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Post-acute care compliance issues, Part 2: Home health and hospicePost-acute care compliance issues, Part 2: Home health and hospice

by Todd J. Selby and Robert W. Markette, Jr.

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This is Part 2 of a series on post-acute compliance issues. Part 1 was published in the January 2018 issue of Compliance Today.

Post-acute providers dealt with many changes in regulations that caused compliance challenges and burdens for their operations. It became harder to operate successfully and avoid citations and penalties in 2016 and 2017. The substantive changes included finalizing the new home health Conditions of Participation (CoPs), which are the first significant revision to the home health regulations in the last 20 years.

The home health industry prevailed in getting the Centers for Medicare & Medicaid Services (CMS) to delay the implementation of a new payment model, called the Home Health Groupings Model, for home health providers. The private equity (PE) investment in post-acute, home health, and hospice care actively continued in 2016 and 2017, bringing with it a renewed interest in understanding the multiple compliance issues to evaluate ahead of any possible investment or acquisition opportunity.

Issues for home health agencies

New home health CoPs take effect January 13, 2018. CMS desired to revise its CoPs, because "[e]nsuring quality through the enforcement of prescriptive health and safety standards, rather than improving the quality of care for all patients, has resulted in expending much of our resources on dealing with marginal providers, rather than on stimulating broad-based improvements in the quality of care delivered to all patients." Much like the long-term care Requirements of Participation (RoPs), CMS's solution was to reorient the focus of the CoPs "to focus on a patient centered, data-driven, outcome-oriented process that promotes high quality patient care at all times for all patients."[1]

Central to this reorientation is a completely new CoP that requires HHAs to use an objective, data-driven approach to the Quality Assurance and Performance Improvement (QAPI) requirement. CMS has treated QAPI as a de facto condition for many years. With the revised CoPs, expect an ever greater focus on QAPI. The revised CoPs also implement many changes to patient rights, which will require significant effort from HHAs.

HHAs will find getting ready for the new CoPs is impacted by the late release of a revised Chapter 10 of the*State Operations Manual* (*SOM*) and the related interpretive guidelines.[2] A draft of the revised Chapter 10 of the *SOM* was released by CMS on October 27, 2017. Although this release is not a final draft of *SOM* Chapter 10, it is the only guidance HHAs are likely to receive prior to the January 13, 2018 RoP effective date. Even more concerning, surveyor training had not begun, and indications were that surveyor training would not begin until December 2017.[3] The combination of a massive revision to the CoPs, delay in publishing the interpretive

guidelines/surveyor guidance, a lack of surveyor training, and the increase in civil monetary penalty (CMP) amounts under the alternative sanctions regulations raises a significant concern about what will happen come January 13, 2018. Agencies must prepare based upon the wording of the regulations, but be prepared to adapt to the final additional guidance when issued.

Home health groupings model

CMS proposed a new payment model, called the Home Health Groupings Model (HHGM), for home health. However, after an outcry from the home health industry, CMS wisely decided to pull HHGM on November 1, 2017. CMS pledged to collaborate with the industry to come up with a new home health payment model. Although HHGM has been scrapped for now, home health providers should familiarize themselves with HHGM, because CMS has stated it is not completely off the table. CMS acknowledged HHGM will reduce home health payments by $950 million. Some are projecting the total impact could be closer to $4 billion. If ultimately passed, HHGM will have a significant impact on the industry, and providers need to carefully analyze its impact on their revenue. HHGM would switch to a 30-day episode and eliminate therapy bonus payments. The elimination of therapy bonus payments will significantly impact HHAs that provide care to post-operative hip and knee replacement patients, as well as patients with chronic conditions, such as multiple sclerosis or other diseases where therapy is provided to maintain current levels of performance.

Home health face-to-face probe and educate

Face-to-face has been a constant source of difficulty since it took effect in 2011. One of the most common reasons HHAs fail face-to-face audits is due to a failure to obtain the actual clinical encounter note from the physician. HHAs are also failing to supplement the physician's record, as allowed under the rule, with additional information from the HHAs' Outcome and Assessment Information Set (OASIS) assessment or other documentation. This supplemental information supports the physician's certification and reduces the likelihood that the physician's records will be found to be insufficient to support the certification. HHAs must take advantage of the opportunity to supplement the physician's record with their own additional information to avoid losing reimbursement on technical non-compliance with face-to-face requirements.