Feature Focus

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

IDPH/LTC Provider Meeting

On January 13, 2016, the Illinois Department of Public Health (IDPH) held the Quarterly LTC Provider Association meeting. Darlene Harney and Connie Jensen represented IDPH and representatives from Illinois Health Care Association, Leading Age, Illinois Nursing Home Administrators Association and the Health Care Council of Illinois were in attendance. These meetings are very valuable in that face-to-face communication and discussion of issues helps see both sides of an issue and also allows for thoughts and ideas to make the LTC survey system work more smoothly. IDPH’s response to the Association’s questions submitted prior to the meeting are as follows:

1) Surveyor Requests for Incident Reports – IDPH stated that surveyors are allowed to have access to incident reports as proof to show that the facility is monitoring and responding to incidents. IDPH stated that surveyors should not be asking for all incident reports to be fishing for deficiencies, but rather a sampling to see that incidents are being documented and followed up on. Surveyors can ask for specific incident reports in response to a survey finding/issue or to have enough information to justify or validate a deficiency. IDPH also stated that surveyors should not be taking incident reports out of the facility unless it is necessary as proof for a deficiency. If there are questions related to incident reports, IDPH stated that the facility should contact the Field Supervisor for the team or the Regional Supervisor for that region immediately to discuss and resolve before the survey is concluded.

2) Excessive Copy Requests by Surveyors – IDPH stated that they are trying to address this with all surveyors. Only material necessary to support a deficiency should be necessary to be copied. The IDPH Regional Supervisors are to be reviewing each survey package to make sure there are no unnecessary documents in the package. IDPH did state that with Electronic Health Records, depending on the availability of facility computers to review information, printing out of certain documents becomes necessary. If you believe that surveyors are requesting too many printed documents, contact the Field Supervisor or Regional Supervisor to discuss.

3) Employee Interviews – There were several issues under this heading:

- **Who can be present** – the employee being interviewed has the choice of whether or not they want another facility person in the interview. If the employee being interviewed wants a witness with them, they can request that of the surveyor and the surveyor is to allow this. However, the interview is with the employee, not the witness, and the witness is to remain quiet and not intervene. Surveyors cannot overrule the employee’s request to have a witness present (if requested by the employee) during the interview.
- **Does the facility have options** – if interview problems occur, the facility is to immediately contact the Field Supervisor or Regional Supervisor for discussion and resolution of the problem.
- **Request for employees to write own responses** – it was stated that sometimes surveyors give an employee written questions to answer and give back to the surveyor. IDPH stated that this practice should be rare and that almost all interviews should be face to face/verbal. If there is a unique situation where written responses
are necessary, the employee is to be allowed to review and agree with the response. Employees are also free to not sign the document, and the surveyor will make a notation that the interviewee did not sign.

- **Provision for facility employees to retain a copy of their responses/interviews** – it is the current IDPH practice to not allow an interviewed employee to have a copy of the interview/response. This was discussed at length and IDPH will take this issue back to IDPH Legal for reconsideration. All of the provider associations strongly requested that this policy be changed and all will continue to push hard for copies of interviews to be given to the interviewee. Also, it is the employees choice as to whether they want to sign the interview form or not. An employee cannot be intimidated or forced into signing. Also, the interviewed employee should mark out any unused blank space on the interview form to prevent the possibility of information being added at a later time.

4) **Physician Concerns Related to Surveyor’s Interviews** – Most times, physician interviews are conducted by phone. Several physicians have complained that the surveyors seem to be questioning their clinical decisions. IDPH stated that this is not acceptable and they will work with their surveyors with regard to physician interviews. The physician interview should not be to question the physician’s clinical decision or to justify their decision, but rather to clarify a time or notification issue, etc.

5) **Bellwood Region** – Bellwood Region facilities have been reporting that surveyors have been arriving early/late to a facility, staying a very short time and stating they need to leave and will return at a later date. IDPH stated that they have heard this and are working with the Bellwood Office to make sure that survey visits are substantive and not just a stop by to satisfy a survey timeframe issue. This apparently is only an issue in the Bellwood Office.

6) **Life Safety Code Plan of Correction Reviews** – Some providers are noting a delay in POC reviews. Bill Meyer was not able to make this meeting and will provide a written response.

7) **Procedure of Reporting Certified Nurse Aides (CNA) to the Registry** – Does the facility have any responsibility in reporting CNAs to the Nurse Aide Registry (NAR)? No, referrals to the NAR are made within IDPH after review of any incident/complaint/survey report. If it appears that a CNA is guilty of a crime or an action that must be reported to the NAR, IDPH handles this internally. The facility is not required to do anything with reporting of CNAs to the NAR, only the normal required reporting of incidents.

8) **Licensure Regulations Related to Nurse Staffing** – A question was raised with respect to the counting of the Director of Nursing’s (DON) time in on RN staffing requirements for licensure. The Nursing Home Care Act states that “For the purpose of computing staff to resident ratios, direct care staff shall include …….50 percent of the Director of Nurses’ time….”. In the SNF/ICF Code, there is a rule that states that “The remaining 75 percent of the minimum required direct care hours may be fulfilled by other staff identified in the statute (DON time).” There appears to be some conflict between the statute and its intent and the later rule. In such cases, statute supersedes rulemaking. IDPH stated that they will take this back to IDPH Legal and get a response.

9) **Civil Monetary Penalty Fund** – One-half of the collected CMP fine monies are deposited into a special CMP Fund to be used for projects and activities that benefit residents. The state of Illinois has a sizeable amount of money in this fund. There has been very little guidance to states as to how to use this money. All uses of the money have to be approved through federal CMS. IDPH is in contact with CMS and is developing a process for application, review and approval of proposed projects. There was some discussion of the provider associations getting together and developing some proposals that would benefit LTC residents.

10) **Involuntary Transfer/Discharge** – A couple of issues here:

- IDPH clarified that on the Involuntary Discharge/Transfer Form, that if a specific location is not identified when the notice is provided, the facility must show/document that they are diligently working on providing options and must notify IDPH and the resident as soon as a location is found.

- There was also discussion with regard to the IDPH Administrative Law Judges (ALJs) not willing to conduct Involuntary Discharge Hearings for non-payment in the individual is applying for Medicaid. We pointed out that federal requirement for Discharge for Non-Payment states, “A resident cannot be transferred for non-
payment if he or she has submitted to a third party payor all the paperwork necessary for the bill to be paid. Non-payment would occur if a third party payor, including Medicare or Medicaid, denies the claim and the resident refused to pay for his or her stay.” We agree that if the individual has filed all the paperwork necessary for Medicaid to determine eligibility, and the individual is merely waiting for a decision, then they may not be discharged. But, if the individual (or their family) has not filed all the paperwork necessary for Medicaid to determine eligibility, therefore causing determination delays, then the federal regulations permit discharge for non-payment. IDPH stated that they will take this back to IDPH Legal for review.

11) Rule and Program Status Updates –

- **Electronic Incident Reporting Form** – The form has been drafted and was shared with the Long Term Care Advisory Board at their last meeting. There was a lot of discussion and suggested changes offered. IDPH is revising the form and will bring back to the LTC Advisory Board for further review and discussion at their next meeting in February.
- **IDR Denial Responses** – IDPH stated that IDPH Legal is working on this and is very close to finalizing a solution. The Nursing Home Care Act states that IDPH must provide reasoning as to why an IDR was refused. This has not been happening.
- **Subpart S Regulations** – The latest draft of the Subpart S regulations is in the Governor’s Office for review and signoff. Once final signoff is received, the draft regulations will be taken to the LTC Advisory Board for review and action.
- **Distressed Facility Regulations** – This draft is also in the Governor’s Office for review and signoff. Once final signoff is received, the draft regulations will be taken to the LTC Advisory Board for review and action.
- **Informed Consent Regulations** – This draft is still under internal review within IDPH.
- **Behavioral Unit Regulations** – There has been no action on this.
- **Electronic Monitoring Rules/Consent Form** – The Electronic Monitoring/“Granny Cam” legislation has passed and had an effective date of January 1, 2016. However, the legislation states that no electronic devices are allowed in nursing homes until a consent form is provided by IDPH. IDPH has 60 days from 1-1-2016 to develop and implement a consent form. IDPH stated that they are working on this and will be made available within the 60 day timeframe. Rulemaking will also be necessary and IDPH is in the process of drafting rules, but they won’t be ready for several months. Once the consent form is made available, facilities will only have the electronic monitoring legislation to work from. Facilities should work with their legal counsel to develop a facility policy that complies with the legislation. That policy may need to be revised once the rulemaking is finalized.
- **Medical Cannabis/Marijuana** – The provider groups stated that the use of medical marijuana in LTC facilities is extremely problematic. We asked IDPH for guidance and if they were developing any rules to implement the use of medical marijuana in LTC facilities. They stated they understood the concerns and would take this issue back to IDPH Legal for review and response.
- **Complaint Intake Questions to be Added to the IDPH Website** – IDPH stated that this is being done. This was required in legislation passed last year.

The next meeting of the IDPH Quarterly Provider Association Meeting is scheduled for April 13, 2016. If you have any issues/questions you would like added to our agenda, please contact me.

**Medical Cannabis in Illinois: What Health Care Providers and Organizations Need to Know**

This article was written by Bob Morgan who is a health care regulatory and policy attorney with extensive experience in public service and the private sector. Prior to joining Much Shelist, Mr. Morgan served in the Office of the Governor of the State of Illinois, serving as associate general counsel and lead attorney on issues involving health care, the Affordable Care Act, private and public insurance issues and health information technology. In this role, he managed a dozen state agency general counsels overseeing health care, insurance, human services, environmental, energy, commerce and housing legal issues. Bob was subsequently appointed to serve as the first statewide project coordinator for the Illinois medical cannabis pilot program, with primary responsibility for developing and implementing a framework for the use of cannabis by eligible patients. This article appeared in *The National Law Review*. 
In Illinois, there are currently no regulations with regard to the use of medical cannabis in health care facilities. This article, written by Mr. Morgan, gives some general guidance to health care providers with respect to the Illinois Compassionate Use of Medical Cannabis Pilot Program Act. The article is in a Question and Answer format.

The passage of the Illinois Compassionate Use of Medical Cannabis Pilot Program Act, which legalizes cannabis use by sufferers of certain debilitating medical conditions, has created concerns among health care providers, hospitals, health systems, pharmacies, nursing homes and other members of the health care community. Now, with some medical cannabis dispensaries expected to begin operations in the coming weeks, questions regarding the impact on providers have grown more pressing by the day.

To help health care providers better understand their roles and responsibilities under the new Illinois law, we answer some of the most relevant questions below.

RESPONSIBILITIES OF HEALTH CARE PROVIDERS

Are Illinois doctors required to sign recommendations for their patients to use cannabis?
No. A licensed Illinois doctor may use his/her discretion in deciding whether to sign a recommendation for the use of cannabis by a patient. Note that a bona fide physician-patient relationship must exist between the doctor and the patient; where such a relationship does not exist, the physician is not allowed to sign a cannabis recommendation.

What is the difference between a “recommendation” and a “prescription?”
Medical cannabis prescriptions are, in fact, illegal. Cannabis is classified by the federal government as a Schedule I drug, and doctors are unable to prescribe cannabis to their patients. What patients can do, however, is obtain a medical cannabis recommendation from a licensed physician. An Illinois medical cannabis physician recommendation form can be found here.

Must hospitals, clinics or nursing homes allow cannabis use within their facilities?
No. Under state law, a health care facility can allow or prohibit non-smokable cannabis use by patients/residents. The smoking of cannabis, however, is prohibited in all health care facilities under the Smoke Free Illinois Act.

Can a health care provider refuse to admit or treat a patient whose doctor has recommended medical cannabis?
Yes, assuming the patient does not require emergency stabilization. Providers should always be mindful of their ethical and professional obligation to treat those in need of medical attention.

PHARMACISTS AND PHARMACIES

What role do pharmacists have in the medical cannabis program?
Unlike medical cannabis programs in other states, there is no formal role for pharmacists in the Illinois Medical Cannabis Program. However, pharmacists may advise, be employed by, or invest in licensed dispensaries, cultivation centers, research studies or other patient-education programs.

How is the pharmaceutical industry involved in the Illinois Medical Cannabis Pilot Program?
There is a pharmacist representative on the Medical Cannabis Advisory Board. Among its other duties, the board’s primary responsibility is to review, approve or deny petitions for the addition of debilitating medical conditions or diseases to the state’s medical cannabis program.

TREATMENT ISSUES

How should — and can — a health care practitioner track the health of patients who use medical cannabis?
A practitioner with a patient who uses medical cannabis should continue to provide the ordinary standard of care subject to the practitioner’s state licensure requirements. There are many resources available to practitioners seeking additional information on proper care and monitoring of medical cannabis patients. Two online resources that can help
physicians seeking to track the status of patients using medical cannabis are the Cannabis Training Institute and the Society of Cannabis Clinicians.

What clinical research exists showing the medical benefits of cannabis for patients?
Scientists in the U.S. and abroad have conducted studies on the safety and efficacy of cannabis and cannabis compounds in the treatment of various medical conditions. However, due to longstanding federal government restrictions, there is a shortage of longitudinal peer-reviewed research in the United States.

EMPLOYER CONCERNS

What obligations and prohibitions do employers have regarding employees who are medical cannabis patients?
The intersection of cannabis laws and employment regulations is complex and nuanced. For example, while some states with medical cannabis programs require an employer to provide an "accommodation" for medical cannabis patients, Illinois does not. However, an Illinois employer may not discriminate against a medical cannabis patient solely due to the patient's status as a program participant. Much Shelist's health care and labor and employment attorneys will dedicate future alerts to the impact of the Illinois program on employers in Illinois.

ILLINOIS LAW IN THE NATIONAL CONTEXT

Where does Illinois fall in the national cannabis industry landscape? Will the Illinois cannabis industry look like the markets in Colorado or Washington, which allow recreational use of cannabis?
The Illinois medical cannabis program is one of the most restrictive regulatory programs in the country, and limits individual usage and industry operations much more than a recreational cannabis state such as Colorado. The Illinois medical cannabis program is a four-year experiment. Illinois government leaders will evaluate a variety of outcomes before deciding whether to restrict, expand or modify the approved uses of cannabis.

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Trending Statistics

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


In recent years, trends in four key sets of data that give insight into nursing home quality show mixed results, and data issues complicate the ability to assess quality trends. Nationally, one of the four data sets—consumer complaints—suggests that consumers' concerns over quality have increased, while the other three data sets—deficiencies, staffing levels and clinical quality measures—indicate potential improvement in nursing home quality. For example, the average number of consumer complaints reported per home increased by 21 percent from 2005-2014, indicating a potential decrease in quality. Conversely, the number of serious deficiencies identified per home with an on-site survey, referred to as a standard survey, decreased by 41 percent over the same period, indicating potential improvement. The Centers for Medicare & Medicaid Services' (CMS) ability to use available data to assess nursing home quality is complicated by various issues with these data, which make it difficult to determine whether observed trends reflect actual changes in quality, data issues, or both. For example, clinical quality measures use data that are self-reported by nursing homes, and while CMS has begun auditing the self-reported data, it does not have clear plans to continue. Federal internal control standards require agencies to monitor performance data to assess the quality of performance over time.
In recent years, CMS has made numerous modifications to its nursing home oversight activities, but has not monitored the potential effect of these modifications on nursing home quality oversight. Some of the modifications have expanded or added new oversight activities, while others have reduced existing oversight activities. According to CMS, some of the reductions to oversight activities are in response to an increase in oversight responsibilities and limited number of staff and financial resources. However, CMS has not monitored how the modifications might affect CMS's ability to assess nursing home quality. For example, CMS reduced the number of nursing homes participating in the Special Focus Facility program—which provides additional oversight of homes with a history of poor performance—from 152 in 2013 to 62 in 2014. State survey agency officials who conduct surveys for CMS also made modifications which could have either a positive or negative effect on oversight, but CMS does not have an effective mechanism for monitoring. Federal internal control standards require ongoing monitoring as a part of normal program operations; without this monitoring, CMS cannot ensure that any modifications in oversight do not adversely affect its ability to assess nursing home quality.

**GAO Recommendations were:**
To improve the measurement of nursing home quality, the Administrator of CMS should take the following two actions:

- Establish specific timeframes, including milestones to track progress, for the development and implementation of a standardized survey methodology across all states.
- Establish and implement a clear plan for ongoing auditing to ensure reliability of data self-reported by nursing homes, including payroll-based staffing data and data used to calculate clinical quality measures.

To help ensure modifications of CMS’s oversight activities do not adversely affect the agency’s ability to assess nursing home quality and that effective modifications are adopted more widely, the Administrator of CMS should establish a process for monitoring modifications of essential oversight activities made at the CMS central office, CMS regional office, and state survey agency levels to better understand the effects on nursing home quality oversight.

**CMS’s response to the GAO Recommendations was:**
We provided a draft of this report to HHS for its review and comment. HHS provided written comments, which are reprinted in appendix IV. In its written comments, HHS described its efforts to improve nursing home quality. HHS also concurred with the report’s three recommendations. To address our first recommendation, HHS stated that it would set timeframes and milestones for the development and implementation of a standardized survey methodology. To address our second recommendation, HHS stated that it would continue to work to address the reliability of self-reported data by, for example, continuing through fiscal year 2017 the auditing of clinical quality measures data, which began in fiscal year 2015. As we describe in this report, ongoing auditing of self-reported data is important for ensuring data accuracy; as a result, whenever self-reported data are used for understanding nursing home quality—including the new electronic payroll system for collecting staffing data and data used to calculate clinical quality measures—our recommendation indicates that HHS should plan for and conduct audits in a continuing manner. To address our third recommendation, HHS stated that it would review its monitoring of key oversight activities and make adjustments as
indicated. HHS also provided technical comments, which we incorporated into the final version of this report as appropriate.

**Important Rules, Regulations & Notices**

1) There were no federal Survey and Certification Letters (S&C) released since the last issue of *Regulatory Beat*.

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

- **IMPACT Act: Connecting Post-Acute Care across the Care Continuum Call — Register Now - Thursday, February 4, 1:30 - 3 pm ET.** To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early. The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long term care hospitals. It specifies that data elements must be standardized and interoperable to allow for the exchange and use of data among these PAC and other providers, including common standards and definitions to facilitate coordinated care and improved beneficiary outcomes. During this call, CMS subject matter experts and the Office of the National Coordinator for Health IT discuss the implications of the IMPACT Act for health information exchange across the care continuum. **Agenda:** Requirements to standardize and make interoperable post-acute care assessment data elements; Using and exchanging clinically relevant assessment data for multiple purposes; Health Information Technology Standards - A Primer; CMS Data Element Library; Electronic health information exchange. **Target Audience:** Providers across the care continuum, including long-term/post-acute care and home and community-based service providers, acute and primary care providers, integrated delivery systems and representatives from other payment models, health IT vendors, and other interested stakeholders. Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) webpage to learn more.

- **Introduction to the IMPACT Act of 2014 Video — New** - In this [MLN Connects video](#), Dr. Patrick Conway, the principle deputy administrator and chief medical officer for CMS, provides an overview of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. This important legislation requires that patient assessment data used in post-acute care settings (skilled nursing facilities, home health agencies, inpatient rehabilitation facilities and long term care hospitals) be standardized to improve quality of care. Run time: 23 minutes: 21 seconds. Visit the [IMPACT Act](#) website for more information.

- **Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training — New** - With Continuing Education Credit - A new Drug Diversion: Schemes, Auditing, and Referrals Web-Based Training course is available through the [Learning Management and Product Ordering System](#). Learn about:
  - Impact of drug diversion on Medicare Part D
  - Common drug diversion fraud schemes
  - Sources of information used to support audits
  - Data analysis tips and techniques relative to drug diversion schemes
  - Techniques for effective on-site and desk auditing
  - How to report results of audits and make strong referrals

- **Medicare Quarterly Provider Compliance Newsletter Educational Tool — New** - A new [Medicare Quarterly Provider Compliance Newsletter [Volume 6, Issue 2]](#) is available. Learn about:
  - How to avoid common billing errors and other erroneous activities when dealing with the Medicare Program
  - How to address and avoid the top issues this quarter
ICD-10 Post-Implementation: Coding Basics Revisited Video — Reminder - In this MLN Connects video, Sue Bowman from the American Health Information Management Association (AHIMA) and Nelly Leon-Chisen from the American Hospital Association (AHA) discuss the unique characteristics and features of the new coding system. Run time: 33 minutes.

- What is a valid code
- Guidelines for coding and reporting
- Coding process and examples: 7th character, unspecified codes, external cause codes, laterality
- How to submit coding questions
- Resources for coders

Visit the ICD-10 Medicare Fee-For-Service Provider Resources webpage for a complete list of Medicare Learning Network resources on ICD-10.

Revised Two-Midnight Rule Guidelines: CMS has revised guidelines on Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016. Starting October 1, 2015 Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) began conducting initial patient status reviews of claims for inpatient admissions. Under the revised exceptions policy (CMS-1633-F), which became effective January 1, 2016, for admissions not meeting the two midnight benchmark, Part A payment may be appropriate on a case-by-case basis where the medical record supports the admitting physician’s determination that the patient requires inpatient care, despite the lack of a two-midnight expectation.

BFCC-QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. Two-Midnight Short-Stay Reviews focus on educating doctors and hospitals about the Part A payment policy for inpatient admission. Recovery auditor patient status reviews will be conducted by recovery auditors for those hospitals that have consistently high denial rates based on the BFCC-QIO Two-Midnight Short-Stay Review outcomes. Visit the Inpatient Hospital Reviews webpage for additional information. CMS will be discussing the new guidance at the Hospital Open Door Forum on January 26.

PECOS FAQs Fact Sheet — Revised - A revised PECOS FAQs Fact Sheet is available. Learn about:

- Information you need before beginning enrollment using the Provider Enrollment, Chain and Ownership System (PECOS)
- Enrollment application issues
- Revalidations

Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21

All Quality Improvement and Evaluation System (QIES) systems will be unavailable from Wednesday, March 16 after 8 pm ET through Monday, March 21, 2016. This downtime will affect all QIES connectivity and systems. The national database, Certification and Survey Provider Enhanced Reporting (CASPER) reports, and quick reference (QW) will not be available during this time. In addition, the following submission systems will be unavailable:

- Hospice Item Set
- Inpatient Rehabilitation Facility (IRF) -Patient Assessment Instrument (PAI)
- Long Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set
- Minimum Data Set (MDS) and Payroll-Based Journal
- Outcome and Assessment Information Set (OASIS)

Affected providers should make contingency plans to accommodate for this downtime.
3) AHCA/IHCA News Items of Interest:

- **5-Star Accuracy Reminder** – Please double check all 5-Star data. CMS/IDPH will not change data that was submitted in error. We have had several cases where providers submitted staffing data and later discovered an error was made. In contacting CMS/IDPH, they stated their strict policy is to not correct the data. The provider will have to wait until the next reporting time to provide the correct data.

- **CMS Proposal to Extend RAC Program to Medicare Advantage** – (click here for the full email). On December 28, 2015, CMS released a request for information (RFI) and statement of work (SOW) soliciting industry feedback on its plans to expand the Medicare Recovery Audit Contractor (RAC) program to Medicare Advantage (MA) organizations. Under the current program, CMS contracts with private RACs to audit providers' Part A/Part B medical and billing records. CMS then pays RACs a contingency fee based on the amount of overpayments collected. AHCA continues to evaluate the RFI and SOW to identify potential downstream impacts for AHCA providers and will keep you informed of any developments. Please contact Narda Ipakchi with any questions or comments.

- **National Site Visit Verification (NSV) Initiative** – This article provides the latest information about the CMS National Site Visit Verification (NSV) initiative. The NSV initiative is part of CMS’s National Fraud Prevention Program (NFPP) and assists CMS in its efforts to prevent fraud and abuse in the Medicare program starting with the enrollment process. In 2011, CMS implemented a site visit verification program using a National Site Visit Contractor (NSVC). The site visit verification program is a screening mechanism to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The NSVC will conduct unannounced site visits for Medicare Part A/B providers and suppliers. During an observational visit, the inspector engages in minimal contact with the provider or supplier and does not inhibit the daily activities that occur at the facility. The inspector may take photographs of the facility as part of the site visit. During a detailed review, the inspector will enter the facility, speak with staff, take photographs, and collect information to confirm the provider or supplier’s compliance with CMS standards. MSM Security Services, LLC was awarded the national site visit contract December 20, 2011. MSM and its subcontractors, Computer Evidence Specialists, LLC (CES) and Health Integrity, LLC (HI) are authorized by CMS to conduct the provider and supplier site visits.

- **Click here** for the latest edition of IHCA Education Update.

4) The Illinois Department of Healthcare and Family Services released several Provider Notices since the last issue of *Regulatory Beat*. They were:

- **Peer Review Organization (PRO)/Quality Improvement Organization (QIO)** - State Medicaid agencies are required to provide quality assurance and fee-for-service utilization review in the inpatient hospital settings for services provided to participants in the Medical Assistance program and Illinois contracts with a PRO/QIO to conduct this function. The department requires the PRO/QIO to assist the department in assuring that quality care is being provided to Medical Assistance program participants. The department has executed a contract with eQHealth Solutions (eQH). eQH provides concurrent, retrospective prepayment and post payment reviews for services provided in the inpatient hospital setting for participants eligible for Medical Assistance. eQH provides quality of services review including medical necessity, reasonableness and appropriateness of care using telephonic, and web-based interactions. Click here for the full notice and attachments.

- **Updated Hospital Rate Sheets and Payment Calculators** – Per the provider notice dated January 6, 2016, the department has posted updated pricing calculators and hospital rate sheets to the HFS website. The pricing calculators contain the new relative weights associated with the APR-DRG grouper version 33 and the EAPG grouper version 3.10. In addition, the calculators have been updated to include the new hospital specific rates and cost-to-charge ratios in order to calculate estimated reimbursement for inpatient discharges and outpatient dates of service on or after January 1, 2016. The pricing calculators can be accessed at the following site: Hospital Pricing Calculators. The new rate sheets have been posted to the following site: Hospital Rate
Sheets Effective January 1, 2016. Hospitals can access their updated rate sheet by clicking on the appropriate link at that site.

- **Managed Care Manual** – The Department is issuing the [Managed Care Manual for Medicaid Providers](#). This manual contains helpful information regarding the Medicaid Managed Care Program for providers enrolled in Medicaid. Please be advised that this manual is not intended to supersede, modify, or replace any policies, guidelines, or other provider handbooks applicable to providers in the Medical Assistance Program under the fee-for-service payment system.

5) The Illinois Department on Aging recently published the [No Wrong Door System Listening Sessions Findings Final Report](#) (click here for the full report). A key part of the NWD planning process is to engage individuals and organizations outside of existing ADRNs, new and potential partners, individuals receiving LTSS and their families to better understand the strengths and existing needs of each NWD System across the state. This ensures the meaningful involvement of consumers, families and other stakeholders in the design, implementation and continuous improvement of the NWD System. To support stakeholder engagement in the development of its NWD Three-Year Plan, Illinois contracted with the Lewin Group to conduct listening sessions across the state.

6) The latest Ttelligen Event Report can be found [here](#).

7) The [University of Exeter](#) recently published results of a study entitled, “[People With Dementia Gain From Learning Self-Management Skills](#).” People with early-stage dementia benefit when they are empowered to manage their own condition, a study led by researchers at the University of Exeter has found. Research involving Bangor University and published in the journal International Psychogeriatrics, found that attending weekly ‘self-management’ group sessions that encouraged socialization, discussion, problem solving and goal setting fostered independence and promoted social support amongst people with dementia.

8) [Medscape](#) published several articles of interest. They include:

- **Joint Guideline Addresses Geriatric Perioperative Care.** The American College of Surgeons (ACS) and American Geriatrics Society (AGS) have issued joint best practice recommendations for geriatric perioperative care. The consensus-based guideline was [published online](#) January 4 on the ACS National Surgical Quality Improvement Program website”. As a start, this guideline functions as an unprecedented educational resource, one that organizes all of the components of perioperative care of the older adult in one place,” guideline coauthor Sanjay Mohanty, MD, an ACS/AGS James C. Thompson Geriatrics Surgical Fellow from Henry Ford Hospital, said in a news release. "Moving forward, perhaps it will one day play an important role in informing us about process, and providing us with insightful metrics on outcomes for geriatric surgical patients."

- **Antidepressant Use Linked to Increased Brain Bleed Risk.** Use of antidepressants is linked to an increased risk for the development of first-time cerebral microbleeds, results of a longitudinal study show. "In this population-based study, we found that antidepressant use was associated with an increased risk of incident first-ever microbleeds after 4 years of follow-up," the authors, led by Bruno H. Stricker, MMed, PhD, Erasmus University Medical Center, in Rotterdam, the Netherlands, write.

- **CDC, ACP Issue Guideline on Antibiotic Use for RTI.** The American College of Physicians (ACP) and the Centers for Disease Control and Prevention (CDC) have released a new clinical guideline on antibiotic use in adults with acute respiratory tract infections (ARTIs). "Providers should apply strict criteria...to determine when antibiotics are needed," lead author Aaron M. Harris, MD, MPH, LCDR, US Public Health Service, medical epidemiologist, Division of Viral Hepatitis, CDC, said. "Except for confirmed bacterial infections like streptococcal pharyngitis or acute bacterial sinusitis, antibiotics should not routinely be used to treat healthy adults with acute respiratory tract infections at outpatient clinics...Treatments to relieve symptoms are available and can be used to reduce discomfort."
• **Urine Test for Early Alzheimer's Steps Closer.** A new study of mice suggests it may be possible to detect the early stages of Alzheimer's disease from the odor signature of urine. While there is still a lot of work to do, the researchers hope the findings will lead to a non-invasive urine test that spots the destructive brain disease before it has had time to do much damage.

• **Eradicating B12 Deficiency for the Elderly is as Simple as Screening for It.** New research published in *Applied Physiology, Nutrition, and Metabolism* reveals that a high proportion of long term care residents have a B12 deficiency. Researchers from the University of Waterloo and the Schlegel-University of Waterloo Research Institute for Aging found that the current state of B12 levels for elderly individuals in long-term care facilities in Ontario warrants considering B12 screening at admission in order to ensure effective treatment. Currently, prospective long term care residents are not systematically screened for a B12 deficiency at admission and in some situations not screened unless the individual has symptoms to suggest that they are anemic. However, B12 is linked with many health issues such as depression and dementia and even suboptimal levels of the vitamin can have negative side effects on cognition, function and quality of life. Screening for deficiency is an especially important practice for older adults who are commonly B12 deficient as a result of medications that interfere with the vitamin's absorption.

• **A Nutrition Supplement is Associated With Lower Death Rate in Patients, New Study Shows.** Results from a new clinical trial show that a specialized oral nutrition supplement was associated with a 50 percent lower death rate in older malnourished patients with a heart or lung disease 90 days following hospitalization. The study, published online today in *Clinical Nutrition* and supported by Abbott, estimated that within this population one life could be saved for every 21 patients who received the specialized nutrition supplement, demonstrating it as a highly effective therapy. The NOURISH (Nutrition effect On Unplanned Readmissions and Survival in Hospitalized patients) study - one of the largest nutrition clinical studies of its kind - was a prospective, randomized, double-blind, placebo-controlled trial. The study was designed to build upon the body of evidence demonstrating that oral nutrition supplements may reduce complications, mortality and hospital readmissions in malnourished patients. Participants in the NOURISH study included 652 malnourished adults, aged 65 or older, who were admitted to the hospital and suffered from heart or lung disease. Researchers compared the effects of a specialized nutrition supplement with high protein (20 grams), HMB* (a muscle-preserving ingredient) and Vitamin D to a placebo supplement on rates of readmissions or death 90-days after leaving the hospital.

• **Exercise for People with Dementia Improves Balance and Reduces Dependence.** Regular exercise improves balance for people with dementia and reduces dependence on assistance. This according to new research on healthcare for people suffering from dementia conducted at Umeå University in Sweden, which has now been published in the *Journal of the American Geriatrics Society*. In a unique study on people with dementia living in residential care facilities, researchers from Umeå University have found that regular functional exercise, similar to everyday activities and performed at high intensity, can improve balance and reduce dependence on assistance in activities of daily living, such as for instance mobility or toilet visits. Training sessions lasting 45 minutes, two to three times per week, can lead to an improved quality of life for individuals suffering from dementia - a progressive illness leading to gradual reduction in cognitive and physical function.

10) **Science Direct** recently published an article entitled, “The Need for a Social Revolution in Residential Care.” Loneliness and depression are serious mental health concerns across the spectrum of residential care, from nursing homes to assisted and retirement living. Psychosocial care provided to residents to address these concerns is typically based on a long-standing tradition of 'light' social events, such as games, trips, and social gatherings, planned and implemented by staff. Although these activities provide enjoyment for some, loneliness and depression persist and the lack of resident input perpetuates the stereotype of residents as passive recipients of care. Research suggests, however, that programs fostering engagement and peer support provide opportunities for residents to be socially productive and to develop a valued social identity. The purpose of this paper is to offer a re-conceptualization of current practices.
11) **MedlinePlus** has published several articles of interest. They include:

- **U.S. Flu Activity Remains Low: CDC.** Flu activity remains low in the United States, possibly due to the mild temperatures that have blanketed much of the nation, federal health officials said Friday. But officials expect flu activity to pick up in the next few weeks, so anyone who hasn't gotten a flu shot should get one now.

- **Regular Mammograms Worthwhile for Elderly Women.** Regular mammograms benefit elderly women, a new study indicates. Previous research has shown that mammography screening reduces breast cancer deaths among women up to age 74, but there is little information about women older than 74, especially minority women, the Florida Atlantic University researchers explained.

- **Dementia Drug May Lower Risk of Falls Among Parkinson’s Patients.** A widely used dementia drug shows potential in reducing the risk of falls among Parkinson's patients, new research suggests. "With the degeneration of dopamine-producing nerve cells, people with Parkinson's often have issues with unsteadiness when walking. As part of the condition, they also have lower levels of acetylcholine, a chemical which helps us to concentrate -- making it extremely difficult to pay attention to walking," said study lead author Emily Henderson, from the University of Bristol in England.

- **Low Bicarbonate Levels May Be a Danger for Seniors.** Seniors who are healthy but have low blood levels of bicarbonate are at higher risk for premature death, a new study contends. Bicarbonate plays an important role in maintaining the body's pH balance. Fruits and vegetables are a source of bicarbonate. Researchers looked at nearly 2,300 Americans, ages 70 to 97, who were followed for an average of just over 10 years. During that time, those who were healthy and had normal or high bicarbonate levels had a similar risk of dying, but those with low bicarbonate levels had a 24 percent increased risk of death.

- **Blood Test Might Predict When Antibiotics Won’t Help.** Researchers say they're closer to developing a blood test that distinguishes between viral and bacterial respiratory infections. This would help doctors predict when antibiotics will and will not work. Such a test, done right in the doctor's office, might also help curb overuse of antibiotics -- a practice that has led to drug-resistant bacteria, experts suggest.

12) **McKnight’s** also had several article of interest. They included:

- **Providers Set Sights On Pay Reform, IMPACT Act Implementation.** The new year brings a stronger focus on payment reform policies, value-based purchasing and observation stays, said a top executive with the nation's largest nursing home association on Monday. After a relatively successful 2015 that came with plenty of surprises for providers, the view "out the windshield" shows 2016 could be relatively quiet policy-wise, said Clif Porter, senior vice president of government affairs and public policy for the American Health Care Association. The group's top policy concerns for the coming year include deadlines and measures related to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and ensuring outcomes associated with the act are "defined in a rational way" and "not just purely cost-focused." Porter also called the act the “railroad track” of future payments, and noted measures concerning the measure are likely to be the top regulatory issue the group faces this year.

- **GAO: Feds Lack Planning, Accountability For Healthcare Workforce.** Current workforce planning efforts conducted by the Department of Health and Human Services are too broad to adequately meet the nation's healthcare needs, according to a new report from the U.S. Government Accountability Office. The GAO report found many of the HHS health care workforce programs — including those for nurses, therapists, pharmacists, physicians and others who provide direct patient care — lack the oversight and planning to directly address healthcare issues. Broad strategies like improving health care access in historically underserved areas and supporting federally funded health centers don't “explicitly reference workforce issues” or how they relate to HHS's goals and performance targets, the report noted.
• **Drug Disposal Rule Sets Up Providers For Noncompliance, Groups Say.** The government’s apparent lack of understanding about the differing characteristics among senior living settings could put some providers “perpetually in noncompliance” with a [proposed federal rule](#) regarding the disposal of unused medications, several industry groups contend. The rule, [published](#) by the Environmental Protection Agency in September, would prohibit health care facilities (defined to include assisted living communities, continuing care retirement/life plan communities and other senior living and health care settings) from disposing down the toilet or drain those pharmaceuticals considered to be hazardous waste. It also would require providers, when they transport drugs off site that are not eligible for a manufacturer's credit, to ship the drugs as hazardous waste, with a hazardous waste manifest, to a Resource Conservation and Recovery Act interim status or permitted facility.

• **More Therapy Increases the Likelihood of SNF Discharge: Ivy League Study.** Increasing the level of therapy for skilled nursing residents recovering from hip fractures may also increase their chances of being discharged, according to a new study. The [first-of-its-kind study](#), conducted by researchers at Cornell, Brown and Harvard universities, analyzed the impact of one extra therapy hour per week in over 480,000 hip fracture patients who were enrolled in Medicare between 2000 and 2009. Results found that patients who received the additional hour of therapy were 3.1 percent more likely to leave the facility for their home than those who didn’t. The study’s findings applied only to relatively healthy patients, researchers noted. Patients with the highest levels of impairment are unlikely to benefit from additional therapy.

• **Mortality Risk Doubles for SNF Residents Readmitted to Hospital.** Skilled nursing facility residents who are readmitted to the hospital are twice as likely to die in the 30 days following hospital discharge than those who stayed in the SNF, according to a new study. The [study](#), conducted by the University of Colorado School of Medicine, reviewed more than 3,200 cases of patients whose hospitalizations were followed by stays in a skilled nursing facility. Researchers found that mortality rates soared for patients who were readmitted to the hospital, with risk of mortality within 30 days of discharge doubling for readmitted patients. Readmitted patients were four times as likely to die within 100 days of hospital discharge. The most common risk factors for readmission were patients who needed an invasive device like a catheter or feeding tube, and those requiring advanced care like dialysis or oxygen therapy. For-profit skilled nursing facilities also saw higher rates of readmission.

• **Poor Sleep in Older Adults Increases Stroke, Cognitive Impairment Risk.** Older adults whose sleep is repeatedly interrupted are at increased risk of stroke and cognitive impairment, according to a newly published study in the American Heart Association's journal, *Stroke*. That's because such “fragmented” sleep, whether it be from awakenings or arousals, is associated with hardened arteries and oxygen deprivation in the brain.

13) **Interesting Fact:** Is “old-person smell” real? Yes. But there’s also a distinctive middle-aged-person smell and a young-person smell, according to a recent study. The research found that older people have a less intense—and more pleasant—scent than the middle-aged folk and young whippersnappers. Not what you expected, right?