Home Care & Hospice 2017: A Washington Update

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The Trump Administration: Impact on Home Care

• New Opportunities
  – Regulatory reversals
    • FLSA rules: companionship services; live-ins; OT
    • Medicare policies: F2F; preclaim review; new Conditions of Participation
  – Obamacare: Employer mandate: block penalties?
2017: Impact on Home Care

- New Risks
  - Medicaid block grants
  - Expanded Medicaid waivers
  - Medicare reform
    - Premium support (defined contribution)
    - Single cost sharing under PART A AND Part B
      - Would mean home health and hospice cost sharing
    - Repeal CMMI (Innovations)
    - Repeal IPAB (good thing!)
  - Spending cuts
    - Medicare rate reductions
    - PAC VBP non-budget neutral

2017: New Congress/New Administration

- New Opportunities for Home Care Interests
  - Reforms
    - NPP Medicare home health authorization
    - Home health rural add-on
American Health Care Act: Is This The Last We See of Repeal and Replace Obamacare?

• AHCA included:
  – Elimination of individual and employer mandates
    • Permits a 30% premium surcharge on insurance where an individual’s coverage lapses
  – Establishes an age and income related refundable tax credit
    • $2000-$4000 with $14,000 family maximum
    • Phases out starting at $75,000 individual/$150,000 joint filers
  – Expands Health Savings Accounts
  – Permits a higher insurance premium charge level for older customers up to 5 times greater than younger customers
  – Establishes a $100B support for safety-net needs and high risk pools
  – Bans denials of insurance based on pre-existing illness
  – Permits dependents on parents’ plans until age 26
  – Lifetime caps on insurance payouts banned
  – “essential benefits” remain with exchange plans; reverts to Medicaid scope on Medicaid benchmark plans

American Health Care Act: Repeal and Replace Obamacare First Try

• Medicaid:
  – Institutes a “per capita caps” federal funding formula tied to 2016 spending
    • Permits federal spending increases tied to state Medicaid enrollments
    • Annual inflation update
  – Permits greater state flexibility on benefit design
  – Continues enhanced federal funding to states that expanded Medicaid until 2020. After 2020, states get enhanced federal funding only for continuing eligibles, new enrollees funded at lower level
  – Drops Community First Choice optional benefit
American Health Care Act: Repeal and Replace Obamacare First Try

• Home care and hospice impact
  – Medicaid eligibility changes should have limited impact as population covered is not likely a home care or hospice population
  – Medicaid per capita caps raise concerns
    • Home care expansion opportunities will be burdened by capped federal financial support
    • State flexibility can favor or disfavor home and community based care and/or hospice
      – HCBS is 53% of LTSS spending
      – Range in HCBS spending is 79%-27%
      – 24 states spend less than 50% of LTSS spending on HCBS
      – Hospice benefit is optional

• Home care and hospice impact
  – Loss of optional Community First Choice benefit may be a significant blow to home care
    • States would lose a 6% increase in federal matching payments that is to encourage LTSS rebalancing
    • 8 states have adopted the program (CA, CT, MD, MT, NY, OR, TX, and WA)
    • 5 states have submitted applications or are actively considering (AK, AR, CO, MN, and WI)
    • States could still use waivers to bring about same scope of benefit (but w/o the 6% FMAP increase)
American Health Care Act: Repeal and Replace Obamacare First Try

• Home care and hospice impact:
  – ACA Employer Mandate repeal
    • Strong positive benefit for Medicaid and private pay personal care agencies
      – No support came from Medicaid programs
      – Consumer willingness to pay higher cost limited
      – Providers shifted to part-time caregivers thereby increasing recruitment and retention costs and concerns

American Health Care Act: Repeal and Replace Obamacare First Try

• Medicare changes:
  – Limited to repeal of increased Medicare tax for high income earners
    • Will reduce Part A Trust Fund solvency
  – Medicare reforms will be left to another time
CONGRESS: What Else Are We Watching?

- Post-Acute Care Value-Based Purchasing
  - House Ways and Means
    - Level of financial risk
    - Measures used in scoring performance
- Chronic Care Management
  - Senate Finance Committee
    - Focus on MA Plans
    - Opening telehealth somewhat
    - Hospice integration with MA not included

Ways and Means PAC VBP

- Combined PAC VBP
- Controversial first versions
  - Not budget neutral
  - Single measure on Medicare spending
  - Pre-IMPACT Act implementation
  - 5% at risk
- Revisions in the works
- Industry opposition
- No Senate counterpart (yet)
Ways and Means PAC VBP (V. 3)

• Combined PAC VBP
• Controversial first versions
• Version 3
  – budget neutral in the aggregate
  – MSPB, Discharge to community, and preventable readmission measures
    • Optional quality measures
  – Two-track risk model
    • 2-5% at risk (high risk track)
    • 1-2% at risk (low risk w/ other VBP involvement, e.g. HHVBP)
• Reduced base rates with performance bonus opportunity
• Industry concerns
• No Senate counterpart (yet)

21st Century CURES Legislation

• Primarily focused on FDA and mental health reforms
• Home care impact:
  – Telehealth study
  – Home Infusion therapy benefit (2021)
  – Medicaid electronic visit verification
    • Personal care (2019)
    • Home health services (2023)
  – Moratoria application to service area
2017 Home Care Legislative Priorities

• Permit Non-physician Practitioners to certify Medicare home health eligibility
• Extend Medicare Home Health Rural Add-on
  — S.2389 (2016)
• Reform Medicare Face-to-Face documentation requirements
• Suspend Medicare Pre-claim Review

Hospice Legislative Action

— Global Issues
  • PCHETA (S. 693/H.R. 1676)
    — Palliative care positions at medical schools
  • Care Planning Act
    — New benefit provided by interdisciplinary team
— Targeted Issues
  • Rural Access to Hospice Act (H.R. 1828)
    — FQHC/RHC billing for attending physician services
  • PAs as Attending Physicians (H.R. 1284)
— Across-the-board payment cuts (Defense)

MedPAC 2017 March Report to Congress – Most Medicare provider types assessed for payment adequacy

HOME HEALTH:
• 2015 average margin: 15.6% (11.1 est. 2017)
• Access to care
  – 12,346 HHAs (-115 since 2014)
• Capital OK

RECOMMENDATIONS:
• 5% cut in 2018
• Elimination of therapy utilization as a payment level determinant under HHPPS
• The institution of a second round of rate rebasing in 2019

NAHC COST REPORT DATA (2015):
Freestanding HHAs

• Margin Range National
  • >50% 3.3%
  • 25-50% 27.0%
  • 20-25% 10.8%
  • <0% 23.0%

• Losses on Outlier, LUPA, and PEP episodes
MEDICARE Home Health Regulatory Developments

• HHPPS 2017 Final rule
  Rates
  Value-Based Purchasing pilot
• Face to Face/physician certification rule
• Program Integrity/Claims Reviews
• New CoPs (effective 7/13/17)
• Star Rating System

As Expected: 2017 Final Medicare Home Health Rate Rule

• Published October 31, 2016
• 2017 Rates
  – 2.8 Market Basket Index
  – 0.3 Productivity Adjustment
  – 0.97 case mix weight change adjustment
  – 2.8 rebasing impact
  – Overall -1.53% rate reduction compared to 2016
• New Outlier proposal
  – Based on 15-minute service units
• Case mix weight recalibrations
• Modifications of HHVBp measures
• New Negative Pressure Wound Treatment benefit
• Status report on IMPACT Act measures
2017 HHPPS Rates

• Outlier Changes
  – New formula for determining eligibility and payment amount
    • Based on a combination of visit number and 15 minute service increments
      – Intended to reflect real resource use
    • Fixed Dollar Loss set at 0.55 (0.45 2016)
    • 80% Loss ratio
    • Fewer episodes will qualify

• Case Mix Weight Recalibration
  – All 153 classifications affected
  – Overall reduction in CMW
    • Leads to higher base episode weight
  – Uneven CMW adjustments
    • Designed to account for changes in resource use
  – Expect continual annual recalibrations
HHPPS 2018

- What may be in the 2018 proposed rule
  - 1% rate update
  - Recalibrated case mix weights
  - Modified outlier standards
  - HHGM unveiling???

HHPPS Rebasing: The Future

- CMS unlikely to change path
- Congressional efforts underway, but limited
  - Delay and replace
  - Repeal and replace with Value Based Purchasing
  - Study
- Impact of rebasing mixed
  - Margins down, but less than forecast
  - New HHAs in market (some closures)
  - Consolidation/Acquisitions shows market promise
  - Limited access concerns surfacing
- MedPAC recommending deeper rate cuts
  - Estimates 2017 margin at 8.8%
Abt/CMS New HHPPS Draft Model

• New model intended to address:
  – Access to care for vulnerable patients
  – Elimination of therapy volume as payment rate determinant
• Home Health Groupings Model (HHGM)
  – 128 payment groups
  – Episode timing: early or late
  – Admission source: community or institutional
  – Clinical grouping: 6 groups
  – Functional level: 2-3 groups
  – Comorbidity adjustment: secondary diagnosis based

Abt/CMS New Draft HHPPS Model

• Notables
  – Therapy volume domain eliminated
  – Cost per minute + NRS approach to resource use
  – 30 day periods within 60 day episode
    • First 30 is an “early” period, all others are “late”
  – Admission source (14 days prior to early episode)
    • Community vs institutional
  – Six clinical groups
    • Musculoskeletal rehabilitation; neuro/stroke rehabilitation/wounds; complex nursing interventions; behavioral health; and medication management, teaching and assessment
  – OASIS-based functional analysis M1800-1860 + M1032
  – Regression analysis (2013 base)
  – What happens to RAPs, LUPAs, and outliers???
Abt/CMS New HHPPS Draft Model

• Timing of implementation TBD
  — Needs adjustments such as ICD-10
• Will go through public comment rulemaking
• Industry needs to model the impact
  — Expected to lower payment rates on therapy episodes, increase rates on high nursing volume cases
  — Geographic impact
• CMS held an Open Forum on 1/18/17
  https://blh.ier.intercall.com/details/87624e330547408593456b114011de08

Opportunity and Risk (low): Value-Based Purchasing Pilot (HHVBP)

• CMS pilots a VBP:
  — Started in 2016
    • Baseline year 2015
    • Performance year 2016
    • Payment year 2018
  — 9 states mandatory participation of all HHAs
  — 3-8% payment withhold for incentive payments
    • “greater upside benefit and downside risk”
    • Phase-in to 8%
  — performance measures
    • Achievement and improvement
    • Process, outcomes, and patient satisfaction
  • Baseline data released in April; first HHA quarterly report in late July
Value-Based Purchasing Pilot: Industry Concerns

• Generally supportive of VBP as a payment model reform
  – Details matter!
• Details here raise concerns
  – Amount at risk
    • 2% is max in other sectors
    • At risk levels may prevent improvements as resources depleted
  – Measures are complex, subject to manipulation, and leave out patient stabilization
    • Do not reflect chronic care population served in home health
  – Will overlap with bundling, ACOs, and other innovations
  – Benchmarks based on all patients with OASIS, not just Medicare FFS

Negative Pressure Wound Treatment: NPWT

• New benefit effective 1/1/2017
• Alternative to DME wound vac
• Disposable device
• Covered under Part B as outpatient service item/service
• HHA is only eligible provider
• Requires home health benefit eligibility
• Permits concurrent HH and OPS payments
• Uses 34X TOB for OPS and 32X TOB for HH
Quality Reporting Updates

• IMPACT Act driven
• New Measures
  – MSPB-PAC HH QRP
  – Discharge to Community-PAC HH QRP
  – Potentially Preventable 30-Day Post-Discharge Readmission for HH QRP
  – Drug Regimen Review conducted with Follow-Up for Identified Issues-PAC QRP
• Still open to considering socio-economic status as factor in risk adjustment
• Potential measures for PAC VBP

Risk: Face-to- Face Physician Encounter Changes

• Effective 1/1/15
• Eliminates physician narrative requirement
• Requires certifying physician to have sufficient records to support certification
• ADVICE: Incorporate HHA records into physician record!!!
• Rejects physician payment claims for certification/recertification when home health claim denied for noncompliant certification/recertification
• CMS nationwide prepayment “probe and educate” on 10/1/15 (5 claims from each HHA)/ ended September 1
  • High rejection rate
Medicaid HH Face-to-Face

• Also clarifies –
  • Coverage of HH services cannot be contingent on need for nursing or therapy services
  • Medicaid HH not subject to “homebound” requirement
    – HH services may NOT be limited to services furnished in the home:
      • Can be in any setting where normal life activities take place
      • NOT where payment could be made under Medicaid for inpatient services/R & B

Recertification

• Longstanding rule with new interpretation: 42 CFR 424.22(b)(2)
• “The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy.
  
• Must be part of the recertification
  – included in the recertification statement
  – separate statement where it is clear that it is part of the recertification
    • I certify that in my estimation services will be required for ..................
    • Agency may complete based on the physician estimate
Risk: Medicare Advantage: Post Pay Audits

- MA plans have begun auditing home health claims on a post-pay basis, including MI
- Some using a contractor: SCIO
- Focus on technical compliance issues
  - Signed physician orders
  - F2F requirements
  - Pre-2015 therapy needs assessments
  - OASIS
- HHAs not aware that MA plans required compliance with technical Medicare FFS standards
- Significant back liabilities
- Costly appeals processes

Medicare Home Health: Notable Litigation

- Jimmo v. Sebelius
  - 5:11-cv-17 (D. VT)
  - Ongoing litigation involving illegal application of an “improvement” standard in home health and SNF claims
  - Longstanding rules focused on “skilled care,” not “improvement”
  - CMS directed to take corrective steps in guidance, provider/MAC education, an web site information
HH Pre-claim Review Demo

- Three-year, five-state demonstration; started in Illinois with episodes beginning August 3
  - Florida, Texas, Michigan, and Massachusetts may be phased in through 2017
- CMS announced expansion into Florida effective April 1, 2017
- MAC review for Pre-claim review
  - All claims processed as complex medical review
  - HHA can start care and receive RAP
  - If submitted for pre-claim review and approved, claim paid
  - If submitted for PA and denied, denied (may appeal)
  - If no PA submission but claim submitted and approved, 25% reduction in payment (3 month grace period)

HH Pre-claim Review Demo

- Illinois experience difficult; recent improvement in affirmation rate to 90.8%
  - HHAs reduced documentation errors
  - Improved MAC performance

HH Pre-claim Review Demo: Goals

- Suspension/rescission of pre-claim review by the incoming Administration.
- Introduction of legislation to suspend pre-claim review in the upcoming 115th Congress in the House and Senate.
- Development of a lawsuit to challenge the legal validity of the project.
- Initiation of a major provider education effort.
- Establishment of standards for CMS to scale back the application of pre-claim reviews to target only high risk providers and that rely on random sampling methodologies for pre-claim reviews overall in order to reduce unnecessary administrative burdens.

HH Pre-claim Review Demo

- What is the next generation PCRD?
  - Optional system
  - Targeting use
    - 1st episode
    - Diagnosis-based
    - Performance-based exemption
  - Alternative solutions to documentation issues
Opportunity: CMS Home Health Star Rating System

Combines outcome measures and process measures from Home Health Care Compare into a single score

Star Rating Concerns
- Focus on Improvement measures
- Formula pushes scores to the middle
- Most HHAs with 3 Stars
- Consumer impression that 3 Stars is mediocre
- Patient experience (HHCAHPS) Star rating a different model
- More traditional design
- Consumer familiarity with model

MEDICARE HOME HEALTH: Intermediate Sanctions

- Civil Money Penalties (CMP)*
- Suspension of payment on new admissions*
- Temporary management*
- Directed plan of correction**
- Directed in-service training**

- * required by statute
- ** required by regulation
Intermediate Sanctions Risk

- 2016
  - 4,976 HHA surveys
  - 2.5% with condition-level deficiency
  - CMP sanctions—79
  - Suspension of payment on new admissions—30
  - Directed plan of correction—5
  - Directed in-service training—11
  - Temporary management--1

HH COPS

- Final Rule
- Federal Register 1/13/2017 (proposed 10/7/14)
  - Final
  
HH CoPs

- First major revision in CoPs in 3 decades
- Provides an outcome oriented, flexible, patient-centered focus
- $293M annual cost
  - Accredited HHAs less since many have systems in place already
- Major changes
  - QAPI
  - Infection control
  - Patient Rights

HH COPS – Patient Rights

d) Standard – Transfer and discharge NEW

The patient and representative (if any), have a right to be informed of the HHA’s policies for admission, transfer, and discharge. The HHA may only transfer or discharge the patient from the HHA if:

1) acuity requires another level of care—HHA must arrange for safe and appropriate transfer
2) no payment
3) physician and HHA agree that goals met
4) patient refuses care or elects transfer/discharge
5) cause – disruptive, abusive, uncooperative behavior;
   i) advise patient, physician etc. of the plan to d/tr
   ii) efforts to resolve problems prior to d/tr
   iii) provide patient with contact information for other agencies/providers
   iv) document efforts made to resolve issues
6) death
7) HHA ceases to operate
HH COPS – Patient Rights

- Transfer and discharge
- **COMMENT:** CMS requires physical or electronic documents outlining acceptable reasons for discharge or transfer. CMS indirectly included discharge for staff safety reasons, but for cause standards may apply. Similarly, CMS did not include “inadequate clinical resources” as a for cause basis for discharge. HHAs need to review state licensing law requirements on discharge and apply standard that most protects patients.

CoP Policy Action

- Request that CMS withdraw CoPs or extend compliance deadline
  - High cost to implement and administer w/o clear ROI
  - Insufficient time to properly implement
  - New administration regulatory freeze/suspension
CMS Joint Replacement Bundling

• Affects total hip and knee replacement patients (April 1, 2016)
• Hospital payments at risk
  – Target spending set by CMS geographic specific data
  – Hospitals may share risk and savings with other providers
  – First year: shared savings only
  – Year 2 and beyond: shared savings and losses
  – Covers costs through 90 days post hospital
• 67 hospital geographic areas in play
• Patient freedom of choice continues
• Providers paid at usual FFS rates
• Expansion/retraction/termination possible depending on results
• Home health impact: mixed, but mostly positive in the aggregate

Hospice Regulatory Developments

• New Payment Model (Began Jan. 1, 2016)
• Two-tiered payment system for RHC
  – Days 1 – 60 of “episode” -- $186.84
  – Days 61 and thereafter of “episode” -- $146.83
  – “Episode” – a hospice election period or series of election periods separated by no more than a 60-day gap
  – SERVICE INTENSITY ADD-ON (SIA)-RN & SW 4hours daily max. in last 7 days of life
Hospice FY2018 PROPOSED Wage Index, Payment Update and Quality Reporting Rule

- Mainly rate updates as expected
  - Overall spending increase ($350M)
  - Market Basket Index update 1.0% (required by MACRA)
  - No Productivity Adjustment
  - No Add’l ACA reduction
  - Hospice 2017 Cap $28,404.99

### 2018 Proposed Hospice Rates

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Hospice Quality Measures

- **PUBLIC REPORTING**
  - Will start late summer 2017
  - Only 7 Hospice Item Set (HIS)-based process measures will be supplied
  - CAHPS Hospice survey measures will be reported in Winter 2018
- **COMPREHENSIVE ASSESSMENT INSTRUMENT**
  - Under development, will replace Hospice Item Set (HIS) data extraction tool currently in use
- **5-STAR RATING** – at least a year out, possibly more

FY 2018 Hospice Proposed Rule

- **SOURCES OF CLINICAL INFORMATION: CMS considering**–
  - Requirement that referring physician/facility records must serve as basis for eligibility determinations; this could not be determined by hospice documentation after admission
  - Requirement that documentation from in-person visit by hospice physician could be used to support eligibility determination ONLY IF NEEDED to augment the referral source medical records
  - How hospices currently ensure comprehensive clinical review to support certification
- **DATA TRENDS**
  - CMS continues to monitor data – biggest concern is spending under Part D, which has gone up. Increased spending not related to the four classes of drugs under prior authorization review – instead related to "maintenance drugs"
  - Hospice should anticipate future activity related to Part D billings
HOSPICE PHYSICIAN CERTIFICATION


• Nothing new, but...

• Five elements
  – Statement on prognosis
  – Patient-specific clinical findings
  – Signature, date signed, and benefit period dates covered
  – Physician narrative

• Location of signature important

HOSPICE ELECTION


• OIG found widespread noncompliance
  – Waiver
  – Palliative care information
  – Medicare reference

• CMS offers a model form
Emergency Preparedness

- **Survey & Certification- Emergency Preparedness Regulation Guidance**
- November 2017 compliance deadline

Home Care as an Employer: FLSA-DoL

- Rule changes directly and indirectly targeting home care
  - “companionship services” exemption
  - Live-in domestic services
  - Professional, executive, and administrative salaried employees
- Policy positions informed through home care
  - Joint employer
  - Independent contractor
- DoL Sleep Time Guidance
- DoL New Audit Focus on mileage reimbursement
DOL Sleep Time Guidance

• Limits ability of employer to discount sleep time
• Varying standards
  – Live-in
  – 24 hour plus shifts
  – Less than 24 hour shifts
• https://www.dol.gov/whd/homecare/sleep_time.htm

DOL New Audit Focus

• Unreimbursed mileage costs (non-exempt employees)
• Reduces wages potentially creating a minimum wage and/or OT issue
  – Minimum wage example: wages ($8 hr X 40 hrs = $320); min wage ($7.25 X 40 = $290); weekly mileage cost (100 mi X $.54 = $54); net wages ($320-$54= $266); minimum wage gap ($34)
  – OT example: wages (50 hrs @ $8hr); weekly mileage cost (100 mi X $.54 = $54); required compensation ($8 hr X 40 hr + $12 hr X 10 hr + $54 = $494 (time and a half of regular wage) + mileage cost
CONCLUSION

• Election results raise policy change speculation to a new level
• Moderately stable times with continued regulatory actions
• Oversight growing on claims and quality performance
• Serious challenges remain in regulatory proposals/changes
• Manage today, plan for the future!