HOME CARE REGULATORY ROUNDUP

HH PAYMENT RATE UPDATE

- Proposed rule published July 7, 2014 in FR

- 2015 - $2922.76

- 2014 - $2869.27

- Rebasing
  - -$80.95
  - +2.2 market basket (Productivity Adjustment -0.4%)
  - +1.0012 wage index budget neutrality factor
  - +1.0237 case mix budget neutrality factor
HH PAYMENT RATE UPDATE

- Per visit rates/LUPAs
  +3.5%

  - Non-routine supplies
    -2.82%

- Outlier eligibility remains the same

- 2% payment sequestration

HH PAYMENT RATE UPDATE

- Case mix weights recalibrated
  + Case mix variables and scores

<table>
<thead>
<tr>
<th>Current</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-13</td>
<td>0-13</td>
</tr>
<tr>
<td>14-19</td>
<td>0-13</td>
</tr>
<tr>
<td>14-19</td>
<td>14-19</td>
</tr>
<tr>
<td>20+</td>
<td>20+</td>
</tr>
<tr>
<td>0-15</td>
<td>0-15</td>
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<tr>
<td>16+</td>
<td>16+</td>
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<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0.1</td>
<td>0.1</td>
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</table>

+ Redefined clinical and functional thresholds

<table>
<thead>
<tr>
<th>1st and 2nd episode</th>
<th>3rd and 4th episode</th>
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<tbody>
<tr>
<td>0-13</td>
<td>0-13</td>
</tr>
<tr>
<td>14-19</td>
<td>14-19</td>
</tr>
<tr>
<td>14-19</td>
<td>20+</td>
</tr>
</tbody>
</table>

Current C1: 0.4 0.6 0.2 0.8 0.7
Proposed C1: 0.1 0.0 0.3 0.3
HH PAYMENT RATE UPDATE

* Case Mix weights
  * Propose to decrease high therapy weight and increase low therapy episode
    - Increase 3.75% for episodes with 0-5 therapy visits;
    - Decrease 2.5% for episodes with 14-15 therapy visits;
    - Decrease 5% for episodes with 20+ therapy visits; and institute gradual weight adjustments for episodes between those thresholds.

  * High therapy cases increased (18-19;20+)

  * Clinical and functional variables off set therapy

HH PAYMENT RATE UPDATE

<table>
<thead>
<tr>
<th>20+</th>
<th>2014</th>
<th>Proposed 2015</th>
<th>Percent change</th>
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<tbody>
<tr>
<td>C1F1S1</td>
<td>1.6745</td>
<td>1.8217</td>
<td>8.79%</td>
</tr>
<tr>
<td>C1F2S1</td>
<td>1.7912</td>
<td>1.8786</td>
<td>4.88%</td>
</tr>
<tr>
<td>C1F3S1</td>
<td>1.8879</td>
<td>1.9611</td>
<td>3.88%</td>
</tr>
<tr>
<td>C2F1S1</td>
<td>1.8096</td>
<td>1.9374</td>
<td>7.06%</td>
</tr>
<tr>
<td>C2F2S1</td>
<td>1.9263</td>
<td>1.9942</td>
<td>3.52%</td>
</tr>
<tr>
<td>C2F3S1</td>
<td>2.0230</td>
<td>2.0767</td>
<td>2.65%</td>
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<tr>
<td>C3F1S1</td>
<td>2.0157</td>
<td>2.175</td>
<td>7.90%</td>
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<tr>
<td>C3F2S1</td>
<td>2.1325</td>
<td>2.2319</td>
<td>4.66%</td>
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<tr>
<td>C3F3S1</td>
<td>2.2292</td>
<td>2.3144</td>
<td>3.82%</td>
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</tbody>
</table>
HH PAYMENT RATE UPDATE

+ Wage index
  × CBSA redistribution
  × Rural to urban and vice versa
    ★ 37 counties urban to rural
    ★ 105 counties rural to urban
  × Some counties change CBSA
  × Transitional wage index - blended 50/50 wage index for 2015
  × 3% rural add-on applies to new rural areas

FACE TO FACE ENCOUNTER

+ Narrative eliminated
  × date of the encounter
  × related to the primary reason for home care
  × within 90 days prior or 30 days after

+ Look at physician record for confirmation
  × HH claim denied
  × Physician claims denied for G1080 – certification
FACE TO FACE ENCOUNTER

+ New SOC and certification/F2F required

- Discharged with goals met and returns to home health

- Remains in hospital over day 61

- Q&A to be removed

FACE TO FACE ENCOUNTER

- Law suit

- Retroactive Reviews

- Narrative ambiguous and complex
THERAPY REASSESSMENT

+ Eliminate 13/19th and every 30 day visit threshold assessments

+ At least every 14 days

+ NAHC recommends at least every 30 days

HOME HEALTH QUALITY REPORTING

× “Pay for Reporting”
  + 2% reduction in payment if quality reporting requirements are not met

  + OASIS submission

× CMS’ ultimate goal is 90% submission rate

× To be phased in over three years
  + 70% 7/1/15 - 6/30/16 — 2017
  + 80% 7/1/16 - 6/30/17 — 2018
  + 90% 7/1/17 - 6/30/18 — 2019
HOME HEALTH QUALITY REPORTING

- CMS defines a “Quality assessment” several ways
  - SOC/ROC with a matching EOC (transfer, discharge or death)
  - SOC/ROC in the last 60 days of reporting period
  - EOC in the first 60 days of the reporting period
  - SOC/ROC followed by one or more recertifications the last of which is in the last 60 days
  - EOC episode that is preceded by a one or more recertification episode last of which occurs in the first 60 days of the reporting period
  - SOC/ROC one visit episode

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

- Follow-up Assessments are neutral
  - Long term care patients
  - Missed recertification

INSULIN COVERAGE

- Additional diagnosis that supports inability to self inject

- Insulin pens

- NAHC comments: Presumptive, require complete review of the medical record
**SPEECH LANGUAGE PATHOLOGY**

- Qualifications
  - Master or doctoral degree
  - State license

**VALUE BASED PURCHASING**

- Begin 2016
- Selected measures
- Five-eight states --all agencies
- 5-8 % increase or decrease in payments
- Payments for achievement and improvement across quality measures
MEDICAID FACE TO FACE

- Proposed rule July 2011
- Unified Agenda - September 2014
- Should have been published within three years
- Will a new proposed rule need to published?
- Some States have a F2F requirement

HOME HEALTH CONDITIONS OF PARTICIPATION (HH COPS)

- Proposed Rule
- Issued October 6, 2014
- Patient centered outcome oriented, data driven, outcome oriented
- More flexibility
HH COPS

× History
  + Proposed rule issued 1997-never finalized
  + Expected to issue another proposed rule in 2006
  + Delayed due to competing priorities at CMS

HH COPS- PRINCIPLES

High quality home health care:

× Patient centered

× Outcome oriented

× Data driven
HH COPS –PRINCIPLES

- Develop a more continuous, integrated care process across all aspects of home health services, based on a patient-centered assessment, care planning, service delivery, and quality assessment and performance improvement.

- Use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions with each other to meet the patient’s needs. Stress quality improvements by incorporating an outcome-oriented, data-driven quality assessment and performance improvement program specific to each HHA.

- Eliminate the focus on administrative process requirements that lack adequate consensus or evidence that they are predictive of either achieving clinically relevant outcomes for patients or preventing harmful outcomes for patients.

- Safeguard patient rights.

HH COPS –CHANGES

Structural changes
- Renumbering
  - Three sections: A - General Provisions 484.1-484.2; B - Patient Care; 484.40-484.80 C - Organizational Environment
  - 484.100 – 484.115

- Several standards combined or incorporated into new CoPs
  - e.g. Current standard for 484.14(g) Coordination of patient services combined with 484.18 Acceptance of patients, Plan of care, and Medical supervision to create 484.60 care planning, coordination of services, and quality of care

- Two new CoPs
  - + 484.65 Quality Assessment and performance improvement (QAPI)
  - + 484.70 Infection Control
HH COPS – CHANGES (CON’T)

- Many of the requirements remain.
- Expands patient rights
- Add a discharge and transfer summary requirement and time frames for submission
- Increased flexibility with HCA assignment, supervision and requirements
- Emphasis on integration and interdisciplinary care planning
- Where standards are written in broad and vague terms, more specificity regarding what is required.
- Increase in Governing body involvement and responsibilities

HH COPS – CHANGES (CON’T)

- Eliminated
  - +60 day summary to physician
  - +Group of professionals (PAC)
  - +Quarterly record review
HH COPS - TOC

- **Subpart A—General Provisions**
  - 484.1 Basis and scope.
  - 484.2 Definitions.

- **Subpart B—Patient Care**
  - 484.40 Condition of participation: Release of patient identifiable outcome and assessment information set (OASIS) information.
  - 484.45 Condition of participation: Reporting OASIS information.
  - 484.50 Condition of participation: Patient rights.
  - 484.55 Condition of participation: Comprehensive assessment of patients.
  - 484.60 Condition of participation: Care planning, coordination of services, and quality of care.
  - 484.65 Condition of participation: Quality assessment and performance improvement (QAPI).
  - 484.70 Condition of participation: Infection prevention and control.
  - 484.75 Condition of participation: Skilled professional services.
  - 484.80 Condition of participation: Home health aide services.

- **Subpart C—Organizational Environment**
  - 484.100 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients.
  - 484.105 Condition of participation: Organization and administration of services.
  - 484.110 Condition of participation: Clinical records.
  - 484.115 Condition of participation: Personnel qualifications

**EMERGENCY PREPAREDNESS**

- Separate Proposed rule issued 12/27/2013
- Part of the CoPs
- Four basis elements
  - Risk assessment
  - Policies and procedures
  - Communication plan
  - Training and testing
- Modified form of hospital preparedness
- Main concern is cost to implement
- Comments due 3/31/2014

**ALternative Sanctions**

- **July 1, 2013**
  - Directed plan of correction
  - Directed in-service training
  - Temporary management

- **July 1, 2014**
  - Civil money penalties
  - Suspension of payment for new admissions
  - Informal dispute resolution
ALTERNATIVE SANCTIONS - CMP

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

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

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

- Lower Range
  - $500 to $4,000 per day
  - related predominate to structure or process-oriented conditions (such as OASIS submission requirements) rather than directly related to patient care outcomes
ALTERNATIVE SANCTIONS - CMP

× Determinants
× The size of the agency;
× Accurate and credible resources that provide information on the operations and the resources of the HHA;
  + Medicare cost reports
  + claims information
× Evidence that the HHA has a built-in, self-regulating quality assessment and performance improvement system (QAPI) program.

ALTERNATIVE SANCTIONS - CMP

× Written notice
  · nature, basis and factors that were considered
  · Effective date – last day of the survey
  · Amount
  · Right to hearing, etc.
× 60 days to file an appeal
  · No delay in imposition of sanction – delays collection schedule
× Waive the right to a hearing
  × CMP reduced by 35 %
  × Accrual begins last day of survey until substantial compliance achieved
× Final Notice
ALTERNATIVE SANCTIONS - SUSPENSION OF PAYMENT

- Suspension of Medicare payment for new admissions
  - Written notice 15 days before effective date.
  - Nature of the non compliance
  - Right to appeal - ALJ

- Agency must notify any new admission of sanction

- May not charge the patient unless notified orally and in writing

ALTERNATIVE SANCTIONS - IDR

- Informal Dispute Resolution
  - Condition level deficiencies
  - Deficiency report to include IDR instructions
  - 10 days to request a hearing
  - Request in writing
ALTERNATIVE SANCTIONS

× Apply to condition level deficiencies only

× Compliance
  + 6 months non-IJ
  + 23 days for IJ


MEDICAL REVIEW

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


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

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

PECOS

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

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


- Physicians dropping off ordering/referring list
  + Fail to revalidate
  + http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html

- PECOS system maintainer issue – fixed last month
OASIS C1

- OASIS C1/ICD – 9 version available
  - Draft until OMB approval
  - OASIS C until 12/31/14
  - OASIS C1/ICD 9 - 1/1/2015

- CMS education webinar 9/3
  - Archive will be available in October 2014 at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Training.html

- Grouper update to coordinate with OASIS and ICD coding


OASIS C1- ASAP SYSTEM

- Conversion To Assessment Submission and Processing (ASAP) System
  - Effective January 1, 2015, OASIS assessment data will be submitted to CMS via the national OASIS Assessment Submission and Processing (ASAP) system.

- Home Health Agencies will no longer submit OASIS assessment data to CMS via their state databases.

- In order to transition data from the state databases to ASAP, the OASIS submission system will shut down permanently at 6:00 p.m. ET on December 26, 2014. The OASIS ASAP system will be available at 12:00 a.m. ET on January 1, 2015.

  - From 6:00 p.m. (ET) on December 26, 2014 through 11:59 p.m. (ET) on December 31, 2014, no OASIS assessments will be accepted.
  - The OASIS ASAP system will become available at 12:00 a.m. ET on January 1, 2015.

- OASIS assessment data files submitted on or after January 1, 2015 using the ASAP system must follow version 2.10 (which supports OASIS-C) and version 2.11 (which supports OASIS-C1) of the OASIS data submission specifications

QIO

× New Contracts - 5 years

× Beneficiary and Family-Centered Care (BFCC) QIO contractors-Aug 1
  + support the program’s case review and monitoring activities separate from the traditional quality improvement activities of the QIOs

× Quality Innovation Network (QIN)-QIOs
  + 14 organizations that will work with providers and communities across the country on data-driven quality initiatives.

The BFCC QIOs will provide services across the five geographic areas listed below.

× **Area 1**: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, Virgin Islands
× **Area 2**: District of Columbia, Delaware, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
× **Area 3**: Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, North Dakota, New Mexico, Oklahoma, South Dakota, Tennessee, Texas, Utah, Wyoming
× **Area 4**: Iowa, Illinois, Indiana, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin
× **Area 5**: Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington

The geographic areas 1 and 5 - awarded to Livanta, LLC.
The geographic areas 2, 3 and 4 - awarded to KePRO
IMPACT ACT

- Signed into law – Oct. 6, 2014
- Standardized assessment tool across PAC settings
- Requires the Secretary to revise or replace current existing patient assessment data elements that are duplicative or overlapping with the new standardized patient assessment data.
- HHA January 2019