The State of Home Care and Hospice:2015
Missouri Alliance for Home Care

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Program Focus

• ACA Employer Mandate
• DoL rules on minimum wage and overtime
• SGR: Medicare reforms
• Medicare hospice
• Medicaid home care
• Medicare home health
• Compliance issues
• “On the way”—the new HHA CoPs

Affordable Care Act: What is in store for home care?

☐ On January 1, 2015, employers of 100 or more FTEs must offer a qualified health plan.
☐ 50-99 FTEs delayed until 2016
☐ Less than 50 FTE exempt
☐ Many, but not all Medicare HHA/hospices have or offer comprehensive health insurance
☐ $3000 per non-insured penalty a risk
☐ Most Medicaid home care providers do not have health insurance for employees
☐ $2000 per FTE penalty a risk
☐ Private pay home care companies rarely have employee health insurance
☐ $2000 per FTE penalty a virtual certainty
Employer Mandate: Advocacy Efforts

- Delay the implementation date
  - S.1350: Realistic Employer Responsibility Act of 2013
- Eliminate the employer mandate
- Change the law
  - E.g., redefine full time to 40 hours per week (30 is current standard)
  - H.R. 30: Save American Workers Act
  - S. 50: Forty Hours is Full Time Act
  - Litigation: Hill v. Burwell
- Employer options
  - Stay below 50 FTE’s and/or 30 full time employees
  - Limit the number of employees at 30 hours or more per week
  - Offer bare bones, qualified health plan
  - Seek higher Medicaid rates (good luck!)
  - Raise charges to clients (tough sell)

COMPANIONSHIP SERVICES/LIVE-IN FLSA EXEMPTIONS

- DOL rule effectively eliminates minimum wage and overtime exemption
  - Eliminates exemption for 3rd party employment
  - Changes definition of companionship services
  - Excludes 3rd party employers from live-in exemption
  - Medicaid and disability rights advocates opposition
- Increased litigation on W&H issues
  - Validity of claimed FLSA exemption status
  - “hours worked”
  - Break time rights

STRATEGIES and TACTICS

- Litigation
    - 12/22/14 Court invalidates the exclusion of 3rd party employers from using the exemptions
    - 1/14/15 Court vacates “companionship services” definitional rule change
  - DOL Notice of Appeal 1/22/15; Oral Argument May 7, 2015; Decision ???
  - In the meantime:
    - Rulings restore longstanding rules
    - Keep state law in mind
    - Stay tuned
SGR (physician payment): The Vehicle for Medicare Reforms

- Physician Medicare payment model to be replaced?
  - SGR -> Value based Reimbursements
  - End to annual "patch"
  - $215 Billion in costs
- Offsets ($70 billion)
  - Split contributions from providers and beneficiaries
    - 1% rate update in 2018
    - HH surety bond changes
- Gains
  - No home health copay
  - 2 year extension of HH rural add on

MEDICARE HOSPICE

- 2015 Payment Final Rule:
  http://www.cms.gov/Medicare/Medicare‐Fee‐for‐Service‐Payment/Hospice/Hospice‐Regulations‐and‐Notices‐Items/CMS‐1609‐F.html
- No new payment model proposed
  - CMS indicates that it wants to evaluate not yet available data from new cost reports and claims submissions; focus on program integrity for now

MEDICARE HOSPICE Final Rule

- 1.4% net payment rate increase
  - 2.9% MBI
  - (0.3%) ACA reduction
  - (0.5%) productivity adjustment
  - (0.7%) BNAF wage index reduction
- Add in 2% sequestration
MEDICARE HOSPICE: Drug Liability

- Who pays for drugs: Part D or the hospice?
- National coalition addressing CMS policy
- Potential solutions under consideration
- Long term risk to hospices?
- Final rule sets out prior authorization standards for 4 drug categories

Medicare Hospice: Regulatory Challenges

- Collection of additional data on claims
- Hospice face-to-face rule
- Terminal illness documentation
- Attending physician listing
- Quality reporting -- Hospice Item Set (July 2014); Hospice Experience of Care Survey (Jan. 2015)
- New Cost report
  - Effective for cost reporting years beginning 10/1/14
  - Final report and instructions???
  - Institution-based TBD

2015 MedPAC Hospice Recommendations

- No inflation update
- Accelerate new payment model
  - U-Shaped reimbursement
- Provide hospice within MA Plans
Medicare Hospice: Legislative Developments

- IMPACT Act: PL 113-185
  - Establishes a requirement for CoP surveys at least every 3 years
  - Modifies Annual Cap update formula to pay for increased survey costs
    - Links to annual hospice inflation (MBI) update
    - Result will be slightly increased number hospices over caps in the long term

Medicaid Home Care

- Rebalancing of LTC spending continues
  - Just less than 50% of Medicaid LTC spending now in home care
  - States’ balance in spending wide ranging
- ACA impacts home care
- Higher federal match to low balance states (BIP)
- New HCBS option benefit
  - [https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid‐program‐state‐plan‐home‐and‐community‐based‐services‐5‐year‐period‐for‐waivers‐provider](https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid‐program‐state‐plan‐home‐and‐community‐based‐services‐5‐year‐period‐for‐waivers‐provider)

- States increasing Medicaid home care audits and oversight
  - Big focus on caregiver qualifications by OIG
  - Documentation weaknesses on care plans ad authorizations

- Major movement to managed care Medicaid
  - MLTSS (Managed Long Term Services and Supports)
  - Duals Demonstration Programs

Medicare Home Health Regulatory Developments

- HHPPS 2014 rule
- Face to Face rule
- Therapy Assessment rule
- Proposed CoPs
- New Medicare CoP sanctions
- Program Integrity/Claims Reviews
- Star Rating System
The New Rule


Home Health Final Rule: So much more that payment rates

• HHPPS 2015 Payment Rates
  - Continued Rate Rebasing
  - Recalibration of Case Mix Weights
  - Major Wage Index Changes
  - Outlier Payment Model
• Face to Face Physician Encounter
• Professional Therapy Assessments
• OASIS Submission Standards
• Qualification of Speech-Language Pathologists
• Standards on the HHA Administration of Insulin Injections
• Value Based Purchasing Model
• Civil Money Penalty Sanctions for CoP Violations
• Changes to Physician Certification/Recertification Requirements

2015 Medicare Home Health Rates

- Year 2 rebasing payment rates (4 year phase-in)
  - Episode rates: full cut (3.5% of 2010 rates) allowed under ACA
  - LUPA per visit rates: full increase (3.5% of 2010 rates)
  - Non-routine Medical Supplies: 2.82% reduction
- Recalibrated case mix weights
  - Major changes in all 153 case mix weights
  - All variables adjusted
  - Budget neutrality adjustment
- New CBSAs in wage index lead to one-year blended index
- Outlier eligibility remains same despite low spending
- Effective for episodes ending January 1, 2015 or later
- Rates reduced by 2% if no quality data submitted
- 3% rural add-on continues through 2015
- Remember 2% payment sequestration (February 1 and later payments)
2015 Medicare Home Health Rates

• Notables
  – CMS does not include case mix creep adjustment (2.32% estimated by CMS)
  – CMS references that its cost report audit showed 6-8% overstatement of costs
  – Rebasings adjustments less than necessary to achieve average cost
  – Anticipate annual case mix recalibration

Face-to-Face Physician Encounter Changes

• Eliminates physician narrative requirement
• Requires certifying physician to have sufficient records to support certification
• Rejects physician payment claims for certification/recertification when home health claim denied for noncompliant certification/recertification

Face-to-Face Physician Encounter Changes

• Physician narrative requirement rescinded
  – Applies to Start of Care episodes beginning January 1, 2015
• CMS rejected requests to rescind the rule retroactive to April 2011
  – “without fault” waiver of overpayments rejected
• CMS acknowledges complaints about confusion and subjective reviews
• Defends validity of the rule
Face-to-Face Physician Narrative

- F2F Litigation underway
- NAHC v. Sebelius/Burwell
  - 1:14-cv-00950 (filed 6-5-14)
  - US District Court for the District of Columbia
- Alleges
  - excess documentation required in relation to ACA requirements
  - failure to provide adequate and clear guidance on acceptable documentation
  - Failure to review whole record
- Court rejected Medicare Motion to Dismiss on narrative requirement
- Lawsuit will continue to address past claims denials and continuing audits

Face-to-Face Physician Encounter Changes: SOC 1/1/15

- Certifying physician must have adequate documentation in the file to support certification
  - “patient’s medical record,…, must support the certification of eligibility”
    - Skilled care need
    - Homebound status
    - Plan of care
    - Under the care of the physician
    - Timely face-to-face encounter
    - Narrative still required where qualifying skilled service is management and evaluation of the care plan

Face-to-Face Physician Encounter Changes

- Physician documentation
  - Physician required to provide HHA with such documentation if HH claim audited
  - HHA can supply certifying physician with its documentation
    - Must show that physician reviewed and signed off on it
    - Corroborates physician documents
  - CMS expects certification at the start of care or as soon as possible thereafter
    - No formal rule standard on exact timing
    - Expects prior to end of episode
  - Significant confusion on how to administer and comply with the requirement
Face-to-Face Physician Encounter Changes

• Physician payment for certification/recertification
  – CMS will reject physician claims where HH certification determined to be noncompliant
  – No formal rule; will be done through guidance

SOC and Certification

• A certification (versus recertification) is considered to be any time that a new Start of Care OASIS is completed to initiate care.
• Certification and F2F requirements apply to:
  – discharge and admit to HH within 60 day episode (PEP)
  – new SOC when episodes are not “continuous” (e.g. inpatient facility over day 60/61)
• Review OASIS consideration document

Therapy reassessment

– Eliminate 13/19th and every 30 day visit threshold assessments

– Proposed at least every 14 days

– Final rule - at least every 30 days
CMS Star Rating System

- Combines outcome measures and process measures from Home Health Care Compare into a single score
  - Process measures:
    - Timely Initiation of Care
    - Drug Education on all Medications Provided to Patient/Caregiver
    - Influenza Immunization Received for Current Flu Season
  - Outcome measures:
    - Improvement in Ambulation
    - Improvement in Bed Transferring
    - Improvement in Bathing
    - Improvement in Pain Interfering With Activity
    - Improvement in Shortness of Breath
    - Acute Care Hospitalization
    - Expected June/July 2015

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

Value-Based Purchasing Pilot

- CMS proposed for consideration
  - 5-8 states mandatory participation of all HHAs
  - 5-8% payment withhold for incentive payments
    - “greater upside benefit and downside risk”
  - CY 2016 start date
  - Unspecified performance measures
    - Achievement and improvement
  - Unspecified risk adjustment
Value-Based Purchasing Pilot

- Comments to CMS
  - Concern on the magnitude of the adjustment
  - Encouragement of pay for performance and pay for reporting
  - Measures: exclude 5-Star system, HHCAPS’ re-hospitalizations, OASIS measures
  - Support risk adjustment strategy, voluntary participation
- CMS intends to invite comments on a more detailed model

COMPLIANCE: FOCUS ON HOME CARE

- ZPICs and RACS looking at home care
  - Homebound status
  - Medical necessity
  - Technical compliance incl. F2F
- High level fraud/False Claims Act investigations
  - E.g., $375M physician-directed fraud allegation
- OIG continues home care efforts
  - New report alleges widespread fraud and abuse
  - Report is weak on facts and methodology, strong on hyperbole
- Medicaid home care now on the agenda
  - Personal care is the main focus
  - Staff credentials including health screening a target

MEDICARE HOME HEALTH: Intermediate Sanctions

- Authorized by OBRA ’87 the intermediate sanctions have been delayed
- OIG letter of March 2012 “reminded” CMS of the implementation requirements and provided an early alert of OIG study on HHA survey and certification
- April 25, 2014 CMS issued a new State Operations Manual (SOM) Chapter 10
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

Civil Money Penalties: 488.845

- Per instance CMPs: $1000-$10,000
- Per day CMPs: $500-$10,000; three tiers
  - Factors considered
    - 488.5 factors
    - Size of the HHA
    - Accurate and credible resources such as PECOS, cost reports, claims information providing information on operations and resources of HHA
    - Evidence of built-in, self-regulating quality assessment and performance improvement system
- Discretion to increase or decrease CMP at revisit

HH Proposed COPS

- Proposed rule
- Federal Register 10/9/2014
- 60 day comment period (12/8)
- CMS reviews and eventually published a final rule
  - Up to three years
HH Proposed COPS

  - Changes
    - Expands patient rights
    - Add a discharge and transfer summary requirement and time frames
    - Emphasis on integration and interdisciplinary care planning
    - Where standards are written in broad and vague terms, more specificity regarding what is required.
    - Increase in governing body involvement/accountability
  - Eliminates
    - 60-day summary to physician
    - Group of professionals (PAC)
    - Quarterly record review

FORECAST FOR HOME CARE

- Political
- Mega-Systems
- Health Care Delivery Systems
- Reimbursement
- Medicare and Medicaid Home Care and Hospice
- Managed Care
- Technology
- Workforce
- Oversight and Management by Payers
- The Business of Home Care

FORECAST: Political

- Political
  - Option A: Republicans control Congress; Democrat in the White House
  - Option B: Congress maintains split control; Democrat in the White House
  - Option C: Split Congress; Republican in White House
- FACTORS: Medicare solvency; Medicaid control/flexibility; Health insurance access and premiums; power of payer or provider (payer as provider)
- RESULT: Gridlock; Shift to conservative policies; shift to liberal policies; or gridlock
- HOME CARE BAROMETER: Positive support for home care expansion
FORECAST: Mega SYSTEMS

- MEGA SYSTEM CHANGE
  - Option A: “Kick the can down the road”
  - Option B: Wholesale Medicare and Medicaid reform comparable to welfare reform in the 90s.
  - Option C: Reform around the edges with continued experimentation
- FACTORS: Politics and the economy
- RESULT: C
- HOME CARE BAROMETER: Living under an environment of threats with minor consequences ultimately

FORECAST: Delivery Systems

- Health Care Delivery Systems
  - Option A: Fully integrated care delivery
  - Option B: post-acute care integration
  - Option C: New delivery models layered on top of existing system
  - Option D: Limited experiments
- FACTORS: Legal barriers; resources; advocacy power; vested interests; successes with innovative experiments
- RESULT: C plus D
- HOME CARE BAROMETER: Positive; home care viewed as a solution, but new players enter the market

FORECAST: Reimbursement

- Reimbursement
  - Option A: Cuts, cuts, cuts, and more cuts
  - Option B: Value Based Purchasing
  - Option C: Shared savings programs
  - Option D: all of the above
- Factors: Market power, political power, sector creativity and engagement
- Result: D
- HOME CARE BAROMETER: Positive with need for home care companies to evolve and adjust to change
FORECAST: Medicare and Medicaid

- Medicare and Medicaid Home Care and Hospice
  - Option A: Medicare peripheral changes; Medicaid moves to managed care
  - Option B: Medicare changes on cost sharing, eligibility age, and premiums; Medicaid moves to managed care
  - Option C: Medicare is privatized; Medicaid gets block granted or privatized
- FACTORS: Political power and control; state of the economy
- RESULT: A + Medicaid privatized (in part)
- HOME CARE BAROMETER: Business as usual in Medicare (headaches without big changes); totally new business model in Medicaid

FORECAST: Managed Care

- Managed Care
  - Option A: growth in enrollment in Medicare Advantage; MLTSS becomes the norm
  - Option B: stagnant enrollment in Medicare Advantage; MLTSS becomes the norm
  - Option C: decrease in Medicare Advantage enrollment; Medicaid is mixed
  - Option D: stagnant MA enrollment; Medicaid returns to fee for service model
- FACTORS: Public perception of managed care; MCO payment rates
- RESULTS:
- HOME CARE BAROMETER: Limited growth in MA enrollment is good for home health based on the track record of the plans. With Medicaid it is TBD—some plans recognize value of home care, others see it as a cost only.

FORECAST: Technology

- Technology
  - Option A: technology replaces the need for in person care
  - Option B: technology greatly expands home care opportunities
  - Option C: technology advances, but home care is taken over by other clinicians
  - Option D: technology establishes value, but no one pays for it
- FACTORS: CBO scoring; whether the nature of technology is a skilled tool or a consumer-directed replacement; skilled sets of home care personnel
- RESULTS: B
- HOME CARE BAROMETER: Current home care providers still have the upper-hand in capture the technology-related opportunities. However, they may be losing ground to outsiders (physicians/hospitals) due to the lack of reimbursement to current providers
FORECAST: Workforce

- Workforce
  - Option A: Unending supply of happy workers
  - Option B: Limited reimbursements challenge recruitment and retention
  - Option C: Adequate reimbursements permit payment of a fair compensation
  - Option D: Widespread unionization
  - Option E: Expanded scope of practice
  - Option F: Robotics takes over
  - Option G: Same as today

FACTORS: Economy, court rulings on public unions, application of overtime requirements, ACA employer mandate impact, identity of joint employers

RESULT: B + E + G

HOME CARE BAROMETER: Difficulties in recruitment and retention of paraprofessional staff will continue

FORECAST: Oversight and Management by Payers

- Oversight and Management by Payers
  - Option A: Increasing for both government and private payers
  - Option B: Licensing/credentialing of private pay home care and registries
  - Option C: Expanded data demands on quality and utilization
  - Option D: Some prior authorization

FACTORS: Perception of industry; actual findings from investigations and prosecutions; and funding

RESULTS: A + B + C + D + More

HOME CARE BAROMETER: Need to raise expectations on the burden of oversight and the need for perfect compliance on technical requirements for payment and provider participation

FORECAST: Business

- The Business of Home Care
  - Option A: Consolidation
  - Option B: New start-ups in Medicare
  - Option C: Expanded development of post-acute providers
  - Option D: Diversification of revenue streams
  - Option E: Integrated working relationships with the health care community

FACTORS: Congress, payment rates, creativity, outsider influence

RESULTS: All of the above

HOME CARE BAROMETER: Ever changing nature of threats and opportunities requires balanced business action on current and emerging matters
CONCLUSION

• Home Care is very diverse
• Opportunities/Challenges abound
• Range of legal/regulatory issues is endless
  — Affecting private pay and government funded services
  — Significant regulatory energy directed towards home care and hospice
  — Compliance issues/concerns
• Center of innovation in care is home care; change triggers action