2017 CONGRESSIONAL ACTION

- Obamacare; repeal or amend (limited home care impact)
  - Unsettled plan of action
    - Early repeal vote
    - Reconciliation instructions
  - Employer mandate: block penalties?
  - Retain prohibition on applying pre-existing illness limitations/26 year old children inclusion?
  - Medicaid expansion?
  - Phased-in change?
  - What replacement?
    - When?
    - Tax credits
    - HSAs
    - Multistate insurance

2017: Impact on Home Care

- New Opportunities
  - Regulatory reversals
    - FLSA rules: companionship services; live-in; OT
    - Medicare policies: 721; preclaim review
    - Medicaid: managed care (MMTS) restrictions
  - Obamacare; repeal or amend (limited home care impact)
    - Employer mandate: block penalties?
    - Retain prohibition on applying pre-existing illness limitations/26 year old children inclusion?
    - Medicaid expansion?
    - Phased-in change?
    - What replacement?
      - Tax credits
      - HSAs
      - Multistate insurance
  - Reforms
    - NPP Medicare authorization
2017: Impact on Home Care

• New Risks
  – Medicaid block grants
  – Expanded Medicaid waivers
  – Medicare reform
    • Premium support (defined contribution)
    • Eligibility age increase
    • 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

• Medicaid
  – What happens to Community First Choice program and other HCBS expansions in the ACA?

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
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

2016 Leftover Home Care Legislation

- Home Health Care Planning Improvement Act of 2015 (allows NPs/PAs to sign home health plans of care.) H.R. 1342, S. 578
- Preserve Access to Medicare Rural Home Health Services Act of 2015 (extends the payment increase (add-on) for Medicare home health services in rural areas through 2020.) S.2389
- Medicare Home Health Flexibility Act of 2015 (allows home health agencies the flexibility to open cases and conduct initial assessments when skilled nursing care is not provided.) S. 2364
- Home Health Documentation and Program Improvement Act of 2015 (requires CMS to develop a standardized form for beneficiary eligibility; allows a home health agency to complete the form to be reviewed and signed by the referring physician.) S.1650

2016 Leftover Home Care Legislation

- To amend title XIX of the Social Security Act to require the use of electronic visit verification for personal care services furnished under the Medicaid program, and for other purposes. (requires states to have in place a system for the electronic verification of visits conducted as part of personal care services.) H.R. 2446
- Ensuring Access to Affordable and Quality Home Care for Seniors and People with Disabilities Act (would preserve the companionship services exemption) H.R. 3860 S. 2221
2016 Leftover Hospice Legislation

- Palliative Care and Hospice Education and Training Act (would amend the Public Health Service Act to increase the number of permanent faculty in palliative care education programs.) H.R.3119
- Care Planning Act (would provide assistance to individuals with serious health conditions by giving them access to more information about potential treatment options and ensuring that the course of treatment they arrive at is consistent with their personal goals, values and preferences.) S. 1549
- Medicare Patient Access to Hospice Act of 2015 (would grant Medicare beneficiaries, upon election of hospice care, the right to select their PAs to serve as their attending physicians for purposes of hospice care.) S.1354 H.R.1202


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

HOME HEALTH:
- 2016 average margin: 8.8% (12.7% in 2012)
- Access to care, capital OK
- Margins affected by recent changes but still healthy

RECOMMENDATIONS:
- NO update in 2017
- Elimination of therapy utilization as a payment level determinant under HHPPS
- The institution of a second round of rate rebasing in 2018

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


- Service Volume (2015)
  - 6.6 M episodes
  - 3.5M users
  - 1.9 episodes per beneficiary
  - 9.1% of Medicare FFS spending
  - $18.1B spending (up from $17.7 in 2014)
  - Some utilization decline in 5 states (TX, LA, IL, TN, and FL)


- Quality
  - Improvement
  - Transfers (58.9 to 63.3%)
  - Walking (63.6 to 66.9%)
  - Hospitalization (27.8 to 25.4%)

- Medicare Margins (2015)
  - 15.6% (10.8% in 2014)
  - 13.2% rural
  - 12.1% Nonprofits
  - 18.1% Marginal profit (efficient, high quality)
  - 11.1% estimated in 2017

NAHC COST REPORT DATA (2015):
National Freestanding HHAs

- Medicare Margin: 17.82% (13.36% 2014)
- Overall Margin: 4.78% (4.98% 2014)
- Visits Per Episode: 18.0 (18.9 2014) [w/0 LUPA]
- Cost per Episode: $2490.05 ($2550.67 2014)
- Rev per Episode: $3051.54 ($2974.15 2014)

NAHC COST REPORT DATA (2015):
Nebraska Freestanding HHAs

- Freestanding All
  - Medicare Margin: 25.76% 16.53%
  - Overall Margin: 2.23% 2.23%
  - Visits Per Episode: 19.1 18.7
  - Cost per Episode: $2493.74 $2625.05
  - Rev per Episode: $3380.82 $2931.71
NAHC COST REPORT DATA (2015)
Hospital-Based HHAs Margins

- National -13.51%
- Nebraska -28.67%

NAHC COST REPORT DATA (2015):
Freestanding HHAs

- Margin Range National Nebraska
  - >50% 3.3% 3.0%
  - 25-50% 27.0% 48.5%
  - 20-25% 10.8% 9.1%
  - <0% 23.0% 18.2%

- Losses on Outlier, LUPA, and PEP episodes

RISK: President’s FY2017 Budget—
what carries-over to new administration?

- Hospice:
  - 1.7 ppt update reduction in each of 2018, 2019, and 2020
  - Other “budget neutral” policy changes
- CMPs for failure to update enrollment records
- Medicaid Expansion states – 3 yrs. At 100% match for new eligibles
- Prior authorization for Medicare FFS items and services
- 1.1 ppt cut in updates for HH, other PAC providers in 2017 and 2019 through 2026
- HH copayments for new patients — $100 per episode beginning in 2020
- PAC bundled payments and VB purchasing
- “User Fees” for resurveys; exploring “risk-based” approach to surveying
Risk/Opportunity: Medicaid HH Face-to-Face


F2F for initial ordering of HH services:
- Ordering physician must document the occurrence of a F2F encounter
- Clinical findings must show that encounter related to home health services order
- F2F may be performed by physician or authorized NPP
- Physician still must order HH services
- F2F occurs no earlier than 90 days prior/no later than 30 days after SOC
- May use telehealth (not phone)
- As much as 2 year delay if state legislative action needed

Opportunity: 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

Opportunity: Medicaid Rules with Indirect Impact

- Methods for Assuring Access to Covered Medicaid Services
  - https://www.federalregister.gov/articles/2015/11/02

- Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability
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

• Final year of rate rebasing
• Base episode rate: $2989.97 ($2965.12 in 2016)
  – Misleading w/o case mix weight (CMW) recalibration considered
  • 1.0214 budget neutrality adjustment
  • Means that the increased base rate still results in reduced payments in the aggregate after the CMW is applied
2017 HHPPS Rates

- LUPA Rates (3.5% increase)
- 3% Rural add-on through 2017
- Non-Routine Medical Supplies
  - -0.32% reduction after rebasing
  - NRS conversion factor drops $52.50 from $52.92
- 2% penalty for non-submission of quality data continues
- Expect 2% sequestration
- Pay attention to wage index changes

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)
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 will hold an Open Forum on 1/18/17 at 1:30 EST
  - [https://blh.iier.intercall.com/details/87624e130547408593456011b11de08](https://blh.iier.intercall.com/details/87624e130547408593456011b11de08)

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 (Nebraska included)
  - 3-8% payment withhold for incentive payments
    - "greater upside benefits 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
Value-Based Purchasing Pilot: 2017 Changes

- Now calculating benchmarks and achievement thresholds at state level
  - Too few “small” HHAs
- Apply VBP based on large vs. small HHAs, but only if at least 8 in the cohort
- Drops 4 measures that were not needed or not ready
- Establishes appeals process
- Submission process/timetable changes

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)
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 statewide prepayment “probe and educate” on 10/1/15 (5 claims from each HHA) ended September 1
- High rejection rate
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

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 reserve 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
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.

Opportunity: CMS Home Health Star Rating System

Combinies outcome measures and process measures from Home Health Care Compare into a single score
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHospitalHealthStarRatings.html

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

- 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
  - 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

Home Health Conditions of Participation: HH CoPs

- Federal Register 1/13/2017 (proposed 10/7/14)
  - Proposed
  - 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 -Principles

• Develop a more continuous, integrated care process across all aspects of home health services, based on a patient-centered assessment, care planning, service delivery, and quality assessment and performance improvement.
  • Use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions with each other to meet the patient’s needs. Stress quality improvements by incorporating an outcome-oriented, data-driven quality assessment and performance improvement program specific to each HHA.
  • Eliminate the focus on administrative process requirements that lack adequate consensus or evidence that they are predictive of either achieving clinically relevant outcomes for patients or preventing harmful outcomes for patients.
  • Safeguard patient rights.

HH CoPs

• Many of the requirements remain
• 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
HH CoPs

• Eliminated
  – 60 day summary to physician
  – Group of professionals (PAC)
  – Quarterly record review

HH CoPs - Patient Rights

484.50 Condition of Participation: Patient Rights

The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights.

Standards

(a) Notice of right
(b) Exercise rights
(c) Rights of the patient
(d) Transfer and discharge
(e) Investigation of complaints
(f) Accessibility

HH CoPs – Patient Rights

a) Notice of rights
   1) Written and verbal notice in a language understandable to the patient and accessible to patients with disabilities
      – Verbal notice no later than completion of second skilled visit
   2) Provide contact information for the HHA Administrator
   3) OASIS privacy notices
   4) Patient/representative signature
      – w/in 4 business days of initial evaluation visit

b) Exercise of rights
   Related to honoring court decisions on competency and recognizing role of appointed representative
HH CoPs - Patient Rights

c) Standard: Rights of the patient to:

1) Have property and person treated with respect
2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property
3) Make complaints regarding treatment or care, etc.
4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to,
   (i) Completion of the comprehensive assessment
   (ii) Care furnished based on the comprehensive assessment
   (iii) Establishing and revising the plan of care
   (iv) The disciplines that will furnish the care
   (v) The frequency of visits
   (vi) Expected outcomes of care, including patient identified goals, and anticipated risk and benefits
   (vii) Any factors that could impact treatment effectiveness
5) Receive all services outlined in the POC
6) Have a confidential clinical record and access to it under HIPAA
7) Be advised of:
   – the extent which payment for HH service are expected from Medicaid, Medicare, and other federal programs
   – the charges for services that may not be covered by Medicare, Medicaid...
   – the charges the individual may have to pay before care is initiated; and any changes in the information
   – any changes in advance of the next home health visit
8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204 (HHCAHPS and NCCN)

HH CoPs - Patient Rights (con’t)

5) Receive all services outlined in the POC
6) Have a confidential clinical record and access to it under HIPAA
7) Be advised of:
   – the extent which payment for HH service are expected from Medicaid, Medicare, and other federal programs
   – the charges for services that may not be covered by Medicare, Medicaid...
   – the charges the individual may have to pay before care is initiated; and any changes in the information
   – any changes in advance of the next home health visit
8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204 (HHCAHPS and NCCN)

HH CoPs – Patient Rights (con’t)

9) Hot line
10) Be advised of the names, addresses, and telephone numbers of:
   • Agency on Aging
   • Center for Independent Living
   • Protection and Advocacy Agency
   • Aging and Disability Resource Center
   • QIO
11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity
12) Be informed of the right to access auxiliary aids and language services and how to access these services.
HH CoPs – Patient Rights

d) Standard – Transfer and discharge
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

(e) Standard: Investigation of complaints
1. Investigate complaints of the following:
   • treatment or care
   • mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.

2. Document both the existence of the complaint and its resolution
3. Take action to prevent further potential violations, including retaliation while the complaint is being investigated
4. Staff must immediately to report to HHA and other appropriate authorities when they identify, notice, or recognize incidences or circumstances of mistreatment, neglect, or verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.
HH CoPs - Patient Rights

f) Standard: Accessibility
Information must be provided to patients in plain language and in a manner that is accessible and timely to—

1) patients with disabilities
   - web site
   - auxiliary aids at no cost in compliance with ADA
2) Limited English Proficiency
   - language services at no cost including oral and written translations

Care Planning

• 484.60(e) Written information to the patient
  – The HHA must provide the patient and caregiver with a copy of written instructions outlining:
    • Visit schedule, including frequency
    • Medication schedule/instructions (name, dosage, frequency, and which medications will be administered by HHA
    • Any treatments to be administered by HHA
    • Any other pertinent instructions related to care and treatment that the HHA will provide
    • Name and contact information of the HHA clinical manager

HH CoPs – QAPI

• “The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA’s governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA’s performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.”
HH CoPs – QAPI (484.65)

• Scope
  • Capable of showing measurable improvement in indicators (measure and track indicators)
• Data (derived from OASIS and more)
  • Measure effectiveness, safety, and quality
  • Identify opportunities for improvement
  • Data collection must be approved by governing body
• Activities
  • Focus on high risk, high volume or problem-prone areas
  • Lead to immediate corrections
  • Track adverse events, analyze causes, and implement preventive actions
  • Measure and track performance to sustain improvements
• Performance improvement projects (beginning January 13, 2018)
  • Monitor and scope
  • Document success for projects and progress achieved
• Executive responsibilities (governing body)
  • Program defined, implemented, and maintained
  • Address priorities and conduct evaluation of program effectiveness
  • Establish clear expectations
  • Address any findings of fraud or waste

HH CoPs—Infection Control (484.70)

• Prevention: The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.
• Control: The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA’s quality assessment and performance improvement (QAPI) program. The infection control program must include:
  • (1) A method for identifying infectious and communicable disease problems; and
  • (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.
• Education: The HHA must provide infection control education to staff, patients, and caregiver(s).

Limited Opportunity: Payment Reforms: PAC Bundling

• CMMI pilots/demos continuing
  • 2100 participating providers in 360 demo agreements
  • Limited home health participation; virtually no risk taking
  • Evidence of impact still unavailable
  • ACO experience shows some home health gains in use
• Administration support for expanded PAC bundling
• Congressional caution
Opportunity: 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
- [https://www.federalregister.gov/articles/2015/07/14/2015‐17190/medicare‐program‐comprehensive‐care‐for‐joint‐replacement‐payment‐model‐for‐acute‐care‐hospitals](https://www.federalregister.gov/articles/2015/07/14/2015‐17190/medicare‐program‐comprehensive‐care‐for‐joint‐replacement‐payment‐model‐for‐acute‐care‐hospitals)

Neutral: Hospice Regulatory Developments

- New Payment Model (Beginning Jan. 1, 2016)
- Two-tiered payment system for RHC
  - Days 1 – 6 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

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

Risk (to Medicare HHAs and hospices, private pay and Medicaid personal care): FLSA-DoL

- Stakeholder impact growing
- 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

Minimum Wage and Overtime:

**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
  - Primary impact is on Medicaid and private pay services
Litigation Update

- Appeal to U.S. Supreme Court
  - Stay denied
  - Petition for Certiorari in process
    - 2/24 DoL response filed
    - 3/9 Reply filed
    - SCOTUS denied the petition on June 27, 2016
  - Shift to legislative remedies and monitoring Medicaid actions

Fallout Forecast

- Post-lawsuit forecast
  - Private parties sue state Medicaid programs, MCOs, and home care companies to enforce rules
  - Industry retracts to limit worker hours and establish new delivery models
  - Turnover increases
  - Client satisfaction diminishes
  - Home care company costs increase
  - Client costs increase with some reducing care levels
  - CMS pushes states to fund overtime
- Ensuring Access to Affordable and Quality Home Care for Seniors and People with Disabilities Act (would reinstate the companionship services and live-in exemptions) H.R. 3860 S. 2221

Limited Risk: New Overtime Rule for Salaried Employees

- Overtime exemption applies to “executive, administrative, and professional” salaried employees
- Minimum qualifying salary increases to $913 weekly ($47,476 annually) December 1
- May affect some home care administrative staff and “per visit” compensated professional staff
- https://federalregister.gov/a/2016-11754
- Federal court injunction; fate with new Administration in doubt
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](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 speculation to a new level
- Moderately stable times
- Opportunities for innovation
- Challenges remain in regulatory proposals/changes
- Quality remains high, but standards and oversight on the increase
- Manage today, plan for the future!