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CMS announces payment changes for Medicare home health agencies for 2016

The Centers for Medicare & Medicaid Services (CMS) today announced changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2016 that will foster greater efficiency, payment accuracy, and improved quality of care. Approximately 3.5 million beneficiaries received home health services from 11,900 HHAs, costing Medicare $17.9 billion in 2014.

CMS projects that Medicare payments to home health agencies (HHAs) in CY 2016 will be reduced by 1.4 percent, or $260 million. This decrease reflects the effects of the 1.9 percent home health payment update percentage ($345 million increase); a 0.9 percent decrease in payments due to the 0.97 percent payment reduction to the national, standardized 60-day episode payment rate to account for nominal case-mix growth from 2012 through 2014 ($165 million decrease); and a 2.4 percent decrease in payments due to the third year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($440 million decrease). Compared to the proposed rule, the maximum payment reduction in the first year of the value-based purchasing program was reduced from 5 percent to 3 percent.

The HH PPS final rule is one of several rules for CY 2016 that reflect a broader strategy to create a health care system that supports better care, smarter spending, and healthier people. Provisions in these rules will help move the nation's health-care system to one that values quality over quantity and focuses on reforms such as measuring for better health outcomes, helping patients return home, managing and improving chronic diseases, and fostering a more-efficient and coordinated health care system.

Background

Medicare pays HHAs through a prospective payment system in which HHAs are typically paid a national, standardized 60-day episode payment amount for all covered home health services, adjusted for case-mix and area wage differences. The national, standardized 60-day episode payment amount is case-mix adjusted based on relevant data from patient assessments conducted by clinicians, as currently required for all Medicare-participating HHAs. The HH PPS payment

rates are updated annually by the home health payment update percentage. The payment update percentage is based, in part, on the home health market basket, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician; have a part-time or intermittent need for skilled nursing care, physical therapy, and/or speech-language pathology services, or a continued need for occupational therapy; and must be homebound. In addition, the beneficiary must receive home health services from a Medicare-approved HHA. Covered home health services include skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, medical social services, and medical supplies.

Payment Policy Provisions

Rebasing the HH PPS Payment Rates
The Affordable Care Act (ACA) directs CMS to apply an adjustment to the national, standardized 60-day episode payment rate and other applicable amounts to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. CMS is required to phase-in any adjustment over a four-year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of the enactment of the ACA (CY 2010), and be fully implemented by CY 2017.

In this CY 2016 final rule, CMS is moving forward with the third year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. As finalized in the CY 2014 final rule, the adjustments include increases to the national per-visit payment rates, a 2.82 percent reduction to the NRS conversion factor, and a reduction to the national, standardized 60-day episode payment rate of $80.95 for CY 2016.

Recalibration of the HH PPS Case-Mix Weights
CY 2016 will be the second year that CMS is annually recalibrating the HH PPS case-mix weights. The methodology used to recalibrate the case-mix weights for CY 2016 is identical to methodology used in CY 2015.

Reduction to the 60-day Episode Rate to Account for Nominal Case-Mix Growth
CMS is decreasing the national, standardized 60-day episode payment amount by 0.97 percent each year in CY 2016, CY 2017, and CY 2018 to account for nominal case-mix growth (i.e., case-mix growth unrelated to changes in patient acuity) from 2012 to 2014. CMS has adjusted home health payment in prior years before to account for nominal case mix growth.

Other Updates
The Affordable Care Act requires that the market basket update for HHAs be adjusted by changes in economy-wide productivity. The CY 2016 home health market basket (2.3 percent) combined with the multifactor productivity adjustment (0.4 percentage points) results in a 1.9 percent home health payment update percentage.

Home Health Quality Reporting Program (HH QRP) Update

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) requires HHAs, Skilled Nursing Facilities (SNFs), Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs) to submit standardized patient assessment data, as well as standardized data on quality measures and resource use and other measures. The data reporting requirements and implementation of standardized patient assessment data is intended to enable interoperability and improve quality, payment, and discharge planning, among other purposes.

The IMPACT Act requires collection of data across eight domains. In keeping with the requirements of the IMPACT Act, CMS is finalizing as proposed one standardized cross-setting measure for CY 2016 under the "skin integrity and changes to skin integrity" domain. Measures for the other domains will be addressed through future rulemaking. CMS received feedback on four future, cross-setting measure constructs to potentially meet requirements of the IMPACT Act domains of:

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

The Home Health Conditions of Participation (CoPs) require HHAs to submit OASIS assessments as a condition of payment and also for quality measurement purposes. HHAs that do not submit quality measure data to CMS will see a two percent reduction in their annual HH payment update percentage. CMS is finalizing its proposal to require all HHAs to submit both admission and discharge OASIS assessments for a minimum of 70 percent of all patients with episodes of care occurring during the reporting period starting July 1, 2015. CMS is also finalizing as proposed to incrementally increase this compliance threshold by ten percent in each of the subsequent periods (July 1, 2016 and July 1, 2017) to reach 90 percent.

Home Health Value-Based Purchasing (HHVBP) Model

CMS is also finalizing a new initiative designed to support greater quality and efficiency of care among Medicare-certified HHAs across the nation. Authorized under the ACA and implemented by the Center for Medicare and Medicaid Innovation, the HHVBP model supports the Department of Health and Human Services' efforts to build a health care system that delivers better care, spends health care dollars more wisely, and results in healthier people and communities.

The HHVBP model leverages the successes of and lessons learned from other value-based purchasing programs and demonstrations – including the Hospital Value-Based Purchasing Program and the Home Health Pay-for-Performance Demonstration – to shift from volume-based payments to a model designed to promote the delivery of higher quality care to Medicare beneficiaries. The model will test whether incentives for better quality care can improve outcomes in the delivery of home health services.

Beginning January 1, 2016, CMS will implement the HHVBP model among all HHAs in nine states representing each geographic area in the nation. All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will compete on value in the HHVBP model, where payment is tied to quality performance. HHAs in these nine states will have their payments adjusted by a maximum payment adjustment of 3-percent (upward or downward) in 2018, a maximum payment adjustment of 5-percent (upward or downward) in 2019, a maximum payment adjustment of 6-percent (upward or downward) in 2020, a maximum payment adjustment of 7-percent (upward or downward) in 2021, and a maximum payment adjustment of 8-percent (upward or downward) in 2022.

This model is designed so there is no selection bias, participants are representative of home health agencies nationally, and there is sufficient participation to generate meaningful results among all Medicare-certified HHAs nationally.

For additional information about the Home Health Prospective Payment System, visit here. For additional information about the HHVBP, visit here. The final rule can be viewed at https://www.federalregister.gov/public-inspection. Please be mindful this link will change once the rule is published on November 5, 2015 in the Federal Register.

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