American Hospital Association™
Advancing Health in America

Special Bulletin

Thursday, November 1, 2018

CMS Issues Final Home Health PPS CY 2019 Update and CY 2020 Redesign

The Centers for Medicare & Medicaid Services (CMS) Oct. 31 issued a final rule that updates the home health (HH) prospective payment system (PPS) for calendar year (CY) 2019 and also makes changes to the HH quality reporting program. In addition, in accordance with the statutory mandate in the Bipartisan Budget Act (BiBA) of 2018, the rule finalizes a redesign of the payment system in CY 2020, largely as proposed.

While we support the general approach of the CY 2020 redesign under the Patient Driven Groupings Model, we are disappointed that CMS is proceeding with prospective behavioral adjustments based on assumptions rather than evidence.

Watch for detailed Regulatory Advisory in the coming weeks. In addition, AHA's HH members will receive a separate invitation to a member call to discuss the final rule, scheduled for Wednesday, Nov. 28, at 12:00 p.m. ET.

Key Takeaways

The final rule will:

- For CY 2019, increase net HH payments by 2.2 percent.
- In CY 2020, overhaul the HH PPS by replacing the current therapy-driven payment system with a new model that relies on a broader clinical profile of the patient. It will be budget-neutral overall, but increase payments for facility-based HH agencies by 3.0 percent.
- Remove seven quality measures from the HH Quality Reporting Program.
- Remove/replace five measures in the HH Value-based Purchasing Program and adjust the performance calculation.
- Create safety and payment standards for new home infusion therapy services.
- Add one new requirement for all accreditation organizations.

CY 2019 Payment Update

The CY 2019 payment provisions in this rule are straightforward, with minimal material policy changes. **Specifically, CY 2019 payments will increase by a net 2.2 percent, or $420 million, after all policy changes, compared to 2018 payment levels.** This increase includes:

- A 3.0 percent market-basket update.
- A statutorily-mandated productivity adjustment of negative 0.8 percentage point.

- A 0.1 percentage point increase in high-cost outlier payments due to lowering the fixed dollar loss ratio in order to set outlier payments at no more than 2.5 percent of total payments.
- A 0.1 percentage point decrease in payments due to the new, BiBA-mandated rural add-on methodology that applies varying add-on payments for CYs 2019 through 2022 based on a HH agency's rural county designation.

FY 2019 HH Quality Measurement Changes

Changes to the Home Health Quality Reporting Program (HH QRP). CMS finalized its proposal to replace the current criteria used to consider a HH QRP quality measure for removal with the eight criteria that are used in the other post-acute care quality reporting programs. These criteria will continue to be applied on a case-by-case basis, and will identify measures for removal if provider performance on the measure was uniformly high and unvarying, if performance on the measure did not result in better patient outcomes, if better (e.g., more clinically valid or more broadly applicable) measures are available, if use of the measure leads to unintended negative consequences, or if the costs associated with the measure outweigh the benefits of its continued use.

Using these criteria, CMS will remove seven quality measures from the HH QRP beginning with the CY 2021 program year. The measures that will be removed include:

- Depression Assessment Conducted
- Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care
- Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate
- Pneumococcal Polysaccharide Vaccine Ever Received
- Improvement in the Status of Surgical Wounds
- Emergency Department Use without Hospital Readmission during the First 30 Days of HH
- Rehospitalization during the First 30 Days of HH

HH agencies will no longer be required to submit several OASIS items for the HH QRP beginning Jan. 1, 2020, and data for these measures will no longer be publicly displayed on *Home Health Compare* after Jan. 1, 2021. However, many of the same items will still need to be collected to inform risk adjustment of other OASIS-based outcome measures.

Standards for Home Infusion Therapy Services. Section 5012 of the 21st Century Cures Act established a new home infusion therapy benefit, which covers the nursing, patient training and education, and monitoring services associated with administering infusion drugs in a patient's home. In this rule, CMS establishes health and safety standards for this therapy as well as regulations for the approval and oversight of organizations that provide accreditation to home infusion therapy suppliers. In addition, CMS also establishes standards for consistency in payment coverage for the services, and provides information on temporary transitional payments for the services in CYs 2019 and 2020.

Changes to the HH Value-Based Purchasing (HHVBP) Program. The HHVBP program, currently a pilot with mandated participation for providers in nine states, was implemented on Jan. 1, 2016. CMS will remove two OASIS-based process measures for the fourth performance year (CY 2019) of the HHVBP program: Influenza Immunization Received for Current Flu Season and Pneumococcal Polysaccharide Vaccine Ever Received. In addition, CMS will replace three other OASIS-based measures with two composite measures. The measures that will be replaced are: Improvement in Bathing, Improvement in Bed Transferring, and Improvement in Ambulation-Locomotion. In their place, CMS will adopt: Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility. These two measures will be calculated based on existing Activities of Daily Living (ADL) items that HH agencies already collect.

CMS also finalized its proposal to reweight the measures used in the HHVBP program. Currently, OASIS-based measures, claims-based measures and HHCAHPS measures are all weighted equally. In this rule, CMS finalizes its proposal to give higher weights to claims-based measures. CMS believes this change "would better support improvement in those measures" – in other words, if claims-based measures contribute more to the Total Performance Scores, CMS reasons, providers will work harder to improve their performance on those measures. Provider performance on OASIS-based measures has improved significantly over the past few performance years, while performance on claims-based measures has not.

Changes to the Accreditation Requirements. CMS also includes a provision not specific to HH agencies, but rather applicable to all accrediting organizations (AOs). To participate in the Medicare program, providers and suppliers of health care services must comply with health and safety requirements called Conditions of Participation (CoPs). Under an agreement with CMS, state health departments or similar AOs survey providers and suppliers survey HH agencies to ascertain compliance with applicable CoPs. CMS is responsible for the review, approval and subsequent oversight of national AOs' Medicare accreditation programs, and AOs must reapply for renewed CMS approval of an accreditation program before the current program expires.

In this rule, CMS finalizes one of two proposed requirements for AOs: if a fully accredited facility in good standing provides written notification that it wishes to voluntarily withdraw from the AO's CMS-approved accreditation program, the AO must continue the facility's accreditation until the effective date of the withdrawal identified by the facility or the expiration date of the accreditation, whichever comes first. This change is in response to several complaints from providers that AOs frequently immediately terminate the provider's accreditation upon notice of intent to voluntarily withdraw accreditation, even if the provider has already paid fees through the end of the accreditation period or requests to extend accreditation until the end of that period.

CMS did not finalize its proposal regarding new requirements for training for AO surveyors. CMS originally proposed that AO surveyors be required to complete the relevant program-specific CMS online trainings initially and then consistently thereafter, as required by CMS. In addition, all AO surveyors would be required to take the CMS

online surveyor training, and each AO would have to provide CMS with documentation proving that each surveyor in the AO completed the training. Based on public comments noting the vagueness of the proposals and the lack of evidence that the proposed requirements would result in more accurate surveys, the agency declined to finalize the requirements.

CY 2020 REDESIGN OF THE HH PPS

The BiBA requires CMS to redesign the HH PPS in a budget-neutral manner by CY 2020. This includes a transition from a 60-day to 30-day episode of care and a shift from payments based largely on therapy volume to payments based on a broader clinical profile of the patient.

In response to this mandate, this rule finalizes the Patient-Driven Groupings Model (PDGM), largely as set forth in the proposed rule. The PDGM relies on clinical characteristics and other patient information, rather than on the current therapy thresholds, to set payments. Specifically, with what appear to be relatively minor changes to the structure of last year's model, patients would be assigned to a PDGM payment category based on key elements of the patient's clinical profile:

- *Admission source*. Institutional referrals will be paid more than community-based referrals.
- *Timing of the episode*. The first episode will be paid more than subsequent episodes in a sequence.
- *Primary diagnosis*. The patient's primary diagnosis will influence the payment amount, with diagnoses organized in these six categories:
    - medication management teaching and assessment;
    - neuro/stroke rehabilitation;
    - wounds (post-op wound aftercare and skin/non-surgical wound care);
    - complex nursing interventions;
    - musculoskeletal rehabilitation; or
    - behavioral health.
- *Functional level*. A payment add-on will be made based on a patient's functional level, depending on whether the functional level is considered low, medium or high. The three functional level categories will be based on the distribution of levels found in the claims for a preceding year, with those levels divided into approximately even thirds.
- *Comorbidity*. Patients with one qualifying secondary diagnosis will receive a "low" comorbidity adjustment, and those with at least two qualifying conditions will receive a "high" comorbidity adjustment.

Per a statutory requirement, CMS will implement the PDGM in a budget-neutral fashion and will incorporate a prospective budget-neutrality adjustment based on three assumptions of how HH agency behavior will change under the new model:

- *Clinical Group Coding*. CMS assumes that HH agencies will change their documentation and coding practices and designate the highest-paying diagnosis

as the principal diagnosis code. Under the PDGM, this would result in a 30-day period being placed in a higher-paying clinical group.

- *Comorbidity Coding*. Since the PDGM adjusts payments based on secondary diagnoses reported on the HH claim, more 30-day periods of care will receive a comorbidity adjustment than if the model only used the more limited OASIS diagnosis codes, which is current practice. Under the PDGM, the comorbidity adjustment can increase payments.
- *LUPA Threshold*. CMS assumes that under PDGM, HH agencies will provide one to two extra visits for about 1/3 of low-volume episodes to qualify for a full 30-day episode payment.

While the proposed rule estimated that, collectively, these assumptions would produce a -6.42 percent behavioral adjustment, the final rule notes that a particular behavioral adjustment amount will not be specified until the agency's CY 2020 rulemaking using the most recent data that are available at that time.

Finally, CMS has released provider-level impact estimates for the PDGM, as well as interactive grouper that allows providers to determine case-mix weights for their patient populations. These resources are available at https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.

NEXT STEPS

Watch for a more detailed Regulatory Advisory and an invitation to an AHA members-only call on Wednesday, Nov. 28, to discuss the final rule.

If you have further questions on the payment provisions, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org; for questions on quality provisions, contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.