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Home Health & Hospice Week

News & Analysis On Reimbursement, Regulations, Finance, Operations, & Compliance

CONTENTS

IN OTHER NEWS...

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CMS Can — And Should — Do Better On Wage Index. Medicare is taking millions out of HHAs' pockets with unfair wage index policies, and its newest rule does little to rectify the problem. So say multiple commenters on the 2023 home health payment proposed rule. From a smaller cap threshold to a chance at reclassification to an industry-specific index, changes are needed. (Page 254)

This Unfair Wage Index Advantage For Hospitals Needs To Go — Pronto. Even before the recent big wage index area shake-up, hospitals still had a competitive advantage over home health agencies due to their ability to request wage index reclassification. And that policy has got to go, multiple commenters tell Medicare officials in their home health proposed rule comment letters. (Page 255)

Private Equity-Backed Regional Chain Makes Buy In Southeast. A three-state hospice chain is enlarging its reach a bit more with a new acquisition. Agape Care Group, backed by Charlotte, North Carolina-based Ridgemont Equity Partners, has acquired GHC Hospice for undisclosed terms, the Spartanburg, South Carolina-based regional provider says in a release. (Page 256)

FBI Raids Tennessee Home Care Provider. Many home health agencies' worst nightmare came true for a provider in Oak Ridge, Tennessee this week. Federal Bureau of Investigation agents carried out "court-authorized activity" at the Patriot Homecare office on Sept. 14, reports a local news station. (Page 256)

Latest VBP FAQs Lays Groundwork For Switching Base Year To 2022. HHAs are waiting on pins and needles to see whether Medicare follows through on its proposal to change the Value-Based Purchasing base year from 2019 to 2022, or drops the idea, as so many agencies begged for in their proposed rule comment letters. (Page 257)

Sidestep HIPAA Audit Dangers By Mixing It Up. While, it's not legally necessary to engage an outside HIPAA expert to perform your annual HIPAA risk analysis, it's never a bad idea to have more than one opinion on ways your agency can decrease its chances of a violation, one HIPAA veteran advises. (Page 258)

REGULATIONS

CMS Can — And Should — Do Better On Wage Index

Rule commenters chastise Medicare officials for discriminatory wage index procedures.

Medicare is taking millions out of HHAs' pockets with unfair wage index policies, and its newest rule does little to rectify the problem. So say multiple commenters on the 2023 home health payment proposed rule.

Reminder: In the home health rule released June 17, the Centers for Medicare & Medicaid Services pitched the idea of capping negative wage index changes from one year to another at 5 percent for home health agencies. The 5 percent cap is "a permanent approach to smooth year-to-year changes in providers' wage indexes," CMS said in the rule published in the June 23 *Federal Register*. It "increases the predictability of home health payments for providers and mitigates instability and significant negative impacts to providers resulting from changes to the wage index," CMS claimed (*see HCW by AAPC, Vol. XXXI, No. 33*).

Plus, "this 5-percent cap on negative wage index changes would be implemented in a budget neutral manner through the use of wage index budget neutrality factors," CMS added in the rule.

Multiple home health agencies and their representatives were glad to see CMS address the issue of wild swings in wage index values. "It is good to see CMS finally codify this request [for protection against drastic changes] into a permanent regulation," praises CPA **John Reisinger** with Innovative Financial Solutions for Home Health in Tampa, Florida, in his comment letter.

University of Pittsburgh Medical Center Home Health Care "supports the CMS proposal to permanently adopt a 5 percent cap on wage index decreases," says UPMC HHC president **Paula Thomas** in her comment letter.

Do this: Other commenters want to see bigger protections. "We urge CMS to finalize the permanent cap on home health wage index decreases to 2 percent," says **Katy Barnett** of LeadingAge, which merged with the Visiting Nurse Associations of America last year. "Even a 2 percent wage decrease impacts operations," Barnett stressed in the trade group's comment letter.

The 2 percent cap is needed, "especially considering the increased inflationary and labor costs HHAs are experiencing in 2022," says **Patrick Conole** with the Home Care Association of New York State in his comment letter.

FYI: Hospice commenters requesting a similar reduction in the protection threshold struck out in the hospice final rule issued in July, which kept the figure at 5 percent (*see HCW by AAPC, Vol. XXXI, No. 27*).

Multiple HHAs and their advocates also asked for CMS to strike the "budget neutral" part of its proposal. "Applying the cap in a non-budget neutral way will ensure that when significant economic downturns occur, all home health agencies will be protected from significant reductions," Barnett explained to CMS.

Do this: "We request the agency utilize its existing authority to [apply the cap] in a non-budget-neutral manner given the … challenges being placed on providers" right now, UPMC HHC's Thomas urges.

Big 2022 Wage Index Drop Needs Correction

But CMS is shirking its duty to address bigger wage index problems, multiple commenters charged in their letters.

"CMS proposes no action to address the unfair discriminatory action it took in 2022 in extending the original wage index transitional 5 percent negative change cap for hospitals, but not other health care providers," blasts the National Association for Home Care & Hospice in its comment letter.

Background: When a big Office of Management and Budget (OMB) Core-Based Statistical Area (CBSA) reorganization caused some areas' wage indices to drop drastically in 2021, CMS put in place the temporary 5 percent negative change cap. But then in 2022, CMS applied that cap again only to hospitals, so that "home health agencies in certain geographic areas experienced 10 to 20 percent wage index reductions in 2022," emphasizes **Jennifer Elder** with the Texas Association for Home Care & Hospice in her comment letter.

"As a result, hospitals have a distinct advantage over home health agencies in relation to staff recruitment and

retention competing with home health agencies for many of the same staff," Elder stresses. "Affected home health agencies have suffered millions of dollars of reduced Medicare payment as a result of the expiration of the wage index reduction cap," she tells CMS.

"With hospitals subject to a wage index with a 5 percent negative adjustment cap since 2021 and HHAs subject to an index that is significant[ly] different as a result [of] having no cap in effect in 2022, HHAs will permanently have a markedly different wage index than hospitals while competing with hospitals for the same type of staff," NAHC criticizes. "The unfairness and predictable impact of that inconsistent action is readily apparent," the trade group concludes in its letter.

Do this: "CMS should apply the 5 percent wage index reduction cap in 2023 as if it had been applied in 2022 without regard to budget neutrality as it relates to the limited geographic areas affected," NAHC urges.

Stay tuned to the 2023 final rule, expected in late October or early November, to see whether CMS implements any commenters' recommendations. ❖

Note: The 84-page proposed rule is at www.govinfo.gov/content/pkg/FR-2022-06-23/pdf/2022-13376.pdf.

REIMBURSEMENT

This Unfair Wage Index Advantage For Hospitals Needs To Go — Pronto

Policy is penalizing HHAs, expert points out.

Even before the recent big wage index area shake-up, hospitals still had a competitive advantage over home health agencies due to their ability to request wage index reclassification. And that policy has got to go, multiple commenters tell Medicare officials in their home health proposed rule comment letters.

"Unlike the hospitals nationally who are given the opportunity to appeal their annual wage index, HHAs do not have appeal rights with regards to their wage index," **Patrick Conole** with the Home Care Association of New York State points out. "This lack of parity between different health care sectors further exemplifies the inadequacy of CMS's decision to continue to use the pre-floor, pre-reclassified hospital wage index to adjust home health services payment rates," Conole slams in his comment letter.

For example: "Hospitals in the Albany-Schenectady-Troy CBSA have been working hard with Congress and CMS to appeal its wage index, which is clearly needed," Conole highlights. "But any inroads or success they may reach, unfortunately, would not apply to HHAs in the same CBSA."

"We have experienced wide swings in wage index adjustments in the past, and these have created significant hardship," relates **Dianne Hansen**, CEO of Partners In Home Care in Missoula, Montana. "Competition for staff with hospitals in our communities is very high, and any significant adjustment in wage index makes it very difficult to keep our salaries within the market rates," Hansen says in her comment letter.

"For too long, the home health industry has been subject to the hospital-based wage index, when the hospital-based wage index has not been representative of too many HH service areas," believes CPA **John Reisinger** with Innovative Financial Solutions for Home Health. "This has been an error in oversight by CMS and has been penalizing to too many HHAs … as the labor costs of many service areas have been understated because of this inequity," Reisinger says in his comment letter.

"Hospitals, SNFs and Hospice have had their own Wage Indices for years," Reisinger tells CMS. "Why not home health?"

Do this: "CMS should create a home health-specific Wage Index, which is based solely on the issues impacting the cost of labor and the ability to attract and retain quality staff to and for the home health industry, and discontinue the use of any other segment (e.g., IPPS Hospitals) of healthcare as a proxy for home health," Reisinger recommends.

And this: LeadingAge wants CMS to adopt a policy "that would allow home health agencies and other post-acute providers to utilize a reclassification board similar to hospitals," **Katy Barnett** suggests. "Home health providers are not afforded these same options to adjust their wage indices yet must compete for the same types of caregiving professionals as and with hospitals," Barnett emphasizes. ❖

MERGERS & ACQUISITIONS

Private Equity-Backed Regional Chain Makes Buy In Southeast

Plus: Hospitals figure in recent market developments.

A three-state hospice chain is enlarging its reach a bit more with a new acquisition.

Agape Care Group, backed by Charlotte, North Carolina-based Ridgemont Equity Partners, has acquired GHC Hospice for undisclosed terms, the Spartanburg, South Carolina-based regional provider says in a release. GHC was founded in 2014 and serves 25 counties in Georgia and South Carolina. GHC will continue to operate under its own name in the "near term," Agape says.

Agape and its affiliates now serve over 85 percent of the counties in the state of Georgia, in addition to its North and South Carolina operations, the company notes. GHC's "reach into more rural communities enables us to connect with more patients and families … in underserved geographies," **Troy Yarborough**, Agape CEO, says in the release. Agape now serves about 3,600 patients with 1,450 employees, it says.

Ridgemont bought Agape from Chicago-based private equity firm The Vistria Group in 2021, after Vistria had backed the provider and its predecessor for three years (*see HCW by AAPC, Vol. XXX, No. 38*). Last year Agape purchased Serenity Hospice in Georgia (*see HCW by AAPC, Vol. XXX, No. 27*), and this year has acquired Lanier Hospice in Georgia (*see HCW by AAPC, Vol. XXXI, No. 4*) and Hospice of the Carolina Foothills in North Carolina (*see HCW by AAPC, Vol. XXXI, No. 19*).

Other recent deals include:

In Texas: St. David's HealthCare at Home and St. David's Hospice & Family Care in Austin are on the lookout to expand. (Reminder: St. David's parent company HCA Healthcare bought an 80 percent stake in Brookdale Health Care Services from Brookdale Senior Living last year [*see HCW by AAPC, Vol. XXX, No. 9*], and their joint home health and hospice businesses in Austin were rebranded as St. David's this summer [*see HCW by AAPC, Vol. XXXI, No. 28*]). There are plans to expand these business lines for St. David's, reports the *Austin American-Statesman* newspaper. "We'll be working

with Brookdale to do that investing together, ramping up staffing, expanding geographic locations or staging of staff to make sure we can address the increasing demands we have," **David Huffstutler**, CEO of St. David's HealthCare, tells the *American-Statesman*.

In Maryland: LHC Group Inc. and University of Maryland Medical System (UMMS) have signed a definitive agreement to form a new joint venture partnership, the Lafayette, Louisiana-based chain says in a release. The JV will include multiple locations serving 20 Maryland counties and Baltimore. LHC expects to purchase majority ownership and assume management responsibility in the fourth quarter of 2022, it says. "Our partnership with LHC Group is an important step forward in our journey to continue improving access to post-acute care for our patients, which is an increasingly essential element in the continuum of care that we provide," UMMS CEO **Mohan Suntha** says in the release. LHC serves patients in 37 states and the District of Columbia with 29,000 employees. The chain also partners with more than 400 hospitals and health systems, it says. ❖

FRAUD & ABUSE

FBI Raids Tennessee Home Care Provider

Plus: One codefendant pleads guilty while another pleads innocent in Boston.

Many home health agencies' worst nightmare came true for a provider in Oak Ridge, Tennessee this week.

Federal Bureau of Investigation agents carried out "court-authorized activity" at the Patriot Homecare office on Sept. 14, reports WBIR-TV. The agency provides largely private duty care, but is reimbursed by Medicaid, Medicare, Veterans Affairs, and other payers, it indicates on its website.

There were six vehicles with at least six "responders" at the agency wearing gloves, moving in and out of the building, reports WVLT News.

"Today, Federal agents were at our office as part of an ongoing investigation which is nearing an end," Patriot confirmed on its Facebook page Wednesday evening. "We do not anticipate another event at our business such as the one that occurred today," the agency said.

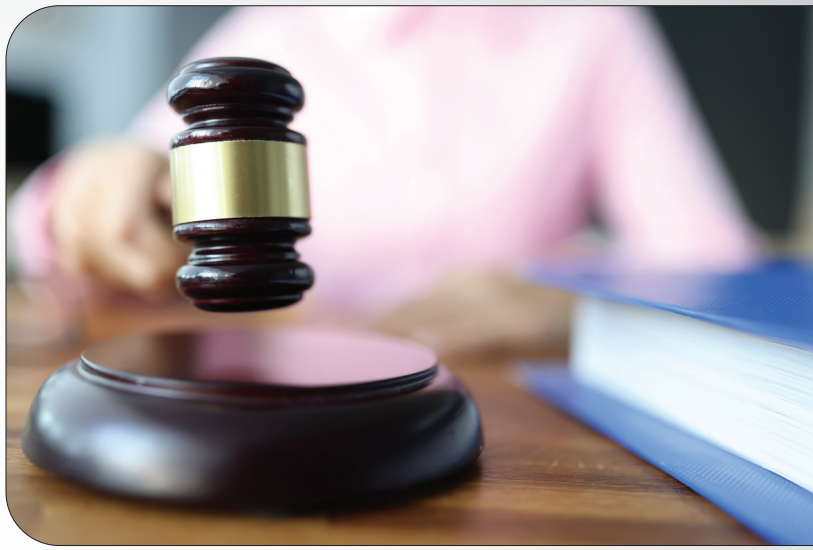
"All employees are to resume the work needed to care for our patients with no interruption," Patriot added. "Our patient care has always been and will continue to be our top priority. Service to our patients and employees has not and will not be affected in any way."

Patriot had not responded to a *HCW by AAPC* request for comment at press time.

Other recent fraud and abuse developments include:

In Massachusetts: Arbor Homecare Services LPN **Winnie Waruru** has pleaded guilty to fraud charges in federal court, the Department of Justice says in a release. Chelmsford-based Arbor billed MassHealth for services that were never rendered, were medically unnecessary, or weren't authorized; developed employment relationships as a way to pay kickbacks for patient referrals; and entered into sham employment relationships with patients' family members, according to the DOJ. "Waruru was personally responsible for causing Arbor to bill MassHealth for over $1.2 million in skilled nursing visits, much of which was fraudulent," the release adds. Waruru also passed cash payments allegedly from Arbor part-owner **Faith Newton** to two Arbor patients to retain those patients. Newton has pleaded not guilty and awaits trial. Waruru is scheduled for sentencing in January 2023.

In Colorado: After it self-disclosed conduct to the HHS Office of Inspector General, Elevation Hospice of Colorado



agreed to pay about $150,000 for allegedly submitting claims for services provided by two unlicensed individuals, the OIG reports on its civil monetary penalties webpage.

In New Hampshire: After it self-disclosed conduct to the OIG, Home Healthcare, Hospice and Community Services Inc. agreed to pay nearly $27,500 for employing an individual that it knew or should have known was excluded from participation in Federal health care programs, the OIG reports on its CMPs webpage.

In Minnesota: And after another self-disclosure to the OIG, Comfort Home Health Care Group Inc. d/b/a Comfort Health agreed to pay nearly $16,500 for allegedly submitting claims for services provided by an unlicensed individual, according to the OIG CMPs webpage. ❖

VALUE-BASED PURCHASING

Latest VBP FAQs Lays Groundwork For Switching Base Year To 2022

Plus: Don't miss new VBP educational materials in the rush.

Home health agencies are waiting on pins and needles to see if Medicare follows through on its proposal to change the Value-Based Purchasing base year from 2019 to 2022, or drops the idea, as so many agencies begged for in their proposed rule comment letters.

HHAs worried that the Centers for Medicare & Medicaid Services will do the former may see a bad omen in the latest round of VBP questions and answers.

An updated question about the Model base year, Q4003.2, says "if CMS finalizes the change to the Model baseline year, from CY 2019 to CY 2022, as cited in the CY 2023 HH PPS proposed rule, CMS will change the achievement thresholds and benchmarks to reflect CY 2022 data. These achievement thresholds and benchmarks will be available in Summer 2023."

CMS adds the language to one other question in the August FAQs as well, Q4004.1 about benchmarks, and adds similar language to Q4007.1 regarding agencies certified after 2019.

Newsletter Question or Comment?

If you have a question or comment about *Home Health & Hospice Week by AAPC*, please contact Development Editor Rebecca Johnson at (888) 234-5896 or rebecca.johnson1@aapc.com.

HIPAA

Sidestep HIPAA Audit Dangers By Mixing It Up

Outside and inside perspectives are both valuable, expert says.

Question: *We take HIPAA very seriously, and we do our best to maintain compliance with the rule. At our last planning meeting, we realized it's time to do another annual HIPAA risk assessment. Since it is a requirement under the HIPAA Security Rule, should we hire an outside consultant to do the assessment and analysis or is it OK for our compliance officer or IT manager to perform the audit?* — South Carolina Subscriber

Answer: No, it is not legally necessary to engage an outside HIPAA expert to perform your annual risk analysis. But that being said, it's never a bad idea to have more than one opinion on ways your agency can decrease its chances of a violation.

The size, scope, and focus of your organization usually determines the necessity of an outside resource. But, if the same person who does the assessment manages the implementations both monthly and annually, it might be a good idea for a change. "I think it is good to engage an outside consultant, to ensure that those issues that staff may be blind to can be revealed," advises **Jim Sheldon-Dean** with Lewis Creek Systems in Charlotte, Vermont.

"But, reviews can also be internally directed, and it can be useful to have a mix, alternating reviews by internal or external parties, or alternating between two external parties," Sheldon-Dean adds.

An outsider can look at your agency challenges objectively and is more likely to call out issues that staff may purposely ignore, particularly as the majority of breaches are caused from insider threats.

"I doubt that insider issues would affect the risk analysis, since the risk analysis will dictate what needs to be done for security, but leave the investigation of what's gone wrong to the processes instituted according to the risk analysis," Sheldon-Dean cautions. "Doing the risk analysis, whether by internal or external parties, will result in exposing the need to look for improper insider activity, which is a required but often ignored process." ❖

Resource: See the 47-page August update to the FAQs, which includes one new FAQ and five updated FAQs, at https://innovation.cms.gov/media/document/hhvbp-exp-faqs.

Meanwhile, HHAs can build their VBP knowledge with three new on-demand videos.

No. 1: The 15-minute *How Measure Performance Becomes Care Points* illustrates "how performance on a quality measure becomes achievement points, improvement points, and care points," CMS explains in a message to providers.

No. 2: The 16-minute *How Care Points Become the Total Performance Score (TPS)* and its accompanying written materials provide "an overview of the use of care points in the TPS calculation," CMS says.

No. 3: The 12-minute *How the Total Performance Score (TPS) Becomes the Final Payment Adjustment* and its accompanying written materials present "an overview of how the TPS informs the calculation of the payment adjustment," CMS concludes. It "includes a review of Model concepts such as the Linear Exchange Function (LEF) and adjusted payment percentage (APP)," the agency adds.

CMS had promised these videos were coming back in June (*see HCW by AAPC, Vol. XXXI, No. 24*).

Keep in mind: "The content of these resources is for informational purposes only," CMS reassures. "HHAs will not need to conduct these calculations themselves under the expanded HHVBP Model."

Resource: Agencies can access these new tools, as well as a host of other educational materials, on the HHVBP webpage at https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model — scroll down to the "Total Performance Score & Payment Adjustment" section for these videos.

And keep an eye out for a "repeat event" of CMS's Aug. 25 webinar, "Navigating Performance Feedback Reports:

Interim Performance Report (IPR) and Annual Performance Report (APR)," later this fall. "Registration will be available soon," CMS pledges in a message to providers.

In the meantime: "The recording, slides, and transcript" of the Aug. 25 event "are available under the 'Model Reports' section" on the HHVBP webpage. ❖

INDUSTRY NOTES

COVID Vax Mandate Develops Along With The Science

One popular religious exemption may no longer be valid.

A Wisconsin health system is telling certain of its religiously exempt employees that they'll now have to get vaccinated for COVID.

In a statement shared with media, Froedtert Health says "the Novavax vaccination for COVID-19 is now available. This protein-based vaccination option eliminates conflicts for those staff with religious or medical exemptions caused by mRNA-based vaccines and other concerns."

Exemption applicants have cited the use of fetal material in mRNA vaccines or in their development.

"Since those staff are now eligible for a vaccination that does not conflict with their religious beliefs or medical situation, their exemption will expire," Froedtert Health's statement says. "This affects a small percentage of staff with a vaccine exemption. Eligible staff continue to be exempt from a COVID-19 vaccine for religious and medical reasons."

The health system takes pains to point out that it "respects the right of staff and providers to engage in activity protected by state and federal law." And "impacted staff were provided the opportunity to apply for an exemption after learning the previous exemption kept on file was no longer valid," Froedtert adds.

Affected employees have until Sept. 21 to get the shot or be "voluntarily resigned," reports WISN.

Whether health care employers will follow this test case remains to be seen, experts note.

• **If you let a medical review records request slip past you,** you may have a chance to somewhat simply redeem yourself.

"Responding to additional documentation/development requests (ADRs) is time sensitive," emphasizes HHH Medicare Administrative Contractor CGS. "If you receive an ADR from medical review and do not respond within the 45-day time limit, we may be able to process the late ADR response as an MR Reopening if requested within 120 days," CGS tells HHAs in a new post on its website.

"This function was previously available to Part B users (submitted as a Redetermination). Now it is available to Part A and HHH users as a 56900 Reopening," CGS explains.

More details are in the myCGS User Manual at https://cgsmedicare.com/mycgs/mycgs_user_manual_mr.html — consult the "Medical Review/MR/56900 Reopening" section.

• **Not everyone shares the view** that the home health staffing situation is the worst it's ever been.

Last year, several home care providers in Lubbock, Texas, told KLBK News they were operating at about 50 percent capacity due to staffing shortages. But now they are doing better, the TV station says. Best In-Home Care said it is now looking for clients instead of turning them down, because it finally has enough staff. Caprock Home Health is now operating closer to 75 percent capacity, it told KLBK.

• **Medicare needs to get with the program** and create procedure codes for hospices to bill telehealth visits. So say 17 hospice and telehealth-related organizations in a Sept. 12 letter to Congress.

Congress needs "to require [the Centers for Medicare & Medicaid Services] to develop and implement Healthcare Common Procedure Coding System (HCPCS) codes or modifiers for telehealth visits and add them to the hospice claim form via any available legislative vehicle," says the letter led by the National Hospice and Palliative Care Organization.

"Hospice providers need the opportunity to reflect the full scope of care provided to patients experiencing serious illness," the letter urges. "Right now, care delivered through telehealth is not measured, and therefore, many visits are not noted in any official record. This means that patients' records fail to reflect the full scope of care they receive, and hospice organizations are left without a way to fully capture the quantity of their patient visits and quality of their work," the letter continues.

"Collecting accurate information is critical to drafting long-term policy, and effective guardrails, around the use of telehealth in the future," NHPCO's **Logan Hoover** says in a release about the letter. "Tracking telehealth visits and incorporating them into the hospice claim form is a simple, common-sense approach for appropriate telehealth policy," Hoover says.

• **You can find out more about** the 2023 hospice final rule that takes effect next month and Hospice Quality Reporting Program updates in a Sept. 28 webinar.

Representatives from the Centers for Medicare & Medicaid Services and contractor Abt Associates will review those topics and answer attendee questions, CMS says in a notice about the session. Register at https://attendee.gotowebinar.com/register/6692944306731233291.

• **Madison Medical Center in Fredericktown, Missouri, is closing down** its home health business.

Staffing shortages and low reimbursement levels were the main reasons for the closure. "Reimbursements in this service area have continued to decline over the years and not kept up with the rising costs associated with providing this service," MMC CEO **Lisa Twidwell** told the *Democrat News* newspaper. Medicare regulations and managed care restrictions also affected the decision, Twidwell said.

Other HHAs in the area operate and can pick up the slack. MMC will take its savings from the closure and reinvest the funds in its other service lines, Twidwell said.

• **If you're in need of more hospice staff,** you may want to take a page from one Texas provider's playbook.

AlēvCare Hospice has partnered with the Texas Tech University Health Sciences Center School of Nursing to provide "didactic classroom education as well as opportunities for the students to make observational visits with AlēvCare Hospice nurses during patient visits in the local community," the Mansfield-based hospice says in a release.

"As we educate our future nurses, it is important for students to be exposed to the many practice settings of nursing across the community," says TTHUSC School of Nursing Dean **Tiffani Wise** in the release. "Partnering with AlēvCare Hospice provides a great opportunity for students to experience hospice and end-of-life care firsthand."

• **Don't turn a blind eye to health inequities** regarding telehealth. New guidance from the feds can help.

The Department of Health and Human Services and Department of Justice have issued guidance to commemorate the 32nd anniversary of the Americans with Disabilities Act. The tools aim to protect the rights of people with disabilities and limited English proficiency and ensure their access to telehealth.

"Telehealth has become an evolving and common pathway for accessing healthcare, particularly as our society becomes increasingly digitized," explains Assistant Attorney General **Kristen Clarke** of the Justice Department's Civil Rights Division in the release. "It is critical to ensure that telehealth care is accessible to all, including patients with disabilities, those with limited English proficiency, and people of all races and national origins."

The HHS Office for Civil Rights and DOJ OCR worked together on the guidance, which explains the obligations providers have regarding telehealth services as well as their patients' rights to these important technologies. "The guidance provides examples of actions that may be discriminatory and describes steps that providers may need to take to ensure that health care offered via telehealth is accessible," HHS explains. "The guidance also provides a list of resources that providers and patients may wish to consult for additional information about telehealth and civil rights protections."

Review the guidance at www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf. ❖

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