Regulatory Update: Home Health PPS

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AHA Policy

July 14, 2016

CY 2017 Proposed Rule

- **Published in July 5 Federal Register**
- **Net Reduction: 1.0%, -$180m**
  - Facility-based agencies: -0.2%
  - Includes:
    - +2.8% market basket update
    - -0.5 productivity cut
    - -2.3% rebasing cut
    - -0.97% case-mix

- **Proposed rates:**
  - 60-day episode: $2,936.68 (drop from CY 2016, $2,965.12)
  - NRS conversion factor: Lower conversion factor of $52.40 (currently 52.71$) includes rebasing cut
  - LUPA: Rates would increase by 2.3%. Details on page 5 of AHA/HPA 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%
  - 60-day rate **dropped** by $80.95 annually
  - LUPA per diem rates, annual **increase**
    - Skilled nursing: +$3.96
    - Home health aide: +$1.79
    - 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

CASEMIX

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%

- **Proposed Case-Mix Cut:**
  - Overall cut of 2.88% (total of 3.41%)
  - -0.97% in each of CYs 2016, 2017, 2018

Disposable Negative Pressure Wound Therapy

- **Today, NPWT can be provided using durable medical equipment (DME) or disposable supplies.**
  - Disposable supplies included in episode payment amount
- **Congress: Consolidated Appropriations Act of 2016 requires a separate HH payment for *disposable* NPWT.**
  - Qualifying bene: Patient separately under a HH plan of care;
  - Qualifying device: integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy;
  - Proposed Payment Process:
    - Report ***time spent*** on HH PPS claim 32x using revenue codes 0559, 042X, or 043X.
      - Don't include time spent furnishing the NPWT in the visit charge of time reported for visit
    - Report ***NPWT*** on OPPS bill 34x, using HCPCS code 97607 or 97608
    - NPWT payment would be lesser of 80% of charge or OPPS amount.
  - Service could be provided by a RN, PT, or OT

Proposed New Outlier Approach

- CMS study of 2015 HH claims: Outlier episodes have significant variation in visit length by discipline for
  - 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 are not generally being used for severely, permanently disable beneficiaries.
- Proposed new methodology intended to correct disincentive to treat medically complex benes who require longer visits.
  - Change from cost-per-visit to cost-per-unit approach
  - One unit = 15 minutes
  - 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

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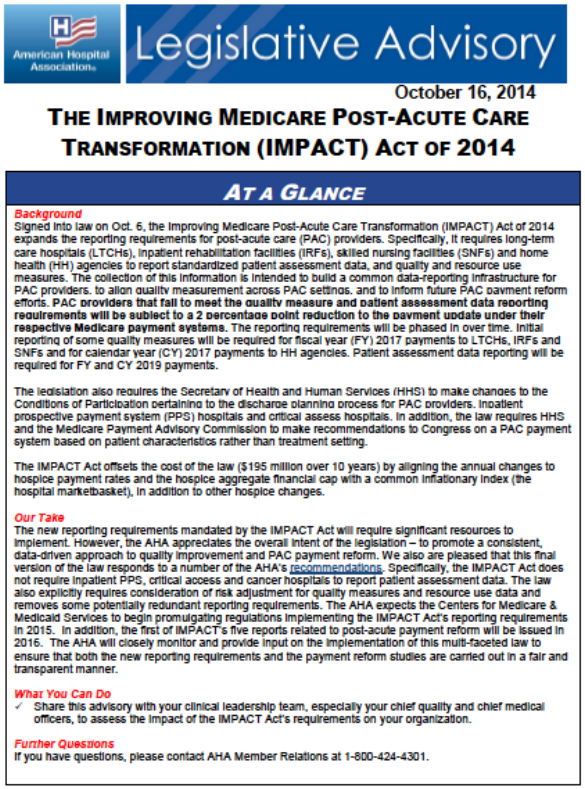
Post-Acute Reporting Changes: IMPACT Act

- 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 (PPS) 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

Proposed in CY 2017 HH PPS Proposed Rule

Detailed proposed measure specifications on CMS website.

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Proposed 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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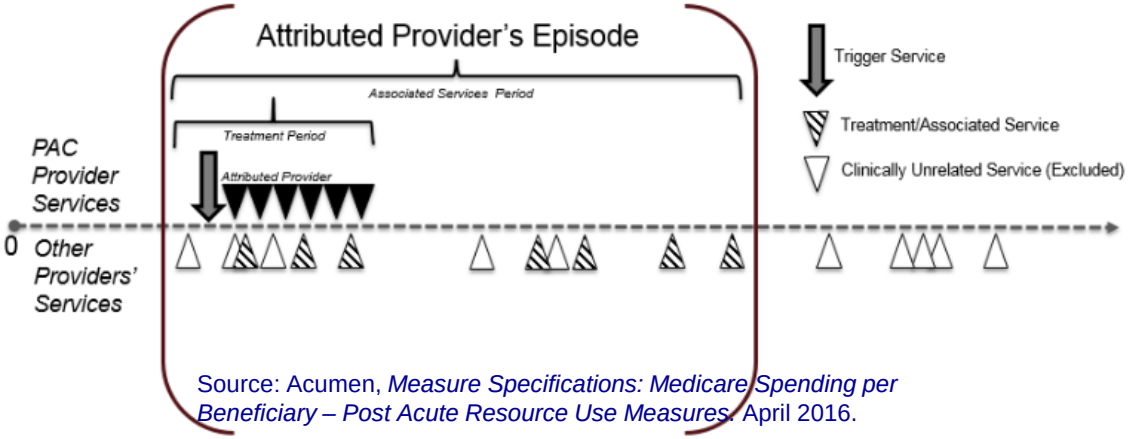
MSPB-HH: Episode Construction

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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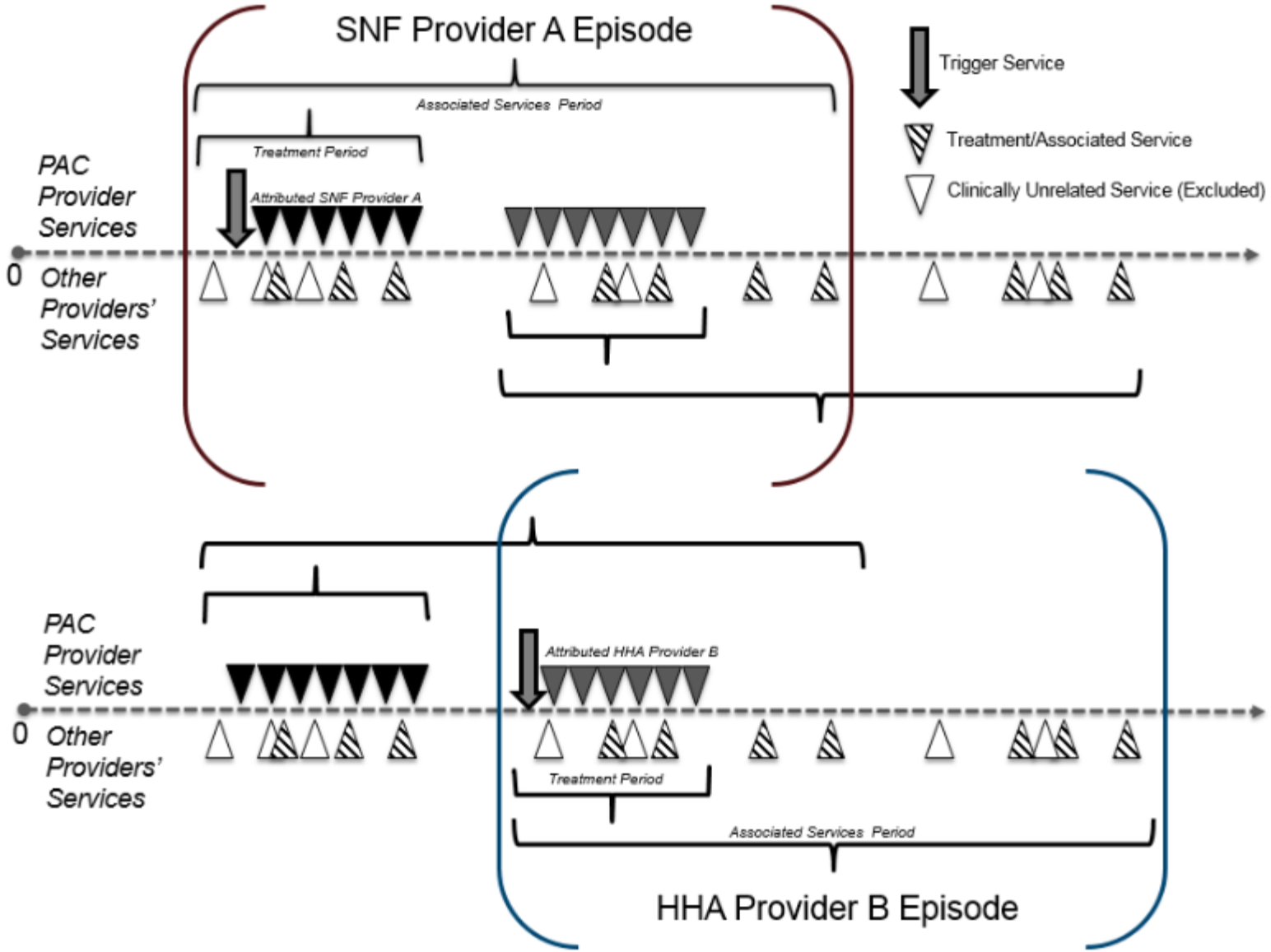
MSPB-HH Measure – Intentional Overlap with other providers



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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Proposed 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 would 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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Proposed 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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Proposed 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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Proposed 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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Proposed 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 would be expected to report starting on Jan. 1, 2017, submitting data quarterly

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HH QRP – Other Proposals

- Removal of 28 “topped out” 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

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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
- **Payment adjustment is greater than existing hospital VBP program**

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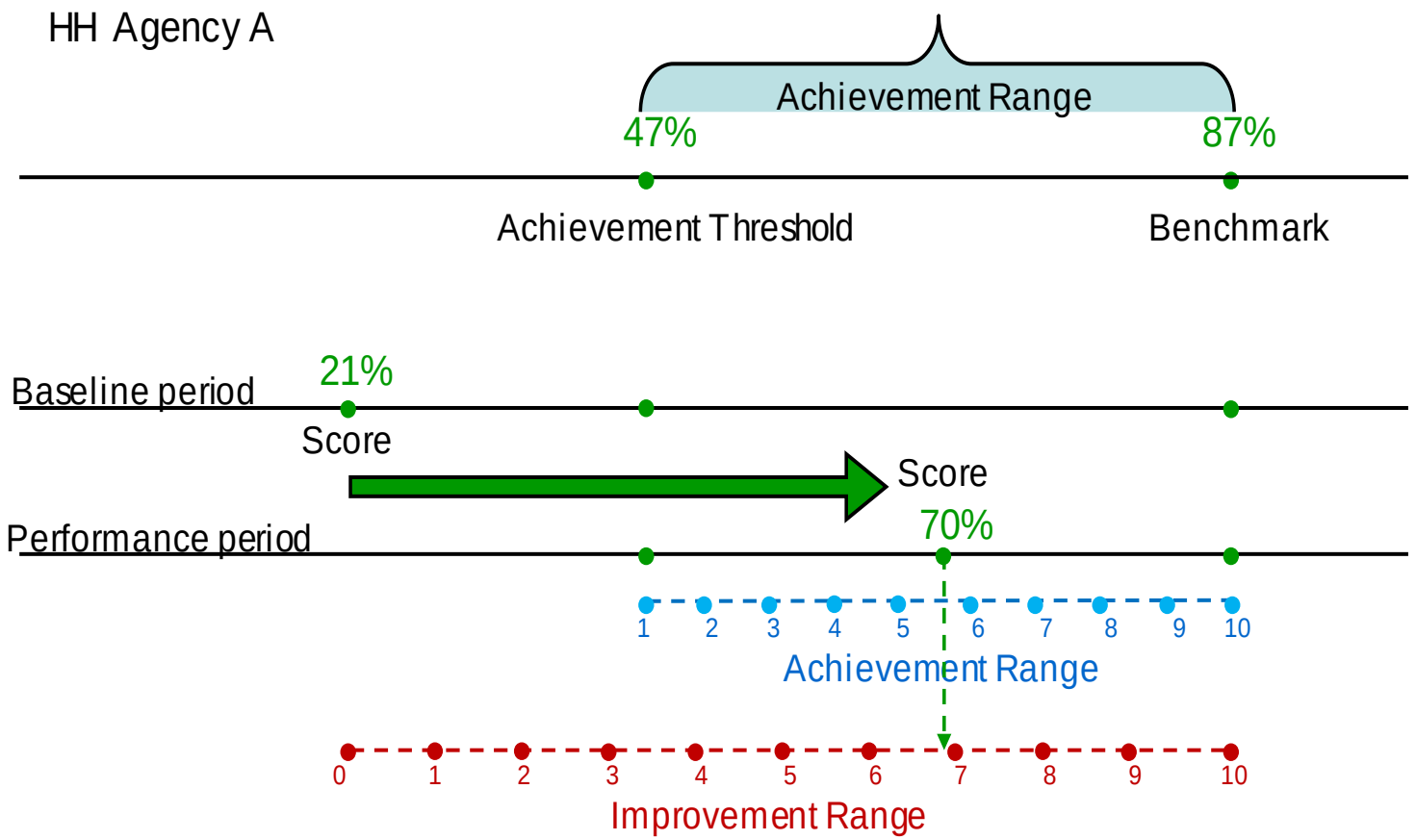
HH VBP Scoring



HH agency A earns 5.675 points for achievement and 6.924 points for improvement

HH agency A score = higher of achievement or improvement = 6.924 points

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Calculating the TPS

Classification	NQS Priority Included in Classification	TPS Weighting
I – Clinical Quality of Care	Clinical quality of care	90 percent, with each measure weighted equally
II – Care Coordination and Efficiency	Efficiency and cost reduction Patient safety Care coordination Population/community health	
III – Person and Caregiver-Centered Experience	Person and caregiver-centered experience	
IV – New Measures	Multiple priority areas	10 percent, with each measure weighted equally

- Measures put into “classifications” reflecting area of National Quality Strategy
- Measures in classifications I, II and III are 90% of TPS, while new measures are 10 percent
  - Must have enough data to be scored on 5 or more measures to receive TPS

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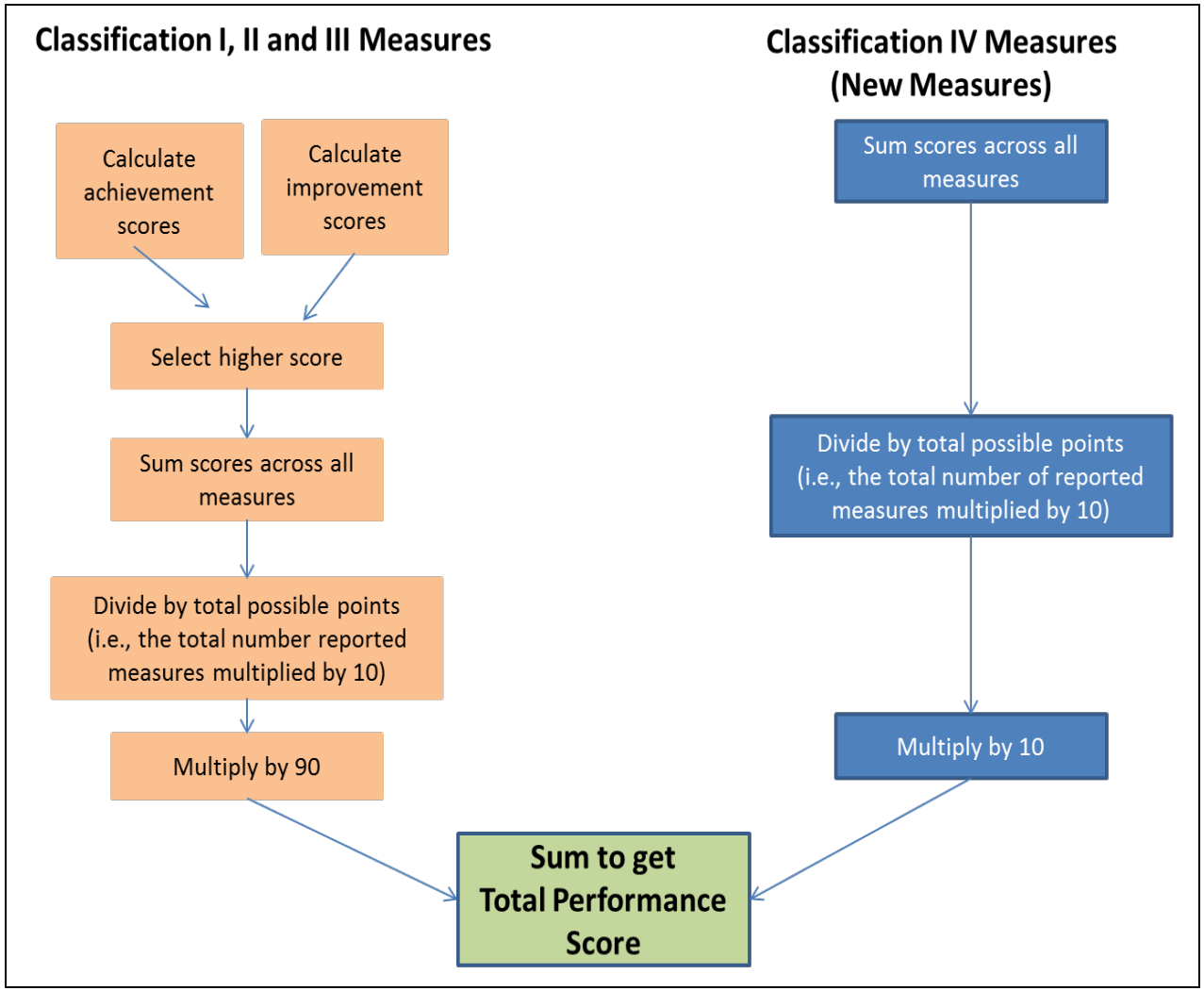
HH VBP – Calculating the TPS



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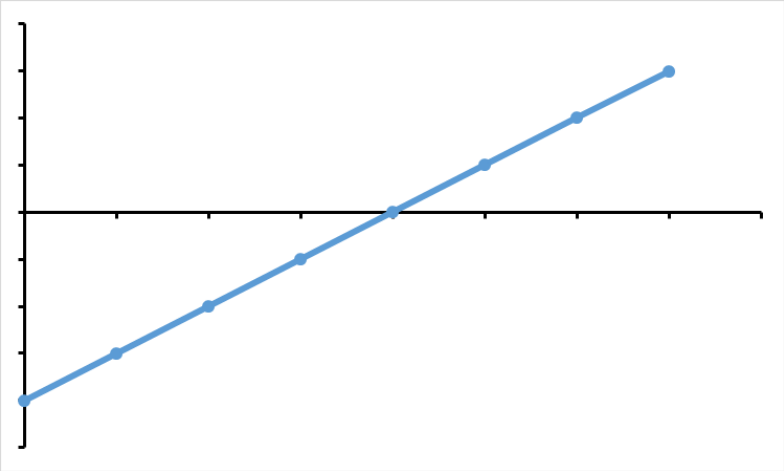
HH VBP - Translating TPS into Payment Adjustments

- CMS will use a 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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Key Proposed 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

- Proposed 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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