Focus on Washington: A Federal Update 2018

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Washington 2018: Impact on Home Care

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

CONGRESS: The FY 2018 Budget

- Medicare cuts: $500 Billion
- Medicaid cuts: $1 Trillion
- Budget= Guideposts
- No substantive legislation---That comes later!

Medicaid Reforms on the Table (2017)

- Institute a "per capita caps" federal funding formula tied to 2016 spending
  - Permits federal spending increases tied to state Medicaid enrollments
  - Annual inflation update
- Permit greater state flexibility on benefit design
- After 2020, states get enhanced federal funding only for continuing eligibles, new enrollees funded at lower level
- Drop Community First Choice optional benefit

Medicaid Reforms on the Table (2017)

- Home care and hospice impact
  - Medicaid eligibility changes should have limited impact as population covered is not likely a home care or hospice population
  - Medicaid per capita caps raise concerns
    - Home care expansion opportunities will be burdened by capped federal financial support
    - State flexibility can favor or disfavor home and community based care and/or hospice
      - HCBS is 53% of LTSS spending
      - Range in HCBS spending is 79%-27%
      - 24 states spend less than 50% of LTSS spending on HCBS
      - Hospice benefit is optional

Medicaid Reforms on the Table (2017)

- Home care and hospice impact
  - Loss of optional Community First Choice benefit may be a significant blow to home care
    - States would lose a 6% increase in federal matching payments that is to encourage LTSS rebalancing
    - 8 states have adopted the program (CA, CT, MD, MT, NY, OR, TX, and WA)
    - 5 states have submitted applications or are actively considering (AK, AR, CO, MN, and WI)
    - States could still use waivers to bring about same scope of benefit (but w/o the 6% FMAP increase)

Medicaid Reform

- **Forecast:**
  - **Lots of talk with little solid action**
  - **Expanded flexibilities for state-based reforms**
    - **Privatization/managed Medicaid**
    - **Cost sharing**
    - **Work requirements**
    - **Dual eligible coordination**

Medicare Reforms in Play? (2018)

- **Privatization**
- **Eligibility age**
- **Provider rate cuts**
- **Cost sharing reforms**

- **Forecast: Lots of talk, little action in an election year; President not supportive**

2017 Home Care Legislative Priorities

- **Stop CMS rule on new HH payment model**
- **Stop Medicaid per capita caps/block granting**
- **Permit Non-physician Practitioners to certify Medicare home health eligibility**
  - **Home Health Care Planning Improvement Act of 2017 H.R.1825; S. 445(2017)**
- **Extend Medicare Home Health Rural Add-on**
  - **S. 353 (2017)**
- **Reform Medicare Face-to-Face documentation requirements-- H.R. 2663**
- **Hospice improvements**
  - **Rural support**
  - **Staffing support**

2018 Home Care Legislative Potential Priorities

- Develop Medicare home health payment model reforms
- Extend Medicare home health rural add-on/ develop targeting approach if needed
- Initiate workforce expansion supports
- 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

Medicare Landscape

- MedPAC
  - HOME HEALTH RECOMMENDATIONS: 5% cut in 2019; Change HHPS; Rebasing
  - HOSPICE RECOMMENDATIONS: Freeze rates in 2019; Integrate hospice w/in MA
- Why these risks?
  - HHA Medicare margins increase despite 2014-17 rebasing while quality up without loss of access
  -

FREESTANDING HHAs	MEDICARE MARGIN	OVERALL MARGIN
2015 National	17.82%	4.78%
2015 NE	25.89%	2.23%
2016 National	18.15%	1.95%
2016 NE	22.54%	(0.75%)

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MEDICAID EVV

- Federal Medicaid requirement
  - Personal care 2019
  - 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)

CY2018 Final Medicare Home Health Rate Rule…and Much More

- Published November 1, 2017
- https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-23935.pdf
- Includes
  - CY 2018 rates
  - HHVBP demonstration program fine tuning
  - Quality measures
- Does Not Include: HHGM 2019

Projected Financial Impact

- CY 2018 rate update: -$80 Million (-0.4 percent) in CY 2018
- CY 2018 HHVBP: $378 million in Medicare savings in CY 2018

CY 2018 Home Health Rates

- 2018 Rates
  - 1% Market Basket Index
  - 0.97 case mix weight change adjustment
  - $3039.64
- Loss of Rural add-on (need Congressional extension)
- Case mix weight recalibrations
- Maintains outlier eligibility and payment standards
- 2% reduction for HHAs that do not submit quality data
- Expect 2% sequestration to continue

2018 HHPPS Case Mix Recalibrations

- Case Mix Weight Recalibration
  - All 153 classifications affected
  - Overall reduction in CMW
    - Leads to higher base episode weight
  - Uneven CMW adjustments
    - Designed to account for changes in resource use
  - Expect continual annual recalibrations

HHGM Model: NOT FINALIZED

- New model intended to address:
  - Access to care for vulnerable patients
  - Elimination of therapy volume as payment rate determinant
- Home Health Groupings Model (HHGM)
  - 144 payment groups
  - Episode timing: “early” or “late”
  - Admission source: community or institutional
  - Clinical grouping: 6 groups
  - Functional level: 2-3 groups
  - Comorbidity adjustment: secondary diagnosis based

HHGM: NOT FINALIZED

- **Notables**
  - **Therapy volume domain eliminated**
  - **Cost per minute + NRS approach to resource use**
  - **30 day periods within 60 day episode**
  - **Admission source (Hospital or PAC 14 days prior to early episode)**
  - **Six clinical groups**
  - **OASIS-based functional analysis M1800-1860 + M1032**
  - **Secondary diagnosis adjustment**
  - **Regression analysis (2016 base)**

HHGM Plan of Action

- **HHGM Alternative Proposal to Congress : United HH community (prior to rule action)**
  - **Withdraw rule**
  - **2020 reform implementation**
  - **30 day payment period**
  - **$1772 rate (CMS proposal-$1600 est.)**
  - **.5 MBI reductions in 2021-2023**
  - **CMS TEP on model—all alternatives are open**
  - **Rural add on 5 year extension**
  - **Physician certification/F2F documentation relief**
  - **NPP bill**
  - **HHVBP extended to all ($3B from reduced hospitalizations)**

Recommended Reform Principles

- **The transition to any new payment model must be fully budget-neutral in relation to the existing payment model.**
- **Any new model should not include system changes that incentivize or encourage behavioral changes that are counter to the provision of necessary and timely care.**
- **Payment models should provide reasonable and sufficient reimbursement such that the entire scope of the home health benefit is covered.**
- **Payment amounts should be based on patient characteristics and clinical needs, not the level of service utilization in order to avoid improper financial incentives to provide unnecessary care.**
- **The payment model should operate consistently with other aspects in service delivery.**
- **All stakeholders should be given sufficient time to implement any changes in operations that are needed with a new payment system to avoid unintended consequences that could affect patients and service continuity.**
- **Significant changes in payment models should be fully tested and validated through such means as a demonstration program prior full application.**

Recommended Reform Process Standards

- Full stakeholder involvement
- Two-way dialogue throughout
- Decision-making transparency
- Data access and data sharing
- Use of a Technical Experts Panel (TEP)
- Public reporting of plan development
- Model testing for validity and reliability to ensure control over unintended consequences
- Administrative Procedures Act ("APA") compliant rulemaking

Home Health CoPs

- CMS delays CoPs until 1/13/17
  - Draft interpretive guidelines issued
  - Final: ????? (CMS says not much will change)
  - NAHC requested further delay: rejected
  - CMS suspends CMPs for one year
- Major changes
  - QAPI
  - Infection control
  - Patient Rights
  - Drops subunits: transition process developed

Home Health CoPs

- Subunit transitions
  - Gap in enrollment to Branch
  - Treatment of claims
  - Patient transfers
- Home health aide competency testing
  - Use of pseudo-patients
- Patient Bill of Rights
- Drug regimen review by therapists
- Plan of care timetable reset with SCIC

Life Continues!

- Claims Oversight: 32% improper payment
  - Three-year, five-state HH preclaim review demonstration; started in Illinois with episodes
  - Suspended by new administration
  - Shows high HHA error rate on documentation
  - CMS searching for options
    - Targeted reviews
    - Probe and Educate
    - Predictive modeling—PEPPER reports
- MA Plans initiate retrospective reviews
- Medicare reviews increase

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Medicare Home Health Oversight Claims Target Areas

- Technical compliance
  - Signed and dated orders
- Homebound
  - Absences documented or reported by patient
  - Conflicting documentation
- Medical Necessity
  - Therapy is a big target
  - Improper "improvement" standard
  - Documentation weakness on skilled nature of care
- Coding
  - diagnoses
- Face-to-Face Encounter
- Therapy Assessments

Face-to-Face Audits

- Most HHAs had 5 claims audited
- HHAs with high denial rate will have a second round
- MAC education of HHAs
- Early indications of excessive denial rate
  - HHA failure to meet technical requirements
  - Physician records insufficient
  - No reply to ADR
- Advocacy efforts continue
  - Congress
  - CMS
  - Court
- Temporary Solution: incorporate HHA records into MD records

Recertification

- Longstanding rule with new interpretation: 42 CFR 424.22(b)(2)
- "The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. "
- Must be part of the recertification
  - included in the recertification statement
  - separate statement where it is clear that it is part of the recertification
    - I certify that in my estimation services will be required for ……..
    - Agency may complete based on the physician estimate

Medicare Advantage: Post Pay Audits

- MA plans have begun auditing home health claims on a post-pay basis, including MI
- Some using a contractor: SCIO
- Focus on technical compliance issues
  - Signed physician orders
  - F2F requirements
  - Pre-2015 therapy needs assessments
  - OASIS
- HHAs not aware that MA plans required compliance with technical Medicare FFS standards
- Significant back liabilities
- Costly appeals processes

HH Pre-claim Review Demo

- What is the next generation PCRD?
  - Optional system
  - Targeting use
    - 1st episode
    - Diagnosis-based
    - Performance-based exemption
  - Alternative solutions to documentation issues

PCRD Alternatives

- Preventative Actions:
  - Reform F2F/physician certification documentation requirements
  - Model documentation forms
  - Documentation certification checklist
  - Expanded education, including physician
  - MAC staff education
- PCR alternatives
  - Make PCR voluntary
  - Automated prepayment reviews
  - Random PCR with significantly reduced volume
  - Targeted performance-based reviews
  - Compliance accreditation by independent review organization

Medicare Home Health Oversight

- Audit of an MA-based HHA https://oig.hhs.gov/oas/reports/region1/11300518.pdf
- estimated overpayments of at least $15.5 million for the audit period.
- Alleged that agency incorrectly billed Medicare because beneficiaries were not homebound, beneficiaries did not require skilled services, documentation from the certifying physicians was missing or insufficient to support the services the Agency provided, or, in one instance, a claim contained an incorrect payment code.
- CMS settled for much less

Medicare Home Health Oversight

- Audit of NY-based HHA https://oig.hhs.gov/oas/reports/region2/21401005.pdf
- Alleges that the agency incorrectly billed Medicare for some beneficiaries who were not homebound, some beneficiaries who did not require skilled services, and some services for which the documentation from the certifying physician was missing or insufficient to support the services.
- OIG estimated that the agency received net overpayments of at least $7.5 million for the audit period.

Medicare Hospice Issues

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

Recent Prosecutions

- **Houston Home Health Agency Owner Sentenced to 480 Months in Prison for Conspiring to Defraud Medicare and Medicaid of More Than $17 Million (8/18/17)**
- **Owner and Healthcare Company Sentenced for Conspiracy to Commit Healthcare Fraud and Conspiracy to Pay and Receive Illegal Kickbacks (9/21/17)**
- **Doctor & Owner of Multiple Home Health Companies Sentenced in a nearly $60 Million Medicare Fraud Scheme (8/18/17)**
- **Owner of Home Health Agency Sentenced to 75 Years in Prison for Involvement in $13 Million Medicare Fraud Conspiracy (8/11/17)**
- **Registered Nurse Who Owned Two Houston Home Health Companies Convicted in $20 Million Medicare Fraud Scheme (8/10/17)**

Recent Prosecutions

- **Common factors**
  - **Billing for services not rendered or not necessary**
  - **Payments to beneficiaries and physicians**
  - **Patient recruiters used to bribe beneficiaries**

Home Care Compliance vs. Fraud

- **Fraud= Jail, Fines, and Repayments**
- **Noncompliance=Administrative headaches and Refunding Overpayments**
- **Compliance Areas**
  - **Claims and Conditions for Payment**
  - **Quality of care (CoPs)**
  - **Provider enrollment**

Referral Risk Areas: Home Care and Hospice issues

- **Hospital discharge planning: patient freedom of choice**
- **Paid Medical Directors**
- **Staff compensation for referrals**
- **Quid pro quo (cross referrals)**
- **Beneficiary inducements**
- **ALF service relationships**
- **Use of recruiters**
- **Hospice/Nursing facility deals**

Referrals: C- Level Screening

- **Where are the referrals coming from?**
- **Has there been any change in referral patterns?**
- **Is there any financial relationship with any referral source?**
- **Does the staff compensation method create any risk?**
- **Do third parties contribute to referrals?**
- **Do staff have any family or personal relationship with referral sources?**

CLAIMS RISK AREAS

- **UTILIZATION LEVELS**
- **AUTHORIZATION OF CARE**
- **COMPLIANCE/CONSISTENCY WITH APPROVED PLAN OF TREATMENT**
- **DOCUMENTATION**
- **TECHNICAL REQUIREMENTS FOR PAYMENT**

CLAIMS COMPLIANCE: Oversight Methods

- **MACs, ZPICs, SMRC, RACs, States looking**
- **Hospice and home care targeted**
- **Audits are data driven based on benchmark aberrancies**
- **Automated and complex claims reviews**
- **Technical compliance the first target**
- **Coverage standards the second stop**
- **Extrapolation through sampling audits**
- **Payment suspensions**

CLAIMS RISKS: Medicaid

- **Personal care services**
  - **Staff credentials**
- **Dual-eligibles (Medicare maximization)**
- **Private duty nursing: pediatric and adults**
  - **Frequency and duration**

Medicaid Hospice Claims Risk Areas

- **Billing for Medicaid personal care to a Medicare hospice patient**
- **Medicaid billing for services and items covered under Medicaid hospice benefit**
  - **Pharmaceuticals**
  - **Ambulance**
- **State Medicaid payment reductions that reflect beneficiary contribution obligation**
  - **http://www.oig.hhs.gov/oas/reports/region1/11000004.asp.**
  - **OIG found that Massachusetts Medicaid did not reduce hospice payments to reflect "spend down" patients' contribution obligation**

Medicare Hospice Claims Risk Areas

- **Technical compliance**
  - **Election**
  - **Attending physician**
- **Related to terminal illness**
  - **drugs**
- **Hospice face-to-face rule**
- **Terminal illness documentation**
- **Hospice and the nursing facility resident**
- **Continuous care**
- **Inpatient days**

HOSPICE COMPLIANCE

- **Concerns and Oversight Increasing**
- **Claims compliance**
  - **Live discharges**
  - **Non-cancer diagnosis**
- **Referral relationships**
- **Patients in Nursing Facilities**

HOSPICE: CLAIMS COMPLIANCE

- Hospice election
  - Benefit waiver
  - Timeliness in relation to Start of Care
  - Competency/Surrogate Authority
- Terminal illness
  - Clinical support
  - Compliant process, i.e. attending physician/medical director certification
- Level of care
  - Focus on increases of continuous care days and appropriateness of inpatient days
- Unbundling of services/non-terminal illness related care
- Face-to-Face Encounter
  - Timing and documentation

HOSPICE ELECTION

- Issues
  - Completed prior to the start of hospice care
  - Compliant waiver of benefits notice
  - Evidence of individual's competency
  - Documentation of surrogate's authority
    - Health Power of Attorney (state law compliant)
    - Where no POA, state law standards met

TERMINAL ILLNESS

- Compliance with hospice LCDs
- Supporting documentation
- Non-cancer diagnoses get extra attention
- Technical compliance crucial in terms of proper physicians involved, consistency with interdisciplinary team findings, timing, and signing/dating

Level of Care

- Inpatient care
  - Audits focus on nursing facility patients
  - Unstated suspicion of some hospices providing inpatient days to the max to maximize revenue share between NF and hospice
  - As always, it is documentation that makes or breaks it
- Continuous care
  - Audits focus on nursing facility patients
  - Gaming is suspected
  - Need to show skilled care needs with precise documentation

Hospice F2F Oversight

- **Face-to-Face physician encounter: 42 CFR 418.22**
- **Enforcement is underway (still very limited)**
  - **Failure to sign F2F certification**
  - **Narrative absent**
  - **Narrative insufficient**

DOJ Enforcement

- May 5, 2016; Two Doctors Convicted of Falsely Certifying 'Patients' as Terminally Ill as Part of $8.8 Million Healthcare Fraud Scheme
  LOS ANGELES - Two doctors were found guilty today of federal health care fraud charges for falsely certifying that Medicare patients were terminally ill, and therefore qualified for hospice care, when the vast majority of them were not actually dying.
- February 9, 2016; Nurse Convicted For Role In Multi-Million Dollar Hospice Health Care Fraud
  PHILADELPHIA - A federal jury, yesterday, returned guilty verdicts against Patricia McGill, 68, of Philadelphia, a registered nurse who took part in a multi-million dollar fraud on Medicare that involved hospice care. The jury found McGill guilty of four counts of health care fraud. The jury acquitted the defendant of a conspiracy charge and nine counts of health care fraud. McGill faces a potential advisory sentencing guideline range of 33 to 41 months in prison, a possible fine, and a $400 special assessment.

Medicaid Hospice Risk Areas

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- **Medicaid billing for services and items covered under Medicaid hospice benefit**
  - **Pharmaceuticals**
  - **Ambulance**
- **State Medicaid payment reductions that reflect beneficiary contribution obligation**
  - **http://www.oig.hhs.gov/oas/reports/region1/11000004.asp.**
  - **OIG found that Massachusetts Medicaid did not reduce hospice payments to reflect "spend down" patients' contribution obligation**

OIG Activity/Studies

- **Hospice patients in nursing facilities**
  - **http://www.oig.hhs.gov/oei/reports/oei-02-06-00221.pdf.**
  - **http://www.oig.hhs.gov/oei/reports/oei-02-06-00223.pdf.**
  - **http://www.oig.hhs.gov/oei/reports/oei-02-09-00202.asp.**
  - **http://www.oig.hhs.gov/oei/reports/oei-02-06-00220.pdf.**
  - **These reports have created an environment of suspicion around hospice care in nursing facilities**
  - **New study on hospice marketing practices with NFs**

OIG ACTIVITY/Studies

- **"Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements'" OEI-02-06-00221, September 2009, http://www.oig.hhs.gov/oei/reports/oei-02-06-00221.pdf.**
  - **31% fewer services than on Plan of Care**
- **OIG Office of Evaluations and Inspections, "Medicare Beneficiaries Residing in Nursing Facilities,: OEI-02-06-00223, (September 4, 2009), http://www.oig.hhs.gov/oei/reports/oei-02-06-00223.pdf.**
  - **31% of hospice beneficiaries reside in nursing facilities**
  - **$2.59B in 2006**
  - **91% routine care days**
  - **4.2 visits per week of nursing, aide, and medical social services**
  - **Aide services higher for for-profit hospices**
  - **Volunteer services lower for for-profit hospices**

OIG REPORT

- **HOSPICES INAPPROPRIATELY BILLED MEDICARE OVER $250 MILLION FOR GENERAL INPATIENT CARE: http://oig.hhs.gov/oei/reports/oei-02-10-00491.asp (March 2016)**
  - **OIG found that hospices billed one-third of GIP stays inappropriately, costing Medicare $268 million in 2012.**
  - **Hospices commonly billed for GIP when the beneficiary did not have uncontrolled pain or unmanaged symptoms.**

OIG Report

- **MEDICARE HOSPICES HAVE FINANCIAL INCENTIVES TO PROVIDE CARE IN ASSISTED LIVING FACILITIES, http://oig.hhs.gov/oei/reports/oei-02-14-00070.asp (January 2015)**
  - **Medicare payments for hospice care in ALFs more than doubled in 5 years, totaling $2.1 billion in 2012.**
  - **Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings.**
  - **OIG has concerns about the financial incentives created by the current payment system**
  - **OIG suggests payment reform and more accountability are needed to reduce incentives for hospices to focus solely on certain types of diagnoses or settings.**

FCA Prosecution

- **U.S. v. AseraCare, Civil Action No: 2:12-CV-245-KOB, United States District Court for the Northern District of Alabama Southern Division**
  - **Based on allegations that Defendant submit false hospice billings using false certifications of terminal illness**
  - **Defendant's Motion for Summary Judgment granted (3/31/16)**
  - **Court found that U.S. could not establish objectively false billing based solely on an expert witness who disagreed with the certifying physicians**

Claims: C-LEVEL SCREENING

- Has there been any change in utilization patterns, e.g. length of stay?
- What does the claims data tell you about changes in HHRGs, therapy utilization, LUPA volume, outliers volume?
- How is "relatedness" to the hospice terminal diagnosis determined?
- Can you account for the actual hours worked by personal care staff?
- Is your number 2 pencil sharpened and ready for perfection on the technical requirements?
- Are your internal claims compliance systems right for the today risks?
- Is claims documentation consistently done?
- Did you forget about MA Plans?
- Have you checked the exclusions list lately?

Quality of Care/Provider Enrollment

- **Increased survey frequency emerging**
- **Immediate jeopardy citations**
- **Terminations on the rise**
- **Alternative sanctions imposed in Medicare home health**
- **Provider enrollment technical perfection**

MEDICARE HOME HEALTH: Alternative Sanctions

- Applies to condition level deficiencies
- Sanctions include:
  - Directed corrective action
  - Temporary management
  - Payment suspension
  - Civil monetary penalties
    - $500-$10,000
    - Per diem/per instance
  - Termination
- Informal dispute resolution possible
- CMPs and payment suspension no earlier than 7/1/14,
- Appeal rights w/o penalty suspension

Intermediate Sanctions Risk

- **2016**
  - **4,976 HHA surveys**
  - **2.5% with condition-level deficiency**
  - **CMP sanctions—79**
  - **Suspension of payment on new admissions—30**
  - **Directed plan of correction—5**
  - **Directed in-service training—11**
  - **Temporary management--1**

Medicare Provider Enrollment

- **Ongoing validation reviews**
- **Change in Information reporting**
- **Disenrollment and reactivation**
- **42 CFR 424.500 et seq.**

Risks of Non-Compliance in Provider Enrollment

- **Denial of enrollment, 42 C.F.R. §424.530(a)(5)**
- **Revocation of billing privileges, 42 C.F.R. §424.535(a)(5)**
- **State enforcement for licensing non-compliance**
- **Section 14 of 855A Penalties for Falsifying Information**
  - **Criminal penalties: 4 statutes – fines, jail, 2X unjust gain**
  - **Civil penalties: 2 statutes – CMP, 3X damages**
  - **Common law: damages, restitution, recovery unjust profit**

Quality and Enrollment: C-Level Screenings

- **Are you ready for an unannounced survey today?**
- **What systems of accountability are in place?**
- **Is every care plan met?**
- **What will your patients say about your care?**
- **How do you respond to patient grievances?**
- **Are you confident the staff knows when to call the doctor?**
- **Are all personnel files complete and up to date?**

Medicare Red Tape Relief Project: NAHC Recommendations

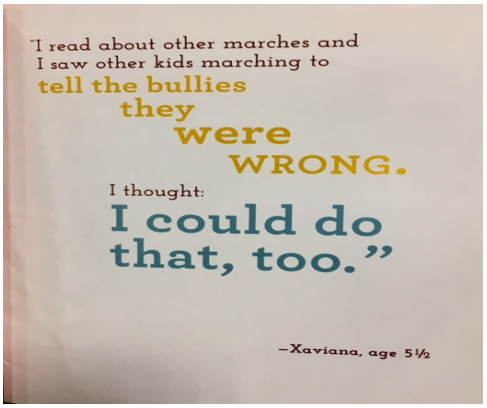
- **Withdraw Proposed Rule to Implement a New Home Health Payment Model in CY 2019**
- **Revise the qualifications of practitioners who can establish home health benefit eligibility certifications**
- **Revise physician documentation and certification requirements in the Medicare home health benefit**
- **Delay the revised HHCoPs until at least six months after the CMS issued the interpretive guidelines**
- **Delay the IMPACT Act implementation timeline for home health agencies**
- **Expand access to home telehealth services**
- **Provide the opportunity to correct minor errors and omissions in Medicare claims**

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
- Grassroots Advocacy Enhancement
  - Intense social media
  - Earned media
  - Force to be reckoned with
- Workforce Summit
  - All stakeholders
  - Practical Solutions
  - Resources to achieve



NAHC 2.0

- All aspects of NAHC to be reviewed and evaluated
  - Mission
  - Membership
  - Structure
  - Governance
  - Relationships with other associations
  - Services
  - Priorities

Design strategic planning process with Board approval (completed)

- Use an expert facilitator who is not in home care
- Select Phase 1 planning team
- No greater than 25
- Member and non-member
- NAHC Board representation (5)
- NAHC staff (3)
- State Association (2)
- Provider sectors (10)
- Industry support sectors (3)
- Non-home care health care sectors (2)

- Open nomination process

Hold the strategic planning event (February 20-21)

- Select convenient and economical location
- Two- day planning event
- Draft plan covering all aspects of NAHC
- Circulate draft to participants with opportunity to comment and revise
- Submit final draft to NAHC board
- Board approves draft for public dissemination

Invite comment on draft (concurrent with announcement of draft plan)

- Full community invitation to comment
- Staff review comments, provide summary to Board with recommended revisions
- Board approves draft plan

Hold invitation-based broad scale event to refine the draft plan (April 16, 2018)

- 75-100 invitees
- Facilitated event
- Share comment from community inputs
- Plan redraft as needed

Plan Implementation

- **NAHC Board approval**
- **Execution of Plan**
- **Plan execution reviews**
- **Plan modification if needed**
- **Public accountability**

CONCLUSION

- **First 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!**