# Home Health Regulatory Update

August 2016

Presented by:
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## Before We Get Started

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## Who is HEALTHCARE*first*?

- Industry leader in Web-based software, outsourced services, and advanced analytics for home health and hospice.
- We enable our customers to:
  - Make timely and accurate decisions for excellent patient care
  - Adapt quickly to changing requirements and needs
  - Automate agency functions quickly and with high value.

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## Home Health Solution Suite

*What's Included:*

- *first*HOMECARE EMR Software
- OASIS Review & Coding Services
- Billing Services
- Business Intelligence
- Home Health CAHPS
- Payer Connectivity

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## Agenda

- 2017 HH PPS Proposed Rule
  - Rates/Payment changes
  - Re-calibration of Case Mix Weights
  - Outlier Payment changes
  - Quality updates
- Updates on current Pilot Programs
  - Value-Based Purchasing
  - Pre-Claim Review Model
- Upcoming changes, updates & mandates
- Important Reminders
- Medicare Administrative Contractors

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## 2017 HH PPS Proposed Rule

- Information can be found at:
  - https://www.gpo.gov/fdsys/pkg/FR-2016-07-05/pdf/2016-15448.pdf
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1648-P.html

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## 2016 vs. 2917 Payment Rates

- Effective for episodes ending on or after January 1, 2017:

| 2016 Base Rate / Rural Base Rate | 2017 Base Rate / Rural Base Rate (Proposed) |
|---|---|
| $2,961.38/ $2990.47 | $2,936.68/ $2,965.65 |

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## 2017 Payment Rates

- Overall impact estimated at -180 million (-1%)
- Fourth and final year of rebasing
- Recalibration of the HH PPS Case Mix Weights
- Updates to reflect case mix growth
- *REMINDER:* Sequestration is still in effect

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## 2016 vs. 2017 Discipline Rates

| Discipline | 2016 Non-Rural / Rural | 2017 Non-Rural / Rural (Proposed) |
|---|---|---|
| **HHA** | $60.87/ $61.47 | $64.09/ $66.01 |
| **MSS** | $215.47 / $217.58 | $226.87 / $233.68 |
| **OT** | $147.95 / $149.40 | $155.77 / $160.44 |
| **PT** | $146.95 / $148.39 | $154.72 / $159.36 |
| **SN** | $134.42 / $135.74 | $141.54 / $145.79 |
| **SLP** | $159.71 / $161.28 | $168.16 / $173.20 |

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## 2016 vs. 2017 Supply Rates

Non-Routine Supply Rates (NRS)

*Note a 2% reduction to these rates when not submitting quality data

| Severity Level | 2016 Non-Rural / Rural | 2017 Non-Rural / Rural (Proposed) |
|---|---|---|
| 1 | $14.22 / $14.65 | $14.14 / $14.56 |
| 2 | $51.35 / $52.89 | $51.05 / $52.58 |
| 3 | $140.80 / $145.02 | $139.97 / $144.16 |
| 4 | $209.18 / $215.46 | $207.95 / $214.19 |
| 5 | $322.57/ $332.24 | $320.68/ $323.86 |
| 6 | $554.79 / $571.42 | $551.53 / $557.00 |

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## LUPA Add-On Rates

| Non-Rural / Rural |
|---|
| SN – 1.8451<br>PT – 1.6700<br>SLP – 1.6266 |

http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp

*Note a 2% reduction to these rates when not submitting quality data

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## Outlier Payment Rates & Changes

- Change to a cost per visit approach based on 15-minute service units

| Discipline | 2017 visit per-visit pmt rates | Average minutes-per visit | Cost-per-unit ( 1 unit = 15 mins) |
|---|---|---|---|
| **HHA** | $64.09 | 62.2 | $15.46 |
| **MSS** | $226.87 | 56.4 | $60.34 |
| **OT** | $155.77 | 47.1 | $49.61 |
| **PT** | $154.72 | 46.6 | $49.80 |
| **SN** | $141.54 | 44.7 | $47.50 |
| **SLP** | $168.16 | 48.1 | $52.44 |

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## Outlier Payment Rates & Changes

- Loss ratio to remain at 80%
- The fixed-dollar loss ratio that is used to calculate outlier payments will be increased from 0.45 to .056
  - Impact to providers: The number of episodes that qualify as outliers will be reduced
  - Review your current visit lengths to determine agency impact

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## Outlier Payment Rates & Changes

- Implementation of a cap on the amount of time per day that can be counted toward the estimation of an episode's cost for outliers.
  - Limit the time of day to eight hours or 32 units per day

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## Quality Reporting Program Changes

- Adopt four measures for CY2018 to meet the requirements of the IMPACT Act
  - Resourced-based measures
    - All-condition risk adj. potentially preventable readmission rates
    - Total estimated Medicare spending per beneficiary
    - Discharge to the community
  - Assessment-based measure
    - Medication reconciliation

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## Quality Reporting Program Changes

- Proposed CY data collection/submission quarter report periods and data submission deadlines

| Quality Measures | Data Collection Source | Proposed Data Collection/ Ssubmission Quarterly Reporting Period* | Proposed Quarterly Review and Correction Periods and Data Submission Quarterly Deadlines * |
|---|---|---|---|
| NQF # 0678:Application of Percent of Patients or Residents with Pressure Ulcers that are New or Worsened<br><br>Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC HH QRP | OASIS | CY 17 Q1 1/1/2017-3/31/2017<br><br>CY 17 Q2 4/1/2017-6/30/17<br><br>CY 17 Q3 7/1/2017-9/30/2017<br><br>CY 17 Q4 10/1/2017-12/31/2017 | CY 2017 Q1 Deadline: **August 15, 2017**<br><br>CY 2017 Q2 Deadline: **November 15, 2017**<br><br>CY 2017 Q3 Deadline: **February 15, 2018**<br><br>CY 2017 Q4 Deadline May 15, 2018 |

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## Value-Based Purchasing Updates

- Establish a minimum of eight HHAs as a cohort for measure application
- Remove four measures that were not fully developed
- Adjust the reporting periods
- Increase the timeframe for submitting New Measure data
- Continue to research/develop a public reporting mechanism for HHVBP
- Establish a formal appeals process

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## Payments for Disposable NPWT Devices

- Payment for disposable negative pressure wound treatment devices (NPWT) would be outside and separate
  - "When the sole purpose for an HHA visit is to furnish NPWT using a disposable device, Medicare will not pay for the visit under the HH PPS."

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## Submitting Comments

- When commenting, refer to file code CMS-1648-P for Medicare.
- To be assured consideration, comments must be received at one of the addressed provided below, no later than 5 pm on August 26, 2016.
- Two of the four ways to submit comments are:
  - Electronically at www.regulations.gov. Follow the instructions under the "More Search Options" tab.
  - Mail to: Centers for Medicare & Medicaid Services, Department of Health & Human Services, Attention: CMS-1648-P, PO Box 8016, Baltimore, MD 21244-8016.

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## Pilot Programs

- Value-Based Purchasing
- Pre-Claim Review Model

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## Value-Based Purchasing

- Began January 1, 2016 for all Medicare-certified HHAs that provide services in MA, MD, NC, FL, WA, AZ, IA, NE, and TN.
- Home Health providers will be assigned a score and those with the highest score will receive the larges upward adjustment.
- Providers will have their payment increased or decreased up to a maximum of 3% in 2018, 5% in 2019, 6% in 2020, 7% in 2021, and 8% in 2022.

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## Value-Based Purchasing

- Utilize real-time data to *preview* and *analyze* your scores to identify trends BEFORE data is public.
  - Don't wait for CMS to report results! July HHC data posted Q1 – Q4 2015 data for OASIS and HHCAHPS, Q4 2014 – Q3 2016 for claims
- Preparation is KEY!
  - Whether you are in a pilot state or not, it's coming to you, so start to prepare now.
  - Preparing for VBP is all about focusing on quality.

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## Value-Based Purchasing

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## Value-Based Purchasing

| Patient Name | Timepoint | Received Flu Vaccine | In Numerator | SOC | Discharge | Primary Diagnosis | Clinician | Provider |
|---|---|---|---|---|---|---|---|---|
| Perch, Becky | Discharge | Yes, this episode | Yes | 3/15/2016 | 7/28/2016 | C111.11 | Cork, Robert | 000001 |

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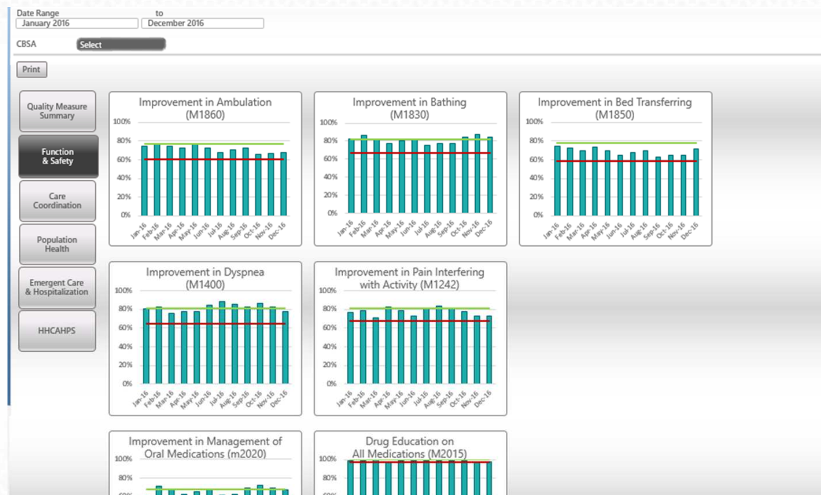
## Value-Based Purchasing

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## Pre-Claim Review Model

- Three-year model impacts providers in five states
- Began August 3, 2016 in Illinois
- Scheduled to begin no earlier than:
  - October 1, 2016 – Florida
  - December 1, 2016 – Texas
  - January 1, 2017 – Michigan & Massachusetts

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Pre-Claim-Review-Initiatives/Downloads/FAQ.pdf

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## Pre-Claim Review Model

- Applies to episodes beginning on or after the effective date for each state
- Pre-claim review submitted prior to final claim
- Final claims are submitted without a Pre-Claim Review/UTN number:
  - Will be stopped for pre-payment review
  - Will be subject to a 25% payment reduction to the full amount of the claim after the first three months (not subject to appeal)

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## What's on the Horizon

- ICD-10 Update
- OASIS C-2
- Eligibility
- Conditions of Participation

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## ICD-10 Update

- Regular annual updates of ICD-10 begin this year
  - October 1, 2016
- HH software vendors normally update their systems prior to October 1 to allow for proper selection of codes for documentation and billing purposes
- HHAs should train their staff on new codes/revised codes to ensure proper usage

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## OASIS C-2

- Scheduled for implementation January 1, 2017
- Three new standardized questions
  - M1028 Active Diagnosis
  - M1060 Height and weight to determine BMI
  - GG0170C Functional Abilities and Goals
- Several updated questions/items
  - Renumbered and content modified
  - Look back period changed and renumbered
- HHAs should train their clinical staff on the new/update items and guidance changes

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## Eligibility Changes

- CMS is in the process of terminating all eligibility systems other than HETS 270/271.
  - Still no final sunset timeline
  - PPTN & VPIQ
    - Multi Carrier System (MSC) – Discontinued April 2013
    - ViPS Medicare System (VMS) – Discontinued April 2013
  - FISS/DDE
    - HIQA/HIQH – Currently still active
    - ELGH/ELGA – Currently still active

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1249.pdf

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## Proposed Conditions of Participation

- Detailed information can be found at:
  - http://w2.healthcarefirst.com/home-health-conditions-of-participation-webinar-recording/
  - http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-10-06-2.html
  - http://www.gpo.gov/fdsys/pkg/FR-2014-10-09/pdf/2014-23895.pdf

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## Reminder: Threshold for Quality Reporting Program

- HHAs must submit 80% of OASIS assessments (reporting period July 1, 2016 to June 30, 2017)
  - It is important to note that submitting OASIS is a condition of participation and providers should make every effort to submit ALL OASIS
- 90% - Report period July 2017 to June 30, 2018 (and all future periods)
- How are you tracking your OASIS submissions?

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## Medicare Administrative Contractors (MACs)

- Stay in tune with your MAC
  - www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/HomeHealthHospice_JurisdictionMap_OCT2013.pdf

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## Palmetto GBA

# Claims Payment Issues Log - Current Issues

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Here is a list of current system-related claims payment issues. These issues have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS). Please check often for updates before contacting the provider contact center. The issues are identified by stand alone articles and will be updated as needed.

Jump to: Return to Full List

1. Hold Claims Due to Problem with FISS Maintainer Code in Change Request 9474 'New Condition Code for Reporting Home Health Episodes With No Skilled Visits'
2. Mass Adjustments to Correct Home Health (HH) Claims Priced with Incorrectly Re-Coded Health Insurance Prospective Payment System (HIPPS) Codes
3. Hospice Payment Rates for Routine Home Care (RHC) on and after January 1, 2016

http://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Home%20Health%20and%20Hospice~Articles~Claims%20Processing%20Issues%20Log

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## National Government Services (NGS)

| Description of Problem | What This Means to You | Current Status of Problem |
|---|---|---|
| NGS is advising home health providers of an issue causing some claims to RTP in error with reason code 31699. | NGS is awaiting official CMS instructions to hold these claims until 8/8/2016, when a fix is scheduled to be installed which will correct the issue. Since the claims are not being paid, denied or rejected in error, providers will be able to resubmit the claims (F9 from Claims Corrections) to NGS for processing once the fix is installed.<br><br>Please review and | **7/19/2016:** Please watch the Production Alerts and Email Updates for additional information confirming the upcoming fix and date on which these clams can be recycled. |

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## CGS Administrators

### Fiscal Intermediary Standard System Claims Processing Issues

*Updated: 07.18.16*

- Resolved Fiscal Intermediary Standard System Claims Processing Issues.

Listed below are current system-related claims processing issues that have been reported to the Centers for Medicare & Medicaid Services (CMS) and/or the Fiscal Intermediary Standard System (FISS) Maintainer. This information is updated as we receive new information or updates to share. Please check this Web page for updates before calling the Provider Contact Center, and watch for Listserv messages announcing updates to this page.

| Provider Types Affected | Reason Code | Issue | Impact | Status | Resolved |
|---|---|---|---|---|---|
| Hospice | NA | **7/15/2016 Update:** **5/6/2016** – An issue has been identified with the 60 day 'high' *and 'low'* Routine Home Care rate being applied incorrectly. | **7/15/2016 Update:** **5/6/2016** – Some hospice claims with dates of service on and after January 1, 2016, are having the high RHC rate applied when the low rate should have been applied, *and vise versa.* | **5/6/2016** – The Centers for Medicare & Medicaid Services (CMS) is aware of, and is researching this issue. | |
| Home Health | E0419 | **03/02/2016** – The issue involving some adjustments (type of bill XXG), continues as | **03/02/2016** – Some home health adjustments (type of bill XXG) are | **5/6/2016** – The April 25, 2016 system implementation failed to fully resolve this issue. The system maintainer has been informed. As mentioned below, CGS will | |

http://www.cgsmedicare.com/hhh/claims/FISS_Claims_Processing_Issues.html

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## Stay in the Loop

- For the latest Regulatory News & Updates, visit HEALTHCARE*first*'s Home Health & Hospice blog at www.healthcarefirst.com/blog.

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## Home Health Solution Suite

- Maximize reimbursement while reducing overhead costs.
- Ensure regulatory compliance with accurate, complete, and compliant clinical documentation.
- Reduce your risk of takebacks by submitting clean claims.
- Grow and strengthen high-value referral relationships.
- Simplify vendor management with one expert partner.

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- We want to hear from you! Please fill out the survey.

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# HOME HEALTH SOLUTION SUITE

## + Accelerate reimbursement and increase profit.
## + Minimize the risk of takebacks and audits.
## + Improve the quality of patient care.

The HEALTHCAREfirst HOME HEALTH SOLUTION SUITE is the most powerful and only total agency management package in the industry. By leveraging first-in-class software and services, home health agencies experience elevated success across the organization.

- Improve your profit margin by minimizing costs and maximizing reimbursement.
- Ensure regulatory compliance with complete and compliant clinical documentation.
- Protect your agency from the risk of takebacks and audits by submitting clean and accurate claims.
- Deliver quality patient care and improve outcomes with automated care planning guidance backed by industry best practices and detailed reporting of patient experience data.
- Proactively manage business operations with robust analytics and detailed reporting.
- Enhance employee satisfaction with easy program implementation and ongoing support from a dedicated team of individuals specializing in implementation, training, and client service.

### What is included:

+ *first*HOMECARE Agency Management Software and Point-of-Care Mobile Solution
+ Coding Services with OASIS Review
+ Billing Services
+ Business Intelligence
+ *first*CONNECT Payer Connectivity and Eligibility Verification
+ Home Health CAHPS

# Home Health Solution Suite

**Improve Revenue | Stay Compliant | Provide Quality Care**

**With the HOME HEALTH SOLUTION SUITE from HEALTHCARE*first*, you have everything you need to achieve operational excellence and improve revenue. Pricing is based upon a percent of collections, so we're invested in your success.**

### *first*HOMECARE

Intuitive, easy-to-use agency management software with a built-in Point-of-Care mobile solution.

- Streamline operations through comprehensive patient care management.

### Coding Services with OASIS Review

Ensure the accuracy of each episode so that you are properly paid for your services, while reducing the red flags that may warrant an audit through expert coding and OASIS review.

- Review of the full chart by RNs, including clinical assessments, physician orders, and care plans/ visit frequencies.

### Billing Services

Experience a more efficient billing process, faster reimbursement, and a stronger bottom line.

- Expert billers manage the entire billing process, from ensuring that claims are billed quickly to monitoring statuses and posting payments.

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### Business Intelligence

Gain valuable insight into your business including receivables, revenue, and patient eligibility.

- Know the exact status of your claims at all times.
- Gain advance notice of changes in Medicare patient eligibility so that you can act quickly.
- Monitor and analyze financial performance to develop operating targets.

### *first*CONNECT Payer Connectivity

Experience a real-time, high-speed payer connection.

- Quickly check the status of your Medicare claims.
- Access benefit and eligibility data for Medicare, Medicaid, and most commercial payers.

### Home Health CAHPS

Simplify HHCAHPS compliance and gain access to detailed analysis and reporting of data for performance improvement.

- Comprehensive, monthly public reporting dashboards help you improve scores months in advance of being published on Home Health Compare.
- Highly acclaimed, real-time "Verbatim Comment Reporting" groups patient comments by category and type for easy analysis.
- Comment Alert! system quickly notifies your agency of any negative or serious comments for immediate action and follow up.

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