Federal Update
For HHAs and Hospice

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Home Health in 2017:
Choose Your Favorite Four Letter Word!

- PCRD
- LUPA
- HHGM
- COPs
- F2F (ok, that's three)
- RAPS
- BPCI
- CCJR

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And the Winner Is…

HHGM

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The Stakes…

- Proposes to reduce HHA payments in 2019 by as much as **$950 million**
- Essentially redesigns the payment system in a non-budget neutral manner without key inputs from the community or complete data from CMS
- Enormous disruptions in the field
- HHGM relies on an untested model that includes patient characteristics that have not been determined to be valid or reliable indicators of care needs
- Replaces historic 60 day episode with 30 day “periods”

HHGM Would…

- Create access to care barriers for vulnerable home patients
- Cut payments to HHAs without Congressional authorization
- Compound 5 years of rate cuts totaling nearly 18% in a benefit that has essentially been spending flat since 2000
- And impose non-budget neutral reforms in HHAs at level that previously caused significant problems and harm to patients, e.g., the Interim Payment System (1998-2000), displacing nearly 1.5 million beneficiaries and closing more than 4,000 HHA virtually overnight
- Redistribute payments away from medically necessary services such as PT, OT, SLP that currently produce savings in value based care models like bundles and APMs

The Solution

- HHGM must be withdrawn from the CY 2018 Final Rule
- HHGM must be revised to be implemented in a true budget neutral fashion
- CMS should initiate a partnership with stakeholders to design and develop a payment model that supports patient-centered, high quality system
- HHGM must be phased in over a multiple year transition period beginning no sooner than 2020

Full Transparency Is Needed

Information Need to Fully Assess Impacts	Included in the Proposed Rule or Other Materials?
CY 16 Claims and OASIS Assessment Data	No
CY 17, 18 and 19 (under HHGM) baseline	No
Explanation for how CMS treated 60 day episodes with no visits day 31+	No
Description of behavior assumptions, other factors included in impact estimates	No
Case Mix Weights	Yes
LUPA thresholds	Yes
Outlier threshold	Yes
ICD-10 codes associated with clinical groupings, comorbidities	Yes
Functional status thresholds	Yes

Face to Face Encounter Update

- HR. 2663 (Marchant, Blumenauer)
  - 23 co-sponsors (none from New York) 16 GOP/7Dem
- “Home Health Documentation and Program Improvement Act of 2017”
- Two sections
  - Information to Satisfy Documentation of Medical Eligibility for HHA Services
    - Secretary shall use documentation in the medical record of the HHA as supportive material
  - Voluntary Settlement of Home Health Claims
    - No later than year after enactment Secretary shall establish a settlement process under which an HHA entitled to an eligible administrative appeal has the option to enter into a settlement with the Secretary (roughly .63 per dollar)

Rural Add-On or "Safeguard"

- Measure enjoys broad bipartisan support in the House but no formal bill introduced – last reauthorization was in MACRA (two years)
- S. 353, Preserve Access to Medicare Rural Home Health Services Act of 2017 (Sens. Collins and Cantwell)
- Look for inclusion in broader Medicare extender package, perhaps included in CHIP reauthorization or end of year package
- Ways and Means has signaled support, questions remain on duration and cost
- 5 year duration costs upwards of 500-800M, paid for by further reduction to the outlier pool (possibly)
- National organizations oppose a temporary policy with a permanent offset
- Predict issues will get resolved and 3-5 year policy will be reauthorized

CoPs

- While appreciative of the delay until January 13, 2018, the CoPs have not been revised in over 30 years and the revisions are estimated to cost over $290 million in the first year and other $290 million thereafter
- Lack of Interpretive Guidance remains a major problem. Promised by December 2017, gives HHAs only a few weeks to modify existing compliance changes in response to the guidance materials
- National organizations are asking for 6 months of additional implementation time after publication of the Interpretive Guidelines
  - Affect on subunit transition to new status
- Not clear surveyors have been trained on the new CoPs; CMS says it will conduct state surveyor training on as “as need basis"

Hospice Face-to-Face Encounter Requirement

- Current policy requires a hospice-employed MD or NP to administer a face-to-face assessment prior to the start of the applicable benefit period
- In practice, MDs and NPs have to prioritize more urgent demands of other hospice patients, resulting in a delayed assessment
- Solution: Congress should permit 5 days from the start of the applicable benefit period for the hospice to perform the face-to-face, and allow hospice-employed PAs to complete the service

Costly & Inefficient Data Reporting Requirement

- Current policy requires hospices to report charges of all staff visits and prescription medications on a line-item basis, generating significant administrative burden for providers
- Solution:
  - Regrading staff visits, CMS should eliminate current data collection procedure, and use cost-report data to estimate care cost
  - Regarding prescriptions, CMS should require claims to include a single charge for medications administered in contracted facilities, and not require documentation of NDC and fill information

Update Hospice “Core Services” Requirement

- Current policy requires all “core services” to be performed only by hospice personnel, except under extreme circumstances
- CMS’ definition of “core services” needs to be modernized to reflect current healthcare practices
- Solution: CMS should work with industry stakeholders to identify ways to ease administrative burdens without lowering quality of care

Revise Hospice Sequential Billing Requirement

- Current policy prevents hospices from submitting claims when previously-submitted claims are pending
- Increase in occurrence of pending claims in transfer patients
  - Hospice patient transferred from does not submit final claim for an extended period of time
  - Accepting hospice is not permitted to bill for services, thus is penalized unjustifiably
- Solution: CMS should instruct MACs to permit the accepting hospice to submit claims, even if there is an outstanding claim from the transferred hospice

Accreditation for Providers Based on the OIG's Voluntary Compliance Program Guidance

- An intent to safeguard the Medicare program from abusive outliers has resulted in increasingly complex and costly requirements that all providers must adhere to
- Solution: CMS should develop a system for providers to contract with accreditation entities to certify a high-compliance record of billing and documentation requirements. If approved, provider will be exempt from specific review efforts for a set period of time.