Table of Contents

INTRODUCTION ..................................................................................................................... 1

REQUIRE PRE-AUTHORIZATION FOR HOME HEALTH SERVICES BE TARGETED TO PROVEN HIGH RISK PROVIDERS ............................................................................. 2

ESTABLISH A FAIR AND EQUITABLE VALUE BASED PURCHASING (VBP) SYSTEM ..................................................................................................................................... 3

ESTABLISH FAIR AND APPROPRIATE STANDARDS FOR REBASING OF MEDICARE HOME HEALTH RATES ................................................................................................. 7

ESTABLISH PROCEDURES FOR TIMELY AND ACCURATE ADJUSTMENTS TO THE CASE-MIX SYSTEM THAT ADDRESS CHANGES IN PATIENT CHARACTERISTICS AND HOME HEALTH RESOURCES ......................................................... 9

ESTABLISH REASONABLE POLICIES AND IMPLEMENTATION PROCEDURES FOR THE PHYSICIAN FACE-TO-FACE ENCOUNTER REQUIRED FOR MEDICARE AND MEDICAID HOME HEALTH CERTIFICATION ................................................................. 12

ENSURE A FAIR PROCESS FOR A FIVE STAR RATING SYSTEM ............................................. 16

ENSURE THE USE OF APPROPRIATE QUALITY INDICATORS AND ACCURACY OF HOME HEALTH COMPARE ........................................................................................................... 18

ELIMINATE DELAYS IN MEDICARE APPEALS TO ADMINISTRATIVE LAW JUDGES ........................................................................................................................................... 20

ENSURE HOME CARE SERVICES UNDER MEDICARE MANAGED CARE .................................................. 21

ENSURE THE ROLE OF HOME HEALTH IN IMPROVED AND INTEGRATED CARE DELIVERY MODELS ......................................................................................................................... 23
INTRODUCTION

The Regulatory Blueprint for Action identifies important regulatory issues for home care, hospice and durable medical equipment providers. It provides a summary of each issue, including background information, recommendations and rationale for the recommendations. This document provides a guide to the home care industry’s position on the issues addressed. The National Association for Home Care & Hospice (NAHC) 2013 Regulatory Blueprint for Action has been reviewed by the Government Affairs Committee and the Forum of State Associations’ Regulatory Affairs Advisory Committee, and has been approved by the Board of Directors.

In order to identify the regulatory issues that are of importance to home care, hospice and durable medical equipment providers throughout the country, NAHC engages in a variety of activities. Member comments gathered from telephone calls, letters and personal contact are analyzed. The current industry trends and government actions are evaluated. NAHC committees, the Forum of State Associations and the Board of Directors participate in development of positions for the annual Regulatory Blueprint for Action. NAHC publishes a list of major issues in the NAHC Report annually, and asks members to score each issue from the least to most important. The results are tabulated and industry priorities are identified.

The Blueprint serves as NAHC’s regulatory plan for action for the upcoming year. Issues that are identified as most important by members become the priorities in the plan for action. However, NAHC recognizes that priorities may shift during the course of any year as a result of federal regulatory action or policy changes.
REQUIRE PRE-AUTHORIZATION FOR HOME HEALTH SERVICES BE TARGETED TO PROVEN HIGH RISK PROVIDERS

ISSUE: The Centers for Medicare and Medicaid Services (CMS) has proposed to institute a system of prior authorization in Medicare home health services [http://federalregister.gov/a/2016-02277](http://federalregister.gov/a/2016-02277). This proposal would apply a prior authorization requirement in Florida, Illinois, Michigan, Texas, and Massachusetts. CMS attempts to justify this action by claiming that those states have high incidence of fraud and abuse in Medicare home health services.

CMS has not released details on the prior authorization plan other than to reference the targeted model in use relative to power mobility vehicles in the Durable Medical Equipment benefit. In addition, the FY 2017 federal budget proposed by the White House includes the allowance of the unspecified use of prior authorization systems in Medicare for a ten year reduction in Medicare spending of $75 million.

RECOMMENDATION: CMS should limit prior authorization to highly targeted elements of the benefit such as application to individually designated providers that demonstrate a high risk of program abuse based on past claims history or new providers of services in high risk geographic areas. In the event that prior authorization is permitted, the system must include adequate due process to reduce the risk of wrongful denials of service authorization along with a simple and efficient process for completing the authorizations.

RATIONALE: Prior authorization is an extraordinary action that triggers significant costs for all parties and establishes barriers to the timely and effective use of home health services. Past trials of prior authorization in Medicare home health services have shown that it has negligible impact on program abuse.
**ESTABLISH A FAIR AND EQUITABLE VALUE BASED PURCHASING (VBP) SYSTEM**

**ISSUE:** Medicare is the largest health care payer in the nation. Growing concerns are being voiced about the poor quality of health care and the country’s lack of an adequate system for compensating providers of care based on the quality of services that they deliver. As a result of the publication of findings about unacceptable quality of care by the Institute of Medicine (IOM), Congress responded to the Medicare Payment Advisory Commission (MedPAC) recommendation to develop legislation that would require the Secretary of Health and Human Services (HHS) to identify quality measures and pay providers of Medicare services based on quality of care, rather than quantity of services. Referred to as Pay for Performance (P4P) in the past, rewarding providers for quality of care is now referred to as Value Based Purchasing (VBP).

Under the DRA, Congress charged MedPAC with the responsibility of submitting a report on its recommendations for models for P4P-type home health reimbursement. In January, 2007, MedPAC provided the first indications of the direction that this report may take. MedPAC proposed a P4P payment model utilizing 20 OASIS-based outcome indicators such as toileting, ambulating, and managing oral medications. Under this system, points would be given for improving or stabilizing functional levels – and deducted for each potentially avoidable adverse event, such as an unplanned hospitalization or emergency room visit. A single quality score for each agency would be calculated through this method. MedPAC staff also suggested calculating a confidence interval around each agency’s score. This would be used to pad the score for agencies with small numbers of patients where results would be likely to vary from the mean due to “luck of the draw.” Finally, MedPAC staff made several recommendations for balancing rewards and penalties. MedPAC commissioners raised several objections to the MedPAC staff proposals and suggested consideration of measures other than OASIS outcome measures.

CMS established a home health P4P demonstration project in order to prepare for eventual legislation. The provisions of this demonstration were very different than those proposed by MedPAC, but reflected many of the recommendations made by the home health industry. Through the CMS P4P demonstration contractor, Abt Associates, home health agencies were recruited to participate in January, 2008. The demonstration ended in December, 2009, with awards amounting to over $15 million to agencies for savings to Medicare spending during the two years of the project. Performance was evaluated based on OASIS outcomes for Medicare patients to agencies with (a) the highest scores on outcomes, and (b) the highest levels of improvement.

CMS has added process measures and HHCAHPs data measures to home health agency quality reporting program and should improve CMS’ capability to reward providers under VBP.

The Affordable Care Act (ACA) of 2010, Section 3006, mandates that the Secretary of HHS develop a plan for a home health value-based purchasing (VBP) program, known in the past as P4P, and submit that plan to Congress. In March, 2012, HHS submitted to Congress its “Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program.” The Report to Congress describes the current efforts to improve quality and payment efficiency in HHAs. In
addition, it considers the following steps required by the statute in designing and implementing an HHA VBP program for payments under the Medicare:

1. Development, selection and modification of process measures of all dimensions of quality and efficiency.
2. Reporting, collection, and validation of quality data.
3. Structure of value-based payment adjustments, including improvement thresholds, size of payments, and sources of funding for VBP payments.

Although the VBP framework includes steps as required by the statute, the plan is a roadmap for a VBP program and does not include specific elements of a VBP plan.

Lastly, in the 2016 HHPPS rate update rule, CMS included a provision for a VBP program for home health to begin in 2016. The VBP model for the program would increase or decrease payments by 3-8% depending on performance. Nine states have been selected to participate and all agencies in those states are subject to the VBP program. CMS has selected an array of quality measures that include outcome, process, HHCAHPS, and claims based measures that are currently reported on HHC or at the agency level through CASPER reports. In addition, three new quality measures have been included. These measures, however, will only be required to be reported. There is not a performance metric associated with the new quality measures. CMS appears to have added two new performance based quality measures that address Communication and Care Coordination (M2102) and Prior Functioning ADL/IADL (M1900). In the final rule there is no numerator or denominator specified for Communication and Care Coordination, and the full measure specifications have not been provided for either of the measures.

RECOMMENDATIONS:

1. Ensure consultation with provider representatives in identification of appropriate VBP outcome and process measures, and in the development of a fair and equitable system.
2. Apply a reasonable payment adjustment percentage that does not exceed the amount of other provider types that have a VBP Program.
3. Require CMS to thoroughly test the validity and reliability of OASIS-C using current guidelines in the real world of home health application.
4. Require that OASIS-C1 quality refinements and new process measures be proven accurate predictors of quality before these measures are used to pay home health agencies for performance.
5. Establish a system that is adequately risk-adjusted and does not negatively impact Medicare beneficiaries.
6. Create a separate pool that would be used to fund VBP, rather than funding by withholding a percentage of payment from home health agencies.
7. Fund VBP incentive from savings realized by the Medicare program as a result of quality care.
8. Base the system on measures that are under the control of, or reasonably susceptible to the influence of, the home health agency while the patient is on service with the agency.

9. Base selected measures on uniform data that home health agencies have collected and reported for a sufficient period of time in order to ensure consistency and reliability.

10. Compensate providers that demonstrate improvement as well as top performers.

11. Facilitate relief from current data collection requirements and administrative burdens and costs.

12. Take into account geographic variations and agencies with anomalous patient populations, such as large numbers of dually eligible patients, chronically ill long stay, or small number of patients served.

13. Apply VBP to the Medicare patient data only.

14. Ensure that the risk adjustment methodology effectively adjusts for age, the number of co-morbidities, and Medicaid eligibility.

15. Consider patient length of stay when measuring the “incidence of acute care hospitalization.”

16. Base the system on measures that are meaningful to patients, providers, payers, and other stakeholders and represent value and important aspects of care and services.

17. Refrain from implementing VBP in home health until completion of demonstration projects, analysis of the results, and pilot testing of any proposed plan.

18. Spread reward payments throughout the calendar year.

RATIONALE: Identification of acceptable, fair and equitable measures can be problematic, especially in light of the many variations in the needs and social and economic status of Medicare beneficiaries. Therefore, development of a VBP system must be undertaken carefully, in concert with the provider community, and only after sufficient research has been conducted in order to ensure that providers are rewarded appropriately and not unfairly penalized. Small providers do not have the reserve funds to invest in costly HIT. Furthermore, it would be unfair to providers to withhold monies needed for daily operation until the end of the year in order to fund VBP.

VBP will only serve as an incentive to providers to improve the quality of care if the agencies that improve, as well as top performers, are rewarded. The model P4P system displayed by MedPAC staff fails on a number of fronts to meet the VBP principles that NAHC and other organizations in the home care community have established. The CMS P4P demonstration appears to be more in line with NAHC’s principles for a workable and appropriate VBP reimbursement model in home health than does the MedPAC staff.

It is generally accepted in government circles that, because of the outcome measures already available to home health providers, home health is a step closer than most other providers in preparing for VBP. However, many questions exist about the validity and reliability of OASIS in light of new changes and additions. In addition, CMS has not tested and validated the new quality measures to be used in the VBP program. In consideration of the P4P demonstration project, as well as any system adopted for implementation, variations of health status and
practice patterns found in various parts of the country necessitate that performance thresholds be compared separately. Therefore, geographic areas that are smaller than entire states should be identified for comparison of agency performance. Core-based statistical areas (CBSAs) may serve as more appropriate for determining performance thresholds.
ESTABLISH FAIR AND APPROPRIATE STANDARDS FOR REBASING OF MEDICARE HOME HEALTH RATES

ISSUE: Section 3131 of the Patient Protection and Affordable Care Act of 2010 (ACA) requires that payment rates for Medicare home health services be rebased beginning in 2014, and that the rebased rates be phased in over a four-year period concluding in 2017. The legislation leaves much to the Centers for Medicare & Medicaid Services (CMS) to decide on the process and factors considered in the rate rebasing. The law itself provides that the rates “shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant.” The legislation also allows the Secretary to consider differences between hospital-based and freestanding providers, for-profit and not-for-profits, and urban and rural providers.

Data demonstrates that there are wide variations between home health agencies in terms of Medicare financial outcomes. The differences may be due to factors both within and outside the control of the agencies. Further, business needs exist that require that agencies have access to capital to a greater degree than is generally assumed. Additionally, the ability to make a profit in Medicare has triggered efficiencies that have benefited Medicare as well as the provider. Finally, data shows that most of any Medicare margin is redistributed to health care through the offsetting of shortfalls from other payers such as Medicaid and Medicare Advantage plans.

The 2013 and 2014 congressional recommendations from the Medicare Payment Advisory Commission (MedPAC) advises Congress to accelerate rebasing with a two rather than four year phase-in. In a public meeting, a commission staff member suggested rates should be based on average costs although previous MedPAC commissioners (and staff) specifically indicated that cost is just one consideration.

Recent data indicates that Medicare margins for home health agencies are quickly declining as the numerous years of rate cuts take their toll. In addition, new regulatory-driven costs are being incurred by home health agencies with more expected in future years.

On November 23, 2013, CMS issued a Final Rule that sets Medicare home health payment rates based on a formula that ostensibly relates to the average cost of care. With this approach, CMS reduces base episode payment rates by the full 14% allowed under PPACA through a 4-year phase in of the rate changes. In addition, CMS limits the increases in per visit payment rates to 3.5% despite a finding that average costs of these visits is as much as 133% of the rates. 78 Fed. Reg. 72256 (December 2, 2013).

The rebased payment rates are founded in old data and based on a formula that ensures that aggregate payments to home health agencies is less than the cost of care. Forecasts of the impact of the new rates show that nearly 73% of all agencies will be paid less than their costs of care by 2017, the final year of the rate phase-in. In addition to the flawed data and rebasing formula, CMS failed to take into account all the costs of home care, the need for business capital by non-profit and proprietary agencies alike, and the wide variation in financial outcomes due to the unique aspects of delivery of care in individuals’ homes rather than a single site institution.
RECOMMENDATIONS: To ensure continued access to high-quality care, in its rebasing of home health payment rates, CMS should revise its rebasing rule to:

1. Ensure that all existing costs of home health care are known and considered, including telehealth, caregivers such as respiratory therapists and nutritionists, marketing, taxes, acquisition of capital, and new regulatory requirements.
2. Ensure that the rates are rebased in a manner that considers the aggregate financial consequences rather than a siloed approach to segments of the rates.
3. Recognize that a reasonable financial margin is needed for any business, including home health agencies, in order to meet cash flow needs and to incent efficiencies.
4. Convene a technical expert panel of home health agency representatives to provide advice and direction to CMS in determining rate rebasing standards.
5. Recognize differences in types and location of providers in setting rebased rates, but only to the extent that the difference relate to factors outside the control of the providers;
6. Publish the standards for rate rebasing with sufficient time for all stakeholders to fully evaluate and develop comments for consideration.
7. Evaluate the impact of rebased payment rates in a manner that considers short and long-term impact, the impact on the viability of the existing businesses, the impact on access to care, and the impact on clinical practices.

RATIONALE: Congress intentionally required a series of payment reforms in home health services to occur on a gradual and periodic basis to provide the opportunity for companies to adjust so that they might stay in business and allow continued access to care. The rebasing of payment rates is the single most important reimbursement action than can be undertaken by Medicare. A well-informed and rationally developed set of rebasing standards can ensure that Medicare beneficiaries maintain access to high-quality care. Conversely, poorly devised rebasing standards can be a disaster for beneficiaries and the providers that serve them. The CMS rebasing rule will result in a loss of access to care as a result of its failure to consider all reasonable elements of cost, trends in Medicare margins, the wide variation in costs in home health care, and the need for capital.

The rebasing standards must be revised with the recognition that home health care is a health care business that needs to operate within reasonably normal business principles, which include the need to accumulate capital for growth and improvement, and the opportunity to secure a margin to justify the investment – whether from a for-profit enterprise or a non-profit entity that needs a margin to support any mission.
ESTABLISH PROCEDURES FOR TIMELY AND ACCURATE ADJUSTMENTS TO THE CASE-MIX SYSTEM THAT ADDRESS CHANGES IN PATIENT CHARACTERISTICS AND HOME HEALTH RESOURCES

ISSUE: Under the Balanced Budget Act of 1997, Congress mandated the creation of a Medicare home health prospective payment system (PPS). That system of PPS was implemented by the Centers for Medicare & Medicaid Services (CMS) on October 1, 2000. At that time, CMS was authorized to annually adjust payment rates solely through the use of a market basket index, which is intended to reflect cost inflation in the delivery of home health services. In addition, CMS is required to include a case-mix adjustment component to PPS to set payment rates in a manner that reflects the varying use of clinical resources among the population of patients receiving Medicare home health services.

Under the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), CMS is authorized to make adjustments to the standard prospective payment amount if it is determined that the changes in the overall case mix result in a change in aggregate payments, whether the result of “upcoding” or classification in different units of service that do not reflect real changes in case-mix. In addition to this payment rate adjustment authority, CMS intends to regularly adjust the case-mix weights with system refinements based upon an expanded database.

On August 29, 2007, CMS published a final rule updating the PPS case-mix adjustor, effective January 1, 2008. This was the first update to the payment system since CMS implemented it on October 1, 2000. The update was made to improve CMS’ power to predict resource utilization, which had eroded to 20% since the start of PPS. In this update, the case-mix adjustor was established based on 2005 and first-quarter 2006 data. The data that was used reflects the resource use of care and supplies at that time.

A case-mix adjuster is used to distribute payments based on variations in patient care needs, as determined by a variety of characteristics. The design is to provide higher payments for patients with needs for higher levels of care, and lower payment for patients needing less care. Case-mix considerations include such variables as the health and functional status of the patients served. The final rule reforming PPS includes a case-mix adjuster with 153 case-mix groupings.

The revised case-mix system reallocates points for all clinical, functional, and service utilization items, expands the diagnoses considered, and allows for case-mix points for both primary and secondary diagnoses. In addition, it provides for payment increases at three therapy thresholds (6, 14, and 20 visits), as opposed to a single 10-visit threshold, and offers graduated payment increases for therapy visits between the thresholds. Another major change made is the assignment of different case-mix points and payment rates based on whether a patient is in an early (first or second) episode of care, or a late (third or after) episode of care. The result is a four-equation case-mix model that appears to offer more equitable payments based on actual resource utilization. CMS reported that the new case-mix system will have a resource utilization predictive rate of over 40%.

In 2011, CMS made changes to the case-mix system in order to address concerns about case-mix creep. This adjustment was due to the evaluation of 2008 and 2009 coding weight changes. CMS
found that three-fourths of the coding increase was a result of increases in therapy visits above the 14 and 20 visit thresholds. CMS finalized significant changes in coding weights by eliminating hypertension as a factor in the calculation, reducing the weights on therapy episodes (2.5 percent reduction on 14+ visit episodes, and 5 percent reduction on 20+ visit episodes), and increasing weights on non-therapy episodes.

NAHC took issue with the therapy episode case-mix weight reductions as being purely arbitrary. Although CMS accepted NAHC’s recommendation to phase in the case-mix creep adjustment, applying a 3.79% adjustment in 2012 and reserving 1.32% for 2013, the rate reduction impacted individual providers unevenly. In the 2016, CMS finalized a three year case mix adjustment of .97% for the CYs 2016, 2017, and 2018. CMS plans to continue evaluating data for further case mix adjustments.

In addition, 2014, CMS proposed and finalized significant changes to the case-mix adjuster, completely recalibrating all of the 164 case mix categories using 2013 data. In doing so, CMS dropped many of the variables that had been part of the adjuster and added new ones. CMS claims that the recalibration improved the explanatory power (R-squared) of the model. CMS recalibrated the case mix categories again in 2015 and stated in the 2016 HHPPS final rule that recalibration will occur annually. While the new model de-emphasizes therapy utilization to an extent, the application of a “service Domain” tied to the volume of therapy visits continues.

The Medicare Payment Advisory Commission (MedPAC) is recommending that CMS replace the case mix adjustment model with a new version that drops therapy utilization from the variables applied to the payment determination. MedPAC views therapy thresholds as problematic, as they encourage unnecessary therapy utilization to increase payments. Through an outside contractor, MedPAC is developing a new adjuster that was expected to be ready for use in 2012. However, MedPAC has not yet brought forward a new adjuster, and has not provided a reason for the delay. Concurrently, CMS is working on a new adjuster that eliminates therapy utilization as a factor. A timeline for this has not been set.

RECOMMENDATIONS:

1. Conduct ongoing analysis of the adequacy of the case-mix adjustor with input from providers and case-mix study contractors.
2. Consider revisions that eliminate the use of the volume of therapy visits to determine payment amounts, while not discouraging medically necessary therapy services.
3. Test the changes and any future revised model prior to nationwide implementation.
4. Validate that a proposed new model performs better than the existing case-mix adjuster model.
5. Implement further refinements that would extend or increase the case-mix system reliability, in a timely manner, based on study findings.
6. Provide at least four months’ notice when making future adjustments to payment rates and the case-mix system.
7. Thoroughly analyze OASIS-C to ensure that the data is employed appropriately in future changes to the case-mix system.
**RATIONALE:** The revised case-mix adjuster established by CMS was based on data from 2013. Home health patient characteristics and resource utilization will continue to change over time. In addition, testing of the new case-mix adjustors will not be complete until in place for some time in home health agencies with real patients. The therapy utilization thresholds are a “lightning rod” for concerns about abuse, and objective clinical characteristics offer a higher integrity approach provided that the explanatory power of the model fairly reflects variations in resource intensity.

Continued refinements should be used only if there is an increase in the models’ explanatory power capabilities. Research is needed into the impact of caregiver access and poverty on resource utilization, which was limited by CMS due to the political implications of inclusion of those items.
ESTABLISH REASONABLE POLICIES AND IMPLEMENTATION PROCEDURES FOR THE PHYSICIAN FACE-TO-FACE ENCOUNTER REQUIRED FOR MEDICARE AND MEDICAID HOME HEALTH CERTIFICATION

ISSUE: The Patient Protection and Affordable Care Act of 2010 (ACA) conditions Medicare payment for home health services on a physician or certain non-physician practitioner having a face-to-face encounter with the patient prior to certifying the need for care. The statute also called for application of this requirement to Medicaid home health services. The Centers for Medicare and Medicaid Services (CMS) promulgated a Final Rule on November 2, 2010, for Medicare that requires the encounter to occur no more than 90 days before or 30 days after the start of care. The rule includes significant, prescribed documentation requirements the physician must comply with, or the home health agency may not bill for the services. The effective date for implementation was to be January 1, 2011. CMS delayed enforcement of the rule until April 1, 2011, to provide agencies and other stakeholders with additional time to establish operational protocols necessary to comply with the regulation. A Medicaid face-to-face proposed rule was published during 2011 with similar requirements. Although some states have already implemented Medicaid face-to-face requirements, no federal final rule has yet been published.

As part of the certification form itself, or as an addendum to it, the physician must document that the physician or NPP saw the patient, and document how the patient’s clinical condition supports a homebound status and need for skilled services. The form may not contain standardized language or check boxes, unless the documentation is done electronically. Although the physician or the physician’s office staff may complete the form from the medical, documentation must include the date of the encounter, supporting evidence of homebound status, and evidence that home health services are medically necessary. CMS clarified that it is not permissible for the physician to dictate the face to face encounter findings to the home health agency staff to transcribe and send for signature. The stringent documentation guidelines are proving to be burdensome to physicians. Many physicians have expressed frustration with the additional documentation requirement, and are resisting complying with the regulation. In response to physician complaints CMS advised them that documentation requirements are far less detailed than home health agencies are asking for, despite the fact that this information is contrary to Federal Register notices, policy manuals guidance and CMS issued Q&As.

CMS provided some flexibility regarding institutional physicians when patients are hospitalized or in skilled nursing facilities. Medicare will allow a physician who attended to the patient but does not follow patient in the community, such as a hospitalist, to certify the need for home health care based on their face to face contact with the patient. However, the documentation requirements and restrictions are the same, and many institutional physicians are not willing to certify patients for Medicare home health services. In addition, CMS took steps to reduce the burden on inpatient physicians by publishing revisions to the face-to-face regulation and policy in the 2012 PPs rate update notice, allowing community physicians to certify a patient for home health based on inpatient physicians’ encounter documentation. CMS allowed for greater flexibility, in the 2013 PPS rate update, by permitting the allowed NPP to conduct the face-to-face encounter in an inpatient facility and communicate the findings to the inpatient physician who would the communicate to the findings to the community physician. However, this has
resulted in even more confusion and many questions as to how these provisions are to be put into practice.

In addition, home health agencies have been subject to high denial rates for insufficient F2F encounter documentation. One of the contractors has reported a denial rate as high 80%. The high denial rates suggest a general misunderstanding by agencies and physicians as to what CMS expects physician’s to include on the F2F encounter document.

Furthermore, home health agencies have been informed that they may not bill a patient for uncompensated care due to noncompliance with the new requirement. Therefore, agencies will be held financial responsible for any care provided to a patient where the face to face encounter has not occurred during the prescribed time frames or the physician’s documentation does not satisfy CMS’ requirements. Agencies will have to choose whether or not to admit patients that are referred but have not had the required face to face encounter, or to discharge patients on services that have not had a face to face encounter with the physician within 30 days of admission. Forcing agencies to choose between providing uncompensated care or not accept a patient onto service will likely result in a lack of access to home health services for certain Medicare beneficiaries. Beneficiaries without transportation or resources to facilitate a visit to the physician are placed at a disadvantage for receiving home care services for which they are entitled.

Finally, CMS imposed restrictions on the use of telehealth technologies for the conduct of face-to-face encounters that make it almost impossible for its application.

In the final rule for the 2015 PPS rate update, CMS revised the F2F encounter requirements. CMS eliminated the narrative requirement, which required the certifying physician to provide a detailed explanation on why the patient was homebound and in need of skilled services. CMS will still require that the face-to-face encounter occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care, be related to the primary reason the patient is receiving home health services, and be performed by a physician or allowed NPP.

In addition to eliminating the narrative requirement, CMS has also altered its medical review process for determining patient eligibility for home health services. CMS will require that the home health agency submit pertinent sections of the certifying physician’s medical record when an agency’s claim is requested for review. If the documentation in the physician’s record is insufficient to support eligibility, the home health agency’s claim will be denied.

CMS will, however, permit the agency to inform the certifying physician of the agency’s findings from their comprehensive assessment that supports the patient’s eligibility for home health care. The certifying physician will need to sign the additional information and incorporate it into his/her medical record.

CMS’ revisions seem to have made the F2F requirements even more burdensome. In addition, the only guidance CMS has provided thus far has been through a National Provider call held in
late December 2014. Both agencies and physicians are struggling to understand what is required to meet the revised F2F encounter rules.

In December, 2014 the National Association for Home Care & Hospice (NAHC) sent a letter and made several attempts to contact the Administrator of CMS requesting a phased-in approach to implementation of the new F2F requirements.

In mid 2015, CMS announced that they would begin a “Probe and Educate program” for medical review of the F2F encounter requirements for home health episodes that began on or after August 1, 2015. CMS will begin sending Additional Documentation Requests (ADRs) after October 1, 2015. CMS will direct Home Health MACs to select a sample of 5 claims for pre-payment review from each HHA within their jurisdiction.

RECOMMENDATIONS:

1. Provide additional flexibility in the documentation requirements to:
   a. Limit the documentation to permit the physician to sign an attestation statement that the face to face encounter had occurred.
   b. Permit the physician to dictate the face-to-face encounter information to the home health staff.
   c. Allow any physician to conduct a face-to-face encounter and certify eligibility for home health services, regardless of whether that physician or another physician is responsible for the plan of care.

2. Apply “without fault” provisions, or permit the agency to bill the patient, when non-compliance is the fault of the physician or beneficiary.

3. Establish exemptions to face-to-face encounter requirements including but not limited to: patients receiving home health services after an inpatient stay; those patients living in medically underserved areas; and any persons with barriers to access to care, such as individuals incapable of leaving home and without access to a home visiting physician.

4. Remove the reference to section 1834(m) of the Social Security Act and substitute a definition of telehealth services that allows an individual to meet the face-to-face encounter requirements through modern technologies available in their home. These technologies should include two-way audio and video communications.

5. Include the changes referenced above as regulatory measures to the extent that CMS is unable under the existing Section 6407 to implement the changes.

6. Establish a process to re-evaluate CMS policies for the face-to-face requirement that includes input from providers, physicians and beneficiaries.

7. Modify Medicare coverage rules to cover an ambulance transport to a physician’s office for beneficiaries that require an ambulance.

8. Delay the enforcement of the revised F2F encounter requirements

9. Allow for a test period of claims review prior to initiating claim denials related to F2F encounter changes.

10. Ensure adequate education is provided to agencies and physicians prior to any medical reviews.

RATIONALE: A face-to-face encounter is an event outside of the home health agency’s control. An agency can facilitate a visit to the physician, but whether or not the encounter takes
place is within the control of the physician and/or patient. We believe that CMS has gone beyond statutory intent in the regulation on two fronts: requiring that the encounter be directly for the primary reason for the prescribed home health services, and conditioning home health payment on unprecedented physician documentation on the encounter including a rationalization of the certification as to how the patient meets Medicare coverage requirements.

Home health agencies are subject to nonpayment of their claim if physicians fail to meet the unprecedented documentation requirements. In other words, the non-compliance of a party outside the control of the agency will cause financial harm to the agency and be of no consequence to the physician. Home health agencies have no authority over the physician to guarantee that the documentation is properly composed in the first place.

In the absence of a uniform certification statement, the physician certification is confusing and overly burdensome to physicians. The majority of physicians will fail to provide a statement that meets CMS’ requirements, which implies the need for an intricately thought out statement that connects encounter reasons to homebound status to Medicare coverage of medically necessary services. Medicare’s own contractors have difficulty themselves with such a task as it is carried out in the appeals process. The current plan of care includes detailed information to support homebound status and the medical necessity of care by requiring medical diagnoses, functional status, medications, and detailed orders for care.

Home health agencies must be held harmless for any non-compliant documentation by the physician or failure of the patient to comply that is outside of their control. CMS should automatically apply the “without fault” provisions in section 1870 of the Social Security Act where the HHA receives a properly completed certification statement from the physician but that the physician is non-compliant with requirements for documentation or the patient fails to see the physician. Also, the good faith efforts of the HHA should be protected against physician or beneficiary non-compliance through payment guarantees under section 1879 of the Social Security Act.

Failure to apply the same considerations to Medicaid face-to-face requirements will severely impact access to care for Medicaid enrollees. Furthermore, it will create further administrative burdens and financial problems for Medicare service providers who are already seriously underpaid.
ENSURE A FAIR PROCESS FOR A FIVE STAR RATING SYSTEM

ISSUE: CMS intends to implement a five star rating system for home health agencies beginning sometime in 2015. A Special Open Door Forum call was held where CMS announced the quality measures it plans to use along with the proposed methodology for obtaining the five star rating, CMS includes 9 quality measures that are currently reported on Home Health Compare. Five of the measures show improvement in functional status or clinical condition. The remaining selected measures consist of several process measures and the measure for acute care hospitalization. Beginning January, 2016 a star rating for the HHCAPHS will added to HHC as a separate rating. In addition, although all measures selected are risk adjusted, the risk adjustment model does not account for all variances among the patient population served by home health agencies.

CMS applies a star rating model that scores each of the 9 quality measures, sorts them low to high and then divides the scores into ten approximately equal size groups (deciles). The HHA’s score on each quality measure is then assigned a rating from 0.5 -5 in 0.5 increments. The preliminary rating is then adjusted according to the statistical significance of the difference between the agency’s individual quality measure score and the national average for that quality measure. If the agency’s preliminary rating for a measure is <2.5 the score is adjusted up by 0.5. If the preliminary rating is >3 the score is adjusted down by 0.5. No adjustment is made to an initial score between 2.5 and 3.. In other words, if the score is anything other than a 2.5 or 3 and there is no significant difference from the national average the rating is adjusted up or down by 0.5 accordingly. For each HHA, the adjusted preliminary ratings are then averaged across all the 9 proposed measures to obtain an overall average rating for the agency. The overall average rating is then translated into a star rating for reporting on HHC.

RECOMMENDATIONS:
1. Include stabilization measures.
2. Develop a model that projects a star rating which more accurately reflects the agency’s actual performance.
3. Avoid using star ratings for measures where the distribution of scores lacks variation and is skewed.
4. CMS must measure consumer comprehension and interpretation based on like-kind models.
5. CMS should use the formal rulemaking process for public notice and comment on any star rating system.
6. Agencies should be provided sufficient time to review their star ratings prior to releasing this data to the public

RATIONALE: The expected outcome for many patients admitted to home health care is to stabilize or prevent decline of a condition or functional limitation. In addition, the recent settlement in the lawsuit in Jimmo v. Sebelius further confirms that the improvement standard does not apply to all Medicare home health patients. Further, an agency’s ability to affect a patient’s improvement in any measure depends largely on the services provided and the length of time the patient spends on service with the agency. The quality measures for home health
agencies include data from four different payment sources: Medicare Fee for Service (FSS); Medicare Advantage (MA); Medicaid; and Medicaid managed care. Each such patient population and the applicable payers have widely varying utilization patterns.

A star rating model that requires providers be placed in deciles even when the performance variation between the providers may be slight, compounds that weakness by grading “on a curve” the result is that all agencies are moved to a middle 2.5-3)) regardless of their unadjusted star rating. Poor performers could rate higher than their actual performance while good or excellent performers could rate lower than their actual performance, with the potential for both performers to be rated as the same star grade.

In addition, a star rating of 3 or less is universally recognized to mean an average or “poor rating. The resulting five star rating system is misleading and could have significant consequences for patients and home health agencies. Not only will consumers be misled, but private insurance plans, referral sources, and state survey agencies could misjudge the quality of care the agency provides.

Going forward NAHC recommends that CMS use the formal rulemaking process for public notice and comment on any star rating system. In addition, CMS should clearly disclose the schedule for publication of the star ratings and any updates. Finally, NAHC requests that CMS offer agencies sufficient time to review their star ratings prior to releasing this data to the public.
ENSURE THE USE OF APPROPRIATE QUALITY INDICATORS AND ACCURACY OF HOME HEALTH COMPARE

ISSUE: In 2003, CMS established a web-based information tool for consumers to aid in their selection of home health agencies for themselves or loved ones. This tool, entitled Home Health Compare, is being used by consumers and other health care professionals, such as discharge planners, to make informed choices. CMS also believes that public reporting through Home Care Compare will stimulate providers to try to continuously improve the quality of the care they deliver.

CMS, in conjunction with the National Quality Forum (NQF), will identify and analyze all available home health quality indicators in order to determine which ones are most appropriate for public reporting. Public reporting of home health quality measures began in 2002 and was limited to outcome-based measures. CMS added 13 process measures to Home Health Compare in October, 2010. Currently, there are 23 quality indicators publicly reported. The indicators consist of 9 outcome measures and 13 process measures. Public reporting of the claims-based emergency department (ED) use without hospitalization measure, rather than OASIS-reported ED use, began in 2012. In addition, CMS added patient perception of care measures (Home Health Consumer Assessment of Healthcare Providers and Systems) to Home Health Compare in late 2012.

Home Health Compare provides a listing of Medicare participating home health agencies and the geographic area that they serve along with information regarding the performance of the agencies in terms of certain patient outcomes. Actual use of this tool as a guide to provider selection is unknown. Further, there have been some questions raised regarding the accuracy and relevance of the information contained in Home Health Compare. The fact that agencies are listed alphabetically could lead consumers to select agencies that appear early, rather than thoroughly reviewing the full list for the best provider. Testing of the site with Medicare beneficiaries has led to concerns about how it is formatted and whether enhancements are needed to the Medicare.gov site for Home Health Compare.

RECOMMENDATIONS:
1. Continue to work with the home care industry, including providers, to ensure the use of valid, reliable quality indicators.
2. Avoid adding unnecessary and burdensome requirements to collect data on quality indicators that have not been researched and proven to be necessary for public awareness and quality assessment.
3. Present measures in ways that are useful and understandable to the public.
4. Continuously evaluate and update measures.
5. Ensure that measures are adequately risk-adjusted before being reported.
6. Establish thresholds or trigger points for quality reporting instead of averages.
7. Provide assistance to home health agencies in identification and implementation of best practices for improved care.
8. Conduct research into home health appropriate structure measures.
9. Consider alternate ways to list agencies other than alphabetically.
10. Include the average number of patients served by each agency in the profile.
11. Identify the time period during which the data the data was collected for the outcomes reported.

RATIONALE: The usefulness of quality reporting hinges on the accuracy of the quality measures selected, as well as the ability of consumers to relate to them. Measures should not be static, but rather need to change with advances in health care. A system of reporting that does not provide opportunities for improvement does little to help consumers in the long run.

A combination of structure, process, and outcome measures are needed to adequately determine whether care is provided in accordance with currently acceptable standards. However, ongoing scrutiny of publicly reported measures is essential. Large numbers of quality indicators are not necessarily helpful to the public, and can be confusing when trying to identify an appropriate provider of care. In addition, unless proven essential to quality, collection of data is unnecessarily costly and burdensome.

The Medicare Home Health Compare website must be user friendly and provide home health agency information in the most useful manner and with sufficient detail to prove helpful to anyone seeking information about the quality of Medicare providers.
ELIMINATE DELAYS IN MEDICARE APPEALS TO ADMINISTRATIVE LAW JUDGES

ISSUE: Under Medicare law, a decision must be issued by a Medicare Administrative Law Judge (ALJ) within 90 days following the filing of the appeal by the Medicare beneficiary or provider. However, the appeal system is irreparably backlog with nearly 900,000 appeals pending review before a handful of ALJs. Despite efforts by the Office of Medicare Hearings and Appeals to expanded the number of ALJs and achieve greater efficiencies in processing appeals, with 14,000 new appeals filed every week, a decision on any current ALJ appeal is years away.

RECOMMENDATIONS:
1. CMS should take all necessary steps to improve the quality and accuracy of initial claim determinations to limit need for an administrative appeal.
2. CMS should monitor its contractors that handle early-stage administrative appeals to ensure a high degree of accuracy and to reduce the number of appeals that end up before an ALJ.
3. CMS should provide a settlement option to all appellants with claims pending before an ALJ in order to reduce the backlog. That settlement should be based on historical data on ALJ reversal rates and the cost savings achieved by Medicare coming through the avoidance of an ALJ appeal.
4. OMHA should increase its resources to handle the level of demand and establish alternative dispute resolution processes to resolves some appeals

RATIONALE: With stepped up claims reviews in all provider sectors in Medicare, the number of appeals has increased exponentially. Alternative remedies must be considered as a means to reduce erroneous claim denials and resulting appeals.
ENSURE HOME CARE SERVICES UNDER MEDICARE MANAGED CARE

ISSUE: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 increased payment to Medicare Advantage (MA) plans to encourage more beneficiaries to leave traditional Medicare and join private HMO and PPO plans. In addition, the Part D Medicare prescription drug plan has created policies that result in the automatic enrollment of special needs Medicaid enrollees into Medicare managed care plans. The Medicare plans have an obligation to provide the same scope of home health services as is available under traditional Medicare by agencies that meet Medicare quality standards. However, these plans have often covered home health services on a “per visit” basis while traditional Medicare covers episodic care. Further, some Medicare Advantage plans impose significant cost-sharing obligations on enrollees, while Medicare has no coinsurance requirements for home health services.

MA plans enrolling Medicare beneficiaries have been known to engage in questionable marketing practices, particularly in conjunction with marketing Part D prescription drug plans. These result in patients being unaware of their enrollment. Beneficiaries who wish to dis-enroll are faced with burdensome procedural requirements and delayed transfer back to fee-for-service Medicare.

In addition, several MA plans have engaged in aggressive medical review practices such as denying the entire claim because of a technical error. For example, providers have received claim denials because the diagnoses on the OASIS are not in the same order as on the claim, even though payment is not affected by the order of the diagnoses. In addition, claims have been denied because the MA plan medical review personnel have misinterpreted the Medicare home health coverage policies.

Further, several of the MA plans have adopted a pre-authorization policy that allows up to 14 days to authorize home health services. The prolonged pre-authorization process has resulted in delayed care for MA enrollees. Home health agencies that accept patients for care prior to authorization risk nonpayment for services.

Finally, timely information is not available in the Common Working File (CWF) and home care providers have difficulty obtaining reimbursement for patients served when the patient did not inform them of their Medicare Advantage enrollment. Despite limitations on services and payments, Medicare certified providers are still responsible for meeting quality standards as outlined in the Medicare Conditions of Participation (CoPs).

RECOMMENDATIONS:
1. Require MA plans to notify patients of authorization of service requirements prior to the effective date of enrollment.
2. Require immediate notification of the HIPAA Eligibility Transaction System (HETS) by MAQ plans Medicare fee-for-service enrollment and disenrollment, and improve the timing for updating HETS by CMS.
3. “Hold harmless” providers, who in good faith provide physician-ordered, reasonable and necessary home health services to beneficiaries before notification of enrollment.
4. Require MA plans to follow Medicare Fee-For-Service coverage and payment guidelines for home health services.

5. Impose penalties on MA plans that fail to pay for authorized services in a timely manner to providers that meet quality requirements imposed in regulation.

RATIONALE: Failure to require MA plans to follow payment and coverage the same Fee-For-Service Medicare results in dual standards. Also, it is unfair to Medicare beneficiaries enrolled in managed care plans that limit the amount of home health service and impose co-pays and/or fail to authorize care. Further, home health agencies unfairly suffered, and will continue to suffer, serious financial problems caused by inadequate communication of beneficiary enrollment in these plans and failure of plans to pay for service provided.
ENSURE THE ROLE OF HOME HEALTH IN IMPROVED AND INTEGRATED CARE DELIVERY MODELS

ISSUE: The Patient Protection and Affordable Care Act (ACA) calls for sweeping health reform. New health delivery models to be tested under the health reform bill include: (a) chronic care coordination services to high-cost Medicare beneficiaries, (b) better transitions, (c) paying for performance, and (d) increased involvement of primary care physicians. In most cases, the delivery of quality home care services is very dependent upon the collaboration and sharing of health information amongst various health care providers across the continuum of care (e.g. physician practices, hospitals, skilled facilities, rehab facilities, case managers, etc.). Therefore, information sharing amongst physicians and hospitals with home care and hospice providers will be critical to advancing care coordination efforts, reducing costs, and improving healthcare transitions. Home health providers will have many opportunities in models, projects, and programs established in the ACA, including the following:

Accountable Care Organizations (Sec. 3022)
ACOs allow hospitals, physician groups, and other group providers identified by the Secretary to enter into agreements with Health and Human Services (HHS) to be held accountable for quality, costs, and overall care of Medicare beneficiaries.

Independence at Home (Sec. 3024)
The IAH program provides a new chronic care coordination benefit under Medicare for high-cost beneficiaries with multiple specific chronic conditions. Physician/nurse practitioner directed teams provide care to beneficiaries in their homes and coordinate their care across all treatment settings.

Health Homes for Chronically Ill Patients (Sec. 2703)
Planning grants to states to develop a new state plan option to permit Medicaid enrollees with (a) at least two chronic conditions, (b) one condition and risk of developing another, or (c) at least a serious and persistent mental health condition, to select a designated provider or health team operating with such a provider to serve as the individual’s health home for purposes of providing the individual with home health services.

Providing Services to Individuals with a Postpartum Condition and Their Families (Sec. 2952)
Award grants to states, local government and/or non-profits to support education and services that diagnose and manage postpartum conditions. Projects may deliver or enhance outpatient home-based supports, inpatient supports, quality of available supports, and education about these issues.

Community Transformation Grants (Sec. 4201)
The Secretary of Health and Human Services shall award competitive grants to state and local governmental agencies and community based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities, in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming.
National Diabetes Prevention Program (Sec. 10501)
The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a national diabetes prevention program targeted at adults at high risk for diabetes in order to eliminate the preventable burden of diabetes. The program shall include a grant program for community based diabetes prevention program model sites.

Healthy Aging, Living Well; Evaluation of Community Based Prevention and Wellness Programs For Medicare Beneficiaries (Sec. 4202)
The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award grants to state or local health departments and Indian tribes to carry out five-year pilot programs to provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

Grants or Contracts to Establish Community Health Teams to Support the Patient-Centered Medical Home (Sec. 3502)
Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care. The health team is to collaborate with local primary care providers and existing state and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings, and case management for patients.

Community Based Transitions Program (Sec. 3026)
Funding will be provided to hospitals with high admission rates and certain community based organizations that improve care transition services for “high-risk Medicare beneficiaries.” A community based entity means an appropriate community based organization that provides care transition services under this section across a continuum of care through arrangements with hospitals. These funds might provide opportunities for home health agencies.

Center for Medicare and Medicaid Innovation (Sec. 3021)
Establish a Center for Medicare and Medicaid Innovation (CMI) in the Centers for Medicare & Medicaid Services (CMS). The purpose of the CMI is to test innovative payment and service delivery models, in order to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. Creates opportunities for chronic care and other initiatives.

Medicaid Money Follows the Person (MFP) Long Term Care Demonstration (Sec. 2403)
Extends the MFP Demonstration Program through September 30, 2016, and appropriates an additional $450 million for each FY 2012-2016, totaling an additional $2.25 billion.

Medicaid Waiver Demonstration Projects for Dual Eligibles (Sec. 2601)
Extends these demonstrations for five years; upon requests from a state, they can be extended for additional five-year periods.
Bundled Payments Medicaid (Sec. 2704)
Demonstration project in Medicaid to pay bundled payments for episodes of care that include hospitalizations, including physician services provided within the hospital. Home health agencies might have an opportunity to partner with the hospital.

Demonstration Program to Improve Immunization Coverage (Sec. 4204)
The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to states to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

Demonstration Based on Study of Home Health Agencies (sec. 10315)
HHS Study and Report: By March 1, 2014, HHS must report results of a study with recommendations for legislative and administrative action, regarding home health agency costs for care provided to low-income beneficiaries or those in medically underserved areas, and those with varying levels of severity.

Home Health Medicare Demonstration Project (Sec. 3131)
HHS Secretary may provide for a four-year (beginning no later than January 1, 2015) $500 million demonstration project to test whether making payment adjustments based on the study substantially improves access to care for (a) patients with high-severity levels of illness, or (b) low-income or underserved Medicare beneficiaries.

National Medicare Pilot Program on Medicare Payment (Sec. 3023)
A national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge.

RECOMMENDATIONS:

1. Make certain that home health agencies are included in planning and opportunities to be leaders and active participants in ACA models, projects, and programs.
2. Identify types of information and essential clinical elements required for safe and efficient transfers between ambulatory and post-acute settings, and home care/hospice agencies (e.g. home care plan of care document, Outcome and Assessment Information Set or OASIS-C, summary of care, etc.).
3. Establish technical standards to facilitate the electronic exchange of that clinical information in a mutually beneficial format.
4. Pilot/test the electronic information exchange between home care/hospice providers and other clinicians involved in patient-centered care delivery.

RATIONALE: Home health care is the natural alternative to the costly institutional care that has been the focus of Medicare health care expenditures. Medicare home health providers are positioned to care for high-cost beneficiaries in their homes. They are experienced in treating chronic illness in the home setting and coordinating health care based on a plan of treatment.
Leaders in home health are well positioned to participate in and develop new health delivery models. NAHC envisions a future where the integration of electronic health records, remote patient monitoring, and community based skilled nursing services will be the backbone of the national health care delivery system.