Maryland Health Care Commission

A NEW APPROACH FOR PLANNING AND REGULATORY OVERSIGHT OF HOME HEALTH AGENCY SERVICES IN MARYLAND

A presentation to the HHA Advisory Group

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MHCC | MARYLAND HEALTH CARE COMMISSION

Highlights: HHA Services in Maryland

Supply and Distribution of HHAs

- number of agencies
- where authorized and actually served

Utilization

- statewide profile of HHA clients in 2013
- statewide trend analyses: 2004 to 2013

Financing

- payer mix: 2013
- payer mix trends: 2004 - 2013

Supply and Geographic Distribution

Supply

- 56 agencies: 50 general; 6 specialty
- Agency type:

  Freestanding (43) CCRC-based (4) Local Health Departments (2)

  Hospital-based (6) Nursing Home-based (1)

- 35 agencies (63%) are for-profit

Geographic Distribution

- majority located in Baltimore metropolitan area, Montgomery, Prince George's, Carroll and Frederick Counties
- vast majority (80%) authorized to serve more than 1 jurisdiction
- however, not all HHAs serve all their authorized jurisdictions

Jurisdictions Authorized and Served: Maryland Home Health Agencies, 2013

Table 1: Distribution of Number of Jurisdictions GENERAL Home Health Agencies Authorized to Serve in 2013

Number of Jurisdictions Authorized	Number of Agencies	Percent of Total Agencies	Cumulative Percent
24	5	10.0%	10.0%
14	1	2.0%	12.0%
12	1	2.0%	14.0%
11	2	4.0%	18.0%
8	1	2.0%	20.0%
7	1	2.0%	22.0%
6	3	6.0%	28.0%
5	4	8.0%	36.0%
4	7	14.0%	50.0%
3	7	14.0%	64.0%
2	8	16.0%	80.0%
1	10	20.0%	100.0%
	50		

Table 2: Distribution of Number of Authorized Jurisdictions GENERAL Home Health Agencies Actually Served in 2013

Number of Jurisdictions Served	Number of Agencies	Percent of Total Agencies	Cumulative Percent
14	1	2.0%	2.0%
13	1	2.0%	4.0%
11	3	6.0%	10.0%
9	1	2.0%	12.0%
8	2	4.0%	16.0%
7	2	4.0%	20.0%
6	1	2.0%	22.0%
5	4	8.0%	30.0%
4	8	16.0%	46.0%
3	6	12.0%	58.0%
2	10	20.0%	78.0%
1	10	20.0%	98.0%
0	1	2.0%	100.0%
	50		

Note: Includes all 50 licensed GENERAL HHAs

Utilization of HHA Services

MHCC's Annual HHA Survey

Profile of a Typical HHA Client: 2013

- Age: 65+ years (70%)
- Gender: female (60%)
- Race: White (59%); African-American (22%); Hispanic (2.1%)
- Admission Source: Hospital (54%); Physician (19%); NH (14%)
- Discharge Destination: Goals Met (69%); Transfer to Hospital (10%)
- Principal Diagnoses: Circulatory; Respiratory; Musculoskeletal

Statewide Utilization Trends: 2004 - 2013

- Overall increase: 21% admissions; 16% clients; 36% visits
- Contributing factors: changes in Medicare's HH PPS; new CMS requirements; ACA implementation; entry of new HHA providers

Figure 1: Total Number of Home Health Agency Admissions and Licensed Agencies: Maryland, Fiscal Years 2004-2013

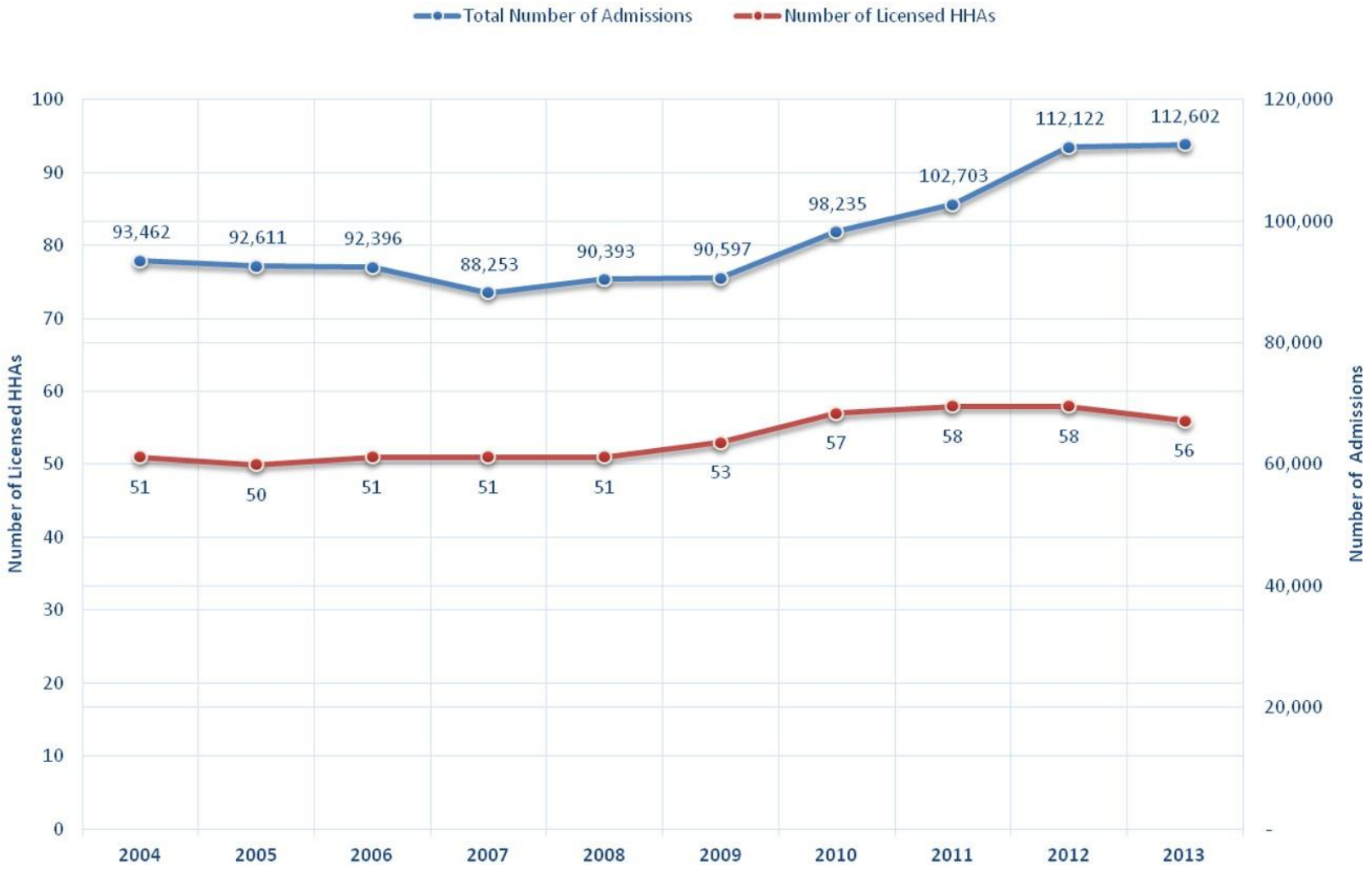


Figure 2: Total Number of Home Health Agency Clients (Unduplicated) and Visits: Maryland, Fiscal Years 2004-2013

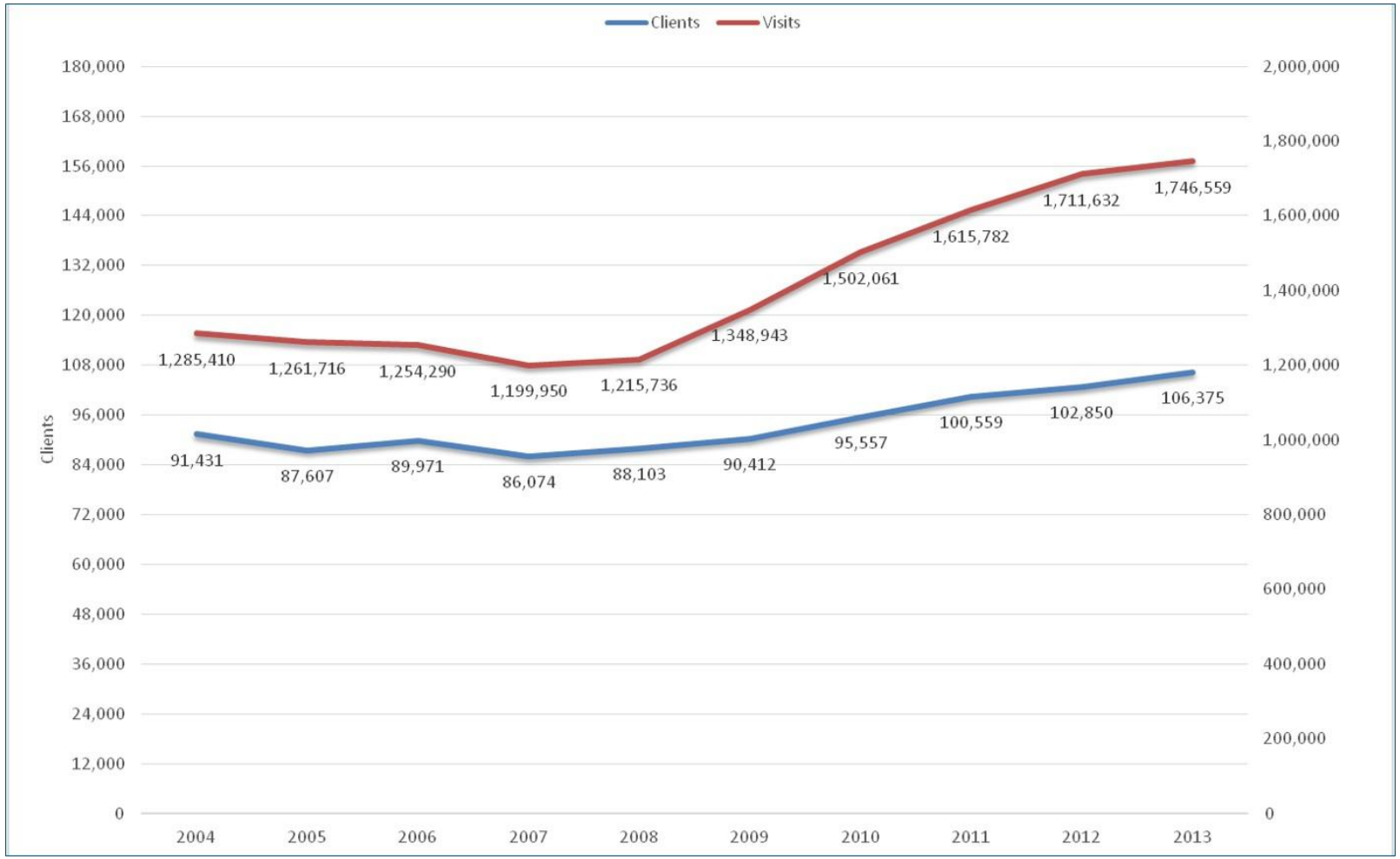


Figure 3. Percent Distribution of HHA Visits by Discipline: Maryland, Fiscal Years 2004 and 2013

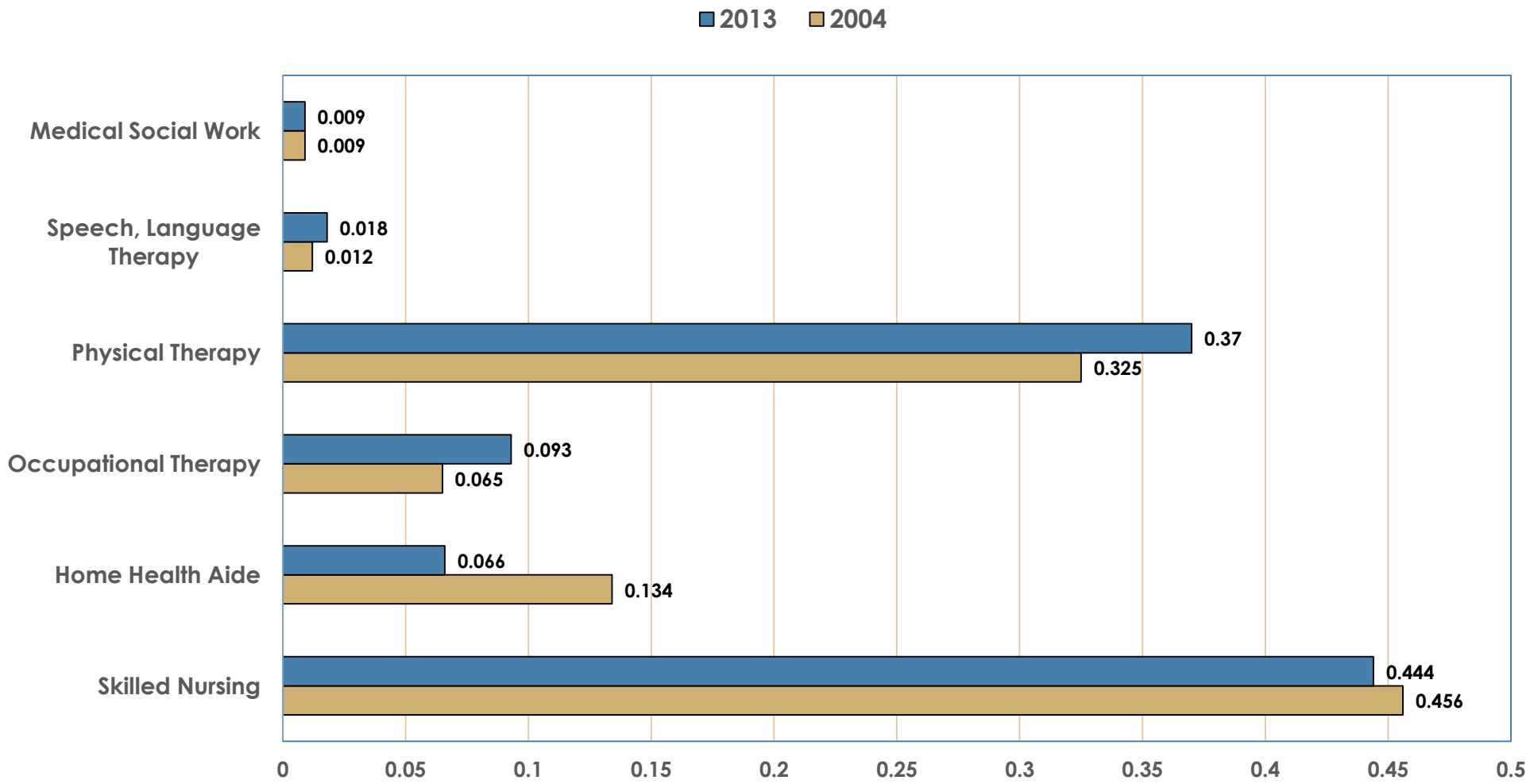
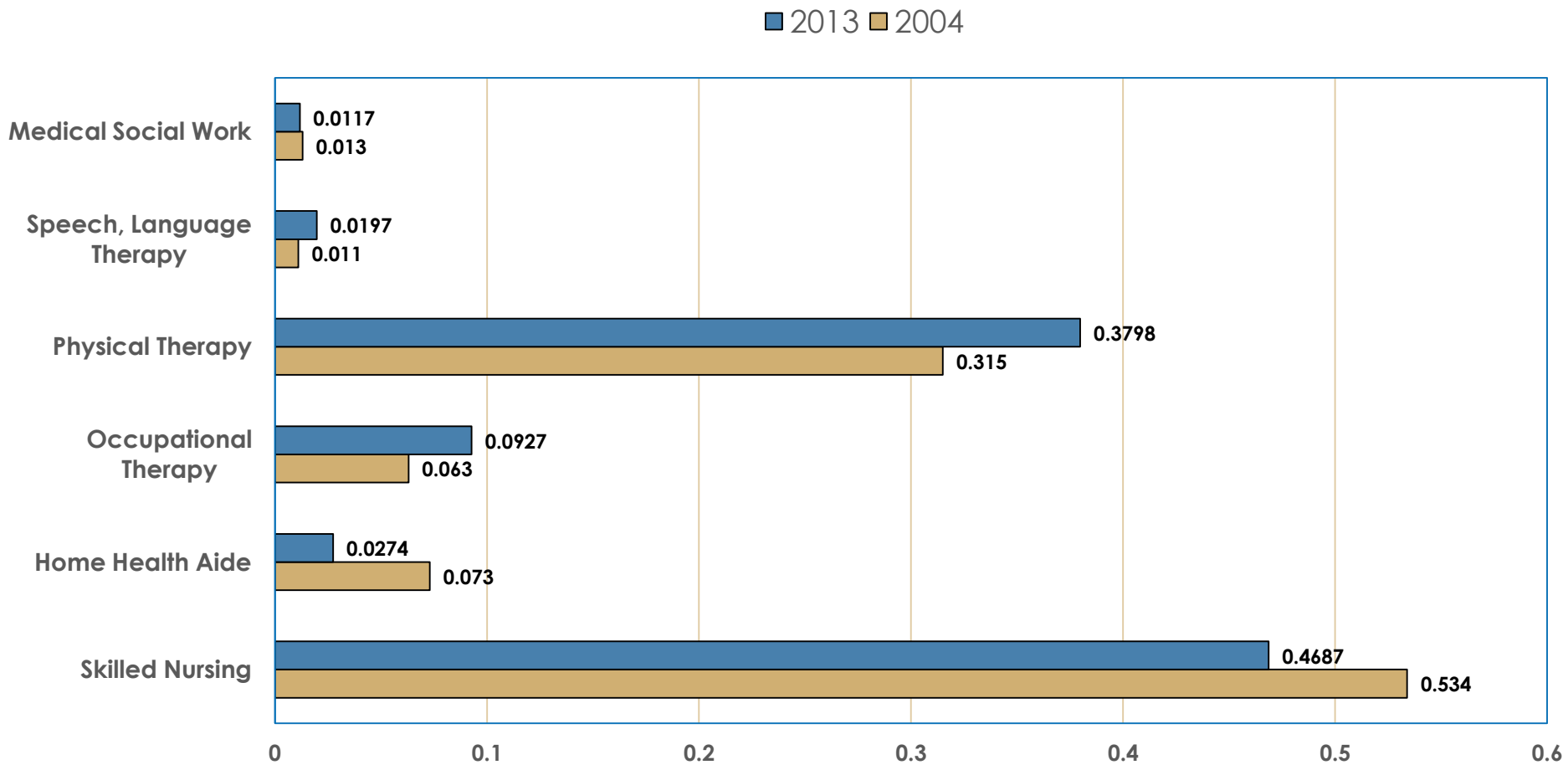


Figure 4. Percent Distribution of HHA Costs by Discipline: Maryland, Fiscal Years 2004 and 2013



Financing of HHA Services

Payer Mix: 2013

- Medicare: 72% client; 83% visits
- Private insurance: 18% clients; 11% visits
- Medicaid: 5% clients; 3% visits
- HMO: 4% clients; 3% visits

Payer Mix Trends: 2004 - 2013

- Private insurance: highest increase in clients (49%) and visits (67%)
- Medicare: 2nd highest increase in clients (33%) and visits (51%)
- Medicaid: no change in percentage of clients
- HMO: declined in percentage of clients (from 12% to 4%)

Overview: Need and Quality

Forecasting Need

- Current approach
- Suggested new approach

Features of New Approach

- Shift towards a greater emphasis on quality and performance measures
- Dynamic approach: create opportunities for development of high quality HHAs in response to changing needs of population and the marketplace
- Qualifying factors for a jurisdiction and for an applicant

Home Health Quality Measures

What is the "State of the Art" in Home Health Quality Measures

Measure Type	What is Measured	Data from	# in Use
Process Measures	care given	OASIS	13
Outcome Measures	result of care	OASIS	7
Potentially Avoidable Event Measures (outcome)	result of care	claims	2
Patient Experience of Care (CAHPS)	patient report	HH CAHPS	5 composites

State of the Art Home Health Quality

- Quality Measures developed after many years of research and testing
- National Quality Forum endorsement for most measures
  - Important
  - Scientifically acceptable
  - Usable, relevant
  - Feasible to collect
- Widely used; withstood "test of time"

Obtaining Measures

CMS has collected standard information about home heath care since the 1990s

The **O**utcome **As**sessment and **I**nformation **S**et **OASIS** is a group of data elements that collect information about the home health patient to:

- document a core comprehensive assessment for each patient
- **measure agency processes and outcomes for individual agency quality improvement and public report**
- calculate provider reimbursement
- use in survey processes

OASIS C, current data set, implemented in 2010

A number of process and outcome measures are generated from the data set. 41 of these measures were used by an expert panel to make recommendations for measures to be publicly reported

OASIS C

Home Health Outcome and Assessment Set (OASIS) C

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized, validated assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

(M1242) **Frequency of Pain Interfering** with patient's activity or movement:

- ☐ 0 - Patient has no pain
- ☐ 1 - Patient has pain that does not interfere with activity or movement
- ☐ 2 - Less often than daily
- ☐ 3 - Daily, but not constantly
- ☐ 4 - All of the time

INTEGUMENTARY STATUS

(M1300) **Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[*Go to M1306*]**
- ☐ 1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool
- ☐ 2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

- ☐ 0 - No **[*Go to M1322*]**
- ☐ 1 - Yes

Home Health Process Measures - CMS

Type	Measure Title	HH Compare	NQF Status	Risk Adjusted[1]	Measure Description	Numerator	Denominator	Measure-specific Exclusions	OASIS C Item(s) Used
Process - Assessment	Pressure Ulcer Risk Assessment Conducted	Yes	Combined into "Pressure Ulcer Prevention and Care" (0538)	No	Percentage of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers at start/resumption of care.	Number of home health episodes of care in which the patient was assessed for risk of developing pressure ulcers either via an evaluation of clinical factors or using a standardized tool, at start/resumption of care.	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	None	(M1300) Pressure Ulcer Risk Assessment
Process - Care Planning	Pressure Ulcer Prevention in Plan of Care	Yes	Combined into "Pressure Ulcer Prevention and Care" (0538)	No	Percentage of home health episodes of care in which the physician-ordered plan of care includes interventions to prevent pressure ulcers.	Number of home health episodes of care in which interventions to prevent pressure ulcers were included in the physician-ordered plan of care.	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes for which a formal assessment indicated the patient was not at risk of developing pressure ulcers at start/resumption of care.	(M2250) f. Intervention(s) to prevent pressure ulcers plan of care
Process - Prevention	Pressure Ulcer Prevention Implemented during All Episodes of Care	Yes	Combined into "Pressure Ulcer Prevention and Care" (0538)	No	Percentage of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Number of home health episodes of care during which interventions to prevent pressure ulcers were included in the physician-ordered plan of care and implemented (since the previous OASIS assessment).	Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes for which formal assessment indicates the patient was NOT at risk of developing pressure ulcers at or since the last OASIS assessment prior to transfer or discharge, OR the patient died.	(M0100) Reason for Assessment (M2400) e. Intervention(s) to prevent pressure ulcers
Process - Care Planning	Depression Interventions in Plan of Care	No	Not endorsed	No	Percentage of home health episodes of care in which the physician-ordered plan of care includes interventions for depression such as medication, referral for other treatment, or a monitoring plan for current treatment.	Number of home health episodes of care in which patients had a physician-ordered plan of care that includes interventions for depression such as medication, referral for other treatment, or a monitoring plan for current treatment.	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes of care where patient does not have symptoms or diagnosis of depression, OR patient is non-responsive.	(M2250) d. Depression intervention(s) plan of care (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious
Process - Care Planning	Diabetic Foot Care and Patient Education in Plan of Care	No	Not endorsed	No	Percentage of home health episodes of care in which the physician-ordered plan of care includes regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper diabetic foot care.	Number of home health episodes of care in which the physician-ordered plan of care includes regular monitoring for the presence of skin lesions on the lower extremities and patient education on proper diabetic foot care.	Number of home health episodes of care ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home health episodes of care where patient is not diabetic OR is a bilateral amputee at start (resumption) of care.	(M2250) b. Diabetic foot care in plan of care

Table 1: CMS Process Quality Measures Used for Public Reports

Domain	Measure	PBQI	HH Compare
Timely Care	Timely Initiation of Care	X	X
Care Coordination	Physician Notification Guidelines Established	X	
Assessment	Depression Assessment Conducted	X	X
	Multifactor Fall Risk Assessment Conducted for Patients 65 and Over[1]	X	X
	Pain Assessment Conducted	X	X
	Pressure Ulcer Risk Assessment Conducted	X	X
Care Planning	Depression Interventions in Plan of Care	X	
	Diabetic Foot Care and Patient Education in Plan of Care	X	
	Falls Prevention Steps in Plan of Care	X	
	Pain Interventions in Plan of Care	X	
	Pressure Ulcer Prevention in Plan of Care	X	X
	Pressure Ulcer Treatment Based on Principles of Moist Wound Healing in Plan of Care	X	

Home Health Quality Measures

Listed in the order in which they appear on the **Maryland Consumer Guide to Long Term Care**

Managing Daily Activities
How often patients got better at walking or moving around
How often patients got better at getting in and out of bed
How often patients got better at bathing
Managing Pain and Treatment Symptoms
How often the home health team checked patients for pain
How often the home health team treated their patients' pain
How often patients had less pain when moving around
How often the home health team treated heart failure (weakening of the heart) patients' symptoms
How often patients' breathing improved
How often patients' wounds improved or healed after an operation
How often the home health team checked patients for the risk of developing pressure sores (bed sores)
How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care
How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)
Preventing Harm
How often the home health team began their patients' care in a timely manner
How often the home health team taught patients (or their family caregivers) about their drugs
How often patients got better at taking their drugs correctly by mouth
How often the home health team checked patients' risk of falling
How often the home health team checked patients for depression
How often the home health team determined whether patients received a flu shot for the current flu season
How often the home health team determined whether their patients received a pneumococcal vaccine (pneumonia shot)
With diabetes, how often the home health team got doctor's orders, gave foot care, and taught patients about foot care
Preventing Unplanned Hospital Care
How often patients receiving home health care needed urgent, unplanned care in the ER without being admitted
How often home health patients had to be admitted to the hospital

Public Report of HH Quality Measures

- Outcome Measures Risk Adjusted
- Potentially Avoidable Event Measures adjusted for patient characteristics
- Process Measures no adjustment
- Patient Experience of Care (HHCAHPS®) adjusted for patient characteristics

Home Health Consumer Assessment of Healthcare Providers and Systems® (HHCAHPS®)

HHCHAPS® reports two <u>Overall</u> measures:

- Overall Rating of Care – the percent of patients who gave a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
- Likelihood to Recommend – the percent of patients reporting YES, they would definitely recommend the HHA to friends and family

and three <u>Composites</u> (a composite is a summary score given to several questions that measure the same concept):

- How often the home health team gave care in a professional way (four questions)
- How well home health team communicated with patients and family (six questions)
- Did the home health team discuss medications, pain, and home safety (seven questions)

Home Health CAHPS Example Questions

- In the last 2 months of care, did you and a home health provider from this agency talk about pain?

- We want to know your rating of your care from this agency's home health providers.

  Using any number from 0 to 10, where 0 is the worst home health care possible and 10 is the best home health care possible, what number would you use to rate your care from this agency's home health providers?

Quality Measures – Maryland Consumer Guide to Long Term Care

Quality Measures

Home Health Quality Measures

Data source: CMS Home Health Compare Measures reported for the time period January - December 2013

Select Category: Treating Wounds and Preventing Pressure Sores

- Managing Daily Activities
- Managing Pain and Treatment Symptoms
- Treating Wounds and Preventing Pressure Sores
- Preventing Harm
- Preventing Unplanned Hospital Care

An asterisk (*) means [illegible] the measure.

Treating Wounds and Preventing Pressure Sores	Baltimore County Department of Health- Home Health Services	Maryland Average
How often patients' wounds improved or healed after an operation.	82%	89%
How often the home health team checked patients for the risk of developing pressure sores (bed sores).	100%	99%
How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care.	95%	98%
How often the home health team took doctor-ordered action to prevent pressure sores (bed sores).	92%	98%

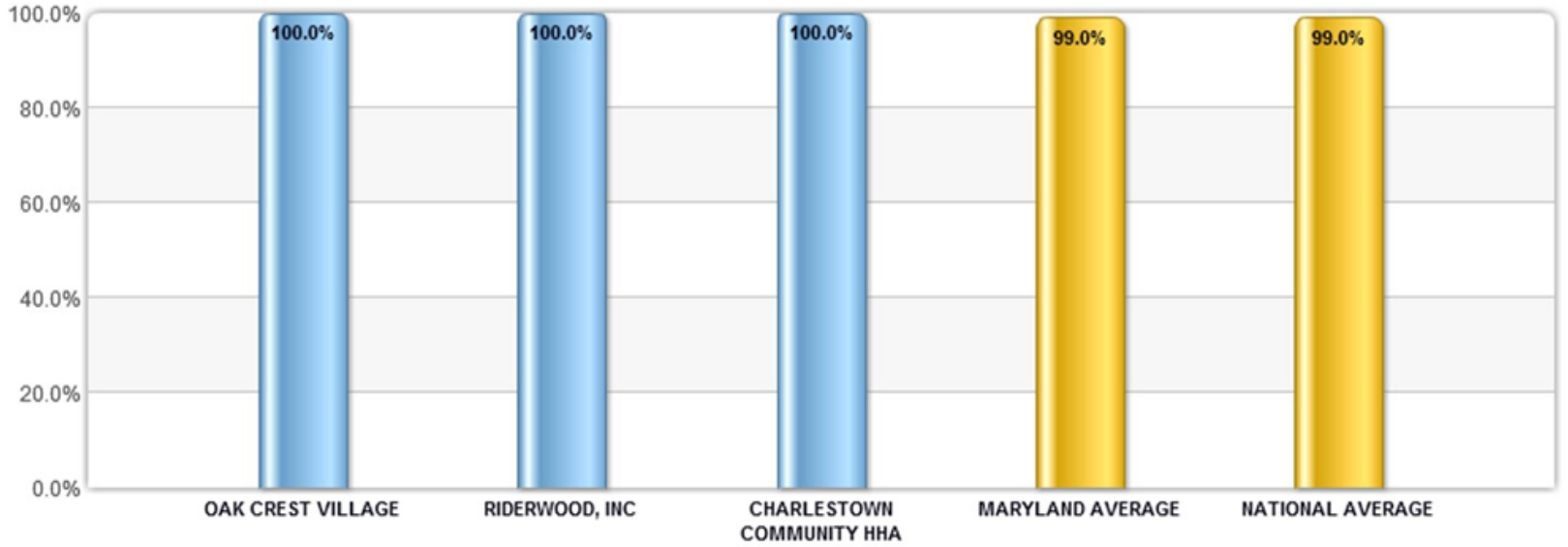
CMS Home Health Compare

How often the home health team checked patients for the risk of developing pressure sores (bed sores)

Why is this important?

Hide Graph

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period **October 1, 2013 - September 30, 2014**



How often the home health team included treatments to prevent pressure sores (bed sores) in the plan of care

Why is this important?

Hide Graph

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period **October 1, 2013 - September 30, 2014**

Questions?
Comments?

Home Health Quality Measures

Listed in the order in which they appear on the **Maryland Consumer Guide to Long Term Care**

Managing Daily Activities
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How often the home health team took doctor-ordered action to prevent pressure sores (bed sores)
Preventing Harm
How often the home health team began their patients' care in a timely manner
How often the home health team taught patients (or their family caregivers) about their drugs
How often patients got better at taking their drugs correctly by mouth
How often the home health team checked patients' risk of falling
How often the home health team checked patients for depression
How often the home health team determined whether patients received a flu shot for the current flu season
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Home Health Consumer Assessment of Healthcare Providers and Systems® (HHCAHPS®)

HHCHAPS® reports two Overall measures and three Composite measures (a composite is a summary score given to several questions that measure the same concept):

Overall Measures
Overall Rating of Care - the percent of patients who gave a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
Likelihood to Recommend - the percent of patients reporting YES, they would definitely recommend the HHA to friends and family

Composite Measures
How often the home health team gave care in a professional way (four questions)
How well home health team communicated with patients and family (six questions)
Did the home health team discuss medications, pain, and home safety (seven questions)

Home Health Quality Measures in CON

- Use selected (not all) measures, a combination of process, outcome, potentially avoidable events and experience of care (HHCAHPS ®)
- Determine a benchmark score for each measure
- Track performance over time
- Achievement of benchmark and improvement in performance qualifying factors for CON

Specific measures, benchmark scores, and degree of improvement to be determined

Examples of Performance-Based Programs In Use

The proposal is very similar to demonstration programs designed to provide incentives to other types of health care providers.

- HSCRC Quality Based Reimbursement
- Premier Hospital Quality Incentive Demonstration (HQID)
- Value-based performance programs

HSCRC QBR Year 2014

ATTAINMENT

Comparing hospital's score to the threshold and benchmark (compares agency to others – state or national or some other average score)

If the hospital's score is:

- Equal to or greater than benchmark, hospital receives points for achievement
- Equal to or greater than the achievement threshold (but below the benchmark), the hospital receives a score based on a scale established for the achievement range

IMPROVEMENT

Comparing hospital's performance to base year (compares agency to itself)

If the hospital's score on a measure is:

- Greater than its baseline period score but below the benchmark, the hospital receives a score of 1-9 based on a scale that defines the improvement range

HSCRC Model; QBR Webinar: measures thresholds and benchmarks for rate year 2014

EXAMPLES of Performance Based Programs

HQID

HQI Composite Score = composite process score + composite outcome score

CMS Nursing Home value based purchasing demonstration

Achievement - Homes with an overall performance score in the 80th percentile or higher qualify

Homes in the 90th percentile or higher receive a score that is 1.2 times that of the 80th to 90th percentile

Improvement - Homes in the 80th percentile or higher qualify as long as their performance level is at least as high as the 50th percentile

(A required minimum level ensures that homes do not qualify if their overall level of performance is low)

Performance payments based on the composite performance score rather than the scores on individual performance measures or categories of measures.

CMS Proposed Five- Star Rating for Home Health Quality

Process Measures
Timely Initiation of Care
Drug Education on all Medications Provided to Patient/Caregiver
Influenza Immunization Received for Current Flu Season
Pneumococcal Vaccine Ever Received

Outcome Measures
Improvement in Ambulation
Improvement in Bed Transferring
Improvement in Bathing
Improvement in Pain Interfering With Activity
Improvement in Dyspnea
Acute Care Hospitalization

CMS Five-Star Rating Criteria

CMS selected the proposed measures to be included in star ratings based on the following criteria:

- The measure should apply to a substantial proportion of home health patients and have sufficient data to report for a majority of home health agencies
- The measure should show a reasonable amount of variation among home health agencies and it should be possible for a home health agency to show improvement in performance
- The measure should have high face validity and clinical relevance
- The measure should be stable and not show substantial random variation over time

Questions?