The Medicare fee-for-service improper payment rate in 2018 is the lowest it has been since 2010. A sharp drop in home health improper payments, in particular, is a big part of the reason why.

Improper payments decreased by roughly $4.59 billion from 2017 to 2018, according to the U.S. Centers for Medicare & Medicaid Services (CMS), which highlighted the reduction late Friday afternoon. For the first time in improper payment reporting history, CMS recorded improper payment rate reductions in Medicare, Medicaid and the Children's Health Insurance Program.

Specifically, the 2017 Medicare fee-for-service improper payment rate was 9.51%. The rate dropped to 8.12% in 2018.

Two prominent home health leaders are trying to keep pressure on federal lawmakers to eliminate components of the forthcoming Patient Driven Groupings Model (PDGM). Bill Dombi, president of the National Association for Home Care & Hospice (NAHC), and Keith Myers, CEO of LHC Group (Nasdaq: LHCG) and chairman of the Partnership for Quality Home Healthcare, penned an op-ed on PDGM that was published Monday in The Hill, a Washington, D.C.-based newspaper that describes itself as "for and about Congress."

"A newly finalized home health payment model from the Centers for Medicare & Medicaid
Services (CMS) moves away from evidence-based decision making toward dangerous assumptions that could disrupt care for some of our nation's most vulnerable seniors," Dombi and Myers wrote.

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Top 10 Reasons Caregivers Leave Home Care Agencies

By Robert Holly

Poor communication, challenging work hours and a lack of recognition are among the top reasons caregivers leave their home care agencies, according to the latest insights from research firm Home Care Pulse. Other prominent reasons include difficult commutes, lackluster training and disappointing compensation.

Undoubtedly, there are several explanations and triggers that cause caregivers to quit their jobs, Home Care Pulse Founder and CEO Aaron Marcum said. Fortunately for employers, though, most of those factors are within their control.

"Focus on [reasons] that are in your control," Marcum said during a recent presentation. "By doing that, you can make a pretty big impact."

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HHS: Medicare Advantage Plans Improperly Denying Claims

By Robert Holly

Roughly one-third of Medicare beneficiaries are currently signed up for Medicare Advantage (MA) plans, the private-insurance alternative to the traditional Medicare program. That figure is growing rapidly, too, especially as more Americans become aware of the non-medical, at-home care services available through MA plans as supplemental benefits starting in 2019.

While popular, the MA program isn't without its flaws.

A recent U.S. Department of Health and Human Services (HHS) investigation revealed that some MA plans have improperly denied medical claims to patients and physicians alike. The New York Times highlighted the investigation in a report published Saturday.

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HOSPICE

OIG Adds Hospice Item to Work Plan

Source: NAHC

Recently the HHS Office of the Inspector General (OIG) added a hospice item to its work plan, Protecting Medicare Hospice Beneficiaries From Harm. The OIG is planning a study to determine the extent and nature of hospice deficiencies and complaints and identify trends. This study is a companion to Trends in Hospice Deficiencies and Complaints (OEI-02-17-00020), and the OIG plans to use hospice survey reports to provide more detail about poor-quality care that resulted in harm to beneficiaries. The OIG indicates it will describe specific instances of harm to Medicare hospice beneficiaries and identify the vulnerabilities in
Medicare’s process for preventing and addressing harm.

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2018 Report: Hospice Agency Challenges

Nearly Half of Hospices Surveyed Are Uncertain They Would Survive an Audit

In this study, Optima Healthcare Solutions explored the challenges hospice agencies face in complying with regulatory requirements. This included understanding the extent to which hospice agencies feel they are able to confidently handle federal audits and respond to Additional Documentation Requests (ADRs), which are used by federal auditors to review hospice claims. The survey also looked at contributing factors influencing their ability to comply, including clinical documentation processes and use of software.

We asked questions such as:

* How confident are you about your hospice agency's ability to survive an audit? (i.e., avoiding penalties, fines or loss of productivity that could negatively impact the business financially as a result of an audit)
* How confident are you about your hospice agency's ability to successfully respond to ADRs?
* How much improvement do you feel is needed in the way your hospice agency manages clinical documentation today?
* To what extent are specific areas of your hospice negatively affected by weaknesses or flaws in your current clinical documentation system or process?

Click here to view results

NHPCO Submits Comments on Burden Reduction Proposed Rule

Source: NHPCO

NHPCO submitted comments this week on the hospice proposals for burden reduction in this CMS proposed rule. Among the proposals suggested by CMS, NHPCO supported the ability of a state to set training requirements for hospice aides. However, NHPCO strongly opposed the proposals to remove a requirement to have someone with specialty knowledge on hospice medications and move the requirements for hospice training in the nursing home setting to include both the hospice and the nursing facility. After meeting in November with hospices who experienced natural disasters in 2018, NHPCO also opposed the recommendation to reduce the number of emergency preparedness exercises from two to one per year. Read the full NHPCO comment letter for more details.

Strengthening The Workforce For People With Serious Illness: Top Priorities From A National Summit

Source: Joanne Spetz and Nancy Dudley

The United States will experience significant growth of the population older than age 65 in the coming decades, which will contribute to an increase in the number of people living with chronic and serious illnesses in the community. Field experts, policy makers, and health care leaders have identified the lack of an adequately prepared workforce as a critical barrier to delivering high-quality, community-based care for this population.
With support from the Gordon and Betty Moore Foundation, the Healthforce Center at UCSF brought together 40 national leaders from practice, payment, labor, advocacy, and research in May 2018 to make recommendations to accelerate progress toward an adequate workforce in the next three to five years. After three days of intensive discussion and prioritization, summit attendees made 16 recommendations within seven areas: expanding the pipeline, incorporating family caregivers into health care teams, supporting the home care workforce, leveraging technology to advance patient-centered team care, advocating for payment models that support community-based team-focused serious illness care, instilling cultural competency and humility skills across all health professions, and tracking the workforce. The list of recommendations is summarized at the end of this article.

QUESTIONS? CONCERNS? COMMENTS?
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