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VNAA Summary: Final CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements

On Thursday, October 29, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the calendar year 2016 home health final rule. The regulation has an overall estimated economic impact of -$260 million (or -1.4 percent) due to several rate cuts, including the third year (of four) of the rebasing phase-in, adjustments due to case-mix coding intensity growth unrelated to changes in patient acuity, and adjustments due to productivity. The rule also implements a new quality measure and a value-based payment model for home health providers.

CMS implements a value-based payment model for all home health agencies in nine states beginning January 2016. Participating agencies will be subject to incentives and penalties in the range of three to eight percent, beginning with three percent in the first year and steadily increasing to eight percent in the fifth year of the model. CMS finalized the states initially proposed, including: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. These states were selected based on a set of characteristics including agency size, population density, patient characteristics, and service utilization to ensure a nationally representative sample.

The overall economic impact of this proposed rule is estimated to be -$260 million or -1.4 percent. Nonprofit home health agencies will be impacted slightly less than proprietary agencies with an estimated impact on nonprofit agencies of -1.1 percent as compared to -1.5 percent for proprietary agencies. CMS estimates that the changes in payment will result in rural home health agencies taking an aggregate 1.8 percent pay cut while urban agencies face a 1.4 percent pay cut in aggregate.

CY 2016 Final National Standardized Episode Rate

CMS calculates the 2016 national standardized episode rate at **$2,965.12**. This rate was calculated using the following methodology:

((2015 rate of $2961.38) **x** (1.0011 wage index budget neutrality factor) **x** (1.0187 case mix weight adjustment budget neutrality factor) **x** (.9903 case mix adjustment) **– (**$80.95 rebasing adjustment**) x** (1.019 market basket update)**) = CY 2016 Rate**

Major Provisions of the Final Rule

1. Implements the third year of rebasing, which results in a 3.45 percent reduction in the payment rate.
2. Reduces the home health episode rate by .97 percent to adjust for coding intensity.
3. Reduces the market basket update by a .4 percent productivity factor.
4. Implements a home health value-based payment program beginning in nine states in October 2016.
5. Implements a new IMPACT Act measure related to new or worsening pressure ulcers.
6. Increases the pay-for-performance reporting threshold to 80 percent for the reporting period beginning July 1, 2016.

Summary of Major Provisions of the Final Rule

- **Provisions of the Final Home Health Prospective Payment System**

CY 2016 HH PPS Case-Mix Weights and Reduction to the National, Standardized 60-day Episode Payment Rate to Account for Nominal Case-Mix Growth

CY 2016 HH PPS Case-Mix Weights

Using the same methodology CMS employed last year, CMS recalibrates the weights assigned to each case mix grouping using the most current claims and OASIS data available. In the final rule, CMS states that it has updated the weights in the final rule with more current data. The methodology used by CMS results in slight changes to the points awarded in scoring, changes in the clinical and therapy thresholds for the steps used in the payment model, and the final weights associated with each case mix group. (*See Tables 3 & 4 in the final rule*). The resulting case mix weights are presented in Table 6 of the rule.

Reduction to the National, Standardized 60-day Episode Payment Rate to Account for Nominal Case-Mix Growth

In the final rule, CMS implements a significant case-mix cut phased in over the next three years based. CMS cites its analysis that the average case mix weight continues to exceed its best estimate of actual case mix increase. The final rule adopts an earlier methodology than used in the proposed rule as well as uses updated data. As a result, the final adjustment is slightly smaller than the proposed adjustment. CMS will reduce payments for nominal case mix growth by -1.45 percent for 2016 and 2017 phased in as a - .97 percent adjustment in 2016, 2017, and 2018. CMS dismisses all the comments against nominal case mix adjustments and pledges to continue to monitor case mix weight increases with an eye toward further adjustments as it deems warranted.

CY 2016 Home Health Rate Update

CY 2016 Home Health Market Basket Update

The final home health market basket for 2016 is calculated at 2.3 percent. However, using the standard methodology it has developed to factor productivity gains into the wage index, CMS has calculated a .4 percent increase in productivity. Thus, the wage index increase for 2016 is reduced to 1.9 percent.

CY 2016 Home Health Wage Index

In addition to the annual usual changes in wage index in each wage index area, CMS phases in the second year of more significant wage index changes that began last year when CMS adopted new CBSA wage index areas. As in the recent years, agencies are advised to check the final tables reflecting these wage index changes. The final wage index tables as well as tables of final case mix weights and ICD-10 conversion tables can be found on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1625-F.html.

CY 2016 Annual Payment Update

In the final rule, CMS indicates that it will maintain the current ratio of labor to non-labor cost for application of the relevant wage index amount at 78.535 percent labor and 21.465 percent non-labor. CMS finalizes the following changes to the payment update:

CY 2016 National, Standardized 60-Day Episode Payment Rate

CMS calculates the national standardized episode rate for 2016 at $2,965.12. This reflects the 2015 rate of $2961.38, multiplied by 1.0011 wage index budget neutrality factor, 1.0141 case mix weight adjustment budget neutrality factor, .97 case mix creep reduction reduced by the -$80.95 rebasing adjustment and multiplied by the market basket update of 1.019. Per standing policy, the rate is further reduced by 2 percent if an agency does not submit quality data. Rates for rural agencies are increased 3 percent to account for the rural add-on. *See Final Rule Tables 7, 8 and15, 16.*

CY 2016 National Per-Visit Rates

CMS adjusts the 2016 per visit rates upward by the wage index budget neutrality factor of 1.0010, a rebasing adjustment and the 1.9 percent market basket with a 3 percent increase for rural agencies and a 2 percent reduction for any agency failing to report quality data. *See tables 9, 10, and 16.*

Low-Utilization Payment Adjustment (LUPA) Add-On Factors

CMS continues its existing methodology for calculating LUPA payments which includes a factor increasing per visit rates for skilled nursing (1.8451), physical therapy (1.6700) and speech language pathology (1.6266)

CY 2016 Nonroutine Medical Supply Payment Rates

CMS reduces nonroutine medical supply payment rates through a reduction in the 2015 conversion factor from $53.23 to $52.71 due to the rebasing adjustment of .9718 and market basket of 1.019. *See Tables 15-18.*

Rural Add-On

The 3 percent rural add-on continues this year and through January 2018 under current law.

Payments for High-Cost Outliers under the Home Health Prospective Payment System (HH PPS)

CMS projects that outlier payments will remain within the 2.5 percent cap for 2016 but will equal it in 2017. The agency concludes that it will not change the outlier policy this year. The fixed dollar loss ratio will remain at .45 and the loss-sharing ratio at .80.

Report to Congress on the Home Health Study Required by Section 3131(d) of the Affordable Care Act and an Update on Subsequent Research and Analysis

In the final rule CMS cites discussion in the proposed rule which summarized the results of the Section 3131(d) Vulnerable Patient Study. CMS responds to critical comments about the inaccuracy in the current HHPPS by indicating that is has contracted with ABT associates to explore possible changes to the system.

Technical Regulations Text Changes

CMS finalizes all of the technical changes in the proposed rule to incorporate or remove material from existing regulations text that have been changed or eliminated by legislation. These include: reduction in the outlier pool to 2.5 percent, the 10 percent outlier payment cap, frequency in review of the plan of care, definition of intervening events in calculating partial episode payment adjustments, clarifying nominal case mix payment reductions, eliminating references to outdated market basket index factors, clarifying the difference between a LUPA add-on and the LUPA add-on factor and deleting text referring to the phase-in of the original prospective payment system.

- **Home Health Value-Based Purchasing Model**

  CMS finalized its proposal to implement a home health value-based purchasing (HHVBP) model. The model will launch in January 2016 and continue for five years (with two additional years to complete the payment cycle). Payment adjustments will begin in 2018 and continue for five years. The proposed model is being tested by CMS' Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Social Security Act.

  CMS has selected nine states for participation in the model. These states were chosen on a semi-random basis with consideration of average agency size, percentage of nonprofit agencies in the state, population density, patient characteristics, average service utilization, and ability to serve as a nationally representative sample. All HHAs in the selected states are required to participate in the program with the sole exceptions of HHAs that have fewer than 20 home health episodes of care in a year and have been certified for at least six months. HHAs in the following nine states will participate in the model: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.

  Incentive Payments/Penalties. CMS will place between three and eight percent of payments at risk for performance for participating HHAs. In the first performance year, HHAs will be subject to a three percent incentive/penalty. This will increase to five percent in year two, six percent in year three, seven percent in year four, and eight percent in year five. CMS will calculate the payment adjustment amount (i.e., incentive/penalty) by analyzing a year's worth of performance data. A payment modifier will be developed and applied to all of the HHA's payments for the payment year aligned with the performance year. Given the amount of time to collect and analyze HHAs' data, there will be a year delay between data collection and payment. In other words, CMS will use performance data collected CY 2016 to modify payments in CY 2018. The final performance period will be CY 2020. However, CMS will make the final payment adjustments in CY 2022.

  Performance Measure Set. CMS will measure HHA performance for all Medicare beneficiaries (and no other patients) treated within the participating state. CMS will assess HHA performance using 6 process measures, 10 outcome measures, 5 satisfaction measures and 3 "New Measures" (see Table 1).

Table: Year 1 (or "Starter") Measure Set

Process	Outcome	New Measures
1. Care Management: Types and Sources of Assistance 2. Influenza Data Collection Period: Does this episode of care include any dates one or between October 1 and March 31? 3. Influenza Immunization Received for Current Flu Season 4. Pneumococcal Polysaccharide Vaccine Ever Received 5. Reason Pneumococcal vaccine not received 6. Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	1. Improvement in Ambulation-Locomotion 2. Improvement in Bed Transferring 3. Improvement in Bathing 4. Improvement in Dyspnea 5. Discharged to Community 6. Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health 7. Emergency Department Use Without Hospitalization 8. Improvement in Pain Interfering with Activity 9. Improvement in Management of Oral Medications 10. Prior Functioning ADL/IADL 11. Care of Patients 12. Communications Between Providers and Patients 13. Specific Care Issues 14. Overall Rating of Home Health Care 15. Willingness to Recommend the Agency	1. Influenza Vaccination Coverage for Home Health Care Personnel 2. Herpes Zoster (Shingles) Vaccination: Has the patient ever received the shingles vaccination? 3. Advance Care Plan

CMS categorizes these measures into four classifications: Clinical Quality of Care, Care Coordination and Efficiency (previously "Outcome and Efficiency"), Person- and Caregiver-Centered Experience, and New Measures. Data used to calculate the process and outcome measures is already collected either via OASIS or claims. CMS will establish an online portal for HHAs to submit data on the New Measures. HHAs have until October 7, 2016 to begin reporting data on the New Measures for the period July 2016 – September 2016. CMS will not collect data on the New Measures for January – June 2016.

CMS opted to remove the following five measures from the model: Timely Initiation of Care (NQF0526), Pressure Ulcer Prevention and Care (NQF0538), Multifactor Fall Risk Assessment Conducted for All Patients who can Ambulate (NQF0537), Depression assessment conducted

(NQF0518), and Adverse Event for Improper Medication Administration and/or Side Effects (New Measures).

Performance Assessment Methodology. Distribution of payments will be based on a combination of performance and reporting, depending on the measure. Performance will be measured by both achievement and improvement. In determining achievement, HHAs will receive points along a range between an achievement threshold and benchmark. The threshold will be calculated as the median of all HHAs' performance on the measure during the baseline period. The benchmark will be calculated as the mean of the top decile of all HHAs' performance on the measure during the baseline period. These calculations will be calculated separately for each state and size cohort. CMS established two size cohorts for comparison purposes in each state – large and small – which are defined by whether the HHA participates in HHCAHPs (large) or is exempt (small). HHAs must meet the achievement threshold to receive any points for a measure. In determining improvement, CMS will award up to 10 points per measure based on where an HHA falls along a range that starts with the HHA's own baseline performance and the benchmark used in the achievement calculation.

CMS will calculate a Total Performance Score (TPS) using the higher of an HHA's achievement or improvement score for each measure. In this model, each measure will be weighted equally. The measures categorized under Clinical Quality of Care, Care Coordination and Efficiency, and Person- and Caregiver-Centered Experience will account for 90 percent of the TPS. The measures included in the New Measures category will account for 10 percent of the TPS and performance will be measured based on reporting only.

Using a statistical approach similar to that employed in the hospital value-based purchasing program, an agency's degree of attainment above the mean and improvement over baseline performance is translated into a numerical score on each quality measure. The sum of those scores will then be statistically arrayed relative to all competing HHAs within the agency's size category and state. A positive or negative payment adjustment percent will be calculated that reflects the agency's relative ranking along the distribution of all scored agencies in its cohort. CMS increased the sensitivity of the calculation in the final rule by opting to round an HHA's score at the third decimal point instead of to the next full point.

CMS will use January 1, 2015 – December 31, 2015 as the baseline performance period for the duration of the program in order to evaluate the degree of change that may occur over the multiple years of the model.

Review Period. HHAs will have several opportunities to review performance reports and engage with CMS to address discrepancies. CMS will provide quarterly performance reports beginning in

July 2016[1], annual payment adjustment reports, and annual publicly-available performance reports. In the final regulation, CMS removed the specific timeframe for providing these reports but extended the HHA review/reconciliation period to 30 days for both the quarterly performance reports and the annual payment adjustment report. CMS maintains that it will advise HHAs of their final payment adjustment no later than November 1 in advance of each payment year.

Evaluation Methodology. CMS intends to evaluate the program at the state, HHA, and patient levels and will procure an outside evaluation contractor for this purpose.

- **Provisions of the Home Health Care Quality Reporting Program (HH QRP)**

CMS finalized its proposed changes to the HH QRP with respect to IMPACT Act measure adoption and the minimum reporting threshold for CY 2016 and CY 2017. CMS also confirmed its intent to pursue the measure constructs and concept areas for measure development included in the proposed rule.

IMPACT Act Measure for 2018

CMS has adopted NQF #0678 – Percent of Residents of Patients with Pressure Ulcers That Are New or Worsened (Short Stay) for use in the HH QRP for CY 2018 HH payment determination and subsequent years.

Measure Constructs for Purposes of Meeting IMPACT Act Requirements

CMS will continue development of the following four cross-setting measure constructs to meet requirements of the IMPACT Act:

- All-condition risk-adjusted potentially preventable hospital readmission rates;
- Resource use, including total estimated Medicare spending per beneficiary;
- Discharge to community; and
- Medication reconciliation.

These measures will be proposed in future rulemaking (See Table 19 for proposed measures).

Future Setting-Specific Measure Constructs under Consideration

CMS sought input on seven high priority concept areas for future measure development:

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[1] Because CMS will allow HHAs until October 7, 2016 to submit the data necessary to calculate the New Measures, the first performance report in July 2016 will not include results for these measures.

- Falls risk composite process measure;
- Nutrition assessment composite measure;
- Improvement in Dyspnea in Patients with a Primary Diagnosis of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), and/or Asthma;
- Improvement in Patient-reported Interference due to Pain;
- Improvement in Patient-Reported Pain Intensity;
- Improvement in Patient-Reported Fatigue; and
- Stabilization in 3 or more Activities of Daily Living (ADLs).

Details regarding measurement definitions, data sources, data collection approaches, and timeline for implementation will be communicated in future rulemaking.

Performance Reporting Thresholds

CMS finalized its proposal to set the quality reporting performance threshold at 80 percent for the reporting period from July 1, 2016 through June 30, 2017 and 90 percent for the periods begin July 1, 2017 and beyond.