HEALTH CARE REFORM

- Insurance reforms through the ACA
- Delivery reforms
- New delivery models under study
  - Chronic care management
  - Transitions in care
  - Accountable Care Organizations
  - Post-acute care bundling
- Cost and financing reforms in public programs
SEQUESTRATION

- April 1, 2013
- 2% payment reduction for Medicare
- Home Health: end of episode
- Hospice: date of service standard
- No Medicaid sequestration
- Medicare Advantage Plan -2%
  - Reduction directed to MA plans
  - Provider impact dependent upon contract

President’s Budget Proposal

- Medicare: -$371 Billion through 2023
  - Replace sequestration
  - -$134.4B drug payments
  - -$79B inflation update reduction on PAC services
    - -1.1% for 10 years
  - -$8.2B bundled PAC services
    - At least half of PAC services
    - -2.85% spending by 2020
  - $730M home health copay
    - 2017; new beneficiaries, community admissions only, $100 per episode
President’s Budget Proposal

- Medicaid - $22.1 Billion
  - No home care cuts
  - Drugs and DME changes
- Program Integrity - $311 Million

Congressional Budget Proposals

- House
  - Medicare
    - Keep sequestration
    - Raise eligibility age beginning 2024
    - No copay or cost sharing changes
  - Medicaid
    - Block grant
Congressional Budget Proposals

- Senate
  - Medicare
    - $285 Billion in savings (no detail)
    - Deficit-neutral reserve fund to replace sequestration
    - No copay or cost-sharing changes

2013 Home Care Legislative Priorities

- Delay ACA provision on individual mandate and employer responsibilities/penalties
  - Seek exemption or protection from employer penalties for home care and hospice employers
- Stop Copays
- Nurse practitioner certification authorization
- Telehealth pilot program
- Case mix creep process improvement
- Program integrity changes
  - Toughened participation standards
- Payment safeguards
- Limit F2F documentation to PoC:
  - Date of encounter
  - Attestation of related home health services
ACA Employer Mandate: Home Care Impact

- Delayed until 2014
- Many, but not all HHAs have 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: Options

- Stay below 50 FTEs
  - Corporate reorganization to break up large companies into multiple small ones
- Limit the number of employees at 30 hours or more per week
- Seek higher Medicaid rates
- Raises charges to clients
Medicaid Home Care

- Nationwide shift to managed Medicaid Long Term Services and Supports (MLTSS)
- CMS supports move with some caution
- Dual-eligible demo programs are the big wave: CA, MA, OH, IL approved; nearly 20 pending
- Managed care programs “flying blind”?
- Great opportunities for some, impossible challenges for others
- Need comprehensive standards for both providers and beneficiaries

Medicaid Demos on Dual Eligibles

- Focus in on LTC
- Various approaches
  - May target a population, e.g. elderly vs. disabled
- Managed care is the primary approach
  - New plans emerging
  - Limited plan experience with LTC
- Passive enrollment in plan
  - Opportunity to opt out with Medicare
- Gradual shift to network providers
  - 6-12 months
  - Medicaid rates at the start
Private Pay Home Care: Companionship Services FLSA Exemption

- DoL proposes to effectively eliminate minimum wage and overtime exemption
  - 76 Fed Reg 811190 (12-27-11)
  - Eliminates exemption for 3rd party employment
  - Changes definition of companionship services
  - Final Rule at OMB
- Increased litigation on W&H issues
  - Validity of claimed FLSA exemption status
  - “hours worked”
  - Break time rights

2014 Medicare Home Health Rate Proposed Rule

- Comments due 8/26/13
- Major Provisions
  - Market basket update minus 1%
  - 4 year phase-in rebasing adjustments including episode, per visit and non-routine supply conversion factor
  - ICD-9-CMS case mix code elimination from grouper
  - Reduction case-mix weights by 3.5%
  - Guidance on conversion to ICD-10
  - Quality measure plans
- No changes at this time to
  - Case mix system (i.e. therapy thresholds, etc.)
  - Outlier calculation
ICD-9-CM Grouper Refinements

- Elimination of 170 codes reflecting
  - Conditions prior to admission that were
    - Too acute for home health
    - Resolved prior to home health
  - Conditions that would not require home health interventions
  - Examples: diabetic coma, obstructions, perforations, abscesses, hemorrhage

Payment Adjustments

- Rebase national standard 60-day episode
- Proposal: reset average case weight to “1” for each group
  - Based on 1/12 through 5/12 data: average weight 1.3517 will be reduced to 1
  - Final rule may differ based on further 2012 data
- Examples new weights
  - 1st & 2nd Episodes 1-5 therapy: weight .8186 reduced to .6056
  - All episodes 20+ therapy 3.0014 reduced to 2.2205
Rebasing

- Based on cost reports and claims files
  - Many problems with cost report accuracy
- Adjust national standard episode payment based on factors such as:
  - Change in number of visits/episode
  - Mix of services in each episode
  - Level of intensity of services
  - Average cost of care per episode

Rebasing and Case-Mix

- Findings:
  - Estimated 2013 cost per episode $2559.59
  - Estimated 2013 payment per episode $2963.65
  - 13.63% difference
- 3.5% maximum annual reduction allowed by Congress each year
  - Reduction 3.5% would be repeated in 2015, 2016, and 2017
  - Final reduction will be based on further study
2014 Episode Payment

- Rebasing reduction 0.9650
- Outlier adjustment .0975
- Standardization factor 1.0017
- Market basket update 1.024 (2.4% minus 1%)
- Estimated 2014 payment $2,860.20
  - Note gains offset by case-mix weight reduction

Other Payment Provisions

- Increase LUPA per visit payments by 3.5%
- Decrease non-routine supplies by 2.58%
- 3% rural add-on
Home Health Quality Reporting

- 2% reduction based on OASIS and CAHPS
- Reduce process measures from 97 to 79
  - By reducing process measures from 45 to 27
  - Reporting “all-episode measures only”
- New “harmonized” claims based measures for 2014 after approval by NQF
  - Re-hospitalization in first 30 days
  - Emergency Department use without re-hospitalization within first 30 days

Program Integrity Proposals

- Implement a targeted, temporary moratorium on new home health agencies
- Require credentialing of home health agency executives
- Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care
- Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan
- Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors
Program Integrity Proposals

- Establish targeted systemic payment safeguards focused on abusive utilization of home health services
- Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
- Require criminal background checks on home health agency owners, significant financial investors, and management
- Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight
- Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards

Face-to-Face Encounter

- Medicare Law
  - Medicare will always expect you to know if the instructions you received were correct or incorrect. You’ll learn whether you guessed right when the audits begin
Face-to-Face: Policy and Enforcement

- 2013 Revisions
  - Allow facility-based NPP to perform encounter
  - Require communication with the physician with whom collaborating (i.e. inpatient or community)
  - Documentation title and date
  - Allow any party to title and date F2F documentation

Requirements for Home Health Services

- Certification
  - Physician attestation of eligibility for home health services
  - Includes F2F attestation
- Plan of Care
  - Physician detailed plan of care developed in consultation with home health agency personnel
Who Are F2F Inpatient Physicians

- Physicians caring for patient during:
  - Acute care stay
  - Post acute inpatient stay
  - ED visit
  - Observation stay at an acute care facility
  - Includes
    - Residents (however documentation and communication via supervising physician)

Encounters: Documentation

- Who must document the encounter?
  - The physician who certifies that the patient qualifies for home health (i.e. is homebound and requires intermittent nursing or therapy)
  - Regardless of whether encounter by that physician, an inpatient physician, or an NPP
Other Considerations

- Checkboxes created by the physician acceptable
- Standardized language prohibited (e.g. taxing effort)
- New starts of care resulting from inpatient on day 60, 61 no new F2F
- Home health agencies may not create, transcribe, alter
- F2F samples may not be patient specific
- Start of Care may be revised if late encounters
  - Realignment of SOC: may update original OASIS
  - Realignment of SOC due to late F2F requires realignment of therapy 13 and 19

Medicare Compliance

- Medical review
  - Aberrant patterns outside the norm
  - Statistical deviation
  - Percent increase billing, payment, number visits/services
  - High utilization services/items
  - High cost services/items
  - Unlawfully present denials
RAC Approved HH Issues

- Region A: Performant Recovery (New England, NJ, DE, MD)
  - Multiple episodes SN observation
  - Dependent services only
- Region C: Connolly, Inc. States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and U.S. Virgin Islands
  - Home Health Agency - Medical Necessity and Conditions to Qualify for Services
  - RAP claim without corresponding home health claim
  - Incorrect billing of Home Health Partial Episode Payment claims
  - Validation of late episode timing
  - Core-based statistical area

Other Medical Review Initiatives

- ZPIC
  - Automated denials for homebound
  - Problem: 1+ year delay in issuance of decisions
- Supplemental Medical Review Contractor
  - Lower improper payments
  - HHAs targeted
- Comparative Billing Reports
  - 5000 agencies with top per beneficiary charges
  - Visit count per beneficiary
  - PT, OT, SLP visits per beneficiary that received
Jimmo Lawsuit (Improvement Standard)
- Settlement: focused on illegal “improvement” standard
  - Permit coverage of skilled maintenance therapy
  - Permit coverage of chronic care/terminal patients
  - Clarify existing guidelines
  - Provider and contractor education will follow
  - Ongoing oversight of claim determinations
- Qualifying and coverage rule unchanged
  - Skilled, medically necessary care
- Existing guidelines recognize such coverage, but MACs changed the “rules”
- Documentation is key
  - Need for care
  - Provision of skilled services

- Any health care provider that transmits an electronic “transaction”
- Provisions of 2013 HIPAA final rule
  - Expands the definition of business associate, subcontractors
  - Clarifies direct liability of business associates
  - Breach evaluated based on: nature, extent, history of compliance, financial state, probability of use of PHI, level of mitigation
  - Breach penalties up to $3M
  - Requires individual authorization for marketing
  - Expands notice of privacy requirements
  - Addresses individuals rights to limit use of PHI, access to PHI
  - Effective 9/23/13, 1 year transition period for static contracts
Therapy Assessments

Do I understand the new therapy assessment requirements?
While I can explain the meaning of life, I don’t dare try to explain how the Medicare system works.

Therapy Reassessment

- Late assessments: The visit on which the reassessment is conducted will be covered
- The visit prior to the late reassessment will not be covered e.g.
  - Reassessment conducted on visit 14
  - Visit 14 will be covered but not visit 13
- In single therapy cases reassessment must be conducted on the 13th /19th therapy visit
Therapy Reassessment

- In multi-discipline cases:
  - Each discipline must conduct a reassessment on therapy visit 11, 12, or 13
  - Each discipline must conduct the reassessment on therapy visit 17, 18, or 19 for each discipline
  - Non-coverage will apply only to the discipline that fails to conduct the reassessment on time
  - Reassessments may be conducted on the visit closest to but no later than the 13/19th therapy visit, if there is no scheduled visit for that discipline within the required time frame.

Additional Claims Data

- Effective July 1, 2013
- Place of service code
  - Q5001: Hospice or home health care provided in patient’s home/residence
  - Q5002: Hospice or home health care provided in assisted living facility
    - Licensed facilities?
  - Q5009: Hospice or home health care provided in place not otherwise specified
PECOS

- ACA and regulation: all home health ordering physicians must be enrolled in Medicare
  - Enrollment record in PECOS (Enrolled, Opt-Out, Referring only)
- Physician name and NPI as they appear in PECOS on the claim
- Awaiting beneficiary liability and HHABN guidance
- Edits were to be activated May 1, 2013
- Claims with a “From” date on or after May 1 will be subject to the edit.
  - Episode starts prior to 5/1 - paid in full
  - Physician enrollment ends after SOC date - paid in full
  - Must verify enrollment “from” date every episode

PECOS

- Who: Physician who signs plan of care
- Exact first and last name
  - No commas, no hyphens (Checking apostrophe with CMS)
- Claims will be denied, RAPS paid at $0
- HHA Response
  - Cancel & re-submit RAPs with corrected information or
  - Submit new SOC with enrolled physician
  - Appeal denied claims (Possibly reopening)
Alternative Sanctions

- Applies to condition level deficiencies
  - In lieu of termination
- Sanctions include:
  - Temporary management of the HHA
  - Suspension of payment for new admissions
  - Civil money penalties
    - $500-$10,000 Per diem/per instance
  - Directed plan of correction
  - Directed in-service training
- Informal dispute resolution possible
- Appeal rights w/o penalty suspension

Alternative Sanctions

- Condition Level with Immediate Jeopardy
  - 2 day notice
  - 23 day termination timeline
- Condition Level Deficiencies w/o IJ
  - 15 day notice of sanctions
  - Termination & sanctions can be combined
  - Sanctions continue until compliance or termination
  - 6 month termination cycle
  - Patient transfers w/in 30 days of termination
Alternative Sanctions

- July 1, 2013
  - Directed plan of correction
    - CMS directs the HHA on specific actions and outcomes to achieve within specific time frames
  - Directed in-service training
    - HHA training by a CMS or stated approved entity
    - Agency responsible for all associated costs
  - Temporary management
    - CMS approved entity
    - Agency responsible for all associated costs

- July 1, 2014
  - Civil money penalties
  - Suspension of payment for new admissions
  - Informal dispute resolution

Home Health Quality

- Draft *Outcome and Assessment Information Set (OASIS) C-1*
  - Draft OASIS-C1 due August 20, 2013
  - Posted on the PRA website

- Other OASIS/Outcome changes
  - Technical specifications for Process Quality and Outcome Measures have been revised
  - OASIS Guidance Manual errata
  - Posted on CMS Quality initiative website
HHABN

- ABN CMS-131 for financial liability protection
  - Replaces Option Box 1
- Home Health Change of Care Notice (HHCCN)
  - New form replaces Option BOX 2 & Option Box 3
  - Prior to reducing or discontinuing care related to HHA reasons
  - Prior to reducing or discontinuing care related to physician orders
- Approved by OMB
  - Instructions will be released soon
  - 60 days after release to implement
  - See cms.hhs.gov/bni for information

Other Issues

- Erroneous outlier payment recoupment
- RAP Payment Suppression
- ICD-10: required for services on or after October 1, 2014
  - March 1, 2013 – December 31, 2013: Conduct high-level training on
  - April – June 2013: Start testing ICD-10 codes and systems with your staff
  - October 2013 – January 2014: Begin testing claims with business partners, payers
  - January 1, 2014 – April 1, 2014: Begin detailed ICD-10 coding training (6-9 months)
  - Work with vendors to complete transition to production-ready ICD-10 systems
  - October 1, 2014 -Complete ICD-10 transition