On Monday, July 6, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the calendar year 2016 home health proposed rule. The regulation, if codified, would have an overall estimated economic impact of -$350 million (or -1.8 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 would also implement a new quality measure and a value-based payment pilot for home health providers.

CMS proposes to implement the value-based payment pilot program for home health agencies beginning January 2016. The program would require participation of all home health agencies in nine states. Participating agencies would be subject to incentives and penalties in the range of five to eight percent, beginning with five percent in the first two years of the program. CMS would select states 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 -$350 million. Nonprofit and proprietary home health agencies will be impacted nearly the same. CMS estimates that the changes in payment will result in rural home health agencies taking an aggregate 2.4 percent pay cut while urban agencies face a 1.7 percent pay cut in aggregate. The difference between urban and rural providers is due to wage index changes.

Comments on the rule are due to CMS by September 4, 2015.

<table>
<thead>
<tr>
<th>CY 2016 Proposed National Standardized Episode Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS calculates the proposed 2016 national standardized episode rate at $2,938.37. This rate was calculated using the following methodology:</td>
</tr>
</tbody>
</table>
| \[
| \text{CY 2016 Rate} = (2015 \text{ rate of } $2961.38 \times (1.0006 \text{ wage index budget neutrality factor}) \times (1.0141 \text{ case mix weight adjustment budget neutrality factor}) \times (.9828 \text{ case mix adjustment}) \times (1.023 \text{ market basket update})) - ($80.95 \text{ rebasing adjustment}) |
|}
Major Provisions of the Proposed Rule

CMS proposes to:

1. Implement the third year of rebasing, which results in a 3.45 percent reduction in the payment rate.
2. Reduce the home health episode rate by 1.72 percent to adjust for coding intensity.
3. Reduce the market basket update by a .6 percent productivity factor.
4. Implement a home health value-based payment program beginning in nine states in January 2016.
5. Implement a new IMPACT Act measure related to new or worsening pressure ulcers.
6. Increase the pay-for-performance reporting threshold to 80% for the reporting period beginning July 1, 2016.

Summary of Major Provisions of the Proposed Rule

1. Proposed Provisions of the Home Health Prospective Payment System

   Monitoring for Potential Impacts – Affordable Care Act Rebasing Adjustments

In the rule, CMS proposes to implement the third of four years of rebasing. CMS would reduce the standardized home health payment by 3.45 percent, the maximum permitted under the law.

CMS summarizes the findings of its ongoing analysis of the impacts of rebasing. Using 2013 cost report and claims data and MedPAC’s most recent analysis, CMS concludes that HHA margins are likely to remain high under the current rebasing schedule. CMS’ analysis found that a -5.02 percent rebasing adjustment would be needed to align payments with costs. This estimate is larger than the -3.45 percent that will be applied to payments in 2016.

CMS also reported on other findings, including changes in home health utilization. In total, there has been a 3 percent decrease in home health users and a 3.8 percent decrease in home health episodes. However, much of this reduction has been concentrated in Texas and Florida – both states that are historically high utilizers and that have been subject to moratoria in this period. Excluding the 6 states with the highest utilization, the number of home health episodes actually declined by 2.6 percent and the number of patients declined by 2.4 percent. CMS suggests that this may be a result of reduced discharges from hospitals and skilled nursing facilities, which impact referrals to home health. Of significance to VNAA is CMS’ admission that the reduction of visits from 21.7 visits in 2009 to 18.0 in 2014 was concentrated in skilled nursing and aide services. This data supports the assertion that the current payment system may discourage admission of clinically complex patients who do not qualify for therapy visits.
CY 2016 HH PPS Case-Mix Weights and Proposed 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 proposes to recalibrate the weights assigned to each case mix grouping using the most current claims and OASIS data available. CMS states that it would update the weights in the final rule when even more current data is available. The methodology used by CMS includes slight changes to the points awarded in scoring as well as changes in the clinical and therapy thresholds for the steps used in the payment model. (See Tables 6 & 7 in the proposed rule). The resulting case mix weights are presented in Table 8 of the rule.

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

CMS elected not to do case mix adjustments (nominal case mix growth) last year. However, this year CMS proposes significant cuts over the next two years based on its analysis that the average case mix weight continues to exceed its best estimate of actual case mix increase. It proposes to reduce payments for nominal case mix growth by 1.72 percent in both 2016 and 2017. CMS 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

CMS proposes to apply the pre-floor, pre-reclassified hospital wage index to home health payments. This wage index is estimated to be 2.9 percent. However, using the standard methodology it has developed to factor productivity gains into the wage index, CMS has calculated a .6% increase in productivity. Thus, the proposed wage index increase for 2016 is reduced to 2.3 percent.

CY 2016 Home Health Wage Index

In addition to the usual changes in wage index, CMS proposes to phase 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 tables reflecting these wage index changes. These can be found on the CMS website here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1625-P.html

CY 2016 Annual Payment Update
In the 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 proposes the following changes to the payment update:

**CY 2016 National, Standardized 60-Day Episode Payment Rate**

CMS calculates the proposed 2016 national standardized episode rate for 2016 at $2,938.37. This reflects the 2015 rate of $2961.38, multiplied by 1.0006 wage index budget neutrality factor, 1.0141 case mix weight adjustment budget neutrality factor, .9828 case mix creep reduction, and the market basket update of 1.023. This amount is then reduced by the -$80.95 rebasing adjustment. Per standing policy, the rate is further reduced by 3 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 Tables 10, 11, 18 and 20.

**CY 2016 National Per-Visit Rates**

CMS proposes to adjust the 2016 per visit rates upward by the wage index budget neutrality factor of 1.0006, a rebasing adjustment and the market basket with a 3 percent increase for rural agencies and a 3 percent reduction for any agency failing to report quality data. See tables 12, 13, and 19.

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

CMS proposes to continue its existing methodology for calculating LUPA payments which includes a factor of the increased 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 proposes to reduce nonroutine medical supply payment rates through a reduction in the 2015 conversion factor from $53.23 to $52.92 due to the rebasing adjustment of .9718 and market basket of 1.023. See Tables 14 and 16.

**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 may exceed 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

CMS summarizes again the results of the Section 3131(d) Vulnerable Patient Study in the rule. CMS indicates that while there were mostly positive access findings, inadequate margins for episodes associated with certain types of cases resulted in challenges to accessing care. While CMS reiterates that some access problems are beyond the control of the payment system, the study pointed to the need to make modifications to the payment model to better match payment to resource use.

CMS has contracted with ABT associates to explore possible changes to the system. One alternative discussed is the Diagnosis on Top model. This model gives more weight to patient diagnosis by starting the payment calculation with diagnosis and then adding the other factors to fine tune the payment. This alternative does not use therapy thresholds and its complexity may lead to more precise payments based on resource use. This model was considered originally but not accepted because its predictive power at the time was not that much greater than the selected system which was simpler to implement and explain.

Another payment alternative discussed in the rule is a Predicted Therapy Model. This model addresses the well-documented concerns of employing actual therapy usage to control payment by substituting a predicted amount of therapy needed rather than the amount actually provided by the agency.

The final alternative discussed is the Home Health Groupings Model. This approach uses clinical judgment to assign each ICD code to one of seven groups (e.g. neuro/stroke rehab, post op wound care, complex medical care) based on the typical care needed. This grouping would then determine payment, perhaps in combination with other OASIS variables.

CMS indicates there will be further work on these models by ABT, as well as the convening of a Clinical Work Group and Technical Expert Panel to consider next steps.

Technical Regulations Text Changes

CMS proposes a number of technical changes 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.
2. Proposed Home Health Value-Based Purchasing Model

CMS proposes to implement a home health value-based purchasing (HHVBP) pilot program. The pilot program would launch in January 2016 and continue for five years. Due to time delays with collecting and processing performance data, payment adjustments will begin in year two (2018) and continue for five years. In total, the process will be completed over seven years. The proposed model would be tested by CMS’ Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Social Security Act.

CMS would select nine states for participation that together form a nationally representative sample. The states would be chosen on a semi-random basis with consideration of average agency size, population density, patient characteristics, and average service utilization. All HHAs in the selected states would be required to participate in the program. If the methodology in the proposed rule is codified, the following states will participate: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. The selection of states is subject to change pending the final regulation.

Overview of the HHVBP Program:

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

Performance Measure Set. CMS would measure HHA performance for all Medicare beneficiaries (and no other patients) treated within the participating state. CMS proposes to assess performance using 10 process measures, 15 outcome measures, and 4 “New Measures” (see Table 1).
Table 1: CMS-Proposed Starter Measure Set

<table>
<thead>
<tr>
<th>Process</th>
<th>Outcome</th>
<th>New Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Timely Initiation of Care</td>
<td>1. Improvement in Ambulation-Locomotion</td>
<td>1. Adverse Event for Improper Medication Administration and/or Side Effects</td>
</tr>
<tr>
<td>2. Care Management: Types and Sources of Assistance</td>
<td>2. Improvement in Bed Transferring</td>
<td>2. Influenza Vaccination Coverage for Home Health Care Personnel</td>
</tr>
<tr>
<td>3. Pressure Ulcer Prevention and Care</td>
<td>3. Improvement in Bathing</td>
<td>3. Herpes Zoster (Shingles) Vaccination: Has the patient ever received the shingles vaccination?</td>
</tr>
<tr>
<td>5. Depression Assessment Conducted</td>
<td>5. Discharge to Community</td>
<td></td>
</tr>
<tr>
<td>6. Influenza Data Collection Period: Does this episode of care include any dates one or between October 1 and March 31?</td>
<td>6. Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health; Hospitalization during first 30 days of Home Health</td>
<td></td>
</tr>
<tr>
<td>7. Influenza Immunization Received for Current Flu Season</td>
<td>7. Emergency Department Use Without Hospitalization</td>
<td></td>
</tr>
<tr>
<td>8. Pneumococcal Polysaccharide Vaccine Ever Received</td>
<td>8. Improvement in Pain Interfering with Activity</td>
<td></td>
</tr>
<tr>
<td>9. Reason Pneumococcal vaccine not received</td>
<td>9. Improvement in Management of Oral Medications</td>
<td></td>
</tr>
<tr>
<td>10. Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care</td>
<td>10. Prior Functioning ADL/IADL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Care of Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Communications Between Providers and Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Specific Care Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Overall Rating of Home Health Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Willingness to Recommend the Agency</td>
<td></td>
</tr>
</tbody>
</table>

CMS proposes to categorize these measures into four classifications: Clinical Quality of Care, Outcome and Efficiency, Person- and Caregiver-Centered Experience, and New Measures.

**Performance Assessment Methodology.** Distribution of payments would be based on a combination of performance and reporting, depending on the measure. Performance would be measured by both achievement and improvement. Participating HHAs would be evaluated based on their performance compared to both the performance of their peers, as defined by the same size cohort within their state, and their own past performance. CMS proposes to use two size cohorts – large and small – which are defined by whether the HHA participates in HHCAHPs (large) or is exempt (small).

CMS proposes to 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 would be
weighted equally. The measures categorized under Clinical Quality of Care, Outcome and Efficiency, and Person- and Caregiver-Centered Experience will account for 90% of the TPS. The measures included in the New Measures category will account for 10% 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 is then statistically arrayed relative to those of all agencies within the agency’s size category and state. A positive or negative payment adjustment percent is calculated that reflects the agency’s relative ranking along the distribution of all scored agencies in its cohort. Big winners and big losers occupy opposite ends of that distribution while mid-level performers experience relatively small prospective payment adjustments.

CMS proposes to use January 1, 2015 – December 31, 2015 as the baseline period. It also proposes to keep 2015 as the baseline 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 would have several opportunities to review their performance reports and engage with CMS to address discrepancies. CMS proposes to use quarterly performance reports, annual payment adjustment reports and annual publically-available performance reports. CMS would share the annual payment adjustment reports with HHAs in the August prior to the payment year. For 2018, the first payment year, HHAs will be notified of their payment adjustment amount on August 1, 2017. The HHA will have a 10 day preview period during which they can work with CMS to reconcile any performance assessment issues. The final payment adjustment will be finalized no later than November 1 in advance of each payment year.

**Evaluation Methodology.** CMS is in the process of procuring an evaluation contractor. Therefore, the proposed rule does not include a detailed evaluation methodology.

### 3. Proposed Provisions of the Home Health Care Quality Reporting Program (HH QRP)

CMS proposes several changes to the HH QRP, including inclusion of new measures and changes to the minimum reporting threshold for CY 2016 and CY 2017. CMS also requests input on measure constructs and concept areas for measure development.

**Proposed IMPACT Act Measure for 2016**

CMS proposes one new standardized cross-setting measure for CY 2016 to meet the requirements of the IMPACT Act: NQF #0678 – Percent of Residents of Patients with Pressure Ulcers That Are New or Worsened (Short Stay). This measure addresses a high risk, high cost performance area and has already been implemented using a harmonized set of data elements in the other IMPACT Act
settings. CMS’ Technical Expert Panel (TEP) and the National Quality Forum’s Measure Applications Partnership (MAP) support the use of this measure.

CMS would calculate the measure using data elements already collected through the OASIS-C1. CMS anticipates risk adjusting the measure based on Activities of Daily Living Assistance, Transferring, and Bowel Incontinence Frequency. CMS seeks comment on whether it should also adjust the measure by body mass index (BMI), which is done in other post-acute care settings. CMS also seeks comment on whether it should hold providers accountable for the development of unstageable pressure ulcers and suspected deep tissue injuries in a future iteration of the measure.

**Proposed Measure Constructs for Purposes of Meeting IMPACT Act Requirements**

CMS identifies four cross-setting measure constructs to potentially meet requirements of the IMPACT Act. CMS seeks input to inform measure development of these constructs.

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

**Future Setting-Specific Measure Constructs under Consideration**

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

- 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).

**Performance Reporting Thresholds**

Home health agencies are currently required to achieve a pay-for-performance reporting threshold of at least 70 percent. CMS seeks to achieve a reporting threshold of 90 percent. Preliminary analysis conducted by CMS indicate that the majority of agencies are already achieving the target goal of 90 percent. In the rule, CMS proposes to set the 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.