

# Medicare Home Health Prospective Payment System

## Final Rule Impact Analysis

### Calendar Year 2016

-Version 1, November 2015-

## Analysis Description

The calendar year (CY) 2016 Medicare Home Health (HH) Prospective Payment System (PPS) Final Rule Analysis is intended to show hospital-based HH providers how Medicare fee-for-service (FFS) payments will change from CY 2015 to CY 2016 based on the policies set forth in the CY 2016 HH PPS final rule.

### CY 2016 HH Final Rule Changes Modeled in this Analysis

- Marketbasket Update : 2.3% marketbasket increase to account for service cost inflation.
- ACA-Mandated Productivity Reduction: 0.4% multifactor productivity reduction, as established under the Affordable Care Act (ACA).
- ACA-Mandated Rebasing Adjustment: The Center for Medicare and Medicaid Services (CMS) is implementing the third year of a four-year phase-in of the rebasing adjustments mandated by the ACA. By law, the rebasing adjustment is limited to 3.5% of the CY 2010 60-day episode rate. To comply with the law, CMS adopted an \$80.95 reduction (3.5% reduction based on the CY 2010 60-day episode rate; resulting in a 2.69% reduction in the CY 2016 rate). The rebasing will reduce the 60-day episode rate and non-routine medical supply (NRS) conversion factor, but increase the per-visit amounts. Payment impacts shown in this analysis are based solely on changes to the 60-day episode rate.
- Nominal Case-Mix Growth Adjustment: CMS is implementing a total reduction of 2.88% over a three year period distributed evenly between the three years. For CY 2016 there will be a 0.97 percent reduction to the national, standardized 60-day episode payment rate. This reduction accounts for estimated case-mix growth unrelated to patient acuity (nominal-case mix growth from budget neutrality factors) between CY 2012 and CY 2014.
- Wage Index and Labor Share Change: Updated wage index values based on the FFY 2016 inpatient hospital wage index without the rural floor or reclassifications. This impact includes the impact of the new core-based statistical area (CBSA) delineations and new wage data. Labor share is remaining constant at 78.535% from CY 2015 to CY 2016.
- Rate Increase for HHRG Case-Mix Budget Neutrality: 1.87% increase to the 60-day episode rate to maintain budget neutrality resulting from CMS' recalibration of the HHRG case-mix weights for CY 2016.
- Wage Index Budget Neutrality Adjustment: 0.11% increase in the marketbasket due to wage index changes to maintain program budget neutrality.

This analysis uses historical HH revenue from the Medicare cost report as its basis and does not estimate the impact of Home Health Agency (HHA) level changes due to volume or case-mix. This analysis does not estimate the hospital specific revenue impacts of changes to Home Health Resource Group (HHRG) weights, which may offset or exacerbate the case-mix budget neutrality impact shown in the analysis.

The impacts do not include the impact of the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2025. The impact of sequester applicable to HH PPS-specific payment has been calculated separately and is provided at the bottom of the impact table.

This analysis also includes a worksheet called "HHRG Weight Changes" that illustrates the HHRG weight changes resulting from CMS' final recalibration of the case-mix weights.

### **Data Sources**

Estimated CY 2015 HH payments are derived from revenue data reported in the most recent Medicare cost report (2012, 2013, or 2014). Estimated CY 2016 HH payments are determined based on HH revenue from the cost report increased by the applicable update factor(s) as determined from year to year changes to the 60-day episode base rate.

Wage indexes, labor shares, and standard payment rates used in this analysis are from the CY 2015 HH PPS final rule and CY 2016 HH PPS final rule. The HHRG weights shown in the worksheet "HHRG Weight Changes" are from the CY 2015 HH PPS final rule and the CY 2015 HH PPS final rule.

### **Methods**

The dollar impact of each component change has been calculated by first determining CY 2015 HH payments. Estimated payments are derived from the Medicare cost report as described above.

The percent change for CY 2015 to CY 2016, for each HH payment change component analyzed, is calculated, and applied to estimated CY 2015 payments. The percentage impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the percent change due to the marketbasket update is applied to total CY 2015 payments. Then, the percent change resulting from the ACA-Mandated Productivity Reduction of the national 60-day episode rate is applied to the dollar result of the first change. This method continues for the remaining changes, creating a compounded effect. The difference between the results after each layered component is the impact of that component.

*This analysis does NOT include impact estimates due to high cost outliers, estimates for payments for Managed Care patients, or any modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods.*

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# Medicare Home Health Prospective Payment System

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## Payment Rule Summary — FINAL CY 2016

### Overview and Resources

On November 5, 2015, the Centers for Medicare and Medicaid Services (CMS) published its final calendar year (CY) 2016 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final rule includes updates of the Medicare fee-for-service (FFS) HH PPS payment rates and other regulatory changes, as well as implements policies as legislated by the US Congress. Among the final regulatory updates and policy changes are:

- Implementation of the third year of a four-year phase-in for rebasing adjustments to the HH PPS payment rates mandated by the Affordable Care Act (ACA) of 2010;
- Reduction to the national, standardized, 60-day episode payment rates of 0.97 percent in CY 2016, CY 2017, and CY 2018 to recoup overpayments for nominal case-mix growth between CY 2012 and CY 2014;
- Updates to the Home Health Resource Group (HHRG) weights;
- Implementation of a home health value-based purchasing (HHVBP) model with payment adjustments beginning January 1, 2018, applicable to Home Health Agencies (HHAs) in selected states;
- Changes to the home health quality reporting program requirements and the addition of one new measure.

A copy of the *Federal Register* (FR) with this final rule and other resources related to the HH PPS are available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html>.

An online version of the final rule is available at <https://federalregister.gov/a/2015-27931>.

A brief summary of the final rule is provided below. Program changes adopted by CMS would be effective for services provided on or after January 1, 2016 unless otherwise noted

### HH PPS Payment Rates

*FR pages 68629-68654*

The tables below show the final CY 2016 conversion factor compared to the final CY 2015 conversion factor and the components of the update factor:

	Final CY 2015	Final CY 2016	Percent Change
<b>60-Day Episode Rate</b>	<b>\$2,961.38</b>	<b>\$2,965.12</b>	<b>0.13%</b>

Final CY 2016 Update Factor Component	Value
Marketbasket (MB) Update	+2.3% (proposed at +2.9%)
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.4 percentage points (proposed at -0.6 percentage points)
Negative Rebasing Adjustment	-\$80.95 (-2.69%)
Nominal Case-Mix Growth Reduction	-0.97% (proposed at -1.72%)
Case-Mix Budget Neutrality Adjustment	1.87% (proposed at 1.41%)
Wage Index Budget Neutrality	0.11% (proposed at 0.06%)
<b>Overall Final Rate Update</b>	<b>0.13%</b>

- National Per-Visit Amounts**

HH PPS payments for episodes with four visits or less are paid on a per visit basis. CMS uses national per-visit amounts by service discipline to pay for these “Low-Utilization Payment Adjustment” (LUPA) episodes. The national per-visit amounts are also used for outlier calculations. The final CY 2016 per-visit amounts include a rebasing increase of 3.5% of the national per-visit payment amounts in CY 2010 and an update factor increase of 1.9%.

Per-Visit Amounts	Final CY 2015	Final CY 2016	Percent Change	Final CY 2016 With LUPA Add-On *
Home Health Aide	\$57.89	\$60.87	+5.2%	N/A
Medical Social Services	\$204.91	\$215.47		N/A
Occupational Therapy	\$140.70	\$147.95		N/A
Physical Therapy (PT)	\$139.75	\$146.95		\$245.41 (1.6700 adj.)
Skilled Nursing (SN)	\$127.83	\$134.42		\$248.02 (1.8451 adj.)
Speech Language Pathology (SLP)	\$151.88	\$159.71		\$259.78 (1.6266 adj.)

\* For SN, PT, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue the use of the LUPA add-on factors established in the CY 2014 final rule.

- NRS Conversion Factor**

In CY 2008, CMS carved out the NRS component from the 60-day episode rate and established a separate national NRS conversion factor with six severity group weights to provide more adequate reimbursement for episodes with a high utilization of NRS. The CY 2016 NRS conversion factor includes a rebasing reduction -2.82% and an update factor increase of 1.9%.

	Final CY 2015	Final CY 2016	Percent Change
<b>NRS Conversion Factor</b>	<b>\$53.23</b>	<b>\$52.71</b>	<b>-1.0%</b>

Severity Level	Points (Scoring)	Relative Weight (no change from prior years)	Final Payment Amount
1	0	0.2698	\$14.22
2	1 to 14	0.9742	\$51.35
3	15 to 27	2.6712	\$140.80
4	28 to 48	3.9686	\$209.18
5	49 to 98	6.1198	\$322.57
6	99+	10.5254	\$554.79

## Effect of Sequestration

*FR page reference not available*

All lines of Medicare payments authorized by Congress and currently in effect through federal fiscal year (FFY) 2025 are subject to a 2.0% sequester reduction. Sequester will continue unless/until Congress intervenes. Sequester adjustments are not applied to payment rates; they are a reduction to the Medicare claim payment after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary adjustments.

## Wage Index and Labor-Related Share

*FR pages 68647-68649*

CMS will maintain the labor-related share at 78.535% for CY 2016. The labor-related portion of the HH payment rate is adjusted for differences in area wage levels using a wage index. CMS is not making any major changes to the calculation of Medicare HH wage indexes. As has been the case in prior years, CMS will use the most recent inpatient hospital wage index, the FFY 2016 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2016. A complete list of the final wage indexes for payment in CY 2016 is available on the CMS Web site 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?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

## Payment Add-On for Rural HH Agencies

*FR pages 68651-68654*

The ACA, by amending the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandated a 3.0% increase to the payments for HH PPS episodes and visits provided in rural areas between April 1, 2010 and January 1, 2016. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended the MMA again, extending the 3.0% increase to payments for HH PPS episodes and visits in rural areas for another two years. The 3.0% rural add-on now applies to payments for episodes and visits ending on or after April 1, 2010, and before January 1, 2018.

This 3.0% add-on is not subject to budget neutrality and is applied to the 60-day episode rate, the national per-visit amounts, LUPA add-on payments, and the NRS conversion factor.

	Final CY 2016 60-Day Episode Rate	Multiply by the 3 percent Rural Add-on	Final Rural CY 2016 60-Day Episode Rate
<b>Rural Add-On Payment</b>	<b>\$2,965.12</b>	<b>X 1.03</b>	<b>\$3,054.07</b>

## Reductions Due To Nominal-Case-Mix Growth

*FR pages 68638-68647*

Previously, CMS accounted for nominal case-mix growth through HHRG weight reductions, implemented from 2008 through 2013, in order to better align payment with real changes in patient severity. In CY 2015 there was no nominal case-mix growth. For CY 2016, CMS proposed a total reduction of 3.41%, implemented and distributed evenly over a two year period. However, after reassessing their methodology in response to comments, CMS is finalizing a total reduction of 2.88%, implemented and distributed evenly over a three year period. This means that each year there will be a 0.97% reduction in CY 2016, CY 2017, and CY 2018 (proposed at 1.72% reduction for both CY 2016 and CY 2017) to the national, standardized 60-day episode payment rate.

This reduction accounts for nominal-case mix growth from CY 2012 to CY 2014. CMS' goal is to have Medicare pay more accurately for the delivery of home health service and this reduction will remain separate from the CY 2014 rebasing adjustments.

## **HHRG Update**

*FR pages 68629-68638*

The HH PPS program uses a 153-category case-mix classification called Home Health Resource Groups (HHRGs). Patients' clinical severity level, functional severity level, and service utilization are extracted from the Outcome and Assessment Information Set (OASIS) instrument and used to assign HHRGs. Each HHRG has an associated case-mix weight which is used in calculating the payment for an episode. According to CMS, the HHRG weights were designed to maintain an average case-mix of about 1.0 for the nation.

In the CY 2015 HH PPS final rule, CMS implemented a recalibration of case-mix weights to occur each year using the most current data available. This annual recalibration guarantees that the case-mix weights will reflect the current status of home health resource use and changes in utilization. For CY 2016, CMS is recalibrating the HH PPS case-mix weights using cost and utilization data from CY 2014. Overall the impact of the change is negative; therefore, CMS is increasing the 60-day episode rate by 1.87% in order to maintain budget neutrality for the HH PPS program.

## **Outlier Payments**

*FR pages 68654-68655*

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever a HHA's cost for an episode of care (calculated using the number of visits in the episode multiplied by a wage index-adjusted national per-visit amount) exceeds a fixed-loss threshold (the HH PPS payment amount for the episode plus a fixed dollar loss [FDL] amount).

The FDL ratio is multiplied by the wage index-adjusted 60-day episode payment rate then added to the HH PPS payment amount for that episode. If the calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments are set aside for outliers. To maintain total outlier payments at 2.5% of total HH PPS payments, CMS will maintain an FDL ratio of 0.45 for CY 2016.

## **Mandatory HH VBP Model Demonstration Project**

*FR pages 68656-68690*

**Background:** CMS is implementing an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, starting January 1, 2016 and concluding December 31, 2022. The Medicare-certified HHAs required to participate are from nine randomly selected states, each from one of nine regional groupings determined by CMS. The demonstration program resembles the VBP Program for inpatient acute care hospitals.

Random states were selected through grouping states by geographic proximity to one another and accounting for certain evaluation characteristics. The nine states are Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. More information on state selection is available in the *Federal Register* pages 68659-68663.

Medicare-certified HHAs that are included in the HHVBP model would be required to compete for payment adjustments to their current PPS reimbursements based on their quality performance. A competing Medicare-certified HHA is defined as “an agency having a current Medicare certification that is being reimbursed by CMS for home health care delivered in the boundaries of any of the randomly selected states to participate”. Payment adjustments for each year of the model would be calculated based on a comparison of how well each of the competing Medicare-certified HHA performed during each one year performance period, beginning in CY 2016, compared to the baseline year CY 2015, as well as performance of their peers. The first payment adjustment will be applied in CY 2018.

Payment Period	Performance Period	Aggregate HHVBP Payment Adjustment
CY 2018	January 1, 2016 – December 31, 2016	3% max (proposed at 5% max)
CY 2019	January 1, 2017 – December 31, 2017	5% max
CY 2020	January 1, 2018 – December 31, 2018	6% max
CY 2021	January 1, 2019 – December 31, 2019	7% max (proposed at 8% max)
CY 2022	January 1, 2020 – December 31, 2020	8% max

The goal of the HHVBP model is to improve the overall quality of home health care and delivering it to the Medicare population in a more efficient manner. The HHVBP demonstration program recognizes both the achievement of high quality standards and the improvement in quality performance. HH agencies in the selected state will be subject to upward and downward payment adjustments based on performance on the measures chosen.

The HHVBP model will adjust Medicare HHA payments over the course of the model by up to 8% depending on the applicable performance year and the degree of quality performance demonstrated by each competing Medicare-certified HHA. The HHVBP program will be budget neutral by state. Similar to the Hospital VBP program, this is redistributive and all HHAs in the mandated state will contribute and receive payments to the VBP pool; some will then get their contribution back, and some may get less.

## Quality Measures

*FR pages 68667-68679*

The initial set of measures for the first performance year of the HHVBP demonstration include 6 process measures, 10 outcome measures, 5 HHCAHPS, and 3 new additional measures in this rule.

Quality Measures:

NQS Domain	Measure Type	Measure Title	Data Source
Clinical Quality of Care	Outcome	Improvement in Ambulation-Locomotion (NQF0167)	OASIS (M1860)
	Outcome	Improvement in Bed Transferring (NQF0175)	OASIS (M1850)
	Outcome	Improvement in Bathing (NQF0174)	OASIS (M1830)
	Outcome	Improvement in Dyspnea	OASIS (M1400)
	Process	Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care	OASIS (M2015)
	Outcome	Discharged to Community	OASIS (M2420)

<b>Communication &amp; Care Coordination</b>	<b>Process</b>	<b>Care Management: Types and Sources of Assistance</b>	<b>OASIS (M2102)</b>
<b>Efficiency &amp; Cost Reduction</b>	<b>Outcome</b>	<b>Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health (NQF0171);</b>	<b>CCW (Claims)</b>
	<b>Outcome</b>	<b>Emergency Department Use Without Hospitalization (NQF0173)</b>	<b>CCW (Claims)</b>
<b>Patient Safety</b>	<b>Outcome</b>	<b>Improvement in Pain Interfering with Activity (NQF0177)</b>	<b>OASIS (M1242)</b>
	<b>Outcome</b>	<b>Improvement in Management of Oral Medications (NQF0176)</b>	<b>OASIS (M2020)</b>
	<b>Outcome</b>	<b>Prior Functioning ADL/IADL (NQF0430)</b>	<b>OASIS (M1900)</b>
<b>Population/Community Health</b>	<b>Process</b>	<b>Influenza Immunization Received for Current Flu Season (NQF0522)</b>	<b>OASIS (M1046)</b>
	<b>Process</b>	<b>Influenza Vaccine Data Collection Period</b>	<b>OASIS (M1041)</b>
	<b>Process</b>	<b>Pneumococcal Polysaccharide Vaccine Ever Received (NQF0525)</b>	<b>OASIS (M1051)</b>
	<b>Process</b>	<b>Reason Pneumococcal vaccine not received</b>	<b>OASIS (M1056)</b>
<b>Patient &amp; Caregiver Centered Experience</b>	<b>Outcome</b>	<b>Willingness to recommend the agency</b>	<b>HHCAHPS</b>
	<b>Outcome</b>	<b>Communications between Providers and Patients</b>	<b>HHCAHPS</b>
	<b>Outcome</b>	<b>Care of Patients</b>	<b>HHCAHPS</b>
	<b>Outcome</b>	<b>Specific Care Issues</b>	<b>HHCAHPS</b>
	<b>Outcome</b>	<b>Overall Rating of Home Health Care</b>	<b>HHCAHPS</b>

The New Measures are:

NQS Domain	Measure Type	Measure Title	Data Source
<b>Population/Community Health</b>	<b>Process</b>	<b>Influenza Vaccination Coverage for Home Health Care Personnel (NQF0431)</b>	<b>Reported by HHAs through Web-based portal beginning no later than October 7, 2016</b>
	<b>Process</b>	<b>Herpes Zoster (Shingles) Vaccination Received by HHA Patients</b>	
<b>Communication &amp; Care Coordination</b>	<b>Process</b>	<b>Advance Care Plan (NQF0326)</b>	

### Inclusion/Exclusion Criteria

*FR pages 68663, 68681-68682, 68685-68687*

Although every HHA in a selected state must participate in the HHVBP model, each HHA may not receive a payment adjustment every period due to an inadequate number of episodes of care to generate sufficient quality measure data. The minimum threshold for a HHA to receive a score on a given measure is 20 home health episodes of care per year for HHAs that have been certified for at least 6-months. In order to receive a payment adjustment the HHA must meet this threshold in at least five of the Clinical Quality of Care, Care Coordination and Efficiency, and Person and Caregiver-Centered Experience measures. Otherwise a payment adjustment will not be made for that particular HHA. If the HHA has greater volume during later performance years, the HHA will be subject to future payment adjustment. The HHA will still receive quality reports on any measures for which they have 20 episodes of care.

When there are too few HHAs in the smaller-volume cohort in a state to compete in a fair manner, these specific HHAs would be included in the state’s larger-volume cohort without being measured on Home Health Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS). This is for purposes of calculating the total performance score and payment adjustment for those HHAs.

## Scoring

FR pages 68679-68688

**Background:** The quality measures are aligned with six National Quality Strategy (NQS) domains. For the HHVBP, CMS is grouping these NQS domains into four classifications in order to correctly calculate payment adjustments based on the other measures. Measure distribution from the six NQS domains into the four classifications has not yet been determined. However, measures within each classification will be weighted the same for the purposes of payment adjustments. The model also includes the HHCAHPS for the competing Medicare-certified HHAs.

HHAs are scored on their quality of care based on performance compared to both the performance of HHAs in the same size cohort and also their own past performance. Points are aggregated on individual measures across the four classifications to calculate the Total Performance Scores (TPS).

Classification	Possible Points	Measure Weight for each Classification
Clinical Quality of Care	0-10 points	30%
Care Coordination and Efficiency		30%
Person- and Caregiver-Centered Experience		30%
New Measures		10%

As for the new measures, HHAs will receive 10 points for each new measure they report and 0 points for each they do not. In total, the new measures will account for 10% of the TPS regardless of the number of measures applied to an HHA in the other three classifications. This is different than proposed in that HHAs were to instead receive 10 points if they reported all of the new measures and 0 points if they did not.

TPS and payment adjustments would be calculated based on an HHA’s CMS Certification Number (CCN) and would be based only on services provided to beneficiaries in the selected nine states. However, HHAs that provide services in a state that have a reciprocal agreement with the HHA’s home state would have those services included in the TPS. CMS will calculate a score for achievement and another score for improvement. The higher of the two scores is used as the TPS for each measure.

$$\text{Achievement: } [9 \times \left( \frac{\text{HHA Performance Score} - \text{Achievement Threshold}}{\text{Benchmark} - \text{Achievement Threshold}} \right) + 0.5]$$

$$\text{Improvement: } [10 \times \left( \frac{\text{HHA Performance Score} - \text{HHA Baseline Period Score}}{\text{Benchmark} - \text{HHA Baseline Period Score}} \right) - 0.5]$$

The achievement threshold and benchmark will be calculated separately for each selected state and each HHA cohort size. CMS will have individual benchmarks and achievement thresholds for both larger-volume (HHAs that participate in HHCAHPS) and smaller-volume cohorts (HHAs that are exempt from participation in

HHCAHPS) of HHAs. The thresholds and benchmarks are defined in each state based on a CY 2015 baseline period. HHAs will be competing with those HHAs in their state and their cohort size.

		Duration
<b>Achievement threshold</b>	<b>Median of HHA's performance on each measure</b>	<b>Baseline Period</b>
<b>Benchmark</b>	<b>Mean of top decile of HHA's performance on each measure</b>	

CMS will use a linear exchange function (LEF) to calculate HHA payment adjustments. The LEF translates a HHAs TPS into a percentage of the value-based payment adjustment earned by each HHA under the HHVBP model. The intercept of LEF will be zero percent, meaning HHAs that are average in relationship to other HHAs in their cohort would receive no payment adjustment. CMS is setting the slope for CY 2016 so that the estimated aggregate value-based payment adjustments for CY 2016 are equal to 3 percent (proposed at 5%) of the total amount of episode payments made to all HHAs by Medicare in each individual state in the larger- and smaller-volume cohorts respectively (aggregate base operating episode payment amounts ) for CY 2018.

### Reporting/Review, Correction and Appeals Process

*FR pages 68664, 68688-68690*

A quarterly report will be provided to each Medicare certified HHA containing information on their performance during the quarter:

Report	First Release	Releases Thereafter	Final Release
<b>Quarterly</b>	<b>July 2016</b>	<b>October, January, and April</b>	<b>April 2021</b>

Another report will be released once a year containing payment adjustment percentage and an explanation of when the adjustment would be applied and how the adjustment was calculated specific and accessible only to each individual HHA. A final annual report would then be publicly available that would provide home health industry stakeholders with information about their home health services quality of care. The first quarterly performance report in July 2016 will not account for any of the new measures.

CMS has finalized a review and recalculation process for the HHVBP model. Medicare-certified HHAs will have the opportunity to review their TPS and payment adjustment calculations and request a recalculation if a discrepancy is identified due to a CMS error. CMS will provide the previously mentioned reports and HHAs will have a 30-day (proposed at 10-day) period to review and correct information after quarterly reports and annual reports are released.

A list of instructions on how to submit an appeal is available on the *Federal Register* pages 68688-68689.

A report on the development/design of a VBP program for HH providers (as mandated by the ACA) is available on the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF>.

## Updates to the HH Quality Reporting Program (HH QRP)

FR pages 68690-68710

CMS collects quality data from HHAs on process, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

All of the process and most outcomes measures required under the HH QRP are derived from the OASIS assessment instrument. Medicare Conditions of Participation (CoPs) require all HH providers that participate in Medicare and Medicaid to collect and report OASIS data to CMS. In addition, HH providers must collect patient experience of care data using the HHCAHPS survey; CMS also calculates two HH QRP outcomes measures based on HH claims data that do not require additional reporting.

CMS discusses amendments to the Improving Medicare Post-Acute Care Transformation (IMPACT) Act which consists of new data reporting requirements for HHAs that CMS must implement by January 1, 2017. The IMPACT Act requires HHAs to submit standardized patient assessment data along with data on quality, resource use, and other measures. The IMPACT Act states that HHAs must begin submitting the standardized patient assessment data no later than January 1, 2019. A reduction will occur to the payment rate if the data is not submitted by that date or it is not considered satisfactory.

In the CY 2015 Final Rule, CMS established a new pay-for-reporting performance standard to be phased in over three years for the submission of OASIS quality data. HHAs must meet a minimum reporting threshold, titled Quality Assessment Only (QAO), for OASIS data in order to avoid a 2% marketbasket reduction. CMS is implementing an increase in the minimum reporting threshold over the next three years:

$$\text{QAO} = \left( \frac{\text{\# of Quality Assessments Reported}}{\text{\# of Quality Assessments Reported} + \text{\# of NonQuality Assessments Reported}} \right) * 100$$

Performance Period	QAO Minimum Reporting Threshold
July 1, 2015 – June 30, 2016	70%
July 1, 2016 – June 30, 2017	80%
July 1, 2017 – June 30, 2018	90%

CMS is implementing a new standardized, cross-setting measure for CY 2016 HH QRP reporting; Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678). This measure reports the percent of patients with Stage 2 through 4 pressure ulcers that are new or worsened since the beginning of the episode of care. Reporting of the measure began January 1, 2015 and will be used for payment determination beginning CY 2018.

A future update is being considered to the numerator of the measure in which providers would also be held accountable for the development of unstageable pressure ulcers and suspected deep tissue injuries.

In addition, CMS identified four future measure constructs under consideration for January 1, 2017 in order to meet IMPACT Act requirements:

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

CMS is also identifying areas for future measure enhancement and development. Seven measure constructs are under development for future rulemaking:

- 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).

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