



## **CMS ISSUES PROPOSED RULE: 2016 HOME HEALTH PAYMENT RATES, VALUE-BASED PURCHASING PILOT, AND MORE**

The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule late Monday, July 6, as most of the United States returned to work from their Independence Day holiday. The proposed rule includes the usual annual payment rate update along with the highly anticipated Value-Based Purchasing (VBP) pilot program. The payment rule has no real surprises in its rebasing implementation as it is the third year of a four year phase-in of rate rebasing. Congress required that the rate rebasing be done with equal installments over 2014 through 2017. However, CMS proposes to reduce rates by 1.72% in each of 2016 and 2017 to recover case mix creep.

### **The proposed rule includes:**

1. 2015 Home Health Prospective Payment System rates
2. The unveiling of the proposed model for Value Based Purchasing

NAHC will be analyzing each of the proposals in depth over the coming weeks and will provide updated analysis on each matter proposed. Public comments are permitted through September 4, 2015 (the 60<sup>th</sup> day following publication) and NAHC will be issuing draft comments to assist members who wish to submit comments. The rule is accessible at: <https://www.federalregister.gov/articles/2015/07/10/2015-16790/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home>. Below is a summary explanation of the proposed changes.

## **2016 HHPPS Payment Rates**

The proposed changes to 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 starts in 2015. While, the proposal does not reference the 2% sequestration, it is definitely expected that such will continue in 2016.

The proposed MBI is 2.9% offset by the Productivity Adjustment (labeled by CMS as "private nonfarm business multifactor productivity" or MFP) required under the Affordable care Act. In 2016 the adjustment is proposed at 0.6% leaving the update at a net of 2.3%. The case mix creep adjustment of 1.72% is factored in prior to the MBI adjustment.

The proposed base episode rate for 2016 is set out at \$2938.37. In contrast, the 2014 base rate was \$2869.27 and the 2015 rate is \$2961.38. The 2014 to 2015 rate change looks like an increase, but the reality is that payment rates are actually decreased as CMS also recalibrated the case mix adjustment weights that effectively reduce those weights in the aggregate by 2.37%. The recalibration is offset in the base rates by increasing that rate by 2.37% to achieve budget neutrality. That budget neutrality adjustment is responsible for making the base rate appear bigger than the 2014 rate.

CMS proposes to recalibrate the case mix weights again in 2016, leading to a budget neutrality adjustment of 1.41%. As such, an apples to apples comparison between 2015 and 2016 is not easily done. CMS estimates that the net result of all of its rate proposals is a 1.8% reduction in Medicare payments to home health agencies or \$350 million in 2016.

Notably, CMS is proposing to reduce rates for its perceived coding creep. CMS alleges that HHAs have up-coded claims to levels that does not reflect actual changes in patients' clinical condition. Coding creep adjustments have been imposed in the past. In the 2015 rate rule, CMS estimated the coding creep at 2.32%. With an additional data year, the level has risen to 3.44%. CMS proposes to phase-in the creep adjustment at 1.72% in each of 2016 and 2017.

In 2016, CMS proposes to fully transition to the new CBSA area designations. The 2015 blend of old and new CBSA wage index values at 50/50 will end. HHAs are cautioned to review the CBSA wage index tables to evaluate the impact on their final payment outcome. Each year, some geographic areas experience wide swings in values, some going up significantly while others decrease significantly. Generally, the vast majority of CBSAs change only to a minor degree.

The rate rebasing also affects LUPA payment rates. Those rates will rise 3.5% through rebasing and an additional 2.3% through the annual inflation update with a wage index budget neutrality adjustment of 0.06%. Non-routine medical supply rates are also downwardly adjusted through the rebasing by a factor of 2.82 percent offset by a 2.3% MBI. The NRS conversion factor drops from \$53.23 in 2015 to \$52.92 in 2016..

With respect to outlier payments, CMS propose to keep the same 80% loss ratio and 0.45 Fixed Dollar Loss components to the outlier eligibility evaluation. CMS projects that such standards will result in spending 2.34% of the 2.5% outlier budget in 2016.

The 3% Rural Add-On continues in 2016 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 proposed rule.

## **VALUE BASED PURCHASING**

It has been a long time coming, but CMS has unveiled its proposed pilot program on value based purchasing (VBP) in the proposed rule. The VBP model follows a path previously traveled with hospitals, but with some significant variation. Generally, a VBP program establishes a financial bonus pool funded by payment reductions to the provider group involved. Performance and outcome standards are established to determine which providers receive bonus payments. Those that do not meet the standards are left with lower payment revenues. Those that outperform the standards receive financial rewards.

CMS has proposed to move forward with a VBP pilot program in 2016. CMS proposes to use 2015 as the baseline year for performance with 2016 as the first year for performance measurement. In 2018, HHAs will see the payment consequences of their 2016 performance.

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 put forward by CMS follows these general guidelines. However, the detailed part of the VBP model deserves special attention. First, the CMS model would reduce or increase Medicare payments in a range of 5-8 percent over the life of the 7 year pilot (ending in 2022) with the first payment years at 5% (2018 and 2019). This is in contrast with the current hospital VBP which puts at risk 1.25 percent rising gradually to 2.0 percent. In 2014 comments, NAHC strongly objected to the suggested 5-8% as putting continued access to care in jeopardy. While the pilot program would be budget neutral, CMS projects that 10% of providers (with the exception of small volume providers in two states) will receive payment reductions ranging from 2.26 to 3.33%. As such, while 5% of payment may be at risk in the first years, the payment impact is expected to be less based on an evaluation of the pilot design on prior year's data.

The VBP measures would be based on both achievement and improvement in quality outcomes. CMS proposes to use 10 process measures, 15 outcome measures, and 4 new measures coming from OASIS, Medicare claims data, and HHCAHPS.

HHAs that reach a minimal threshold level in quality performance would receive the incentive bonus payments with the amount determined by the level of quality above the threshold. Performance and bonus payment determinations would be made based on an HHA's performance in comparison to other HHAs in

the state. CMS proposes to compare the performance based on HHA size, separating smaller-volume HHAs from larger-volume HHAS.

CMS proposes to institute the VBP program in 9 states. It would be a mandatory program in all the affected states. The proposed states are: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. CMS selected the states randomly from 9 regions. The final states in the pilot can change with further data analysis.

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.

## **MISCELLANEOUS PROPOSALS**

CMS also is including some technical clarifications in a few existing rules along with updates on the quality data measures used to avoid the 2% rate penalty.

## **SUMMARY**

Overall, the rule is a combination of expected rate proposals, a Value Based Purchasing pilot program that looks very much like the one unveiled for consideration last year, a few technical changes, and the highly disfavored case mix creep adjustments. This is the year of VBP creation and it promises to be a very charged one given the nature of the CMS proposal. Stay tuned!

CMS projects the overall financial impact of the payment rate changes to be \$350 million in 2016. The VBP program is estimated to reduce overall Medicare spending by just \$300 million over its term.

NAHC will be scheduling a nationwide videocast on the proposed rule in the coming days..

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