June 19, 2019 Edition

Feature Focus

Each edition of the IHCA Regulatory Beat features focus articles on specific regulatory topics. If you have a topic you’d like to see covered here, please let us know!

IDPH Quarterly Provider Association Meeting
The following is a summary of the issues discussed at the June 10, 2019 IDPH Quarterly Provider Association Meeting:

1) Updated status of:
   • Subpart S Rulemaking – Still in internal IDPH review
   • Distressed Facility Rulemaking and Legislation – drafts being prepared for Parts 350 and 390. With regard to the LTC Part, IDPH is focusing on parts 350 and 390 for now. The LTC Associations have suggested legislative changes to this Section to make it more workable. This session’s legislation was stalled in committee. We will attempt to bring it back to life in either the fall veto session or next spring. Certain advocates are pressuring IDPH to move forward with distressed facility language. Whatever language is decided upon must go through the LTC Advisory Board and the rulemaking process.
   • Behavioral Health Unit Rulemaking – No action on this item. This rule is supposed to be a joint venture between IDPH and Human Services.
   • Senate Bill 1510 dealing with informed consent, staffing and an updated IDPH computer system – this legislation was passed in the last days of the General Assembly Session and was included in the Budget Implementation Act (BIMP) rather than SB 1510. The LTC Associations are asking IDPH to develop a workgroup of the LTC Associations and providers along with IDPH to draft the implementation rules. There are significant concerns as to how to make sure the changes in this section of the BIMP are implemented. For example, the staffing part uses the federal CMS PBJ data that does not directly correspond to the IDPH staffing rules. IDPH is to internally discuss the workgroup request and get back to us by the end of the week.

2) Informed Consent [210 ILCS 45/2-106.1]
   • Rulemaking – IDPH is currently drafting rules with regard to informed consent. However, it was noted that the changes made in the above BIMP language will require IDPH to work with the LTC Associations to agree on how to implement.
   • Web-based Form and Black Box info – IDPH will have to rework its draft informed consent form to comply with the new language included in the BIMP.

3) Identified Offender – Reporting of Felonies [210 ILCS 45/1-114.01]. Request ISP, Sergeant Jones, to attend to explain why the ISP believes all crimes must be reported to ISP – the statute clearly states that only felonies are required to be forwarded to ISP. Persons within the management of ISP have stated that they want all crimes
4) Requesting Relocation Assistance from IDPH [210 ILCS 45/3-417] – all requests for relocation assistance should be directed to Aimee Isham, Bureau Chief for LTC. Resident and LTC facilities can request assistance when necessary.

5) Request an IDPH ALJ to attend to discuss Involuntary Discharges. Issues include:
   - ALJs refusing to rule when the discharge is for Non-Payment due to a Medicaid Pending, even though the Pending has exceeded the 45-day limit;
   - ALJs allowing multiple re-filing of Medicaid Apps to delay a Involuntary Discharge; and
   - ALJs refusing to rule on “the safety of individuals in this facility is endangered,” when the discharge also includes Non-Payment. – IDPH has not had the lead ALJ position filled for many months. We want a meeting with the lead ALJ or any IDPH ALJ to discuss the above issues. IDPH stated that they will attempt to get an ALJ to the next Quarterly Meeting. These issues are causing significant concerns/problems for LTC providers and they need to be resolved sooner rather than later.

6) E-POC - How has the implementation gone? Any additional guidance to share with our members? – All questions regarding ePOC issues/questions are to be forwarded to Aimee Isham. Both Sherry Barr and Pam Winzel have left IDPH and their respective positions have not been filled yet.

7) LSC Surveyors are requesting Facility Name & Address to be on Policies & Procedures. We have found no LSC, federal or state regulation that requires this, or allows IDPH to deny a POC for this information not being on the Policies and Procedures. – IDPH stated that a facility name and/or address are NOT required to be on facility policies and procedures.

8) Guidance on how IDPH will implement PA 100-0217 (Eff 8/18/17) with regard to nurse staffing waivers? When will the rules be ready? – IDPH is drafting rules to implement PA 100-0217. IDPH will need to consider the recent changes in the BIMP to accurately allow for the use of nursing waivers.

9) Any progress of information regarding rulemaking or guidance with regard to electronic monitoring devices and medical marijuana? The issue of medical marijuana in LTC facilities is beginning to ramp up and many facilities are being approached about this. Questions also regarding privacy issues related to smart speaker devices like Amazon Echo and Google Home that residents have or want in their rooms. IDPH perspective on this? – IDPH is not pursuing any rules with regard to the use of medical marijuana within LTC facilities. This is the direction IDPH is getting from federal CMS. IDPH is also not providing any guidance with respect to the use of devices such as Amazon Echo or Google Home. They stated it is a facility decision. If a facility is going to allow for their use, they should follow the same statutory requirements for other electronic monitoring devices (granny cams).

10) Status of the ID/DD Statement of Deficiencies conforming with the LTC Statement of Deficiencies? There are differences in how IDPH processes Statements between the ID/DD facilities and the LTC facilities. The statute/process is the same for both. IDPH stated that they are internally reviewing this issue and agreed to address and correct discrepancy in the near future – Status? – IDPH stated they will not finalize their review of this issue until the new LTC Quality Assurance Division Chief position is filled. When filled, IDPH agreed to conduct a meeting to understand and fix the issue.

11) Update on the implementation of the new survey process. Major issues noted, most common deficiencies, guidance for providers? Any updates or information with regard to Phase 3? Any other survey updates from your CMS meeting in Baltimore? – IDPH stated that they have not gotten any direction from federal CMS on Phase 3 implementation.

12) Update on the implementation of the new emergency preparedness requirements. Most common deficiencies and any guidance for providers? Additional or expanded issues to be reviewed during EP surveys? – IDPH stated...
that they have not gotten any new direction for federal CMS on surveying for the EP requirements. However, as surveyors get more comfortable and knowledgeable on the EP requirements, providers can expect a closer review of all of the EP requirements during upcoming surveys.

13) How to address CNAs walking out during their shift – resident abandonment – action that can be taken by IDPH? At the last meeting, IDPH stated they would review this issue with Legal and get back to us. – This issue also needs to be in the discussion of the new BIMP language. Can abandonment be considered neglect? How can this best be reported to the Nurse Aide Registry? We asked that George Logan from the Registry Section be at the next meeting to discuss options.

14) IDPH Fine Reduction. IDPH takes the position that any state fines can’t be reduced to 25% until the federal fine has been paid. They rely on the word “paid” in the statute. This to the LTC Industry is another example of IDPH taking an unreasonable position. The timing of a provider paying the federal fine shouldn’t dictate whether we are entitled to the 75% reduction. What if we waive the state fine and pay 65%? Is there a mechanism to get back the money from IDPH once we’ve paid the corresponding federal fine? To us, IDPH should just accept that the federal fine is going get paid at some point and just let us pay the 25%. IDPH LTC understands the issue and will discuss with IDPH Legal for possible solutions and report back at the next Quarterly meeting. – This item is still in IDPH Legal review.

15) What can a family paid caregiver do in an LTC facility? Is the facility liable for anything the paid caregiver does? Can a family give a waiver and will CMS/IDPH accept it should something go wrong? Is strict liability in play here? – IDPH Legal refuses to give guidance on this issue. Any action of a paid caregiver without proper training and facility acceptance, can result in a strict liability issue for the LTC facility. IDPH stated that providers should fully document discussions in the area. The resident assessment should note what needs a resident has and what if anything a paid caregiver can do.

16) IDPH stated that they were going to develop a Q&A on the new survey process for Illinois LTC providers. Any update on this? – Connie Jensen stated that federal CMS is prohibiting her from doing this. LTC facilities can consult the federal FAQs.

17) Discussion of the requirement (300.1620(c), requiring that the Drug Regimen Review be conducted at the facility. Federal requirements don’t require this and with all of the advancements of electronic monitoring, this could be done electronically saving a lot of travel time and be more efficient. – This was resolved during the last LTC Advisory Board Meeting. Off-site Drug Regimen Reviews will be allowed once the rules are approved.

18) With regard to PA 100-0754 (Eff 8/10/18) (DSP Credentialing Pilot Program), Does this mean that a CNA, who is also a DSP, can use their active role/duties as a DSP, to show they are actively “performing nursing or nursing-related services,” to prevent losing their CNA Certification? Does this allow CNAs to work in ICFDD/IDs without becoming DSPs? – IDPH is still reviewing this issue.

19) Personnel Update
   • IDPH Chief of Staff – Justin Dewitt
   • Chief of Legislative Affairs – Laura Vaught
   • Legislative Affairs Staff
   • ALJ Supervisor – still vacant
   • Current Organizational Charts with Staff Names for
     o IDPH
     o OHCR
     o Div of QA
     o Div of FO
Will provide names in near future as soon as positions are filled. Kim Stoneking, Regional Supervisor for Peoria and Rockford Regions has resigned and Connie is temporarily handling those functions until the position can be filled.

20) Are there any statistics on IDR results? Number changed, unchanged, modified? Any future plans to again allow independent IDRs? – IDPH does not keep this information due to their outdated computer system.

21) Question about surveyors calling facility staff at their homes? Causing issues with overtime and other personnel matters. – Connie stated that this should only occur in rare circumstances. Usually they try to talk to the employee when at the facility.

22) Is the notice to a resident’s representative to be the same as the notice given to the resident? Any privacy concerns or HIPAA issues here? – In most cases it should be the same notice. If a resident changes their mind as to who their resident representative is or does not want the information passed along, then resident rights trumps. All of this information/discussion should be well documented.

23) Some facilities are wanting to be able to do blood transfusions that are not connected to a hospital. Other states allow this. If acceptable to IDPH, would you want to see a rule change or handle by a waiver? – Current IDPH rules prohibit this. Facilities can request a waiver. This item will be on the agenda at the next LTC Advisory Board Meeting.

24) Survey question on the baseline care plan and when to be given to resident/resident representative. Some surveyors are saying within 48 hours, regs appear to say at time of the completion of the comprehensive care plan? – The summary of the baseline care plan should be given to the resident/resident representative as soon as possible and before the completion of the comprehensive care plan.

25) Can we get the most recent list of Top Ten Health, LSC and EP deficiencies for Illinois? –

Health
1. F689—Supervision to Prevent Accidents
2. F880—Infection Control
3. F686—Pressure Ulcers
4. F690—Incontinence Care and F812—Food Sanitation—TIE
5. F677—ADL Care for Dependent Residents
6. F684—Quality of Care
7. F755—Pharmacy Services
8. F758—Unnecessary Drugs
9. F550—Exercise of Resident Rights
10. F558—Reasonable Accommodation of Needs

Emergency Preparedness
2. E30—Names and Contact Information
3. E9—Local, State, Tribal Collaboration Process
4. E26—Roles Under a Waiver Declared by Secretary
5. E35—LTC and ICF/IID Sharing Plan with Patients

26) Can a sex offender be allowed to be in the same room as their spouse? – yes if both partners consent. Section 2-108(e) of the Nursing Home Care Act states: (e) The administrator shall ensure that married residents residing in the same facility be allowed to reside in the same room within the facility unless there is no room available in the facility or it is deemed medically inadvisable by the residents’ attending physician and so documented in the residents' medical records.
27) Can facilities use CoaguChek for checking PT/INR? Need a CLIA waiver? Any other consideration(s)? – IDPH is currently doing research on this issue.

28) IDPH is still finalizing the Town Hall Meeting dates and locations.

29) IDPH is internally reviewing the new EPA requirements with regard to hazardous waste and its impact on LTC facilities.

30) As part of the facility’s Emergency Plan, a strike plan should be included, if appropriate.

31) Connie stated that every facility should have a “meaningful” exit. Phone exits should be rare if at all.

32) If LTC facilities are having trouble with surveys being left open for several days, the facility should contact the Regional Supervisor or Connie.

How to Prepare for Trauma-Informed Care
Most of us go about our daily routine with a sense of relative safety and security. That feeling of well-being can be quickly shattered by a traumatic event — the kind of unexpected, life-altering occurrence that we are accustomed to watching on the news.

Unfortunately, traumatic events are not unusual. One estimate places a person’s lifetime chance of experiencing a traumatic event at about 70%. For veterans, that exposure can reach as high as 85%.

Exposure to trauma, whether it involves combat, assault, childhood abuse or a natural disaster, has the potential to change the way we experience ourselves and the world around us. This change is physiological as well as psychological, as trauma has the potential to “rewire” victims in significant ways. Although not everyone who experiences trauma will manifest Post-Traumatic Stress Disorder, those who do often perceive themselves as more vulnerable and the world as more dangerous than they did before the trauma. Many of these patients will be chronically suspicious and fearful of their environment, which can have a profound impact on their post-acute care needs.

New trauma requirements for post-acute care
Beginning November 28, 2019, the Centers for Medicare & Medicaid Services will require nursing homes to put in place a process to identify residents who have experienced trauma and to consider the resident’s needs when developing a person-centered care plan. This new requirement mandates that facilities identify residents suffering from acute trauma reactions and those with chronic symptoms, i.e. post-traumatic stress disorder. A major aspect of trauma-informed care involves ensuring that interactions with staff and care routines are developed in a manner that avoids “re-traumatization.”

When establishing a screening process, nursing homes should recognize that while all individuals exposed to a traumatic event have experienced distress, not all of them will develop post-traumatic stress reactions. In the period immediately following a traumatic event, acute traumatic reactions are not unusual, and on a short-term basis these symptoms can be viewed as an adaptive response. That makes it imperative that facility staff, optimally led by behavioral health clinicians, differentiate between acute and chronic trauma reactions.

Distinguishing acute and chronic trauma
It is common for individuals who have experienced recent trauma to exhibit hyper-vigilance, altered mood, increased startle responses and sleep problems. In these cases, processing recent events, to the degree the resident is willing, can go a long way in helping them rebound. At this stage, aggressive pharmacological interventions may actually interfere with the resident’s processing of these emotional experiences and lead them to conclude they are doing fine. This is a critical stage to establish integrated care and involve all disciplines in developing a treatment plan.
In cases of chronic trauma reactions, an individual may have established maladaptive coping strategies and resist treatment. Their symptoms can often escalate due to the change in environment and unfamiliar demands. Significant increases in anxiety, combativeness, and isolation are common. This will frequently lead residents to refuse services and struggle for control of their care routine. These behaviors will often lead staff to conclude that the resident is problematic, as opposed to recognizing them as symptomatic.

Understanding trauma
Educating staff about PTSD will help them recognize the condition as more than just a psychological state. Trauma, especially severe and extended exposure, leads to a rewiring of the brain’s neurophysiology. Essentially the brain is reset to be hyper-reactive at lower thresholds of stimulation. Residents with PTSD may manifest extreme reactions to seemingly routine events that a non-traumatized individual would likely ignore or experience as relatively innocuous. That’s because the physiologic changes in the brain trigger hormonal responses (fright, flight, and flight) and powerful physiological states that further distort the resident’s perceptions, thinking and interpersonal relationships. These altered physiological states can be very uncomfortable and lead the individual to adopt coping strategies involving avoidance and isolation as a strategy.

Self-medication is very common in trauma, sometimes leading to medication- or drug-seeking behavior that may develop into addiction. The neurophysiological changes and reactions are conditioned and don’t necessarily resolve with time. In the case of PTSD, time is not a reparative variable in the treatment process. Staff members need to be taught that events that occurred decades ago may still have immediate and powerful effects on the resident’s reactions and view of the world.

For example, telling a resident who is experiencing an escalation in PTSD symptoms to calm down will not be effective. As always, the best responses will be unique to the individual, but will commonly involve giving them as much control over the situation as possible and establishing a non-judgmental, supportive atmosphere. Residents experiencing these symptoms are stuck in survival mode based on their perception that they are being threatened. What presents as unreasonable to the objective observer makes perfect sense to the resident based on their perceptions. Asking these residents to calm themselves doesn’t work because, from their perspective, they are in real danger.

It’s not hard to imagine how common nursing home routines could re-traumatize a resident. For example, a resident with a history of physical assault might have a strong reaction to physical therapy, where various manipulations and interventions involving physical discomfort or acute pain are common. Another example would be a resident who experienced the trauma of sexual abuse. They could easily be triggered by the daily routine of being dressed, toileted, or bathed. These situations may quickly make the resident feel unsafe or threatened.

Preparing for trauma-informed care
The facility impact of the new CMS requirements will depend on the resident population in any particular SNF. In the general population, estimates of PTSD are around 8%. With certain groups, for example the military, the rate of trauma reactions is as high as 17%. PTSD in a psychiatric or homeless population is likely to be much higher than the general population. Facilities that serve a high percentage of residents with primary psychiatric issues and/or active duty military experience will likely have a robust percentage of residents who trigger for trauma, while other facilities may have a relatively small number. The bottom line is that you won’t know until you get started.

A road map for complying with the new requirements around trauma can be broken down as follows:

1. Staff education. Staff members need to understand the basic principles of trauma and of trauma-informed care. When training takes place, don’t be surprised to see light bulbs go off as staff members finally understand the connection between well-known resident behaviors and the underlying trauma experiences that fuel them.

2. Trauma screening. Facilities will need to create a screening process for trauma that is specifically designed to identify residents with trauma history and, potentially, PTSD.
3. Diagnosis. An accurate diagnosis of PTSD requires both a history of trauma and level of functioning that is consistent with DSM diagnostic criteria for the disorder. Remember, not everyone who experiences trauma winds up with PTSD.

4. Care planning. Person-centered care planning for residents with PTSD should take into account all departments and staff members who have close contact with the resident. Nursing staff, and particularly CNAs, because they spend the most time with residents and provide the most hands-on care, will require the most specific care-planning focus. To successfully establish a culture sensitive to trauma, staff will have to be knowledgeable and sensitive to how their interpersonal approaches will play a key role in mitigating symptoms and avoiding re-traumatization of these residents.

5. Behavioral health services. Residents with PTSD can be both highly distressed and very challenging to staff from a behavior management perspective. Following the trauma screening, the facility’s behavioral health team can play a valuable role in establishing a correct diagnosis and developing different facets of the care plan. There could not be a better example of where a strong behavioral health team and person-centered care planning will play a critical role in meeting a resident’s needs.

With some preparation, understanding and training, post-acute facilities can position themselves to comply with CMS requirements and deliver quality, appropriate care to residents who have experienced trauma.

*Article printed out of McKnight’s and authored by Robert Figlerski, Ph.D.*

**Focus F-Tag – F867 QAPI/QAA Improvement Activities**

This *Regulatory Beat*’s Focus F-Tag is **F867 QAPI/QAA Improvement Activities**, which is the third F-Tag in the Quality Assurance and Performance Improvement regulatory group. This regulation was partially effective in Phase 1 as it relates to the QAA, and then has two major components which become effective this November with Phase 3.

**Quality Assessment and Assurance (QAA)**

This section of the regulation became effective with Phase 1 of the RoPs, November 28, 2016 with the exception of the part related to implementation the QAPI program. This regulation requires that the facility’s QAA Committee reports to the Governing Body. The Committee is responsible for developing and implementing appropriate corrective action plans for identified quality deficiencies. The Committee must routinely review and analyze data, including data from Drug Regimen Reviews and act on that data to make improvements.

In Phase 3, the QA Committee must also report to the Governing Body regarding implementation of the QAPI program as it relates to the major requirements of this regulation – Program Systematic Analysis and Systemic Action and Program Activities. This includes using QAPI data for routine analysis and action.

**Program Systematic Analysis and Systemic Action**

F867 requires a facility to conduct performance improvement actions that are measured for success and track performance improvements to ensure they are realized and sustained. Nursing homes need to have policies in place that are the related “hows” for this process, including:

- How a systematic approach will be used to determine the underlying causes of problems that impact larger systems
- How corrective action plans will be developed to effect change at the systems level to prevent problems related to quality of care, quality of life or safety
- How performance improvement activities will be monitored for effectiveness

This part of the regulatory requirement is effective Phase 3.

**Program Activities**

The other part of F867 that will be effective with Phase 3 relates to the QAPI Program activities. The facility’s QAPI program needs to prioritize performance improvement activities that:
• Focus on high-risk, high-volume, problem-prone areas
• Consider the incidence, prevalence and severity of problems
• Include areas that impact quality of care, resident safety, health outcomes and resident autonomy and choice

Performance improvement activities must track medical errors and adverse resident events. The causes of these issues must be analyzed, and preventive actions put into place to prevent recurrence. This includes “feedback and learning throughout the facility” per the Interpretive Guidance (IG), so there is a staff education component included here as well.

Performance Improvement Projects (PIPs)
Performance Improvement Projects (PIPs) are one of the QAPI program’s features that has been emphasized since QAPI was initially announced. PIPS are focused performance improvement activities that the facility must conduct. There are two important requirements to note here:

• The number and frequency of PIPs must reflect the scope/complexity of the facility’s services and resources as per the Facility Assessment.
• One PIP, annually, must focus on a facility-identified high-risk or problem-prone area that has been identified through data collection and analysis.

As you can see from the regulatory requirements under this F-Tag as well as the requirements at F865 and F866, there is a tremendous focus on the facility’s ability to capture and analyze data to identify potentially problematic issues before the surveyors do. The importance of ensuring that once an issue has been identified, that your facility understands the need to prioritize implementation of corrective actions to address the issues at a systems level to prevent recurrence cannot be stressed enough. The Facility Assessment continues to be a key element of compliance as well, since the care and services listed in the Facility Assessment will also be driving PIPs in Phase 3. Needless to say, the QAPI Committee meeting once on a quarterly basis is probably not going to be enough.

Trending Statistics

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

Families List Health Care as Top Financial Problem
Health care costs are the top financial issue facing most American families, according to a new Gallup poll released Thursday.

About 17 percent of Americans said health care was their most significant financial issue, followed by 11 percent citing lack of money or low wages, 8 percent saying college expenses, 8 percent saying the cost of owning or renting a home and 8 percent saying taxes.

Health care costs were also the most significant financial issue for Americans in 2017 and nearly tied with lack of money or low wages for the top spot in 2018, according to the poll.

Health care costs are most likely to be the top concerns for older Americans, with 25 percent of adults between the ages of 50 and 64, and 23 percent of those aged 65 and older listing them as their top financial problems. Health care costs tie with lack of money, college expenses and housing costs as the greatest financial worries among adults younger than 50.

Health care also ranked as the top financial concern for Americans among all income levels.

Health care costs, energy costs or oil and gas prices and lack of money or low wages are the only three issues to ever top the “most important family financial problem” question in the 48 times Gallup has asked it since 2005.
However, mentions of energy costs have declined as gas prices have gone down over the last decade.

Reflecting a time of high economic confidence, 20 percent of Americans say they do not have a “most important financial problem,” one of the highest responses to the question in the Gallup poll’s 14 years. That figure was only surpassed in February 2005, when 21 percent of Americans said they do not have a top financial issue.

Despite strong economic numbers, Democrats are likely to highlight health care issues in the 2020 race after focusing on the issue to win back the majority in the House in 2018.

“Even in generally good economic times, Americans still face significant personal financial challenges. Foremost among these are healthcare costs, which have been a consistent concern over time but currently stand above all other concerns. As such, healthcare will likely continue to be a major focus in national elections, including the 2020 presidential election,” Gallup concluded.

Important Regulations, Notices & News Items of Interest

1) There was one new Federal CMS Quality, Safety and Oversight Letter (formerly known as Survey and Certification (S&C) Letters) released since the last issue of Regulatory Beat.

- **QSO 19-14 – Hospitals, CAHs - State Operations Manual (SOM) Emergency Medical Treatment and Labor Act (EMTALA) and Death Associated With Restraint or Seclusion Complaint Investigation Timeline Revisions.**
  
  *Complaint Investigation Timelines:* The timeline for investigations in hospitals and critical access hospitals (CAH) for complaints specific to EMTALA and deaths associated with restraint or seclusion is being changed for CMS Regional Office (RO) and State Survey Agency (SA) surveyors from completion in five working days to onsite within two business days. This change brings these two categories of complaint investigations in line with other potential immediate jeopardy (IJ) investigations in Medicare-participating non-long term care facilities. **Appendix V Revisions:** SOM Appendix V contains the EMTALA regulations, interpretive guidelines and survey process. Part I – Investigative Procedures of Appendix V is being revised to address the change in complaint investigation timelines along with other minor clarifications to the survey process.

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

- **CMS Seeks Public Input on Patients over Paperwork Initiative to Further Reduce Administrative, Regulatory Burden to Lower Healthcare Costs.** On June 6, CMS issued a Request for Information (RFI) seeking new ideas from the public on how to continue the progress of the Patients over Paperwork initiative. Since launching in fall 2017, Patients over Paperwork has streamlined regulations to significantly cut the “red tape” that weighs down our healthcare system and takes clinicians away from their primary mission—caring for patients. As of January 2019, we estimate that through regulatory reform alone, the healthcare system will save an estimated 40 million hours and $5.7 billion through 2021. These estimated savings come from both final and proposed rules.

  This RFI provides an opportunity to share new ideas not conveyed during the first Patients over Paperwork RFI in 2017 and continue the national conversation on improving healthcare delivery. We are especially seeking innovative ideas that broaden perspectives on potential solutions to relieve burden and ways to improve:

  o Reporting and documentation requirements
  o Coding and documentation requirements for Medicare or Medicaid payment
  o Prior authorization procedures
  o Policies and requirements for rural providers, clinicians, and beneficiaries
  o Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
  o Beneficiary enrollment and eligibility determination
CMS processes for issuing regulations and policies

Key Burden Reduction Milestones to Date:
We gathered feedback on burdensome requirements from medical and patient communities through other RFIs, listening sessions, and on-site meetings with frontline clinicians, healthcare staff, and patients and are working every day to reduce regulatory burden while safeguarding patient safety, quality and program integrity.

Achievements so far:
- Simplified Documentation and Coding
- Improved Quality and Operational Efficiency
- Meaningful Measures
- Changing CMS Culture

For More Information:
- RFI on Reducing Administrative Burden to Put Patients over Paperwork
- Patients over Paperwork webpage

- **Pain Management Best Practices Inter-Agency Task Force Final Report.** Patients with acute and chronic pain in the United States face a crisis because of significant challenges in obtaining adequate care, resulting in profound physical, emotional, and societal costs. According to the Centers for Disease Control and Prevention, 50 million adults in the United States have chronic daily pain, with 19.6 million adults experiencing high-impact chronic pain that interferes with daily life or work activities. The cost of pain to our nation is estimated at between $560 billion and $635 billion annually. At the same time, our nation is facing an opioid crisis that, over the past two decades, has resulted in an unprecedented wave of overdose deaths associated with prescription opioids, heroin, and synthetic opioids.

The Pain Management Best Practices Inter-Agency Task Force (Task Force) was convened by the U.S. Department of Health and Human Services in conjunction with the U.S. Department of Defense and the U.S. Department of Veterans Affairs with the Office of National Drug Control Policy to address acute and chronic pain in light of the ongoing opioid crisis. The Task Force mandate is to identify gaps, inconsistencies, and updates and to make recommendations for best practices for managing acute and chronic pain. The 29-member Task Force included federal agency representatives as well as nonfederal experts and representatives from a broad group of stakeholders. The Task Force considered relevant medical and scientific literature and information provided by government and nongovernment experts in pain management, addiction, and mental health as well as representatives from various disciplines. The Task Force also reviewed and considered patient testimonials and public meeting comments, including approximately 6,000 comments from the public submitted during a 90-day public comment period and 3,000 comments from two public meetings.

- **Hospice Provider Preview Reports: Review Your Data by July 1.** 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 fourth quarter of 2017 to the third quarter of 2018
  - Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) provider preview report: Review facility-level CAHPS survey results from the fourth quarter of 2016 to the third quarter of 2018

Review your HIS and CAHPS results by July 1. 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
• **ICD-10-PCS Procedure Codes**: FY 2020. FY 2020 ICD-10-PCS procedure code updates including a complete list of code titles are posted on the [2020 ICD-10-PCS](#) webpage. FY 2020 ICD-10-CM diagnosis code updates will be posted in June.

• **LTCH Provider Preview Reports**: Review Your Data by July 10. Long-Term Care Hospital (LTCH) Provider Preview Reports are now available with fourth quarter 2017 to third quarter 2018 data. Review your performance data on quality measures by July 10, prior to public display on LTCH Compare in September 2019. Corrections to the underlying data are not permitted during this time; request a CMS review if you believe that your data is inaccurate.

   Access your report by logging into the [Quality Improvement and Evaluation System](#) (QIES). At the main screen, select “Reports;” then “My Reports.” For more information, visit the [LTCH Quality Public Reporting](#) webpage.

• **Provider Compliance Tips for Urological Supplies — Revised**. A revised [Provider Compliance Tips for Urological Supplies](#) Medicare Learning Network Fact Sheet is available. Learn:
  - Reasons for denials
  - How to prevent claim denials
  - Documentation requirements
  - Specific criteria that must be met to quality for payment

• **Medicare Billing: Form CMS-1450 and the 837 Institutional Web-Based Training Course — Reminder**. With Continuing Education Credit. The Medicare Billing: Form CMS-1450 and the 837 Institutional Web-Based Training (WBT) course is available through the Medicare Learning Network [Learning Management System](#). Learn:
  - Billing requirements
  - Claim completion information
  - How to identify aspects of paper and electronic claims

3) **Important! New Livanta BFCC-QIO Provider Bulletin**.

4) **The federal HHS Office of the Inspector General (OIG) released a report on Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated**. This audit report is one of a series of OIG reports addressing the identification, reporting and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including the elderly and individuals with developmental disabilities. Our objectives were to determine (1) the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries residing in skilled nursing facilities (SNFs) who had a hospital emergency room (ER) Medicare claim in calendar year 2016 containing a high-risk diagnosis code, (2) whether these incidents of potential abuse or neglect were properly reported by the SNFs, (3) whether the Centers for Medicare & Medicaid Services (CMS) and State Survey Agencies (Survey Agencies) reported findings of substantiated abuse to local law enforcement and (4) the extent to which CMS requires incidents of potential abuse or neglect to be recorded and tracked.

5) **The federal Environmental Protection Agency (EPA) recently released a Final Rule on Pharmaceutical Hazardous Waste**. Some pharmaceuticals are regulated as hazardous waste under the Resource Conservation and Recovery Act (RCRA) when discarded. This final rule adds regulations for the management of hazardous waste pharmaceuticals by healthcare facilities and reverse distributors. Healthcare facilities (for both humans and animals) and reverse distributors will manage their hazardous waste pharmaceuticals under this new set of sector-specific standards in lieu of the existing hazardous waste generator regulations. Among other things, these new regulations prohibit the disposal of hazardous waste pharmaceuticals down the drain and eliminates the dual regulation of RCRA hazardous waste pharmaceuticals that are also Drug Enforcement Administration (DEA) controlled substances. The new rules also maintain the household hazardous waste exemption for pharmaceuticals collected during pharmaceutical take-back programs and events, while ensuring their proper disposal. The new rules codify Environmental Protection Agency (EPA)'s prior policy on the regulatory status of nonprescription pharmaceuticals going through reverse logistics. Additionally, EPA is excluding certain U.S. Food and Drug Administration (FDA) approved over-the-counter...
(OTC) nicotine replacement therapies (NRTs) from regulation as hazardous waste and is establishing a policy on the regulatory status of unsold retail items that are not pharmaceuticals and are managed via reverse logistics, fulfilling the commitment we made in the Retail Strategy of September 2016.

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 New Inpatient APR-DRG and Outpatient EAPG Grouper Version Updates Effective July 1, 2019. To view this notice, click here.

- HFS posted a new Provider Notice regarding June 7th WebEx – SharePoint Site for Information Exchange with LTC Providers. You may view the new notice here.

- HFS posted a new Provider Notice regarding Due Date for Payment of the Monthly Occupied Bed Provider Assessment. You may view the new notice here.

- HFS posted a new Provider Notice regarding New Comprehensive Billing Guide for Medicaid Managed Care Services. You may view the new notice here.

- HFS posted a new Provider Notice regarding Dental Member Eligibility Verification. You may view the new notice here.

- 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.

- HFS is sending out the login information for the LTC Exchange Sharepoint site to LTC providers in two separate emails Once received, providers should be able to login to the LTC Exchange. Thank you for your patience.

- HFS posted an updated Birth Center Fee Schedule, effective DOS 05/01/2019. You may view the new fee schedule here.

- HFS posted a new provider notice regarding UPDATE: New Section Published under the Comprehensive Billing Guide for Medicaid Managed Care Services. You may view the new notice here.

7) The Illinois Department of Public Health (IDPH) reports:

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

- The Illinois Department of Public Health recently adopted rules for Alzheimer’s Disease and Related Dementias Services Code. This rulemaking creates a new Part, 77 Ill. Adm. Code 973, implementing PA 99-822, which created the Alzheimer’s Disease and Related Dementias Services Act [410 ILCS 406] (the Act), and PA 100-1074, trailer legislation that amended the Act pursuant to negotiations between the Department and the Alzheimer’s Association.

- Effective Monday (June 17, 2019), Mr. Ben Arbise has accepted the temporary assignment as Central Illinois Regional Supervisor for the Peoria and Champaign regions. He will be assuming the duties previously assigned to Mr. Kim Stoneking who has accepted another job outside of State government. Please join me in welcoming Ben to this new assignment.

Please let your staff know of the changes. Ben will be the contact person for anything that Kim previously handled. Ben Arbise’s contact info is:

- Email: Ben.Arbise@Illinois.gov
- Phone: 309-693-5368
The Illinois Department of Financial and Professional Regulation recently adopted rules for Administration for the Compassionate Use of Medical Cannabis Pilot Program. PA 100-1114 created the Opioid Alternative Pilot Program (OAPP) within the existing framework of the Medical Cannabis Pilot Program (MCPP). This was a significant expansion of the program and these adopted rules allow for the implementation of the new Opioid Alternative Pilot Program (OAPP). Specifically, the rules allow for OAPP participants to enter dispensaries and purchase medical cannabis. PA 100-1114 also involved smaller changes within MCPP and the adopted rules implement those statutory changes and add clarifications on previous rules. Specifically, the adopted rules add clarification to previous rules regarding ownership structure and who is considered a principal officer.

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

- **Special Focus Facility (SFF) Candidate List.** Here is information on how CMS creates the candidate list, background on the SFF program and an excel file with SNFs on the SFF candidate list. The file has two tabs, one with the number of candidate and SFF facilities in each state and the second with the list of all the facilities that have 1 Star on the survey component of Five Star along with:
  - a flag showing if they are on the SFF candidate list (note: if they are an SFF, they will have no other information because CMS is suppressing all the other information for facilities classified as SFF);
  - their five-star three-year survey score (note: this survey score is slightly different than the survey score CMS used to create the list but they have not provided the survey score publicly); and
  - their five-star ratings on the overall, staffing and quality measure components of five star.

CMS also announced today that they will be publishing the SFF candidate list updated monthly. They did not specify how or where they will publish this information. AHCA will work to get this information and provide it to you in similar format when CMS releases it.

How do you get on the SFF list (e.g. how is the candidate list created)?
  - Each State Survey Agency picks the facilities to be considered SFF from a list given to them from CMS.
  - CMS creates a list of potential candidates nursing homes for potential SFF designation based on the survey findings from the last three survey cycles from their standard and complaint surveys using the
    - number of survey deficiencies that are not corrected in a timely manner, or
    - when the nursing home has a pattern of problems that persist over a long period of time.
  - CMS calculate a survey score for each nursing homes and ranks SNFs based on the survey score. This is similar to but slightly different than the survey score used to assign for the survey component of Five Star. Those facilities with the worst ranking are on the candidate list. The number of nursing homes on the candidate list is based on five candidates for each SFF slot for the state, with a minimum candidate pool of five nursing homes and a maximum of 30 per State.

- **TAN Lookup Tool.** Currently there are almost 275,000 TANs listed covering several thousand pages. In an attempt to make this more user friendly IHCA Reimbursement Consultant Matt Werner has developed the Excel look up sheet linked below. Please note that right now this only includes TANs that are new or have a change in status, and excludes TANs without a change in status to keep the file manageable. The tool is updated weekly as new data is available. [TAN Lookup Tool](#).

- **New Assisted Living Top-Line -Q1.** Your AL Top-Line is a LTC Trend Tracker™ publication that includes metrics and charts outlining progress of individual assisted living communities on AL Quality Measures, the Quality Initiative for Assisted Living, and other necessary data to help them achieve their desired goals. Distributed each quarter, the report also highlights member resources that may help providers.

As a registered state affiliate user of LTC Trend Tracker, you can download any Your AL Top-Line for any community in your state by following these steps:

1. [Log into LTC Trend Tracker](#)
2. Once you’re logged in, on the left-hand menu, click on "Manage Publications" and then select "View and Download Publications".
3. From the "Select a Publication" drop-down list, select "Your AL Top-Line". Please note: if you wish to view Your Top-Line for skilled nursing centers in your state, select "Your Top-Line."
4. From the "Select an Organization" drop-down list, select the organization of interest.
5. Then either use the "Download by Division" pane to download multiple PDFs by quarter, or use the "View and Download Publications by Building" pane to view or download a PDF for a single building.

(Make sure your web browser allows pop-ups from https://ltctt.ahcancal.org/login, to be able to access the downloaded report.)

- **AHCA/NCAL Social Media Update** ([click here](#))
- **AHCA/NCAL ED Webinar Reminder**. This is a reminder to attend AHCA PDPM Academy Monthly Live Webinars. Test your sound and video in advance! Click [here](#) to test your sound and video for the webinar. In some cases, sound will not work in Internet Explorer. If this happens, try using either Chrome or Firefox. For additional support or questions, you may reach out to educate@ahca.org. Please plan to log in 15 minutes prior to the event! To access the webinar:
  - Once the page opens, click on the "Live Webinar" button on the right hand side of the page. The presentation will open in a new window for you to view and hear the program.
  - Click on the Handout tab to download your copy of the handouts and other available materials.

For technical questions or support, please email ahca@commpartners.com. Please [click here if you have forgotten your password](#).

Event: AHCA PDPM Academy Monthly Live Webinars -- PDPM Academy Monthly Webinar- June 25

Event starts 10 days from now (06/25/2019 at 2:00 PM (CDT))

[Add to Calendar]. [Get More Information and Attend the Event].

- **AHCA PDPM Academy Weekly Update: June 13.**
  - CMS Video Tutorials to Assist with Coding Specific Section GG Items. The SNF PPS Patient Driven Payment Model (PDPM) relies on accurate coding of several MDS Section GG mobility and self-care items that impact the PT, OT, and Nursing component per-diem case-mix payment rates. On June 7, 2019, the Centers for Medicare & Medicaid Services released a series of short videos to assist providers with coding select Section GG items on the OASIS, IRF-PAI, LTCH CARE Data Set, and the MDS. These videos, ranging from 4-12 minutes, are designed to provide targeted guidance using simulated patient scenarios. To access the videos, click on the links below:
    - [Coding GG0110. Prior Device Use with Information from Multiple Sources](#) (3:58)
    - [Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility](#) (11:56)
    - [Coding GG0130B. Oral Hygiene](#) (4:25)
    - [Coding GG0170C. Lying to Sitting on side of bed](#) (4:33)
  - AHCA’s Virtual PDPM Training is Now Available! Did you miss the in-person PDPM training in your state? Did you attend the training but feel like you could benefit from taking it again? AHCA’s [Virtual PDPM Training](#) can set your skilled nursing facility up for success.

AHCA’s [Virtual PDPM Training](#) prepares AHCA SNF members for PDPM and will mirror the in-person trainings that have been held for AHCA provider members in almost every state in recent months. The virtual training allows AHCA SNF members to learn about the critical steps necessary on the pathway to
success under PDPM. Included with the virtual training is access to all materials on AHCA’s PDPM Academy. The PDPM Academy is where updates, tools, webinars and other supporting materials are housed. AHCA SNF members who attend the Virtual PDPM Training will also be able to join in free monthly PDPM Academy webinars hosted by AHCA.

This training is available to AHCA SNF provider members only. The cost for the training – whether first time or repeated - is $350. The training has been approved for 8 NAB CE credits.

NOTE: Members will need to login with their AHCA/NCAL usernames and passwords. For assistance obtaining AHCA/NCAL usernames and passwords, please e-mail educate@ahca.org with your name and facility contact information.

- **Live webinar June 17th at 3pm ET - Strengthening Your Care Delivery Under PDPM – Deep Dive on LTC TeamSTEPPS**

In this PDPM Academy webinar, participants will learn about the Agency for Healthcare Research and Quality (AHRQ’s) teamwork and communication curriculum for nursing homes, TeamSTEPPS® 2.0 for Long Term Care and hear from AHCA members who have used TeamSTEPPS® 2.0 for Long Term Care. Teamwork has been found to be one of the key initiatives within patient safety that can transform the culture within health care. Patient safety experts agree that communication and other teamwork skills are essential for the provision of quality health care and for the prevention and mitigation of medical errors and of patient injury and harm. TeamSTEPPS is an evidence-based program aimed at optimizing performance among teams of health care professionals, enabling them to respond quickly and effectively to whatever situations arise and offers a solid basis for PDPM team work redesign.

Speakers:
- Margie Shofer, BSN, MBA Director, Patient Safety Program, Center for Quality Improvement and Patient Safety, AHRQ
- Sharon Kostboth Harper, SHRM-CP and PHR, Project Director, TeamSTEPPS and Resident Safety Initiative Consultant, Tealwood Senior Living
- Amanda Johnson RN, LNHA, CHC, Vice President of Clinical Operations, Chief Compliance Officer, Tealwood Senior Living.

- **AHCA Submits Comments on FY20 SNF PPS Proposed Rule**

10) **Telligen** reports:

- Telligen Weekly Digest – June 3, 2019
- Telligen Weekly Digest– June 17, 2019

11) The *Southern Illinoisan* reports Illinois Passes Budget to Increase Nursing Home Funding by $240 million. The *Southern Illinoisan* reported, Illinois lawmakers have passed a new budget that will increase funding “for nursing homes serving the state’s most vulnerable elderly populations" by $240 million next fiscal year. Of that total, "which will be split between the state and federal government, $70 million will be directly appropriated to help nursing homes meet minimum staffing requirements." Nursing home industry advocates "say the added funding will help stem a tide of 20-plus skilled- and intermediate-care facility closures that occurred over the past five years due to crippling budget cuts and decades-old Medicaid reimbursement rates."

12) The *South Florida Sun Sentinel* reports About 20% of Medicare Beneficiaries in Nursing Homes Who Went to the ER May Have Been Abused, Neglected, Analysis Indicates. The *South Florida Sun Sentinel* says that some "20 percent of Medicare beneficiaries in nursing homes who were transported to hospital emergency rooms in 2016 and treated for a variety of high-risk conditions had been potentially abused or neglected, a report released Wednesday by the federal government shows." Data also indicate "nursing homes failed to report many of the incidents to state health
care agencies as required by federal law." The article says, "Kristen Knapp, a spokeswoman for the Florida Health Care Association, an industry group, said nursing homes ‘fully support more transparent reporting,’” although "she said the current definition of neglect is ‘vague and creates confusion about what should be reported.” The HHS-OIG conducted the analysis.

13) Reuters reports, Falls are a Major Reason Elderly Patients Return to Hospital After Being Discharged, Study Indicates. Reuters reports that research indicates "when elderly patients are discharged, one of the major reasons they end up back in the hospital is that they’ve suffered a fall." Investigators found that, of "more than 8.3 million patients, age 65 and above, who were hospitalized in 2013 and 2014," nearly "14% of the patients were readmitted within 30 days of being discharged," about five percent of whom "were readmitted due to injuries caused by falling, making it the third leading cause of readmissions after blood poisoning due to bacteria and heart failure." The findings were published in JAMA Network Open.

14) MedicalXpress recently reported, Study Finds Over a Quarter of Adults Aged 50+ are Deficient in Vitamin D. Over a quarter of adults aged 50+ are deficient in vitamin D according to researchers from Trinity College Dublin who announced their findings today (Thursday, June 13). Over half (57%) had inadequate serum vitamin D levels, of which 26% were classed as vitamin D deficient. Vitamin D has a known role in bone health, with growing evidence for beneficial effects on muscle strength and other non-skeletal outcomes. The study was recently published in the international, peer-reviewed journal Nutrients.

15) HealthDay reports on a Study Says Immigration Crackdown Efforts to Impact Care for Elderly, Disabled. HealthDay reports that "immigration crackdown efforts, the border wall included, are very likely to cost the elderly and disabled the care that they desperately need, a new study argues." Over "3 million immigrants work in the U.S. health care system, accounting for about 1 in 4 people in that field, said lead researcher Dr. Leah Zallman, an assistant professor of medicine at Harvard Medical School," and "attempts to limit immigration will serve to further deplete a system that’s already struggling to find enough workers to care for the aging and infirm, Zallman said." Lindsay Schwartz, associate vice president of workforce and quality improvement at the American Health Care Association and National Center for Assisted Living, commented, "This study reinforces what we’ve been saying for years – foreign-born workers are an intricate part of the senior living workforce." Schwartz added, "Population projections indicate we have a surmounting challenge in having enough caregivers for our residents in the years to come. Therefore, the ability to recruit and train immigrants is key, and we support legislation that would help expand opportunities for migrants, ‘Dreamers’ and those with temporary protected status." The study was published in the journal Health Affairs.

16) ModernHealthcare reports, Many Older Adults Will be Priced Out of Long-Term Home Care, Study Finds. ModernHealthcare reports that some experts are warning that the "rising costs and demand for home health care services will make it less affordable for many older adults to pay for the services long term." Richard Johnson, Urban Institute senior fellow in the Income and Benefits Policy Center, said, "We’re already facing a crisis in terms of how to pay for long-term services and supports. ... It’s creating a real quandary for states." Johnson authored a study recently published in Health Affairs finding about "13% of adults pay for their care out-of-pocket, which will become more difficult to sustain due to the financial burden." According to HHS, about 69 percent of Americans will require long-term care services at some point in their lives for an average of three years.

17) Provider Magazine reports:

- FDA Considers Blister Packaging in Nursing Facilities to Reduce Opioid Abuse. Provider Magazine reported that the FDA is implementing new strategies under the SUPPORT Act to improve monitoring of "prescription opioids through the use of blister packaging" in nursing facilities. The agency "said it is focused on encouraging ‘right size’ prescribing of opioid pain medication as well as reducing the number of people unnecessarily exposed to opioids, while also ensuring appropriate access" for pain patients.

- CMS Unveils Final Rule to Improve Flexibility of PACE. Provider Magazine reports CMS has released a final rule that is its "first major update to the Programs of All-Inclusive Care for the Elderly (PACE) initiative since 2006,"
which the agency "said would give PACE providers greater administrative flexibility and regulatory relief." The rule "removes redundancies and eliminates outdated information," and, as CMS said, "finalizes several operational flexibilities for PACE organizations that will improve care and access for individuals enrolled in PACE."

- **SNF Occupancy Registers First Y-O-Y Increase Since 2015, Data Shows.** *Provider Magazine* provides coverage of the newest Skilled Nursing Report issued by the National Investment Center (NIC) for Seniors Housing and Care, which found "83.7 percent of skilled nursing facility (SNF) beds were occupied on average for the first quarter of 2019, marking the first time since January 2015 that average occupancy levels experienced a year-on-year gain." NIC Senior Principal Bill Kauffman "said the continued upward trend for the first three months of 2019 point to more than just the traditional uptick for flu season." He stated, "Occupancy was also up between March 2018 and 2019, suggesting supply and demand are becoming more closely aligned."

18) **Skilled Nursing News** reports:

- **HHS, DOJ Report Reveals Government Recouped $2.3 Billion in Medicare, Medicaid Fraud.** *Skilled Nursing News* reported that the Department of Health and Human Services and Department of Justice "last week released a joint report on their health care fraud activities for the previous fiscal year," finding that the government "recovered $2.3 billion in allegedly fraudulent health care reimbursements in fiscal 2018." That sum "included $1.2 billion in Medicare recoveries, along with $232 million in Medicaid money transferred back to the federal treasury" and "about $47 million in skilled nursing recoveries last fiscal year, driven primarily by a $30 million settlement with operator Signature HealthCARE over allegations of improper or unnecessary rehabilitation reimbursements."

- **Some Nursing Homes Face Challenges in Providing Behavioral Health Services, Study Suggests.** *Skilled Nursing News* reports a new study led by a team from the University of Rochester School of Medicine and Dentistry found providing "even basic behavioral health (BH) services was rated as ‘difficult’ or ‘very difficult’ at 20% to 40% of all nursing facilities nationwide." Researchers wrote in the study, published in the June issue of the *Journal of the American Geriatrics Society*, "Almost half reported that lacking appropriate staff education was an obstacle in providing BH services, and at least one third were not able to adequately meet residents’ BH needs."

- **CMS “Just Getting Started” on Nursing Home Oversight Amid “Secret” List Controversy.** The federal government again defended its work to regulate and punish underperforming nursing homes, as the controversy surrounding a “secret” list of troubled skilled nursing facilities entered its third day. CMS chief medical officer Kate Goodrich confirmed a report that the agency will soon begin releasing a monthly list of candidates for inclusion in the Special Focus Facility program — while also touting the transparency of its existing data.

19) **McKnight’s** reports:

- **Provider Groups Criticize CMS’ Decision to Downgrade Nursing Facility Scores.** *McKnight’s Long Term Care News* reports that "a decision by the government to downgrade nursing facility scores with little explanation is a disservice to both operators and consumers, provider groups alleged." CMS "defended the late-April move by insisting scores were lowered at facilities where staffing levels were inadequate. But the sector isn’t buying it." David Gifford, M.D., senior VP for quality at the American Health Care Association, said, "By moving the scoring ‘goalposts’ for two components of the Five-Star system, CMS will cause more than 30 percent of nursing centers nationwide to lose one or more stars overnight – even though nothing changed in staffing levels and in quality of care."

- **Nursing Home Workers Applaud Illinois Law Mandating Staffing Levels.** *McKnight’s Long Term Care News* reports nursing home employees are "cheering" the passage of a bill in Illinois "that will penalize providers who under-staff their facilities, and in what might be a surprise to some, operators are also taking a supporting position on it." The new law "fines nursing homes that don’t meet the state’s required 2.5 hour daily direct care level," and according to the article, "The Illinois Health Care Association said it was generally in favor of the bill – in its final
form." IHCA Executive Director Matt Harman said, "It will allow the state to regulate in a way that it should have been doing since the previous reform bill," adding, "With the removal of some of the most punitive components, IHCA’s position switched to one of passive support. ... But we remain cautious because of the subjective nature of how DPH [the Department of Public Health] has historically regulated centers."

- **US Population of Adults 85 and Older to Increase 123 Percent by 2040, Report Finds.** McKnight’s Senior Living reports that the federal Administration for Community Living released an analysis indicating that the US population "aged 85 or more years is projected to more than double by 2040, increasing from 6.5 million in 2017 to 14.4 million in 2040" – an increase of 123 percent. The report also indicates the "population aged 65 or more years has increased 34% over the past 10 years, going from 37.8 million in 2007 to 50.9 million in 2017, or to 15.6% of the overall population." In addition, the population of adults aged 65 and older "is projected to reach 80.8 million by 2040 – doubling from 2000 and representing 21.6% of the overall population – and 94.7 million in 2060, according to the authors."

- **More Hospital Admissions Than Previously Thought May be “Unavoidable,” Study Suggests.** McKnight’s Long Term Care News reported that a new study to published in July’s Journal of Nursing Care Quality suggests injuries, "infections, behavioral incidents and family insistence often drive hospital admissions among nursing home residents," and "many of those transfers may be unavoidable." The findings "highlight the challenges faced by 16 Missouri nursing homes participating in a CMS-backed initiative to reduce hospitalizations," a program through which CMS in 2018 "began docking reimbursement by up to 2% for SNFs with poor 30-day readmission rates back to hospitals." The study indicates that over 20 months, the facilities "managed to reduce hospitalizations by 30% overall, but the interventions only netted a 17% reduction in unavoidable transfers."

- **About One-Third of LTC Directors “Ahead of the Curve” in Tech Innovation, Study Finds.** McKnight’s Long Term Care News reports in continuing coverage that the 2019 McKnight’s Mood of the Market Survey found about "one-third of directors of nursing and almost one-fourth of administrators say they feel ‘ahead of the curve’ when it comes to their ability to keep up with technology and innovation at work." In addition, "about the same percentages said they don’t trust their supervisors to get them ready for nursing homes’ future tech challenges." Overall, the survey found "more than 92% of respondents said they were personally either ‘ahead of the curve’ (28%) or ‘average’ (64.4%) when it comes to tech prowess at work."

**20) Interesting Fact:** It is well known that weather and mood are linked. Scientists have discovered the ideal temperature at which happiness peaks: 57.02 degrees Fahrenheit. Turn down the AC and be happy 😊.