

Hospice and Home Health Update: Recent Legislative and Regulatory Efforts Continue to Change the Regulatory Landscape for Hospice and Home Health Providers

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October and November 2014 have been marked by several legislative and regulatory efforts impacting the hospice and home health industries:

- President Obama signed the Improving Medicare Post-Acute Care Transformation Act of 2014 (“the IMPACT Act”) into law;¹
- The Centers for Medicare and Medicaid (“CMS”) published the Medicare Home Health Prospective Payment System final rule for calendar year 2015 (“Final Rule”);² and
- CMS published proposed changes to the home health conditions of participation and are accepting comments through December 8, 2014.³

Each of these announcements has the potential to result in substantial changes to the hospice and home health industries.

The IMPACT Act

The IMPACT Act was introduced in June 2014 and quickly moved through the legislative process with industry and bi-partisan support. Enacted on October, 6, 2014, the IMPACT Act includes several provisions affecting the home care industry with three (3) provisions that directly affect hospice providers:

¹ H.R. 4994, 113th Congress (to be codified in scattered sections of 42 U.S.C.).

² CMS-1611-F, 79 Fed. Reg. 66,032 (Nov. 6, 2014).

³ 79 Fed. Reg. 61,164 (proposed October 9, 2014).

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1. Medicare-certified hospice providers will be subject to mandated surveys at least every three years for the next ten years.
2. Hospice programs with a certain percentage or number of patients receiving care for more than 180 days will be subject to medical reviews.
3. The hospice aggregate financial cap will be aligned with hospice reimbursement using a common inflationary index that will likely not change hospice reimbursement to providers.

The first provision, requiring increased hospice surveys, addresses two Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) reports (issued in 2007 and 2013) that recommended increased hospice survey and certification frequency.⁴ The 2007 and 2013 OIG reports noted that, in contrast to other health care providers, neither law nor regulation specified the frequency of Medicare certification surveys for hospices. Instead, CMS set the frequency and priority of hospice certification as part of the budget process for state agency survey and certification activities.

From FY 2000 through FY 2005, CMS required certification surveys of hospices at least every six years.⁵ In FY 2006, survey frequency was pushed to eight years but by FY 2013 the target timeframe had returned to 6.5 years.⁶

Despite the CMS-set timeframes, the 2007 OIG report found that 14 percent of hospices were past due for survey, and that, on average, hospices that were past due for certification had not been surveyed for nine years. Similarly, the 2013 OIG report found that 17 percent of state-surveyed hospices had not received a survey within the six-year recertification timeframe. Based on these findings and concern that infrequent and untimely recertification surveys indicated inadequate oversight of hospice compliance with the Medicare conditions of participation and quality of care requirements, the OIG recommended in both reports that CMS set specific timeframes for the frequency of hospice recertification surveys and suggested the three-year interval used by accrediting organizations.

With the passage of the IMPACT Act, beginning in April 2015, HHS must, through an appropriate state, local, or recognized accreditation entity, conduct routine hospice surveys at least once every three years. Hospice providers that participate in the Medicare program should, therefore, expect increased surveys by their state survey agency. Most private accrediting agencies have already been conducting site visits or surveys of hospice providers every three years, and as such, accredited providers may not see a similar increase. To ensure continued compliance, Medicare-certified

⁴ Dep’t of Health & Human Serv., Office of the Inspector Gen., OEI-06-05-00260, Medicare Hospices: Certification and Centers for Medicare & Medicaid Services Oversight (April 2007) (*hereinafter* 2007 OIG Report); Dep’t of Health & Human Serv., Office of the Inspector Gen., OEI-06-13-00130, Recommendation Followup memorandum Report: Frequency of Medicare Recertification Surveys for Hospice is Unimproved (August 2013) (*hereinafter* 2013 OIG Report).

⁵ 2007 OIG Report, pg. 2–3.

⁶ 2013 OIG Report, pg. 3.

hospice providers in states with a backlog for state survey may want to consider pursuing accreditation through a third party (e.g., the Accreditation Commission for Health Care (“ACHC”), the Community Health Accreditation Program (“CHAP”), or the Joint Commission).

The second provision affecting hospice providers—calling for focused review of hospices with long patient stays—fixes a technical drafting error in the Affordable Care Act (“ACA”) provisions regarding the hospice medical review process. The focused medical review of hospices with long patient stays was initially proposed in a 2009 MedPAC Report as a way to identify providers with inappropriate admissions and recertification practices.⁷ Medicare pays for hospice care when a beneficiary’s physician and the hospice medical director certify that the beneficiary is terminally ill and has a prognosis of six months or less to live if the terminal illness runs its normal course. As such, patient stays that are longer than 180 days have come under scrutiny by CMS and its audit contractors, as well as by government enforcement agencies. CMS noted in the 2015 hospice wage index and payment rate update final rule that the average lifetime hospice length of stay for Medicare beneficiaries increased 59 percent between 2000 and 2011,⁸ and MedPAC noted that in 2011 over half of Medicare hospice spending was on patients whose hospice stays exceeded 180 days.⁹

Although hospice medical review provisions were included in the ACA, a drafting error prevented CMS from implementing the review requirement. With the passage of the IMPACT Act, CMS is now required to conduct a medical review of all hospice agencies that reach a specific threshold of patients who receive care from the hospice for more than 180 days. This threshold will likely be calculated as a percentage of the total number of patients that receive hospice care; however the specific threshold and the procedures for medical review still need to be determined by CMS through the administrative rulemaking process. Hospice providers and stakeholders should follow the development of these reviews and provide CMS with comments when the proposed threshold and review processes are published.

The third provision affecting hospices concerns how the hospice aggregate financial cap (the “hospice cap”) is indexed each year. The hospice cap is an absolute dollar limit on the average annual payment, per beneficiary, that a hospice can receive. If a hospice agency exceeds its cap, it must return those dollars to the Medicare program. Previously, the hospice cap had been calculated using the medical expenditure component of the Consumer Price Index for All Urban Consumers (“CPI-U”). However, as a result of the IMPACT Act, the hospice cap will be tied to the hospital market basket, which will more closely align the methodology for the hospice cap update amount and hospice payment rate updates. Although the change in the calculation of the hospice cap update will likely not impact most hospices, it is

⁷ March 2009 Report to Congress: Medicare Payment Policy, *available at* <http://www.medpac.gov/documents/reports/march-2009-report-to-congress-medicare-payment-policy.pdf?sfvrsn=0>.

⁸ 79 Fed. Reg. at 50,498 (Aug. 22, 2014).

⁹ June 2013 Report to Congress: Medicare and the Health Care Delivery System, *available at* http://www.medpac.gov/documents/reports/jun13_entirereport.pdf?sfvrsn=0.

expected to slow the rate of growth in the hospice cap, which may mean that, over time, more providers exceed the cap or those who exceed the cap do so by a higher amount. This may provide incentive for hospices with cap-related overpayments to review their admission and discharge criteria. The change in hospice cap calculations will apply to accounting years that end after September 30, 2016, and end before October 1, 2025.

The IMPACT Act also includes provisions that effect home health providers by implementing standardized data collection and reporting of patient assessment data, quality measures, and resource use measures to CMS.¹⁰ Patient assessment data includes functional status; cognitive function; special services, treatments, and interventions; medical conditions and co-morbidities; and impairments. Quality measures include functional status and cognitive function, skin integrity, medication reconciliation, the incidence of major falls, and patient preference regarding treatment and discharge options. Resource use measures include Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions. Home health agencies (“HHAs”) must report on the skin integrity and medical reconciliation quality measures to CMS by January 1, 2017. Reports on the remaining three quality measures (*i.e.*, functional status, major falls, and patient preference) as well as the standardized patient assessment data are due to CMS by January 1, 2019.

In addition, the IMPACT Act states that CMS is to provide HHAs with confidential feedback reports on their performance with respect to the resource use measures by January 1, 2018. By January 1, 2019, CMS will create procedures to make the information about individual HHA performance related to the resource use measures publicly available. Although the report dates were included in the IMPACT Act, the reporting process and requirements for HHAs will still be subject to the administrative rulemaking process. Home health providers should stay engaged and provide CMS with comments when the proposed rule is published.

The 2015 Medicare Home Health Prospective Payment System Final Rule

On November 6, 2014, CMS published its changes to the Medicare Home Health Prospective Payment System (“HH PPS”) for calendar year 2015. As discussed in a previous Client Alert by Epstein Becker Green,¹¹ the most significant change offered by CMS in the proposed rule related to the physician face-to-face encounter documentation requirements for HHA reimbursement.¹²

¹⁰ These standardized data collection and reporting requirements apply to other post-acute providers including: skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals.

¹¹ Emily Bajcsi and Serra Schlanger, “Client Alert: Medicare’s Proposed Home Health Rule for 2015: CMS Suggests Only Limited Relief to the Face-to-Face Encounter Documentation Requirements but Continued Compliance Burdens on Home Health Agencies” (July 2014), *available at* <http://www.ebglaw.com/publications/medicares-proposed-home-health-rule-for-2015-cms-suggests-only-limited-relief-to-the-face-to-face-encounter-documentation-requirements-but-continued-compliance-burdens-on-home-health-agencies/>.

¹² 79 Fed. Reg. 38,366 (July 7, 2014).

By way of background, as a condition for payment, the Affordable Care Act (“ACA”) established a requirement that, prior to certifying a patient’s eligibility for the Medicare home health benefit, a physician must document that the physician himself or herself (or an allowed non-physician practitioner) had a face-to-face encounter with the patient. In addition to documenting the face-to-face encounter, the physician is responsible for including an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services.¹³

CMS received over 330 comments from interested stakeholders in response to the proposed rule, with the face-to-face documentation requirements proposal drawing industry-wide concern.¹⁴

In the Final Rule, CMS finalized three changes to the face-to-face encounter documentation requirements that will be effective for start of care episodes beginning on or after January 1, 2015.

First, CMS eliminated the current physician narrative requirement for most services.¹⁵ The certifying physician must still certify that the face-to-face encounter occurred within the required timeframe¹⁶ and that the encounter was related to the primary reason for home health services. The physician also must continue to document the date of the face-to-face encounter. However, instead of requiring the physician narrative to be part of the HHA’s required documentation, CMS will now require the medical records of the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home health) to contain sufficient documentation to support the physician’s certification of beneficiary eligibility for home health services. CMS confirmed that the physician’s records should include the visit note from the face-to-face encounter.

Second, CMS finalized its proposal that a physician’s claims for certification or recertification visits will not be covered if the HHA’s claim is denied due to insufficient documentation to support the patient’s eligibility, because there is no longer a respective claim for Medicare-covered home health services.

Third, CMS clarified that face-to-face encounters are required for certifications, rather than initial episodes. CMS also noted that certification, as opposed to recertification, is typically considered to be whenever a new assessment is completed to initiate care.

¹³ 42 C.F.R. § 424.22(1)(a)(v).

¹⁴ See http://www.nahc.org/NAHCReport/nr141001_1/.

¹⁵ For instances where the physician is ordering skilled nursing visits for management and evaluation of the patient’s care plan, the physician will still be required to include a brief narrative describing the clinical justification as part of the certification/recertification of eligibility. See 42 C.F.R. § 424.22(a)(1)(i) and § 424.22(b)(2).

¹⁶ The face-to-face encounter may be completed up to 90 days prior and no more than 30 days after the start of home health care services.

Although CMS is eliminating the burden of the physician narrative requirement, ambiguity as to what constitutes “sufficient” documentation remains. CMS will now permit HHAs to provide certifying physicians with copies of the HHA’s records in order to aid the physician in the accuracy and integrity of the certification documentation. Providing such records to the certifying physician may help HHAs ensure that adequate documentation is incorporated into the physician’s record, however the certifying physician must review and sign off on anything that is incorporated into the medical record and used to support the certification/recertification of patient eligibility. Additionally, CMS stated that providers should refer to recently published educational articles and Q&As for guidance regarding adequate documentation. Specifically, CMS cited its article *Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter*,¹⁷ which we note pre-dates the Final Rule and is focused primarily on how providers can comply with the now-retracted physician narrative requirement. It is, therefore, unclear how helpful this guidance will be, and whether it suggests that all the Final Rule has done is change the location, but not the substance, of the documentation necessary to support the certification of homebound status and skilled care need by certifying physicians.

Allowing HHAs to provide documentation to the physicians may help alleviate the burden on HHAs to ensure that certifying physicians are including sufficient documentation of patient eligibility in their medical records. However, it will not entirely resolve the ongoing tension between HHAs and physicians, as HHAs will continue to bear a disproportional financial risk if documentation is determined to be insufficient. Furthermore, the Final Rule does not provide HHAs with any relief or clarity regarding compliance with the physician narrative requirement for home health services provided before January 1, 2015, when the Final Rule will take effect, or for claims that are currently under review and appeal. Although one may hope that the Medicare Administrative Contractors and other reviewing bodies would take these changes into account, these claims still remain at risk for denial due to insufficient physician narrative documentation.

The Final Rule also updated the Home Health Quality Reporting Program. The home health conditions of participation (“CoPs”) require HHAs to submit Outcome and Assessment Information Sets (“OASIS”) assessments as a condition of payment. In the Final Rule, CMS established the minimum submission threshold number of OASIS assessments that each agency must submit in order to avoid being subject to a two percent reduction in their annual payment updates. For episodes beginning on or after July 1, 2015, and before June 30, 2016, HHAs will be required to submit admission and discharge OASIS assessments for at least 70 percent of all patients with episodes of care occurring during the reporting period. CMS intends to increase the compliance threshold over the next two years to reach a maximum threshold of 90 percent. CMS’s focus on increasing compliance with the OASIS assessment reporting requirements aligns with the provisions of the IMPACT Act discussed above. CMS

¹⁷ Dep’t of Health & Human Serv., Center for Medicare and Medicaid Services, *MLN Matters® SE1405: Documentation Requirements for Home Health Prospective Payment System (HH PPS) Face-to-Face Encounter*, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1405.pdf>.

has indicated that it believes that gathering more information and documentation will increase quality of care. CMS stated that it does not want to rely on state surveyors to ensure compliance with the submission of OASIS data because (1) state surveyors have limited access to the data, (2) state surveyors do not have access to the claims or billing information necessary to determine if complete quality episodes have been submitted for each patient, and (3) compliance with OASIS reporting requirements must be assessed on an annual basis in order to determine whether an HHA will receive its full market basket update or be subject to the two percent reduction for non-compliance.

In the Final Rule, CMS also eliminated the 13th and 19th reassessment visit requirements for therapists. Instead, for episodes beginning on or after January 1, 2015, a qualified therapist, not an assistant, is required to provide the needed services and reassess the patient at least once every 30 days. While the Final Rule specified these requirements for therapists, CMS acknowledged the role of therapy assistants and stated that assistants may still provide the medically reasonable and necessary services they are qualified to perform throughout the duration of the patient's care episode. CMS hopes this change will reduce the burden on HHAs, as well as reducing the risk of non-covered stays by allowing therapists to focus on providing higher quality of care.

The Proposed Modifications to the Conditions of Participation for Home Health Agencies

CMS is currently seeking input and comment from providers on proposed changes to the CoPs for HHAs.¹⁸ CMS last published a proposed rule with changes to the CoPs for HHAs in March 1997.¹⁹ However, that rule was never finalized in its entirety; only pieces of the proposed rule were finalized.²⁰ Seventeen years later, CMS has issued a new proposed rule that changes the CoPs for HHAs and purports to more closely align the CoPs with the modern realities of home health practice. The proposed CoPs also seek to develop more continuous, coordinated, and integrated care for home health patients.

The proposed changes to the CoPs include:

- Enhanced and expanded patient rights requirements;
- Changes to plan of care requirements and the processes for transfer and discharge of patients;
- New requirements for the development of Quality Assessment and Performance Improvement (“QAPI”) programs; and
- New requirements for infection prevention and control.

¹⁸ 79 Fed. Reg. 61,164 (proposed October 9, 2014).

¹⁹ 62 Fed. Reg. 11,004 (March 10, 1997).

²⁰ For example, the Outcome and Assessment Information Set (“OASIS”) data collection requirements were finalized in other rules.

Many HHAs may already have some practices in place that may satisfy the new requirements. However, the proposed changes still significantly impact the practice of providing home health care. For example, the expanded patient rights requirements call for additional information to be provided to patients. These requirements will likely increase the administrative burden on HHAs. Similarly, the development of new QAPI programs will result in additional costs and burdens on HHAs. In response to the addition of the QAPI program requirements, the CoPs call for the elimination of the professional advisory group requirement. However, states and third party accrediting bodies may maintain different standards than the CoPs and therefore may continue to require professional advisory groups. Similarly, states and third party accrediting bodies may have different requirements for infection prevention and control. Home health providers will need to closely analyze and assess their policies and practices to ensure that they remain in compliance with the CoPs as well as other relevant regulations and guidance. Once the CoPs are finalized, HHAs may want to encourage states and third party accrediting bodies to adopt requirements that match those in the CoPs.

Home health providers and other interested stakeholders should consider submitting comments about the proposed CoPs to CMS. ***Any interested party can submit comments on the Proposed Rule until 5:00 p.m. on December 8, 2014.***

Conclusion

The passage of the IMPACT Act, the significant changes included in the Medicare HH PPS Final Rule, and the release of new proposed CoPs for HHAs signal that both hospice and home health providers continue to face a changing regulatory landscape. In order to maintain compliance and a competitive advantage, hospice and home health providers—as well as physicians, referring facilities, and other interested stakeholders—must stay on top of these regulatory changes and issues. Epstein Becker Green attorneys are available to help providers follow these moving targets and navigate issues and changes as they develop.

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