American Hospital Association

Regulatory Advisory

November 21, 2016

HOME HEALTH PPS: FINAL RULE FOR CY 2017

AT A GLANCE

The Issue:

On Nov. 3, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2017 final rule for the home health (HH) prospective payment system (PPS). The agency estimates that, under this rule, HH agencies will receive an overall net payment reduction of 0.7 percentage point (or -$130 million) compared to CY 2016. This overall cut includes a 2.8 percentage market-basket update, which will be offset by two statutorily mandated reductions: a 0.3 percentage point cut for productivity and a 2.3 percentage point cut for the final of four annual installments of the HH PPS rebasing process. CMS also will offset the market-basket update with a case-mix cut of 0.97 percentage point, the second of three such cuts that, collectively, are intended to account for case-mix increases that the agency states are not due to increasing patient acuity. The final rule also includes a statutorily-mandated new payment for disposable negative pressure wound therapy (NPWT) and a move from per visit to per minute-based outlier payments.

CMS adopts four new measures for the CY 2018 HH quality reporting program (QRP). The agency also finalizes its proposal to remove six measures from the HH QRP whose performance has "topped out" and no longer adds value. This is in addition to the removal of 28 measures from reporting in the HH Quality Initiative (HHQI), which includes a broader set of quality data than the HH QRP. CMS also adopts several changes to the HH value-based purchasing (VBP) program, a mandatory payment model for all HH agencies in nine states that began on Jan. 1, 2016. Specifically, the agency removes four measures, modifies the data submission deadlines for certain measures, and adopts an appeals process allowing HH agencies to contest CMS's calculation of their performance prior to the application of payment adjustments. CMS also will benchmark participating HH agencies against other HH agencies in their states, rather than HH agencies in their size cohort and state.

Our Take:

As expected, this rule continues two multi-year payment cuts that are already in process. However, we are disappointed that CMS will implement the outlier payment changes, as proposed, without incorporating improvements recommended by AHA and other stakeholders. With regard to the new NPWT policy, we are pleased that CMS took steps to streamline the associated billing protocols, as urged by AHA and the HH field, and will seek member input during an upcoming member call (see below) to confirm any remaining shortcomings. In addition, we applaud CMS for taking steps to streamline the HH QRP measure set. However, we remain concerned that the amount of payment at risk for HH VBP in its out years is excessive. This is especially true for hospital-based HH agencies, whose average Medicare margins are *negative* 15.5 percent, which is starkly lower than the positive 12.7 percent margin for freestanding agencies. Given their far lower margins, we are disappointed that the hospital-based segment of the field will face, on average, CY 2017 rates that remain equal to CY 2016 levels.

A detailed summary of the rule prepared for the AHA by Health Policy Alternatives (HPA) is attached.

What You Can Do:

AHA will host a member call on Tuesday, Nov. 29, at 1:00 p.m. ET to solicit your feedback on this rule. Register at: https://www.surveymonkey.com/r/6W7H6V7.

Please share this advisory with your senior management team to examine the impact of these changes on your organization for CY 2017.

Further Questions:

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org for questions about the final rule's payment provisions, and Akin Demehin, director of policy, at ademehin@aha.org for quality-related questions.

Medicare and Medicaid Programs; CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (CMS-1648-F)
Summary of Final Rule

The Centers for Medicare & Medicaid Services (CMS) published in the November 3, 2016 *Federal Register* (81 *FR* 76702-76797) a final rule updating the CY 2017 Home Health Prospective Payment System, the Home Health Value-Based Purchasing model and home health quality reporting requirements. Page references given in this summary are to this published document, which is available at: https://www.federalregister.gov/documents/2016/11/03/2016-26290/medicare-and-medicaid-programs-cy-2017-home-health-prospective-payment-system-rate-update-home.

The final rule is effective on January 1, 2017.

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Summary

Update to Home Health Prospective Payment System (HH PPS): CMS finalizes its update to the national standardized 60-day episode rate with a market basket increase of 2.8 percent, reduced by a 0.3 percent productivity adjustment, for a 2.5 percent update for home health agencies (HHAs) submitting quality data and 0.5 percent for those that do not submit such data. The rule implements the final year of the four-year rebasing adjustment, which is a reduction of $80.95 to the national standardized amount, a 2.82 percent decrease in the non-routine medical supply (NRS) conversion factor, and annual fixed dollar increases in each of the per-visit rates. The rates also include the second year of the previously finalized three-year nominal case mix adjustment of 0.97 percent per year to account for nominal case-mix growth between CYs 2012 and 2014. CMS makes its annual recalibration of the HH PPS case-mix weights and the home health wage index using current hospital wage data.

Payment for High Cost Outliers under the HH PPS: CMS finalizes its proposal to change the methodology used to calculate the cost of an episode of care for purposes of outlier payments. CMS establishes a cost-per-unit calculation taking into account visit length rather than the previous cost-per-visit approach.

Negative Pressure Wound Therapy (NPWT): CMS finalizes changes with several technical clarifications in payment for NPWT performed using a disposable device for a patient as directed by the Consolidated Appropriations Act of 2016, with payments based on comparable payments under the Hospital Outpatient Prospective Payment System, including the 20 percent patient coinsurance under that system.

Home Health Value-Based Purchasing (HHVBP): CMS finalizes changes and updates to the HHVBP model adopted in the CY 2016 final rule as a demonstration in nine states. It sets benchmarks and achievement thresholds at the statewide level rather than separately for smaller- and larger-volume cohorts in each state; a revised timeframe for submitting new measure data; removal of four measures from the set of applicable measures; and it codifies an appeals process that includes the current recalculation process as well as a reconsideration process.

Home Health Quality Reporting Program (HH QRP): CMS finalizes updates to the HH QRP, including adoption of four new measures and the removal of six others, along with data submission and data review and correction policies.

Impact: The HH PPS updates are estimated to reduce home health payments by a net of $130 million, or -0.7 percent, in 2017. The HHVBP model is estimated to reduce Medicare program spending (not HH spending) for 2018-2022 by $378 million through a reduction in unnecessary hospitalizations and skilled nursing facility (SNF) usage, resulting from quality improvements in home health care.

II. Background (pages 76704-76706)

CMS reviews the statutory and regulatory provisions for the HH PPS and updates to that system. The Affordable Care Act (ACA) required CMS to implement a rebasing adjustment to the national, standardized 60-day episode rate and other rates. The 2014 HH PPS final rule set out three rebasing adjustments that remain applicable for CY 2017, which is the fourth and final year of these adjustments:

- A fixed dollar reduction of $80.95 per year in the national standardized 60-day episode rate for 2014 through 2017.
- Annual fixed dollar increases to the national per visit rates for each type of visit for 2014 through 2017:

Skilled nursing:	+$3.96
Home health aide:	+$1.79
Physical therapy:	+$4.32
Occupational therapy:	+$4.35
Speech-language pathology:	+$4.70
Medical social services:	+$6.34

- An annual decrease of 2.82 percent in the Nonroutine Medical Supply (NRS) conversion factor for 2014 through 2017.

CMS finalized in the 2016 HH PPS final rule a 0.97 percent reduction to the national, standardized 60-day episode payment rate in each of 2016, 2017, and 2018 to account for

nominal case-mix growth from 2012 through 2014. It will also continue to apply the 3 percent payment increase for HH services provided in rural areas, for episodes ending before January 1, 2018.

III. Provisions of the Proposed Rule and Analysis and Response to Comments (pages 76706-76737)

A. Monitoring for Potential Impacts – Affordable Care Act Rebasing Adjustments (page 76706)

CMS reported in detail on its monitoring of the impact of rebasing in the proposed rule, and notes in the final rule that it will continue to monitor the impacts due to the rebasing adjustments and other future policy changes and provide the industry with periodic updates in future rulemaking or in announcements on the HHA Center webpage at https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

B. CY 2017 HH PPS Case-Mix Weights (pages 76706-76714)

CMS finalizes its annual recalibration of the HH PPS case-mix weights using updated claims data as of June 30, 2016. CMS sets out the detailed methodology it uses to recalibrate the case-mix weights (see Tables 3-5 on pages 76707-76709). Table 6 (pages 76710-76712) presents the resulting 2017 case-mix payment rates for each payment group and step.

CMS finalizes a case-mix budget neutrality factor of 1.0214 for 2017, calculated as the ratio of total payments when 2017 case-mix weights are applied to 2015 utilization to total payments when 2016 case-mix weights are applied to 2015 utilization.

Comments: CMS responds to a number of comments about the recalibration of the case mix weights. It notes that it did not change the methodology from previous years, and describes the methodology. It notes that changes in case-mix weights reflect changes in use from 2014 to 2015 (the data used for the CY 2017 recalibration). CMS notes that it is conducting research and analysis to potentially revise the case-mix methodology, and it plans to release a Technical Report in the future.

C. CY 2017 Home Health Payment Rate Update (76714-76724)

1. CY 2017 Home Health Market Basket Update

CMS reviews the methodology for updating the HH PPS rates and finalizes the 2017 update based on IHS Global Insight Inc.'s (IGI) third quarter 2016 forecast (more current than the first quarter forecast used for the proposed rule.)

HH market basket increase:	2.8 percent.
Multi-factor productivity (MFP) adjustment:	-0.3 percent
MFP adjusted HHA market basket update:	2.5 percent

That market basket update is reduced by 2.0 percentage points for HHAs that do not submit quality data required by the Secretary. Thus the updates for 2017 will be:

For HHAs reporting the required quality data:	2.5 percent
For HHAs not reporting the required quality data:	0.5 percent

2. CY 2017 Home Health Wage Index

CMS continues to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates. CMS continues to use the Office of Management and Budget's (OMB's) February 28, 2013 revisions to the delineations of Metropolitan Statistical Areas (MSAs) and the creation of Micropolitan Statistical Areas, and Core-based Statistical Areas (CBSAs), and OMB's most recent update published July 15, 2015 in OMB Bulletin 15-01. The finalized home health wage index for 2017 is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

3. CY 2017 Payment Update

CMS finalizes two wage index budget neutrality adjustments. One applies to the standardized episode payment rate for episodes other than those involving the Low-Utilization Payment Adjustment (LUPA); and the other is specific to the national per visit rate for LUPA episodes, which are episodes with four or fewer visits, resulting in a per visit payment rate.

- A wage index budget neutrality adjustment of 0.9996 applies to the standardized episode payment rate. It is computed by dividing total payments for non-LUPA episodes using the CY 2017 wage index by the total payments for such episodes using the CY 2016 wage index.
- A wage index budget neutrality adjustment of 1.0000 applies to national per visit payments for LUPA episodes, computed by dividing total payments for LUPA episodes using the CY 2017 wage index by the total payments for such episodes using the CY 2016 wage index.

CMS also applies the previously noted case-mix budget neutrality adjustment (1.0214), the adjustment for nominal case mix growth (0.97 percent), the 2 percentage point reduction for HHAs not submitting quality data, and the statutory 3 percent increase for rural HHAs. See Tables 7-18 on pages 76716-76719 for details on the updates; below is a summary of the calculations.

2017 60-day National, Standardized 60-Day Episode Payment Amount, for HHAs submitting and not submitting quality data, and those in rural areas		
	HHAs submitting quality data	HHAs not submitting quality data
National standardized amount (Tables 7 and 8)		
2016 amount	$2,965.12	
Wage index budget neutrality factor	x 0.9996	
Case-mix budget neutrality factor	x 1.0214	
Nominal case mix growth adjustment (1-0.0097)	x 0.9903	
CY 2017 rebasing factor	-$80.95	
HH payment update percentage	x 1.025	x 1.005
2017 payment amount	$2,989.97	$2,931.63
Rural add-on (Table 15)	x 1.03	x 1.03
2017 rural payment amount	$3,079.67	$3,019.58

Computations are presented for the LUPA, the per-visit amounts for each type of service (these are amounts paid in lieu of the 60-day episode payment when there are four visits or fewer in an episode). CMS reminds the reader that the LUPA per-visit amounts are not calculated using case-mix rates. The per-visit amounts for those HHAs submitting and not submitting the required quality data, and the rates with the 3 percent rural add-on, are as follows:

2017 National, Per-Visit Amounts for HHAs that do and do not Submit Quality Data, and with rural add on (see CMS Tables 9, 10, 16)						
	Home health aide	Medical social services	Occu-pational therapy	Physical therapy	Skilled nursing	Speech-language pathology
All HHAs						
2016 per visit rates	$60.87	$215.47	$147.95	$146.95	$134.42	$159.71
Wage index budget neutrality factor	1.0000					
2016 rebasing, year 3	+$1.79	+$6.34	+$4.35	+$4.32	+$3.96	+$4.70
HHAs submitting required quality data						
Payment update	1.025					
2017 per visit rates	$64.23	$227.36	$156.11	$155.05	$141.84	$168.52
Rural rates (+3%)	$66.16	$234.18	$160.79	$159.70	$146.10	$173.58
HHAs not submitting required quality data						
Payment update	1.005					
2017 per visit rates	$62.97	$222.92	$153.06	$152.03	$139.07	$165.23
Rural rates (+3%)	$64.86	$229.61	$157.65	$156.59	$143.24	$170.19

LUPA Add-On Factors: CMS finalizes the LUPA add-on factors, which apply for the first or only visit in an episode. The per-visit adjusters for the initial visit are 1.8451 for skilled nursing, 1.6700 for physical therapy, and 1.6266 for speech-language pathology.

Non-routine Medical Supply (NRS) payment rates: CMS updates the NRS conversion factors for particular severity levels and sets payments for the six severity levels for HHAs that submit and do not submit required quality data.

CY 2017 NRS Conversion Factor for HHSs that do and do not Submit the Required Quality Data and resulting NRS payment amounts by severity level			
		HHAs that submit quality data	HHAs that do not submit quality data
NRS Conversion Factors (Tables 11 and 13)			
CY 2016 NRS Conversion Factor		$52.71	
CY 2017 Rebasing Adjustment		x 0.9718	
CY 2017 Payment Update		1.025	1.005
CY 2017 NRS Conversion Factor		$52.50	$51.48
NRS Payment Amounts by Severity Level (Tables 12 and 14)			
Severity level	Relative Weight		
1	0.2698	$14.16	$13.89
2	0.9742	$51.15	$50.15
3	2.6712	$140.24	$137.51
4	3.9686	$208.35	$204.30
5	6.1198	$321.29	$315.05
6	10.5254	$552.58	$541.85

Table 18 in the rule shows the impact of the 3.0 percent rural add-on to the NRS Conversion Factor and Payment Amounts.

Comments: CMS responds to a number of wage index comments; it continues to believe that the pre-floor, pre-reclassified hospital wage index is appropriate, and without use of the hospital geographic recalculations. CMS notes that the MSA and CBSA delineations are determined by OMB, and that rising minimum wage standards will likely be reflected in future cost data used to calculate the wage index.

CMS responds to comments about rebasing. MedPAC commented that the adjustments will not sufficiently reduce home health payments, but CMS notes that MedPAC acknowledged that CMS is constrained by the statutory language. CMS responds to a number of comments by saying that the rebasing adjustments were set out in the CY 2014 HH PPS final rule, and commenters should review the response to comments in that final rule. CMS notes that in the proposed rule it described an alternative case-mix model, the Home Health Groupings Model (HHGM), and plans to release a more detailed technical report that will be posted for review and comment at the HHA Center website at https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html. Finally, in response to comment, CMS notes that MedPAC

has cited various reasons for the decline in home health use since 2010, and that it plans to continue to monitor the effects of rebasing as data become available.

CMS responds to comments about the nominal case mix reduction. It notes that it finalized the reductions for 2016, 2017 and 2018 in the 2016 HH PPS Final Rule, and did not propose further changes in the 2017 proposed rule; it refers commenters to responses to similar comments in the 2016 final rule.

D. Payments for High-Cost Outliers Under the HH PPS (pages 76724-76730)

1. Background

CMS reviews the current method for calculating outlier costs. Currently:

- The outlier pool target is set at 2.5 percent.
- The outlier threshold for each Home Health Resource Group (HHRG) is set at the 60-day episode payment for that group plus the fixed-dollar loss (FDL) ratio of 0.45 of that amount.
- For purposes of computing whether costs exceed the threshold, costs of an episode are computed by multiplying the national wage-adjusted per-visit payment amounts by discipline by the number of visits by discipline.
- The loss-sharing ratio is 80 percent, so that Medicare pays 80 percent of the costs above the outlier threshold.
- There is a 10 percent cap on agency-level outlier payments.

2. Changes to the methodology used to estimate episode cost

CMS presented analysis and data in the proposed rule on current experience. It reports that agencies with 10 percent of their total payments as outlier payments have more frequent skilled nursing visits, but that those visits are shorter; and the number of skilled nursing visits for such HHAs is significantly higher than the number of visits for the five other disciplines of care. It concludes that outlier payments are driven by skilled nursing visits, and expresses concerns that the current method may create a financial disincentive for providers to treat medically complex beneficiaries who require longer visits. CMS further notes a Mathematica Policy Research report it commissioned in 2010 titled "Home Health Independence Patients: High Use, but Not Financial Outliers," found that outlier payments are not generally being used to serve the types of severely, permanently disabled beneficiaries that should be the target group.

CMS finalizes its proposal to change the methodology used to calculate outlier payments by using a cost-per-unit approach rather than the current cost-per-visit approach, a change that requires regulatory changes at §484.240(d). CMS finalizes its proposal to convert the national per-visit rates into rates per 15 minute unit, as set out in Table 19 and presented below.

Cost-per-Unit Payment Rates for the Calculation of Outlier Payments (CMS Table 19)			
Visit Type	**CY 2017 National Per-Visit Payment Rates**	**Average Minutes-per-Visit**	**Cost-per-unit (1 unit = 15 minutes)**
Home health aide	$64.23	63.0	$15.29
Medical social services	$227.36	56.5	$60.36
Occupational therapy	$156.11	47.1	$49.72
Physical therapy	$155.05	46.6	$49.91
Skilled nursing	$141.84	44.8	$47.49
Speech-language pathology	$168.52	48.1	$52.55

Those rates per unit will be used to calculate the estimated cost of an episode to determine whether the episode qualifies for an outlier payment and the amount of payment. CMS believes that this change will result in more accurate outlier payments where the calculated cost per episode accounts for not only the number of visits, but also the length of time of the visits. CMS believes that this may address its previous finding that margins were lower for patients with medically complex needs that typically require longer visits, which is seen as an incentive to treat less complex patients.

CMS finalizes its proposal to cap the amount of time per day that will be counted toward the estimate of an episode's cost for calculation of outliers. The cap, summed across the six disciplines of care, is 8 hours or 32 units of care per day, which is consistent with the definition of "part-time" or "intermittent" set out in the statute. CMS stresses that it is not limiting the amount of care that can be provided on any given day – only the amount of time that can be credited to the cost of the episode for purposes of determining whether it is an outlier and how much to pay. In cases where more than 8 hours of care are provided and more than one discipline of care is involved, CMS will use a hierarchical method based on the cost per discipline, with the units of service of the higher cost discipline counted first. CMS' analysis shows that only 17,505 episodes (0.3 percent of all home health episodes) in 2015 reported instances where more than 8 hours of care were provided in a single day, and that of these, only 8,305 would have qualified as outlier episodes under the new methodology.

3. Fixed Dollar Loss (FDL) Ratio

To retain outlier payments within the 2.5 percent statutory cap, CMS finalizes its proposal to raise the FDL used to compute the outlier threshold from the current level of 0.45 to 0.55 for CY 2017 (the change from 0.56 in the proposed rule to 0.55 in the final rule is due to updated data.) CMS retains the loss-sharing ratio of 80 percent for Medicare payments of outlier costs above that threshold.

Comments: CMS responds to comments on the proposed outlier policy and finalizes the rule as proposed. CMS notes that the change to a payment per 15 minute increment of service does not add or change provider reporting requirements, as HHAs are already required to report visit length, in 15 minute increments, by discipline, on home health claims. It will monitor the visit length per discipline and may propose updates to the rates if necessary. The 2.5 percent target

for outlier payments and the 10 percent cap on outlier payments are statutory requirements that CMS cannot alter by regulation. CMS notes that the adjustment in the FDL is standard practice in other payment systems with outlier payments. CMS reiterates several times that the purpose of the change is to better align outlier payments with the estimated cost per episode, accounting for not only the number of visits but the length of the visits. CMS estimates that over two-thirds of outlier episodes under the current methodology would continue to qualify for outlier payments under the finalized change in approach. The payments are subject to the 3 percent rural add-on. CMS is considering possible edits to the cost report and quality checks at the time of submission, and encourages providers to provide accurate data so NRS cost information can be used in the future.

E. Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device (pages 76730-76736)

Conventional NPWT systems are classified as durable medical equipment (DME), and DME is paid outside the HH PPS. NPWT can also be performed with a single-use disposable system, pocket-sized and easily transportable. As such it is considered a non-routine supply for home health, and included in the national, standardized 60-day episode payment amount.

However, the Consolidated Appropriations Act of 2016 (P.L. 114-113) requires a separate payment to an HHA for an applicable disposable device, defined as a disposable negative pressure wound therapy device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy used in lieu of a conventional NPWT DME system, furnished on or after January 1, 2017, to an individual who receives Medicare covered HH services. The separate payment is equal to the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level 1 Healthcare Common Procedure Coding System (HCPCS). Under the OPPS, HCPCS 97607 and 97608 are used for negative pressure wound therapy.

CMS finalizes its proposed rule, with several clarifications noted below in response to comments. It sets out two payment situations.

- If the sole purpose of an HHA visit is to furnish NPWT using a disposable device, Medicare will not pay for the visit under the HH PPS. Instead, the HHA must bill these visits separately using type of bill 34x (for patients not under a HH plan of care, Part B medical and other health services, and osteoporosis injections) along with the appropriate HCPCS code (97607 or 97608). It is not to be reported on the HH PPS claim.
- If the NPWT using a disposable device is performed during an otherwise covered HHA visit, the HHA will not include the time spent furnishing the NPWT in its visit charge or in the length of time reported for the visit. It will be separately paid based on the OPPS amount. The HHA will bill for the NPWT under type bill 34x along with the appropriate HCPCS code (97607 or 97608). This visit will be reported on the HH PPS claim but only for the time spent furnishing the services unrelated to the provision of NPWT.

CMS believes that it is appropriate for these visits to be performed by a registered nurse, physical therapist or occupational therapist. Coverage will be determined based on a doctor's

order as well as patient preference. Payment is equal to the payment that would be made under the OPPS, subject to the area wage adjustment in place. CMS directs readers to the OPPS Addendum webpage at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html.

CMS also finalizes its proposed rule that, as set out in the Consolidated Appropriations Act of 2016, beneficiary coinsurance is 20 percent of the payment amount, with regulatory authority at §409.50 incorporating that coinsurance provision.

Comments: CMS responds to a number of comments and clarifies and codifies several items. First, it clarifies that when a HHA furnishes NPWT using a disposable device, the HHA is furnishing a new disposable NPWT device – thus all the services associated with NPWT must be reported on type of bill 34x and reimbursement for all of the services is included in the OPPS payment amount. CMS codifies this definition at §484.202. CMS provides several billing scenarios. CMS codifies at §484.205(b) a technical clarification that the separate payments for NPWT devices are not included in the episode payment. CMS also notes that it expects that payment for furnishing NPWT using a disposable device will almost always be made in addition to a HH episode payment.

F. Update on Subsequent Research and Analysis Related to Section 3131(d) of the Affordable Care Act (page 76736)

CMS summarizes previous discussions related to Section 3131(d) of the ACA. In the CY 2016 proposed rule, CMS reviewed studies done to assess vulnerabilities in the case-mix adjustment and payment system. The studies found that HH margins vary substantially by patient characteristics and were lower for certain patients with high severity or poorly controlled conditions, as well as those with dual Medicare-Medicaid eligibility. Abt Associates developed several model options for changing or replacing the current case-mix classification system. CMS reviewed the three models in detail in that CY 2016 proposed rule.

CMS in the CY 2017 proposed rule provided an update on research and analysis on one model, the "home health groupings model" (HHGM), which groups home health episodes by principal diagnosis and the expected types of home health interventions that would be required during an episode of care. While the details are not repeated in the final rule, the proposed rule stated that under the HHGM option each home health episode would be grouped by primary diagnosis, and then categorized into different subgroups within each of the following five categories:

- Timing (early or late) – episodes are modeled as 30-day instead of 60-day episodes, and the first 30-day episode is classified as an early episode.
- Referral source: referred from the community, from an acute facility, or from a post-acute facility.
- Clinical grouping: there are six groupings based on primary diagnosis: Musculoskeletal Rehabilitation; Neuro/Stroke Rehabilitation; Wound Care; Medication Management, Teaching and Assessment (MMTA); Behavioral Health Care; and Complex Medical Care.
- Functional/cognitive level: low, medium or high functional/cognitive level.

- Comorbidity adjustment: episode is in one of three tiers based on secondary diagnoses.

CMS noted in the proposed rule that there would be a total of 324 possible payment groups for an episode. CMS then determined the case-mix weight for each of the 324 HHGM payment groups by estimating the expected resource use. The resulting case-mix weight is used to adjust the base payment to determine each episode's payment.

CMS notes that it received nine comments on the HHGM model, and that it plans to release a more detailed Technical Report that will be posted for additional comments and feedback at https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html.

G. Update on Future Plans to Group HH PPS Claims Centrally During Claims Processing (pages 76736-76737)

CMS reviews its proposed enhancements on grouping HHS PPS claims centrally to match the claim and the OASIS assessment in order to validate the Health Insurance Prospective Payment System (HIPPS) code. The purpose is to collect all of the other necessary information to assign a HIPPS code within the claims processing system, which would improve payment accuracy and decrease costs and burden on HHAs.

Comments: CMS notes in response to comments that it will consider continuing to provide the grouper and/or algorithm so that providers can calculate their HIPPS codes and determine expected reimbursement. CMS will continue to explore options for grouping HH PPS claims centrally, and will provide HHAs and other interested parties sufficient notice and updates regarding its plans via future rulemaking.

IV. Provisions of the Home Health Value-Based Purchasing (HHVBP) Model (76737-76752)

A. Background (pages 76737-76738)

The CY 2016 final rule provided for implementation of the HHVBP model beginning on January 1, 2016 through the Center for Medicare and Medicaid Innovation (CMMI). It tests the model in nine states; the details are set out in that final rule.

B. Smaller- and Larger Volume Cohorts Proposals (76738-76742)

CMS currently compares a competing HHA's performance with other competing HHAs in the same state and size cohort. There are two size cohorts:

- Smaller volume cohort: those HHAs within the state that are exempt from the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) reporting requirements, which is defined as an HHA with fewer than 60 HHCAHPS patients annually.
- Larger volume cohort: all other HHAs within the state.

If there are too few HHAs in the smaller volume cohort, they all are included in the larger volume cohort.

1. Proposal to Eliminate Smaller-and Larger Volume Cohorts Solely for Purposes of Setting Performance Benchmarks and Thresholds.

The CY 2016 final rule provides that HHAs receive a score for each measure along an achievement range, which is a scale between the achievement threshold (a lower threshold, set at the median of performance during the baseline period) and the benchmark (a higher threshold set at the mean of the top decile of performance during the baseline period.) The achievement threshold and benchmark are computed separately for each state and HHA cohort size.

Since publication of that final rule, CMS continued to analyze the calculated achievement thresholds and benchmarks, and finds that variation in the benchmarks among the smaller volume cohorts was greater than expected. CMS is concerned that the variation is the result of the small cohort size. Tables 21-23 (pages 76739-76740) illustrate the interstate variation in the small volume cohorts.

CMS finalizes its proposal, based on these assessments, to revise the policy and to calculate the benchmarks and achievement thresholds at the state level rather than at the smaller- and larger-volume cohort level within each state, with regulatory changes in the definition of "Benchmark" at §484.305. The policy is effective beginning in CY 2016.

Comments: CMS, in response to comments, clarifies the calculation of the benchmarks and sets out in detail the schedule for calculating and notifying HHAs of the benchmarks.

2. The Payment Adjustment Methodology

The CY 2016 final rule provides for a Linear Exchange Function (LEF) to translate an HHA's Total Performance Score (TPS) into a value-based payment adjustment percentage. That LEF is computed separately for each smaller- and larger-volume cohort in each state. If an HHA does not have a minimum of 20 episodes of care during a performance year to generate a performance score on at least five measures, it is not included in the LEF and there would not be a payment adjustment percentage for that HHA.

CMS, on further analysis, concludes that if there are only three or four HHAs in a cohort, one HHA outlier can skew the payment adjustment and payment distribution in the LEF payment methodology.

CMS finalizes its proposal that a smaller-volume cohort must have a minimum of eight HHAs in order for the HHAs in that cohort to be compared with each other for purposes of the payment adjustment methodology. If a smaller-volume cohort has fewer than eight HHAs, those HHAs will be included in the larger-volume cohort for that state for purposes of calculating the LEF and payment adjustment percentages. This change will apply starting with the CY 2018 adjustments.

Comments: CMS notes in response to comments that its modeling indicates that a minimum of 8 HHAs per cohort represents a figure significant enough to mitigate the effect of outliers.

C. Quality Measures (76742-76747)

CMS in the CY 2016 HH PPS final rule established a "starter set" of quality measures, with 6 process measures, 10 outcome measures and 5 HHCAHPS, and 3 new measures (see summary table). CMS determined that four of the measures finalized for payment year one (PY1), which is CY 2016, require further consideration before inclusion, and finalizes its proposal to remove them beginning with performance year CY 2016. The four measures removed are:

- Care Management; Types and Sources of Assistance;
- Prior Functioning ADL/IADL;
- Influenza Vaccine Data Collection Period: Does this episode of care include any dates on or between October 1 and March 31; and
- Reason Pneumococcal Vaccine not Received.

CMS sets out its rationale for the removal of each of the four items. CMS also finalizes its proposal at §484.315(a) to eliminate use of the term "starter set" and to refer to this as a set of quality measures.

Table 24 on pages 76743-76745) describes the measures remaining, including details on data source, and the numerator and denominator each measure. The table below provides a summary.

Measure Set for the HHVBP Model (CMS Table 24)		
NQS Domains	**Measure Title**	**Measure Type**
Clinical Quality of Care	Improvement in Ambulation-Locomotion	Outcome
	Improvement in Bed Transferring	Outcome
	Improvement in Bathing	Outcome
	Improvement in Dyspnea	Outcome
Communication & Care Coordination	Discharged to Community	Outcome
Efficiency & Cost Reduction	Acute Care Hospitalization: Unplanned hospitalization during first 60 days of Home Health	Outcome
	Emergency Department Use without Hospitalization	Outcome
Patient Safety	Improvement in Pain Interfering with Activity	Outcome
	Improvement in Management of Oral Medications	Outcome
Population Community Health	Influenza Immunization Received for Current Flu Season	Process
	Pneumococcal Polysaccharide Vaccine Ever Received	Process
Clinical Quality of Care	Drug Education on All Medications Provided to	Process

Measure Set for the HHVBP Model (CMS Table 24)		
NQS Domains	**Measure Title**	**Measure Type**
	Patient/Caregiver during all Episodes of Care	
Home Health CAHPS: Satisfaction Survey Measures		
Patient & Caregiver Centered Experience	Care of Patients	Outcome
	Communications between Providers and Patients	Outcome
	Specific Care Issues	Outcome
	Overall Rating of Home Health Care	Outcome
	Willingness to Recommend the Agency	Outcome
New Measures in CY 2016 HH PPS Final Rule		
Population/Community Health	Influenza Vaccination Coverage for Home Health Care Personnel	Process
	Herpes Zoster (shingles) Vaccination: Has the Patient Ever Received the Shingles Vaccination?	Process
Communication & Care Coordination	Advance Care Plan	Process

The CY 2016 final rule requires HHAs to submit their first round of data on new measures no later than October 7, 2016 for the period July 2016 through September 2016. CMS finalizes its proposal to change reporting timeframes for one of the new measures (Influenza Vaccination Coverage for Home Health Care Personnel). HHAs will report on this measure in October 2016 and January 2017, but switch to annual rather than quarterly reporting for that measure starting with the first annual submission in April 2017 for the prior 6-month reporting period of October 1 – March 1 to coincide with the flu season.

CMS also finalizes its proposal to increase the timeframe for submitting data on new measures from seven calendar days to fifteen calendar days following the end of each reporting period.

Comments: CMS responds to a number of comments. It monitors measures where providers have achieved "full performance" and may propose in future rulemaking to remove measures no longer appropriate for the model. CMS states that the model is designed to leverage reporting structures already in place. CMS notes that several comments were outside the scope of the proposed rule, and notes that more information about OASIS is found at https://wee.cms.gov/Medicre/Quality-Initiatives-Patient -Assessment-Instruments/OASIS/Regulations.html.

D. Appeals Process (pages 76747-76750)

CMS finalizes its proposal at §484.335 (with one technical correction) an appeals process for the HHVBP Model which includes a period to review and request recalculation of both the Interim Performance Reports and the Annual Total Performance Score (TPS) and Payment Adjustment Reports, and to request reconsideration for the Annual TPS and Payment Adjustment Report only, which may occur only after an HHA has first submitted a recalculation request.

As background, CMS notes that the CY 2016 final rule provides HHAs the opportunity to review their Interim Performance Report each quarter; the first report was provided to all HHAs in July 2016. CMS provides at Table 25 (page 76748) the data schedule. HHAs have the opportunity to identify and correct calculation errors and resolve discrepancies.
HHAs also have the opportunity the review their Annual TPS and Payment Adjustment Report prior to the calendar year for which the payment adjustment will be applied.

CMS, at new §484.335, codifies the recalculation request process set out in the CY 2016 final rule and the proposed reconsideration request process for the Annual TPS and Payment Adjustment Report. CMS notes that there is, under section 1115A(d) of the Social Security Act, no administrative or judicial review of the selection of models for testing or expansion, the selection of organizations, sites or participants to test those models, the elements, parameters, scope and duration of the models, budget neutrality determinations, termination or modification of design and implementation, and decisions about expansion of the duration or scope of a model.

1. Recalculation (§484.335(a))

CMS finalizes its proposal that an HHA may submit a request for recalculation to dispute interim performance scores, annual total performance scores, or application of the formula to calculate annual payment adjustment percentages.

HHAs must submit a recalculation request in writing within 15 days after CMS posts information on the HHVBP secure portal, a reduction from the 30 day period set out last year. CMS believes that the 15 day period will allow recalculation of the Interim Performance Reports posted in July to be completed prior to the posting of the Annual TPS and Payment Adjustment Report in August, and to allow for a second level of appeals.

CMS codifies the CY 2016 final rule's requirements for the content of the requests for recalculation, CMS' review, and its recalculation decision – a decision that is subject to the request for reconsideration.

2. Reconsideration (§484.335(b))

CMS finalizes its proposal that an HHA may submit a request for reconsideration of a recalculation decision for the Annual TPS and Payment Adjustment Report. A request will need to be submitted within 15 calendar days from CMS' notification of the outcome of the recalculation.

CMS finalizes requirements for the content of a reconsideration request, including the basis, the specific quality measure data or calculation that the HHA believes is inaccurate, and additional documentary evidence for CMS. An HHA may not include data that should have been filed by the applicable deadline.

Comments: CMS responds to comments, and reiterates its belief that the 15 calendar day time frame is sufficient time for an HHA to submit a recalculation request.

E. Discussion of the Public Display of Total Performance Scores for the HHVBP Model (pages 76751-76752)

CMS notes again, as it did in the proposed rule, that it is considering various public reporting platforms, including Home Health Compare (HHC) and the CMMI webpage. It is considering public reporting beginning no earlier than CY 2019 to allow analysis of at least eight quarters of performance data and the opportunity to compare how the results align with other publicly reported quality data. CMS appreciates comments it received and will continue to gather information as it considers mechanisms for public reporting under the HHVBP model.

V. Updates to the Home Health Care Quality Reporting Program (HH QRP) and Analysis and Response to Comments (pages 76752-76789)

A. Background and Statutory Authority (page 76752)

CMS reviews background on the HH quality reporting program (QRP), the Outcome and Assessment Information Set (OASIS) used for HHAs, and the pay-for-reporting program implemented in 2007, under which the market basket percentage increase is reduced by 2 percentage points for HHAs that do not report required quality data.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113-185) imposed new reporting requirements for post-acute care (PAC) providers, including HHAs. This includes standardized patient assessments for HHAs, SNFs, Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs), coupled with payment reductions for non-reporting. CMS has created a modified version of the OASIS, the OASIS-C2, to satisfy the requirement for submission of standardized patient assessment data. That form will be effective for data collected on or after January 1, 2017.

B. General Considerations Used for the Selection of Quality Measures for the HH QRP (pages 76752-76754)

CMS reviewed its approach to adopting measures for the HH QRP and its process for developing measures in the CY 2016 final rule. CMS finalizes its proposal to adopt for the HH QRP four new measures.

One measure will meet the Medication Reconciliation domain: Drug Regimen Review Conducted with Follow-up for Identified Issues-Post Acute Care Home Health Quality Reporting Program (PAC HH QRP). The other three measures will meet the Resource Use and other Measures domain:

- Total Estimated Medicare Spending per Beneficiary (MSPB) for PAC HH QRP
- Discharge to Community for PAC HH QRP
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for PAC HH QRP

CMS reviews its process for selection and specification of the measures, which include technical expert panels (TEPs) with stakeholder and patient representatives for each of the four measures. CMS released draft measures for each of the four measures and sought input from the National Quality Forum (NQF) Measure Applications Partnership (MAP) Post-Acute Care, Long-Term Care Workgroup during its annual public meeting in December, 2015. Information on the MAP recommendations is at http://www.qualityforum.org/Publications/2016/02/MAP_2016_Considerations_for_Implementing_Measures_in_Federal_Programs_-_PAC-LTC.aspx.

Comments: CMS notes in response to comments recommending NQF-endorsement prior to finalization that it appreciates the importance of consensus endorsement and considers NQF-endorsed measures where possible, but must balance that with the need to address quality and adhere to statutory timelines in order to meet the requirements of the IMPACT Act. In the case where there are not NQF-endorsed measures, CMS adopts measures that align with the National Quality Strategy, and intends to seek NQF-endorsement when it is feasible. CMS also notes in response to comments about risk adjustment that the NQF is currently undertaking a 2-year trial period to assess whether risk-adjusting for sociodemographic factors is appropriate, and the HHS' Office of the Assistant Secretary for Planning and Evaluation is conducting research on that topic as well.

CMS provides in Section G. below additional detail on each of these four new measures.

C. Process for Retaining, Removing, and Replacing Previously Adopted Home Health Quality Reporting Program Measures for Subsequent Payment Determinations (pages 76754-76755)

CMS finalizes its proposal that when it adopts a measure for the HH QRP for payment determination, the measure will be automatically retained unless CMS proposes to remove or replace the measure, or unless the exception below applies (this is consistent with CMS' policy for other provider QRPs.)

"Remove" will mean that the measure is no longer part of the measure set, data will no longer be collected for purposes of the QRP, and data from the measure will no longer be on HH Compare. CMS finalizes the following criteria for removal of a measure:

- Performance is so high and unvarying that distinctions in improvement can no longer be made.
- Performance or improvement on a measure does not result in better patient outcomes.
- A measure does not align with current clinical guidelines or practice.
- A more broadly applicable measure is available.
- A measure that is more proximal in time to the desired patient outcomes is available.
- A measure that is more strongly associated with desired patient outcomes is available.

CMS notes that the removed items may still appear on OASIS, not related to the HH QRP, and that HHAs will be able to access that information.

"Replace" will mean that CMS will adopt a different quality measure in place of a currently used measure, for one or more of the reasons listed above for removal.

CMS finalizes its proposal that removal or replacement would take place through notice-and-comment rulemaking, unless CMS determines that a measure is causing concern for patient safety or other unintended consequences. In that case, CMS will promptly remove the measure and publish its justification in the *Federal Register* during the next rulemaking cycle. CMS will also immediately notify HHAs.

D. Quality Measures That Will Be Removed From the Home Health Quality Initiative, and Quality Measures That Are Proposed for Removal from the HH QRP Beginning with the CY 2018 Payment Determination (pages 76755-76756)

CMS reevaluated all 81 HH quality measures in 2015, some of which are used only in the HH Quality Initiative (HHQI) and others which are used also in the HH QRP. The development and maintenance contractor convened a TEP on August 15, 2015 to advise on the results of the reevaluation.

CMS identified 28 HHQI measures that were either topped out and/or determined to be of limited clinical quality improvement, and will no longer be included in the HHQI. CMS also identified and now finalizes its proposal to remove 6 process measures from the HH QRP, beginning with the CY 2018 payment determination, because they are topped out. Unlike the 28 measures noted above, these will be removed from the HH QRP program but may still appear on the OASIS for purposes that are not related to the QRP:

- Pain Assessment Conducted;
- Pain Interventions Implemented during All Episodes of Care;
- Pressure Ulcer Risk Assessment Conducted;
- Pressure Ulcer Prevention in Plan of Care;
- Pressure Ulcer Prevention Implemented during All Episodes of Care; and
- Heart Failure Symptoms.

The analysis supporting the removal of the 28 measures from the HHQI and the six measures from the HH QRP is at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.

E. Process for Adoption of Updates to HH QRP Measures (page 76756)

For non-substantive updates to HH QRP measures, CMS finalizes its proposal to use the same sub-regulatory process as finalized for hospitals in the FY 2013 IPPS/LTCH PPS final rule (77 *FR* 53504-53505). Examples of non-substantive changes might include updated diagnosis or procedure codes, medication updates, broadening of age ranges, exclusions from a measure, and updates to NQF-endorsed measures based upon changes to guidelines.

F. Modifications to Guidance Regarding Assessment Data Reporting in the OASIS (pages 76756-76757)

CMS finalizes two changes in coding guidance for the reporting of current pressure ulcers: Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678), effective January 1, 2017.

- Full-thickness (Stage 3 or 4) pressure ulcers should not be reported on OASIS as unhealed pressure ulcers when complete re-epithelialization has occurred.
- Once a graft is applied to a pressure ulcer, the wound is to be reported on OASIS as a surgical wound, and no longer reported as a pressure ulcer.

G. HH QRP Quality, Resource Use, and Other Measures for the CY 2018 Payment Determination and Subsequent Years (76777-76780)

As noted under B. above, CMS finalizes four new measures for the HH QRP for the CY 2018 payment determination and subsequent years:

- Drug Regimen Review Conducted with Follow-up for Identified Issues for PAC HH QRP
- Total Estimated Medicare Spending per Beneficiary for PAC HH QRP
- Discharge to Community for PAC HH QRP
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for PAC HH QRP

CMS discusses the role that socioeconomic status plays in care and its potential role in risk-adjustment, along with CMS' continued concerns about holding agencies to different standards. It notes the NQF's 2-year trial in which measures will be assessed to determine if risk-adjusting for sociodemographic factors is appropriate, and the research underway at the Office of the Assistant Secretary for Planning and Evaluation (ASPE), as directed by the IMPACT Act.

CMS reviews, as it did in the proposed rule, the four new measures, noting in each case its external consultations with TEPs and the NQF MAP. Technical specifications for the four measures are at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.

1. Measure that Addresses the IMPACT Act Domain of Resource Use and Other Measures: MSPB-PAC HH QRP

CMS could not identify an NQF-endorsed resource use measure for PAC settings. This MSPB PAC HH measure is intended to hold HH providers accountable for Medicare payments within an episode of care. CMS notes that it mirrors the general construction of the comparable measure in the inpatient hospital prospective payment system.

In general, an episode begins at the episode trigger, which is admission to an HHA, which is the attributed provider. The episode window would have two parts: a treatment period and an associated services period. The treatment period begins at the episode trigger and ends after 60 days. It includes services that are provided directly or reasonably managed by the HHA that are

directly related to the care plan. The associated services period begins at the episode trigger and ends 30 days after the end of the treatment period. This is the time during which Medicare Part A and Part B services (with certain exclusions) are counted toward the episode. This is a claims-based measure, requiring no new reporting by HHAs. CMS sets out several specific scenarios.

The measure would be a risk-adjusted and payment-rate-standardized ratio that compares a given HHA's Medicare spending against the Medicare spending of other HHAs within the performance period. CMS notes that it includes Medicare spending for hospice services but risk adjusts for that service.

CMS intends to provide initial confidential feedback to HHAs prior to public reporting. It intends to publicly report this measure using claims data from discharges in CY 2017. It sets a minimum of 20 episodes for reporting and inclusion in the HH QRP.

2. Measure that Addresses the IMPACT Act Domain of Resource Use and Other Measures: Discharge to Community-PAC HH QRP

CMS could not identify an NQF-endorsed resource use measure of discharge to community for PAC settings. It finalizes this measure to report an HHA's risk-standardized rate of Medicare FFS patients who are discharged to the community following a HH episode, do not have an unplanned readmission to an acute care hospital or LTCH and remain alive in the 31 days following discharge to the community, compared with the risk-adjusted expected number of such discharges. The measure is effective for the CY 2018 payment determination and subsequent years. Community for purposes of this measure is defined as home/self-care, with or without home health services. CMS notes that this measure is conceptualized uniformly across the PAC settings.

CMS notes that this is a claims-based measure requiring no new reporting. The measure is calculated based on 2 years of data, with a minimum of 20 eligible episodes in a given HHA for public reporting. CMS intends to provide initial confidential feedback to providers, prior to public reporting, based on Medicare FFS claims data from discharges in CY 2015 and 2016. It intends to publicly report the measure using claims data from discharges in CY 2016 and 2017.

3. Measure that Addresses the IMPACT Act Domain of Resource Use and Other Measures: Potentially Preventable 30-Day Post-Discharge Readmission Measure for PAC HH QRP

CMS could not identify an NQF-endorsed resource use measure for potentially preventable hospital readmissions for PAC settings. CMS finalizes its proposed measure to assess the HHA level risk-standardized rate of unplanned and potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days post HH discharge, effective for the CY 2018 payment determination. To be counted, the HH admission must have occurred within 30 days of discharge from a prior proximal hospital stay.

Hospital readmissions include readmissions to a short-stay acute care hospital or an LTCH, with a diagnosis considered to be unplanned and potentially preventable. CMS notes that this measure is conceptualized uniformly across the PAC settings. CMS categorizes three clinical

rationale groups for potentially preventable readmissions: inadequate management of chronic conditions, inadequate management of infections, and inadequate management of other unplanned events. It uses the CMS Planned Readmission Algorithm as the main component for identifying planned readmission – details on that algorithm and additional procedures considered planned for post-acute care are included in the technical specifications above.

The measure is calculated based on three calendar years of FFS data, and a minimum of 20 eligible episodes for public reporting. CMS intends to provide confidential feedback to providers, prior to public reporting, based on three years of Medicare FFS claims data from discharges in CYs 2014, 2015 and 2016. It intends to publicly report the measure using claims data from discharges in CYs 2015, 2016 and 2017.

4. Proposal to Address the IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted with Follow-Up for Identified Issues- PAC HH QRP

CMS finalizes its proposed patient-assessment based measure to assess whether HH providers were responsive to potential or actual clinically significant medication issues when such issues were identified, effective for the CY 2018 payment determination. CMS notes that the measure will be applied uniformly across PAC settings.

The measure reports the percentage of patient episodes in which a drug regimen review was conducted at the start of care or resumption of care and timely follow-up with a physician occurred each time potentially significant medication issues were identified throughout the episode. It requires documentation of drug regimen review at the start or resumption of care, and at the end of care with a look back during the episode with all potentially clinically significant medication issues identified during the course of care and followed-up with a physician or designee by midnight of the next calendar day. The measure is not risk-adjusted. Drug regimen review is defined as the review of all medications or drugs the patient is taking to identify any potential clinically significant medication issues.

CMS notes that three standardized items will be added to the OASIS, replacing existing items, and collected through the Quality Improvement Evaluation System (QIES) Assessment Submission and Procession (ASAP) system. The data collection will be at admission and discharge. Data collection will begin January 1, 2017.

Comments: CMS responds to comments on each of the four measures, and finalizes the measures as proposed.

H. HH QRP Quality Measures and Measure Concepts Under Consideration for Future Years (pages 76780-76781)

CMS invited comments on the quality measures identified in Table 28 (summarized below) regarding their importance, relevance, appropriateness, and applicability for use in future years of the HH QRP.

HH QRP Quality Measures Under Consideration for Future Years

(CMS Table 28)
IMPACT Act Domain: accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions
Measure: Transfer of health information and care preferences when an individual transitions
IMPACT Act Domain: Incidence of major falls
Measure: Application of NQF #0674 – Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)
IMPACT Act Domain: Functional status, cognitive function, and changes in function and cognitive function
Measure: Application of NQF #2631 – Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function
National Quality Strategy Priority: Patient- and Caregiver-Centered Care
Measure: Application of NQF #2633- Change in Self-Care Score for Medical Rehabilitation Patients
Measure: Application of NQF #2634- Change in Mobility Score for Medical Rehabilitation Patients
Measure: Application of NQF #2635- Discharge Self-Care Score for Medical Rehabilitation Patients
Measure: Application of NQF #2636- Discharge Mobility Score for Medicare Rehabilitation Patients
Measure: Application of NQF #0680- Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay)

CMS also identified additional measure concept areas. These include efficiency measures that pair processes, such as assessment and care planning, with outcomes, such as emergency treatment for injuries or increase in pain. The prevalence of mental health and behavioral problems was identified as an option to address outcomes for special populations. CMS is also considering development of measures that assess if functional abilities were maintained during a care episode, and composite measures that combine multiple evidence-based processes.

CMS summarizes comments and responses and notes that it will consider the comments when it develops future measure proposals.

I. Form, Manner, and Timing of OASIS Data Submission and OASIS Data for Annual Payment Update (pages 76781-76784)

CMS reviews current regulatory policies for OASIS data submission for assessments. The pay for reporting system is based on the principle that each HHA is expected to submit a minimum set of two matching assessments for each patient admitted, a Start of Care (SOC) or Resumption of Care (ROC) Assessment and a matching End of Care (EOC) Assessment. In the CY 2016 final rule, CMS established a standard for submission of a successful assessment, defined in its

Quality Assessments Only (QAO) formula. The pay for reporting standard that must be met to avoid the 2 percentage point reduction in the market basket update is:

- 70 percent on the QAO metric for CY 2017 (July 1, 2015-June 30, 2016 reporting period);
- 80 percent on the QAO metric for CY 2018 (July 1, 2016-June 30, 2017 reporting period);
- 90 percent on the QAO metric for CY 2019 (July 1, 2017-June 30, 2018 reporting period).

CMS proposed no additional policies related to the pay-for-reporting requirement, but clarifies in the final rule that when a beneficiary changes from Medicare Advantage to Medicare FFS coverage, the SOC assessment submitted while the beneficiary was in the MA plan (not the SOC assessment submitted when the change in coverage occurs) would be considered a quality assessment within the pay-for-reporting methodology.

Timeline and Data Submission Mechanisms for measures proposed for the CY 2018 Payment Determination and Subsequent Years

Claims based measures: Three of the new finalized measures: MSBP-PAC HH QRP, Discharge to Community-PAC HH QRP, and Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH QRP, are claims-based measures, requiring no new reporting.

Assessment based measures using OASIS Data Collection: The fourth new measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues – PAC HH QRP, requires submission of data elements on OASIS and submission through the QIES ASAP system starting January 1, 2017. CMS finalizes its proposal to use standardized data elements in OASIS C-2 to calculate the measure.

CMS finalizes its timeline for data collection on the proposed new Drug Regimen Review measure, and the revised timeline for one measure finalized last year: NQF #0678 Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay). In the CY 2016 final rule, CMS finalized a policy of submission of a full calendar year of data for CY 2017 for the CY 2018 annual payment update. However, CMS recognized that the timeline is impossible to achieve given the process it set out, such as the opportunity for HHAs to seek reconsideration for determination of non-compliance. Therefore, for the measure finalized last year (NQF #0678) and the new Drug Regimen Review measure, CMS finalizes collection of just two quarters of data in CY 2017 (January 1, 2017 – June 30, 2017) for the CY 2018 payment determination.

CMS sets out in Tables 29 and 30 (page 76784) the timeline for future years for assessment-based measures and IMPACT Act measures. In general,

- Data collection will be on a quarterly basis, with the quarterly review and data correction periods extending 4.5 months after the conclusion of each quarter.

- Thus, for example, the 1st quarter data collection period will be January 1-March 31. The quarterly review and data correction period will extend from April 1 – August 15 (4.5 months after the collection period).
- That cycle will repeat each quarter.

J. Public Display of Quality Measure Data for the HH QRP and Procedures for the Opportunity to Review and Correct Data and Information (pages 76784-76787)

1. Review and Correction of Data Used to Calculate the Assessment-Based Measures Prior to Public Display

For assessment based measures, CMS finalizes its proposal to provide confidential feedback reports (the HH Quality Measure (QM) Reports) to HHAs during the review and correction period, so that HHAs can correct the data submitted via the QIES ASAP system and request correction of any errors in the assessment-based measure rate calculations.

These confidential feedback reports will be made available to HHAs using the Certification and Survey Provider Enhanced Reporting (CASPER) System. CMS intends to provide monthly updates to the data in the QM Reports as assessment-based data become available, containing both agency- and patient-level data used to calculate quality measures, including the agency rate and national rate. It would also contain individualized patient information so that the agency could identify potential errors. CMS will also make other reports available through the CASPER System, including OASIS data submission reports and provider validation reports. Additional information on these feedback reports will be provided at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html.

HHAs will have 4.5 months after the conclusion of each reporting quarter to review and update their reported assessment-based measure data, including correcting any errors on the CASPER-generated Review and Correct QM Reports. At the conclusion of the 4.5 month review and correction period, the data will be "frozen" and used for public reporting.

CMS also finalizes a 30-day preview period prior to public display during which HHAs can preview the information on their measures that will be made public. That preview will also be provided using the CASPER System. HHAs will not be permitted to correct the underlying data in this 30-day period (such corrections would have to be made in the earlier 4.5 month review and correction period). HHAs will be able to ask for a correction to measure calculations. If CMS determines that a measure displayed in the preview report contains a calculation error, it will suppress the data on the public website, recalculate and publish the corrected rate at the time of the next scheduled public display date.

CMS intends to use a sub-regulatory mechanism, such as the HH QRP website, to provide technical details.

2. Review and Correction of Data Used to Calculate Claims-Based Measures Prior to Public Display.

CMS finalizes its proposal to make available through the CASPER System a confidential preview report on claims-based measures, again for a 30-day period, containing information on claims-based measure rate calculations, including agency and national rates, along with additional confidential information based on the most recent administrative data available.

The data are for feedback only and cannot be corrected. This is the only time that HHAs would be able to see their claims-based measure rates before public display. As with the assessment-based measures, the HHA may request a correction of the measure calculation if it believes it is incorrect. If CMS agrees that the measure as displayed contains a calculation error, it could suppress the data on the public reporting website, recalculate the measure, and publish it at the time of the next scheduled public display date.

CMS will create data extracts at least 90 days after the last discharge date in the applicable period, which CMS will use for the calculations. For example, for data collection January 1, 2017 – December 31, 2017, CMS would create the data extract approximately March 31, 2018 at the earliest, and use that data to calculate the claims-based measures for public reporting. CMS recognizes that the 90-day "run out" period is less than the one year from the date of discharge allowed for timely claims filing, but believes that allowing one year will create an unacceptably long delay in reporting.

The confidential CASPER QM reports will be refreshed annually, since the claims-based measures are calculated on an annual basis. It will include claims-based measures satisfying the IMPACT Act as well as all other HH QRP claims-based measures.

K. Mechanism for Providing Feedback Reports to HHAs (page 76787)

CMS finalizes its proposal to provide confidential feedback reports to HHAs through the CASPER System, as required under the Act. CMS intends to provide detailed procedures on the HH QRP website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health Quality-Reporting-Requirements.html.

L. Home Health Care CAHPS® Survey (HHCAHPS) (pages 76787-76789)

CMS reviews previously established requirements for the HHCAHPS Survey and its reconsideration and appeals process, but it had proposed no changes. In this rule, CMS only updates quarterly data collection periods for the CY 2019 and CY 2020 APUs, which mirror those previously set for the CY 2017 and CY 2018 APUs.

VI. Collection of Information Requirements (page 76789-76790)

The rule does not add new, or revise any of the existing information collection requirements or burden estimates.

VIII. Regulatory Impact Analysis (pages 76790-76795)

CMS provides a regulatory impact analysis (RIA) because the final rule is a major rule that meets the threshold of an economic impact of $100 million or greater.

It first presents the regulatory impact of the changes in the HH PPS system on HHAs:

Summary of overall regulatory impact analysis		
Policy	**2017 impact**	
	Percentage	**Dollars**
HH PPS update	+ 2.5%	+$450 million
Fourth year of rebasing	- 2.3%	-$420 million
Nominal case-mix growth adjustment	-0.97%	-$160 million
Net impact	-0.7%	-$130 million

Table 31 on pages 76792-76793 provides details on the impact of each change by facility type and ownership, by rural and urban area, by census region and by facility size.

For the HHVBP model, CMS presents at Table 32 on page 76794 estimates of the distribution of possible payment adjustments by percentile of performance on the total performance score (TPS) for the 3%, 5%, 6%, 7%, and 8% payment adjustments over the five years of the demonstration. The table below summarizes the data for the 10th percentile (lowest quality providers), 50th percentile, and 90th percentile (highest quality performers).

Payment adjustment distribution by percentile of quality TPS (from CMS Table 32)			
	Lowest, 10th percentile	50th percentile	Highest, 90th percentile
3% payment adjustment (year 1)	-1.23%	-0.02%	1.85%
5% payment adjustment (year 2)	-2.04%	-0.03%	3.08%
6% payment adjustment (year 3)	-2.45%	-0.04%	3.70%
7% payment adjustment (year 4)	-2.86%	-0.04%	4.32%
8% payment adjustment (year 5)	-3.27%	-0.05%	4.93%

Table 33 on page 76794 presents the estimates for the two size cohorts in each of the nine states, and Table 34 on page 76795 the estimates by beneficiary characteristic, including dual eligibility, acuity, rural status, and organizational type. CMS notes, as it did in last year's final rule, that a higher proportion of dual-eligible patients is associated with better performance, but that the payment adjustments are consistent across the other categories.

CMS provides at Tables 35 and 36 on page 76795 the required accounting statements. Table 35 presents the accounting statement for HH PPS for CY 2017, setting out the $130 million in government savings in payments to HHAs. Table 36 provides the accounting statement for the HHVBP Model estimated cost savings for the CY 2018-CY 2022. It estimates an overall impact of $378 million in total savings from a reduction in unnecessary hospitalizations and SNF usage as a result of greater quality improvement in HH over the life of the model.