The 2017 Medicare Update

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The 2017 Medicare Update

Happenings in 2017

- Impact Act of 2014
- Value Based Purchasing
- Face to Face Regulations
- Pre Claim Reviews
- Case-Mix Changes in 2017

IMPACT ACT OF 2014

- Improving
- Medicare
- Post
- Acute
- Care
- Transformation

Background

- Legislation passed by Congress on September 18, 2014
- Requires the submission of standardization data by Long-term Care Hospitals (LTCHs), Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs).
- Requires the reporting of standardized patient assessment data with regard to quality measures, and patient assessment instrument categories.
- Specifies that data be standardized and interoperable so as to allow such data among such post-acute providers and other providers for the exchange standards in order to facilitate coordinates care and improved Medicare beneficiary outcomes.
- Intends to cross-reference outcomes to capture patient preferences and goals.

IMPACT Act Will Address

1. Better Care: Improve the overall quality of care by making healthcare more patient-centered, reliable, accessible, and safe.

2. Healthy People, Healthy Communities: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, & environmental determinants of health in addition to delivering higher-quality care.

3. Affordable Care: Reduce the cost of quality healthcare for individuals, families, employers, and government.

Goals of the IMPACT Act

The act supports these three areas of concern by upholding CMS’s Quality Strategy Goals, which are:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family is engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular diseases
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.
Domains to be Standardized

- Skin integrity and changes in skin integrity
- Functional status, cognitive status, and changes in function and cognitive status
- Medication reconciliation
- Incidence of major falls
- Transfer of health information and care preferences when an individual transitions to another post acute setting
- Resource use measures, including total estimated Medicare spending per beneficiary
- Discharge to community; and
- All-condition risk-adjusted potentially preventable hospital readmissions rates

EFFECT ON OASIS

Longer look back period on items collected at discharge & transfer

The OASIS-C2 guidelines have changed the look back period to begin at the time of the most recent SOC/ROC assessment. This means a longer look back period, from the beginning of the quality care episode.

Items that could not be assessed

In the new OASIS guidelines, several items include an option to write in a dash symbol (-) when the item could not be assessed. Some reasons to use the dash include: patients who unexpectedly died, transferred or was discharged

Item Number Changes

<table>
<thead>
<tr>
<th>C1 Item #</th>
<th>C2 Item #</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1308</td>
<td>M1311</td>
<td>Current # of unhealed pressure ulcers</td>
</tr>
<tr>
<td>M1309</td>
<td>M1313</td>
<td>Worsening in pressure ulcer status since SOC/ROC</td>
</tr>
<tr>
<td>M1500</td>
<td>M1501</td>
<td>Symptoms of heart failure</td>
</tr>
<tr>
<td>M1510</td>
<td>M1511</td>
<td>Heart failure F/U</td>
</tr>
<tr>
<td>M2000</td>
<td>M2001</td>
<td>Drug regimen review</td>
</tr>
<tr>
<td>M2002</td>
<td>M2003</td>
<td>Medication F/U</td>
</tr>
<tr>
<td>M2004</td>
<td>M2005</td>
<td>Medication interview</td>
</tr>
<tr>
<td>M2015</td>
<td>M2016</td>
<td>Patient/Caregiver drug education</td>
</tr>
<tr>
<td>M2300</td>
<td>M2301</td>
<td>Emergent care</td>
</tr>
<tr>
<td>M2400</td>
<td>M2401</td>
<td>Intervention Synopsis</td>
</tr>
</tbody>
</table>

New Items on OASIS

1. **M1028: Active Diagnosis of PVD, PAD, or DM**
   
   This new item checks for the presence of 3 comorbidities /co-existing conditions: peripheral vascular disease (PVD), peripheral arterial disease (PAD) or diabetes mellitus (DM). These conditions must be active and documented by a physician or legally diagnosing clinician. Check the CMS guidance manual to see the allowed diagnoses codes for this item. Be sure to use only exact diagnoses that have been documented by the physician.

2. **M1060: Height & Weight**
   
   The M1060 height and weight item has been added to comply with IMPACT Act standardized reporting. It is also to be used in calculating nutrition and hydration status, heart failure assessments, BMI and pressure ulcer risk adjustment (when BMI is between 12.0 and 19.0).

   Height and weight should be calculated at SOC/ROC and according to a standard agency practice (for example: in the morning, after voiding, and
before a meal.) Weight should be rounded to the nearest whole pound. Some valid reasons a dash (-) may be entered here include:

- extreme pain
- immobility
- risk of pathological fracture
- unexpected transfer, discharge or death

Be sure to document your reasons if you are unable to assess patient weight.

3. GG0170C: Mobility

This new item complies with IMPACT Act initiatives, as mobility limitations can adversely affect wound healing, and are a risk factor for pressure ulcers. The item is designed to measure the patient’s level of mobility through observation of a patient’s transfer from lying in bed to a seated position. Upon reaching a seated position, the patient must sit with both bare feet touching the floor and no back support for the transfer to be complete. The use of assistive devices during this activity is permitted and does not affect scoring. If the patient’s mobility varies during the look back period, report the patient’s usual status. This item is reported on a scale from 01 (most dependent) to 06 (most independent). A few codes for reporting a patient that was unable or unwilling to complete the transfer includes:

- 07 – Patient refused.
- 09 – NA (if pt could not perform the activity prior to current illness/ injury.
- 088 – Not attempted due to medical condition or safety concerns.

Stakeholders Opportunities

- All post-acute facilities LTCHs, SNFs, HHAs, and IRFs are required to submit data on the aforementioned quality measures using tools for each entity.
- Stakeholders are encouraged to do one or more of:
  + Attend an On Open Door Forum (ODF) which is an opportunity to hear live dialogue between CMS and the community at large.
  + Participate in A National Provider Call designed to educate and inform participants about new policies and/or changes to the Medicare program
  + Participate in A Technical Expert Panel (TEP) which contributes direction and thoughtful input to the measure contractures during the development and maintenance of the actual measure. Participants can nominate themselves or others for consideration as a member of the panel.
  + Comment on a CMS Quality Measure during the public comment period which provides an opportunity for the widest array of interested parties to provide input on the measures under development and to provide critical suggestions not previously considered by the measure contracture or its technical expert panel (TEP)
  + Get involved in the Measure Application Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF) to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.
VALUE BASED PURCHASING (VBP)

• Modeled after the 2014 VBP Model
• Currently in place in 9 states for home health
  + Florida, Massachusetts, Maryland, North Carolina, Washington, Arizona, Iowa, Nebraska, & Tennessee
• The overall purpose of the Home Health Value Based Purchasing (HHVBP) Model is to improve the quality and delivery of home health care services to Medicare beneficiaries with specific goals to:
  + Provide incentives for better quality care with greater efficiency and penalize those agencies that are providing less than standard care
  + Study new potential quality and efficiency measures for appropriateness in the home health setting and,
  + Enhance the current public reporting process

VBP Details

+ Effective January 1, 2016 CMS implemented the HHVBP among all agencies in the aforementioned nine states. Payments in these nine states will have their episode reimbursement adjusted in the following manner – a maximum payment adjustment of:
  • 3 percent (up or down) in 2018
  • 5 percent (up or down) in 2019
  • 6 percent (up or down) in 2020
  • 7 percent (up or down) in 2021
  • 8 percent (up or down) in 2022
+ This model is designed so that there is no selection bias, participants are representative of home health agencies nationally, and there is sufficient participation to generate meaningful results among all Medicare HHAs.

If You Haven’t Already...

+ Establish your Agency’s Point of Contact: HHAs should provide to the HHVBP Help Desk at HHVBPquestion@cms.hhs.gov the name and email address of a primary point of contact for each CMS Certification Number (CCN). Include the agency name, agency address and phone number.
+ Obtain a User Account on the CMS Secure Portal: This is an important first step towards registration for the HHVBP Model portal where HHAs will receive performance reports and enter data for new measures.
+ Obtain a User Account on HHVBP Connect: Access to HHVBP Connect will allow participants to find the latest updates for the HHVB, download valuable resources to help you succeed in the Model, view HHVBP events and milestones, view and register for webinars, share best practices, view Q&As and get reminders about when to submit data.

Effect on Everyday Workings...

+ Payment adjustments will be based on performance data from two years prior to the actual payment year
+ Determine how your agency will QA specifically for the VBP measures
+ Focus especially on End-Result outcome measures (improvements) and process measures (best practices)
+ Start collecting data for the 3 new measures (vendor should be able to assist)
+ Use results of your QA studies as an educational opportunity for your staff
Going Forward

+ Ensure OASIS coding accuracy
  • Education
  • Audit

+ Pay attention to claims accuracy

+ Staff education on HHVBP requirements
  • 20 measures
  • TPS

+ Evaluate business processes and operations to ensure compliance
  • Cost-effective delivery of services
  • Improving beneficiary experience and outcome

+ QAPI
  • Create tracking tools to identify areas of current excellence, areas needing improvement, deficiencies and/or documentation issues

Looking Back

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>CY for Payment Adjustment</th>
<th>Maximum Payment Adjustment (up or down)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2018</td>
<td>4%</td>
</tr>
<tr>
<td>2017</td>
<td>2019</td>
<td>5%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>6%</td>
</tr>
<tr>
<td>2019</td>
<td>2021</td>
<td>7%</td>
</tr>
<tr>
<td>2020</td>
<td>2022</td>
<td>8%</td>
</tr>
</tbody>
</table>

Included Measures

+ 9 Outcome Measures – *End result of direct care*
+ 3 Process Measures – *Evidence based processes*
+ 5 HHCAHPS Measures – *Patient/Caregiver experience*
+ 3 New Measures – *Reported through a special web portal*
### Outcome Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>OASIS Item Data Source</th>
<th>Other Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Ambulation-Locomotion</td>
<td>M1860 (Ambulation-Locomotion)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Bed Transferring</td>
<td>M1850 (Transferring)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Bathing</td>
<td>M1830 (Bathing)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>M1400 (Shortness of Breath)</td>
<td></td>
</tr>
<tr>
<td>Discharged into the Community</td>
<td>M2420 (Discharge disposition)</td>
<td>Claims Data</td>
</tr>
<tr>
<td>Acute Care Hospitalization: Unplanned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospitalization during first 60 days of HH;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospitalization during first 60 days of HH;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Dept. Use without Hospitalization</td>
<td></td>
<td>Claims Data</td>
</tr>
<tr>
<td>Improvement in Pain Interfering with Activity</td>
<td></td>
<td>M1242 (Frequency of Pain Interfering)</td>
</tr>
<tr>
<td>Improvement in Management of Oral Meds</td>
<td>M2020 (Management of Oral Meds)</td>
<td></td>
</tr>
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</table>

### Process Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>OASIS Item Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Immunization Received for Current Flu Season</td>
<td>M1046 (Influenza vaccine received)</td>
</tr>
<tr>
<td>Pneumonia Vaccine Ever Received</td>
<td>M1051 (Pneumonia vaccine)</td>
</tr>
<tr>
<td>Drug Education on All Meds Provided to Patient/ Caregiver During All Episodes</td>
<td>M2015 (Patient caregiver drug education interventions)</td>
</tr>
</tbody>
</table>

### HHCAHPS Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of Patients</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Communications between Providers &amp; Patients</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Specific Care Issues</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Overall Rating</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Willingness to Recommend</td>
<td>HHCAHPS</td>
</tr>
</tbody>
</table>

### New Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza Vaccination Coverage for HH Care Personnel</td>
<td>New measure, reported through web portal</td>
</tr>
<tr>
<td>Herpes Zoster (Shingles) Vaccination: Has patient ever received shingles vaccination?</td>
<td>New measure, reported through web portal</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>New measure, reported through web portal</td>
</tr>
</tbody>
</table>
Reporting the 3 New Measures
There is no penalty for not submitting/reporting the new measures, however the HHA that does not report data on all three new measures can earn only up to 90% of the total possible points for the Total Performance Score.

What if You're Next
+ It's anyone’s guess who will be in the next round of states for VBP.
+ Proceed as though Minnesota is next in line.
+ Project relies on a baseline year, a model year and a payment year.
+ If you are in the next round, 2016 could be your base year and 2019 would be your payment year based on 2018 data. (So you’re already behind)

PRE-CLAIM REVIEWS
+ Program goal is “To assess PCR as a means of reducing Medicare FFS expenditures for HH services by reducing improper payments while maintaining or improving the quality of care experienced by the beneficiary.”
+ The Pre Claim Review (PCR) Demonstration is being implemented as a result of findings that show extensive evidence of fraud and abuse in the Medicare FFS HH program.
+ Most of the states in the demonstration have also been identified as high fraud states and counties.
+ Improper percentage payment rate for HH services increased from 17.3 in 2013 to 51.4 in 2014 and is projected to increase to 59 in 2015.

Down But Not Out
+ Originally introduced in 5 states but because of excessive problems with MACs, only Illinois active now with the other 4 states delayed.
+ But will it go away? Unlikely but hopefully the kinks can be worked out.
+ States should proceed with nationwide roll-out in mind.

Process
+ Agencies are asking for a provisional affirmation of coverage by submitting any and all documentation that will support the need for services.
+ Review will assure that applicable coverage, payment and coding rules are met before the final claim is submitted.
+ The pre-claim review (PCR) demonstration (previously referred to as prior authorization) applies to HH services in the Medicare Fee-for-Service program. The demonstration does not apply to Medicare HMOs.
+ PCR does not change beneficiary eligibility standards or Medicare’s documentation requirements for home health care.

PCR vs PA
+ Prior authorization is requested prior to any services are rendered.
+ PCRs are submitted after the initial assessments and intake procedures are completed and services are rendered but before a final claim is submitted.
+ If an agency accepts a patient, services cannot be held until PCR decision is made.

What About the RAP?
+ RAP is not subject to the PCR process
+ RAP can be submitted as usual
+ No changes in the processing and payment of a RAP
+ Auto cancellation of a RAP when the final claim has not been submitted timely will not change with PCR
  • Agencies are allowed either 120 days after the start of the episode or 60 days after the RAP date to submit a final claim
Episodes

+ Only applies to 60 day episodes but episodes that are not 60 days in length of services will still require a PCR unless that episode is a LUPA. (Episode with 4 or fewer visits)

+ If patient is admitted, discharged and readmitted during the same 60 day episode, the new SOC will require another PCR.

+ If a patient is transferred to another agency during a 60 day episode, the receiving agency will need to submit a PCR.

Requirements

+ PCR requests will require:
  • Beneficiary information
  • Certifying practitioner information
  • HHA information
  • Submitter information
  • Other information
  • Required documentation

Home Health Documentation

+ Documentation from the medical records to support:
  • that patient is confined to the home
  • that patient is under the care of a physician
  • that a POC has been established and reviewed by physician
  • that patient is in need of skilled services for:
    • intermittent nursing services, or
    • physical or speech therapy services, or
    • have a continuing need for occupational therapy
  • Documentation that there was a F2F encounter within the required time-frame

Additional Documentation

+ Therapy evaluations supporting skilled needs
+ Detailed referral from physician
+ OASIS (?acknowledged by physician)

Pre-Claim Authorization Process

+ Medicare will make every effort to issue a decision on a PCR request within 10 business days for an initial request and 20 business days for a resubmitted request following a non-affirmative decision.

+ Agency will receive a decision letter (affirmed or non-affirmed) and a Unique Tracking Number (UTN) that needs to be submitted on the Final Claim.

+ If the initial PCR was non-affirmed due to an error(s), then a HHA may resubmit the request with additional documentation as many times as necessary.

+ MACs will begin accepting PCR requests two weeks prior to implementation in participating state.

+ The decision letter will specify why a HHA’s pre-claim review request was non-affirmed.

+ The agency can correct the deficiencies and resubmit the request with a new coversheet and relevant documentation as many times as necessary.

+ If the agency does not wish to resubmit the request, it can submit claims with the unique tracking number identified on the non-affirmed decision letter.

+ If denied, the Medicare Administrative Contractors will follow their standard procedures to recoup a RAP for any denied claims.

+ If the claim is denied, and the HHA can appeal the denial.

+ If a provider submits a claim for payment without a PCR being submitted, the home health claim will undergo pre-payment review.

+ No new review is necessary if services are added mid-episode.
+ Does not apply to LUPA episodes.

+ All existing claims appeal rights remain unchanged. Claims that are denied under the demonstration are appealable. Non-affirmative pre-claim review determinations are not appealable; however, providers have the option of:

1. Resubmitting the PCR before filing a claim
2. Submitting a claim which will be denied, and then submitting an appeal

An Incomplete Decision

When the PCR request is incomplete (required info missing)

+ The notification will include an explanation of what info is missing

Resubmissions

+ Can be done when a non-affirmation is received
+ Submission process is the same as for an initial request except it needs to be identified as a resubmission
+ No limit to the number of times the PCR can be resubmitted
+ Provide the previously received UTN from the non-affirmed letter
+ Decision is expected within 20 business days
+ Notification will be sent to submitter and the beneficiary for any provisional affirmations or non-affirmations
+ If agency chooses not to resubmit a non-affirmed case, it can be final billed with the UTN, claim will be denied but can be appealed

Impact of PCR Decision

+ Claims are subject to all processing edits
+ If all requirements are met and an affirmation decision was issued the payment will be made as usual
+ If a non-affirmation was received, Medicare will deny payment on the final claim
+ A denied claim based on a non-affirmation decision will constitute an initial payment decision and the standard claims appeals process will apply
+ If agency does not submit a PCR request, the claim will automatically be held for pre-payment review
+ The provider will receive an ADR (then you have to send in all the info anyway)
+ If the reviewer determines that all Medicare criteria are not met, the claim will be denied and agency may appeal the denial
+ If reviewer determines that all Medicare criteria were met, the claim will be paid. But...
+ If no PCR request was submitted and the claim is determined to be valid, it will be paid with a 25% reduction in final payment
+ 25% reduction cannot be transferred to patient
+ 25% reduction is not subject to appeals
+ The payment reduction will not be applied during the first three months of the demonstration in each state.

Agencies’ Challenges

+ Assuring that patient meets all criteria for HH services prior to admission
  • Patient is under the care of a physician
  • F2F done, signed and documentation is received by agency
  • Certification present with all signature and dates
  • Patient meets homebound status (as defined by Benefit Manual)
  • There is a skilled need
+ Documentation of certification requirements are a permanent part of physician's records
+ OASIS is completed timely and accurately
+ Therapy evaluations are completed timely
+ PCR request is submitted timely
IMPACT OF 2017 FINAL RULE ON REIMBURSEMENTS

+ Proposed changes are within NAHC’s expectations given the 4-year phase-in of rate rebasing which began in 2014
+ CMS is capped at reducing the base-episode rate by no more than $80.95 which is 3.5% of the 2010 base rates.
+ Proposed rule did not mention the 2% sequestration but it’s expected to continue in 2017.
+ Proposed base episode rate for 2017 is set at $2936.65 compared to $2965.12 in 2016.
+ CMS estimates that the net result of all of its rate proposals is a $180 million reduction in Medicare payments to home health agencies in 2017.
+ The rate rebasing also affects LUPA payment rates.
+ Those rates will rise 3.5% through rebasing and an additional 2.3% through the annual inflation update.
+ Non-routine medical supply rates are also downwardly adjusted through the rebasing by a factor of 2.82 percent offset by a 2.3% MBI.
+ The NRS conversion factor drops from $52.71 in 2016 to $52.40 in 2017.
+ The 3% Rural Add-On continues in 2017 along with the 2% rate reduction for HHAs that fail to comply with the quality data submission requirements that involve OASIS & HHCAHPS.
+ No further case mix creep adjustment is proposed beyond the current 3-year reduction of 0.97% annually through 2018.
+ Significant changes proposed for outlier payments:
  • CMS proposes to change to cost per visit approach based on 15 minute service units.
  • This change would mitigate the current disincentive to treat medically complex patients that require extended visits.
  • CMS proposes to keep the same 80% loss ratio, but would increase the Fixed Dollar Loss Ratio from 0.45 to 0.56.
  • This would have the effect of reducing the number of episodes that qualify for outlier payment.
  • CMS indicates that such a change is needed to keep outlier spending within the 2.5% spending limit.

RESPONDING TO ADRS

Top 10 Reasons for Denials

1. Care not reasonable & necessary
2. Documentation does not support medical necessity
3. Homebound status
4. Services not documented
5. Problematic POC
6. Frequency of services not warranted
7. Medical review down-code
8. No certification (POC or F2F)
9. Insufficient orders
10. No response to ADR in 30 days

ADRs

+ Additional Documentation Request
+ Probe or focused directed
+ Responding – Do not procrastinate or ignore!
  • Identifying
  • Timeliness
  • Preemptive actions
+ Reconsiderations and appeals
Reviewing Charts for ADRs
+ The request is made but you can still mitigate damages
+ Use exact address on ADR
+ Look closely at all signatures & dates
+ Review start of care date
+ Review documentation supporting homebound status
+ Write cover letter to accompany ADR
+ Collect ALL documentation
+ Write addendum if necessary
+ Number all pages and keep exact copies of everything

Don't Let Response Error Become a Denial Letter
+ Reason for denial: “Medical records not received in response to ADR in the required time frame”
+ How to avoid:
  • Monitor Direct Data Entry (DDE) daily
  • Be aware of deliveries
  • Timeliness of response imperative
  • Gather all info & submit at one time with attached copy of ADR
  • Submit with signature receipt
Thanks for Attending!
Feel free to contact us with any questions.
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1-888-897-9136

Join the PPS Plus Conversation!