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CY 2017 Medicare Home Health Final Rule

OVERVIEW

On October 31st, the Centers for Medicare and Medicaid Services (CMS) issued a final rule for the CY 2017 Medicare home health prospective payment system (HH PPS). The final rule will update the payment rates for home health agencies (HHAs) in 2017, add new measures to the Home Health Quality Reporting Program (HH QRP), and make changes to the Home Health Value-Based Purchasing (HH VBP) model. The overall impact of the HH PPS payment rate update is an estimated reduction of 0.7 percent, or $130 million, in payments to HHAs in 2017 at current coding intensity levels.

This document summarizes several major provisions of the rule. The full text of 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, CMS is required to incrementally rebase home health payment rates by 2018. For CY 2017, the final year of the four-year phase-in of rebasing adjustments, CMS will:

- Increase the HH PPS payment rate by the home health payment update percentage of 2.5 percent;
- Reduce the national standard payment amount by 2.3 percent;
- Decrease the national, standardized 60-day episode payment amount by 0.97 percent to account for coding intensity growth unrelated to changes in patient acuity between 2012 and 2014;
- Establish a separate payment for disposable negative pressure wound therapy devices that is equivalent to the payment for an applicable disposable device under the Medicare Hospital Outpatient Prospective Payment System;
- Increase the fixed-dollar loss ratio from 0.45 to 0.55 percent to target up to 2.5 percent of HHA payments as outlier payments; and
- Calculate outlier payments using a cost per unit methodology, rather than a cost per visit methodology. Under the cost per unit methodology, one unit is equivalent to a 15-minute visit.

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 finalized its proposal to add four standardized cross-setting measures to the HH QRP to satisfy the domain requirements of the IMPACT Act:

- Potentially preventable 30-day post-discharge readmission rates;
- Medicare PAC spending per episode;
- Discharge to the community; and
- Drug regimen 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 incrementally increased to 80 percent on July 1, 2016 and will increase to 90 percent on July 1, 2017. HHAs that do not meet these reporting requirements will be subject to a 2 percent payment penalty.

HOME HEALTH VALUE-BASED PURCHASING (HH VBP) MODEL

In the 2016 HH PPS final rule, CMS finalized a new HH VBP model in nine randomly-selected states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. Beginning in 2018, HHAs in these states will have their payments adjusted upward or downward according to their performance on select quality measures.

The maximum payment adjustment will gradually increase each year from 3 percent in 2018 to 8 percent in 2022. CMS estimates that the HH VBP model will save CMS $378 million in CY 2018 through reduced hospitalizations and SNF usage.

The 2017 HH PPS rule finalizes changes and updates to the HH VBP model. Changes include, but are not limited to:

- Benchmarks and achievement thresholds will be calculated at the state-level, rather than the cohort-level;
- Each quality measure benchmark will be calculated as the average of the top 10 percent of state-wide HHA performance on that quality measure during the baseline period, CY 2015; and
- The following measures will be removed from the list of applicable measures: care management - types of source assistance, prior functioning ADL/IADL, influenza vaccine data collection period, and reason pneumococcal vaccine not received.