Legal and Regulatory Developments in Home Health

Alliance Learning Collaborative

July 17, 2014

Alliance for Home Health Quality and Innovation

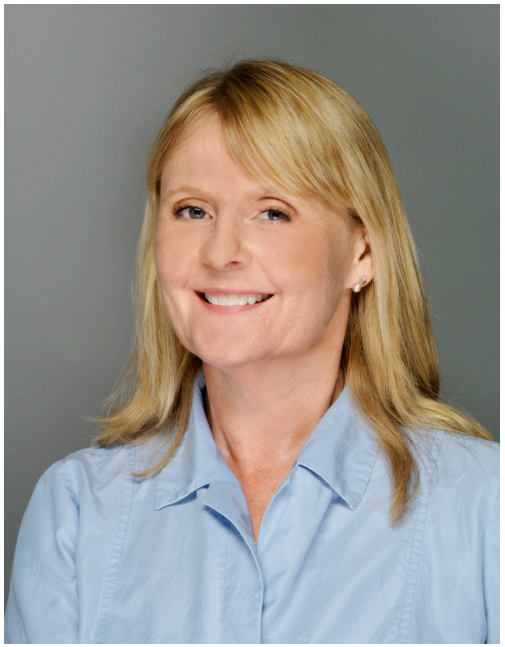
About the Alliance

- 501(c)(3) non-profit research and education foundation
- Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.
- *www.ahhqi.org*

Alliance for Home Health Quality and Innovation

Today's Speaker: Mary Carr

Mary Carr, BSN, MPH
Vice President for Regulatory Affairs, National Association for Home Care & Hospice



Mary Carr is the Vice President for Regulatory Affairs at the National Association for Home Care & Hospice (NAHC). In her current position she represents home care providers before government agencies and other national organizations that impact home care. She provides regulatory and operational guidance to home care providers on a daily basis, writes for NAHC publications, and presents educational seminars.

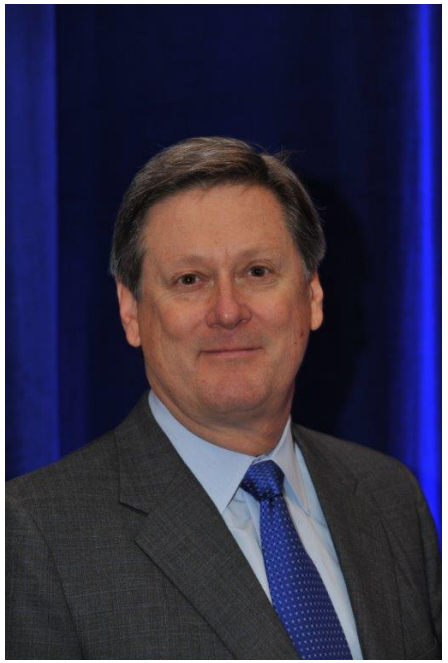
Mary has over 25 years of experience as a registered nurse in a variety of health care setting which include acute care, managed care and home health care. Her positions in home care include Director of Quality Improvement, Manager of Staff Development and Employee Health, and Field R.N.

Mary holds a Bachelor in Science of Nursing and Master of Public Health.

Alliance for Home Health Quality and Innovation

Today's Speaker: Bill Dombi

Bill Dombi, JD
Vice President for Law, National Association for Home Care & Hospice
Director, Center for Health Care Law
Executive Director, Home Care and Hospice Financial Managers Association
Executive Director, National Council on Medicaid Home Care



Bill Dombi specializes in legal, legislative, and regulatory advocacy on behalf of patients and providers of home health and hospice care. With over 37 years of experience in health care law and policy, Bill Dombi has been involved in virtually all legislative and regulatory efforts affecting home care and hospice since 1975, including the expansion of the Medicare home health benefit in 1980, the formation of the hospice benefit in 1983, the institution on Medicare PPS for home health in 2000, and the national health care reform legislation in 2010. With litigation, Dombi was lead counsel in the landmark lawsuit that reformed the Medicare home health services benefit, challenges to HMO home care cutbacks for high-tech home care patients, lawsuits against Medicaid programs for inadequate payment rates, a nationwide class action against then-HCFA for its failure to enforce the federal HMO Act, litigation directed against the "Interim Payment System" for the Medicare home health benefit, and a lawsuit addressing the so-called Medicare "case mix creep adjustments" in 2008-2010.

In addition to litigation, Bill offers extensive community and professional educational services through lectures, publications, teleconferences, and videos. He is the Editor and lead author of Home Care & Hospice Law: A Handbook for Executives, the only comprehensive legal treatise on the topic. His lectures include market trends in home care, compliance, risk management, patient rights, fraud and abuse, health care reimbursement, legislative and regulatory reforms, and legal issues in telehealth services.

Bill Dombi is admitted to practice in Connecticut and Washington, DC. He is also admitted to numerous federal courts including, the US Supreme Court and several Court of Appeals. He serves on the Advisory Board for BNA's Health Law Report and Medicare Report. Bill also is a longstanding member of the American Health Lawyers Association and the American Bar Association.

Alliance for Home Health Quality and Innovation

Today's Webinar

- During the presentation submit questions to "Teresa Lee" at the Fuze Chat Box.
- Slides will be posted on the "Webinars" portion of the Alliance website. We are also recording the webinar for playback on the website.

Alliance for Home Health Quality and Innovation

HOME CARE LEGAL AND REGULATORY ROUNDUP

Mary Carr, BSN,MPH
Vice President for Regulatory Affairs

William A. Dombi, Esq.
Vice President for Law

National Association for Home Care & Hospice

PROGRAM FOCUS: LEGAL AND REGULATORY UPDATE

Private Pay Home Care

- Department of Labor FLSA Companionship Services rule
- ACA employer mandate

Medicaid home care

- Expanded HCBS
- Managed LTSS

Medicare

- Home Health Services

PRIVATE PAY HOME CARE: COMPANIONSHIP SERVICES FLSA EXEMPTION

DoL rule effectively eliminates minimum wage and overtime exemption

- http://www.gpo.gov/fdsys/pkg/FR-2013-10-01/pdf/2013-22799.pdf
- Eliminates exemption for 3rd party employment on companionship services and live-in domestic services
- Changes definition of companionship services
- Excludes 3rd party employers from live-in exemption
- Medicaid and disability rights advocates opposition

HCAOA, et al v Perez

- Case No. 1:14-cv-00967 (D.DC) filed 6-6-14
- Challenges validity of rule

Increased private litigation on W&H issues

- Validity of claimed FLSA exemption status
- "hours worked"
- Break time rights

IMPACT

DoL sees limited impact

- Transfer of dollars from employer/payer at $232M annually

Industry sees greater impact

- Increased staff recruiting
- Higher staff turnover
- Shift to part-time workers
- Limited Medicaid rate support
  - NAMD requests DoL delay
  - Gov. Brown (CA) limits MediCal worker hours
- Lower customer satisfaction

ACA EMPLOYER MANDATE: HOME CARE IMPACT

On January 1, 2015, employers of 100 or more FTEs must offer a qualified health plan

- 50-99 FTEs delayed until 2016
- Less than 50 FTE exempt

Many, but not all Medicare HHA/hospices have or offer 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: ADVOCACY EFFORTS

Delay the implementation date

Eliminate the employer mandate

Change the law

- E.g., Redefine full time to 40 hours per week (30 is current standard)

Employer options

- Stay below 50 FTEs and/or 30 full time employees
- Limit the number of employees at 30 hours or more per week
- Offer bare bones, qualified health plan
- Seek higher Medicaid rates (good luck!)
- Raise charges to clients (tough sell)

MEDICAID HOME CARE

Rebalancing of LTC spending continues
- Just less than 50% of Medicaid LTC spending now in home care
- States' balance in spending wide ranging

ACA incents home care
- Higher federal match to low balance states (BIP)
- New HCBS option benefit
  - https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

States increasing Medicaid home care audits and oversight
- Big focus on caregiver qualifications by OIG
- Documentation weaknesses on care plans ad authorizations

Major movement to managed care Medicaid
- LTSS
- Duals

MEDICAID MANAGED 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

Managed care programs “flying blind”?

Great opportunities for some, impossible challenges for others

- Expanded home care?
- Lower rates; restricted utilization; limited networks?

Need comprehensive standards for both providers and beneficiaries

MEDICARE HOME HEALTH REGULATORY ISSUES

HHPPS 2015 proposed rule

- Rate rebasing
- Face to Face
- Therapy assessments
- More….

PECOS

Medicare “improvement” standard

New Medicare CoP sanctions (and potential new CoPs)

Moratorium on new HHAs

2015 MEDICARE HOME HEALTH RATE PROPOSED RULE

CMS Proposed Rule (July 2, 2014)
http://www.ofr.gov/OFRUpload/OFRData/2014-15736_PI.pdf.

Continued rebasing payment rates

- Full cut (3.5%) allowed under law (14 points total)

Recalibrated case mix weights

- Focus on therapy episodes
- Budget neutrality adjustment
- Proposed weights confusing

Outlier eligibility remains same despite low spending

MBI: 2.6%

- New Productivity Adjustment (-0.4%) net MBI at 2.2%

Remember 2% payment sequestration (February 1 and later payments)

New wage index blend of CBSAs

- ??? who gets the rural add-on

2014 MEDICARE HOME HEALTH RATE PROPOSAL: ASSESSMENT

CMS continues 4 year phase-in from 2014

- CMS chose unfavorable calculation method
  - Used proxies for episode revenue and costs
  - Formula guarantees aggregate payments less than average cost
- Better alternatives available
- Ignored cost increases and costs not on cost report

PROPOSED HHPPS RATES -2015

Case mix weights recalibrated unevenly

- Complete recalibration
  - Therapy variable adjustments
    - 0-5 therapy visits + increase weights 3.75%
    - 14- 15 therapy visits decrease weights by 2.5%
    - 20+ therapy visits decrease weights by 5%
  - HOWEVER—recalibration on all variables actually increases payments on high therapy episodes
- Budget neutrality adjustment of 1.0237

Base rate in 2014 –$2869.27

Base rate in 2015 –$2922.76

This is an aggregate decrease because of case mix weight recalibration

1.45% effective decrease in aggregate payments from 2014 level

Add in 2.0% Sequestration

PRPOSED RULE: OTHER REGULATORY DEVELOPMENTS AFFECTING HOME HEALTH SERVICES

Face-to-Face Physician Encounter rule modifications

Significant change to the requirement for professional therapy reassessments

A new standard for the submission of OASIS to avoid payment rate reductions

Modifications of the standards for qualification of speech-language pathologists under the CoPs

The introduction of possible new coverage standards on the administration of insulin injections

The unveiling of a likely model for Value Based Purchasing

Clarifications of the requirements for imposition of alternative Civil Money Penalty sanctions for CoP violations

Changes to recertification requirements

FACE-TO- FACE PHYSICIAN ENCOUNTER PROPOSED CHANGES

Eliminate physician narrative requirement

Require certifying physician to have sufficient records to support certification

Reject physician payment claims for certification/ recertification when home health claim denied for noncompliant certification/recertification

FACE-TO- FACE PHYSICIAN ENCOUNTER

- Lawsuit Filed
  - NAHC v. Sebelius/Burwell
    - 1:14-cv-00950 (filed 6-5-14)
      - US District Court for the District of Columbia
  - Alleges
    - excess documentation required in relation to ACA requirements
    - failure to provide adequate and clear guidance on acceptable documentation
    - Failure to review whole record

Lawsuit will continue to address past claims denials and continuing audits

MEDICAID F2F

Proposed rule July 2011

Unified Agenda - October 2014

Some States have a F2F requirement

- CMS permits, but does not encourage

PROPOSED RULE CHANGE/CLARIFICATION

Clarification of Start of Care certifications/OASIS

- Readmission w/in episode where discharged with goals met
- Would require another F2F

NEW CMS IDEA!

Value-based Purchasing

- Request for input
- CMS possible VBP model
  - 5-8 selected states
  - Mandatory application of VBP
  - 5-8% of payment at risk
  - Sliding scale of bonuses and penalties
  - Based on performance and improvement in performance

NEW MEDICARE COVERAGE GUIDELINES

Jimmo v Sebelius settlement

http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf.

Focused on illegal "improvement" standard

CMS is clarifying existing guidelines; provider education will follow

Permit coverage of skilled maintenance therapy

Permit coverage of chronic care/terminal patients

Existing guidelines recognize such coverage but MACs changed the "rules"

CMS clarified guidelines with specific prohibition of an improvement standard (w/in 6 months) http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf

On claim reopening, Plaintiff Jimmo denied again; new lawsuit filed

COMPLIANCE: FOCUS ON HOME CARE

ZPICs and RACS looking at home care

- Homebound status
- Medical necessity
- Technical compliance incl. F2F

High level fraud/False Claims Act investigations

- E.g., Phantom patients in Miami; $375M Dallas physician-directed fraud allegation

OIG continues home care efforts

- New report alleges widespread fraud and abuse
- Report is weak on facts and methodology, strong on hyperbole

Medicaid home care new on the agenda

- Personal care is the main focus
- Staff credentials including health screening a target

MORATORIUM ON NEW HHAS

- https://www.federalregister.gov/articles/2014/02/04/2014-02166/medicare-medicaid-and-childrens-health-insurance-programs-announcement-of-new-and-extended-temporary.
  - Miami - Dade counties in Florida
  - Cook County (Chicago area) in Illinois
  - Dallas, Houston, Detroit, Ft. Lauderdale
  - New providers
    - CHOWS allowed
    - Relocation w/in area permitted
    - New Branches included in moratoria
- Ends July 31—Will CMS extend and expand???

MORE ON THE MEDICARE PROPOSED RULE

Mary Carr

THERAPY REASSESSMENT: PROPOSED RULE

Proposes to replaces 13/19 visit and 30 day reassessment requirements

- Did not achieve goal
- Complex and burdensome

Therapy reassessment every 14 days

OASIS SUBMISSION THRESHOLD

Pay for reporting

- 2% reduction in payment if quality reporting requirements are not met

CMS ultimate goal is 90% submission rate

To be phased in over three years

- 70% 7/1/15 -6/30/16 ---2017
- 80 % 7/1/16-6/30/17----2018
- 90% 7/1/17 -6/30/18 ----2019

OASIS SUBMISSION THRESHOLD

CMS defines a “Quality assessment” several ways

- SOC /ROC with a matching EOC (transfer, discharge or death)
- SOC/ROC in the last 60 days of reporting period
- EOC in the first 60 days of the reporting period
- SOC/ROC followed by one or more recertifications the last of which is in the last 60 days
- EOC episode that is precede by a one or more recertification episode last of which occurs in the first 60 days of the reporting period
- SOC/ROC one visit episode

Non quality assessments : SOC/ROC, EOC that do not meet the above conditions

Recertifications are neutral

OASIS SUBMISSION THRESHOLD

Formula

$$\frac{\text{\# Quality Assessments}}{\text{\# Quality Assessments + Non-Quality Assessments}} * 100$$

INSULIN COVERAGE STANDARD

- Additional diagnosis to support patient's inability to self inject
  - List of acceptable diagnoses

- Insulin pens
  - Presumes a patient is able to self inject

SPEECH LANGUAGE PATHOLOGY

Qualifications

- Master or doctorial degree
- State license

ALTERNATE SANCTIONS

July 1, 2013

- Directed plan of correction
- Directed in-service training
- Temporary management

July 1, 2014

- Civil money penalties
- Suspension of payment for new admissions
- Informal dispute resolution

ALTERNATE SANCTIONS- CMP

Civil Monetary Penalties

- $500-$10,000 Per diem/per instance
- Not to exceed $10,000 per day

ALTERNATE SANCTIONS-CMP

Upper Range

- $8,500 to $10,000 per day for immediate jeopardy.

Middle Range

- $1,500 to $8,500 per day
- directly related to poor quality patient care outcomes.

Lower Range

- $500 to $4,000 per day

related predominately to structure or process-oriented conditions (such as OASIS submission requirements) rather than directly related to patient care outcomes

ALTERNATE SANCTIONS-CMP

Determinants

The size of the agency and its resources;

Accurate and credible resources that provide information on the operations and the resources of the HHA;

- Medicare cost reports
- claims information

Evidence that the HHA has a built-in, self-regulating quality assessment and performance improvement system (QAPI) program .

ALTERNATE SANCTIONS - CMP

Written notice

- nature, basis and factors that were considered
- Effective date –last day of the survey
- Amount
- Right to hearing , etc.

- 60 days to file an appeal
  - No delay in imposition of sanction – delays collection schedule
- Waive the right to a hearing
  - CMP reduced by 35 %
- Accrual begins last day of survey until substantial compliance achieved
- Final Notice

ALTERNATE SANCTIONS

Suspension of Medicare payment for new admissions

- Written notice 15 days before effective date.
  - Nature of the non compliance
  - right to appeal - ALJ
- Agency must notify any new admission of sanction
- May not charge the patient unless notified orally and in writing

ALTERNATE SANCTIONS -IDR

Informal Dispute Resolution

- Condition level deficiencies
- Deficiency report to include IDR instructions
- 10 days to request a hearing
- Request in writing

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html?DLPage=1&DLSort=0&DLSortDir=ascending

CONDITIONS OF PARTICIPATION

- Revised HHA Conditions of Participation
- In OMB and expected to be released late August
- Initially attempted to release in 2006

MEDICAL REVIEW

Medical Review

- Medicare Administrative Contractors (MAC)
  - Claims processing contractor
  - Pre and post payment reviews
- Recovery Audit Contractors (RAC)
  - New procurement phase
  - Nationwide wide HHA contractor
- Zone Program Integrity Contractors (ZPIC)
  - Fraud
- Supplemental Medical Review Contractor (SMRC)
  - Strategic Health Solutions
  - Topics reviewed under the request and direction of CMS
  - SMRC Strategic Health Solutions review OIG and GAO reported issues
- Comprehensive Error Rate Testing (CERT) contractors
  - error rate testing on the MACS

MEDICAL REVIEW

CR 8690

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R527PI.pdf

Require that the MAC and SMRC post issues under review on the web site.

SMRC must post the associated OIG/GAO report that triggered the review

PECOS

Effective 1/1/2014 edits to ensure ordering/referring physician has a valid enrollment record in Medicare

Effective July 1, the attending physician who signed the patient's plan of care as well as the certifying physician must be listed on claims

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1413.pdf

Physicians dropping off ordering /referring list

- Fail to revalidate
- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

- PECOS system maintainer issue
  - Fix due this month

OASIS

OASIS C1/1CD – 9 version available

- OASIC C until 12/ 31/14
- OASIS C1 - 1/1/2015

CMS education webinar planned for September

Grouper update to coordinate with OASIS and ICD coding

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1.html

Discussion & Questions

- Submit questions to “Teresa Lee” at the Fuze Chat Box.

- Presentation slides will be available at: http://ahhqi.org/education/webinars

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Speaker Contact Information

If you have additional questions regarding today's webinar, please feel free to contact the speakers via email.

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Thank You!

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