March 4, 2020 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!

Coronavirus Disease (COVID-19) Update

With the recent Coronavirus Disease (COVID-19) outbreak, we encourage you to prepare your facility and review/update your infection prevention and control plans and your emergency communication plan. COVID-19 was first detected in China in late 2019. As of today, the disease has been detected in 10 states across the nation, including at a SNF in Kirkland, Washington. At the Washington facility, 4 residents have been hospitalized and 3 have died. Multiple staff are presenting symptoms. The facility has restricted all visitors and closed to new admissions. They are working closely with their local health department and CDC is on-site conducting an investigation. Also, there have been several cases that detected in the Chicagoland area including Northwest Community Hospital in Arlington Heights.

COVID-19 has been identified to mainly spread via person-to-person contact through respiratory droplets between people in close contact, within six feet. Symptoms mock influenza including fever, cough, sore throat, aches, and shortness of breath. The population we serve is at greatest risk and those with chronic diseases and are immunocompromised (i.e. chronic steroids and chemotherapy). Treatment consists of clinical management including prompt implementation of recommended infection prevention and control measures and supportive care. There is no vaccine or antiviral medication at this time.

The CDC has updated guidelines specific to health care facilities. As a part of that, they will be hosting a webinar titled “Coronavirus Disease 2019 (COVID-19) Update—What Clinicians Need to Know to Prepare for COVID-19 in the United States.” The webinar is scheduled for Thursday March 5, 2020 at 1:00 CST, and you can register for it here.

During this COCA call, clinicians will learn what they can do to prepare for COVID-19 including identifying persons under investigation, applying infection prevention and control measures, assessing risks for exposures, optimizing the use of personal protective equipment supplies, and managing and caring for patients (inpatient and at home).

You can access the CDC COVID-19 website here for detailed information on the disease in long term care facilities. Please continue to monitor this resource as it will be updated as more information and resources become available.

AHCA also held a webinar on COVID-19 yesterday and is accessible here. You can access the AHCA/NCAL website for more information on the disease here. If a resident is presenting symptoms or your facility is in shortage of supplies you can contact DPH at 1-800-889-3931 or email DPH.SICK@ILLINOIS.GOV to have all your COVID-19 questions answered.
There are ways you can protect yourself at work and at home - and help prevent the spread of the virus in your area and facility. Please review the following information and resources to help you stay prepared.

**Protect yourself at work:**
- Advise all staff to wear their PPE diligently when appropriate. At this time, the CDC is not recommending use of PPE for workers who are not providing direct patient care.
- When it is appropriate, use social distancing from anyone displaying symptoms.
- Wash or sanitize your hands after every interaction with a resident or visitor.
- More stringent standards are called for if you have reason to suspect a possible cause, such as droplet precautions for the resident; full PPE for all staff within a six-foot radius; N95 masks; isolation gowns; and face/eye protection.
- If you suspect a possible coronavirus case, please report it to the Department of Public Health immediately.

**Protect your building:**
- Consider adding more robust language to your entrance signs, such as warning signs in bold letters asking visitors having flu and/or respiratory symptoms to temporarily refrain from visiting the facility even if they don't have travel history.
- Encourage all staff to self-isolate at home if they display symptoms of the flu, especially if they have received the flu vaccine.
- Take precautionary removal of care staff who identify as suspected cases. Have them self-isolate at home as well.
- Prohibit staff from reporting to work if they are sick until cleared to return.
- Consider restricting admissions or heightened screening.
- Environmental cleaning: At this time, retrain to and follow these guidelines from CDC about infection control and cleaning.
- Post visual alerts that remind everyone to wash their hands and cover their coughs.

**Protect yourself at home and in the community:**
- Practice social distancing when possible. Stay away from anyone coughing or sneezing - particularly, if you do not know the person.
- Practice good hand washing hygiene.
- If you are sick: Stay home and self-isolate if you have flu symptoms or a fever.
- Prepare for schools or businesses to close.
- If you are sick, call the physician, clinic or hospital before you visit them. Do not go to a clinic or hospital with symptoms without calling first - they will instruct you on the proper procedures.

**Visitor Restrictions:** While the threat of contamination is still widespread, limiting potential contact with those who may carry the virus is important. Of course, any action you take in this regard must be done in compliance with appropriate regulations on visiting hours, but this could include:
- Restricting very young children from visiting as they are in more direct contact with a wide variety of people through school and other activities and are at a higher risk of contracting and carrying the virus.
- Restricting visitors who have flu-like symptoms from visiting the center.
- Limiting the number of visitors to a resident at a given time.

**Travel Related Restrictions:** Based on the CDC’s Information for Travel, centers should consider implementing precautions regarding staff and visitors who have traveled to countries affected by COVID-19. A good measure is a restriction of at least 14 days, at which time the disease should have presented itself and/or run its course, for those who have visited a CDC warning level 2 or 3 country or region, which are and will be updated on the CDC travel website.

AHCA has compiled talking points if you should receive any media inquiries on COVID-19. If you do receive media outreach, we also ask that you direct them to Matt Hartman at IHCA.
IHCA staff is here to assist you in any way that we can on this issue. We will continue to work with the CDC, CMS and DPH on this. Please reach out to Matt Hartman or IHCA clinical or policy staff if you have any questions or concerns.

Requirements of a LTC Facility Emergency Preparedness Plan
IHCA has received many questions with regard to the LTC Facility Emergency Preparedness Plan. On September 26, CMS took action at President Trump’s direction to “cut the red tape,” by reducing unnecessary burden for American’s health care providers allowing them to focus on their priority – patients. The Omnibus Burden Reduction (Conditions of Participation) Final Rule removes Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on hospitals and other health care providers to reduce inefficiencies and moves the nation closer to a health care system that delivers value, high quality care and better outcomes for patients at the lowest possible cost. These regulations are effective as of November 29, 2019.

Emergency Preparedness Changes Pursuant to the Omnibus Burden Reduction (Conditions of Participation) Final Rule
Below is a quick summary of the final rule regarding emergency preparedness. AHCA was supportive of the proposed changes however, some of the proposed changes will not apply to SNFs.

Emergency program: We have decreased the requirements for facilities to conduct an annual review of their emergency program to a biennial review. However, based on industry feedback, long term care (LTC) facilities will continue to review their emergency program annually.

Emergency plan: Eliminating the requirement that the emergency plan include documentation of efforts to contact local, tribal, regional, State, and federal emergency preparedness officials and a facility's participation in collaborative and cooperative planning efforts;

Training: Decreasing the training requirement from annually to every two years. Nursing homes will still be required to provide annual training and additional training when the emergency plan is significantly updated.

Testing (for inpatient providers/suppliers): Increasing the flexibility for the testing requirement so that one of the two annually-required testing exercises may be an exercise of the facility's choice; and

Testing (for outpatient providers/suppliers): Decreasing the requirement for facilities to conduct two testing exercises to one testing exercise annually.

Last year, CMS released Appendix Z which provides interpretive guidance for each E-Tag. Below you will find a list of the 26 E-Tags that encompass the emergency plan.

LTC Facility Emergency Preparedness Plan and E-Tag Listing

Emergency Preparedness Plan
E-0001 Developing and Maintain Emergency Preparedness Program
  • Facility provides documentation for an emergency preparedness plan (E-0001 is only cited if the facility does not have any emergency preparedness plan)

Elements of the Emergency Plan
E-0004 Emergency Plan Updated Annually
E-0006 Facility and Community Risk Assessment Documentation
  • Facility based risk assessment
  • Community based risk assessment
  • Documentation having procedures for Missing Residents
E-0007 Patient Population and Continuity of Operations Documentation
  • Patient populations at risk during an emergency event
  • Services the facility would be able to provide during an emergency
- Continue operations during an emergency
- Delegations of authority and succession plans

E-0009 Cooperation and Collaboration
  - Documentation of the facility’s efforts to contact officials in collaborative and cooperative planning efforts (email / letter to show effort to communicate)

Policies and Procedures
E-0013 Policies and Procedures Updated Annually

E-0015 Subsistence Needs Policies and Procedures Documents
  - Policy and procedure for normal loss of power
    - Delegation document for building evacuation during an emergency event when the building loses main electrical power
    - Alternate energy source for maintaining temperatures
    - Alternate energy source for the safety storage of provisions
    - Alternate energy source for emergency lighting
    - Alternate energy source for fire detection, extinguishment, and alarm systems
    - Policy and procedures for all emergency events
      - Food
      - Water
      - Medical supplies, equipment, and pharmaceutical supplies

E-0018 Tracking of Staff and Patients
  - Policy and procedure for a staff and resident tracking system

E-0020 Safe Evacuation
  - Policy and procedures for safe evacuation of residents from the building when needed

E-0022 Sheltering in Place
  - Delegation document for building evacuation during an emergency event when the building loses main electrical power (evacuation procedure and when to evacuate procedure)
  - Policy and procedure for sheltering-in-place

E-0023 Policy and Procedures for Medical Documents
  - Policy and procedures documentation for a system to preserve medical records, protects confidentiality, and secures and maintains availability of records

E-0024 Policies and Procedures for Volunteers
  - Policy and procedures for a volunteer system

E-0025 Arrangements with Other Facilities
  - Policy and procedures for transfer arrangements with other medical facilities
  - Policy and procedure documents for arrangements with transportation companies

Communication Plan
E-0029 Development of Communication Plan

E-0030 Names and Contact Information
  - Policy and procedure for contacts list with contact information for staff, entities providing service, physicians, other facilities, and volunteers

E-0031 Emergency Officials Contact Information
- Policy and procedure for a contact list with information for federal, state, tribal, regional, and local emergency management officials

E-0032 Primary and Alternate Means of Communication
- Facility has a primary and alternate means for communicating with staff, federal, state, tribal, regional, and local emergency officials (cell phone or any other system)

E-0033 Methods for Sharing Information
- Policy and procedures identifying a method for sharing information and medical documentation including the means the facility will use to release patient information of general condition and location of patients

E-0034 Sharing Information on Occupancy Needs
- Policy and procedure or the means of sharing information about the facility's occupancy needs, and its ability to provide assistance, to the authority having jurisdiction, the incident Command Center, or designee

E-0035 LTC and ICF/DD Family Notifications
- Policy and procedure for a method of sharing information from the emergency plan with residents and their families / representatives

Training and Testing
E-0036 Training and Testing Program Updated Annually

E-0037 Training Program
- Initial and annual emergency preparedness training documents for all staff, including a facility employee roster of all personnel, dates personnel were initially trained and annually

E-0039 Testing Requirement Documentation Emergency Preparedness Exercises
- Annual tabletop exercise
- Annual full-scale exercise

Emergency Power
E-0041 Hospital and LTC Emergency Power Provision Documentation
- Facility has a delegation document for building evacuation during an emergency event when the building loses main electrical power and uses battery backup systems
- Policy and procedures for monitoring and maintaining the alternate source of power for the following:
  - Building temperatures
  - Heating, air-conditioning and ventilation (HVAC) systems for the entire building
  - HVAC systems for a selected portion of the building where care for the resident population is without a loss of privacy or access to medical equipment and personnel
  - Safety storage of provisions
  - Emergency lighting
  - Fire detection, extinguishment, and alarm systems
- Policy and procedures for continued use of the emergency generator
  - Emergency fuel monitoring and refueling
  - Arrangements with venders for fuel delivery
  - [maintenance and testing of the emergency generator shall be cited under K918 only]
Integrated Health System
E-0042 Integrated Health System Documentation
• Facility is part of a unified and integrated emergency preparedness program and has provided the same documentation as an individual emergency plan

Use of 1135 Waiver
E-0026 Roles Under a Waiver Declared by the Secretary
• This waiver requires approval from CMS

If you have any questions or concerns regarding the LTC Facility Emergency Preparedness Plan please reach out to Kimberly Palermo at IHCA or members of the IHCA policy staff.

Focus F-Tag – F713 Physician for Emergency Care, Available 24 Hours
This Regulatory Beat’s Focus F-Tag is F713 Physician for Emergency Care, Available 24 Hours. The regulation F713 is part of the Physician Services regulatory group. This regulation requires that nursing facilities provide or arrange for physician services 24 hours a day/ 7 days a week in case there is an emergency.

Surveyors are guided to see if a facility has an on-call physician for medical emergencies, but also – does the physician respond? This is where the many issues cited on survey are identified. Facilities have been cited at an Immediate Jeopardy or Actual Harm level for instances where staff attempted to contact the on-call physician and did not receive a timely response, resulting in a delay in timely treatment or transfer of the resident to the emergency room for care. The Interpretive Guidance (IG) notes that facilities are responsible for having a physician available 24/7 for emergencies that do not require medical care in an alternative setting, but ensuring that a resident is transported to a medical facility does not relieve the facility of its responsibility to have a physician available.

Surveyors are also asked to review whether residents are unnecessarily sent to the hospital, and if their needs could have been met in the facility if a physician had been available during the emergency situation. Facilities have been cited under F713 for failure to have a physician respond to critical/abnormal lab results and/or radiology findings, not being able to have a physician clarify issued orders needed for the provision of emergency care, or even when physician’s orders state that the practitioner should be alerted when a resident had elevated blood sugar and the physician does not respond.

In many of these cited situations, the on-call physician was on vacation, out of the country, or in a similar situation that prevented timely response, but coverage had not been arranged prior to the physician’s availability status changing. In other cases, staff made multiple attempts to reach the physician, received no response and ended up contacting the Director of Nursing to get permission to transfer the resident to the hospital. Unfortunately, this is more common than we would like to think and a delay in response from the physician with the Director of Nursing having to make a transfer decision has a high potential for a negative outcome for the resident. It is important that staff make attempts to reach the physician and document these attempts, but staff need to ensure that they do not unduly delay contacting decision-makers so as to not delay treatment for emergency situations. Facilities should have a written protocol in place that staff can follow in these situations, but it is also essential to ensure that there is a process in place to identify when a physician may need coverage and how it will be obtained. The Medical Director should be actively involved in monitoring the medical staff’s response to emergency situation and implementing necessary changes in medical staff schedules and coverage arrangements. In the case of one physician, there was a death in the family that required travel outside of the country on short notice – how would you address this situation if it happened in your building?

Trending Statistics

Each issue of Regulatory Beat features an interesting statistic or trend in the long term care regulatory arena.
Most Prevalent K-Tags in Long Term Care

The Centers of Medicare and Medicaid (CMS) require participating skilled nursing facilities to comply with the requirements of the National Fire Protection Association 101-2012 Edition, commonly referred to as the Life Safety Code (LSC) as well as the NFPA 99 – 2012 edition known as the Health Care Facilities Code.

These codes are a comprehensive set of requirements, which provide nursing home residents a high level of safety and security due to the nature of illness, impairment and the inability to self-evacuate in an emergency. There are specific occupancy chapters of the LSC which apply to your center. Facilities certified originally before July 5, 2016 are considered existing and Chapter 19 applies. Facilities that have been certified after July 5, 2016 are addressed as new facilities and then Chapter 18 applies. The Life Safety and Health Care Facilities Codes themselves are not all inclusive and often reference other editions of NFPA codes.

A number of issues have arisen based on the requirements of the NFPA 99, Health Care Facilities Code. NFPA 99 establishes criteria for systems in nursing facilities such as gas and vacuum, electrical, etc. The requirements, however, generally are applied only to new construction and new equipment. Several chapters begin with specifying which criteria are applicable to existing facilities. Generally, existing facility systems are permitted to remain, even if they are not in strict compliance with the code, unless the authority having jurisdiction determines that their continued use constitutes a distinct hazard to life. If facilities are consider altering, modernizing or replacing equipment, the ‘new’ system or individual component are required to meet the installation and equipment requirements stated in NFPA 99.

The K-Tags listed below are ones AHCA has found to be frequently cited across the country.


<table>
<thead>
<tr>
<th>Tag</th>
<th>Description</th>
<th># Cites</th>
<th>Percentage of Providers</th>
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<tbody>
<tr>
<td>K0353</td>
<td>Sprinkler System - Maintenance and Testing</td>
<td>3,536</td>
<td>43.9%</td>
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<tr>
<td>K0918</td>
<td>Electrical Systems - Essential Electric System</td>
<td>2,108</td>
<td>25.2%</td>
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<tr>
<td>K0363</td>
<td>Corridor - Doors</td>
<td>2,054</td>
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<td>K0321</td>
<td>Hazardous Areas - Enclosure</td>
<td>1,863</td>
<td>23.1%</td>
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<tr>
<td>K0920</td>
<td>Electrical Equipment - Power Strips and Extension Cords</td>
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<td>22.2%</td>
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<tr>
<td>K0712</td>
<td>Fire Drills</td>
<td>1,773</td>
<td>22.0%</td>
</tr>
<tr>
<td>K0345</td>
<td>Fire Alarm System - Testing and Maintenance</td>
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<td>20.4%</td>
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<tr>
<td>K0372</td>
<td>Subdivision of Building Spaces - Smoke Barrie</td>
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<td>17.7%</td>
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<tr>
<td>K0761</td>
<td>Maintenance, Inspection and Testing - Doors</td>
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<tr>
<td>K0324</td>
<td>Cooking Facilities</td>
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<tr>
<td>K0923</td>
<td>Gas Equipment - Cylinder and Container Storage</td>
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<tr>
<td>K0211</td>
<td>Means of Egress - General</td>
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<td>K0511</td>
<td>Utilities - Gas and Electric</td>
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<td>K0222</td>
<td>Egress Doors</td>
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<td>Electrical Systems - Maintenance and Testing</td>
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<td>K0355</td>
<td>Portable Fire Extinguishers</td>
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<tr>
<td>K0351</td>
<td>Sprinkler System - Installation</td>
<td>817</td>
<td>10.1%</td>
</tr>
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</table>

*QCOR FY 2019 through August 1, 2019*
Important Regulations, Notices & News Items of Interest

1) There were no 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.

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

- **COVID-19: New ICD-10-CM Code and Interim Coding Guidance.** The Centers for Disease Control and Prevention’s National Center for Health Statistics will implement a new ICD-10-CM diagnosis code for the 2019 Novel Coronavirus (COVID-19), effective with the next update on October 1. See the [announcement](#) and [interim coding guidance](#) for more information.

- **SNF PDPM Claims Issue.** Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) initial claims that are processed out of sequence are not paying the correct Variable Per Diem (VPD)-adjusted rate. Also, all adjustment claims are not processing correctly. Claims need to process in date of service order for each stay for the VPD to calculate correctly. We will correct this issue in October. In the interim:
  - Submit claims in sequence by waiting at least 2 weeks before billing subsequent claims
  - To adjust claims, cancel the initial claim and all subsequent claims in the SNF stay then rebill in sequential order; or, hold adjustments (when allowable) until October when they will process correctly
  - We encourage you to submit a complete bill at the time of entry

- **FQHC: Mass Adjustment of Claims.** As a result of the [Further Consolidated Appropriations Act, 2020](#), Medicare Administrative Contractors will be mass adjusting certain Federally Qualified Health Center (FQHC) claims with dates of service on or after January 1 through March 1, 2020.

- **Develops New Code for Coronavirus Lab Test.** On February 13, CMS took further action to ensure America’s health care facilities and clinical laboratories are prepared to respond to the threat of the 2019 Novel Coronavirus (COVID-19). Specifically, CMS developed a new HCPCS code for providers and laboratories to test patients for SARS-CoV-2. This code will allow those labs conducting the tests to bill for the specific test instead of using an unspecified code, which means better tracking of the public health response for this particular strain of the coronavirus to help protect people from the spread of this infectious disease.

  Health care providers who need to test patients for Coronavirus using the Centers for Disease Control and Prevention 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel may bill for that test using the newly created HCPCS code (U0001). The Medicare claims processing system will be able to accept this code on April 1, 2020, for dates of service on or after February 4, 2020. HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients.

  For More Information:
  - [Memo](#): Critical steps for health care facilities to prepare
  - [Memo](#): Information for CLIA-certified laboratories on how to test

  See the full text of this excerpted [CMS News Alert](#) (issued February 13)

- **Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31.** The data submission period is open for Merit-based Incentive Payment System (MIPS) eligible clinicians who participated in the 2019 performance period of the Quality Payment Program. Submit and update your data until 8 pm ET on March 31. Note: The data submission period for accountable care organizations and pre-registered groups and virtual groups also closes on March 31.
For More Information:
  o Resource Library webpage
  o Access User Guide
  o Introduction and Overview of 2019 Data Submission Video
  o File Upload and Quality Scoring Video
  o Manual Attestation of Improvement Activities Video
  o Manual Attestation of Promoting Interoperability Measures Video
  o Support for Small, Underserved, and Rural Practices webpage
  o Contact qpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)

• Anesthesia Modifiers: Comparative Billing Report in March. In early March, CMS will issue a Comparative Billing Report (CBR) on Anesthesia Modifiers, focusing on providers who submit Medicare Part B claims. These reports contain data-driven tables with an explanation of findings that compare your billing and payment patterns to those of your peers in your state and across the nation.

CBRs are not publicly available. Look for an email from cbrpepper.noreply@religroupinc.com to access your report. Update your contact email address in the Provider Enrollment, Chain, and Ownership System to ensure accurate delivery. Visit the CBR website for more information.

• Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements. In a recent report, the Office of Inspector General (OIG) determined that payments for Inpatient Rehabilitation Facility (IRF) services did not comply with Medicare billing requirements. Medical record documentation did not support that IRF care was reasonable and necessary. Use the following resources to bill correctly:

  o IRF Prospective Payment System (PPS) Booklet
  o Medicare Benefit Policy Manual Chapter 1 (PDF), Section 110
  o FY 2020 IRF PPS Final Rule
  o IRF Quality Reporting Program website
  o Many IRF Stays Did Not Meet Medicare Coverage and Documentation Requirements OIG Report

• Part A Providers: QIC Appeals Demonstration Call — March 5. Thursday, March 5 from 1 to 2 pm ET. Register for Medicare Learning Network events.

  During this call, learn about the May 2019 expansion of the Qualified Independent Contractor (QIC) Telephone Discussion and Reopening Process Demonstration. It now includes Part A providers that submit second level claim appeals (reconsiderations) to C2C Innovative Solutions Inc., the Part A East QIC. Topics:

  o Benefits
  o Who can participate
  o How to participate

A question and answer session follows the presentation; however attendees may email questions in advance to MedicareFFSappeals@cms.hhs.gov with "Appeals Demonstration" in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, visit the Original Medicare Appeals webpage.
Target Audience: Part A providers located in these areas may participate in the demonstration; however, any Part A provider may attend.

- **Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12.** Thursday, March 12 from 1 to 2 pm ET. [Register](#) for Medicare Learning Network events.

  During this call, ground ambulance organizations that also provide fire, police, and other public safety services learn how to collect information for reporting to the new Ground Ambulance Data Collection System.

  A question and answer session follows the presentation; however, you may email questions in advance to AmbulanceDataCollection@cms.hhs.gov with “March 12 Call” in the subject line. These questions may be addressed during the call or used for other materials following the call. For more information, including ground ambulance organizations selected for the first round of reporting, see the Ambulances Services Center webpage, CY 2020 Physician Fee Schedule [final rule](#), and Bipartisan Budget Act of 2018.

  Target Audience: Ground ambulance organizations that also provide fire, police, or other public safety services.

- **Open Payments: Your Role in Health Care Transparency Call — March 19.** Thursday, March 19 from 2 to 3 pm ET. [Register](#) for Medicare Learning Network events.

  Did you know that reporting entities annually submit records to CMS of payments or transfers of value they made to physicians and teaching hospitals? Beginning in April, you have 45 days to review and dispute Program Year 2019 records. CMS will publish this data and updates to previous program years’ data by June 30. Topics:

  - Overview of the Open Payments national transparency program
  - Program timeline
  - Registration process
  - Critical deadlines for physicians and teaching hospitals to review and dispute data

  A question and answer session follows the presentation.

  Target Audience: Physicians, teaching hospitals, and physician office staff.

- **Program Statistics: 2018 Data.** CMS updated Program Statistics with data for 2018. These statistics present a detailed summary of Medicare populations, utilization, and expenditures, as well as counts for Medicare-certified institutional and non-institutional providers. This release includes several enhancements:

  - New tables presenting Medicare Outpatient Prospective Payment System hospital and Medicare outpatient critical access hospital emergency room visits and observation stays
  - New table showing utilization and expenditure data for special-category hospitals
  - The addition of the count of hospital discharges that began with an emergency room visit to the existing Inpatient Prospective Payment System short-stay hospital tables

- **Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier.** Medicare pays Medicare Diabetes Prevention Program (MDPP) suppliers to furnish group-based intervention to at-risk eligible Medicare beneficiaries:

  - Centers for Disease Control and Prevention (CDC)-approved National Diabetes Prevention Program curriculum
  - Up to 2 years of sessions delivered to groups of eligible beneficiaries
Found out how to become a Medicare enrolled MDPP supplier:

- Obtain CDC preliminary or full recognition - Takes at least 12 months to obtain preliminary recognition and up to 24 additional months to achieve full recognition: See the Supplier Fact Sheet and CDC website
- Prepare for Medicare enrollment: See the Enrollment Fact Sheet and Checklist
- Apply (PDF) to become a Medicare enrolled MDPP supplier (existing Medicare providers must re-enroll): See the Enrollment Webinar Recording and Enrollment Tutorial Video
- Furnish MDPP service: See the Session Journey Map
- Submit claims to Medicare: See the Billing and Claims Webinar Recording, Billing and Claims Fact Sheet, and Billing and Payment Quick Reference Guide

For More Information:

- MDPP Expanded Model (PDF) Booklet
- Materials from Medicare Learning Network call on June 20, 2018
- MDPP webpage
- CDC - CMS Roles Fact Sheet
- Contact mdpp@cms.hhs.gov

- **Bill Correctly for Medicare Telehealth Services.** In a recent report, the Office of Inspector General (OIG) determined that the Centers for Medicare & Medicaid Services (CMS) improperly paid practitioners for some telehealth claims associated with services that did not meet Medicare requirements. CMS released the Medicare Telehealth Services video to help you bill correctly. Additional resources:
  - Telehealth Services (PDF) Medicare Learning Network Booklet
  - Medicare Claims Processing Manual, Chapter 12 (PDF), Section 190
  - Medicare Telehealth Payment Eligibility Analyzer
  - List of Covered Telehealth Services webpage
  - CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements OIG Report

- **Administrative Simplification: EFT and ERA Transactions.** The Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) (PDF) fact sheet provides information on the adopted standards and operating rules for these transactions. This fact sheet is part of a series of fact sheets on Administrative Simplification. Visit the Transactions Overview and Code Sets Overview webpages for more information.

- **Reassignment of Medicare Benefits: Revised CMS-855R Required May 1.** Physicians and non-physician practitioners: Use the revised CMS-855R (Reassignment of Benefits) application once it is posted on the CMS Forms List in early February 2020. Medicare Administrative Contractors will accept current and revised versions of the form through April 30, 2020. Starting May 1, 2020, you must use the revised form. Form updates:
  - Can select Change of Reassignment Information as submission reason
  - Option to identify a secondary practice address

Visit the Medicare Provider-Supplier Enrollment webpage for more information about Medicare enrollment.
• **Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2.** A new [Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2 (PDF)](#) Medicare Learning Network Educational Tool is available.
  
  - Comprehensive Error Rate Testing: Lumbar sacral orthosis
  - Recovery Auditor Finding: Trastuzumab multi-dose vial wastage
  - Visit the newsletter [archive (PDF)](#) for past editions.

• **Quality Payment Program: 2020 Resources.** CMS posted Quality Payment Program (QPP) resources to help you understand how to participate in the 2020 performance period:

  Merit-based Incentive Payment System (MIPS) Quick Start Guides:
  
  - [Overview](#)
  - [Eligibility and Participation](#)
  - [Part B Claims Reporting](#)
  - [Quality Performance Category](#)
  - [Promoting Interoperability Performance Category](#)
  - [Improvement Activities Performance Category](#)
  - [Cost Performance Category](#)

  Measure Specifications and Lists:
  
  - [Quality Measures List](#)
  - [Medicare Part B Claims Measure Specifications and Supporting Documents](#)
  - [Clinical Quality Measure Specifications and Supporting Documents](#)
  - [CMS Web Interface Measure Specifications and Supporting Documents](#)
  - [Qualified Clinical Data Registry Measure Specifications](#)
  - [Improvement Activities Inventory](#)
  - [Promoting Interoperability Measure Specifications](#)
  - [Cost Measure Information Forms](#)
  - [Cost Measure Code Lists](#)
  - [Summary of Cost Measures](#)

  Other Resources:
  
  - [MIPS Data Validation Criteria](#)
  - [Quality Benchmarks](#)
  - [Shared Savings Program and QPP Interactions Guide](#)
  - [Scores for MIPS Alternative Payment Models (APMs) Improvement Activities](#)
  - [Comprehensive List of APMs](#)
  - [Qualified Registries Qualified Posting](#)
  - [Qualified Clinical Data Registries Qualified Posting](#)

  For More Information:
  
  - [Resource Library](#) webpage
  - Contact gpp@cms.hhs.gov or 866-288-8292 (Customers who are hearing impaired can dial 711 to be connected to a TRS communications assistant)
• **Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements.** In a recent report, the Office of Inspector General (OIG) determined that payments for physical therapy services did not comply with Medicare billing requirements. CMS developed the *Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements* (PDF) Booklet to help you bill correctly, reduce common errors, and avoid overpayments.

**Additional Resources:**
- Updated Editing of Always Therapy Services - MCS (PDF) MLN Matters Article
- Update to Editing of Therapy Services to Reflect Coding Changes (PDF) MLN Matters Article
- Outpatient Therapy Functional Reporting Requirements (PDF) MLN Matters Article
- Medicare Benefit Policy Manual, Chapter 12 (PDF)
- Medicare Benefit Policy Manual, Chapter 15 (PDF), Sections 220 and 230
- Medicare Claims Processing Manual, Chapter 5 (PDF)
- Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5 (PDF)
- Medicare Program Integrity Manual Chapter 3 (PDF)
- Medicare Program Integrity Manual Chapter 13 (PDF)
- Comprehensive Error Rate Testing Program webpage
- Functional Reporting webpage
- Local Coverage Determinations State Index Tool
- Social Security Act § 1128J (d)
- Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements OIG Report

• **Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update.** A new MLN Matters Article MM11661 on [Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update (PDF)] is available. Learn about new and revised codes.

• **Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment.** A new MLN Matters Article MM11616 on [Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment (PDF)] is available. Learn about DPP for different cost reporting periods.

• **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims — Revised.** A revised MLN Matters Special Edition Article SE20002 on [Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims (PDF)] is available. Learn about G-codes for qualifying clinical decision support mechanisms.

• **Accepting Payment from Patients with a Medicare Set-Aside Arrangement — Revised.** A revised MLN Matters Special Edition Article SE17019 on [Accepting Payment from Patients with a Medicare Set-Aside Arrangement (PDF)] is available. Learn about electronic attestations via the Workers’ Compensation Medicare Set-Aside Arrangement.

• **January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 — Revised.** A new MLN Matters Article MM11564 on [January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 (PDF)] is available. Learn about modifications and effective dates.

• **The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM).** A new MLN Matters Special Edition Article SE20005 on [The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM) (PDF)] is available. Learn about eligibility criteria and coverage, including therapy services.

• **Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM).** A new MLN Matters MM11632 on [Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) (PDF)] is available.
Nursing Facility (SNF) Patient Driven Payment Model (PDPM) (PDF) is available. Learn about corrected edits that allow proper claims processing for interrupted stays.

- **New Medicare Beneficiary Identifier (MBI) Get It, Use It — Revised.** A revised MLN Special Edition Article SE18006 on New Medicare Beneficiary Identifier (MBI) Get It, Use It (PDF) is available. Learn what happens in the MBI look-up tool if the beneficiary record has a date of death.

- **What New Home Health Agencies (HHAs) Need to Know about Being Placed in a Provisional Period of Enhanced Oversight — Revised.** A revised MLN Matters Special Edition Article SE19005 on What New Home Health Agencies (HHAs) Need to Know About Being Placed in a Provisional Period of Enhanced Oversight (PDF) is available. Learn about the impact of the final rule with comment.

- **International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - April 2020 Update — Revised.** A revised MLN Matters Article MM11491 on International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2020 Update (PDF) is available. Learn about amendments to the spreadsheet for NCD 110.4.

3) The federal Centers for Disease Control and Prevention (CDC) reports on:

- **Weekly U.S. Influenza Surveillance Report.** CDC’s Influenza Division produces a weekly influenza surveillance report. According to this week’s report (February 16 – February 22), influenza activity in the United has remained high but decreased for the second week in a row. Severity indicators (hospitalizations and deaths) remain moderate to low overall, but hospitalization rates differ by age group, with high rates among children and young adults.

- **Webinar on Coronavirus Disease 2019 (COVID-19) Update.** The CDC has updated guidelines specific to healthcare facilities. As a part of that, they will be hosting a webinar titled “Coronavirus Disease 2019 (COVID-19) Update—What Clinicians Need to Know to Prepare for COVID-19 in the United States.” The webinar is scheduled for Thursday March 5, 2020 at 1:00 CST, and you can register for it here.

  During this COCA call, clinicians will learn what they can do to prepare for COVID-19 including identifying persons under investigation, applying infection prevention and control measures, assessing risks for exposures, optimizing the use of personal protective equipment supplies, and managing and caring for patients (inpatient and at home).

- **Travel Related Restrictions:** Based on the CDC’s Information for Travel, centers should consider implementing precautions regarding staff and visitors who have traveled to countries affected by COVID-19. A good measure is a restriction of at least 14 days, at which time the disease should have presented itself and/or run its course, for those who have visited a CDC warning level 2 or 3 country or region, which are and will be updated on the CDC travel website.

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

- The Illinois Department of Healthcare and Family Services has posted a new Provider LTC Monthly Occupied Bed Provider Assessment. You may view the new notice here.

- The Illinois Department of Healthcare and Family Services has posted a new Provider Notice ICF/IID and MC/DD 3.5% Rate Increase Effective August 1, 2019. You may view the new notice here.
The Illinois Department of Healthcare and Family Services has posted a new Provider Notice Implementation of New Policy for Long Term Care Admission Processing. You may view the new notice here.


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

- There was a notice of a change for long term care facilities ONLY located in the Chicago/Bellwood Region in regards to long term care facility incident reports. Effective immediately, all incident reports for these facilities are to be faxed to the following number: 708-544-9250. (No changes for submission of reports for IID, MC/DD or SMHRF facilities.) If there are questions regarding this change, please contact Janette Williams-Smith at Janette.Williams-smith@Illinois.gov or Kimberly Hollowell at Kimberly.Hollowell@illinois.gov.

- The Office of Policy, Planning & Statistics, Division of Patient Safety and Quality announced a series of educational webinars with a focus of healthcare associated infections (HAIs). You can find the flyer here.

6) The Illinois Department on Aging reports:

- Facilities licensed under the Nursing Home Care Act (210 ILCS 45/2-214), the MC/DD Act (210 ILCS 46/2-214), and the ID/DD Community Care Act (210 ILCS 47/2-214) are all mandated to complete the electronic questionnaire provided by the Office of the State Long-Term Care Ombudsman. The questionnaire must be updated annually or when changes occur within the facility. The Questionnaire and the Facility Letter the Ombudsman are handing to facilities are included. Surveyors will be asking for this information during the annual survey.

- Consumer Choice Website. The Illinois Department on Aging and the Office of the State Long-Term Care Ombudsman Program have developed a website for consumers to use when seeking a long-term care facility. The website meets the requirement of the Illinois Act on the Aging 20 ILCS 105/1) (from Ch. 23, par. 6101) (c-5). The intent of the website is to provide consumers with information about facilities in their preferred area regarding medical care, services and treatment, special services and amenities, staffing, facility statistics and demographics, ownership and administration, safety and security, meals, nutrition, rooms, furnishings, and equipment as well as family, volunteer and visitation provisions. The consumer will be able to filter their search based on location, needs, and preferences.

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

- AHCA/NCAL Email Update. Coronavirus (COVID-19) Update #1

- AHCA/NCAL Email Update. Coronavirus (COVID-19) Update #2

- AHCA/NCAL Email Update. Coronavirus (COVID-19) Update #3

- AHCA/NCAL Email Update. CMS Message on SNF PDPM Claims Issue.

- AHCA/NCAL Social Media Update.

- IHCA VCAST – Discussion on Governor Pritzker’s February 19th annual Budget Address to the General Assembly with IHCA Budget Consultants Greg Cox and Cecelia Hylak-Reinholtz with C&G Consulting.
• **Article Highlights Long-Term Care Coronavirus Prevention.** *Skilled Nursing News* (2/29, Yamshon) reported "concerns over the coronavirus are creeping into the nursing home sector, and industry experts are alerting operators and clinicians to take extra care, especially with the steady influx of frailest residents who are most susceptible." According to the article, "while it may be too early to determine the eventual clinical and financial effects on the nursing home space, the novel nature of the disease could bring new challenges for skilled nursing operators." Specifically, "the American Health Care Association urged nursing homes to take immediate action," issuing a statement that said, "Centers must review their infection prevention and control policies and procedures among residents and staff as this is key to not only prevention of coronavirus but other common viruses from spreading. ... We are in close contact with the CDC, and state officials to monitor this virus and communicate any information and materials with our members."

• **Virginia Long-Term Care Providers, Organizations Express Excitement About Proposed Bill That Would Allow Administration Of CBD, THC-A Oil to Certified Residents.** *McKnight’s Long Term Care News* (2/28, Brown) reported that "providers in Virginia are excited about a proposal that would allow nursing homes to administer CBD and THC-A oil to certified residents." Proposed "Senate Bill 185, which would also apply to assisted living facilities and hospice programs, allows employees to administer the medications to residents who have been issued a valid, written certification for it." The Virginia Health Care Association – Virginia Center for Assisted Living also expressed their "excitement for the legislation, adding that it worked with bill sponsor Sen. Siobhan Dunnivant (R) and its state agency partners on the bill."

• **Emanuel County Facility Honored.** *Emanuel County (GA) Live* (2/28, Clifton) reported "Swainsboro, a skilled nursing and rehabilitation center serving the Emanuel County community, recently was named to the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Quality Initiative List for meeting all four standards of excellence: Hospitalizations, Consumer Satisfaction, Antipsychotics and Functional Outcomes." According to the article, "the award is one of three distinctions available through the AHCA/NCAL National Quality Award Program, which spotlights providers across the nation that have demonstrated their dedication to improving quality of care for residents and patients in long term and post-acute care."

• **Nursing Homes May Be Able to Grow into Home Health Space Following Exit of Smaller Agencies, Experts Suggest.** *Skilled Nursing News* (3/1, Spanko) reports that "while the skilled nursing world has largely adapted to its new Medicare payment model, the home health industry is currently in the midst of its own seismic shift – a change that could potentially open the door for nursing homes to grow in the space as smaller agencies rush for the exits." According to the article, "the new Patient-Driven Groupings Model (PDGM) for home health may present skilled nursing operators with a chance to gain more control over patients as they move along the health continuum, S&P Global Ratings asserted in a report released last week." S&P said, "We expect skilled nursing facility (SNFs) and long-term acute care hospital (LTACHs) companies could enter the home-health market, for the right opportunity, as that would give them the ability to better manage their discharged patients through the continuum of care (more control to avoid readmissions), and enable them to establish a relationship with potential future customers."

• **Coronavirus Linked to Long-Term Care Facility in Washington State.** *CNN* (3/1, Karimi, 83.16M) reports "a second person has died in Washington state and five more people have tested positive with the novel coronavirus, health officials said Sunday." The piece says that "four of the new cases, including the second death, are among residents of a long-term nursing facility where officials have been investigating a possible outbreak of coronavirus." According to a health officer for Seattle and King County, over 50 residents and staff from the facility are experiencing symptoms and will be tested for the coronavirus.

• **Experts Say Coronavirus May Pose Greater Risk for Older Adults, Men.** *HealthDay* (2/28, Thompson, 17K) reported that experts say older adults and men may be at higher risk for death and serious illness from the coronavirus than others. HealthDay cited several sources, including the Chinese CDC, which reported last week that "the coronavirus death rate among men in China stands at 2.8%, compared with 1.7% among women."
Marijuana Use in Older Adults Increased 75 Percent Between 2015 To 2018, Study Shows. Provider Magazine (2/26, Connelle, 151K) reports "a fresh study in JAMA Internal Medicine said the share of adults 65 and older using marijuana in the previous year has rocketed from 2.4 percent in 2015 to 4.2 percent in 2018, a leap of 75 percent over that time frame." Specifically, "the report said the climb in marijuana use was fueled in part by older women who saw their frequency of cannabis use go from 1.5 percent to 2.8 percent in the 2015 to 2018 period," while "seniors on the male side experienced a smaller but still sharp 58 percent rise in usage from 3.6 percent to 5.7 percent for the study’s time frame." According to the article, "the relaxation of laws criminalizing marijuana use across the country for both medical and recreational purposes is one significant factor for the increased usage, as are the more relaxed attitudes of aging baby boomers to marijuana, the study said."

Researchers Say Cognitive Decline May Happen Faster in Widowed Adults Than Those Who Are Married. CNN (2/26, LaMotte, 83.16M) reports researchers found that over a period of three years that "cognitive abilities declined three times faster in widowed adults with high levels of beta-amyloid – a key marker for Alzheimer’s – than in married people with equally high levels," suggesting that losing a spouse may accelerate cognitive decline. The researchers also found that "even for those without beta-amyloid accumulation and no signs of cognitive decline, the risk for dementia was greater for men and women who were widowed." The findings were published in JAMA Network Open.

Contributor Highlights Virtual Reality Use Among Seniors. Forbes (2/26, 9.71M), Contributor Sol Rogers writes, "Virtual Reality (VR) is being used to better the lives of senior citizens all over the world by reducing loneliness, improving their mental health and transporting them to far-flung places without needing to leave the comfort of their home." Although "virtual reality experiences are usually done alone, running a programme in a nursing home allows multiple patients to use the technology at once." According to Rogers, "sharing their feelings and experience with those around them creates a sense of community which can counteract feelings of loneliness."

Moral Distress Reportedly Common in Physicians Caring for Older Adults Who Need Surrogate Decision-Maker, Research Indicates. McKnight's Long Term Care News (2/25, Lasek) reports "physicians often experience significant moral distress when caring for elders who cannot participate in decision-making, say the authors of a new study." Approximately "four in 10 doctors experience this problem when caring for older adults who require a surrogate decision-maker, reported scientist Alexia Torke, M.D., from the Regenstrief Institute, Indianapolis." A big contributor to this feeling is "care plans that include more life-sustaining treatment for the patient than the physician believes is appropriate, wrote Torke," but "odds of distress lessened when physicians learned that patients' wishes were clearly outlined before they became cognitively impaired, the authors added." Moreover, "physicians were also less likely to experience moral distress when caring for nursing home residents."

Verma Discusses CMS Quality Strategy at Tuesday Conference. McKnight’s Long Term Care News (2/26, Brown) reports "the Centers for Medicare & Medicaid Services has unveiled a ‘new, reimagined’ quality strategy that places a strong emphasis on improving the performance of state survey agencies and tougher enforcement on providers, Administrator Seema Verma said Tuesday," at the 2020 CMS Quality Conference. Verma "noted CMS recently revised the State Performance Standards System, which is used to assess surveyor performance." She said, "These revisions include new and better applications of data to monitor performance and ensure states are protecting residents from harm consistently across the country."

Georgia House Committee Adopts Proposal to Improve Safety, Oversight In State’s Assisted Living Facilities, Personal Care Homes. The Atlanta Journal-Constitution (2/25, Teegardin, Schrade, 895K) reports that Georgia’s House Health and Human Services Committee adopted a proposal "to improve safety and oversight in Georgia’s assisted living facilities and personal care homes" on Tuesday. The vote "signaled that the plan to increase penalties for neglect and abuse as well as require more safeguards for those with dementia has broad support among lawmakers, advocates and leaders in the industry." House Bill 987 would also "require
administrators who run assisted living and large personal care homes to receive special training and licenses, similar to the requirements placed on nursing home administrators."

- **Length of Stay At Rehab Facility Correlated With Mobility Independence For Hip Fracture Surgery Patients.** [Healio](2/24, Cogan, 28K) reports that the rate "of recovery and length of stay in skilled nursing facilities and inpatient rehabilitation facilities correlated with mobility and self-care results at discharge in patients who underwent hip fracture surgery, according to study results." The researchers "evaluated 150 patients aged 65 years or older who received rehabilitation services for hip fractures from four inpatient facilities and seven skilled nursing facilities. Investigators noted patients had Medicare fee-for-service as the primary payer." After discharge "medium-gain patients with a mean length of stay of 27 days achieved mobility independence while those with a mean length of stay of less than 21 days required supervision with toilet transfers and needed assistance with stairs."

- **Florida Groups Concerned Federal Medicaid Proposal Would Jeopardize Funding for State's Nursing Home Industry.** [WLRN-FM](2/24, Miller, 12K) reports Florida groups are concerned about "a federal Medicaid proposal, that among other things, would charge nursing homes a new bed tax." Facility residents "would pay about $1,000 more a year if the Centers for Medicare and Medicaid Services proposal goes into effect later this year." The Florida Health Care Association has estimated "the proposed changes could jeopardize more than $600 million in Medicaid funding for the state’s nursing-home industry."

- **Long-Term Care Providers Contend NY County Officials Overstepped Authority in Requiring Nursing Homes to Report Injuries, Abuse Twice A Year.** [McKnight’s Long Term Care News](2/25) reports "officials for a New York county overstepped their authority when they created a law that requires nursing homes to report injuries and abuse to county officials twice a year," according to arguments long-term care providers recently made "in a lawsuit looking to overturn the mandate." The providers’ lawyer said, "We were frankly dismayed that for so long we were being portrayed as scofflaws and noncompliant nursing homes, which is the furthest thing from the truth. ... The irony is that it was Erie County that was actually violating the law, not us."

- **Long-Term Care Construction Market "Remains Steady," According to Recent Report.** [McKnight’s Senior Living](2/25, Bowers) reports "a labor shortage is necessitating longer amounts of time to complete long-term care construction projects, and labor costs are rising due to annual hourly increases, overtime and labor risk, Larry Graeve and Amy Burk of The Weitz Company write in a new issue brief for the American Seniors Housing Association." However, overall, "the long-term care construction market ‘remains steady,’ they said." The cost per square foot "of construction in winter 2020 in independent living has averaged $168 to $255 per gross square foot, depending on materials and finishes used, according to the brief," while "costs in assisted living, meanwhile, have averaged $194 to $309 per gross square foot, and costs in skilled nursing have averaged $223 to $361 per gross square foot."

- **Blood Thinner Apixaban May Present Fewer Risks Than Warfarin, Regardless of Prior Stroke History, Blood Clots, Presentation Suggests.** [McKnight’s Long Term Care News](2/25, Lasek) reports "the blood thinner apixaban (Eliquis) is safe and effective in stroke patients and may present fewer risks than warfarin, according to a secondary analysis," as presented at the American Stroke Association’s International Stroke Conference 2020. Moreover, "the drug is associated with less bleeding, death and hospitalization than warfarin, regardless of prior stroke history or blood clots, reported investigators." These findings come "as more clinicians choose to treat nursing home residents with anticoagulants."

- **USPSTF Says Insufficient Evidence Exists to Assess Benefits, Harms of Screening For Cognitive Impairment In Older Adults.** [Kaiser Health News](2/25) reports the U.S. Preventive Services Task Force (USPSTF) "declined to endorse cognitive screening for older adults, fueling a debate that has simmered for years." The USPSTF "said it could neither recommend nor oppose cognitive screening, citing insufficient scientific evidence of the practice’s benefits and harms and calling for further studies." The expert panel published "its recommendations, an accompanying scientific statement and two editorials...in the Journal of the American Medical Association."

[MedPage Today](2/25, George, 75K) reports the USPSTF concluded, "The current evidence is insufficient to
assess the balance of benefits and harms of screening for cognitive impairment in older adults." However, Healio (2/25, Miller, 28K) reports the USPSTF "stated that physicians should continue to assess cognitive abilities in these patients." In arriving at its conclusion, the USPSTF "reviewed 287 studies, which included more than 280,000 older adults."

- **Op-Ed: Proposed Changes to Maine's Long-Term Care Are "Essential".** McKnight's Long Term Care News In a Bangor (ME) Daily News (2/25, Butler, 198K) op-ed, contributor Sandra Butler says Maine’s Commission to Study Long-term Care Workforce Issues has made "both bipartisanship and policy progress" over the last five months. Though the commission has only proposed "incremental" changes, "they could be profoundly important to Maine’s direct care workers, the providers who employ them, and the adults with disabilities who rely on their services." Though the proposal will be subject to revision in the legislature, Butler says the changes are "essential for sustaining and growing our long-term services and support system."

- **Health Officials Warn That Novel Coronavirus Will Likely Spread Within the US and Say Americans Should Take Steps to Prepare.** The New York Times (2/25, Belluck, Weiland, 18.61M) reports Dr. Nancy Messonnier, director of the CDC’s National Center for Immunization and Respiratory Diseases, said that the novel coronavirus will most likely spread in the US and Americans should take steps to prepare for such outbreaks now. Dr. Messonnier said, "It’s not so much of a question of if this will happen anymore but rather more of a question of exactly when this will happen." Meanwhile, HHS Secretary Alex Azar "told a Senate panel that federal and local health departments will need as many as 300 million masks for health care workers and additional ventilators for hospitals to prepare for an outbreak of coronavirus in the U.S." Azar also said, "This is an unprecedented potentially severe health challenge globally." The Washington Post (2/25, A1, Werner, Abutaleb, Bernstein, Sun, 14.2M) reports officials from the CDC, NIH, and other health agencies spoke about the virus in "a closed-door meeting with senators as well as a separate briefing with reporters by phone." Speaking with reporters, Dr. Messonnier said, "Ultimately we expect we will see community spread in the United States. It’s not a question of if this will happen, but when this will happen, and how many people in this country will have severe illnesses." NPR (2/25, Stein, 3.12M) reports Dr. Messonnier warned that Americans should be prepared for the possibility of workplace and schools being closed and public events being canceled.

- **AHCA Addresses CMS Administrator Verma’s Enhanced Enforcement Strategies.** Provider Magazine (2/20, Connole, 151K) reported, "In a blog post on the Trump administration’s strategies for ensuring safety and quality in skilled nursing facilities (SNFs), Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS), focused on enhanced enforcement efforts to strengthen oversight of facilities." In response to the blog post, "Holly Harmon, vice president of quality, regulatory, and clinical services for the American Health Care Association (AHCA), says the group appreciates CMS’ effort to ensure quality care in all of the nation’s nursing homes." Specifically, she said, "We are glad to see CMS work to improve the state survey agency oversight process. Inspectors should be held to the same standards on thoroughness, completeness, and timeliness as providers."

- **Bipartisan Lawmakers Express Concern About CMS' MFAR.** McKnight’s Long Term Care News (2/21, Brown) reported "both Republicans and Democrats are expressing skepticism about a proposed federal rule that may cost long-term care providers billions in Medicaid funding and negatively affect supplemental payments." Lawmakers from both parties "have expressed concerns about the Centers for Medicaid and Medicare Services’ Medicaid Fiscal Accountability Regulation, The Hill reported." The American Health Care Association has also "demanded that the regulation be withdrawn, stating it has serious implications for providers’ supplemental payments and could eliminate up to $50 billion from the Medicaid program annually."

- **Alabama Apprenticeship Program Hopes to Encourage Students to Work in Long-Term Care.** WSFA-TV Montgomery, AL (2/22, Nusbaum, 53K) reported, "Alabama nursing homes will need about 9,600 Licensed Practical Nurses (LPN) by 2030 to meet the necessary demand, according to a 2017 U.S. Department of Health and Human Services study." The Alabama Nursing Home Association and the Alabama Community College System "created an apprenticeship program this year giving college students real life experience working in
nursing homes," in hopes "this will encourage students to stay in the industry long term." The program "allows students to receive a scholarship if they agree to continue working at a nursing home."

- **New York Medicaid Redesign Team Considering Ending "Spousal Refusal" For Nursing Care.** *Newsday (NY)* (2/23, Gormley, 932K) reports New York’s "Medicaid Redesign Team is considering whether to scrap" a practice known as "spousal refusal" which "allows one spouse to legally refuse to pay for nursing home care for the other," forcing Medicaid to cover the bill. However, "a growing number of advocates for middle-class elderly New Yorkers strongly support it as an essential option to keep a ‘well’ spouse out of poverty when health care costs are exploding." In addition, the process is "further complicated by federal law aimed at protecting more assets to avoid ‘spousal impoverishment.’"

- **Declines in Gait, Memory May Be Linked to Dementia in Cognitively Healthy Adults Over Age 60, Research Indicates.** *McKnight’s Long Term Care News* (2/22, Lasek) reported, "Declines in both memory and gait are linked to dementia among cognitively healthy adults over age 60," and "clinicians may want to target this group for prevention and therapeutic interventions, say researchers" of a study recently published in JAMA Network Open. In a meta-analysis that involved "nearly 8,700 adults from the United States and Europe, participants who experienced a decline in both memory and gait had about six times greater odds of developing dementia compared to adults with no decline, reported" study authors. According to the study team, clinicians may be able to identify the dual decline early by using free-recall memory tests and routine assessments of gait speed in older adults.

- **Opinion: When Treating Residents With Pain, Documentation, Monitoring Of Bowel Movements Is Vital.** In an article for *McKnight’s Long Term Care News* (2/21), Yvonne D’Arcy, MS, CRNP, CNS, pain management and palliative care nurse practitioner, wrote that her personal experience with poor pain management inspired her to prioritize education of "fellow NPs about how to properly manage their patients’ pain," leveraging her "unique dual insight as both a patient and provider." D’Arcy included various suggestions for dealing with pain patients, specifically strict monitoring and recording of patient bowel movements (BMs), "especially when treating patients taking opioids who are older or who have cognitive impairments, as they might not be able to provide accurate self-reports." According to D’Arcy, "there are adverse consequences, such as impaction, or for patients on long-term opioid therapy, OIC, that can occur from lack of BMs, which is why monitoring and documentation is vital."

- **Caring for An Older Adult Family Member May Take A Toll on Caregiver’s Health, Study Suggests.** *HealthDay* (2/20, Reimberg, 17K) reported, "Caring for a loved one at home can be rewarding, but it can also be overwhelming and take a toll on your own health, a new study" published in the CDC’s Morbidity and Mortality Weekly Report suggests. The new report indicates "nearly 1 in 5 of the nearly 18 million Americans who provide informal, unpaid care may be in fair or poor health." According to one expert in geriatric emergency medicine who reviewed the study, "Although the report did not identify the drivers of this finding, it is not hard to understand that trying to balance work, family responsibilities and caring for an older adult could at the very least cause increased stress and also lead to lack of personal time to attend to one’s health issues."

- **AHCA/NCAL Working to Help Monitor Potential Coronavirus Cases.** *Provider Magazine* (3/2, Conole, 151K) reports "the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) on Monday said it is in regular and close contact with officials at the Centers for Disease Control (CDC) and Prevention to help long term and post-acute care providers (LT/PAC) and the government monitor any potential cases of the COVID-19, or coronavirus." David Gifford, MD, senior vice president of quality and regulatory affairs at AHCA, said, "The safety and health of the residents, their families, employees and their families is a top priority for our members. ... We’re monitoring the spread of this virus and continue to be in close contact with the CDC to ensure our members are receiving timely information and relaying information to CDC about the challenges members are facing with acquiring the appropriate supplies." Gifford also "says AHCA/NCAL is advising centers to ensure their infection prevention and control policies and procedures are in place and using everyday preventive actions to prevent the spread of coronavirus since it spreads very like the influenza virus."
• **News of Potential Coronavirus Outbreak At Washington State SNF Raises Issues For Long-Term Care Facilities Nationwide.** *McKnight’s Long Term Care News* (3/2, Berklan) reports that "a skilled nursing facility in the state of Washington became the first U.S. site of a coronavirus outbreak, officials announced Saturday." A recent report published "in JAMA noted that the coronavirus in China has had a 1% to 2% fatality rate – but that soars to 8% to 15% in the elderly population." In response to the coronavirus news, the American Health Care Association "issued updated guidelines over the weekend." *Kaiser Health News* (3/1, Aleccia) reported the "outbreak of coronavirus disease in a nursing home near Seattle is prompting urgent calls for precautionary tactics at America’s elder care facilities, where residents are at heightened risk of serious complications from the illness because of the dual threat of age and close living conditions." The American Health Care Association’s updated guidelines "largely echo strategies recommended to stem the spread of other respiratory viruses, such as influenza," since "the new virus is thought to spread primarily via droplets in the air." AHCA’s chief medical officer and senior vice president of quality and regulatory affairs Dr. David Gifford said the organization’s members had anticipated cases of the virus. *McKnight’s Senior Living* (3/2, Bowers) reports that one nationwide long-term care organization has taken the approach of "be prepared but not panicked" in response to the new coronavirus and its potential impact on senior living communities. The chief medical officer of that organization recommends that staff practice infection control, and form a committee "to prepare for possible COVID-19...and to respond in a coordinated way if it happens." Additionally, he recommends education and training, starting with the CDC website, along with communication between staff, residents and families, and continued contact with local public health officials.

• **Washington State Senator O’Ban: Legislature’s Projected Surplus Could Save SNF Facilities In The State.** In an opinion piece for the *Seattle Times* (3/1, 935K), Republican state Senator Steve O’Ban writes that with the state Legislature’s "projected $2.4 billion surplus over four years, lawmakers have the chance to do something transformative for seniors – to save the skilled-nursing facilities that provide the level of care our aging parents and grandparents so desperately need." According to O’Ban, "the majority party is taking a stopgap approach" to "shore up the gaping chasm created by years of inadequate Medicaid reimbursements," by increasing "Medicaid payments, but only by less than 50% of what is needed, if you include federal matching funds." O’Ban argues, "With a $2.4 billion surplus, we should do better. After raising us, paying a lifetime of taxes and building our communities, our seniors deserve proper care."

• **Report Urges Health Care Providers to Integrate Social and Medical Care, Particularly for Older Adults.** *McKnight’s Senior Living* (3/2, Haseltine) reports "a new report published by the National Academies of Sciences, Engineering, and Medicine proposes a paradigm shift" in health care: "the integration of social care and medical care." Specifically, "the report urges public health leaders and health care providers to acknowledge the relevance of social needs to medical needs and adjust their service delivery systems accordingly." According to the article, "older adults who have easy access to social and medical services as they age stand a better chance of managing certain health risks and behaviors early on, as well as remaining an active participant in community life."

• **Older Americans Bill Of Rights Introduced by House Democratic Caucus Task Force on Aging & Families.** *McKnight’s Senior Living* (3/2) reports that "a new ‘Older Americans Bill of Rights’ introduced by the House Democratic Caucus Task Force on Aging & Families has four pillars: financial and retirement security for seniors and their families; guaranteeing access to affordable, equitable and comprehensive health care; full participation and contribution to their communities; and aging with dignity and respect." Rep. Debbie Dingell (D-MI), a caucus vice chair, said, "The Older Americans Bill of Rights makes clear that every older American deserves high-quality, affordable health care and long-term care, financial and retirement security, and the ability to fully participate in and contribute to their communities." According to McKnight’s, "the resolution was introduced Friday by the caucus’ co-chairs" and vice chairs, and "136 House Democrats, representing more than half of the House Democratic caucus, have signed on as co-sponsors."

• **Chronic Pain Management in Older Adults, Long-Term Care Residents May Be Best Achieved by Utilizing Pharmacologic Strategies, Nondrug Therapies Concurrently, Commentary Suggests.** *Mayo Clinic* (3/2, Dangor, 1.9M) reports that "chronic pain affects a large proportion of older adults and most long-term care residents."
According to a commentary in Mayo Clinic Proceedings, there can be safe optimization of pain management by utilizing a plan that balances both benefits and risks of treatments. Specifically, "treating chronic pain is best achieved when pharmacologic strategies and nondrug therapies are used at the same time."

- **People Over 65 Who Are Excessively Tired During the Day Have About Twice The Risk Of Being Diagnosed With Some Health Conditions, Research Shows.** HealthDay (3/2, Gordon, 17K) reports, "If you’re over 65 and sleeping well at night, yet find yourself nodding off during the day, you may have a higher risk of developing new medical conditions." The piece explains that "new research found that people who were excessively tired during the day had about twice the risk of being diagnosed with high blood pressure, type 2 diabetes or cancer." HealthDay adds that other "conditions linked to daytime fatigue include... obstructive sleep apnea, depression, heart failure, low thyroid hormone levels, and certain vitamin deficiencies."

- **USPSTF Recommends Screening for Hepatitis C Infection In All Adults Ages 18 To 79 Without Known Liver Disease.** The AP (3/2, Neergaard) reports, "Most American adults need to be checked for hepatitis C, say guidelines released Monday" by the US Preventive Services Task Force "that urge millions more people to get screened for the liver-damaging virus that can fester for decades [before] it’s spotted." The USPSTF’s "call for expanded screening for Americans ages 18 to 79 is the first since 2013 when U.S. health authorities urged all baby boomers to get a one-time hepatitis C test because that age group appeared at particularly high risk." On March 2, the USPSTF announced that "hepatitis C is on the rise because of the opioid crisis, prompting the recommendation to expand testing." CNN (3/2, Howard, 83.16M) reports the task force "now recommends screening for hepatitis C infection in all adults ages 18 to 79 without known liver disease, regardless of their risk," an updated recommendation that "expands the task force’s previous 2013 recommendation, which was to screen only adults born between 1945 and 1965 and others at high risk for infection." The recommendation statement was published online in JAMA. According to Medscape (3/2, Frellick, Subscription Publication, 277K), "the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America" recommend "one-time, opt-out HCV screening for everyone at least 18 years old and one-time testing for all people younger than 18 years at increased risk of exposure." In addition, they suggest "periodic screening for people with increased risk of exposure as well as yearly HCV tests for all people who inject drugs and HIV-infected men who have unprotected sex with men." Providing similar coverage are ModernHealthcare (3/2, Johnson, Subscription Publication, 214K), HealthDay (3/2, Thompson, 17K), and MD Magazine (3/2, Rosenfeld).

9) **Interesting Fact:** On this day in 1861, Abraham Lincoln was inaugurated as president.