Washington Update 2018

Oklahoma Association FOR HOME CARE & HOSPICE

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Home Care Future

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Mid-Term Elections Are Coming

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Control of Congress Up for Grabs

- Trump Administration in its second year
- November 6 (General Election)
  - Democrats hope to win two new seats in the Senate to take control; however, most seats up for re-election are held by Democrats.
  - Democrats need to flip 24 seats to capture the 218 seats necessary to control the House Chamber
  - A number of retirement / resignations

Politics As Usual?

The Outcome Potential

- Democrats Control
  - "Fix" ACA
  - Continuing to Fight Fraud
  - More Regulations
  - Medicare Advantage Carve-In for Hospice
  - Health care protections various programs

FY2018 Budget
Medicare Cuts: $500B
Medicaid Cuts: $1T

- Republicans Control
  - Continuing to Fight Fraud
  - Fewer Regulations
  - Medicaid Block Grants for States
  - Piecemeal efforts to repeal ACA elements
  - Entitlement reform (Copays?)
  - PAC VBP & Unified PAC PPS

Fraud, Waste and Abuse

- Who's on First, What's on Second…
  - For the past decade and beyond the ebb and flow of fraud and abuse in the news has haunted our industry. A shadow we've yet to get out from behind.
  - Countless hearings on the Hill highlighting CMS failures and OIG field agents going after "fraudsters" continue and likely will into 2018 and beyond.

Medicaid Personal Care Fraud

Recent House E&C Hearing on Medicaid PCS Fraud

- **GAO**:
  - Differing federal standards on beneficiary safety, billing integrity, and data for PCS programs
  - Need to 'harmonize' standards
- **OIG**:
  - 200 investigations on PCS in last 5 years
  - Fraud schemes
  - Recommendations: Min Standards and Enrollment of PCS attendants; Claims integrity improvements
- **CMS**:
  - High value of PCS
  - Quality guidance
  - RFI on program improvements
  - Program Integrity guidance to States
  - Focused compliance reviews

What's the Root Cause for HH?

- Affordable Care Act in 2010 & Face-to-Face Requirement
  - Implementation
  - Confusion
  - Denied Claims
  - Frustrated Physicians
  - Appeals Backlog 7+Years
  - Improper Payments "Perceived as Fraud" at 32%

F2F Update in 2018

- Originally required MD narrative
- Update in 2015 without narrative
- Requires certifying MD have medical record that support the patient need for HH / "sufficient" to support certification
- Today – focus is on eligibility determination documentation – 4 Key Elements
  - Confined to the home
  - Skilled Need
  - Face-to-Face by authorized practitioner
  - POC Followed / Reviewed by MD

Program Integrity Actions

Claims Oversight: 32% Improper Payments HH

- Pre-Claim Review: Three year; Five State
  - Suspended
  - Shows high error rate on documentation
- Moratoria Expansion in four states
- Legislative / Regulatory Approaches
- CMS searching for options
  - Targeted reviews
  - Probe and Educate
  - Predictive Modeling – PEPPER Reports
- MA Plans initiate retrospective reviews
- Medicare reviews increase

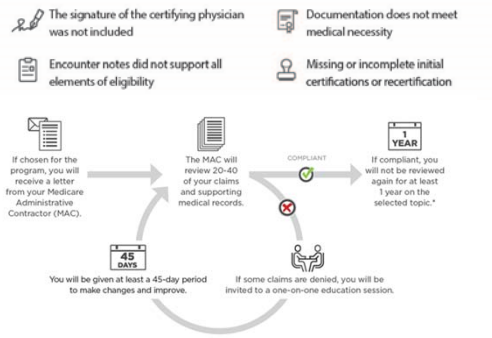
Probe & Educate Audits

- Improper Payments (insufficient documentation)
- Began in 2015; All HHAs have 5-Claim Probe
- Second Round Began in 2017 – High Initial Denials
  - HHA Failure to respond to ADR
  - Insufficient MD Record to Support Skilled Need
  - Failure to meet Certification Technical requirements
- Targeted Probe & Educate

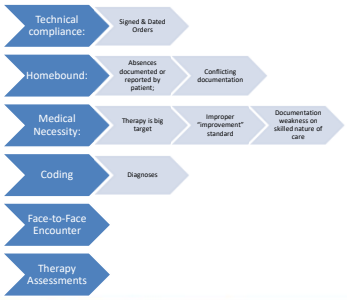
Targeted Probe and Educate

- Targeted PE began Fall 2017
  - Targeted HHAs identified by MACs through data analysis and that are a
    - 'potential risk to the Medicare Trust Fund', or who
    - Vary significantly from their peers
    - Includes 20-40 claims per round followed by
    - Individualized education based on review results
  - Providers with High error rates after three rounds TPE
    - Referred to CMS for additional action, including
      - » 100% prepay review; extrapolation; referral to a RAC

How does TPE Work?



Medicare Home Health Oversight Claims Target Areas



Recertification New Interpretation Important

- Same longstanding regulation 42 CFR 424.22(b)(2)
  - "The recertification must indicate the continuing need for services and estimate how much longer the services will be required. Need for OT may be the basis for continuing services that were initiated because the individual needed SN care or PT/ST."

Recertification Statement Must Include

Separate Statement: Continuing need for care and a statement estimate for how long….

- "I certify that in my estimation that this patient will continue to require services for ….."
- The physician will sign and date the recertification statement estimate at the same time as review of the POC (every 60 days)

Improper Doesn't Mean Fraud

- HH IP rates were up to 59%; but for 2017 are down to 32%; still yielding need for TPE / RACs.
- Federal requirement to keep IP less than 10%
- CMS using Predictive Analytics, Fraud Prevention System to assess billing practices, enrollment activities, etc.
- Instead of pay-and-chase, stop payments upfront

Moratoria Expansion

- Effective 7/29/16 CMS expanded the localized moratoria in specific areas to the entire states of Florida, Texas, Michigan and Illinois.
- CMS continues to extend full state-wide moratoria
- Expansion of moratoria as a method by which to control fraud
- Sales and acquisitions are still possible, but new branches are not; service area expansion is also still possible by existing HHA

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2018 Industry Legislative Priorities

HOME HEALTH

- Develop Medicare home health payment reform models
- Extend Medicare HH rural add-on
- Permit NP/PA to order and follow HH POC
- Reform Medicare F2F documentation requirements
- PAC VBP

PCS / HCBS

- Reform Medicaid EVV requirements
- Stop Medicaid per capita caps / block grant

HOSPICE

- Need proactive plan for MA carve-in of Hospice benefit
- Rural Access to Hospice Act (FQHC / RHC)
- Advance care planning
- Opioid / Disposal Assistance

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HHGM Not Finalized

- New model intended to address
  - Access to care for vulnerable patients
  - Elimination of therapy volume as payment rate determinant
- Home Health Groupings Model (HHGM)
  - 144 payment groups
  - Episode timing “Early” or “Late”
  - Admission source: Community or Institutional
  - Clinical groupings: 6 groups
  - Functional level: 2-3 groups
  - Comorbidity adjustment: Secondary diagnosis based

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HHGM Not Finalized

- Notables
  - Therapy volume domain eliminated
  - Cost per minute +NRS approach to resource use
  - 30-day periods within 60-day episode
  - Admission source (Hospital or PAC 14 days prior to Early episode)
  - Six clinical groups
  - OASIS-based functional analysis (M1800-1860 + M1032)
  - Secondary diagnosis adjustment
  - Regression analysis (2016 based)

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Focus on HH Payment Reform

- FY18 HHGM proposed rule was withdrawn
- TEP conducted on 2/1/18 by Abt / CMS
- Congress intervened
  - 30-day 'unit of service' statutory standard (1/1/20)
  - Budget neutrality requirement
  - Behavioral adjustments – 'assumed' and based on actual behavior changes by CMS in one of three ways: prospectively, permanently and temporarily during 2020 – 2026.

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Episode Implications

- 30-day episodes?
  - Increase administrative burden on physicians and providers by:
    - Requiring certification, F2F, OASIS and other administrative elements be done every 30 days
      - » Access to care issues
      - » Increased LOS in acute care facilities / re-hospitalizations

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Behavioral Implications

- Statute now permits CMS to guess about what providers will do under a new 30-day unit of service, and
  - Make prospective payment cuts based on presumed behavior;
  - Retrospective payment cuts to adjust for actual observed behaviors
  - Make permanent changes to standardized payments much like rebasing based on observed actual and presumed behaviors

So What's Next: HHGM Plan of Action

United National Industry Representatives including:

- Partnership for Quality Home Health,
- National Association for Home and Hospice Care, and
- Elevating Home
  - 1. Change Unit of Service to Unit of Payment
  - 2. Remove 'assumption' based changes from Secretary
  - 3. Require any changes be 'not earlier than 1/1/20'
  - 4. IF CMS proceeds with payment reform, consider demo
  - 5. On F2F, make the documentation requirement a "shall"

Reform Principles Needed

- Budget neutrality maintained
- Discourage behavioral changes in policy
- Adequate reimbursement
- Patient characteristic based payment
- Consistent with benefit and service delivery
- Sufficient time to implement
- Demonstration / testing requirement

Process Standards of New Payment Model

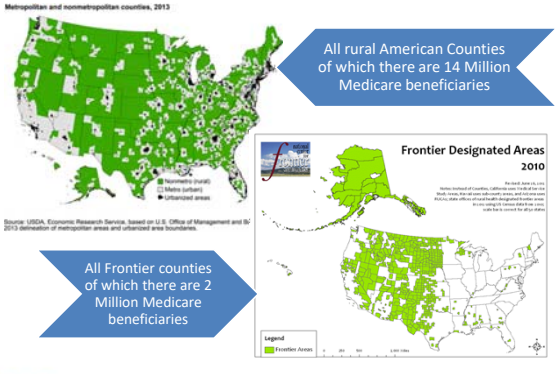
- Transparency: All stakeholders, open communication between CMS and industry, full data sharing of all aspects
- TEP – Technical Expert Panel
- As new model develops, time for public involvement in planning process
- Assurances for demonstrations to validate
- Notice of comment and rulemaking

Additional Industry Focus

Rural Add-On Phase Out

- MedPAC Influence
- New statute that phases out rural add-on by 2022; applies different payments to different population based communities
- OIG Study by 2023 (Claims, utilization, recommendations)
- 14 million Medicare beneficiaries will no longer meet qualification for rural add-on

Industry seeks changes to restore straight extension



Face-to-Face

- HHA records included as part of MD Certification on patient need and qualifications
- Need to change passed BiBA 2018 language from “may” to “shall” as Walden intended

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Quality & New Models of Care

- Better care, Improved outcomes, Lower cost
- Goal: 50% of Medicare FFS payments through APM by 2018 (already at 30%)
- Star ratings
- Continued payment reform based on performance
  - Bundled payment, Value Based, PAC Inclusive
  - New Advanced Alternative Payment Models
  - BPCI Advanced model begins 8/1/18; voluntary

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Comparing Care & Star Ratings

- Home Health
  - Compare Quality Star Ratings based on process and outcomes measures into single score
  - Patient Survey Star Ratings is separate model from Compare reports
  - Concerns for HH are:
    - Focus on ‘improvement’ versus other measures
    - Most agencies with 3 Star average nationally
    - MA paying based on HHA Star Rating (BCBS)
    - Consumer perception that 3 stars is mediocre
    - CAHPS ratings are a completely different model

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Compare & Star Ratings….Hospice

- Hospice
  - Hospice Compare of HIS Measures Launched March 2017
  - Composite measures will not be in first round of public reporting
  - CAHPS – If too few patients, provider won't be included in public reporting (number TBD); exclude patients with less than 48 hour LOS
  - CMS anticipates 85% of hospices will have data to report publicly
  - HIS Measures – 20 stays "admission and discharge" in 12-month period
  - Star ratings will not happen until at least one year (likely longer) after start of compare reports

Hospice on the Horizon

- Far fewer legislative / regulatory issues for hospice
- Hospice Radar is Up!
  - Increasing claim oversight
  - Expanded quality and utilization data
  - Payment model updates / new versions?
- PA's serve as Attending – Begins 1/1/19
- Hospital Discharge to Hospice
  - Impact to hospitals begins 10/1/18
  - MedPAC evaluation report due 3/2021

Payment Reform

- Bundling / Episode Payment Model
- VBP - Value versus Volume
- Increase of Quality Performance
- Unifying prospective payments across PAC settings (SNF/IRF/LTACH/HHA)

Value Based Purchasing Models

- HHVBP
  - Mandatory 9 state pilot
  - Began in 2016; Baseline year 2015; Performance year 2016; Payment adjustment year 2018
  - 3%(2018) to 8%(2022) of HH payment withhold for incentives based in achievement and improvement (process, outcomes, CAHPS)

HHVBP Finalized FY2018 Changes

- Changed definition of 'applicable measure' to mean measure a measure for which a competing HHA has provided a minimum of 40 completed surveys for (HHCAHPS) measures, beginning with Performance Year (PY) 1, for purposes of receiving a performance score for any of the HHCAHPS measures
- For PY 3 and subsequent years, finalized the removal of the (OASIS)-based measure, Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care, from the set of applicable measures.
- Predict $378M in Medicare FY18 savings

Post-Acute Care VBP

- In 2015 Ways and Means proposed a model to bundle PAC providers under a much larger VBP program
  - Proposes to include HHA/SNF/IRF/LTACHs
  - Sweeteners for PAC Providers
- Expect W&M to issue another version and press forward on this effort to launch in 2018

PAC Providers Oppose PAC-VBP

- PAC providers unanimously answered the call for a response to the modified version of the bill with a resounding – **NO**
- Without specific changes, PAC providers will likely stay aligned to push back on Congress and it's attempts to implement this too soon
- Numerous problems identified

Problems with PAC-VBP

- PAC providers unanimously opposed the proposal because
  - Use of single Resource Use Measure MSPB; geographically based resource use measure between PACs is contraindicated
  - Potential 2nd measure on functional assessment TBD
  - Congress should wait for IMPACT Act measures to be collected, tested and determined valid
  - Program must be budget neutral; 5% flat withhold with some dollars to be held for 'regulatory relief' is a non-starter.
  - Withhold should not exceed 2% and should be phased in over five years
  - Inclusion of HH with these facility based providers is questionable
  - Overall support PAC VBP but not in this present form

Regulatory Landscape and Room for Relief?

- HH COPs effective 1/1/2018
  - Guidelines issued; Provider compliance TBD
  - CMPs suspended for one year
  - Major changes: QAPI; Infection control; Patient Rights, and Subunit dropped – transition process developed
- Delay of IMPACT Act implementation timeline for HHAs
  - Not likely as Congress and MedPAC move ahead quickly
- Expansion of home telehealth services
- Sequestration likely to continue; expand?
- Major payment reform proposals

New Templates Improve HH Compliance

- Home Health Provider Compliance Special ODF included Templates and Clinical Data Elements.
- CMS also released draft Home Health Templates and the associated Clinical Data Elements (CDEs)
  - These templates are *optional* for providers—CMS emphasized that providers may continue to solely document these issues in the medical record.

MedPAC March 2018 Report – Home health

– This year's March report to Congress:

- Home health: $18.1B; 12,200 HHA; 6.6M episodes for 3.4M beneficiaries; 5% of FFS Medicare spending
  - – Access adequate; quality improves; MM predicted to be 14.4% for 2018
    - » Expect March report to continue to recommend:
      - Eliminate therapy from payment rate determinant
      - Reduce payments to HHAs by 5%; additional years of rebasing of HH payments as early as 2020; reform HHPPS that is patient characteristic based and better aligns payments with costs

MedPAC March 2018 Report - Hospice

– This year's March report to Congress:

- Hospice: $16.8B; 4,400 Hospices; 1.4M beneficiaries; including 50% of all decedents.
  - – Access to care good; supply of providers continues to grow; Hospice use and LOS is increasing
  - – Quality data is now available (limited)
  - – MM predicted at 8.7% for 2018 (down from 10% in 2015)
- Eliminate FY19 update (Implication: Reducing Medicare spending to hospices $250-$750M over 1 year; and $1B to $5B over 5 years.) No beneficiary / provider impact.

MedPAC March 2018 Report

- Unified Post-Acute Care Value Based Purchasing for SNF / LTCH / HH / IRF with goal of increasing equity of payments within each setting (Site neutral)
  - PAC PPS redistribution of payments across all settings
  - Interim step of using a blend of setting specific and unified PAC PPS with relative weight establishment to
  - Redistribute payments within each setting across conditions and be based on patient mix and therapy practices, across all providers
  - Keep payments to each setting at a set level

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IMPACT Act for HH

Overall: Standardized Assessment data for exchangeability, comparison of quality data, care coordination to enable assessment and further quality data development for coordination and transfers across PAC settings (HHA/SNF/IRF/LTACH)

- OASIS remains the HHA assessment instrument
- Collection began in 2017 for HHAs of skin integrity and medication reconciliation as well as other resource use measures (Medicare spending per beneficiary)
- Other HH functional / cognitive measures begin in 2019
- Providers may voluntarily participate in the field testing and receive honorarium

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Legislative Horizon

- Home Health
  - Home Health Planning Improvement Act (S. 445 / HR 1825)
  - TBD, Corrections / Clarifications on HH payment reform
  - PAC VBP?
- Hospice
  - Controlled Substances Act (HR 5041)
  - Patient Choice and Quality Care Act (S. 1334 / HR 2797)
  - Rural Access to Hospice Act (S. 980 / HR 1828)
  - Palliative Care and Hospice Education and Training Act (S. 693 / HR 1676)

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Looking Ahead – Opportunities for Home Care Providers

- Implement best practices (clinical, functional, operational)
- Tell your story – Services, ROI, Cost Saving Capabilities
- Innovate and participate in unique projects where possible (BPCI Advanced)
- Emphasize quality and cost-saving ROI to partners (ACOs, bundlers, etc.)
- Demonstrate outcomes (Readmission reduction, lower cost of HH vs. competitors (SNF/IRF)); CAHPS and HH Compare Scores – Excel! Insurers (MA) are looking at these scores as another way to reduce reimbursement
- Streamline billing practices, QA and Compliance programs – Ensure records are timely, complete and meet both state and federal requirements
- Utilize all your agency data, scores, and outcomes to maximize your leverage in negotiating contracts, partnerships, joint ventures, etc.
- Demonstrate how you can minimize risk for your selves and for partnerships.

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Resources / Links

- **HHPPS** - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
- **HHGM** – https://abtassociates.com/AbtAssociates/files/e8/e81bd5e3-b676-40d0-b286-590fc0daaa09.pdf
- **TEP** - https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html
- **IMPACT ACT** – https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-MeasuresMeasures.html
- **HHVBP** - https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model
- **TPE** - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/What_Is_TPE-Infosheet.pdf
- **PCR** – https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Overview.html
- **CMMI** - https://innovation.cms.gov/ ; https://innovation.cms.gov/initiatives/bpci-advanced
- **Low volume Appeals Process** - https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative.html
- **Energy and Commerce Hearing on Medicaid Fraud** - https://energycommerce.house.gov/hearings/combating-waste-fraud-and-abuse-medicaid-s-personal-care-services/

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