Medicare Home Health Proposed Rule
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CY2019 Proposed Medicare Home Health Rate Rule…and Much More

- **Published July 2, 2018**
- **https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14443.pdf**
- **Includes:**
  - **CY 2019 rates (2.1% increase over 2018)**
  - **Rural add-on**
  - **HHVBP demonstration program fine tuning**
  - **Quality measures modifications**
  - **2020 Payment Model Reform**
  - **Home Infusion Therapy benefit**
  - **Physician certification/recertification documentation standards**

2019 Proposed Payment Rates

TABLE 18: CY 2019 60-DAY NATIONAL, STANDARDIZED

60-DAY EPISODE PAYMENT AMOUNT

CY 2018 National, Standardized 60-Day Episode	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality	CY 2019 HH Payment Update	CY 2019 National, Standardized 60-Day Episode
$3,039.64	X 0.9991	X 1.0163	X 1.021	$3,151.22

2019 Proposed Payment Rates

TABLE 20: CY 2019 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

HH Discipline	CY 2018 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2019 HH Payment Update	CY 2019 Per-Visit Payment
Home Health Aide	$64.94	X 1.0000	X 1.021	$66.30
Medical Social Services	$229.86	X 1.0000	X 1.021	$234.69
Occupational Therapy	$157.83	X 1.0000	X 1.021	$161.14
Physical Therapy	$156.76	X 1.0000	X 1.021	$160.05
Skilled Nursing	$143.40	X 1.0000	X 1.021	$146.41
Speech- Language Pathology	$170.38	X 1.0000	X 1.021	$173.96

2019 Proposed Payment Rates

TABLE 23: CY 2019 NRS PAYMENT AMOUNTS
FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

Severity Level	Points (Scoring)	Relative Weight	CY 2019 NRS Payment Amounts
1	0	0.2698	$ 14.61
2	1 to 14	0.9742	$ 52.74
3	15 to 27	2.6712	$ 144.62
4	28 to 48	3.9686	$ 214.86
5	49 to 98	6.1198	$ 331.33
6	99+	10.5254	$ 569.85

Rural add-on

- **Revised by BiBA 2018**
  - **Low Population Density HHAs (counties with 6 or fewer people per square mile)**
    - **4% add-on in 2019**
    - **3% add-on in 2020**
    - **2% add-on in 2021**
    - **1% add-on in 2021**
  - **High utilization counties (top quartile of utilization on average)**
    - **1.5% add-on in 2019**
    - **.5% add-on in 2020**
  - **All other rural areas (All MA rural counties)**
    - **3% add-on in 2019**
    - **2% add-on in 2020**
    - **1% add-on in 2021**

Rural Add-on

- CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
- High Utilization (2015 data)
  - Top quartile in episodes per 100 enrollees
  - 510 rural counties (778 total)
- Low Population Density [not otherwise "high utilization" (2010 Census data)
  - 6 or fewer people per square mile
  - 334 counties
- All Other
  - 1162 counties

2019 Proposed Payment Rates

- Market Basket Index
  - Rebased input factors
  - 76.1% labor-related share
  - 2.8% update
  - 0.7% Productivity Adjustment
  - 2% reduction w/o quality data submission
- Multiple wage index area changes

2019 Proposed Payment Rates

- 2019 Outlier Formula
  - Continuing the cost per 15 minute unit approach
    - Amount to be published in the 2019 rate change request
  - Loss sharing ratio stays ay .80
  - Fixed Dollar Loss ratio change from 0.55 to 0.51
    - Needed to spend the 2.5% outlier budget
    - Would increase incidence of outliers
- CMS provides an ALS patient outlier illustration
  - $25k+ cost with $20k reimbursement

Medicare Home Health Payment Reform

- Planning ongoing for several years
- New model intended to address:
  - Access to care for vulnerable patients
  - Elimination of therapy volume as payment rate determinant
    - Longstanding MedPAC, CMS, Congressional, and Industry concerns

Bipartisan Budget Act of 2018 (BiBA)

- **Mandates payment model reform**
  - **2020**
  - **Budget neutral transition**
  - **Behavioral adjustment guardrails**
  - **Stakeholder involvement**
  - **Prohibits therapy volume thresholds for payment amount**
  - **30-day payment unit**
- **MBI (inflation update) set at 1.5% in 2020**

Recommended Reform Principles

- **Budget neutral transition to any new payment model.**
- **No incentives that trigger undesirable behavioral changes**
- **Sufficient reimbursement to cover the entire scope of the home health benefit**
- **Payment amounts should be based on patient characteristics and clinical needs**
- **The payment model should operate consistently with other aspects in service delivery.**
- **All stakeholders should be given sufficient time to implement any changes in operations**
- **Significant changes in payment models should be fully tested and validated**

PDGM Model: HHGM Revisited

- **Patient-Driven Groupings Model (PDGM)**
  - **216 payment groups**
  - **Episode timing: "early" or "late"**
  - **Admission source: community or institutional**
  - **Six Clinical groupings**
  - **Functional level**
  - **Comorbidity adjustment: secondary diagnosis based**

PDGM NOTABLES

- **Therapy volume domain eliminated**
- **Cost per minute + NRS approach to resource use**
- **30 day periods within 60 day episode**
- **Admission source (Hospital or PAC 14 days prior to early episode)**
- **Six clinical groups**
- **OASIS-based functional analysis**
- **Secondary diagnosis adjustment**
- **Regression analysis (2017 base)**

PDGM NOTABLES

- **Budget Neutral transition**
- **Behavioral Adjustments (6.42%)**
  - **Diagnosis coding**
  - **Commorbidities**
  - **LUPA avoidance**
- **$1753.68 "unit of payment" ($1607 w/HHGM)**
- **LUPA: 2-7 visits @ 10th percentile value of total visits in payment group**
- **RAP continues except for new HHAs**
- **Outlier based on 30 day unit of payment**

PDGM Behavioral Adjustment/Rates

Behavioral Assumption	30-day Budget Neutral (BN) Standard Amount	Percent Change from N Behavioral Assumption
No Behavioral Assumptions	$1,873.91	
LUPA Threshold (1/3 of LUPAs 1-2 visits away from threshold get extra visits and become case-mix adjusted)	$1,841.05	-1.75%
Clinical Group Coding (among available diagnoses, one leading to highest payment clinical grouping classification designated as principal)	$1,793.69	-4.28%
Comorbidity Coding (assigns comorbidity level based on comorbidities appearing on HHA claims and not just OASIS)	$1,866.76	-0.38%
Clinical Group Coding + Comorbidity Coding	$1,786.54	-4.66%
Clinical Group Coding + Comorbidity Coding + LUPA Threshold	$1,753.68	-6.42%

PDGM Measure: Timing of Care

TABLE 34: AVERAGE RESOURCE USE BY TIMING (30-DAY PERIODS)

Timing	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Early 30-Day Periods	$2,113.66	2,785,039	32.3%	$1,236.30	$1,232.23	$1,866.79	$2,707.04
Late 30-Day Periods	$1,311.73	5,839,737	67.7%	$1,125.44	$534.82	$987.94	$1,735.69
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 37: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE: COMMUNITY, INSTITUTIONAL, AND OBSERVATIONAL STAYS

	Average Resource Use	Number of 30-day Periods	Percent of 30-day Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,350.90	6,242,043	72.4%	$1,114.94	$564.31	$1,048.86	$1,799.27
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Observational Stays	$1,820.06	166,762	1.9%	$1,180.96	$960.15	$1,589.08	$2,399.68
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

PDGM Measure: Source of Admission

TABLE 35: AVERAGE RESOURCE USE BY ADMISSION SOURCE (14 DAY LOOK-BACK; 30 DAY PERIODS) ADMISSION SOURCE, COMMUNITY AND INSTITUTIONAL ONLY

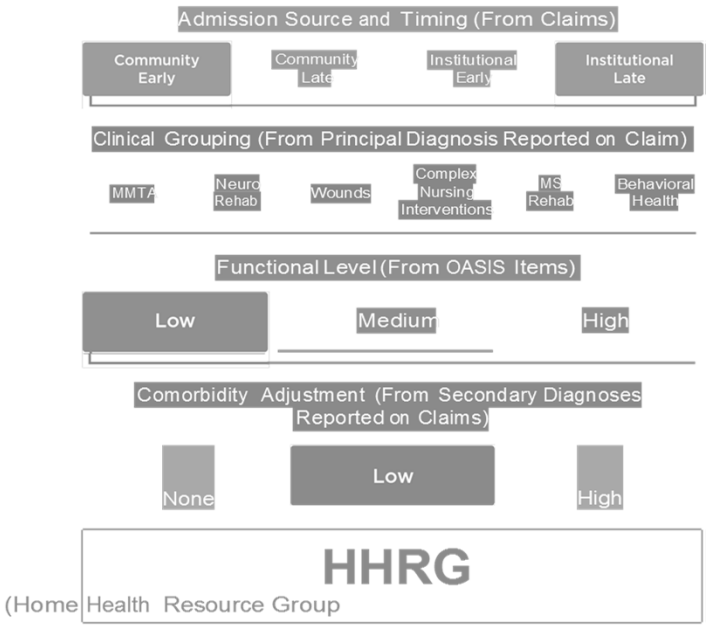
	Average Resource Use	Frequency of Periods	Percent of Periods	Standard Deviation of Resource Use	25th Percentile of Resource Use	Median Resource Use	75th Percentile of Resource Use
Community	$1,363.11	6,408,805	74.3%	$1,119.20	$570.26	$1,062.05	$1,817.75
Institutional	$2,171.00	2,215,971	25.7%	$1,303.24	$1,246.05	$1,920.06	$2,791.91
Total	$1,570.68	8,624,776	100.0%	$1,221.38	$679.12	$1,272.18	$2,117.47

Clinical Groups

TABLE 40: PROPOSED CLINICAL GROUPS USED IN THE PDGM

Clinical Groups	**The Primary Reason for the Home Health Encounter is to Provide:**
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions, including substance use disorders
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups.

FIGURE 4: STRUCTURE OF THE PDGM



PDGM Estimated Impacts

	Number of Agencies	PDGM
All Agencies	**10,480**	**0.0%**
Facility Type and Control		
Free-Standing/Other Vol/NP	1,055	2.6%
Free-Standing/Other Proprietary	8,309	-1.2%
Free-Standing/Other Government	260	1.1%
Facility-Based Vol/NP	604	3.8%
Facility-Based Proprietary	76	4.4%
Facility-Based Government	176	4.6%
Subtotal: Freestanding	9,624	-0.4%
Subtotal: Facility-based	856	3.9%
Subtotal: Vol/NP	1,659	2.9%
Subtotal: Proprietary	8,385	-1.2%
Subtotal: Government	436	2.9%

PDGM Estimated Impacts

Facility Location: Region of the Country (Census Region)		
New England	354	2.5%
Mid Atlantic	479	3.1%
East North Central	2,012	-1.1%
West North Central	703	-3.9%
South Atlantic	1,643	-5.3%
East South Central	423	0.9%
West South Central	2,750	4.1%
Mountain	675	-5.2%
Pacific	1,400	3.8%
Other	41	11.0%

Early Concerns/Issues

- **Impact on therapy patients**
  - **Regression-based methodology includes therapy volume**
  - **Change in costing methodology reduces case weights, i.e. payment amounts**
- **Incentives to focus on inpatient discharges and avoid community admissions**
- **LUPA structure change**
- **Clinical groupings heavy on MMTA**
- **Big swings for some HHAs**
- **Behavioral adjustment "wild card"**

PDGM Tools

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-P.html
  - CY2019 HH PPS Wage Index [ZIP, 105KB]
  - CY2019 HH PPS Proposed Case-Mix-Weights [ZIP, 13KB]
  - PDGM Grouper Tool [ZIP, 1MB]
  - CY 2019 through CY 2022 Rural Add-on Payments: Analysis and Designations [ZIP, 479KB]
  - PDGM Weights and LUPA Thresholds [ZIP, 30KB]
  - PDGM Agency-Level Impacts, Estimated for CY 2019 [ZIP, 1MB]
  - Summary of the Home Health Technical Expert Panel Meeting [PDF, 1MB]

2019 Proposed Rate Update Rule: Other Parts

- **Physician certification/ recertification**
- **VBP**
- **HHQRP**
- **Home Infusion Therapy Benefit**
- **Request for information**
- **Remote monitoring**

Physician Certification

Determining patient eligibility for HHS

- **Codify in the regulation**
  - **Documentation from the HHA medical record may be used to support eligibility**
    - **Documentation can be corroborated by other documentation in the physician's record**
    - **Certifying physician's signs and dates the HHA documentation**
    - **HHA documentation can include: POC and the initial and/or comprehensive assessment**

Recommend CMS clarify that the POC with information from the assessment(s) be permitted documentation for the physician to sign and date.

Physician Recertification

- **Eliminate the statement that estimates how much longer skilled services will be needed as part of the recertification**
- **Efforts to reduce burden/ Patient over paperwork initiative**

HHVBP

- **Remove two OASIS based measures**
  - **Influenza Immunization received**
    - **limited in scope**
  - **Pneumococcal Polysaccharide vaccine ever received**
    - **Does not reflect current Advisory Committee on Immunization Practice (ACIP) guidelines**
- **Replace the three ADL measures (improvement in bathing, transfer and ambulation) with two composite measures**
  - **Total Normalized Composite Change in Mobility**
  - **Total Normalized Change in Self Care**
- **Each new composite measure counts for a maximum of 15 points**

HHVBP

Composite Change in Mobility Measure

Total Normalized Composite Change in Mobility measure computes the magnitude of change, either positive or negative, based on the normalized amount of possible change on each of three OASIS based quality outcomes. These three outcomes areas follows:

- **Improvement in Toilet Transferring (M1840)**
- **Improvement in Bed Transferring (M1850)**
- **Improvement in Ambulation/Locomotion (M1860)**

HHVBP

Composite Change in Self-Care Measure

The proposed Total Normalized Composite Change in Self-Care measure computes the magnitude of change, either positive or negative, based on a normalized amount of possible change on each of six OASIS- based quality outcomes. These six outcomes are as follows:

- **Improvement in Grooming (M1800)**
- **Improvement in Upper Body Dressing (M1810)**
- **Improvement in Lower Body Dressing (M1820)**
- **Improvement in Bathing (M1830)**
- **Improvement in Toileting Hygiene (M1845)**
- **Improvement in eating (M1870)**

- **Currently not part of the VBP model**

HHVBP

- **Revising weights for the measures**
  - **OASIS and Claims based measures each count for 35 % of 90% of the TPS**
  - **HHCAPHS counts for 30 % of the 90 % TPS**
  - **Reported measures a.k.a "new" measures count for 10%**
  - **Within the claims based measure: Unplanned hospitalization three times as much as ED use measure 26.25%/8.75%**
  - **Maximum points earned for performance score reduced to 9 points from 10, except for the composite measures. which if approved, would count for 13.5 points**
  - **Weights will change if categories of measure are not reported. i.e. no HHCAHPs measures included in the calculation.**
- **Seeking comments on what information from the annual score and payment reports should be publicly reported**

HHVBP

- **Lots of moving parts**
- **Changes apply to performance year 2019 for payment year 2021, adjustment will be up or down 7%**
- **Strategies for success will need change**
- **Recommend CMS delay implementation by 6 months to a year**

HHQRP

In accord the CMS' Meaningful measure initiative: a parsimonious set and with more meaningful measures

7 measures to be removed from HHC in 2021

- **Depression assessment conducted- too high/still needed for risk adjustment**
- **Diabetic foot care and PT/CG education – too high M2401(a)**
- **Fall risk assessment conducted - too high no longer reported**
- **Pneumococcal Polysaccharide Vaccine ever received does not fully reflect current ACIP guidelines**
- **Improvement of status of surgical wounds – too limited in scope needed for risk adjustment**
- **ED use without hosp. readmission 30 days – a more broadly applicable measure is available 60 hospitalization**
- **Re-hospitalization first 30 days SSA**

HHQRP

- Proposes an additional factor when considering the removal of a quality measure
  - The costs associated with a measure out weight the benefit of its continued use.
- Revise the regulation at §484.250(a) to clarify that not all OASIS data items are needed to comply with the HHQRP
- Proposing to increase the number of years of data used to calculate the MSPB-PAC HH QRP for purposes of display from 1 year to 2 years.
  - reporting still for 2019, or as soon thereafter but using two years of data

Home Infusion Therapy Benefit

- New benefit under Part B
- New supplier designation
- Coverage for associated professionals services for infusion on a pump in the home
- Currently professionals services (nursing services) are not covered under Medicare for beneficiaries receiving home infusion outside the HH benefit

Home Infusion Therapy

- **Benefit for beneficiaries receiving Infusion therapy IV or Subq via a pump that is an item of DME**
- **Only certain infusion drugs are covered under Part B DME (antifungals, chemotherapy, inotropic and some pain medications)**
- **A qualified home infusion therapy supplier is defined as a pharmacy, physician, or other provider licensed by the state where service are provided.**
- **The professional services under the benefit Include:**
  - **Professional services (nursing)**
  - **POC**
  - **Training and education(vascular access site, medications administration and disease management)**
  - **Remote monitoring**
  - **availability 24/ 7**
  - **Patient must be under the care physician, NP, or PA**
- **Intention is to instruct patient /CG on safe administration and care, same as with HHS**

–Accredited as a infusion therapy supplier by an AO approved by CMS (many requirements for the AOs)

Home Infusion Therapy

- **Payment**
  - **Enroll as home infusion therapy supplier**
  - **Bill on a professional claim CMS-1500/837P**
  - **Single payment for day the nurse is in the home and drug is infused**
- **Full implementation in 2021**
- **Transitional period 2019-2020**
  - **DME enrolled as pharmacies and pharmacies already enrolled in Medicare to provide infusion therapy permitted (drugs and pumps)**

Home Infusion Therapy

- **If a beneficiary is receiving HHS by agency that is also a qualified home infusion supplier, CMS will permit the HHA to bill for the infusion therapy services separately under new Part B home infusion benefit???**
- **May allow for additional reimbursement but would require a 20% copay by the beneficiary that otherwise is not require under the HH benefit**

Home Infusion Therapy

Recommendations:

- **CMS to be clear that the new home infusion benefit does not alter infusion services currently provided under the HH benefit**
- **Allow home health agencies to bill under their existing provider number TOB 34x, do not require a separate supplier number/enrollment**
  - **HHAs provide Part B covered services currently under the HHA number (e.g. outpatient therapy)**
- **Allow Medicare certified agencies to be suppliers regardless of state licensure requirements**
- **Require home infusion therapy benefit be available only the beneficiaries not eligible for the HH benefit**
  - **Full access to entitled benefits**

Request for Information (RFI)

Two RFIs

Advancing interoperability

- **CMS recognizes that obstacles to electronic exchange of patient clinical info persist**
- **How can CMS use existing CoP and CfC to advance electronic exchange of info that supports safe transitions of care?**
- **In all post-acute care provider payment rules. NAHC will submit comments similar to comments submitted for the Hospice proposed payment rule**

RFI

- **Seeking information on increasing communication with patients on accessibility and access to charge information.**
  - **price list, chargemaster, etc.**
- **How to Inform patient of out of pocket costs before furnishing services?**

Remote monitoring

- Allow as administrative cost on the cost report
- May not substitute a HH visit
- Cost of remote monitoring will factor into the cost per visit

Physician Certification

- Physician certification documentation support modified
  - Permit incorporation of HHA record into MD record
  - Can use POC as incorporation method???
- Physician recertification statement on how much longer care needed would be rescinded

CONCLUSION

- **2019 Proposed Rule is a lot to digest**
- **2019 payment changes minor, but positive generally**
- **2020 new model is improved over HHGM but still raises important concerns**
- **Other additions fairly positive**
- **HHAs need to plan for operational chnages ASAP**