Home Health Line

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

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Special Issue

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'Mega-rule' could mean you'll have to notify patients of breaches more often

Prepare for a greater number of costly breach notifications as a result of HHS' new "mega-rule" on patient privacy and security.

The mega-rule aggregates the final versions of four different proposed or interim final rules governing patient recordkeeping and disclosures under the Health Insurance Portability and Accountability Act (HIPAA).

The most significant change for agencies: HHS is changing the rules for when patients must be notified of a breach of their data, says Robert Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis. As a result, agencies should expect to notify patients of breaches much more often.

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Outcomes

Home Health Compare update includes claims-based hospitalization measure

The Jan. 17 update of Home Health Compare marked the debut of a claims-based acute care hospitalization measure that could help you increase referrals from hospital referral sources.

However, the measure also suffers from some of the same limitations as the OASIS-based measure, potentially curtailing

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HIPAA

'Mega-rule' expands the definition of who's a business associate

The new HHS mega-rule clarifies who qualifies as a "business associate" under patient privacy rules. Make sure your contracts reflect that new definition to reduce your liability for notification costs when such associates cause a breach.

Basically, anyone who maintains protected data is considered a business associate under the expanded definition, says Robert Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis. That includes associates who don't personally access your patients' data, or only do so rarely, such as vendors who supply cloud-based storage platforms.

The rule also codifies a Health Information Technology for Economic and Clinical Health (HITECH) Act provision which established that, in addition to providers, business associates also are responsible for compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Many business associates are already aware of the HITECH requirements and have taken steps to come into compliance, Markette says. However, that doesn't necessarily hold true for those organizations that have only now been included in HHS' definition of a business associate.

You're still liable for BA breaches

Note that even though business associates are now separately liable for HIPAA violations, your agency still will be liable for business associates' noncompliance as well. For example, you'll still be responsible for notifying affected patients of breaches caused by a business associate, says Amy Fehn, a partner at Wachler & Associates in Royal Oak, Mich.

As a result, it's crucial that you take steps to modify contracts to protect your agency when breaches do happen. Do this:

- **Notify all business associates** to make sure they're aware of the new rule. In particular, target those contractors who are newly classified as business associates, such as companies that store, but don't access, your patient data, Markette recommends.

- **Determine when your contracts come up for renewal.** If it's between now and September, get to work on modifying those contracts now to ensure they require the business associate to comply with HIPAA, Markette says. If a renewal isn't due until later, at least amend the contracts where necessary.

- **Include financial responsibility clauses to minimize the burden of breach notification.** When renewing contracts, make sure they address financial responsibility for breach reporting where breaches were caused by the business associate, Fehn recommends. In such cases, the associate should be liable for all costs,

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including the purchase of credit monitoring services where credit card information was compromised.

• **Establish a tight deadline for timely notification.** When a breach occurs, you'll have to notify affected patients within 60 days, Fehn notes. As a result, it's a good idea to include a provision in your contract that requires the associate to notify you of a breach in a timely manner — say, within two business days, she recommends. — *Tina Irgang (tirgang@decisionhealth.com), with additional reporting by Burt Schorr (bschorr@decisionhealth.com)*

Editor's note: *See future issues of HHL for ways to decrease costs of breach notifications.*

HIPAA

Other notable provisions of the 'mega-rule'

The rule:

• **Codifies a four-tier penalty system for HIPAA violations.** The highest possible penalty for violations of a given HIPAA requirement is $1.5 million per calendar year. However, violations of different requirements will be counted separately for purposes of the penalty, so that the total annual amount could in fact exceed $1.5 million. The rule also provides more details on how penalty amounts will be determined. For example, prior HIPAA violations may be a factor, as may the number of affected individuals and the provider's financial resources.

• **Establishes HIPAA protections for data stored on office devices, such as fax machines and photo copiers.** Providers must monitor or restrict access to any such devices which are used to send protected information and have the ability to store that information. Providers also must take steps to remove any stored information from the device before it's removed from the office, for example because the lease on a copier is up.

• **Limits the applicability of HIPAA provisions to 50 years after the patient's death.** This provision will be especially useful for VNA providers with a long history who may want to use patients' stories or likenesses in materials detailing that history, notes Robert Markette, an attorney with Benesch, Friedlander, Coplan & Aronoff in Indianapolis. — *Tina Irgang (tirgang@decisionhealth.com)*

Therapy

Analyze therapy utilization for spikes at visit 13 to minimize audit risk

New data show the percentage of 13-visit episodes is trending upwards, raising the possibility of targeted auditor reviews that could cost your agency $300 or more per episode.

The percentage of episodes that ended at the 13th visit rose to 4.69% in 2012. That compares with 3.82% in 2010, before the therapy reassessment requirement took effect. (*For complete benchmark, see box p. 5.*)

"It's just disheartening to me," says Diana Kornetti, co-owner of Integrity Home Health Care in Ocala, Fla. "We're just short of falling into the spotlight [of auditors] again." Changes in utilization after the 14- and 20-visit thresholds were adopted a few years ago triggered major scrutiny from CMS and its contractors, Kornetti reminds.

"It's kind of going in a direction where we need to be careful," agrees Cindy Krafft, director of rehabilitation consulting services with Fazzi Associates in Northampton, Mass. One explanation for the trend is that agencies are deliberately stopping at 13 visits to avoid conducting reassessments. The other is that a lot of agencies are experiencing non-covered visits, which could also knock 14- or 15-visit episodes back to 13 visits, she notes. "It could be a blending of both, but it's something for agencies to look at."

When non-covered visits or auditor determinations knock an episode down one level to 13 visits, an agency stands to lose $343.53, according to a calculation by John Reisinger, owner of Innovative Financial Solutions for Home Health in Tampa, Fla. Note that this calculation assumes a wage index of 1.0000 and a non-routine supply (NRS) level of 1.

Analyze spikes in utilization

If you want to find out whether your agency has seen an uptick in 13-visit episodes, start with data analysis. Visits 11, 12 and 13 usually are lumped together in software reports because they're paid at the same rate. But it's worth finding out whether your software allows you to break out visit 13 alone, Krafft says. If you notice an upward trend that's not in line with an upward trend for other visit counts, you have to investigate the cause, she says.

The general trend for 13-visit episodes notwithstanding, any time discharges are noticeably

more frequent at a specific visit than at others, it's something you need to look at, Kornetti says.

Use these expert tips to deal with any spikes in utilization at visit 13:

- **Find out who or what the data point to.** Is the spike in utilization specific to one therapist or have all therapists at one of your locations increased their discharges at visit 13? Once you've determined that, you can implement targeted audits of those therapists' documentation, says Arlynn Hansell, program manager, clinical excellence at American-Mercy Home Care in Cincinnati.

- **Talk to your billers and schedulers to find out what the spike means.** Your billers should be able to tell you how many episodes they've adjusted downwards due to non-covered visits. Meanwhile, your schedulers may be able to point to changes in the discharge patterns for specific therapists, Krafft says.

- **Audit documentation for red flags that could indicate visit-padding.** After you've traced the problem to specific individuals or locations, get started on auditing documentation for the affected episodes to see if the discharges at 13 were justified, Krafft recommends. First, determine whether patients were provided more visits than was necessary. Possible red flags include boilerplate phrases such as "continue per plan of care" or "continue per physician order," she says. For every visit, make sure the documentation shows not only what skilled service the therapist needed to provide at that visit, but also outlines a plan for what will be accomplished at the next visit.

- **Determine whether discharges at visit 13 made sense within the progression of the episode.** If visits weren't padded, another possibility is that the discharge occurred too early to prevent reassessment issues. To make sure this isn't the case, look for indicators in documentation that the therapist was working toward a discharge on visit 13, Hansell recommends. For example, the documentation should show that on the last two or three visits, the patient was close to meeting his or her goals, and that the therapist began planning for other ways the patient can receive care after discharge, she says. Alternatively, look for signs in documentation that the therapist felt he or she couldn't do anything else for the patient. If that's the case, documentation also needs to show that this was addressed with the patient's physician, Hansell notes.

- **Follow up with targeted conversations and education.** In many cases, the reason for what you've observed in your analysis will simply be therapists' or supervisors' lack of confidence in their ability to comply with the assessment requirements, Kornetti notes. Sit down with the affected individuals for candid conversations and determine what education they need to help them gain that confidence. — *Tina Irgang (tirgang@decisionhealth.com)*

Care transitions

ACO costs influenced a venerable VNA's farewell to Medicare

Many agencies are trying hard to qualify as home health providers for CMS-approved accountable care organizations (ACOs) these days, but VNA of Texas isn't one of them. What's more, experts believe the VNA's ACO experience could be a sign of things to come.

The seven hospital-based ACOs in its service area are one reason the 78-year-old Dallas agency has ended its care of Medicare fee-for-service patients and enrollees in home and community-based Medicaid waiver programs.

ACO contracts could have meant reimbursement lower than standard Medicare, along with expensive IT improvements and the need to hire two "higher thinking people" to prepare and administer both the complex ACO applications and the requirements for chart and quality reviews, CEO Robert Carpenter estimates. Altogether, it could have cost the agency $100,000 or more annually, with no certain return on the investment, Carpenter says.

ACOs aren't required to make an initial payment similar to the request for anticipated payment (RAP). There also is no requirement that ACOs pay an agency within a specified period after an episode has concluded, says Rebecca Burke, an attorney with Powers, Pyles, Sutter & Verville in Washington, D.C. (*HHL 4/11/11*).

So far, home health interest in ACOs has been running in the opposite direction, with agencies striving to improve their quality and readmission scores to attract referrals from the 250 ACOs CMS has approved so far. But while VNA of Texas may be the nation's first agency to say no to ACOs, it's certain not to be the last, predicts Anne Tumlinson, senior VP for post-acute care at Avalere Health, a health care policy and research firm in Washington, D.C.

Some ACOs Avalere works with already are asking preferred provider agencies to foot the cost of transitional care nurses who check on how discharged hospital patients are faring. The sweetener for the agency is the prospect of getting an ACO's referrals, Tumlinson says. And while many agencies now have electronic health records that make internal movement of patient information easier, exchanging information with an ACO will prove "a bridge too far" without a costly upgrade, she believes.

Taking such costs into account, the coming age of ACOs will see a large-scale reduction in the number of home health agencies, Tumlinson predicts.

No Medicare/Medicaid means no losses

Now that the VNA of Texas has dropped its home health services, it will instead focus on hospice care, Meals on Wheels and private duty home care, it said in a Jan. 8 announcement of the change.

The policy change allows the VNA to offer more charitable care to the aging and dying. But "the decision was not an easy one," says Carpenter. "We held on as long as we possibly could, hoping that industry conditions would become more compatible with [our] levels of service and quality."

Over the decades, the agency's policy has been to accept all eligible patients regardless of cost and their ability to pay. However, at present reimbursement rates, it no longer can afford the red ink its approximately 150 Medicare patients and 450 Medicaid home-support patients had been generating, Carpenter explains.

As a result of the change, the VNA's budget this year will shrink to around $21 million from $28 million, but the agency had been losing $2 million annually on the $7 million difference, Carpenter says.

Outright fraud plus fierce competition among the more than 400 agencies now operating in the Dallas-Fort Worth area also influenced the VNA's Medicare/Medicaid exit strategy, he notes. As a result of the growing competition, the agency's Medicare census had fallen to only half of what it was three years ago and the patients it was caring for all had high-cost needs, such as wound care and infusion therapy, Carpenter relates. — *Burt Schorr (bschorr@decisionhealth.com)*

Editor's note: *Find a list of 106 new ACOs released by CMS earlier this month at http://tinyurl.com/b3pjjx6.*

'Mega-rule'

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That's bad news considering the costs involved in breach notification, including the days of staff time usually spent in identifying and contacting affected patients and fielding questions from them, he notes.

Independent research firm Ponemon Institute in Traverse City, Mich., estimates in its 2012 patient privacy benchmarking study that the average cost of dealing with a patient data breach currently is $2.4 million over a two-year period.

HHS published the long-awaited rule Jan. 17. Its provisions are effective March 26, but providers won't have to comply until Sept. 23.

The rule also expands the definition of "business associates" who are obligated to comply with HIPAA. (*See related story, p. 2.*)

"The government tries to make things right but what they do sometimes creates an additional burden," says Mark Berger, CEO of VIP Certified Health Services in Brooklyn, N.Y., of the HIPAA changes.

BENCHMARK of the Week

Percent of therapy episodes ending at visit 13, 2010 through 2012

The data below show a steady increase in the percentage of therapy episodes ending at visit 13.

The therapy reassessment requirements took effect April 1, 2011, and seem to coincide with the upswing in 13-visit episodes. The numbers bear out a trend previously observed anecdotally by consultants during chart audits. (*See related story, p. 3.*)

The data are based on 1.2 million standard episodes in 2010, 1.6 million standard episodes in 2011 and 1.3 million standard episodes in 2012, all provided at some 2,000 agency locations.

Year	Percent episodes with exactly 13 therapy visits
2010	3.82%
2011	4.31%
2012	4.69%

Source: OCS HomeCare, Seattle

Rule ends notification 'harm standard'

Previously, breach notification was only necessary if there was a significant risk of harm to affected patients as a result of the breach. The final rule officially removes this so-called "harm standard."

Instead, providers now will have to notify patients *unless* a risk assessment shows that "there is a low probability that the protected health information has been compromised," according to the rule.

As a result, the burden of proof is on the agency to show that notification wasn't necessary, Markette notes. And that burden of proof is heavy under the new standard.

The final rule outlines a few scenarios for cases where notification is likely unnecessary, such as when a stolen laptop is discovered and an expert analysis shows the data on it weren't accessed.

But even in those limited circumstances, it's not clear that you can always hold off on notifying patients, Markette notes. For example, the rule makes it clear that providers can't wait to issue notifications based on the hope that a stolen laptop will be recovered.

Is notification necessary?

The risk assessment to determine whether notification was necessary must take into account at least the following four factors, according to the rule:

- **The nature and extent of the disclosed information.** For example, a record that includes patients' Social Security or credit card numbers would be considered higher risk, the rule says.

- **The person to whom the disclosure was made.** Factors to consider here are whether the person has obligations under HIPAA or, on the other hand, whether the person has the capability to access other pieces of information that would make it easy to identify individual patients. For example, a patient's employer might find it fairly easy to identify specific individuals when comparing a health record to documentation of sick days, the rule says.

- **Whether the information was actually acquired or viewed.** It'll be hard for you to prove that this didn't happen, Markette notes. You may be able to do so in cases where a stolen laptop is recovered, but the necessary forensic analysis would likely cost your agency a fair amount, he says.

- **The extent to which risk to the information has already been mitigated.** For example, you may be able to show that you've contacted the recipient and received assurances that the information won't be disclosed, the rule states.

Tips to prepare for new standards

Use these tips to prepare for the new standards on patient notification:

- **Evaluate your current breach response policy** to determine whether it will allow you to easily investigate and evaluate the four factors outlined by HHS, Markette recommends. For each of the four factors, determine who's in the best position to follow through on and document this part of the investigation.

- **Put together a checklist to guide your investigation.** The checklist should outline your procedure for breach response step by step, Markette says. This will allow a more structured approach when a breach does happen. In addition to the minimum-required four factors, include steps such as "identify employees involved" and "interview employees involved," as well as specific deadlines for when you want each step to be completed. (*See a future issue of* HHL *for a sample checklist.*) — *Tina Irgang (tirgang@decisionhealth.com), with additional reporting by Burt Schorr (bschorr@decisionhealth.com)*

Editor's note: *Find the HIPAA mega-rule at http://homehealthline.decisionhealth.com/Resources/GetFile.ashx?FileId=100858. Download the Ponemon Institute study at www.ponemon.org/blog/third-annual-patient-privacy-data-security-study-released.*

Home Health Compare

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its usefulness for both marketing and quality improvement, experts say.

As a result of the new method for calculating this measure, the national average for acute care hospitalizations plummeted to 17% from 26%.

Hospitals will find it easier to relate to a claims-based outcome, says Lisa Kidd, administrator of Baptist Home Health Care in Jacksonville, Fla. Hospitals have long kept track of admissions based on claims data (*HHL 10/01/12*).

The measure also will be easier for hospitals to understand because it's based on a specific timeframe, Kidd says. While the OASIS-based hospitalization outcome covered a patient's entire home health stay regardless of length, the new measure reflects the percentage of patients for whom a hospital inpatient claim was filed within the first 60 days after home health admission, according to a CMS document which outlines the measure specifications (*http://tinyurl.com/9zfugfe*).

However, the measure shares at least one limitation with the OASIS-based version: a lack of timeliness, Kidd notes. The score currently displaying on Home Health Compare is based on claims data collected between July 2011 and June 2012.

For that reason, Baptist Home Health Care has used its hospitalization rates as calculated by Strategic Healthcare Programs (SHP) in Santa Barbara, Calif., when talking to hospitals and other providers about readmissions, and likely will continue to do so, Kidd says.

It's also not clear that the claims-based outcome will really be a more accurate measure of hospitalizations, as CMS has argued, says Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C. Because the measure is based on inpatient claims, its accuracy depends to some extent on how quickly hospitals filed claims for their patients, she notes. The usefulness of a comparison between the claims-based measure and the OASIS-based version, which will continue to be available in CASPER, will be limited by this unknown factor.

Tips on how to pitch your outcome

Whether you plan to use the new claims-based measure or rely on vendor-generated data for conversations with referral sources, here's how to make the most of your hospitalization outcome:

- **Compare yourself to the state rather than the national average.** The more localized the data, the more meaningful the comparison, Adams believes. Depending on where your agency is located, the state average can be significantly different from the national average, and the agencies in your state are the ones you're actually competing with.

- **Don't forget to share your hospitalization data with physicians.** While readmission penalties provide an obvious reason for hospitals to be interested in your outcomes, physicians also are increasingly conscious of their patients' hospitalization rates, Kidd believes. The agency saw referrals for congestive heart failure (CHF) patients nearly triple within a month after showing a group of cardiologists how its CHF program had helped reduce hospitalizations (*HHL 10/8/12*).

- **Get to know referral source's patient base and tailor your pitch accordingly.** For example, ask hospitals you're talking to to tell you about their top five readmission diagnoses, suggests Ann Rambusch, president of Rambusch3 Consulting in Georgetown, Texas. If they're reluctant to share that information, ask about the top five admission diagnoses for Medicare patients instead. Once you have that information, it

creates an opening for you to talk about any specialty programs you have in place for those diagnoses, and how they've affected readmissions.

Dyspnea, transferring up 1%

If you're using outcome scores in marketing, you may be facing increased competition for a few Home Health Compare measures. The January update included the following outcome and process measure improvements:

- Transferring: 55%, up from 54%
- Dyspnea: 64%, up from 63%
- Pneumococcal vaccine administration: 67%, up from 66%
- Diabetic foot care and education: 93%, up from 92%
- Oral medication management: 49%, up from 48%

The dyspnea improvement could indicate that clinicians are getting better at observing the patient to score the outcome, as opposed to asking whether the patient is short of breath, Rambusch says.

Patients will almost always portray themselves as being less short of breath than they actually are, so there is no substitute for observing the patient during a test that requires activity, such as the Timed Up and Go (TUG), she says.

Patient satisfaction data also were refreshed on Jan. 17, but the national averages didn't change compared to the October update. — *Tina Irgang (tirgang@decisionhealth.com)*

M&A trends, Part 2

Hospice industry remains a hot market for M&A activity in 2013

Hospice mergers and acquisition activity may be back on the rise in 2013, but deal volumes are likely to settle below the peaks set in previous years.

After a substantial increase in activity from 2008 through 2011, hospice transaction activity was down 33% in the first nine months of 2012 versus the same period last year, says Dexter Braff, president, The Braff Group, a health care M&A company in Pittsburgh.

Rather than being a reflection on the state of the industry, the lower volume is more of an indication of reduced demand, as buyers take time to digest four consecutive years of record acquisition activity, Braff says.

Expect to see a rise in activity in 2013. As more Medicare-certified hospice providers become established and the inventory of possible sellers increases, M&A activity will continue to increase and valuations will remain high, says Jack Eskenazi, managing partner, Healthcare Advisory Partners, Los Angeles.

Hospice growth has been dramatic as palliative care has gained greater acceptance among consumers, and payers have demanded greater economic efficiency from providers for end-of-life care, he says. That's consistent with the Affordable Care Act and general regulatory trends, he says.

Another reason prices remain high is that this industry attracts buyers from many different market segments, including home health agencies and private equity groups. Significant cuts to Medicare-certified skilled nursing facilities also have many skilled nursing facility operators looking at in-home hospice as a way to offset margin erosion and to sustain growth and profitability through diversification, Eskenazi says.

Threat of copays creates risk

The threat of copays and other unknowns, such as hospice payment reform and the possibility of reduced reimbursement for hospice patients residing in skilled nursing facilities, has contributed to an overall increase in risk profile, Braff says. This, in turn, has constrained acquisition multiples, particularly for the larger providers with revenues in excess of $20 million.

If copays are introduced, they would significantly change the profitability and delivery of services and thus would be a "game-changer" for home health and hospice M&A, Braff says. — *Marci Heydt (mheydt@decisionhealth.com)*

Discharge note

- **CMS has published its January OASIS Q&As.** The Q&As instruct clinicians to score a patient as a falls risk on M1910 if two separate standardized, validated and multifactorial tools were used, but reached different conclusions about the patient's risk. For more in-depth analysis of the Q&As, see next week's *HHL*. Find the Q&As at *www.oasisanswers.com/aboutoas_links.htm*.