for assistance in whatever manner is most efficient.

i)(1)(i) New requirement that facilities may procure food directly from local producers, farmers or growers, in accordance with state and local laws or regulations.

i)(1)(ii) New requirement that allows facilities to use produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
i)(3) New requirement that facilities have a policy in place regarding use and storage of foods brought to residents by visitors to ensure safe and sanitary handling.

**Q. Specialized Rehabilitative Services (483.65)**

a) Revised requirement to specifically add respiratory therapy to the list of specialized rehabilitative services.

a)(2) Clarifies regulation that when it is necessary for facilities to obtain services from an outside source, the provider should be a certified Medicare and/or Medicaid provider.

Add in 483.65 a cross reference to the PASARR regulations at 483.120(c), which defines mental health or intellectual disability services that a nursing facility must provide to all residents who need these services. Current regulations do not clarify what specialized rehabilitative services for mental illness are and this has led to confusion among providers, states and others.

**R. Outpatient Rehabilitative Services (483.67)**

This is a new section to address facilities that choose to provide outpatient rehabilitative therapy services for individuals that do not reside in the facility. This is not addressed in the current regulations. CMS is proposing that facilities that provide outpatient rehabilitative services must meet requirements similar to those already established by hospitals. All of the requirements in this section are new.

If the facility provides outpatient rehabilitation, physical therapy, occupational therapy, audiology or speech pathology services, the services must meet the needs of the patients in accordance with acceptable standards of practice and the facility must meet the following requirements.

a) The organization of the service must be appropriate to the scope of the services provided and staffed to ensure the health and safety of the clients.

b)(1) The facility must assign one or more individuals to be responsible for outpatient rehabilitative services and that individual responsible for the outpatient rehabilitative services must have the necessary knowledge, experience and capabilities to properly supervise and administer the services.

b)(2) The facility must have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered.

b)(3) Physical therapy, occupational therapy, speech-language pathology or audiology services, if provided, must be provided by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists or audiologists.

c)(1) Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under state law.

(c)(2) All rehabilitation services orders and progress notes must be documented in the patient’s clinical record.

(c)(3) The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice.

The next edition of *Regulatory Beat* will focus on Administration (483.70), Quality Assurance and Performance Improvement (483.75), and Infection Control (483.80).
IDPH/LTC Association Quarterly Meeting
The first of the reinstituted IDPH/LTC Quarterly Provider Association meetings was held on October 20, 2015. IHCA, LSN, The Center and HCCI were represented at the meeting. Darlene Harney, Connie Jensen and George Logan (IDPH attorney) were present from IDPH. IDPH solicited questions from the various provider associations and the summary of the issues discussed is as follows:

1) Clarification on identifying location for an involuntary discharge/transfer – this was in response to an email that Debra Bryars sent to the Associations - stating that a location had to be inserted and stating “none known at this time” was not acceptable. This was discussed and IDPH will be reviewing the federal language, which we believe allows for the location to be left blank if a new location has not yet been determined. IDPH Legal will review and provide future clarification regarding this.

2) Reasoning/explanation on the IDR denial responses. IDPH agrees that the NHCA statute does require IDPH to give an explanation as to why an IDR was denied. IDPH LTC staff and IDPH Legal staff are working on this and stated that they will have this resolved by the end of the year (2015). We asked if we could see the final product before it is implemented and IDPH stated they would have to check to see if that would be possible. We suggested that working together on this would be beneficial to both parties.

3) Subpart S rules. IDPH stated that the Subpart S rules are in the Governor’s Office for review. They have been there for quite a while. IDPH stated that their new internal rulemaking process is as follows: rules are developed by program staff; then reviewed by IDPH Legal; back to program staff for any changes requested/required by IDPH Legal; then to Governor’s Office for review; back to IDPH Legal and program staff for any changes or questions; final sign-off by Governor’s Office (if changes) and then to the Long Term Care Advisory Board for review and action. If there are problems or concerns noted by the LTC Advisory Board, the whole process could start over again. IDPH stated that they will not share drafts of proposed rules until they are ready for the LTC Advisory Board.

4) Distressed Facilities rule. Based on the IDPH internal rulemaking process noted above in #3, this proposed rulemaking is in the first IDPH Legal review after program development.

5) Informed Consent rules. Based on the IDPH internal rulemaking process noted above in #3, these are reportedly under development by LTC program staff.

6) Behavioral Units rules. These new rules were to be developed in conjunction with DHS and there is no known progress on this rule.

Note: For 3, 4, 5 and 6 above; these were all part of SB 326 (PA -96-1372) passed back in 2010.

7) Electronic monitoring/granny cams/legislation/rules. IDPH stated that they are working with the AG’s Office in drafting some rules. No date was given as to when they will be ready. The new statute is effective 1-1-2016. IDPH doubted rules would be ready by then. The state rulemaking process, once published in the Illinois Register, takes a minimum of six months to adopt. We would surmise there would be a lot of comments and concerns. We also don’t believe they could justify emergency rules. IDPH offered no guidance on what to do after 1-1-2016.

8) Waivers for two-year ban for nurse aide training. IDPH acknowledged that there has been some confusion on this issue. Darlene stated that all such waiver requests should be submitted to the attention of Jennifer Kempiners (IDPH) and that she will review and then forward them on to federal CMS for their review and decision.

9) Electronic Incident Reporting. IDPH stated that they have a form ready for review by the LTC Advisory Board at their next meeting which is on November 17, 2015.

10) Electronic submission of Plans of Corrections (POCs) for Illinois. IDPH stated that this is currently not high on their priority list. The Associations explained that this would be very beneficial and since so many other states were
already doing this, Illinois should be able to take one of the product of one of these other states and implement it in Illinois with very little effort. The Associations asked that this be moved up higher on IDPH’s priority list.

11) IDPH IT network transition from 3270 system to increase availability of information. IDPH agrees this needs to be done, but they stated they have little control over the IT system. Most of IT rests in Central Management Services (state CMS) and IDPH stated it is hard to get them to understand program concerns and to move this up on their (CMS) priority list. IDPH will continue to push for this upgrade.

12) New IDPH Website. There was also some discussion on the new IDPH Website and that it is very confusing and not user-friendly. IDPH staff stated they would take the information back to their IT people, but again this is outside of their (LTC Program Staff) control.

13) Filling vacancies on the LTC Advisory Board. Associations raised the concern that the LTC Advisory Board meetings are being cancelled too often. They asked that if there are vacancies on the Board that need to be filled, IDPH let the Associations know and we can recommend names. There is still a delay in the Governor’s Office for approval to fill various Board vacancies. Also, the Associations stated we would work with our members on the Board that if they cannot make a meeting, that we would get a proxy to replace them for that meeting. There are too many important issues that need discussion, IDPH cannot keep cancelling meetings.

14) OHCR staffing. IDPH is not adding many new staff at this time. They are just trying to fill vacancies that occur due to retirements or staff leaving for other reasons. Wanda Higgenbotham is the new Regional Supervisor for the Bellwood Region replacing Joy Ward (who left IDPH).

15) If the VA will provide medication to a VA resident in a LTC facility, is there a rule/requirement that the resident must use the facility’s pharmacy? There is no such rule/requirement. It would be up to the facility to work this out with the VA resident.

16) How is IDPH interpreting the term “authorized representative” as it pertains to psychotropic medication in NHCA 2-106.1(b) and 300.686(b)? IDPH stated this is part of informed consent and needs to be reviewed by the guardian or POA. After some discussion on this, IDPH Legal said they would review further and provide additional guidance.

17) How does OHCR determine the number of surveyors that are sent on a survey? IDPH stated it varies due to many different factors. They include: number of beds; history of the facility; layout of the facility; if there is a specialized unit; number of days available to do the survey; and number of new staff that need training, etc.. If facilities believe there are too many surveyors and it is causing problems with care delivery, they should contact the Regional Supervisor to discuss.

18) Idle time by surveyors. IDPH stated that if it appears that surveyors are just wasting time and hanging out at the facility to avoid going to a new assignment, the facility should contact the Regional Supervisor to discuss. The facilities fear retribution if they make this call. IDPH stated that they cannot fix something unless they are made aware of a problem. Tough call on this one.

19) Length of time it takes surveyors to complete a complaint investigation. IDPH stated that they are working hard to make sure complaint investigations are completed quickly. IDPH stated they are working hard to stop/prevent the past practice of starting/initiating a complaint investigation, leaving and then coming back days or weeks later to finish it. The field supervisors are now able to monitor their staff better since they are not doing surveys, so that also should help. Again, if there are any concerns, contact Regional Supervisor.

20) Surveyor behavior/complaining to providers about budget and other state problems. Surveyors are expected to conduct themselves in a professional manner. If problems, contact Regional Supervisor.
21) Standardization of survey/survey findings from region to region. There have been some problems in the Division of LTC Quality Assurance due to some key staff retiring and addition of new staff. IDPH is working on this and hopes to have the key positions filled in the near future. If problems are noted in this area, facilities are to contact Allison Retzer (IDPH QA) to discuss.

22) MDS and Dementia Special Focus Surveys. The Dementia Special Focus surveys were completed the end of August. Federal CMS conducted these surveys with their staff. The current phase of the MDS Special Surveys was also completed the end of September. However, it is expected that the MDS Special Surveys will continue on into the future, but no information available at this time as to format, number, etc.

23) Comments/thoughts from OHCR regarding what providers could do to help survey process be more efficient. Nothing specific offered by IDPH. All agreed that the Town Hall Meetings were a welcomed addition and were seen as very valuable and that they should continue. IHCA suggested that ID/DD and Assisted Living issues should be included in these future meetings. IDPH agreed and will be working on the agenda for next year’s round of Quarterly Association Meetings.

24) OHCR’s comments on new CMS proposed rulemaking. IDPH had not spent much time reviewing them to this point. Currently, this issue is not high on their priority list.

IDPH will hold the next LTC Provider Association Meeting on January 13, 2016. If any members have issues or questions they would like addressed, please contact Bill Bell at IHCA.

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**Trending Statistics**

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

**ICD-10 Transition Moves Forward**

On October 1, 2015 health systems across the country transitioned to the International Classification of Diseases, 10th Revision – ICD-10. This change will enable providers to capture more details about the health status of their patients to improve patient care and public health surveillance.

CMS has been carefully monitoring the transition and is pleased to report that claims are processing normally. Generally speaking, Medicare claims take several days to be processed and, once processed, Medicare must—by law—wait two weeks before issuing a payment. Medicaid claims can take up to 30 days to be submitted and processed by states. For this reason, we will have more information on ICD-10 transition in November.

With this in mind, CMS is continuing its vigilant monitoring process of the ICD-10 transition and can share the following metrics detailing Medicare Fee-for-Service claims from 10/1 - 10/27.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>October 1-27</th>
<th>Historical Baseline*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Submitted</td>
<td>4.6 million per day</td>
<td>4.6 million per day</td>
</tr>
<tr>
<td>Total Claims Rejected due to incomplete or invalid information</td>
<td>2.0% of total claims submitted</td>
<td>2.0% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Rejected due to invalid ICD-10 codes</td>
<td>0.09% of total claims submitted</td>
<td>0.17% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Rejected due to invalid ICD-9 codes</td>
<td>0.11% of total claims submitted</td>
<td>0.17% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Denied</td>
<td>10.1% of total claims processed</td>
<td>10% of total claims processed</td>
</tr>
</tbody>
</table>
NOTE: Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions. It’s important to know help remains available if you experience issues with ICD-10:

- For general ICD-10 information, we have many resources on our Road to 10 website and www.cms.gov/icd10.
- Your first line for help for Medicare claims questions is your Medicare Administrative Contractor. They’ll offer their regular customer service support and respond quickly.
- You can contact the ICD-10 Coordination Center.
- The ICD-10 Ombudsman, Dr. Bill Rogers, can be your impartial advocate.

### Important Rules, Regulations & Notices

1) **Administrator License Renewal REMINDER**: IFDPR is no longer sending out renewal notices for nursing home administrator licenses. Current licenses expire November 30, 2015, so it’s time to renew! Click here to renew your license online. Once you go to that link you can either renew online or print out the renewal and mail it in.

2) The following federal Survey and Certification (S&C) Letters were released since the last issue of Regulatory Beat:

- **S&C 16-01 – Hospitals** - Revised Hospital Guidance (click here) for Pharmaceutical Services and Expanded Guidance Related to Compounding of Medications. CMS has updated the State Operations Manual (SOM) Appendix A with respect to both the hospital survey process and the interpretive guidelines for the pharmaceutical services Condition of Participation (CoP). Revisions were made to portions of the pharmaceutical services CoP to bring them into alignment with current accepted standards of practice. To improve clarity, the revised guidance addresses: accepted professional pharmacy principles, including United States Pharmacopeia (USP) standards; compounding of medications, particularly compounded sterile preparations (CSPs); determining beyond-use dates (BUDs); safe and appropriate storage and use of medications; and, policies and procedures related to high-alert medications and minimizing drug errors. They added a new standard-level tag to allow surveyors to cite to the regulatory language found in the condition stem statement at either the standard- or condition-level, as appropriate, in the Automated Survey Processing Environment (ASPEN). They are also updating the guidance for the nursing service regulatory requirements concerning medication administration to clarify that hospitals must ensure staff adherence to accepted standards of practice in those limited instances when CSPs may be prepared outside of the pharmacy.

3) Federal CMS/HHS released several notices/announcements since the last issue of Regulatory Beat. They include:

- **National Partnership to Improve Dementia Care and QAPI Call — Register Now** - Tuesday, December 1 from 1:30-3pm ET. To Register: Visit MLN Connects Event Registration. Space may be limited, register early. This MLN Connects National Provider Call will focus on nursing home providers, as well as transitions of care between acute and long term settings. A physician will share approaches to effectively manage high-risk medications, and a pharmacist will discuss the importance of drug regimen reviews and medication reconciliation. Additionally, CMS subject matter experts will update you on the progress of the National Partnership and Quality Assurance and Performance Improvement (QAPI). A question and answer session will follow the presentations. The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care, and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.
Discussion Topics include: Discussion from Washington Post (Popular blood thinner causing deaths, injuries in nursing homes); Medication Management; Drug Regimen Review & Medication Reconciliation; QAPI; National Partnership. Target Audience: Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations, and other interested stakeholders. Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

- **CMS to Release a Comparative Billing Report on Physical Therapy in November.** CMS will issue a national provider Comparative Billing Report (CBR) on Physical Therapy in November 2015. The CBR, produced by CMS contractor eGlobalTech, will focus on providers with a specialty of physical therapy and will contain data-driven tables with an explanation of findings that compare these providers’ billing and payment patterns to those of their peers in their state and across the nation. The goal of these reports is to offer a tool that helps providers better understand applicable Medicare billing rules. These reports are only accessible to the providers who receive them; they are not publicly available. Providers are advised to update their fax numbers in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) because faxing is the default method for disseminating CBRS. Providers should contact the CBR Support Help Desk at 800-771-4430 or CBRsupport@eglobaltech.com if they prefer to receive CBRS through the U.S. Postal Service. For more information, contact the CBR Support Help Desk, or visit the CBR website.

- **CMS strengthens access to essential health care services for Medicaid beneficiaries.** Meaningful access to health care services is crucial for the 72 million Americans who rely on the Medicaid program for coverage. As our nation moves towards better sharing and utilizing of information to improve health access, treatment, and outcomes, it is critical for us to work together to ensure continued access to preventive, primary, and specialty service that are needed to maintain the health and well-being of our most vulnerable populations. CMS released a final rule that not only improves our ability to measure and ensure meaningful access to covered services, but also provides greater safeguards for beneficiaries who may otherwise experience great difficulty in receiving needed health care services. The intent of this final rule is to provide a framework for us to use to make better informed, data-driven decisions that support more effective service delivery systems, service rate structures, and provider payment methodologies that reflect our unique and evolving Medicaid population.

- **CMS Finalizes 2016 Medicare Payment Rules for Physicians, Hospitals & Other Providers.** CMS issued final rules detailing how the agency will pay for services provided to beneficiaries in Medicare by physicians and other health care professionals in 2016 that reflects the administration’s commitment to quality, value and patient-centered care. Payment rules for the 2016 calendar year for End-Stage Renal Disease Prospective Payment System, the Hospital Outpatient Prospective Payment System, Home Health Prospective Payment System, and the Physician Fee Schedule were all finalized this week. "CMS is pleased to implement the first fee schedule since Congress acted to improve patient access by protecting physician payments from annual cuts. These rules continue to advance value-based purchasing and promote program integrity, making Medicare better for consumers, providers, and taxpayers," said CMS Acting Administrator Andy Slavitt. “We received a large number of comments supporting our proposal to allow physicians to bill for advanced care planning conversations and we are finalizing this rule accordingly.”

- **Fact Sheet: Two-Midnight Rule.** On October 30, 2015, CMS released updates to the Two-Midnight rule regarding when inpatient admissions are appropriate for payment under Medicare Part A. These changes continue CMS’s long-standing emphasis on the importance of a physician’s medical judgment in meeting the needs of Medicare beneficiaries. These updates were included in the calendar year (CY) 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule.

- **New Medicare Part D Opioid Drug Mapping Tool Available.** Interactive online mapping tool allows public to search Medicare Part D opioid prescription claims data at the state, county, and ZIP code levels. CMS released an interactive online mapping tool that shows geographic comparisons at the state, county and ZIP code levels of de-identified Medicare Part D opioid prescription claims – prescriptions written and then
submitted to be filled—within the United States. This new mapping tool allows the user to see both the number and percentage of opioid claims at the local level and better understand how this critical issue impacts communities nationwide.

- **Discharge Planning Proposed Rule Focuses on Patient Preferences.** CMS proposed to revise the discharge planning requirements that hospitals, including long term care hospitals and inpatient rehabilitation facilities, critical access hospitals and home health agencies, must meet in order to participate in the Medicare and Medicaid programs. The proposed changes would modernize the discharge planning requirements by: bringing them into closer alignment with current practice; helping to improve patient quality of care and outcomes; and reducing avoidable complications, adverse events and readmissions.

- **Telligen Events Update [click here]**

4) The Illinois Department of Healthcare and Family Services (HFS) issued four Informational Notices since the last issue of *Regulatory Beat*. They were:

- Effective this past Monday (11-9-15), HFS has "sunset" their old site (http://www2.illinois.gov/hfs) and it will no longer be updated. Any new change will occur only on the new site (http://www.illinois.gov/hfs). The old site will remain for a short period, but will be completely phased out no later than 11/20/2015. We encourage you to change any bookmarks or hyperlinks that you may have that link to our old website.

- **IMPACT (Illinois Medicaid Program Advanced Cloud Technology) Enhancement To Allow For The Entering Of A Remittance Address.** Beginning December 12, 2015, the IMPACT Provider Enrollment system will be modified to allow providers with an Enrollment Type of Typical or Atypical Sole Proprietor, Group, Facility/Agency/Organization (FAO) or Atypical Agency with multiple NPI’s (National Provider Identifiers) to enter an optional address termed the Remittance Address, in addition to the required Pay To Address, Correspondence Address and Location Address. The optional additional Remittance Address can be entered on the “Add Locations” step of the Business Process Wizard (BPW).

- **Health Alliance Medicare-Medicaid Alignment Initiative (MMAI) Enrollees.** This Notice informs providers that Health Alliance will no longer be part of the MMAI program after December 31, 2015.

- **IMPACT (Illinois Medicaid Program Advanced Cloud Technology) Provider Revalidation.** This Informational Notice is a reminder that Facility/Agency/Organizations (FAOs) are required to revalidate their provider enrollment applications in IMPACT on or before December 31, 2015.

5) Latest summary of IDPH State Licensure Fines for LTC Facilities from 1999 to present [click here].

6) **IMPORTANT NOTE FROM AHCA.** AHCA is ending the use of generic AHCA/NCAL Web login credentials for members. [Click here](#) for the AHCA memorandum and [here](#) for instructions to create a unique login and password. This changeover is effective December 30, 2015.

7) **AHRQ: More Patients Getting Effective Treatment, but Progress Lags for Managing Chronic Diseases.** More patients are getting the right treatment at the right time for their health condition, but progress remains modest for patients with chronic diseases such as diabetes and asthma, according to AHRQ’s recently released [Chartbook on Effective Treatment](#).

8) **MedlinePlus** had several articles of interest. They Include:

- **Many Seniors Given Antipsychotic Meds, Despite Potential Problems** - Risks include kidney damage, stroke and even death, researchers note. Antipsychotic drug use in American seniors increases with age, a new study cautions. The researchers found that the percentage of people aged 80 to 84 who received a
prescription for an antipsychotic drug was twice that of people aged 65 to 69. This increase is occurring despite the known risks of serious side effects such as stroke, kidney damage and death, they added.

- **Illnesses, Deaths Spur FDA Warning on Hepatitis C Drugs** - Cautionary label will be added to Viekira Pak and Technivie, agency says. Reports of deaths and illnesses occurring soon after use are prompting the U.S. Food and Drug Administration to issue warnings on two drugs used to fight the hepatitis C virus. The drugs, called Viekira Pak and Technivie, appeared linked to serious liver damage in patients with advanced liver disease, the agency warned in a statement issued Thursday.

- **Medication Errors Seen in Half of All Operations in Study** - And 80 percent of the mistakes were preventable, researchers report. In a new study on how often medication errors occur during surgery, researchers report that mistakes were made during almost half of the operations they analyzed. The mistakes included drug labeling errors, incorrect dosing, drug documentation mistakes and/or failing to properly treat changes in a patient’s vital signs during surgery.

- **Few Americans Know Warning Signs of Stroke** - New song can help people recall symptoms and act quickly if one occurs, experts say. One in three people can't list any warning signs of stroke, research from the American Stroke Association shows. However, the association added that putting common stroke symptoms into the lyrics of a song could help more people recognize when someone is having a stroke. And that could save lives.

- **Too Many Seniors With Diabetes Are Overtreated, Study Suggests** - Even when blood sugar, blood pressure levels dropped too low, doctors didn't cut back on meds. When it comes to treating seniors with diabetes, new research suggests that doctors often don't cut back on medications, even when treatment goals are surpassed. The study found that when people had potentially dangerous low blood sugar levels, just 27 percent had their medicines decreased. And when blood pressure treatments lowered blood pressure levels too much, just 19 percent saw a reduction in their medications.

9) The **National Institutes of Health (NIH)** recently issued a press release regarding “**Health Care Costs for Dementia Found Greater Than for Any Other Disease.**” In the last five years of life, total health care spending for people with dementia was more than a quarter-million dollars per person, some 57 percent greater than costs associated with death from other diseases, including cancer and heart disease. The new analysis, appearing in the October 27, 2015, online issue of the *Annals of Internal Medicine*, estimates that total health care spending was $287,000 for those with probable dementia and $183,000 for other Medicare beneficiaries in the study.

10) **ConsumerAffairs** recently reported on “**A Three Minute Test For Dementia.**” Early detection is important in cognitive diseases like Alzheimer’s, and researchers are hard at work trying to find ways to diagnose these illnesses earlier. A neuroscientist at Florida Atlantic University says he has developed a simple, three-minute test to identify the onset of Lew Body disease (LBD), a little-understood condition but the second-most-common cognitive disease after Alzheimer’s.

11) **Medicalxpress** recently published an article entitled, “**Scientists Say Alzheimer's is Probably a Collection of Diseases that Should be Classified and Treated Separately.**” Deciphering the mechanism that underlies the development of Alzheimer's disease in certain families but not in others, researchers at the Hebrew University of Jerusalem's Faculty of Medicine have proposed that the malady is actually a collection of diseases that probably should be treated with a variety of different approaches.

12) **ScienceDaily** reports that “**Mayo Clinic Researchers Reduce Inflammation in Human Cells, A Major Cause of Frailty.**” Chronic inflammation, closely associated with frailty and age-related diseases, is a hallmark of aging. Mayo Clinic researchers have discovered that inhibiting key enzyme pathways reduces inflammation in human cells in culture dishes and decreases inflammation and frailty in aged mice. The results appear today in Proceedings of the
National Academy of Sciences of the United States of America. While further studies are needed, researchers are hopeful that these findings will be a step toward treatments for frailty and other age-related chronic conditions.

13) *The Washington Post* published an article entitled “Nearly 60 Percent of Americans – The Highest Ever – Are Taking Prescription Drugs.” Nearly 3 in 5 American adults take a prescription drug, up markedly since 2000 because of much higher use of almost every type of medication, including antidepressants and treatments for high cholesterol and diabetes. In a study published Tuesday in the *Journal of the American Medical Association*, researchers found that the prevalence of prescription drug use among people 20 and older had risen to 59 percent in 2012 from 51 percent just a dozen years earlier. During the same period, the percentage of people taking five or more prescription drugs nearly doubled, to 15 percent from 8 percent.

14) *The New York Times* recently published an article entitled “New Medicare Rule Authorizes ‘End-Of-Life’ Consultations.” Six years after legislation to encourage end-of-life planning touched off a furor over “death panels,” the Obama administration issued a final rule on Friday that authorizes Medicare to pay doctors for consultations with patients on how they would like to be cared for as they are dying.

15) *Reuters* recently published an article entitled, “Old Drug May Help Keep Alzheimer’s Patients Out of Nursing Homes.” A cheap off-patent drug that relieves some symptoms of Alzheimer's disease may also help keep people at an advanced stage of the illness out of nursing homes, at least for a while. Research published on Tuesday showed that withdrawing the commonly used drug donepezil in moderate-to-severe patients doubled their risk of moving into nursing care within a year, although it made no difference during the following three years.

16) *McKnight’s* noted several articles of interest. They include:

- **Despite Risks, Antipsychotic Use Rises in Seniors.** Seniors between ages 80 and 84 are taking antipsychotic medications at twice the rate of younger seniors, a new analysis finds.

- **OIG Plans Civil Monetary Penalties Crackdown.** The government will continue ramped-up efforts against healthcare fraud cases that involve program exclusions and civil monetary penalties, officials shared on Monday.

- **Common Drugs Might Hurt Flu Shot Effectiveness, Studies Show.** Statins may reduce the efficacy of flu vaccinations in seniors, according to new research.

- **Injury Rates Down, But Nursing Facilities Retain Top Spots on Workplace Injury Report.** Nursing facilities again rank among the industries with the highest amount of occupational injuries, according to a report released by the Bureau of Labor Statistics. Privately owned nursing homes and residential care facilities had a 7.1 percent injury rate in 2014, down .2 percent from 2013. That decrease moves nursing homes from the industry with the highest rate of injury to the second highest — air transportation ranked the highest with 7.4 percent.

- **HIPAA Being Cited Incorrectly, Expert Warns.** Care coordination is often stymied by incorrect understanding of the Health Insurance Portability and Accountability Act (HIPAA), a former CMS official noted last Tuesday.

- **CMS Seeks Comments on Preventable Readmissions Project.** CMS is seeking comments on a new project that would develop measures for preventable hospital readmissions, the agency announced recently. The project, dubbed the “Development of Potentially Preventable Readmission Measures for Post-Acute Care,” aims to develop and implement potentially preventable readmissions measures. The measures would be aligned with the Post-Acute Care Transformation Act, as well as the Protecting Access to Medicare Act.

- **New Fire Safety, Emergency Rules For LTC on Their Way.** Two new rules that would update fire safety and emergency preparedness standards for healthcare facilities arrived at the White House for review this
week. The rules, which the Office of Management and Budget began reviewing recently, would amend safety requirements for any healthcare facility that receives Medicare or Medicaid funding. Entities covered by the rules include long-term care facilities, inpatient hospices and programs of all-inclusive care for the elderly (PACE) operations. The emergency preparedness rule would require facilities to have plans in place for both natural and manmade disasters that align with Federal, State, regional and local emergency systems.

17) **Interesting (Scary/Sad) Fact:** A new study found that one in ten (10 percent) of pregnant women continue consuming alcohol during their pregnancy.