PRIORITY 1

Short Description: Withdraw Proposed Rule to Implement a New Home Health Payment Model in CY 2019

Summary: CMS has proposed to implement a new payment model for home health services that would start in CY 2019. The new model radically changes the existing system that has been in place, with modifications, since 2000. The proposal raises serious questions regarding the validity and reliability of the new patient classification system, concerns regarding the impact on patients and providers of home health services, and impact on overall Medicare spending. The proposed system is untried and untested. Also, CMS has not made the data or tools available to assess potential impacts on an individual provider level. Overall, the proposed model is unmanageably complex and would institute highly burdensome changes in home health agency operations without a demonstrated value.

Related Statute/Regulation: 82 FR 35270 (July 28, 2017)

Proposed Solution: Withdraw the proposed CY 2019 changes to the home health payment system, convene a comprehensive stakeholder group to evaluate and design a new payment model consistent with the scope of the Medicare benefit that would be applied in a fully budget neutral manner, establish the model’s validity and reliability, and provide adequate lead time for implementation.
Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017
Name of Submitting Organization: National Association for Home Care & Hospice
Address for Submitting Organization: 228 7th St SE Washington, DC 20003
Name of Submitting Staff: William A. Dombi
Submitting Staff Phone: 202-547-7424
Submitting Staff E-mail: wad@nahc.org

Statutory ___ Regulatory ___

Please describe the submitting organization’s interaction with the Medicare program:

The National Association for Home Care & Hospice (NAHC) is the largest trade association representing the interests of Medicare home health providers throughout the nation. On an ongoing basis, NAHC is involved with Medicare statutory and regulatory matters with Congress, CMS, and others with respect to the home health and hospice benefits.

PRIORITY 2

Short Description: Revise the qualifications of practitioners who can establish home health benefit eligibility certifications

Summary: Medicare law requires that an individual's eligibility for the home health benefit must be certified by a physician. The law does not permit a non-physician practitioner such as a Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist to certify eligibility despite that such practitioners are authorized under many states laws to order and manage home health service and the number of primary care physicians continues to decline. Instead, the non-physician practitioners must “hand off” their patients to a physician in order to comply with the Medicare requirement. As a result, Medicare certification is provided by a practitioner who had not previously cared for the patient rather than the one who has had an ongoing patient relationship. This requirement interferes with the patient-practitioner relationship needlessly and may even compromise the value of the certification.

Related Statute/Regulation: 42 USC 1395f(a)(2)(C); 42 USC 1395n(a)(2)

Proposed Solution: H.R 1825 Home Health Care Planning Improvement Act—amends Medicare law to permit non-physician practitioners to certify eligibility provided that it is within the scope of their practice under state law.
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PRIORITY 3

Short Description: Revise physician documentation and certification requirements in the Medicare home health benefit

Summary: Medicare rules require that the physician certification of home health eligibility be fully supported solely on the basis of the records within the certifying physician’s record. The certifying physician can rely upon records from other providers and practitioners, including the home health agency, but only if the physician records indicate a specific written acknowledgement by the physician that these records were considered by the physician in determining whether the certify eligibility. CMS recognizes that the non-physician records are very useful in accurately determining a patient’s eligibility for coverage, but continues to maintain a highly burdensome and confusing requirement on what it takes to have non-physician records be part of the eligibility evaluation. When considering the whole record of a patient, the accuracy and integrity of the eligibility is exponentially improved. CMS should eliminate its burdensome, paperwork focused standard that leads to erroneous claim determinations.

Related Statute/Regulation: 42 CFR 424.22(c)

Proposed Solution: A solution is included in H.R. 2663. However, that solution is within CMS regulatory powers as well. CMS should revise 42 CFR 424.22(c) to provide that the patient records of a home health agency are automatically considered when determining eligibility provided that the records are used to supplement or clarify consistent physician records.
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PRIORITY 4

Short Description: Delay the revised HHCoPs until at least six months after the CMS issued the interpretive guidelines.

Summary: Revisions to the Home Health Conditions of Participation (HHCoPs) are estimated to have a total cost of $290.3 million in the first year and $290 million the second year and thereafter. This is the first complete revision of the HHCoPs in over 30 years. In addition to the burden associated with revising policies, processes and operations in order to comply with the requirements, the burden is compounded by the lack of guidance materials available to home health agencies. CMS delayed the implementation date for the revise HHCoPs until January 13, 2018. However, CMS does not expect to have guidance materials for implementation issued until December 2017. Agencies must implement the revised requirements based on their individual interpretations of compliance expectations. Additional modification to policies, processes and operations will need to be made if the agency has not applied the revised HHCoPs in accord with CMS’ intentions.

Related Statute/Regulation: Medicare and Medicaid Programs; Conditions of Participation for Home Health Agencies; Delay of Effective Date; Federal Register /Vol. 82, No. 130; 82 FR 31729 (July 10, 2017)

Proposed Solution: CMS should delay the implementation of the revised HHCoPs until at least six months after the interpretive guidelines are issued and seek stakeholder input during the development of these guidelines.
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PRIORITY 5

Short Description: Delay the IMPACT Act implementation timeline for home health agencies

Summary: The IMPACT requires CMS to develop cross setting measure and standardized assessment data for four post acute care providers (SNF, IRF, LTCH, and HHAs). The assessment items must be incorporated into each of the provider’s respective assessment tools. For HHAs, that tool is the Outcome and Assessment Information Set (OASIS). Data derived from the OASIS date set is used for developing home health quality measures, the case mix system for payment, the home health value based purchasing pilot, and care planning.

In order to meet the requirements of the IMPACT significant changes will need to be made to the OASIS assessment tool by 1/2019. Revising the assessment instrument could take CMS several months. CMS must finalize the assessment data they intend to incorporate into OASIS assessment tool, develop the tool, receive clearance for a final version, and begin provider outreach and education. Agencies are at risk for having to apply system and operation changes in a short period of time in order to implement a dramatically different assessment tool that has various applications for home health providers. Software modifications, staff education and training, and the leaning curve associated with changes to the assessment tool all contribute the burden agencies will face if the 1/2019 time line is maintained.

In addition, in order for CMS to meet the timeline for implementation of the requirements of the IMPACT Act and to also maintain the various applications for which the OASIS data set instrument is used (quality, payment, and care planning) CMS is proposing to
implement an assessment tool that contains assessment items that overlap. Agencies will be required to respond to several data assessment items that measure the same patient characteristics (i.e. mobility, self care, behavior, and cognition)

Related Statute/Regulation: Improving Medicare Post-Acute Care Transformation Act of 2014

Proposed Solution: Delay the implementation of a revised OASIS data set instrument related to the IMPACT act until such time that overlapping assessment items can be removed. Additionally, agencies should be provided a minimum of one year to implement a revised OASIS data set instrument.
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PRIORITY 6

Short Description: Expand access to home telehealth services

Summary: Medicare law limits coverage of telehealth services to services provided by physicians and other practitioners to the exclusion of home health agencies. In addition, current law restricts telehealth services coverage in terms of a limiting “originating site” that does not include a patient’s home. Today’s telehealth technologies provide the opportunity for skilled patient monitoring, care management and coordination, and patient education using a variety of telehealth systems. Expanding the breadth of the Medicare telehealth benefit to cover home telehealth provided by Medicare participating home health agencies to patients not otherwise covered under the home health benefit would improve patient care, reduce hospital admissions and readmissions, and reduce Medicare overall spending.

Related Statute/Regulation: 42 USC 1395m(m)

Proposed Solution: Amend 42 USC 1395m(m) to permit home health agencies to provide remote patient monitoring, patient education, and clinical oversight through the use of telehealth service to patients in their home.
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PRIORITY 7

Short Description: Provide the opportunity to correct minor errors and omissions in Medicare claims

Summary: Over the past several years, 98% of the home health claim error rate relates to documentation errors rather than the merits of the patient’s eligibility. As a result, home health agencies are often on a paper-chase to secure missing documentation or correction of submissions when that is even possible. Also, these minor errors and omissions are the source of costly appeals. Paperwork errors can include missing dates on physician signatures, illegible physician signatures, missing records, incomplete “insufficient” documentation, among many others. CMS’s zero defect standard on documentation compliance results in significant application of health resources that ultimately subordinates care to paperwork priorities.

Related Statute/Regulation: General claim documentation standards

Proposed Solution: Establish a policy that permits the correction of minor errors and omissions in paperwork without need for an appeal.