Home Health Regulatory Roundup 2015

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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 0.97% 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

<table>
<thead>
<tr>
<th>Safety</th>
<th>Effective Prevention and Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Improvement in Patient-Reported Pain Intensity: Percent of home health patients whose self-reported level of pain severity on the PROMIS tool improved.</td>
<td></td>
</tr>
<tr>
<td>Improvement in Patient-Reported Fatigue: Percent of home health patients whose self-reported level of fatigue on the PROMIS tool improved.</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>

## The Final Rule

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
* 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


* 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 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)

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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

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**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


**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:
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