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Medicaid Expansion on Hold By Charles E. Wilbrand

The Nebraska State Legislature debated Legislative Bill 577 in mid April, and after two days of discussion lawmakers did not reach a decision. The bill introduced by Sen. Kathy Campbell required Nebraska to opt-into the expanded Medicaid coverage under the federal Patient Protection and Affordable Care Act (ACA). Opting-in required the Department of Health and Human Services to extend coverage to adults age 19-64 with incomes of zero to 133 percent of the Federal Poverty Level, which is just under \$16,000. The Affordable Care Act does not automatically make low income adults eligible for Medicaid, as each State must decide whether to extend benefits to them.

If LB 577 were adopted, the federal government would

match 100 percent of the cost for the first three years and then the match will decrease each year until the match reaches 90 percent. An amendment to the bill allowed the Legislature to repeal the law if the federal match ever dropped below 90 percent. The bill also provides that the eligibility for this age group will only continue until July 30, 2020 unless the legislature extends it.

One concern of the bill is the price that Nebraskans would have to pay. Sen. Campbell said that Nebraskans are already paying higher medical bills and insurance premiums due to uncompensated hospital care that individuals within this income group receive. Sen. Jeremy Norquist said adopting the bill would free up nearly \$2.3 million in the state general

fund. He also said that through insurance reform under the ACA, the cost of Medicaid expansion could be paid without endangering the budget.

Not everyone was in support of LB 577. Sen. Dan Wattermeier expressed concern that the medical system is not prepared for the extra increase of Medicaid recipients. He said that the number of Medicaid recipients will already increase by 50,000 under another provision of the ACA, and the potential of 54,000 more people covered by LB 577 raises concerns about the quality of care recipients would receive.

Senators debated the bill for 10 hours before discussion stalled and without voting the Legislature moved on to another agenda item without voting.

HIPAA Omnibus Final Rule Goes Into Effect By Laura K. Essay

The HIPAA Omnibus Final Rule went into effect on March 26, 2013 and full compliance is expected by September 23, 2013. The amended rule expands the accountability of business associates, and requires business associates to assume responsibility for keeping data safe and secure. After March 26, if a breach occurs for

which a business associate is responsible, the business associate must pay the cost of breach remediation. Further, similar to covered entities, business associates are responsible for assessing risk when a breach occurs and reporting the breach.

In order to assist business associates and covered entities with HIPAA compliance,

the new rule provides four factors that business associates and covered entities must evaluate to determine if a breach has occurred. Under the HIPAA Omnibus Final Rule, risk assessments focus on the risk that Protected Health Information (PHI) has been compromised as opposed to an evaluation of (continued on pg. 2)



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what happens to
you; it's what you
do with what
happens to you.

Aldous Huxley



Accounting of Disclosures Rule to be Delayed By Tammy Schroeder

A controversial provision of the HITECH Act may very well not be finalized by the January 1, 2014 deadline. Leon Rodriguez, Director of the HHS Office for Civil Rights, stated during the Health Care Compliance Association's annual conference that the deadline for the HITECH rule was now "fluid", and he did not give any indication when the rule could be issued as the agency is still reviewing the comments it has received in regards to

the rule.

Under HIPAA providers are required to give people certain information about how their healthcare data has been shared. Once this provision of HITECH takes effect it will allow a person to ask for a simple version of the existing HIPAA disclosure and a report that would include a wide range of information. That information would include the names of the individuals who have accessed the health information and

what those individuals did with the records. Also under HITECH, the provider will only have 30 days to respond to the person's request v. the current 60 days under HIPAA.

The American Health Care Association (AHCA) states that the current 60 day timeline should be maintained as it is impractical to believe that a provider can put together such a comprehensive report in (continued pg. 3)

HIPAA Omnibus Final Rule (continued)

harm to a particular individual resulting from a breach.

The rule includes four factors to consider when a breach occurs to determine if PHI has been compromised and to what level reporting of the breach must be made. The *Journal of AHIMA* outlined the four factors, which include:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification.
- The unauthorized person who used the protected health information or to whom the disclosure was made.
- Whether the protected health information was actually acquired or viewed.
- The extent to which the risk to the protected health information has been mitigated; for example, was the breached information received via facsimile and then destroyed or actually used and/or shared?

information received via facsimile and then destroyed or actually used and/or shared?

In addition to the four risk assessment factors, 19 unique identifiers must be reported with each risk assessment. According to the *Journal of AHIMA*, the unique identifiers include:

- Name
- All geographic subdivisions smaller than a state
- For dates directly related to the individual, all elements of dates, except year (i.e., date of birth, admission date, discharge date, date of death)
- All ages over 89 or dates indicating such an age
- Telephone number
- Fax number
- Email address
- Social Security number
- Medical Record number
- Health Plan number
- Account numbers
- Certificate or license numbers
- Vehicle identification numbers, including license plate numbers
- Device identification/serial numbers
- Universal Resource Locators
- Internet Protocol addresses
- Biometric Identifiers
- Full face photographs and comparable images
- Any other unique identifying number, characteristic, or code

Facilities should begin considering these more objective factors when conducting risk assessments to determine if PHI has been compromised and breach notification is necessary. In order to ensure compliance with HIPAA guidelines, the four risk factors and 19 unique identifiers should be considered and reported with each potential breach.

New W-Visa to Help Nursing Homes Fill Jobs By Michael W. Khalili

There are many jobs at nursing homes that even desperate unemployed Americans won't consider because they are seen as too demanding. A solution to this employment problem could be as simple as immigration reform, one of President Obama's highest priorities.

A new visa, called the W-Visa, would cover low-skilled workers employed by a variety of non-seasonal industries, including long-term care. Beginning in 2015, the program would admit 20,000 workers, and then it will progressively go up in subsequent years with a cap of 200,000. The yearly al-

lotment of available visas would vacillate based on factors such as the national unemployment rate. The W-Visa beneficiaries would be paid the same wages as American workers or industry-standard wages, and would be able to apply for permanent residency and citizenship.

The American Health Care Association urged lawmakers to allow nursing homes to employ more immigrant workers in order for nursing home operators to fill vacancies and to save money. Fred Benjamin, chairman of the Kansas Health Care Association and COO of Medi-

calodges Inc., addressed a Congressional panel about this issue.

"We've offered signing bonuses, set up tables in grocery stores, sent direct mail, posted job openings on the Web, even laundromats, and it's still not enough to fill positions," he said. "It's tough work taking care of people...but we believe there are a lot of people from other countries who would gladly take these jobs." said Fred Benjamin.



Updated Palliative Care Guidelines By Tammy Schroeder

In its first update since 2009 to the "Clinical Practice Guidelines for Quality Palliative Care", the National Consensus Project for Quality Palliative Care states that palliative care should follow the care coordination and quality improvement processes that are called for by the Affordable Care Act. The guidelines state that the ACA's delivery and payment models provided a way for hospice and palliative care providers to join accountable care organizations and bundled payment groups

and thus the best practices should be followed in order to promote palliative care across all settings.

The guidelines also state that providers should start using quality assessment and performance improvement (QAPI) reviews as a part of a way to improve outcomes through ongoing data driven processes. "Quality improvement activities are routine, regular, reported, and demonstrate influence upon clinical practice. Designated staff with experience in QAPI

planning, direct the QAPI process in collaboration with leaders of the palliative care program."

The guidelines were also revised on the psychological and psychiatric aspects of care such as adding a section on bereavement programs. This section calls for an assessment at admission to identify families who may have complicated bereavements and specifically with older adults who may be at risk for developing co-morbid complications related to grief.

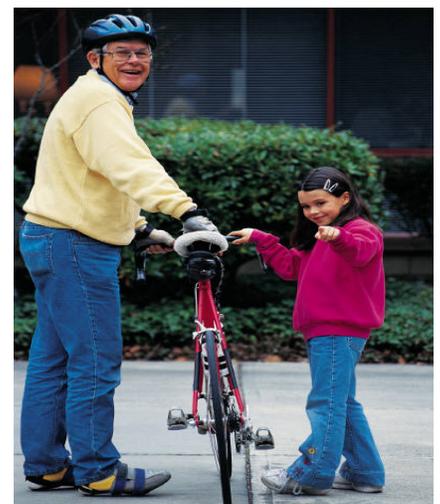
Disclosures Rule Delayed (continued from pg. 2)

that time period. In addition, AHCA states that the aggregate access report requirement should be eliminated for long-term care providers due to the fact that in cases involving a nursing home resident, their health record will be comprised of both paper and electronic information from a variety of places such as the hospital, pharmacy, therapists and so on. AHCA states that if not elimi-

nated then it should be limited to just the system that the provider maintains and controls.

HHS received over 400 comments after the proposed rule was released in May 2011. Some providers believe the rule should be eliminated due to it being excessively burdensome while other providers state that they feared a disgruntled patient could and would retaliate against any employees named in

the access report.



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