



Special Bulletin

Thursday, November 2, 2017

CMS Finalizes CY 2018 Home Health PPS Rule

The Centers for Medicare & Medicaid Services (CMS) Nov. 1 issued a [final rule](#) that updates home health (HH) prospective payment system (PPS) payments for calendar year (CY) 2018 and makes changes to the HH quality reporting program (QRP). In addition, as urged by the AHA, the rule did not finalize the major modifications to the PPS, called the home health groupings model (HHGM), that the agency had proposed. On Nov. 17, the AHA will host a call for members to discuss the rule. Watch for details and registration information.

Highlights of key provisions in the final rule follow.

PAYMENT UPDATE

Under the final rule, CY 2018 payments will decrease by a net 0.4 percent, after all policy changes, compared to 2017 payment levels. This decrease includes:

- A 1.0 percent update to current rates, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015;
- A payment reduction due to the sunset of the rural payment add-on. This add-on payment of 3 percent had been provided for services furnished in rural areas. It was initially authorized by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and has been extended several times by subsequent legislation through Dec. 31, 2017; and
- The third and final 0.97 percentage point cut for estimated case mix growth from CYs 2012 through 2014 that the agency states was unrelated to increases in patient acuity.

HH PPS REFINEMENT

In the proposed rule, CMS had set forth a potential major reconfiguration of the HH PPS, the HHGM, which would have taken effect on Jan. 1, 2019. However, as urged by the AHA, CMS did not finalize the HHGM. Instead, the agency stated that it will further engage with stakeholders in moving toward a revised payment system. It also summarized comments on the HHGM as being “generally supportive of the concept of revising the HH PPS case-mix methodology to better align payments with the costs of providing care,” but stated that there were many concerns about the proposed change to move from a 60-day to a 30-day episode, and to implement the model in a non-

budget-neutral manner. **The AHA is pleased that CMS did not implement the HHGM and will, instead, take additional time to consider this complicated model and its effect on patients and providers.** For more information on the HHGM, see our [Regulatory Advisory](#) or [comment letter](#) on the proposed rule.

CHANGES TO THE HH QRP

CMS finalized nearly all of its proposed changes to the CY 2020 HH QRP. First, CMS will remove 235 data elements from 33 Outcome and Assessment Information Set (OASIS) items collected at various points during the episode. CMS purports that these data elements are not used to calculate quality measures, payment rates, or survey outcomes. The agency also will replace a measure addressing pressure ulcer changes, and add two measures to the HH QRP beginning with the CY 2020 program year (data collection beginning Jan. 1, 2019). These measures include Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (which has already been implemented or proposed for implementation in the other post-acute care settings) and Percent of Residents Experiencing One or More Falls with Major Injury.

In response to concerns raised by stakeholders, including the AHA, CMS significantly scaled back its proposal to require HH agencies to collect certain standardized patient assessment data upon admission and discharge for all Medicare patients. In its initial proposal, the agency would have required HH agencies to collect data in five categories including functional status, cognitive function, special treatments and services (e.g., cancer treatments, respiratory treatments and transfusions), conditions and comorbidities, and impairments. However, due to comments noting the significant burden associated with the adoption of these new data elements, CMS will only require HH agencies to collect and submit data on two of the five categories: functional status and conditions/comorbidities. Data for these categories are already required to be reported to calculate existing quality measures and, thus, providers will not face an increased reporting burden.

CHANGES TO THE HH VALUE-BASED PURCHASING (VBP) MODEL

The HH VBP program, currently a pilot with mandated participation for providers in nine states, was implemented on Jan. 1, 2016. In this rule, the AHA is pleased that CMS increased the minimum number of completed Home Health Care Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys necessary to compute measures based on the survey from 20 to 40. In addition, CMS finalized the removal of one OASIS-based measure, Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care, from the program starting in performance year 3.

NEXT STEPS

Watch for a more detailed Regulatory Advisory and an invitation to an AHA members-only call on Friday, Nov. 17, to discuss the final rule.

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