Proposed CMS Rulemaking – Part 8
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 Administration (483.70), Quality Assurance and Performance Improvement (483.75), and Infection Control (483.80).

S. Administration (483.70)
c) Clarify that violations of other HHS regulations, as determined by the agency or entity with enforcement authority for those regulations, may result in a finding by CMS of non-compliance with the requirements of this Administration Section.

d)(2)(iii) New requirement that specifies that the Administrator reports to and is accountable to the governing body.

d)(3) New requirement that the governing body is responsible and accountable for the facility’s QAPI program.

e) New requirement to establish an annual facility assessment. The assessment must include, but not be limited to, activities such as determining staffing requirements, establishing a QAPI program and conducting emergency preparedness planning. This assessment would have to be facility and community-based, utilizing an all-hazards approach. The facility would have to review and update the assessment as necessary, but at least annually and whenever there was, or the facility planned for, any change that would require substantial modification to any part of the assessment. The facility assessment is required to address or include: facility population; staff competencies;
physical environment; ethnic, cultural and religious factors; facility resources; services provided; personnel; contracts; and health information technology.

i) This section is revised to better conform to the requirements of HIPAA and other confidentiality provisions.

j)(1)(i) Modify the current language to allow a practitioner other than the attending physician to determine that a hospital transfer is medically appropriate in an emergency situation and consistent with state law and facility policy.

j)(1)(ii) Modify the current language to require the exchange of information during a transfer in order to reduce the risk inherent to transitions of care and to promote improved resident outcomes.

n) Modification to the current binding arbitration agreement language. The agreement is to be explained to the resident in a form, manner and language that the resident can understand and the resident must acknowledge that he or she understands the agreement. The agreement must not contain language that prohibits or discourages a resident or any other person from communicating with federal, state or local officials. The agreement must be entered into by the resident voluntarily and provide for the selection of a neutral arbitrator and a venue convenient to both parties—the resident and the facility. CMS is soliciting comments to whether binding arbitration agreements should be totally prohibited.

p) Relocate the requirement for and qualifications of a social worker to this section and add “gerontology” to the list of human service fields.

q) Add the new requirement requiring facilities to submit staffing information based on payroll data in a uniform format.

T. Quality Assurance and Performance Improvement (QAPI) (483.75)
The new QAPI requirements do not replace the Quality Assessment and Assurance (QAA) Committee, but rather enhance and coordinate with the current QAA committee provisions.

a) New requirement that would require a facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program, reflected in its QAPI plan, which focuses on systems of care, outcomes and services for residents and staff.

a)(1) New requirement that the facility would maintain documentation and demonstrate evidence of its QAPI program.

a)(2) New requirement that the facility must submit its QAPI plan to the state agency or federal surveyor at the first annual recertification survey that occurs at least one year after the effective date of these regulations.

a)(3) New requirement that the facility present the QAPI plan to the state agency surveyor at each annual recertification survey and upon request to the state agency for federal surveyor at any other survey and to CMS upon request.

a)(4) New requirement that the facility present its documentation and evidence of an ongoing QAPI program upon request of a state agency, federal surveyor or CMS.

b) New requirement that the facility design its QAPI program to be ongoing, comprehensive and address the full range of care and services provided by the facility. It would have to utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a facility and reflect the complexities, unique care and services that the facility provides.
c) New requirements for QAPI program feedback, data systems and monitoring.

c)(1) New requirement to maintain effective systems to obtain and use feedback and input from direct care/direct access workers, other staff, residents, resident representatives and families to identify opportunities for improvement.

c)(2) New requirement that the systems, governed by appropriate policies and procedures, also include how the facility would identify, collect and use data from all departments, including how the information would be used to identify high risk, high volume or problem-prone areas.

c)(3) New requirement that facility policies and procedures include a description of the methodology and frequency for developing, monitoring and evaluating performance indicators.

c)(4) New requirement to require that the system, policies and procedures include process for identification, reporting, analysis and prevention of adverse events and potential adverse events or near misses.

d) New requirements for QAPI program systematic analysis and action.

d)(1) New requirement to require that the facility take actions aimed at performance improvement and, after implementing those actions, to measure the success of those actions and to track performance to ensure that the improvements are sustained.

d)(2) New requirement that the facility develop policies describing how they would use a systematic approach to determine underlying causes of problems impacting larger systems.

e) New requirement to establish requirements for program activities.

e)(1) – (3) New requirement that facility establish priorities for performance improvement activities that focus on patient safety; coordination of care; autonomy; choice; high risk; high volume; and/or problem-prone areas identified as a result of the facility assessment in 483.70(e). Require that performance improvement activities track medical errors and adverse resident events, analyze their causes and implement preventative actions and mechanisms that include feedback and learning throughout the facility. QAPI program activities would be required to include Performance Improvement Projects (PIPs). CMS proposes that each facility would be required to implement at least one PIP annually that focused on a high risk or problem prone area identified through the required data collection and analysis.

f) New requirement that the facility ensure, through the governing body or executive leadership, that an ongoing QAPI program is defined, implemented and sustained during transitions in leadership and staffing and that the QAPI program is adequately resourced, including staffing time, equipment and technical training as needed. The governing body or executive leadership would have to ensure that the QAPI program identified and prioritizes problems and opportunities based on performance indicator data; resident and staff input that reflected organizational processes, functions and services provided to residents; that corrective actions addressed gaps in systems and were evaluated for effectiveness; and that clear expectation were set around safety, quality, rights, choice and respect.

g)(1) Revise current QAA language to clarify that the QAA committee membership requirements are a minimum requirement. Facilities may, at their discretion, include additional individuals on the QAA committee.

g)(2) Revise to specify that the QAA committee report to the facility’s governing body, or designated persons functioning as a governing body, regarding activities, including implementation of the new QAPI program. Further specify that the QAA committee coordinate and evaluate activities under the QAPI program, including performance improvement projects, and that the QAA committee review and analyze data collected under the QAPI program as
well as data from pharmacists resulting from monthly drug regimen reviews and the resulting reports as not in proposed 483.45(c)(4).

h) New requirement to address disclosure of information.

h)(1) Move existing regulation 483.75(o)(3) to 483.75(h)(1) regarding disclosure of records to the state or CMS.

h)(2) New requirement to clarify that facilities, in order to demonstrate compliance with the requirements of this section, may be required to disclose or provide access to certain QAPI information. Specifically, CMS would require, to the extent necessary to demonstrate compliance with the requirements of this section, access to systems and reports demonstrating systematic identification, reporting, investigation, analysis and prevention of adverse events; documentation demonstrating the development, implementation and evaluation of corrective actions or process improvement activities; and other documentation considered necessary by a state or federal surveyor in assessing compliance.

U. Infection Control (483.80)
Each of the current infection control requirements remain important; however, as a result in advances in the study and practice of infection prevention and control and given impact of health care-associated infections (HAIs), CMS finds that the current requirements for infection control warrant updating and strengthening.

a) New requirement specifying the elements of the infection prevention and control program (IPCP).

a)(1) CMS is requiring that the IPCP follow accepted national standards, be based upon the facility assessment conducted according to proposed 483.70(e) and include, at a minimum, a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement.

a)(2) CMS is requiring written standards, policies and procedures for the IPCP, including but not limited to, a system of surveillance designed to identify possible communicable disease or infections before it can spread to other persons in the facility; reporting requirements for possible incidents of communicable disease or infections; standard and transmission-based precautions to be followed to prevent spread of infections; circumstances in which generally, isolation should be used for a resident; the circumstances under which the facility must prohibit employees with a communicable disease of infected skin lesions from direct contact with residents or their food, if the contact is likely to transmit the disease; and the hand hygiene procedures to be followed by all staff as indicated by professional practice. Facility would be required to train staff to the IPCP.

a)(3) New requirement that the facility’s IPCP must also include an antibiotic stewardship program that included antibiotic use protocols and systems for monitoring antibiotic use and recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

b) New requirement that the facility must designate an infection prevention and control officer (IPCO) who is responsible for the IPCP and who has received specialized training in infection prevention and control. CMS is requiring that the IPCP be a major responsibility for the individual assigned as the facility’s IPCO. CMS is also requiring that the IPCO be a healthcare professional with specialized training in infection prevention and control beyond their initial professional degree.

c) New requirement that the IPCO be a member of the facility’s QAA committee.

d) CMS is revising/eliminating the pneumococcal immunization requirement with regard to the 2nd pneumococcal immunization.

f) New requirement that the facility review its IPCP annually and update the program as necessary.
The next edition of *Regulatory Beat* will focus on **Compliance and Ethics Program (483.85)**, **Physical Environment (483.90)** and **Training Requirements (483.95)**.

**Are You Fully Using AHCA’s Trend Tracker Tool?**

LTC Trend Tracker℠ is a web-based tool that enables long term and post-acute care providers to access key information that can help their organization succeed. This exclusive benefit for AHCA members, allows skilled nursing organizations to benchmark personal metrics to those of their peers and examine ongoing quality improvement efforts. LTC Trend Tracker is AHCA members’ one-stop-shop to gain timely information and valuable insight about their own performance as well as the entire profession’s.

**Behold the Power of Information**

With just a few clicks of a button, LTC Trend Tracker gives you access to government data collected by the Centers for Medicare and Medicaid Services (CMS) on skilled nursing centers – providing you with one central hub for all your reporting needs. Use the Dashboard to quickly see how you are trending on key metrics compared to your peers. Quickly download reports to share and engage staff members as well as area providers to build partnerships.

**Enhance Your Commitment to Quality**

Improving quality care is a journey, and LTC Trend Tracker is the tool you need to ensure your organization stays on track. Monitor your progress on quality measures, Five-Star, AHCA Quality Initiative goals, hospital readmission rates and more. Identify areas your organization should address in order to improve and set your own performance targets. Demonstrate your dedication to quality to your patients and residents with verifiable results.

**Gain a Competitive Edge**

Monitoring only your own performance isn’t enough to stay relevant in today’s long term and post-acute care market. LTC Trend Tracker provides information on fellow providers from a local, regional and national perspective, so you can see how you measure up (individual organization’s information stays private; LTC Trend Tracker only reports in the aggregate). Benchmark yourself to those of your peers and keep your organization ahead of the curve.

**Take Advantage of Your AHCA Membership**

More than 6,000 skilled nursing centers have signed up to use LTC Trend Tracker – at no additional cost to their organization. You must be an AHCA member to access this valuable resource. If you’re not a member of AHCA, [learn how to sign up](#).

**Features**

**Reports**: LTC Trend Tracker℠ allows you to generate as many reports as you wish. Perhaps you are working on the goals of the Quality Initiative or wanting to demonstrate the value your center provides to external parties. You can generate reports with a variety of data to see how your center measures up and how you compare with other centers in your state. Those reports can then be used to collaborate with your staff and in your marketing outreach, among other ways.

LTC Trend Tracker also provides users with the ability to save reports, once designed, so that you can come back and re-run the same report at a future time quickly and easily. Two options are available – scheduling reports and saving reports. [Click here](#) to learn more.

**Reports Offered in LTC Trend Tracker**

- Five-Star Reports
  - Overall Rating Report
  - Staffing Rating Report
  - Quality Measure Report
- Nursing Home Compare (CMS) Quality Measures Report
• AHCA Quality Measures
  o AHCA Hospital Readmissions Report
  o AHCA Discharge to Community Report
• CASPER Reports
  o Citation Reports: Combined Health Survey
  o Citation Reports: Complaint Health Survey
  o Resident Report
  o Staffing Report
• AHCA Staffing Turnover and Retention Report
  o Cost Report
  o Medicare Utilization Report
  o Quality Initiative Recognition Program Report

Measures
LTC Trend Tracker not only pulls CMS-reported data into one central location for users, but includes exclusive measures for members developed by AHCA or partners.

• *Discharge to Community Measure* – Based on MDS 3.0 data, this measure determines the percentage of all new admissions from a hospital who are discharged back to the community (non-clinical settings) and remain out of any skilled nursing center for the next 30 days. This information allows users to compare their center to other centers and can help centers in their negotiations with hospitals, Managed Care organizations, and others. It can also tell users if they are sending more or fewer individuals back to the community than expected given the clinical characteristics of the population of individuals admitted to their center. Click here to learn more.

• *Hospital Readmissions Measure* – Developed by PointRight, Inc. and made available to AHCA, PointRight® Pro 30™ calculates 30-day, risk-adjusted hospital readmission rates for skilled nursing centers. PointRight® Pro 30™ uses MDS 3.0 data, giving providers access to rehospitalization data within four to six months of submitting their information to CMS – the fastest any of hospital readmission measure currently available. This measure can help centers stay on track with AHCA’s Quality Initiative hospital readmissions goal and prepare providers for the value-based purchasing program to be developed by CMS. Click here to learn more.

Dashboard
As soon as you login to LTC Trend Tracker, you can access the Dashboard and see a snapshot of your organization compared to your peers... all on one screen. The Dashboard is a summary of selected reports in the LTC Trend Tracker system. Instantly review how you're trending with Five-Star, AHCA Quality Initiative goals, survey, post-acute care and more. Click here for more information.

CoreQ is now available on LTC Trend Tracker!
The AHCA/NCAL new customer satisfaction measure, the CoreQ is now available to upload in LTC Trend Tracker. AHCA/NCAL has developed this short customer satisfaction questionnaire in order to have a satisfaction quality measure for use as part of the AHCA/NCAL Quality Initiative. This questionnaire has been independently tested as a valid and reliable measure of customer satisfaction across long term care providers. No other measure like this exists and AHCA/NCAL is pleased to share this with our members.

For more information about this questionnaire and satisfaction measure you can visit the AHCA or NCAL Quality Initiative website. AHCA/NCAL is working with many of the customer satisfaction vendors to add the 3-4 CoreQ questions to their existing questionnaires or administer just the CoreQ questionnaire. A list of vendors who have added the CoreQ to their questionnaires can be found at the AHCA and NCAL Quality Initiative websites. If you do not see your vendor listed, we encourage you to ask them to add these questions to their questionnaire or to contact Lindsay Schwartz (lschwartz@ncal.org) if they have questions. If you don’t currently use a vendor to collect customer satisfaction, don’t worry you can still participate and find information on our Quality Initiative websites.
**Trending Statistics**

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

**New Report: Health Care Spending Grew 3.4 Percent in 2014, With More Dollars Going to Brand Drugs**

Spending on health care for the privately insured in the United States grew at a steady rate over the past five years, increasing 3.4 percent in 2014, finds a new report from the Health Care Cost Institute (HCCI). Use of health care services continued to fall in 2014, while prices for all categories of services continued to rise. Despite a nearly 16 percent decrease in use of brand prescriptions, spending on these prescriptions jumped by $45 per capita in 2014—an increase four times larger than in 2013. Much of this increase was due to use of high-priced Hepatitis C drugs Olysio, Sovaldi and Harvoni, which became available starting in late 2013.

HCCI’s [2014 Health Care Cost and Utilization Report](#) analyzes the health care spending trends for Americans younger than age 65 and covered by employer sponsored insurance (ESI) for the years 2010 through 2014, and provides a detailed look at components of health care cost growth for 2014. Over the five year study period, per capita spending growth was relatively steady, rising between three and four percent in each year. In 2014, health care spending averaged $4,967 per person, up $163 (3.4 percent) from the year before. Out-of-pocket spending grew 2.2 percent to $810.

---

**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 16-02 – CLIA**: Advanced Notification: Revisions to State Operations Manual (SOM), Appendix C – Survey Procedures and Interpretive Guidelines for Laboratories and Laboratory Services. The Clinical Laboratory Improvement Amendments (CLIA) Individualized Quality Control Plan (IQCP) procedure in the revised SOM will supersede the IQCP procedure in S&C 13-54. Revisions include the removal of Equivalent Quality Control (EQC) in the Interpretive Guidelines for §493.1256(d) and the insertion of IQCP in the Interpretive Guidelines for §493.1256(d). The IQCP Education and Transition Period will conclude on 2015-12-31. The IQCP effective date will be 2016-01-01.

3) **Federal CMS/HHS released several notices/announcements since the last issue of Regulatory Beat.** They include:
   - **CMS Finalizes Bundled Payment Initiative for Hip and Knee Replacements** ([click here](#)). Model supports quality and care improvements for patients’ transition from surgery to recovery. In 2014, more than 400,000 Medicare beneficiaries received a hip or knee replacement, costing more than $7 billion for the hospitalizations alone. Despite the high volume of these surgeries, quality and costs of care for these hip and knee replacement surgeries still vary greatly among providers. For instance, the rate of complications, like infections or implant failures, after surgery can be more than three times higher for procedures performed at some hospitals than others. And the average total Medicare expenditure for surgery, hospitalization, and recovery ranges from $16,500 to $33,000 across geographic areas. CMS finalized the Comprehensive Care for Joint Replacement (CJR) model, set to begin on April 1, 2016, which will hold hospitals accountable for the quality of care they deliver to Medicare fee-for-service beneficiaries for hip and knee replacements and/or other major leg procedures from surgery through recovery. Through this payment model, hospitals in 67 geographic areas will receive additional payments if quality and spending performance are strong or, if not, potentially have to repay Medicare for a portion of the spending for care
surrounding a lower extremity joint replacement (LEJR) procedure. This model furthers the administration’s commitment to create a health care system that provides better care, spends health care dollars more wisely and makes people healthier. It builds on measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients.

- **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.

- A revised [Skilled Nursing Facility Prospective Payment System](#) Booklet is available. Learn how facilities are paid for Skilled Nursing Facility (SNF) services, including:
  - Elements of the SNF Prospective Payment System
  - SNF Quality Reporting Program
  - SNF Value-Based Purchasing Program

4) The Illinois Department of Healthcare and Family Services (HFS) released two Provider Notices since the last issue of [Regulatory Beat](#). They were:

- **Annual Rate Changes for Participating Hospice Providers, Effective October 1, 2015.** CMS recently notified the Department of the annual update of Medicaid hospice rates for federal fiscal year 2016. Medicaid hospice rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the Social Security Act, which also provides for an annual increase in payment rates for hospice care services. Revised rates for continuous home care, inpatient respite care, and general inpatient care will be effective for claims with dates of service from October 1, 2015 through September 30, 2016. **The revised rate for routine home care is effective for claims with dates of service from October 1, 2015 through December 31, 2015.** The Department will provide additional information at a later date regarding future rate changes for routine home care.

- **Claims Processing Systems Issues.** HFS is experiencing the following system problems. Once the system problems have been resolved, they will notify the providers by updating this website. If your question is not answered by the HFS Claims Processing System Issues informational pages, please send your question to HFS via: [Email HFS Claims Processing System Issues](#). The links will provide you with the most current system issues that the department is experiencing as well as information regarding resolutions.

5) The Agency for Healthcare Research and Quality (AHRQ) recently published a study that states that flu vaccines in nursing homes save thousands of lives each year. Effective influenza vaccines in U.S. nursing homes save about
2,560 lives and prevent more than 3,200 hospitalizations annually, according to an AHRQ-funded study. Researchers studied more than 1 million Medicare fee-for-service, long-stay nursing home residents between 2000 and 2009. With well-matched vaccines, deaths dropped by an estimated 2 percent; pneumonia/influenza hospitalizations dropped 4.2 percent. Authors concluded influenza vaccination is an important strategy for preventing both flu and pneumonia in these elderly adults. The study, “Estimating the Effect of Influenza Vaccination on Nursing Home Residents’ Morbidity and Mortality,” appeared online August 17 in the Journal of the American Geriatrics Society. Read the abstract.

6) Telligen Upcoming events can be found at https://www.telligenqinqio.com/.

7) U.S. News and World Report reports that Medicare has set the 2016 “Part B” premiums (click here). Most Medicare beneficiaries will keep paying the same monthly premium ($104.90 per month) for outpatient care next year, the Obama administration said Tuesday. But new beneficiaries will pay a larger amount ($121.80 per month), and upper-income retirees are looking at considerably higher charges. Separately, all beneficiaries face a $19 increase in the Part B deductible — the amount they pay for outpatient care each year before Medicare kicks in. That's rising to $166 next year, from the current $147 — the first such increase since 2013.

8) The New England Journal of Medicine recently published an article on Elder Abuse (click here). Although it has probably existed since antiquity, elder abuse was first described in the medical literature in the 1970s. Many initial attempts to define the clinical spectrum of the phenomenon and to formulate effective intervention strategies were limited by their anecdotal nature or were epidemiologically flawed. The past decade, however, has seen improvements in the quality of research on elder abuse that should be of interest to clinicians who care for older adults and their families. Financial exploitation of older adults, which was explored only minimally in the initial studies, has recently been identified as a virtual epidemic and as a problem that may be detected or suspected by an alert physician.

9) Tech Times recently published an article entitled, “Experimental Alzheimer's Drug Shows Anti-Aging Effects.” Scientists at the Salk Institute for Biological Studies in California have developed an experimental medication that can help address the effects of Alzheimer's disease by slowing down the aging process.

10) HealthDay recently published two articles of interest. They were:
   • Widely Used Antibiotics May Raise Heart Risks. A widely used class of antibiotics is associated with a small but measurable increased risk of sudden cardiac death, researchers report. These antibiotics -- called macrolides -- are used to treat infections such as pneumonia, bronchitis and some sexually transmitted diseases.
   • Failing Sense of Smell Might Be Alzheimer’s Warning. Losing your sense of smell may mark the start of memory problems and possibly Alzheimer's disease, a new study suggests. Researchers found that older adults who had the worst smell test scores were 2.2 times more likely to begin having mild memory problems. And if they already had these memory problems, they were more likely to progress to full-blown Alzheimer's disease, said lead researcher Rosebud Roberts, a professor of neurology at the Mayo Clinic in Rochester, MN.

11) CNN recently reported that “Alzheimer's is a Younger Person’s Disease – So Get To Work.” Isaacson runs one of the few Alzheimer's prevention clinics in the country, and he also stresses the need to look at the disease holistically. "We now have research that shows very specific types of exercise, brain stimulation, taking control of diabetes, even in the pre-diabetes phase, can all make a difference."

12) Medical News Today recently published a couple of articles of interest. They were:
   • Could a Commonly Prescribed Antibiotic Worsen MRSA Infections? The global medical community has witnessed a rise in antibiotic-resistant "superbugs" as the use of antibiotics has increased. But now, a new study suggests that certain antibiotics are not only ineffective at treating such infections, but they can also
potentially make the patient even sicker.

- **Antibiotic Prescribing for UTIs Improves With Intervention.** Around the world, health care professionals have cautioned that antimicrobial resistance poses an immediate threat; meanwhile, the overuse and overprescribing of antibiotics is contributing to the problem. Now, a new initiative that aimed to improve prescribing of antibiotics for urinary tract infections has proven effective, suggesting future interventions like this one could be key.

13) *Nursing Times* recently reported that “**Dementia And Diabetes Increase Risk of Elderly Dehydration.**” Older people in care homes with dementia, diabetes and kidney problems are at most risk of dehydration, according to UK researchers.

14) *The New York Times* recently published an article entitles, “**IMS Health: Drug Spending to Jump 30% to $1.3 Trillion in 2020.**” As criticism of soaring prescription drug prices in the U.S. grows, global spending on medicines is expected to rise 3 percent to 6 percent annually for the next five years, according to a new forecast from IMS Health. The health data firm predicts global spending will increase by about 30 percent cumulatively from about $1 trillion now to about $1.3 trillion in 2020, driven by expensive new drugs, price hikes, aging populations and increased generic drug use in developing countries. The increase would be higher but for a huge, looming wave of patents for expensive brand-name pills expiring over that stretch, allowing cheaper generic versions to then enter the market.

15) *MedlinePlus* published several articles of interest. They include:

- **U.S. Adult Smoking Rate Dips Below 15 Percent: CDC.** Fewer Americans smoke than a decade ago, and those who still light up do so less often, federal health officials reported Thursday. Less than 17 percent of adults said they smoked in 2014, down from nearly 21 percent in 2005, a U.S. Centers for Disease Control and Prevention report reveals. And the average number of cigarettes smoked daily fell from nearly 17 to fewer than 14 by 2014.

- **Physical Fitness Linked to Mental Fitness in Seniors.** Connections between different parts of the brain weaken with age, but new research suggests that being physically fit can boost long-term brain function. A study from the University of Illinois at Urbana-Champaign found that age-related differences in the brains of older adults varied, depending on their level of aerobic endurance. The researchers found greater fitness is associated with stronger brain connections later in life. However, the study did not prove a cause-and-effect relationship between the two.

- **Nearly Half of Americans With High Blood Pressure Not Controlling It: CDC.** Nearly half of Americans with high blood pressure are not properly controlling their condition, increasing their risk of heart attack, stroke and heart disease, a new government report shows. About 47 percent of people with high blood pressure have not brought their numbers to a normal range, through either lifestyle changes or medications, according to data published Nov. 12 from the U.S. Centers for Disease Control and Prevention.

- **Adult Obesity Still Growing in U.S., Youth Rates Hold Steady: CDC.** Although obesity rates continued to climb among U.S. adults over the past decade, they stabilized for children and teens, federal health officials reported Thursday. More than 36 percent of adults and 17 percent of America's kids were obese between 2011 and 2014, said researchers from the U.S. Centers for Disease Control and Prevention. These are the latest years for which national statistics are available.

16) *McKnight's* also published several articles of interest. They include:

- **OIG Work Plan Targets SNF Therapy Billing, Background Checks.** The U.S. Department of Health and Human Services Office of Inspector General will take aim at the payment system for skilled nursing facilities as part of its *Fiscal Year 2016 Work Plan*. The plan includes a review of the prospective payment system for SNFs and the documentation requirements for claims paid by Medicare. OIG also plans to review whether claims
by SNFs were paid “in accordance with Federal laws and regulations,” following its September report blasting therapy overbilling. The 2016 work plan, which was released last week, also includes plans to report on the progress of the National Background Check Program for long term care employees who have direct patient access.

- **Medicaid Final Rule Aims to Improve Access, Transparency.** CMS has released its final rule on Medicaid, which will include state requirements to review access plans for beneficiaries. The rule reflects the White House’s goal to ensure those under Medicaid will have access to services. States will be required to evaluate how proposed rate reductions and payment restructuring would impact the program, and establish ways for beneficiaries and providers to give input, including surveys and hotlines. Under the final rule, new structures will assist the federal government in making “better informed, data-driven decisions” that support care delivery services, structures and payment methods, the agency said in a late October press release. The rule will also help CMS “ensure Medicaid payment rates are consistent with efficiency, economy and quality and care,” the agency said. The original rule was first proposed in 2011.

- **RAC Document Request Limit to Drop.** The number of medical records a recovery audit contractor can request from a provider will take a serious hit starting January 1. The new annual additional document request limit, released by CMS, is 0.5 percent of a health care facility's total amount of paid Medicare claims from the previous year. The current limit is 2 percent of all paid claims. RACs use the requested documents to support claims that are being audited. The update follows previous measures from CMS to slowly phase out RACs. A report published earlier this month revealed quality improvement organizations are now handling inpatient status reviews, and RACs won’t conduct any future inpatient reviews unless they’ve received a referral from a QIO.

- **Budget Bill Includes CMP Increase.** A provision included in the Bipartisan Budget Act of 2015 that would double the maximum amount civil monetary penalties for providers has one leading healthcare organization crying foul. Under the provision, facilities governed by the Social Security Act or the Occupational Safety & Health Administration would no longer be exempt from a 1996 law that requires federal agencies who impose CMPs to increase those fines each year in accordance with the consumer price index. Currently, the maximum CMP for healthcare providers is capped at $10,000 per day for each day a facility is out of compliance. Without that cap, which was put in place by the Nursing Home Reform Act of 1987, the maximum per day fine would rise to $20,626. Although the maximum fines are reserved for the “most egregious” offenders, providers should be aware that CMPs will increase — up to 150 percent — across the board, Lyn Bentley, senior director of regulatory services for the American Health Care Association, told McKnight’s recently. Without the cap on maximum CMPs, those fines will be updated annually as the CPI changes.

17) **Interesting Fact:** In 2014, there were 19.3 million veterans in the U.S.