May 19, 2015 Edition

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!

The AHCA Quality Initiative
The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) launched the Quality Initiative in 2012. The Quality Initiative is an expansion of Quality First, which was initiated by AHCA/NCAL back in 2002. Since the inception of Quality First, 6,500 AHCA/NCAL members have pledged their commitment to ensuring quality long term care services that maintain and foster the trust of the American public. Quality First established seven core principles that reflect long term care providers’ commitment to continuous quality improvement, leadership and transparency. The original seven core principles were:

- Continuous Quality Improvement
- Public Disclosure and Accountability
- Resident and Family Rights
- Workforce Excellence
- Public Input and Community Involvement
- Ethical Practices
- Financial Stewardship

Based on the seven core principles, five goals were established. They were:

- Performance in CMS Quality Measures
- Compliance with Federal Survey Processes
- High Rates of Resident/Family Satisfaction
- High Staff Satisfaction Rates
- Leadership/Staff Retention – Reduce Turnover Rates

The next generation of Quality First is the Quality Initiative. AHCA/NCAL has set forth an ambitious agenda of strategic goals, which includes working to encourage a stable financing system that enhances quality long term care; an oversight system that is fair, consistent and rewards quality; and a workforce that meets the growing needs of our profession and the nation. As an organization that has been advocating for the long term care profession for more than 50 years, we recognize that these will be hard-fought battles to achieve complete victory.

AHCA/NCAL has been working to change the debate regarding long term care to focus on quality – quality of life for residents and staff; quality of care for the one million frail, elderly and disabled individuals who require long term care services. AHCA/NCAL continues to work with CMS and others to move forward the agenda of quality care and life in our nation’s long term care facilities.
AHCA/NCAL created and is now broadening and enhancing the Quality Initiative to further improve the quality of care in America’s long term care facilities. The expansion will challenge members to apply the Baldrige Performance Excellence Framework—the foundation of the 2015-2018 Quality Initiative—to meet measurable targets in eight areas with a focus on three key priorities: improvements in organizational success, short-stay/post-acute care, and long-term/dementia care. These areas are aligned with CMS’s Quality Assurance/Performance Improvement (QAPI) program and federal mandates, such as Five-Star and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

The Quality Initiative Goals include:

- Increasing Staff Stability
- Adopting Customer Satisfaction Questionnaire and Measure
- Reducing the Number of Unintended Health Care Outcomes
- Safely Reducing Hospital Readmissions
- Improving Discharge Back into the Community
- Adopting Functional Outcome Measures
- Safely Reducing Off-Label Use of Antipsychotics
- Safely Reducing Hospitalizations

**National Initiatives Alignment**

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**CMS includes dementia partnership, regulatory compliance, QAPI, and adverse events.**

AHCA will use CMS data and measures to track progress of the goals. Members can view their progress using AHCA’s LTC Trend TrackerSM, a web-based, data collection and benchmarking tool. Visit qualityinitiative.ahcancal.org for more information about the AHCA Quality Initiative.

**What to Do if Selected for an OCR HIPAA Audit**

In March of 2014, the Office for Civil Rights (OCR) announced that HIPAA audits would start in the fall of 2014. To date, no audits have taken place, and as of this writing, the audit program is still on hold. That said, the OCR is gearing up for the pre-selection process and has announced that audits will commence when the audit portals and project management software are completed.

Like the start-date, the exact number and types (desk vs. on-site) of audits has been in a state of flux. However, all indicators point to significantly more than the 115 that were selected as part of the pilot audit program of
2011/2012. Participants will include health plans, healthcare providers and clearinghouses (covered entities), and in a second round, a cross section of business associates.

For some healthcare organizations, submitting to an OCR audit will be challenging at best. The HIPAA audit pilot program revealed an egregious lack of attention to HIPAA rules and regulations across the industry. As a result, the OCR Audit participants can expect a particular focus on areas that had the most significant observations and findings in 2012: lack of risk assessments; attention to media movement and disposal; and implementation of audit controls and monitoring.

But even if an entity has been reasonably attentive to compliance, it still behooves them to do some upfront research on what to expect should they be selected.

OCR Audits: How to Respond
The OCR has not been particularly forthcoming with information on the upcoming audits, so it’s up to individual organizations to interpret what to expect and how to prepare. But the OCR has indicated that—unlike the 2012 pilot program—the audits will be conducted by OCR personnel rather than by a third party. And unlike last time, the audits will lean more heavily toward desk audits, with onsite audits occurring on a case-by-case basis.

According to information in presentations from Department of Health and Human personnel, here is what audited entities need to be aware of:
- Data request will specify content and file organization, file names and any other document submission requirements.
- Only requested data submitted on time will be assessed.
- All documentation must be current as of the date of the request.
- Auditors will not have opportunity to contact the entity for clarification or to ask for additional information, so it is critical that the documents accurately reflect the program.
- Submitting extraneous information may increase difficulty for auditor to find and assess the required items.
- Failure to submit response to requests may lead to referral for regional compliance review.
- Document submissions will be no small task, so gathering necessary evidence up front will minimize disruption to day-to-day operations.

Getting Ahead of the OCR Audits
Once an organization receives notification, it should immediately mobilize. If subsequently chosen to submit to an audit, participants will only have a short time to respond. The following provides basic steps for a strategic OCR Audit plan:

Gather a team. Privacy and security officials should be assigned to a task force responsible for handling audit requests. It’s also a good idea to notify internal or external legal counsel to keep them on stand-by should guidance be necessary.

Follow guidelines on how to respond. The OCR will provide specific instructions on how and when to respond. The OCR will not look favorably on a delayed response, and if unrequested documentation is submitted, it can be used in all observations and findings.

Here are some of the areas the OCR audits will cover:
1. Risk analysis.
2. Evidence of a risk management plan (e.g. list of known risks and how they are being dealt with).
3. Policies and procedures and descriptions as to how they were implemented.
4. Inventories of business associates and the relevant contracts and BAAs.
5. An accounting of where electronic protected health information (ePHI) is stored (internally, printouts, mobile devices and media, third parties).
6. How mobile devices and mobile media (thumb drives, CD’s, backup tapes) are secured and tracked.
7. Documentation on breach reporting policies and incident response policies and procedures.
8. A record of security training that has taken place.

**Question findings if they appear to be inaccurate.** Historically, the OCR has allowed organizations to respond to observations and findings. Organizations that have documented all compliance decisions will fare better when trying to defend their position. There are many areas where HIPAA lacks specific direction; the ability to demonstrate a thoughtful and reasonable approach (in writing) will tend to be viewed favorably.

By preparing up front and responding in a timely fashion, most OCR audits should progress fairly smoothly. For organizations that have instituted a reasonably compliant security program, there may be little or no follow-up. If there are a significant number of observations and findings, an organization may be subject to voluntary compliance activities, or a more in-depth compliance review. Should an in-depth review uncover significant issues, additional corrective action must be taken and/or fines may be imposed.

*This article was reprinted out of HealthData Management. It was authored by Mark Fulford who is a Partner in the security and risk services practice at LBMC, an accounting and consulting firm in Brentwood, Tenn. He has more than 20 years of experience in information systems management, IT auditing, and security.*

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**Trending Statistics**

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

Nearly 7.2 percent of the population (22.5 million) paid $2,000 or more in out-of-pocket medical expenses in 2012, compared with 6.9 percent (21.5 million) in 2011. In both 2011 and 2012, nearly 1.5 percent (4.8 million) of Americans paid $5,000 or more, and 0.4 percent (1.3 million) paid at least $10,000. (Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey Statistical Brief #450, *Differentials in the Concentration in Out-of-Pocket Health Expenditures across Population Subgroups in the U.S., 2012*.)

**Highlights**

- In 2012, the top 1 percent ranked by their out-of-pocket health care expenses accounted for 20.5 percent of total out-of-pocket health care expenditures with an annual mean out-of-pocket expenditure of $12,500. Overall, the top 50 percent of the population ranked by their out-of-pocket expenditures accounted for 97.8 percent of overall out-of-pocket health care expenditures while the lower 50 percent accounted for only 2.2 percent of the total.
- In 2012, 7.2 percent of the population (22.5 million individuals) had out-of-pocket expenditures for medical care that were equal to or greater than $2,000. Nearly 4.8 million individuals (1.5 percent) paid $5,000 or more out of pocket for their medical care. When considering higher spending thresholds, approximately 1.3 million individuals (0.4 percent) incurred out-of-pocket expenditures of at least $10,000.
- In 2012, only 3.9 percent of medical expenditures for inpatient hospitalizations were paid out of pocket. Alternatively, 12.3 percent of ambulatory care expenditures, 19.2 percent of prescribed medical expenditures, and 48.5 percent of dental expenditures were paid out of pocket.
- Children under the age of 18 were characterized by substantially greater concentrated levels of out-of-pocket health care spending relative to their older counterparts. Alternatively, the elderly had the highest mean levels of out-of-pocket health care expenditures relative to younger population subgroups at the top quantiles of the expenditure distribution.
- Non-Hispanic whites and other races had the highest mean levels of out-of-pocket health care expenditures at the top quantiles compared with other racial/ethnic groups.
- The top 5 percent of the publicly insured population under age 65 ranked by their health care expenses accounted for 68.1 percent of the out-of-pocket health care expenditures incurred by this subpopulation with
an annual mean of $2,682. Individuals with public insurance had the most concentrated levels of out-of-pocket health care expenditures and the lowest annual mean out-of-pocket expenses.

**Important Rules, Regulations & Notices**

1) The following federal Centers for Medicare and Medicaid Services (CMS) Survey and Certification Letters were released since the last issue of *Regulatory Beat*:

- **S&C 15-37 – Nursing Homes** - Proposed Rule: SNF Medicare FY 2016 Payments, Quality Reporting, Value-Based Purchasing and Staffing Requirements – Informational Only. A notice of proposed rule-making (“FY 2016 SNF PPS for Staffing Data Collection in Long-Term Care Facilities”) regarding the collection of staffing data in long term care facilities was published on April 20, 2015. The proposed rule would implement the new requirements regarding the submission of staffing data to CMS based on payroll and other verifiable and auditable data. The document can be found here. The public has until 5 p.m. on June 19, 2015 to comment on the proposed regulatory document.

To further summarize, this proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2016. In addition, it includes a proposal to specify a SNF all-cause all-condition hospital readmission measure, as well as a proposal to adopt that measure for a new SNF Value-Based Purchasing (VBP) Program and a discussion of SNF VBP Program policies we are considering for future rulemaking to promote higher quality and more efficient health care for Medicare beneficiaries. Additionally, this proposed rule proposes to implement a new quality reporting program for SNFs as specified in the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). It also would amend the requirements that a long term care (LTC) facility must meet to qualify to participate as a skilled nursing facility (SNF) in the Medicare program, or a nursing facility (NF) in the Medicaid program. These requirements implement the provision in the Affordable Care Act regarding the submission of staffing information based on payroll data.

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

- **Pioneer ACO Model achieves substantial savings, meets criteria for first-ever expansion.** The Department of Health and Human Services released an independent evaluation report showing an innovative payment model created as a pilot project by the Affordable Care Act generated substantial savings to Medicare in just two years. Additionally, the independent Office of the Actuary in CMS has certified that this patient care model is the first to meet the stringent criteria for expansion to a larger population of Medicare beneficiaries.

The Pioneer ACO Model was found to generate over $384 million in savings to Medicare over its first two years, according to the independent evaluation report. This equates to an average savings of approximately $300 per participating beneficiary per year, while continuing to deliver high-quality patient care. Pioneer ACOs generated Medicare savings of $279.7 million in 2012 and $104.5 million in 2013. To date, actuarial analyses show that ACOs in the Pioneer ACO Model and the Medicare Shared Savings Program have generated over $417 million in total program savings for Medicare. The primary analyses in the evaluation are also reported in an article recently published in the *Journal of the American Medical Association*.

Additional information about the Pioneer ACO Model and its actuarial certification can be found on the [Pioneer ACO Model web page](#).

- **National Partnership to Improve Dementia Care and QAPI Webinar — Register Now** - Tuesday, June 16; 1:30 – 3 p.m. ET. To Register: Visit [MLNConnects’ Upcoming Calls](#). Space may be limited, register early. During this MLN Connects National Provider Call, CMS subject matter experts will provide updates for the
The National Partnership to Improve Dementia Care in Nursing Homes and QAPI are partnering on MLN Connects Calls to broaden discussions related to quality of life, quality of care and safety issues. The National Partnership was developed to improve dementia care in nursing homes through the use of individualized, comprehensive care approaches to reduce the use of unnecessary antipsychotic medications. QAPI standards expand the level and scope of quality activities to ensure that facilities continuously identify and correct quality deficiencies and sustain performance improvement.

**Agenda:**
- National Partnership and QAPI updates
- Antipsychotic reduction success – The Cedars, Maine
- Evidence-based dementia care training

**Target Audience:** Consumer and advocacy groups, nursing home providers, surveyor community, prescribers, professional associations and other interested stakeholders.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

- **ICD-10: Preparing for Implementation and New ICD-10-PCS Section X Webinar — Register Now** - Thursday, June 18; 1:30 – 3 p.m. ET. To Register: Visit MLN Connects’ Upcoming Calls. Space may be limited, register early. It’s not too late to get ready for ICD-10 implementation on October 1, 2015. During this MLN Connects National Provider Call, CMS subject matter experts will present strategies and resources to help you prepare. Also, learn about ICD-10-PCS Section X for new technologies, which will be used by hospitals. A question and answer session will follow the presentations.

  **Agenda:**
  - National implementation update and preparation strategies
  - ICD-10-PCS Section X for new technologies
  - Testing update
  - Provider resources

  **Target Audience:** Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories and all Medicare providers.

  Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

- **Final Opportunity to Volunteer for ICD-10 End-to-End Testing in July — Forms Accepted May 11 – 22.**
  
  **Deadline extended.** During the week of July 20 – 24, 2015, a final sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. CMS is accepting additional July volunteers May 11 – 22, 2015. Don’t miss your chance to participate in end-to-end testing with Medicare prior to the October 1, 2015 implementation date.

  Approximately 850 volunteer submitters will be selected to participate in the July end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a
broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers. Note: Testers who are participating in the January and April end-to-end testing weeks are able to test again in July without re-applying.

To volunteer as a testing submitter:

- Volunteer forms are available on your MAC website
- Completed volunteer forms are due May 22
- CMS will review applications and select additional July testers
- The MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing by June 12

If selected, testers must be able to:

- Submit future-dated claims.
- Provide valid National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), and beneficiary Health Insurance Claim Numbers (HICNs) that will be used for test claims. This information will be needed by your MAC for set-up purposes by the deadline on your acceptance notice; testers will be dropped if information is not provided by the deadline.

Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

For more information:

- MLN Matters® Article #MM8867, “ICD-10 Limited End-to-End Testing with Submitters for 2015”
- MLN Matters Special Edition Article #SE1435, “FAQs – ICD-10 End-to-End Testing”
- MLN Matters Special Edition Article #SE1409, “Medicare FFS ICD-10 Testing Approach”

- Depression is Not a Normal Part of Growing Older. May is Mental Health Month. This year’s theme, “B4Stage4: Changing the Way We Think About Mental Health” draws attention to how people can address their mental health early, rather than at “Stage 4,” when symptoms are more severe and recovery a longer process. Older adults are at an increased risk for experiencing depression. Many have at least one chronic health condition and often have two or more. Depression is more common in people who have other illnesses or limited functions. Depression in older adults is often misdiagnosed and undertreated; mistaken as a natural reaction to illness or life changes as adults’ age. Not understanding that they might be suffering from depression and could feel better, older adults often accept how they feel as part of the normal aging process and don’t seek help. Depression is a treatable medical condition, not a normal part of aging. Continue reading.

- Therapy Caps Exceptions Process Extended through CY 2017. When the Medicare Access and CHIP Reauthorization Act was signed into law on April 16, 2015 the therapy caps exceptions process for Physical Therapy (PT), Occupational Therapy (OT) and Speech-Language Pathology (SLP) services was extended through CY 2017. Additional information is available on the Therapy Services web page.

- “Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model” MLN Matters® Article — Released. MLN Matters® Special Edition Article #SE1514 is now available in downloadable format. This article is designed to provide education on the importance of compliance with documentation requirements for the repetitive scheduled non-emergent ambulance prior authorization model. It includes background and additional information.

- Proposed Updates to Hospice Wage Index and Payment Rates. On April 30, CMS issued a proposed rule (CMS-1629-P) that would update FY 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. As proposed, hospices would see an estimated 1.3 percent ($200 million) increase in their payments for FY 2016. The $200 million increase in estimated payments for FY 2016 reflects:
The distributional effects of the 1.8 percent proposed FY 2016 hospice payment update ($290 million increase)

- The use of updated wage index data and the phase-out of the wage index budget neutrality adjustment factor (-0.7 percent/$120 million decrease)
- The proposed implementation of the new Office of Management and Budget Core Based Statistical Area (CBSA) delineations for the FY 2016 hospice wage index with a one-year transition (0.2 percent/$30 million increase)

The proposed rule also includes:

- Alignment of cap year
- Proposed routine home care rates
- Service intensity add-on
- Clarification of diagnoses on claim form

Public comments on the proposal will be accepted until June 29, 2015.

Full text of this excerpted CMS fact sheet (issued April 30).

3) The Illinois Department of Healthcare and Family Services (HFS) issued two notices of interest since the last issue of Regulatory Beat. They include:

- **Enrollment Timeline and Deadlines for the Illinois Medical Assistance Program - Illinois Medicaid Program Advanced Cloud Technology (IMPACT).** This notice provides information on the time frames and requirements for launching the new computer-based enrollment system, called Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Illinois will temporarily suspend processing applications from providers seeking to participate in the Medical Assistance Program, as well as update requests from currently enrolled providers.

- **Introducing Illinois Medicaid’s Pharmacy Benefits Management System.** HFS announced that later this year, they will implement a new Pharmacy Benefits Management System (PBMS) for pharmacy claims billed fee-for-service to the Department. This notice does not impact pharmacy claims billed to managed care plans for participants enrolled in those plans.

4) The Illinois Department of Human Services (HHS) recently adopted two sets of rulemaking that should be of interest to long term care facilities and their pharmacies (see Illinois Register). The two rulemakings are:

- **Electronic Prescription Monitoring Program** (page 6421) - This rulemaking is necessary to make several updates that will comply with the provisions of 21 CFR Parts 1300, 1304, 1306, 1311 and 1313.

- **Electronic Prescription Monitoring Program** (page 6444) - This rulemaking is necessary to comply with the provisions of PA 97-334; PA 96-1372 and 305 ILCS 5/5-2.12 (DPH) that requires Long Term Care pharmacies to report on selected medications to the Prescription Monitoring Program.

5) AHCA released several important notices since the last issue of Regulatory Beat. They include:

- **AHCA/NCAL LTC Trend Tracker – Turnover and Retention Upload Now Available.** AHCA/NCAL recently launched the new Turnover and Retention Upload available in LTC Trend TrackerSM. The new upload replaces the annual AHCA/NCAL staffing survey and includes data for both assisted living and skilled nursing. In addition to being shorter than the previous survey, AHCA/NCAL members will now be able to benchmark themselves against their peers and have instant feedback on turnover and retention rates.

AHCA has also developed additional resources, including two help documents, Create a Turnover and Retention Data File and Upload Turnover and Retention Data, as well as Frequently Asked Questions. If you have any questions about this new resource, please email help@ltctrendtracker.com.
• **Expansion of the Quality Initiative for Assisted Living.** On May 12, NCAL announced the next phase of the [Quality Initiative for Assisted Living](https://www.ncal.org) and renewed the four goals for three more years. Through March 2018, the Quality Initiative for Assisted Living aims to increase staff stability and customer satisfaction, while safely reducing hospital readmissions and the off-label use of antipsychotics medications. Find resources and more at [QualityInitiative.ncal.org](http://QualityInitiative.ncal.org). The Quality Initiative website has been updated, a national press release was distributed and an email is being sent to members announcing the expansion. NCAL has updated the Quality Initiative [overview](https://www.ncal.org) and getting started [guide](https://www.ncal.org).

• **NFPA Annual Conference – Educational Sessions/CEUs.** NFPA will be providing NAB approved CEUs for the Health Care education sessions during their Annual Conference and Expo in Chicago June 22 – 25, 2015. Additional information about the conference can be found at [http://www.nfpa.org/conference](http://www.nfpa.org/conference).

6) IHCA recently sent out the **May 2015 Education Access.** [Click here](#) to find more information about the upcoming educational offerings.

- Review Course for the Illinois Licensure Examination for Nursing Home Administrators
- Web seminar: POLST is More Than a Form...It is a Process
- ID/DD Symposium
- OASIS Train-the-Trainer
- I Want My Stars Back! An In Depth Look at the Five-Star Quality Rating System
- National Research Corporation Webinar
- Countdown to ICD-10: Making Sure Your Coders Are Ready

7) The **Agency for Healthcare Research and Quality (AHRC)** recently noted two articles of interest. They were:

• **AHRQ Study Identifies Characteristics Associated With Hospital Readmission.** Three-quarters of patients readmitted to a hospital after being discharged return to the same hospital, according to a [new AHRQ-funded study](https://www.ahrq.gov). Researchers found that patients admitted for orthopedic conditions and patients who entered the hospital through the emergency department were the most likely to have a same-hospital readmission. Regarding readmissions overall, the highest rates were found in patients aged 65 to 84, though patients aged 45 to 64 who underwent spinal fusion had similar readmission rates. The condition most commonly associated with readmission was heart failure, and the conditions for which a readmission was least likely were hip and knee arthroplasty. Women made up a larger portion of readmissions across all conditions, except for heart attack. To conduct this research, investigators used the State Inpatient Databases, a component of AHRQ’s Healthcare Cost and Utilization Project (HCUP). They analyzed data on adults discharged from hospitals in 16 states. HCUP is the nation’s most comprehensive source of hospital data, including information on inpatient care, ambulatory care, and emergency department visits. The study, “Patient Factors Contributing to Variation in Same-Hospital Readmission Rate,” and abstract were published in the March 30 issue of the journal *Medical Care Research and Review*.

• **New AHRQ Continuing-Education Resources Explore Ways To Prevent Patient Falls and Pressure Ulcers.** AHRQ’s new continuing-education resources offer health care professionals continuing education and continuing medical education credits on improving patient safety by preventing pressure ulcers and falls in hospitals. Each year an estimated 2.5 million U.S. patients will develop a pressure ulcer, and a single large hospital could experience more than 1,000 patient falls per year. Approximately 30 to 50 percent of falls result in injuries, and complications from hospital-acquired pressure ulcers cause as many as 60,000 deaths each year. When patients fall in the hospital, they are more likely to stay in the hospital longer or be transferred to institutional or long term care. Costs associated with hospital-acquired pressure ulcers could be as high as $11 billion per year. New videos and topic profiles that explore prevention of [in-facility pressure ulcers](https://www.ahrq.gov) and [in-facility falls](https://www.ahrq.gov) are available for continuing-education credit. Additional resources related to these topics include “[Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices](https://www.ahrq.gov)”, the “[Preventing Falls in Hospitals](https://www.ahrq.gov)” toolkit and “[Preventing Pressure Ulcers in...](https://www.ahrq.gov)"
Hospitals’ toolkit and a student workbook and instructor’s guide on falls prevention and management in long term care facilities.

8) **MedlinePlus** recently published several article of interest. They include:

- **Nursing Homes Using Hospice Care More, But at a Cost - Spending increased about $6,800 for those getting end-of-life comfort care, study says.** More nursing home residents are opting for hospice care as they near death, choosing comfort and reassurance over medical interventions aimed at squeezing out every possible extra day of life. But while hospice care has proven effective in providing peace to the dying, it’s also more expensive than previously thought, according to a new study published in the May 7 *New England Journal of Medicine*.

- **Many Aging Boomers Face Chronic Illness, But Death Rate Is Falling: CDC - Report finds nearly half need a heart drug, almost a fifth are diabetic.** A new study finds mixed results for the health of America’s aging "Baby Boom" generation, with nearly half of people ages 55 to 64 taking a prescription heart drug and about 1 in 5 dealing with diabetes. However, the report from the U.S. Centers for Disease Control and Prevention also finds that the overall death rate in this age group has gone down over the past decade. The report shows that the "prevalence of diabetes and obesity among Baby Boomers remains remarkably high and is a public health concern," said Dr. Ronald Tamler, who directs the Mount Sinai Clinical Diabetes Institute in New York City.

- **More Aging Americans Using Canes, Walkers - Many seniors rely on more than one mobility device, study finds.** Older Americans aren't taking old age sitting down. Canes, walkers and other mobility aids are used by about one-quarter of American seniors, a new study reveals. Use of canes and other mobility devices soared almost 50 percent over a recent eight-year period, according to interviews of more than 7,600 Medicare beneficiaries. And nearly 10 percent of seniors use more than one mobility device, researchers found.

9) **HealthData Management** stated in a recent article that criminal attacks now are the number one cause of healthcare data breaches. For the first time, criminal attacks are the leading cause of data breaches in health care, with such attacks up 125 percent versus five years ago, replacing lost laptops as the top cybersecurity threat to the industry.

10) **EurekAlert** recently published an article entitled “**Treatment reduces risk of recurrence of C. difficile infection.**” Among patients with *Clostridium difficile* infection (CDI) who recovered following standard treatment with the antibiotics metronidazole or vancomycin, oral administration of spores of a strain of *C difficile* that does not produce toxins colonized the gastrointestinal tract and significantly reduced CDI recurrence, according to a study in the May 5 issue of *JAMA*.

11) **McKnight’s** published several articles of interest since the last issue of *Regulatory Beat*. They include:

- **CMS Plan Would Hike Hospice Rates in 2016.** CMS plans to raise hospice payment rates by nearly $200 million, or 2 percent, in fiscal year 2016. They come under a sweeping proposal establishing payment tiers based on length of stay and laying the groundwork for additional quality reporting measures.

- **Study Strengthens Diabetes-Alzheimer’s Link.** Washington University School of Medicine researchers believe they have found closer definitive links between diabetes and Alzheimer’s disease after discovering elevated blood glucose levels stimulate the chemical culprit in the formation of AD’s characteristic brain “plaques.” While the relationship between diabetes and Alzheimer’s has long been suspected and studied, the newly discovered link could help researchers develop treatments that reduce the harmful effects of elevated blood sugar on brain function, lead author Shannon Macauley, Ph.D., told reporters. See for the full article.

- **CMS Plan Would Completely Overhaul Medicaid Managed Care.** CMS is soon expected to unveil an ambitious and comprehensive policy-making effort that promises to completely transform and radically
overhaul the Medicaid managed care marketplace. Few specifics are known about the plan, but observers say it could align Medicaid managed care regulations “with existing commercial, marketplace, and Medicare Advantage regulations,” as well as provide guidance to states on rate setting, Bloomberg News services reported.

- **Report Leads to Question Whether CMS Has Raised the Quality Bar Too High.** More than one-third of the nation's 15,500-plus nursing homes now bear the stigma of poor quality as a result of a tough new star ratings system implemented in February by the CMS and posted on its Nursing Home Compare website.

12) **Interesting Fact:** About 0.3 percent of older Americans – that is one in every 300 – were hospitalized with the flu at some point this season. This is by far the highest rate in the 10 years the CDC has been tracking this statistic.