

Impact of Health Reform: Home Health and Hospice Providers

Under the new health reform laws, home health agencies (HHAs) and hospices will be impacted directly, through payment reductions, and indirectly, through new provider relationships. Health care reform constitutes sweeping change in every sense, beginning with a ground-up transformation from an acute care-based, institutionally-oriented health care delivery system, to one that focuses on disease prevention and home and community-based care. Below are highlights of some of the provisions that could impact your business.

Payment reductions for home health agencies

Reductions to Medicare home health agencies payments are estimated to be \$37.9 billion between 2011 and 2019. A 3 percent rural-add was incorporated for episodes and visits ending April 1, 2010 through January 1, 2016. However, beginning in 2011, the market basket rate will be reduced by 1 percent each year through 2013. Outliers are capped at 2.5 percent with an aggregate individual agency cap of 10 percent of Medicare payments. A payment rebasing is expected to be phased-in starting in 2014 through 2017 with a maximum annual reduction of 3.5 percent per year.

Payment reductions for hospice agencies

Medicare hospice payments will be reduced an estimated \$7.8 billion between 2013 and 2019 as a result of a productivity factor adjustment and 0.3 percent market basket rate reduction.

New face to face requirement for certifying consumer for home health services

As of January 1, 2010, under Medicare, physicians, physician assistants, nurse practitioners or clinical nurse specialists will now be required to have face-to-face encounters with a patient prior to certifying them for home health services or durable medical equipment. These encounters can include telehealth visits but must occur within six months prior to the written order for services.

Value-based purchasing and promoting high-value health care

The HHS Secretary is authorized to test value-based purchasing for long-term care providers, including home health and hospice providers, no later than January 1, 2016. The law calls for accumulating qualitative outcome measurements expected to be reported in future years. As new value-based payment mechanisms evolve, it's expected that payments will be diverted to agencies showing the highest qualitative measurements from those exhibiting lower quality.

New Patient Care Models affecting home health and hospice providers

Several new programs established to test new patient care models could present opportunities for home health providers.

The **Community-based Care Transitions** program focuses on implementing evidence-based care transitions for high-risk Medicare beneficiaries with cognitive impairment, depression, a history of multiple readmissions or any other chronic disease or risk factor as determined by the HHS Secretary. This five-year program begins January 1, 2011 and if deemed effective, can be expanded by the Secretary.

The **Hospital Readmission Reduction program** reduces Medicare payments to hospitals with poor readmission rates for certain conditions. This will be a catalyst for hospitals to partner with home health providers to reduce readmissions by improving care for patients following a hospitalization for heart attack, heart failure, and pneumonia, and later, other conditions.

The five-year **Bundled Payment Pilot Program** provides a bulk payment to be shared by a hospital, a physician group, a skilled nursing facility, and a home health agency to integrate a patient's care beginning three days prior to

a hospitalization through 30 days post-discharge for a chronic or acute care episode. The demonstration will identify a uniform post acute care patient assessment instrument and develop quality measures for the program.

The **Medicare Hospice Concurrent Care Demonstration** is a three-year demonstration involving up to 15 hospice providers to combine home health and hospice provider services. This demonstration is an opportunity for hospice providers that also operate home health agencies.

The **Community Living Assistance Services and Supports (CLASS) Act** establishes a voluntary national insurance program that provides a cash benefit to individuals who need assistance with two or more Activities of Daily Living, and have paid into the plan for more than five years. The cash benefit can be used to pay for home care services.

The **Community First Choice option** allows states to receive a 6% increase in their Federal Medical Assistance Percentage (FMAP), if they increase access to personal attendant care for Medicaid recipients who have a skilled need and meet certain related criteria. This option could encourage states to reduce or eliminate waiver waiting lists for personal care services.

The **HCBS Rebalancing Incentive Program** offers states a financial incentive to increase their spending on non-institutional long term care services (LTCS) by increasing the FMAP for state expenditures on Medicaid 1915(c) waivers, PACE, home health and personal assistant services under the Medicaid state plan. States that currently spend less than 50% of their Medicaid LTC dollars on non-institutional services will be eligible to receive up to 5% FMAP increase by rebalancing their Medicaid long term care to spend more on non-institutional services. States must also change their HCBS delivery system and implement the following structural reforms to be eligible for the increased FMAP:

- No Wrong Door / Single Point of Entry
- Conflict-free case management program
- Core standardized assessment.

The law extends the **Money Follows the Person Demonstration grant** from 2011 to 2016. It also reduces the residency eligibility requirement for the program from 6 months to 3 months increasing the number of people eligible to be transitioned from nursing homes back into the community.

This summary does not reflect all health reform initiatives impacting HHA and Hospices. Instead, it is meant to contrast the payment reductions with potential new payment opportunities available under health care reform. We recommend providers budget for payment reductions, as necessary, focus on opportunities to partner with other providers and develop internal strategies to take advantage of these newly-created, potential revenue sources.

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