HOMECARE & HOSPICE
National Association for Home Care & Hospice

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

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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 café services in HCBS
- Medicare Hospice
  - Growing number of providers
  - Growing spending
  - Growing utilization

TABLE 9–1 Changes in supply and utilization of home health care, 1997–2016

	1997	2000	2015	2016	Percent change 1997–2000	Percent change 2000–2015	Percent change 2015–2016
Agencies	10,917	7,528	12,346	12,204	–31%	64%	–1%
Total spending (in billions)	$17.7	$8.5	$18.1	$18.1	–52	113	0.1
Users (in millions)	3.6	2.5	3.5	3.5	–31	38	0.1
Number of visits (in millions)	258.2	90.6	115.1	114.4	–66	27	–1
Visit type (percent of total)							
Skilled nursing	41%	49%	52%	51%	20	5	–2
Home health aide	48	31	10	10	–37	–66	–9
Therapy	10	19	37	39	101	94	5
Medical social services	1	1	1	1	1	–28	<–0.1
Number of visits per user	73	37	33	33	–49	–10	–1
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.1%	9.0%	–30	24	–1

TABLE 9-2 Medicare visits per episode before and after implementation of PPS

Type of visit	Visits per episode				Percent change in:		
	1998	2001	2015	2016	1998–2001	2001–2015	2015–2016
Skilled nursing	14.1	10.5	9.6	9.4	–25%	–9%	–2%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	7.1	7.5	39	36	5
Home health aide	13.4	5.5	2.0	1.8	–59	–64	–9
Medical social services	0.3	0.2	0.1	0.1	–36	–52	<–0.1
Total	31.6	21.4	18.8	18.8	–32	–12	0.1

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TABLE 9-3 Number of participating home health agencies declined in 2016 but remained high relative to earlier years

	2004	2008	2012	2015	2016	Percent change 2004–2015	Percent change 2015–2016
Active agencies	7,651	9,787	12,311	12,346	12,204	61%	–1.2%
Number of agencies per 10,000 FFS beneficiaries	2.1	2.8	3.3	3.3	3.2	55	–2.1

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TABLE 9-4 Fee-for-service home health care services have increased significantly since 2002

	2002	2011	2013	2014	2015	2016	Percent change 2002–2015	Percent change 2015–2016
Home health users (in millions)	2.5	3.4	3.4	3.4	3.5	3.4	37%	<0.1%
Share of beneficiaries using home health care	7.2%	9.4%	9.2%	9.0%	9.1%	9.0%	26	<–1
Episodes (in millions):	4.1	6.8	6.7	6.6	6.6	6.5	61	<–1
Per home health user	1.6	2.0	1.9	1.9	1.9	1.9	17	<–1
Per FFS beneficiary	0.12	0.19	0.18	0.17	0.17	0.17	48	–2
Payments (in billions)	$9.6	$18.4	$17.9	$17.7	$18.1	$18.1	87	<1
Per home health user	3,803	5,347	5,169	5,156	5,225	5,223	37	<–0.1
Per home health episode	2,645	2,916	2,899	2,908	2,965	2,988	12	<1

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TABLE 9–5

Home health episodes not preceded by hospitalization or PAC stay increased at a higher rate than other episodes

	Episodes			Cumulative percent change	
	2001	2011	2016	2001–2011	2011–2016
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.2	14.8%	2.4%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.4	127.4	–7.7
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	26	–3.3
Total (in millions)	3.9	6.8	6.6	74.0	–4.6

TABLE 9–8

Medicare margins for freestanding home health agencies, 2015 and 2016

	Medicare margin		Percent of agencies, 2016	Percent of episodes, 2016
	2015	2016		
All	15.6%	15.5%	100%	100%
Geography				
Majority urban	16.0	15.8	84	83
Majority rural	13.2	13.4	17	17
Type of ownership				
For profit	16.7	16.6	88	77
Nonprofit	12.1	12.0	12	23
Volume quintile				
First (smallest)	7.4	7.9	20	3
Second	9.6	10.1	20	6
Third	12.4	11.3	20	11
Fourth	13.8	14.1	20	19
Fifth (largest)	17.6	17.4	20	62

Washington 2018-19: Impact on Home Care

- Administration in its third year
- Congress thinking mid-term elections
- 2018 Health Care Focus
  - –Entitlement reforms?
  - –Reduce regulatory burdens
  - –Opioid abuse
  - –Repeal and Replace Obamacare (try again?)
- 2019 Health Care Focus???

MedPAC Recommendations: 2018 and 2019

- Cut base rate by 5%
- Engage in rate rebasing over two years

2019 Home Care & Hospice Policy Likely Priorities

- Develop Medicare home health payment model reforms
- 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 in Medicare innovation models
- Stop Medicaid per capita caps/block granting
- Permit Non-physician Practitioners to certify Medicare home health eligibility
- Reform Medicare Face-to-Face documentation requirements
- Reform Medicaid EVV requirements
- Address options for integration of hospice into Medicare Advantage
- Hospice improvements
  - Rural support
  - Staffing support

2018 Successes

- HHGM detoured—-$17B
- Medicaid Community First Choice—$11B
- Home health Rural Add-On—$300m
- Hospice Notice of Election—$300M
- Administrative Burden Reductions—$200M (est)

MEDICAID EVV

- Federal Medicaid requirement
  - Personal care 2020 (recently amended by Congress)
  - Home health 2024 (needed?)
- Stakeholder involvement
  - Minimally burdensome
  - Taking into account best practices
- Six elements for verification (time, attendance, service)
- State flexibility

Medicaid Personal Care

- Recent House Energy & Commerce Hearing https://energycommerce.house.gov/hearings/combating-waste-fraud-and-abuse-medicaid-s-personal-care-services/
  - GAO
    - Differing federal standards on beneficiary safety, billing integrity, and data for personal care programs
    - Need to "harmonize "standards
  - OIG
    - 200 investigations on PCS in last 5 years
      - Patient harm included
    - Fraud schemes
    - Recommendations
      - Minimum standards for PCS attendants
      - Enrollment of PCS attendants
      - Claims integrity improvements
  - CMS
    - High value of PCS
    - Program integrity guidance to states
    - Quality guidance
    - Request for Information on program improvements
    - Focused compliance reviews (NY included)

CY2019 Final Medicare Home Health Rate Rule…and Much More

- Published October 31, 2018
- https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24145.pdf
- Includes:
  - CY 2019 rates (2.2% increase over 2018)
  - Rural add-on
  - HHVBP demonstration program fine tuning
  - Quality measures modifications
  - 2020 Payment Model Reform
  - Home Infusion Therapy benefit
  - Physician certification/recertification documentation standards

OVERALL IMPACT

- 2019 HHPPS--- +$420M
  - Outlier--+$20M
  - Rural add-on-- -$20M
- 2020 PDGM--- Budget Neutral
- Home Infusion Therapy--- +$48M
- OASIS changes--- $60M in annualized HHA savings

2019 Final Payment Rates

- Market Basket Index
  - Rebased input factors
  - 76.1% labor-related share
  - 3.0% update
  - 0.8% Productivity Adjustment
  - 2.2% net increase
  - 2% reduction w/o quality data submission
- Multiple wage index area changes
  - 76.1% labor-related share - down from 78.5%
- Sequestration continues

2019 Payment Rates: Episodes

TABLE 16: CY 2019 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2018 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2019 HH Payment Update	CY 2019 National, Standardized 60-Day Episode Payment
$3,039.64	X 0.9985	X 1.0169	X 1.022	$3,154.27

2019 Final Payment Rates: Visits

TABLE 18: CY 2019 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2018 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2019 HH Payment Update	CY 2019 Per-Visit Payment
Home Health Aide	$64.94	X 0.9996	X 1.022	$ 66.34
Medical Social Services	$229.86	X 0.9996	X 1.022	$234.82
Occupational Therapy	$157.83	X 0.9996	X 1.022	$161.24
Physical Therapy	$156.76	X 0.9996	X 1.022	$160.14
Skilled Nursing	$143.40	X 0.9996	X 1.022	$146.50
Speech- Language Pathology	$170.38	X 0.9996	X 1.022	$174.06

2019 Final Payment Rates: NRS

- **NRS CF $54.14**

TABLE 21: CY 2019 NRS PAYMENT AMOUNTS

Severity Level	Points (Scoring)	Relative Weight	CY 2019 NRS Payment Amounts
1	0	0.2698	$ 14.62
2	1 to 14	0.9742	$ 52.80
3	15 to 27	2.6712	$ 144.78
4	28 to 48	3.9686	$ 215.10
5	49 to 98	6.1198	$ 331.69
6	99+	10.5254	$ 570.48

2019 Final Payment Rates

- **2019 Outlier Formula**
  - **Continuing the cost per 15 minute unit approach**
    - **Amount to be published in the 2019 rate change request**
  - **Loss sharing ratio stays ay .80**
  - **Fixed Dollar Loss ratio change from 0.55 to 0.51**
    - **Needed to spend the 2.5% outlier budget**
    - **Would increase incidence of outliers**
- **CMS provides an ALS patient outlier illustration**
  - **$25k+ cost with $20k reimbursement**

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 2021
  - 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

Rural Add-on

- CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
- High Utilization (2015 data)
  - Top quartile in episodes per 100 enrollees
  - 510 rural counties (778 total)
- Low Population Density [not otherwise "high utilization" (2010 Census data)
  - 6 or fewer people per square mile
  - 334 counties
- All Other
  - 1162 counties

Medicare Home Health Payment Reform: 2020

- Planning ongoing for several years
- New model intended to address:
  - Access to care for vulnerable patients
  - Elimination of therapy volume as payment rate determinant
    - Longstanding MedPAC, CMS, Congressional, and Industry concerns

Bipartisan Budget Act of 2018 (BiBA)

- Response to CMS 2017 HHGM proposal
- 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

PDGM Model: HHGM Revisited

- Patient-Driven Groupings Model (PDGM)
  - 432 payment groups
  - Episode timing: "early" or "late"
  - Admission source: community or institutional
  - Six Clinical groupings (7 subgroups in MMTA)
  - Functional level (OASIS based)
  - Comorbidity adjustment: secondary diagnosis based

PDGM NOTABLES

- Therapy volume domain eliminated
- Cost per minute + NRS approach to resource use
- 30 day periods within 60 day episode
- Regression analysis (2017 base)

PDGM NOTABLES

- Budget Neutral transition
- Behavioral Adjustments (6.42%???)
  - Diagnosis coding
  - Comorbidities
  - LUPA avoidance
- $1753.68 "unit of payment" ($1607 w/HHGM) if at 2019 (2020 TBD)
- LUPA: 2-6 visits @ 10th percentile value of total visits in payment group
- RAP continues except for new HHAs
- Outlier based on 30 day unit of payment

PDGM Behavioral Adjustment/Rates: NPRM (not final)

Behavioral Assumption	30-day Budget Neutral (BN) Standard Amount	Percent Change from N Behavioral Assumptions
No Behavioral Assumptions	$1,873.91	
LUPA Threshold (1/3 of LUPAs 1-2 visits away from threshold get extra visits and become case-mix adjusted)	$1,841.05	-1.75%
Clinical Group Coding (among available diagnoses, one leading to highest payment clinical grouping classification designated as principal)	$1,793.69	-4.28%
Comorbidity Coding (assigns comorbidity level based on comorbidities appearing on HHA claims and not just OASIS)	$1,866.76	-0.38%
Clinical Group Coding + Comorbidity Coding	$1,786.54	-4.66%
Clinical Group Coding + Comorbidity Coding + LUPA Threshold	$1,753.68	-6.42%

PDGM Measure: Timing of Care

TABLE 34: AVERAGE RESOURCE USE BY TIMING (30-DAY PERIODS)

Timing	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Early 30-Day Periods	$2,113.66	2,785,039	32.3%	$1,236.30	$1,232.23	$1,866.79	$2,707.04
Late 30-Day Periods	$1,311.73	5,839,737	67.7%	$1,125.44	$534.82	$987.94	$1,735.69
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 37: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE: COMMUNITY, INSTITUTIONAL, AND OBSERVATIONAL STAYS

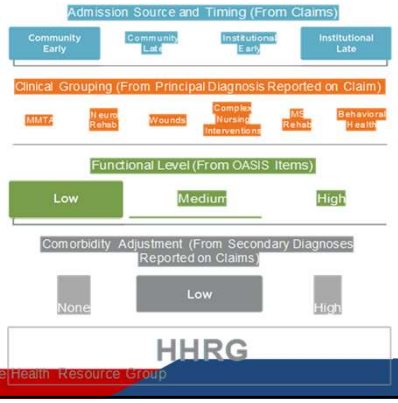
	Average Resource Use	Number of 30-day Periods	Percent of 30-day Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,350.90	6,242,043	72.4%	$1,114.94	$564.31	$1,048.86	$1,799.27
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Observational Stays	$1,820.06	166,762	1.9%	$1,180.96	$960.15	$1,589.08	$2,399.68
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 35: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE, COMMUNITY AND INSTITUTIONAL ONLY

	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,363.11	6,408,805	74.3%	$1,119.20	$570.26	$1,062.05	$1,817.75
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

FIGURE 4: STRUCTURE OF THE PDGM



PDGM ESTIMATED IMPACTS

	Number of Agencies	PDGM
Free-Standing/Other Vol/NP	1,055	1.8%
Free-Standing/Other Proprietary	8,377	-0.9%
Free-Standing/Other Government	252	0.6%
Facility-Based Vol/NP	590	2.8 %
Facility-Based Proprietary	64	4.0%
Facility-Based Government	182	3.9%

PDGM Estimated Impacts

Facility Location: Region of the Country (Census Region)		
New England	355	2.0%
Mid Atlantic	480	2.4%
East North Central	2,019	-1.3%
West North Central	706	-4.2%
South Atlantic	1,647	-5.1%
East South Central	423	1.0%
West South Central	2,753	4.6%
Mountain	679	-5.0%
Pacific	1,417	3.8%
Outlying	41	10.6%

Concerns/Issues

- Impact on therapy patients
  - Regression-based methodology includes therapy volume
  - Change in costing methodology reduces case weights, i.e. payment amounts
- Incentives to focus on inpatient discharges and avoid community admissions
- LUPA structure change
- Clinical groupings heavy on MMTA
- Big swings for some HHAs
- Behavioral adjustment "wild card"

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasm/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

PDGM Advocacy Plan

- **Legislative Action**
- **S.3458. (Kennedy-R.LA/Cassidy-R.LA)**
- **S.3545 (Collins-R.ME/ Nelson-D.FL/ Stabenow-D.MI)**
- **HR.6932 Abraham/ Buchanan/Sewell/DesJarlais/Graves**

- **Behavioral adjustment only after change**
- **Phase-in adjustments greater than 2 points**

PDGM Tools

- https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-P.html
  - CY2019 HH PPS Wage Index [ZIP, 105KB]
  - CY2019 HH PPS Proposed Case-Mix-Weights [ZIP, 13KB]
  - PDGM Grouper Tool [ZIP, 1MB]
  - CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
  - PDGM Weights and LUPA Thresholds [ZIP, 30KB]
  - PDGM Agency-Level Impacts, Estimated for CY 2019 [ZIP, 1MB]
  - Summary of the Home Health Technical Expert Panel Meeting [PDF, 1MB]

2019 Final Rule: Other Changes

- Physician certification/ recertification
- Remote monitoring
- HHVBP
- HHQRP
- Home Infusion Therapy Benefit
- Changes to AO Requirements

Physician Certification

Codify in the regulation:

Physician's medical record to determine patient eligibility for HHS

- Documentation from the HHA medical record may be used to support eligibility
  - Documentation must be corroborated by other documentation in the physician's record
  - Certifying physician signs and dates the HHA documentation
- HHA documentation can include: POC or the initial or comprehensive assessment

CMS accepted our recommendation that the POC with information to support eligibility be permitted as the sole documentation for the physician to sign and date.

Physician Recertification

- Eliminate the statement that estimates how much longer skilled services will be needed as part of the recertification
- Efforts to reduce burden/ Patient over paperwork initiative

Remote monitoring

- Allow as administrative cost on the cost report
- May not substitute a HH visit
- Cost of remote monitoring will factor into the cost per visit

HHVBP

Proposed and finalized

- Remove two OASIS based measures
  - Influenza Immunization received
  - Pneumococcal Polysaccharide vaccine ever received
- Replace the three ADL measures (improvement in bathing, transfer and ambulation) with two composite measures
  - Total Normalized Composite Change in Mobility
  - Total Normalized Composite Change in Self Care
- Each new composite measure counts for a maximum of 15 points

HHVBP - Composite Change in Mobility Measure

Total Normalized Composite Change in Mobility.

Uses these three outcome measures:

- Improvement in Toilet Transferring (M1840)
- Improvement in Bed Transferring (M1850)
- Improvement in Ambulation/Locomotion (M1860)

HHVBP-Composite Change in Self-Care Measure

Total Normalized Composite Change in Self-Care measure.
Uses these six outcomes measures :

- Improvement in Grooming (M1800)
- Improvement in Upper Body Dressing (M1810)
- Improvement in Lower Body Dressing (M1820)
- Improvement in Bathing (M1830)
- Improvement in Toileting Hygiene (M1845)
- Improvement in eating (M1870)

*Currently not part of the HHVBP model

HHVBP-Revising weights for the measures

OASIS and Claims based measures each count for 35 % of 90% of the TPS

HHCAPHS counts for 30 % of the 90 % TPS

Reported measures a.k.a "new" measures count for 10%

Within the claims based measure: Unplanned hospitalization three times as much as ED use measure 26.25%/8.75%

Maximum points earned for performance score reduced to 9 points from 10, except for the composite measures. which will count for 13.5 points

Weights will change if categories of measure are not reported. i.e. no HHCAHPs measures included in the calculation.

Sought comments on what information from the annual score and payment reports should be publicly reported ----- Nothing finalized in this rule

HHVBP

- Changes apply to performance year (PY4-5)2019 & 2020 for payment years 2021& 2022, adjustment will be up or down 7% & 8%, respectively
- Strategies for success will need change
- NAHC recommended that CMS delay implementation by 6 months to a year and reconsider the weight for unplanned hospitalization measure
  - CMS did not accept any of our recommendations

HHQRP

In accord the CMS' Meaningful measure initiative: a parsimonious set and with more meaningful measures

7 measures to be removed from HHQRP for 2021

- Depression assessment conducted- topped out /still needed for risk adjustment
- Diabetic foot care and PT/CG education – topped out
- Fall risk assessment conducted - topped out
- Pneumococcal Polysaccharide Vaccine ever received does not fully reflect current ACIP guidelines
- Improvement of status of surgical wounds – too limited in scope ;needed for risk adjustment
- ED use without hosp. readmission 30 days – a more broadly applicable measure is available 60 hospitalization
- Re-hospitalization first 30 days SSA

HHQRP

- Replaces the six criteria used when considering a quality measure for removal, finalized with seven new criteria used in other post - acute care settings removal factors,
- Finalized an additional factor when considering the removal of a quality measure
  - The costs associated with a measure out weight the benefit of its continued use.
- Revises the regulation at §484.250(a) to clarify that not all OASIS data items are needed to comply with the HHQRP
- Increases the number of years of data used to calculate the MSPB-PAC HH QRP for purposes of display from 1 year to 2 years.
  - reporting still for 2019, or as soon thereafter but using two years of data

Home Infusion Therapy Benefit

- New benefit under Part B (2021)/transition benefit in 2019
- New supplier designation
- Coverage for associated professionals services for infusion on a pump in the home
- Currently professionals services (nursing services) are not covered under Medicare for beneficiaries receiving home infusion outside the HH benefit

Home Infusion Therapy

- Benefit for beneficiaries receiving Infusion therapy (IV and subcutaneous) via a pump that is an item of DME; Part B
- Only certain infusion drugs are covered under Part B DME (antifungals, chemotherapy, inotropic and some pain medications, IGs)
- A qualified home infusion therapy supplier is defined as a pharmacy, physician, or other provider licensed by the state where service are provided.

- The professional services under the benefit Include:
  - Professional services (e.g. nursing)
  - POC established and reviewed by a physician
  - Training and education(vascular access site, medications administration and disease management)
  - Remote monitoring
  - availability 24/ 7
  - Patient must be under the care physician, NP, or PA

Intention is to instruct patient /CG on safe administration and care, same as with HHS

Accredited as a infusion therapy supplier by an AO approved by CMS (many requirements for the AOs)

Home Infusion Therapy

- Payment
  - Enroll as home infusion therapy supplier
  - Bill on a professional claim CMS-1500/837P
  - Single payment for day the nurse is in the home and drug is infused
- Full implementation in 2021
- Transitional period 2019-2020
  - pharmacies already enrolled in Medicare to provide infusion therapy (drugs and pumps)
  - HH benefit continues for IV therapy as alternative payment approach

Home Infusion Therapy

Coordination with Home health

- Professional service associated with this new home infusion therapy benefit must be provided by the home infusion therapy supplier under Part B, not home health
- If a beneficiary is receiving HHS by agency that is also a qualified home infusion supplier, CMS will permit the HHA to bill for the infusion therapy services separately under new Part B home infusion benefit (2021)

Home Infusion Therapy

Concerns ---Beneficiary Impact

- Additional costs—20% copay
- Limitation to entitled benefits
- Fragmented care

Home Infusion Therapy

Recommendations:

- Transitional period (2019 -2020) and the HH benefit
- Allow home health agencies to bill under their existing provider number TOB 34x, do not require a separate supplier number/enrollment {CMS ACCEPTED THIS!}
  - HHAs provide Part B covered services currently under the HHA number (e.g. outpatient therapy)
- Require home infusion therapy benefit be available only the beneficiaries not eligible for the HH benefit – Congressional action

AO Requirements

- AO must continue the facility's current accreditation until the effective date of withdrawal identified by the facility or the expiration date of the term of accreditation, whichever comes first.
- CMS did not finalize it's proposal to require the surveyors for AOs to take the CMS online surveyor training.

Request for Information (RFI)

- Two RFIs
- Advancing interoperability
- • CMS recognizes that obstacles to electronic exchange of patient clinical info persist
- • How can CMS use existing CoP and CfC to advance electronic exchange of info that supports safe transitions of care?
- • In all post-acute care provider payment rules.

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RFI

- Seeking information on increasing communication with patients on accessibility
- and access to charge information.
- – price list, charge master, etc.
- How to inform patient of out of pocket costs
- before furnishing services

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Remote monitoring

- Allow as administrative cost on the cost report
- • May not substitute a HH visit
- • Cost of remote monitoring will factor into the cost per visit

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HHCOPs - Interpretive Guidelines

- IGs issued 8/31/2018
- Revised protocols issued 1/17/2018
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html
  - type in home health
- Survey and Certification division at CMS - Quality, Safety & Oversight

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HHCOPS- Interpretive Guidelines

- Draft HHCoP IGs were not issued publically
- Sent to select individuals
- Only one set of comments permitted to be sent by NAHC.

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HHCOPS- Interpretive Guidelines

- The guidance changes the regulatory requirements in several areas- HCA assignment and supervision
- Long standing guidance has changed with no change in the regulation – Pseudo patient
- The IGs are not regulation
- Question whether CMS followed proper procedures with changes in guidance

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Proposed Rule – Regulatory Burden

- *FR* 9/20/2018
- Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction. https://www.gpo.gov/fdsys/pkg/FR-2018-09-20/pdf/2018-19599.pdf
- Proposes to eliminate:
  - Oral notification of patient rights
  - Clinical record retrieval by the next visit
  - Repeat full competency evaluation when aide concern identified

Requesting additional recommendations

Comments due 11/19/2018

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OASIS-D

- Second FR notice – 8/13/2018
- 30 day public comment period
- Changes in items related to the IMPACT Act
- GG items for functional ability and goals, and self care
- J Health conditions
- Effective 1/1/2019- expect it to clear OMB in time
- No changes in the OASIS–D assessment tool
- Draft users manual – https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
- CMS sponsored on-site and webcast training 11/6-7 /2018 https://www.eventbrite.com/e/home-health-quality-reporting-program-provider-training-tickets-50119686331
-

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Star Rating

- Home Health Quality of Patient Care Star Rating
- Removal of the Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care measure
- Addition of the Improvement in Management of Oral Medications measure

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MEDICARE ADVANTAGE: Supplemental Benefits

- Effective 2019, MA Plans can offer a wider range of "supplemental health benefits"
- CMS offered an example of personal care services
- Little guidance
- Some MA Plan uptake
- Questions: extent of benefits; provider qualifications; payment rates
  - Up to the individual plans

Life Continues!: Oversight in Home Health

- 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???)
  - Ohio; North Carolina; Texas; and
  - Illinois PCRD show high HHA error rate on documentation
  - 10-15% spending reduction throughout state
  - Industry suggests alternatives
    - Targeted reviews
    - Probe and Educate
    - Predictive modeling—PEPPER reports
- MA Plans initiate retrospective reviews
- Medicare reviews increase nationwide

Review Choice Demo (RCD)

- Revised PCR that was paused in April, 2017
- GAO report issued 4/20/2018
- 100% Pre-claim review
- 100% Post-claim review/prepayment
- Opt out-25% payment reduction and subject to RAC referral

RCD

- Five states: Illinois, Ohio, North Carolina, Florida, and Texas for five years, with the option to expand to other states
- All Palmetto/JM Jurisdiction

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RCD

- First notice in the *FR* 5/31/2018
- 60 day comment period
- Second Notice in the *FR* 9/26/2018
- 30 day comment period-comments due 10/29/2018
- Proposed to begin 12/10/2018 in IL.
- 90% approval rate over a six month period

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RCD

- CMS has ignored what it could learned from its earlier demonstration program, PCRD, to shape future program integrity measures
- PCRD showed that there are common characteristics of HHAs at risk of improper claims that would permit efficient targeting of claims reviews
- Viable alternatives to RCD readily exist that are far less costly and burdensome with potentially more effectiveness

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Probe and Educate

- P&E medical review - began 10/2017
- Provider specific issues based on analytics
- 20-40 claims
- Notified by letter
- One-on-One Education
  - Intra probe education
  - Post probe education

–Three rounds of review before further action is taken

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Conditions of Participation = Conditions of Payment

- Plan of Care 42 CFR 484.60/409.43
  - CERT audits focused on POC inclusion of:
    - Advance directives
    - Authorized representative
  - Some HHAs may not have included sufficient information on Ads on POC
  - Began 1/13/18
  - Opportunity to correct

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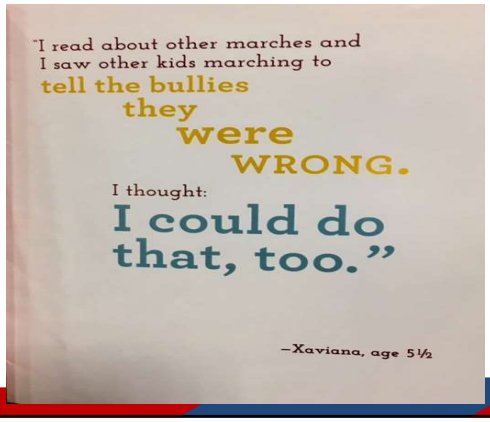
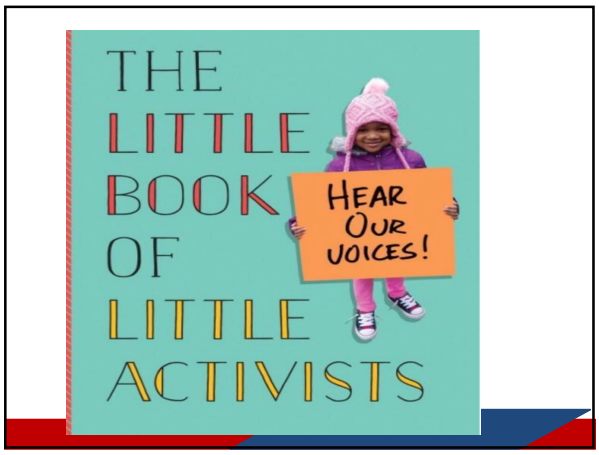
Home Care as an Employer: FLSA-DoL

- Rule changes directly and indirectly targeting home care
  - "companionship services" exemption
  - Live-in domestic services
  - Professional, executive, and administrative salaried employees
- Policy positions informed through home care
  - Joint employer
  - Independent contractor
- DoL Sleep Time Guidance
- DoL New Audit Focus on mileage reimbursement
- Significant W&H litigation nationwide

NAHC 2.0---2018

- Ownership Culture/Servant Leadership
  - Transparency
- Grassroots Advocacy Enhancement
  - Intense social media
  - Earned media
  - Force to be reckoned with
- Workforce Summit
  - All stakeholders
  - Practical Solutions
  - Resources to achieve





NAHC Strategic Plan

Mission Statement

Promote, advance, and protect the highest quality health care at home

Vision Statement

Be the leading and unifying voice for home care and hospice

Improve Advocacy to Heighten the Image, Awareness, and Effectiveness of Home Care and Hospice

Strategies:

- Secure a "unified message" agreement with collaborating organizations to ensure message consistency and impact
- Launch an information campaign through NAHC website, social media, and possible earned media
- Assert NAHC as the unifying voice for home care and hospice
- Mobilize members to amplify advocacy directly and through partnerships with state associations

Tactics with Metrics:

1. Establish 3 formal collaborative partnerships with other national advocacy organizations within and outside of home care and hospice
2. Publish monthly white papers on the value of home care and hospice
3. Increase the number of social media likes and shares of NAHC publications (*Establish a baseline in 2018 to identify an appropriate target*)
4. NAHC leaders appear at least twice per month in national media (print, online, radio, and/or television)
5. Increase participation in the NAHC Legislative Action Center by 25%
6. Establish a network of community-level advocates (minimum 1 per Congressional District)
7. Integrate and coordinate advocacy activities with state associations as full advocacy partners

Enhance Member Relations and Membership Value

Strategies:

- Develop a culture of transparency and ownership by establishing a process to gather regular input and feedback from members
- Allocate an increased proportion of resources to NAHC's advocacy and lobbying efforts in response to expressed member needs and value
- Strengthen NAHC's educational services and events, with a specific focus on content related to advocacy, regulations, and policies and what they mean for members today and in the future
- Undertake leadership role in care and payment innovations
- Evaluate expanded focus on clinical excellence and best practices

Tactics with Metrics:

1. Identify unmet member and non-member needs as well as varied interests of nonprofit and proprietary organizations
2. Increase staff hours dedicated to consultative services (i.e., expert advice for members)
3. Increase conference attendance by 10%
4. Increase number of members using core NAHC programs by 20%
5. Increase number of promoters by 10% (Net Promoter Score)
6. Improve member satisfaction (Establish a baseline for member satisfaction in 2018 to set specific targets for 2019 and

Strengthen and Grow NAHC

Strategies:

- Establish and execute a targeted membership expansion strategy
- Improve employee culture and address capacity and capability issues by restructuring teams and clearly defining employee roles and responsibilities
- Upgrade or install new systems for managing NAHC's business operations to create effectiveness and efficiencies – including financial management, information technology, membership data, and HR management

Tactics with Metrics:

1. Confirm NAHC leadership team (roles & responsibilities) Q4 2018
2. Begin implementing a new governance structure by January 2019
3. Double number of current-to-desired culture values matches FYE 2019
4. Increase membership revenue by 5% FYE 2019
5. Grow sponsorship, affinity program, and advertising revenue by 20% FYE 2019
6. Achieve an operational surplus in FY 2019
7. Modify dues structure as needed to achieve equitable treatment of members FYE 2019

Improve Advocacy to Heighten the Image, Awareness, and Effectiveness of Home Care and Hospice

Strategy 1		Strategy 2		Strategy 3		Strategy 4	
Secure a "unified message" agreement with collaborating organizations to ensure message consistency and impact		**Launch an information campaign** through NAHC website, social media, and possible earned media		**Assert NAHC as the unifying voice for home care and hospice**		**Mobilize members to amplify advocacy directly and through partnerships with state associations**	
Tactics	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**
Establish formal collaborative partnerships with other national advocacy organizations within and outside of home care and hospice	Secure 3 Partners-hips in 2019	1. Publish white papers on the value of home care and hospice 2. Increase social media likes and shares of NAHC publications 3. Increase participation in the NAHC Legislative Action Center	1. Monthly 2. Baseline in 2018 3. 25% Q4 2019	NAHC leaders appear in national media (print, online, radio, and/or television)	At least twice per month	1. Increase participation in the NAHC Legislative Action Center 2. Establish a network of community-level advocates 3. Integrate and coordinate advocacy activities with state associations as full advocacy partners	1. 25% 2. min. 1 per Congressional District 3. Monthly State Assoc calls;; rep. on NAHC GA comm.

Supporting Activities

- ❑ Prioritize up to three policy issues or focus areas
- ❑ Define key audiences and align communication methods
- ❑ Address internal structure, staffing, and systems gaps

Enhance Member Relations and Membership Value

Strategy 1		Strategy 2		Strategy 3		Strategy 4		Strategy 5	
Develop a culture of member ownership by establishing a process to gather regular input and feedback from members		**Allocate an increased proportion of resources to NAHC's advocacy and lobbying efforts in response to expressed member needs and value**		**Strengthen NAHC's educational services and events, with a specific focus on content related to advocacy, regulations, and policies and what they mean for members today and in the future**		**Undertake leadership role in care, payment, and workforce innovations**		**Evaluate expanded focus on clinical excellence and best practices**	
Tactics	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**
1.Identify unmet member and non-member needs of nonprofit and proprietary organizations, 2.Improve member satisfaction	1. Survey member and non-member annually 2.Establish a baseline in 2018 to set specific targets for 2019 and beyond	1.Increase number of members using core NAHC programs 2.Increase number of promoters 3.Improve member satisfaction	1. 20% FYE 2019 2. 10% (net promoter score) FYE 2019 3. baseline for in 2018 & specific targets for 2019 on	1.Increase staff hours dedicated to consultative services (i.e., expert advice for members) 2.Increase conference attendance 3.Increase number of members using core NAHC programs	1. Add casework staff member Q3 2018 2. 10% FYE 2019 3. 20%FYE 2019	1. Refocus Foundation on care and payment innovations 2. Add expanded innovations role to NAHC policy staff responsibilities 3. Workforce Summit	1. Q1 2019 2. Q4 2018	1. Refocus Foundation for Home Care and Hospice on clinical best practices and innovations	1. Reform Foundation board (2019) Hire staff with clinical/research focus (2019)

Supporting Activities

- ❑ Define and communicate the member value proposition
- ❑ Clarify intended audiences for educational services and events
- ❑ Create space in programming to cultivate a member community

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Strengthen and Grow NAHC

Strategy 1		Strategy 2		Strategy 3	
Establish and execute a targeted membership expansion strategy		**Improve employee culture and address capacity and capability issues** by restructuring teams and clearly defining employee roles and responsibilities		**Upgrade or install new systems for managing NAHC's business operations to create effectiveness and efficiencies** – including financial management, information technology, membership data, and HR management	
Tactics	**Metrics**	**Tactics**	**Metrics**	**Tactics**	**Metrics**
1. Increase membership revenue 2. Grow sponsorship, affinity program, and advertising revenue 3. Modify dues structure as needed to achieve equitable treatment of members	1. 5% FYE 2019 2. 20% FYE 2019 3. Q3 2018	1. Confirm NAHC leadership team (roles & responsibilities) 2. Begin implementing a new governance structure 3. Double number of current-to-desired culture values matches	1. Q4 full 2. 1/19 3. FYE 2019	1. Achieve operational Surplus in FY2019	1. Q4 2019

Supporting Activities

- ❑ Address internal structure, staffing, and systems gaps
- ❑ Determine capabilities needed to execute plan
- ❑ Maximize value performance of existing staff and resources consistent with the plan
- ❑ Hire on talent needed to fill required skill gaps
- ❑ Evaluate NAHC brand modernization

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CONCLUSION

- Second year of new Administration raises policy change speculation to a new level: range is modest to all-encompassing
- Moderately stable times with continued regulatory actions
- Oversight growing on claims and quality performance
- Serious challenges remain in regulatory proposals/changes
- Look beyond Medicare
- Manage today, plan for the future!

UPCOMING EVENTS

2019 March on Washington
March 31-April 2
Washington, DC

2019 Financial Management Conference and Expo
July 14-16
Chicago, IL

2019 Home Care and Hospice Conference and Expo
October 13-15
Seattle, WA

