NATIONAL ASSOCIATION FOR HOME CARE AND HOSPICE
Key Home Health Payment and Regulatory Provisions in Health Care Reform – March 23, 2010

Patient Protection and Affordable Care Act (H.R. 3590) as amended by the Manager's Amendment (S.AMDT. 2786) and the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872)
MEDICARE HOME HEALTH PAYMENT ADJUSTMENTS
1. 3% rural add-on for episodes and visits ending on or after April 1, 2010 and before January 1, 2016 (Sec. 3131)
2. Beginning in 2011, cap total outliers at 2.5%; impose individual agency outlier cap of 10% (Sec. 3131)
3. Reduce market basket update by 1 percentage point in 2011, 2012, and 2013 (Sec. 3401, Sec. 10319 of Manager's Amendment)
4. Rebase starting in 2014 phasing in through 2017; rebasing adjustment limited to no more than 3.5% reduction per year (Sec. 3131, Sec. 10315 of Manager's Amendment). MedPAC shall report by Jan. 1, 2015, on impact of rebasing (Sec. 3131). By March 1, 2014, HHS Secretary must report on home health rebasing and impact on access and quality (Sec. 3131(d))
5. Annual productivity adjustment (estimated 1 percentage point reduction) beginning 2015 (Sec. 3401)
6. Reduce hospital payments for readmissions (Sec. 3025): Community-Based Care Transitions Program (Sec. 3026)
7. Directs HHS Secretary to develop a national, voluntary pilot program encouraging bundled payment models for hospitals, doctors, and post-acute care providers. Entities including a hospital, a physician group, a SNF and a home health agency may apply to participate. Requires the Secretary to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will result in improving the quality of patient care and reducing spending. (Sec. 3023)
8. Secretary of HHS shall submit plan for value—based purchasing program for home health agencies to Congress by Oct. 1, 2011 (Sec. 3006)
9. (a) HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity. (b) Medicare Demonstration Project: HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) $500M demonstration project to test whether making payment adjustments based on the study substantially improve access to care for patients with high severity levels of illness or for low-income or underserved Medicare beneficiaries (Sec. 10315 of Manager's Amendment)
10. Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning January 15, 2014, in years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. Hospitals and hospices (through 2019) will not be subject to cost reductions proposed by the Board. (Sec. 3404)
MEDICARE HOME HEALTH PAYMENT REDUCTIONS (2011 – 2019) – ($39.7B)

INNOVATIONS IN HEALTH CARE/PRIVATE LONG TERM CARE INSURANCE PROGRAM (CLASS)
11. Establish a Center for Medicare and Medicaid Innovation in CMS; opportunities for chronic care and other initiatives (Sec. 3021) -Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams. (xiv)
12. Telehealth advancement opportunities through new CMS Innovations Center but no guarantee (Sec. 3021)
13. Independence at Home demonstration program (Sec. 3024)
14. Establish voluntary national home and community-based long term care insurance program (CLASS) (Secs. 8001-8002)
PROGRAM INTEGRITY
15. Require background screening and credentialing of provider and supplier owners and managers, require compliance plans, gives CMS the authority to impose a temporary moratorium on new providers (Sec. 6401)
16. Participating physician requirement regarding care plan certification (Sec. 6405)
17. Face-to-face physician encounter requirement (including telehealth encounter) with patients within a reasonable timeframe as determined by the Secretary; nurse practitioners, advanced practice nurses, and physician assistants may substitute for physicians to meet the face-to-face encounter requirement (Sec. 6407, Sec. 10605 of Manager's Amendment)
18. Physician must maintain and provide access to documentation on Medicare home health referrals if requested (Sec. 6406)
19. Criminal background check pilot program expansion (Sec. 6201)
MEDICAID HOME AND COMMUNITY-BASED SERVICES EXPANSIONS
20**.** Community First Choice Option (expanded Medicaid home care through agencies and self-directed care) (Sec. 2401) (Effective October 1, 2011) - $**6.0B**
21. Removal of barriers to Home and Community based Care (expanded rebalancing requirements and waiver authority and removal of restrictions on waivers) (Sec. 2402) - **$2.4B**
22. Money Follows the Person Demonstration extension (Sec. 2403) (Through September 2016) - **$1.7B**
23. Spousal impoverishment protection for home care eligibility (Sec. 2404) - **$1.5B**

EMPLOYER REQUIREMENTS
24. Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014) (Sec. 1513) Exempt employers with 50 or fewer employees from any of the above penalties. Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014) (Sec. 10108) The term 'full-time employee' means an employee who is employed on average at least 30 hours of service per week.