CY 2017 Home Health PPS Final Rule

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AHA Policy

Nov 28, 2016

HH PPS CY 2017 Final Rule: Payment Provisions

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409 and 484

[CMS–1648–F]

RIN 0938–AS80

Medicare and Medicaid Programs; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule updates the Home Health Prospective Payment System (HH PPS) payment rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor; effective for home health episodes of care ending on or after January 1, 2017. This rule also: Implements the last year of the 4-year phase-in of the rebasing adjustments to the HH PPS payment rates; updates the HH PPS case-mix weights using the most current, complete data available at the time of rulemaking; implements the 2nd-year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between CY 2012 and CY 2014; finalizes changes to the methodology used to calculate payments made under the HH PPS for high-cost "outlier" episodes of care; implements changes in payment for furnishing Negative Pressure Wound Therapy (NPWT) using a disposable device for patients under a home health plan of care; discusses our efforts to monitor the potential impacts of the rebasing adjustments; includes an update on subsequent research and analysis as a result of the findings from the home health study; and finalizes changes to the Home Health Value-Based Purchasing (HHVBP) Model, which was implemented on January 1, 2016; and updates to the Home Health Quality Reporting Program (HH QRP).

DATES: These regulations are effective on January 1, 2017.

FOR FURTHER INFORMATION CONTACT:

For general information about the HH PPS, please send your inquiry via email to: *HomehealthPolicy@cms.hhs.gov.*

For information about the HHVBP Model, please send your inquiry via email to: *HHVBPquestions@cms.hhs.gov.*

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FY Fiscal Year
HAVEN Home Assessment Validation and Entry System
HCC Hierarchical Condition Categories
HCIS Health Care Information System
HH Home Health
HHA Home Health Agency

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CY 2017 Final Rule

- **Published in Nov 3 Federal Register**
- **Net Payment Reduction: -0.7%; $-130 million (-1.0% proposed)**
  - Facility-based agencies: 0.0% change (-0.2% proposed)
  - Includes:
    - +2.8% market basket update
    - -0.3 productivity cut
    - -2.3% rebasing cut
    - -0.97% case-mix
- **Final rates:**
  - 60-day episode: $2,989.97 (slight increase from CY 2016, $2,965.12)
  - NRS conversion factor: Lower conversion factor of $52.50 (currently $52.71) includes rebasing cut
  - LUPA: Rates increase by 2.5%. Details on page 5 of advisory.
  - Rural add-on of 3% remains in effect for episodes and visits ending before January 1, 2018.

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Rebasing

- Authorized by ACA
- 4th of 4 installments in CY 2017
- Overall CY 2017 impact: -2.3% *(as proposed)*
  - 60-day rate **dropped** by $80.95 annually
  - LUPA per diem rates, annual **increase**
    - Home health aide: +$1.79
    - Skilled nursing: +$3.96
    - Physical therapy: +$4.32
    - Occupational therapy: +$4.35
    - Speech-language pathology: +$4.70
    - Medical social services: +$6.34
  - NRS Factor: **reduced** by 2.82% annually

CY 2017 Case-Mix Cut

- **Nominal Case-Mix Increases**
  - Portion of CMS case-mix increase not driven by rise in patient acuity
  - CY 2012 to 2014: 2.88%

- **CY 2016 Final Rule's Case-Mix Cut:**
  - -0.97% in each of CYs 2016, 2017, 2018

FINAL: New Outlier Approach

CMS Research & Goal

- 2015 HH claims: outlier episodes significantly vary in visit length.
- Agencies with 10% of total payments as outliers providing shorter but more frequent skilled nursing visits.
  - Visits by discipline for outlier episodes:
    - HH aide: 8.8
    - Medical social services: 0.3
    - OT: 2.3
    - PT: 5.1
    - Skilled nursing: 34.0
    - SLT: 0.7
- Mathematica research (2010): Outlier payments not generally used for severely, permanently disabled beneficiaries.
- **CMS Goal: correct disincentive to treat medically complex benes requiring longer visits.**

NEW Methodology

SAME as PROPOSED: Change from cost-per-visit to cost-per-unit approach

- One unit = 15 minutes
- P.8: Cost per 15-min unit. Used to calculate episode costs to determine outlier eligibility.
- Budget neutral change, outlier pool stays at 2.5%.
- Raise margins for medical-complex patients that require longer visits.
  - Also projected to redistribute outlier funds to agencies will lower overall outlier payments.
- Impact estimate: 2/3+ of outlier episodes would continue under new approach.

Disposable Negative Pressure Wound Therapy

PRIOR TO FINAL RULE

- Conventional NPWT classified as DME and paid outside of the HH PPS.
- Under HH PPS, single-use disposable systems (pocket sized, easily transportable) treated as a HH non-routine supply and included in the 60-day episode rate.

CONSOLIDATED APPROPRIATIONS ACT OF 2016

Authorized additional HH payment option for disposable NPWT beginning Jan 1, 2017. Under the final rule *(see final rule page 76730),*

- Payment is equal to Outpatient PPS amount for Level 1 HCPCS 97607 and 97608
- Beneficiary coinsurance is 20% of the payment amount.
- 34x Bills: Used for new disposable NPWT devices and services associated with a new device; the *device* payment will typically be in addition to the episode payment.
- Follow-up services when a new NPWT device is not applied should be reported on 32x.
- Service can be provided by a RN, PT, or OT, and in accordance with state laws, LPNs.

NPWT Example #1 in Final Rule

Example #1:

- On Monday, a nurse assesses the patient's condition, assesses the wound, and applies a **new disposable NPWT device**. The nurse also provides wound care education to the patient and family.
- On the following Monday, the nurse returns, assesses the wound, and replaces the device that was applied the week before with an **entirely new disposable NPWT device**.

CMS's recommended billing procedures:

- For both visits, all the services provided by the nurse were associated with furnishing new NPWT.
- Therefore, all the **nursing services for both visits** should be reported on **TOB 34x** with CPT® code 97607 or 97608 (not TOB 32x).

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NPWT Example #2 in Final Rule

Example #2:

- On **Monday**, a nurse assesses the wound, applies a **new disposable NPWT device,** and provides wound care education to the patient and family.
- The nurse returns on **Thursday** for wound assessment and replaces the fluid management system (or dressing) for the **existing disposable NPWT**, but does not replace the entire device.
- The following **Monday**, the nurse assesses the patient's condition and wound, and replaces the device that had been applied on the previous Monday with a **new disposable NPWT device**.

CMS's recommended billing procedures:

- For **both Monday visits**, all nurse services were associated with **furnishing new, disposable NPWT**. Therefore, these nursing services should be reported on **TOB 34x** (not TOB 32x).
- For the Thursday visit, the nurse **did NOT apply a new disposable NPWT device**. Therefore, the services should be reported on **TOB 32x** (not TOB 34x).

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NPWT Example #3 in Final Rule

Example #3:

- On **Monday**, the nurse applies a **NEW disposable NPWT device**.
- On **Thursday**, the nurse returns for a scheduled visit to change the beneficiary's **indwelling catheter**. While there, the nurse assesses the wound and applies a new fluid management system (or dressing) for the existing disposable NPWT device, but **does NOT replace the entire NWPT device.**

CMS recommended billing procedures:

- For the **Monday** visit, all the nursing services were associated with furnishing NPWT using a disposable device. Therefore, the HHA should report the nursing visit on **TOB 34x** (not a TOB 32x).
- For the **Thursday** visit, since the nurse **did NOT furnish a new disposable NPWT device**, report all the nursing services, including the catheter change and the wound care, on **TOB 32x**

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NPWT Example #4 in Final Rule

Example #4:

- On Monday, the nurse applies a **new disposable NPWT device**, and provides instructions for ongoing wound care. During this same visit, per the HH plan of care, the nurse **changes the indwelling catheter** and provides troubleshooting information and teaching regarding its maintenance.

CMS recommended billing procedures:

Submit **two bills** for the **two unrelated services**:

- For **furnishing new NPWT** and time spent instructing the beneficiary about ongoing wound care, the HHA would **bill with a TOB 34x.**
- Bill under **TOB 32x** for the replacement of the **indwelling catheter** and instructions about troubleshooting.

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- **Further NPWT billing questions?**
  - **Please email them to rarchuleta@aha.org.**
- **Additional questions to be shared with CMS.**

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HH PPS CY 2017 Final Rule: Quality Provisions

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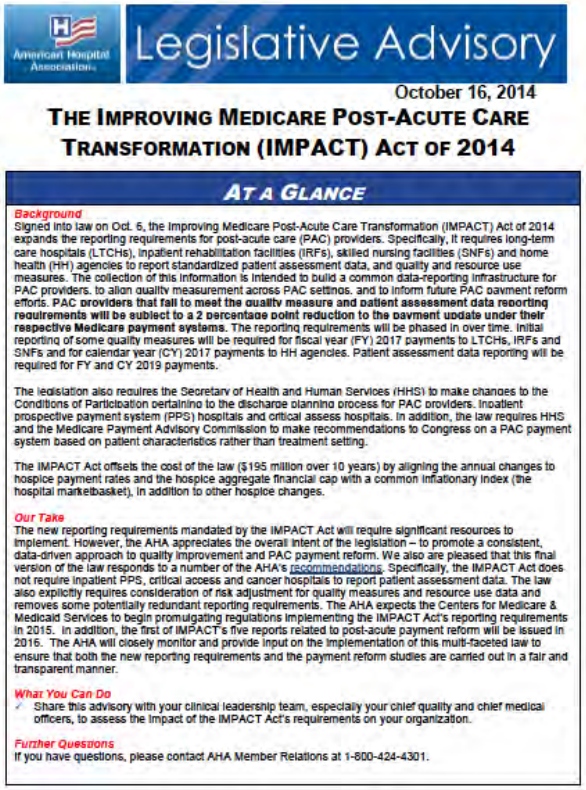
Post-Acute Reporting Changes: IMPACT Act

- 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 continues in 2016 and future years



American Hospital Association 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 allow 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: HH QRP

Measures must address following topics:

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

Addressed in CY 2016 HH PPS Final Rule

Adopted in CY 2017 HH PPS Final Rule

Detailed measure specifications on CMS website.

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CY 2018 HH QRP Measures: Medicare Spending per Beneficiary (MSPB)

- Assesses risk adjusted, standardized Medicare part A and B payments during a defined episode of care
  - Calculates ratio of observed to expected

- Three episode types (which are combined into an overall result, but NOT directly compared to one another)
  - Standard
  - LUPA
  - PEP
    - Episodes subject to both LUPA and PEP adjustments are treated as PEP episodes

- Episode "Trigger"
    - First day of HH claim
      - Each HH claim triggers an episode

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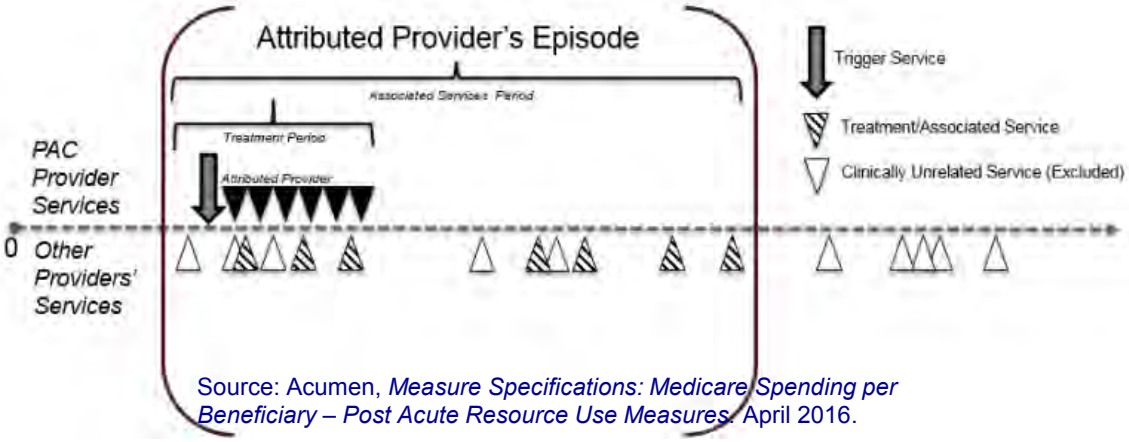
MSPB-HH: Episode Construction

Episodes include two timeframes:

- Treatment Period
  - **Standard and LUPA:** Begins at trigger, ends after 60 days
  - **PEP:** Begins at trigger, ends at discharge
  - For all episode types, includes part A and B services "directly or reasonably managed" by HH agency and related to care plan

- Associated Services Period
  - Begins at trigger, ends 30 days after the end of treatment period



Source: Acumen, *Measure Specifications: Medicare Spending per Beneficiary – Post Acute Resource Use Measures*, April 2016.

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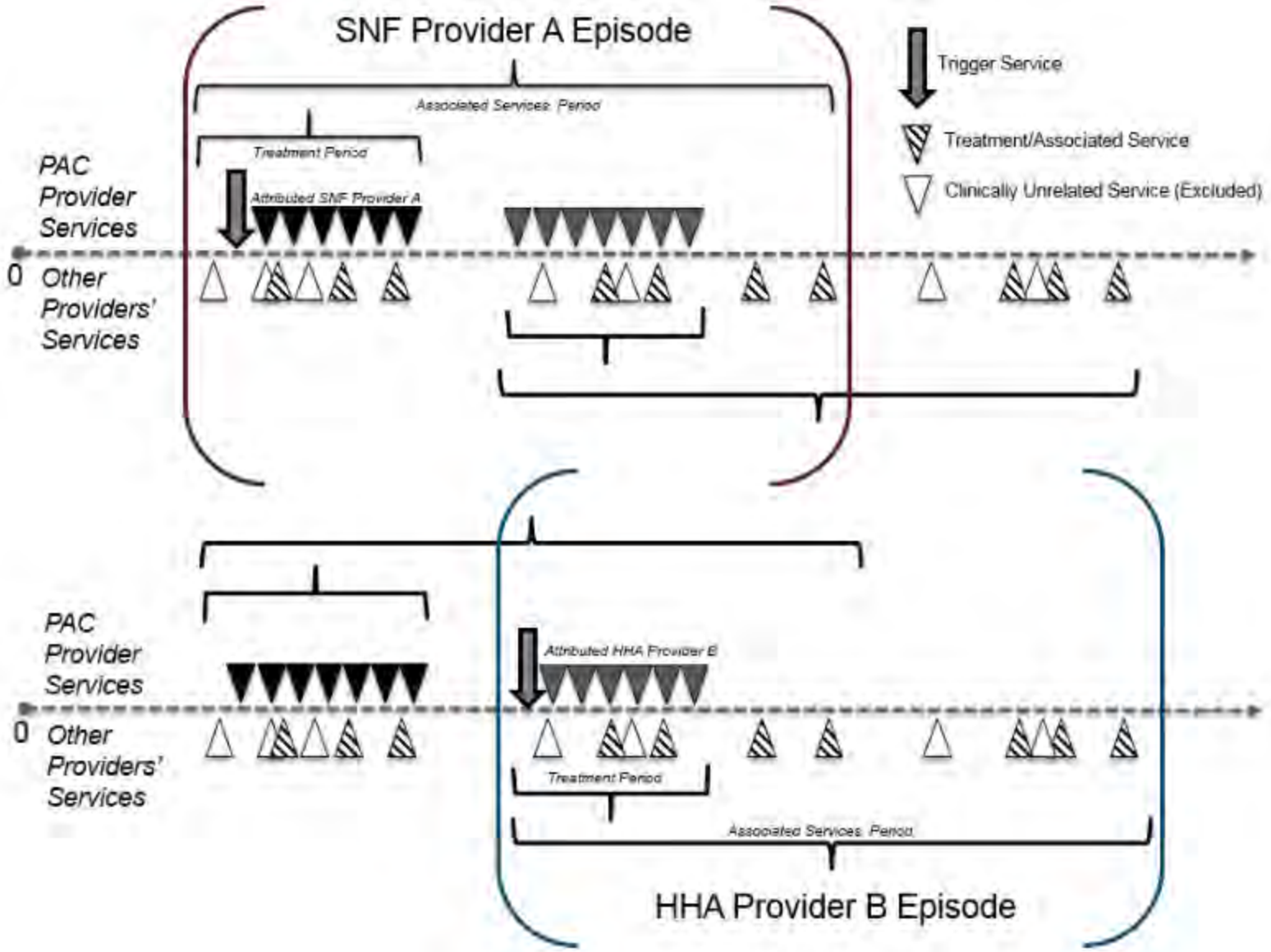
MSPB-HH Measure – Intentional Overlap with other providers



MSPB-HH Measure – Other details

- Excluded from MSPB-HH calculation
  - Planned hospital admissions within episode
  - Certain services outside HH agency control
    - Management of some preexisting chronic conditions (e.g., dialysis)
    - Treatment for preexisting cancers, organ transplants, preventive screenings
  - Other exclusions
    - Claims for patients not enrolled in Medicare FFS, episodes outside US

- Measure is standardized and risk adjusted
  - Standardization removes geographic variation like wage index and other add-on payments
  - Risk adjusted for clinical factors contributing to spending
  - **NOT adjusted for socioeconomic factors**

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CY 2018 HH QRP Measures: Discharge to Community

- Measure assesses "successful discharge to the community" in the 31 days after discharge from HH setting

- "Successful" in this context means risk standardized rate of Medicare FFS patients discharged to community who
  - Are NOT readmitted to acute hospital or LTCH; and
  - Remain alive during time period

- "Community" defined as
  - Home/self-care without home health services
  - Uses patient discharge status codes 01 and 81 on the FFS claim

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Discharge to Community: Other measure details

- Performance calculated using two years of Medicare claims data (for CY 2018, CMS will use CYs 2016 and 2017)

- Key Exclusions
  - Discharges to inpatient psych
  - Discharges to hospice
  - Patients with prior short-term acute care stay for non-surgical cancer treatment

- Risk adjusted for clinical factors contributing to likelihood of readmission or death, but **not adjusted for socioeconomic factors**

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CY 2018 HH QRP Measures: Potentially Preventable Readmissions

- Assesses risk-adjusted rate of unplanned, potentially preventable hospital readmissions in the 30 days post-HH discharge
- HH admission must have occurred within 30 days of a prior proximal hospital stay
- Measure is risk adjusted for clinical factors contributing to likelihood of readmission, **but not for socioeconomic factors**

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CY 2018 HH QRP Measures: Potentially Preventable Readmissions

What is "Potentially Preventable"?

CMS uses ICD codes to define three broad categories of potentially preventable readmissions

- Inadequate management of chronic diseases
  - Adult asthma, COPD, CHF, Diabetes complications,
- Inadequate management of infections
  - Flu, bacterial pneumonia, C Difficile, sepsis, cellulitis
- Inadequate management of other unplanned events
  - Dehydration/electrolyte imbalance, aspiration pneumonia, acute renal failure, arrhythmia, pressure ulcers, intestinal impaction

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CY 2018 HH QRP Measure: Drug Regimen Review

- Measures the percentage of HH episodes for which the following three things are true:
  - Drug regimen review was conducted at start or resumption of care;
  - *For issues identified at start/resumption of care*, HH agency contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues
  - *For other issues identified during HH episode*, the facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified

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CY 2018 HH QRP Measure: Drug Regimen Review

- Measure will be reported by HHs filling out the relevant items on the OASIS

- To meet CY 2018 requirements, HH agencies will be expected to report starting on Jan. 1, 2017, submitting data quarterly

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HH QRP – Other Final Policies

- Removal of six "topped out" measures, along with 28 HHQI measures

- Continued increase to data completeness threshold

Payment Determination Year	New 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)

- Adopted in CY 2016 HH PPS Final Rule
- CMS invoking its authority under the ACA to “test” payment models intended to improve quality / reduce cost
- CMS mandates 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 24 measures
- Program will score HH agencies both on achievement versus CMS-established benchmarks, and improvement versus their own baseline
  - Somewhat like Hospital VBP

HH VBP – Assessment and Payment Adjustment Timeframes

Performance Period	Payment Adjustment Year	Level of Payment Adjustment
CY 2016	CY 2018	+/- 3.0 percent
CY 2017	CY 2019	+/- 5.0 percent
CY 2018	CY 2020	+/- 6.0 percent
CY 2019	CY 2021	+/- 7.0 percent
CY 2020	CY 2022	+/- 8.0 percent

- Performance period occurs two years before payment adjustment
- Level of payment at stake will rise over time

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Key HH VBP Changes

- Performance benchmarks and thresholds based on statewide data (rather each size cohort and state)

- Removal of four measures:
  - Care Management: Types and Sources of Assistance
  - Prior Functioning ADL/IADL
  - Influenza vaccination data collection period
  - Reason PN vaccine not given

- Process to ask for “reconsideration” (or appeal) of HH VBP performance score

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HH VBP – What Can You Do Now?

- ✓ Familiarize yourself with program requirements and quality measures

- ✓ Register a point of contact (POC) with CMMI so that you can:
  - Receive communications from CMMI
  - Report new measures on web-based portal
  - Get access to data reports

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HH VBP – Registration

- Email helpdesk: HHVBPquestions@cms.hhs.gov
- You will then be directed to set up a user ID in the CMS Secure Portal
- Once you have completed registration with CMS, provide HH help desk with user ID
- CMS also planning additional communications resources and tools

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Questions
&
Discussion

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AHA's Post-acute Care Resources:

www.aha.org/postacute

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