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### Prepare for new CoPs

## CoPs will impact operations, financials more than any other requirement in 2018

Within the revised Home Health Conditions of Participation (CoPs) slated to take effect Jan. 13, QAPI and care planning/discharge are the changes of greatest concern.

The emergency preparedness requirements, which took effect in November, are the next-most common CoP of concern, according to the 186 respondents of *HHL's* 2018 Trends Survey.

"There seems to be too much room for interpretation in the QAPI terminology," says the director for one Alabama-based agency. "It's difficult to know if what we're doing will be good enough."

(see *CoPs*, p. 7)

### Claims reviews

## Improve documentation, avoid pitfalls ahead of targeted probe-and-educate review

Between the cost of denials and additional staffing expenses to cover the time involved in gathering and submitting paperwork, CMS' probe-and-educate review cost one Indiana agency \$50,000 to \$60,000.

But targeted probe-and-educate reviews will cause even greater strain for many small to midsized agencies caught up in the claims review process in 2018, industry experts say.

"This would have a trend of putting agencies out of business," says Joe Osentoski, reimbursement recovery and appeals director with Quality in Real Time (QIRT) in Troy, Mich.

(see *Claims*, p. 9)

## 2018 Home Health Administrator's Summit



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*Quality outcomes***Attending doctors' visits can be key to value-based improvement & 5-star success**

The amount of money at stake in CMS' value-based purchasing demonstration for home health continues to increase. Agencies must continue to think outside the box in 2018 about how they can ensure they'll provide the highest quality care and receive the maximum payment adjustments.

Even providers outside the nine value-based states should closely monitor top-performing agencies' strategies.

Learning from top agencies' efforts can improve patient outcomes and satisfaction. It also can help agencies in other states prepare for a potential expansion of value-based purchasing.

At Nemaha County Home Care in Auburn, Neb., the unorthodox approach of having nurses accompany patients to doctors' appointments whenever possible allowed it to place in the 99th percentile among agencies in its state cohort of 34.

The strategy also led to a significant payout.

The agency will receive a 2.43% reimbursement increase out of a maximum increase of 3% for value-based agencies in 2018.

Value-based agencies will face a maximum payment adjustment of 5% in 2019 and 6% in 2020.

Nemaha County's quality improvement efforts also have paid off when it comes to five-star ratings.

The agency is one of only 30 providers nationwide to earn 5 stars on both quality of care and HHCAHPS ratings during the October 2017 refresh.

**Improve on care coordination**

Nemaha County, a hospital-based agency with a daily census of about 30, started like most agencies tasked with reporting under value-based purchasing — emphasizing education around documentation accuracy and improved performance tracking.

But as the agency reviewed its episodes, leaders found improvements were necessary to reduce emergency room visits and rehospitalizations.

Leaders believed the agency required improved communication between physicians, patients and caregivers, says Jere Gravatt, the agency's director. Patients, Gravatt says, often leave physician visits without understanding what they need to do or how and when to take medications.

By attending those appointments — with the permission of the patient and provider — the agency's staff can offer further education to patients.

This increases the chances that patients will take correct medications properly and adhere to other care instructions, Gravatt says.

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The strategy has “been awesome” in terms of clarifying medications and providing additional patient education, Gravatt notes.

Nemaha County doesn’t have firm numbers on how its decision to send nurses to doctors’ appointments for the past 18 months has affected rehospitalization rates. But Gravatt says if her nurses didn’t attend appointments and help educate patients on new physician directives, some would inevitably end up in the emergency room.

Nemaha County’s 60-day rehospitalization rate on Home Health Compare is 15.8%, nearly 1% lower than state and national averages.

Accompanying patients on visits has definitely helped with patient satisfaction, Gravatt adds.

Patients “feel like we’ve paid attention to them and taken our care for them one step further,” she says.

While HHCAHPS is sometimes overlooked for value-based agencies, it is included within the value-based purchasing scoring system, notes Diane Link, director of clinical services for BlackTree Healthcare Consulting in Conshohocken, Pa.

Nemaha County earned a score of 95% on the HHCAHPS question “Did the home health team discuss medicines, pain, and home safety with patients?”

The state and national average is 83%.

While sending nurses to appointments costs time and money, Gravatt believes the value-based purchasing bonus, HHCAHPS scores, increased referrals and overall welfare of the patients makes it cost effective.

“How much dollar value do you put on relationships that you build with patients, physicians and families?” she asked.

### Staff education leads to success

CMS’ value-based purchasing pilot began exactly two years ago.

Agencies learned in July 2017 whether they would be penalized or receive an increased reimbursement this year based on their success with the program in 2016.

While CMS hasn’t released overall statistics on the initial outcomes of the value-based purchasing participants, some agencies responding to *HHL’s* 2018 Trends Survey listed education as key to their success in receiving added payments.

For Camellia Home Health and Hospice, an agency with 11 total locations in three states, educating staff on improving documentation allowed it to increase its reimbursement rates by 0.642% in 2018.

Although just one of its locations is in a value-based state (Tennessee), the agency modified one of its existing positions to create a director of education who developed an in-house program to educate all staff — value-based or not — on the program.

Rather than putting staff through an OASIS boot camp, Brandi Seals, director of education, went through CMS’ free guidance and focused on a different line item of OASIS each week, developing scenarios so clinical staff could understand the reasons behind each requirement and how that documentation benefits the patient.

For example, one lesson focuses on bed transferring, describing challenges a patient exhibited when transferring from the bed to a chair. It includes the rationale behind why a patient who managed to transfer with some intervention on behalf of the caregiver and an assistive device would be classified as “unable to transfer self” under CMS guidelines.

### Keys to setting up visits with doctors

- **Set parameters for visits.** Nurses at Nemaha County try to attend all in-town physician visits for patients — something practical for the agency since the main clinic is a block away. Nurses don’t attend out-of-town visits.

To ensure they can attend in-town visits, nurses have the ability to add them to their own schedules.

- **Explain why having nurses attend visits would be beneficial.** The agency called doctors when it implemented the program, and only has had one specialist ask that nurses not attend appointments.

- **Document.** Nemaha County’s nurses record patient visit information in the electronic medical records (EMR) system. — *Angela Childers (angela.childers@gmail.com)*

**Related link:** View *Camellia’s* bed transferring scenario at <http://bit.ly/2BtJxMM>.

### Trump administration

## Trump’s first-year efforts don’t eliminate ACA, but do cut the individual mandate

President Donald Trump came into office promising the end of Obamacare, which he would replace with something “great.”

The Republican House and Senate were unable to repeal and replace the Affordable Care Act (ACA) — something

Trump promised to do “immediately” upon assuming office in a “special session” of Congress. But on Dec. 20, Congress took a step toward breaking down the ACA when it passed a tax bill that also eliminates the individual mandate.

Repealing the mandate will reduce the deficit by \$338 billion from 2018 through 2027 but will increase the number of uninsured Americans by 13 million by the end of that period, according to the Congressional Budget Office.

“Adding the repeal of the individual mandate to tax reform could be the most consequential step this Congress takes to date in fulfilling our promises to the American people to both reform the tax code and repeal Obamacare,” the House Republican Study Committee’s Steering Committee said in a statement.

### Administration kneecaps the ACA

During his first year in office, Trump’s executive actions seemed meant to kneecap Obamacare — such as his recent order to cease subsidy payments to insurers, says Mike Strazzella, head of the Washington, D.C., office of law firm Buchanan, Ingersoll & Rooney and practice group leader for federal government relations.

But they are not just, as some observers have suggested, made out of pique over Congress’ failure to eliminate the ACA, Strazzella says. Instead they are strategic provocations to pressure Congress to do what Trump wants.

“The Hill will have a reactionary approach [to Trump] and that will empower Trump to move forward,” Strazzella says. “He will think it forces them to enact reforms.”

It will be instructive to see what happens with a recent proposed rule targeting the ACA. HHS’ Notice of Benefit and Payment Parameters for 2019, which came out Oct. 27, may offer a clue as to how far Trump is willing to go with this putative strategy.

CMS proposes in the rule “to provide states with additional flexibility in the definition of essential health benefits (EHBs) and outline potential future directions for defining EHBs” and to solicit stakeholder input.

### More on administration’s efforts

Beyond Obamacare, the Trump administration’s health care efforts have involved appointing small-government types to health-related positions — such

as Scott Gottlieb, a former resident fellow at the conservative think tank American Enterprise Institute, now heading the Food and Drug Administration (FDA).

The administration also has trimmed some aggressive Obama-era measures, such as the mandatory episodic payment programs for common cardiac and orthopedic conditions that were supposed to start in 2018 (*HHL 8/28/17*).

In the future, CMS plans to create more opportunities for providers to participate in voluntary initiatives as opposed to large, mandatory bundled payment models, a CMS release states (*HHL 12/11/17*).

The administration also plans to lead the Center for Medicare and Medicaid Innovation (CMMI) in a new direction.

In late 2017, it issued a request for information to gather ideas on where it should take CMMI.

“We are analyzing all innovation center models to determine what is working and should continue, and what isn’t and shouldn’t,” CMS Administrator Seema Verma wrote in a Sept. 19 editorial in the Wall Street Journal. — Roy Edroso ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com)) and Josh Poltilove ([jpoltlove@decisionhealth.com](mailto:jpoltlove@decisionhealth.com))

**Related link:** View a fact sheet about the Notice of Benefit and Payment Parameters at <http://go.cms.gov/2zLYk3E>.

## Trump administration

### Prediction: Trump’s pick for HHS secretary will combat ACA, high drug prices

Expect Alex Azar to remain faithful to the Republican line on the Affordable Care Act (ACA) and other health policy issues if he is confirmed as HHS secretary.

In his Nov. 29 confirmation hearing before the Senate Committee on Health, Education Labor & Pensions (HELP), Azar said he planned as secretary to focus on four critical areas:

**1. Drug prices.** Azar, a former pharmaceutical company president, said drug prices are too high.

**2. The ACA.** He said he is committed to “make health care more affordable” by driving down “skyrocketing premiums” and looking after Americans “left out of the insurance market” by the ACA.

**3. “Strengthening” Medicare.** Azar said the president’s commitment was to make Medicare “as

efficient as possible” and that he would fight “waste, fraud and abuse in the program” to “stretch out the resources in the Medicare program to keep its solvency longer.”

**4. Opioids.** Azar said he would heed President Donald Trump’s call to action on opioid addiction with “aggressive prevention” policies and “compassionate treatment for those suffering from addiction.”

### Azar is strongly against the ACA

Sen. Bob Casey, D-Pa., asked during the confirmation hearing whether Azar would oppose “efforts made by the administration to undermine the ACA.”

“I would disagree that there’s any effort to sabotage the program,” Azar replied.

But he said he wanted to make sure citizens “get the insurance that they want, not the insurance that we want to give them,” a typical anti-ACA talking point.

Azar approved of Trump’s suspension of cost sharing reduction (CSR) payments to ACA insurers and his rollback of ACA outreach via advertising and navigators, saying “there’s no point in funding any aspects of the program that are not working well.”

Sen. Margaret Hassan, D-N.H., asked about the recent proposed rule that would allow states to cut back essential health benefits as they chose.

Azar replied that states are most effective when determining benefits packages. — *Roy Edroso* ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com))

### Mergers & Acquisitions

## Experts forecast 2018 as another big year of home health transactions

Highlighted by the blockbuster sale of Kindred Healthcare to three companies including Humana, the number of transactions in the Medicare home health industry picked back up in 2017 after a two-year dip.

The elevated number of mergers and acquisitions likely will continue this year, industry experts say.

“I think the market is going to remain strong in 2018 because the pressures are still there,” says Mark Kulik, managing director at Pittsburgh-based mergers and acquisitions advisory firm The Braff Group.

For small agencies, these pressures include declining reimbursement and significant regulatory oversight, he says. “I foresee continued consolidation as a necessity to maintain the margins.”

Data from The Braff Group show the industry was on pace for about 70 transactions in 2017.

Among the highlights: Almost Family of Louisville, Ky., and LHC Group of Lafayette, La., announced on Nov. 16 that they will merge into a company with more than 31,000 employees and a revenue of \$1.8 billion. This merger will lead to a combined company with 781 locations in 36 states, a release states (*HHL 11/16/17*).

The end of 2017 also is hinting at a different consolidation landscape.

Kindred — the nation’s biggest home health and hospice provider — announced Dec. 19 that its board approved a \$4.1 billion agreement under which it will be acquired by three companies including Humana, the Louisville, Ky.-based health insurance provider.

That deal is historic as it begins to blur the line between payer and provider.

The number of transactions in 2017 was a significant improvement after a lull in the market in recent years. There only were 56 transactions in 2016 and 51 in 2015.

By comparison, there were 73 to 81 transactions each year from 2007 through 2014, Braff Group data show.

The drop in transactions in recent years likely was “due to a temporary lull in the supply of acquisition candidates resulting, in part, from a seven-year run of high acquisition rates in the market,” says Jack Eskenazi Jr., managing partner of Healthcare Advisory Partners, based in Soquel, Calif.

But the transactions of 2017 “are very bright markers” about the kinds of investment that companies are making into the home health industry, Kulik says.

### Deals have become more strategic

In the past, larger home health agencies looked to gobble up smaller ones in certain geographic areas. But now acquisitions are strategic, says Dexter Braff, president of The Braff Group.

“The dominant consolidation strategy today is not to amass a large regional or national footprint of providers,” Braff says. “Rather, under emerging population-based or condition-specific global payment models, companies are now being rewarded for coordinating care.”

Buyers in 2018 will look to have “a continuum of companies, from primary to acute to post-acute providers, to efficiently handle an episode of care,” he says. “What this means is that buyers of either [Medicare]

certified or private duty agencies are more likely to be local hospital systems, skilled nursing providers, large physician groups and the like, instead of huge home health agency companies.”

Eskenazi adds that the Affordable Care Act, with value-, risk-, and outcome-based compensation models, is the driving force for a pressure on efficiency.

“Combine that with the ever-expanding market and demand for services — those are the fundamentals shaping the market,” he says.

### Regulations may impact 2018 deals

With the Trump administration in place, potential buyers have “greater confidence that the operating and regulatory conditions will not get worse,” Eskenazi says.

But, he says, agencies aren’t out of the woods. The revised Home Health Conditions of Participation (CoPs) take effect Jan. 13, and the tax plan approved by Congress on Dec. 20 also potentially could affect providers, he adds.

But within the past year, CMS has backed off a few regulations that were a cause for concern for potential buyers.

When the Home Health Groupings Model (HHGM) was announced in the 2018 proposed PPS rule, “that had some potential buyers tapping the breaks out of fear,” Kulik says. But about 1,300 commenters voiced opposition to HHGM, and as a result it wasn’t included in the final rule and won’t launch in 2019.

Note, however, that CMS is continuing to discuss revising the home health payment model.

In addition, CMS’ pre-claim review demonstration was a much greater concern for buyers in the past few years than it is now.

“When pre-claim review came out in Illinois, it froze the marketplace,” Kulik says. “You had four other states lined up, and it froze the activity because nobody wanted to buy in a state that was going to be under a magnifying glass.”

On March 31, 2017, just a day before the pre-claim review demo was set to expand to include Florida in addition to Illinois, CMS paused the demo (*HHL 4/10/17*).

HHS’ then-secretary and CMS’ administrator didn’t appear to look favorably upon the model, industry experts said at the time. The demo hasn’t resumed.

When the review was ongoing, agencies in Illinois improved significantly in terms of compliance. That

actually might make them of higher interest to potential buyers, Kulik notes. Only about 30% of the requests submitted in weeks 3 and 4 of Illinois’ pre-claim were fully affirmed; by week 24, about 90% of pre-claim review requests were fully affirmed.

### How to become attractive to buyers

- **Get your agency in compliance if it isn’t right now.** Other factors might determine if your agency sells high or low, but compliance is the factor that may determine if you sell at all, Eskenazi says.

Kulik agrees. “If I had to point to one significant change in M&A today, I’d point to due diligence and the buyer’s insistence on compliance across the board. They’re not looking to buy fixer-uppers. This includes all compliance, federal and state, and in all areas. I had a deal almost derail because the 401k program wasn’t compliant.”

- **Develop a specialty in a particular area of care.** And build relationships with doctors who specialize in this area. This way, a large hospital might have better reason to discharge particular patients to your agency over their usual — or even facility-owned — agency, Eskenazi says. — *Tami Swartz (tswartz@hcpro.com)*

### Mergers & Acquisitions

## Private duty agency transactions continue to see a big boost

The number of mergers and acquisitions in the private duty industry hit record numbers in 2016 and 2017.

Consider that private duty mergers and acquisitions never topped 21 in a five-year stretch ending in 2015. But the market skyrocketed to 49 transactions in 2016, and was on pace for another year of elevated activity in 2017, according to data from Pittsburgh-based mergers and acquisitions advisory firm The Braff Group. There were 28 private duty transactions through the third quarter of 2017.

There’s no reason 2018 won’t be a strong year for private duty transactions, as the industry is becoming increasingly important within the continuum of care, says Jack Eskenazi Jr., managing partner of Healthcare Advisory Partners, based in Soquel, Calif.

“This reflects growing sentiment that the deployment of longer-term, paraprofessional services may prove to be a crucial component to managing the overall health care spend of post-surgical and/or chronically ill patients,” says Dexter Braff, president of The Braff Group.

“With growth comes a higher degree of regulation and licensure, even in private care — which translates to higher costs,” Eskenazi says. “These regulatory demands mean small private duty agencies are looking to consolidate to handle the burden.”

Eskenazi adds that there is a strong interest from private equity investors.

“There’s a real separation between your mom and pops just sending an aide and larger agencies that partner with medical providers and provide a greater array of services,” Eskenazi says.

The latter, he contends, will do better in the long run.  
— Tami Swartz ([tswartz@hcpro.com](mailto:tswartz@hcpro.com))

## CoPs

(continued from p. 1)

Adds the director of nursing for an Ohio-based agency: “Staff feels this an added burden to something that we already strive to do. New requirements are driving experienced nurses with excellent skills and knowledge out of the home health field.”

### Survey shows CoPs are a major worry

Overall, the revised CoPs will have a massive effect on agencies’ attention and bottom lines in 2018.

Survey respondents believe the CoPs will have a bigger effect on their operations and financials than any other requirement or regulatory change for home health agencies this year.

And 84% of the 156 respondents to a question about budgeting say their agencies plan to spend more on training on the revised CoPs in 2018 than they had in 2017. No respondents said they plan to spend less. (See *benchmark*, p. 9.)

However, most survey respondents indicated they spent less than \$5,000 in 2017 preparing for the CoPs and would spend less than \$5,000 preparing this year.

That’s because many agencies think they can prepare on their own, without assistance — and because many agencies remain in denial that the CoPs’ implementation date will remain Jan. 13, says J’non Griffin, president of Home Health Solutions, LLC in Carbon Hill, Ala.

In actuality, the revised CoPs are coming and are one of the biggest changes for home health that Griffin has seen.

“We have had to change almost all processes to meet the requirements as opposed to possibly changing one thing,” Griffin says.

The good news is that civil monetary penalties will be imposed in 2018 only for recertification surveys where a situation resulted in immediate jeopardy (*HHL 12/4/17*).

Deficiencies still will be written, however, and if agencies don’t make the proper corrections to comply, they “may be terminated or another alternative sanction may be imposed temporarily in lieu of immediate termination,” a CMS spokeswoman told *HHL*.

In 2018, many agencies will be cited for standard- and condition-level deficiencies in addition to immediate jeopardy, says Sharon Litwin, senior managing partner for 5 Star Consultants LLC in Camdenton, Mo.

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PAS 2018

With just weeks to go before the CoPs are set to take effect, she adds, the industry is “not at all ready” to comply. Many agencies are only now nearing compliance on the emergency preparedness requirements that went into effect Nov. 15.

### Tips to prepare for the QAPI CoP

- **Examine CMS’ guidance about what constitutes high-risk, high-volume and problem-prone areas.** CMS previously said performance improvement activities needed to focus on these three categories, and the draft interpretive guidelines provide some additional detail. There’s some overlap in how CMS views these categories, notes attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman.

For high-risk areas, consider “global” and “geographic” concerns, among other things.

Global concerns are areas where you provide a specific type of service to many patients, such as if you’re a pediatric agency. The risk potential increases because you have such a large volume, Markette says.

Geographic concerns would be, for example, the safety of a neighborhood served, the draft guidelines state. It’s unclear how an agency would conduct a performance improvement project (PIP) based on a neighborhood’s safety, Markette says.

The draft guidelines also indicate agencies should consider specific patient care services including administration of intravenous medications or tracheostomy care. These areas might be high-risk based upon the nature of care provided.

For high-volume areas, CMS explains it means care or services often provided to a large patient population. Examples listed include laboratory testing, physical therapy, infusion therapy and diabetes management.

CMS’ explanation about high-volume areas doesn’t define what a “large patient population” means, so agencies should use their best judgment, Markette says.

For problem-prone areas, CMS explains this refers to the potential for negative outcomes associated with conditions or diagnoses for a particular patient group or particular component of the agency.

Prior to the draft guidelines, many agency leaders thought “problem prone” referred to areas in which agencies had past performance issues/deficiencies, Markette says.

- **Review CMS’ guidance about adverse patient events.** Adverse events at §484.65(c) in the revised CoPs are described as events that are negative and unexpected, impact the plan of care and “have the potential” to cause a decline in the patient’s condition, the draft guidelines state.

This is subjective because it’s possible the event will be considered adverse even if it doesn’t cause a decline, Markette says.

- **Spell out the rules for each individual PIP you conduct.** For each project, have a section of your documentation where you clearly explain the procedures for data collection, measurement and analysis.

It may be difficult to have a one-size-fits-all measurement process for your QAPI program’s projects, so for each project, you should detail your specific measurement and collection expectations, Markette says.

- **Involve your governing body in QAPI and remember that the governing body is ultimately responsible for it.** While the governing body doesn’t perform quality improvement projects, it ensures actions happen through approval and budgeting, for example, Markette says. If the QAPI program is unsuccessful, the governing body must act.

It’s important that your governing body budgets enough money to allow the QAPI program to succeed, Markette says.

Unfortunately, the draft guidelines don’t provide insight into what surveyors will expect to see when reviewing governing body documentation.

But the kinds of things Markette recommends agencies look at include: meeting minutes that reflect discussions about QAPI, agenda items discussing QAPI and budget items for the board to approve.

There should be resolutions approving the QAPI program, data collection and PIPs.

In preparing for the CoPs, agencies should alert governing body members that they might be contacted during a survey to discuss QAPI, Markette adds.

“Consider giving them the same survey prep training you would give anyone else that might have to interact with a surveyor,” he says. — *Josh Poltilove* ([jpoltilove@decisionhealth.com](mailto:jpoltilove@decisionhealth.com))

**Related link:** Read the draft interpretive guidelines at <http://bit.ly/2gNUKIA>.

## Claims

*(continued from p. 1)*

For all agencies — especially those included in the review — it’s vital to closely examine documentation you’re about to submit to ensure it fulfills everything reviewers expect to see.

Targeted reviews will involve the analysis of 20 to 40 claims per round, with up to three rounds depending upon an agency’s success. That’s far more claims reviewed than during the two rounds of probe-and-educate review (*HHL 9/4/17*).

Consequences for failure in the targeted review are far worse, too.

Agencies that show a high percentage error rate and no effort to get payments under control during the reviews could face extrapolation, referral to a Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC), 100% prepay review or referral to the recovery auditor (RAC), according to CMS.

If extrapolation is used and, for example, if an agency has an 80% denial rate in the three rounds of targeted probe, CMS potentially could go back several years and recoup 80% of the agency’s payments, Medicare Administrative Contractor (MAC) National Government Services (NGS) said during a Nov. 28 webinar.

Recoupment would be based on the assumption that the agency was historically paid improperly.

### Review forced agency to cancel bonuses

Santa Claus didn’t come to Excel Home Health Care in Lebanon, Ind., in 2017. After the agency spent \$50,000 to \$60,000 on probe-and-educate, agency leaders decided to forgo the annual Christmas party and not offer year-end bonuses.

In the first round of probe-and-educate, the agency received two denials.

One of those denials was overturned on appeal, but it still counted toward the agency’s denial rate and pushed the agency into the next round, agency administrator Shari Pryor says.

“That is what’s really frustrating, because all of the information was there,” Pryor says.

Based on the agency’s performance, Pryor expects Excel to be included in the targeted probe. It hadn’t heard official word as of late December.

## Use these strategies to survive the probe

- **Conduct pre-billing audits on all claims.**

Running your own audits of all claims ahead of final billing can minimize the risk of future audits by an outside source, says Kathy Roby, a consulting director for home health care at Qualidigm in Wethersfield, Conn.

Excel has given additional hours to part-time employees in order to conduct pre-billing audits of all records.

Staff look at all referral and face-to-face documentation, check requirements on the Home Health Certification and Plan of Care form and make sure there is evidence of coordination with the primary physician.

“Those are our main hot buttons, and every one of our records is looked at before it goes out now,” Pryor says.

View CMS’ review tool at <http://go.cms.gov/2xcHqL4> to ensure you’re gathering and supplying the necessary documentation.

- **Evaluate the use of hypertension diagnoses.**

MAC CGS will include within the review providers that submitted claims with a diagnosis of hypertension and a length of stay greater than 120 days.

## BENCHMARK of the Week

### Will agencies spend more or less on training in 2018?

About 84% of agencies plan to spend more money to train on the revised Medicare Conditions of Participation (CoPs) in 2018 than they had in 2017, according to 156 respondents to a question on HHL’s 2018 Trends Survey. No respondents plan to spend less on this. (*See story, p. 1.*)

	Spend more	Spend less	No change
Training on the revised CoPs	84.0%	0.0%	16.0%
Training on existing CoPs	38.7%	14.0%	47.3%
Training on emergency preparedness requirements	72.3%	0.6%	27.1%
Training on the OASIS	63.9%	1.9%	34.2%
Coding training	33.8%	2.6%	63.6%
Clinical training	48.1%	3.9%	48.1%

**Source:** HHL’s 2018 Trends Survey

- **Get the full assessment from hospitals.** When a patient is discharged, there is usually an electronic or paper referral document that includes some information about admitting diagnosis, a paragraph on the course of care, a list of medications and the date of the last physician face-to-face encounter before discharge, Roby says.

But agencies should ask for the full clinical care summary that also includes tests and results, lab work, consultations and discharge summaries from each discipline that saw the patient in the hospital, she says.

“These documents will make all the difference in supporting the claim,” Roby says.

Similarly, if a patient comes to your agency from a skilled nursing facility (SNF) or rehabilitation facility, ask for the facility’s copy of any hospital information it might have received.

Many additional documentation requests (ADRs) get “denied because the acute care hospital that referred hasn’t yet billed,” Roby says.

- **Train staff to list the most specific, accurate codes.** The use of generic or non-specific ICD-10 codes increases your risk for inclusion in the targeted review, Osentoski says.

Proper, specific coding also goes a long way in demonstrating the need for skilled care, Roby adds.

In the Home Health Groupings Model, which was not finalized as proposed, 23% of start-of-care (SOC) assessments in 2016 would have been deemed questionable encounters due to the primary diagnosis used (*HHL 8/25/17*).

View a list of the 10 most common questionable encounters at <http://bit.ly/2youFQU>.

- **Don’t use highlighters, paper clips or sticky notes when submitting documentation.** If you are part of the targeted review, keep in mind that records get scanned into the computer, NGS officials said during a recent webinar.

This means that at best, highlighting won’t show up and is a waste of time and at worst, highlighting could obscure the area you wanted to stand out to the reviewer, NGS officials said.

Similarly, you should avoid using paper clips and sticky notes because they will be removed before records reach the reviewer, officials said.

Typically, agencies will use these items as dividers or to keep documents together, Roby says.

Instead, Roby recommends using a blank page and labeling that with bold black pen.

Number your pages and keep a detailed, itemized list of what you submit so you can later show that a certain document or page was sent. — *Kirsten Dize* ([kdize@decisionhealth.com](mailto:kdize@decisionhealth.com))

### Home health payments

## MedPAC — yet again — eyes recommending home health payment reductions

The Medicare Payment Advisory Commission (MedPAC) will vote this month on whether to once again recommend a 5% Medicare payment reduction for home health agencies, as well as a two-year rebasing of the payment system.

During its Dec. 7 meeting, MedPAC discussed a draft recommendation to ask Congress to reduce Medicare payments in 2019.

The draft recommendation also includes a two-year rebasing beginning in 2020 and eliminating “the use of therapy visits as a factor in payment determinations, concurrent with rebasing.”

MedPAC plans to vote on the draft recommendations during its next meeting, Jan. 11-12.

Many MedPAC commissioners “indicated they would support the recommendations,” according to the National Association for Home Care & Hospice.

In its report to Congress last year, MedPAC recommended a 5% payment reduction and a two-year rebasing.

CMS finalized a 0.5% reduction in home health payments for 2018.

But the federal Medicare agency initially considered drastically revising the home health payment model beginning in 2019. In the final PPS rule, CMS decided not to make major changes — for now (*HHL 11/1/17*).

MedPAC has previously contended that home health agencies’ profit margins justified omission of an inflation update for them (*HHL 3/28/16*).

Congress has rejected MedPAC’s recommendations in recent years, but allegations of provider overpayments could affect how payment system innovations are constructed, industry experts contend (*HHL 2/6/17*). — *Josh Politlove* ([jpolitlove@decisionhealth.com](mailto:jpolitlove@decisionhealth.com))

**Related link:** Read the transcript from MedPAC’s December meeting at <http://bit.ly/2CAEvh8>.

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