Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Home Health Services to Medical Assistance Clients

Engrossed Substitute House Bill 1109; Section 211(33); Chapter 415; Laws of 2019

November 30, 2019

Home Health Services to Medical Assistance Clients

Acknowledgments

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Executive Summary

This report addresses requirements of the Home Health work group convened at the direction of the Legislature by the Health Care Authority (HCA). The work group met five times in person and via phone conference calls to develop recommendations for future home health service payment methods. This report represents the Home Health work group's recommendations and not that of the HCA.

The work group recommends two separate models of payment with a two tiered implementation phase. The first phase recommendation is a fee-for-service (FFS) model with an increase in the current payment rate with an addition of social work and a telephone encounter payment. Phase one anticipated start date is January 2021. Phase two recommendation is a prospective payment system (PPS) with value based purchasing (VBP), and a recommended start date of January 2022. Additional time, funding, and hiring of an outside consultant would be essential in order to research and develop a PPS model with VBP that meets the needs of Washington Apple Health (Medicaid), clients, and our providers.

It was out outside the scope of this report to estimate the system wide savings associated with avoided emergency room use, avoided hospitalizations, and reduced hospital length of stays. However, increased access to home health for Apple Health patients will allow these patients to move out of acute care settings and access timely, cost efficient home health care.

Background

Home health is a mandatory Washington State Apple Health benefit.. HCA, under the State Plan Amendment and Department of Social and Health Services (DSHS), under a waiver, provide home health services for both acute and chronic care conditions, respectively. The Department of Health (DOH) regulates and licenses home health agencies under the In-Home Services statute RCW 70.127.

The Apple Health home health benefit includes a wide range of care and service types provided in a client's home for an illness or injury with the goal of maintaining or improving the client's health and function. This benefit includes nursing care, physical therapy, occupational therapy, and speech therapy and assistance with daily living activities delivered by a certified home health aide. For many clients recovering from illness or injuries, home health services may provide safe, effective and less costly alternatives to inpatient facilities, including hospitalization and/or emergency department (ED) visits.

Currently, Apple Health, including contracted managed care organizations (MCOs), reimburse home health service providers on a FFS basis. Home health agencies in our state report they have not received adequate reimbursement to cover the cost of providing the service since 2000. They report that low reimbursement rates have financially limited the ability of many home health agencies to take Apple Health patients without incurring significant financial risk to their

organizations. When hospital discharge planners are unable to send patients home with skilled nursing care or rehabilitative therapies, the patients remain unnecessarily in the hospital – costing the hospital money and the public access to hospital beds. If a hospital has capacity challenges, this can result in diversion to other facilities and cancelled elective surgeries.

With this report, HCA satisfies the requirements in the budget proviso (see below) by reporting the Home Health work group's recommendations for new Apple Health payment method for both acute and chronic home health services.

Prior to the formation of this work group and during the 2019 legislative session, the Washington State Legislature introduced Senate Bill (SB) 5828, concerning the Medicaid home health reimbursement rate for medical assistance clients.[1] SB 5828 included language requiring:

- Increased payment for Medicaid home health services to no less than 100 percent of the Medicare rate;
- Provision for reimbursement for a social worker and telemedicine under the Medicaid home health benefit; and
- Creation of a work group to redesign the home health reimbursement payment methodology.[2]

A fiscal note[3] for this bill was completed, is available publicly and serves as a reference for aspects of this report. Though SB 5828 did not pass during the 2019 legislative session, the Legislature included similar language in the 2019-2021 biennial operating budget: Engrossed Substitute House Bill 1109 (2019). The budget proviso in section 211(33) of that act states:

> The authority shall facilitate a home health work group consisting of home health provider associations, hospital associations, managed care organizations, the department of social and health services, and the department of health to develop a new payment methodology for home health services. The authority must submit a report with final recommendations and a proposed implementation timeline to the appropriate committees of the legislature by November 30, 2019. The work group must consider the following when developing the new payment methodology:
>
> (a) Reimbursement for telemedicine;
> (b) Reimbursement for social work for clients with behavioral health needs;
> (c) An additional add-on for services in rural or underserved areas;

[1] SB 5828 - 2019-20 Concerning the medicaid home health reimbursement rate for medical assistance clients., from https://app.leg.wa.gov/billsummary?BillNumber=5828&Year=2019&Initiative=false, accessed on September 9, 2019.
[2] SB 5828 – Digest, from http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Digests/Senate/5828.DIG.pdf, accessed on September 9, 2019.
[3] Multiple Agency Fiscal Note Summary, Bill Number: 5828 SB, from https://fortress.wa.gov/ofm/fnspublic/FNSPublicSearch/Search/bill/5828/66, accessed on November 1, 2019.

(d) Quality metrics for home health providers serving medical assistance clients including reducing hospital readmission;
(e) The role of home health in caring for individuals with complex, physical, and behavioral health needs who are able to receive care in their own home, but are unable to be discharged from hospital settings; and
(f) Partnerships between home health and other community resources that enable individuals to be served in a cost-effective setting that also meets the individual's needs and preferences.[4]

HCA Home Health Policy (Acute Care Services)

As called out above, home health acute care services are a covered benefit in the Apple Health program. Program policy and billing requirements are published in the Home Health (Acute Care Services) Billing Guide (July 1, 2019) and include the following definitions:

> Acute care [is defined as care] provided by a home health agency for clients who are not medically stable or who have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.[5]

> The purpose of the Medicaid agency's home health program is to provide equally effective, less restrictive quality care to the client, in any setting where the client's normal life activities take place, when the client is not able to access the medically necessary services in the community, or in lieu of hospitalization. Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment.[6]

Apple Health is currently administered through managed care and FFS programs. The majority of enrollees (86 percent) receive benefits through one of five contracted MCOs. MCOs administer Apple Health benefits across all communities in the state and must meet the same benefit requirements as FFS enrollees. HCA contracts with each MCO for the provision of this benefit management. Home health agencies provide these services for the HCA fee-for-service (FFS) program and the agency's MCOs. In FY18, 4,675 unique FFS and MCO clients received home health services under this benefit.

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[4] Engrossed Substitute House Bill 1109, Chapter 415, Laws of 2019 (partial veto), from http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1109-S.SL.pdf, page 127, accessed on September 9, 2019.
[5] Home Health (Acute Care Services) Billing Guide (July 1, 2019), from https://www.hca.wa.gov/assets/billers-and-providers/Home-Health-Services-bi-20190701.pdf, page 9, accessed on October 4, 2019.
[6] Home Health (Acute Care Services) Billing Guide (July 1, 2019), from https://www.hca.wa.gov/assets/billers-and-providers/Home-Health-Services-bi-20190701.pdf, page 11, accessed on October 4, 2019.

DSHS Chronic Care Skilled Nursing Services

DSHS provides skilled nursing only under a home health type of benefit to clients who are 21 years of age and older and have a chronic, long term condition through two of their administrations. This benefit does not include coverage for all the services (physical therapy, occupational therapy, speech therapy, and home health aide) a home health agency provides under the HCA Apple Health benefit. Nor is it available for clients who require acute care services, as provided under Apple Health, or more than 4 hours of services, the minimum required for the private duty nursing benefit.

The Aging and Long-Term Support Administration (ALTSA) provides skilled nursing services through 1915(c) waivers administered by Home and Community Services Division. These are community and home-based service waiver programs that pay for services such as personal care, home delivered meals, home health care, adult day services, respite, transportation and other services for adults (age 18 or older) who are blind, aged, or disabled per Social Security criteria, in their homes, adult family homes or assisted living facilities. This skilled nursing care is available to support a client who lives in their home or an alternative environment in the community, such as an assisted living residence. The purpose of these programs is intended to provide an option to institutional settings.

The Developmental Disabilities Administration (DDA) also covers skilled nursing services for clients who are developmentally disabled and enrolled in one of four DDA waivers: Individual and Family Services, Basic Plus, Core and Community Protection. The nursing care provided is an intermediate level of care, lasting less than 4 hours per visit, and to offer an option to an institutional setting.

Nursing services under both of these programs are provided through a contracted home health agency or independent licensed nurses when the service is not available through a licensed home health agency. The majority of these services are provided by and independent licensed nurse. In FY18, 46 clients received services under the Community Options Program Entry System (COPES) program and 1,566 received services under the DDA program.

Home Health Work Group

The subsections below detail the efforts of the Home Health work group to address the requirements of the budget proviso and to produce the Home Health Report.

Work Group Membership and Process

HCA convened a Home Health work group that included representatives from the following:

- State Government Organizations:
    - Department of Health
    - Department of Social and Health Services

    - Health Care Authority
    - Washington State Senate
- Apple Health Managed Care Organizations:
    - Amerigroup Washington
    - Community Health Plan of Washington
    - Coordinated Care of Washington
    - Molina Healthcare of Washington
    - United Health Care Community Plan
- Home Health Services Provider Organizations:
    - Home Care Association of Washington
    - Others
- Hospitals:
    - Washington State Hospital Association

Appendix A contains a list of the work group member organizations and their representatives that attended work group meetings.

The work group met five times between July and October 2019. The work group members:

- Defined the scope of the work group's requirements, key terms in the budget proviso, and the role of home health services;
- Shared information about and discussed current and potential alternative home health payment options in Apple Health;
- Qualitatively evaluated alternative payment methods for acute home health services;
- Drafted and reviewed financial models based on increased benefits and higher service rates; and
- Achieved consensus about the alternative payment methods to recommend.

Appendix B contains agendas, notes, and other materials from each work group meeting.

Key Definitions

By consensus the work group developed and agreed to the following definitions for key terms identified in the budget proviso:

Telemedicine –Refers to telemonitoring, under RCW 74.09.658, which allows home health and other providers to monitor the conditions of clients remotely using audio, video and data.

Social Worker (for the purposes of this report) – is defined as a Licensed Masters in Social Work (MSW) with training in medical social work providing assessment and referrals to community agencies, short term counseling and linkages to services tailored to the individual.

Rural – Rural is defined in many different ways. The U.S. Census Bureau defines rural as what is not urban—that is, after defining individual urban areas, rural is what is left.[7] "Rural County" means a county with a population density of less than one hundred persons per square mile or a county smaller than two hundred twenty-five square miles as determined by the office of financial management and published each year by the department for the period July 1st to June 30th (RCW 82.14.370).[8] The Washington Department of Health 2016 guidelines has developed a four tier classification system, based on the federal Rural-Urban Commuting Area (RUCA) model.[9] This report will utilize the definition as written in RCW.

Underserved Areas – Underserved areas are identified geographic areas and populations with a lack of access to primary care services.[10]

Underserved Populations – Underserved populations include consumers who share one or more of the following characteristics.[11]

- Receive fewer health care services.
- Encounter barriers to accessing primary health care services (e.g., economic, cultural, and/or linguistic).
- Have a lack of familiarity with the health care delivery system.
- Face a shortage of readily available providers.

Quality Metrics – Per Centers for Medicare & Medicaid Services (CMS) definitions, Quality measures are tools that helps measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include: effective, safe, efficient, patient-centered, equitable, and timely care.[12]

Value Based Purchasing- Value-based programs reward health care providers with incentive payments for the quality of care they provide to clients. Value-based programs support:

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[7] Defining Rural at the U.S. Census Bureau (December 2016), from https://www.census.gov/content/dam/Census/library/publications/2016/acs/acsgeo-1.pdf, page 1, accessed on October 31, 2019.
[8] Office of Financial Management, from https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/population-density/population-density-and-land-area-criteria-used-rural-area-assistance-and-other-programs, accessed on October 31, 2019.
[9] Guidelines for Using Rural-Urban Classification Systems for Community Health Assessment, from https://www.doh.wa.gov/Portals/1/Documents/1500/RUCAGuide.pdf, accessed on November 20, 2019.
[10] Health Resources and Services Administration, from https://data.hrsa.gov/tools/shortage-area/mua-find, accessed November 1st, 2019.
[11] Serving Vulnerable and Underserved Populations, from https://marketplace.cms.gov/technical-assistance-resources/training-materials/vulnerable-and-underserved-populations.pdf, page 15, accessed on October 31, 2019.
[12] CMS.gov, Centers for Medicare & Medicaid Services, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html, accessed on November 1, 2019.

- Better care for individuals
- Better health for populations
- Lower cost[13]

Role of Home Health Services

Home health services provide a vital role to communities by facilitating a safe discharge from hospitals back into the clients' home, allowing for continuum of care of the client's medical needs.

Although behavioral health is not a component of the home health benefit, individuals can currently receive outpatient behavioral health services through the Apple Health mental health benefit, with no limitations in place for outpatient mental health services. Clients can receive home health and behavioral health services concurrently which could be coordinated by a social worker.

Home health services provided by medical social workers are covered by Medicare as a dependent service, although is not currently a covered service through the Apple Health home health benefit. Social work would be able to facilitate available community resources for the client, assess the social and emotional factors related to the clients' illness, and provide intervention as appropriate. Social work has been an identified need that needs to be a covered benefit for Apple Health clients.

Telemedicine is currently a covered benefit through Apple Health. RCW 74.09.658 states that:

> (7) For the purposes of this section, "telemedicine" means the use of telemonitoring to enhance the delivery of certain home health medical services through:
>
> (a) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit; or
>
> (b) The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry.

Telemedicine and telemonitoring do not include clinical phone calls to the client. Telephone communications instead of a face to face visit can help determine the client's condition, needs, and address any concerns or questions. Home health providers can gather critical patient information and provide timely interventions as needed. Access to this clinical information provides the ability to modify care within the home, and potentially decrease unnecessary Emergency Department visits, potentially reduce the number of unnecessary home visits and promptly address any clinical concerns as needed.

[13] CMS.gov, Centers for Medicare & Medicaid Services, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html, accessed on November 1, 2019.

Criteria for the Alternative Acute Care Services Payment Method

The work group determined that the payment method it would recommend should meet the following criteria:

- Reimburse for specific services, including services not reimbursable under the current model;
- Use home health outcome measures to determine value-based reimbursement incentives;
- Include payment add-ons and enhancements by client needs and service location; and
- Be cost effective in the administration of the benefit.

There are many different payment methods within health care to consider. However, the work group determined that it would not be feasible to consider a payment method that home health services do not use currently in some context, in order to facilitate transition to the ultimate goal of a prospective payment value based purchasing system.

Services Eligible for Reimbursement: Current and Proposed

Current home health acute care services available for Apple Health reimbursement include skilled health care (nursing, specialized therapy, and home health aide) services provided on an intermittent or part-time basis by a Medicare-certified home health agency, in any setting where the client's normal life activities take place.[14]

- **Skilled Nursing** – A registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a RN, performs one or more of the following activities during a visit to the a client:
    - Observation
    - Assessment
    - Treatment
    - Teaching
    - Training
    - Management
    - Evaluation
- **Specialized Therapy** – means skilled therapy services provided to clients that include:
    - Physical Therapy
    - Occupational Therapy
    - Speech Language Pathology

[14] Washington State Legislature (WAC 182-551-2000), from https://apps.leg.wa.gov/wac/default.aspx?cite=182-551-2010, accessed November 1, 2019.

- **Home Health Aide** – A person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

The work group acknowledged the need to add the following covered benefits to the recommended payment method for acute care services:

- **Telephone Encounter** – It is recommended by the work group that clinical monitoring, via a phone call to the client for the purpose of gathering data be a reimbursed benefit. This data would be interpreted by a qualified professional to assess the client's current health status and need for any skilled intervention. Reimbursement may be at a per phone call rate.
- **Social Work** – Medical social services that are provided by a licensed medical social worker (MSW).

Work group members raised concerns that the $10 rate per visit increase in July 2016 did not increase client access to home health services, which in turn may have caused a decrease in enrolled providers.

Value-Based Reimbursement Outcome Measures

The work group selected the following quality metrics to be part of the recommended, value-based payment method for acute care services:

- **Decreased emergency department use** – percentage of home health stays in which clients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.[15]
- **Decreased hospital readmissions**– percentage of home health stays in which clients who had an acute inpatient discharge within the 5 days before the start of their home health stay were admitted to an acute care hospital during the 30 days following the start of the home health stay.[16]
- **Timeliness of care** – current Medicare requirement is face-to-face skilled home health visit within 48 hours of the hospital discharge date.
- **Increased client access** – increase in percentage of Apple Health clients served from existing home health agencies that currently provide service to Apple Health clients and an increase in home health agencies that will accept Apple Health clients. Percentage to be determined at a later date.

[15] Home Health Quality Measures – Outcomes, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Home-Health-Outcome-Measures-Table-OASIS-D-11-2018c.pdf, page 5, accessed November 1, 2019.
[16] Home Health Quality Measures – Outcomes, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Home-Health-Outcome-Measures-Table-OASIS-D-11-2018c.pdf, page 5, accessed November 1, 2019.

Home health service providers that perform well per these outcome measures would receive additional reimbursement, and providers that do not perform well would receive less reimbursement. Additional measures may be added, such as a telehealth utilization metric, as deemed operationally appropriate and implementable.

Payment Add-Ons for Rural and Underserved Areas

Providers' costs to provide services vary by client needs and service locations. For example:

- Clients with more complex health care needs often require more services, supplies, and other resources than clients with less complex health care needs.
- Providers serving clients in rural or underserved areas often incur higher expenditures such as transportation costs, decreased staff productivity related to driving distances, and the need to pay competitive wages in order to recruit and retain staff in rural areas.

Cost-Effective Benefit Administration

Altering or replacing payment methods incur implementation costs associated with software system changes, staff training, and other related activities. The work group determined that the implementation cost of the alternative payment method it recommends would be an important consideration. Some payment methods and their related systems are easier to administer than others. The work group acknowledged that the administrative burden on providers to implement a new payment model should not be unnecessarily burdensome such as cost or manpower.

Home Health Acute Care Services Alternative Payment Method Evaluation

The work group considered four alterative payment methods for home health acute care services: per diem, FFS with a higher rate, FFS with a higher rate and incentives, and a PPS with VBP model.

Per Diem

The per diem payment method reimburses providers for each day the client is on home health services. This is not the same as reimbursement per visit, though clients might receive only one visit per day. Hospice care uses this payment method, and hospice care providers use client volume to ensure they can receive sufficient revenue to cover their expenses.

The work group began considering a per diem method. However, it did not perform a full evaluation of this alternative payment method, because home health service providers do not currently use any per diem reimbursement method. Additionally, the per diem payment option could potentially produce a disincentive to providers from taking on clients who have complex medical needs, which would result in reduced client access.

Fee-for-Service with an Increase in Rate

This payment method is consistent with the current home health acute care services payment method, with an increase in rate that would be reflected in the fee schedule.

- **Current use in home health services** – FFS is the current payment method for home health services.
- **Reimbursement for additional services** – the additional services to be added to the home health benefit are:
    - A licensed social worker.
    - Telephone encounter to monitor clients clinical status, with a cap of one telephone encounter per day.
    - Increase in payment rate, based on a percentage of the rate set by CMS and comparable to Medicare rates.
- **Incentives from outcome measures** – no incentive payment from outcome measures will be paid.
- **Add-ons and enhancements** – providers would not receive an additional add-on payment when serving clients in underserved, and/or rural, areas or enhanced payments when serving clients with more complex health care needs. Add-ons and enhancement payments will be bundled into the statewide rate increase.
- **Client access** – there is an anticipated increase in client access to home health services based on assumed additional Apple Health enrolled providers, due to an increase in reimbursement for services.
- **Administrative burden** – there will be minimal administrative burden, as this is the current Apple Health payment method for home health services.
- **Cost-effective benefit administration** – FFS is the current payment model and the implementation of this model will require a change to the current fee schedule to reflect the new payment rate, and the addition of social work home visit, and telephone encounter.

Fee-for-Service with an Increase in Rate and Addition of Incentive Pay

This payment method is similar to the current home health acute care services payment method, with an increase in rate, reimbursement for additional services, and the addition of incentive pay based on the performance of identified quality metrics. This payment model was considered, but ruled out due to the complexity in the development of the payment model within the designated timeframe.

Prospective Payment System with Value Based Purchasing

PPS is an episodic payment method where providers are reimbursed on the episode of care which includes all visits provided. Currently Medicare and numerous Medicare Advantage plans use a PPS payment model to reimburse home health providers. PPS with VBP provides incentive pay to providers based on predetermined outcome measures.

- **Current use in home health services** – currently, this is Medicare's model for home health payment.
- **Reimbursement for additional services** – there will be no reimbursement for additional services, all services are inclusive in payment model, including social work.

- **Incentives from outcome measures** – the payment will include incentive pay for outcome measures, similar to the current Medicare model, which utilizes a prospective payment for a designated 60-day episode of care. Home health agencies will need to develop systems for programming, reporting and monitoring of performance indicator results and Apple Health will need to develop payment and quality reporting/monitoring/management systems for performance incentive indicators, in order to adequately monitor, report and implement these incentives.
- **Add-Ons and enhancements** – add-ons and enhancement payments are to be bundled in to the PPS payment model. Providers would not receive add-on payments when serving clients in underserved, and/or rural, areas or enhanced payments when serving clients with more complex health care needs.
- **Client access** – there is an anticipated increase in client access to home health services based on assumed additional Apple Health enrolled providers, due to an increase in reimbursement for services.
- **Administrative burden** – there is a minimal administrative burden to providers, as this is the current payment model for Medicare clients. The administrative burden to Apple Health is undetermined and the employment of a consultant would be crucial in the development of the PPS system and identifying implementation and administrative costs.
- **Cost-effective benefit administration -** the cost effective benefit is undetermined and the employment of a consultant would be crucial in the development of the PPS system and identifying implementation and administrative costs and the cost effective benefit.

Current Chronic Care Services Payment Method

The 1915(c) programs currently use the same FFS payment method that HCA uses. Compared to HCA's acute home health services program, the 1915(c) programs serve significantly fewer clients and the care is not episodic with a predictable start and end date; it is for managing chronic conditions that may only require a simple blood draw or injection once a month. This type of home nursing service does not lend itself to an episodic PPS payment system where risk is shared with the provider based on value based incentives. In addition, most of the nurses who provide these services are individuals who contract independently with DSHS. These independent nurses do not have the patient volume a home health agency manages and the services they render are direct care and cannot be performed in a more cost effective manner. The small number of cases and the type of care is not conducive to a risk sharing reimbursement model. Therefore, increasing the FFS rates for these programs to the same levels as HCA's acute home health services program is the most appropriate recommendation to assure access for services rendered under DSHS. However, applying a PPS payment method these programs would not be appropriate, due to the relative administrative burden on the small program, and the risk that individually contracted nurses or home health agencies with very small volumes would have to bear.

Recommendations with Implementation Timelines

The work group recommends two separate models of payment for HCA, with a two tiered implementation phase. The Community Options Program Entry System (COPES) program would follow the same reimbursement increase as FFS in phase one, although they would not transition to a PPS model of payment.

Phase One payment method would be the FFS model with an increase in payment rate comparable to current Medicare rates with the addition of services to be added to the home health benefit. Table 1 below compares the current reimbursement rates per visit to what the new reimbursement rates would be during phase one. The anticipated start date for phase one of the FFS payment model would be January 1, 2021. Table 2 below shows the additional costs of the proposed reimbursement rates, totaling about $9.07 million in state fiscal year 2021 and about $18.14 in each subsequent year.

Table 1 – Comparing Calendar Year 2019 Home Health Services Fee-for-Service Reimbursement Rates per Visit to Proposed Fee-for-Service Reimbursement Rates per Visit

Service	CY 2019 FFS Rates per Visit	Proposed FFS Rates per Visit	Difference	Percent Difference
Physical Therapy	$73.76	$226.89	$153.13	207.6%
Occupational Therapy	$75.80	$228.44	$152.64	201.4%
Speech Therapy	$97.19	$246.61	$149.42	153.7%
Skilled Nursing	$97.43	$207.56	$110.13	113.0%
Home Health Aide	$55.32	$93.99	$38.67	69.9%
Brief Skilled Nursing	$29.58	$43.53	$13.95	47.2%
Social Work	(None)	$332.70	$332.70	N/A
Telemedicine	(None)	$11.00	$11.00	N/A

Sources: HCA Financial Services Division, December 2019; see also 10/22/2019 meeting notes and Appendix D

Notes: CY means calendar year. FFS means fee-for-service. N/A means not applicable.

Table 2 – Additional Cost of the Proposed Home Health Services Fee-for-Service Reimbursement Rates per Visit from State Fiscal Year 2021 through State Fiscal Year 2025

Fund	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025
General Fund - State	$4,447,995	$8,895,991	$8,895,991	$8,895,991	$8,895,991
General Fund - Federal	$4,623,622	$9,247,244	$9,247,244	$9,247,244	$9,247,244
Total	**$9,071,617**	**$18,143,235**	**$18,143,235**	**$18,143,235**	**$18,143,235**

Source: HCA Financial Services Division, December 2019

Notes: SFY means state fiscal year. The amounts in SFY 2021 are lower, because phase one would begin at the start of the second-half of the state fiscal year (January 1, 2021).

Phase Two would transition from FFS to a PPS with VBP model and a recommended start date of January 2022. Additional time and funding is required in order to adequately research a PPS model with VBP that would include incentive and disincentives based on predetermined outcome measures. Hiring of an outside consultant would be essential in order to research and develop a PPS with VBP model that meets the needs of Apple Health, our providers, and clients.

Currently Medicare utilizes the Outcome and Assessment Information Set (OASIS) system to process their required home health service outcome measures. The OASIS is a data collection system designed to measure adult, non-maternity patient outcomes in the home health care setting, with the intent to provide a standardized assessment tool that supports a case mix index adjusted PPS, with a mechanism to monitor the quality of care provided to clients. "OASIS data are collected by a home care clinician (e.g., nurse or therapist) via direct observation and interview of the care recipient and/or caregiver. Select OASIS indicators are used to assign patients to a Home Health Resource Group (HHRG) for each 60-day home care episode. The HHRG is then used to calculate each patient's reimbursement rate under the Prospective Payment System (PPS)."[17] See Appendix C for additional information about OASIS.

For the HCA home health PPS with VBP payment model, it is recommended to limit the number of metrics to address the main concerns such as hospital readmissions, reduction in unnecessary ED visits, increase in client access to home health services, and timeliness of care.

The PPS payment model is the recommended choice and aligns with HCA's goal to achieve a healthier Washington. According to the HCA value based roadmap, the 2021 vision is that all HCA programs implement VBP and tie 90 percent of provider payments for service delivery to quality outcomes. "Health Care Authority's (HCA's) goal is to achieve a healthier Washington by containing costs while improving outcomes, patient and provider experience, and equity through innovative, value-based purchasing (VBP) strategies."[18]

Conclusion

In conclusion, all participants in the workgroup were participatory and the work group consensus is to recommend two separate models of payment with a two tiered implementation phase. Phase one is a FFS model with an increase in the current payment rate with an addition of social work and a telephone encounter payment. The phase one anticipated start date is January 2021.

Phase two recommendation is to transition to a PPS with VBP payment model, and a recommended start date of January 2022. Additional time, funding and the employment of an outside consultant

[17] The Outcome and Assessment Information Set (OASIS)(August 2015): A Review of Validity and Reliability, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4529994/#R9, accessed November 1, 2019.
[18] Value-based Purchasing Roadmap, 2019-2021 and beyond (October 2019), from https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf, page 4, accessed November 1, 2019.

would be essential in order to research and develop a PPS with VBP model that is inclusive of an implementation plan.

The workgroup agreed that a rate increase for home health for Medicaid patients will create much needed access for these patients. Increased home health access will help stabilize patients in communities and help prevent avoidable hospitalization and emergency room utilization. The workgroup recommendations to increase Medicaid home health reimbursement will help provide patients with the right care at the right place and time.

Appendix A: Home Health Work Group Roster

The table below contains the names and organizations of work group members who attended at least one work group meeting.

Apple Health Managed Care Organizations	Provider Organizations	State Organizations
Amerigroup Washington: • Donnell Barnette • Elizabeth Johnson • Erika Lang **Community Health Plan of Washington:** • Cathy Neiman • Jennifer Vincenti **Coordinated Care of Washington:** • Edie Dibble • Jessi Giulio • Melissa Knopp • Paula (Hoskins) Newell • Carrie Robertson • Callie MacLeod **Molina Healthcare of Washington:** • June Smith **United Health Care Community Plan:** • Julie Newman • Regina Vasquez	**Community Home Health and Hospice:** • Randy Dalton • Greg Pang • Alisa Van Sickle **Home Care Association of Washington:** • Leslie Emerick • Donna Goodwin • Sheena Paylor • Christine Opiele **Virginia Mason Memorial:** • Amber Hahn-Keena • Gail McGaffick **Other:** • Gretchen Anderson, Sunshine Health Facilities • Marc Berg, Berg Data Solutions • Carolyn Bonner, Social Health Connections, Highline Community Health • Bob Cooper, National Association of Social Workers • Brent Korte, EvergreenHealth • Kyle Long, Aveanna Healthcare • Geoff Meinken, Careforce • Mike Pugsley, Ashley House • Zosia Stanley, Washington State Hospital Association • Sheena Tomar, Service Employees International Union (SEIU) 775 Benefits Group	**Health Care Authority (HCA):** • Cathy Carroll, Clinical Quality and Care Transformation (CQCT) • Cynde Rivers, CQCT • Amanda Avalos, CQCT • Dean Runolfson, CQCT • Gail Kreiger, Medicaid Programs and Operational Integrity (MPOI) • Collette Jones, MPOI • Kimberly Aguirre, MPOI • Gary Hanson, Planning and Performance Division (PPD) • Ed Hicks, ProviderOne Operations and Services (P1OS) • Joan Chappell, CQCT • Josh Morse, CQCT • Robin Brake, Financial Services Division (FSD) • Sarah Pearson, CQCT • Suzanne Swadener, PD **Department of Social and Health Services (DSHS):** • Doris Barret, Developmental Disabilities Administration (DDA) • Jerome Spearman, Aging and Long-Term Services Administration (ALTSA) **Other:** • Pat Justis, Department of Health (DOH) • Sandy Stith, Senate Ways and Means (Senate)

Appendix B: Home Health Work Group Meetings

The Home Health Work Group held meetings on the following dates to produce this report:

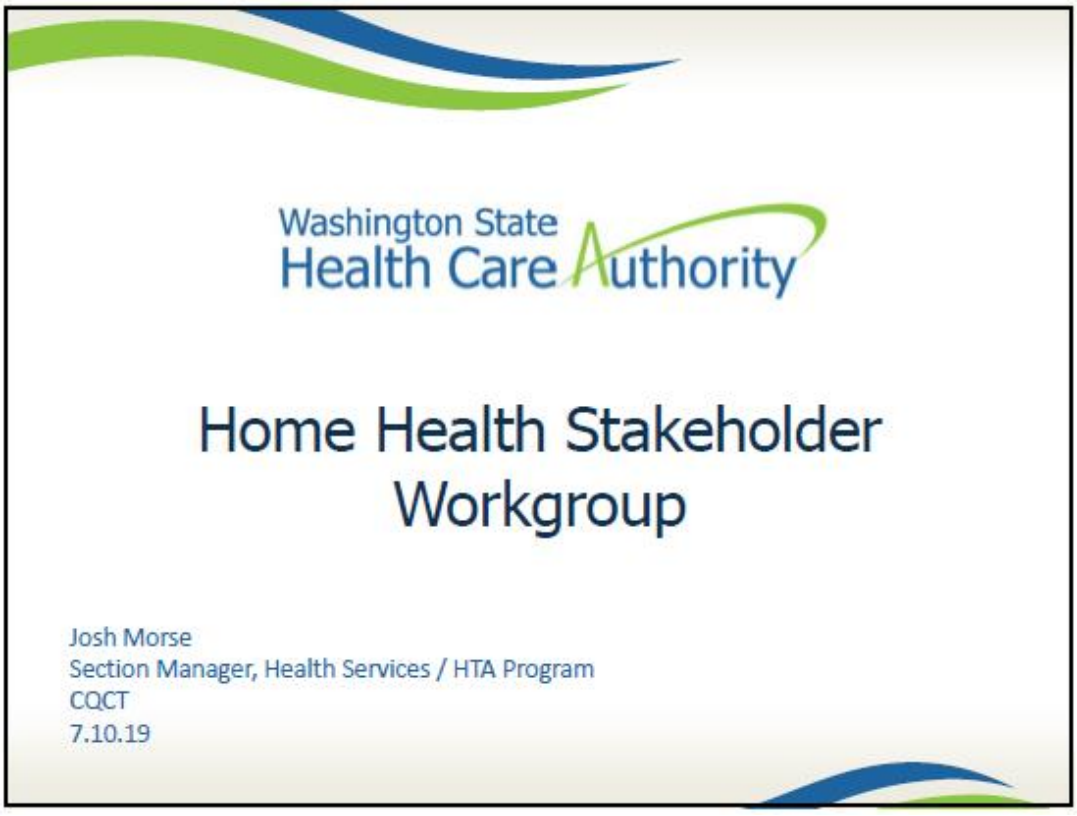
- July 10, 2019
- August 7, 2019
- August 27, 2019
- September 4, 2019
- October 22, 2019

In the sections below are materials from each work group meeting.

Meeting on July 10, 2019

Below are the slides of the PowerPoint presentation that HCA shared with the work group during the meeting and notes from that meeting.

PowerPoint Presentation Slides



Washington State Health Care Authority

Goals

- Introductions / Workgroup Attendees
- Review Budget Proviso
- Workgroup Purpose
- Workgroup Expectations and Legislative Report Timeline
- Homework

2

Washington State Health Care Authority

Introductions

- Name
- Agency / Group / Affiliation

3

Washington State Health Care Authority

HB 1109 Budget Proviso

- The authority shall facilitate a home health work group consisting of home health provider associations, hospital associations, managed care organizations, the department of social and health services, and the department of health to develop a new Medicaid payment methodology for home health services. The authority must submit a report with final recommendations and a proposed implementation timeline to the appropriate committees of the legislature by November 30, 2019. The work group must consider the following when developing the new payment methodology:

  (a) Reimbursement for telemedicine;

  (b) Reimbursement for social work for clients with behavioral health needs;

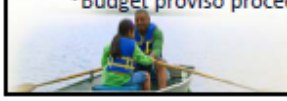
  (c) An additional add-on for services in rural or underserved areas;

  (d) Quality metrics for home health providers serving medical assistance clients including reducing hospital readmission;

  (e) The role of home health providers serving medical assistance clients including reducing hospital readmission;

  (f) Partnerships between home health and other community resources that enable individuals to be served in a cost-effective setting that also meets the individual's needs and preferences.

*Budget proviso proceeded by SB 5828.



4

Washington State Health Care Authority

Home Health Workgroup Purpose

- Develop a new Medicaid payment methodology for home health services
- Consider specific criteria as indicated in budget proviso when developing the new payment methodology
- Report final recommendations and a proposed implementation timeline to the Legislature by 11/30/19

5

Washington State Health Care Authority

Home Health Workgroup and Legislative Report Timeline

Initial Workgroup Meeting → 2nd Workgroup Meeting → 3rd Workgroup Meeting → Early Sept. – 1st draft Leg. Report → Follow up Workgroup Meetings → Early Oct. – 2nd draft Leg. Report → Finalize and Submit Report to Legislature → 11.27.19

- Workgroup Expectations
  - Workgroup purpose
  - Workgroup representatives from each organization
  - Roles and Responsibilities

6

Washington State Health Care Authority

Home Health Benefit

- Current – Home Health
  - SPA: 7. Home Health Services
  - WAC
    - 182-551-2000
    - 182-551-2125
    - 182-551-2130
    - 182-551-2220
    - 182-551-2010
    - 182-551-2100
    - 182-551-2120
- Telemedicine (WAC 182-551-2010)

  For the purposes of WAC 182-551-2000 through 182-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through: (a) and (b)
- Proposed:
  - Payment for social work with behavioral health needs

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Washington State Health Care Authority

Payment Methodology

- Payment Methodology
  - WAC 182-551-2220: (2) Payment to home health provider is: (a) A set rate per visit for each discipline provided to a client; (7) Covered home health services for clients enrolled in an agency-contracted managed care organization (MCO) are paid for by that MCO.
  - Current Billing Guide: https://www.hca.wa.gov/assets/billers-and-providers/Home-Health-Services-bi-20190701.pdf
  - Previously Proposed: HB 5828 Fiscal Note
  - Future: TBD
  - Proposed:
    - Add-on for rural or underserved areas
    - Quality Metrics

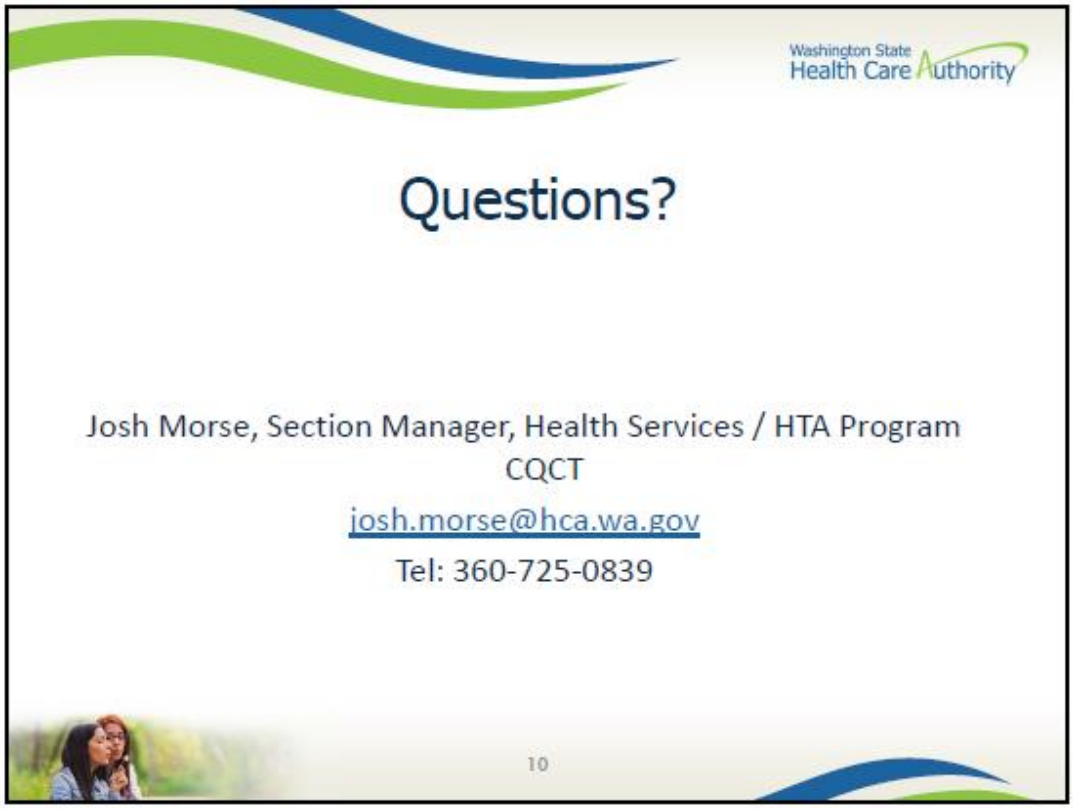
8

Washington State Health Care Authority

Homework

- Models of Payment Methodology
- Quality Metrics
- Resources
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Stage-2-NPRM.pdf
  - https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model
- Next Meeting: July 25, 2019

9



Meeting on August 7, 2019

Below are the agenda and notes from this meeting.

Agenda

Washington State Health Care Authority

Home Health Stakeholder Group

Date: Wednesday, August 7, 2019
Time: 8:30 a.m. – 3:30 p.m.
Location: Lacey Community Center
6729 Pacific Avenue SE
Olympia, WA 98503

Facilitator: Gary Hanson

Attendees: Representatives of HCA, home health provider associations, hospital associations, managed care organizations, DSHS, and DOH.

----- Agenda -----

Main Outcomes: Agreement on main points for the proviso report.

Agenda Items	Lead	Estimated Time	Time Period	Decision Making? Outcomes.
Introductions	Gary Hanson	10 minutes	8:30-8:40	N/A
Ground Rules Success Factors Scope- what are the boundaries	Gary Hanson	15 minutes	8:40-8:55	Ground Rules for meeting. Agreement on success Factors for meeting. Agreement on the scope of what is to be discussed.
Discussion of role of home health	Josh Morse/Gail Kreiger	25 minutes	8:55 – 9:20	Clarification of HCA support.
General discussion of proviso Get agreement on meaning	Josh Morse/Gail Kreiger	25 minutes	9:20-9:45	Agreement on the proviso and the general outline of what is to be reported to legislature.
Break		15 minutes	9:45 – 10:00	
Discussion on Methodologies • Value based • Medicaid style Medicare • Fee for service (existing)	Josh Morse/Gail Kreiger	45 minutes	10:00-10:45	Agreement on Methodology to use for payments.
Reimbursement for telemedicine (a) • Review current definitions	Josh Morse/Gail Kreiger	30 minutes	10:45– 11:15	Recommendations for telemedicine reimbursement.

Reimbursement for social work (b) • Is there a need for adding in another professional category for reimbursement	Josh Morse/Gail Kreiger	45 minutes	11:15-12:00	Recommendations for the addition of social workers and the reimbursement for them.
Lunch		60 minutes	12:00-1:00	
Add-on for rural/underserved area services • Discussion on the constraints • Ways to accomplish the goal	Josh Morse/Gail Kreiger	45 minutes	1:00-1:45	Recommendations for reimbursement for rural and underserved areas.
Break		15 minutes	1:45-2:00	
Quality Metrics • How to measure • How to get the data to support request	Josh Morse/Gail Kreiger	45 minutes	2:00-2:45	Recommendation for the use of measurements to support legislative requests.
Next steps	Gary Hanson	10 minutes	2:45-2:55	Plans for how to proceed.
Close	Gary Hanson	5 minutes	2:55-3:00	

Notes

Ground Rules

- Respect everyone's opinion
- Challenge ideas, not people
- Data driven
- Take non-related business outside
- Take things like they are now – current state
- Have fun

Success Factors

- improve Clinical outcomes for members
- Improve access for patients
- Reimbursement rate equals or exceeds cost
- Reimbursement rate adjusted for rural areas
- Understand roles moving forward
- Fiscal note – project out hospital savings (quantify reduced readmissions; cost differential between increased home health vs. hospital visits)
    - Previous fiscal note for SB 5828 (2019-20) discussed Medicare rates, but not Medicare methodology

- Home health agencies competing for patients
- Legislative funding
    - Legislature needs options
- Keeping patients out of the ED/hospital
- Home health agencies are fighting to get Medicaid patients
    - Example: Per Brent Korte, only about 2 percent of EvergreenHealth clients are on Medicaid
- Best providers get paid more, and worst providers get paid less

Scope

- Proviso language (need to determine whether this includes both HCA *and* DSHS Home Health programs)
- Report out on the new payment methodologies (considering "a" through "f" of the budget proviso)
- Need to include information about Medicare bundled rate (average $250) includes both professional fee and supplies/equipment
    - WA is one of 9 states participating in the Medicare value-based, bundled payment method (based on care outcomes)

Role of Home Health

- Key in delivery model
- Value partners
- Reduce hospital stays, emergency department (ED) visits, and hospital readmissions
- Strengthen role of home health
- Strong recommendation to legislature, building upon the goals in the proviso
- Potential / opportunity
- Patient satisfaction / engagement
- Keep people in their homes
- Court case indicated that home health can focus on preventing deterioration (within the constraints of Medicaid), not just improving health
- Provide services at least restrictive setting; that is why Medicaid does not use the homebound rule
- Maintenance on home health; Medicare requirement includes "homebound status"; Medicaid needs to figure out what to do about the homebound status requirement
- Interaction with discharge planners (social workers)
    - Hard to find facilities (e.g., adult family homes, assisted living facilities, skilled nursing facilities, etc.) that will take Medicaid/Medicare patients; social worker at the hospital is typically the one who identifies the appropriate level of care; reach out to the plan/agency to make those arrangements; primary care providers make their own decisions; about 60 percent of referrals come from the community; another attendee indicated about 40 percent come from the community (and 60 percent from facility)

- Provide supplies (issues)
    - Medicaid's $99 only includes professional fee; struggle to get supplies/equipment covered by Medicaid; facilities eat the cost of supplies/equipment; difficult to order the supplies also; Medicaid patients have a bag of supplies/equipment when they enter care, but difficulty getting more

---

Difference between services provided by HCA and DSHS

HCA

- Acute needs
- Release from hospital
- Receives home health benefit in lieu of going to a skilled nursing facility
- Physical therapy (PT), occupational therapy (OT), speech therapy
- Example: myocardial infarction (MI / heart attack), chronic obstructive pulmonary disease (COPD)

Once it escalates to chronic (e.g., daily or long-term but intermittent), transfers to DSHS. (Example: diabetic in rural area needing someone to administer daily insulin shots.) The budget proviso needs to consider both acute and chronic care. Need to keep HCA and DSHS policies in sync. Funding streams must stay separate.

DSHS

- Limited access in rural areas
- Need in home (daily) care and possibly lacking other support
- Reduce hospital readmissions
- Daily chronic nursing care

Definitions

Telemedicine

- Telemedicine in Home Health WAC = Telemonitoring (see WAC 182-551-2125)
- Other HCA RCW and WAC includes the definition of telemedicine (see RCW 74.09.325 and WAC 182-531-1730)
- It does not include telephone calls
- The group discussed telemedicine as telehealth and wants to include telephone calls
- Insight could be gathered from the Telemedicine Collaborative
- Telemedicine must use HIPAA compliant face-to-face systems, such as HIPAA compliant Skype
- Pat Justis at DOH can speak to the "telehealth case consultation model"
- Telehealth requires a visit, per definition
- Medicare bundle includes telemedicine visits, and HCA pays for face-to-face visits

- Kaiser found that there were barriers with the cost of equipment and technology knowledge (i.e., user error)
- Kaiser uses high-touch phone calls which are called telehealth encounters ($10)
- May need to change the RCW and WAC to include telephone for home health, as an exception to the rule

Social Workers

- Provide resources to behavioral health and mental health interventions / connections
- Help with completing DSHS eligibility forms
- Community Options Program Entry System (COPES)
- Addressing financial issues
- Care coordination
- Assessment of psycho-social issues
- Advanced care planning
- In Medicaid, social workers are not currently reimbursed as part of the home health benefit; we pay for social work as a behavioral health provider
- Independent or advanced social workers: some requirements specify that the social worker be an LICSW, but Medicare only requires MSW
- Number of social worker visits would vary by needs of patient
- Sheena Tomar (SEIU 775, representing long-term care workers)- Home Care Aides – Opportunity to incorporate into home health team
- Home care aides perform some tele-monitoring
- Colorado state leans heavily on home care aides
- HCA does not pay Home Care Aides outside of the Home Health Agency; home health aides are part of the home health benefit
- Nationally, for home health services, group health is the highest (one visit per episode; incentive to have those visits); in Yakima, use 1.6 visits (high Medicaid population)

Rural / Underserved

- How far out is rural? Reviewed page 15 of There's No Place Like Home report (DOH, January 2019): urban core, sub-urban, large rural town, small town / isolated rural
- A definition needs to be established for the legislative report that is at the sub-county level
- Also discussed cost of living based on the wage index

Home Health Utilization and Network Adequacy / Workforce Issues:

- WA is significantly below the national average for home health utilization; we don't know why we are much lower than the national average; Spokane and Southwest WA tend to be higher (closer to the national average); it does not reflect the payer's reimbursement rates; if low rates are due to insufficient workforce, then we might need to ask how many patients we turn away due to insufficient capacity; it creates a disincentive to providers to refer to home health services, which drives utilization down generally; quality of care varies significantly at different providers (e.g., Evergreen vs. University of Washington); if go into hospice at Evergreen, about 75 percent will die on hospice; however, only about 30 percent of UW patients on hospice die on hospice – they tend to die in the ICU and receive expensive procedures at end-of-life
- Network adequacy problem with providing services in rural areas; need to be careful about what we assume / assert; workforce issue; very few nurses in WA that are licensed that are not already working; need more nurses; get them from somewhere else? Worker reinvestment might begin to increase workforce after 2020
- Discussion about whether increasing reimbursement rate would overcome the workforce shortages; pull from other states? What about the lag? Divert from other healthcare fields (i.e., to be attractive to incoming nursing students); every change will take time (e.g., two years), but we shouldn't be worried about it; this is a huge problem that might be outside the scope of this work group; will provide a constraint to implementing reimbursement change (relevant to the two-year state budget)
- Home health services workforce differs significantly by agency; mixed between RNs and PTs, some have LPNs or PTAs; question about what paraprofessionals can do; while workforce is an issue, making home health services more attractive in rural areas is relevant to this work group;
- If home health is more attractive, then patients that had worse health will not need to be in the hospital, which means RNs in the hospital will have less incentive to move to home health; however, there likely is not excess capacity in the hospitals; most nurses are trained to work in acute care settings and might not move to home health

Service Cost and Payment Methodology:

Service Costs:

- Data – Cost. Reduce hospital readmissions vs providing services in rural areas (total cost of care). This is an opportunity for savings.
- Example: $300 plus per day for hospital stay vs. $99 for a home health visit. Approximately $250 Medicare rate (bundled, includes supplies).
- Burden – cost of supplies. Supplies are bundled in Medicare payment model.
- Costs are $150 plus for the home health visit. Home health agencies are starting to drop out, not providing the services due to the cost and low reimbursement rate from Medicaid.

Payment methods and considerations:

- Medicare bundled payment system with or without value-based purchasing
    - Bundled payment method groups patients and provider types (e.g., OB, hospice, etc.)
- Medicare bundled payment with value-based purchasing;
- FFS model (current model),
- Per diem (like the hospice model);
- Episodic payment (e.g., number of visits, or length of time);
- Capitated;
- Consider using episodic payment with three tiers, based on the severity of the patient's needs – similar to the results of the Continuity Assessment Record and Evaluation (CARE) tool:
    1. General population
    2. Population with fewer resources, social determinates of health
    3. Population with multiple co-morbidities, social determinates of health
- The continuum of care goes from HCA (acute) to DSHS (chronic);
- Agencies using episodic payments can manage their population however they want;
- Base rate multiplied by some risk-based or value-based or geography-based factors:
    - Do not want to dis-incentivize taking more extreme / difficult cases, those with higher risk. Avoid cherry-picking patients, but account for outliers.
- Need to consider the pros and cons of various models
- Appetite for creating something new vs. tweaking something already existing
    - HCA is expert in Medicaid, but need info about Medicare; HCA pays a consultant to pay our diagnosis-related groups (DRGs); HCA does not have that skillset; we might need consultants to help us with the methods; administrative burden of Medicare's Outcome and Assessment Information Set (OASIS) system is high; consider using a common system (OASIS) to avoid adding administrative burden; we want to know what Medicare is doing
    - OASIS is our master document; probably shouldn't move too far away from that
- Outcomes must be measureable;
- Incentivize efficiency
- How are other states managing their home health? Are others using FFS or other methods? Oregon uses FFS, based on cost, independent of Medicare reimbursement methodology;

Outcome and Assessment Information Set (OASIS) System

OASIS assesses patients' function, etc. – similar to the Minimum Data Set (MDS) for skilled nursing facilities; administered at start of care, resumption of care, discharge, etc.

- OASIS has been around since 2000; home health services has been built around OASIS and Medicare HIPPS; outcome measures are in it; examples are ER use and hospital readmissions;
- OASIS determines the HIPPS (Health Insurance Prospective Payment System) code, which translates into a dollar amount; on claim form, enter G codes and HIPPS codes; uses a separate revenue code; covers 60 days of care; on 1/1/2020, the new Patient-Driven

Groupings Model (PDGM) goes into effect, changes to 30 days of care; there are 480 HIPPS codes now, will be reduced to fewer codes (100-or something) in 2020;

- Homebound status is part of this, otherwise would not be eligible for Medicare; if a patient is not homebound, OASIS might allow us to complete the form, but acuity score might reduce the payment amount; it's similar to a diagnosis-related group (DRG);
- The clinician fills out the OASIS form, which produces the HIPPS code; and the agency's software uses that code to produce a rate; Medicare often performs adjustments; in 2020, institutions will have different HIPPS codes than for community claims; also codes and reimbursements will differ by the length of the care;
- The system has a table that gives reimbursement based on geographical area (like hospice) – wage index, to calculate the base rate; we need a list of reimbursement rates by codes; need data around the codes, by county, to model it out for a fiscal note; compare Medicare reimbursement to FFS reimbursement.

There are 29 measures in the Oasis system which includes patient satisfaction, hospital readmissions, ED use, employees getting flu vaccinations, etc. The reimbursement base changes once a year and varies by geographical area. DOH collects the HIPPS data; DOH also has claims data for Medicare, Medicare managed care, and Medicaid. The contact at DOH is Jane Hawk, who runs the Medicare program at DOH (Health Systems Oversight).

Performance Measures

- Decrease ED
- Decrease Hospital Readmissions
- Increase Timely Access
- Increase Access
- Medication Reconciliation
- Pain

What would increase the level of social work needed?

- Social determinates of health
- Mental health diagnosis
- Multiple co-morbid conditions

Methodologies – Discussion of Options

Fee for Service (FFS)	
Definition	Current State Home Health Services
Services	Skilled Nursing, OT, PT, Speech, Home Health Aid, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on.

Method to Create the Rate	Rates are paid at the service level.
Fiscal Analysis Creation	HCA created a fiscal note previously based on the Medicare Low Utilization Payment Adjustment (LUPA) rate. The fiscal note included a 3% increase to the base rate for rural areas.
Notes	Could offer a capitated FFS model with limitation extension. PF/OT/Speech were all capped at 6 units, but all subject to limitation extensions. We might want to increase the number of therapies to match the higher cap. Do we use the Medicare episodic or the LUPA rate? The LUPA rate differentiates between the specific service/professional involved. Leslie Emerick to facilitate a conference call with Marc Berg and Robin Brake about the financial analysis. LUPA rates might be too low; regular Medicare rate is higher. Perhaps there needs to be a number of visits within a certain time after discharge, and fewer periods after that time (which might be difficult for providers to manage). FFS does not have an acuity consideration. Some think that FFS is dead nationally; does not hold providers accountable; consider the rural element, that success is not the same for a DSHS patient as for a hip-replacement patient. All MCOs' reimbursement methodology is the same as the state methodology (FFS); need to check nationally; in the 9 states piloting the value-based purchasing demonstration with Medicare, need to find out what methods they use in managed care; if state changed their methodology, it would flow to the MCOs;

Medicare Bundling	
Definition	Medicare prospective payment system (including the PDGM – patient-driven groupings model – starting on 1/1/2020).
Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. 30-day payment periods for 60-day episodes. 60-day recertification.

Method to Create the Rate	Use Health Insurance Prospective Payment System (HIPPS) codes from the Outcome and Assessment Information Set (OASIS) system. Continuation of funding based on CMS annual rule.
Fiscal Analysis Creation	Use HIPPS codes. DOH receives the current Medicaid claims. HCA would need a data share agreement (DSA) with DOH to receive the data. HCA would run the model based off of the data.
Notes	Bundling offers the opportunity to provide additional services such as the telephone calls, advance care planning and the palliative care assessment (checklist/screening tool). Projected utilization based on past clients' utilization and Medicare rates; need to consider a statewide average; currently there is established information we could use; however, PDGM is coming 1/1/2020, which changes things (e.g., 30-day episodes); claims data lag over a year; Medicare assumes same level of care (at agency level) under new payment system; can roll up to the state level; CMS has total payments under the old and total (reduced) payments under the new; Marc Berg to help with this.

Medicare VBP	
Definition	Medicare bundling with reimbursement changes (increase or decrease) based on performance outcome from previous two years (i.e., baseline year vs. performance year). Varies up or down based on the previous two years.
Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. Opportunity to include services for which we could not reimburse at a line-item level: tele-monitoring (telephone calls), advanced care planning, and palliative care assessment/checklist (standardized screening tool) – in addition to Oasis; concern about adding administrative burden to agencies;
Method to Create the Rate	Receive a percent of total billable amount. This could be budget neutral with upside and downside risk. Performance measures would be based on previous two years success or lack of success.
Fiscal Analysis Creation	Based on bundle using HIPPS codes, but includes VBP component.

	Unsure whether we can use Medicare's data in the analysis; much like the Medicare bundled model, but need more information about performance; assume an unweighted average of roughly $2,347 - $4,263 per 60-day episode (i.e., in the current system – not after 1/1/2020)
Notes	Two years ago, Doris Barret (DSHS-DDA) and Leslie Emerick-Bloom met with Susan Birch; discussed decision package; Medicaid reimbursement ($99) is less than the cost to provide the service ($150); home health agencies are dropping out; determined that we will not look at rate increases, because there is plenty of money in the system to use value-based purchasing. Value-based method should consider both improvement and stabilization; not necessarily mirroring the OASIS form, create a set of metrics that makes sense for the Medicaid population; need to consider outliers carefully; regarding tele-monitoring, population receiving home health services do not have the technology, so it will be expensive to implement. Medicare value-based purchasing baseline year in 2016; reset every 4 years; providers need to meet benchmarks or show percentage improvement; graded on a curve; if all providers improve, it becomes harder to excel; about 9 measures, weighted by importance. Correlation between home health visits occurring vs. outcomes; some visits do not produce outcomes, so would not be cost-effective; maybe have fewer, more effective visits, but pay more for them. Would need to lead to improved outcomes and improved access. Would the measure be improvement or maintaining the level? How could you incentivize access? Maybe give points for rural clients? Would there be an opt-out option (example: rural or smaller providers without the resources)? If so, how would this work? Are all considered equal or would there be adjustment for rural or higher risk populations? Case mix adjustment for agency or type of patient. VBP takes lots of effort to perform well, and the reward is not realized by most; could be budget neutral across state by grading on the curve (top 25 percent gets money from other providers) – unless everyone improves, and the state has to pay everyone; begin with a positive payment incentive, and then gradually incorporate negative incentives (payment reductions); need to be careful that providers do not cherry-pick clients to improve their performance; discussed the possibility of giving certain providers certain measures, based on

	what is attainable; perhaps rural providers could opt in/out might work for some; would need to determine which providers would be required to participate (e.g., some serve both urban and rural areas); how many rural agencies are there? How do we incentivize access? Perhaps set a threshold – percent of clients served on their caseloads; try to increase actual numbers of Medicaid clients served; need to case-mix adjust for each agency or type of agency, based on what kind of patients they serve (e.g., orthopedic differs from cancer); HIPPS codes consider this, and will be more case-mix adjusted (by diagnosis codes instead of discharge codes) in 2020; decrease ER use; decrease readmissions; increase timeliness; increase access; incentivize percentage of panel of admissions be Medicaid; medication reconciliation and pain; also consider payment model adjustment that considers mental health diagnosis and comorbid diagnoses; need to consider how to treat rural providers differently; don't want to penalize rural provides (i.e., too rural to fail).

Per Diem	
Definition	Per day rate (like the hospice model; Medicare bundling by 60 days; everything else is the same; volume helps agencies manage their bottom lines) – not per visit
Services	Skilled Nursing, OT, PT, Speech, Home Health Aide, Supplies, Telehealth. Include the services to fill in the gap: Telemedicine, social worker, and rural add-on. Opportunity to include services for which we could not reimburse at a line-item level: tele-monitoring (telephone calls), advanced care planning, and palliative care assessment/checklist (standardized screening tool) – in addition to Oasis; concern about adding administrative burden to agencies;
Method to Create the Rate	Distribute the total amount for the episode to pay more at the first part of the episode and less at the end of the episode, because few patients are on the caseload for the whole time; hospice calls it a "service intensity add-on"; hospice has a failsafe (patients die or graduate to other services); what is the average length of treatment for the patients; how to operationalize (actuarially complicated); what is the base rate ($3,000 as an example);
Fiscal Analysis Creation	Use the same method as for Medicare bundled payment (i.e., develop model from $3,000 base and average length of treatment. The

	Medicare average payment per episode is $2,347-$4,263.); need to look at our Medicaid claims/encounter data to determine what proportion of clients experience worse health after their home health services end – tie the data together; will involve an actuarial analysis and forecasting data;
Notes	Would beginning days or initial episode be reimbursed at a higher rate than the subsequent days or subsequent episodes? How would this be operationalized? In hospice this is called a service intensity add-on. Consider how the per diem rate would change if the patient went from acute to chronic care. More services could also be provided in the first 1-2 weeks in order to avoid ED/hospital readmissions (danger zone); consider reconciling three times per week.

Next Steps and Action Items:

- In the next meeting, we need to focus on what we need to do for the fiscal analysis / note; get access to the data we need to perform the analysis; determine how to incorporate DSHS data in the model
- Leslie Emerick to facilitate a conference call with Marc Berg and Robin Brake about the financial analysis (i.e., LUPA vs regular Medicare rates)
- Marc Berg to help with Medicare bundling fiscal analysis
- MCOs to check with their national organizations about home health reimbursement for Medicaid managed care (i.e., FFS or other) – especially in the 9 states piloting the value-based purchasing demonstration with Medicare

Meeting on August 27, 2019

Below are the agenda, payment model recommendations from the Home Care Association of Washington, and notes from this meeting.

Agenda

Washington State Health Care Authority

Home Health Stakeholder Group

Date: Tuesday, August 27, 2019
Time: 9:00 – 11:00 a.m.
Location: Azalea 326
Cherry Street Plaza
Health Care Authority
626 8th Avenue
Olympia, WA 98501
Skype: 360-407-3811 Pin: 319039

Facilitator: Gary Hanson

Attendees: Representatives of HCA, home health provider associations, hospital associations, managed care organizations, DSHS, and DOH.

----- Agenda -----

Main Outcomes: Agreement on main points for the proviso report.

Agenda Items	Lead	Estimated Time	Time Period	Decision Making? Outcomes.
Introductions	Gary Hanson	5 minutes	9:00 – 9:05	N/A
Discuss Four Methodologies from Previous Meeting / Assign Data/Reimbursement Team for Analysis • FFS • Medicare Bundling • Medicare VBP • Per Diem	Josh Morse/Gail Kreiger	40 minutes	9:05 – 9:45	Discuss the four options discussed at the previous meeting. Assign data/reimbursement team for analysis. Obtain agreement on Methodology to use for payments.
Determine Agenda for September 4 meeting • Homework?	Gary Hanson	10 minutes	9:45 – 9:55	
Next steps	Gary Hanson	10 minutes	9:55 – 10:05	Plans for how to proceed.
Close	Gary Hanson	5 minutes	10:05 – 10:10	

Payment Model Recommendations from the Home Care Association of Washington

HCAW Payment Model Recommendations (DRAFT 08-27-19)

Fee For Service (FFS) + Incentive

- Includes all traditional services (Nursing, PT, OT, SLP, HHA, MSW)
- Includes option for remote patient monitoring (daily scripted phone calls based on diagnoses) with option for telehealth if provider chooses.
- Per visit payment amount varies based on discipline. Per phone call reimbursement would be included.
- Care provided is based on physician orders and practice standards (MCG) as a guide.
- Outcome measures: (per OASIS answers)
  - Decreased hospital utilization (need baseline information)
  - Decreased ER use (need baseline information)
  - Medication reconciliation
  - Timeliness of care (current Medicare requirement is within 48 hrs of discharge/referral or MD ordered care.)
  - Increased access
  - Determine methodology for incentive payment

Prospective Payment System (PPS) + incentive (value based)

- Includes all traditional services (Nursing, PT, OT, SLP, HHA, MSW)
- Includes option for remote patient monitoring (daily scripted phone calls based on diagnoses) based on diagnosis with an option for telehealth if provider chooses.
- Care provided is based on physician orders and practice standards (MCG) as a guide.
- Prospective payment for designated episode of care (60 day episode)
- PPS amount is generated from completed OASIS assessments that creates a home health resource group (HHRG) and subsequent HIPPS code. The HIPPS code generates the payment amount. The PPS system should mirror the most current Medicare episodic payment model (PDGM).
- Outcome measures:
  - Same as noted above
    - Determine how to access outcome data for Medicaid or use CASPER reports as proxy.
    - Determine methodology for incentive pay.

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Notes

Agenda Items	Lead	Notes
Introductions	Gary Hanson	
Discuss Four Methodologies from Previous Meeting / Assign Data/Reimbursement Team for Analysis • FFS • Medicare Bundling • Medicare VBP • Per Diem	Josh Morse/Gail Kreiger	**FFS** • Add community health workers to FFS as services to close the gap; it would be difficult to have FFS reimburse for this • Chronic care management home health via DSHS, using community health workers (CHW)? Category of worker is fairly broad; would include individual provider, CNAs, etc. Defer to Laura about this; different kind of training/scope, etc.; not licensed or registered in any way; broaden it as community health workers or other folks; don't narrow to a specific worker; ensure scope is appropriate to need; referring HCBS (home and community-based services; non-skilled care)? Totally separate from home health; looking for an individual who would watch over the person's social health and physical health? Current FFS program, gap is hands-on, community health worker, to address social determinants of care; should be linked to home health model; request is more of a case manager that would fall to the MSW type visit but would look to the client's overall care; sounds like there is a gap in the overall member's care; health connections gap addressing social determinants of care; saw 40% reduction of hospital use as a result; service worked best when coordinated with a home health service; not a social worker level individual, but a community coordinator (coordinated with home health agency), home health agency would be on point for home health services; • Distinction between the acute and chronic models; however, community health worker is necessary for both; HCBS services come from a separate funding stream; bring the two services together might be important and create another safety net; higher level care does not miss the lower-level care; • What are the barriers to MCOs trying different payment methodologies; MCOs follow the state methods; MCOs must cover what is in the State Plan; what we are talking about is not in the SP; cannot cover HCBS; HCA could add this to the SP (refer to memo back in 2014); reached out to lots of entities about this, but nobody responded; process we would need to follow; if it's not in the SP, then we can't expect MCOs to do this

Agenda Items	Lead	Notes
		• FFS plus incentives – (Donna and Randy): incentives / value-based payment; include the 5 services in Medicare; include tele[health/medicine/monitoring] option; outcome measures based on OASIS; Kaiser Permanente in Oregon doing this now; covers all the disciplines we've identified; in discussions with Kaiser about outcome metrics; incentive piece = identify outcome measures, three-year review of measures, average, bonus payments; similar with CMS with 2-3% increase reimbursement; increase reimbursement with agencies that perform well, and decrease for agencies that do not perform well; upside and downside risk from the start; risk-reward on both ends; take back ; use the Medicare episodic rate as the base rate; this is too small, needs to be 250% more; Marc Berg to work with HCA analysts to calculate the rates, which would be higher than Medicare rates; • Incentive to the whole agency, or by discipline? Per visit rate, per episode rate, etc.? traditional visit rates based on Medicare; how to sort out PT's; average PT visit is $260; need to be more than that; Medicare per-visit rate is too low; current rate plus 150% might be an option; • Options are either (1) increase Medicare by 150%; or (2) or look at episodic rate $300 per day, and turn that into FFS; include wage index adjustment (for cost of living) and rural adjustment (for access issues) **Medicare Bundling Prospective Payment System** • Two options – regular bundling and value-based purchasing; not sure Medicare bundling is the right term; could get confused with bundled payment care improvement model; it is a prospective payment model that could be value-based; include the traditional services, option for telemonitoring; prospective payment could be designated for 60-day episodes (January 1, 2020); GPS amount would be based on HIPPS codes; still use outcome measures; need to figure out whether it's possible to pull out data from OASIS for Medicaid patients only, otherwise would not work; need to get the OASIS data; working on this now; could model this if we had the patient-level claims detail; PPS model with or without VBP needs patient-level claims detail data for the analysis; DSHS tracks utilization of services; HCA has encounter and claims data, but do not have the capacity to analyze this; how to apply the PPS

Agenda Items	Lead	Notes
		model on Medicaid data; recommend to the Legislature that we get the resources to do this; we don't have the resources to do that quickly; wondering whether care data in DSHS has some of that information, but do not have all elements; without those elements, not possible to compare Medicare PPS model vs Medicaid model; Legislature would want to know how they compare; pros and cons of different payment methodologies; prospective based on anticipated health of the client or increase FFS rates; difficult to do this analysis in time; if this was a fiscal note, would likely over-estimate the costs and note significant limitations; need to come up to an average per client cost; providers are asking for value, because they don't think it will go through without it; X% up or down; likely double number of clients (increased access); if mandated providers to self-report metrics, would not need to run through the HCA's financial model; Kaiser Permanente self-reports; decide whether to audit periodically; value-based piece could be put onto • Zosia at hospital association – do all home health agencies have EHR? Maybe some have paper, but all aggregated into EHR; some challenges in rural areas having robust those records; opportunity to increase access and save some money, but probably only for a portion of patients in hospital into home health; not a panacea, but a good step; consider VBP in any model; first step is taking a step; remain open to how VBP will change over time; it will be very difficult to analyze this in time for the legislative report; HCA is using VBP; how would this proposal fall under Healthier Washington? Suzanne to provide info to Leslie about background; when transforming delivery system, unique opportunity to make a difference; if bundling, maintain partnerships between clinics and agencies, so move the outcome measures and save money as a result; accountable communities of health have opportunities; it might be simpler to do in some sectors based on claims/encounter data works; VBP is not required for home health services by 2020, it's required for other services; WA has been doing this since 2016 (only one of 9 states doing this); we assume that we'll do this in WA; • Another idea: simple matrix (timeliness of care, readmission, functional progress, patient satisfaction); if we self-report them, and below a certain threshold, then cannot participate; access issues; outcomes

Agenda Items	Lead	Notes
		measures are scary, but trying to do what is necessary for clients; goal of VBP is to measure and talk about success we're having; making them explicit in what they are doing already **Per Diem** • (Gary read definition); volume helps agencies to manage their bottom lines; Donna Goodman – recommend that we do not consider this model; no structure for this under current Medicare payment methodology; no data to support a per diem rate; no math behind it, like there is for other models; recommendation is to strike it from consideration, looked at it and explained that it was not an appropriate model; take off the table, because nothing existing for home health; could this not be a simpler landing point between FFS and VBP – figure out a number for an episode; a bridge too far, in a way; recreating a wheel; PPS model divided by number of days in an episode; not fundamentally different from a PPS model; • Disincentive to plans from taking on clients who need longer-term care; we don't want to do that; would reduce access, and would not work regarding the front-loading issues; • How to make this administratively simple without having to go into a lot of data modeling; no foundation to build on; someone will want an analysis; while it's simple, not a lot to build on, and reinventing the wheel; start simple, but get complex, because people will want answers; take per diem off the table for now? • PPS model is specific and episodic, requiring OASIS data; per diem rate • Average episode for Medicare, about $3,200 or something? Questionable dollar figure; some of Medicaid need a lot of services; bundling is a step toward adding value, but if we start simple, the question is how to tie value to those days; • In chronic situations, how would the model fit for long-term situations; greater need is on the chronic situations; bundling would need to vary by population • Leslie reminded that we still have bill alive on the Senate side that could pass next session; this group could produce a legislative report with different recommendations; treat us like a focus group;

Agenda Items	Lead	Notes
		• Hospice is the ultimate model, and we need some data under our feet to get it right; • Narrowing it down to two; FFS and PPS with incentives to both; value needs to be in any model we consider; FFS was created a long time ago; • Need to determine the measures, and how do we measure that if we go with FFS vs. PPS; question about the ability to have differential payments; pay providers differently for the same service; Kaiser does this; MCOs have a hold-back to the provider and pay out based on evaluation of metrics later; MCOs are not using this for home health; easier for hospitals and clinics; using measures in the common measure set; Molina could do this; United could do this, using the current FFS model; most of the codes are per visit codes (per diem?); • Robin Brake not sure how to implement VBP in FFS; need to discuss with rates folks and ProviderOne folks about this; • MCOs don't have a lot of flexibility; administrative day rate ($299 per day right now) is not cheaper than using home health; Discussion of admin day rate and home health utilization; (goal of managed care (home health?) is to get the client out of the hospital; no guiding principle that indicates that an administrative day is cheaper; how difficult is it for MCOs to find home health agencies to take Medicaid patients? It varies by area in the state; some providers are not willing to accept Medicaid patients, but MCOs can work that out more; hospital association can speak with Leslie about the admin day rate; • Sometimes home health agencies say they'll take the case, but they never come; hospitals end up having to keep the patient, because home health do not show up to take them away; discharge planning struggles; home health utilization declined over the last two years, related to the rate decrease; two of the larger providers in the state are saying that Medicaid patients are taken less frequently; providers can no longer sustain treating Medicaid patients
Determine Agenda for September 4 meeting • Homework?	Gary Hanson	• Bring as much data to the table as we can; Marc to help identify what we can gather; identify the data sources; need to put together a draft; • Need to include a reference in the report about what we need to do in the future; • Not sure how to pull DSHS into either model; need to think about whether to keep DSHS piece separate;

Agenda Items	Lead	Notes
		• Legislature will use this report to inform the budget discussion related to the bill in the Senate • Robin Brake will have some time to discuss financial • Regarding potential cost offsets (i.e. saving money on hospital costs by increasing home health services) is something that we cannot comment on without involving budget folks • In an underfunded system, where hospitals are not getting enough, reducing hospital admissions and increasing home health admissions might not work for all
Next steps	Gary Hanson	• Leslie and Robin (and others) to discuss analysis • HCA to develop draft agenda; group to provide feedback by end of this week (8/30)
Close	Gary Hanson	

Meeting on September 4, 2019

Below are the following from this meeting:

- Agenda;
- Financial information that the work group reviewed from a draft financial model in Excel;
- A comparison between the Home Care Association of Washington's proposed payment models;
- A document explaining the cost savings from a partnership between Community Home Health and Hospice and Kaiser Permanente;
- A preliminary outline of the legislative report; and
- Notes from this meeting.

Earlier meeting materials were also available to the work group during this meeting.

Agenda

Washington State Health Care Authority

Home Health Stakeholder Group

Date: Wednesday, September 4, 2019
Time: 1:30 – 4:30 p.m.
Location:
Lacey Community Center
6729 Pacific Avenue SE
Olympia, WA 98503
Skype: 360-407-3811 Pin: 319039

Facilitator: Gary Hanson

Attendees: Representatives of HCA, home health provider associations, hospital associations, managed care organizations, DSHS, and DOH.

----- Agenda -----

Main Outcomes: Agreement on main points for the proviso report.

Agenda Items	Lead	Estimated Time	Time Period	Decision Making? Outcomes.
Introductions	Gary Hanson	5 minutes	1:30 – 1:35	N/A
Discuss Methodologies • FFS Model Discuss VBP / Incentive Component	Josh Morse/Gail Kreiger	60 minutes	1:35 – 2:35	Discuss the FFS option as outlined in the last meeting, pros and cons and the payment methodology. Discuss the VBP/ Incentive component and how that would be incorporated.
Discuss Methodologies • PPS Model Discuss VBP / Incentive Component	Josh Morse/Gail Kreiger	60 minutes	2:35 – 3:35	Discuss the PPS option as outlined in the last meeting, pros and cons and the payment methodology. Discuss the VBP/ Incentive component and how that would be incorporated.
Break		10 minutes	3:35 – 3:45	
HCA / DSHS Continuum	Doris / Gail	15 minutes	3:45 – 4:00	Discuss the continuum from HCA (Acute) to DSHS (Chronic).
Report Scope	Dean Runolfson	15 minutes	4:00 – 4:15	Discuss the scope of the legislative report.
Next steps	Gary Hanson	10 minutes	4:15 – 4:25	Discuss how to proceed.
Close	Gary Hanson	5 minutes	4:25 – 4:30	

Financial Information from a Draft Financial Model

HCA Calculation Using Non Wage Indexed Adjusted LUPA Rates

Service	Current Units/Visit	Approx # of Visits	Current Rate/Visit	New Rate/Visit	Difference	Base Amount	Rural Add-On	Total Impact
Physical Therapy	3.26	16,220	$ 73.76	160.14	$ 86.38	$ 1,401,004	$ 4,826	$ 1,405,830
Occupational Therapy	3.35	7,159	$ 75.80	161.24	$ 85.44	$ 611,669	$ 2,107	$ 613,775
Speech Therapy	1	2,212	$ 97.19	174.06	$ 76.87	$ 170,036	$ 586	$ 170,622
Skilled Nursing	1	102,471	$ 97.43	146.5	$ 49.07	$ 5,028,252	$ 17,319	$ 5,045,571
Home Health Aide	1	1,164	$ 55.32	66.34	$ 11.02	$ 12,827	$ 44	$ 12,871
Brief Skilled Nursing	1	56	$ 29.58	44.48	$ 14.90	$ 834	$ 3	$ 837
Social Work	N/A	15,382	N/A	234.82	$ 234.82	$ 3,612,095	$ 12,442	$ 3,624,537
Telemedicine	N/A	5,768	N/A		$ 24.63	$ 142,076	N/A	$ 142,076
					TOTAL	$ 10,978,794	$ 37,326	$ 11,016,120

	SFY2020	SFY2021	SFY2022	SFY2023	SFY2024	SFY2025
General Fund - State	$2,669,176	$5,401,414	$5,401,414	$5,401,414	$5,401,414	$5,401,414
General Fund - Federal	$2,838,884	$5,614,706	$5,614,706	$5,614,706	$5,614,706	$5,614,706
Total Cost	$5,508,060	$11,016,120	$11,016,120	$11,016,120	$11,016,120	$11,016,120

HCAW Calculation Using 2018 Medicare PPS Rates (See tab PPS Visit Rates for Calculations)

Service	Current Units/Visit	Approx # of Visits	Current Rate/Visit	New Rate/Visit	Difference	Base Amount	Rural Add-On	Total Impact
Physical Therapy	3.26	16,220	$ 73.76	226.61	$ 152.85	$ 2,479,148	$ 4,826	$ 2,483,973
Occupational Therapy	3.35	7,159	$ 75.80	228.44	$ 152.64	$ 1,092,753	$ 2,107	$ 1,094,860
Speech Therapy	1	2,212	$ 97.19	246.61	$ 149.42	$ 330,517	$ 586	$ 331,103
Skilled Nursing	1	102,471	$ 97.43	207.56	$ 110.13	$ 11,285,131	$ 17,319	$ 11,302,451
Home Health Aide	1	1,164	$ 55.32	93.99	$ 38.67	$ 45,012	$ 44	$ 45,056
Brief Skilled Nursing	1	56	$ 29.58	44.48	$ 14.90	$ 834	$ 3	$ 837
Social Work	N/A	15,382	N/A	332.70	$ 332.70	$ 5,117,724	$ 12,442	$ 5,130,166
Telemedicine	N/A	5,768	N/A		$ 24.63	$ 142,076	N/A	$ 142,076
					TOTAL	$ 20,493,196	$ 37,326	$ 20,530,522

	SFY2020	SFY2021	SFY2022	SFY2023	SFY2024	SFY2025
General Fund - State	$4,974,443	$10,066,526	$10,066,526	$10,066,526	$10,066,526	$10,066,526
General Fund - Federal	$5,290,818	$10,463,997	$10,463,997	$10,463,997	$10,463,997	$10,463,997
Total Cost	$10,265,261	$20,530,522	$20,530,522	$20,530,522	$20,530,522	$20,530,522

2017 Average Medicare Payment Rate per Visit by Discipline

	2017 Base Medicare LUPA Rates	2017 Total Visits by Discipline	2017 Payments Calculated at LUPA Rates	2017 Payments Calculated at Full PPS Rates	2017 Average WA Payment Rate	% Variance from Base LUPA Rates
Skilled Nursing Intervention/Skilled, High-Risk Obstetrical Nursing(Rever	$ 141.84	406,593	$ 57,671,151	$ 85,166,535	209.46	48%
Brief Skilled Nursing Visit (Revenue Code 0580)			$ -	$ -		
Physical Therapy (Revenue Code 0421/ HCPCS G0151)	$ 155.05	466,322	$ 72,303,226	$ 106,774,620	228.97	48%
Speech Therapy(Revenue Code 0441/CPT Code 92507)	$ 168.52	129,296	$ 21,788,962	$ 32,177,100	248.86	48%
Occupational Therapy(Revenue Code 0431/HCPCS G0152)	$ 156.11	70,080	$ 10,940,189	$ 16,156,049	230.54	48%
Medical Social Worker	$ 227.36	17,713	$ 4,027,228	$ 5,947,255	335.76	48%
Home Health Aid(Revenue Code 0571)	$ 64.23	63,531	$ 4,080,596	$ 6,026,067	94.85	48%
Total		1,153,535	$ 170,811,352	$ 252,247,626		

2018 Average Medicare Payment Rate per Visit by Discipline

	2018 Base Medicare LUPA Rates	2018 Total Visits by Discipline	2018 Payments Calculated at LUPA Rates	2018 Payments Calculated at Full PPS Rates	2018 Average WA Payment Rate	% Variance from Base LUPA Rates
Skilled Nursing Intervention/Skilled, High-Risk Obstetrical Nursing(Rever	$ 143.40	408,390	$ 58,563,126	$ 84,763,447	207.56	45%
Brief Skilled Nursing Visit (Revenue Code 0580)			$ -	$ -		
Physical Therapy (Revenue Code 0421/ HCPCS G0151)	$ 156.76	484,357	$ 75,927,803	$ 109,896,837	226.89	45%
Speech Therapy(Revenue Code 0441/CPT Code 92507)	$ 170.38	41,031	$ 6,990,862	$ 10,118,475	246.61	45%
Occupational Therapy(Revenue Code 0431/HCPCS G0152)	$ 157.83	180,480	$ 28,485,158	$ 41,229,019	228.44	45%
Medical Social Worker	$ 229.86	20,114	$ 4,623,404	$ 6,691,850	332.70	45%
Home Health Aid(Revenue Code 0571)	$ 64.94	64,782	$ 4,206,943	$ 6,089,070	93.99	45%
Total		1,199,154	$ 178,797,297	$ 258,788,699		

Washington Home Health Agencies Medicare Payment Data

	2017 WA HHA Payment Data	2018 WA HHA Payment Data	% Variance 2018/2017
Total Visits RN	406,593	408,390	0.44%
Total Visits PT	322,107	330,997	2.76%
Total Visits OT	129,296	142,997	10.60%
Total Visits ST	37,830	41,031	8.46%
Total Visits MSW	17,713	20,114	13.56%
Total Visits HH Aide	63,531	64,782	1.97%
Total Visits PT Aide	144,215	153,360	6.34%
Total Visits OT Aide	32,250	37,483	16.23%
Total Visits	**1,153,535**	**1,199,154**	**3.95%**
Total Payments	**$ 252,247,626**	**$ 258,788,699**	**2.59%**
Total Episodes	74,915	74,981	0.09%
Average Payment per Episode	**3,367**	**3,451**	**2.50%**
Total Admissions	56,932	56,533	-0.70%
Average Payment per Admission	**4,431**	**4,578**	**3.32%**
Total Visits	1,153,535	1,199,154	3.95%
Average Payment per Admission	**218.67**	**215.81**	**-1.31%**

Comparison between the Home Care Association of Washington's Proposed Payment Models

Comparing Home Care Association of Washington's Proposed Payment Models

Fee For Service (FFS) + Incentive	Prospective Payment System (PPS) + incentive (value based)
Includes all traditional services (Nursing, PT, OT, SLP, HHA, MSW).	(Same)
Includes option for remote patient monitoring (daily scripted phone calls based on diagnoses) with option for telehealth if provider chooses.	Includes option for remote patient monitoring (daily scripted phone calls based on diagnoses) based on diagnosis with an option for telehealth if provider chooses.
Per visit payment amount varies based on discipline. Per phone call reimbursement would be included.	(N/A)
Care provided is based on physician orders and practice standards (MCG) as a guide.	(Same)
(N/A)	Prospective payment for designated episode of care (60 day episode).
(N/A)	PPS amount is generated from completed OASIS assessments that creates a home health resource group (HHRG) and subsequent HIPPS code. The HIPPS code generates the payment amount. The PPS system should mirror the most current Medicare episodic payment model (PDGM).
Outcome measures (per OASIS answers): • Decreased hospital utilization (need baseline information) • Decreased ER use (need baseline information) • Medication reconciliation • Timeliness of care (current Medicare requirement is within 48 hours of discharge/referral or MD ordered care.) • Increased access	(Same)
Determine methodology for incentive payment.	(Same)
(N/A)	Determine how to access outcome data for Medicaid or use CASPER reports as proxy.

Community Home Health and Hospice / Kaiser Permanente Partnership

9-4-19 Community Home Health & Hospice
Submitted by Randy Dalton

Community Home Health and Hospice/Kaiser Permanente Partnership

CHHH arranged a partnership with Kaiser to decrease un-necessary Acute Care Hospitalizations (ACH) while improving care outcomes to their members. The contractual arrangement was for CHHH to provide Home Health Services to their member's in Cowlitz and Clark Counties. CHHH would be paid a per visit rate for all Disciplinary services provided (RN,PT,OT,SLP,MSW and HHA) and would be reimbursed for each Telehealth encounter provided to these patients. At the time of the arrangement the previous 12 month ACH percentage for Kaiser Members serviced by CHHH was 13.7%. CHHH has been successful in reducing the ACH percentage for Kaiser Members to 8.4%. CHH provided 1,232 episodes of care to Kaiser Members over the last 12 months.

To quantify the savings to Kaiser of ACH reduction, the American Hospital Directory* estimated in 2018 that the average cost of a hospitalization was $10,000. Becker's Hospital Review** estimated the cost of a Hospitalization in Washington State was $13,813.80.

Total Cost of Care Pre Telehealth:
744 Episodes
11.1 avg visits per episode x rate=
$1,569,096 Home Health cost
$2,109.00 cost per episode

102 (13.7%) ACH x $10,000*/$13,813**
= $1,020,000* / $1,410,066**

Total cost for Home Health patients=
$2,589,096*

Total Cost per episode=
$3,479.96*

Total Cost of Care with telehealth:
1,232 Episodes
9.6 avg visits per episode x rate=$2,365,440
19 avg Telehealth encounters per episode=
$257,488
$2,622,928 Total Home Health cost
$2,129.00 cost per episode

103 (8.4%) ACH x $10,000* /$13,813**
= $1,030,000* / $1,422,739**

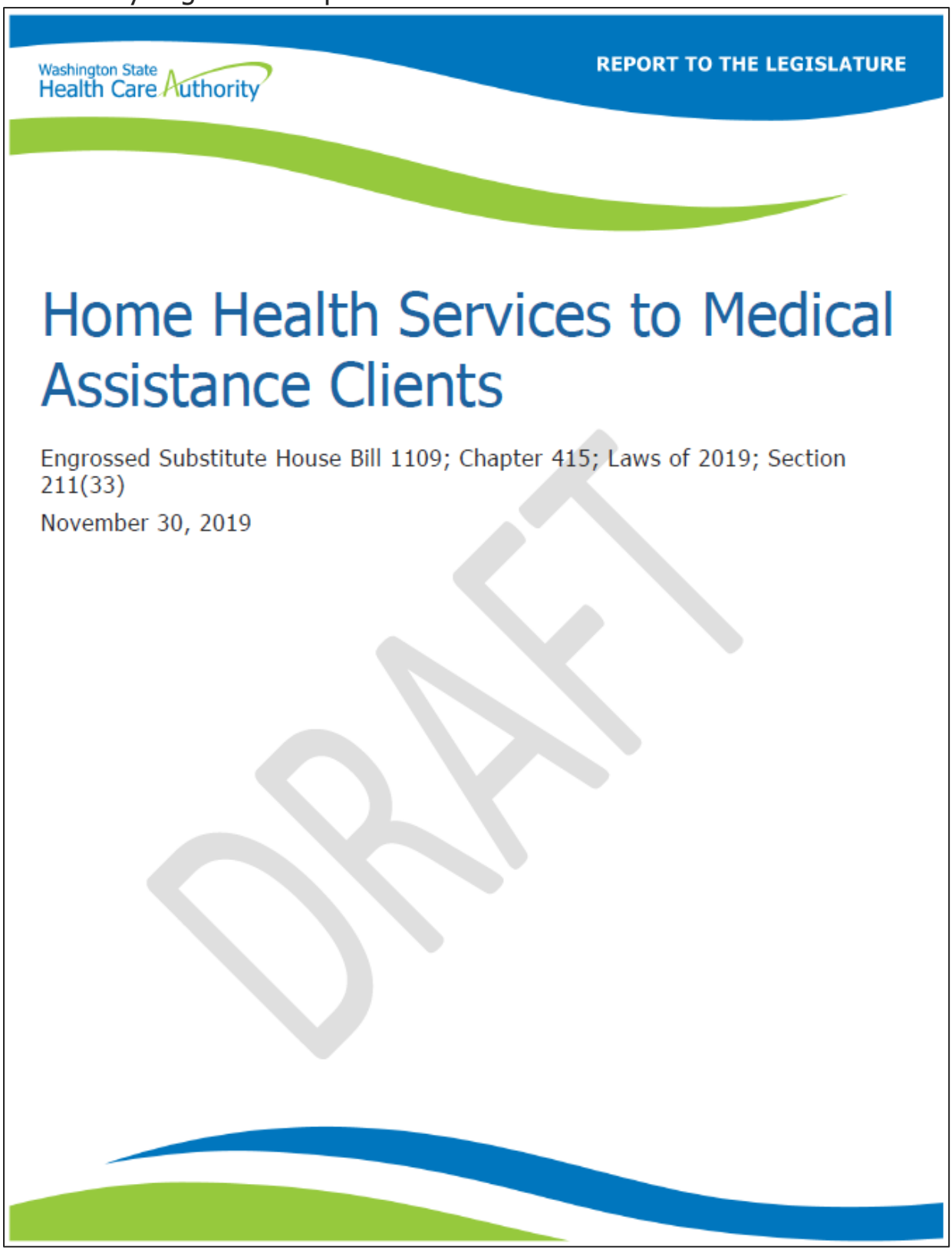
Total cost for Home Health patients=
$3,652,928*

Total cost per episode=
$2,965.03*

15% savings per episode

Savings due to 65 deferred ACH= $650,000*-$897,845**

Preliminary Legislative Report Outline



Home Health Services to Medical Assistance Clients

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Table of Contents

Executive Summary

[Draft later]

Background

[Draft introduction to the subject; describe the current Medicaid payment method for home health services; consider including relevant RCWs and WACs as appendices or referencing them as footnotes; consider referencing the Department of Health's Washington Rural Palliative Care Initiative titled "There's No Place Like Home: Rural Home Health and Hospice Care in Washington State, A Discussion of Challenges and Solutions" articulates the need for additional add-on services in rural or underserved areas]

Legislative Action

[Introduce Senate Bill 5828 (2019) and explain its relevance to the budget proviso]

Engrossed Substitute House Bill 1109 (2019), section 211(33) states:

> The authority shall facilitate a home health work group consisting of home health provider associations, hospital associations, managed care organizations, the department of social and health services, and the department of health to develop a new medicaid payment methodology for home health services. The authority must submit a report with final recommendations and a proposed implementation timeline to the appropriate committees of the legislature by November 30, 2019. The work group must consider the following when developing the new payment methodology:
>
> (a) Reimbursement for telemedicine;
> (b) Reimbursement for social work for clients with behavioral health needs;
> (c) An additional add-on for services in rural or underserved areas;
> (d) Quality metrics for home health providers serving medical assistance clients including reducing hospital readmission;
> (e) The role of home health in caring for individuals with complex, physical, and behavioral health needs who are able to receive care in their own home, but are unable to be discharged from hospital settings; and
> (f) Partnerships between home health and other community resources that enable individuals to be served in a cost-effective setting that also meets the individual's needs and preferences.

Report Overview

[Outline report and explain how we satisfy the legislative reporting requirements]

Home Health Work Group

[Summarize the sections below]

Work Group Membership and Process

[Include a list of organizations that participated in one or more work group meetings; ensure that we identify the following organizations to demonstrate compliance with the budget proviso: home health provider associations, hospital associations, managed care organizations, the department of social and health services, and the department of health; include more detailed work group membership information (names, titles, etc.) Appendix A; list the meetings the work group held, but include agendas and notes from those meetings in Appendix B; describe at a high level the process by which the work group produced its recommendations – transition to the next subsections]

Interpretation of Legislative Language

[Explain the work group's interpretation of the requirements (e.g., telemedicine means tele-monitoring) for the purposes of this legislative report]

Role of Home Health Services

[Discuss the work group's conclusion about the role of home health in caring for individuals with complex, physical, and behavioral health needs who are able to receive care in their own home, but are unable to be discharged from hospital settings; also discuss partnerships between home health and other community resources that enable individuals to be served in a cost-effective setting that also meets the individual's needs and preferences.]

Payment Method Considerations

[Summarize the subsections below]

Services Eligible for Reimbursement

[Discuss current services (nursing, physical therapy, occupational therapy, speech language pathology, home health aide); discuss adding telemedicine/tele-monitoring and social work for clients with behavioral health needs, etc.; discuss how each payment method could or could not reimburse for those services]

Units to Reimburse

[Discuss reimbursing for individual services (fee-for-service), days visited (per diem), and grouping/bundling services (prospective payment system)]

Fee-for-Service

[Define and discuss]

Per Diem
[Define and discuss]

Medicare Bundling
[Define and discuss]

Medicare Value Based Purchasing
[Define and discuss]

[QUESTION: Are we subsuming Medicare Bundling and Medicare Value Based Purchasing under "Prospective Payment System" in the report?**]**

Reimbursement Rates and Enhancements
[Discuss rates for specific services and whether/how they would vary by client characteristics; discuss an additional add-on for services in rural or underserved areas; quality metrics for home health providers serving medical assistance clients including reducing hospital readmission / value based purchasing]

Payment Method Evaluation

[Describe the work group's criteria for evaluating the payment method options; and how the work group came to its recommendation; if some of the criteria includes the financial impact and the work necessary to implement, include that here]

Recommendation and Implementation Timeline

[Summarize the subsections below]

Payment Model Recommendation

[Describe the payment model the work group recommends; include high-level financial information]

Timeline for Implementation

[Describe the next steps and timing for implementing the work group's recommended payment model]

Conclusion

[Summarize the main points of the report; refer to next steps]

Appendix A: Home Health Work Group Roster

[Include a table that identifies the work group members: names, titles, organizations, and organization type]

Appendix B: Home Health Work Group Meetings

[Include agendas and notes (more polished) for each home health work group meeting]

Home Health Services to Medical Assistance Clients
November 30, 2019

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Notes

Agenda Items	Lead	Notes
Introductions	Gary Hanson	
Discuss Methodologies • FFS Model Discuss VBP / Incentive Component	Josh Morse / Gail Kreiger	**HCA Fiscal Analysis with Home Care Association of Washington (HCAW) Additions:** • Reviewed the Excel file printouts; discussed utilization rates (specifically for social workers and telemedicine) and population of home health clients (4,807 enrolled in Medicaid during state fiscal year 2018). ***Social Workers*** • Nationally, about 1 in 3 home health (HH) clients received a social worker visit; about 20 percent are dual-eligible; Medicare clients are not included in HCA's HH client count, because HCA does not pay for them. • Discussed paying more for the first few social work visit and less for subsequent visits, and a different way of billing within the FFS option. • Hybrid model between the two models; use diagnosis codes to determine payment rate? • Need to adjust the social worker utilization rate down; Robin Brake's model assumed 80 percent of the clients get 4 visits; 20 percent do not get any visits; Marc Berg's model assumed everyone gets some visits; assume every patient has 2 visits, paid at the same rates or lower rates for the second visits. • Nurses' reimbursement rates are about 5 percent less than for social workers; rates for social workers are high; Robin Brake will update the spreadsheet. • Need to make assumptions about home health nurse vs. social worker coordination (if one goes, the other might not); need to assume an average about the number of visits of what type per client. • Nurses will be case managing and provide nursing care; social workers do other tasks, but nurses sometimes get pulled into this, which takes more time. ***Telemedicine / Telemonitoring*** • Marc Berg made no changes, because it is not a separate service in Medicare; the model that Robin Brake and Gail Kreiger did on telemedicine does not apply to what the Home Health Associations want.

Agenda Items	Lead	Notes
		• Telemonitoring will be more advantageous in rural areas if it is reimbursed; also a great way to manage visit type / frequency / etc. when distances are greater. • Assume 1.3 episodes per client with 19 televisits per episode. ***Supplies*** • How to work the supply issue into the model? Fee-for-service (FFS) needs to cover supplies billed through the home health agencies. • Supplies are bundled into the rates Marc Berg assumed; however, a caller has a separate billing and fee schedule for supplies; not using durable medical equipment (DME) companies for this; they are not charging DSHS; agencies automatically get a denial, because they are not DME providers and do not have the correct taxonomy. • We could work within the new CMS rules to enable agencies to bill for supplies, versus bundling it; providers keep track of supply usage for cost reporting, but do not bill for it; would average over total population (medical vs. surgical) – case acuity consideration; to keep it simple, it should be part of the rate; providers do what's right for the patient. • Current cost for HCA is slightly more than zero for supplies, because they are not billing HCA; need to distinguish between supply types? No, because bundle supplies with home health; a provider could be getting both kinds of supplies; need to determine what assumptions we make about supplies. • Marc Berg's numbers include new rates that include supplies; used 2018 data; non-routine supplies (e.g., wound care supplies, tracheostomy, etc.); add-on for episodic? Built into the HIPPS code that comes from OASIS. ***Community Home Health & Hospice / Kaiser Permanente Partnership (Telehealth)*** • Discussed the telehealth costs (one-page submitted by Randy Dalton, Community Home Health & Hospice); return on investment for telehealth is substantial; helps to determine whether visits are necessary (reductions result). • Assume about $11 per episode per client. • If we change the WAC to telemonitoring instead of telemedicine, we can reimburse what we need to reimburse; discussed the difference between WAC and RCW requirements; need to change the WAC only – frame it in the "new world". • Would result in an increased cost, from about $142k to $1.3 million for the telemedicine.

Agenda Items	Lead	Notes
Discuss Methodologies • PPS Model Discuss VBP / Incentive Component	Josh Morse / Gail Kreiger	**Prospective Payment System (PPS)** • Episodic payment, based on Outcome and Assessment Information Set (OASIS) Health Insurance Prospective Payment System (HIPPS) codes. ***Access to Department of Health (DOH) OASIS Data*** • DOH collects OASIS data on Medicaid home health clients on Medicaid; providers enter the data the same way for both Medicare and Medicaid clients; DOH uses the Medicare data, but nobody is using the Medicaid data; DOH transmits the Medicaid data to some national entity. • Marc Berg spoke with Jane Hawk (DOH's state OASIS coordinator); she referred Marc Berg to the help desk; they forwarded it to the Centers for Medicare and Medicaid Services (CMS); Mark Berg has not heard back. • There was a brief reference to CASPER reports. • Getting the OASIS data is only important if we model it for the Legislature; important going forward with either model if we want to use a value based purchasing method. • OASIS data does not use ER usage; there are about 150 HIPPS codes; HIPPS codes are almost 20 years old; next year (2020) will be the first significant change; we can't do any better; very comprehensive assessment. • HCA has access to the OASIS data via DOH; however, DOH would require compensation from HCA if HCA needs it; would be less costly for HCA to pull a random sample of claims and review the agencies' data directly. • HCA will reach out to DOH to determine how much it would cost to share the data and put that cost in the report; the Legislature could decide whether to pay that amount or require DOH to provide the data. • Possible contacts at DOH about accessing OASIS data include: Jane Hawk, Kristin Peterson (Assistant Secretary), and Kelley Cooper (new Legislative Liaison). ***Patient-Driven Groupings Model (PDGM)*** • What happens on 1/1/2020 when payments are no longer going through PPS, but, instead, are going through PDGM? Some similarities and differences; moving forward, all we need is the HIPPS codes; we'll know the rates for each HIPPS code; need to model a comparison between FFS and PPS. • If we model it now, will the model be void after 1/1/2020? PDGM model is budget-neutral; assume the model will still hold.

Agenda Items	Lead	Notes

		• Randy Dalton has plugged in current data into the new model; payments will be 30-days; frequency of payments will change; instead of $3,400 per episode, it will be about $1,700 per episode.
		• Need to assume that implementation for the Washington Apple Health (Medicaid) managed care organizations (MCOs) would begin 1/1/2021 to give them enough time; would include the PDGM method.
		
		Comparing FFS with PPS/PDGM
		
		• Reviewed and made edits to the side-by-side document that compared FFS and PPS:
		  ○ Kaiser Permanente uses Milliman Care Guidelines (MCG) on physician orders and practice standards as a guide for providing care; based on primary diagnosis and comorbidities, will kick out the number of visits in an authorization based on 50th-percentile.
		  ○ Code of Federal Regulations (CFR) requires that HCA pay the MCOs in a way that is actuarially sound.
		  ○ Medication reconciliation is something the home health nurses already do; it's not an outcome measure that we want to include.
		  ○ Increased access: like Amber Hahn-Keenan in Yakima, taking a large population of Medicaid patients; more urban providers will see an increase in access; how to protect providers who are already serving lots of Medicaid clients? Assume some providers are already doing great and should get the enhanced rate or not get the penalty; other providers who do not serve as many Medicaid clients will need to improve to earn their way.
		
		Potential Advantages to Using a PDGM Payment Method
		
		• Hospitalization rates per thousand speak to potential savings; we don't know what to assume; HCA could use a similar calculation as Kaiser (per Randy Dalton); compare hospital readmission rates (assumption).
		• How to isolate the impact of home health services in the decrease in hospital readmission? How do we know it's not because people moved? Numbers are national. We should look at hospital readmission rates for the 4,800 clients and not for all clients.
		• Use an episodic rate; if include some incentives, then it's a win-win; need to make sure the assumptions and the model we use will put some risk management expectation on the home health agencies.
		• (Brief reference to another legislative report Gail Kreiger is working on about home health.)

Agenda Items	Lead	Notes
		• PDGM method enables top providers to get more, middle providers get the same, and lower providers get a cut; it's based on 100 percent of the providers' payments; if HCA recommends PDGM, then providers will have one less reimbursement method to manage after 1/1/2020. • Use OASIS data to spit out a HIPPS code; if we use a hybrid model, then the data will not go into the same database; instead, use the episodic rate with a value based component; there is a risk-reward element; • Providers who manage their cases well can do well in this system; providers' preference is basically a PPS model. • No other states are doing what we are considering; if we pull this off, we'll be the national model. ***Potential Implementation Costs and Risks*** • Rural agencies are using the PPS model; are there any downsides to impact smaller, rural agencies? Cost to provide care might be higher, due to increased travel time and less access to trained staff; Medicare uses rural add-ons; Marc Berg has some of the wage index information; rurality / wage index / etc. are a part of the OASIS calculation to produce the HIPPS code for reimbursement. • If HCA has a HIPPS code and an amount, then home health agencies would be more subject to payment verifications and audits than in the past; HCA does not currently have this capacity and does not do a lot of home health auditing right now; home health agencies will have a more robust program integrity on the back end. • HCA needs to determine how we would implement the PDGM method at HCA; need to discuss changes with the system folks; change to a 60-day episode and 30-day payment. • Are we confident that providers will have sufficient volume to manage the risks associated with the payment model change to the PDGM? • Getting people into the door to hire them is not the problem; if all we receive from HCA are wound care patients, then it would be a problem; clinical cases need to be there; Medicare is a bigger population than Medicaid; any qualms? • Amber in Yakima is similarly concerned; Medicaid patients are complex, so it will be hard to win on a Medicare model; need to have quality metrics involved, but Medicaid clients do not always respond as well as Medicare clients; requires a lot of visits, which would not be easy to manage in a Medicare-like reimbursement/payment method. • In Medicaid Transformation, interested in ensuring linkages between home health and other providers (especially in rural

Agenda Items	Lead	Notes
		areas) occur; difficult population with different needs than Medicare. • What happens when there is a more complicated Medicare client (e.g., dual-eligible)? Difficult to code; same challenges; social worker is the key to ensure we include more community resources. • Is there a way to identify clients whose original discharge plan was to a higher level of care, but ended up in home health (because facilities for a higher level of care were unavailable)? Refer to outlier payments? Most of the outcome measures are not impacted by outliers; it is averaged out. • MCOs can help with placement, but it would be hard to capture cases when alternative placement occurs. • Zosia Stanley does not know how to identify data about alternative placement arrangements; hospitals will probably track that somewhere (social workers keep track of it in individual Excel files, or something like that), but not sure how to get it; that data will not be in the electronic health records (EHRs).
HCA / DSHS Continuum	Doris Barret / Gail Kreiger	• Is it feasible to apply this model to chronic care? Need to consider DSHS chronic care separately; totally different funding mechanism with DSHS money. • Need to increase funding for COPES nursing? Providers might be willing to accept chronic cases to provide continuity of care, depending on the rates; paid for on a per-visit bases. • Not private duty nurses; it's about brief nursing visits (e.g., catheter changes, etc.); • COPES skilled nursing costs $52.02 or $86.86 per hour; home health nurse does a skilled assessment and then a decision to perform certain procedures; COPES skilled nursing is pre-defined work. • How many do move from home health to COPES nursing, and how does that transition occur? Gail Kreiger is considering a data pull that would show the clients that touch both home health and COPES skilled nursing. HCA has claims data for paid claims. • CareForce does not provide skilled home health nursing for Medicaid, nor do they provide COPES skilled nursing.
Report Scope	Dean Runolfson	• Dean walked the group through the draft report outline; recommendations included: (1) Add a reference to the Kaiser model and how we are thinking about savings; (2) Remove references to Medicare Bundling and replace with Prospective Payment System / PDGM;

Agenda Items	Lead	Notes
		(3) Address reimbursement rates/enhancements for each payment model – FFS, Per Diem (address very briefly), and PPS; and (4) Need to include considerations about ProviderOne system changes in implementation. (5) Add outcome measures (which we label as "quality metrics" currently).
Next steps	Gary Hanson	• Amber Hahn-Keenan and Brent Korte to come up with incentives based on specific outcome measures; access (i.e., home health service providers serving Medicaid clients); not sure how to determine access change at the provider level; consider whether to do it at a county level – we would want more providers within a county (usage rate per thousand beneficiaries). • Cathy Carroll to write content about acute home health services. • Doris Barret to write content for DSHS chronic home health services. • Gail Kreiger will ask contacts at DOH (possibly Jane Hawk, Kristin Peterson, or Kelley Cooper) about the potential cost to HCA to use DOH's OASIS data. • Gail Kreiger, Marc Berg, Robin Brake, and Benjamin Davis-Bloom to design a data pull that would show the clients that touch both HCA home health and COPES skilled nursing in DSHS. • Gail Kreiger will ask HCA's ProviderOne system folks about costs to make changes for home health service reimbursements, based on 60-day episodes and 30-day payment periods. • Robin Brake will update the financial model with different social work and telemedicine values. • Dean Runolfson to follow up with Robin Brake about the financial model.
Close	Gary Hanson	

Meeting on October 22, 2019

Below are the following from this meeting:

- Agenda; and
- Notes from this meeting.

Another draft of the legislative report was available for the work group to review, but the meeting time elapsed before it was possible to review the document. Consequentially, we do not include it here.

Agenda

Washington State Health Care Authority

Home Health Stakeholder Group

Date: Tuesday, October 22, 2019
Time: 8:30 – 10:30 a.m.
Location:
Lacey Community Center
6729 Pacific Avenue SE
Olympia, WA 98503
Skype: 360-407-3811 Pin: 319039

Facilitator: Gary Hanson

Attendees: Representatives of HCA, home health provider associations, hospital associations, managed care organizations, DSHS, and DOH.

----- Agenda -----

Main Outcomes: Agreement on main points for the proviso report.

Agenda Items	Lead	Estimated Time	Time Period	Decision Making? Outcomes.
Introductions	Gary Hanson	5 minutes	8:30 – 8:35	N/A
Data Analysis Update	Gail Kreiger	10 minutes	8:35 – 8:55	Provide an update on the data analysis.
Legislative Report Recommendations Review	Josh Morse/Gail Kreiger	60 minutes	8:55 – 9:55	Review the recommendations that will go in the legislative report. Gain consensus
Draft Legislative Report Review and Timeline Discussion	Dean Runolfson	30 minutes	9:55 – 10:15	Discuss the current draft of the legislative report and the timeline.
Next steps & Closing	Gary Hanson	10 minutes	10:15 – 10:30	Discuss the next steps.

Notes

Agenda Items	Lead	Notes
Introductions	Gary Hanson	• Introductions on the phone and around the room • Reviewed the success factors from the first meeting; long-term goals; the legislative report is one milestone
Data Analysis Update	Gail Kreiger	• Gail Kreiger is working with Krista Umejesi on data analysis; about 250k lines of data; cannot use later episodes, because no dates for follow-up after the dataset date range; Gail will say how many episodes she needs to remove; looking for episodes of care in which Gail identifies home health claims and related diagnoses • Randy Dalton indicated that whenever a client in home health that goes to the hospital for any reason is considered a "failure / ACH"; Gail will use that approach • One thing that Gail consistently finds in the data is treatment for hyperbilirubinemia (too much bilirubin) in home health setting; some providers are not agencies; single-case RN; need to discuss what to do with that; one-offs, not private duty nursing, because classified as a home health claim; change in CFR a few years back that enabled HCA to allow that as a reimbursable service; Nancy was looking at that; Cathy will work with Gail on the data • To treat hyperbilirubinemia, need a light; before 2015, CFR changed • What portion of home health dataset is children vs. adults? Gail does not know yet, but will know later • Results are not surprising so far • Marc Berg – use the same data set that Gail is using to compare PPS methodology relative to the current model; need to make assumptions; if we had OASIS data, we could do it perfectly, but should get close to OASIS if we use an average HIPPS code; HCA would need to de-identify the dataset to share • No HIPPS code in the dataset that Gail and Krista are working on; ProviderOne does not have a HIPPS code field; it would be in the OASIS data • Any luck working with CMS getting the OASIS data? No, but HCA is working on it; not sure we have submitted the request • *[Moved tables and chairs in the room]* • Group is moving toward the PPS; getting data on PPS for a fiscal note? Does Gail have data needed for a PPS? • Marc Berg – Convert FFS Medicare rate; dollar amount; need something similar for PPS; outside Robin's expertise; need data from CMS; need codes and their rates (or rates

Agenda Items	Lead	Notes
		for buckets of codes); how many codes? (fewer in 2020, but more than 100 codes); possible to do the modeling, but a lot of work; need to access the CMS database (Quality Improvement and Evaluation System, or QIES – pronounced like "Keys") • Two approaches; granular (visits to episodes to HIPPS codes); vs. average HIPPS code applied (less precise, but faster and easier); no crosswalk; roll up HCA claims for home health into an episode; represent each episode for HIPPS codes; can identify episodes in ProviderOne claims data; if we use the average HIPPS code, would not need specific OASIS data; average HIPPS would be the amounts on Medicare rates from Medicare data (factual) • HIPPS codes are like DRGs; multiply base rate by acuity factor • Systems issue; need to analyze costs for CNSI (the vendor that administers the ProviderOne system) and MCOs to make changes to systems to include OASIS data (HIPPS code) • Are MCOs currently using the PPS method currently? Molina (per June Smith) is using PPS for Medicare members already, guessing about 90 days to make the transition; Coordinated Care also; CHPW representative (no response); home health agencies have used PPS with CHPW; United? Amerigroup? • Marc Berg – thinks it should be the same for all the other MCOs • More HCA's system changes that others' systems changes • Split between FFS and MC types on dataset? • Many are dual eligible; Medicare would be first, and typically paid in full before asking Medicaid • What ProviderOne field is it in? Existing field not used vs. adding a new field; mostly the issue is in the payment process, which would need to change • System enhancement should probably be reimbursed by about 90/10 federal/state; (need to check with Cathie Ott in HCA's P1OS division) • Need to have an intelligent conversation with systems folks about the code and related changes; need to get it through the change process, which would require significant time (maybe a year or more) • System change (probably a 6-figure cost for an FTE and system changes), state plan amendment (SPA), WAC changes (6 months), consultant, etc.

Agenda Items	Lead	Notes
		• Need a basic claim to see where the information is; also need to know what the payment process would look like; get into the • Leslie Emerick indicated that the plan is to rerun SB 5828 again in the 2020 legislative session
Legislative Report Recommendations Review	Josh Morse/Gail Kreiger	• Start with FFS with higher pay; request funding for consultant to get the PPS in place at a later date • Leslie thought it was fine; asked Donna Goodwin; original concern was that it is a lot of work to get ready for PPS • It would take until January 2021 to implement the higher FFS rates; need to ask Cathie Ott (Jennifer Robinson is the IT System Admin Manager) about feasibility of implementing PPS by January 2022; work group decided do not recommend the FFS plus incentives • Reimbursement for telephone calls; not calling it telemedicine or tele-monitoring; right now, it's about $11 per phone call (typically one per day, not every day); okay with $10 per phone call?; 19 tele-visits per episode • Call it "phone encounter" instead? Need to include "tele" in the name for CMS's sake; stick with tele-monitoring and include phone call piece in it; keep some of the content of the current WAC to be under • Current restrictions about what we can bill under that model; continue to bill separately, or move into the same thing under the $10 option • Nobody is using the current tele-monitoring benefit; too complicated • Easier to stay with the WAC about tele-monitoring (changed to telemedicine); can clean up WAC 182-551-2125 / WAC 182-531-1730 and not run afoul of the RCW or CMS • A certified nursing assistant (CNA) can get the information, but registered nurse (RN) can follow up; both are getting paid • Evergreen is using tele-visits; typically nurses or physical therapists are calling; Evergreen is not reimbursed for it; they do it to keep readmissions low • RCW 74.09.658 – need to clean up; should not have said "or" • What about necessity for charting the phone calls? • Phone call rates different for the various professions? No; it's a one-year stop-gap, no need to complicate it; keep it at a flat $10 per phone call • Cap on number of telephone interventions? Allow for cell-phone / remote visit, if HIPAA compliant?

Agenda Items	Lead	Notes
		• Kaiser has no cap; averaged about 19 per episode; • Currently, Medicaid folks are discharged much earlier than Medicare population (Medicare is about 42 days on average); not sure whether Medicaid population is discharging appropriately or inappropriately • Current WAC limits it to 1 tele-visit per day; • Separate tele-monitoring reimbursement component will disappear in PPS; agencies will continue to be incentivized to call to keep readmission rates • Let's stick with a flat $11 for the one-year stop-gap; use the existing county differential payment in the system right now; county differential is fairly minimal, and it is more geared toward rural than urban (expensive) areas • PPS value-based component does not have a requirement for tele-monitoring • Basic concept in CMS is statewide access; it we put a qualifier that • Incentivize / promote tele-monitoring; one of the measures (binary: have an acceptable tele-monitoring program, per HCA – Y/N) among the other measures; association would want to figure out how to help the agencies to do • Social worker – per visit for a licensed social worker; compare it to Medicare; Marc thought the reimbursement or utilization rate might be a little high; Marc thinks it should be about double the Medicare rate; Marc needs to get exact numbers for Medicare population, but it was about 1 in 3; recommend one social work visit per client per episode • Outcome measures – descriptions are appropriate? Timeliness of care: publicly reported vs. what actually happens is different; probably 40 percent actually get there within 48 hours from hospital discharge; referral date is not the same as discharge date; measure that is 48 hours from discharge date or 48 hours of physician referral date; (agencies can game the system by asking for new referrals and using that) • The work group is okay with decreased ED use and readmission rates • Access – increase the number of billing providers • Consider tele-monitoring as a binary measure • Add a recommendation to continue the home health work group during the implementation process • Of the measures in the PPS, what percentages for the incentives? • CMS validates the Medicare performance measures

Agenda Items	Lead	Notes
		• COPES as a separate work group? If we adjust FFS for 2021, COPES would need to be part of that; should not be separate; we do things hand-in-hand; would not want to separate them; it's a totally different kind of care; COPES is a waiver service; model is so different, HCA's home health trajectory will not have any bearing on COPES after HCA implements the PPS • Leave COPES as FFS at the higher rate, and not participate in PPS when we get to it; do not include ongoing rate increases for COPES FFS; maintain wage parity at first, but not when HCA's program moves toward value-based purchasing model (consistent with HCA's direction for managed care, etc.)
Draft Legislative Report Review and Timeline Discussion	Dean Runolfson	• Per Sandy Stith, the Legislature needs the official, final draft before session starts; will plan to submit on or before 1/10/2020; need to send out report for review by 11/5/2019 • Try to shorten internal review period for the report • Take what we learned from the work group and make a new draft; reach out as needed to individuals for clarification and feedback before 11/5
Next steps & Closing	Gary Hanson	• (None)

Appendix C: Outcome and Assessment Information Set (OASIS)

OASIS assesses patients' function, etc. – similar to the Minimum Data Set (MDS) for skilled nursing facilities; administered at start of care, resumption of care, discharge, etc.

- OASIS has been around since 2000; home health services has been built around OASIS and Medicare HIPPS; outcome measures are in it; examples are ER use and hospital readmissions;
- OASIS determines the HIPPS (Health Insurance Prospective Payment System) code, which translates into a dollar amount; on claim form, enter G codes and HIPPS codes; uses a separate revenue code; covers 60 days of care; on 1/1/2020, the new Patient-Driven Groupings Model (PDGM) goes into effect, changes to 30 days of care; there are 480 HIPPS codes now, will be reduced to fewer codes (100-or something) in 2020;
- Homebound status is part of this, otherwise would not be eligible for Medicare; if a patient is not homebound, OASIS might allow us to complete the form, but acuity score might reduce the payment amount; it's similar to a diagnosis-related group (DRG);
- The clinician fills out the OASIS form, which produces the HIPPS code; and the agency's software uses that code to produce a rate; Medicare often performs adjustments; in 2020, institutions will have different HIPPS codes than for community claims; also codes and reimbursements will differ by the length of the care;
- The system has a table that gives reimbursement based on geographical area (like hospice) – wage index, to calculate the base rate; we need a list of reimbursement rates by codes; need data around the codes, by county, to model it out for a fiscal note; compare Medicare reimbursement to FFS reimbursement.

There are 29 measures in the OASIS system which includes patient satisfaction, hospital readmissions, ED use, employees getting flu vaccinations, etc. The reimbursement base changes once a year and varies by geographical area. DOH collects the HIPPS data; DOH also has claims data for Medicare, Medicare managed care, and Medicaid.

Appendix D: Calculating Higher Home Health Services Apple Health Fee-for-Service Rates

The Home Care Association of Washington (HCAW) obtained calendar year (CY) 2018 data[19] about paid Medicare claims from home health agencies in Washington State to approximate equivalent fee-for-service (FFS) per-visit rates for Apple Health home health services reimbursements to each health care or service provider discipline. Table D1 below contains the HCAW's calculation results.

Table D1 – Higher Home Health Services Apple Health Fee-for-Service Rates per Visit

Provider Discipline	CY 2018 Base Medicare LUPA Rates	CY 2018 Total Visits by Discipline	CY 2018 Payments Calculated at LUPA Rates	CY 2018 Payments Calculated at Full PPS Rates	CY 2018 Average Payment Rate per Visit	Percent Variance from Base LUPA Rates
Skilled Nursing Intervention/ Skilled, High-Risk Obstetrical Nursing	$143.40	408,390	$58,563,126	$84,763,447	$207.56	44.7%
Physical Therapy (PT) or PT Aide	$156.76	484,357	$75,927,803	$109,896,837	$226.89	44.7%
Speech Therapy (ST) or ST Aide	$170.38	41,031	$6,990,862	$10,118,475	$246.61	44.7%
Occupational Therapy (OT) or OT Aide	$157.83	180,480	$28,485,158	$41,229,019	$228.44	44.7%
Medical Social Worker	$229.86	20,114	$4,623,404	$6,691,850	$332.70	44.7%
Home Health Aide	$64.94	64,782	$4,206,943	$6,089,070	$93.99	44.7%
TOTALS		**1,199,154**	**$178,797,297**	**$258,788,699**		

Source: HCAW, September 2019

Notes: CY is calendar year. LUPA is Low Utilization Payment Adjustment. PPS is Prospective Payment System. All rates are per-visit. HCAW used the following codes to identify the paid Medicare home health services claims by provider discipline: Revenue Code 0551 for Skilled Nursing Intervention/Skilled, High-Risk Obstetrical Nursing; Revenue Code 0421/HCPCS G0151 for PT or PT Aide; Revenue Code 0441/Current Procedural Terminology (CPT) Code 92507 for ST or ST Aide; Revenue Code 0431/HCPCS G0152 for OT or OT Aide; HCPCS G0155 for Medical Social Worker; and Revenue Code 0571 for Home Health Aide. HCAW did not find any paid Medicare payments for Brief Skilled Nursing Visit (Revenue Code 0580) in their CY 2018 dataset.

[19] Limited Data Set (LDS) Files, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/LimitedDataSets/index.html, accessed on November 1, 2019.

Below is a brief explanation of Table D1 and HCAW's calculations. HCAW:

1. Identified the CY 2018 base Low Utilization Payment Adjustment (LUPA) per-visit payment rate for each provider discipline.[20]
2. Summed the number of home health services visits by provider discipline in the CY 2018 paid claims for all Medicare-certified home health agencies in Washington State, totaling 1,199,154 visits for all provider disciplines.
3. Summed all CY 2018 Medicare home health payments from Medicare's Prospective Payment System (PPS) for Medicare-certified home health agencies in Washington State, totaling $258,788,699.
    a. These payments include wage index adjustments, rural add-ons, supplies adjustments, and a 2-percent adjustment related to federal sequestration.
    b. Medicare normally pays home health claims on a 60-day episode basis, not per visit.
    c. The only time Medicare pays on a per-visit basis is when an episode has fewer than 5 visits.
4. Multiplied the CY 2018 base LUPA rates for each discipline by the number of visits for each discipline to calculate the CY 2018 payments at LUPA rates, totaling $178,811,352.
    a. The CY 2018 payments at LUPA rates do not include wage index adjustments, rural add-ons, supplies adjustments, or a 2-percent adjustment related to federal sequestration.
5. Used the CY 2018 payments at LUPA rates as a proxy to convert the episodic payments into a per-visit payments at rates that approximate Medicare PPS payments by:
    a. Calculating each provider discipline's payment percentage of the total CY 2018 payments calculated at LUPA rates (e.g., Home Health Aide's $4,206,943 is about 2.4 percent of $178,797,297); and
    b. Multiplying each provider discipline's percentage by the total Medicare PPS payments to calculate the 2018 payments calculated at full PPS rates (e.g., 2.4 percent multiplied by $258,788,699 yields $6,089,070).
6. Divided each provider discipline's CY 2018 payments calculated at full PPS rates by the provider discipline's total number of CY 2018 visits to calculate the CY 2018 average payment rate (e.g., $6,089,070 divided by 64,782 visits yields an average rate of $93.99).

Note: In these calculations, HCAW assumes a proportional distribution of Medicare PPS adjustments and add-ons between provider disciplines. The percent variance from base LUPA rates for each provider discipline's 2018 average payment rate is about 44.7 percent, because the total CY 2018 payments calculated at full PPS rates (i.e., $258,788,699) is about 44.7 percent greater than the total CY 2018 payments calculated at LUPA rates (i.e., $178,797,297).

[20] Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019, Table 3, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10992.pdf, accessed on November 1, 2019.