CAHSAH® Annual Conference & Home Care Expo
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Home Care and Hospice 2017: A Washington Update
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SESSION EVALUATIONS

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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

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

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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

<table>
<thead>
<tr>
<th>Margin Range</th>
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<tr>
<td>&gt;50%</td>
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<tr>
<td>20-25%</td>
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<tr>
<td>&lt;0%</td>
<td>23.0%</td>
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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

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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

2017 HHPPS Rates

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 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

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

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.
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

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<th>Description</th>
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<tr>
<td>2016</td>
<td>4,976 HHA surveys</td>
<td>4,976</td>
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<tr>
<td></td>
<td>2.5% with condition-level deficiency</td>
<td>124</td>
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<td></td>
<td>CMP sanctions—79</td>
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<td>Temporary management—1</td>
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## 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 (Beginning 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 FY2017 FINAL Wage Index, Payment Update and Quality Reporting Rule


Mainly rate updates as expected
- 2.1% overall spending increase ($350M)
- Market Basket Index update 2.7%
- Productivity Adjustment -0.3%
- Add’l ACA reduction -0.3%

Hospice 2017 Cap $28,404.99

Hospice Quality Measures

Two new reporting measures
- Hospice visits when death is imminent
- Hospice and palliative care Composite Process measure: % of patients received care processes

Public reporting beginning in 2017
- Hospice Compare
- Likely Spring/Summer start

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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 @ $8/hr); 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!

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