CY 2018 Home Health PPS Proposed Rule

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AHA Policy

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CY 2018 Proposed Rule

- **Published in July 28 Federal Register**
- **Net Reduction: 0.4%, -$80m**
  - Same for facility-based agencies
  - Includes:
    - +1.0% market basket update, per MACRA
    - -0.97% case-mix (CY 2012-2014 non-alignment)
    - NO rebasing cut; ACA cut concluded in CY 2017
    - NO rural add-on

- **Proposed rates:**
  - 60-day episode: $3,038.43 (increase from $2,989.97 in CY 2017)
  - NRS conversion factor: $53.03 for the 6 severity levels (CY 2017 factor: $42.40)
    - Table 14: Range of $14.31 for lowest severity level; $558.16 for highest.
  - LUPA: Rates would increase by 1.0% (See AHA advisory or rule's Table 11)

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CY 2018 Case-Mix Cut

- **Nominal Case-Mix Increases**
  - In CYs 2012 through 2014, a portion of CMS case-mix increase not driven by rise in patient acuity
- **Proposed Case-Mix Cut:**
  - -0.97% in each of CYs 2016, 2017, 2018
  - CY 2018: **Final installment**

Home Health Quality Reporting Requirements

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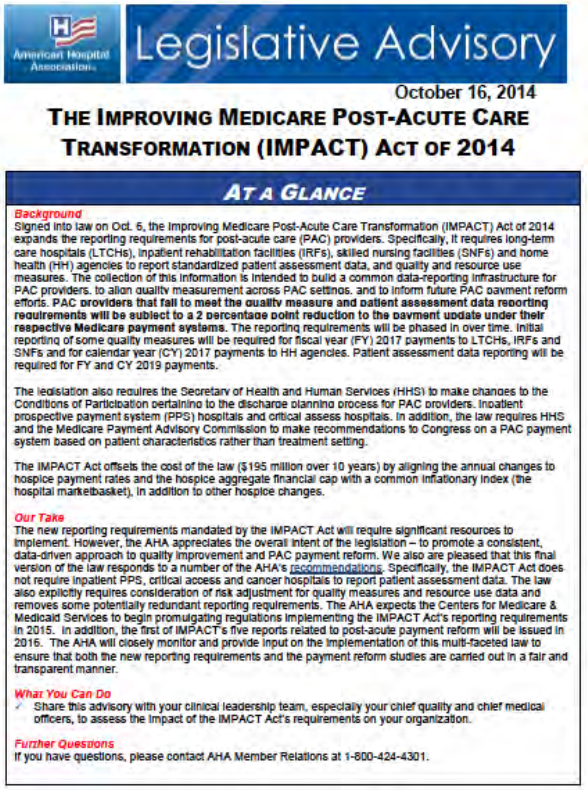
Post-Acute Reporting Changes: IMPACT Act

- 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 2017



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 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 (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

Adopted in CY 2017 HH PPS Final Rule

Detailed measure specifications on CMS website.

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CY 2020 HH QRP Measures: Changes in Skin Integrity: Pressure Ulcer/Injury

- Proposes to remove current pressure ulcer measure, "Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay)"
- Replace with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
  - Includes unstageable pressure ulcers, including deep tissue injuries (DTI)
  - Uses number of unhealed pressure ulcers at each stage after subtracting number present upon admission
- No universally accepted definition of injuries
- New data element

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CY 2020 HH QRP Measures: Functional Assessment Measure

- CMS proposes to add **Application of Percent of Long-Term Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function**
- Required by IMPACT Act
- Coded using 6-level rating scale indicating level of independence
- Originally developed and tested as part of PAC-PRD
  - Not NQF-endorsed for HH setting
  - Potentially duplicative with existing OASIS function items

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CY 2020 HH QRP Measures: Falls with Major Injury

- CMS proposes to add **Percent of Residents Experiencing One or More Falls with Major Injury**
- Required by IMPACT Act
- Implemented in SNF setting in 2011
  - Not NQF-endorsed in HH setting
  - MAP raised concerns about attribution, data collection
    - Suggestion of stratification by referral origin
- Would add two standardized items to OASIS for collection at end of care
  - OASIS already contains process falls measure

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CY 2020 HH QRP Measures: Removal of OASIS Items

- CMS proposes to remove 247 data elements from 35 OASIS items collected at various points
  - Start of care, resumption of care, follow-up, transfer, death at home, discharge
- Elements not being used to calculate quality measures, payments, surveys, or care planning

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Standardized Patient Assessment Data

- IMPACT Act requires collection of standardized patient assessment data; **failure to comply would result in payment reduction**
- Currently four different assessment instruments (LCDS, MDS, PAI, OASIS)
- Elements must satisfy five domains:
  - Functional status
  - Cognitive function
  - Special services
  - Medical conditions and comorbidities
  - Impairments
- Most elements tested in PAC-PRD
  - Most already implemented in other PAC tools

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CY2020 Standardized Patient Assessment Data Reporting Details

- IMPACT Act requires data reporting **starting with CY 2019**
  - Pressure Ulcer measure for Q1 and Q2 of CY 2018
  - Subsequent years based on full calendar year of data
- For **CY 2020**, reporting required for Medicare admissions (SOC or ROC) and discharges starting on **January 1, 2019**
- CMS proposes to extend administrative requirements for QRP data to patient assessment data, including
  - Participation
  - Exception and extension
  - Reconsiderations
  - Data completion thresholds

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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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Key HH VBP Changes

- Increase in minimum number of completed HHCAHPS surveys
  - Proposes new minimum of 40
- Removal of Drug Education measure beginning in CY 2018
- Future measures for considerations
  - Total change in ADL/IADL performance
  - Composite functional decline
  - HHA correctly identifies patient's need for mental or behavioral health supervision
  - Caregiver can/does provide for patient's mental or behavioral health supervision needs

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HHGM Proposal for CY 2019

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HHGM

- **Home Health Groupings Model (HHGM)**
- ***More details***: pages 10-15 in AHA regulatory advisory.
  - Slide 21: Link to full proposed rule text. HHGM proposal starts on p. 35294.
- Complete HH PPS redesign proposed for CY 2019.
- Multi-tiered payment model would move from 153 to 144 HHRGs.
- Switch from a 60-day to 30-day episode.
- Same methodologies for: LUPA, PEP, Outliers
- Estimated impact for CY 2019 -- Two approaches:

1. No transition assistance:
   - Total HH field: -4.3%, $950 million (without accounting for annual update)
   - Facility-based agencies: 0.0% change

2. Partial transition assistance
   - Total HH field: -2.2%, -$480 million (without accounting for annual update)
   - Facility-based agencies: +2.2%

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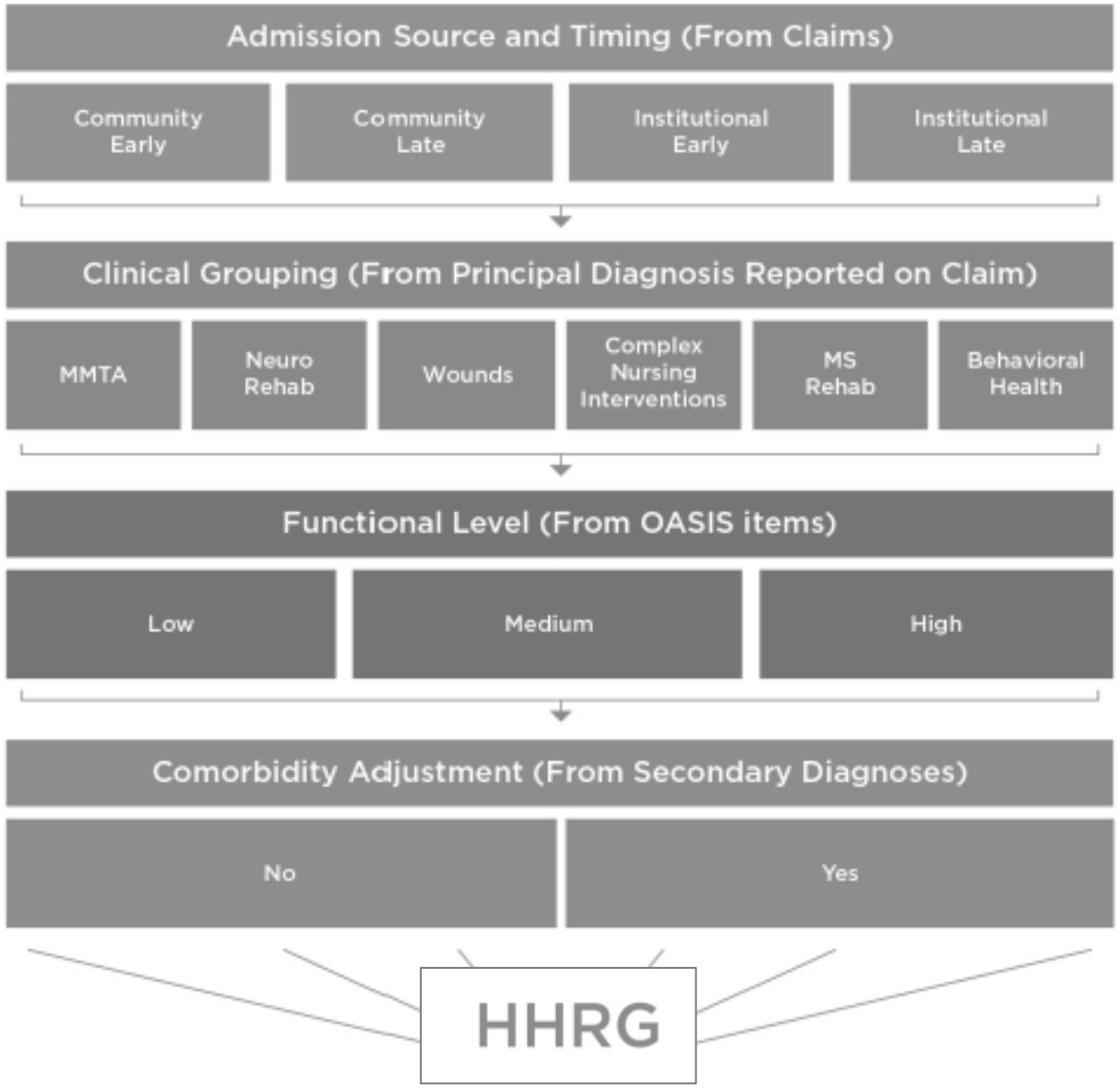
Proposed Rule Figure 5. Structure of HHGM



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AHA Comment Letter to CMS

Letters due to CMS by Sept 25.

DRAFT **list of HHGM-related comments:**

- In general, we support efforts that improve payment accuracy and the negative Medicare margins for hospital-based HH agencies.
- We support using patient characteristics, rather than volume, to set payments.
- Need more details and further explanation: 30-day episode rationale; changing the source of cost data from wage-weighted minutes of care (WWMC) to a combination of cost reports, claims, NRS data.
- Non-budget neutral approach under examination by legal counsel.
- The new model is complex, a major departure from the current PPS, and needs to be implemented well in order to ensure a workable transition and continued access to care. These needs are not ensured by the proposed rule and CMS should proceed when they are achievable.
- Any new HH PPS model should be implemented with a phase-in.
- **FEEDBACK/QUESTIONS/SUGGESTIONS?**
- **WHAT'S MISSING?**

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AHA Comment Letter to CMS

Letters due to CMS by Sept 25.

DRAFT list of quality-related comments:

- Applicability of new quality measures to HH setting
- Duplication of efforts around functional status quality measure
- Feasibility of new standardized patient assessment data reporting requirements
- **FEEDBACK/QUESTIONS/SUGGESTIONS?**
- **WHAT'S MISSING?**

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Questions
&
Discussion

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CMS's Proposed Rule Text:

https://www.gpo.gov/fdsys/pkg/FR-2017-07-28/pdf/2017-15825.pdf

Advisory and Slides Available at:

www.aha.org/postacute in HH section

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