

Home Care, Hospice Care, and the Affordable Care Act

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The Patient Protection and Affordable Care Act, as amended, (Affordable Care Act or Act) makes substantial cuts in Medicare payment for home care.¹ These reductions are part of the way Congress intends to pay for the programs established under the Affordable Care Act. The Act also makes other changes that will affect home care operations and may indirectly affect payment. For example, the Act changes the face-to-face requirements for home care and hospice certification and recertification. The Act provides for additional future changes in home care operations and payment to be determined by the Centers for Medicare and Medicaid Services (CMS) based

on studies and various factors discussed below. Finally, the Act also provides for future changes in hospice payment. According to the Congressional Budget Office, the Affordable Care Act is expected to reduce Medicare spending on home healthcare services by \$4.2 billion for federal fiscal years 2010 - 2014, and over \$39.5 billion through 2019.² CMS estimates the cuts to be \$900 million in 2011.³

In July, CMS promulgated proposed regulations (Regulations)⁴ to implement the Affordable Care Act's changes in home health payment, and in home health and hospice certification requirements.



Affordable Care Act Home Health Payment Changes

2011 Changes

Medicare pays for medically necessary skilled nursing, therapy, medical social services, aide visits, medical supplies, and other services (with the exception of durable medical equipment) furnished to beneficiaries in their homes, subject to certain limitations. The Medicare Act provides payment for home health services at a prospectively determined rate per episode of home healthcare. Policy and regulation have been to pay on the basis of 60-day episodes of home care, subject to several adjustments. In addition, the Medicare Act provides outlier payments for exceptionally costly and resource-intensive cases.

For budget neutrality, CMS capped aggregate outlier payments at 5% of total home health payments, and the prospectively determined rate per episode was reduced by 5%. From 2000 through 2009, CMS implemented this policy. The 5% outlier cap was a projection and not an absolute limit. In the home health prospective payment regulation for each upcoming year, CMS would set the level of outlier payments so that they were projected to equal 5% of total home health payments, based on historical data adjusted as determined appropriate by CMS. In general, whether because of flaws in the projection methodology or industry behavioral responses or both, aggregate outlier payments would exceed 5% of aggregate home health payments notwithstanding the 5% projection.

Concerned with rising outlier payments, CMS for 2010 implemented a 10% agency level cap. CMS also reduced the allocation to the outlier payment pool from 5% of total home health payments to 2.5% of total payments. In 2010, the 5% amount was first added back to the per episode payment and the 2.5% amount was then subtracted from the per episode amount to fund the outlier pool, again projected at 2.5% of aggregate home healthcare payments.⁵

The Affordable Care Act's most significant change to home health payment policy is to the update and outlier provisions, which are effective January 1, 2011. The Act requires a home health outlier policy in which the standard episode payment is reduced by 5%, and the outlier payment is targeted to be 2.5% of total home health payments.⁶ For example, if the per episode prospectively determined payment were \$100.00 before consid-

eration of outliers, under 2010 law and regulation, the per episode payment would be reduced to \$97.50, and \$2.50 would be added to the pool for outlier payments. Under the Affordable Care Act, the per episode payment is reduced to \$95.00 and \$2.50 is allocated to the outlier pool. Under the Affordable Care Act, therefore, the aggregate payment for home health services, including the per episode payment and the outlier pool payment, is reduced from \$100.00 to 97.50. In the Regulations, CMS states that because this change is required by the Affordable Care Act, it has no discretion as to whether to implement the change.⁷ This change reduces the national standardized per 60-day episode payment rate for calendar year 2011 from \$2,312.94 to \$2,253.63.

The Affordable Care Act also reduces the home health market basket update factor. In general, the payment rates for home health services are annually updated by a market basket index factor, which reflects the changes in the costs of goods and services purchased by the home health agency. The Affordable Care Act provides that after "determining the home health market basket percentage increase . . . the Secretary shall reduce such percentage . . . for each of 2011, 2012 and 2013 by 1 percentage point."⁸ The Affordable Care Act further provides that these changes may result in negative market basket updates in these years. According to the Congressional Research Service, "[w]ith these changes to the market basket updates, the rate of growth in payments to HHAs [home health agencies] would likely slow and could even fall below zero."⁹ For 2011, in the absence of the changes made by the Affordable Care Act, the update factor would have been 2.4%, according to CMS. Under the Affordable Care Act, the update factor is 1.4%.¹⁰

In addition, the Affordable Care Act legislatively codifies the CMS administrative practice of separating changes in the case mix adjustment into real changes driven by clinical severity of illness factors, and nominal changes driven by changes in coding practices by home health agencies. In the Regulations, CMS estimated that if it fully accounted for the difference between nominal and real case mix changes, the result would have been a 7.43% reduction in the standardized per episode payment amount for 2011. However, because of

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other reductions in home health payments under the Affordable Care Act, CMS determined to phase in this reduction over two years, 2011 and 2012, at the rate of a 3.79% reduction per year. For 2011, the effect of the Affordable Care Act's market basket provision, together with its codification of CMS' approach to case mix adjustment, is to change the national standardized per 60-day episode payment rate from \$2,253.63 to 2,198.58. Thus, the cumulative effect of the Affordable Care Act for 2011 is to change the national standardized 60-day episode payment rate from \$2,312.94 to \$2,198.58.¹¹

The Affordable Care Act provides relief from the effect of these provisions to rural home health agencies, which will receive a 3% increase over the payment that would otherwise be made from April 1, 2010 through December 31, 2015.¹²

Future Changes

Under the Affordable Care Act, CMS must rebase home health payments by a percentage, considered appropriate by CMS, to reflect the number, mix, and level of intensity of services in an episode, and the average cost of providing care. In so doing, Congress directed CMS to consider the differences between hospital-based and freestanding providers, for-profit and nonprofit providers, and the varying resource costs of urban and rural providers.¹³ Any resulting adjustments would be required to be made before the next following home health payment market basket update. A four-year phase-in, beginning in 2014 and ending in 2017, is provided, in equal increments that may not exceed 3.5% of the applicable amounts for each year.

The Affordable Care Act makes significant payment changes for home health services furnished to Medicare beneficiaries. Through various methodology and amount changes, the Affordable Care Act will require home health agencies to become more efficient in order to be able to cost effectively and viably provide quality home health services to Medicare beneficiaries.

Other Home Health Changes

Among the more important changes in Medicare home health requirements are those relating to physician certification. The Affordable Care Act amends physician certification requirements for home health services by requiring that, prior to making such a certification, a physician must document that

the physician himself or herself, or a specified non-physician practitioner, has had a face-to-face encounter with the patient, related to the services involved.¹⁴ This encounter may be through the use of telehealth, subject to the requirements of Section 1834(m) of the Social Security Act. The Affordable Care Act does not amend the statutory requirement that a physician must certify a patient's eligibility for the home health benefit. Instead, it provides that specific non-physician practitioners may conduct the encounter, and it authorizes CMS to prescribe a time frame for the encounter. CMS has stated that it "believe[s] that the face-to-face statutory provision was enacted to strengthen physician accountability in certifying that home health patients meet home health eligibility requirements."¹⁵

Importantly, CMS has exercised this discretion to provide that the face-to-face encounter must occur closer to the start of home healthcare than the six-month period recommended, but not required, by the Affordable Care Act for Part B services. Therefore, the Regulations provide that the physician responsible for the certification of home health services must document that he or she, or the appropriate non-physician practitioner, has had the face-to-face encounter no more than 30 days prior to the home health start of care date.¹⁶

In addition, if this general requirement is satisfied, but the patient's clinical condition changes such that the "primary reason" the patient requires home care is unrelated to the patient's condition at the time of the face-to-face encounter, the original encounter will not satisfy the requirement.¹⁷ Instead, under this scenario, another face-to-face encounter is required within two weeks of the start of home care. Similarly, if no encounter occurred within the 30 days prior to the start of care, the face-to-face encounter must take place within two weeks after the start of home care. CMS does not make clear how the two-week encounter rule will be applied, and some clarification may be provided in the final Regulations. However, it would be prudent for home health agencies to obtain new face-to-face documentation prior to the start of an episode of care and new certifications whenever the patient's condition is different from the condition supporting the initial certification, including by secondary diagnosis. In the absence of additional guidance, the conservative course is to obtain more recent certification in any case in which the patient's



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condition changes or becomes more complicated from a diagnostic perspective, rather than the original certification diagnosis changing merely in degree.

CMS also is proposing that the documentation of the encounter would clearly state that either the certifying physician himself or herself, or the applicable non-physician practitioner, has had a face-to-face encounter with the patient and would include the date of the encounter. The documentation also would describe how the clinical findings of the encounter support eligibility for the home health benefit. CMS states that “[s]pecifically, the physician would document how the clinical findings of the encounter supported findings that the patient was homebound and in need of intermittent skilled nursing and/or therapy services.”¹⁸ Home health agency forms will not suffice for this purpose. Instead, the certifying physician is required to sign and date the certification “and document the face-to-face encounter in his/her practice’s medical record. As such, the physician’s medical [record] keeping for that patient must be consistent with and supportive of the required documentation of the face-to-face encounter as part of the certification.”¹⁹

Home Health Studies and Demonstration Projects

The Affordable Care Act requires CMS to conduct a study of home health agency costs, involved with assuring ongoing access to care for low-income Medicare beneficiaries and beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. Taking into account this study’s results, CMS could provide for a four-year demonstration, beginning no later than January 2015, to test whether payment adjustments for home health services would substantially improve access to care for patients in medically underserved areas, and in treating beneficiaries with severe illnesses. CMS is to provide \$500 million for the period from 2015 through 2018 for the design, evaluation, and implementation of the evaluation and demonstration projects.²⁰ The Regulations as proposed do not outline a mechanism for submitting projects that could access these funds.

Hospice Care Certification Changes

A person must be considered terminally ill to be eligible for the Medicare hospice benefit. For a person to be considered terminally ill, the person’s attending physician and the medical director of the hospice (or a physician member of the hospice team) must certify that the person has a life expectancy of six months or less. The medical director or physician member of the hospice team must recertify that the beneficiary is terminally ill at the beginning of each 60 or 90-day eligibility period. Medicare payments to hospices are predetermined fixed daily amounts for each case, and are based on one of four prospectively determined units of payment, which correspond to four different levels of care—routine home care, continuous home care, inpatient respite care, and general inpatient care.



Home health is not alone in having heightened face-to-face requirements under the Act. The Medicare Payment Advisory Commission (MedPAC) expressed concern over the appropriate utilization of the hospice benefit. MedPAC made specific recommendations concerning hospice eligibility and payment policy. In general, the Affordable Care Act requires hospices to adopt MedPAC’s eligibility and certification requirements. Specifically, the Affordable Care Act requires that on and after January 1, 2011, a hospice physician or nurse practitioner must have a face-to-face encounter with every hospice patient to determine the continued eligibility of the patient prior to the 180-day recertification, and prior to each subsequent recertification. The Affordable Care Act also requires that each hospice physician or nurse practitioner attest that such a visit took place. Hospices that admit a patient who received hospice services previously, from the admitting hospice or another hospice, must consider the patient’s entire hospice stay to determine which benefit period the patient is in, and whether a face-to-face visit will be required for recertification.²¹

CMS interprets this provision to involve medical necessity determinations, rather than being a more formal require-

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ment. Under the Regulations, therefore, recertification visits by physicians or nurse practitioners must be made not sooner than 15 calendar days prior to the recertification and subsequent recertifications, and the visit findings must be used by the certifying physician to determine continued eligibility for hospice care.²² The 15-day time frame aligns with the time frames for comprehensive assessment updates specified in the conditions for participation.

Thus, CMS in the Regulations is amending hospice certification requirements, especially with regards to long-stay patients. The Regulations require both certifications and recertifications to be based on visits within 15 calendar days of the effective date of a hospice election (for initial certification), or the start date of a subsequent benefit period (for recertifications).²³ The documents must include both the signature of the physician and the date each physician signed.

Future Hospice Payment Changes

The Affordable Care Act requires that not later than October 1, 2013, CMS must implement revisions to the methodology for hospice payment for routine home care and other services included in hospice care. These changes generally must be budget neutral.²⁴ It may be expected that the hospice-related changes will be based on the experience and payment amounts of the Medicare program for home health services. Consequently, these changes are not likely to be positive for hospices. The Office of Management and Budget projects hospice payments will be reduced by \$100 million through 2019.²⁵

Conclusion

Most of the focus on the Affordable Care Act has related to its insurance reform provisions rather than the changes to Medicare Parts A and B. Changes to home care and hospice payment and certification requirements have received even less attention. Nevertheless, the changes under the Affordable Care Act for home care and hospice providers are meaningful and substantial. These providers will be forced to adapt to an even

leaner payment environment than previously, and will face challenges to become more efficient in continuing to deliver quality care to Medicare beneficiaries. **C**

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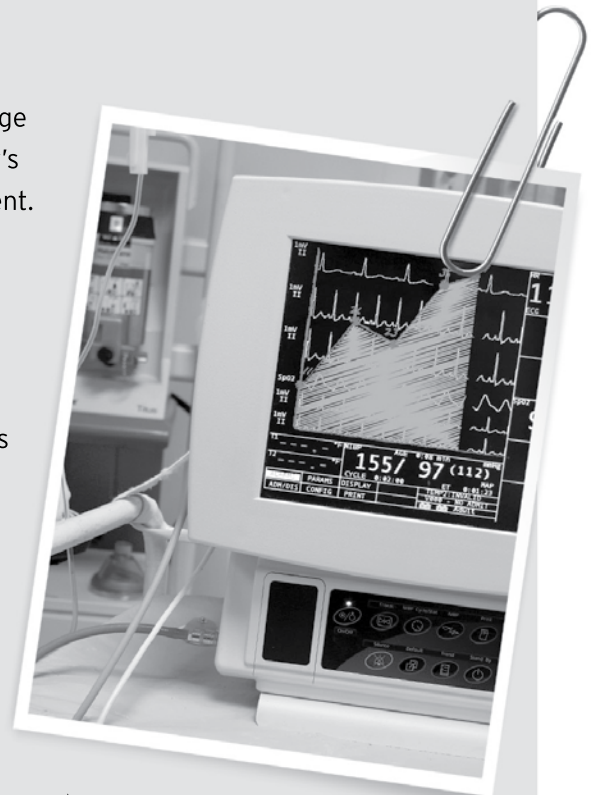
Endnotes

- 1 See Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111 – 148, § 3131, as amended by the Health Care Education and Reconciliation Act of 2010 (HCERA), Pub. L. No. 111 - 152 (collectively referred to in this article as the Affordable Care Act or Act).
- 2 See Congressional Research Service, *Medicare Provisions in PPACA (P.L. 111-148)*, 7-5700, at 40 (Apr. 21, 2010).
- 3 See Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies; Proposed Rule, 75 Fed. Reg. 43236 (July 23, 2010) (to be codified at 42 C.F.R. pts. 409, 418, 424, 484, 489) (Regulations).
- 4 See *id.*
- 5 See *id.* at 43249.
- 6 See Affordable Care Act, § 3131(b).
- 7 See Regulations at 43249.
- 8 Affordable Care Act, § 3401(e).
- 9 See Congressional Research Service, *supra* note 2, at 8.
- 10 See Regulations at 43250.
- 11 See *id.* at 43257.
- 12 See Affordable Care Act § 3131(c).
- 13 See *id.* § 3131(a)(1).
- 14 See *id.* § 6407(a).
- 15 See Regulations at 43267.
- 16 See *id.*
- 17 *Id.*
- 18 *Id.*, at 43267, 43268.
- 19 *Id.*, at 43268.
- 20 See Affordable Care Act § 3131(d).
- 21 See Regulations at 43270.
- 22 See *id.*
- 23 See *id.*
- 24 See Affordable Care Act § 3132(a).
- 25 See Congressional Research Service, *supra* note 2, at 40.

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