

PUBLICATION

Home Health PPS CY 2017 Proposed Rule: Payments Rebased, Quality Measures Updated [Ober|Kaler]

2016

Downward adjustments to home health episode payments arising from rebasing of the national payment rates, case mix adjustments, and an increase to the fixed dollar loss ratio for calculating outliers will result in an overall 1% decrease to home health payments in the upcoming year, according to the proposed rule [PDF] released July 5th.

The rebasing adjustments represent the last year of a four-year phase of the rebased payment rates. The decreases overcome a 2.3% overall increase to the payment rate. The proposed rule also includes updated quality measures and continued adjustments to the value-based purchasing pilot program announced last year. **Comments to the proposed rule are due by August 26, 2016.**

Payment Adjustments

The rebasing project accounts for changes in the number of visits in an episode, the mix of services provided, and other factors. The Affordable Care Act allowed the reduction to be phased in over four years and limited the impact of reductions to 3.5% of the total payment. In this case, the reduction related to the rebasing is wholly offset by the 2.3% increase to the payment rate. Additional downward adjustments relate to nominal case mix growth prior to the rebasing in 2012 and 2014. Changes in the method for calculating outliers from a per-visit cost approach to a per-unit cost approach and an upward adjustment of the fixed dollar loss ratio from .45 to .56 also result in payment decreases. The outlier adjustments will ensure that the provisions of the Social Security Act that limit home health outlier payments to 2.5% of total spending will be followed.

In addition, Congress recently acted to require separate payment for disposable negative pressure wound therapy devices. These will be reimbursed at the applicable rate under the Outpatient Prospective Payment System.

Quality Initiatives

The proposed rule continues the process of implementing standardized measures of patient assessment, quality, resource use, and other measures mandated by the IMPACT Act. For home health agencies, CMS proposes to use claims data and data collected via OASIS assessments to gather information on four measures:

- All condition, risk-adjusted, potentially preventable hospital readmission rates,
- Total estimated Medicare per-beneficiary spending,
- Discharge to community, and
- Medication reconciliation.

Home health agencies that fail to submit admission and discharge OASIS assessments for at least 90% of patients will be penalized by 2% of their adjusted payment rate. Finally, a panel of technical experts identified

28 home health quality measures that have "topped out" or are of limited clinical or quality improvement value, and, therefore, will no longer be included in the quality data.

Value Based Purchasing

Last year, CMS announced that it would pilot a home health value-based purchasing project in nine states, phasing in potential upward or downward adjustments to payments starting at 3% in 2018, and reaching up to 8% in 2022. With this rule, CMS provided more information about how it would benchmark home health agency performance, the measures it would use, and the details of an appeals process for adjustment amounts.

Ober|Kaler's Comments

CMS continues, with this proposed rule, to demonstrate that it is keenly focused on controlling costs and measuring quality for post-acute care providers. In particular, home health agencies should attend to the continued focus on rehospitalization rates as a measure of quality. Since other value-based purchasing initiatives in the acute care setting also focus on rehospitalization rates, home health agencies can expect scrutiny on these measures from private sources as well as CMS in the future.