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M E M O R A N D U M

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| TO: | Community Services Members |
| **FROM:** | Cheryl Udell, Community Services Policy Analyst |
| **DATE:** | December 8, 2016 |
| **SUBJECT:** | Home Health Agency Final Medicare Rule for 2017 |
| **ROUTE TO:** | Administrator/Director, CFO |

ABSTRACT: CMS releases HHA PPS final rule for CY 2017.

**Introduction**

The Centers for Medicare and Medicaid Services (CMS) has issued the Medicare Home Health Prospective Payment System (HH PPS) final rule for Calendar Year (CY) 2017. The complete rule is published in the [*Federal Register*](https://www.gpo.gov/fdsys/pkg/FR-2016-11-03/pdf/2016-26290.pdf)*.*

CMS estimates that approximately 3.5 million beneficiaries receive home health services from nearly 11,850 home health agencies (HHAs), costing Medicare approximately $17.9 billion. The Office of the Inspector General (OIG) stated in their nationwide analysis report submitted to Congress earlier this year that $18.4 billion was paid to more than 11,000 HHAs in CY 2015.

**Overall Impact and Summary of Key Provisions**

CMS estimates in their final rule that the overall percentage reduction is 0.7 percent, not the 1.0 percent decrease in total Medicare payments to HHAs for CY 2017 that they had proposed. This will result in a $130 million reduction instead of the projected total Medicare revenue reduction of approximately $180 million. The estimated decrease reflects the effects of the 2.5 percent home health payment update percentage ($450 million increase); the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor (an impact of -2.3 percent, or a $420 million decrease); and the effects of the -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth, for an expected impact of -0.9 percent (a $160 million decrease).

This reduction of 0.7 percent, or $130 million, is vastly different from last year’s final HH PPS reduction of 1.4 percent, or $260 million.

CMS continues in this final rule the implementation of the fourth and final year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit rates, and the NRS conversion factor. The rebasing adjustments for CY 2017 will continue to reduce the national, standardized 60-day episode payment amount by $80.95.

CMS also finalized the proposal to change the outlier payment methodology and the fixed dollar loss (FDL) ratio. They changed the methodology used to calculate outlier payments, moving from a cost-per-visit approach to a cost-per-unit approach (1 unit = 15 minutes). They stated that they think this approach more accurately reflects the cost of an outlier episode of care and thus better aligns outlier payments with episode costs than the cost-per-visit approach. In addition, CMS finalized the proposal to increase the FDL ratio from 0.45 to 0.55 in order to ensure that outlier payments do not exceed 2.5 percent of total payments for CY 2017, as required by the Social Security Act.

CMS finalized several changes to the Home Health Value-Based Purchasing (HH VBP) model. In last year’s HH PPS, there was an extensive section on the HH VBP model that was implemented earlier this year. As we reported, Medicare-certified HHAs selected for inclusion in the HH VBP model would be required to compete for payment adjustments to their current PPS reimbursements based on quality performance. New York is NOT one of the nine states selected, but a careful review of the proposed changes is warranted because of the potential impact it could have on New York going forward.

In the final rule, CMS incorporated the suggested payment policies for negative pressure wound therapy (NPWT) performed using a disposable device for patients being served by HHAs.

Other proposals include the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) that requires HHAs to submit standardized patient assessment data, as well as standardized data on quality measures and resource use, and other measures. The IMPACT Act requires collection across eight domains. In the final rule, CMS did adopt the four new payment determination measures for 2018 to meet the IMPACT Act requirements. The measures are preventable hospital readmission rates, total estimated Medicare spending per patient, discharge to the community, and medication reconciliation.

The final rule also includes changes to the home health quality reporting program (HH QRP).

In the CY 2015 proposed rule, the *Face-to-Face (F2F)* requirement was extensively covered with several proposals to reduce the burden to home health agencies (HHAs) and physicians, and to mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements. For the last two years, there has been no mention of the F2F requirement in the proposed or final HH PPS.

**Final HH PPS in Greater Detail**

***Rebasing***

The Affordable Care Act (ACA) required that CMS, beginning in CY 2014, apply an adjustment to the national, standardized 60-day episode rate and other applicable amounts to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. Additionally, CMS must phase-in any adjustment over a four-year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year, and be fully implemented by CY 2017. CY 2017 will the fourth and final year for rebasing adjustments to the HH PPS payment rates.

CMS continues to monitor potential impacts of rebasing. They stated that a 3.45 percent adjustment for CY 2014 through CY 2017 would result in larger dollar amount reductions than the maximum dollar amount allowed under the Affordable Care Act. The statute specifies that the maximum rebasing adjustment is to be no more than 3.5 percent based on the CY 2010 rates, not the CY 2013 rates. Therefore, in the CY 2014 HH PPS final rule, for each year, CY 2014 through CY 2017, they finalized a fixed dollar reduction to the national, standardized 60-day episode payment rate of **$80.95 per year**. The overall impact due to rebasing adjustments is estimated to be a 2.3 percent decrease in HH PPS payments. This is being offset by the home health payment update percentage, which would increase overall HH PPS payments in CY 2017 by 2.5 percent.

***CY 2017 HH PPS Case-Mix Weights***

To recalibrate the HH PPS case-mix weights for CY 2017, CMS had proposed to use the same methodology finalized in past HH PPS rules, including the CY 2008, CY 2012, and the CY 2015 HH PPS final rule. Annual recalibration of the HH PPS case-mix weights ensures that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns. To generate the proposed CY 2017 HH PPS case-mix weights, CMS used CY 2015 home health claims data (as of Dec. 31, 2015) with linked OASIS data. They will use CY 2015 home health claims data (as of June 30, 2016) with linked OASIS data to generate the CY 2017 HH PPS case-mix weights in the CY 2017 HH PPS final rule.

To ensure the changes to case-mix weights are implemented in a budget-neutral manner, CMS would apply a case-mix budget neutrality factor for CY 2017 of **1.0214** to the national, standardized 60-day episode payment rate.

In the proposed rule, CMS stated that they planned to release a more detailed technical report in the future on the additional research and analysis conducted on the Home Health Groupings Model (HHGM), an alternative to the current case-mix system. The report would address vulnerable beneficiaries as identified in the home health study, which include those beneficiaries that have more complex care needs. CMS has just released the [technical report](https://downloads.cms.gov/files/hhgm%20technical%20report%20120516%20sxf.pdf) that describes efforts to date on reassessing the current Home Health Prospective Payment System (HH PPS) and developing potentially large-scale payment methodology changes to better align payment with patient needs, to address payment incentives and vulnerabilities in the current system, and to respond to the concerns laid out in the prior Home Health Study Report to Congress, required by section 3131(d) of the Affordable Care Act, and from the Medicare Payment Advisory Commission. CMS contracted with Abt Associates (Abt) to reassess the current Home Health Prospective Payment System (HH PPS) and develop potentially large-scale payment methodology changes.

See Appendix A for the CY 2017 Final Case-Mix Weights.

***CY 2017 Home Health Market Basket Update***

The ACA requires that the market basket update for HHAs be adjusted by changes in economy-wide productivity for CY 2017 (and each subsequent calendar year). Therefore, CMS had estimated the CY 2017 home health market basket would be 2.3 percent (2.8 percent adjusted for multifactor productivity), or MFP (0.5 percentage points) would result in a 2.3 percent payment update.

In the final rule, the CY 2017 HH market basket percentage of 2.8 percent will be reduced by the MFP adjustment of 0.3 percent. The resulting HH payment update percentage is equal

to **2.5 percent**, or 2.8 percent less 0.3 percentage point. This is slightly higher than CMS had estimated.

As a reminder, the ACA Section 1895(b)(3)(B) requires that the home health market basket percentage increase be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary.

***CY 2017 Home Health Wage Index***

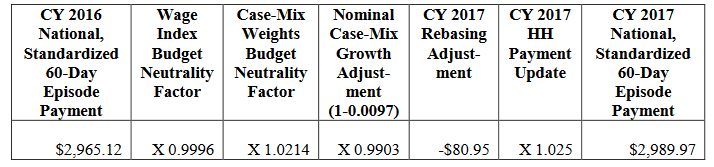
In 2015, CMS proposed and finalized changes to the wage index based on the newest Core Based Statistical Area (CBSA) changes for the HH PPS wage index and Office of Management and Budget (OMB) delineations, as described in [OMB Bulletin No. 13-01](http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf). CMS believed that using the most recent OMB delineations would create a more accurate representation of geographic variation in wage levels. Therefore, in CY 2016, CMS finalized the wage index to be fully based on the revised OMB delineations adopted in CY 2015. See Appendix B.

***Final National, Standardized 60-Day Episode Payment Rate***

CMS’s final rule for the CY 2017 national, standardized 60-day episode payment rate is based upon the CY 2016 standardized 60-day episode payment, applying an average wage index standardization factor, a case-mix budget neutrality factor, a reduction of 0.9903 percent to account for nominal case-mix growth from 2012 to 2014, the rebasing adjustment, and then the MFP-adjusted home health market basket update.

***The final national, standardized 60-day episode payment for CY 2017 is higher than what was proposed; it is $2,989.97.*** See Table 1.

**Table 1 – Final CY 2017 60-Day National, Standardized 60-Day Episode Payment Amount**



Source: CMS

***CY 2017 National Per-Visit Rates***

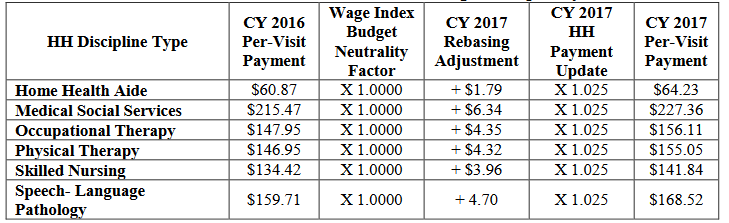
The national per-visit rates are used to pay LUPAs (episodes with four or fewer visits)

and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by either the type of visit or the home health discipline. They include: home health aide, medical social services, occupational therapy, physical therapy, skilled nursing, and speech-language pathology.

CMS calculated the CY 2017 national per-visit rates by starting with the CY 2016 national per

-visit rates. They then applied a wage index budget neutrality factor of 1.000 to ensure budget neutrality for LUPA per-visit payments, and then increased each of the six per-visit rates by the maximum rebasing adjustments, and the final market basket update. The LUPA per-visit rates are not calculated using case-mix weights. See Table 2.

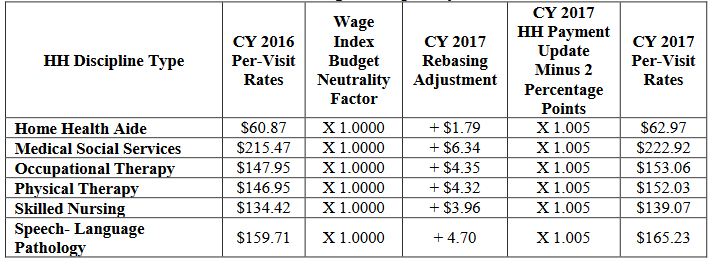
**Table 2 – Final CY 2017 National Per-Visit Payment Amounts for HHAs That DO Submit the Required Quality Data**



Source: CMS

Please note that the CY 2017 national per-visit rate for an HHA that does not submit the required quality data is updated by the CY 2017 HH payment update (2.5 percent) minus 2 percentage points. See Table 3.

**Table 3 – Final CY 2017 National Per-Visit Payment Amounts for HHAs That DO NOT Submit the Required Quality Data**



Source: CMS

***CY 2017 Low-Utilization Payment Adjustment (LUPA) Add-On Factors***

The Low-Utilization Payment Adjustment (LUPA) in the final CY 2017 HH PPS is the same as the LUPA “add-on factor” in the 2014 final HH PPS rule. In the CY 2014 HH PPS, CMS changed the methodology for calculating the LUPA add-on amount by finalizing the use of three LUPA add-on factors:

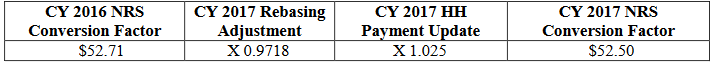
* 1.8451 for Skilled Nursing (SN);
* 1.6700 for Physical and Occupational Therapy (PT/OT); and
* 1.6266 for Speech Language Pathology (SLP).

CMS then multiplied the per-visit amount for the first SN, PT, OT, or SLP visit in a LUPA episode that occurs as the only episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount. For instance, for a LUPA episode that occurs as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit would be $261.16 (1.8451 multiplied by $141.54), subject to the area wage adjustment. The LUPA per-visit rates are not calculated using case-mix weights.

***CY 2017 Non-Routine Medical Supply (NRS) Payment Rates***

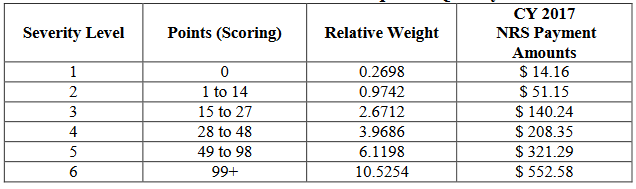
CMS determined the final CY 2017 NRS conversion factor by starting with the 2016 NRS conversion factor of $52.71, applying the -2.82 percent rebasing adjustments, and then updating the conversion factor by the CY 2017 HH payment update of 2.5 percent. The final NRS conversion factor is shown in Table 4 for those HHAs who submit the required quality data. Using the CY 2016 NRS conversion factor, the payment amounts for the six severity levels are in Table 5.

**Table 4 – Final CY 2017 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data**



Source: CMS

**Table 5 – Final CY 2017 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data**



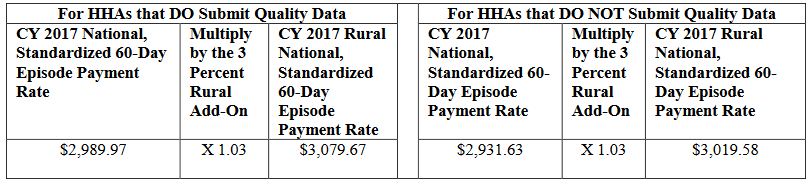
Source: CMS

***CY 2017 Rural Add-On Extended***

Section 3131(c) of the ACA amended Section 421(a) of the Medicare Modernization Act to provide an increase of 3 percent of the payment amount for HH services furnished in a rural area for episodes and visits ending on or after April 1, 2010 and before Jan. 1, 2016. This has been extended for HH services provided in a rural area for episodes and visits ending before Jan. 1, 2018.

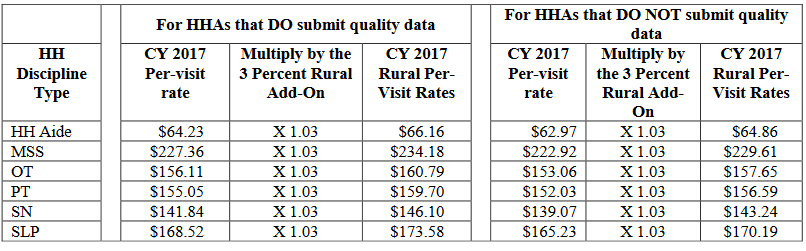
Tables 6 and 7 show the final payment amount in rural areas.

**Table 6 – Final CY 2017 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area**



Source: CMS

**Table 7 – Final CY 2017 Per-Visit Amounts for Services Provided in a Rural Area**



Source: CMS

***The Final CY 2017 Payment Changes for High-Cost Outliers***

CMS finalized the proposal to change the methodology used to calculate outlier payments, moving from a cost-per-visit approach to a cost-per-unit approach (1 unit = 15 minutes). They think this approach more accurately reflects the cost of an outlier episode of care and thus better aligns outlier payments with episode costs than the cost-per-visit approach.

They also finalized the proposal to increase the FDL ratio from 0.45 to 0.55 in order to ensure that outlier payments do not exceed 2.5 percent of total payments for CY 2017, as required by the Social Security Act.

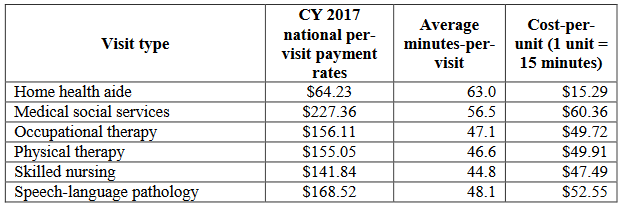
In the past, CMS targeted up to 2.5 percent of estimated total payments to be paid as outlier payments and then applied the 10 percent agency-level outlier cap. The 10 percent cap was a result of excessive growth in outlier payments, primarily the result of unusually high outlier payments in a few areas of the country. This was the premise on which CMS based its proposed changes.

In the proposed rule, CMS analyzed CY 2015 home health claims data and found that there was significant variation in the visit length by discipline for outlier episodes. HHAs with 10 percent of their total payments as outlier payments were providing shorter but more frequent skilled nursing visits than HHAs with less than 10 percent of their total payments as outlier payments.

CMS continued their analysis and found the number of skilled nursing visits was significantly higher than the number of visits for the five other disciplines of care. They concluded, therefore, that outlier payments were predominately driven by the provision of skilled nursing services.

According to CMS, as a result of the analysis of CY 2015 home health claims data, the “current methodology for calculating outlier payments may create a financial disincentive for providers to treat medically complex beneficiaries who require longer visits.” Therefore, the first change CMS had proposed was to change the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. They suggested converting the national per-visit rates into per 15-minute unit rates. The new per-unit rate by discipline would then be used, along with visit length data by discipline reported on the home health claim in 15-minute increments. CMS stated that the change in methodology would be budget neutral and that they would still target to pay out 2.5 percent of total payments as outlier payments. This is what they did in the final rule. See Table 8.

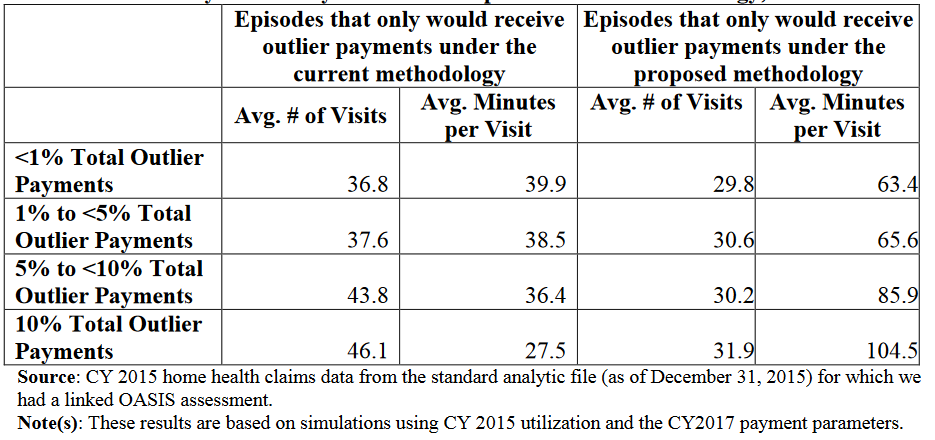
**Table 8 – Final Cost-Per-Unit Payment Rates for the Calculation of the Outlier Payments**



Source: CMS

CMS thought this change in approach would result in more accurate outlier payments where the calculated cost per episode accounts not only for the number of visits during an episode, but also the length of the visit. In the proposed rule, CMS stated, “This, in turn, may address some of the findings from the home health study, where margins were lower for patients with medically complex needs that typically require longer visits, thus potentially creating an incentive to treat less complex patients.”

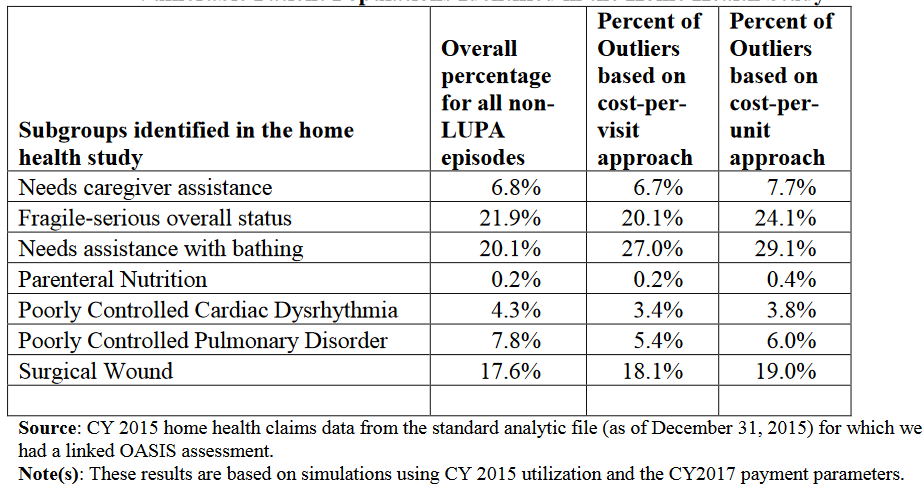
In the proposed rule, CMS included two additional tables for review. Table 9 shows the average number of visits and the visit length for the episodes that would receive outlier payments under the current cost-per-visit approach, but not under the proposed cost-per-visit approach. They also show the average number of visits and the visit length for the episodes that would receive outlier payments under the proposed cost-per-unit approach, but not under the current cost-per-visit approach.

**Table 9 – Average Number of Visits and Visit Length for Episodes that Receive Outlier Payments Only Under the Current Outlier Methodology and for Episodes that Receive Outlier Payments Only Under the PROPOSED Outlier Methodology, CY 2015**

CMS continued their analysis by examining the potential impact from changing the methodology from the current cost per visit to the proposed cost per unit on a subset of vulnerable patient populations. See Table 10.

**Table 10 –** **Impact of the PROPOSED Outlier Methodology Change on Subgroups of**

**Vulnerable Patient Populations Identified in the Home Health Study**



CMS concluded these results suggest that the proposed change to the outlier methodology may address some of the findings from the home health study and may alleviate potential financial disincentives to treat patients with medically complex needs.

The second change CMS proposed that was finalized was to implement a cap on the amount of time per day that would be counted toward the estimation of an episode’s costs for outlier calculation purposes. They finalized limiting the amount of time per day (summed across the six disciplines) to eight hours, or 32 units. They state that this is consistent with the definition of “part-time” or “intermittent” set out in Section 1861(m) of the Act, which limits the amount of skilled nursing and home health aide minutes combined to less than eight hours each day and 28 or fewer hours each week. CMS points out that they are not limiting the amount of care that can be provided on any given day; rather, they are limiting the time per day that can be credited toward the estimated cost of an episode when determining if an episode should receive outlier payments and calculating the amount of the outlier payment. They provided an example in the final rule: when there are “instances when more than 8 hours of care is provided by one discipline of care, the number of units for the line item will be capped at 32 units for the day for outlier calculation purposes. For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in one day, the episode cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline shown in Table 8. The discipline of care with the lowest associated cost per unit will be discounted in the calculation of episode cost in order to cap the estimation of an episode’s cost at 8 hours of care per day. For example, if an HHA provided 4.5 hours of skilled nursing and 4.5 hours of home health aide services, all 4.5 hours of skilled nursing would be counted in the episode’s estimated cost and 3.5 hours of home health aide services would be counted in the episode’s estimated cost (8 hours - 4.5 hours = 3.5 hours) since home health aide services has a lower cost-per-unit than skilled nursing services.”

CMS stated that their analysis shows that out of approximately 6.47 million episodes in their analytic file for 2015, only 17,505 episodes, or 0.3 percent of all home health episodes, reported instances where over 8 hours of care were provided in a single day (some episodes of which could have resulted from data entry errors). Of those 17,505 episodes, only 8,305 would be considered outlier episodes under the proposed outlier methodology. Therefore, they estimate that approximately 8,300 episodes, out of 6.47 million episodes, would be impacted due to

the proposed 8-hour cap.

***Fixed Dollar Loss (FDL) Ratio and Loss-Sharing Ratio***

In past rules, CMS continued the Fixed Dollar Loss (FDL) ratio at the same amount of 0.45 and a loss-sharing ratio of 0.80. CMS believed this was appropriate given that the percentage of outlier payments is estimated. Given the different outlier payment changes, CMS finalized a different FDL ratio.

CMS had stated that for a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of episodes that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio and therefore increase outlier payments for qualifying outlier episodes. Alternatively, a

lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.

CMS cited the statutory requirement to target up to, but no more than, 2.5 percent of total

payments as outlier payments. Therefore, they had proposed a change to the FDL ratio for CY

2017, as they believed that maintaining an FDL ratio of 0.45 with a loss-sharing ratio of 0.80 is no longer appropriate given the percentage of outlier payments projected for CY 2017.

CMS did not propose a change to the loss-sharing ratio (0.80) in order for the HH PPS to be consistent with the payment for high cost outliers in other Medicare payment systems. Under the current outlier methodology, they suggested changing the FDL from 0.45 to 0.48 to pay up to, but no more than, 2.5 percent of total payments as outlier payments. Under the proposed outlier methodology, which would be cost per unit, they finalized an increase in the FDL ratio of 0.45 to **0.55** to pay up to, but no more than, 2.5 percent of total payments as outlier payments.

***Final Payment Policies for Negative Pressure Wound Therapy***

Negative pressure wound therapy (NPWT) is a medical procedure in which a vacuum

dressing is used to enhance and promote healing in acute, chronic, and burn wounds. The

therapy involves using a sealed wound dressing attached to a pump to create a negative

pressure environment in the wound. Applying continued or intermittent vacuum pressure helps

to increase blood flow to the area and draw out excess fluid from the wound. NPWT can be used for days or months. It can be used in a conventional system and classified as a durable medical equipment (DME), or it can be performed with a single-use disposable system that consists of a non-manual vacuum pump. The disposable systems have a preset continuous negative pressure, no intermittent setting, are pocket-sized, easily transportable, and generally are battery operated.

DMEs are considered routine or non-routine, and a disposable NPWT system would be considered a non-routine supply for home health. Patients under a home health plan of care,

payment for part-time or intermittent skilled nursing, physical therapy, speech-language

pathology, occupational therapy, medical social services, part-time or intermittent home health

aide visits, and routine and non-routine supplies are included in the episode payment amount. A

disposable NPWT system is currently considered a non-routine supply, and thus payment for the

disposable NPWT system is included in the episode payment amount. However, the Consolidated Appropriations Act of 2016 (Pub. L 114-113) requires a separate payment to an HHA for an applicable disposable device when furnished on or after Jan. 1, 2017 to an individual who receives home health services for which payment is made under the Medicare home health benefit. An applicable disposable device is defined as a disposable negative pressure wound therapy device.

As required by the Consolidated Appropriations Act of 2016, the separate payment amount for NPWT using a disposable system is to be set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective Payment System (OPPS) using the Level I Healthcare Common Procedure Coding System (HCPCS) code. The codes are:

HCPCS 97607 **–** Negative pressure wound therapy (for example, vacuum assisted drainage

collection), utilizing disposable, non-durable medical equipment including provision of

exudate management collection system, topical application(s), wound assessment, and

instructions for ongoing care, per session; total wound(s) surface area less than or

equal to 50 square centimeters.

HCPCS 97608 **–** Negative pressure wound therapy (for example, vacuum assisted

drainage collection), utilizing disposable, non-durable medical equipment including provision of

exudate management collection system, topical application(s), wound assessment, and

instructions for ongoing care, per session; total wound(s) surface area greater than 50 square

centimeters.

The change in payment policy finalized by CMS is that for instances where the sole purpose for an HHA visit is to furnish NPWT using a disposable device, Medicare will not pay for the visit under the HH PPS. Instead, CMS finalized, since furnishing NPWT using a disposable device for a patient under a home health plan of care is to be paid separately based on the OPPS amount, which includes payment for both the device and furnishing the service, that the HHA must bill these visits separately under type of bill (TOB) 34x (used for patients not under an HH plan of care, Part B medical and other health services, and osteoporosis injections) along with the appropriate HCPCS code (97607 or 97608). Visits performed solely for the purposes of furnishing NPWT using a disposable device are not to be reported on the HH PPS claim (type of bill 32x).

If the NPWT using a disposable device is performed during the course of an otherwise

covered HHA visit (for example, while also furnishing a catheter change), CMS proposed that the HHA must not include the time spent furnishing NPWT in their visit charge or in the length of time reported for the visit on the HH PPS claim (TOB 32x). Providing NPWT using a

disposable device for a patient under a home health plan of care will be separately paid

based on the OPPS amount relating to payment for covered OPD services. In this situation, the HHA bills for NPWT performed using an integrated, disposable device under TOB 34x along with the appropriate HCPCS code (97607 or 97608).

Included in the final rule were several examples of how to bill and over 10 pages of comments and responses from CMS. They did acknowledge the concerns about the education of providers, beneficiaries, and other stakeholders with regard to this new payment policy. They stated that they will utilize existing outreach and educational mechanisms such as Open Door Forums, Medicare Learning Network articles, and other products with the goal of educating stakeholders regarding this new payment policy for disposable NPWT devices. LeadingAge NY will be sure to notify members when CMS posts additional information and educational opportunities.

***Update on Future Plans to Group HH PPS Claims Centrally During Claims Processing***

In the CY 2011 HH PPS proposed rule, CMS solicited comments on potential plans to group HH PPS claims centrally during claims processing and received many comments in support of this initiative. In grouping HH PPS claims centrally during processing, CMS described a process whereby all of the information necessary to group the claim and assign a Health Insurance Prospective Payment System (HIPPS) score which determines payment is available and processed within the Fiscal Intermediary Shared System (FISS). After CMS conducted further analysis, they determined that the use of the treatment authorization field was not a viable option. They concluded that the information they planned to report in this field was not permitted by the Health Insurance Portability Accountability Act (HIPAA).

In the proposed rule, CMS had asked for feedback on another process identified whereby all of the information necessary to group HH PPS claims occurs centrally during claims processing.

In the rule, CMS described the current billing process. They review that Medicare makes payment under the HH PPS on the basis of a national, standardized 60-day episode payment amount that is adjusted for case-mix and geographic wage variations. The national, standardized 60-day episode payment amount includes services from the six HH disciplines (skilled nursing, HH aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) and non-routine medical supplies. As we described earlier under NPWT, DMEs covered under HH is paid for outside the HH PPS payment. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification to assign patients to a home health resource group (HHRG). Clinical needs, functional status, and service utilization are computed from responses to selected data elements in the Outcome & Assessment Information Set (OASIS) instrument. On Medicare claims, the HHRGs are represented as HIPPS codes.

CMS continues to find OASIS assessments submitted with erroneous HIPPS codes through a process of comparing the submitted HIPPS code to the HIPPS code returned by their assessment system. These errors may occur when HHAs or their software vendors inaccurately replicate the HH PPS Grouper algorithm into the HHA’s customized software.

CMS thought that embedding the HH PPS Grouper within the claims processing system would mitigate the provider’s vulnerability and improve payment accuracy. They implemented a process where they match the claim and the OASIS assessment in order to validate the HIPPS code on the Medicare bill. They believe that making additional enhancements to the claim and OASIS matching process would enable them to collect all of the other necessary information to assign a HIPPS code within the claims processing system. CMS thought that adopting this process would improve payment accuracy, decrease costs, and make it easier for HHAs. Most of the comments that CMS received agreed that this potential process would simplify and improve accuracy of the HIPPS code assignment and OASIS matching, reduce errors, and reduce HHA costs and administrative burdens.

***Final Changes to Home Health Value-Based Purchasing (HHVBP) Model***

In the CY 2016 HH PPS final rule, CMS implemented the HHVBP Model to begin on Jan. 1, 2016. The purpose of the HHVBP Model has been to improve the quality and delivery of home health care services to Medicare beneficiaries. The specific goals are to: (1) provide incentives for better quality care with greater efficiency; (2) study new potential quality and efficiency measures for appropriateness in the home health setting; and (3) enhance the current public reporting process.

Nine states were selected for inclusion in the HHVBP Model representing each geographic

area across the nation. All Medicare-certified HHAs that provide services in Arizona, Florida,

Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington

are required to compete in the Model. New York was NOT selected; however, this model warrants attention given the ongoing development of New York’s VBP through Medicaid.

As finalized in the CY 2016 HH PPS final rule, the HHVBP will adjust Medicare payment rates

beginning in CY 2018 based on performance on applicable measures. Payment adjustments will be increased incrementally over the course of several years.

CMS finalized several changes to HHVBP. They include:

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

The HHVBP Model compares a competing HHA’s performance on quality measures

against the performance of other competing HHAs within the same state and size cohort. CMS has continued to evaluate the calculation of the benchmarks and achievement thresholds using the most recent CY 2015 data that is now available. CMS has detailed in three tables results highlighting that there is a greater degree of interstate variation in the benchmark values for the cohorts that have fewer HHAs as compared to the variation in benchmark values for the cohorts that have a greater number of HHAs.

CMS finalized to calculate the benchmarks and achievement thresholds at the state level rather than at the smaller- and larger-volume cohort level for all model years.

1. *The Payment Adjustment Methodology*

CMS had proposed that a smaller-volume cohort have a minimum of eight HHAs in order for the HHAs in that cohort to be compared only against each other, and not against the HHAs in the larger-volume cohort. They believe this would better mitigate the impact of outliers.

CMS finalized a required minimum of eight HHAs in any size cohort.

1. *Quality Measure Proposals*

CMS reviewed and believe that four measures require further consideration before inclusion in the HHVBP Model. They proposed to remove the following measures: (1) CareManagement: Types and Sources of Assistance; (2) Prior Functioning ADL/IADL; (3) InfluenzaVaccine Data Collection Period; and (4) Reason Pneumococcal Vaccine Not Received.

CMS finalized and removed the four measures.

1. *Public Display of Total Performance Scores*

One of the goals of the HHVBP is greater transparency in the industry. Having annual public performance reports will increase transparency on Medicare data on quality and align the competitive forces within the market to deliver care based on value over volume. The reports will inform home health industry stakeholders as well as all competing HHAs delivering care to Medicare beneficiaries within selected state boundaries on their level of quality relative to both their peers and their own past performance. As CMS develops the public reporting mechanism for the HHVBP Model, they are considering which data elements reported would be meaningful. They plan on having this available beginning no earlier than CY 2019.

CMS intends to continue to provide opportunities for stakeholders’ input as they develop a mechanism for public reporting under the HHVBP Model. They continue to examine models that balance access and reduce confusion.

***Home Health Care Quality Reporting Program (HH QRP)***

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) amended Title XVIII of the Act, in part, by adding a new section 1899B, which imposes new data reporting requirements for certain post-acute care (PAC) providers, including HHAs. In last year’s rule, CMS sought feedback on four cross-setting measure constructs to potentially meet requirements of the IMPACT Act domains of:

1. All-condition risk-adjusted potentially preventable hospital readmission rates;
2. Resource use, including total estimated Medicare spending per beneficiary;
3. Discharge to the community; and
4. Medication reconciliation.

In this year’s HH PPS, CMS had proposed and finalized for the CY 2018 payment determination to adopt four new measures to meet the requirements of the IMPACT Act:

1. Proposal to Address the IMPACT Act Domain of Resource Use and Other Measures (MSPB-PAC)

Rising Medicare expenditures for post-acute care as well as wide variation in spending for these services underlines the importance of measuring resource use for providers rendering these services. According to CMS, given the current lack of resource use measures for Post-Acute Care (PAC) settings, this MSPB-PAC measure has the potential to provide valuable information to HHAs on their relative Medicare spending in delivering services to approximately 3.5 million Medicare beneficiaries.

1. Discharge to the Community

This measure assesses successful discharge to the community from a home health (HH) setting, with successful discharge to the community including no unplanned hospitalizations and no deaths in the 31 days following discharge from the HH agency setting. Specifically, this measure reports an HHA’s risk-standardized rate of Medicare FFS patients who are discharged to the community following an HH episode, do not have an unplanned admission to an acute care hospital or LTCH in the 31 days following discharge to community, and remain alive during the 31 days following discharge to community.

1. Potentially Preventable 30-Day Post-Discharge Readmission Measure for PAC

This measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries that take place within 30 days of an HH discharge. The HH admission must have occurred within up to 30 days of discharge from a prior proximal hospital stay, which is defined as an inpatient admission to an acute care hospital. 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 cites in the HH PPS:

*“Hospital readmissions among the Medicare population, including beneficiaries that utilize PAC, are common, costly, and often preventable. The MedPAC estimated that 17 to 20 percent of Medicare beneficiaries discharged from the hospital were readmitted within 30 days. MedPAC found that more than 75 percent of 30-day and 15-day readmissions and 84 percent of 7-day readmissions were considered ‘potentially preventable.’ In addition, MedPAC calculated that annual Medicare spending on potentially preventable readmissions would be $12 billion for 30-day, $8 billion for 15-day, and $5 billion for 7-day readmissions. For hospital readmissions from one post-acute care setting, SNFs, MedPAC deemed 76 percent of these readmissions as ‘potentially avoidable’–associated with $12 billion in Medicare expenditures. An analysis of data from a nationally representative sample of Medicare FFS beneficiaries receiving home health services in 2004 show that home health patients receive significant amounts of acute and post-acute services after discharge from home health care. Within 30 days of discharge from home health, 29 percent of patients were admitted to a hospital. The 30-day rehospitalization rate was 26 percent with the largest proportion related to a cardiac-related diagnosis (42 percent).”*

1. Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post-Acute Care

This measure assesses whether PAC providers were responsive to potential or actual clinically significant medication issue(s) when such issues were identified. Specifically, the quality 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 that timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that episode.

In late October, CMS released a Fact Sheet on the final rule that included: “In 2015, CMS undertook a comprehensive reevaluation of all 81 HH quality measures, some of which are used only in the Home Health Quality Initiative (HHQI), and others which are also used in the HH QRP. The goal of this reevaluation was to streamline the measure set, consistent with Measures Management System (MMS) guidance and in response to stakeholder feedback. This reevaluation included a review of the current scientific basis for each measure, clinical relevance, usability for quality improvement, and evaluation of measure properties, including reportability and variability.

CMS’s measure development and maintenance contractor convened a Technical Expert Panel (TEP) on Aug. 21, 2015, to review and advise on the reevaluation results. Information regarding the TEP’s feedback is available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Health-Quality-Reporting-Program-HHQRP-TEP-.zip>. As a result of the comprehensive reevaluation, CMS identified 28 HHQI measures that were either “topped out” and/or determined to be of limited clinical and quality improvement value by TEP members. Therefore, these measures will no longer be included in the HHQI. A list of these measures, along with CMS’s reasons for no longer including them in the HHQI, can be found at the following link: [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html](http://links.govdelivery.com:80/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTYxMDMxLjY1NzQwOTkxJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE2MTAzMS42NTc0MDk5MSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3ODQxODA0JmVtYWlsaWQ9ZW11bmxleUBsZWFkaW5nYWdlLm9yZyZ1c2VyaWQ9ZW11bmxleUBsZWFkaW5nYWdlLm9yZyZ0YXJnZXRpZD0mZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&101&&&https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html). In addition, based on the results of the comprehensive reevaluation and the TEP input, CMS finalized to remove six process measures from the HH QRP, beginning with the CY 2018 payment determination, because they are “topped out” and therefore no longer have sufficient variability to distinguish between providers in public reporting.”

***Update on Form, Manner, and Timing of OASIS Data Submission***

**Background –** The HH conditions of participation (CoPs) at § 484.55(d) require that the comprehensive assessment be updated and revised (including the administration of the OASIS) no less frequently than: (1) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary-elected transfer, significant change in condition, or discharge and return to the same HHA during the 60-day episode; (2) within 48 hours of the patient’s return to the home from a hospital admission of 24-hours or more for any reason other than diagnostic tests; and (3) at discharge.

It is important to note that to calculate quality measures from OASIS data, there must be a complete quality episode, which requires both a Start of Care (initial assessment) or Resumption of Care OASIS assessment and a Transfer or Discharge OASIS assessment. Failure to submit sufficient OASIS assessments to allow calculation of quality measures, including transfer and discharge assessments, is a failure to comply with the CoPs.

CMS’s previous goal was to require all HHAs to achieve a pay-for-reporting performance

requirement compliance rate of 90 percent or more. In last year’s HH PPS, it was finalized that HHAs must score at least 70 percent on the QAO metric of pay-for-reporting performance requirement for CY 2017 (reporting period July 1, 2015 to June 30, 2016), 80 percent for CY 2018 (reporting period July 1, 2016 to June 30, 2017), and 90 percent for CY 2019 (reporting period July 1, 2017 to June 30, 2018), or be subject to a 2 percentage point reduction to their market basket update for that reporting period.

In the final rule, CMS is not proposing any additional policies related to the pay-for-reporting performance requirement.

**Home Health Care CAHPS Survey (HHCAHPS)**

CMS continues with the policy from the CY 2015 HH PPS final rule **–** that the home health quality measures reporting requirements for Medicare-certified agencies include the Home Health Care CAHPS® (HHCAHPS) Survey for the CY 2017 Annual Payment Update (APU).

CMS has previously stated that Medicare-certified HHAs are required to contract with an

approved HHCAHPS survey vendor. This requirement continues, and Medicare-certified

agencies also must provide on a monthly basis a list of all their survey-eligible home health care

patients to their vendors. All of the requirements about home health patient eligibility for the HHCAHPS survey, as well as which home health patients are ineligible for the HHCAHPS survey, are delineated and detailed in the HHCAHPS Protocols and Guidelines Manual, which is downloadable at <https://homehealthcahps.org>.

The final rule outlines the dates and times for the CY 2017, CY 2018, CY 2019, and CY 2020 APU. These deadlines are firm; no exceptions are permitted.

In the final rule, there are no changes to the HHCAHPS participation requirements, or to the requirements pertaining to the implementation of the Home Health CAHPS® Survey. In this rule, CMS updated the information to reflect the dates for future APU years. CMS continues to strongly encourage HHAs to keep up-to-date about the HHCAHPS by regularly viewing the official website for HHCAHPS at <https://homehealthcahps.org>.

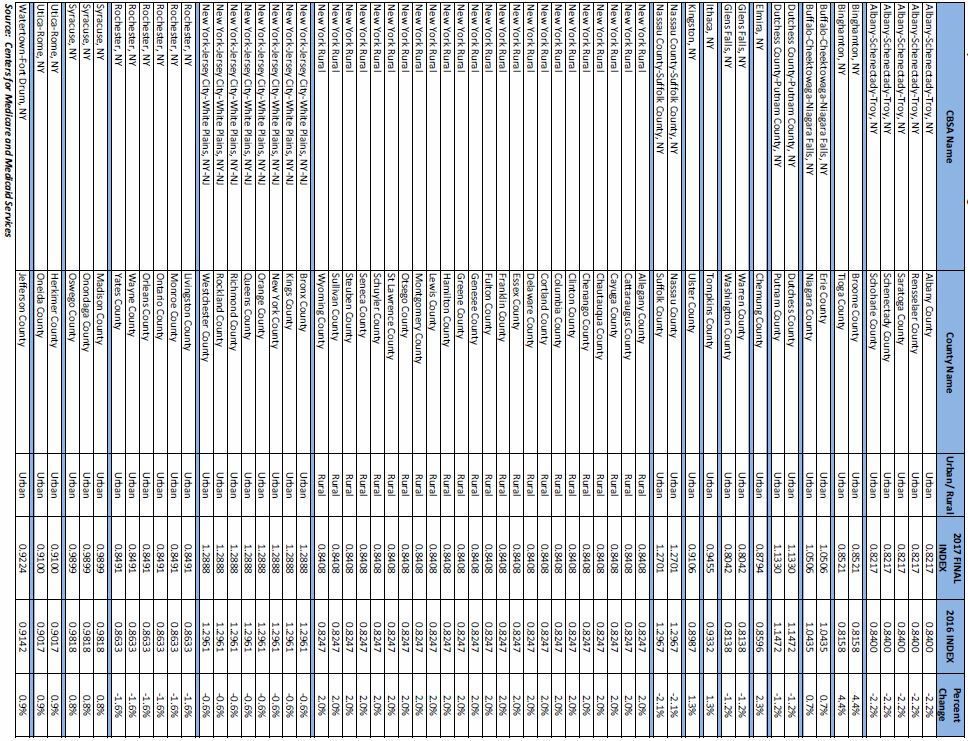
**Conclusion**

LeadingAge NY was pleased to report the slight increase in payment from what we initially reported in July (the overall percentage reduction of 0.7 percent, not the 1.0 percent decrease in total Medicare payments to HHAs for CY 2017 that CMS had proposed). This will result in a $130 million reduction instead of the projected total Medicare revenue reduction of approximately $180 million. That was welcome news. The final rule focuses on many of the same areas of HH PPS case-mix weights, non-routine medical supplies (NRS), home health market basket, and per-visit payment rates. We will watch for any problems with implementing payment changes for high-cost outliers and continue to express concern about rebasing and the impact it has on our HHAs. Even though HHVBP and the Pre-Claim Review Demonstration (PCRD) do not impact New York, we will watch the progress and problems that are encountered with these two projects. In addition, we are surprised that for the last two years, the HH PPS has been silent on the continued problems with the Face-to-Face requirements.

Please contact Cheryl Udell at [cudell@leadingageny.org](mailto:cudell@leadingageny.org) or 518-867-8871 and LeadingAge National at [congress@leadingage.org](mailto:congress@leadingage.org) to share your concerns or ask questions regarding the CY 2017 HH PPS final rule.

**Appendix A: CMS’s CY 2017 Final Case-Mix Weights**

|  |  |  |  |
| --- | --- | --- | --- |
| **Payment Group** | **Step (Episode and/or Therapy Visit Ranges)** | **Clinical and Functional Levels**  **(1 = Low;**  **2 = Medium;**  **3 = High)** | **Final CY**  **2017**  **Case-Mix Weights** |
| 10111 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F1S1 | 0.5857 |
| 10112 | 1st and 2nd Episodes, 6 Therapy Visits | C1F1S2 | 0.7168 |
| 10113 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F1S3 | 0.8479 |
| 10114 | 1st and 2nd Episodes, 10 Therapy Visits | C1F1S4 | 0.9790 |
| 10115 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F1S5 | 1.1100 |
| 10121 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F2S1 | 0.6896 |
| 10122 | 1st and 2nd Episodes, 6 Therapy Visits | C1F2S2 | 0.8030 |
| 10123 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F2S3 | 0.9164 |
| 10124 | 1st and 2nd Episodes, 10 Therapy Visits | C1F2S4 | 1.0298 |
| 10125 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F2S5 | 1.1433 |
| 10131 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F3S1 | 0.7460 |
| 10132 | 1st and 2nd Episodes, 6 Therapy Visits | C1F3S2 | 0.8630 |
| 10133 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F3S3 | 0.9800 |
| 10134 | 1st and 2nd Episodes, 10 Therapy Visits | C1F3S4 | 1.0970 |
| 10135 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F3S5 | 1.2140 |
| 10211 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F1S1 | 0.6193 |
| 10212 | 1st and 2nd Episodes, 6 Therapy Visits | C2F1S2 | 0.7526 |
| 10213 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F1S3 | 0.8860 |
| 10214 | 1st and 2nd Episodes, 10 Therapy Visits | C2F1S4 | 1.0193 |
| 10215 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F1S5 | 1.1526 |
| 10221 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F2S1 | 0.7232 |
| 10222 | 1st and 2nd Episodes, 6 Therapy Visits | C2F2S2 | 0.8389 |
| 10223 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F2S3 | 0.9545 |
| 10224 | 1st and 2nd Episodes, 10 Therapy Visits | C2F2S4 | 1.0702 |
| 10225 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F2S5 | 1.1858 |
| 10231 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F3S1 | 0.7796 |
| 10232 | 1st and 2nd Episodes, 6 Therapy Visits | C2F3S2 | 0.8988 |
| 10233 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F3S3 | 1.0181 |
| 10234 | 1st and 2nd Episodes, 10 Therapy Visits | C2F3S4 | 1.1373 |
| 10235 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F3S5 | 1.2565 |
| 10311 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F1S1 | 0.6643 |
| 10312 | 1st and 2nd Episodes, 6 Therapy Visits | C3F1S2 | 0.8204 |
| 10313 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F1S3 | 0.9765 |
| 10314 | 1st and 2nd Episodes, 10 Therapy Visits | C3F1S4 | 1.1325 |
| 10315 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F1S5 | 1.2886 |
| 10321 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F2S1 | 0.7682 |
| 10322 | 1st and 2nd Episodes, 6 Therapy Visits | C3F2S2 | 0.9066 |
| 10323 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F2S3 | 1.0450 |
| 10324 | 1st and 2nd Episodes, 10 Therapy Visits | C3F2S4 | 1.1834 |
| 10325 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F2S5 | 1.3218 |
| 10331 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F3S1 | 0.8246 |
| 10332 | 1st and 2nd Episodes, 6 Therapy Visits | C3F3S2 | 0.9666 |
| 10333 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F3S3 | 1.1086 |
| 10334 | 1st and 2nd Episodes, 10 Therapy Visits | C3F3S4 | 1.2505 |
| 10335 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F3S5 | 1.3925 |
| 21111 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F1S1 | 1.2411 |
| 21112 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F1S2 | 1.4125 |
| 21113 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F1S3 | 1.5838 |
| 21121 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F2S1 | 1.2567 |
| 21122 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F2S2 | 1.4388 |
| 21123 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F2S3 | 1.6209 |
| 21131 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F3S1 | 1.3310 |
| 21132 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F3S2 | 1.5089 |
| 21133 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F3S3 | 1.6868 |
| 21211 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F1S1 | 1.2859 |
| 21212 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F1S2 | 1.4769 |
| 21213 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F1S3 | 1.6679 |
| 21221 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F2S1 | 1.3014 |
| 21222 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F2S2 | 1.5032 |
| 21223 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F2S3 | 1.7049 |
| 21231 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F3S1 | 1.3757 |
| 21232 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F3S2 | 1.5733 |
| 21233 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F3S3 | 1.7708 |
| 21311 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F1S1 | 1.4446 |
| 21312 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F1S2 | 1.6636 |
| 21313 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F1S3 | 1.8826 |
| 21321 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F2S1 | 1.4602 |
| 21322 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F2S2 | 1.6899 |
| 21323 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F2S3 | 1.9197 |
| 21331 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F3S1 | 1.5345 |
| 21332 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F3S2 | 1.7601 |
| 21333 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F3S3 | 1.9856 |
| 22111 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F1S1 | 1.2523 |
| 22112 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F1S2 | 1.4200 |
| 22113 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F1S3 | 1.5876 |
| 22121 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F2S1 | 1.2523 |
| 22122 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F2S2 | 1.4359 |
| 22123 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F2S3 | 1.6195 |
| 22131 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F3S1 | 1.3315 |
| 22132 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F3S2 | 1.5093 |
| 22133 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F3S3 | 1.6870 |
| 22211 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F1S1 | 1.3117 |
| 22212 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F1S2 | 1.4941 |
| 22213 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F1S3 | 1.6765 |
| 22221 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F2S1 | 1.3117 |
| 22222 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F2S2 | 1.5100 |
| 22223 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F2S3 | 1.7083 |
| 22231 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F3S1 | 1.3909 |
| 22232 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F3S2 | 1.5834 |
| 22233 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F3S3 | 1.7759 |
| 22311 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F1S1 | 1.5203 |
| 22312 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F1S2 | 1.7141 |
| 22313 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F1S3 | 1.9079 |
| 22321 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F2S1 | 1.5203 |
| 22322 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F2S2 | 1.7300 |
| 22323 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F2S3 | 1.9398 |
| 22331 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F3S1 | 1.5995 |
| 22332 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F3S2 | 1.8034 |
| 22333 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F3S3 | 2.0073 |
| 30111 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F1S1 | 0.4785 |
| 30112 | 3rd+ Episodes, 6 Therapy Visits | C1F1S2 | 0.6333 |
| 30113 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F1S3 | 0.7880 |
| 30114 | 3rd+ Episodes, 10 Therapy Visits | C1F1S4 | 0.9428 |
| 30115 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F1S5 | 1.0976 |
| 30121 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F2S1 | 0.5578 |
| 30122 | 3rd+ Episodes, 6 Therapy Visits | C1F2S2 | 0.6967 |
| 30123 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F2S3 | 0.8356 |
| 30124 | 3rd+ Episodes, 10 Therapy Visits | C1F2S4 | 0.9745 |
| 30125 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F2S5 | 1.1134 |
| 30131 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F3S1 | 0.6039 |
| 30132 | 3rd+ Episodes, 6 Therapy Visits | C1F3S2 | 0.7494 |
| 30133 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F3S3 | 0.8949 |
| 30134 | 3rd+ Episodes, 10 Therapy Visits | C1F3S4 | 1.0405 |
| 30135 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F3S5 | 1.1860 |
| 30211 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F1S1 | 0.4955 |
| 30212 | 3rd+ Episodes, 6 Therapy Visits | C2F1S2 | 0.6587 |
| 30213 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F1S3 | 0.8220 |
| 30214 | 3rd+ Episodes, 10 Therapy Visits | C2F1S4 | 0.9852 |
| 30215 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F1S5 | 1.1485 |
| 30221 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F2S1 | 0.5748 |
| 30222 | 3rd+ Episodes, 6 Therapy Visits | C2F2S2 | 0.7222 |
| 30223 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F2S3 | 0.8695 |
| 30224 | 3rd+ Episodes, 10 Therapy Visits | C2F2S4 | 1.0169 |
| 30225 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F2S5 | 1.1643 |
| 30231 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F3S1 | 0.6208 |
| 30232 | 3rd+ Episodes, 6 Therapy Visits | C2F3S2 | 0.7748 |
| 30233 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F3S3 | 0.9288 |
| 30234 | 3rd+ Episodes, 10 Therapy Visits | C2F3S4 | 1.0829 |
| 30235 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F3S5 | 1.2369 |
| 30311 | 3rd+ Episodes, 0 to 5 Therapy Visits | C3F1S1 | 0.6140 |
| 30312 | 3rd+ Episodes, 6 Therapy Visits | C3F1S2 | 0.7953 |
| 30313 | 3rd+ Episodes, 7 to 9 Therapy Visits | C3F1S3 | 0.9765 |
| 30314 | 3rd+ Episodes, 10 Therapy Visits | C3F1S4 | 1.1578 |
| 30315 | 3rd+ Episodes, 11 to 13 Therapy Visits | C3F1S5 | 1.3391 |

**Appendix B: Summary of Final FY 2017 HH Wage Index**