June 5, 2019 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!

5 Common Questions about HIPAA, Answered

2018 saw the federal Office for Civil Rights issue a record-breaking $28 million in fines for HIPAA violations and, judging by how many hospitals, insurance providers, government health departments, nonprofits and more are already under investigation by the HHS, 2019 could be well on its way to topping that record.

Despite the prevalence of news and updates about HIPAA and its many violations, however, questions may still arise about the law’s rules and regulations, who it concerns and how violations can be prevented, all of which is necessary knowledge for healthcare providers hoping to avoid legal trouble and hefty fines.

Here are answers to five of the most common questions about HIPAA.

What is HIPAA and who must abide by it?
The Health Insurance Portability and Accountability Act was enacted in 1996 to protect individuals’ private health information (PHI) from fraud and theft, among several other health insurance-related policies. Examples of protected information are medical records, conversations between clinicians about an individual’s treatment plan and patient billing information.

Entities required to comply with all HIPAA regulations include health insurance companies, government programs like Medicare and Medicaid, most healthcare providers, billing companies, claims processing firms and any company that stores or destroys medical records.

Parties outside the traditional realm of healthcare must comply with HIPAA, too. New software allowing healthcare organizations to transmit patient information using Amazon’s voice assistant Alexa is HIPAA-compliant, as is the Uber Health medical transportation service.

What constitutes a HIPAA violation?
HIPAA requires all covered entities to establish safeguards to protect patients’ medical information, procedures to limit who can view and access information and training programs to educate employees about protecting the covered information.

Additionally, under HIPAA, patients have the right to ask for a copy of their health records, issue corrections to the records, request reports of how their records have been or will be used and shared and permit or deny the sharing of PHI for marketing and other purposes.
Potential violations of these rules and regulations are investigated by the HHS' Office for Civil Rights if a complaint is filed or an OCR review finds an entity is not in compliance with HIPAA. Noncompliance is determined to be a civil violation if an unintentional breach is found and the entity does not satisfactorily resolve the matter; a criminal violation, meanwhile, occurs when an entity is found to have knowingly disobeyed HIPAA.

What are the most common causes of HIPAA violations?
No matter how many electronic safeguards a covered entity enacts to comply with HIPAA, numerous violations can still occur due to human error. Citations are commonly issued when, for example, devices containing PHI are lost or stolen, patients' photos are shared on social media, unauthorized employees access records out of curiosity or medical records are mishandled.

Read more about 10 of the most common HIPAA-violating forms of human error — and how they can be prevented — here.

What is the most costly HIPAA violation in history?
The largest individual HIPAA settlement was reached in October 2018, when OCR fined health insurer Anthem $16 million. The violation came about, according to OCR Director Roger Severino, because "Anthem failed to implement appropriate measures for detecting hackers who had gained access to their system to harvest passwords and steal people's private information."

Between December 2014 and January 2015, cyber-attackers breached Anthem's system to steal names, Social Security numbers, medical identification numbers, addresses, dates of birth, email addresses and employment information of almost 79 million individuals, in what OCR has called "the largest health data breach in U.S. history."

How could HIPAA change in 2019?
In December 2018, OCR issued a request for input from stakeholders about ways to modify HIPAA to promote value-based healthcare. At the time, the office expressed its desire to update the law to better allow information sharing that will improve care coordination — especially in the case of patients with substance abuse and mental health issues — and patients' ability to access their own PHI.

The public comment period ended on Feb. 11, just days after the American Medical Association issued a letter imploring OCR not to make any concrete rule changes that could potentially endanger patients' privacy. Though OCR has not yet offered any further information about potential HIPAA updates related to this request for input, on April 26, the HHS announced its decision to implement a tiered system of annual fine caps determined by level of culpability, based on a reinterpretation of the existing Health Information Technology for Economic and Clinical Health (HITECH) Act that amended HIPAA in 2009.

More articles about cybersecurity:
Hospitals can leverage AI to combat cyberattacks, report finds
Virus prevented California medical group from accessing records, exposed 198,000 patients
Baystate Health hit with class-action suit after phishing attack exposed 12,000 patients

*Article printed out of Becker’s Hospital Review and authored by Andrea Park.*

Hospital and Healthcare Facilities – Security Awareness for Soft Targets and Crowded Places
Hospitals and healthcare facilities, including nursing homes, face a unique set of challenges in an active shooter incident. These incidents have no patterns in victim selection or method, creating an unpredictable and quickly evolving situation that can lead to loss of life and injury. Numerous factors associated with hospital and healthcare environments complicate traditional response to active shooter incidents, including the “duty-to-care”, also known as “duty-to-act”, commitment and the varying levels of patient mobility and patient special needs. Additionally, staff must consider response planning for patients that require the greatest allocation of resources, as well as the unique characteristics within the hospital and healthcare environment.
Potential Indicators
Healthcare facilities are open, healing environments with limited restricted access areas such as the emergency department, Intensive Care Unit, behavioral health, and radiology. Since active shooter events occur with little or no warning, response requires significant thoughtful planning and preparation, taking into account an organization-specific area and vulnerabilities critical for an effective response and recovery. Below are several potential warning signs that may be applicable to staff, patients, visitors, students, contractors, and volunteers:

- Individual presents increasingly erratic, unsafe, or aggressive behaviors;
- Individual threatens harm to themselves or others;
- Claims of marginalization or distancing from friends and colleagues;
- Changes in performance at work by staff member;
- Sudden and dramatic changes in home life or personality;
- Appearing out of place in staff-only, restricted access locations;
- Stalking/harassing of staff/patients;
- Observable grievances and making statements of retribution;
- Auditory indicators and menacing, antagonistic behavior;
- Staff, students, contractors and volunteers not displaying proper identification such as an ID badge.

In the event of an active shooter, there is no single method that is guaranteed to be effective. The Department of Homeland Security recommends the “Run, Hide, Fight” strategy, which provides three options in order of preference. Those who find themselves in an active shooter situation should choose whichever option is best in their respective environment. In a hospital setting, response will vary depending on the mobility of patients and area affected by the shooting.

What Should Healthcare Staff Do in Case of an Active Shooter?
Respond immediately, communicating the threat to law enforcement and others present at the facility using appropriate protocols involving auditory systems, visual cues and plain text messaging where possible.

- Provide real-time intelligence to local law enforcement and first responders from command center.
- Ensure law enforcement familiarity with and access to a first responder kit that includes facility maps, access keys, two-way radios and other items applicable to the facility.

RUN - Avoid the assailant – if safe to do so, evacuate the immediate areas where the shooter(s) are located, and lock down other units; leave personal belongings behind. Avoid escalators, elevators and encourage others to come with you. Call 911 when safe to do so.

- Secure patients and lockdown critical areas, such as operating rooms, treatment and intensive care units; move mobile and immobile patients to a secure area if possible; run to designated safe location in unit if escape from the building is not immediately possible.

HIDE - If running is not an option, preserve the safety of patients and visitors. Seek to hide in room with thick walls and limited windows. This will likely be the primary response for immobile patients and their caregivers.

- Silence electronics.
- Secure entryways or rooms by locking door(s) and securing with available furniture/equipment.

FIGHT - Defend yourself and your patients – as a last resort, attempt to disrupt or subdue the attacker, using available items, such as a fire extinguisher.

Mitigation Strategies and Protective Measures
Due to the unpredictable nature of active shooter incidents, it is critical that hospitals and healthcare facilities take proactive steps to prepare. Planning should take the specific characteristics of the hospital or healthcare facility into
account and include partnering with local law enforcement and first responders. Plans should be dynamic and adaptive to changes that may occur. All active shooter preparedness plans should seek to maximize the protection of staff and patients.

**Physical Security**

- Select optimal shelter-in-place locations (thick walls, solid doors with locks, minimal interior windows, first-aid emergency kits).
- Implement facility-wide notification system, complete with plain text, electronic hospital signage and PA system alerts.
- Post signage relating to emergency exit and entry, first aid locations, and shelter.
- Share detailed facility layout with local first responder units and law enforcement by installing first responder kits at entrances to various wings, complete with hospital maps, key cards, and two-way radios.
- Designate “safe” location in each unit.
- Limit facility access, especially at night, with monitored entrances.

**Access, Planning, and Personnel**

- Develop Emergency Action and Notification Plan.
- Develop a Threat Assessment Team to review potential warning signs of workplace violence, report suspicious behavior to security office.
- Periodic background checks on staff and conduct personnel safety/security training.
- Monitor credential systems, access control and badges; install badge-access checkpoints to prevent tailgating.
- Conduct active shooter exercises at least annually.
- Evacuate lockdown procedures, taking into account access and functional needs of patients.
- Early, consistent coordination with local police is critical; request initial site assessment; institute an annual walkthrough with local police.
- Consider adding language to job descriptions such as SAY SOMETHING timely to security if you SEE SOMETHING that concerns you.

**Additional Resources for Owners & Operators**

For direct regional support, visit Hometown Security Initiative: [https://www.dhs.gov/hometown-security](https://www.dhs.gov/hometown-security)
For additional resources, products, and information regarding the security of soft targets and crowded places, please visit [www.dhs.gov/active-shooter-preparedness](http://www.dhs.gov/active-shooter-preparedness)


**Focus F-Tag – F-Tag 866 - QAPI/QAA Data Collection and Monitoring**

This *Regulatory Beat’s* Focus F-Tag is **F866 – QAPI/QAA Program Feedback, Data Collection and Monitoring** which is part of the Quality Assurance and Performance Improvement Regulatory Group. This F-Tag becomes effective in Phase 3 (November 28, 2019). F866 outlines a provider’s responsibilities for developing and implementing policies and procedures related to its QAPI program feedback, data collection systems and monitoring (§483.75(c)(1-4)).

Nursing homes must develop and implement written policies and procedures related to how feedback and data will be collected and monitored, including monitoring of adverse events. The P&Ps must include:

- How the facility will maintain effective systems to obtain and use feedback/input provided by stakeholders including direct care and other staff and residents/representatives
- How feedback will be utilized to identify problems that are high risk, high volume, problem-prone or present opportunities for improvement
• How effective systems for identification, collection and use of data from all departments will be maintained and how this information will be used for developing and monitoring performance indicators. This information, per the regulation, includes the Facility Assessment.
• How the facility will develop, monitor and evaluate performance indicators, including the methodology and frequency
• How the effectiveness of the facility’s performance improvement activities will be monitored to ensure improvements are sustained
• How the facility will monitor adverse events, including the systematic ways it will identify, track, report, investigate, analyze and use adverse event data, as well as how the facility will develop activities that will prevent adverse events in the future

QAPI requires proactivity from providers in order to develop a program that can systematically capture facility-specific data and ensure it is used for performance improvement activities related to identified problematic areas. In our last F-Tag post, we looked at F865 to provide an overview of the QAPI Program requirements, and we will continue to examine the rest of the QAPI regulations in our next few posts.

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Trending Statistics

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

Preventable Hospitalizations: All 50 States Ranked
Hawaii is home to the fewest preventable hospitalizations in the nation per 1,000 Medicare patients, whereas Kentucky far exceeds the national average of 49.4.

Preventable hospitalizations most often occur when conditions are not treated early in an outpatient setting. They often affect people without health insurance and add an estimated $30.8 billion annually in nonessential financial burden on the U.S. healthcare system, according to the United Health Foundation.

UHF factors preventable hospitalizations as an indication of the quality of primary healthcare received when calculating its annual America’s Health Rankings report, which is the longest-running annual assessment of the nation’s health on a state-by-state basis.

Here are the complete state-by-state rankings the foundation used to calculate states' 2018 overall health scores, the most recent available. Values reflect the number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees. Access the complete report here.

1. Hawaii — 23.3
2. Utah — 27.9
3. Colorado — 31.2
4. Idaho — 32.3
5. Washington — 32.7
6. Oregon — 33.9
7. Alaska — 36
8. Arizona — 36.1
9. California — 36.2
10. Minnesota — 36.6
11. Vermont — 39.4
12. New Mexico — 39.5
13. Montana — 41.1
14. Nevada — 42.2
15. Virginia — 42.8
16. Wyoming — 43.1
17. Wisconsin — 45
18. South Carolina — 45.6
19. Connecticut — 46.2
20. Maryland — 46.7
21. New York — 46.8
22. New Hampshire — 47.1
23. Delaware — 47.2
24. Nebraska — 48.3
25. Iowa — 48.9
27. North Dakota — 49.1
28. Maine — 49.4
29. New Jersey — 49.6
30. Georgia — 50.2
31. South Dakota — 50.5
32. Kansas — 51.3
33. Pennsylvania — 51.7
34. Texas — 53.2
35. Florida — 53.6
36. Rhode Island — 54
37. Massachusetts — 54.3
38. Illinois — 54.8
39. Michigan — 55.4
40. Missouri — 56.6
41. Indiana — 56.8
42. Ohio — 57
Important Regulations, Notices & News Items of Interest

1) There were no new Federal CMS Quality, Safety and Oversight Letters (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:

   • **MD 3.0 RAI Manual v1.17 is Now Available for Download.** In response to stakeholder feedback and to help reduce burden, we are releasing the Minimum Data Set (MDS) 3.0 RAI Manual. The PDF file labeled “MDS 3.0 RAI Manual v1.17 October 1, 2019” is now available in the Related Links section of the [MDS 3.0 RAI Manual webpage](#). The MDS 3.0 Manual contains many updates, including information related to the Patient Driven Payment Model. Please check back shortly prior to October 1, 2019, for a final posting that may contain additional updates.

   • **No Shortcuts to Safer Opioids Prescribing: CDC Commentary.** In a new [commentary](#) in the New England Journal of Medicine, authors of the 2016 Centers for Disease Control (CDC) [Guideline for Prescribing Opioids for Chronic Pain](#) advise against misapplication that can put patients’ health and safety at risk. Some policies and practices attributed to the guideline are inconsistent with its recommendations. The CDC has resources to help you correctly apply the guideline:
     - **Pocket Guide: Tapering Opioids for Chronic Pain** - Quick-reference tool for when and how to taper and important considerations for safe and effective care
     - **CDC Opioid Prescribing Guideline Mobile App** - Apply the recommendations in clinical practice, including a morphine milligram equivalent calculator, key recommendations, motivational interviewing techniques, resources, and glossary

   • **CMS Takes Action to Lower Prescription Drug Prices and Increase Transparency.** On May 16, CMS finalized improvements to Medicare Advantage and Medicare Part D, which provide seniors with medical and prescription drug coverage through competing private insurance plans. These changes ensure that patients have greater transparency into the cost of prescription drugs, so they can compare options and demand value from pharmaceutical companies. For More Information:
     - **Final Rule**
     - **Press Release**
     - **Fact Sheet**

   • **April – June Quarterly Provider Update.** The April – June [Quarterly Provider Update](#) is available, including issuances and regulations. Find out about:
     - Regulations and major policies currently under development during this quarter
     - Regulations and major policies completed or cancelled
     - New or revised manual instructions

   • **Provider Minute Video: The Importance of Proper Documentation.** Why is proper documentation important to you and your patients? Find out how it affects items/services, claim payment, and medical review in the [Provider Minute: The Importance of Proper Documentation](#) video. Learn about:
- **Hospice Provider Preview Reports Now Available.** Hospice provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® provider preview reports have been updated and are now available. These two separate reports are available in your Certification and Survey Provider Enhanced Reports (CASPER) non-validation reports folder. Hospice providers are encouraged to review their Hospice Item Set (HIS) quality measure results from **Quarter 4, 2017 to Quarter 3, 2018** and their facility-level CAHPS® survey results from **Quarter 4, 2016 to Quarter 3, 2018**.

  Providers have 30-days to review their HIS and CAHPS® results (**May 30, 2019 through July 1, 2019**) prior to the **August 2019** Hospice Compare site refresh, during which this data will be publicly displayed. Should a provider believe the denominator or other HIS quality metric to be inaccurate or if there are errors within the results from the CAHPS® Survey data, a provider may request CMS review. Providers must adhere to the process outlined on the [Public Reporting: HIS Preview Reports and Requests for CMS Review of HIS Data](#) webpage and the [Public Reporting: CAHPS® Preview Reports and Requests for CMS Review of CAHPS® Data](#) webpage.

  For more information on how to access these reports, view the [HIS Preview Report Access Instructions](#) and the [Hospice CAHPS® Provider Preview Reports Access Instructions](#).  

- **Hospice Compare Quarterly Refresh Available.** The May 2019 quarterly Hospice Compare refresh of quality data is now available. It is based on Hospice Item Set (HIS) quality measure results from data collected Q3 2017-Q2 2018 and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey® results reported Q3 2016 – Q2 2018.

  Beginning with the May 2019 refresh, Hospice Compare will include additional information on hospice characteristics to complement the quality and patient experience metrics already available. This information will further empower Hospice Compare users to engage in meaningful conversations with their providers and make informed decisions about selecting a hospice. Empowering consumers with useful information is one way CMS works to ensure safety and quality in the healthcare system. In addition, in May 2019, CMS is updating the zip code database powering Hospice Compare’s search function, helping to ensure accurate search results.

  For more information please see the “Hospice Compare May 2019 Refresh Fact Sheet” and the “Hospice Compare May 2019 Refresh Question & Answer” document in the Downloads section of the [Public Reporting: Background and Announcements](#) webpage.

  We invite you to visit [Hospice Compare](#) to view the data.

- **Programs of All-Inclusive Care for the Elderly Final Rule.** On May 28, CMS finalized a rule to update and modernize the Programs of All-Inclusive Care for the Elderly (PACE). PACE provides comprehensive medical and social services to certain frail, elderly individuals who qualify for nursing home care but, at the time of enrollment, can still live safely in the community. The majority of participants are dually eligible for both Medicare and Medicaid.

  The final rule revises and updates the requirements for the PACE program under Medicare and Medicaid, including:
  - Strengthening protections and improving care for participants
  - Providing administrative flexibility and regulatory relief for organizations

  The changes will provide greater operational flexibility, remove redundancies and outdated information, and codify existing practice. For More Information:
• SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1. On October 1, the new Patient Driven Payment Model (PDPM) is replacing the Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has resources to help you prepare:
  o PDPM webpage, including fact sheets, FAQs, presentation and coding crosswalks/classification logic
  o Materials from the Medicare Learning Network call in December
  o New Medicare Webpage on PDPM MLN Matters Article
  o Implementation of the SNF PDPM MLN Matters Article

• Chiropractic Services: Comply with Medicare Billing Requirements. In a recent report, the Office of Inspector General (OIG) determined that payments for chiropractic services did not comply with Medicare billing requirements. Overall, medical record documentation did not support medical necessity or corrective treatment. CMS developed the Medicare Documentation Job Aid for Doctors of Chiropractic Educational Tool to help you bill correctly. Additional resources:
  o Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits MLN Matters Article
  o Use of the AT modifier for Chiropractic Billing (New Information Along with Information in MM3449) MLN Matters Article
  o Educational Resources to Assist Chiropractors with Medicare Billing MLN Matters Article
  o Medicare Benefit Policy Manual, Chapter 15, Sections 30.5 and 240
  o Medicare Claims Processing Manual, Chapter 12, Section 220
  o Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services OIG Report, February 2018

• Delivering Dementia Capable Care within Health Plans: Why & How? Webinar — Wednesday, June 19, 11 a.m. – 12:30 p.m. CST. Register for this webinar. Learn about strategies and tools for the delivery of dementia capable care, as well as tips for leveraging resources within federal, state, and local environments to build more responsive systems of care delivery. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

• Practices for Supporting Dually Eligible Older Adults with Complex Pain Needs Webinar — Thursday, June 27, 10:30 a.m. – 12:00 p.m. CST. Register for this webinar. Learn about common causes and types of pain among dually eligible older adults, and identify promising practices that support older adults in achieving their pain management and wellness goals. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

• Special Open Door Forum – Developing a Hospice Assessment Tool – Status Update – Wednesday, June 12, 2019 1pm – 2pm CST. CCSQ will host a Special Open Door Forum (ODF) to allow hospices and other interested parties to ask questions on the development of a Hospice Assessment Tool. This SODF is part of a series of regular SODF’s CMS plans to host on this tool and other key topics related to the Hospice Quality Reporting Program.

The purpose of a hospice assessment tool is to develop a tool that enables CMS and hospices to understand the care needs of people through the dying process and to ensure the safety and comfort of individuals enrolled in hospice institutions nationwide. The SODF will provide a status update and welcomes your questions. You can learn about the hospice assessment tool here.

• Home Health (HH) Patient-Driven Groupings Model (PDGM) – Additional Manual Instructions — Revised. A revised MLN Matters Article MM11272 on Home Health (HH) Patient-Driven Groupings Model (PDGM) –
Additional Manual Instructions is available. This Article is revised to show that the new diagnosis instructions added to section 40.2 also apply to section 40.1.

- **Outpatient Rehabilitation Therapy Services: Complying with Documentation Requirements.** A new Outpatient Rehabilitation Therapy Services: Complying with Medicare Billing Requirements Medicare Learning Network Booklet is available. Learn about:
  - Comprehensive Error Rate Testing program
  - Billing correctly for Medicare Part B outpatient
  - Reducing common errors and overpayments

- **Hospice Quality Reporting Program: Review and Correct Report Webinar** — Tuesday, June 11, 1 – 2:30 p.m. CST. Register for this webinar. Learn how to use the new Review and Correct Report to verify that the data displayed on the Hospice Compare website for your facility is accurate. See the Spotlight & Announcements webpage for details.

- **Claim Status Category and Claim Status Codes Update.** A new MLN Matters Article MM11292 on Claim Status Category and Claim Status Codes Update is available. Learn about updates for the Accredited Standards Committee X12 276/277, Health Care Claim Status Request and Response, and ASC X12 277 Health Care Claim Acknowledgment transactions.


- **Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update.** A new MLN Matters Article MM11252 on Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update is available. Learn about updates to the RARC and CARC lists for these systems.

- **Reporting the HCPCS Level II Modifiers of the Patient Relationship Categories and Codes.** A new MLN Matters Article MM11259 on Reporting the HCPCS Level II Modifiers of the Patient Relationship Categories and Codes is available. Learn about voluntary reporting of HCPCS Level II code modifiers.

- **Proper Use of Modifier 59 — Revised.** A revised MLN Matters Article SE1418 on Proper Use of Modifier 59 is available. Learn about clarifications to existing policy, including appropriate and inappropriate use of the modifier.

- **Provider Compliance Tips for Positive Airway Pressure (PAP) Devices and Accessories Including Continuous Positive Airway Pressure (CPAP) — Revised.** A revised Provider Compliance Tips for Positive Airway Pressure (PAP) Devices and Accessories Including Continuous Positive Airway Pressure (CPAP) Medicare Learning Network Fact Sheet is available. Learn:
  - Coverage guidance
  - Reasons for denials
  - How to prevent future claim denials

- **Medicare Basics: Commonly Used Acronyms — Reminder.** The Medicare Basics: Commonly Used Acronyms Medicare Learning Network Educational Tool is available. Learn about:
  - Frequently used acronyms
  - How to create a personalized list of acronyms
3) BFCC-QIO transition from KEPRO to Livanta effective June 8, 2019. Here is a copy of the Provider Bulletin that Livanta sent to providers on May 28, 2019. The Livanta BFCC-QIO MOA is now available for providers to review and execute. Instructions for completing the MOA are found on page 1 of the Agreement. Please complete the MOA.

4) The federal Agency for Healthcare Research and Quality Assurance (AHRQ) reports on:
   - Technical Brief: Pharmacologic and Non-pharmacologic Treatments for Post-traumatic Stress Disorder

5) The Illinois Department of Healthcare and Family Services (HFS) released the following notices since the last issue of Regulatory Beat:
   - HFS published an updated Supportive Living Program Currently Active Waiver. You may view the updated waiver here.
   - HFS posted a new Provider Notice regarding Prescriber National Provider Identifier (NPI) Requirements Effective July 1, 2019. You may view the new notice here.

6) The Illinois Department of Public Health (IDPH) reports:
   - Schedule for IDPH Town Hall Meetings will be out shortly.

7) The Illinois Health Care Association (IHCA) and the American Health Care Association (AHCA) report on:
   - An Update from the AHCA Chair. Your AHCA Board of Governors met earlier this month in Bluffton, South Carolina for its second in-person meeting of 2019. It was held in conjunction with the Spring Conference for Multifacility CEOs and Senior Executive Leaders. Our board is working hard to represent you and is focused on several issues of vital importance to our profession. I like to keep you up-to-date by sharing highlights from the AHCA Board meeting. I hope you find this helpful as we continue to live our mission each day and deliver solutions for quality care.
   - Get ICD-10 Savvy, and be Ready for PDPM. It’s coming. The Patient-Driven Payment Model (PDPM) will replace the Resource Utilization Groups (RUG-IV) system this October. Payment will rely on rapid, accurate patient assessment and diagnosis on the Minimum Data Set (MDS) and ICD-10 coding for each patient. Ensuring adequate, appropriate reimbursement will depend on having teams and tools for quality coding. ACHA/NCAL has training courses to enable members to be PDPM pros. Make no mistake. There are thousands of ICD-10 codes, and no one person can digest or comprehend them all. However, AHCA has partnered with the American Health Information Management Association (AHIMA) to offer two key targeted training courses. These will provide the information participants need to help their organizations thrive under PDPM without being overwhelmed. The Courses are:
     - ICD-10 Training for PDPM – Coder. This in-depth course features seven modules covering coding and clinical document improvement (CDI). SNF coders will learn ICD-10 coding guidelines, CDI program implementation, and best practices for transition to PDPM (designed for SNF billing, MDS nursing, and therapy, admissions, and discharge staff).
     - AHCA/AHIMA ICD-10 Training for PDPM – Non-Coder. This four hour course is designed to give non-coders the knowledge they need to lead successful PDPM transition (designed for administrators, DONs, and management staff).

Sign up for the course for coders at www.ahcancal.org/icd10pdpmcoder and www.ahcancal.org/icd10pdpmnoncoder for non-coders.
   - AHCA/NCAL Social Media Update.
• **Seema Verna Heightens Scrutiny and Oversight of Facility Antipsychotic Use.** AHCA learned recently that Seema Verma is calling the CEOs of some nursing home chains about their antipsychotic use. She has made two calls to date and is scheduling others. CMS has flagged facilities on the “late adopter list” into group 1 and group 2 facilities that also have received a citation for inappropriate use of psychotropic medications or unnecessary medications (F605 use medications as restraints, F744 dementia care, or F758 unnecessary medications) on **ANY** survey from January 1, 2016 - January 15, 2019 with a scope and severity D or higher. They have sent this list to the state survey agencies to conduct surveys. If any of these facilities are cited again for one of those three tags, CMS will impose a CMP and DPNA immediately (within 2 days for IJs and 15 days for non-IJs of the survey). The QSO memo is here for your review.

AHCA received the list of group 1 and group 2 facilities last week through a Freedom of Information Act (FOIA) request. We will be sending you the list of facilities in your state with a flag to indicate which are on the late adopter list and which are in group 1 or group 2 and are subject to heightened survey scrutiny and immediate DPNA.

Additionally, AHCA/NCAL has a package of tools to help your facilities lower their unnecessary antipsychotic use (click here for more information).

• **Recording of Webinar: AHCA PDPM Academy Monthly Live Webinars is Ready.** The archived recording of AHCA PDPM Academy Monthly Live Webinars is now ready for you to view at your convenience.
  - Go [here](#) and log in using your username and password.
  - Once the page opens, click on the “**View Archived Recording**” button on the right-hand side of the page. The presentation will open in a new window for you to view and hear the program.
  - Click on the Handout tab to download your copy of the handouts and other available materials.

For questions or support, please email ahca@commpartners.com

• **AHCA PDPM Transition Guide Toolkit Now Available.** The AHCA PDPM Academy **AHCA PDPM Transition Guide Toolkit** described during the May 28 PDPM Academy Monthly Webinar is now available at: [https://educate.ahcancal.org/products/ahca-pdpm-transition-guide-toolkit-pdpm-academy](https://educate.ahcancal.org/products/ahca-pdpm-transition-guide-toolkit-pdpm-academy). Below is a list of the resources available in the toolkit:

  **Toolkit contents:**
  - PDPM Transition Guide – May 2019 PDPM Drivers Role Assignment Analysis Tool
  - PDPM IPA Determination Model Policy
  - PDPM Assigning and Maintaining Resident Diagnosis Tool
  - PDPM Skilled Documentation Clinical Coordination Communication Tool
  - PDPM Model Job Description – MDS Coordinator/MDS Nurse
  - PDPM Triple Check Considerations Tool
  - PDPM Academy Monthly Webinar – May 2019: PDPM Transition Guide Webinar, Slides, & FAQs

**How to Access Your PDPM Academy Resources.** To locate all AHCA PDPM Academy resources, please follow these 4 steps:
  - Go to the AHCA PDPM academy web page at [https://educate.ahcancal.org/pdpmacademy](https://educate.ahcancal.org/pdpmacademy).
  - Click on the yellow “**LOG IN**” button on the left side of the page and enter your logon information (contact educate@ahca.org if you have logon problems).
  - Click on the “**MY DASHBOARD**” button on the left side of the page.
  - Scroll down to the “Packages” near the bottom of the page and click on “AHCA PDPM Academy.”

Please contact educate@ahca.org for assistance.

• **AHCA PDPM Academy Weekly Update: May 30**
8) **Today’s Geriatric Medicine** reports:

- **Sepsis: When Infections Turn Deadly.** Sepsis is arguably one of the least-talked about—and least-recognized—illnesses in the United States. But each year, roughly 1 million adults in America develop the condition, and nearly 270,000 die as a result. For older adults, the statistics are even more staggering: 65% of sepsis cases in American hospitals involve older adults.

  Sepsis is a potentially life-threatening condition caused by the body's response to infection. This complication of infection is characterized by a systemic inflammatory response that produces symptoms such as low blood pressure, dizziness, fatigue, and chills. Typically, the first recognizable sign of sepsis is fever, though this can differ among older adults. Sepsis is generally diagnosed through blood and urine tests, and additional tests may be used to determine the source of the infection. For example, sepsis as a result of pneumonia may warrant chest X-rays, but sepsis as a result of meningitis may warrant a CT scan of the head. As soon as sepsis is recognized, a course of antibiotics will be started.

- **Upper Age Limits in Clinical Trials — Research Data Lacking With Older Adults for Evidence-Based Medicine.** By the year 2030, the demographics of the United States is projected to reach a historical turning point: People older than age 65 will outnumber children.

  The aging population has created a demand for research evidence to guide clinical practice for older adults, especially those with preexisting medical conditions. Yet one-half of all clinical trials have precise upper age limitations, and others restrict participation of older adults based on indirect exclusion criteria such as comorbid conditions, cognitive impairment, and polypharmacy.

  When older people are excluded from clinical trials and other research, how can geriatricians determine the best course of treatment for patients? This has frustrated many providers for years, especially regarding drug research, in which, for example, the average age of the subjects may be 45. How can physicians extrapolate the data for a 75-year-old patient? When many of the patients who have diabetes, heart disease, cancers, osteoporosis, and other illnesses are older than 65, it can be challenging to find relevant evidence-based medicine to implement, leaving some practitioners to make assumptions for care plans.

9) **Skilled Nursing News** reports **CMS Chief Verma ‘Spending a Lot of Time on Nursing Homes’**. The administrator of CMS placed nursing homes among her top areas of focus for the months to come, though she provided scant few other details during a wide-ranging press conference this week.

10) **ModernHealthcare** reports on **Challenge of Transition to PDPM May be Tied to Volume of Therapy Currently Offered**. ModernHealthcare reported implementation of the Patient Driven Payment Model on October 1 is driving nursing homes to reconsider their operational strategies; and while for some "the model is a welcome change," for others "it may be a tough transition" that "depends on how much the facility has relied on the volume of therapy services for its operational strategy, stakeholders say." Mike Cheek, Senior Vice President of Reimbursement Policy at the American Health Care Association, said, "I wouldn’t say that a building that offers ultra-high therapy services is going to fail, but (they) are going to have some work to do to adopt a whole-person assessment process and service delivery arrangement." Cheek also discussed how nursing homes may be less familiar with the other clinical components of the MDS assessment besides logging therapy services.

11) **Reuters** reports that **SNFs Often Discharge Medicare Patients When Co-Pays Activate**. Reuters reports a new study published in *JAMA Internal Medicine* finds that SNFs "often discharge Medicare patients before daily co-payments kick in," suggesting "some patients may be sent home for financial reasons before they're medically ready to leave." The investigators assessed "examined data on more than 4.5 million skilled nursing facility discharges from January 2012 through November 2016," finding "220,037 patients were discharged on day 20, more than the 131,558 sent home on day 19 and the 121,339 released on day 21." The patients "sent home on day 21 were more likely to suffer from multiple chronic medical conditions, live in poor neighborhoods, and be racial or ethnic minorities." Dr. Jennifer Goldstein of the Christiana Care Health and Sidney Kimmel Medical College observed that "patients more
likely to be discharged on day 20 tended to fit the profile of patients who have had higher rates of hospital use and repeat hospitalizations in other studies," the piece says.

12) McKnight’s reports:

- Palliative Care Outside of Hospitals Spreading to More States. McKnight’s Long Term Care News reports more states are expanding coverage of palliative care outside of hospitals, according to a study "released Tuesday by the Pew Charitable Trust’s Stateline news service." A number of states "have expanded benefits to adult Medicaid beneficiaries" seeking palliative care, while others "require providers to tell patients when palliative care could be beneficial."

- Review Uncovers Discrepancies in Identifiers Undermining EHRs. McKnight’s Long Term Care News reports a recent "review of more than 700 comments on a proposed rule to standardize the exchange of electronic health records points to one major concern: inconsistently or improperly recorded patient names." Researchers found multiple patients "often share names and birth dates, and without unique identifiers, their records may be combined or split accidentally," an issue which "might be especially challenging for rural skilled nursing providers." The Health and Human Services Administration discussed Monday how it "will determine if its Office for the National Coordinator for Health IT will coordinate patient-matching efforts in the industry."

13) Interesting Fact: Messages from the human brain travel along nerves at up to 200 miles an hour (322 km/h).