Proposed CMS Rulemaking – Part 9 – FINAL SEGMENT

My ongoing plan was, over the previous issues of Regulatory Beat, to take the various sections of the new CMS proposed rulemaking and explain the major/significant changes. I did this from the regulatory side, but you as providers, need to determine if the new or modified provisions are workable and can be implemented within your facility. 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. It is believed that CMS will implement these new requirements in stages as opposed to all at one time.

This CMS proposed rule would revise the requirements that Long-Term Care facilities must meet to participate in the Medicare and Medicaid programs. 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 last segment will focus on Compliance and Ethics Program (483.85), Physical Environment (483.90), and Training Requirements (483.95).

V. Compliance and Ethics Program

This is a totally new section. The Affordable Care Act (ACA) requires the operating organizations for SNFs and NFs to have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil and administrative violations under the Act and in promoting quality of care consistent with regulations developed by CMS. The current regulations do not address this provision.

a) This new subsection adds definitions for compliance and ethics program; high-level personnel and operating organization for the purposes of this section.

b) New requirement that the operating organization for each facility, beginning on the first year after the effective date of the final rule, must have in operation a compliance and ethics program that meets the requirements of this section.

c) New requirement that the operating organization for each facility be required to develop, implement and maintain an effective compliance and ethics program that contains several components noted below.
c)(1) New requirement that the operating organization must establish its own written compliance and ethics standards, policies and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil and administrative violations under the ACA and which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization’s entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers’ expected roles.

c)(2) New requirement that the operating organization would assign the specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization’s compliance and ethics program’s standards, policies and procedures.

c)(3) New requirement that the specific individuals designated with oversight responsibility have sufficient resources (human and financial) and authority to assure compliance with these standards, policies and procedures.

c)(4) New requirement that the operating organization would be required to use due care not to delegate discretionary authority to individuals whom the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil or administrative violations under the ACA.

c)(5) New requirement that the operating organization would be required to effectively communicate the standards, policies and procedures in the operating organization’s compliance and ethics program to the operating organization’s entire staff including individuals providing services under a contractual arrangement and volunteers.

c)(6) New requirement that the facility takes reasonable steps to achieve compliance with the program’s standards, policies and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil and administrative violations under the Social Security Act by any of the operating organization’s staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.

c)(7) New requirement that there is consistent enforcement of the operating organization’s standards, policies and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization’s compliance and ethics program.

c)(8) New requirement that after a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization’s program to prevent and detect criminal, civil and administrative violations under the Act.

d) New requirement that requires operating organizations that operate five (5) or more facilities must designate a compliance officer, and require that such individuals be designated as high-level personnel of the operating organizations with the overall responsibility to oversee the compliance and ethics program. In addition, the designated compliance officer should report directly to the governing body for the operating organization and there are to be designated compliance liaisons located at each of the operating organization’s facilities.

e) New requirement that the operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing and detecting violations under Act and in promoting quality of care.
W. Physical Environment (483.90)

(1) Revised requirement to add the resident’s individual assessment, including preferences and choices, as an element to consider in addition to the resident’s plan of care when considering the space and equipment requirements of the facility.

(2) Remove the term “essential” with regard to equipment so that all patient care equipment is maintained in a safe operating condition.

(3) New requirement that all facilities are specifically required to conduct regular inspection of all bed frames, mattresses and bed rails and to ensure that bed rails are compatible with the bed frame and mattress.

(1)(i) New requirement that new construction (after effective date of the final rule) allow no more than two residents per bedroom.

(1)(ii) New requirement that new construction (after effective date of the final rule) require that each resident room must have its own bathroom equipped with at least a toilet, sink and shower.

(1)(iii) New requirement that new construction (after effective date of the final rule) require that each resident room must have its own bathroom equipped with at least a toilet, sink and shower.

f) Revised requirement to allow flexibility with regard to a resident call system. The facility must be adequately equipped to allow residents to call for staff assistance through a communication system that relays the call directly to a staff member or to a centralized staff work area.

(5) New requirement that would require facilities to establish policies, in accordance with applicable federal, state, and local laws and regulations, regarding smoking, including tobacco cessation, smoking areas and safety, including but not limited to non-smoking residents.

X. Training Requirements (483.95)

This is a proposed new section that a facility must develop, implement and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. The facility is required to determine the amount and types of training necessary based on a facility assessment as specified at 483.70(e).

a) New requirement that a facility must include effective communications as a required training topic for direct care personnel.

b) New requirement that a facility must train staff members on the rights of the resident and the responsibilities of an LTC facility to properly care for its residents as set forth in 483.10 and 483.11, respectively.

c) New requirement that the facility must provide training its staff on the freedom from abuse, neglect and exploitation requirements found in 483.12.

d) New requirement that the facility must provide mandatory QAPI training to its staff.

e) New requirement that the facility must provide staff training as part of their efforts to prevent and control infection.

f) New requirement that facilities must include as part of their compliance and ethics program, training for staff that outlines the standards, policies and procedures; if five or more facilities, the training must be done annually.

g) New requirements for required in-service training for nurse aides.

(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(2) Include dementia management training and resident abuse prevention training.
g)(3) Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

h) New requirement that a facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a state-approved training program for feeding assistants, as specified in § 483.160.

i) New requirement that a facility must provide behavioral health training consistent with the requirements at § 483.40 and as determined by the facility assessment at § 483.70(e).

This is the last in the series of in-depth reviews of the proposed CMS Requirements of Participation (RoPs).

**Dementia Care Survey Tools**

According to a recent CMS Survey and Certification Letter (S&C 16-04), CMS is releasing information regarding the pilot project of the dementia focused surveys that took place in 2014 in order to examine the process for prescribing antipsychotic medications and assess compliance with other federal requirements related to dementia care practices in nursing homes. The pilot was initiated to gain new insights about surveyor knowledge and skills and ways that the current survey process may be streamlined to more efficiently and accurately identify and cite deficient practice. In 2015, the expansion project involved a more intensive and targeted effort to cite poor dementia care and the overutilization of antipsychotic medications, and broaden the opportunities for quality improvement among providers. Illinois was one of the pilot states for both the 2014 and 2015 pilot surveys.

In response to feedback from stakeholders and partners of the *National Partnership to Improve Dementia Care in Nursing Homes*, CMS is sharing the revised survey materials that were developed for the 2014 Focused Dementia Care Survey Pilot and 2015 expansion effort. **The intent is that facilities would use these tools to assess their own practices in providing resident care.**

[Click here](#) for the surveyor worksheets for the focused dementia care survey process/pilot (attached to the memo). The worksheets are divided into 4 parts:

**Part 1:** This section contains general nursing home characteristics.

**Part 2:** This section focuses on facility dementia care polices, leadership, training and documentation.

**Part 3:** This section focuses on quality assessment and assurance (QAA).

**Part 4:** This section is an extensive surveyor worksheet that was to be filled out for each dementia resident in the sample.

All of these parts give surveyors specific direction as to what F-tags to cite if there are deficiencies noted by the worksheets. CMS has not stated yet if these survey tools will be incorporated into annual surveys or whether they will continue as “special” surveys. **However, you can be sure that CMS will continue in this effort and will use these tools in some manner. Facilities need to use these tools to be assured that they will be in compliance when CMS or the state surveyors come for a facility visit.**
Trending Statistics

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

AHRQ Stats: Causes of Death
Heart disease remained the leading cause of death in the United States, followed by cancer and chronic lower respiratory disease, in 2010. Cancer was the leading cause of death for adults age 45 to 64, while accidents were the leading cause of death for adults age 25 to 44. (Source: Agency for Healthcare Research and Quality, 2014 National Healthcare Quality and Disparities Report, Chartbook on Effective Treatment.)

Rank of Leading Causes of Death by Age Group, 2010

<table>
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<tr>
<th>Cause of Death</th>
<th>Total</th>
<th>1-9</th>
<th>10-24</th>
<th>25-44</th>
<th>45-64</th>
<th>65+</th>
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<td>2</td>
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<tr>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<td>2</td>
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<tr>
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<td>4</td>
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<td>8</td>
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<td>3</td>
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<td>Respiratory Diseases</td>
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Important Rules, Regulations & Notices

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

- **S&C 16-03 – ESRD** – The ESRD Core Survey Data Worksheet has been updated for FY 2016 with current clinical indicators and corresponding national thresholds for facility comparison. CMS is providing the revised worksheet to ensure consistent administration of a standardized ESRD survey process and is requiring surveyor’s use of the ESRD Core Survey Data Worksheet for all recertification surveys of ESRD facilities.
**S&C 16-04 – Nursing Homes** – Focused Dementia Care Survey Pilot: CMS completed a pilot project in 2014 to examine the process for prescribing antipsychotic medications and assess compliance with other federal requirements related to dementia care practices in nursing homes. Additionally, it was initiated to gain new insights about surveyor knowledge and skills and ways that the current survey process may be streamlined to more efficiently and accurately identify and cite deficient practice. In 2015, the expansion project involved a more intensive, targeted effort to cite poor dementia care and the overutilization of antipsychotic medications, and broaden the opportunities for quality improvement among providers. In response to feedback from stakeholders and partners of the National Partnership to Improve Dementia Care in Nursing Homes, CMS is sharing the revised survey materials that were developed for the 2014 Focused Dementia Care Survey Pilot and 2015 expansion effort. The intent is that facilities would use these tools to assess their own practices in providing resident care.

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

- **ICD-10 Website Wheel Educational Tool — Revised**: A revised [ICD-10 Website Wheel](#) Educational Tool is available. Learn about ICD-10 through links to CMS web pages, including:
  - ICD-10-CM/PCS Frequently Asked Questions
  - Statute and Regulations
  - Medicare Fee-For-Service Provider Resources

- **CMS Program Statistics Website Now Available**: The CMS Program Statistics website replaces the former Medicare and Medicaid Statistical Supplement, which was published annually in electronic form from 2001-2013. The website will include over 100 detailed, easy-to-access data tables on national health care, Medicare populations, utilization and expenditures, as well as counts for Medicare-certified institutional and non-institutional providers. The first two sections, which include information on national health expenditures, life expectancy, population projections and Medicare enrollment and providers, have been released. Additional sections will be released on a rolling-basis. [CMS Program Statistics Website](#).

- **CMS Publishes Proposed Rule on Hospital Discharge Planning**: CMS proposed a revision to the requirements for discharge planning for hospitals participating in Medicare and Medicaid. The proposal includes requirements for medication reconciliation. Comments are due January 5, 2016.

3) The Agency for Healthcare Research and Quality (AHRQ) recently published several reports of interest. They include:

- **AHRQ Toolkit Helps Hospitals Reduce Catheter-Associated Urinary Tract Infections**: AHRQ released a new toolkit to help hospital staff prevent catheter-associated urinary tract infections (CAUTI) in patients and improve safety culture at the unit level. CAUTIs are health care-associated infections that cause suffering for approximately 250,000 hospital patients each year at a cost of about $250 million. CAUTIs are largely preventable, and stopping them can reduce the chance that hospital superbugs will develop resistance to overused antibiotics. The new [Toolkit for Reducing CAUTI in Hospitals](#) builds on the framework of the [core CUSP Toolkit](#) to help ensure that hospital teams adhere to [guidelines from the Centers for Disease Control and Prevention (CDC)](#). It includes checklists and modifiable teaching tools and resources to help clinical teams specifically address questions about whether catheters need to be used, and, if so, to place them safely and to remove them before patients develop infections. It also includes special resources for resident physicians and nurses in intensive care units and emergency departments. The toolkit is the latest in a series of AHRQ tools and training materials that help frontline providers go beyond the “what” of improving care to actually show them “how” to make changes in workflow processes to keep patients safer.

- **AHRQ Introduces First-Ever Readmissions Database**: AHRQ has introduced a new database, the [Nationwide Readmissions Database (NRD)](#), to analyze national hospital readmission rates. The NRD is the first all-payer nationwide database that supports tracking hospital readmissions, a critical health policy issue, thus addressing a major gap in health care data. Researchers, public health professionals, administrators, policymakers and clinicians will be able to use the new database in their analyses and decision-making. The
NRD is part of the AHRQ-sponsored Healthcare Cost and Utilization Project (HCUP), a group of related databases that includes information from administrative billing data. The value of the NRD is illustrated in a new HCUP Statistical Brief, which examines trends in hospital readmissions for four high-volume conditions: congestive heart failure, chronic obstructive pulmonary disease, heart attack and pneumonia. According to the statistical brief, there were 500,000 readmissions totaling $6.8 billion in aggregate hospital costs for those four conditions in 2013. HCUP includes the largest and most robust databases available of inpatient and outpatient care provided to patients in U.S. hospitals, including information on 97 percent of all U.S. hospital discharges. For information on the NRD, visit the HCUP User Support website.

- **AHRQ Report: Hospital-Acquired Conditions Continue To Decline, Saving Lives and Costs:** A new AHRQ report released by the Department of Health and Human Services shows that an estimated 87,000 fewer patients died in hospitals and nearly $20 billion in health care costs were saved as a result of reductions in hospital-acquired conditions (HACs) from 2010 to 2014. The report indicates that HACs were reduced by 17 percent in 2014, contributing to an overall reduction of 2.1 million HACs since 2010. A new infographic highlights important findings. To develop the report, Saving Lives & Saving Money: Hospital-Acquired Conditions Update, AHRQ analyzed the incidence of avoidable HACs compared with 2010 rates, using as a baseline estimates of deaths and excess health care costs that were developed when the Partnership for Patients was launched. AHRQ’s analysis included a number of HACs including adverse drug events, catheter-associated urinary tract infections, central line-associated bloodstream infections, pressure ulcers and surgical site infections, among others. AHRQ has produced a variety of tools and resources to help hospitals and other providers prevent hospital-acquired conditions, such as infections, pressure ulcers and falls. Recently the Toolkit for Reducing CAUTI in Hospitals was released, which is based on the experiences of more than 1,200 hospitals nationwide that participated in an AHRQ-funded project to apply the Comprehensive Unit-based Safety Program to reducing catheter associated urinary tract infections (CAUTI). This new report updates data released in December 2014.

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

- **Fiscal Year 2016 Long Term Care Provider Assessment** - Pursuant to Public Act 96-1530, long term care providers are to be assessed an amount equal to $6.07 times the number of occupied bed days due and payable each month. An "occupied bed day" is defined as the sum of all beds multiplied by the number of days during the month on which each bed was occupied by a resident, other than a resident for whom Medicare Part A is the primary payer. By law, this assessment cannot be billed or passed on to any resident of a nursing home.

- **Specialized Mental Health Rehabilitation Facilities (SMHRF) Provisional License** - In conjunction with the Illinois Department of Public Health (IDPH), this Notice provides information on the process for applying for provisional Specialized Mental Health Rehabilitation Facilities (SMHRF) licensure.

5) Telligen (Illinois QIO) Upcoming events can be found at https://www.telligenqinqio.com/.

6) Two items recently released by the American Health Care Association (AHCA) may be of interest to you. They were:

- Slides from the Care for Joint Replacement final rule WebEx are available here. By clicking “Register” you will get a link titled “Download Comprehensive Care for Joint Replacement (CJR) Final Rule” where you can download the slides directly.

- National Quality Forum Releases Measures Under Consideration List for Public Comment. On Friday, November 27, the National Quality Forum released a list of 133 Measures Under Consideration (MUC) for future rule-making in 2016, 12 of which are specific to the Skilled Nursing Facility (SNF) setting. This is a critical step in the CMS annual process which requires review and voting by the NQF Measure Applications Partnership (MAP) to arrive at a set of measures recommended for use in federal pay for performance and public reporting programs. Click here for the full memo.
7) MedicalXpress published an article entitled, “Drug-Resistant Bacteria Carried by Nursing Home Patients Focus of Study.” A Rhode Island Hospital and The Miriam Hospital study found that a small percentage of nursing home patients carrying multi drug-resistant bacteria are admitted to hospitals without showing symptoms caused by the bacteria. The research, published in the American Journal of Infection Control, highlights the importance of hospital and nursing home infection control practices.

8) The Senior Care Pharmacy Coalition released “New Avelere Health Study Reveals Substantial Variation in PDP/PBM Reimbursements for Most Commonly Prescribed Drugs in Long Term Care Settings.” Amid growing scrutiny of Pharmacy Benefit Manager (PBM) pricing practices, along with increasing concern from Congress, regulators and consumer groups about the rapid pace and broader implications of U.S. health sector mergers and consolidations, the Senior Care Pharmacy Coalition (SCPC) today released a new analysis of long term care (LTC) pharmacy transaction data.

9) The New York Times recently published an article entitled “New Diabetes Cases, at Long Last, Begin to Fall in the United States.” After decades of relentless rise, the number of new cases of diabetes in the United States has finally started to decline. The rate of new cases fell by about a fifth from 2008 to 2014, according to researchers at the Centers for Disease Control and Prevention, the first sustained decline since the disease started to explode in this country about 25 years ago.

10) Medical News Today recently published three articles of interest. They were:

   - Loneliness Alters the Immune System to cause illness, Study Finds. While previous research has demonstrated the negative impact loneliness can have on health, the mechanisms underlying this association have been unclear. Now, a new study sheds light on the issue, finding that loneliness can alter immune system cells in a way that increases susceptibility to illness.

   - Better Memory Linked to Physical Activity. The list of health benefits that accompany staying physically active is lengthy, but a new study suggests a further advantage; older adults who take more steps - either by walking or jogging - score better on memory tasks than their sedentary peers.

   - Yet Another Role for Aspirin. Aspirin and salicylic acid derivatives could help fight against a number of neurodegenerative diseases, according to new research published in PLOS One.

11) The Wall Street Journal reports “Risk of Off-Label Uses for Prescription Drugs.” About 12 percent of drugs doctors prescribe are for uses other than those approved by regulators, a recent study found. So-called off-label prescribing significantly raises the rate of negative side effects, the research showed.

12) Crain’s Detroit Business reports “Health Care Anchors Strong October Jobs Report.” The health care industry’s employment spree has continued into autumn with an increase of 44,900 jobs in October. Health care has now created almost 407,000 jobs so far in 2015, which almost equals the 410,000 jobs the industry added in 2013 and 2014 combined. Nearly 11 percent of all U.S. nonfarm jobs are now in health care.

13) HealthDay recently published an article entitled “Those in Their 50s Now Largest Group Battling Addiction to Narcotics: Study.” Older adults are now the largest age group seeking help in narcotic painkiller and heroin treatment programs, a study based in New York City found.

14) MedlinePlus had several articles of interest. They included:

   - Doctor’s Group Urges Greater Use of Generic Drugs. Whenever possible, doctors should prescribe generic drugs for their patients, the American College of Physicians suggests. Doing so could help patients save money, and might increase the odds that they’ll take their medications as directed, the national organization said.

   - Ah-Choo! Sneeze “Cloud” Quickly Covers a Room, Study Finds. Just in time for cold and flu season, a new study finds the average human sneeze expels a high-velocity cloud that can contaminate a room in minutes.
It's well known that sneezes can spread infectious diseases such as measles or the flu, because viruses suspended in sneeze droplets can be inhaled by others or deposited on surfaces and later picked up as people touch them.

- **Pricey Hepatitis C Drugs Denied to Almost Half of Medicaid Patients: Study.** Nearly half of Medicaid patients with chronic hepatitis C have been denied cutting-edge medications that would most likely cure their condition, due to tight controls that states have placed on coverage of the pricey drugs, a new study shows.

- **Why You Need Flexibility Exercises.** Flexibility exercises should be part of your regular workouts, an expert says. Effective fitness programs should include cardiovascular training, strength building and flexibility exercises, but the flexibility component is often overlooked, according to the American Academy of Orthopedic Surgeons. Including flexibility exercises in your workouts helps reduce back and joint pain, increases circulation, improves joint motion, boosts athletic performance and improves muscle health, he added.

- **FDA Approves First Flu Shot With Added Ingredient to Boost Immune Response.** The first flu vaccine with an adjuvant has been approved for use in seniors, the U.S. Food and Drug Administration said Tuesday. An adjuvant is any compound used in vaccines to boost the immune response of vaccinated people.

15) McKnight’s published several recent articles that may be of interest to you. They include:

- **CMS Seeks Comment on Two-Midnight Rule Following Court Decision.** CMS is seeking input on a section of its two-midnight policy that would cut inpatient payments to hospitals, after a judge ruled the cuts need to be better justified. CMS’s request for comment follows a September ruling by a federal judge that required the Department of Health and Human Services to reopen a portion of the two-midnight rule that would cut 0.2 percent from hospital inpatient payments.

- **Analysis: Observation Stays Skyrocket, Jeopardize SNF Admissions.** Recent decreases in hospital readmissions may be the result of more return visits being defined as observation stays, which leave many Medicare beneficiaries without nursing home coverage, the Wall Street Journal reports in an extensive analysis. The article illustrates for its business-focused consumer audience what long term care providers and other stakeholders have decried for several years: Observation stays, which often last as long and provide the same care as inpatient stays, can provide a loophole for hospitals that face penalties for having too many readmissions. Observation stays are outpatient visits, which typically disqualify a patient from receiving Medicare coverage for a nursing home stay.

- **Panel Issues Definition of “Person-Centered Care.”** A panel of eldercare experts has developed a definition for person-centered care that they believe addresses a lack of standardization and understanding of the term across the senior care continuum. The panel, organized by the American Geriatrics Society, released its definition for person-centered care on Tuesday. The updated definition stresses the importance of individuals' values, and a collaboration between the patient, their family and the provider. “‘Person-centered care' means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their healthcare, supporting their realistic health and life goal,” the definition reads. “Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires.”

- **OSHA Upps Workplace Violence Prevention Efforts.** New online resources may help prevent health care workplace violence, the Occupational Safety and Health Administration has said. New online resources may help prevent healthcare workplace violence, the Occupational Safety and Health Administration has said. Its new webpage, titled “Preventing Workplace Violence in Healthcare,” is set as a companion guide for OSHA's workplace violence guidelines, updated earlier this year. The resources include a summary of the issue of workplace violence, and a “Road Map,” which highlights real-world scenarios of violence prevention programs.
• **Improper Payment Rate for SNFs Jumps to 11 Percent.** The improper payment rate for skilled nursing facilities increased to 11.04 percent in 2015 largely due to insufficient documentation, a new report has shown. The U.S. Department of Health and Human Services' Fiscal Year 2015 Agency Financial Report found the improper payment rate for SNF claims rose by a net 60 percent, up from last year's improper payment rate of 6.94 percent. The primary cause for the increase was insufficient documentation, a “common” problem among skilled nursing facilities, the report noted. Medical necessity errors and administrative or coding errors also contributed to the rise.

• **GAO, AARP Report Slam “Disastrous” Prescription Drug Prices.** New reports from the Government Accountability Office and AARP are taking aim at increasing prescription drug prices and the potential burdens they pose to consumers and government programs. The report released by the GAO on Friday found that expenditures on new medicines in Medicare's Part B program were limited to a few drugs, typically biologics, which were “costly to beneficiaries.” The 20 most costly drugs amounted to 92 percent of the expenditures on new medicines covered by Part B in 2013, the report found. That amount translates to 26 percent of the total expenditures for Part B drugs.

• **HHS: Improper Medicaid Payments Almost Doubled Since 2013.** The rate of improper Medicaid payments has almost doubled over the past two fiscal years, according to a financial report from the Department of Health and Human Services. The rate of improper payments jumped from 5.8 percent in FY 2013 to 9.78 percent in FY 2015, the report found. The dramatic jump has been caused by compliance issues states are having with new provider enrollment and screening requirements implemented by the Affordable Care Act, said Patrick Conway, M.D., CMS’s Principal Deputy Administrator and Chief Medical Officer, in a blog post published last month.

• **LTC Liability Costs to Rise by 5 Percent for 3rd Straight Year.** Long term care facilities can expect their annual loss rate to increase by 5 percent over the course of 2016, according to a new report released Thursday by AHCA and Aon Global Risk Consulting. This is the third year in a row that the loss rate — the annual amount per occupied bed it costs to defend, settle or litigate claims — has increased by 5 percent. The loss rates have been steadily increasing since 2010, the report found. That increase will bump the annual loss rate for long term care facilities from $2,030 to $2,150 per occupied bed. That means a facility with 100 occupied beds should be prepared to pay upwards of $215,000 in liability expenses in 2016.

16) **Interesting Fact:** Bacteria cells in a human body outnumber human cells 10 to 1.