HEALTH FINANCIAL SYSTEM USER MEETING

AUGUST 21, 2015

NASHVILLE, TN

9:30 A.M. – 10:45 A.M.

OWNERS/ADMINSTRATORS

JAMES PLONSEY

PRESIDENT

MEDICARE TRAINING & CONSULTING

708-895-0381 PHONE

PLONSEY@AOL.COM

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HFS USER MEETING

- GOOD NEWS FIRST
- 55 MILLION ON MEDICARE
- 10,000 RECEIVE MEDICARE CARDS EVERY DAY UNTIL 2029
- 66.6 MILLION ON MEDICAID
- OBAMACARE EMPLOYER MANDATE DELAYED UNTIL 1/1/2015
- MEDICARE FREEZE IN CHICAGO & DADE COUNTY 7/24/2013 – 6 MONTHS

HFS USER MEETING

• 2015 TOTAL AGENCIES	11,949 (-324)	100.0%
• TEXAS	2,665(-117)	22.3%
• FLORIDA	1,149(-87)	9.6%
• CALIFORNIA	1.050(-152)	8.8%
• OHIO	800(+40)	6.7%
• ILLINOIS	784(-18)	6.6%
• MICHIGAN	657(- 40)	5.5%
• PENNSYLVANIA	418(+ 0)	3.5%
• OKLAHOMA	269(+ 7)	2.3%
• INDIANA	229(+ 5)	1.9%
• TOP 7 STATES	65.2%	

HFS USER MEETING

• 2014 TOTAL AGENCIES	12,273	100.0%
TEXAS	2,782 (+112)	22.7%
• FLORIDA	1,269 (- 87)	10.3%
• CALIFORNIA	1,202 (+ 75)	9.8%
• ILLINOIS	802 (+ 17)	6.5%
• OHIO	760 (+ 52)	6.2%
• MICHIGAN	715 (+ 28)	5.8%
• PENNSYLVANIA	418 (+ 11)	3.4%
• OKLAHOMA	262 (+ 7)	2.1%
• TOP 7 STATES	66.8%	

HFS USER MEETING

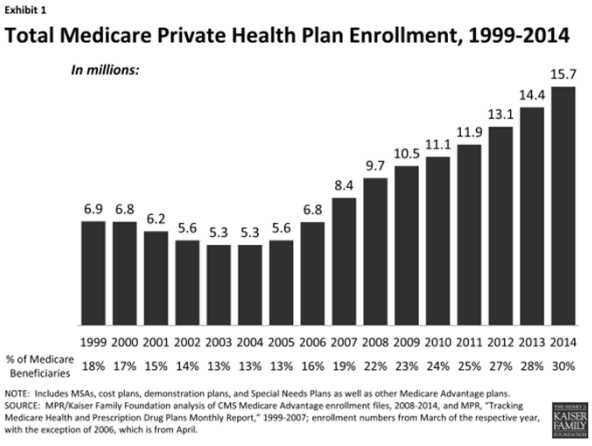
• 2013 TOTAL BENEFICIARIES	50.674,000	
• CALIFORNIA	5,140,000	10.1%
• FLORIDA	3,611,000	7.1%
• TEXAS	3,282,000	6.4%
• PENNSYLVANIA	2,397,000	4.7%
• OHIO	2,015,000	4.0%
• ILLINOIS	1,949,000	3.9%
• MICHIGAN	1,770,000	3.5%
• MISSOURI	1,064,000	2.1%
• ARIZONA	977,447	0.2%

HFS USER MEETING

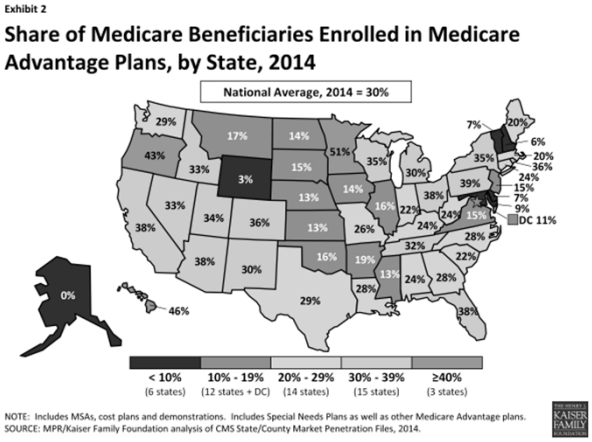
- ADVANTAGE PAIENTS
- 15.7 MILLION PATIENTS
- 30% OF ALL BENEFICIARIES
  $5,500/BENEFICIARY
  $4,100/BENEFICIARY – FFS

$129 B REDUCTION PAYMENTS BY 2019
REDUCTION FROM 2524 TO 2034 PLANS

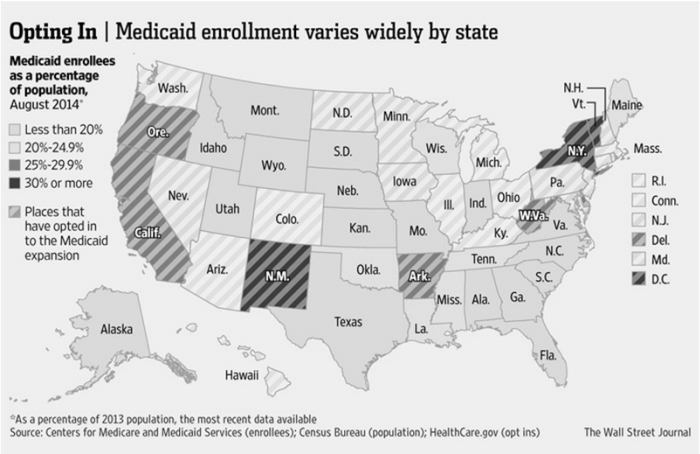
Medicare Private Health Plan Enrollment, 1999-2014



Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2014



Medicaid enrollment by state



HFS USER MEETING

ICD-10 WILL EFFECTIVE 10/1/2015

- FINAL VERSION HHRG JULY 1, 2015
- EPISODES BEGINNING AUGUST 3, 2015
- MUST BE DUAL CODED
- EPISODES ENDING BEFORE 9/30/2015 WILL HAVE ICD-9 CODE ONLY
- CROSS-OVER EPISODES WILL HAVE ICD-10 CODES ONLY

BE READY TO FILED ACCELERATED PAYMENT REQUESTS!

HFS USER MEETING

- TOTAL VISITS
- W/S S-3 PT. IV LINE 42 = 2,568
- TOTAL EPISODES
- W/S S-3 PT. IV LINE 45 = 99
- VISITS PER EPISODE
- 2,568/99 = 25.9 VISIT/EPISODE

REVENUE PER EPISODE (non-LUPA): FY 2012-2013

	»	2013	2012
• **ALL HHAs**		**$2913.91**	**$2886.29**
• **URBAN**		**$2993.89**	**$2959.58**
• **RURAL**		**$2537.29**	**$2539.82**
• **FREESTANDING**		**$2938.35**	**$2906.11**
• **FREESTANDING URBAN**		**$3011.41**	**$2973.90**
• **FREESTANDING RURAL**		**$2550.63**	**$2547.67**
• **HOSPITAL BASED**		**$2685.39**	**$2702.42**
• **HB URBAN**		**$2788.02**	**$2795.55**
• **HB RURAL**		**$2477.43**	**$2503.52**

HFS USER MEETING

- 4/2/2015 MEDICARE ACCESS & CHIP REAUTHORIZATION ACT (MACRA)
- DOC FIX PERMANENTLY FIXED
- PART B CAP EXTENDED TO 1/1/2018
- NEW BENE MUST PAY FIRST $100 BEGINNING 1/1/2020
- POST ACUTE PROVIDERS UPDATE MAX AT 1% 2018-2025
- $50,000 SURETY BOND REQUIRED
- 3% RURAL ADD-ON EXTENDED TO 2018

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HFS USER MEETING

- **HH Payment Update 2016 "Proposed"**
- 2016 Home Health Prospective Payment System Rate Update
- 2016 National Per Visit Rates
- 2016 NRS Rates
- Changes to HH PPS case-mix weights - Recalibration
- Geographic Wage Index Changes Purchasing
- Home Health Value Based Purchasing
- HHCHAPS
- Case Mix Creep Adjustment

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HFS USER MEETING

- PAYMENT ADJUSTMENTS
- $350M Reduction in HH Payments Estimated
- Market Basket Increase – 2.9%
- ACA Productivity Adjustment – (.6%)
- Rebasing Adjustment – (-80.95 per episode)
- Case Mix Creep Adjustment – (1.72%) – 2016 & 2017
- Urban National Rate - $2,938.37 / $2,880.92 (2%)
- Reduction of $23.01 per Episode
- Rural National Rate - $3,050.22 / $2,990.47 (2%)

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STANDARDIZED PAYMENT AMOUNT 2016

CY 2015 National Standardized 60-day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	Nominal Case-Mix Growth Adjustment	CY 2016 Rebasing Adjustment	CY 2016 HH Payment Update %	CY 2016 National Standardized 60-Day Episode Payment	R/U
$2,961.38	X 1.0006	X 1.0141	X .9828	-80.95	X 1.023	$2,938.37	U
$2,961.38	X 1.0006	X 1.0141	X .9828	-80.95	X 1.003	$2,880.92	U
						$3,026.52	R
						$2,967.35	R

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Urban LUPA Rates

HH Discipline	2015 Rate	2016	iNCREASE
SN	$127.83	$134.90	$7.07
PT	$139.73	$147.47	$7.74
OT	$140.68	$148.47	$7.79
SLP	$151.85	$160.27	$8.42
MSW	$204.87	$216.23	$11.36
HHA	$57.88	$61.09	$3.21

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RURAL LUPA Rates

HH Discipline	2015 Rate	2016 Rate	iNCREASE
SN	$131.64	$138.95	$7.31
PT	$143.92	$151.89	$7.97
OT	$144.90	$152.92	$8.02
SLP	$156.41	$165.08	$8.67
MSW	$211.02	$222.72	$11.70
HHA	$ 59.62	$ 62.92	$3.30

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HFS USER MEETING

- **Other Payment Adjustments**
- Outlier FDL – Remain at 45%
- Rural Add-on – 3% EXTENDED THROUGH 2018
- LUPA Rebasing - +3.5%
- NRS Rebasing – (2.82%)
- 2% Sequester to continue thru 2023

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HFS USER MEETING

- **OASIS Submission Timeliness**Currently required to submit timely to avoid 2% Penalty
- Enforcement of this requirement is an issue
- Episodes beginning on or after July 1, 2015 and before June 30, 2016 – Must score 70%
- 2% Penalty enforced for less than 70% timely submission
- Expected this will go to 80-90%, not final in the FR
- Impact could be significant with new enforcement in place – HHA's should keep documentable records

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HFS USER MEETING

	2013	2012
• **ALL HHAs**	**11.65%**	**11.7%**
• **URBAN**	**12.26%**	**12.07%**
• **RURAL**	**8.22%**	**9.58%**
• **FREESTANDING**	**14.71%**	**14.74%**
• **FREESTANDING URBAN**	**14.75%**	**14.64%**
• **FREESTANDING RURAL**	**14.45%**	**15.34%**
• **HOSPITAL BASED**	**(16.64%)**	**(17.23%)**
• **HB URBAN**	**(15.86%)**	**(17.56%)**
• **HB RURAL**	**(18.51%)**	**(16.41%)**

HFS USER MEETING

- **MEDICARE MARGINS BY EPIDODE TYPE: FY2013**
- **Full Episodes** **15.9%**
- **Outlier Episodes** **(50.9%)**
- **LUPA Episodes** **(36.6%)**
- **PEP Episodes** **(50.7%)**

HFS USER MEETING

ADDED 1/30/2014 EXTENDED TO 1/31/2016

- OBAMACARE EMPLOYER MANDATE DELAYED UNTIL 1/1/2015
- MEDICARE FREEZE IN CHICAGO & DADE COUNTY 7/24/2013 – 6 MONTHS
  - DETROIT
  - HOUSTON
  - DALLAS
  - FORT LAUDERDALE

Number of home health agencies continues to rise, 2002-2012

percent	2004	2006	2008	2009	2010	2011	2012	2013	AvG 2012-13
Number of Agencies	7,804	8,955	9,787	10,973	11,453	12,026	12,311	12,613	2.5%
Agencies that Opened	565	828	780	1,100	831	730	N/A		
Agencies that Closed	183	176	167	150	181	218	N/A		
Number of agencies per 10,000 beneficiaries	2.1	2.4	2.8	3.1	3.2	3.3	3.3	3.4	2.1%
Medicare Payments (Bill)	$11.4	$14.0	$16.9	$18.8	$19.2	$18.4	$18.6	$17.9b	

N/A = Not Available

Only 312 Net New Agencies in 2013

TABLE 9–4 **Fee-for-service home health care services have increased rapidly since 2002**

	2002	2006	2010	2012	2013	Percent change 2002–2012	Percent change 2012–2013	Cumulative change, 2002–2013
Home health users (in millions)	2.5	3.0	3.4	3.4	3.5	36.6%	0.9%	37.8%
Share of beneficiaries using home health care	7.2%	8.4%	9.4%	9.2%	9.3%	28.2	0.5	28.9
Episodes (in millions):	4.1	5.5	6.8	6.7	6.7	64.5	–0.5	63.6
Per home health user	1.6	1.8	2.0	2.0	1.9	20.4	–1.4	18.7
Per FFS beneficiary	0.12	0.15	0.19	0.18	0.18	54.4	–0.9	53.0
Payments (in billions)	$9.6	$14.0	$18.4	$18.0	$17.9	88.5	–0.6	87.3
Per home health user	$3,803	$4,606	$5,679	$5,247	$5,169	38.0	–1.5	35.9
Per FFS beneficiary	$274	$387	$540	$484	$479	76.9	–1.0	75.2

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of home health standard analytical file.

COST PER EPISODE (non-LUPA): FY 2012-2013

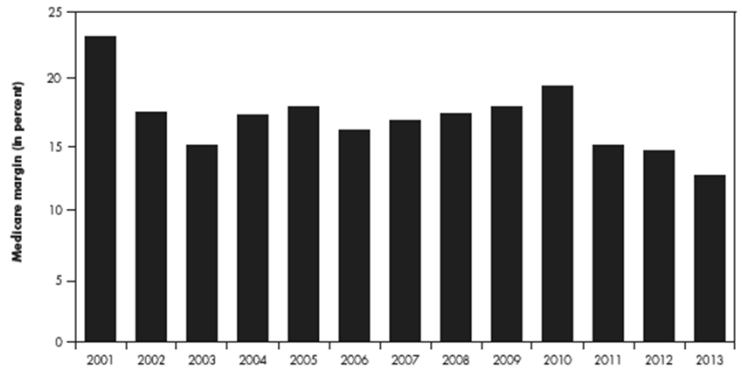
	» 2013	2012
• ALL HHAs	$2546.50	$2519.53
• URBAN	$2598.33	$2570.07
• RURAL	$2302.41	$2280.63
• FREESTANDING	$2486.45	$2451.88
• FREESTANDING URBAN	$2546.54	$2510.09
• FREESTANDING RURAL	$2167.53	$2144.14
• HOSPITAL BASED	$3107.93	$3147.13
• HB URBAN	$3206.85	$3257.12
• HB RURAL	$2907.50	$2912.20

TABLE 9–10 Performance of relatively efficient home health agencies

Provider characteristics	All	Relatively efficient provider	All other providers
Number of agencies	4,280	711	3,569
Share of for-profit agencies	83%	76%	84%
Medicare margin			
2012	14.5%	19.0%	13.5%
2011	15.2%	21.1%	14.0%
Quality			
Hospitalization rate (2011)	28%	23%	29%
Costs and payments			
Cost per visit, standardized for wages (2012)	$130	$126	$144
Average payment per episode (2012)	$2,662	$2,552	$2,687
Patient severity case-mix index	0.99	1.02	0.99
Visits per episode			
Total visits per episode (2012)	16.7	15.7	16.9
Share of visits by type			
Skilled nursing visits	51%	52%	51%
Aide visits	13%	10%	14%
MSS visits	1%	1%	1%
Therapy visits	35%	37%	34%

FIGURE 9–1

Medicare margins of freestanding home health agencies since 2001



Note: An audit of 2011 cost reports indicated that home health agencies overstated their costs that year by 8 percent.

Source: Medicare cost reports 2013.

TABLE 9–9

Medicare margins for freestanding home health agencies

	2012	2013	Percent of agencies, 2013	Percent
All	14.5%	12.7%	100%	
Geography				
Majority urban	14.9	13.1	84	
Majority rural	12.8	11.0	16	
Type of ownership				
For profit	15.3	13.7	89	
Nonprofit	14.5	10.0	11	
Government*	N/A	N/A	N/A	
Volume quintile				
First (smallest)	7.1	6.1	20	
Second	8.1	7.8	20	
Third	10.1	8.9	20	
Fourth	13.2	11.2	20	
Fifth (largest)	16.8	14.8	20	

Note: N/A (not available). Agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.
*Government-owned providers operate in a different context from other providers, so their margins are not necessarily comparable.

TABLE 9–2

Impact of PPACA rebasing on payments for 60-day episodes

	2014	2015	2016	2017	Cumulative change, 2014–2017
Rebasing adjustment	–2.8%	–2.8%	–2.9%	–3.0%	–11.6%
Legislated payment update	2.3	2.2	2.5	2.4	9.6
Net annual payment reduction	–0.6	–0.6	–0.4	–0.4	–2.0*

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Payment update estimates are based on the second-quarter 2014 forecast of the home health market basket. Effects of payment changes are multiplicative.
* Total payment decline would be 4 percent in 2017 if the sequester were in effect.

Source: MedPAC analysis based on data from CMS.

TABLE 9–1

Changes in supply and utilization of home health care, 1997–2013

				Percent change	
	1997	2000	2013	1997–2000	2000–2013
Agencies	10,917	7,528	12,613	–31%	64%
Total spending (in billions)	$17.7	$8.5	$17.9	–52	111
Users (in millions)	3.6	2.5	3.5	–31	39
Number of visits (in millions)	258.2	90.6	114.1	–65	26
Visit type (percent of total)					
Skilled nursing	41%	49%	53%	20	8
Home health aide	48	31	13	–37	–57
Therapy	10	19	36	101	85
Medical social services	1	1	1	1	–22
Number of visits per user	73	37	33	–49	–11
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.3%	–30	26

TABLE 9–11 Medicare visits per episode before and after implementation of PPS

Type of visit	Visits per episode			Percent change in:	
	1998	2001	2013	1998–2001	2001–2013
Skilled nursing	14.1	10.5	9.4	–25%	–10%
Therapy (physical, occupational, and speech–language pathology)	3.8	5.2	6.4	39	23
Home health aide	13.4	5.5	2.4	–59	–57
Medical social services	0.3	0.2	0.1	–36	–32
Total	31.6	21.4	18.3	–32	–15
Visits per episode for fully prospective episodes (excludes outlier episodes and episodes with 6 or more therapy visits)	N/A	16.2	11.9	N/A	–27

Note: PPS (prospective payment system), N/A (not applicable). The PPS was implemented in October 2000. Data exclude low-utilization episodes.

Source: Home health standard analytic file.

2015 FINAL RULE

- 2015 Home Health PPS rates / Rebasing
- 2015 National Per Visit Rates LUPA
- 2015 Non-Routine Supplies Rates
- Face-to-Face Physician Encounter rule modifications
- Changes to HH PPS case-mix weights
- Significant change to the requirement for professional therapy reassessments
- A new standard for the submission of OASIS to avoid payment rate reductions
- Modifications of the standards for qualification of speech-language pathologists under the CoPs

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HFS USER MEETING

- Pay-For-Performance (P-4-P)
- Quality Assessment Only(QAO)
- FORMULA QAO=

$$\frac{\text{\# of Quality Assessments}}{\text{\# of Quality Assessments + \# of Non Quality Assessments}} * 100$$

HFS USER MEETING

HHA Must achieve 70%

- Episodes beginning 7/1/2015 – 6/30/2016

HHA Must achieve 80%

- Episodes beginning 7/1/2016 – 6/30/2017

HHA Must achieve 90%

- Episodes beginning 7/1/2017 – 6/30/2018

2% Reduction in MBI the following year

HFS USER MEETING

- OASIS DATA SUBMISSION VERIFIED BY CASPER REPORT

CLERICAL STAFF SHOULD ACCESS

http://tinyurl.com/pht9m4g

Fatal Errors include

Misspelled Name

Incorrect Medicare HICN

Episode out of Sequence

2015 FINAL RULE

- ALJ HAS 900,000 APPEALS PENDING
- 30,000 ARE FROM HHA
- 13,000 TO 14,000 FILED/WEEK
- ALJ TEAMS CAN HANDLE 7,000 CLAIMS PER YEAR
- DO THE MATH

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TABLE 9–6

Growth in therapy services has been significant in recent years

	2008	2009	2010	2011	2012	2013	Percent change, 2012–2013	Cumulative change, 2008–2013
Episodes with 5 or fewer therapy visits (in millions)	3.9	4.2	4.2	4.1	4.0	3.9	–3.3%	1.0%
Episodes with 6 or more therapy visits (in millions)	2.2	2.4	2.7	2.7	2.7	2.8	3.4	26.0
Total episodes	6.1	6.6	6.8	6.8	6.7	6.7	–0.5	10.2
Share of episodes qualifying for additional payments based on the amount of therapy provided	36.7%	37.0%	39.3%	39.8%	40.4%	42.0%	N/A	N/A

Note: N/A (not applicable). Annual episode values have been rounded to the nearest hundred thousand, but percent change columns were calculated using unrounded data. The sum of column components may not equal the stated total due to rounding.

Source: MedPAC analysis of home health standard analytical file 2013.

HFS USER MEETING

- PPS REBASING PHASED-IN OVER 4 YEARS STARTING IN 2014
- COST REPORT FROM 2010 WILL BE USED
- MAXIMUM REDUCTION IN 3.5% PER YEAR ALLOWED
- AVG HHA PROFIT IS 13.63%
- HHS MUST REPORT BY 3/1/2011 HOW REBASING AFFECT ACCESS & QUALITY

HFS USER MEETING

10,327 2011 COST REPORTS FILED
2,348 MISSING EPISODE COUNT
874 NOT SETTLED
375 MISSING VISITS WHEN COST NOT REPORTED & VICE VERSA
210 SHORT COST REPORT YEAR
163 TOP & BOTTOM 1% OF COST/EPISODE
60 LESS THAN EPISODES
4,075 ELIMINATED OR 39.5%

HFS USER MEETING

- 100 SELECTED FOR AUDIT
- 98 RESPONDED
- 8% OF COST DISALLOWED
- 8 PROVIDERS REFERRED TO ZPIC FOR FURTER FRAUD INVESTIGATION!
- 13.09% REDUCTION OVER 4 YEARS
  - 3.45% 2014 = $80.95/EPISODE
  - 3.45% 2015 = $80.95/EPISODE
  - 3.45% 2016 = $80.95/EPISODE
  - 3.45% 2017 = $80.95/EPISODE

HFS USER MEETING

IMPORTANT TO GET IT RIGHT

- CMS ASSUMES ALL NUMBERS ARE CORRECT AS FILED
- THERE ARE NO AUDITS!
- NEW COST REPORT CLIENT FILED CR WITH
  - NO RENT ON LINE 1!
  - NO ADMINISTRATIVE & GENERAL COSTS ON LINE 5
  - NO A-5 OFFSETS
  - SPEECH THERAPY COSTS $8,525.33!!
  - MEDICAL SUPPLIES RATIO 1.79
  - MEDICARE PROFIT MARGIN -$6,975
  - PGBA HAD ISSUED A NO AUDIT NOTICE

HFS USER MEETING

- MTC REFILED COST REPORT CLIENT FILED CR WITH
  - RENT ON LINE 1 WAS $33,600
  - ADMINISTRATIVE & GENERAL COSTS ON LINE 5 $142,022
  - A-5 OFFSETS WERE $34,332
  - SPEECH THERAPY COSTS $309.67
  - MEDICAL SUPPLIES RATIO 1.08
  - MEDICARE PROFIT MARGIN $104
  - PGBA ACCEPTED THE AMENDED COST REPORT

HFS USER MEETING

- CMS 339 CHANGES
- TRANSMITTAL 8 ISSUED OCTOBER, 2014
- ONLY HHA, CMHC, RHC, FQHC, HOSPICES & OPO NEED TO COMPLETE
- APPLIES TO 9/30/2014 FYE
- ELIMINATES EXHIBIT 2 THROUGH 4A & EXHIBIT 6
- EXHIBIT 5 BECOMES EXHIBIT 2 FOR BAD DEBTS
- CMS 339 CHANGES
- Submit copies of financial statements that are compiled, reviewed or audited by the independent public accountant *together with the independent public accountant's opinion and footnotes.*
- *If the audited financial statements are not available for submission with this questionnaire, indicate when the MAC can expect to receive them*

HFS USER MEETING

CMS 339 CHANGES.

- The other interesting additions are to Exhibit 1 A. 2.
- *The provider is involved in business transactions, including management contracts and services under arrangements, with individuals or entities (e.g., chain home offices, drug or medical supply companies, etc.) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships.*
- RELATED PARTIES MUST BE DISCLOSED ON W/S A-6
- MOST COMMON IS COMMON OWNERSHIP OF A BUILDING OWNED BY THE HHA AND OCCUPPING THE BUILDING
- CMS IS EMPHASIZING COMPLIANCE!

HFS USER MEETING

- HHA OWNER OWNS BUILDING
- RENT EXPENSE (W/S A LINE1) $250,000
- ALLOWABLE EXPENSES
- DEPRECIATION $20,000
- PROPERTY TAX $10,000
- INTEREST $20,000
- INSURANCE $ 2,000
- TOTAL EXPENSES $52,000

- WORKSHEET A-6 ADJUSTMENT $198,000

HFS USER MEETING

- *WORSKHEET A-5 ADJSUTMENT*
- *MARKETING COSTS*
- *ADVERTISING (EXCLUDING YELLOW PAGES)*
- *CONTRIBUTIONS*
- *TAXES & PENALTIES (INCLUDING ACA HEALTH INSURANCE PENALTIES)*
- *NSF BANK FEES*
- *EXCESS OWNERS COMPENSATION*
- *PERSONAL EXPENSES OF OWNERS*
  - *CAR LEASES*
  - *LANDSCAPING OF PERSONAL HOMES*
  - *BABYSITTING*
  - *PERSONAL LEGAL FEES*

HFS USER MEETING

- MARKETING COSTS ARE:
  - LEGAL
  - NON-REIMBURSABLE
  - CANNOT PAY FOR REFERRALS
  - PAID MARKETERS VS CONTRACTORS
  - TAX DEDUCTIBLE

HFS USER MEETING

- MARKETERS CAN BE PAID FOR REFERRALS
- SALARY IS BEST
- BONUSES ARE PERMITTED
- PAY PER REFERRAL SHOULD BE AVOIDED
- ALL MARKETING COSTS MUST BE REMOVED FROM THE COST REPORT!

HFS USER MEETING

- BILLABLE MEDICAL SUPPLIES EXPENSES
- WORKSHEET A LINE 12
- PROVIDERS MUST HAVE MARK-UP POLICY
- EXAMPLE = 300% MARK-UP
- FOLEY COST $10 - $30 CHARGE
- CANNOT BILL INSURANCE IF MEDICARE IS NOT BILLED

2016 Urban Non-Routine Supplies

Severity Level	Points (Scoring)	Relative Weight	CY 2016 NRS Payment Amts	CY 2016 NRS Pay Amt (-2%)
1	0	0.2698	$14.28	$14.00
2	1-14	0.9742	$51.55	$50.54
3	15-27	2.6712	$141.36	$138.58
4	28-48	3.9686	$210.32	$205.89
5	49-98	6.1198	$323.86	$317.50
6	99+	10.5254	$557.00	$546,06

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2015 Urban Non-Routine Supplies

Severity Level	Points (Scoring)	Relative Weight	CY 2015 NRS Payment Amts	CY 2015 NRS Pay Amt (-2%)
1	0	0.2698	$14.36	$14.08
2	1-14	0.9742	$51.86	$50.84
3	15-27	2.6712	$142.19	$139.41
4	28-48	3.9686	$211.25	$207.12
5	49-98	6.1198	$325.76	$319.39
6	99+	10.5254	$560.27	$549.32

53

2016 Rural Non-Routine Supplies

Severity Level	Points (Scoring)	Relative Weight	CY 2016 NRS Payment Amts	CY 2016 NRS Pay Amt (-2%)
1	0	0.2698	$14.71	$14.42
2	1-14	0.9742	$53.10	$52.06
3	15-27	2.6712	$145.61	$142.75
4	28-48	3.9686	$216.33	$212.08
5	49-98	6.1198	$333.59	$327.04
6	99+	10.5254	$573.74	$562.48

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2015 Rural Non-Routine Supplies

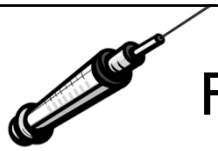
Severity Level	Points (Scoring)	Relative Weight	CY 2015 NRS Payment Amts	CY 2015 NRS Pay Amt (-2%)
1	0	0.2698	$14.79	$14.50
2	1-14	0.9742	$53.42	$52.37
3	15-27	2.6712	$146.46	$143.60
4	28-48	3.9686	$217.60	$213.35
5	49-98	6.1198	$335.55	$329.00
6	99+	10.5254	$577.11	$565.85

55

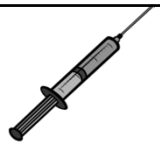
2	Other diagnosis = Anal Fissure, fistual and abscess	13
3	Primary diagnosis = Cellulitis and abscess	14
4	Other diagnosis = Cellulitis and abscess	8
5	Primary or other diagnosis = Diabetic ulcers	20
6	Primary diagnosis = Gangrene	11
7	Other diagnosis = Gangrene	8
8	Primary diagnosis = Malignant neoplasms of skin	15
9	Other diagnosis = Malignant neoplasms of skin	4
10	Primary or Other diagnosis = Non-pressure and non-stasis ulcers	13
11	Primary diagnosis = Other infections of skin and subcutaneous tissue	16
12	Other diagnosis = Other infoections of skin and subcutaneous tissue	7
13	Primary diagnosis = Post-operative complications	23
14	Other diagnosis = Post-operative complications	15
15	Primary diagnosis = Traumatic Wounds and Burns	19
16	Other diagnosis = Traumatic Wounds and Burns	8
17	Primary or other diagnosis = V code, Cystostomy care	16
18	Primary or other diagnosis = V code, Traceostomy care	23

19	Primary or other diagnosis = V code, Urostomy care	24
20	OASIS M01322 = 1 or 2 pressure ulcers, stage 1	4
21	OASIS M01322 = 3+ pressure ulcers, stage 1	6
22	OASIS M01308 = 1 pressure ulcer, stage 2	14
23	OASIS M01308 = 2 pressure ulcers, stage 2	22
24	OASIS M01308 = 3 pressure ulcers, stage 2	29
25	OASIS M01308 = 4+ pressure ulcers, stage 2	35
26	OASIS M01308= 1 pressure ulcer, stage 3	29
27	OASIS M01308 = 2 pressure ulcers, stage 3	41
28	OASIS M01308 = 3 pressure ulcers, stage 3	46
29	OASIS M01308 = 4+ pressure ulcers, stage 3	58
30	OASIS M01308 = 1 pressure ulcer, stage 4	48
31	OASIS M01308 = 2 pressure ulcers, stage 4	67
32	OASIS M01308 = 3+ pressure ulcers, stage 4	75
33	OASIS M01308 = 1 + Unstageable Dressing/Device	17
34	OASIS M01332 = 2 (2 stasis ulcers)	6
35	OASIS M01332 = 3 (3 stasis ulcers)	12
36	OASIS M01332 = 4 (4+ stasis ulcers)	21
37	OASIS M01332 = 1 (unobserved stasis ulcers)	9
38	OASIS M01334 = 1 (status of most problematic stasis ulcer: fully granulating)	6

39	OASIS M01334 = 2 (status of most problematic stasis ulcer: early/partial granulation)	25
40	OASIS M01334 = 3 (status of most problematic stasis ulcer: not healing)	36
41	OASIS M01342 = 2 (status of most problematic surgical wound: early/partial granulation	4
42	OASIS M01342 = 3 (status of most problematic surgical wound: not healing)	14
43	OASIS M01630 = 1 (ostomy not related to inpt stay/no regimen change)	27
44	OASIS M01630 = 2 (ostomy related to inpt stay/regimen change)	45
45	Any "Selected Skin Conditions" (rows 1-42 above) AND M01630 = 1 (ostomy not related to inpt stay/no regimen change)	14
46	Any "Selected Skin Conditions" (rows 1-42 above) AND M01630 = 2 (ostomy not related to inpt stay/no regimen change)	11
47	OASIS M01030 (Therapy at home) = 1 (IV/Infusion)	5
48	OASIS M01610 = 2 (Patient requires urinary catheter)	9
49	OASIS M01620 = 2 or 5 (bowel incontinence, daily or >daily	10



FLU SHOTS



1. RN SALARY ON W/S A LINE 13
2. VACCINE – LINE 13.2 – COST
3. PROVIDER MUST CHARGE ALL PTS SAME
4. CHARGES FOR NON-MEDICARE MUST BE TRACKED IN THE FINANCIAL STATEMENTS
5. WORKSHEET C SHOULD BE LESS THAN 1.000

HFS USER MEETING

ENROLLED BEFORE 3/25/2011
1.8 MILLION INDIVIDUALS & FACILTIES
275,000 REVALIDATIONS HAVE OCCURRED
34,000 REVOKED OR DEACTIVATED

- 1/5 OF PROVIDERS RE-ENROLL/YR
- NEW PROVIDER & REVALIDATING PROVIDERS APPLICATION FEE IS $525
- WWW.PAY.GOV
- FILE BEFORE SUBMIT APPLICATION
- INCLUDE RECEIPT WITH APPLICATION
- SITE VISIT
  - HHA & HOSPICE
  - OPEN FOR BUSINESS; PERSON AT PRACTICE LOCATION

Exclusion of Entity Controlled by Family Member

This provision authorizes the DHHS to exclude from Medicare or any State health care program, those entities where a person transfers ownership or control to an immediate family member or member of the household, in anticipation of, or following a conviction, assessment, or exclusion.

WEBSITE WWW.OIG.HHS.GOV

HFS USER MEETING

- ADVISORY BULLETIN 5/09/2013

  MUST CHECK VOLUNTEERS, CONTRACTOR
  - $10,000 PENALTY PER ITEM OR SERVICE FURNISHED BY THE EXCLUDED INDIV
  - 3 TIMES THAT AMOUNT IN DAMAGES AND
  - LOSS OF MEDICARE CERTIFICATION
  - AMBULATORY HEALTH CARE SERVICES WAS BANNED FROM MEDICARE AGENCY IS NOW CLOSED 3/19/2015

HFS USER MEETING

- CMS BUDGETED MONEY FOR WHISTLEBLOWERS SUPPLYING TIPS
- 15% OF MONEY RECOVERED UP TO $66M
- HHA CAN USE SELF REPORTING PROTOCOL
- CHILDREN'S HOME HEALTH CARE PAID $318,598.43

HFS USER MEETING

- 5% OR MORE OWNERS ARE INCLUDED
- MAC NOW SENDING FINGERPRINT REQUEST TO HHA
- MLN MATTER SE 1417
- CEO & CFO
- MD'S CAN BE CHECKED WITH NPI

HFS USER MEETING

- MEDICAID & OIG EXPECT MONTHLY

OIG POSITION:

"HAD REASON TO KNOW " THE INDIVIDUAL WAS EXCLUDED

- SEASONS HOSPICE AND PALLIATIVE CARE OF SOUTHERN FLORIDA $73,428 SETTLEMENT
- COOPERATIVE HOME CARE IN MISSOURI $121,010 SETTLEMENT

HFS USER MEETING

CAP OUTLIER 10% PROVIDER SPECIFIC CAP

- REDUCE OUTLIER 5% TO 2.5%
- REDUCE 5.5% BASE RATE CUT
- TO 3.0%
- EFFECTIVE EPISODES ENDING 1/1/10

HFS USER MEETING

OUTLIER	%	PPS	OUTLIER
FY2005	4.09%	$12.9M	$ 527M
FY2006	5.00%	$14.0M	$ 702M
FY2007	6.36%	$15.7M	$ 996M
FY2008	6.59%	$17.1M	$1.127M
FY2009	6.37%	$18.9M	$1.204M
FY2010	1.91%	$19.3M	$ 369M
FY2012	2.18%	$18.6M	$ 405M
FY2013	2.01%	$18.4M	$ 370M

- 70% OF HHA HAD LESS THAN 1%

HFS USER MEETING

METRO	#OUTLIER CLAIM	TOTAL PAYM PPS (MILLIONS)	TOTAL OUTLIER CLAIMS (MILLIONS)	TOTAL OUTLIER INSULIN (MILLIONS)
MIAMI	44,717	$527.8	$396.3	$277.8
CHICAGO	1,086	$493.8	$ 3.7	$ 0.9
ATLANTA	707	$ 74.4	$ 3.2	$ 1.5
HOUSTON	2,194	$325.1	$ 15.7	$ 9.7
DALLAS	13,124	$480.6	$ 95.3	$ 57.4

2007Outlier Claims by State

State	Outlier Claim	%	% to Tot
FLA	$521,603,378	25.88%	52.34%
CAL	$135,157,642	10.99%	13.56%
TEX	$188,157,854	7.53%	18.87%
UTAH	$ 14,893,982	14.90%	1.49%
LA	$ 3,624,779	.71%	.36%
ILL	$ 1,758,722	.22%	.18%
IN	$ 1,579,186	.65%	.16%
MO	$ 1,001,648	.44%	.10%
IA	$ 566,450	.86%	.06%

HFS USER MEETING

- PROVIDERS MUST SIGN UP FOR
- INDIVIDUALS AUTHORIZED ACCESS TO CMS COMPUTER SERVICES(IACS)
- NEW SYSTEM EIDM
- PS& R ARE NOT BE SENT TO HHA
- MUST SIGN UP SECURITY OFFICER
- REMEMBER TO HAVE A BACK UP
- THEN SEND DOCUMENTS
- 2 MONTHS TO COMPLETE
- MUST RESET PASSWORD EVERY 60 DAYS

HFS USER MEETING

- HHCAHPS
- 34 Question survey
- Must use approved vendor
  Less than 60 exempt – Must register each/yr
- Letters sent 9/16/2011 – 30 days to appeal
- Decision by 12/31/2011
- Can appeal to PRRB
- Failure to report data 2% decrease episodes 1/1/12!
- Scores will posted on www.Home Health Care
- Fields Research 513-821-6266

PPS REFINMENT 2015

- MARKETING COSTS ARE:
  - LEGAL
  - NON-REIMBURSABLE
  - CANNOT PAY FOR REFERRALS
  - PAID MARKETERS VS CONTRACTORS
  - TAX DEDUCTIBLE

HFS USER MEETING

- MARKETERS CAN BE PAID FOR REFERRALS
- SALARY IS BEST
- BONUSES ARE PERMITTED
- PAY PER REFERRAL SHOULD BE AVOIDED
- ALL MARKETING COSTS MUST BE REMOVED FROM THE COST REPORT!

PPS 2015

- DALLAS FRAUD CASE (DR. ROY)
- 78 AGENCIES PAYMENTS SUSPENDED
- 6 OWNERS ARRESTED
- $375 MILLION BILLING FRAUD BY HHA
- 1000 PATIENTS PER WEEK
- 20,000 PTS ON SERVICE
- 485 DEPARTMENT

PPS REFORM: OUTLIER

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2015 PPS REFINEMENT

EFFECTIVE 1/1/2011

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HFS USER MEETING

- EFFECTIVE EPISODES ENDING JANUARY 1, 2010
- 10% OUTLIER CAP/PROVIDER
- RHHI WILL USE YTD PAYMENTS
- 1137 ARE OVER CAP
- $340 MILLION REDUCTION TO HHA(EST) ACTUAL $835 MILLION
- ADJUST PAYMENT TOTAL NOT PER PATIENT

HFS USER MEETING

- MUST TRACK ALL HOURS BEGINNING 1/1/2014
- LPN'S MUST BE PAID OVERTIME
- RN'S CAN BE EXEMPT
- COMPANION EXEMPTION ENDS 12/31/2014!
- PRIMARILY AFFECTS MEDICAID & PRIVATE DUTY AGENCIES

HFS USER MEETING

- HOSPITAL 5 YEAR DEMO PROJECT
- 75 URBAN MSA PARTICIPATING
- EFFECTIVE JANUARY 1, 2016
- BUNDLED PAYMENT FOR 90 DAYS INCLUDING HHA
- PROFIT THE FIRST YEAR BUT LOSSES YEAR 2-5
- WILL COVER 25% OF HIP & KNEE PAYMENTS

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HFS USER MEETING

IN 2014

430,000 MEDICARE BENEFICIARIES HAD

- HIP & KNEE AND HOSPITALS RECEIVED$ 7B IN PAYMENTS
- INDIANAPOLIS
- PROVO, UT
- OPPORTUNITY TO WORK WITH HOSPITALS

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Value Based Purchasing

- VBP programs establish a financial bonus pool funded by payment reductions to the provider group involved.
- Can withhold up to 8% of your payment to fund the bonus pool.
- Performance and outcome standards are established to determine which providers receive bonus payments.
- Those that do not meet the standards are left with lower payment revenues. Those that outperform the standards receive financial rewards.
- Proposed as **Mandatory** for 9 States on 1/1/16.

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HHVBP – 9 States

- Washington
- Massachusetts
- Maryland
- North Carolina
- Florida
- Arizona
- Iowa
- Nebraska
- Tennessee

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HHVBP

- Competing Medicare-certified HHA's
- Applies only to services provided within the specific State boundaries
- Payment adjustments each year depending on performance
- 5 Year Program 2016 – 2020
- 7 Implementation Plan – 2022

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HHVBP Goals

- Incentivize HHA's to provide better quality of care with greater efficiency

a. Improved Planning

b. Coordination and Management of Care

- Study new potential quality and efficiency measures for appropriateness in the home health setting
- Enhance current public reporting processes

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HHVBP – Performance Assessment

- Base Year – Calendar Year 2015
- Model-Specific Quarterly Performance Report
- HHA's will receive Quarterly reports that contains information on their performance during the Quarter
- HHA's will be able to track where they stand against peers and their past performance
- First quarterly report made available July 2016
- Subsequent Reports October 2016, January 2017 & April 2017…
- Final quarterly report April 2021

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HHVBP – Payment Adjustment Report

- Released once a year to competing HHA's
- Report focus:

a. Payment Adjustment %
b. Explanation when Adjustment to be applied
c. How the adjustment was determined

- Report specific and only viewable by the HHA
- Note: Also proposing a separate, annual, publically available quality report for industry stakeholders

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HHVBP – Payment Adjustment Timeline

- 2018 – based on 2016 data – Max 5%
- 2019 – based on 2017 data – Max 5%
- 2020 – based on 2018 data – Max 6%
- 2021 – based on 2019 data – Max 8%
- 2022 – based on 2020 data – Max 8%
- New Agencies will be competing in the program in their first full calendar year following the full calendar year baseline period
- Anticipated the Payment Adjustment may be updated for frequently beginning CY 2019

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HHVBP – Quality Measures

- Initially predominantly drawn from current OASIS
- Expect to use quality measures that address critical gaps in care:

a. Patient outcomes and functional status
b. Appropriateness of care
c. Incentives for HHA's to build infrastructure to facilitate measurement with the quality framework

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HHVBP – 7 Objectives

1. Use a broad measure set that captures the complexity of the HHA service provided.
2. Incorporate flexibility to include improving Medicare Post-Acute Care.
3. Develop second-generation measures of patient outcomes, health and functional status, shared decision making and patient activation.
4. Include a balance of process, outcome, and patient experience measures.
5. Advance the ability to measure cost and value.
6. Add measures for appropriateness or overuse.
7. Promote infrastructure investments.

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HHVBP – Quality Measures

Proposed Year 1:

- 10 Process Measures
- 15 Outcome Measures
- Data drawn from:

a. OASIS
b. Medicare Claims
c. HHCAHPS survey data
d. Data reported directly from HHA's to CMS

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PY1 Proposed Measures

NQS Domains	Measure Title	Measure Type	Identifier	Data Source
Clinical Quality of Care	Improvement in Ambulation / Locomotion	Outcome	NQF0167	OASIS M1860
Clinical Quality of Care	Improvement in Bed Transferring	Outcome	NQF0175	OASIS M1860
Clinical Quality of Care	Improvement in Bathing	Outcome	NQF0174	OASIS M1830
Clinical Quality of Care	Improvement in Dyspnea	Outcome	NA	OASIS M1400
Clinical Quality of Care	Timely Initiation of Care	Process	NQF0526	OASIS M0102; M0030
Communication and Care Coordination	E/R Use w/o hospitalization	Outcome	NQF0173	CCW Claims
Patient Safety	Pressure Ulcer Prevention and Care	Outcome	NQF0177	OASIS M1300 & M2400

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PY1 Proposed Measures

NQS Domains	Measure Title	Measure Type	Identifier	Data Source
Patient Safety	Improvement in pain interfering with activity	Outcome	NQF0177	OASIS M1242
Patient Safety	Improvement in management of Oral Medications	Outcome	NQF0176	OASIS M2020
Patient Safety	Multifactor Fall Risk Assessment Conducted for All Patients that can Ambulate	Process	NQF00537	OASIS M1910
Patient Safety	Prior Functioning ADL/IADL	Outcome	NQF0430	OASIS M1900
Pat & Caregiver Centered Experience	Care of Patients	Outcome	NA	CAHPS
Pat & Caregiver Centered Experience	Communications between providers and patients	Outcome	NA	CAHPS

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PY1 Proposed Measures

NQS Domains	Measure Title	Measure Type	Identifier	Data Source
Patient & Caregiver Centered Experience	Specific Care Issues	Outcome	NA	CAHPS
Patient & Caregiver Centered Experience	Overall rating of home health care	Outcome	NA	CAHPS
Patient & Caregiver Centered Experience	Willingness to recommend the agency	Outcome	NA	CAHPS
Population / Community Health	Depression Assess Conducted	Process	NQF0518	OASIS M1730
Population / Community Health	Influenza Vaccine Data Collection Period: Does this episode	Process	NA	OASIS M1041

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HHVBP – HHCAHPS Elements for PY1

Care of Patients	Response Categories
Q9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?	Never, Sometimes, Usually, Always
Q16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?	Never, Sometimes, Usually, Always
Q19. In the last 2 months of care how often did home health providers from this agency treat you with courtesy and respect?	Never, Sometimes, Usually, Always
Q24. In the last 2 months of care, did you have any problems with the care you got through this agency?	Yes, No

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HHVBP – HHCAHPS Elements for PY1

Communication Between Providers & Patients	Response Categories
Q2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?	Yes, No
Q15. In the past 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?	Never, Sometimes, Usually, Always
Q17. In the past 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?	Never, Sometimes, Usually, Always
Q18. In the past 2 months of care, how often did home health providers from this agency listen carefully to you?	Never, Sometimes, Usually, Always
Q22. In the past 2 months of care, when you contacted this agency's office did you get the help or advice you needed?	Yes, No
Q23. When you contacted this agency's office, how long did it take for you to get the help or advice your needed?	Same day, 1 to 5 days, 6 to 14 days; More than 14 days

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HHVBP – HHCAHPS Elements for PY1

Specific Care Issues	Response Categories
Q3. When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?	Yes, No
Q4. When you first started getting home health care from this agency, did someone from the agency talk with you about all the prescription medications you are taking?	Yes, No
Q5. When you started getting home health care from this agency, did someone from the agency ask to see all the prescriptions medicines you were taking?	Yes, No
Q10. In the past 2 months of care, did you and a home health provider from this agency talk about pain?	Yes, No
Q12. In the past 2 months of care, did home health providers from this agency talk with you about the purpose for taking your new or changed prescriptions medicines?	Yes, No
Q13. In the last 2 months of care, did home health providers from this agency talk with your about when to take these medicines?	Yes, No
Q14. In the last 2 months of care, did home health	Yes, No

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HHVBP – HHCAHPS Elements for PY1

Global Type Measures	Response Categories
What is your overall rating of your home health care?	Use rating scale 1-10
Would you be willing to recommend this home health agency to family and friends?	Never, Sometimes, Usually, Always

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HHVBP - Other

- CMS proposed calculation methodology for Total Performance Score
- Makes provision for Preview Period and Request for Recalculation

- Note: All provisions in the Proposed Rule are subject to change after the 60 days comment period!

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