



SPECIAL REPORT October 31, 2016

CMS ISSUES FINAL RULE: 2017 HOME HEALTH PAYMENT RATES, VALUE-BASED PURCHASING PILOT, AND MUCH MORE

Happy Halloween!

The Centers for Medicare and Medicaid Services (CMS) issued the 338 page Final Rule late today, October 31, 2016, giving the home care world a “trick or treat” night to remember. The final rule includes the expected annual payment rate update along with modifications of the HHRG case mix weights due to a recalibration and changes to the standards for outlier payments. In addition, modest but important changes in the new Home Health Value-Based Purchasing (HHVBP) pilot program are included. The newest item in this annual rule is a set of standards governing Negative Pressure Wound Treatments that implement a 2016 change in the law permitting Medicare coverage of disposable negative pressure wound treatment systems. Finally, CMS advances the development of IMPACT Act measures.

NAHC will be analyzing each of the rule in depth over the coming weeks and will provide updated analysis on each matter proposed. The rule is accessible at <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26290.pdf>.

2017 HHPPS Payment Rates

The payment rate part of the final rule is consistent with the rate rebasing requirements and has only minor modifications from the proposed rule. There are no real surprises in its rebasing implementation as it is the fourth and final year of the phase-in of rate rebasing. Congress required that the rate rebasing be done with equal installments over 2014 through 2017.

In addition, the rule includes the second year of a 0.97% case mix creep adjustment. The annual Productivity Adjustment set at 0.3%. Finally, the rule includes the scheduled update for quality of care data submission to avoid a 2% rate penalty.

The 2017 home health prospective payment rates are within NAHC's expectations given the 4-year phase-in of rate rebasing that started in 2014. CMS is capped at reducing the base episode rate by no more than \$80.95 which is equal to 3.5% of the 2010 base rates. The proposal imposes such a cut offset by the annual Market Basket Index (MBI) and the annual Productivity Adjustment which started in 2015. While the proposal does not reference the 2% sequestration, it is definitely expected that such will continue in 2017.

The 2017 rates are determined through the application of the Market Basket Index (MBI) that reflects inflation in costs. For 2017, the MBI is 2.8%. The MBI is offset by the annual Productivity Adjustment (labeled by CMS as "private nonfarm business multifactor productivity" or MFP) as required under the Affordable Care Act. In 2017, the adjustment is 0.3%. The case mix creep adjustment of 0.97% also factored in prior to the MBI adjustment. That leaves a net adjustment of 1.53%, before the impact of the rate rebasing. CMS estimates that Medicare spending on home health services in 2017 will be \$130 million less than would occur without the adjustments. Effectively, it is a rate reduction of 1.27% in comparison to 2016 rates..

The base episode rate for 2017 is set out at \$2989.97. In contrast, the 2016 base rate is \$2965.12. The base rate appears as an "increase" even though rates have been reduced overall because of the high budget neutrality adjustment (1.0214) that is triggered by the case mix weight recalibration. In other words, the case mix weight recalibration must be done in a budget neutral manner. With the reduction in case mix weights in a number of groupings, it is necessary to apply a budget neutrality adjustment in order to bring estimated Medicare spending to the level that would occur in the absence of recalibration. The reduction of certain case mix categories is so severe that it warranted a 1.0214 adjustment to achieve budget neutrality. That brings the base rate up above 2016 levels. However, when the case mix weights are applied to 2017 claims, a net revenue reduction will occur in the aggregate nationwide. That means that what CMS gives in a budget neutrality adjusted base rate, it takes back with reduced case mix weights.

CMS's recalibration the case mix weights in 2017 is budget neutral in the aggregate. Each HHA's case mix needs to be individually evaluated to determine whether the bottom-line impact is positive, neutral, or

negative. Even an individual analysis leads only to an estimated impact as an HHA's 2017 case mix is not known until the end of 2017.

The rate rebasing also affects LUPA payment rates. Those rates will rise 3.5% through rebasing and an additional 2.5% through the annual inflation update with a wage index budget neutrality adjustment of 1.0%.

Home Health Aide	\$64.23
Medical Social Services	\$227.36
Occupational Therapy	\$156.11
Physical Therapy	\$155.05
Skilled Nursing	\$141.84
Speech-Language Pathology	\$168.52

Non-routine medical supply rates are also downwardly adjusted through the rebasing by a factor of 2.82 percent offset by a 2.5% MBI. The NRS conversion factor drops from \$52.92 in 2016 to \$52.50 in 2017.

The 3% Rural Add-On continues in 2017 along with the 2% rate reduction for HHAs that fail to comply with the quality data submission requirements that involve OASIS and HHCAHPS.

Detailed rate tables are available in the Final Rule.

Outlier Payments

The rule changes to the outlier payment standards and a recalibration of the case mix weights are noteworthy as these changes may have the greatest impact on HHAs.

The proposed rule indicated CMS's plan to modify the outlier standards by using a formula that takes into consideration the number of 15 minute service increments received by a patient. This is in contrast to the current formula that uses the number of visit by discipline as a proxy for cost. The change was proposed to better align outlier eligibility with resources use. CMS had found that care episodes with a high volume of short visits qualified for the same level of outlier payment as episodes with the same volume of visits, but with much longer visits. NAHC had expressed qualified support for outlier reform, but indicated that the increments of service needed to be weighted as the first 15 minute increment was always more costly than later increments since certain costs, e.g. travel, is a cost in every visit regardless of the visit duration.

In the Final Rule, CMS rejected NAHC concerns and finalized its proposal to use a unit of service (15 minute increments) in determining eligibility for outlier payments. CMS also will continue to use the same 80% loss ratio it has employed for years, but adjusts the Fixed Dollar Loss to 0.55 in contrast to the current 0.45. This change in FDL will lead to fewer episodes eligible for outlier payments. CMS projects that such standards will result in spending up to but no more than the 2.5% outlier budget in 2017.

Recalibration of Case Mix Weights

NAHC voiced an identical concern with the recalibration of case mix weights as CMS proposed a wholesale revision based on the use of a 15 minutes of service resource use methodology. CMS has recalibrated the case mix weights a number of times in past years as visit-based resource data became available. The 2017 proposal appeared to be the first time that CMS proposed recalibrations based on 15 minute increments of services. As a result, the proposed case mix weights showed some significant changes from the 2016 weights. In the Final Rule, CMS rejected these concerns stating,

“We have used wage weighted 15 minute units as our measure of resource use since the inception of the HH PPS. We did not propose any changes to the methodology or method of estimating resource use in the proposed rule. Weighting the first 15 minute unit to account for fixed costs is not appropriate as payment for the fixed costs of an episode, such as transportation, are already accounted for under the national, standardized 60 day episode payment rate. We will continue to conduct ongoing data analysis to monitor resource use patterns.”

This translates to CMS continuing a methodological flaw that it had initiated several years ago.

VALUE BASED PURCHASING

NAHC has supported the use of VBP reimbursement provided it is based on reliable, risk adjusted measures and does not pose an access or quality of care problem for beneficiaries. As usual, the devil is in the details of the VBP model.

The VBP model in place in nine states since January 2016 gets some minor tweaks for 2017. Among the changes are the elimination of several of the measures as CMS found that these measures overlapped with other measures or the measure were not yet ready for prime time. Also, CMS adds detail to the provider notice and appeal rights regarding HHVBP scoring and rate adjustments.

The nine affected states are: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. CMS selected the states randomly from 9 regions.

Specifically, CMS finalized NAHC-supported proposals to:

1. Calculate benchmarks and achievement thresholds at the state level rather than the level of the size-cohort and revise the definition for “benchmark” to state that benchmark refers to the mean of the top decile of Medicare-certified HHA performance on the specified quality measure during the baseline period calculated for each state;
2. Require a minimum of eight HHAs in any size-cohort;
3. Increase the timeframe for submitting New Measure data from seven calendar days to fifteen calendar days following the end of each reporting period to account for weekends and holidays;

4. Remove four measures (Care Management: Types and Sources of Assistance, Prior Functioning ADL/IADL, Influenza Vaccine Data Collection Period, and Reason Pneumococcal Vaccine Not Received) from the set of applicable measures;
5. Adjust the reporting period and submission date for the Influenza Vaccination Coverage for Home Health Personnel measure from a quarterly submission to an annual submission; and
6. Implement the recalculation and reconsideration appeal processes.

Beyond the welcome refinements to HHVBP, NAHC remains concerned with elements of the original design that remain unchanged such as the amount of payment at risk (3-8%) over the five year term of the pilot, the sole use of improvement measures whereas the Medicare patient population includes chronically infirm home health patients, and the inclusion of non-Medicare patient outcomes in a Medicare VBP.

While CMS is moving forward with a proposed VBP pilot, an effort to legislate VBP in all of post-acute care is going on as well. At this point, available information indicates that the two governmental forces are not moving in tandem. That will make for a very interesting health policy dynamic to see what model prevails ultimately. Nevertheless, the signals are very clear that VBP is a contender for serious payment reform in Medicare.

Negative Pressure Wound Treatments (NPWT)

Based on a 2016 change in the law, CMS proposed a separate payment to a HHA for a disposable NPWT device when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit. The proposal raised a number of questions on how it actually works.

Among the areas needing clarification was the connection between Medicare home health payment and the NPWT payment under Medicare Part B. Given that disposable device-related NPWT is intended to substitute for DME-related NPWT, NAHC commented that the reimbursement consequences should not favor one care method over the other. With the proposed reimbursement standards, there is a high risk that disposable-related NPWT would provide significantly lower reimbursement, well below HHA costs," states NAHC.

In the Final Rule, CMS clarified that payment for the NPWT device is when a HHA "furnishes NPWT using a disposable device" to mean when the HHA provider is either initially applying an entirely new disposable NPWT device, or removing a disposable NPWT device and replacing it with an entirely new one. These visit would be billed on a Type of Bill (TOB) 34x. However, follow up visits related to the wound care where the device is not replaced are to be billed as HH visits on TOB 32x. CMS provided

several examples of how its payment policy relative to the disposable NPWT device should be applied for billing.

In most instances, an HHA providing NPWT will bill both a 34X for the NPWT device along with the professional services and a 32X bill for other HHA professional and dependent services. This will mean a Medicare Part B payment for the NPWT visits and a LUPA or full episode payment for the other services. The NPWT professional services do not count towards the 4 visit LUPA threshold. The NPWT is also subject to a 20% beneficiary coinsurance.

UPDATES TO THE HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

CMS proposed to add four new measures that were developed to meet the requirements of the IMPACT Act. These proposed measures are:

- MSPB–PAC HH QRP;
- Discharge to Community-PAC HH QRP;
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH QRP; and
- Drug Regimen Review Conducted With Follow-Up for Identified Issues-PAC HH QRP

CMS proposed to end the “treatment episode” 60 days after for all episodes except partial episode payments (PEPs). NAHC expressed concerns regarding the construct of the episode window and episode length for home health patients that are not under a home health plan of care for the entire 60 days (treatment episode). Patients are often discharged from care prior to the end of the 60 day home health episode. Since the treatment period is for the full 60 days, these patients could be under a treatment episode for days, even weeks, where care is not being provided by the agency. In addition, since the associated episode does not end until 30 days after the treatment episode ends, MSPB could include costs that occur months after patients have been discharged from the home health agency’s care. The proposed episode window can unfairly attributes spending for home health patients discharged prior to the end of the 60 day episode.

Also, the proposed risk adjustment model does not include variables for socio-economic/socio-demographic status or caregiver support. Both of these variables are key indicators of an individual’s ability to be discharge to, and remain in the community following a post-acute care stay.

NAHC urged the developers to include in the risk adjustment model variables to address socio-economic status, socio-demographic status, and caregiver support.

In the Final Rule, CMS maintains the proposed measure specifications for all of the measures. However, CMS did agree to address the potential for including socio-demographic status and socio-economic status (SES) as a risk factor for select measures once the national Quality Forum (NQF) completes their trial for inclusion of SDS as a risk adjustment factor.

SUMMARY

Overall, the final rule is a combination of expected rate adjustments, improvements in proposals for outlier reform and case mix weight recalibrations, a necessary tweaking of the Value Based Purchasing pilot program, clarifications on the new NPWT benefit, and advancement of the development of IMPACT Act measures. HHA impact will vary, particularly with the case mix weight recalibrations and the new formula for outliers. NAHC remains concerned for the erosion of home health care access caused by rate reductions. CMS's analyses tends to aggregate the impact evaluation using averages and a host of assumptions. NAHC is heartened by the growing attention that CMS is giving to evaluating impact on patients in medically underserved areas and the segment of the patient population that has high needs that may be disadvantaged by the averaging of reimbursements.

NAHC will provide in-depth analysis of the rule in coming days.