



901. Legislative, Regulatory, and Legal Update 2019: A Very Busy Time in Washington Once Again

FINANCIAL MANAGEMENT CONFERENCE & EXPO



National Update: Federal Legislative and Regulatory Issues Affecting Home Care and Hospice

Home Care & Hospice Landscape

- Medicare home health
 - Stagnant number of HHAs
 - Spending growth is flat (\$18B)
 - Utilization trend shows slight decline in visits per episode and episodes per patient
 - Increasing community admissions
- Medicaid home care
 - States shifting to Managed LTSS
 - Tightening utilization and tighter rates
 - \$70B annually, primarily personal care services in HCBS
- Medicare Hospice
 - Growing number of providers
 - Growing spending
 - Growing utilization

Private Duty Home Care Landscape

- Endless growth
- New models of operation
- No uniform data
- Licensure variations
- Quality measures absent
- Demand exceeding supply

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2019 Home Care & Hospice Policy Priorities

- Develop Medicare home health payment model reforms (S.433/H.R.2573)
- Extend Medicare home health rural add-on/develop targeting approach if needed
- Initiate workforce expansion supports
- Address Medicare pre-claim review
- Expand flexibility in the use of home health and telehealth in Medicare innovation models
- Stop Medicaid per capita caps/block granting
- Permit Non-Physician Practitioners to certify Medicare home health eligibility (S.296/H.R. 2150)
- Reform Medicare Face-to-Face documentation requirements
- Reform Medicaid EVV requirements
- Address efforts at integration of hospice into Medicare Advantage
- Hospice improvements
 - Rural support (S1190/HR2594)
 - Palliative Care Education and staffing support (HR647 PCHETA)
- <https://p2a.co/zr0juwz>

CY2020 Proposed Medicare Home Health Rate Rule...plus

- Published July 11, 2019
- <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-14913.pdf>
- Includes:
 - 2020 Payment Model Reform (PDGM)
 - CY 2020 HHPPS rates (1.5% increase over 2019)
 - 2020 Rural add-on
 - HHVBP demonstration program public reporting
 - Quality measures and patient assessment modifications
 - 2021 Home Infusion Therapy benefit restated
 - Therapist assistants permitted to provide maintenance therapy
 - Reduction of POC requirements as conditions of payment

Medicare Home Health Payment Reform: 2020

- PDGM architecture finalized in 2019 rulemaking
- 2020 Proposed Rule sets out:
 - Payment rates
 - Revised behavioral adjustment
 - Outlier standards
 - Updated wage index
 - Recalibrated case mix weights
 - RAP changes
 - Notice of Admission requirement

Bipartisan Budget Act of 2018 (BiBA)

- P.L. 115-123, Section 51001
- Mandates payment model reform
 - 2020
 - Budget neutral transition
 - Behavioral adjustment guardrails
 - Stakeholder involvement
 - Prohibits therapy volume thresholds for payment amount
 - 30-day payment unit
- MBI (inflation update) set at 1.5% in 2020 (P.L. 115-123, Section 53110)

2020 PDGM Model Basics

- Patient-Driven Groupings Model (PDGM)
 - 30-day payment unit
 - Therapy utilization domain of HHPPS dropped
 - 432 payment groups
 - Episode timing: “early” or “late”
 - Admission source: community or institutional
 - Six Clinical groupings (plus subgroups in MMTA)
 - Functional level (OASIS based)
 - Comorbidity adjustment: secondary diagnosis based
 - LUPA range of 2-6 visits
 - Bundled services and supplies
 - Case mix weights recalibrated from 2018 version

Proposed 2020 PDGM Base Rates

- 30-day payment unit: \$1791.73
 - estimated CY2020 30-day period cost of \$1,577.52 (+14%)
 - CY 2020 estimated 30-day budget neutral payment amount of \$1,754.37 (pre-required 1.5% update in BiBA 2018)
 - CY 2019 PDGM rate estimated to be \$1,753.68 if PDGM started in 2019 = \$1779.90 in 2020 with 1.5% update

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Behavioral Adjustment

- Proposal maintains framework for behavioral adjustment
 - Clinical Group -5.91% (-4.28%)
 - Comorbidity -0.37% (-0.38%)
 - LUPA -1.86% (-1.75%)
- Increases adjustment to 8.01% from 6.42%
 - CMS neglected to consider earlier change to 12 diagnosis categories

Rural Add-On

- Revised by BiBA 2018
 - Low Population Density HHAs (counties with 6 or fewer people per square mile)
 - 4% add-on in 2019
 - 3% add-on in 2020
 - 2% add-on in 2021
 - 1% add-on in 2022
 - High utilization counties (top quartile of utilization on average)
 - 1.5% add-on in 2019
 - .5% add-on in 2020
 - All other rural areas
 - 3% add-on in 2019
 - 2% add-on in 2020
 - 1% add-on in 2021

Notice of Admission

- Notice of Admission w/in 5 days
 - Electronic option
- Intended to make CWF most current and avoid difficulties “early” and “late” designations in PDGM
- Penalty for late NOA proportionate to degree of lateness (1/30th rate reduction for each late day)

RAP Phase-Out

- No RAP in 2020 for new HHAs
- Existing HHAs get reduced RAP at 20% in 2020
- No RAPs for any HHA starting 2021
- CMS concerns on fraud and abuse
- CMS view that 30-day billing obviates need for RAP

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OUTLIER

- 2019 formula continued
 - 15 minute unit approach
- FDL increases from 0.51 to 0.63
 - Decreases volume of outlier claims

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CY 2020 HHPPS

- PDGM applies only to care episodes that begin January 1, 2020
- HHPPS rates updated for CY 2020 (episodes that begin before January 1 and end after that date)
 - 2019 payment model uses an “end date” approach to payment.
 - CMS proposes to update the 2019 episodic rates from \$3154.27 to \$3,221.43.
 - The latest the 60-day episodic payment will cover is an episode ending February 28, 2020 for an episode that began prior to January 1.
- The per visit rates for LUPA claims are increased by 1.5% over 2019 rates plus a 1.0065 adjustment to account for wage index budget neutrality.
- NRS add-on updated

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PDGM ADVOCACY

- Focus on the behavioral adjustment
- S. 433 (Collins, Kennedy, Stabenow, Cassidy) 14 cosponsors
- H.R. 2573 (Sewell, Buchanan, Abraham) 28 cosponsors
 - Only permits adjustments after changes occur
 - 2% max or phase-in required
- <https://p2a.co/zr0juwz>
- Proposed 2020 rule release any day: will drive upcoming advocacy

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Compliance Oversight in Home Health Continues

- Claims Oversight: 17.6% improper payment rate (2016-17): significant reduction in last two years
- Five-year, five-state HH preclaim review demonstration; starting again in Illinois (start date: 6/1/19)
 - Ohio; North Carolina; Texas; Florida; and Illinois
 - Illinois PCRD show ed high HHA error rate on documentation
 - 10-15% spending reduction throughout state
- Industry suggests alternatives
 - Targeted reviews
 - Probe and Educate
 - Predictive modeling—PEPPER reports
- Early indications in IL that RCD is an improvement over PCR
- Expansion timeframe unknown

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Medicare Hospice Issues

- Much quieter than home health
- Pattern developing that hospice follows home health experiences
 - Increasing claim oversight
 - Expanded quality and utilization data
 - Publication of quality of care rankings
 - Potential reforms
 - New payment model in the future?

Hospice and Medicare Advantage

- Original “carve-out” of hospice from Medicare managed care
- CMMI planning a demonstration program for certain MA plans (VBID participants)
 - Carve-in of hospice into MA benefit package
 - MA plan can choose to include hospice
 - Details stills lacking
 - 2021 start
- Significant concerns
 - What is the problem or need for improvement?
 - Hospice is working well; already innovative managed care
 - Will the benefits of hospice be compromised?
 - Payment and participation risks
 - Slippery slope for expansion
- NAHC opposes: https://www.nahc.org/wp-content/uploads/2019/01/NAHC_FactSheet_Hospice.pdf

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SUPPORT for Patients and Communities Act

- **HR 6 SEC. 3222. Disposal of controlled substances of a hospice patient by employees of a qualified hospice program.**
- **Permits Physician, PA, nurse or other person licensed to provide medical or nursing services to dispose of unused controlled substances onsite under certain conditions**
 - Scope of practice
 - Patient death or expired medications
 - Attending physicians without limitation
 - DEA-registered physician who is treating patient may dispose of drugs when care plan changes
 - “Disposers” must be trained by hospice
- <https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-H4DF794476D9D4351B5C2A9F51244CA26>

Opioid Disposal

- **Hospice must:**
 - Have policies/procedures for disposal
 - Discuss with and supply to patient/family
 - Document disposal in clinical record
 - Train disposers
- Other issues in HR 6 may serve as model language in discussions at state level for exclusion of hospice, palliative care(*NAHC Report 9/28*)

Proposed FY 2020 Update to Base Payments Plus More

- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1714-P.html>
- **FY 2020 rate update**
 - Recalibrating CHC, Respite, and GIP rates
 - Reducing RHC to achieve budget neutrality
 - Hospice cap at \$29,993.99
- **Shifting to current wage index, eliminating time lag**
- **Significant changes in the patient election statement with focus on “unrelated” services**
- **RFI re: hospice in Alternative Payment Models**

Proposed Election Statement Changes

- **Information about the holistic, comprehensive nature of the Medicare hospice benefit;**
- **A statement that there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions;**
- **Information about beneficiary cost-sharing for hospice services; and**
- **Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the BFCC-QIO if the beneficiary (or representative) disagrees with the hospice's determination.**
- **Condition of Payment**

Proposed Election Statement Addendum

- **Specifics on the list and rationale of unrelated services**
- **At beneficiary's (or rep's) request**
- **At request of non-hospice treating providers and Medicare contractors**
- **Within 48 hours of request (exceptions)**
- **Updating required**
- **Required information set**

NAHC Comments on Proposed Rule

- Phase-in rebasing of GIP; CHC, and Inpatient Respite rates over 3 years
 - Leads to an increase in RHC from 2019 rates in 2020
 - Reduces GIP, CHC, Respite rate increase over proposed
 - Data reliability concerns
 - Disruption
 - Incent inpatient care?
 - Reduces RHC

NAHC Comments on Proposed Rule

- Wage index change
 - Blend lag year with current at 50/50
 - Reduces disruptions
 - Recommend new wage index approach
 - All provider sectors should be on level field

NAHC Comments on Proposed Rule

- Election Statement
 - NAHC supports better information to patients/representatives
 - However, CMS proposal is “over the top”
 - Not realistic for hospices to provide a list of all the possible services and items that might be “unrelated” to the terminal condition
 - Recommendations:
 - Focus on waiver statement
 - Tie info to diagnoses that may be unrelated
 - Do not use as a condition of payment

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HOSPICE OIG ACTIVITY

- Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm (7/3/19)
 - https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00021
 - (1) strengthen requirements for hospices to report abuse, neglect, and other harm
 - (2) ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm
 - (3) strengthen guidance for surveyors to report crimes to local law enforcement
 - (4) monitor surveyors' use of immediate jeopardy
 - (5) improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

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HOSPICE OIG ACTIVITY

- Hospice Deficiencies Pose Risks to Medicare Beneficiaries (7/3/19)
 - https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00020
 - (1) expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices
 - (2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices
 - (3) include on Hospice Compare the survey reports from State agencies
 - (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained
 - (5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries
 - (6) increase oversight of hospices with a history of serious deficiencies. CMS either concurred or partially concurred with all the recommendations except the third.

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CONCLUSION

- Lots going on!
- Opportunities and challenges—as usual
- Strong policy-based support
- Strong political support
- Reality—much of home care and hospice is bought by the government
- Notable—the rest of health care is shifting to community care

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