Welcome & Happenings at PACCRR

We hope everyone had a wonderful Thanksgiving holiday. As Thanksgiving passes and winter approaches so does implementation of new policies for 2016. In addition to the calendar year (CY) payment rules, CMS recently released new mandatory value-based payment programs that may have significant impact on post-acute care.

Home Health Value-Based Purchasing (HHVBP) Model
The Centers for Medicare & Medicaid Services (CMS) released the final rule for HHVBP on October 29, 2015. Beginning January 1, 2016, CMS will implement the HHVBP Model among all home health agencies (HHAs) in 9 states – Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee – representing each geographic area in the nation. Medicare will tie payment to quality performance for all Medicare-certified HHAs in the 9 states. Maximum payment adjustments are up to:
- +/- 3% in 2018
- +/- 5% in 2019
- +/- 6% in 2020
- +/- 7% in 2021
- +/- 8% in 2022
Unlike in the Hospital Value-Based Purchasing program, the HHVBP is limited to 9 states rather than all HHAs. However, the HHVBP creates a requirement for participation with significant payment impacts. For more information, the HHVBP Report to Congress is here.

Comprehensive Care for Joint Replacement (CJR) Model
On November 16, 2015, CMS released the final rule for CJR. CJR is a mandatory bundled payments model that will cover 67 metropolitan statistical areas (MSAs) in 33 states. Beginning on April 1, 2016, Hospitals will be responsible for the total episode cost and quality of care for Medicare beneficiaries receiving lower-extremity joint replacements under MS-DRGs 469 and 470. Hospitals in the 67 MSAs will be financially responsible for Medicare spending from hospital admission through 90 days post-discharge for their patients. CJR is intended to create incentives to improve care and outcomes for patients during hospitalization, as well as throughout the post-acute care episode. Hospitals are expected to collaborate with PAC providers, and may share financial incentives and risk with PAC providers.

Faculty Spotlight
We are pleased to focus this month on Dr. Robert J. Rosati, who serves as Vice President of Data Analytics and Research at the Visiting Nurse Association Health Group (VNAHG). He is responsible for directing analysis and reporting of clinical outcomes for patients served by the VNAHG, as well as the evaluation of new initiatives and research related to home and community-based care. Dr. Rosati has over 25 years of experience in healthcare in varied research, quality management, education and administrative roles. He has published over 40 healthcare quality related articles and been an investigator on a number of research studies. His most recent research and publications have focused on issues related to home health care. Dr. Rosati is the Associate Editor of the Journal for Healthcare Quality, and a faculty member of Hofstra University. Prior to joining the VNAHG, Dr. Rosati was at CenterLight Healthcare—which runs one of the largest PACE programs in the country. He also ran the internally funded research program at the Visiting Nurse Service of New York for over a decade.

See Us In Action!

- **November 9**
  Quarterly naviHealth Case Manager Meeting – Livermore, California
- **November 10**
  Quarterly naviHealth Case Manager Meeting – Austin, Texas
- **November 11**
  Quarterly naviHealth Case Manager Meeting – Raleigh, North Carolina
- **November 12**
  Quarterly naviHealth Case Manager Meeting – Pittsburgh, Pennsylvania

**Next MedPAC Meeting**
December 10-11, 2015
Ronald Reagan Building,
International Trade Center, Horizon Ballroom
1300 Pennsylvania Avenue, NW

**PACCRR Webinar**
Complex Rehabilitation Technology (CRT): Potential Impact on Post-Acute Care Outcomes & Cost
Medicare’s Durable Medical Equipment (DME) benefit covers a wide range of products including Complex Rehabilitation Technology (CRT), such as individually configured manual
The Medicare Payment Advisory Commission (MedPAC) held a public meeting on November 5 – 6, 2015 focusing on a number of issues. Below are highlights from select MedPAC sessions:

**Next Steps in Continuing to Support Primary Care, Julie Somers and Kevin Hayes**

This past March, the Commission recommended replacing the primary care incentive payment program with a per-beneficiary payment. Somers and Hayes proposed two different models to implement a per-beneficiary payment: Model 1 - **full fee-for-service (FFS) plus a per-beneficiary payment for care management** & Model 2 - **partial capitation plus**. The latter Model is similar to Model 1, with the inclusion of a per-beneficiary payment—however, Model 2 shifts a part of FFS payments to partial capitated payments. MedPAC staff discussed the implications of the two models, and opened the floor for discussion.

**Telehealth Services and the Medicare Program, Zach Gaumer, Amy Phillips, Ariel Winter, and Jeff Stensland**

Utilization of telehealth services under Medicare is low. However, the program has experienced quick growth between 2008 and 2014—despite the limited Medicare coverage. MedPAC staff reported that often telehealth services were utilized by young and disabled beneficiaries. Non-Medicare payers have pointed to obstacles that hinder the ability to expand the delivery of telehealth services, one of which is the staff training requirements. MedPAC staff also discussed the varying impact of telehealth on quality and cost of care.

**Mandated Report: Developing a Unified Payment System for Post-Acute Care, Carol Carter and Dana Kelley**

The focus of the November presentation was to continue the dialogue around the payment system, address topics that were raised at the September meeting, and propose companion policies to accompany system development. MedPAC staff recognized that despite the unified payment model, FFS incentives—such as minimizing the care provided during the stay, discharging patients quickly to the next setting, and the need for multiple PAC stays that may not support care coordination—would continue. If the PAC PPS payment only held providers accountable for a beneficiary’s stay, it could create some less desirable incentives. This could lead to stunting of care, early discharge, transfer of beneficiary to another PAC setting, among other issues. Hence, MedPAC staff introduced companion policies to mitigate FFS incentives. The complete PACCR overview of the session can be found on our [website](http://www.paccr.org).

**Dual-Eligible Beneficiaries: Status Report on Current and Future Analytic Work, Eric Rollins**

In 2014, there were approximately 9.9 million dual-eligibles, with about half eligible for Medicare as a result of a disability. Rollins presented on the current state (utilization, spending, etc.) of dual-eligibles—in 2010, dual-eligibles represented 34% of spending for each program, where dual-eligibles accounted for 20% of enrollment in Medicare and 14% of enrollment in Medicaid. Additionally, Rollins provided the Commissioners with three potential scenarios that illustrate the positive and negative effect on participation rates, federal spending, and state spending if the Medicare Savings Programs are expanded. Lastly, Rollins briefly discussed 13 innovative care models employed across the nation—MedPAC staff will prepare a “status report” on the models this spring.

**Upcoming Comment Deadlines**

- The comment period for the [Development of Potentially Preventable Hospital Readmission Measures for Post-Acute Care](http://www.paccr.org) has been extended—it is set to close on December 1st, 2015.
- The comment period for the [Discharge Planning](http://www.paccr.org) proposed rule ends on January 4th, 2016.

**CMS Updates: Home Health Final Rule Highlights**

CMS released the calendar year 2016 Home Health Prospective Payment System final rule on Thursday, October 29th, which updates payments and policies related to home health agencies (HHAs). In 2014 alone, an estimated 3.5 million beneficiaries were receiving home health services, provided by 11,900 HHAs at a cost of approximately $17.9 billion for Medicare. Final rule includes the following payment changes: rebas[ing the HH PPS payment rates](http://www.paccr.org), recalibration of the HH PPS case-mix weights, reduction in the 60-day episode rate to account for nominal case-mix growth, establishment of a mandatory HHVBP model in 9 states, and other updates. The HH final rule also establishes a quality metric to meet one of the domain requirements under the Improving Medicare Post-Acute Care Transformation Act of 2014—the skin integrity and changes to skin integrity domain. Read the full PACCR summary!