spg SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

2017 Medicare Home Health Proposed Rule

OVERVIEW

On June 28th, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the Calendar Year 2017 Medicare home health prospective payment system (HH PPS). The proposed rule would update the payment rates for home health agencies (HHAs) for 2017. The overall impact of the HH PPS payment rate update is an estimated reduction of one percent, or $180 million, in payments to HHAs in 2017.

CMS will accept comments on the proposed rule until August 26th. The proposed 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, 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 proposes to:

- Update the HH PPS payment rates by the home health payment update percentage of 2.3 percent in 2017;
- Move forward with the final year implementation of the four-year phase-in of the rebasing adjustments to the HH PPS. The 2017 rebasing adjustments would reduce the national standard payment amount by 2.3 percent, or $80.95;
- Decrease the national, standardized 60-day episode payment amount by .97 percent to account for coding intensity growth unrelated to changes in patient acuity between 2012 and 2014;
- Increase the fixed-dollar loss ratio from 0.45 to .65, resulting in a 0.1 percent decrease;
- Establish a separate payment to HHAs for disposable negative pressure wound therapy devices. The separate payment amount would be equal to the payment for an applicable disposable device under the Medicare Hospital Outpatient Prospective Payment System; and
- Calculate outlier payments using a cost per unit methodology, rather than cost per visit methodology.

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires post-acute care providers, including HHAs, to report standardized assessment data and quality measures by January 1, 2017. Measure domains to be standardized include: functional status, skin integrity and changes to skin integrity, medication reconciliation, incidence of major falls, resource use, and patient preference regarding treatment and discharge options.

For 2018 payment determinations, CMS is proposing to add four standardized cross-setting measures under the resource use and medication reconciliation domains of the IMPACT Act:

- Potentially preventable 30-day post-discharge readmission rates;
- Total estimated Medicare spending per beneficiary;
- Discharge to the community; and
- Drug regiment review conducted with follow-up for identified issues.

In the 2016 HH PPS final rule, CMS required that HHAs submit both admission and discharge Outcome and Assessment Information Set (OASIS) assessments for at least 70 percent of all patients with episodes of care occurring after July 1, 2015. This compliance threshold will incrementally increase to 80 percent on July 1, 2016 and to 90 percent on July 1, 2017. HHAs that do not meet these reporting requirements will be subject to a two percent payment penalty.