American Hospital Association

# Regulatory Advisory

**August 4, 2015**

# HOME HEALTH PPS: PROPOSED RULE FOR CY 2016

## AT A GLANCE

***The Issue:***

On July 10, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2016 proposed rule for the home health (HH) prospective payment system (PPS). The agency estimates that HH agencies will receive an overall net payment reduction of 1.8 percent (or $350 million) as compared to CY 2015. Hospital-based HH agencies will, on average, see a slightly larger decrease of 2.0 percent below CY 2015 levels. The proposed overall update for CY 2016 includes a 2.9 percentage point market-basket update, which would be offset by two statutorily mandated reductions: a 0.6 percentage point cut and a 2.5 percentage point cut for the third of four annual installments for HH PPS rebasing. CMS also proposes to offset the market basket with a case-mix cut of 1.72 percentage points to account for case-mix increases that CMS states are not due to increasing patient acuity. Beginning in CY 2018, the proposed rule also would test a new HH value-based purchasing (VBP) model in selected states. CMS estimates that for CY 2018 through CY 2020, this model would produce savings to the Medicare Trust Fund of $380 million by improving HH services in a manner that would reduce unnecessary hospitalizations and skilled-nursing facility use.

***Our Take***:

While the next installment of the rebasing cut was expected, the proposed rule contains two other provisions that cause concerns: the HH VBP model and the case-mix adjustment. While we applaud CMS for proposing a pay-for-performance model that recognizes both improvement from baseline performance and achievement, the AHA believes placing up to 8 percent of payment at risk for performance is too much, too fast. This is especially true for hospital-based HH agencies whose average Medicare margins are negative 15 percent. We also are concerned about the scale of the proposed case-mix adjustment, 3.41 percent over two years, and the across-the-board application of this cut, which would also penalize those agencies that have not driven the case-mix growth that is not caused by increasing patient acuity. We must also note that, given their historically lower Medicare margins, the proposed case-mix cut would disproportionately affect hospital-based agencies – which is inappropriate and could harm patient access to medically necessary services.

***What You Can Do:***

- ✓ Share this advisory with your senior management team to examine the impact of these proposed changes on your organization for CY 2016.
- ✓ **Participate in AHA's upcoming HH member call to discuss the major issues in this proposed rule and help develop key messages for AHA's comment letter to CMS. Use this link to register for this call on Thursday, Aug. 6, at 2 p.m. ET.**
- ✓ Submit a comment letter to CMS by Sept. 4, which explains your concerns and their impact on your patients and organization. Submission details are included in this advisory.

***Further Questions:***

Please contact Rochelle Archuleta, director of policy, at (202) 626-2320 or rarchuleta@aha.org, or for questions about the quality provisions, Akin Demehin, senior associate director of policy, at (202) 626-2365 or ademehin@aha.org.

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# HOME HEALTH PPS: PROPOSED RULE FOR CY 2016

## BACKGROUND

On July 10, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2016 proposed rule for the home health (HH) prospective payment system (PPS). CMS estimates that HH agencies will receive a net payment reduction of 1.8 percent, a $350 million decrease, from CY 2015 payment levels. Facility-based HH agencies, such as hospital-based agencies, will see an average decrease of 2.0 percent above 2015 levels, due to case-mix differences.

## PROPOSED CY 2016 PAYMENT UPDATE

The overall payment update for HH agencies is composed of several distinct parts, and the overall impact on individual agencies depends on how the following factors affect them specifically: the market-basket update, the rebasing of payments, the case-mix adjustment and the area wage index.

### Market-basket Update

The HH PPS standard rates are updated annually using a HH-specific market basket. For CY 2016, HH agencies that report quality data would receive a 2.9 percent market-basket update. Agencies that do not report quality data would face a decrease of 2.0 percentage points in their market-basket update, making their update 0.9 percent. In addition, agencies then will have their market-basket update reduced by a 0.6 percentage point productivity cut mandated by the Affordable Care Act (ACA).

### Rebasing of Payments and Proposed 2016 Rates

As required by the ACA, CMS is rebasing HH PPS payments via a four-year process initiated in CY 2014. The stated purpose of this rebasing is to adjust for changes in HH service delivery that have occurred over time, such as a reduction in the number of visits per HH episode, changes in the mix and intensity of services provided and the average cost of providing an episode of care. By law, the per-year payment reduction due to this rebasing cannot exceed 3.5 percent of total 2010 payments. The rebasing process for CY 2016 reduces the 60-day episode rate and the non-routine supplies

(NRS) conversion factor, and increases the per-visit rates, which are used for low-volume episodes.

Overall, the proposed CY 2016 rebasing cut is 2.5 percent, which would reduce HH payments by $470 million relative to CY 2015 payment levels. This cut would include an $80.95 reduction to the 60-day episode rate, increase low-utilization payment adjustments (LUPA) (ranging from $1.79 to $6.34), and reduce the NRS conversion factor by 2.82 percent.

60-day Episode Rate. For CY 2016, CMS proposes a 60-day episode rate of $2,967.35, which includes the rebasing cut. Even with this cut, the CY 2016 rate would increase from the CY 2015 rate of $2,961.38, due to positive adjustments for the wage index and case-mix weights, which maintain budget neutrality with the 2015 rate. CMS notes that the statutory cap for each of the four rebasing cuts (3.5 percent of the CY 2010 60-day episode rate) prevents it from proposing the larger cut the agency states would be needed to more closely align payments to the cost of the average 60-day episode.

LUPA Rates. Episodes with four or fewer visits are subject to a LUPA and are paid on a per-visit basis per type of service. Below are the current CY 2015 and proposed CY 2016 per-visit rates used to pay LUPA episodes.

| | CY 2015 Per-visit Rates | Proposed CY 2016 Per-visit Rates |
|---|---|---|
| HH Aide | $57.89 | $61.09 |
| Medical Social Services | $204.91 | $216.23 |
| Occupational Therapy | $140.70 | $148.47 |
| Physical Therapy | $139.75 | $147.47 |
| Skilled Nursing | $127.83 | $134.90 |
| Speech-language Pathology | $151.88 | $160.27 |

NRS Conversion Factor. NRS include, for example, dressings for wounds, syringes, intravenous supplies and catheters. Payment rates for NRS are established by applying a conversion factor to the relative weight assigned to each of the six NRS severity levels. The proposed CY 2016 rates for the six NRS severity levels, which are calculated using the final NRS conversion factor of $52.92, are listed in Table 15 of the proposed rule and range from $14.28 for the lowest severity level to $557.00 for the highest severity level. As with each of the four rebasing installments, these proposed rates were reduced by a 2.82 percent rebasing adjustment applied to the conversion factor.

### *Case-mix Adjustment and Weights*

CMS proposes a substantial payment reduction to account for nominal case-mix growth – case-mix increase that it states is not associated with a rise in patient acuity – of 2.32 percent from CY 2012 to 2013 and 1.18 percent from CY 2013 to 2014. Although CMS reported the CY 2012 to 2013 nominal case-mix growth in its rulemaking for CY 2015, this is the agency's first proposal to implement a case-mix cut simultaneously with the rebasing cut. To account for the nominal case-mix growth and to "better align payment with real changes in patient severity," CMS proposes to implement a 3.41 percent reduction that is generated by 1.72 percent cuts in each of CYs 2016 and 2017.

### *Case-mix Weights*
The HH PPS uses the home health resource groups (HHRG) along with the patient assessment data collected using the Outcome and Assessment Information Set (OASIS) tool to categorize patients for payment purposes. As of CY 2015, CMS annually recalibrates the HH case-mix weights with more current data to align payments with the most current HH service utilization data. For CY 2016, CMS used CY 2014 claims data to recalibrate the proposed weights for 60-day episode payments, which are presented in Table 9 of the proposed rule.

### *Area Wage Index*
In the fiscal year (FY) 2015 inpatient PPS final rule, CMS applied updated labor market boundaries to the area wage index that were based on updated core-based statistical area (CBSA) definitions. For the CY 2015 HH wage index, CMS phased-in these new CBSA boundaries through a one-year transition that used a 50/50 blend of the wage index values using the Office of Management and Budget's (OMB) previous labor market delineations and the wage index values using OMB's updated labor market delineations. For CY 2016, the new boundaries will be in full effect, as shown in the rule's proposed CY 2016 wage index amounts.

### *Labor-related Share*
The proposed rule would maintain a labor-related share of 78.535 percent for the case-mix adjusted 60-day episode rate, as initially set in the CY 2013 HH PPS final rule.

### *High-cost Outliers*
CMS does not propose any changes to the HH PPS high-cost outlier policy in CY 2016. The agency estimates that outlier payments will comprise approximately 2.25 percent of total HH PPS payments in CY 2015, although CMS targets a 2.5 percent outlier pool.

### *Rural Add-on*
The add-on payment for HH services furnished in rural areas was originally established by the Medicare Modernization Act of 2003. Later, the add-on was expanded by the Deficit Reduction Act and then by the Affordable Care Act. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 extended the 3-percent add-on for rural HH episodes concluding before Jan. 1, 2018. The proposed rule implements this add-on to the 60-day episode, individual visit, and NRS payment amounts.

## *OTHER*

### *Update on Statutorily-mandated Research*
In the proposed rule, CMS shares preliminary findings from statutorily-required research on HH costs. Specifically, CMS is researching the cost of providing ongoing access to HH care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with high levels of severity of illness. To help meet this mandate, CMS contracted with L&M Policy Research and Abt Associates. L&M Policy Research found that HH margins in CY 2010 varied substantially and were lower for the following types of patients:

- Patients who required parenteral nutrition, had traumatic wounds or ulcers, or required substantial assistance in bathing;
- Patients admitted after acute or post-acute stays or who had high-hierarchical condition category scores or certain poorly controlled clinical conditions, such as poorly-controlled pulmonary disorders; and
- Dually-eligible Medicare and Medicaid beneficiaries.

In addition, research by Abt Associates yielded three model options for changing or replacing the current case-mix classification system to address concerns about access to care for the patients identified above:

- The "diagnosis on top" model combines diagnosis groups with a regression model to create separate weights for patients with different diagnoses;
- The "predicted therapy model" is similar to the current approach, but replaces actual therapy visits with predicted therapy visits to develop case mix weights and payment amounts; and
- The "home health groupings model" groups HH episodes by diagnoses and the expected types of HH interventions.

The proposed rule describes these models, which will be the focus of an upcoming technical expert panel and CMS report that further describe and analyze the three model options and next steps for policymakers.

## ***HH QUALITY REPORTING PROGRAM***

The Deficit Reduction Act of 2005 required CMS to establish a quality of care data reporting program for HH agencies beginning in CY 2007 that links reporting to payment of the full annual update. HH agencies failing to report the required data receive a payment reduction of 2.0 percentage points.

CMS proposes to add one new measure to satisfy the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. The IMPACT Act is intended to foster greater alignment of measures across CMS's post-acute care quality reporting programs, including the HH Quality Reporting Program (HH QRP), by requiring the collection of measures on specific topics that are "standardized and interoperable" across post-acute care settings. A detailed summary of the IMPACT Act's requirements can be found in the AHA's Oct. 16, 2014 *Legislative Advisory*. CMS also proposes to raise the minimum data completeness threshold for OASIS assessments used to calculate HH QRP measures.

### *IMPACT Act Proposals*

IMPACT Act Implementation Timing. The IMPACT Act requires that penalties for non-compliance with the new HH QRP measure requirements begin Jan. 1, 2017. However, CMS proposes to use an implementation timeframe whereby IMPACT Act reporting requirements would be tied to payment in the CY that begins two years after they are adopted in rulemaking. **As a result, the HH QRP measure CMS proposes to fulfill IMPACT Act requirements will not affect HH QRP payment until CY 2018.** The

agency suggests such a timeframe "reflects operational and other practical constraints, including the time needed to specify and adopt valid and reliable measures, collect the data, and determine whether an HH agency has complied with our quality reporting requirements."

Proposed New Measure for CY 2018. To address the IMPACT Act's "skin integrity" measure domain, CMS proposes a pressure ulcer measure that assesses the percentage of patients with stage 2 to 4 pressure ulcers that are new or worsened since the beginning of an episode of HH care. This measure is endorsed by the National Quality Forum (NQF) and was supported for use in the HH QRP by the multi-stakeholder Measure Applications Partnership (MAP). As mandated by the ACA, CMS seeks review of measures it intends to propose for its quality reporting and pay-for-performance programs in advance of formal rulemaking.

CMS proposes to calculate the pressure ulcer measure using items that HH agencies already complete and submit on the OASIS assessment tool. These items include M1308 (current number of unhealed pressure ulcers at each stage or unstageable), and M1309 (worsening in pressure ulcer status since start of care / resumption of care). CMS also suggests it will use several other OASIS items to perform risk adjustment, such as M1850 (activities of daily living assistance).

Future IMPACT Act Measures. In addition to skin integrity, the IMPACT Act requires HH agencies to report measures on several other topics. CMS solicits comment on, but does not specifically propose, several measures it is considering for future years including:

- Rates of potentially preventable hospital readmissions;
- Resource use;
- Discharges to the community; and
- Medication reconciliation.

### *OASIS Data Completeness Standards*

HH agencies are required to submit OASIS assessments for both payment and quality measurement purposes. In order to appropriately calculate quality measures using OASIS data, CMS needs to match OASIS assessments completed at the start or resumption of HH agency care with OASIS assessments completed at the time of patient transfer or discharge. Taken together, these matched OASIS assessments create what the agency terms an OASIS "quality assessment."

CMS has the authority to establish data submission requirements under the statute, which requires HH agencies to submit measure data "in a form and manner, and at a time, specified by the Secretary [of Health and Human Services]." As a result, CMS used the CY 2015 HH PPS final rule to establish a "minimum data submission threshold" – or data completeness threshold – to assess whether HH agencies have submitted sufficient data to calculate measures. For the CY 2017 payment determination, HH agencies will be required to submit complete OASIS quality assessments on a minimum of 70 percent of patients with episodes of care occurring during the applicable data reporting period. HH agencies that do not meet the data

completeness standard will be subject to a 2.0 percentage point reduction to their annual payment updates. The reporting period for CY 2017 is July 1, 2015 through June 30, 2016.

In this rule, CMS proposes to increase the minimum data threshold to 80 percent for CY 2018 payment determinations, and 90 percent for CY 2019 payment determinations and beyond. CMS proposes to continue to use a mathematical formula to calculate whether HH agencies have met the data completeness standards for quality assessments.

## ***HH VALUE-BASED PURCHASING PROGRAM***

Invoking its authority under the ACA to test payment models intended to improve quality and/or reduce cost, CMS proposes to implement a HH VBP program. Participation in the HH VBP would be mandatory for all CMS-certified HH agencies in nine states – Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington. HH agencies in these states would be subject to upward and downward payment adjustments of up to 8 percent based on performance on 29 measures. The proposed scoring approach would recognize HH agencies for both their level of achievement versus benchmarks, as well as improvement over their own baseline performance.

CMS proposes to begin the HH VBP program Jan. 1, 2016 and end the program Dec. 31, 2022. The program would adjust payments to the affected HH agencies in CYs 2018 – 2022. The sections below highlight the key aspects of the HH VBP program. **The AHA encourages HH agencies in the nine affected states to review CMS's detailed policy proposals in the rule**.

Goals and Rationale for the Proposed HH VBP Model. CMS states that the HH VBP program is intended to:

- Provide incentives for HH agencies to improve quality and efficiency of care;
- Study the potential suitability of new quality and efficiency measures for HH agencies; and
- Enhance the current process for publicly reporting HH agency quality information.

CMS suggests the proposed model also aligns with its recently announced goals to promote a movement from volume-based reimbursement for health care providers to value-based approaches. Furthermore, the agency is interested in determining whether tying larger amounts of payment to quality performance leads to greater improvement. In contrast to the hospital VBP program, in which 2 percent of hospital reimbursement is linked to quality performance, the proposed HH VBP ties up to 8 percent of HH agency payments to quality.

CMS indicates that it considered a HH VBP model in which participation would be voluntary and open to all HH agencies nationally. However, CMS chose to propose the mandatory participation of HH agencies within certain states in an effort to reduce self-selection bias, to ensure sufficient participation to generate meaningful results, and to

obtain a more representative sample of HH agencies. CMS also suggests testing the model for entire states would reduce the potential for market disruption resulting from non-VBP model HH agencies competing against HH agencies in the VBP model.

State Selection Methodology. To identify the nine states that would be required to participate in the HH VBP model, CMS proposes a methodology in which it places all 50 US states into nine groups. CMS proposes to group states using several factors intended to result in groups that have states with as many characteristics in common as possible. These factors include geographic proximity, patterns of home health utilization, the proportion of non-profit HH agencies, and the types of beneficiaries served. CMS considered beneficiary characteristics such as the severity, number and type of co-morbid conditions, and socioeconomic status. Once CMS identified the nine groups, it randomly selected one state from each group using a statistical software program. The nine groups and selected states are listed below in Table 1.

**Table 1: Proposed HH VBP Model Groupings of States and Selected States**

| Group | States | Selected State |
|---|---|---|
| 1 | VT, MA, ME, CT, RI, NH | MA |
| 2 | DE, NJ, MD, PA, NY | MD |
| 3 | AL, GA, SC, NC, VA | NC |
| 4 | TX, FL, OK, LA, MS | FL |
| 5 | WA, OR, AK, HI, WY, ID | WA |
| 6 | NM, CA, NV, UT, CO, AZ | AZ |
| 7 | ND, SD, MT, WI, MN, IA | IA |
| 8 | OH, WV, IN, MO, NE, KS | NE |
| 9 | IL, KY, AR, MI, TN | TN |

Performance Assessment and Payment Adjustment Timeframes. The proposed HH VBP model would provide upward or downward payment adjustments based on quality performance during specific performance periods. CMS proposes that the model include five performance years – CYs 2016 through 2020. Payment adjustments based on quality performance would be made two CYs after a performance period. For example, CY 2016 performance would be used to determine the payment adjustment for CY 2018. Furthermore, CMS proposes that the level of payment adjustment increase gradually over time, starting at 5.0 percent in CY 2018, and rising to 8.0 percent in CY 2021 and CY 2022. The HH VBP's proposed performance assessment and payment adjustment timeframes are outlined in Table 2.

**Table 2: HH VBP Proposed Performance Assessment and Adjustment Timeframes**

| Performance Period | Payment Adjustment Year | Level of Payment Adjustment |
|---|---|---|
| CY 2016 | CY 2018 | 5.0 percent |
| CY 2017 | CY 2019 | 5.0 percent |
| CY 2018 | CY 2020 | 6.0 percent |
| CY 2019 | CY 2021 | 8.0 percent |
| CY 2020 | CY 2022 | 8.0 Percent |

Quality Measures. To determine the quality performance of participating HH agencies, CMS proposes to use a total of 29 measures, 25 of which are currently collected and reported by HH agencies, and four of which are new measures that would be collected for the first time in CY 2016. The proposed measures address all six of the National Quality Strategy's (NQS) priority areas – clinical quality of care, care coordination, population/community health, efficiency and cost reduction, patient safety, and person and caregiver-centered experience. A full list and description of the 25 existing measures and four new measures CMS proposes to use in the HH VBP – mapped to NQS priority area – can be found in Figures 4a and 4b of the proposed rule.

Scoring Methodology. CMS proposes to calculate a total performance score (TPS) of zero to 100 points (with 100 points being best) for each participating HH agency. The TPS would be determined using the higher of a HH agency's improvement versus its own baseline performance or its achievement versus CMS-determined performance standards. CMS would calculate so-called "improvement" and "achievement" scores for each measure for which the HH agency has data. The agency would then combine the results from all measures to create each HH agency's TPS. CMS's proposed approach is similar to that used in the hospital VBP program, but differs in a number of ways that are noted below.

*Performance Standards for Achievement Points.* CMS proposes to establish a minimum "achievement threshold" for each measure that participating HH agencies must meet to receive any points for achievement, as well as a "benchmark " above which HH agencies would get the maximum number of points for the measure. **In contrast to the hospital VBP program, which uses nationwide data, CMS would calculate the achievement thresholds and benchmarks separately for each state and for each HH agency cohort size within a state.** CMS believes this approach ensures that HH agencies would compete against only those HH agencies in their states and size cohorts.

The "achievement threshold" for each measure would be the median performance of all HH agencies in a given state and size cohort during the baseline period. The "benchmark" would be the mean of the top decile of all HH agencies in a given state and size cohort during the baseline period. **CMS proposes to use CY 2015 as the baseline period for all years of the HH VBP program in order to "evaluate the degree of change that may occur over multiple years of the model."** In contrast, the hospital VBP program uses a different baseline for each year of the program.

*Calculating Achievement and Improvement Points.* CMS proposes to award each HH agency zero to 10 points on each measure for which they have sufficient data. CMS would give each HH agency the better of its achievement score or improvement score.

To calculate achievement scores, CMS proposes to assign HH agencies zero to 10 points along a range between the achievement threshold (the minimum level of HH agency performance required to receive achievement points) and the benchmark (the standard at which a HH agency would receive the maximum number of points):

- If a HH agency's score is equal to or greater than the benchmark, the HH agency would receive 10 points for achievement.

- If the HH agency's score is less than the achievement threshold, the HH agency would receive zero points for achievement.

- If the score is equal to or greater than the achievement threshold but below the benchmark, the HH agency would receive a score of one to nine based on where its score falls on the scale between the achievement threshold and the benchmark according to the following formula:

$$9 \times \left(\frac{\text{performance period score} - \text{achievement threshold}}{\text{benchmark} - \text{achievement threshold}}\right) + 0.5$$

All achievement scores would be rounded to the nearest whole number.

In determining the improvement score, HH agencies would receive points along a range between the HH agency's score during the baseline period and the benchmark score:

- If the HH agency's score is lower than its baseline period score on the measure, the HH agency would receive zero points for improvement.

- If the score is greater than the baseline period score but below the benchmark, the HH agency would receive from zero to nine points based on where its score falls on its own unique improvement range, according to the following formula:

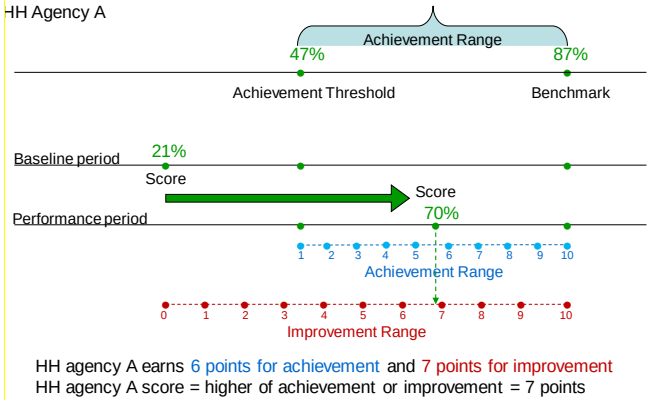
$$10 \times \left(\frac{\text{performance period score} - \text{baseline period score}}{\text{benchmark} - \text{baseline period score}}\right) - 0.5$$

All improvement scores would be rounded to the nearest whole number.

Figure 1 provides an example of how a HH agency would be scored. In this example, the achievement threshold is 47 percent and the benchmark is 87 percent. The HH agency has a baseline score of 21 percent and a performance period score of 70 percent. To score the HH agency on achievement, CMS would assign the HH agency points along the range between the achievement threshold and the benchmark according to the achievement formula above. Under this formula, the HH agency scores 5.675 points, which rounds up to 6 points for achievement.

To score the HH agency on improvement, CMS will assign the HH agency points along the range between the HH agency's score during the baseline period and the benchmark score according to the improvement formula above. Under this formula, the HH agency scores 6.92 points, which rounds up to 7 points for improvement. The HH agency then receives the higher of its achievement or improvement score, and thus, receives 7 points for this measure.

**Figure 1: Sample HH VBP Scoring for a Measure**




*Scoring the New Measures.* CMS proposes not to calculate achievement and improvement scores for the four new measures in Table 4b of the proposed rule. Instead, the agency will award 10 points for each measure that the HH agency reports successfully. If the HH agency has sufficient data to report the measure but fails to submit it, CMS proposes that the HH agency receive zero points for the measure.

Determining the TPS.

*Measure Classifications and Weighting.* CMS proposes to sort the 29 proposed HH VBP measures into four domains, or "classifications," outlined in Table 3 below. The classification of a measure would depend on its NQS priority area, and whether it is one of the four new measures. CMS proposes that the measures in classifications I, II and III would account for 90 percent of the TPS; each measure would be weighted equally. The new measures in classification IV would account for 10 percent of the TPS, with each measure weighted equally within the classification.

CMS chose this approach because it did not want any one measure within a classification to be more important than another measure. The proposed weightings would be applied for at least the first years of the model. However, CMS may reconsider its proposed weightings in future rulemaking.

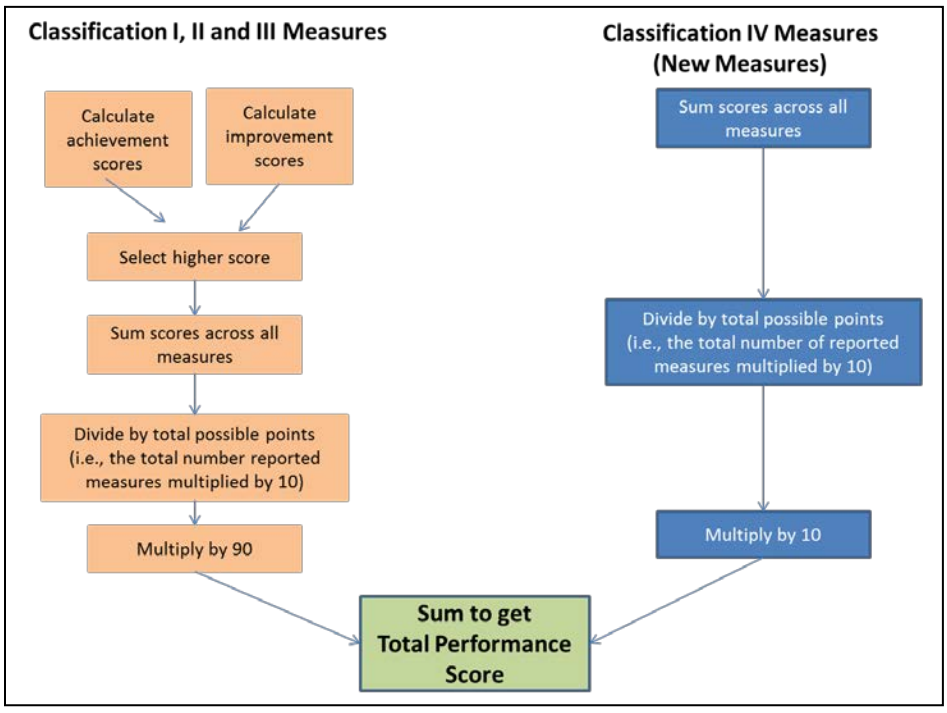
**Table 3: HH VBP Proposed Measure Classifications and Weightings towards Total Performance Score (TPS)**

| Classification | NQS Priority Included in Classification | TPS Weighting |
|---|---|---|
| I – Clinical Quality of Care | Clinical quality of care | 90 percent, with each measure weighted equally |
| II – Outcomes and Efficiency | Efficiency and cost reduction<br>Patient safety<br>Care coordination<br>Population/community health | |
| III – Person and Caregiver-Centered Experience | Person and caregiver-centered experience | |
| IV – New Measures | Multiple priority areas | 10 percent, with each measure weighted equally |

*Minimum Number of Measures to receive a TPS.* CMS proposes that HH agencies must have data on at least five measures in classifications I, II and III in order to receive a TPS. Those HH agencies that can be scored on fewer than five measures would not receive any upward or downward payment adjustment under the HH VBP. CMS suggests that less than 0.5 percent of the HH agencies it proposes to include in the HH VBP model are currently reporting fewer than five measures in classifications I, II and III.

*Calculating the TPS.* Figure 2 below summarizes the process CMS proposes to calculate the TPS. To calculate the TPS, CMS would select the higher of improvement or achievement scores for each measure, and sum the scores across all measures. Each measure would be weighted equally. The total points for all measures in classifications I, II and III would then be divided by the HH agency's total points possible (i.e., the total number of measures in classifications I, II and III that the HH agency reported multiplied by 10). The result would be multiplied by 90 to obtain a score for classifications I, II and III. To calculate the score for the new measures in classification IV, CMS would simply sum the measure scores, divide by the total possible points and multiply by 10.

**Figure 2: Proposed Approach to Calculating Total Performance Scores**




To use an example, suppose a HH agency had the following scores for 10 measures from classification I, II and III – 5, 7, 3, 9, 7, 4, 8, 5, 9 and 10. CMS would first add the scores from classification I, II and III to obtain 67 points. It would then divide that number by the total points possible for classifications I, II and III, which is 100 (10 applicable measures times 10 points). The result is 0.67, which CMS will multiply by 90

to obtain a score of 60 the measures in classifications I, II and III. Further suppose that the same HH agency reported all four of the classification IV measures. Since the successful reporting of each classification IV measure is worth 10 points, the agency would receive 40 points out of a possible 40 points. Thus, the agency would get 10 points for the classification IV measures, and a TPS of 70 points.

Payment Adjustment Approach. CMS proposes to translate each HH agency's TPS into an incentive payment using a simple linear exchange function (LEF). A similar approach is used to determine payments under the hospital VBP program. CMS proposes that the function's intercept be set at zero percent adjustment, meaning that HH agencies with average TPS scores compared to their cohort would receive a zero percent payment adjustment. Payment adjustments for each HH agency with a score above zero percent would be determined by the slope of the LEF.

Figure 9 in the proposed rule provides a detailed explanation of how CMS would calculate the LEF and apply payment adjustments. To calculate the payment adjustment percentage, CMS would start by estimating the dollar amount of the maximum payment reduction possible for the program year. The agency would then adjust that amount upward using each HH agency's TPS and the slope of the LEF.

## *NEXT STEPS*

**The AHA will host a member call Thursday, Aug. 6 at 2 p.m. ET to discuss the provisions of this proposed rule and to gather input from the field for AHA's comment letter to CMS.** AHA members may use this link to register. Related materials and a recording of this call will be available at: www.aha.org/postacute in the HH section.

Submitting Comments. The AHA urges all HH agencies to submit comments to CMS. Comments are due to CMS by Sept. 4 and may be submitted electronically at: www.regulations.gov. Follow the instructions for "Comment or Submission" and enter the file code "CMS-1625-P." You also may mail written comments (an original and two copies) to CMS; instructions are in the proposed rule.

Questions. If you have further questions regarding the proposed rule's payment provisions, contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. Questions regarding the quality provisions should be directed to Akin Demehin, senior associate director of policy, at ademehin@aha.org.