Home Care Advocacy Ask: Regulatory Relief for Home Care Providers

Home care agencies are highly regulated providers in the health care system. Many of these regulations are important to preserve patient safety, quality and ensure the highest standards of care. However, many regulations have been put forth that do little or nothing to enhance the safety and quality of patient care or services. Instead, these regulations result in increased paperwork burdens, unnecessary and unfair delays in care, or denials of payment for necessary services already provided to patients.

The Home Care Association of New York State, representing hundreds of home health providers – and hundreds of thousands of patients served by these providers – asks Congress to take a proactive approach to reforming or rescinding unnecessary, duplicative or onerous regulations, mandates, or rules.

This document outlines the top five federal home care mandates, laws and rules that should be on the agenda for change, along with recommendations for action.

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Face-to-Face (F2F) Rule

Background: Home health agencies must obtain documentation from physicians certifying that each Medicare home health patient has been seen "face-to-face" with the physician; otherwise home care services are not allowed, and any claims for services will not be paid if the face-to-face documentation is lacking or improperly completed.

Problems: This F2F mandate aims to ensure physician oversight of home care. While this is laudable, doctors have already provided robust oversight, well before the F2F requirement came about in 2010. Home care services have long required a physician referral and orders, as well as a **signed physician plan of care**.

This F2F mandate puts the financial burden on home care providers for the actions of another party: the physician. Thus, if a physician does not conduct the F2F assessment, or does not complete it properly, the home health agency may either serve the patient unreimbursed (taking on bad-debt) or must spend hours contacting physicians to obtain the proper paperwork.

According to the U.S. Centers for Medicare and Medicaid Services (CMS), the F2F regulation is the source of almost all documentation issues – largely due to the regulation's contradictory and confusing instructions for home care and physician providers and the inability to secure this additional documentation from physicians or the unwillingness of physicians to do so. This has resulted in millions of dollars in home care claims being denied even though the patient was eligible for services and received necessary care.

History: HCA has advanced legislation to simplify the mandate by allowing physicians to certify the F2F encounter on the existing plan-of-care rather than requiring this duplicative documentation or new and onerous procedures. New York's Congressional Delegation led a bipartisan letter, cosigned by 75 members of Congress, urging CMS to fix the F2F rule, accordingly, while noting that CMS's implementation of F2F has well exceeded the intent of Congress. F2F is a provision of the Affordable Care Act (ACA), but CMS was given the authority to implement it. To date, all of the measures to repeal and replace ACA leave this problematic F2F rule completely intact. Also, the state's Medical Society has passed a resolution supporting efforts to streamline F2F, consistent with HCA's proposals.

Recommended Action: HCA urges Congressional legislation to rescind or simplify the F2F requirement. Home care providers agree that physician oversight is important. The physician's plan of care is sufficient for this purpose, and this plan of care can be easily amended to allow for physicians to certify that they have met face-to-face with patients, rather than requiring a whole additional set of duplicative, unnecessary and confusing paperwork standards to meet this purpose.

Limits on Practitioners Referring/Ordering Home Care

Background: Federal regulations prohibit nurse practitioners, physician assistants, clinical nurse specialists and other non-physician advanced-practice professionals to order and certify Medicare home health services. These clinicians have an increasingly vital role in our health care system, ensuring access to care for patients. Their clinical training and expertise permit them to oversee a range of patient care responsibilities – and home health orders/certifications should be one of them.

Problems: In communities where physician shortages exist, home health agencies have difficulty obtaining required certifications. These certifications are needed so that providers can begin delivering services to covered beneficiaries who need home care to remain safe in the community. In many regions, non-physician advanced-practice clinicians are filling a community and public health gap; and they should be similarly equipped to meet the need for timely ordering of home health services when the physician is unavailable to provide this documentation or is not the practitioner most closely involved in the care of the patient.

The current process of restricting sign-off to physicians creates unnecessary delays and administrative time spent tracking down the physician's orders. This process is also unnecessarily expensive. A study by Dobson Davanzo and Associates estimated a five-year savings of $82.5 million resulting from more flexibility in the home care certification and ordering process.

History: The home care community advanced a bipartisan bill in 2016 ("The Home Health Care Planning Improvement Act") which would allow nurse practitioners, physician assistants, clinical nurse specialists and other non-physician advanced-practice professionals to order and certify Medicare home health services. A majority of Congressional and Senate representatives agree that this kind of flexibility makes common sense. The Senate version of this bill had over 50 bipartisan co-sponsors. Companion legislation in the House had over 200 bipartisan co-sponsors.

Recommended Actions: Reintroduce and pass the "Home Health Care Planning Improvement Act" or similar legislation to allow for efficient ordering and certification of home health services by non-physician practitioners.

Pre-Claim Review

Background: In August 2016, CMS initiated a pre-claim review demonstration for home health services in five states. While it is called a demonstration – meaning it goes into effect in select areas on a purportedly trial basis – this pre-claim review initiative resembles more of an indefinite program than a mechanism for testing new procedures or outcomes. Under this intrusive demo, third-party Medicare Administrative Contractors (MACs) decide whether the claims for care provided by home health agencies should be approved for payment. The MACs are directed to make determinations of whether the care was medically necessary and whether all coverage requirements were met *prior to* the submission of a claim for billing. By requiring agencies to submit documentation before the claim is submitted, this demo is a sweeping departure from past Medicare integrity efforts, which have largely focused on post-payment audits, targeting those agencies, services or regions which exhibit risk, rather than subjecting *all* claims to an onerous pre-claim audit regardless of historical accuracy.

Problems: The bottleneck and burdens created by pre-claim review contradict the very goals, procedures and technical designs of CMS's own new payment innovations. These new payment models – including value-based payments, bundling initiatives, Accountable Care Organizations or the Comprehensive Care for Joint Replacement (CJR) program – all rely on the smooth, expeditious and flexible assignment or discharge of patients when care is needed at the outset, and where billing predictability is essential. Unfortunately, CMS's pre-claim demonstration process redirects care-planning decisions from the patient's care team to the Medicare contractors. These government contractors are not directly liable for the timely initiation of care at the clinical level and they are not intimately involved in urgent clinical decisions where time is of the essence, especially during discharge from hospitals on weekends and evening hours and in other critical circumstances. This is onerous, delays care, and it puts bureaucrats in charge rather than clinical providers.

By requiring agencies to submit multiple documents for the pre-claim review, nursing staff are redirected away from patient care, worsening the shortage of nursing staff for vital services and threatening the ability of home health agencies to respond to timely hospital referrals, as patients await care at home. Hospitals rely on timely referral to home care, so they can free up resources, and this timeliness is threatened when home health billing is unpredictable or left up to bureaucratic decision-making from contractors, which also incentivizes referral to costlier settings.

According to a 2012 study by Dobson DaVanzo and Associates, home care accounts for nearly 40 percent of hospital discharge episodes to a post-acute setting; yet these episodes represent less than 30 percent of Medicare episode payments (costs). In contrast, skilled nursing facilities represent 50 percent of post-discharge episodes and approximately 50 percent of episode payments (costs).

History: The rollout of pre-claim review in Illinois, the first demo state, has been particularly problematic, prompting CMS's decision to indefinitely pause the program's implementation in other states (Florida, Massachusetts, Michigan and Texas are also in the demo). Reports from Illinois show that claim denials and affirmations are inconsistent, with some agencies submitting claims, getting rejections, and then resubmitting the same claims unchanged, only to have them approved.

A bipartisan bill in 2016, the "Pre-Claim Undermines Senior's Health" (PUSH) Act, would delay pre-claim review for one year and require CMS to report on the project's impact. This provides an opportunity for a more meaningful understanding of the program's flaws, which are already well documented. "After seven weeks of challenges in Illinois, CMS has plentiful information available to get to the root of any paperwork concerns and work with Congress on a more targeted corrective action plan," states the 2016 "Dear Colleague" letter recently circulated by Congress in support of the PUSH Act.

Recommendations: HCA strongly urges CMS to rescind this demonstration and solicit feedback from the provider community on other, more appropriate ways to address Medicare integrity issues. Given that documentation is the key area of alleged noncompliance, CMS should instead opt for education, clear guidelines and compliance standards, and provider support in place of this pre-claim review proposal, which will have many adverse and unintended consequences including: jeopardizing access to care; increasing system and operational costs; and undermining current CMS innovations and projects.

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FLSA Overtime Changes

Background: This U.S. Department of Labor rule now prohibits home care agencies from utilizing the long-standing companionship exemption of the Fair Labor Standards Act (FLSA). The most direct effect of this rule, implemented in October 2015, is that home care aide overtime is paid at time-and-a-half of the regular rate of pay rather than time-and-a-half of minimum wage in states that have minimum wage laws, like New York. The rule has also implemented more stringent record-keeping for live-in/sleep-in cases.

HCA has long advocated for improved reimbursement to support home care worker wages and benefits. We agree that staff should be compensated in measure to the valued work they do. However, funding and provider reimbursement for additional overtime expenses and other labor mandates are vital. Home health aide services are substantially reimbursed through the state-managed Medicaid program, which is subject to expenditure caps in New York's case. State Medicaid funds to cover the new FLSA overtime costs and other mandates, through reimbursement changes, have either fallen short or been unevenly distributed throughout the system, and Medicare rates have not been adjusted to account for these new costs.

Problems: Reimbursement cuts and cost-containment measures in New York State all are designed in such a way that the payment mechanisms, rates and premium schedules for home care do not accommodate these increased overtime costs, which are being shouldered by providers now. Without commensurate funding, the overtime requirements are incentivizing providers to assign fewer hours to home health aides (contrary to the goal of increased employee earnings), assigning more than one aide to a patient and, thus, fragmenting care in cases where patients have intensive needs requiring many hours of services.

History: The rule decision has prompted the home care industry to seek relief from the courts, including the U.S. Supreme Court, which declined action on the case in October 2015 but has, in the past, unanimously upheld the companionship exemption (in *Long Island Care at Home, Ltd. v. Coke*).

Recommendations: The FLSA changes are well-intentioned, but, to date, the federal and state governments have not acted to appropriately fund providers for the enormous cost and administrative burden of compliance. This cost burden, in particular, further tips the balance against providers who are already operating substantially in the red in New York State, according to our latest financial analyses. This lack of reimbursement support also incentivizes fragmented care by causing providers to scale back substantially on overtime hours, contrary to the goals of providing home health aides and personal care aides with higher overtime compensation, and it interrupts the continuity of care by forcing agencies to utilize multiple aides for one patient. Absent a funding mechanism that offers direct, timely and appropriate relief, HCA urges legislation or executive action to suspend the FLSA overtime rule change until such time that a process is developed to examine and appropriately account for provider costs in both the Medicare reimbursement methodologies as well as through appropriations or requirements for state Medicaid coverage of these costs.

New Home Health Conditions of Participation (CoPs)

Background: On January 9, 2017, CMS finalized the most substantial single set of regulatory changes and new operating requirements for home health agencies since 1989. The changes include extensive amendments and additions to the Medicare Home Health Conditions of Participation (CoPs).

The CoPs are a set of rules that home health agencies and many of their contractors must abide by in order to participate in the Medicare program and deliver services to Medicare beneficiaries. Some Medicaid services are affected as well.

CMS's changes contain an array of new requirements and changes related to: nursing, therapy and aide services; supervision assessments; patients' rights; care planning; quality improvement; clinical records; agency structure; governance; management; and other CoPs that dictate the operation and function of HHAs certified by Medicare (and Medicaid).

Problems: Providers **only have six months** to understand and implement these sweeping new changes, which take effect on **July 13, 2017**. CMS estimates these changes will cost home health agencies **$293 million** nationally in the first year and **$290 million** in year two and thereafter. Meanwhile, state-level surveillance agencies, tasked with enforcing the new rules, have yet to even receive Interpretive Guidance from CMS, putting a strain on states and providers alike.

Recommendations: Given the costs and severe implementation pressures, **HCA is seeking a delay in the CoP effective date to no earlier than January 13, 2018**. An extension of the implementation date would allow CMS to develop guidance and training for state surveyors, and it would give providers the opportunity to prepare their agencies for the changes and to try to address the associated costs in a more reasonable timeframe.

OUTCOME:
CMS Proposes HCA-Sought Delay to Jan 1, 2018.