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CY 2016 Proposed Rule Highlights

CY (Calendar Year) 2016 Proposed Rule has been pre-released. CMS (Centers for Medicare & Medicaid Services) is continuing with year three of the HH PPS (Home Health Prospective Payment System) payment and case-mix rebasing, introducing a home health value based purchasing model for select states, and introducing a new quality measure. In addition, several payment model options are being considered by CMS for future implementation: Diagnosis on Top Model, Predicted Therapy Model, and Home Health Groupings Model.

Year three of payment and case-mix readjustment is upon us, which will find home health agency payments reduced by 1.72%. Overall, the 60-day episode payment amount will be reducing by $80.95, the per-visit amount will be increasing by 3.5%, and the non-routine supply reimbursement will be decreasing by 2.82%. Case mix weights are being computed via 130 point-giving variables for CY 2016 versus the 124 point-giving variables currently in use. CMS added nine variables and dropped three. 18 variables have an increase in point values, 43 have a decrease in point values, and 58 variables will maintain the same point values.

Some more specific point changes:

- Cancer diagnoses are losing one point in early and late episodes with high therapy.
- Diabetes is losing one point in early episode with high therapy and losing three points in later episode with high therapy.
- Dysphagia and neuro 3 diagnoses are gaining one point in both early and later with low therapy visits and losing one point in early and later episodes with high therapy.
- GI disorders with M1630 marked one or two gain six points in a later episode with high therapy.
- Brain disorders and paralysis with M1840 marked two or more, are gaining two points with high therapy visits in both early and later episodes.
- MS and either M1830, M1840, M1850, or M1840 are gaining points in early episode with high therapy and losing three points in later episode with high therapy.

- Ortho 1 or Ortho 2 diagnoses and M1030 points are changing in both early and late episodes with low and high therapy utilization.

- Skin 1 diagnoses will be losing two points in early, high therapy episodes when primary diagnosis, and when other diagnosis, will gain one point in later episode with low therapy and lose two points when high therapy in later episode.

- Tracheostomy diagnosis is losing points in all except later, high therapy use episodes.

The following OASIS items will have a point change:

OASIS item	1 or 2	1 or 2	3+	3+
	0-13	14+	0-13	14+
M1030 1 or 2	Up 1			Down 4
M1030 – 3		Down 1		Down 2
M1308	Up 1		Up 1	Up 1
M1324 – 1 or 2	Up 1			
M1324 = 3 or 4		Down 1	Down 1	
M1334 – 2		Down 1		Down 10
M1334 – 3		Down 1		Down 1
M1342 – 2	Down 1		Down 1	Down 1
M1342 – 3			Down 1	Down 7
M1400 – 2, 3, 4		Down 1		Down 2
M1620 – 2 to 5				Up 1
M1810 or 1820 – 1, 2, 3			Down 1	
M1830 – 2 or more		Down 1		
M1840 = 2 or more		Up 1		Down 2
M1850 – 2 or more		Down 2	Down 1	Up 1
M1860 – 1, 2, 3			Up 1	
M1860 – 4 or more		Up 1		Down 1

CY 2016 Clinical and Functional Thresholds

		1st and 2nd episodes		3rd+ episodes		All episodes
		0 to 13 therapy	14-19 therapy	0-13 therapy	14-19 therapy	20+ therapy
Dimension	Severity Level					
Clinical	C1	0 to 1	0	0	0 to 3	0 to 3
	C2	2 to 3	1 to 7	1	4 to 12	4 to 16
	C3	4+	8+	2+	13+	17+
Functional	F1	0 to 14	0 to 6	0 to 6	0	0 to 2
	F2	15	7 to 13	7 to 10	1 to 7	3 to 6
	F3	16+	14+	11+	8+	7+

Items highlighted this color indicate the requirement points increased, and this color indicates point requirement decreased from CY 2015 Final Rule.

CMS contracted with Abt Associates to explore possible payment methodology changes. Three models have been introduced in the Proposed Rule: Diagnosis on Top, Predicted Therapy, and Home Health Groupings Models. The Diagnosis on Top model combines diagnosis groups with a regression model to create separate weights for a patient with different diagnoses. In this model, the therapy variable is removed and there are 13 diagnosis groups considered for primary diagnosis payment groups. This model is very similar to the current four-equation model, except the clinical and functional levels are replaced with an overall severity level. That change allows for a richer set of variables than the clinical and functional levels in the current payment system.

The Predicted Therapy model is similar to the current payment model. Actual visits used in the current model are replaced with predicted therapy visits to develop case mix weights and payment amounts based on the predicted number of visits. This model includes the four-equation model, the payment regression, and the 153 HHRGs as in the current payment model.

The final model is the Home Health Groupings model. This model groups episodes by diagnosis and the expected types of home health interventions required. ICD-9 codes are assigned to seven groups, including musculoskeletal rehabilitation, neuro/stroke rehab, skin/non-surgical wound care, post-op wound aftercare, behavioral health care, complex medical care, and medical management, teaching, and assessment. This model does not include any therapy thresholds. The Home Health Group model "may be one way to better define the types of care that patients receive under the home health benefit and thus the role of home care."

The Proposed Home Health Value-Based Purchasing (HHVBP) Model was introduced in CY 2015's Proposed Rule and is being revisited this year. The ultimate goal being quality of care improvements in home health agencies, CMS is planning to use this model as an incentive, beginning January 1, 2016. The expectation is that by tying quality to payment, the beneficiaries will experience improved quality of care and outcomes. Payments will reward improved quality and penalize poor performance. In other words, the program will link quality performance to payment.

Let's take a look at what data will be used to determine quality performance and what percentage of payment will be incentivized.

CMS has set two goals. First, approximately 30 percent of traditional, fee-for-service Medicare payments will be tied to quality or value-based payments through alternative payment models by the end of 2016, and 50 percent of payment will be tied to these models by the end of 2018. Second, 85 percent of all traditional payments will be tied to quality or value by 2016 and 90 percent by 2018. A similar model is already in use for hospital reimbursement; CMS is using the hospital model as a guideline to implement the program in the home health industry. Several participation requirements have been set in place for participation.

All Medicare-certified HHAs in randomly selected states will be required to participate with implementation occurring over five performance years, beginning January 1, 2016 through December 31, 2022. The specific goals of the HHVBP model are to 1) incentivize HHAs to provide better quality care with greater efficiency, 2) study new potential quality and efficiency measures for appropriateness in the home health setting, and 3) enhance current public reporting processes. Payment adjustments will be based on quality performance, which is measured by achievement and improvement through quality measures. If the HHA demonstrates they can deliver

higher quality of care, their payment for each episode of care could be adjusted higher. Alternatively, HHAs not performing as well when compared to the other agencies of same size in the same state could have their payment adjusted down. Payment adjustment would depend on the level of quality achieved or improved.

HHAs in each of the following randomly selected states could be required to compete in the HHVBP model: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. CMS seeks comments in every state on the randomized selection proposed. Each competing HHA will receive its own payment adjustment report viewable only to that HHA. The report will focus on the payment adjustment percentage and include an explanation of when the adjustment would be applied and how the adjustment was determined relative to performance scores, including four new quality measures to be introduced in 2016.

There are 10 process measures (evaluate the rate of HHA use of specific evidence-based processes of care based on the evidence available) and 15 outcome measures (illustrate the end result of care delivered to HHA patients), plus the 4 new measures being introduced in 2016. The new measures include one outcome measure: Adverse Event for Improper Medication Administration and/or Side effects, and three process measures: Influenza Vaccination Coverage for Home Health Care Personnel, Herpes Zoster (shingles) vaccination, and Advanced Care planning.

There are currently six National Quality Strategy (NQS) domains, which CMS is realigning into four: Clinical Quality of Care will measure the quality of health care services provided by eligible professionals and paraprofessionals within the home health environment, Outcome and Efficiency will measure the end result of care provided to the beneficiary, Person and Caregiver-Centered Experience measures the beneficiary and their caregivers' experience of care, and New Measures are those not currently reported by Medicare HHAs to CMS, but that may fill in the current information gaps.

HHAs will be required to submit additional data on quality, resource use, and other measures required, and for CY 2019 and beyond, the standardized patient assessment data. If this data is not submitted appropriately, the HHA's payment will be reduced by a pre-determined amount.

As of July 2015, the new claims based measures, Rehospitalization during the first 30 days of HH and Emergency Department Use without Hospital Readmission during the

firsts 30 days of HH, are to be reported publicly. The proposed rule has one new standardized cross-setting measure that will address skin integrity and changes in skin integrity: Percent of Residents or Patients with Pressure Ulcers that are new or worsened (short stay), to be added by January 1, 2017. This new measure will report the percentage of patients with Stage 2 through 4 pressure ulcers that are new or worsened since the beginning of the episode of care. HHAs are already submitting this data on the OASIS C1-ICD9 with item M1308 (Current number of unhealed pressure ulcers at each stage or unstageable) and M1309 (Worsening in pressure ulcer status since SOC/ROC).

An update to M1309 is under consideration, in which providers will be held accountable for the development of unstageable pressure ulcers and suspected deep tissue injuries. CMS would like feedback on this potential development. Additionally being considered is whether body mass index should be used as a covariate for risk-adjustment in home health as it is used for other post-acute care settings and four future, cross-setting measures: 1) all-condition risk-adjusted potentially preventable hospital readmission rates; 2) resource use, including total estimated Medicare spending per beneficiary; 3) discharge to community; and 4) medication reconciliation. There are additional setting-specific measure concepts under development, which include: 1) fall risk composite process measure; 2) nutrition assessment composite measure; 3) improvement in dyspnea in patient with a primary diagnosis of CHF, COPD, or Asthma; 4) improvement in patient-reported interference due to pain; 5) improvement in patient-reported pain intensity; 6) improvement in patient reported fatigue; and 7) stabilization in three or more activities of daily living.

HHA is expected to submit a minimum set of two matching assessments for each patient admitted to their agency, which make up the quality episode of care, and include a Start of Care or Resumption of Care assessment and a matching End of Care assessment. Follow-up assessments are considered Neutral assessments and do not count toward or against the pay-for-reporting performance requirement. CMS's goal is for all HHAs to achieve a compliance rate of 90% or higher for submission. In 2015, HHAs had to score at least 70% for assessment submission required for July 1, 2015 through June 30, 2015 or be subject to a 2-percentage point reduction in payment.

This year's Proposed Rule is proposing to set the performance threshold at 80% for the July 2, 2016 through June 30, 2017 time frame and 90% submission from July 1, 2017 through June 30, 2018. All OASIS submissions are required to go into the ASAP system with receipts of no fatal error messages.

Beginning April 1, 2015, HHAs began receiving Provider Preview Reports (for all process measures and outcome measures) on a quarterly, rather than annual, basis. This gives HHAs the opportunity to preview and review their data and to submit corrections prior to public reporting. Beginning in July 2015, Home Health Compare will begin Star ratings. Each agency will receive a rating between one and five stars dependent upon the agency's quality measure submission.

This year's Proposed Rule has an estimated net impact of approximately $250 million in decreased payments to HHAs in CY 2016. This decrease includes the 2.3 percent HH payment update, the third year of the four year phase-in of the rebasing adjustment to the national, standardized 60-day episode payment amount, the national per-visit payment rates, the NRS conversion factor for an impact of -2.5 percent, and the effects of the -1.72 percent adjustment for nominal case-mix growth. The proposed HHVBP Model would adjust the final claim amount for home health agency's for each episode in a calendar year by an amount equal to the applicable percent in the nine states aforementioned.

You can find the complete Proposed Rule for CY 2016 by clicking HERE.

To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 4, 2015.

In commenting, please refer to file code CMS-1625-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.
You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1625-P, P.O. Box 8016, Baltimore, MD 21244-8016.
Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following

address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1625-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.
(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.
If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.