HEALTHTECH S3
strategy solutions support

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Compliance *with the ACA and IRS Code regarding Community Health Needs Assessments is not optional, and unfortunately a hospital recently realized that the IRS will change your non-profit status if you do not comply with the requirement to conduct a "community health needs assessment" (CHNA), develop an action plan based on the CHNA, and to "widely disseminate" the plan once it's developed and approved by the hospital's board.*

Hospitals must conduct a CHNA every three years, and any hospital that fails to meet the CHNA requirement must pay a $50,000 excise tax (§4959 of the Internal Revenue Code). CHNAs encourage nonprofit hospitals to do two things: 1) substantiate their existence as charitable institutions rather than as medical organizations; and 2) assess the healthcare-related needs of their communities without regard to the services they currently provide or are planning to provide.

According to a blog written by the law firm Baird Holm in June 2017, the IRS is scrutinizing nonprofit hospitals through audits to determine compliance with Section 501(r) and the requirement to perform a CHNA.[1] In the blog, there are a number of recommendations that are offered regarding preparations for such an audit such as: 1) review of billing and collections policies; 2) Public notification of the financial assistance policies (FAP); 3) a summary version of the FAP on the hospital website, and 4) An analysis of the FAP should be done to determine if the FAP needs to be translated into a foreign language.[2]

HTS3 has a lead consultant who is able to assist you with your CHNA and answer questions you may have. Our lead CHNA consultant is:

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[1]Kloeckner, A. Baird Holm. IRS Actively Auditing Hospitals For 501(r) Compliance. June 14, 2017.
[2]http://www.bairdholm.com/publications/entry/irs-actively-auditing-hospitals-for-501-r-compliance.html

Regulatory Report

When Congress returns from summer recess, the travesty from Hurricane Harvey that has affected Texas will be center stage. The response from health care organizations and nurses across the country has been astounding. Clearly, there will be lessons learned regarding emergency preparedness for disasters.

Kentucky's START program for Opioid Addicted Patients. *A number of states are introducing an innovative program modeled after Kentucky's Sobriety Treatment and Recovery Teams START program specifically designed for opioid-addicted parents prior to losing their children permanently. The START program includes home visits, help paying for child care, transportation and mentorship.*

Rural West Virginia Responds to Opioid Injection Epidemics: From Data to Action*. This program which was developed by researchers will deploy an integrated prevention, harm reduction and treatment team across the region to rapidly identify and mitigate small HIV "microepidemics". This is a collaborative effort between local communities and public health agencies. The researchers are developing an evidence-based road map to screen, prevent and treat opioid-related infections.*

Hospice Quality Reporting Program (HQRP) *Perhaps your organization has a hospice program or you outsource that service from a community provider, and if so, it is important to note that the Centers for Medicare & Medicaid Services (CMS) developed quality metrics specific to hospice care which leads to reporting on the Hospice Compare website. The requirement to report the quality of hospice services is defined in the ACA, Section 3004. If the hospice does not report, a 2% reduction will occur in their Annual Payment Update (APU). For FY 2018, each hospice must comply with 2 reporting requirements to avoid the 2% penalty. For further information regarding specific data to be reported, refer to the following website:*

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Hospice-Quality-Reporting-Program_FY-2018-Fact-Sheet-August-2017.pdf ***AND*** *visit the Hospice Quality Public Reporting webpage for more information,* ***HospiceQualityQuestions@cms.hhs.gov***

SAMPLE REPORT:

Quality of patient care - Patient Preferences

Measure Categories	*VISITING NURSE HOSPICE AND PALLIATIVE CARE*	*NATIONAL AVERAGE*
Patients or caregivers who were asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care	*99.6%*	*98.3%*
Patients or caregivers who were asked about their beliefs and values at the beginning of hospice care	*98.6%*	*93.6%*

Managing pain and treating symptoms

Quality of patient care - Managing pain and treating symptoms

Measure Categories	*VISITING NURSE HOSPICE AND PALLIATIVE CARE*	*NATIONAL AVERAGE*
Patients who were checked for pain at the beginning of hospice care	*96.1%*	*93.9%*
Patients who got a timely and thorough pain assessment when pain was identified as a problem	*78.8%*	*77.7%*
Patients who were checked for shortness of breath at the beginning of hospice care	*99.3%*	*97.3%*
Patients who got timely treatment for shortness of breath	*88.5%*	*94.6%*
Patients taking opioid pain medication who were offered care for constipation	*86.2%*	*93.3%*

Source: cms.gov Hospice Compare

The Centers for Diseases Control and Prevention (CDC) urges early recognition, prompt treatment of sepsis. The Centers for Disease Control and Prevention today launched Get Ahead of Sepsis, an educational initiative to protect Americans from the devastating effects of sepsis. This initiative emphasizes the importance of early recognition and timely treatment of sepsis, as well as the importance of preventing infections that could lead to sepsis. For many patients, sepsis develops from an infection that begins outside the hospital.

Get Ahead of Sepsis calls on healthcare professionals to educate patients, prevent infections, suspect and identify sepsis early, and start sepsis treatment fast. In addition, this work urges patients and their families to prevent infections, be alert to the symptoms of sepsis, and seek immediate medical care if sepsis is suspected or for an infection that is not improving or is getting worse. "Detecting sepsis early and starting immediate treatment is often the difference between life and death. It starts with preventing the infections that lead to sepsis," said CDC Director Brenda Fitzgerald, M.D. "We created Get Ahead of Sepsis to give people the resources they need to help stop this medical emergency in its tracks." Source: cdc.gov

For more information about Get Ahead of Sepsis and to access materials, visit: www.cdc.gov/sepsis.

The Joint Commission

Beginning January 1, 2018, TJC has made changes to the Medication Management (MM) standards for ambulatory care, behavioral health care, critical access hospital, home care, hospital, nursing care center, and office-based surgery practice programs in an effort to assure that evidence-based practices and quality and safety issues are reflected. As a result, there are some changes to the Environment of Care [EC] standards and Record of Care, Treatment, and Services [RC] standards as well. Based on the changes, organization will need to:

1. Implement a policy to provide emergency backup for essential medication dispensing equipment identified by the organization.

2. Implement a policy to provide emergency backup for essential refrigeration for medications identified by the critical access hospital.

3. Manage hazardous medications in behavioral health care settings that engage in the medication management processes.

4. Add "wasting" of medications to the required written policy addressing the control of medications between when they are received by an individual health care provider and when they are administered.

5. Implement a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews when automatic dispensing cabinets are used.

6. Record, in the patient's clinical record, the date and time of any medication administered.

Some of these actions are not new and have been requirements for some time.

In response to the opioid crisis, TJC is implementing new and revised pain assessment and management standards beginning January 1, 2018. The new standards apply to all Joint Commission-accredited hospitals. To assure compliance with the new standards, TJC has released a new R3 Report which provides the rationale behind the development of the new standards along with references and evidence.

The pain standards appear in the following sections of the CAMH: Leadership; Medical Staff; Provision of Care, Treatment, and Services; and Performance Improvement. For accredited hospitals, the following are requirements: "to identify pain assessment and pain management as a priority; actively involve medical staff in leadership roles in organization performance improvement activities to improve care, treatment and services; assess and manage patients' pain and minimize the risks associated with treatment; and collect, compile and analyze data to monitor performance." The R3 Report can be accessed on TJC's website, ***jointcommission.com***

The Agency for Healthcare Research and Quality's (AHRQ) Technology Assessment Program will be posting a draft systematic review for review on September 1, 2017. This draft is entitled, "Definition of Treatment-Resistant Depression in the Medicare Population." The document is available on the following website:

http://www.ahrq.gov/research/findings/ta/index.html.

Many organizations see and treat Medicare customers, therefore this information is extremely valuable. Please take a few moments to go to the website and read the review.

Update to the OIG Work Plan

In the past, the OIG Work Plan (WP) was usually updated a couple times a year, however this year the updates are generally happening more frequently, sometimes monthly. One update t focuses on reimbursement reform and is entitled "Review of Quality Measures Data Reported by Accountable Care Organizations in the Medicare Shared Savings Program," which addresses the Medicare Shared Savings Program (MSSP) established by Section 3022 of the Patient Protection and Affordable Care Act (ACA). There is a minor update which stated the OIG's intent to conduct a review of the MSSP related to beneficiary assignment, including the shared savings payments to those beneficiaries. Additionally, the OIG will be reviewing the MSSP ACOs' "performance on quality metrics and cost savings over the first 3 years of the program" and determine the "characteristics of the ACOs that performed well on measures and achieved savings" as a means of identifying cost saving and quality achievement strategies.

For those organizations that have skilled nursing facilities and transport by ambulance to another level of care, the OIG will be reviewing the process under which ambulance services are paid by Medicare under skilled nursing facility (SNF) consolidated billing requirements. According to sections 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act, outside suppliers must bill and receive payments from the SNFs, not Medicare Part B. As a result, the OIG will be determining whether these services were overpaid, by being reimbursed through both Medicare Part B and the SNF consolidated billing.

The Medicare Part A Inpatient Prospective Payment System (IPPS) states that hospitals receive a set amount per discharge so long as the Medicare beneficiary has at least one inpatient day at the time of admission and signifies the total amount to be paid by Medicare. A conundrum that has been identified is that Medicare makes duplicate payments if Part B payments are made for non-physician outpatient services. OIG has discovered that providers are continuing to inappropriately bill under this system and that current processes and controls are failing to prevent and detect such payments.

In the 2017 OIG WP, there was a focus on the technological reform of the Quality Payment Program (QPP), which was categorized through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Two aspects of the QPP were identified to assure program success: (1) "providing sufficient guidance and technical assistance to ensure that clinicians are ready to participate in the QPP"; and, (2) "developing backend information technology (IT) systems to support key QPP functions, such as data reporting and validation." A review of CMS's training and clinical outreach efforts is being conducted by the OIG, as well as IT system development, including "…the extent to which CMS has conducted security and functionality," in order to determine whether CMS is adequately assisting providers in navigating this shift in healthcare reimbursement. If one recalls, Medicare incentive payments were provided to hospitals who implemented the electronic health record (EHR). The OIG it intends to review hospital calculations in order to identify and correct future overpayments.
In an effort to increase access to healthcare in rural areas, certain telehealth services are covered under Medicare Part B, when those services are provided through an interactive telecommunications system, however to bill Medicare for these services, the physician must provide these services from a specified medical facility or the practitioner's office, specifically referred to an originating site in the WP. Since there is some confusion regarding this requirement, the OIG intends to review telehealth claims that do not have corresponding claims at the originating site. So far, there has not been any mention of the consequences, if any, to patient access to telehealth. It is likely there will be more to come on telehealth reimbursement and access. Source: Health Capital Topics. August 2017.