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LEGISLATIVE BILL REVIEW FORM: 2015

Bill Number: S.30

Name of Bill: An Act Relating to Establishing a Prospective Payment System for Home Health Services

Agency/ Dept: DVHA **Author of Bill Review:** Kara Suter

Date of Bill Review: March 10, 2015 **Related Bills and Key Players** Introduced by Senators Mullin and Ashe

Status of Bill: (check one): **__X__Upon Introduction** **_____ As passed by 1st body** **_____As passed by both**

Recommended Position:

_____Support **_____Oppose** **__X__Remain Neutral** **_____Support with modifications identified in #8 below**

Analysis of Bill

1. **Summary of bill and issue it addresses.** *Describe what the bill is intended to accomplish and why.*

This bill would direct the Department of Vermont Health Access (DVHA) to adopt a prospective payment system (PPS) for home health agencies for each 60-day episode of care by January 1, 2016. This bill applies to certified home health agencies enrolled in Medicaid that provide services to Medicaid beneficiaries, including:

- nursing, therapies, licensed nursing assistants, nutritionists, and hospice care*;
- pediatric rehabilitation services, including physical therapy, occupational therapy and speech-language pathology; and
- services under the Choices for Care program.

*In H.225 introduced this legislative sessions "hospice care" was *removed* from the list of services provided by home health agencies under Medicaid. The DVHA would support hospice care being excluded, as this is consistent with Medicare's PPS systems, which treats hospice care and home health care separately.

The PPS adopted by DVHA shall pay home health agencies a predetermined rate for each 60-day episode of home health care, regardless of the number of visits the patient receives per episode. This rate shall be adjusted annually for inflation. The PPS adopted by DVHA shall:

- be budget neutral;
- not adjust payments based on patient acuity;
- not limit the number of episodes of care;
- eliminate the need for prior authorization for pediatric rehabilitation services;
- establish risk corridors of 3%; and
- require home health agencies to report data to the Agency of Human Services (AHS) to evaluate the PPS payment methodology.

Issues addressed are:

- Payment reform and Medicaid spending – Adopting a PPS in place of a fee-for-service model for home health services would encourage more effective and cost-efficient health care service delivery. A PPS may contain or reduce health care costs to Medicaid, while fairly compensating home health agencies and addressing access issues for home health services.

2. Is there a need for this bill? *Please explain why or why not.*

No. The DVHA can implement a PPS for home health without a legislative mandate. The DVHA is in the process of assessing the feasibility of doing so, per the previous request of the Home Health Associations, prior to the legislation being introduced. To implement a PPS, the DVHA would need to submit for approval to the Centers for Medicare and Medicaid Services (CMS) an amendment to the Medicaid State Plan; approval of this amendment would ensure federal match to state funds.

3. What are likely to be the fiscal and programmatic implications of this bill for this Department?

Fiscal impact to DVHA

Costly system changes to the claims adjudication system would be necessary to implement a PPS system. Impacts to the MMIS system would likely include the following:

- Commercial grouper integration (if you decide to use one)
- Database changes
- Pricing logic
- Edits/Audits
- Reporting

The DVHA expects to be able to adopt a PPS for home health agencies that is budget neutral. However, the bill does require that DVHA adjust the rates annually for inflation, so legislative appropriations would be needed to increase according to the inflationary method mandated or chosen during the implementation process. Since the budget process does not currently appropriate over future years, there is a risk that this component be mandated but not funded in future years.

Programmatic impact to DVHA

The proposed bill represents a significant change in methods and standards for setting payment rates for Medicaid home health services. Per federal regulations, the DVHA would need approval from CMS of an amendment to the Vermont Medicaid State Plan in order to change the reimbursement methodology for home health services and to ensure that Vermont continues to receive federal financial participation for these services. As part of this state plan amendment process, a public notice and comment period will be required (per 42 CFR 447.205) prior to implementation.

There are also implementation considerations for DVHA, including the need for additional FTE staff to design and implement this new PPS methodology according to a set timeline. There would be a need to use scarce consulting resources to be allocated toward the design and implementation process, particularly the complex financial and rate setting modeling.

4. **What might be the fiscal and programmatic implications of this bill for other departments in state government, and what is likely to be their perspective on it?**

   The DVHA is collaborating closely with the Department of Disabilities, Aging and Independent Living (DAIL) to identify the universe of services across the medical benefit and Choices for Care (CFC) waiver that would be appropriate for inclusion in the PPS. We are also working with DAIL on a strategy to leverage a data use agreement (DUA) it has with CMS in order to use OASIS data as part of the PPS; this is consistent with the Medicare approach.

5. **What might be the fiscal and programmatic implications of this bill for others, and what is likely to be their perspective on it?** (f*or example, public, municipalities, organizations, business, regulated entities, etc)*

   The concept of payment reform and efficient use of health care resources is overall favorable. However, DVHA estimates that only a portion of home health spending would be appropriate for inclusion in the PPS (approximately seven million) and therefore, depending on the implementation costs described above, the investment in resources compared to overall amount of service spending raises questions about the value of investment in the overall approach.

6. **Other Stakeholders:**

   6.1 Who else is likely to support the proposal and why?

   The Vermont Association of Home Health Agencies (VAHHA) would be in support of this bill, as it would represent an evolution to a more sophisticated payment system that more closely mirrors Medicare, is more predictable over time, and embeds some flexibility in the provision of services. Medicaid-enrolled home health agencies may be able to reduce administrative costs.

   The Governor's budget also included funding to reform home health agency payment, but specifically called for inclusion of a quality/value-based component which is currently lacking in this version of the bill. Payment reform is a broader goal of the Vermont Health Care Innovation Project (VHCIP) as well as the Green Mountain Care Board (GMCB).

   6.2 Who else is likely to oppose the proposal and why?

   None known at this time.

7. **Rationale for recommendation:** *Justify recommendation stated above.*

   DVHA is supportive of payment reform that allows for more efficient and cost-effective service delivery. Regarding S.30, DVHA has the following concerns with the specific components of the bill:

   1. Stability of a PPS: PPS relies on being able to accurately set a predictable price target for groups of services that are similar clinically and in resources needed to be provided. And in these systems, the larger the volume of services and the more data that is available, the more stable and reliable the

prospective rates will be. There is very a low sample size for the universe of services appropriate for this type of model in Vermont (an estimated $7 million in Home Health medical benefit spending); this will create challenges for DVHA to accurately set rates and ensure budget neutrality for a PPS. For comparison, Medicaid currently sets Vermont-specific MS-DRG rates via it's inpatient hospital system (spending upwards of $140 million) and this is insufficient to model Medicare methodology exactly; Medicare by comparison, uses all the data from across the country (and is the predominant payer of Home Health medical services) to set its rates. Therefore, DVHA remains concerned about the validity of the PPS given the small sample size.

2. Scope of Services: The definitions currently included in the legislation are broader than would likely be appropriate for a PPS system. Using Medicare PPS as a basis, DVHA estimates that approximately $7 million in Home Health medical benefit spending would be appropriately included in the PPS. This is based on traditional Home Health revenue codes 250-980 and excludes some specialized programs like HiTech and CFC specialized services.
3. Not use patient acuity: PPS typically incorporate a case-mix adjustment. DVHA does not support eliminating the option to use patient acuity in the PPS design, as it unfairly penalizes those providers who care for more difficult patients. The DVHA is currently exploring how to mirror Medicare's methodology to the extent possible, which does adjust for patient characteristics/OASIS data.
4. Limits on number of episodes and elimination of prior authorizations: The DVHA believes that these changes are independent of the PPS design, as they are more closely related to clinical coverage decisions as opposed to a payment model design element. DVHA would suggest that these issues be discussed or resolved in collaboration with the Clinical Utilization Review Board (CURB), rather than be included as part of PPS legislation or independent adoption.
5. Risk corridors: Most PPS methodologies have an outlier policy as opposed to a risk corridor per se. DVHA would prefer to have the flexibility to adopt an outlier policy appropriate to the final PPS design and would mirror Medicare to the extent possible.
6. Time constraints: A statute requiring a certain type of prospective payment system will be difficult to enact given the time constraints facing the department. If CMS asks to alter any part of the PPS and that change does not conform to the statute, legislative approval will be needed, forcing delay. The better approach is to provide guidance but allow latitude for federal approval.
7. There is no mandate in the bill that DVHA adopt a value-based component to the system redesign which is inconsistent with the Vermont's health care reform goals of moving from volume to value.
8. There is a home health tax at 18 VSA 1952 that is not consistent with the inclusion of services found on Page 2 and 3 lines 19 to 4 of the bill. If the reimbursement in the PPS is not consistent with the definition of what is in "net core home health services," it will be difficult to collect the tax and extricate the PPS payment from what is considered in the tax.

8. Specific modifications that would be needed to recommend support of this bill*:* *Not meant to rewrite bill, but rather, an opportunity to identify simple modifications that would change recommended position.*

DVHA recommends amending the bill language to include the following components:

1. Give DVHA flexibility to define scope of services and design of a PPS that is appropriate for this provider and that would mirror Medicare to the extent possible. This may also be important given federal approval of the final design will be essential to ensure there is no misalignment between federal and state requirements.

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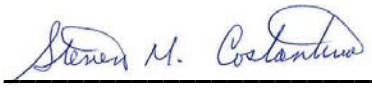
2. Give DVHA flexibility and time to study and report on the reliability of a PPS given the small sample size in Vermont.
3. Define some threshold that must be demonstrated to support implementation of PPS, such as percent of spending on services to the investment in resources to achieve system re-design, and appropriately allocate resources to support design, implementation (including system changes).
4. Give DVHA the flexibility to use existing mechanisms like the CURB to determine clinical appropriateness of lifting prior authorization requirements or episode limits, as these are outside scope of the PPS redesign.
5. Require a value-based approach be designed in consultation with VHCIP and GMCB.
6. Ensure that the requirement to update annually based on inflation is contingent upon legislative appropriations.

9. Gubernatorial appointments to board or commission?

No.

Secretary/Commissioner has reviewed this document:  ***Date: _3/11/15___***

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