PUBLICATION

Home Health Agency PPS Update for 2017: Quality, Quality, Quality [Ober|Kaler]

2016

On November 3rd, CMS published the Final Prospective Payment System (PPS) Rule for Home Health Agencies (HHAs) for CY 2017 at 81 FR 76702 (Nov. 3, 2016). The rule implements annual changes to the PPS rate for HHAs and represents the final year in a four-year rebasing of the rate and the second year of three years of adjustments related to case mix changes. The rule also implements a statute requiring separate payment for negative pressure wound therapy provided by HHAs and makes adjustments to the outlier payment methodology. In addition, it includes updates on the value-based purchasing pilot that began in eight states last year.

Payment Updates: Final Year of Rebasing Adjustments; Case Mix Adjustments Continue

This year constitutes the final year of a four-year phase-in of a rebasing adjustment to the national standardized 60-day episode payment amount and the national per-visit payment amounts. In CY 2017, the episode payment amount will decrease by $80.95, or a 2.3% decrease. In addition, in accordance with the proposal to adjust the case-mix weights annually based on the most current cost and resource-use data available (CY 2012-CY 2014), the 60-day episode payment will be reduced .97% for each of CY 2016, CY 2017, and CY 2018. These decreases will be partially offset by a 2.5% increase in overall payment rates for a net decrease of .9%.

Negative Pressure Wound Therapy

In accordance with a statutory mandate, negative pressure wound therapy using disposable devices will be reimbursed separate from the home health episode payment. The payment will be based on the payment that would otherwise be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS).

Outlier Adjustments

CMS has adjusted the methodology for calculating outlier payments to HHAs. Rather than using a cost-per-visit approach, the new method will use a cost-per-unit approach, where one unit equals 15 minutes. The fixed dollar loss ratio will be adjusted to .55 from .45 to ensure that outlier payments do not exceed the 2.5% statutory maximum.

Quality Reporting

Under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), HHAs and other post-acute providers must submit standardized assessment data on their patients. For HHAs, this occurs through the submission of OASIS data as well as claims submitted by the HHAS. In the Final Rule, CMS discussed how it would add and remove quality measures going forward and detailed the addition of several new measures that will be effective for CY 2018, including:

- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Post-Acute Care Home Health Quality Reporting Program;
- Total Medicare Spending per Beneficiary - Post Acute Care Home Health Quality Reporting Program (MSPB-PAC HH QRP);
- Discharge to Community- Post Acute Care Home Health Quality Reporting Program; and
- Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care Home Health Quality Reporting Program.

Value-based Purchasing Pilot Project Update

Last year, CMS selected nine states — Maryland, Massachusetts, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee — to participate in a multi-year pilot value-based purchasing program (HHAVBP). Participation is mandatory for Medicare-certified HHAs in the selected states, and all Medicare patients are included. No fraud and abuse waivers have been issued in connection with the program. The program allows CMS to apply reductions or increases of up to 8% over each of five performance years (CY 2016-2020). Payments in CY 2018 will be adjusted by a maximum of 3 percent (upward or downward), 5 percent in 2019, 6 percent in 2020, 7 percent in 2021, and 8 percent in 2022. Rules for the pilot are located at 42 C.F.R. § 484.300 *et seq*.

The benchmark performance year for the program is 2015. In the 2016 rule, CMS indicated that smaller-volume HHAs would be considered as one cohort within a state and larger-volume HHAs would be considered as another. The 2017 final rule removes that distinction for the purposes of setting benchmarks and achievement thresholds, noting substantial variation within small-volume cohorts that could lead to disparate standards. Further, for purposes of evaluating performance against benchmarks, a cohort within a state must have at least 8 HHAs. If a cohort does not have at least 8 HHAs, all HHAs statewide will be measured together.

Information about each HHA's benchmarks, performance, and total scores is available through the HHVBP Secure Portal. Reports on the first quarter of performance became available in July of 2016. The portal provides the mechanism for an HHA to request a recalculation of its quarterly Interim Performance Score (IPS) and its annual Total Performance Score (TPS). HHAs must submit appeals of their IPSs and TPSs within 15 days of their being posted on the Portal, according to the final rule, and a request for reconsideration of a recalculation should be made through the Portal within 15 days of receiving notification of a recalculation determination.

Starting in CY 2018, payment adjustments will be made based on a TPS that reflects the HHA's performance compared (i) to other HHAs in the state and (ii) to the HHA's own performance baseline. The data used to calculate performance scores will be collected from claims data, OASIS data, and from Home Health Agency Consumer Assessment of Providers and Systems (HHACAPS) data. Additional data on so-called New Measures is collected through the Portal. Payment adjustments in 2018 will be based on 2016 performance scores. Performance will be evaluated based on a linear evaluation function that takes into account scores on the various quality measures.

Ober|Kaler's Comments

The final HHA payment rule for CY 2017 reflects few substantive changes for the majority of HHAs outside of the VBP pilot program. However, HHAs all over the country should watch the evolution of the VBP closely. If it is successful in increasing quality according to CMS measures, then providers should expect a broader roll-out. In the interim, HHAs should continue to be attentive to quality measures as tracked by CMS.