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August 1, 2016

CMS Proposes CY 2017 Home Health PPS Rate, Updates to Value-Based Purchasing Model and Quality Reporting

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The US Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) released proposed updates to its Calendar Year (CY) 2017 Home Health Prospective Payment System (HH PPS) in the July 5, 2016, *Federal Register*. In addition to updating HH PPS rates for the CY 2017 wage index and case-mix weights, the proposal implements the final year of the four-year phase-in of the rebasing adjustments to the national standardized 60-day episode payment rates, the national per-visit rates and the non-routine medical supplies conversion factor. CMS also proposes changes to the methodology used to calculate outlier payments and changes in payment for Negative Pressure Wound Therapy (NPWT) performed using a disposable device for patients under a home health plan of care. The proposed rule also would implement several quality measure updates, as well as changes to CMS's Home Health Value-Based Purchasing (HH VBP) Model.

CMS estimates that the combined effect of all the policies in the CY 2017 proposal, affecting more than 11,000 home health agencies (HHAs), would result in a 1 percent decrease in payments (*i.e.*, $180 million) to HHAs over CY 2017. Comments on the proposed rule are due by 5 pm EDT on August 26, 2016.

Proposed HH PPS Updates

Medicare pays under HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted annually for case-mix and wage index updates. The standardized 60-day episode payment rate includes the six home health disciplines of skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical and social services.

Routine and non-routine medical supplies, both of which must be provided by the HHA, are included in the 60-day episode payment for every Medicare home health patient regardless of whether the patient requires medical supplies during the episode. Routine supplies are supplies used in small quantities for patients during the usual course of most home visits; non-routine supplies are supplies necessary to treat a patient's specific illness or injury under the physician's plan of care. Payment for non-routine supplies that an HHA must provide while the patient is under a home health plan of care is determined separately. Payment for durable medical equipment (DME) covered under the home health benefit is made outside HH PPS payment. Under consolidated billing requirements, only the HHA can bill for home health services, with the exception of DME and therapy services provided by physicians, when a patient is under a home health plan of care.

With extensive and technically detailed commentary, CMS released its proposal updating the payment rates that will be effective for home health episodes of care ending on or after January 1, 2017. CMS will complete the final year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. The rate is minus $80.95. The overall impact of

the rebasing adjustments is estimated to be a 2.3 percent decrease in HH PPS payments for CY 2017. Additionally, as required by the Social Security Act, CMS proposes to update the HH PPS payment rates by the home health payment update percentage, which is an increase of 2.3 percent. According to CMS, the 2.3 percent decrease due to the rebasing adjustment thus will be offset by the home health payment update percentage, which would increase overall HH PPS payments in CY 2017 by 2.3 percent.

Under the proposal, CMS will implement a 0.9 percent reduction to the national standardized 60-day episode rate in CY 2017 to account for nominal case-mix growth between CY 2012 and CY 2014. Case-mix growth, which in this instance is labeled as "nominal," comprises increases in case mix unrelated to increases in patient acuity.

Outlier Payments

"Outliers" are episodes that incur unusually high costs or require unique care types because of patient care needs. The law allows for an addition or adjustment to 60-day episode payment amounts for HHAs in the case of such outlier episodes. An episode's estimated cost is determined by multiplying the national wage-adjusted per-visit payment amounts by discipline by the number of visits by discipline reported on the home health claim. An episode's estimated cost determines whether an episode will receive an outlier payment and, if so, the amount of that payment.

In its 2017 rate proposal, CMS observed that an analysis of CY 2015 home health claims data indicates a significant variation in visit length by discipline for outlier episodes. Agencies whose outlier payments comprise 10 percent of their total payments provide shorter but more frequent skilled nursing visits than agencies whose outlier payments are less than 10 percent of their total payments. Moreover, the number of skilled nursing visits is significantly higher than the number of visits for the other five disciplines of care, and therefore outlier payments are predominately driven by the provision of skilled nursing services. As a result of its analysis of CY 2015 claims data, CMS expressed concern that its current methodology for calculating outlier payments may create a financial disincentive for providers to treat medically complex beneficiaries who require longer visits. Patients may not be getting the care that they need, and providers may not be accurately compensated for the amount of work medically complex home care cases may take.

To address this problem, CMS proposes to change the methodology used to calculate outlier payments, moving from a cost-per-visit approach to a cost-per-unit approach (1 unit = 15 minutes). CMS believes this change will more accurately calculate the cost of an outlier episode of care and thus better align outlier payments with episode cost and episode intensity. CMS's analysis indicates that approximately two-thirds of outlier episodes that received payment under the current cost-per-visit approach would still receive payment under the proposed cost-per-unit approach. CMS noted that this change, in addition to benefitting patients, would be budget neutral, because the Social Security Act requires CMS to pay up to, but no more than, 2.5 percent of total HH PPS payments as outlier payments.

In concert with CMS's proposal to change to a cost-per-unit approach to estimate episode costs and determine whether an outlier episode should receive outlier payments, CMS proposes to implement a cap on the amount of time per day that would be counted towards the estimation of an episode's cost for outlier calculation purposes. CMS proposes a limit of eight hours or 32 units per day, summed across the six disciplines of care. CMS notes that it is not limiting the amount of care that can be provided on any given day, but only the time per day that can be credited towards the estimated cost of an episode when determining if an episode should receive outlier payments and calculating the amount of the outlier payment. CMS estimates that the proposed eight-hour cap would affect only about 1,600 out of 5.4 million episodes.

CMS invites comments on its proposed changes to the outlier payment calculation methodology and the associated changes in the regulation.

New Proposed Payment Policy for Negative Pressure Wound Therapy

Prompted by the requirements of the Consolidated Appropriations Act of 2016 that on or after January 1, 2017, HHAs be paid separately for NPWT using a disposable device, CMS proposes a new payment methodology for NPWT. NPWT uses a vacuum dressing to help heal acute, chronic

and burn wounds, and can be a multi-use piece of DME or a single-use, disposable system.

In order for a beneficiary to receive NPWT using a disposable device under the home health benefit, the beneficiary must meet each of the eligibility requirements for Medicare home health services, including, for example, being homebound and receiving services under a plan of care established and reviewed by a physician with whom the patient has had a face-to-face encounter. If the sole purpose for a home health visit is to furnish NPWT using a disposable device to a beneficiary receiving home health services covered by Medicare's home health benefit, Medicare will not pay for such visit under the HH PPS. Because furnishing NPWT using a disposable device is to be paid separately, Medicare will instead pay for NPWT at a rate equivalent to the Medicare Hospital Outpatient Prospective Payment System (OPPS) rate for CY 2017, noting that payment under OPPS includes payment for both the disposable device and furnishing the service. Medicare consolidated billing requirements for HHAs will apply to the claim.

Visits performed solely for furnishing NPWT using a disposable device are not to be reported on the HH PPS claim. If NPWT using a disposable device is performed during the course of an otherwise covered home health visit, CMS proposes that the HHA must not include the time spent furnishing NPWT in its visit charge or in the length of time reported for the visit on the HH PPS claim.

CMS expressly solicits comments on all aspects of the proposed payment policies for furnishing a disposable NPWT device.

Updates to CMS's Quality Initiatives, Home Health Quality Reporting Program

CMS proposes several changes to its quality-related requirements for CY 2017. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires certain post-acute care providers, including HHAs, to submit data on quality measures across several measure domains, including patient assessment data and data on HHA resource use. HHAs also are generally required to submit Outcome and Assessment Information Set (OASIS) data to Medicare as a condition of participation in and payment from the Medicare program. This data also is required for quality measurement purposes. In the CY 2016 HH PPS final rule, CMS finalized a proposal to define the quantity of OASIS assessments each HHA must submit to meet the pay-for-reporting requirement, with escalating thresholds set through CY 2019. CMS will continue to enforce its pay-for-reporting requirement and reduce relevant payment rates by 2 percent for HHAs that do not submit quality measure data sufficient to meet this pay-for-reporting requirement.

CMS proposes four new measures to be effective for the CY 2018 payment determination. One of these measures, centering on medication reconciliation, is assessment based and draws from patients' OASIS data. The other three—discharge to the community, total estimated Medicare spending per beneficiary, and potentially preventable 30-day post-discharge hospital readmission rates, respectively—are resource-based and are measured using Medicare claims data. CMS invites public comment on a host of additional quality measures for use in future years in the Home Health Quality Reporting Program (HH QRP).

CMS has completed its initiative to reevaluate all HHA outcome and process quality measures, and has decided to exclude from its Home Health Quality Initiative 28 home health quality measures that it identified as no longer valuable to the program. The measures to be removed include notations of certain interventions and prevention steps in patients' plans of care, emergent care measures that had such low incidence that their quality improvement value was limited, and certain behavioral outcome improvement measures that CMS has deemed of low priority and low clinical relevance based on stakeholder feedback.

CMS also proposes to exclude six process measures from its HH QRP based on the results of expert input and its comprehensive reevaluation. These measures relate to pain assessments and interventions, pressure ulcer risk and prevention, and heart failure symptoms. In addition, CMS proposes to implement a broader policy for quality measure removal and to make measures permanent year-over-year in subsequent payment determinations absent certain exceptions or removal. In light of the various requirements on HHAs in the quality space, CMS proposes to move to a CY reporting period

timeframe for quality measures, as opposed to the current quarterly timeframe, beginning on January 1, 2017.

For CY 2017, CMS also proposes to implement a policy, modeled on its policy for hospital inpatient quality reporting, to update and make changes to measures in the HH QRP. This policy would allow CMS to use a subregulatory process to make "nonsubstantive updates" to measures. CMS would determine on a case-by-case basis what constitutes a substantive versus a nonsubstantive change. CMS included updates to diagnosis or procedure codes and measure exclusions as examples of nonsubstantive changes. CMS believes this process will balance the need to update the HH QRP measures in an expeditious manner with the public's right to comment on updates to measures. CMS specifically invited public comment on this proposal.

CMS noted that, in future rulemaking, it intends to propose a policy to publicly display individual HHA quality performance information on IMPACT Act measures. In the meantime, CMS proposes procedures to provide HHAs with an opportunity to review and submit corrections to their data and information that will be made public, as well as an opportunity to preview such information before publication.

Home Health Value Based Purchasing

In the final CY 2016 HH PPS rule, CMS finalized its proposal to implement its HH VBP Model in nine geographically representative states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. Medicare-certified HHAs in these states are required to participate in the HH VBP, which beginning in CY 2018 will adjust payment to these HHAs based on each HHA's total performance score on applicable measures. Total potential upward or downward payment adjustments for HHAs will increase incrementally over the course of the HH VBP model, with a maximum adjustment of plus or minus 3 percent in CY 2018, 5 percent in CY 2019, 6 percent in CY 2020, 7 percent in CY 2021 and 8 percent in CY 2022.

Changes to Structure and Measures

As finalized in the CY 2016 HH PPS rule, the HH VBP Model separated competing HHAs within each selected state into either a larger-volume or smaller-volume cohort for purposes of benchmark calculation and achievement thresholds. HHAs were grouped based on their size, as measured by their exemptions from the Consumer Assessment of Healthcare Providers and Systems Survey requirements. CMS's intent was to group similarly situated HHAs and to only subject them to a standard set by either their in-state, similarly sized cohort counterparts or their own prior performance.

CMS has engaged in continued analysis, however, and is concerned that because of cohort size, this model could require HHAs in smaller-volume cohorts to meet performance standards that are even higher than the standards set for HHAs in the larger-volume cohorts. For this reason, CMS proposes to calculate benchmarks and achievement thresholds at a state level only, beginning with CY 2016. Also because of cohort size and outlier data, CMS proposes to increase the number of HHAs that must be part of a state's smaller-volume cohort to a minimum of eight, in order to maintain an inter-cohort comparison for payment adjustment calculation purposes; otherwise, all HHAs would be included in the state's larger-volume cohort. If finalized, these changes would apply to the CY 2018 payment adjustments and thereafter.

For technical and practical reasons (including certain measures that require data that is not currently, and has never been, collected by HHAs), CMS also proposes to remove four of the quality measures that were previously finalized as part of the HH VBP's "starter set." In addition, CMS proposes to require annual, as opposed to quarterly, reporting of data for one measure (Influenza Vaccination Coverage for Home Health Personnel) and to permit 15 calendar days, as opposed to seven, for HHAs to submit certain measure data following the end of each reporting period.

Appeals: Recalculations and Reconsiderations

As finalized in the CY 2016 HH PPS final rule, each quarter HHAs have the opportunity to review an Interim Performance Report (IPR), which shows an HHA's measure scores based on currently available data. The IPRs give HHAs the opportunity to identify and correct calculation errors and resolve discrepancies through recalculation requests, minimizing future issues with the annual performance scores linked to payment adjustments. HHAs also have the opportunity to review their Annual Total Performance Score

(TPS) and Payment Adjustment Report, which show HHAs their TPS and payment adjustment percentage before the payment adjustment is applied. CMS proposes to add a new regulatory section that would codify the appeals process for HHAs in the VBP Model. This regulation would add the recalculation request process finalized in the CY 2016 HH PPS final rule with proposed slight modifications and would add a proposed reconsideration process for the Annual TPS and Payment Adjustment Report. CMS's proposed reconsideration pathway would be available only when an HHA has first completed a recalculation request. In addition, it would only be available for the Annual TPS and Payment Adjustment Report, not for an HHA's IPR.

Public Reporting of HH VBP Data

CMS noted that it is considering various public reporting platforms to publish performance reports for each of the HHAs in the HH VBP Model. The platforms under consideration include Home Health Compare and the Center for Medicare and Medicaid Innovation web page. As the mechanism for publicly reporting on the HH VBP Model is being developed, CMS also is considering which data elements reported will be meaningful to stakeholders and may inform the selection of HHAs for care. CMS plans to begin public reporting on the HH VBP Model no earlier than CY 2019.

Continued Focus on Quality, Areas of Potential Abuse

In its press release announcing the HH PPS proposed rule, CMS characterized the rule as "one of several [] for calendar year 2017 that reflect a broader Administration-wide strategy to create a health care system that results in better care, smarter spending, and healthier people. Provisions in these rules are helping to move our health-care system to one that values quality over quantity and focuses on reforms . . . ." Not only can CMS's focus on value- and quality-based payment initiatives be seen across multiple rules proposed by the agency, CMS's determined development of the HH VBP Model and its attention to the HH QRP evidence this keen regulatory focus in the home health space specifically. CMS has been careful to consider changes such as the NWPT payment and the financial incentives inherent in its reimbursement structure. CMS's proposal to have quality measures continue to apply year-to-year may also suggest that it views the QRP as an important and permanent fixture in its home health reimbursement scheme.

CMS's characterization of its proposed rule as one that helps focus on "reforms" is also apt, given the sustained and intense government focus on fraud and abuse in the home health space over the past several years. In recent publications, the HHS's Office of Inspector General has stated that in Fiscal Year 2015, almost 60 percent of Medicare's payments to HHAs were "improper." In this context, CMS's VBP Model appears aimed not only at value-based metrics but also at ensuring the medical necessity of care provided to beneficiaries. Additionally, CMS's inclusion of total estimated Medicare spending per beneficiary as a quality metric may stem from its larger home health fraud and abuse concerns. In its proposed rule, CMS not only noted the extreme variation in Medicare payments to HHAs for standard episodes of care, but also pointed to this new measure's role in creating a much-needed "continuum of accountability" for providers. Required reporting on this metric would give CMS a relatively easy way to identify HHAs for subsequent attention, as poor performance on this measure might be an indicator of potential fraud. CMS clarified that it was aware of beliefs that "resource use measures do not reflect quality of care in that they do not take into account patient outcomes or experience beyond those observable in claims data." However, CMS felt that the need to measure and recognize HHAs that were involved in the provision of high-quality care at lower cost outweighed this concern.

Stakeholders are encouraged to review this rule and consider comment strategy. CMS is accepting comments on the proposed rule until 5 pm EDT on August 26, 2016.

Click here to view the proposed rule published in the July 5, 2016, *Federal Register*.

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