Issue Brief

FEDERAL ISSUE BRIEF • October 29, 2015

KEY POINTS

- the final rule will reduce home health payments by 1.4 percent from 2015, amounting in a $260 million decrease
- case mix weight adjustments
- finalizing a .97 percent reduction to the national, standardized 60-day episode payment rate in calendar years 2016, 2017 and 2018
- adoption of home health value-based purchasing model in selected states

CMS Finalizes Home Health Update for CY 2016

The Centers for Medicare & Medicaid Services has issued a final calendar year 2016 update to the home health prospective payment system. The changes will become effective Jan. 1, 2016.

The 297-page rule is currently on display at the *Federal Register* at: https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home. Publication is scheduled for Nov. 5.

The rule will (1) update the payment rates for HHAs for CY 2016; (2) reflect the 3rd year of the 4-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, and the NRS conversion factor finalized in the CY 2014 HH PPS final rule as required under section 3131(a) of the Affordable Care Act; (3) update the case-mix weights; (4) provide a clarification regarding the use of the "initial encounter" seventh character applicable to certain ICD-10-CM code categories; (5) finalize reductions to the national, standardized 60-day episode payment rate in CY 2016, CY 2017, and CY 2018 of 0.97 percent in each year to account for case-mix growth unrelated to increases in patient acuity (nominal case-mix growth) between CY 2012 and CY 2014; (6) finalize proposals to implement an HH Value-Based Purchasing model, in which certain Medicare-certified HHAs are required to participate, beginning Jan. 1, 2016, under the authority of section 1115A of the Act; (7) finalize changes to the home health quality reporting program requirements; and (8) finalize minor technical regulations text changes in 42 CFR parts 409, 424, and 484 to better align the payment requirements with recent statutory and regulatory changes for home health services.

The rebasing adjustments will reduce the national, standardized 60-day episode payment amount by $80.95, increase the national per-visit payment amounts by 3.5 percent of the national per-visit payment amounts in CY 2010 with the increases ranging from $1.79 for home health aide services to $6.34 for medical social services, and reduce the NRS conversion factor by 2.82 percent.

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continued

COMMENT

According to CMS, the overall economic impact of the HH PPS payment rate update is an estimated loss of $260 million (-1.4 percent) in payments to HHAs. The -$260 million impact reflects the distributional effects of the 1.9 percent HH payment update percentage ($345 million increase), the effects of the third year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit payment rates, and the NRS conversion factor for an impact of -2.4 percent ($440 million decrease), and the effects of the -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth ($165 million decrease).

The overall economic impact of the HHVBP model provision for CY 2018 through 2022 is an estimated $380 million in total savings from a reduction in unnecessary hospitalizations and SNF usage as a result of greater quality improvements in the HH industry.

There is a trend developing throughout the various PPS programs in which CMS continues tinkering with adjustments to reduce payments to account for only "real case-mix changes" and not those that are not related to an underlying change in patient health status. This is troubling since it does not appear these reductions to payments may cease any time soon as CMS appears intent on determining yearly adjustments.

If CMS is going to continue the case-mix issue, it needs to be called to task of making adjustments for all other errors it makes, not just those that may benefit the program.

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

1. CY 2016 HH PPS Case-Mix Weights

The following table identifies the CY 2016 case-mix weights. We have added the current CY 2015 weights that were in the proposed rule for comparison purposes.

Final CY 2016 Case-Mix Payment Weights

Payment Group	Step (Episode and/or Therapy Visit Ranges)	Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)	CY 2015 Case-Mix Weights	Final CY 2016 Case-Mix Weights
10111	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F1S1	0.5985	0.5908
10112	1st and 2nd Episodes, 6 Therapy Visits	C1F1S2	0.7242	0.7197
10113	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F1S3	0.8499	0.8485
10114	1st and 2nd Episodes, 10 Therapy Visits	C1F1S4	0.9756	0.9774
10115	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F1S5	1.1013	1.1063
10121	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F2S1	0.7277	0.7062
10122	1st and 2nd Episodes, 6 Therapy Visits	C1F2S2	0.8353	0.8217
10123	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F2S3	0.9429	0.9372
10124	1st and 2nd Episodes, 10 Therapy Visits	C1F2S4	1.0505	1.0527
10125	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F2S5	1.1581	1.1681
10131	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F3S1	0.7914	0.7643
10132	1st and 2nd Episodes, 6 Therapy Visits	C1F3S2	0.9056	0.8832
10133	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F3S3	1.0198	1.0021
10134	1st and 2nd Episodes, 10 Therapy Visits	C1F3S4	1.1340	1.1210
10135	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F3S5	1.2482	1.2399

Final CY 2016 Case-Mix Payment Weights				
Payment Group	**Step (Episode and/or Therapy Visit Ranges)**	**Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)**	**CY 2015 Case-Mix Weights**	**Final CY 2016 Case-Mix Weights**
10211	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F1S1	0.6370	0.6281
10212	1st and 2nd Episodes, 6 Therapy Visits	C2F1S2	0.7718	0.7690
10213	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F1S3	0.9066	0.9098
10214	1st and 2nd Episodes, 10 Therapy Visits	C2F1S4	1.0413	1.0507
10215	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F1S5	1.1761	1.1915
10221	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F2S1	0.7662	0.7435
10222	1st and 2nd Episodes, 6 Therapy Visits	C2F2S2	0.8829	0.8710
10223	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F2S3	0.9996	0.9985
10224	1st and 2nd Episodes, 10 Therapy Visits	C2F2S4	1.1163	1.1259
10225	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F2S5	1.2330	1.2534
10231	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F3S1	0.8299	0.8016
10232	1st and 2nd Episodes, 6 Therapy Visits	C2F3S2	0.9532	0.9325
10233	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F3S3	1.0765	1.0633
10234	1st and 2nd Episodes, 10 Therapy Visits	C2F3S4	1.1998	1.1942
10235	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F3S5	1.3230	1.3251
10311	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F1S1	0.6951	0.6810
10312	1st and 2nd Episodes, 6 Therapy Visits	C3F1S2	0.8541	0.8362
10313	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F1S3	1.0131	0.9913
10314	1st and 2nd Episodes, 10 Therapy Visits	C3F1S4	1.1720	1.1465
10315	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F1S5	1.3310	1.3017
10321	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F2S1	0.8242	0.7964
10322	1st and 2nd Episodes, 6 Therapy Visits	C3F2S2	0.9651	0.9382
10323	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F2S3	1.1061	1.0800
10324	1st and 2nd Episodes, 10 Therapy Visits	C3F2S4	1.2470	1.2218
10325	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F2S5	1.3879	1.3635
10331	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F3S1	0.8880	0.8544
10332	1st and 2nd Episodes, 6 Therapy Visits	C3F3S2	1.0355	0.9996
10333	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F3S3	1.1830	1.1449
10334	1st and 2nd Episodes, 10 Therapy Visits	C3F3S4	1.3305	1.2901
10335	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F3S5	1.4780	1.4353
21111	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F1S1	1.2270	1.2351
21112	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F1S2	1.4220	1.4323
21113	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F1S3	1.6171	1.6296
21121	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F2S1	1.2657	1.2836
21122	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F2S2	1.4649	1.4719
21123	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F2S3	1.6640	1.6601

Final CY 2016 Case-Mix Payment Weights				
Payment Group	**Step (Episode and/or Therapy Visit Ranges)**	**Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)**	**CY 2015 Case-Mix Weights**	**Final CY 2016 Case-Mix Weights**
21131	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F3S1	1.3624	1.3588
21132	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F3S2	1.5565	1.5450
21133	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F3S3	1.7506	1.7313
21211	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F1S1	1.3109	1.3324
21212	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F1S2	1.5142	1.5307
21213	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F1S3	1.7175	1.7289
21221	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F2S1	1.3497	1.3809
21222	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F2S2	1.5570	1.5702
21223	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F2S3	1.7643	1.7595
21231	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F3S1	1.4463	1.4560
21232	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F3S2	1.6486	1.6434
21233	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F3S3	1.8509	1.8307
21311	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F1S1	1.4900	1.4569
21313	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F1S3	1.7142	1.9234
21321	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F2S1	1.9384	1.5053
21322	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F2S2	1.5288	1.7297
21323	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F2S3	1.7570	1.9540
21331	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F3S1	1.9853	1.5805
21332	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F3S2	1.6255	1.8028
21333	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F3S3	1.8487	2.0252
22111	3rd+ Episodes, 14 to 15 Therapy Visits	C1F1S1	2.0718	1.2722
22112	3rd+ Episodes, 16 to 17 Therapy Visits	C1F1S2	1.2407	1.4571
22113	3rd+ Episodes, 18 to 19 Therapy Visits	C1F1S3	1.4312	1.6419
22121	3rd+ Episodes, 14 to 15 Therapy Visits	C1F2S1	1.6217	1.2877
22122	3rd+ Episodes, 16 to 17 Therapy Visits	C1F2S2	1.2500	1.4746
22123	3rd+ Episodes, 18 to 19 Therapy Visits	C1F2S3	1.4544	1.6615
22131	3rd+ Episodes, 14 to 15 Therapy Visits	C1F3S1	1.6587	1.3721
22132	3rd+ Episodes, 16 to 17 Therapy Visits	C1F3S2	1.3730	1.5539
22133	3rd+ Episodes, 18 to 19 Therapy Visits	C1F3S3	1.5635	1.7357
22211	3rd+ Episodes, 14 to 15 Therapy Visits	C2F1S1	1.7541	1.3589
22212	3rd+ Episodes, 16 to 17 Therapy Visits	C2F1S2	1.3772	1.5483
22213	3rd+ Episodes, 18 to 19 Therapy Visits	C2F1S3	1.5584	1.7378
22221	3rd+ Episodes, 14 to 15 Therapy Visits	C2F2S1	1.7396	1.3743
22222	3rd+ Episodes, 16 to 17 Therapy Visits	C2F2S2	1.3865	1.5658
22223	3rd+ Episodes, 18 to 19 Therapy Visits	C2F2S3	1.5815	1.7573
22231	3rd+ Episodes, 14 to 15 Therapy Visits	C2F3S1	1.7766	1.4587

Final CY 2016 Case-Mix Payment Weights				
Payment Group	**Step (Episode and/or Therapy Visit Ranges)**	**Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)**	**CY 2015 Case-Mix Weights**	**Final CY 2016 Case-Mix Weights**
22232	3rd+ Episodes, 16 to 17 Therapy Visits	C2F3S2	1.5095	1.6452
22233	3rd+ Episodes, 18 to 19 Therapy Visits	C2F3S3	1.6907	1.8316
22311	3rd+ Episodes, 14 to 15 Therapy Visits	C3F1S1	1.8720	1.5722
22312	3rd+ Episodes, 16 to 17 Therapy Visits	C3F1S2	1.5480	1.7670
22313	3rd+ Episodes, 18 to 19 Therapy Visits	C3F1S3	1.9578	1.9619
22321	3rd+ Episodes, 14 to 15 Therapy Visits	C3F2S1	1.5573	1.5876
22322	3rd+ Episodes, 16 to 17 Therapy Visits	C3F2S2	1.7760	1.7845
22323	3rd+ Episodes, 18 to 19 Therapy Visits	C3F2S3	1.9948	1.9815
22331	3rd+ Episodes, 14 to 15 Therapy Visits	C3F3S1	1.6803	1.6721
22332	3rd+ Episodes, 16 to 17 Therapy Visits	C3F3S2	1.8852	1.8639
22333	3rd+ Episodes, 18 to 19 Therapy Visits	C3F3S3	2.0901	2.0557
30111	3rd+ Episodes, 0 to 5 Therapy Visits	C1F1S1	0.4942	0.4758
30112	3rd+ Episodes, 6 Therapy Visits	C1F1S2	0.6435	0.6351
30113	3rd+ Episodes, 7 to 9 Therapy Visits	C1F1S3	0.7928	0.7944
30114	3rd+ Episodes, 10 Therapy Visits	C1F1S4	0.9421	0.9536
30115	3rd+ Episodes, 11 to 13 Therapy Visits	C1F1S5	1.0914	1.1129
30121	3rd+ Episodes, 0 to 5 Therapy Visits	C1F2S1	0.5746	0.5611
30122	3rd+ Episodes, 6 Therapy Visits	C1F2S2	0.7097	0.7064
30123	3rd+ Episodes, 7 to 9 Therapy Visits	C1F2S3	0.8448	0.8518
30124	3rd+ Episodes, 10 Therapy Visits	C1F2S4	0.9798	0.9971
30125	3rd+ Episodes, 11 to 13 Therapy Visits	C1F2S5	1.1149	1.1424
30131	3rd+ Episodes, 0 to 5 Therapy Visits	C1F3S1	0.6313	0.6085
30132	3rd+ Episodes, 6 Therapy Visits	C1F3S2	0.7796	0.7613
30133	3rd+ Episodes, 7 to 9 Therapy Visits	C1F3S3	0.9280	0.9140
30134	3rd+ Episodes, 10 Therapy Visits	C1F3S4	1.0763	1.0667
30135	3rd+ Episodes, 11 to 13 Therapy Visits	C1F3S5	1.2246	1.2194
30211	3rd+ Episodes, 0 to 5 Therapy Visits	C2F1S1	0.5116	0.4913
30212	3rd+ Episodes, 6 Therapy Visits	C2F1S2	0.6847	0.6648
30213	3rd+ Episodes, 7 to 9 Therapy Visits	C2F1S3	0.8578	0.8383
30214	3rd+ Episodes, 10 Therapy Visits	C2F1S4	1.0310	1.0118
30215	3rd+ Episodes, 11 to 13 Therapy Visits	C2F1S5	1.2041	1.1854
30221	3rd+ Episodes, 0 to 5 Therapy Visits	C2F2S1	0.5920	0.5766
30222	3rd+ Episodes, 6 Therapy Visits	C2F2S2	0.7509	0.7362
30223	3rd+ Episodes, 7 to 9 Therapy Visits	C2F2S3	0.9098	0.8957
30224	3rd+ Episodes, 10 Therapy Visits	C2F2S4	1.0687	1.0553
30225	3rd+ Episodes, 11 to 13 Therapy Visits	C2F2S5	1.2276	1.2148

Final CY 2016 Case-Mix Payment Weights				
Payment Group	**Step (Episode and/or Therapy Visit Ranges)**	**Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)**	**CY 2015 Case-Mix Weights**	**Final CY 2016 Case-Mix Weights**
30231	3rd+ Episodes, 0 to 5 Therapy Visits	C2F3S1	0.6487	0.6241
30232	3rd+ Episodes, 6 Therapy Visits	C2F3S2	0.8208	0.7910
30233	3rd+ Episodes, 7 to 9 Therapy Visits	C2F3S3	0.9930	0.9579
30234	3rd+ Episodes, 10 Therapy Visits	C2F3S4	1.1652	1.1249
30235	3rd+ Episodes, 11 to 13 Therapy Visits	C2F3S5	1.3373	1.2918
30311	3rd+ Episodes, 0 to 5 Therapy Visits	C3F1S1	0.6350	0.6143
30312	3rd+ Episodes, 6 Therapy Visits	C3F1S2	0.8176	0.8058
30313	3rd+ Episodes, 7 to 9 Therapy Visits	C3F1S3	1.0002	0.9974
30314	3rd+ Episodes, 10 Therapy Visits	C3F1S4	1.1828	1.1890
30315	3rd+ Episodes, 11 to 13 Therapy Visits	C3F1S5	1.3654	1.3806
30321	3rd+ Episodes, 0 to 5 Therapy Visits	C3F2S1	0.7155	0.6996
30322	3rd+ Episodes, 6 Therapy Visits	C3F2S2	0.8839	0.8772
30323	3rd+ Episodes, 7 to 9 Therapy Visits	C3F2S3	1.0522	1.0548
30324	3rd+ Episodes, 10 Therapy Visits	C3F2S4	1.2206	1.2324
30325	3rd+ Episodes, 11 to 13 Therapy Visits	C3F2S5	1.3889	1.4100
30331	3rd+ Episodes, 0 to 5 Therapy Visits	C3F3S1	0.7721	0.7470
30332	3rd+ Episodes, 6 Therapy Visits	C3F3S2	0.9538	0.9320
30333	3rd+ Episodes, 7 to 9 Therapy Visits	C3F3S3	1.1354	1.1170
30334	3rd+ Episodes, 10 Therapy Visits	C3F3S4	1.3170	1.3020
30335	3rd+ Episodes, 11 to 13 Therapy Visits	C3F3S5	1.4987	1.4870
40111	All Episodes, 20+ Therapy Visits	C1F1S1	1.8122	1.8268
40121	All Episodes, 20+ Therapy Visits	C1F2S1	1.8631	1.8484
40131	All Episodes, 20+ Therapy Visits	C1F3S1	1.9446	1.9176
40211	All Episodes, 20+ Therapy Visits	C2F1S1	1.9208	1.9272
40221	All Episodes, 20+ Therapy Visits	C2F2S1	1.9717	1.9488
40231	All Episodes, 20+ Therapy Visits	C2F3S1	2.0532	2.0180
40311	All Episodes, 20+ Therapy Visits	C3F1S1	2.1626	2.1567
40321	All Episodes, 20+ Therapy Visits	C3F2S1	2.2135	2.1784
40331	All Episodes, 20+ Therapy Visits	C3F3S1	2.2950	2.2475

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

CMS is finalizing a 0.97 percent reduction to the national, standardized 60-day episode payment rate each year in CY 2016, CY 2017, and CY 2018 to account for nominal case-mix growth from 2012 to 2014.

3. Clarification Regarding the Use of the "Initial Encounter" Seventh Character, Applicable to Certain ICD-10-CM Code Categories, Under the HH PPS

The ICD-10-CM coding guidelines regarding the seventh character assignment for diagnosis codes under Chapter 19, Injury, poisoning, and certain other consequences of external causes (S00-T88) were revised in the Draft 2015 ICD-10-CM, The Completed Official Draft Code Set. CMS did not receive any comments on the ICD-10-CM draft translation list and the elimination of initial encounter seventh character extension.

CY 2016 RATE UPDATE

1. CY 2016 Home Health Market Basket Update

The HH PPS market basket update for CY 2016 is 2.3 percent. It was proposed at 2.9 percent. This amount is reduced by the Affordable Health Care Act multifactor productivity adjustment of 0.4 percent, resulting in a net increase of 1.9 percent. The MFP was proposed at 0.6 percent.

For HHAs that do not submit the required quality data for CY 2016, the home health market basket update will be -0.1 percent (1.9 percent minus 2.0 percent).

2. CY 2016 Area Wage Index

The HH PPS wage index for CY 2016 is fully based on the revised OMB delineations adopted in CY 2015. The CY 2016 wage index is available on CMS' website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

The wage index budget neutrality factor is 1.0011.

3. CY 2016 Labor Portion

The labor-related share of the case-mix adjusted 60-day episode rate will continue to be 78.535 percent and the non-labor-related share would continue to be 21.465 percent.

4. CY 2016 National, Standardized 60-Day Episode Payment Rate

The CY 2016 national standardized 60-day episode payment rate will be $2,965.12. It was proposed at $2,938.37. The current rate is $2,961.38

CY 2016 60-day National, Standardized 60-Day Episode Payment Amount						
CY 2015 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	Nominal Case-Mix Growth Adjust-ment (1-0.0172)	CY 2016 Rebasing Adjustment	CY 2016 HH Payment Update Percent-age	CY 2016 National, Standardized 60-Day Episode Payment
$2,961.38	X 1.0011	X 1.0187	X 0.9903	-$80.95	X 1.019	= $2,965.12

The CY 2016 national, standardized 60-day episode payment rate for an HHA that does not submit the required quality data is updated by the CY 2016 HH payment update (1.9 percent) minus 2 percentage points or $2,906.92.

5. National Per-Visit Rates

The national per-visit rates are used to pay LUPAs and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by type of visit or HH discipline. The six HH disciplines are as follows:

- Home health aide (HH aide);
- Medical Social Services (MSS);
- Occupational therapy (OT);
- Physical therapy (PT);
- Skilled nursing (SN); and
- Speech-language pathology (SLP).

The CY 2016 national per-visit rates are shown below.

CY 2015 National Per-Visit Payment Amounts for HHA That DO SUBMIT Required Data					
HH Discipline Type	**CY 2015 Per-Visit Payment**	**Wage Index Budget Neutrality Factor**	**CY 2016 Rebasing Adjustment**	**CY 2016 HH Payment Update Percentage**	**CY 2016 Per-Visit Payment**
Home Health Aide	$57.89	X 1.0011	+ $1.79	X 1.019	$60.87
Medical Social Services	$204.91	X 1.0011	+ $6.34	X 1.019	$214.47
Occupational Therapy	$140.70	X 1.0011	+ $4.35	X 1.019	$147.95
Physical Therapy	$139.75	X 1.0011	+ $4.32	X 1.019	$146.95
Skilled Nursing	$127.83	X 1.0011	+ $3.96	X 1.019	$134.42
Speech-Language Pathology	$151.88	X 1.0011	+ 4.70	X 1.019	$159.71

The CY 2016 per-visit payment rates for an HHA that does not submit the required quality data are updated by the CY 2016 HH payment update (1.9 percent) minus 2 percentage points as shown below.

HH Discipline Type	CY 2015 Per- Visit Rates	Wage Index Budget Neutrality Factor	CY 2016 Rebasing Adjustment	CY 2016 HH Payment Update Percentage Minus 2 Percentage Points	CY 2016 Per-Visit Rates
Home Health Aide	$57.89	X 1.0011	+ $1.79	X 0.099	$59.68
Medical Social Services	$204.91	X 1.0011	+ $6.34	X 0.099	$211.24
Occupational Therapy	$140.70	X 1.0011	+ $4.35	X 0.099	$145.05
Physical Therapy	$139.75	X 1.0011	+ $4.32	X 0.099	$144.07
Skilled Nursing	$127.83	X 1.0011	+ $3.96	X 0.099	$131.79
Speech-Language Pathology	$151.88	X 1.0011	+ 4.70	X 0.099	$156.58

6. Low-Utilization Payment Adjustment Add-On Factor

LUPA episodes that occur as the only episode or as an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences. In the CY 2014 HH PPS final rule, CMS changed the methodology for calculating the LUPA add-on amount by finalizing the use of three LUPA add-on factors: 1.8451 for Skilled Nursing; 1.6700 for Physical Therapy; and 1.6266 for Speech Language Pathology.

7. Nonroutine Medical Supply Conversion Factor Update

Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. The NRS conversion factor for CY 2016 is $52.71, as shown below.

CY 2016 NRS Conversion Factor			
CY 2014 NRS Conversion Factor	2016 Rebasing Adjustment	2016 HH Marketbasket	CY 2016 Conversion Factor
$53.23	X 0.9718	X 1.019	= $52.71

CY 2016 NRS Payment Amounts for HHAs that Submit Quality Relative Weights for the 6-Severity NRS System			
Severity Level	Points (Scoring)	Relative Weight	CY 2016 NRS 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

CY 2016 NRS Payment Amounts for HHAs that Submit Quality Relative Weights for the 6-Severity NRS System			
Severity Level	**Points (Scoring)**	**Relative Weight**	**CY 2016 NRS Payment Amount**
5	49 to 98	6.1198	$322.57
6	99+	10.5254	$554.79

8. Rural Add-On

ACA Section 3131(c), as amended further, provides an increase of 3.0 percent to the payment amounts for HH services furnished in a rural area ending after April 1, 2010, and before Jan. 1, 2018. There is no budget neutrality associated with this mandate.

The 3.0 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-CBSA) areas.

The CY 2016 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustments for HHAs that Do submit quality data is $3,054.07 ($2,965.12 X 1.03), and for HHAs that do not it is $2,994.13.

The CY 2016 national per-visit rates per discipline provided in a rural area are shown below.

HH Discipline Type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2016 Per-Visit rate	Multiply by the 3 Percent Rural Add-On	CY 2016 Rural Per-Visit Rates	CY 2016 Per-Visit Rate	Multiply by the 3 Percent Rural Add-On	CY 2016 Rural Per-Visit Rates
HH Aide	$60.87	X 1.03	$62.70	$59.68	X 1.03	$61.47
MSS	$215.47	X 1.03	$221.93	$211.24	X 1.03	$217.58
OT	$147.95	X 1.03	$152.39	$145.05	X 1.03	$149.40
PT	$146.95	X 1.03	$151.36	$144.07	X 1.03	$148.39
SN	$134.42	X 1.03	$138.45	$131.79	X 1.03	$135.74
SLP	$159.71	X 1.03	$164.50	$156.58	X 1.03	$161.28

9. Payment for High Cost Outlier

For CY 2011 and subsequent calendar years CMS targets up to 2.5 percent of estimated total payments to be paid as outlier payments, and applies a 10 percent agency-level outlier cap.

CMS is finalizing its proposal not change to the FDL ratio or loss-sharing ratio for CY 2016. However, CMS says it will continue to monitor outlier payments and continue to explore ways to maintain an outlier policy for episodes that incur unusually high costs due to patient care needs without qualifying episodes of care that do not meet that criteria.

HOME HEALTH VALUE-BASED PURCHASING MODEL

CMS is adopting a HHVBP model, which includes a randomized state selection methodology; the reporting framework; the payment adjustment methodology; payment adjustment

continued

schedule by performance year and payment adjustment percentage; the quality measures selection methodology, classifications and weighting, measures for performance year one, including the reporting of new measures, and the framework for proposing to adopt measures for subsequent performance years; the performance scoring methodology, which includes performance based on achievement and improvement; the review and recalculation period; and the evaluation framework.

As proposed, CMS is using section 1115A(d)(1) waiver authority to apply a reduction or increase of up to 8-percent to current Medicare payments to competing HHAs delivering care to beneficiaries in selected states, depending on the HHA's performance on specified quality measures relative to its peers.

The HHVBP model will apply to all Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee.

As proposed, the first performance year will be CY 2016, the second will be CY 2017, the third will be CY 2018, the fourth will be 2019, and the fifth will be CY 2020.

CMS is finalizing all the definitions as proposed in §484.305 except for two: CMS is revising "applicable percent" so the final definition reflects the revised percentages as 3-percent for CY 2018, 5-percent for CY 2019, 6-percent for 2020; 7-percent for CY 2021 and 8-percent for CY 2022,

HHAs located in a MSAs included in the proposed hip and knee model will not be excluded from the HHVBP Model. The initial set of measures proposed for PY1 of the model utilizes data collected via OASIS, Medicare claims, HHCAHPS survey data, and data reported directly from the HHAs to CMS.

CMS is finalizing the proposed starter set of measures with modification; specifically, there are in total six process measures and 15 outcome measures and three New Measures Process measures evaluate the rate of HHA use of specific evidence-based processes of care based on the evidence available.

CMS is not finalizing the following proposed measures:

- 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)
- Adverse Event for Improper Medication Administration and/or Side Effects (New Measure)

The final starter set includes six process measures, 10 outcome measures and five HHCAHPS, and three new measures. The final PY1 measures are presented in the following figures.

FINAL PY1 MEASURES

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Clinical Quality of Care	Improvement in Ambulation-Locomotion	Outcome	NQF 0167	OASIS (M1860)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in ambulation/locomotion at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Bed Transferring	Outcome	NQF 0175	OASIS (M1850)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in bed transferring at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Bathing	Outcome	NQF 0174	OASIS (M1830)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in bathing at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Dyspnea	Outcome	NA	OASIS (M1400)	Number of home health episodes of care where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Communication & Care Coordination	Discharged to Community	Outcome	NA	OASIS (M2420)	Number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge.	Number of home health episodes of care ending with discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure- specific exclusions.

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Communication & Care Coordination	Care Management: Types and Sources of Assistance	Process	NA	OASIS (M2102)	Multiple data elements.	Multiple data elements.
Efficiency & Cost Reduction	Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health; Hospitalization during first 30 days of Home Health	Outcome	NQF 171	CCW (Claims)	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12- month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Efficiency & Cost Reduction	Emergency Department Use without Hospitalization	Outcome	NQF 0173	CCW (Claims)	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12- month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Patient Safety	Improvement in Pain Interfering with Activity	Outcome	NQF 0177	OASIS (M1242)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less frequent pain at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Patient Safety	Improvement in Management of Oral Medications	Outcome	NQF 0176	OASIS (M2020)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.

continued

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Patient Safety	Prior Functioning ADL/ IADL	Outcome	NQF 0430	OASIS (M1900)	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Daily Activity (that is, ADL and IADL) functioning.	All patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or alternatively, based on CPT codes relevant to treatment goals focused on Daily Activity function.
Population/ Community Health	Influenza Vaccine Data Collection Period: Does this episode of care include any dates on or between October 31 and March 31?	Process	NA	Oasis (M1041)	NA	NA
Population/ Community Health	Influenza Immunization Received for Current Flu Season	Process	NQF 0522	OASIS (M1046)	Number of home health episodes during which patients a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider.	Number of home health episodes of care ending with discharge, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Population/ Community Health	Pneumococcal Polysaccharide Vaccine Ever Received	Process	NQF 0525	OASIS (M1051)	Number of home health episodes during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).	Number of home health episodes of care ending with discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure- specific exclusions.

continued

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Population/ Community Health	Reason Pneumococcal vaccine not received	Process	NA	OASIS (M1056)	NA	NA
Clinical Quality of Care	Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care	Process	NA	OASIS (M2015)	Number of home health episodes of care during which patient/ caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (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 CAHPS: Satisfaction Survey Measures						
Patient & Caregiver-Centered Experience	Care of Patients	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Communications between Providers and Patients	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Specific Care Issues	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Overall rating of home health care and. (there may be something missing from CMS' Table)	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Willingness to recommend the agency	Outcome		CAHPS	NA	NA

FINAL PY1 NEW MEASURES

QS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Population/ Community Health	Influenza Vaccination Coverage for Home Health Care Personnel	Process	NQF 0431 (Used in other care settings, not Home Health)	Reported by HHAs Through Web Portal	Healthcare personnel in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year: a) received an influenza vaccination administered at the healthcare facility, or reported in writing or provided documentation that influenza vaccination was received elsewhere: or b) were determined to have a medical contraindication/ condition of severe allergic reaction to eggs or to other components of the vaccine or history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination; or c) declined influenza vaccination; or d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.	Number of healthcare personnel who are working in the healthcare facility for at least 1 working day between October 1 and March 31 of the following year, regardless of clinical responsibility or patient contact.
Population/ Community Health	Herpes zoster (Shingles) vaccination: Has the patient ever received the shingles vaccination?	Process	NA	Reported by HHAs through Web Portal	Total number of Medicare beneficiaries aged 60 years and over who report having ever received zoster vaccine (shingles vaccine).	Total number of Medicare beneficiaries aged 60 years and over receiving services from the HHA.

continued

QS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Communication & Care Coordination	Advanced Care Plan	Process	NQF0326	Reported by HHAs through Web Portal	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advanced care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	All patients aged 65 years and older.

COMMENT

The rule's material on the HH VBP model is extensive. The information contains the complex scoring and benchmark factors. CMS has devoted a third of the rulemaking to this subject – some 104 pages. With an effective date of Jan. 1, 2016, there is little time to become truly knowledgeable. Careful review is required. If there is anything to be gleaned from this and other changes to the various PPS programs, it is that CMS is no longer seeking volunteers to participate in payment experiments. It appears CMS is now mandating such participation.

PROVISIONS OF THE HOME HEALTH CARE QUALITY REPORTING PROGRAM

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) amended Title XVIII of the Act, in part, by adding a new section 1899B, which imposes new data reporting requirements for certain post-acute care providers, including HHAs.

CMS is adopting its proposed one standardized cross-setting new measure for CY 2016 to meet the requirements of the IMPACT Act. The quality measure that addresses the domain of skin integrity and changes in skin integrity is a National Quality Forum-endorsed measure: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) (http://www.qualityforum.org/QPS/0678).

The rule contains the Form, Manner, and Timing of OASIS Data Submission and OASIS Data for Annual Payment Updates.

CMS is adopting to implement an 80 percent Pay-for-Reporting Performance Requirement for Submission of OASIS Quality Data for Year 2 reporting period July 1, 2016, to June 30, 2017, and a 90 percent Pay-for-Reporting Performance Requirement for Submission of OASIS Quality Data for the reporting period July 1, 2017, to June 30, 2018, and thereafter.

CMS is not proposing any changes to the participation requirements, or to the requirements pertaining to the implementation of the Home Health CAHPS® Survey (HHCAHPS).

COMMENT

The issue of quality reporting continues to grow in importance and for payments. In today's payment arena, the mechanics of payment changes are somewhat simple to understand and project. Quality, on the other hand, appears much more complicated and requires significant resources for compliance. Nothing can help an organization obtain proper payments than billing correctly for services provided the first time. Based on the number of comments CMS received to its proposed rulemaking, providers are indeed heeding the call to become knowledgeable in the subject.

FINAL COMMENT

This is a very well written rule. It gets to the point, does not contain an overload of history, and provides clear "Final Decision" sections.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting