Home Care & Hospice
ALLIANCE OF MAINE

Federal

Regulatory Update

Regulation	Major Provisions	Why This Matters to Providers
Discharge Planning **Proposed Rule** **October 2015**	• Proposes that hospitals and home health agencies establish discharge planning processes • Proposes minimum content for discharge and transfer summaries • Proposes that providers take into account quality, resource use, and other performance when informing patients about selecting a post-acute care provider	• HHAs will need to change their processes for discharge planning • New rules around assisting patients in the selection of a post-acute care provider may impact patient choice • Significant anticipated staff/financial burden on HHAs (aggregate estimate impact is $34M in one-time costs and $283M recurring annual costs)
Home Health Conditions of Participation **Proposed Rule** **October 2014**	• Would modernize Medicare's Home Health Agency Conditions of Participation to ensure safe delivery of quality care to home health patients. • Reflects the most current home health agency practices by focusing on the care provided to patients and the impact of that care on patient outcomes. • Focuses on assuring the protection and promotion of patient rights; enhances the process for care planning, delivery, and coordination of services • Streamlines regulatory requirements; and builds a foundation for ongoing, data-driven, agency-wide quality improvement.	

Measuring Access for Medicaid **Final Rule** Effective date: **January 4, 2016**	• Requires states to develop and implement a plan to measure access to specific fee-for-service services, including home health • Does not dictate how states measure access • Requires states to address access problems although CMS does not dictate which strategies states must use	• Provides opportunities for HHAs to advocate for appropriate access standards within their states • A companion Request for Information issued by CMS provides opportunity for comment on the development of national standards
Physician Fee Schedule **Final Rule** Effective date: **January 1, 2016**	• Effective January 1, 2016, physicians and other eligible providers may be reimbursed for advance care planning consultations with Medicare patients	• While neither home health agencies nor hospices may bill for these services, this change will increase patient engagement and appropriate use of hospice and palliative care services
Comprehensive Care for Joint Replacement **Final Rule** Effective date: **January 15, 2016**	• This rule finalizes CMS' proposal to implement mandatory bundled payments for hip and knee replacements in 75 MSAs around the country. • The final rule was placed on display on November 16, 2015	• While home health and hospice agencies are not financially responsible for this model, hospitals are encouraged to partner with other providers to improve quality and efficiencies. Hospitals may opt to share savings with provider partners, including home health and hospice agencies.
Medicaid Face-to-Face **Final Rule** Effective date: **July 1, 2016**	This rule finalizes CMS' proposal to implement the same face-to-face documentation requirements on home health agencies under Medicaid as exist under Medicare. This rule was originally proposed in 2011.	Providers must determine any variations between the Medicare and Medicaid rules. Different processes and/or forms may need to be used.
Medicare Prior Authorization of Home Health Services Demonstration **Final Notice**	This notice, dated 6/10/16, announces a 3-year Medicare pre-claim review demo for home health services in Illinois, Florida, Texas, Michigan, and Massachusetts where there have been high incidences of fraud and improper payments for these services.	This demonstration will begin in Illinois no earlier than August 1, 2016, in Florida no earlier than October 1, 2016, and in Texas no earlier than December 1, 2016. The demonstration will begin in Michigan and Massachusetts no earlier than January 1, 2017.

Nondiscrimination in Health Programs and Activities (HHS) **Final Rule** Effective date: **July 18, 2016**	The Department of Health and Human Services (HHS) has issued this rule to advance health equity and reduce disparities in health care to assist some of the populations that have been most vulnerable to discrimination and will help provide those populations equal access to health care and health coverage. The basic requirement of the law is that consumers cannot be denied health services or health coverage or discriminated against in other ways in health services or coverage because of their race, color, national origin, sex, age, or disability.	The rule applies to any health program or activity, any part of which receives funding from HHS, such as hospitals that accept Medicare patients or doctors who treat Medicaid patients. It applies to any health program that HHS itself administers. And it applies to the Marketplaces and to all plans offered by issuers that participate in those Marketplaces. Read the Press Release Summary of the Final Rule
Mandatory Cardiac Bundled Care Initiative **Proposed Rule** **September 2, 2016** Comments on the proposed rule are due **October 3, 2016.**	On August 2, 2016, CMS issued the proposed rule: Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR). The proposed rule outlines the structure for a bundled payment project for acute myocardial infarctions (AMI), coronary artery bypass graphs (CABG), and adds surgical hip/femur fracture treatments (SHFFT) to the CJR bundled initiative that went into effect April 1, 2016. The EPMs under the proposed rule are similar to the CJR bundled project. NAHC believes these EPMs will have similar benefits and draw backs for home health agencies (HHAs) as the CJR initiative. Hospitals will be looking to partner with cost efficient post-acute care providers.	• Hospitals will be looking to partner with cost efficient post-acute care providers. • Home health care is the least costly of all post-acute care settings, with home health agencies continually rising to the challenge of caring for sicker and frailer patients. • Agencies that can demonstrate effective episode management and good quality outcomes for these patients should be proactive in working the local hospitals and physicians to develop relationships as preferred providers, with or without a formal collaborative arrangement.

2017 Home Health Prospective Payment System (HHPPS) **Proposed Rule** **July 5, 2016**	In addition to the HHPPS Proposed 2017 Payment Rates, the CMS Proposed Rule also includes significant changes in HHRG scoring and weights, a revised standard for outlier episode payments, modifications in the current Home Health Value-Based Purchasing (VBP) pilot program, and several revised quality measures for the Home Health Quality Reporting Program.	That final rule is expected to be released in late October or early November as it must be issued at least 60 days prior to its January 1, 2017 effective date.
FY2017 Hospice Payment Rule **Final Rule** Effective date: **October 1, 2016**	In late July, 2016, CMS issued its final rule governing Medicare hospice payment and quality reporting requirements for Fiscal Year (FY2017). As expected and represented in the proposed rule issued April 21, the principal focus of the FY2017 rule is issues related to the Hospice Quality Reporting Program (HQRP), while also including information related to the FY2017 wage index, payment rates, and cap amount. Overall, CMS estimates the rule to increase payments to hospice programs by $350 million during FY2017.	
Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers **Final Rule** Effective date: **60 days after publication in the Federal Register**	CMS has finalized the rule to bolster emergency preparedness of entities participating in Medicare and Medicaid. The proposed rule was published December, 2013. The final rule establishes consistent emergency preparedness requirements for health care providers, increases patient safety during emergencies, and establishes a more coordinated response to natural and man-made disasters.	• Requires providers and suppliers to plan for disasters and coordinate with federal, state tribal, regional, and local emergency preparedness systems to ensure that facilities are adequately prepared to meet the needs of their patients during disasters and emergency situations. • Providers and suppliers affected by this rule must comply and implement all regulations one year after the effective date.