Home Health Regulatory Roundup 2015

Mary Carr, V.P. for Regulatory Affairs
National Association for Home Care & Hospice

Home Health Proposed Rule: So much more that payment rates

* HHPPS 2016 Proposed Payment Rates
* Finalized 10/29
  * Continued Rate Rebasing
  * Recalibration of Case Mix Weights (again!)
  * Wage Index Changes
  * Case Mix Creep Adjustments (again!)
  * Value Based Purchasing Model
  * HHQRP

2016 Proposed Medicare Home Health Rates

- Year 3 rebasing payment rates (4 year phase-in)
  - Episode rates: full cut (3.5% of 2010 rates) allowed under ACA
  - LUPA per visit rates: full increase (3.5% of 2010 rates)
  - Non-routine Medical Supplies: 2.82% reduction
- Recalibrated case mix weights
  - Changes in all 153 case mix weights
  - Budget neutrality adjustment
- New CBSAs in wage index
- Outlier eligibility remains same despite low spending
- Rates reduced by 2% if no quality data submitted
- 3% rural add-on continues through 2017
- Remember 2% payment sequestration (February 1 and later payments)

2016 Medicare Home Health Rates

* Payment rate updates
* CY 2015 Base Episode Rate: $2,961.38
* CY 2016 Proposed Base Episode Rate: $2,965.12
  * Market basket Index (inflation factor): 2.3%
  * **Down to 1.9 due top Productivity Adjustment: 0.4%**
* Case mix creep adjustment: 1.72% over two years
* Final=.97% over three years; total 2.88% reduction rather than 3.41%.
* Rebasing Adjustment: -$80.95
* Wage Index Budget Neutrality Factor: 1.0001 from 1.0006
* Case Mix Weight Budget Neutrality factor: 1.0187 from 10141

2016 Medicare Home Health Rates

* Per-Visit Rates : proposed;final
* Home Health Aide: $61.09 ; $60.87
  - MSW: $216.23; $215.47
  - OT: $148.47; $147.95
  - PT: $147.47; $146.95
  - SLP: $160.27; $159.71
  - SN: $134.90; $134.32
* 3.5% rebasing increase over 2015 + 1.9% update
* Non-routine Medical Supplies: $52.71 conversion factor
  - 2.82% rebasing reduction + 1.9% update

2016 Medicare Home Health Rates

* Notables
  * CMS includes case mix creep adjustment (3.41%) at 1.72% in 2016 and 2017; changed to .97%over three years =2.88%
    * Relates to 2012-2014 changes in case mix weights
    * Represents changes in coding that does not reflect changes in patients
    * MedPAC explains that access and quality is OK
  * Anticipate annual case mix recalibration

2016 Proposed Medicare Home Health Rates

- Recalibration:
  - ∗ Case mix scores
  - ∗ Clinical and functional thresholds
  - ∗ Case mix weights

Value-Based Purchasing Pilot (VBP)

- CMS proposes piloted VBP:
  - Starting in 2016
    - Baseline year 2015
    - Performance year 2016
    - Payment year 2018
  - 9 states mandatory participation of all HHAs
  - 3-8% payment withhold for incentive payments; from 5-8%
    - "greater upside benefit and downside risk"
    - Phase-in to 8%
  - performance measures
    - Achievement and improvement
    - Process, outcomes, and patient satisfaction
  - Comparison based on "smaller-volume" and "larger-volume"
    - State-based comparison

Value-Based Purchasing Pilot (VBP)

* Proposed states: MA, MD, NC, FL, WA, AZ, IA, NE, TN
  - 9 regions
  - Randomized selection w/in each region
  - Subject to change--- No change

Value-Based Purchasing Pilot

* Payment Adjustment Timeline
  - 5 performance years beginning in 2016
    * 2016 > 2018 payment adjustment (5%) (3%)
    * 2017 > 2019 payment adjustment (5%)
    * 2018 > 2020 payment adjustment (6%)
    * 2019 > 2021 payment adjustment (8%) (7%)
    * 2020 > 2022 payment adjustment (8%)
  - May modify schedule beginning in 2019 with more frequent adjustments

Value-Based Purchasing Pilot

* Measures
* OASIS; Claims; HHCAPS
  - 10 Process; 6 process measures
  - 10 Outcome; 5 HHCAPHS no change
  - 4 New Measures; 3 New measures
* Principles:
  - Broad set to capture HHA complexities
  - Flexibility to include IMPACT Act proposed PAC measures
  - Develop second-generation measures of outcomes, health and functional status, shared decision making and patient activation
  - Balance of process, outcome, and patient experience
  - Advance ability to measure cost and value
  - Measures on appropriateness and overuse
  - Promote infrastructure investments

Value-Based Purchasing Pilot: Measures

- Outcome
  - Improvement in ambulation-locomotion (OASIS)
  - Improvement in bed transferring
  - Improvement in Bathing
  - Improvement in Dyspnea
  - Discharged to community
  - Improvement in pain interfering with activity
  - Improvement in oral medication management
  - Prior functioning ADL/IADL NQF 0430
  - Acute care hospitalization (unplanned w/in 60 days; during first 30 days) (Claims)
  - Emergency Department use w/o hospitalization(Claims)
  - Care of Patients (CAHPS)
  - Communication between providers and patients (CAHPS)
  - Specific care Issues (CAHPS)
  - Overall rating (CAHPS)
  - Willingness to recommend the agency (CAHPS)

Value-Based Purchasing Pilot: Measures

* Process
  * Depression assessment conducted (OASIS)**
  * Influenza vaccine data collection
  * Influenza immunization received
  * Pneumococcal vaccine received
  * Reason Pneumococcal vaccine not received
  * Drug education
  * Timely initiation of care**
  * Care management: Types and sources of assistance
  * Pressure ulcer prevention and care**
  * Multifactor fall risk assessment /pts who can ambulate**

  * **measure dropped in the final rule

Value-Based Purchasing Pilot: Measures

* New Measures: HHA reporting through portal
* Pay for Reporting = 10% TPS ? Final
* Influenza vaccination of HH staff
  * Herpes zoster (shingles) vaccines for HHA patients
  * Advanced Care planning
  * Adverse event for improper medication **

  * **measure dropped in the final rule

Value-Based Purchasing Pilot: Scoring

* Total Performance Score (TPS)
  * Use only those measures out of the 25 with 20 or more episodes
  * Use higher of improvement or achievement score
  * Divide total earned points by total possible points multiplied by 90
  * Add New Measure points (points earned/possible points X 10)

Home Health Quality Reporting Program (HHQRP)

* OASIS Submission
* Oasis submission threshold established in 2015 final rule
* "Quality Assessments Only" (QAO) defined several ways
* Agencies must report 70 % of quality assessments between July 1, 2015-June 30, 2016 to receive the full APU for CY 2017.
* CMS proposes to require 80% of quality assessment be reported between July 1, 2016 –June 30,2017 to receive full APU for CY 2018
* .
* For reporting year July 1, 2017-June 30, 2018 and after 90% of quality assessments must be reported to receive full APU for the respective payment year
* HHCAHPS requirement remains without change

Proposed HHQRPs

Safety	**Falls risk composite process measure:** Percentage of home health patients who were assessed for falls risk and whose care plan reflects the assessment, and which was implemented appropriately.
Effective Prevention and Treatment	**Nutrition assessment composite measure:** Percentage of home health patients who were assessed for nutrition risk with a validated tool and whose care plan reflects the assessment, and which was implemented appropriately.
	Improvement in Dyspnea in Patients with a Primary Diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and/or Asthma: Percentage of home health episodes of care during which a patient with a primary diagnosis of CHF, asthma and/or COPD became less short of breath or dyspneic.
	Improvement in Patient-Reported Interference due to Pain: Percent of home health patients whose self-reported level of pain interference on the Patient-Reported Objective Measurement Information System (PROMIS) tool improved.
	Improvement in Patient-Reported Pain Intensity: Percent of home health patients whose self-reported level of pain severity on the PROMIS tool improved.
	Improvement in Patient-Reported Fatigue: Percent of home health patients whose self-reported level of fatigue on the PROMIS tool improved.
	Stabilization in 3 or more Activities of Daily Living (ADLs): Percent of home health patients whose functional scores remain the same between admission and discharge for at least 3 ADLs

The Final Rule

∗https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-27931.pdf

Face to Face (F2F)

* Changes effective 1/1/2015
* Eliminated the narrative
* Must Certify:
  * that a F2F encounter occurred within the required time frame
  * Related to the primary reason for home health services
  * Date of the encounter

Face to Face

* The physician's record will be used to determine eligibility
* Physician may incorporate agency information Into the record that substantiates eligibility (assessment, summary of finding, etc.)
* Agency information must be signed by the certifying physician in a timely manner and incorporated into the physician/hospital record
* incorporated timely is when the information is signed off prior to or at the time of claim submission
* Physician's record must corroborate the agency's information
* If the certifying physician is the acute-post acute care physician, the physician who follows the patient must be identified as part of the certification

Face to Face

* Because the narrative has been eliminated there is no longer a requirement that the acute-post acute care physician's or the allowed NPP's encounter be co-signed
* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R603PI.pdf

Face to Face

* Clinical template for the HH F2F encounter
* Comments due 10/13
* Voluntary
  * Too much free text
  * When the facility physician must identify the community physician is confusing
  * Conflicts with co-signature guidance for NPPs

Recertification

* The physician must include an estimate of how much longer the skilled services will be required
* Estimation of how much longer the patient will be on service
* Must be part of the recertification
  * included in the recertification statement
  * separate statement where it is clear that it is part of the recertification
    * I certify that in my in my estimation services will be require for ………………..
    * Agency may complete based on the physician estimate

Probe and Educate

* Begin Oct. 2015 effective for episodes Aug. 2015 and later
* One contractor has stated:
  * A minimum of five records audited
  * Last one year

Medicaid Face to Face

* Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health (CMS-2348-F)
* Sent to OBM 9/08/2015
* Expect more flexibility

Star Rating System

* Began on HHC July 2015
  * Data – Jan-Dec 2014
  * Claims data Oct 2013-Sept 2014
  * Updated quarterly

Star Rating System

* Measures
* Process Measures:
* 1. Timely Initiation of Care
  2. Drug Education on all Medications Provided to Patient/Caregiver
  3. Influenza Immunization Received for Current Flu Season
* Outcome measures:
* 4. Improvement in Ambulation
  5. Improvement in Bed Transferring
  6. Improvement in Bathing
  7. Improvement in Pain Interfering With Activity
  8. Improvement in Shortness of Breath
  9. Acute Care Hospitalization

Star Rating System

Method

* Half stars
* Curves towards the middle
* Agencies grouped between 2.5 -3.5 stars

Star Rating System

* Quarterly preview reports available in CASPER mailboxes
* HHC Star Rating Provider Preview report includes:
  * Overall HHC Star Rating for the provider
  * Description of how the HHC Star Rating is calculated (pp. 1-2)
  * Process for requesting review (*"If Your Rating Isn't What You Think it Should Be…"*) (p.3)
  * Helpdesk contact information (p.3)
  * "Scorecard" showing the actual calculation of the HHC Star Rating for the provider (p.4)

Star Rating System

* January 2016 - HHCAPHS data to receive a star rating report – five stars
* Composite Measure
  * Care of patients
  * Communication between providers and patients
  * Specific care issues
* Global item
  ∗Overall rating of Care provided by the agency
* Summary star rating
* Initially separate report , but plan is to incorporate into overall star rating report
* HHCAPHS web site to review reports

PEPPER

Program for Evaluating Payment Patterns Electronic Report

* July 2015
* Areas at risk for improper payments
* Target areas
  * Average case mix
  * Average #of episodes
  * Episodes with 5-6 visits
  * Non LUPA payments
  * High therapy utilization
  * Outlier payments
* Summarizes three years of data
* https://www.pepperresources.org/

ICD-10

* Effective for claims with a "through" date on or after Oct 1, 2015
* 7th character in complication diagnoses (i.e. post-op infection) may be an "A" - initial encounter
  * Change in previous instructions
  * Impact HH Grouper for 2015
* ICD-10 code R26.0 – Ataxic gait is listed as DG 05- Dysphagia, rather than DG 06-Gait Abnormality.
* Claims processing issue
  * Claims that span Oct. 1, 2015 - RAP will have an ICD-9 code while the claim has an ICD-10 code were erroneously RTP'd

ICD -10

* ICD-10 Transition Workgroup
  * NAHC along with other stakeholders
  * Met with Dr. Rogers –CMS ICD-10 Ombudsman
  * Plan to continue discussion
  * Send issues to mkc@nahc.org
  * ICD10_Ombudsman@cms.hhs.gov

Proposed Conditions of Participation

* Issued Oct. 2014
* Expands patient rights
* Add a discharge and transfer summary requirement and time frames
* Emphasis on integration and interdisciplinary care planning
* Where standards are written in broad and vague terms, more specificity regarding what is required.
* Increase in Governing body involvement/accountability
* Two new CoPs
  * 484.65 Quality Assessment and performance improvement (QAPI)
  * 484.70 Infection Control

IMPACT ACT

* Passed Sept 2014
* Requires CMS to develop and report cross setting
  * standardized patient assessment
  * data on quality measures
  * data on resource use, and other measures
  * 2017 - 2019
* Data elements must be standardized and interoperable for the exchange among such post-acute care providers
* Data elements to be incorporated into the assessment instruments currently required
* HHAs, SNFs, IRFs, and LTCHs

IMPACT Act

* Standardized assessment data domains – HH 2019
  * Functional status
  * Cognitive , function, and mental status
  * Special services, treatments, and interventions
  * Medical conditions and co-morbidities
  * Impairments

IMPACT ACT

* Quality measure on domains between 2016-2019
* Assessment data HHA 2019; others 2018
* Measure Domains (HH)
  * Functional and cognitive status and changes in functional and cognitive status (2019)
  * Skin integrity and changes (2017)
  * Medication reconciliation (2017)
  * Incident of falls (2019)
  * Transition of care (2019)
* Resource use measures
- Medicare spending per beneficiary
* Discharge to community
* Measures to reflect all-condition risk- adjusted potentially preventable hospital readmission rates

IMPACT ACT

* To meet statutory required timeline consider measures in place that are:
  * Already endorsed
  * Finalized for use
  * Minimize burden

IMPACT ACT

* 2016 HH Proposed rule included:
* Skin integrity and changes in skin integrity
  * *Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (NQF #0678*)
  * Uses OASIS C-1 data set items M01308 and M01309
  * Feedback on this measure and future measures to implement the IMPACT Act
  * Notice of proposed rule making for all new measures

IMPACT ACT

* CMS measures under consideration (MUC) list
* Measure Application Partnership(MAP)-National Quality Forum (NQF)
* Guides HHS in measure selection for Federal programs
* Public - private partnership

IMPACT ACT

- CMS Measure Management web page
  - Call for Measures
  - Public comments on measures
  - Technical Expert Panel nominations

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/index.html

IMPACT ACT

- **NQF Calendar of activities:** http://www.qualityforum.org/EventList.aspx
- • **MAP Coordinating committee project page:** http://www.qualityforum.org/Project_Pages/MAP_Coordinating_Committee.aspx
- • **MAP PAC-LTC workgroup project page:** http://www.qualityforum.org/Project_Pages/MAP_Post-Acute_CareLong-Term_Care_Workgroup.aspx
- • **CMS's Pre-Rulemaking page:** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Pre-Rule-Making.html

IMPACT Act

* **Open Door Forums (ODFs):** SNF, LTC: October 29 and December 1
* HH, Hospice, DME: November 4 and December 16
* •**Special Open Door Forum (SODF):** Understanding The IMPACT Act-Patient and Family Focused for Informed Decision Making. Wednesday, October 28, 2015, from 1:00 p.m. –3:00p.m. Eastern Time
* **CMS Quality Conference Presentation:** December 1 –3, 2015 (planned)
* **CMS National Training Program Partner Update Webinar: January 2016** (planned)

New G codes

* For home health and hospice claims G0154 "Direct skilled nursing service of a licensed nurse (RN or LPN) in the home health or hospice setting" will be replaced with two new codes
* G0299 - RN services
* G0300 - LPN services
* Effective for HH claims with dates of service on or after 1/1/2016
* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3378CP.pdf