Regulatory Update: Home Health PPS

Rochelle Archuleta & Akin Demehin

AHA Policy

August 2015

CY 2016 Proposed Rule

- **Comments due to CMS by Sept 4**
- **Net Update: -1.8%** (-$350m)
  - Facility-based agencies: +2.0%
  - Includes:
    - +2.9% market basket update
    - -0.6% productivity cut
    - -2.5% rebasing cut.
- **Proposed rates:**
  - 60-day episode: $2,967.76 (inc. rebasing cut, but still a slight increase)
  - NRS: See Table 21 in proposed rule (includes rebasing cut)
  - LUPA: See p. 2 of the AHA advisory (includes rebasing increase)

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Proposed Rebasing

- Authorized by ACA
- 3rd of 4 installments in CY 2016
- Overall impact: 2.5%
  - 60-day rate dropped by $80.95
  - LUPA per diem rates increase
  - NRS Factor: reduced by 2.82%

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Proposed Case-Mix Cut

- **Nominal Case-Mix Increases** *(not driven by rise in patient acuity)*
  - CY 2012 to 2013: 2.3%
  - CY 2013 to 2014: 1.18%
- **Proposed Cut:**
  - -1.72% in CY 2016; and
  - -1.72% in CY 2017.
  - Combined impact: 3.41% reduction

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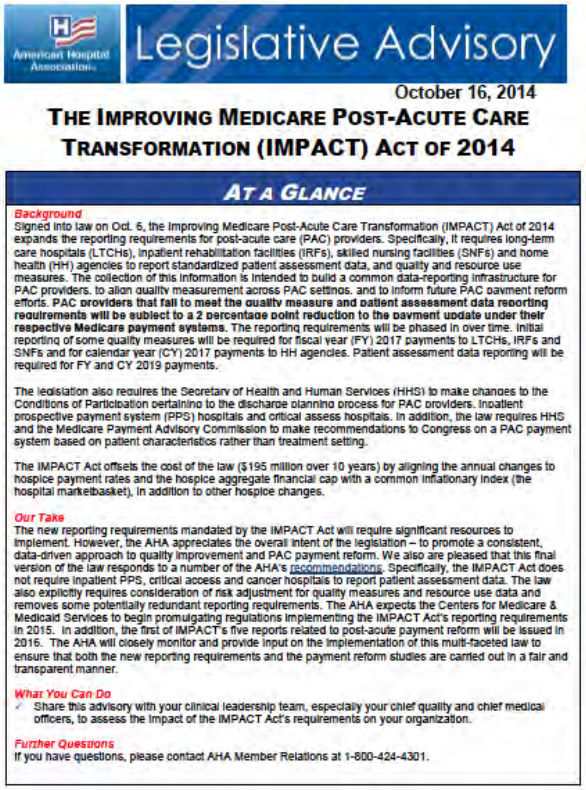
Post-Acute Reporting Changes: IMPACT Act

- Signed into law Oct. 6, 2014
- Framed as creating "building blocks" of post-acute care reform through collection and reporting of "**standardized and interoperable**":
  - Patient assessment data
  - Quality measures
- Expands data collection and reporting requirements for LTCHs, IRFs, SNFs and HHAs
  - Payment penalties for non-reporting
- Significant regulatory activity in 2015



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Legislative Advisory

October 16, 2014

THE IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION (IMPACT) ACT OF 2014

AT A GLANCE

Background

Signed into law on Oct. 6, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 expands the reporting requirements for post-acute care (PAC) providers. Specifically, it requires long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health (HH) agencies to report standardized patient assessment data, and quality and resource use measures. The collection of this information is intended to build a common data-reporting infrastructure for PAC providers, to align quality measurement across PAC settings, and to inform future PAC payment reform efforts. **PAC providers that fail to meet the quality measure and patient assessment data reporting requirements will be subject to a 2 percentage point reduction to the payment update under their respective Medicare payment systems.** The reporting requirements will be phased in over time. Initial reporting of some quality measures will be required for fiscal year (FY) 2017 payments to LTCHs, IRFs and SNFs and for calendar year (CY) 2017 payments to HH agencies. Patient assessment data reporting will be required for FY and CY 2019 payments.

The legislation also requires the Secretary of Health and Human Services (HHS) to make changes to the Conditions of Participation pertaining to the discharge planning process for PAC providers. Inpatient prospective payment system (IPPS) hospitals and critical assess hospitals. In addition, the law requires HHS and the Medicare Payment Advisory Commission to make recommendations to Congress on a PAC payment system based on patient characteristics rather than treatment setting.

The IMPACT Act offsets the cost of the law ($195 million over 10 years) by aligning the annual changes to hospice payment rates and the hospice aggregate financial cap with a common inflationary index (the hospital marketbasket), in addition to other hospice changes.

Our Take

The new reporting requirements mandated by the IMPACT Act will require significant resources to implement. However, the AHA appreciates the overall intent of the legislation – to promote a consistent, data-driven approach to quality improvement and PAC payment reform. We also are pleased that this final version of the law responds to a number of the AHA's recommendations. Specifically, the IMPACT Act does not require inpatient PPS, critical access and cancer hospitals to report patient assessment data. The law also explicitly requires consideration of risk adjustment for quality measures and resource use data and removes some potentially redundant reporting requirements. The AHA expects the Centers for Medicare & Medicaid Services to begin promulgating regulations implementing the IMPACT Act's reporting requirements in 2015. In addition, the first of IMPACT's five reports related to post-acute payment reform will be issued in 2016. The AHA will closely monitor and provide input on the implementation of this multi-faceted law to ensure that both the new reporting requirements and the payment reform studies are carried out in a fair and transparent manner.

What You Can Do

- Share this advisory with your clinical leadership team, especially your chief quality and chief medical officers, to assess the impact of the IMPACT Act's requirements on your organization.

Further Questions

If you have questions, please contact AHA Member Relations at 1-800-424-4301.

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IMPACT Act – Patient Assessment Data Domains

To be addressed in future rulemaking

- **Functional status** (e.g., mobility, self care)
- **Cognitive function and mental status** (e.g., depression, ability to understand)
- **Special services, treatments, and interventions** (e.g., ventilator use, dialysis, chemotherapy, central line placement, TPN)
- **Medical condition** (e.g., diabetes, CHF, comorbidities such as severe pressure ulcers)
- **Impairments** (e.g., incontinence, impaired and an impaired ability to hear, see, or swallow.
- Other categories deemed necessary and appropriate by the Secretary of HHS

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IMPACT Act: Quality Measures

Measures must address following topics:

- **Skin integrity**
- Functional Status
- Major falls
- Medication reconciliation
- Patients preferences
- Resource use, including at a minimum:
  - Medicare spending per beneficiary
  - Discharges to community
  - Potentially preventable admissions and readmissions

Addressed in CY 2016 HH PPS Proposed Rule

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CY 2018 HH QRP Measure Proposal: Pressure Ulcers

- Assesses percentage of patients with one or more stage 2 through 4 pressure ulcers new or worsened

- Items needed to calculate measure already collected via OASIS
  - M1308 (current number of unhealed pressure ulcers at each stage or unstageable)
  - M1309 (worsening in pressure ulcer status since start/resumption of care)

- CMS also proposes to use several OASIS items for risk adjustment
  - M1850 (activities of daily living assistance)

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HH QRP: Data Completeness

- CMS indicates it needs to match OASIS assessments at start/resumption and discharge of HH care in order to create “quality assessment”

- CMS proposes to raise the percentage of OASIS assessments that must have data complete enough to calculate a quality assessment (currently 70 percent, see table below for proposals)

- ***HH agencies that fail to meet completeness standard subject to 2 percent payment penalty***

Payment Determination Year	Proposed Data Completeness Threshold	Applicable OASIS Data Reporting Period
CY 2018	80 percent	July 1, 2016 – June 30, 2017
CY 2019 and beyond	90 percent	July 1, 2017 – June 30, 2018

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HH Value-Based Purchasing (VBP)

- CMS invoking its authority under the ACA to “test” payment models intended to improve quality / reduce cost
- CMS proposes to mandate participation in a VBP program for HH agencies in 9 states
  - AZ, FL, IA, MD, MA, NE, NC, TN, WA
- HH agencies in selected states subject to upward, neutral or downward adjustments of up to 8 percent based on performance on 29 measures
- Program would score HH agencies both on achievement versus CMS-established benchmarks, and improvement versus their own baseline
  - Somewhat like Hospital VBP

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HH VBP – Assessment and Payment Adjustment Timeframes

Performance Period	Payment Adjustment Year	Level of Payment Adjustment
CY 2016	CY 2018	+/- 5.0 percent
CY 2017	CY 2019	+/- 5.0 percent
CY 2018	CY 2020	+/- 6.0 percent
CY 2019	CY 2021	+/- 8.0 percent
CY 2020	CY 2022	+/- 8.0 percent

- Performance period occurs two years before payment adjustment
- Level of payment at stake would rise over time
- **Payment adjustment is greater than existing hospital VBP program**

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HH VBP – Scoring Methodology

- Each HH agency would get a "Total performance score" (TPS) based on the better of "achievement" or "improvement" scores on each measure
  - Baseline year for all program years is CY 2015

- Achievement scores
  - "Achievement threshold" = median performance of HH agencies in baseline year
  - "Achievement benchmark" = top decile of scores)
  - Receive 0 points if performance period score below threshold, and 10 points if at or above benchmark
  - If performance period score between threshold and benchmark, score of 0-9 using formula
  - **Achievement threshold and benchmark calculated separately for each state and for each HH agency cohort size within a state**

- Improvement scores
  - Score of 0 if HH agency scores worse in performance period than baseline
  - Receive 0 to 10 points if score better than baseline but below achievement benchmark using formula

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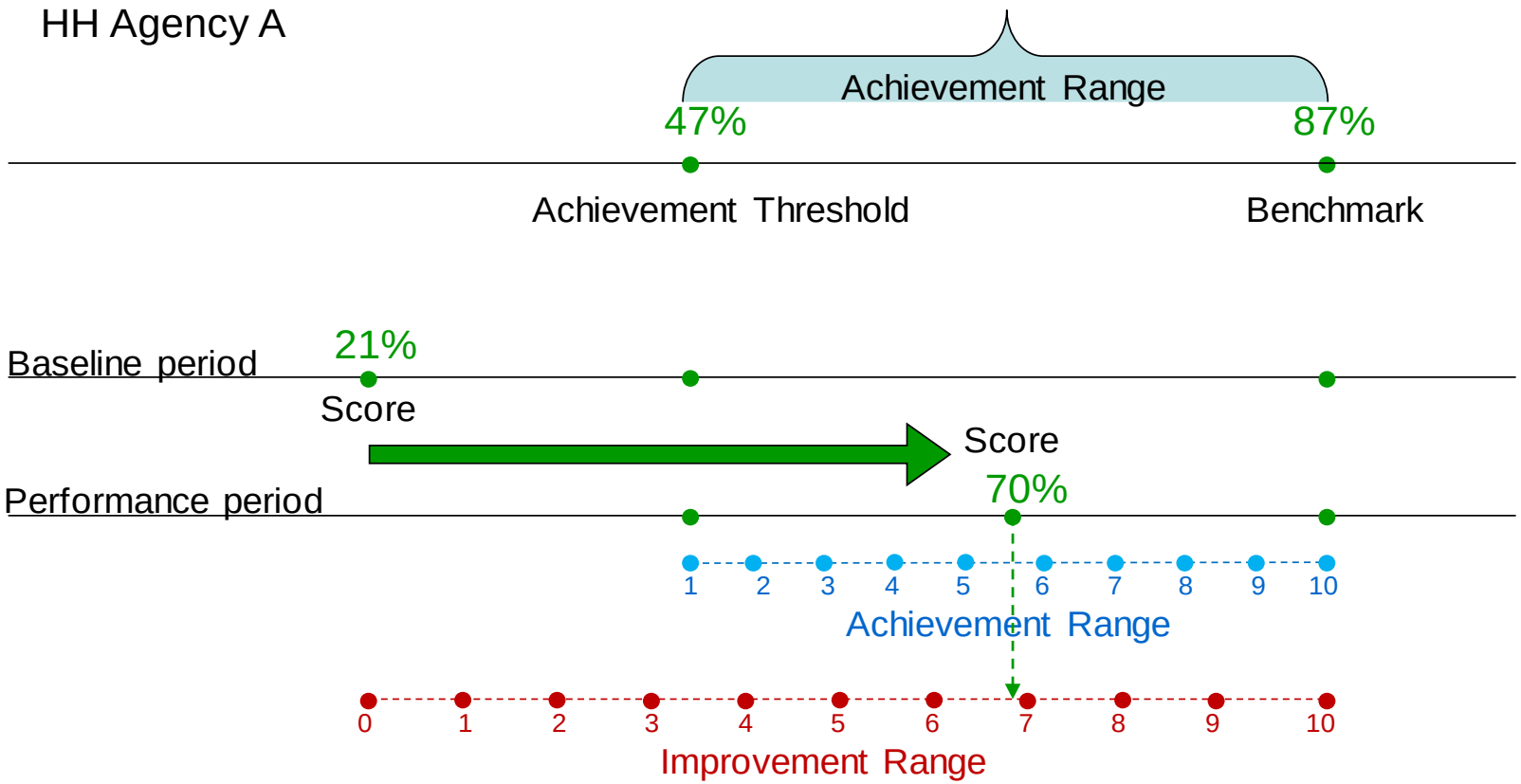
HH VBP – Sample Scoring



HH agency A earns 6 points for achievement and 7 points for improvement
HH agency A score = higher of achievement or improvement = 7 points

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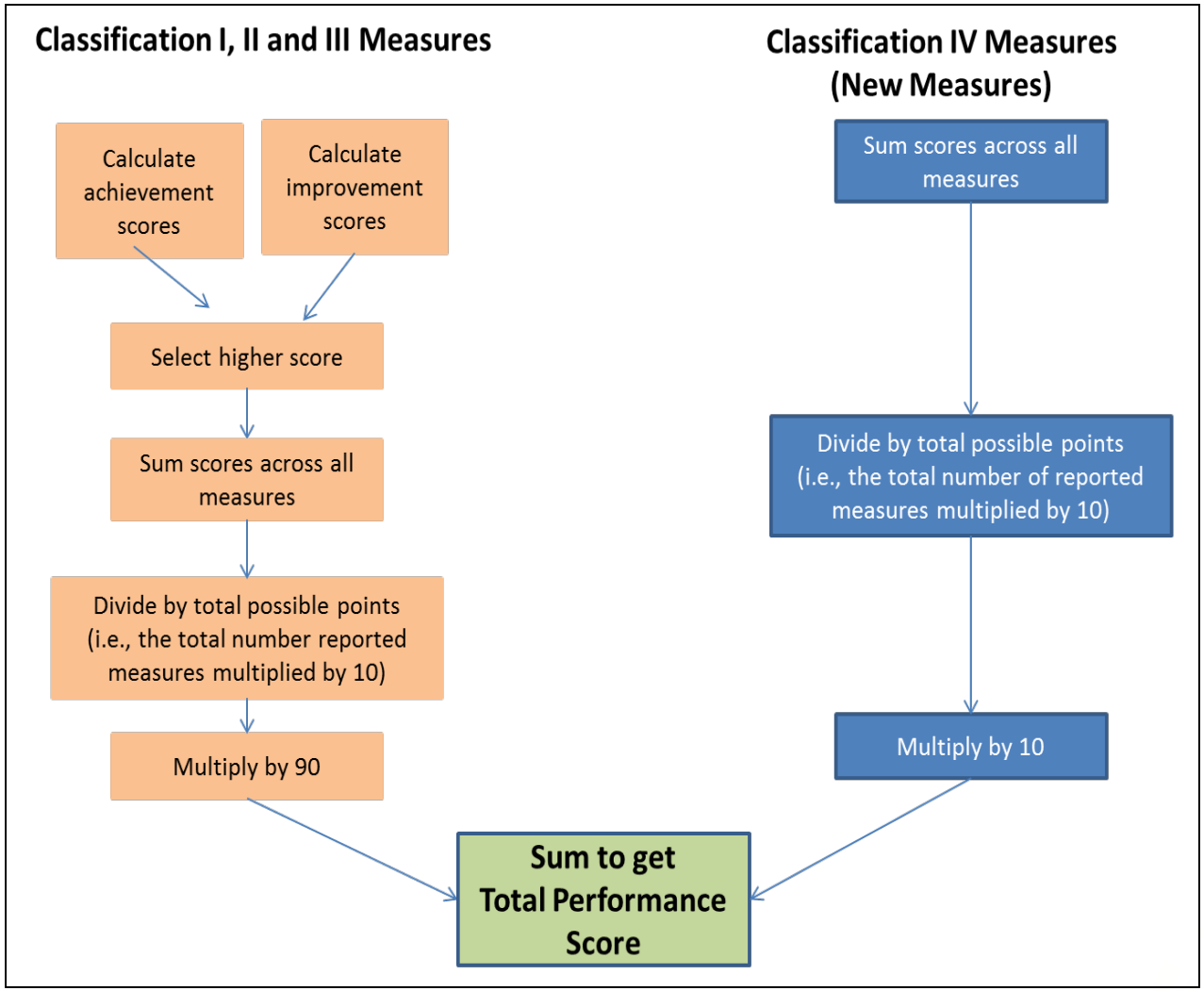
HH VBP – Calculating the TPS



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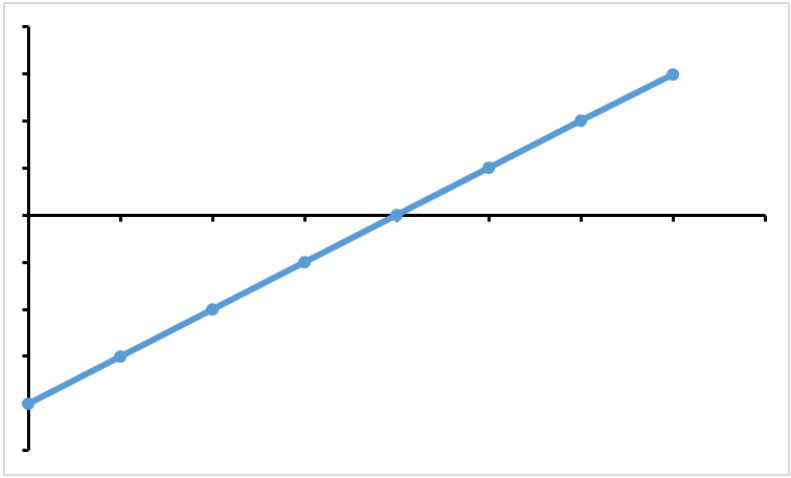
HH VBP - Translating TPS into Payment Adjustments

- CMS proposes linear exchange function to translate total performance score into incentive payment
  - Same marginal incentive to improve
- Program budget neutral...some get bonuses, others penalties
- Exact scale will not be known until performance period data is final



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Questions
&
Discussion

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