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Landscape for Long Term Care and Home Health PDGM Compliance Risks

Presented by: Myla Reizen, Partner and Sarah Carlins, Of Counsel

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Hot Topics For Long-Term Care Facilities

By: Myla Reizen

AGENDA

- Statistics
- Reporting Requirements and other Regulatory Guidance
- Recent Regulatory and Industry Enforcement Activity
- Potential Liability, Surveys, Fines
- DOJ Trends
- OIG Initiatives
- Takeaways

NURSING HOMES STATISTICS

- United States
- States
- Variance in Reporting

NURSING HOMES STATISTICS

- Nursing home deaths due to COVID-19 represent a significant percentage of total virus mortality
- U.S.: >40% of country's total COVID-19 deaths
- Recent CDC Data

COMPARISON TO AUSTRALIA

GUIDANCE

- CMS
- CDC
- States
- Other

REPORTING

- Changes to 42 CFR 483.80
  - Requirements for reporting to CDC
  - Requirements for reporting to residents, their representative, and families
- Q&As
- Revisions to Surveying Standard
- Enforcements

REPORTING

- Nursing homes are required to report the following types of information to CDC about COVID-19:
  - Suspected and confirmed infections among residents and staff, including residents previously treated for COVID-19;
  - Total deaths and COVID-19 deaths among residents and staff;
  - PPE and hand hygiene supplies in the facility;
  - Ventilator capacity and supplies in the facility;
  - Resident bed and census;
  - Testing access while the resident is in the facility;
  - Staff shortages; and
  - Other information as specified by the Secretary
- Timeframes

REPORTING

- CMS requirement to report to residents, representatives, and families.
- This information must be reported in accordance with existing privacy regulations and statute.
- This measure augments requirements for reporting infectious disease to State and local health departments.

INFECTION CONTROL

- Early Guidance
- Changes Over Time
- Recent Guidance

SURVEYING

- Funding
- CMS Guidance
- Focused Surveys
- Findings
  - Early Findings
  - Recent Findings
- Future Surveys
  - Routine Inspections

NURSING HOMES HIT WITH $15 MILLION IN COVID-RELATED FINES

- A state and federal inspection of nearly all U.S. nursing homes resulted in $10 million in fines for serious infection control deficiencies (at 180 facilities across 22 states with immediate jeopardy) and approximately $5.5 million in fines for failure to report COVID-19 data to federal authorities (at 3,300 facilities).
- CMS and state partners have inspected 99% of all nursing homes facilities since the beginning of the pandemic.
- Nursing homes face fines of up to $5,000 for low-level infection control deficiencies identified on a previous inspection and up to $20,000 for violations that occurred twice or more in the last two years.

NURSING HOMES – EFFORTS

- Federal Efforts
  - $8 billion in certain funding for nursing homes
    - Nursing homes must participate in a new online Nursing Home COVID-19 Training program in order to qualify for funding
  - QIOs to provide immediate assistance to nursing homes in COVID-19 hotspot areas
  - Large-scale procurement of rapid point-of-care diagnostic test instruments and tests
  - CMS to report to Governors' offices

TESTING REQUIREMENTS

- Staff
- Residents
- Survey
- Fines for Non-compliance

NURSING HOME CDC GUIDANCE

- Guidance
- Resources
  - Assessment tool
  - Checklist
  - Other

STATE GUIDANCE

- Florida
- Other States

POTENTIAL LIABILITIES

- Fines & Penalties
- State Attorney General
- Immunity
- Wrongful death cases
- Other State cases

CERTAIN OIG INITIATIVES

- Meeting the Challenges Presented by COVID-19: Nursing Homes
- Skilling Nursing Facility Reimbursement
- Background Checks for Nursing Home Employees
- Facility-Initiated Discharge in Nursing Homes
- Accuracy of Nursing Home Compare Website's Reported Health, Fire Safety, and Emergency Preparedness Deficiencies
- Corporate integrity agreement
- Assessing Trends Related to the Use of Psychotropic Drugs in Nursing Homes

CERTAIN DOJ INITIATIVES

- Saber Healthcare Settlement Agreement
- Longwood Settlement Agreement
- Diversicare Settlement Agreement
- Settlement Agreement between OIG
- Vanguard Healthcare Settlement

CERTAIN TAKEAWAYS

- Dedicated employee
- Policy and Procedures
- Training
- Self-assessment and mock survey
- Documentation
- Corporate integrity agreement
- Quality focus
- Emergency preparedness
- Infection control

PDGM Home Health Reimbursement and Compliance Risks

By: Sarah Carlins

HOME HEALTH CARE REIMBURSEMENT CHANGES

- New payment rules governing home health agencies – January 1, 2020
- Old system = reimbursement based on number of therapy visits provided
- CMS suspected over usage and sought to eliminate therapy volume as a determinant of payment
- New system = reimbursement based on patient characteristics

PATIENT-DRIVEN GROUPINGS MODEL

- PDGM goal is to pay based on most appropriate cost-effective care that is not based on volume of services but rather a complex calculation of patient need
- PDGM is complicated
- PDGM is new
- Compliance risks heightened by CMS' suspicions that therapy industry had been practicing to payment

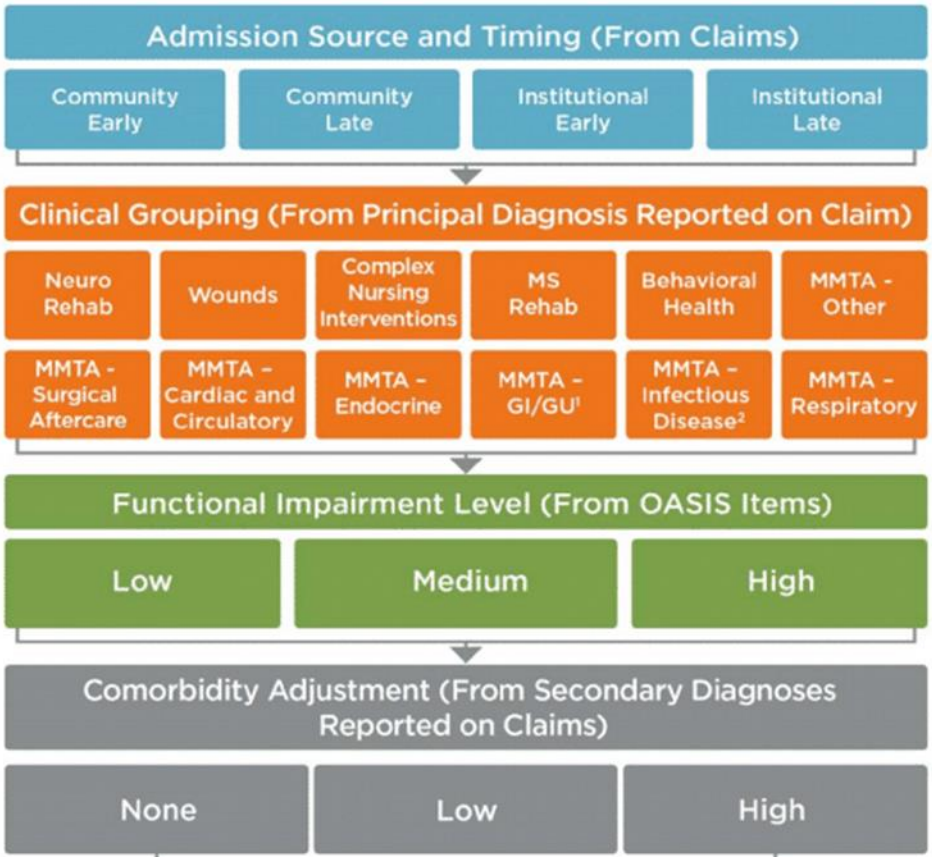
PATIENT-DRIVEN GROUPINGS MODEL

- Change in unit of home health payment from a 60 day period to a 30 day period
  - Had been that home health was paid for each 60-day episode of care provided (up to)
  - Now, payment will be made for each 30-day period
  - ONLY AFFECTS PAYMENT – not certification/recertification requirements, updates to pt plan of care etc, all of which will continue to be done on 60-day basis

PATIENT-DRIVE GROUPINGS MODEL

- Four main case-mix variables
  - Admission Source and Timing
  - Clinical Grouping
  - Functional Impairment Level
  - Comorbidity Adjustment
- A 30-day period is grouped into one subcategory within each of these categories, resulting in 432 possible case-mix adjusted payment groups (!)

PATIENT-DRIVEN GROUPINGS MODEL



PATIENT-DRIVEN GROUPINGS MODEL

- Admission Source
  - Institutional – inpatient hospital, SNF, LTCF, inpatient psychiatric facility, long term care hospital
  - Community – No acute or post-acute care in 14 days prior to home health admission
- Timing
  - Early – the first 30 day period in sequence of HH periods (gets paid more)
  - Late – second and later 30-day periods

PATIENT-DRIVEN GROUPINGS MODEL

- Clinical Groups – from principal diagnosis code on claim (12)
- Functional Impairment – from OASIS items (3)
  - Low, Medium, High
- Comorbidity Adjustment – from secondary diagnoses on claim (3)
  - None, Low, High

COMPLIANCE RISKS

- New billing cycle = increased pressure on staff
- Patient scoring is new so supporting documentation needs will change =
  - Claims submissions are not timely
  - Inadvertent mistakes in coding
  - Missing documentation and/or not getting it back from other providers quickly enough due to shorter billing cycle

COMPLIANCE RISKS

- CMS scrutiny of utilization changes
  - Had indicated suspicions that therapy was provided in excess to increase home health reimbursement and has indicated its belief that new PDGM system will adequately reimburse therapy
  - Any utilization shifts may trigger suspicions that providers were over utilizing
  - Have indicated they will be monitoring impact of case adjustments including utilization patterns and this could result in enforcement actions

COMPLIANCE RISKS

- What will constitute a suspicious change?
  - Shift in institutional versus community admissions ?
    - New focus on institutional patients and drop in community admissions
    - Are care choices being made based on perceived financial incentives rather than actual need of patient?
    - Should a change in provider model automatically be seen as suspect?
    - Criticism regarding assumption that institutional admissions should automatically be assumed to represent a higher level of care (outpatient surgeries, ASCs, etc)

COMPLIANCE RISKS

- What will constitute a suspicious change?
  - Shift in early versus late episode admissions ?
    - Old system = First two 60 day episodes were considered early, which reimburses at a higher rate
    - New system = Only first 30 day episode is considered early
    - Consequence?
      - Treat patients more aggressively during first 30 days and then push to discharge?
      - Treat patients longer to make up for reduced reimbursement?

    Patients with a particular condition or need may now have fewer or more episodes of care = so when were you over utilizing?

COMPLIANCE RISKS

- LUPA payments
  - Low Utilization Payment Adjustment
    - Claims at or lower than the threshold are paid at lower rate
    - Had been 4 visit threshold is a 60 day payment episode
    - Now is 2-6 visits in a 30-day period depending on the payment group (again, potential for confusion with new system)
    - July 2020 OIG Report targeting claims with visits slightly above the LUPA threshold stated the majority of the claims in that did not comply with Medicare requirements under the previous PPS methodology would also have not complied with those requirements under the new PDGM methodology.

COMPLIANCE RISKS

- Uncertainties – What will CMS response be?
- Uncertainties – How can HHA best avoid and/or defend against compliance scrutiny?
  - Move slowly with any changes?
  - Diversify?
  - Focus on proper supporting documentation?
  - Focus on staff education/support?

OIG WORK PLAN

- Skilled Nursing Facility Reimbursement
  - CMS to review whether Medicare payments to SNFs complied with new Patient Driven Payment Model (PDPM) requirements (Oct. 2019)
- Home Health Agencies' Challenges and Strategies in Responding to COVID 19 Pandemic
  - CMS to study strategies HHAs have used to respond to pandemic and how helpful these have been (procuring PPE, implementing telehealth services and addressing staffing shortages)
- Audit of Home Health Services Provided as Telehealth During the COVID-19 Public Health Emergency
  - CMS to evaluate which types of services were provided via telehealth during the public health emergency and whether these were provided in accordance with Medicare requirements

Questions

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