

# Home Health Line

Regulatory news, benchmarks and best practices to build profitable home care agencies

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### Comply with new CoPs

## Expert answers agencies' questions on building performance improvement projects

Following a recent DecisionHealth webinar about implementing a compliant performance improvement project (PIP) as part of a QAPI program, agencies asked questions of expert J'non Griffin, president of Home Health Solutions LLC in Carbon Hill, Ala. Here are some of her answers.

**Q:** How do you determine PIP report frequency? What kind of factors would determine whether a PIP report should be given weekly, monthly, etc.?

(see **PIP**, p. 5)

### Operations

## Nation's new tax law might encourage some agencies to become C corporations

Closely examine the nation's new tax law and start crunching numbers with a tax professional to determine if your agency might be better off as a C corporation.

The Tax Cuts and Jobs Act of 2017, which President Donald Trump signed into law Dec. 22, was touted as a win for businesses. But the plan will affect different types of home health agencies in different ways.

(see **Taxes**, p. 7)

## Learn more about the Budget Act of 2018



During a webinar from 1 p.m. to 2 p.m. EST March 27, attorney Robert Markette will review the home health-specific provisions of the Budget Act of 2018 and advise agencies on steps they need to take. Sign up at <http://bit.ly/2GToapB>.

*Medicare Advantage***Medicare Advantage is growing, but so are the headaches it's causing agencies**

Agencies are experiencing an uptick in claims reviews from auditing companies working for insurers offering Medicare Advantage (MA). And the number of MA claims reviewed is sure to become more plentiful in the coming years as MA itself continues expanding at a massive rate, industry experts say.

With 17.5 million MA enrollees to date, more than one third of all seniors are under an MA plan. Some experts estimate that more than half of all Medicare recipients will be enrolled in an MA program through a private insurer by 2025.

But MA utilization isn't what is causing the biggest problem for home health agencies. It's the audits.

Unlike with Medicare fee-for-service, insurers offering MA have their own requirements beyond what is demanded by CMS, and they also have their own restrictions on appealing denials, says Robert Markette, an attorney at Indianapolis-based Hall, Render, Killian, Heath & Lyman.

Dr. Erum Inam, a reimbursement recovery and appeals associate at Quality in Real Time in Troy, Mich., says of her company's national base of clients, agencies in Illinois, Michigan, California and Texas have faced the highest number of MA reviews.

SCIO Health Analytics is often cited as one of the leading auditing companies scouring claims for mistakes, and Blue Cross Blue Shield of Michigan and Medica are among the insurers contracting with the company for auditing services. SCIO claims that it has delivered \$540 million of value to its clients by identifying overpayments, fraudulent billing, clinical waste and price variations in billing. It boasted that though audits it saved a 65,000-member Texas-based Medicare Advantage insurer more than \$24 million in 2017.

**What problems lead to denials?**

In the last few years, many denials were for overlapping visits of therapy services, Inam says. For example, if an occupational therapy visit overlaps with a physical therapy visit — even by just a few minutes — the insurer will deny one of the visits.

Inam also has seen an uptick in claims denials due to a lack of credentials, such as if a clinician or physician forgets to write them after his or her name.

Even if agencies are getting a partial denial, they could be losing \$2,000 per claim and spend \$300 to \$400 to appeal, she says.

Providers with a high number of patients using MA plans are getting hit particularly hard, she says. "The insurance payers think it's easy recovery."

More worrisome is that some insurers have tucked into their manuals the ability to audit as much as 10 years from the date of the contract, and reduce the number of

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appeals generally available from CMS for fee-for-service Medicare denials.

### Avoid denials with MA plans

- **Check, check and recheck your documentation.** “If you know you’re going to be scrutinized, you need to be extremely thorough,” Markette says. He urges agencies to self-audit and make sure everyone at the agency understands the importance of not cutting corners in documentation.

- **Study up on the manuals for MA insurers from which you have patients.** Understand what their expectations are, what they deny and what their appeals processes look like, Inam says.

Pay close attention to categories that have been targeted by auditors, Inam says. In addition to reviewing whether credentials are marked, agencies need to closely examine whether recertifications meet the criteria of medical necessity. Read more about those requirements at <http://go.cms.gov/2EH4glf>.

- **Don’t back off if you get audits and denials.** Call the insurance company directly — not the auditor who is paid to deny claims, Inam urges.

“You do have options to move ahead and recover your claim,” she says. — *Angela Childers* ([angela.childers@gmail.com](mailto:angela.childers@gmail.com))

## OSHA

### Consider these 9 ways to avoid the hazards of an OSHA investigation

The lack of an appointed head of the Occupational Safety and Health Administration (OSHA) has apparently not affected OSHA’s investigations of health and safety hazards in the workplace.

These investigations continue to be robust.

OSHA can investigate an alleged violation of its requirements at any time, warns attorney Carla Gunnin with Jackson Lewis in Atlanta.

In most instances, OSHA will not provide advance notice of an inspection, which entails an opening conference, a walk-through in the employer’s offices and a closing conference.

Complying with OSHA’s standards is the best way to avoid violations and steep fines.

In the event of an OSHA investigation, take these steps to reduce the risk that a citation will be issued:

1. **Avoid an on-site visit.** OSHA can’t investigate every complaint it receives. In some instances, OSHA will send a “phone and fax letter” to the employer telling it to investigate an alleged violation and report back to OSHA, Gunnin says.

This is as serious as an on-site investigation and warrants hiring an attorney for assistance. Your agency will have five working days to identify any problems it found and note the corrective action it took or plans to take. If you report that you can resolve the issue on your own and OSHA is satisfied, then it doesn’t have to conduct an on-site visit, Gunnin says.

2. **Make sure you have protocols in case OSHA comes to the office.** Designate someone to deal with the investigation. This includes everything from verifying the investigator’s credentials to including outside help, such as your attorney or safety consultant.

“How you handle the investigation can help control the result,” Gunnin says.

3. **Escort the inspector during the walkaround.** At least one member of your staff should be with the inspector at all times.

A representative of the employer and a representative of the employees may accompany the inspector during the walkaround.

Ask to see the complaint or referral and attach a photocopy to your final notes. An inspector’s failure to provide details of the employee complaint, other than identification of an employee who filed a complaint, may be cause for appeal.

4. **Don’t be intimidated.** You don’t have to allow an inspection unless OSHA has a subpoena or inspection warrant, says attorney Steven Swirsky with Epstein Becker & Green in New York. Note that this will delay but not stop the inspection.

5. **Contain the scope of the inspection.** For instance, if the inspection is limited to an employee’s complaint about a specific hazard, you should object if the inspector wants to broaden the investigation.

6. **Show you’re willing to make things right.** When possible, correct violations the OSHA representative observes during the walk-through inspection. Remember to take a photo.

While the hazard still needs to be cited, OSHA sees that as a sign of good faith.

7. **Create a complete record of the inspection.** Take careful notes. If the inspector takes a picture, take the same picture and ask why he took the picture.

If you feel the inspector's picture is misleading, take additional pictures that you feel are more accurate. Ask questions about the process and the next steps such as further onsite inspections and when you should expect to receive OSHA's decision.

**8. Don't retaliate against an employee who asserted his OSHA rights**, such as reporting a health or safety concern or filing a complaint. That is not allowed and could get your agency into additional trouble.

**9. Remember your appeal rights in the event of a citation.** There are some defenses to a citation, such as a hazard caused by an employee violating a well-enforced rule.

A settlement agreement may be an option if, for example, there are mitigating factors such as no prior history of hazards and a low likelihood that the violation would cause harm. — *Marla Durben Hirsch* ([mdhirsch@comcast.net](mailto:mdhirsch@comcast.net))

## Hospice

### Publicly posted Hospice CAHPS data uncover opportunities to stand out

Ensure patients and their loved ones understand the efforts your hospice is taking to help with pain and constipation symptoms patients are suffering.

It's now increasingly important to stand out in these areas. Questions involving help for pain and constipation are within the lowest scoring composite on the Hospice CAHPS survey. And hospices' scores on those composites are now publicly facing on Hospice Compare for the first time.

Hospice Compare was updated Feb. 21. The website includes hospices' scores on CAHPS survey composites in addition to providing scores on Hospice Item Set (HIS) measures. HIS scores have been publicly available quarterly since August 2017.

Adding CAHPS scores to Hospice Compare makes the website more valuable to referral sources, says Theresa Forster, vice president for hospice policy & programs for the National Association for Home Care & Hospice (NAHC).

Having all the data available will help hospices identify areas for performance improvement, adds Jennifer Kennedy, senior director, regulatory & quality for the National Hospice and Palliative Care Organization.

### Improve scores on pain and symptoms

Hospices scored 75% on the composite involving help for pain and symptoms. (*See benchmark, p. 6.*) The composite includes CAHPS survey questions 16, 22, 25 and 27.

The question in the composite involving help for feelings of anxiety or sadness is the lowest-scoring, but it's likely the toughest to improve, says Katie Wehri, director of operations consulting for Healthcare Provider Solutions, Inc. in Nashville, Tenn. The easiest scores to improve on the composite involve help with pain and help with constipation.

To improve results, Wehri recommends:

- **Use the terms "pain" and "constipation" when providing help.** Don't say "abdominal discomfort," for example, because families might not realize you're addressing constipation.

- **Tell patients and families exactly what you're going to do to help with pain and constipation.** Explain what you're doing as you're doing it. Then describe what you did.

For instance, Wehri says the clinician might say, "We are going to give you a new medication for your constipation. This medication should provide some relief in eight hours."

The clinician would explain the patient should call the agency if she doesn't experience relief, and that you're going to check back too.

"Follow up with a phone call to see if the medication was effective," Wehri says. "If not, consider a different intervention and explain this to the patient. If it was effective, remind the patients to let you know anytime they have constipation again and that in order to avoid having constipation in the future, keep taking the medication as instructed. Always be sure to ask about constipation at each visit."

- **Understand there are things to say about your efforts to reduce pain even if pain remains and is hard to control.** Even if patients are experiencing less pain, the pain level might not be what patients or family members want it to be.

Hospice staff members should remind them about the improvement in pain level "and that you will continue to work on alternative interventions until you find what works," Wehri says. "Then be sure to follow up, and this often requires communication between visits." — *Josh Poltilove* ([jpoltlove@decisionhealth.com](mailto:jpoltlove@decisionhealth.com))

**Related link:** View information about hospices' latest HIS data at <http://bit.ly/2EURQq8>.

*Hospice***CMS improves the functionality of its Hospice Compare website**

Hospice Compare's location search field appears to function properly now — and that's something industry experts contend will be extremely helpful for the website.

When Hospice Compare launched, many hospices appearing in the website's location search result didn't serve the correct ZIP code, city or even state.

Industry experts had expressed concern that if Hospice Compare provided inaccurate information about hospices' locations, that would lead patients and families to growing frustrated with the website in their time of need — and discouraging them from recommending the website for others to use (*HHL 12/11/17*).

Having a properly functioning location search field is “a game-changer,” says Theresa Forster, vice president for hospice policy & programs for the National Association for Home Care & Hospice (NAHC). “I think that's something that makes [Hospice Compare] far more credible and usable.” — *Josh Poltilove (jpoltilove@decisionhealth.com)*

**Related link:** *View Hospice Compare's website at [www.medicare.gov/hospicecompare](http://www.medicare.gov/hospicecompare).*

**PIP**

*(continued from p. 1)*

**A:** I think it really depends on the project that you're working on. Weekly may not be enough time if it's a complicated performance improvement project.

The entire PIP, or the length of the PIP, may need to be dictated by the governing body to begin with. But then let's say we're working on a PIP and we have a six-month timeframe, how often should that PIP team meet depends on the PIP in and of itself.

If it's something you can measure in a week, then maybe a week is enough. Maybe you want to start more frequently at the beginning and then if you determine you aren't getting enough information in a week, change that frequency to every other week or once a month.

As long as there is good communication with the entire QAPI team, or at least the steering committee on that PIP, the frequency can be adjusted.

That being said, you really don't want to go six months or even three months and not revisit it at all.

There needs to be some kind of balance. The further away we get from the project, the more it gets put in the back of our minds because we're all busy.

If we're only meeting every three months, then likely the team will get together and look at what's really going on the week before that meeting. I think the more frequently we do it, the more frequently it stays in our minds.

**Q:** *Could a surveyor take issue with the way an agency formats its PIP? Is there anything to avoid from a formatting perspective (spreadsheet vs. word document; appropriate document length)?*

**A:** CMS does not dictate any type of format for your PIP at all. It could be a plain, simple Microsoft Word document.

It doesn't have to be exactly like what is on the template, though, as long as you're addressing all of the factors, including what exactly you're planning to do, what you have already done, how you monitored what you did, the resulting outcomes and if you made any variations in that.

That's really all you need to have. It can be in a Word document, it can be in an Excel document, it can be in a template, it can be any format you want.

That being said, each PIP you do should be consistent in format.

**Q:** *What are the two or three specific standards related to PIPs or QAPI as a whole that surveyors are most likely to cite? And how should agencies bolster their compliance with these specific standards?*

**A:** It's going to be data-driven. They're going to be looking at your high frequency, problem-prone, high-risk areas and those are things that are going to be agency-specific. Even if you've done QAPI in at a previous agency, you can use the same format but you don't need to use the types of data. Every agency will be standalone.

This is because if a surveyor notices a trend, they're likely going to look at your QAPI program to see if you've also noticed that trend, are monitoring it and have put actions in place to prevent it from happening in the future.

**Q:** *Should agencies create a new PIP each year, even if they're not done with the initial PIP? How much time is reasonable to spend on a PIP? Six months, one year, two years, more?*

**A:** Really that depends on your PIP. Now what I did say is whatever your measurement timeframe, you need to have that sustainability.

Maybe your goal was going to reach 80% in the measure you are aiming to improve, but you can't get over 70%. In that instance, you may keep the same PIP but you obviously need some modifications if you're planning to get to 80%.

You may decide 70% is as high as your agency can go and retire that PIP at that point. Again, that's going to have to be agency specific. Now, would I have a single PIP and only focus on that for three years? No. That's not your only problem.

You should ask yourself if that is the most critical problem and are you really working to improve or simply marking it as your project on paper without making efforts to improve.

**Q:** *To what degree should the governing body be involved in the PIP process?*

**A:** In the PIP process they just need an overview of the QAPI plan — which includes the data that needs to be collected and what performance improvement projects you're working on.

Once the performance improvement projects have been put into place, the governing body certainly needs

to know what you're working on. All of your other staff needs to know this as well, because I think surveyors will ask staff and the governing body what performance improvement projects your agency is working on.

**Q:** *What high-risk areas do we need to concentrate on?*

**A:** This again would be agency specific. If you have a mainly geriatric population, high risk could be pediatric population. It could be high-risk devices, such as a left ventricular assist device (LVAD). High risk could be something like we missed supervisory visits — that's something that could be high risk and problem prone.

**Q:** *How do I prioritize projects?*

**A:** First and foremost, you need to look and see which would involve patient care and safety. It all needs to be data-driven so you need to have something in place that shows why you picked this project.

If you are falling really low in a score, then I would probably pick that project. So, let's say medication management. You only do it 40% of the time. To me that's a really low number, and that would probably be one of my first ones. The reason being medications can affect so many other things in the patient care and the patient outcomes.

**Q:** *Who needs to be on our project teams?*

**A:** QAPI teams can be bigger. I would not keep it to just people in the office. A lot of times we have the administrator and the QAPI nurse and that's our QAPI team. That's not enough. Really, it needs to be representative of all disciplines, though you don't necessarily have to have each discipline on your QAPI team.

Your PIP teams need to be those that are most related to the project you are working on. They don't have to be on the QAPI committee. They could even be patients or patients' families. You just need to decide who that's going to be and you need to have a way to work together.

**Editor's note:** *For more on PIPs, purchase the on-demand recording of this 60-minute webinar, "QAPI: How to Craft a Robust, Compliant Performance Improvement Project." Order your copy at <https://store.decisionhealth.com/qapi-performance-improvement-project>.*

## Taxes

*(continued from p. 1)*

"Most home health agencies are likely pass-through entities such as S corps or LLCs," says Mark Kulik, managing director at Pittsburgh-based mergers and acquisitions advisory firm The Braff Group. These are business in which the business income passes through onto the owner's personal taxes.

### BENCHMARK of the Week

#### Hospices' scores on Hospice CAHPS measures

With Hospice CAHPS data, the highest scoring composite — by far — involves treating patients with respect, according to the Feb. 21 refresh of Hospice Compare.

Hospices nationwide scored 91% on it.

The two lowest scoring composites for hospices are help for pain and symptoms and training family to care for patient. Hospices scored 75% on these composites. *(See story, p. 4.)*

Hospice CAHPS data were collected between April 1, 2015, and March 31, 2017.

Measure	February 2018 score
Emotional and spiritual support	89%
Rating of this hospice	80%
Willing to recommend this hospice	84%
Treating patient with respect	91%
Help for pain and symptoms	75%
Communication with family	80%
Getting timely help	78%
Training family to care for patient	75%

**Source:** CMS' Hospice Compare

It's possible lower-earning owners of these types of companies might receive a tax break with the new plan. However, because home health would be considered a service business, income caps may prevent owners from using some or all of the deduction.

### Understand the pass-through deduction

Some owners of S corporations or LLCs will, in fact, see a deduction.

The law allows owners to exclude 20% of their income from taxation.

But agency owners won't receive the full 20% deduction if their personal business income exceeds \$315,000 a year if they're married and filing jointly, and if their personal business income exceeds \$157,500 if they're single, says Jackie Perlman, principal tax research analyst at The Tax Institute at H&R Block in Kansas City, Mo.

That amount includes all sources of business income, including a spouse's job or a side job.

Exceeding these caps will lower the deduction, which completely disappears after income reaches \$415,000 for married joint filers and \$207,500 for single filers.

If the owner's income is that high, the old rules would apply and the owner would pay tax using an individual tax rate, Perlman says.

There also are other factors that might play into how much of this deduction businesses receive, including how much is paid in wages and how much property the business owns, says Scott Greenberg, senior analyst at the Center for

Federal Tax Policy at the Tax Foundation, an independent tax policy research organization in Washington, D.C.

### Does it make sense to change?

High-earning owners of S corporations or LLCs might want to talk to their tax practitioner about whether it would make more sense tax-wise to become a C corporation, Perlman says.

Large, chain agencies that are C corporations, which file business taxes, will benefit from the switch from a gradual tax rate of up to 34% to a flat 21%.

Perlman and Greenberg caution, however, that there's a lot to consider before changing a business' status to a C corporation in the eyes of the IRS. Owners become shareholders, and stockholder and board of director meetings must be held with minutes recorded.

The business is also held to different state and federal regulations, Greenberg says.

Then there are tax considerations.

Unlike with S corporations or LLCs, C corporations are directly taxed on net earnings.

When the C corporation distributes after-tax income to shareholders, shareholders are taxed on those dividends, Perlman says.

"Agencies must consider this double-taxation, the fact that an S-corp shareholder may already be in a low-tax bracket, and that all S-corp owners must agree to the switch," Perlman says. "At this point, owners should be meeting with their tax advisor and crunching the numbers to see if the company and owners would be better off becoming a C corp."

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PAS 2018

**Other issues to act on:**

- **Update paycheck withholdings and let employees know.** The IRS has changed its withholding table to reflect changes in the new tax plan.

Employers should begin using the new 2018 withholding tables as soon as possible. A press release from the IRS said this should have been done no later than Feb. 15. Employers who continue to use the old tables could be subjecting employees to over-withholding and possible complaints.

The new tables reflect the increase in the standard deduction, repeal of personal exemptions and changes in tax rates and brackets.

For many employees, this will mean more money in the paycheck. However, employees may want to use the IRS calculator — coming by the end of February — and new 2018 W-4 form (when available) to ensure they are withholding what they prefer. Employees also should consider their own personal circumstances to help determine their withholdings.

Agency leaders might be wise to let employees know of the change in withholding for recent or forthcoming paychecks, Perlman says. This will help agencies prevent complaints and confusion.

Language you use to convey this information can be simple and can point to the IRS withholding tables, Perlman says.

You also should explain how employees can change their withholding status with the company by filing a new W-4. The 2017 version is still acceptable.

- **Understand changes involving parking and transportation.** Employees no longer can deduct employer-subsidized parking and transportation reimbursement from their taxable income. Employers can still reimburse this expense, but employees can't take deduct this reimbursement like they could in the past (if they itemized), Perlman says. — *Tami Swartz (tswartz@hupro.com)*

*CMS open door forum***CMS forum provides noteworthy updates about rural add-on payments, OASIS-D**

During a Feb. 28 open door forum, CMS provided details about how the extension of 3% add-on payments for rural home health agencies will work.

Rural add-on payments ended as of Jan. 1, 2018. But on Feb. 9, President Donald Trump signed into law a bill to keep the federal government funded. That bill includes rural

add-on payments of 3% for home health agencies in 2018, and those payments will be retroactive to cover all of 2018.

Rural add-on payments aren't currently being made in Medicare systems. But on April 2, revised pricing software will be implemented, CMS officials said during a home health, hospice and durable medical equipment (DME) open door forum.

Home health claims with through dates that are received on or after April 2 will receive the rural add-on correctly, officials said.

Shortly after, Medicare Administrative Contractors (MACs) will begin to adjust claims for episodes during the first quarter of 2018, officials said. Those adjustments will cause the rural add-on payments to occur.

Agencies won't need to contact MACs or take other actions, officials said.

**A revision of OASIS is forthcoming**

OASIS-D is coming soon. CMS is working on a revision of the OASIS instrument to accommodate changes, officials said during a Q&A portion of the forum.

CMS plans to post OASIS-D in July in a draft format and to finalize it in November.

With all the changes CMS included in the 2018 final PPS rule, it's not surprising that CMS is releasing a new version of the OASIS, Ann Rambusch, owner of Rambusch3 Consulting in Georgetown, Texas, tells *HHL*.

CMS finalized changes to 33 items — resulting in the collection of 235 fewer data elements at certain time points. The changes equate to the complete removal of 31 items at time points CMS specified and the paring down of two other items (*HHL 11/13/17*).

CMS also will add or replace six OASIS items.

**CMS posts HHGM technical panel info**

CMS has posted slides that contractor Abt Associates discussed during a Feb. 1 technical expert panel meeting about the future payment system for home health.

CMS has not posted detailed feedback from the panel itself, but plans to do so.

Abt and CMS will use the panel's insights to help strengthen a Home Health Groupings Model (HHGM) concept and/or consider alternative payment models, according to the slides posted Feb. 22. — *Josh Poltilove (jpoltilove@decisionhealth.com) and Kirsten Dize (kdize@decisionhealth.com)*

**Related links:** View the slides from Abt's presentation at <http://go.cms.gov/2Gdt7Tz>. Comment to Abt about the slides at [HomeHealth@abtassoc.com](mailto:HomeHealth@abtassoc.com).

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