

## **Home Care Updates**

February 15, 2010

### **Federal Issues**

The National Association for Home Care held a strategic planning meeting last week. During the meeting NAHC staff provided the NAHC board and participants with an update on what is happening in D.C. related to home care issues. Following is a summary of the issues and the results of the NAHC strategic planning session.

#### Federal Health Care Reform:

With the election of Brown to the U.S. Senate, a republican, the democrats no longer have 60 votes in the Senate. This development has totally changed the landscape for any health care legislation. The President is hosting a bi-partisan meeting on February 25<sup>th</sup> to attempt to develop a consensus among House and Senate leadership. It is unclear if this meeting will have any impact on the ultimate results.

Basic proposals and differences between the bills passed by the House and Senate can be viewed at:

[http://www.congressweb.com/nahc/docfiles/march\\_on\\_wash\\_09/Comparison%20of%20Proposals%20for%20Home%20Health%20Payment%20and%20Regulatory%20Reform.pdf](http://www.congressweb.com/nahc/docfiles/march_on_wash_09/Comparison%20of%20Proposals%20for%20Home%20Health%20Payment%20and%20Regulatory%20Reform.pdf)

In general, NAHC is supporting the senate bill which contains major cuts in payment for the home health industry, but much less than the house version. The House bill would cut \$54.7 billion from home health right away. The senate bill cuts \$39.4 billion. However, those cuts are spread out over several years and include a heavy emphasis on outliers. Both bills, to some degree, expand Medicaid, enact the CLASS Act (see information about the CLASS Act at: <http://www.homecaremissouri.org/members/documents/classact.pdf> ), include chronic care provisions, hospital transition and re-admission

programs, and call for a demonstration of a post-acute bundling initiative with home care agencies responsible for the bundling and payments.

Within the overall issues facing Congress related to health care are the reform bills, the physician fix (adjusting physician reimbursements) and Medicare solvency. All of these issues pose concern for the home care industry and at the same time offer opportunities.

On the positive side there is a lot of interest in state initiatives and pilots especially ideas involving chronic care management, transition of care, re-admission strategies, bundling ideas and re-balancing expenditure of state's long term care dollars (institutional percent vs. home and community percent). Missouri and most states have been working on some of these concepts and programs for several years. The interest from the federal government to consider successful program ideas from states could be a positive for home care and community programs.

On the negative side MedPAC is still making recommendations that are alarming and that would ultimately make serious cuts to reimbursement. MedPAC is recommending reducing home health payments immediately, rebasing payments soon, re-structuring the payment methodology soon. MedPAC indicates that margins are too high, there are too many home health providers, spending on home health is increasing too much and too fast, the agencies tend to follow the money/funding, and that it is not clear what home health really does for the health care system overall.

Contained in the health care reform bills are several issues that impact state Medicaid programs including a focus on home care, money follows the person, removing barriers to home care, free choice options, removing spousal impoverishment provisions for home care consumers and increased federal contribution to the state's Medicaid funding.

NAHC's goals for health care reform are to decrease the impact on home health providers, reduce the level of cuts to the programs, target cuts that are implemented to appropriate places and to smooth implementation of cuts. To achieve these goals NAHC has offered constructive alternatives, and, with the help of providers across the nation NAHC has put a human face on home care and the impact of cuts. They have emphasized the value of home care on the

quality of life and as a way to reduce acute care hospitalization and, in general, NAHC has been in support of reform efforts.

#### NAHC Strategic Planning Session Results:

Approximately 125 home care providers and consultants from across the U.S. met with the NAHC board and staff to develop a strategic plan. Participants were provided with information about the health care industry climate and issues. After hearing from staff and consultants, the group divided into ten topic areas to develop specific action items for NAHC. Below is a brief summary of the ten areas.

### **1. Care transitions**

- a. Define the 6 C's of care
  - i. Collaboration
  - ii. Coordination
  - iii. Cost effectiveness
  - iv. Client centered
  - v. Care
  - vi. Continuous
- b. Lead
  - i. Home care leadership
  - ii. Set the table for discussions
  - iii. Engage others
- c. Develop a template
  - i. Need research by NAHC staff
  - ii. Develop a task force to look at reimbursement, regulatory and legislative issues
- d. Evaluate
  - i. Need evidence based data to prove case
  - ii. Demo project
  - iii. Sponsor a summit

### **2. Complex Chronic Care 2010**

- a. Form a Board committee to
  - i. Develop a template for business and operations chronic care model
    1. Successful model with metrics
    2. "How to" guide for agencies
    3. Model legislation on chronic care that aligns Medicare and Medicaid to enhance cost savings
  - ii. NAHC to hire a full time staff person to work on this

### **3. Managed Care**

- a. Rest in Peace (no one but Bill Dombi attended this group – so this is Bill’s idea)
- 4. **Fraud and Abuse**
  - a. Establish minimum credentialing requirements
    - i. Fingerprint owners and those with financial interest
    - ii. Require CE’s at administrator and owner level
    - iii. Conduct field audit of cost report for first year
  - b. Beneficiary educational outreach
    - i. Engage beneficiaries in efforts
    - ii. Educate them about F/A in home care
    - iii. Send out consumer alerts when there are issues identified
  - c. Extend the whistleblower concept to states
    - i. Share of recovery to reporter
- 5. **Retooling payment**
  - a. Reevaluate homebound status with chronic disease management and post episodic care
  - b. Revise cost report to reflect IRS approved business costs and establish a consequence for not reporting correctly
  - c. Be proactive with P4P and promote value based purchasing
- 6. **Hospice**
  - a. Establish a dedicated team for hospice to include resources, structure, leadership, consistent presence and visibility within NAHC
  - b. More immediate and consistent attention to public policy issues
  - c. Include hospice in development of chronic care model and transition of care model
- 7. **Medicaid**
  - a. Need a study to determine cost benefit of home care vs. institutional – use that information to find more federal funds for state budget shortfalls for HCB services
  - b. NAHC and state assns need to develop a data base by state of
    - i. Services
    - ii. Regulations
    - iii. Reimbursement
  - c. Release NAHC’s white paper on self directed care
- 8. **Technology**
  - a. Promote telemedicine to decrease costs and improve outcomes
  - b. Standardize plan of care and telemedicine requirements for data collection and reporting
  - c. Standardization and simplification of interoperability between vendors
- 9. **High Quality Services and Workforce**
  - a. Attract/retain high caliber staff/team
    - i. PR campaign
    - ii. Scholarships
    - iii. Mentoring program

- iv. Mandate home care and hospice curriculum for clinical programs and physicians
  - b. Regulatory standardization
    - i. Stat regulations
    - ii. Practice Act
    - iii. Intermediaries
  - c. Care conferencing standardization
- 10. Private duty**
  - a. NAHC needs a full time employee dedicated to private duty who will
    - i. Communicate with providers
    - ii. Implement action items
    - iii. Advocate integration of private duty in all aspects of industry and NAHC
    - iv. Facilitate and leverage common goals
    - v. Work with state assns to encourage them to include private duty
  - b. Consumer protection
    - i. Develop national standards
  - c. Define private duty/pay delivery model

These ten topic area recommendations are taken from my notes. I am sure that NAHC will release the official results at some point. As you can see NAHC has a lot on their plate already and many of these recommendations will require additional staff and resources in order for them to be accomplished.

## **State Issues**

### **Home Care and Medicaid Issues in MO General Assembly:**

Budget cuts – Governor Nixon has proposed significant cuts to home care programs, both in-home and CDS. His budget recommendations contain the following major provisions: cap the maximum number of hours an in-home client or CDS consumer can receive per month at 60 hours; stop the provider nurses from initiating the level of care determination and from establishing a plan of care and instead, pay a private vendor to do all of the initial assessments and plan of care development; reduce the APC rate to the same rate as PC; require telephony for all in-home and CDS providers; and establish a “high cost review team” to review certain clients and consumers who have high utilization rates and determine if the level of care they are receiving is justified. The GA must ultimately approve or modify the Governor’s budget. MAHC, MCHS and MOCIL are working together to combat these cuts. A joint position paper with recommendations was developed by the associations and is

available at:

<http://www.homecaremissouri.org/members/documents/associationsjointpositions.pdf>

HB 1918 (Sater) – Rep. Sater, (R) Cassville, introduced HB 1918 that changes the MO statutes to allow for the cuts proposed by the Governor. The bill was scheduled for a hearing last week, but the hearing was cancelled. At this time it has not been rescheduled. HB 1918 is available at:

<http://www.house.mo.gov/billtracking/bills101/biltxt/intro/HB1918I.htm>

### **MISSOURI SUPREME COURT ISSUES THREE EMPLOYMENT DECISIONS**

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On February 9, 2010, the Missouri Supreme Court issued three opinions in the area of employment law that could have a significant impact on decisions affecting employees in Missouri.

First, in Keveney v. Missouri Military Academy, Docket No. SC89925, the Court held that a wrongful discharge cause of action applies equally to employees who are at-will with no definite term of employment and to employees whose employment is governed by a written contract. In this case, Plaintiff Michael Keveney was employed by Defendant Missouri Military Academy (“MMA”) pursuant to an employment contract. Following his termination, Keveney filed suit alleging wrongful discharge and breach of contract, claiming his termination resulted from his insistence that his superiors report evidence of a student’s physical abuse to the Division of Family Services (“DFS”). Following the circuit court’s dismissal of his wrongful discharge claim, Keveney appealed, asserting that wrongful discharge claims should be available to contract employees.

The Court reversed prior Missouri precedent and extended the wrongful discharge cause of action to contract employees because such an action (which serves to refrain employers from discharging employees who refuse to participate in or conceal actions inconsistent with public policy) should be made available to contract employees irrespective of the terms and conditions of the employment contract; an employee discharged in violation of public

policy should be permitted to recover the distinct remedies available; and because it is inconsistent and illogical to grant greater protection against wrongful terminations in violation of public policy to at-will employees than to contract employees.

Second, in Margiotta v. Christian Hospital Northeast Northwest d/b/a Christian Hospital, and BJC Health System, Docket No. SC90249, the Court held that the plaintiff's acts did not constitute reporting violations of law or public policy to his superiors, commonly referred to as "whistleblowing," in that the reported acts did not entail "*serious* misconduct that constitutes a violation of the law and of ... *well established* and *clearly mandated* public policy." Daniel J. Margiotta, an at-will medical image technician, brought a wrongful termination action against his former employer, Defendant Christian Hospital Northeast Northwest ("the Hospital"), alleging the Hospital terminated him for reporting violations of federal and state regulations. Following the trial court's grant of summary judgment in favor of the Hospital, Margiotta appealed.

On review, the Missouri Supreme Court noted that Margiotta had reported and/or complained three times about the treatment and/or care of certain patients. Margiotta claimed the Hospital retaliated against him for reporting these incidents and alleged wrongful termination of an at-will employee for refusing to perform an illegal act or reporting wrongdoing or violations of law to superiors or third parties. Margiotta based his wrongful discharge claim on a federal regulation concerning a patient's right to receive care in a safe setting, and a state regulation requiring hospitals to develop a mechanism for identifying and correcting safety hazards to the patients, staff or public.

Reviewing the federal regulation, the Court found that it operates solely for the protection of the patient and does not grant protection to, or authorize any affirmative conduct by, an employee. Moreover, the federal regulation does not prohibit the acts which Margiotta reported. Thus, the federal regulation relied upon by Margiotta to support his claim was held to be too vague. As for the state regulation, the Court found it to be inapplicable because it "clearly deals with building safety, not patient treatment."

In reaching its decision that Margiotta's acts did not constitute protected whistleblowing, the Court noted "there is no whistleblowing protection for an employee who merely disagrees personally with an employer's legally-allowed policy." This holding narrowly construes the wrongful discharge public policy exception and instructs Missouri courts to find in favor of the employer in whistleblower cases absent a sufficiently defined statute, regulation,

constitutional provision or rule which clearly notifies the parties of its requirements.

Third, in Fleshner v. Pepose Vision Institute, P.C., Docket No. SC90032, the Court held that the proper standard to be applied in cases alleging wrongful discharge in violation of the public-policy exception to the at-will doctrine is “contributing factor.” This is the same standard the Court has held should be applied in cases arising under the Missouri Human Rights Act. Thus, the Court has extended the scope of cases which will subject an employer to liability where there is some unlawful factor which *contributed* to the employer’s decision to discharge.