

THE SKILLED HOME HEALTH INTEGRITY AND PROGRAM SAVINGS ACT OF 2011 (SHHIPS)

The Skilled Home Health Integrity and Program Savings Act strengthens the integrity of the home health benefit, ensures accurate and efficient payment processes, improves quality through the use of proven patient care technologies, and achieves significant program savings without restricting patient access, cutting benefits, or increasing the cost of Medicare for its beneficiaries.

Overview of Cost-Saving Provisions

Dobson DaVanzo / Holtz-Eakin

<u>Payment Reforms</u> : Establishes maximum thresholds relating to outlier payments (3%), low-utilization payment adjustments (5%), and episode utilization (135%).	\$15.8 billion
<u>Market Basket Adjustment and Stability</u> : Reduces the market basket percentage increase by 1% for 2012-2016 and maintains the 2010 case-mix measurement for 3 years.	\$7.8 billion
<u>Entry Limitations to Prevent Excess Growth</u> : Suspends the issuance of new provider numbers where there is a significant potential for fraud, waste, or abuse.	\$3.1 billion
<u>Industry Funding for Program Integrity Activities</u> : Establishes a fee structure on all new and existing providers to fund the provisions of this title.	\$0.1 billion
Total Estimated 10-Year Medicare Savings (<i>Less Beneficiary Premium Offsets</i>)	<u>\$22.9 billion</u>

Overview of Other Program Integrity and Quality Provisions

Strengthened Conditions of Participation: Requires all agencies to comply with requirements, including:

- comprehensive credentialing requirements including criminal background checks,
- comprehensive compliance and ethics program based on Inspector General guidelines,
- medical director for utilization review and patient care conferences,
- sufficient resources for 12 months of operations and a surety bond, and
- utilization of an electronic health records platform and telehealth technology.

Mandatory Data Transparency: Makes publicly available all claims filed by and payments made to all home health agencies and the methodologies and analyses for payment changes.

Independent Accountability Agency: Establishes dedicated entity to analyze market data, investigate potential aberrant market practices, and report to the HHS Secretary, OIG, and Department of Justice.

Payment Accuracy and Claims Validation: Delays payment for 90 days in 1st year of operation to allow for pre-payment claims review, and provides for claims validation using applicable OASIS submission.

Case Mix Adjustment Integrity: Directs the Secretary to develop case mix adjustment factors that do not include the level and amount of therapy visits in determining payment amounts.