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CMS Proposes Value-Based Purchasing Model, Other Updates to the 2016 Home Health Prospective Payment System

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The U.S. Department of Health and Human Services (HHS) ***Centers for Medicare & Medicaid Services (CMS)*** published its proposed update to the home health prospective payment system (HHPPS) for calendar year (CY) 2016 in the July 10, 2015 Federal Register. In addition to the annual payment rate and wage index updates, CMS is also proposing quality measure updates and a new ***Home Health Value-Based Purchasing (HHVBP)*** model. CMS estimates these proposed changes would reduce net Medicare payments to home health agencies (HHAs) by $350 million in CY 2016. Comments on the proposed rule are due by 5:00 pm on September 4, 2015.

The Medicare HHPPS governs payments to Medicare-certified HHAs for services provided to homebound beneficiaries. CMS pays HHAs on a national standardized 60-day episode payment rate, adjusted based on the location and needs of the beneficiary. CMS uses patient assessment data submitted by HHAs to set and adjust payment rates. According to CMS's fact sheet announcing the proposed payment changes, home health services are provided to approximately 3.5 million Medicare beneficiaries; the benefit costs Medicare an approximated $17.9 billion dollars annually.

The proposed updates to the CY 2016 HHPPS (Proposed Rule), which are hyper-technical in their complexity, would update the HHPPS rates and wage index for CY 2016. In the Proposed Rule, CMS is implementing the third year of the four year phase-in of the rebasing adjustments to the HHPPS payment rates required by the Affordable Care Act. In addition, CMS is proposing to decrease the national standardized 60-day episode payment amount by 1.72 percent in each year for CY 2016 and CY 2017 to account for what CMS characterizes as "nominal case-mix growth" between CY 2012 and CY 2014, unrelated to increases in patient acuity. This "nominal case mix growth" is sometimes characterized as "coding creep." CMS invites comments on the proposed reduction to the national standardized 60-day episode payment amount of 1.72 percent in CY 2016 and CY 2017 to account for the nominal case mix growth and the associated changes in the regulation text. The Proposed Rule would also update certain quality and data reporting requirements for HHAs, and would revive a minimum reporting requirement previously proposed in CY 2015. In addition, CMS is proposing to launch a HHVBP model to test value-based incentives for delivery and care improvements in the home health setting. The HHVBP would apply a five percent to eight percent payment adjustment to

all Medicare-certified HHAs in each of nine states selected for the model. The proposed HHVBP would utilize methodologies similar to CMS's other value-based initiatives, including the hospital value-based purchasing (HVBP) program. Other key highlights include:

Updates to the HHPPS Payment Rates

CMS's estimate of 1.8 percent (or $350 million decrease) in Medicare payments to HHAs for CY 2016 results from the following factors. As required by the Affordable Care Act, and finalized in the CY 2014 HHPPS final rule published December 2, 2013, CMS is implementing 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 rates and the non-routine supplies conversion factor. The rebasing adjustments for CY 2016 would 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 amount in CY 2010 (with the increases ranging from $1.79 for home health aide services to $6.34 for medical social service), and reduce the non-routine supplies conversion factor by 2.82 percent. CMS would also recalibrate the HHPPS case-mix weights, using the most current cost and utilization data available, doing so in a budget neutral manner. CMS would update the payment rates under HHPPS by the home health payment update percentage of 2.3 percent. CMS proposes to update the CY 2016 home health wage index using solely the new geographic area designations incorporated in the CY 2015 final rule. In a notice on the CMS website, CMS called to the public's attention that there was a misalignment between the case-mix weights and the payment groups in Table 9 of the Proposed Rule, and posted the corrected table on the website July 10, 2015, advising the public that a correction notice will be published. CMS invites public comments on its proposed payment adjustment methodology.

For outlier payment, CMS is not proposing a change in the fixed dollar loss ratio or loss-sharing ratio of the national standardized 60-day case-mix and wage adjusted episode payment amounts in the case of episode payment amounts for episodes that incur unusually high costs due to patient care needs — so-called "outliers." CMS believes that maintaining a fixed dollar loss of 0.45 and a loss-sharing ratio of 0.80 are appropriate, given the percentage of outlier payments is estimated to increase as a result of the increase in the national per-visit amounts through the rebasing adjustments, and the decrease in the national standardized 60-day episode payment amount as a result of the rebasing adjustment and nominal case-mix growth reduction. CMS would continue to monitor the percent of total HHPPS payments paid as outlier payments to determine if future adjustments to either the fixed dollar loss ratio or loss-sharing ratio are warranted.

Home Health Quality Reporting Program (QRP) and Pay-for-Reporting Metrics

CMS is proposing several changes to its quality-related requirements for CY 2016. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) requires certain post-acute care providers, including HHAs, to submit data on quality measures across eight measure domains. CMS is proposing one standardized cross-setting measure related to short-stay pressure ulcers in the skin integrity domain for CY 2016. CMS also introduced certain updates to measures and four measure constructs it is considering for future proposals. While such other measures will be adopted through future rulemaking, CMS is soliciting feedback to refine these updates going forward. CMS is also soliciting feedback regarding the use of body mass index (BMI) as a risk-adjustment factor in the home health setting.

CMS is also proposing to escalate the compliance thresholds in ten percent increments for the home health pay-for-reporting requirements. As a Medicare Condition of Participation (CoP), HHAs must

submit certain assessments and quality data to CMS. HHA compliance with such requirements is measured using a “Quality Assessment Only” (QAO) metric. CMS finalized a pay-for-reporting performance requirement in the CY 2015 HHPPS, subjecting HHAs to a two percent reduction in their market basket update if they did not hit a specified performance threshold. The first performance period for which this compliance level will be measured is July 1, 2015 through June 30, 2016, and the minimum compliance standard for this period is 70 percent. CMS had initially proposed to increase this threshold in ten percent increments over three years (targeting a goal QAO compliance rate of 90 percent). However, after receiving persuasive comments on the proposal, CMS limited the rule to the first performance period only, with the requirements for subsequent years to be set after evaluating HHA performance in 2014–2015.

Once again, CMS is proposing to increase the QAO compliance threshold in ten percent increments until HHAs achieve 90 percent compliance. CMS analyzed prior HHA performance and concluded that a ten percent increase per year would be “nominal” and would “provide the greatest opportunity for successful implementation” as compared to other alternatives. For the reporting period spanning July 1, 2016 to June 30, 2017, CMS proposes an 80 percent performance threshold. For July 1, 2017 to June 30, 2018, the performance threshold would be 90 percent. HHAs with compliance levels below the performance thresholds will see a two percentage point reduction in their annual payment update (APU) for subsequent calendar years. CMS is inviting public comment on these proposed QAO compliance threshold increases.

Home Health Value-Based Purchasing (HHVBP) Model

CMS has proposed to move forward with a HHVBP pilot program in 2016. Under the Affordable Care Act, the secretary of HHS was directed to implement a value-based purchasing program for HHAs. In the CY2015 HHPPS proposed rule, CMS invited comments on an HHVBP model involving eight or less pilot states that would reduce or increase Medicare payments, in a five percent to eight percent range, depending on the degree of quality performance demonstrated by a set of measures. The Proposed Rule adopts a very similar model, including nine pilot states to capture a representative nationwide picture of the effectiveness of quality-based incentive programs. CMS expects the model will reduce unnecessary hospitalizations and SNF usage, and as a result will net savings totaling $380 million.

CMS noted it leveraged its experience with other value-based purchasing programs and demonstrations — including the Hospital Value-Based Purchasing Program (HVBP) and the Home Health Pay-for-Performance Demonstration — to develop an HHVBP model that deemphasizes case volume and promotes higher quality care delivered to Medicare beneficiaries. If implemented, the HHVBP would begin January 1, 2016, and collect data for CY 2016–CY 2020. Under the model, HHAs in the selected states would experience a quality-based payment adjustment up or down to their reimbursement rates. Payment adjustments would be assessed once per year, though CMS noted it would consider increasing the adjustment to more than once per year in CY 2019 to accelerate quality improvement.

Pilot State Selection

CMS proposes to launch the HHVBP model in nine pilot states, which represent each geographic area in the nation, so that there is a fair and unbiased sample for analysis. With very limited exception, all Medicare-certified HHAs providing services in the selected states must participate in the model. To identify the nine pilot states, CMS first grouped states, mainly by geography, into regions. CMS then selected Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona,

Iowa, Nebraska and Tennessee from these regions. These states are subject to change, CMS noted, if the final HHPPS rule alters the methodology for sample selection. CMS is specifically seeking comments on alternative geographic and state selection methodologies.

Quality Measures

To determine appropriate payment adjustments under the model, CMS proposes to score the Medicare-certified HHAs in the nine pilot states on their compliance with a set of key quality measures, and to consider both achievement of, and improvement within, each measure in its evaluation. The proposed initial set of quality measures includes 25 outcome and process measures, with many drawn from already existing HHA quality reporting requirements (Outcome and Assessment Information Set (OASIS) data). The measures included in the proposed initial set mainly address: (1) the clinical quality of care, (2) care outcomes and efficiency, or (3) person/caregiver-centered experiences. In the Proposed Rule, CMS made it abundantly clear that this initial set will be continuously under review and the measures included will most likely change over time.

The Proposed Rule also builds in a set of "new measures" to the HHVBP. CMS is taking the opportunity with the HHVBP to study such measures, which were developed in other care settings, and apply them to the home health industry for the first time. The four new measures in the proposed HHVBP cover the following topics: (1) advance care planning, (2) adverse events due to improper medication administration and/or side effects, (3) influenza vaccine coverage for HHA personnel, and (4) shingles vaccinations received by HHA beneficiaries. HHAs do not currently report on these measures. Initially CMS will not evaluate HHAs by their compliance with these measures; rather, HHAs merely have to provide data about such measures to receive full marks. These new measures appear to align with other CMS initiatives across the Medicare landscape. For example, the advance care planning quality measure appears to complement CMS's CY 2016 physician fee schedule proposal to reimburse physicians for end-of-life discussions. CMS has specifically solicited comments on the proposed initial set and proposed new measures.

Payment Adjustment Methodology

Under the Proposed Rule, all Medicare-certified HHAs in each of the nine HHVBP pilot states would have their payments adjusted (either up or down) by five percent in each of the first two payment adjustment years, six percent in the third payment adjustment year, and eight percent in the final two payment adjustment years. CMS proposes to use CY 2015 as the baseline year for performance with CY 2016 as the first year for performance measurement. In CY 2018, HHAs will see the payment consequences of their CY 2016 performance. HHAs that are newly formed in the pilot states during the HHVBP would have an initial year of benchmark-generating data before they would be incorporated into the program. In addition, HHAs that did not have a sufficient number of episodes of care to produce data for at least five measures (at least 20 episodes per year) would not be subject to a payment adjustment (but would still be responsible for reporting applicable measure data).

CMS is proposing to calculate the benchmarks and achievement thresholds for each individual measure by state and by cohort (small or large, depending on the HHA's exemptions from the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) requirements). As a result, HHAs earn points under the HHVBP based on the higher of their achievement or improvement on each measure as compared to their in-state, similarly sized cohort counterparts or to their prior performance. The measures in the initial proposed set would account for 90 percent of an HHA's final score; 10 percent would be drawn from reporting of new measures. CMS would utilize 2015 HHA data to perform such calculations.

HHAs would receive three reports regarding their performance in the HHVBP: (1) a quarterly performance report, (2) an annual report summarizing the payment adjustment to be applied, and (3) an annual performance report, which would be made publicly available. For the CY 2016 measurement year, the annual payment adjustment report would be issued in August of 2017 with the payment adjustment effective beginning January 1, 2018. HHAs would only have two opportunities for reviewing and requesting score recalculations; one within ten days of the quarterly performance report and one within ten days of the annual payment adjustment report. Under the Proposed Rule, no other recalculation requests would be considered. CMS is particularly interested in feedback on the performance scoring methodology of the proposed HHVBP.

Though CMS attempted to use "key elements" from the HVBP, it did not address why the proposed home health counterpart has a significantly higher payment adjustment percentage (one–two percent over the course of the program, as compared to five to eight percent for the HHVBP). CMS has also increased the number of states included in the HHVBP since its initial discussion in the CY 2015 HHPPS proposed rule, where only five–eight states would be selected for participation in the model. These factors, combined with the new measures HHAs must collect, may have significant financial and operational impacts upon HHAs' daily operations.

CMS will likely receive extensive feedback on the Proposed Rule given the complexity and significance of CMS's HHVBP proposal. Initial comments on the Proposed Rule from the National Association for Home Care and Hospice (NAHC) have focused on the 1.72 percent episode payment cuts due to "perceived coding creep," which NAHC has called "heavy-handed" and "unwarranted," and on the HHVBP proposed model, which NAHC does not consider to be "fair and rational."

Stakeholders are encouraged to review this rule and consider comment strategy. CMS is accepting comments on the Proposed Rule until 5:00 pm on September 4, 2015.

CMS published the Proposed Rule in the July 10, 2015 Federal Register, which can be found here.

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