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Medicare Home Health Final Rule

OVERVIEW

On October 29th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for the Calendar Year (CY) 2016 Medicare home health prospective payment system. The final rule will update the payment rates for home health agencies (HHAs) for CY 2016 and aims to move home health toward value-based payments. CMS projects that Medicare payments to HHAs in CY 2016 will be reduced by 1.4 percent, or $260 million total.

This document summarizes several major provisions of the final rule. The final rule is available here.

PAYMENT POLICY PROVISIONS

HHAs are paid a national, standardized 60-day episode payment for all covered home health services, adjusted for case mix and area wage differences. Under the Affordable Care Act (ACA), CMS is required to rebase home health payment rates beginning in 2014, and the phase-in is scheduled to occur over the course of four years.

CMS will finalize its proposal to move forward with the implementation of Year Three of the four-year phase-in of the rebasing adjustments. The CY 2016 rebasing adjustments will reduce the standard payment amount by $80.95.

CMS originally proposed to decrease the episode payment amount by 1.72 percent in CY 2016 and CY 2017 to account for coding intensity growth unrelated to changes in patient acuity between CY 2012 and CY 2014. In the final rule, CMS re-evaluates the methodology used to calculate case-mix growth and finalizes a 1.45 percent payment reduction for CY 2016 and CY 2017.

HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

CMS finalized a new Home Health Value-Based Purchasing (HHVBP) model for select geographies. The model will adjust HHA payments, depending on quality performance, for all HHAs in nine randomly-selected states. As proposed, the model will become effective January 1, 2016 in the following states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee.

In the proposed rule, payment adjustments were to be applied on an annual basis, beginning at 5 percent in each of the first two payment years, 6 percent in the third payment year, and 8 percent in the final two adjustment years. In the final rule, only 3 percent of provider payments will be at risk based on quality in 2018, the program's first year. The maximum payment adjustments will gradually increase as follows: 5 percent in 2019; 6 percent in 2020; 7 percent in 2021; and 8 percent in 2022.

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HOME HEALTH QUALITY REPORTING (HH QRP) UPDATE

On October 6, 2014, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act was signed into law and makes changes to requirements for post-acute settings, including long-term care and home health. By January 1, 2017, HHAs will be expected to report standardized assessment data and meet the requirements for new quality measure reporting. These quality measures include: functional status changes, skin integrity and changes, medication reconciliation, incidence of major falls and patient preference regarding treatment and discharge options.

For CY 2016, CMS finalizes its proposal to add one standardized cross-setting measure under the "skin integrity" and "changes to skin integrity" domain in order to align with the IMPACT Act. This measure is a National Quality Forum endorsed measure (NQF#0678): Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay). Measures for the other domains will be addressed in future rule making.

Currently, HHAs are required to submit Outcome and Assessment Information Set (OASIS) assessments for quality measurement purposes or face a 2 percent payment penalty. CMS adopts 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 period starting July 1, 2015, and incrementally increasing the compliance threshold by 10 percent each year to reach 90 percent by July 1, 2017.