Medicare and Medicaid Programs; CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (CMS-1625-F; RIN 0938-AS46)
Summary of Final Rule

The Centers for Medicare & Medicaid Services (CMS) published in the November 5, 2015 *Federal Register* (80 *FR* 68624-68719) a final rule "CY 2016 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements." Page references given in this summary are to this published document. CMS received 118 timely comments from the public.

Summary Overview

Update to Home Health Prospective Payment System (HH PPS): CMS updates the national standardized 60-day episode rate with a market basket update of 2.3 percent, reduced by a 0.4 percent productivity adjustment, for a 1.9 percent update for home health agencies (HHAs) submitting quality data and -0.1 percent for those that do not submit such data. It includes the third year of the four-year rebasing adjustment, which is a reduction of $80.95 each year on the episode rate, a 2.82 percent decrease in the nonroutine medical supply (NRS) conversion factor, and annual fixed dollar increases in each of the per-visit rates. CMS finalizes for this year a nominal case mix adjustment of -0.97 percent for CY 2016 as the first year of a three-year adjustment (with another -0.97 percent in CYs 2017 and 2018) to account for nominal case-mix growth it quantifies between CYs 2012 and 2014.

Home Health Value-Based Purchasing (HHVBP): In the most significant policy development, CMS will establish a new home health value-based purchasing (HHVBP) model in nine randomly selected states (Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee). CY 2015[1] is the base year, 2016 is the initial performance year and 2018 is the initial year in which payment adjustments are made. The demonstration would proceed through payment year 2022.

Home Health Quality Reporting: CMS finalizes its updates to the home health quality reporting system, including continuation of the phasing schedule for reporting "Quality Assessments Only" (QAO) in order to avoid the two percent payment penalty for non-reporting. Last year's final rule set a standard of QAO reporting for 70 percent of episodes, for reporting for payment year 2017. This final rule will increase that standard to 80 percent for reporting for payment year 2018, and 90 percent for payment year 2019.

Impact: The HH PPS updates are estimated to reduce home health payments by a net $260 million, or -1.4 percent, in 2016. The HHVBP model is estimated to reduce program spending for 2018-2022 by $380 million through a reduction in unnecessary hospitalizations and skilled nursing facility (SNF) usage, resulting from quality improvements in home health care.

[1] Since home health payment policy is set on a calendar year basis, all years refer to calendar years unless otherwise noted.

III. Provisions of the Home Health Prospective Payment System (pages 68629-68656)

A. Monitoring for Potential Impacts – Affordable Care Act Rebasing Adjustments

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:

- 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 maintains these three rebasing adjustments for 2016. CMS reported on its monitoring of the impact of rebasing and presented information on Medicare home health utilization using CY 2014 HHA claims data (the 1st year of the 4 year phase-in as mandated by the ACA). These data were included in the proposed rule. CMS notes that it will continue to monitor the impact of future payment and policy changes and provide the industry with updates in future rulemaking or on its website.

B. 2016 HH PPS Case-Mix Weights and Reduction to the National, Standardized 60-day Episode Payment Rate to Account for Nominal Case-Mix Growth

1. 2016 HH PPS Case-Mix Weights

CMS finalizes the recalibration of the HH PPS case-mix weights using 2014 data as proposed. CMS sets out the detailed methodology it uses to recalibrate the case-mix weights (see Tables 3-5 on pages 68630-68634). CMS presents in Table 6 (pages 68635-68637) the resulting final 2016 case-mix payment rates for each payment group and step.

CMS finalizes a case-mix budget neutrality factor of 1.0187 for 2016, calculated as the ratio of:

- total payments when 2016 case-mix weights are applied to 2014 utilization to;
- total payments when 2015 case-mix weights are applied to 2014 utilization.

CMS updates its analysis from the proposed rule using 2014 claims data as of June 30, 2015.

Commenters had questions about the level of the case-mix weights for certain categories of patients. For example, one commenter was confused as to why high-therapy episodes tend to get increased case-mix weights. In response, CMS notes that increases in the case-mix weights for the high-therapy case-mix groups (with a corresponding decrease in the low-therapy case-mix groups) is generally attributable to shifts away from the use of home health aides to more nursing or therapy care. CMS also notes that the 2016 HH PPS weights change very little compared to the final 2015 case mix weights.

2. Reduction to the National, Standardized 60-day Episode Payment Rate to Account for Nominal Case-Mix Growth

After consideration of comments received, CMS finalizes a 0.97 percent reduction to the national, standardized 60-day episode payment rate each year in 2016, 2017, and 2018 to account for nominal case-mix growth from 2012 through 2014. In the 2016 HH PPS proposed rule, CMS had proposed to implement a 3.41 percent reduction in equal increments of 1.72 percent in each of 2016 and 2017 to account for the nominal case-mix growth.

Section 1895(b)(3)(B)(iv) of the Social Security Act gives the Secretary authority to adjust payments for nominal case-mix growth (growth unrelated to changes in patient acuity) in order to better align payment with real changes in patient severity. In the 2015 HH PPS final rule, CMS estimated nominal case mix growth of 2.32 percent between 2012 and 2013. It did not implement a reduction to the 2015 rate, but stated that it would continue to monitor and may consider nominal case-mix reductions in the future. In the proposed rule, CMS estimated nominal case-mix growth of another 1.18 percent from 2013-2014, for total nominal case-mix growth of 3.41 percent in this two year period.

CMS received numerous comments on its proposed policies, many of which questioned its methodology used to determine case-mix growth from 2012 through 2014 and the portion of such growth that is nominal versus real. Among other comments, some commenters suggested that CMS increase its program integrity efforts to address provider-specific up-coding rather than implementing across-the-board reductions. Commenters also recommended phasing-in the proposed reduction over more years than the two proposed by CMS. In response, CMS notes that it did re-evaluate the methodology to determine case-mix growth and has decided to move forward with a more familiar and slightly more accurate methodology (one that CMS has used in the past). This methodology results in a 1.45 percent reduction each year for 2016 and 2017 (instead of the 1.72 percent reduction in the 2016 HH PPS proposed rule). With respect to increasing its program integrity efforts, CMS notes first that system-wide case-mix levels have risen over time and thus the problem is not just the case-mix billed by any specific HHA. Having said that, CMS notes that it has taken various measures to reduce payment vulnerabilities and to identify fraudulent and abusive activities. With respect to phasing-in the reduction over more years, CMS notes that it has decided to phase-in the case-mix reductions over 3 years (2016, 2017, and 2018) rather than the 2 years (2016 and 2017) described in the proposed rule. Implementing the reduction over three years results in a 0.97 percent reduction for each of these years and gives home health agencies more time to adjust to CMS' intended aggregate reduction of 2.88 percent.

C. 2016 Rate Update

1. 2016 Home Health Market Basket Update

CMS reviews the methodology for updating the HH rates. The estimates are based on IHS Global Insight Inc.'s (IGI) third quarter 2015 forecast (CMS notes and explains IGI's revision in its method for estimating aggregate capital inputs). CMS finalizes the following update for 2016:

Market basket increase:	2.3 percent.
Multi-factor productivity (MFP) adjustment:	-0.4 percent
MFP adjusted HHA market basket update:	1.9 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 2015 would be:

For HHAs reporting the required quality data:	1.9 percent
For HHAs not reporting the required quality data:	-0.1 percent

2. 2016 Home Health Wage Index

CMS will continue to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates. CMS will continue 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). For 2015, CMS had implemented a one-year transition from the prior delineations to these new OMB delineations.
The wage index for 2016 is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1625-F.html.

3. 2016 Payment Update

CMS updates the standardized 60-day episode payment, the per-visit amounts, and the NRS conversion factor, along with adjustments for HHAs not reporting quality data and for those in rural areas.

It reviews the methodology and payment amounts for the national standardized 60-day episode payment and the national visit amounts for HHAs submitting and not submitting quality data, along with the 3 percent rural adjuster (see Tables 7-18 on pages 68649-68652 for details on the updates). See below for a summary of these calculations.

2016 60-day National, Standardized 60-Day Episode Payment Amount		
	HHAs submitting quality data	HHAs not submitting quality data
National standardized amount (Tables 7, 8)		
2015 amount	$2,961.38	
Wage index budget neutrality factor	x 1.0011	
Case-mix budget neutrality factor	x 1.0187	
Nominal case mix growth adjustment (1-0.0097)	x 0.9903	
2016 rebasing factor	-$80.95	
HH payment update percentage	x 1.019	x 0.999
2016 payment amount	$2,965.12	$2,906.92
Rural add-on (Table 15)	x 1.03	x 1.03
2016 rural payment amount	$3,054.07	$2,994.13

CMS shows the computations for 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). The per-visit amounts for those HHAs submitting the required quality data is as follows:

2016 National, Per-Visit Amounts for HHAs that Submit Quality Data (see Table 9)						
	Home health aide	Medical social services	Occupational therapy	Physical therapy	Skilled nursing	Speech-language pathology
2015 per visit rates	$57.89	$204.91	$140.70	$139.75	$127.83	$151.88
Wage index budget neutrality factor	1.0010					
2016 rebasing, year 3	+$1.79	+$6.34	+$4.35	+$4.32	+$3.96	+$4.70
Payment update %	1.019					
2016 per visit rates	$60.87	$215.47	$147.95	$146.95	$134.42	$159.71

As with the payments for a 60-day episode of care, HHAs that do not submit required quality data would have the payment update for per-visit services reduced from 1.9 percent to -0.1 percent (see Table 10 on page 68650), and the rural add-on of 3.0 percent would be provided for services in rural areas (see Table 16 on page 68652).

Low-Utilization Payment Adjustment (LUPA) Add-On Factors: CMS made no changes in the LUPA add-on factors, which apply for the first 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.

NRS payment rates: CMS sets out the update to the conversion factor for particular severity levels (the NRS conversion factor update), yielding a 2016 NRS conversion factor of $52.71. CMS shows the NRS payment amounts for 2016 for each of the six severity levels based on that

conversion factor, as well as the 2.0 percent reductions for HHAs that do not submit required quality data (see Tables 12-14 on page 68651).

D. Payments for High-Cost Outliers Under the HH PPS

CMS does not propose any changes in outlier policy for 2016. It maintains the:

- Outlier pool target at 2.5 percent;
- Outlier threshold for each case-mix group set at the 60-day episode payment for that group plus the fixed dollar loss (FDL) ratio of 0.45 of that amount; and
- Loss-sharing ratio of 80 percent, so that Medicare pays 80 percent of the costs above the outlier threshold.

Commenters differed in their viewpoint on the outlier policy – some favored support of this policy as currently structured while others recommended changes, including eliminating the outlier policy altogether. CMS in its response notes that the Secretary has the statutory discretion as to whether or not to have an outlier policy under the HH PPS. CMS also states that as part of a larger research effort by Abt Associates to study home health, CMS may have them examine potential revisions to the HH outlier policy. CMS makes no changes to the FDL ratio or loss sharing ratio for 2016. CMS will continue to monitor utilization to determine if future adjustments to the FDL ratio or loss-sharing ratio are needed.

E. Report to Congress on the Home Health Study Required by Section 3131(d) of the Affordable Care Act and an Update on Subsequent Research and Analysis

In the proposed rule, CMS reviewed studies done under contract with L&M Policy Research and Abt Associates 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. In brief, it identified three models:

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

CMS reviewed the three models in detail in the proposed rule and noted its plans to issue a technical report under the Abt Associates contract to further analyze the options.

In the final rule, CMS notes that it will continue to provide the home health industry with periodic updates on the progress of its research in future rulemaking or on its website.

F. Technical Regulations Text Changes

CMS sought comments on several technical corrections in the proposed rule that were designed to better align the payment requirements with recent statutory and regulatory changes for home health services. CMS did not receive any comments. CMS is finalizing the technical regulation text changes at §409, §424, and §484.

IV. Provisions of the Home Health Value-Based Purchasing (HHVBP) Model (pages 68656-68690)

A. Background and Overview

The ACA directed the Secretary to develop a plan to implement a home health value-based purchasing plan (HHVBP). The Secretary issued a report to Congress in 2012 setting out a roadmap for implementation (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF). CMS indicated in its 2015 rulemaking for home health that it was considering development of a HHVBP model, and sought comments.

The HHVBP Model, as finalized, will be tested by CMS's Center for Medicare and Medicaid Innovation (CMMI) under section 1115A of the Social Security Act. CMS notes that it is not issuing any fraud and abuse waivers for this model, and that it is not implementing the model under ACA section 3131 authority ("Payment Adjustments for Home Health Care").

This model will be conducted in nine randomly selected states – one from each of nine groups of states that CMS identified. The states are Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. It will encompass all Medicare beneficiaries being provided care by any Medicare-certified HHA delivering care within those states. CMS reviews its rationale for requiring all Medicare-certified HHAs within the selected states to participate, notably that absent mandatory participation, low performing HHAs in areas of limited competition may not choose to participate. The reluctance to participate in voluntary models when there is the risk of a payment reduction, and resulting self-selection bias, presents challenges in evaluation.

The base year for each HHA will be performance in 2015. The initial performance year (for measurement of performance) will be 2016, with payment adjustments for that year made in 2018, and the demonstration will proceed through five years (through payment year 2022). Payment adjustments will be calculated based on the higher of how each HHA either improved, compared to its performance in the base year, or performed relative to its peers in its size cohort/state in the performance year. Payment adjustments ("applicable percentage") will be three percent in the first year and phasing up to eight percent in the final year of the model.

B. Selection methodology

CMS sets out its rationale for using states as the geographic basis for the test, for grouping the states into nine logical groupings of states, and for randomly selecting one state from each group to participate in the demonstration.

While CMS proposed that the geographic basis for the test be at the state level, it sought comments on potential alternatives that might use smaller geographic areas. CMS proposed that performance scores and payment adjustments would only be based on the services provided by an HHA within a selected state, unless the HHA has a reciprocal agreement with another state. CMS noted that such agreements are rare.

Commenters expressed a number of concerns including that HHAs in nonparticipating states would fall behind in innovation; state selection was not sufficiently representative of the Medicare population; and selection of certain states (i.e. Maryland and Florida) was not appropriate. With respect to HHAs "falling behind", CMS notes that if the model yields early positive results, CMS may consider expansion if the statutory requirements are met. CMS notes that its approach for state selection took into account multiple factors, including the level of utilization and socioeconomic status of patients in grouping states and that it also conducted a statistical analysis to ensure the sample size was sufficient to effectively detect the model's impact. In response to the selection of certain states, CMS notes that the Maryland All-Payer Model (hospital-based model) does not directly intersect with HHVBP, and thus CMS does not believe it is a compelling reason to exclude the state. In addition, CMS dismisses the commenter's reasons—complexity of tracking all relevant policies and regulations—for excluding Florida from participation,

CMS finalizes the state selection methodology as proposed, including the nine states selected under this methodology. All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee will be required to participate in the HHVBP model.

C. Performance Assessment

HHAs within a selected state will be divided into two size cohorts for purposes of comparing their performance with their peers within the state.

- The larger-volume cohort within a state is composed of HHAs that are required to participate in reporting on Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS) measures (HHAs with 60 or more HHCAHPS-eligible participants in a year).
- The smaller-volume cohort would be those with fewer than 60 such participants. In the case of a state with too few HHAs in the smaller-volume cohort (such as only one or two competing HHAs) these smaller HHAs will be included in the larger-volume cohort for purposes of peer comparison and payment adjustment, but the calculations for the smaller-volume HHAs would not include the HHCAHPS scores.

As result, there are potentially 18 different peer groupings (if all of the selected states have a larger- and smaller-volume cohorts) for purposes of comparing performance with peers.

Commenters were mixed in their support of the proposed cohort structure. Commenters not supportive of this approach suggested that performance should be based solely on comparison to prior year performance, while others suggested comparisons using national data for all HHAs. CMS in response believes that dividing HHAs into large and small cohorts results in a higher likelihood of fair and accurate performance comparisons. CMS finalizes the large and small cohort structure as proposed.

CMS finalizes its proposal to use quarterly performance reports for HHAs, starting with data collected for the January 1, 2016 to March 31, 2016 performance quarter. CMS expects those reports to be available July 1, 2016, with subsequent quarterly performance reports available every three months. Those reports would include an HHA's model-specific performance compared with other competing HHAs within its size cohort/state. In response to commenters' concerns about timeliness of reports, CMS states that it intends to meet all performance report timeline expectations. CMS notes that it will also provide technical assistance and other tools for HHAs in selected states to encourage best practices.

D. Payment Periods

As noted above, the baseline year will be performance data submitted on services provided during 2015. Based on comments received, CMS modifies the final payment adjustment percentages. For example, instead of a maximum percent adjustment of 5 percent (upward or downward) in 2018, CMS modifies the percent adjustment to 3 percent.

The overall schedule is summarized below.

Overview of payment adjustment timeline under the HH VBP			
Baseline data year	Performance year	Payment year	Applicable percentage
2015	2016	2018	3%
	2017	2019	5%
	2018	2020	6%
	2019	2021	7%
	2020	2022	8%

In the case of new market entries, the baseline year will be the first full calendar year of services in the state. In the case of new measures not reported in 2015, the baseline data for that measure will use data from the previous calendar year.

A separate payment adjustment report will be provided annually. The first payment adjustment report will be provided in August 2017 (for the payment adjustment that would be made in 2018). In the final rule, CMS removes the specific day of the month to allow for greater flexibility for the industry and CMS to meet these expectations and to account for the possibility of a specific day falling on a weekend or holiday. HHAs will have a thirty-day preview period, with a process for reconciliation of any data issues (see below).

CMS notes that it may consider, beginning in 2019, revising the payment adjustment schedule and updating the adjustment more frequently than once each year. Specifically, it expects that having payment adjustments transpire through more frequent performance periods would accelerate improvement. For example, this could be operationalized based on overlapping 12-month performance periods that occur every 6 months instead of annually.

Many commenters recommended a delay in the payment adjustment schedule with some suggesting a one-year delay citing the timeline as too aggressive. Several commenters expressed concern about the time lag between performance measurement and payment adjustment. In addition, many commenters expressed concern with both the magnitude of the 8-percent maximum payment risk in 2020 and the proposed 5 percent payment risk for the first year of the model.

In response, CMS states that delaying the payment adjustment limits its ability to understand the intervention's associated effect on quality and that it intends to provide model-specific technical assistance to all competing HHAs. CMS acknowledges there is merit in closing the gap between performance measurement and payment adjustment and that it will continue to closely monitor whether shorter performance assessment cycles are warranted. With respect to concerns about the payment risk, CMS agrees that providing some additional leeway for HHAs to ensure compliance with the model is important and thus is establishing a more gradual payment adjustment schedule that begins with 3 percent in 2018 (see above for full schedule).

E. Quality Measures

CMS proposed a "starter set" of quality measures for the first year of the model. It sets out the policy considerations and data sources it used to select the measures, with the majority using OASIS data currently reported to CMS. Based on comments received, CMS finalizes 6 process measures, 10 outcome measures and 5 HHCAHPS, and three new measures (see summary table). The starter set for PY 1 noted above includes measures from the HHCAHPS. Figures 4a and 4b on pages 68671-68673 describes the measures including details on data source, and what is in the numerator and denominator each measure.

Final PY1 Measures

NQS Domains	Measure Title	Measure Type
Clinical Quality of Care	Improvement in Ambulation-Locomotion	Outcome
Clinical Quality of Care	Improvement in Bed Transferring	Outcome
Clinical Quality of Care	Improvement in Bathing	Outcome
Clinical Quality of Care	Improvement in Dyspnea	Outcome
Communication & Care Coordination	Discharged to Community	Outcome
Communication & Care Coordination	Care Management: Types and Sources of Assistance	Process
Efficiency & Cost Reduction	Acute Care Hospitalization: Unplanned hospitalization during first 60 days of home health	Outcome
Efficiency & Cost Reduction	Emergency Department Use without	Outcome

	Hospitalization	
Patient Safety	Improvement in Pain Interfering with Activity	Outcome
Patient Safety	Improvement in Management of Oral Medications	Outcome
Patient Safety	Prior Functioning ADL/IADL	Outcome
Population/Community Health	Influenza Vaccine Data Collection Period	Process
Population Community Health	Influenza Immunization Received for Current Flu Season	Process
Population Community Health	Pneumococcal Polysaccharide Vaccine Ever Received	Process
Population Community Health	Reason Pneumococcal Vaccine Not Received	Process
Clinical Quality of Care	Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care	Process
Home Health CAHPS: Satisfaction Survey Measures		
Patient & Caregiver Centered Experience	Care of Patients	Outcome
Patient & Caregiver Centered Experience	Communications between Providers and Patients	Outcome
Patient & Caregiver Centered Experience	Specific Care Issues	Outcome
Patient & Caregiver Centered Experience	Overall Rating of Home Health Care	Outcome
Patient & Caregiver Centered Experience	Willingness to Respond to Agency	Outcome
New Measures		
Population/Community Health	Influenza Vaccination Coverage for Home Health Care Personnel	Process
Population/Community Health	Herpes Zoster (shingles) Vaccination: Has the Patient Received the Shingles Vaccination	Process
Communication & Care Coordination	Advance Care Plan	Process

With respect to the "starter set" of quality measures for the first year, CMS received numerous comments stating concerns about a number of issues: (1) the number of measures proposed for use in the model, (2) not all measures in the set are endorsed by NQF, (3) inclusion of measures with respect to the Jimmo v. Sebelius settlement agreement, (4) the use of certain OASIS data elements as a basis for quality, and (5) alignment of measures in the starter set with the requirements of the IMPACT Act. CMS also received many comments with respect to its proposal to adopt four new measures: advance care planning, adverse drug events, staff influenza vaccination coverage, and herpes zoster vaccine (shingles vaccine) for patients.

In response, CMS agrees with commenters about the number of measures and the need to place more emphasis on outcome measures over process measures. For these reasons, CMS reduces the number of process measures by four resulting in a final starter set with six process measures, 10 outcome measures and five HHCAHPS. In addition, CMS reduces the number of new measures from four to three (dropping the adverse event measure). CMS notes its policy that wherever possible NQF measures should be utilized, but that other measures are needed to address quality improvement in HH, and it would make any needed adjustments in future rulemaking. CMS specifies that the Jimmo settlement agreement pertains only to the clarification

of CMS's manual guidance on coverage standards, not payment measures, and expressly does not pertain to or prevent the implementation of new regulations. With respect to the use of OASIS data, CMS states that it intentionally crafted this initial "starter set" to minimize burden and that the majority of measures rely on OASIS data already reported by HHAs. CMS also agrees that the HHVBP measure set should be in alignment with the IMPACT Act and that, for example, once baseline data is available for NQF "#0678 pressure ulcers" it will consider using this measure in future years through rulemaking. CMS also agrees to give HHAs more time to submit data on the new measures. Specifically, HHAs will now be required to submit their first round of data on new measures no later than October 7, 2016 for the period July 2016 through September 2016.

F. Performance Scoring Methodology

CMS finalizes its proposed methodology for scoring HHAs under the HHVBP Model, with one modification to decimal scoring. All achievement and improvement points will be rounded up or down to the third decimal point.

An HHA's total performance score (TPS) will be determined using the higher of the HHA's achievement or improvement score for each measure. All of the performance measures will have equal weight, and would account for 90 percent of the TPS.

Points for "new measures" will be awarded for submission of the data. Data reporting for each new measure is equally weighted, and will account for 10 percent of the TPS.

CMS reports that many of the key elements of the HHVBP scoring methodology would be aligned with the scoring methodology of the Hospital Value-Based Purchasing program.

Points will be awarded only for "applicable measures": that is a measure for which the HHA has provided 20 home health episodes of care per year.

Setting performance benchmarks and thresholds: CMS will set achievement and benchmark thresholds separately for the lower-volume cohort and the higher-volume cohort in each of the nine selected states based on performance during the baseline period (2015).

- The achievement threshold for a measure is the median of all HHA's performance on that measure in that size cohort/state during the baseline period; and
- The benchmark for a measure is the mean of the top decile of all HHA's performance on that measure in that size cohort/state during the baseline period.

For achievement scoring, an HHA will be awarded 0-10 points based on its performance during the performance period on each measure compared with the achievement threshold and the benchmark. Scoring will be based on the following formula:

$$9 \times \frac{\text{HHA Performance Score} - \text{Achievement Threshold}}{\text{Benchmark} - \text{Achievement Threshold}} + 0.5$$

In brief, under the formula:

- For performance at or above the benchmark, 10 points will be awarded.
- For performance below the achievement threshold, 0 points will be awarded.
- For performance between the achievement threshold and the benchmark, 1-9 points will be awarded based on the formula.

All scores will be rounded up or down to the nearest point.

For improvement scoring, an HHA will be awarded 0-10 points based on how much its performance improved during the performance period compared with the baseline period. Thus, each HHA has a unique improvement range for each measure, based on the following formula set out in the proposal:

$$10 \times \frac{\text{HHA Performance Score} - \text{HHA Baseline Period Score}}{\text{Benchmark} - \text{HHA Baseline Period Score}} - 0.5$$

In brief, under the formula:

- For performance at or above the benchmark, 10 points will be awarded.
- For performance below the HHA's baseline period score, 0 points will be awarded.
- For performance greater than the baseline period score but below the benchmark, 1-9 points will be awarded based on the formula.

As with achievement scores, all scores will be rounded up or down to the nearest point. CMS provides examples in Figures 7 and 8 on pages 68684-68685.

As noted above, for new measures, HHAs will be awarded 10 points for reporting, 0 points if they do not report.

The minimum threshold for an HHA to receive a score on a given measure is 20 home health episodes of care per year for HHAs that have been certified for at least 6 months. If an HHA does not meet this threshold to generate scores on five or more performance measures, no payment adjustment will be made.

Computing the total performance score (TPS). The TPS would be calculated as follows.

- Assume an HHA is scored on all 25 performance measures for PY 1, with 10 scores of 7, 10 scores of 8, and five scores of 0. The total score would be 150 (10x7 + 10x8 + 0). That is 150 out of the possible 250 points (25x10), or 60 percent of the possible points. Since these measures account for 90 percent of the TPS, the HHA would receive 54 points.
- Assume that it reported on two of the four new measures. It would receive 20 of the 40 possible points for new measures, or 50 percent of the points. Since the new measures account for 10 percent of the TPS, the HHA would receive 5 points.

- The HHA's TPS would be 54 plus 5 or 59.

In the case of an HHA receiving a score on only 15 (instead of 25) of the measures, its total score on those measures would be divided by 150 (15x10) instead of 250 to determine what percentage of the possible points it had achieved, in order to then determine what portion of the 90 possible points is to be included in the TPS.

Commenters expressed concern that HHAs will not know what benchmark is needed to avoid penalty until the end of the 2015 performance year giving them little time to invest in quality improvement activities. With respect to the proposed methodology for improvement scoring, many commenters opposed awarding credit for improvement noting the concern that the methodology could reward a HHA with a low performance score, but a high improvement score. On the other hand, some commenters favored weighting improvement scores more heavily. Other commenters were concerned about the HHVBP structure that requires that HHAs be penalized each year, regardless of their performance or improvement, even if the difference between the highest and lowest scoring is only a few points. Commenters were supportive of CMS' proposal to allow them to gain full credit toward their TPS on the new measures just for reporting data to CMS.

CMS notes in its response that the 2015 base year achievement threshold and the benchmarks for each cohort will be provided to the HHAs in April 2016 and believes this is sufficient notice. CMS notes its belief that providing opportunities to earn points for both achievement and improvement provides the greatest opportunity for the quality of care to rise for all beneficiaries. In addition, CMS understands commenters concerns, but reiterates that the purpose of the model is to improve quality across the HH sector and notes the HHAs may end up in the bottom decile in relationship to other HHAs in their cohort if their quality does not improve at the same or higher rate than their cohort peers. CMS notes, however, that the amount of the downward payment adjustment could be lessened because performance scoring is anchored to the 2015 benchmark. CMS also makes a modification to decimal scoring finalizing that all achievement and improvement points be rounded up or down to the third decimal point (e.g., an achievement score of 4.5555 would be rounded to 4.556). CMS acknowledges commenters support of its decision to allow attestation for reporting of new measures recognizing that this would allow HHAs time to acclimate to reporting the new measures that have not previously been endorsed for home health.

G. <u>The Payment Adjustment Methodology</u>

In consideration of the comments received, CMS finalizes the proposed payment adjustment methodology with modifications. CMS finalizes the following maximum payment adjustment percentage for each payment year: in 2018, 3 percent; in 2019, 5 percent; in 2020, 6 percent; in 2021, 7 percent; and in 2022, 8 percent.

CMS finalizes it proposal to use a "linear exchange function" (LEF) to translate an HHA's TPS into a percentage of the value-based payment adjustment earned by each HHA under the HHVBP model. CMS will set the function's intercept at zero percent, meaning that those HHAs that have a TPS that is average in relationship with other HHAs in their size cohort/state would

receive zero payment adjustment. There is a different LEF for each of the two size cohorts in each of the nine selected states. Those with a lower than average TPS in the performance year would receive a payment reduction in the payment year, and those with a higher than average TPS would receive a payment increase.

CMS presents an example of the calculation for one HHA size cohort in one state (see text and Figure 9, page 68688). It is summarized in the table below. Working from left to right:

- It sets out a list of eight HHAs, assumes a TPS for each of the HHAs (column 1), and assumes a range of prior year payments to each of the HHAs (column 2).
- It calculates an 8% reduction amount, (column 3) by multiplying the prior year payment (column 2) by 8%. It sums those amounts, and that sum becomes the numerator of the LEF.
- It calculates a TPS adjusted payment reduction amount (column 4) by multiplying the 8% reduction amount (column 3) by the TPS amount divided by 100 (the TPS expressed as a percent of a perfect score of 100). It sums those amounts, and that sum becomes the denominator of the LEF.
- It calculates the LEF (column 5) by dividing the sum of the 8 percent payment adjustment amounts (sum in column 3) by the sum of the TPS adjusted payment reduction amounts (sum in column 4). That yields a standard LEF for all HHAs in this size cohort in this state.
- It calculates an "intermediary value" for a TPS adjusted payment amount (column 6), which is the TPS adjusted reduction amount (column 4) times the LEF (column 5).
- It calculates the quality adjusted payment rate that the HHA would receive instead of the 8 percent reduction in payment (column 7), by dividing the TPS adjusted payment amount (column 6) by the prior year aggregate payments (column 2) and dividing that amount by 100 to express it as a percent.
- Finally, it calculates the final payment adjustment percentage (column 8) by subtracting 8 percent from the quality adjusted payment rate (column 7). This is the payment adjustment that would be applied to HHA final claim amounts for that HHA in the payment year.

Example of Payment Adjustment Methodology using 8% Payment Adjustment Percent (From Figure 9 in Final Rule)								
HHA	TPS	Prior year payments	8% payment reduction amount *(2) * 8%*	TPS adjusted reduction amount *(1)/100*(3)*	Linear Exchange Function (LEF) *Sum (3)/ Sum (4)*	TPS adjusted payment amount *((4)*(5))*	Quality adjusted payment rate *(6)/(2)*100*	Percent payment adjustment percentage *(7)-8%*
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
HHA1	38	$100,000	$ 8,000	$ 3,040	1.93	$ 5,867	5.9%	-2.1%
HHA2	55	$145,000	$ 11,600	$ 6,380	1.93	$12,313	8,5%	+0.5%
HHA3	22	$800,000	$ 64,000	$ 14,080	1.93	$27,174	3.4%	-4.6%
HHA4	85	$653,222	$ 52,258	$ 44,419	1.93	$85,729	13.1%	+5.1%
HHA5	50	$190,000	$ 15,200	$ 7,600	1.93	$14,668	7.7%	-0.3%
HHA6	63	$340,000	$ 27,200	$ 17,136	1.93	$33,072	9.7%	+1.7%
HHA7	74	$660,000	$ 52,800	$ 39,072	1.93	$75,409	11.4%	+3.4%
HHA8	25	$564.000	$ 45,120	$ 11,280	1.93	$21,770	3.9%	-4.1%
		SUM	$276,178	$143,007		$276,002		

Note that the result illustrates what is intended by CMS under the final rule: HHAs with a higher TPS receive higher payment adjustments, and those with a lower TPS receive lower and negative adjustments. For example, HHA4, with a TPS of 85, would receive a 5.1% payment increase on each claim in the payment year, and HHA3, with a TPS of just 22, would face a 4.6% reduction.

Several commenters raised concerns with the magnitude of the 8-percent maximum payment risk citing, among other concerns, that it might threaten the viability of HHAs and limit their ability to reinvest in infrastructure and conduct care coordination. CMS, in response, notes that the model does not reduce the overall payments to HHAs and, as a result, the aggregate average margins of all competing HHAs will be unaffected by the model. In addition, CMS further points out that only HHAs with very poor quality of care, relative to their competing cohort, would be subject to the highest downward payment adjustments. CMS, however, does modify its policy to establish a more gradual payment adjustment schedule.

H. Preview and Period to Request Recalculation

CMS finalizes its proposal with modifications to when the recalculation form must be submitted.

An HHA will have the opportunity to review quarterly performance reports, within 30 days (rather than 10 as in the proposed rule) to request a recalculation of a measure if it believes there is evidence of a discrepancy. In the same manner, HHAs will have an opportunity to review annual payment adjustment amounts, provided each August prior to the payment year, starting with August of 2017. The final TPS and payment adjustment would then be provided to the HHA no later than 60 days in advance of the payment adjustment taking effect.

I. Evaluation

CMS finalizes its proposal to conduct an independent evaluation, with analyses at the state, HHA and patient levels. The evaluation will focus primarily on understanding how successful the model is in achieving quality improvement, and will also examine the likelihood of unintended

consequences. The evaluation will require participating HHAs to submit additional data for evaluation purposes, in compliance with regulatory requirements.

Several commenters expressed concern that beneficiary access may be affected as HHAs may avoid treating beneficiaries that could have a negative impact on their performance scores. Others suggested that CMS employ a process to continuously monitor quality improvement and evaluate other aspects of the model. CMS states that beneficiary access to care is of paramount concern and that its monitoring and evaluation designs will be able to detect the types of concerns noted by commenters. In addition, CMS agrees that competing HHAs should have every opportunity to share lessons learned from the model and that the model contains multiple mechanisms for doing so: use of a model-specific website, a collaboration website, and model-specific technical assistance.

V. Provisions of the Home Health Care Quality Reporting Program (HH QRP) (68690-68710)

A. Background and Statutory Authority

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.

CMS notes two newer laws which it addresses in the final rule. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113-185) imposes 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 notes that it intends to follow the same timing and sequence of events for measures specified in the IMPACT Act that it currently follows under the HH QRP. It intends to require HHAs to report data on any finalized measure for the year that begins 2 years after the specified application date for that measure.

The Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93) directed the Secretary not to adopt ICD-10 prior to October 1, 2015. Since the OASIS-C1 data item set used for HHA reporting had been revised to include five data elements that required the use of ICD-10 codes, CMS made interim changes to the OASIS-C1 data item set to allow its use with ICD-9 codes until that October 1, 2015 implementation date, and solicited a new information collection request to the Office of Management and Budget. Information on the OASIS-C1 can be located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1.html.

CMS received multiple public comments pertaining to the general timeline and plan for implementation of the IMPACT Act, sequencing of measure implementation, and standardization of PAC assessment tools. In response, CMS notes that it intends to adopt

measures that comply with the IMPACT Act in a manner that is consistent with the sequence it follows in other quality reporting programs. CMS also notes that it has provided multiple opportunities for stakeholder input and that it looks forward to continued and regular input from the provider communities as it continues to implement the IMPACT Act. CMS also agrees that standardization is important for data comparability and outcome analysis and that it is working to ensure that measures required under the IMPACT Act are standardized and aligned across the assessment instruments. CMS also stated that it would take under consideration a suggestion requesting that, in the future, cross-setting measures and assessment data changes related to the IMPACT Act be addressed in one stand-alone notice and rule that applies to all four post-acute care settings.

B. General Considerations Used for the Selection of Quality Measures for the HH QRP

CMS reviewed its approach to adopting measures for the HH QRP and its process for developing measures for this final rule.

C. HH QRP Quality Measures Under Consideration for Future Years

The CMS Home Health Quality Initiative website identifies the current HH QRP measures at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html

CMS finalizes its proposal to adopt one standardized cross-setting new measure for 2016 to meet the requirements of the IMPACT Act: this measure addresses the domain of skin integrity and changes in skin integrity using the following NQF-endorsed measure:

> Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678). See http://www.qualityforum.org/QPS/0678.

This measure reports the percent of patients with Stage 2 through 4 pressure ulcers that are new or worsened since the beginning of the episode of care. CMS notes that data collection for this measure began on January 1, 2015, through the OASIS-C1. It will be used for the 2018 HH payment determination and subsequent years. The data items include M1308 (Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable) and M1309 (Worsening in Pressure Ulcer Status Since SOC/ROC).

CMS notes that it is considering a future update for NQF #0678 to include in the numerator of the measure unstageable pressure ulcers, including suspected deep tissue injuries (sDTIs), as well as Stage 1 or 2 pressure ulcers that became unstageable. CMS is also considering whether body mass index (BMI) should be used as a covariate for risk-adjustment. CMS invited public feedback on these items.

CMS has identified future, cross-setting measure constructs in four domains to potentially meet requirements of the IMPACT Act for implementation on January 1, 2017. The four domains are (1) all condition risk-adjusted potentially preventable hospital readmission rates; (2) resource use, including total estimated spending per beneficiary; (3) discharge to community; and (4)

medication reconciliation. Table 19 on page 68701 presents the specific measures in these four domains for which CMS sought comment. CMS also identifies seven priority areas for future measure development in Table 20 on page 68702.

The majority of commenters supported the addition of the proposed quality measure with respect to pressure ulcers. Some commenters were concerned about the fairness of using this measure to compare performance within home health and across post-acute care providers. In response, CMS states that it intends to provide specific guidance through the OASIS manual and provider trainings to support clinicians in appropriately coding the stages of pressure ulcers to ensure standardization of reporting. In addition, CMS notes that it will monitor the impact of sociodemographic status on facilities' results on its measures. CMS also received comments on future, cross-setting measures and a discussion of those measures can be found on pages 68699-68703.

D. Form, Manner, and Timing of OASIS Data Submission for Annual Payment Update (page 242)

CMS finalizes its proposals to implement an 80 percent Pay-for-Reporting Performance Requirement for Submission of OASIS Quality Data for the Year 2 reporting period July 1, 2016 to June 30, 2017, and a 90 percent Pay-for-Reporting Performance Requirement for the Year 3 reporting period.

By way of background, CMS in the 2015 final rule finalized standards and a formula for the OASIS assessments that HHAs must submit in order to meet the pay-for-reporting requirements. It incorporated a principle that each HHA would be expected to submit a minimum set of two "matching" assessments for each patient to create what CMS would consider to be a "quality episode of care." Ideally, that would include a Start of Care (SOC) or Resumption of Care (ROC) assessment, and a matching End of Care (EOC) assessment. CMS reviews several scenarios spelled out in the final rule that could meet that standard for a "quality episode of care" in different patient situations.

In the event that SOC, ROC, and EOC assessments do not meet any of the definitions set out, they are labeled as "nonquality" assessments in the formula below. CMS instituted a "Quality Assessments Only" (QAO) formula to measure performance. Only those OASIS assessments meeting one of the standards would be counted as a "quality assessment." SOC, ROC and EOC assessments not meeting one of the standards would be counted as a "nonquality assessment." The QAO formula expresses the percentage of assessments that are quality assessments, as follows:

$$\text{QAO} = \frac{(\text{\# of quality assessments})}{(\text{\# of quality assessments plus \# of nonquality assessments})} * 100$$

CMS noted in the proposed rule that its ultimate goal is that HHAs would have to achieve a compliance rate of 90 percent quality assessments under this QAO formula in order to meet the pay-for-reporting requirement and avoid the 2 percent payment reduction. Last year, it set a QAO standard of 70 percent for episodes beginning between July 1, 2015 and June 30, 2016

(effective for the annual payment update in 2017), but did not finalize its proposed phased increases of 10 percentage points per year over the next two years to reach the 90 percent level.

In the 2016 final rule, CMS implements a 10 percentage point increase in the QAO standard in each of the next two years, as shown in the following table.

Summary of current and final phasing schedule for QAO standard		
Reporting period	**QAO Performance Standard**	**Effective for Annual Payment Update**
Current policy (2015 Final Rule)		
Episodes beginning on or after July 1, 2015 through June 30, 2016	70 %	2017
Final rule		
Episodes beginning on or after July 1, 2016 through June 30, 2017	80%	2018
Episodes beginning on or after July 1, 2017 through June 30, 2018	90%	2019

Several commenters supported CMS' proposed phased-in approach for the QAO reporting requirements. A few commenters encouraged CMS to defer the increase to 90 percent beyond the schedule included in the rule and maintain 80 percent. In addition, one commenter wanted clarification on whether the QAO calculation includes Medicare Advantage and Medicaid patients, in addition to traditional Medicare. In response, CMS appreciated the support, but states that it does not intend to defer the increase to 90 percent; based on its analysis compliance is already at this level for the vast majority of agencies. CMS clarifies that patients receiving care under a Medicare or Medicaid managed care plan are not excluded from the OASIS reporting requirement, and that HHAs are required to submit OASIS assessments for these patients.

E. Home Health Care CAHPS® Survey (HHCAHPS)

CMS reviews background on the development and implementation of the HHCAHPS Survey. CMS makes no changes to the HHCAHPS requirements for 2016. It reviews the previously established reporting requirements, oversight activities to ensure that survey vendors comply with HHCAHPS protocols, and requirements for HHCAHPS data collection and reporting, and the reconsideration and appeals process.

The HHCAHPS data collection and reporting requirements for annual performance periods for Annual Payment Updates (APU) are as follows:

Overview of HHCAHPS data collection and reporting schedule	
HHCAHPS data collection and reporting for each quarter in the following performance periods	**Effective for APU**
2nd Q 2014 through 1st Q 2015	2016
2nd Q 2015 through 1st Q 2016	2017
2nd Q 2016 through 1st Q 2017	2018

Reports are due three months and 15 days following the completion of each calendar quarter. CMS sets out exceptions for HHAs receiving Medicare certification after the beginning of one of the annual performance periods, and requires that HHAs with fewer than 60 HHCAHPS eligible unique patients in the annual performance period submit the Participation Exemption Request Form.

F. Public Display of Home Health Quality Data for the HH QRP

CMS reviews the requirements for making data on HHA performance available to the public. Beginning April 1, 2015, HHAs began to receive Provider Preview Reports for all process and outcomes measures on a quarterly, rather than an annual basis, so that the agencies have an opportunity to review the data before it is made public. The HH QRP has developed a CMS HH Compare website (http://www.medicare.gov/HHCompare/Home.asp for home health agencies; a subset of quality measures has been made publicly available on HH Compare since 2003.

To provide consumers a summary of existing quality measures, CMS published a star rating based on the quality of care measures for home health agencies on HH Compare starting in July 2015. Each HHA is assigned a rating between one and five stars. HHAs are eligible to receive a star rating if they have quality data reported on at least five of the nine quality measures included in the calculation. The quarterly preview of data provided to HHAs starting in April 2015 includes their star rating, providing them an opportunity to review and provide feedback. The methodology and additional information about the star rating system is at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.

VI. Collection of Information Requirements (page 68710)

The rule does not add new, or revise any of the existing information collection requirements. As previously noted, the extension of OASIS-C1 reporting using ICD-9 and the transition to ICD-10 versions have been previously submitted to OMB (see page 17).

VII. Regulatory Impact Analysis (pages 68710-68716)

CMS provides a regulatory impact of the HH PPS changes which is summarized below.

Summary of overall regulatory impact analysis		
Policy	**2016 impact**	
	Percentage	**Dollars**
HH PPS update	+ 1.9%	+$345 million
Third year of rebasing	- 2.4%	-$440 million
Nominal case-mix growth adjustment	-0.9%	-$165 million
Net impact	-1.4%	-$260 million

Table 21 on pages 68713-68714 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 22 on page 68715 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. It is based on what would have happened with a baseline year of 2013 and performance year of 2014 in the two size cohorts in the nine selected states, on 10 process and outcome measures currently available on Home Health Compare. 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			
	Lowest, 10th percentile	50th percentile	Highest, 90th percentile
3% payment adjustment (year 1)	-1.8%	0.09%	2.82%
5% payment adjustment (year 2)	-2.98%	0.16%	4.71%
6% payment adjustment (year 3)	-3.60%	0.18%	5.64%
7% payment adjustment (year 4)	-4.17%	0.22%	6.60%
8% payment adjustment (year 5)	-4.77%	0.25%	7.54%

In Table 23 on page 68715, CMS presents the estimates for the two size cohorts in each of the nine states, and Table 24 on pages 68715-68716 presents the estimates by beneficiary characteristic, including dual eligibility, acuity, rural status, and organizational type. CMS notes that a higher proportion of dual-eligible patients is associated with better performance, but that the payment adjustments are consistent across the other categories.