American Hospital Association

Regulatory Advisory

August 15, 2017

HOME HEALTH PPS: PROPOSED UPDATE FOR CY 2018 AND PROPOSED REFINEMENTS FOR CY 2019

AT A GLANCE

The Issue:

On July 28, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2018 proposed rule for the home health (HH) prospective payment system (PPS). Under this rule, the agency estimates that HH agencies, including hospital-based agencies, will receive an overall net payment reduction of 0.4 percent (or -$80 million) relative to CY 2017 payments. In addition, the rule proposes a complete redesign of the payment system beginning in CY 2019, including a new case-mix structure and a transition from a 60-day to a 30-day episode of care. The rule indicates that its impact would result in a 2.2 percent reduction to FY 2019 payments if partially phased in (not including the payment update) or a 4.3 percent reduction if implemented without a phase-in period. CMS also proposes to remove 247 data elements from 35 Outcome and Assessment Information Set (OASIS) items, the replacement of a measure on pressure ulcers for the 2020 quality reporting program, and the addition of several standardized patient assessment data elements to the program to comply with the requirements of the Improving Medicare Post-Acute Care Transformation Act.

Our Take:

While the payment update for CY 2018 is relatively straight forward, the substantial proposed change for CY 2019 raises many questions with regard to complexity, whether CMS used the best data to design the new system, operational considerations, and whether CMS has the legal authority to implement the change in a non-budget neutral manner. The AHA will be investigating these issues as we prepare to comment on the rule. In addition, the AHA supports the removal of patient assessment data elements that are not used for quality improvement efforts, but is concerned that the expanded patient assessment data reporting requirements would impose a significant burden on providers.

What You Can Do:

- ✓ Share this advisory with your senior management team to examine the impact of these proposed changes on your organization for CY 2018.
- ✓ **Participate in the AHA's Aug. 24 member call to discuss the major issues in this proposed rule and help develop key messages for the AHA's comment letter to CMS. Click here to register for this 4 p.m. ET call.**
- ✓ Submit a comment letter to CMS by Sept. 25 to explain your concerns with the rule and its impact on your patients and organization. Submission details are included in this advisory.

Further Questions:

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

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OVERVIEW

On July 28, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2018 proposed rule for the home health (HH) prospective payment system (PPS). CMS estimates that under this rule HH agencies would receive a net payment reduction of 0.4 percent, an $80 million decrease, from CY 2017 payment levels. Facility-based HH agencies, such as hospital-based agencies, would be subject to the same impact as the field at large.

CMS also proposes a new payment methodology for CY 2019 called the Home Health Groupings Model (HHGM). As described below, the model includes a new case-mix methodology that groups patients into payment categories using primarily clinical characteristics and other patient information, and eliminates therapy service use thresholds that currently are used to case-mix adjust payments. In conjunction, the agency is proposing to change from a 60-day to a 30-day episode of care.

Further, CMS proposes to remove 247 data elements from 35 Outcome and Assessment Information Set (OASIS) items, the replacement of a measure on pressure ulcers for the fiscal year (FY) 2020 quality reporting program, and the addition of several standardized patient assessment data elements to the program to comply with the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

PROPOSED CY 2018 PAYMENT UPDATE

Market-basket Update

Typically, the HH PPS standard rates are updated annually using a HH-specific market basket. However, for CY 2018, a 1.0 percent update was mandated by the Medicare Access and CHIP Reauthorization Act (MACRA).

Proposed CY 2018 Rates

60-day Episode Rate. For CY 2018, for agencies that submit required quality data, CMS proposes a 60-day episode rate of $3,038.43, an increase from the CY 2017 rate of $2,989.97. The proposed CY 2018 rate is calculated by updating the CY 2017 rate with budget neutrality adjustments for wage index and case-mix weights, the statutory 1.0 percent market basket update, and a case-mix cut. The case-mix cut, which is the third of three equal installments, would reduce CY 2018 payments for 60-day episodes by a 0.97 percent; this cut was implemented by CMS to account for the agency's estimated increases in payment between CYs 2012 and 2014 that were not found to correspond to increases in patient acuity.

Low-utilization Payment Adjustment (LUPA) Rates. Episodes with four or fewer visits are subject to a LUPA and are paid on a per-visit basis per type of service. Below are the CY 2017 and proposed CY 2018 per-visit rates used for LUPA episodes.

	CY 2017 Per-visit Rates	**Proposed CY 2018 Per-visit Rates**
HH Aide	$64.23	$64.90
Medical Social Services	$227.36	$229.75
Occupational Therapy	$156.11	$157.75
Physical Therapy	$155.05	$156.68
Skilled Nursing	$141.84	$143.33
Speech-language Pathology	$168.52	$170.29

Non-routine Supplies (NRS) Conversion Factor. NRS include dressings for wounds, syringes, intravenous supplies, catheters and other items. Payment rates for NRS are established by applying a conversion factor to the relative weight assigned to each of the six NRS severity levels. For those agencies submitting quality data, the proposed CY 2018 rates for the six NRS severity levels, would be calculated using the proposed NRS conversion factor of $53.03, are listed in Table 14 of the proposed rule and range from $14.31 for the lowest severity level to $558.16 for the highest severity level.

Case-mix Weights

The HH PPS currently uses the home health resource groups (HHRG) along with the patient assessment data collected using the OASIS tool to categorize patients for payment purposes. As of CY 2015, CMS annually recalibrates the HH case-mix weights with more current data to align payments with the most current HH service utilization data. For CY 2018, CMS used CY 2016 claims data to recalibrate the proposed weights for 60-day episode payments, presented in Table 8 of the proposed rule, in a budget-neutral manner.

Area Wage Index

The CY 2018 home health wage index would be updated using FY 2014 hospital cost report data. The pre-floor, pre-classified wage index amounts for CY 2018 are found online. Wage index budget neutrality adjustments are applied to the 60-day episode and national per visit rates used for LUPA cases.

Labor-related Share

The rule would maintain a labor-related share of 78.535 percent for the case-mix adjusted 60-day episode rate, as set in the CY 2013 HH PPS final rule.

High-cost Outliers

CMS does not propose any changes to the HH PPS high-cost outlier policy in CY 2018 because its analysis of preliminary CY 2016 claims, in combination with the proposed CY 2018 payment rates, found that outlier payments would constitute approximately 2.47 percent of total HH PPS payments in CY 2018. Given the statutory requirement to target up to, but no more than, 2.5 percent of total payments as outlier payments, in FY 2018 CMS proposes to maintain the current fixed-dollar-loss ratio of 0.55, which is multiplied by the 60-day episode payment to determine the outlier threshold. The rule also continues the statutorily mandated 10 percent agency-level cap on outlier payments per year.

Rural Add-on

The 3 percent add-on payment for HH services furnished in rural areas, which has been authorized by Congress through several pieces of legislation, is currently scheduled to expire at the end of CY 2017. Originally established by the Medicare Modernization Act, the add-on was later extended by the Deficit Reduction Act, the Affordable Care Act, and most recently, MACRA.

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

The Social Security Act required CMS to establish the HH QRP. Starting in CY 2007, agencies that fail to meet all HH QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments. A detailed summary of the Social Security Act's statutory authority can be found on CMS's HH QRP website.

In this rule, CMS proposes changes to the measures required in the HH QRP and new requirements for the reporting of certain standardized patient assessment data to meet the mandates of the IMPACT Act.

FY 2020 Measurement Proposals

The HH QRP currently comprises 23 measures. In this proposed rule, CMS would revise one measure, add two new measures and remove several data elements from OASIS.

Changes in Skin Integrity Post-acute Care: Pressure Ulcer/Injury. CMS proposes to remove the current pressure ulcer measure in the HH QRP, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay), and replace it with a modified version of that measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. This modified version includes new or worsened unstageable pressure ulcers, including deep tissue injuries (DTIs), in the measure numerator in addition to Stage 2, 3 and 4 pressure ulcers. This modified measure would satisfy the requirements of the IMPACT Act domain of skin integrity and changes in skin integrity.

Another difference is that the current measure is calculated using retrospective data elements that assess the number of new or worsened pressure ulcers at each stage, while the proposed measure is calculated using the number of unhealed pressure ulcers at each stage after subtracting the number that were present upon admission. The data for this measure would be collected using the OASIS-C2 data set, which is currently submitted by agencies through the Quality Improvement and Evaluation Assessment Submission and Processing (QIES ASAP) system. **The AHA is concerned that the new data elements included in the proposed measure will be difficult for providers to capture, as there is no universally accepted definition of injuries like DTIs and providers will be asked to report on a wholly different data element. We will urge CMS to provide guidance on the correct collection and calculation of the measure results.**

Application of Percent of Long-term Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function. The IMPACT Act requires that the HH QRP must adopt a measure that addresses the domain of "Functional status, cognitive function, and changes in function and cognitive function." CMS proposes to adopt this measure for the HH QRP beginning with the CY 2020 program year. This process measure reports the percentage of patients with an admission and discharge functional assessment and treatment goal that addresses function. It requires collection of admission and discharge functional status data regarding function activities coded using a six-level rating scale indicating the resident's level of independence.

This measure was originally developed and tested as part of the Post-Acute Care Payment Reform Demonstration (PAC PRD) and was field tested in 12 agencies in 2016-2017. The measure requires that at least one activity performance (function) goal is recorded for at least one of the standardized self-care or mobility function items at the start of care. At the time of discharge, goal setting and establishment of a care plan to achieve the goal is reassessed using the same six-level scale. However, if a patient has an unplanned discharge, then the discharge functional status data are not required to be reported.

This measure is not endorsed by the National Quality Forum (NQF) for the HH setting. CMS contends that the current NQF-endorsed HH measures do not meet the specified IMPACT Act domain because they do not include standardized data elements that are included in the other post-acute care settings' assessment instruments. CMS also argues that "the current OASIS function items evaluate current ability, whereas the proposed functional items would evaluate an individual's usual performance at the time of admission and at the time of discharge for goal setting purposes," and, thus, the new measure and current items are not duplicative and agencies would be required to submit data on both sets of items. If the measure is finalized, CMS would provide initial confidential feedback to HHAs prior to the public reporting of this measure.

Percent of Residents Experiencing One or More Falls with Major Injury. The IMPACT Act also requires the HH QRP to adopt a measure addressing the domain of "incidence of major falls, including falls with major injury." To meet this requirement, CMS proposes to adopt the measure Application of Percent of Residents Experiencing One or More Falls with Major Injury for which HHAs would be required to begin submitting data on

Jan. 1, 2019. This measure reports the percentage of residents who have experienced falls with major injury during episodes ending in a three-month period.

This measure was implemented in the skilled nursing facility (SNF) setting in 2011 and uses items that are collected uniformly in each setting's assessment instrument. However, the measure is not NQF-endorsed for the HH setting (although CMS claims that it plans to submit the proposed measure for endorsement "as soon as it is feasible"). In addition, several stakeholders, including the NQF's Measure Applications Partnership (MAP), raised concerns about attributing falls to a particular provider as well as data collection regarding falls given that HH clinicians are not present with the patient at all times. The MAP suggested that CMS explore stratification of measure rates by referral origin when publicly reporting data for this measure; CMS is inviting feedback on this suggestion.

HH agencies already are evaluated on a falls measure, Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate. This is a process-based measure that assesses an HHA's efforts to determine fall risk. CMS purports that this measure is not sufficient because it does not meet the domain of "incidence of falls" (and it is not standardized across post-acute settings). Thus, CMS would add two standardized items to the OASIS for collection at end of care, which comprises discharge, death at home, and transfer to an inpatient facility.

Removal of Data Elements from OASIS. CMS proposes to remove 247 data elements from 35 OASIS items collected at various points during the episode of care, including start of care (SOC), resumption of care (ROC), follow-up (FU), transfer, death at home, or discharge. CMS notes that these elements are not being used to calculate quality measures, payment, survey outcomes, or care planning. See the Appendix for a list of the items proposed for removal.

Proposed Standardized Patient Assessment Data Reporting: CY 2019 and CY 2020

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is made a requirement of the post-acute care quality reporting programs, and as a result, failure to comply with the requirements would result in a payment reduction. Currently, each post-acute setting collects different patient assessment data in setting-specific tools. The HH setting collects this data in OASIS, whereas long-term care hospitals (LTCHs), SNFs, and inpatient rehabilitation facilities collect different data elements in their own tools— the LTCH CARE Data Set (LCDS), the Minimum Data Set (MDS) 3.0, and the Patient Assessment Instrument (PAI), respectively.

The standardized patient assessment data elements must satisfy five domains specified by CMS, including functional status, cognitive function, special services, medical conditions and comorbidities, and impairments. CMS is testing data elements to be included in a standardized data set; some of the items have been tested, either for individual settings or in the PAC PRD study, and are already implemented in some settings.

CY 2019 Proposals. The IMPACT Act requires HH agencies to report standardized patient assessment data starting with the CY 2019 HH QRP. CMS has determined that the data elements used to calculate the current pressure ulcer measure (Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened, Short Stay) meet the definition of standardized patient assessment data with respect to the "medical conditions and co-morbidities" domain. Thus, successful reporting of that data for start of care/resumption of care and discharges during the first two quarters of CY 2018 would satisfy the requirement to report standardized patient assessment data for the CY 2019 HH QRP.

CY 2020 Proposals. For the FY 2020 HH QRP, CMS proposes the reporting of several patient assessment data elements with respect to admissions (start or resumption of care) and discharges beginning on Jan. 1, 2019. Following this initial reporting year (which would be based on six months of data), subsequent years for the HH QRP would be based on a full calendar year of data reporting. CMS proposes to extend the current administrative requirements for quality data to the patient assessment data, which includes:

- Participation
- Exception and extension
- Reconsiderations
- Data completion thresholds

Below is the list and our analysis of proposed data elements in Table 1, including whether they currently exist in the OASIS or other post-acute care tools, whether they were tested in the PAC PRD, and the number of items the measure would add to the tool. Many of these items consist of a "principal" element, which identifies whether a patient is receiving a particular service, as well as two or more "sub-elements," which provide options regarding that service. For example, a principal element might ask if a patient is receiving chemotherapy, and sub-elements will ask what type of chemotherapy the patient is receiving: intravenous, oral, or other. In some of the items, more than one of these sub-elements could be selected; in others, the sub-elements are mutually exclusive.

We note that five of these elements are proposed for removal from OASIS in this proposed rule. Thus, while these elements may exist in the OASIS as of this date, they would be removed and subsequently replaced with new (albeit similar or identical) elements if this rule is finalized.

For more detail on the specifications of these elements and screenshots of how these elements would look in the tool, download the *Proposed Specifications for HH QRP Quality Measures and Standardized Data Elements* document on CMS's HH QRP website.

Table 1: AHA Analysis of Proposed Standardized Patient Assessment Data Elements

Domain	Element	Currently in OASIS?	Currently in other PAC tool?	Tested in PAC PRD?	Number of items
Functional Status	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	No	LCDS IRF-PAI	Yes	1
Cognitive Function & Mental Status	Brief Interview for Mental Status (BIMS)	No	IRF-PAI MDS	Yes	7
	Confusion Assessment Method (CAM)	No	LCDS MDS	Yes	6
	Behavioral Signs and Symptoms	Yes	MDS	Yes	3
	Patient Health Questionnaire-2	Yes[1]	MDS	Yes	2
Special Services, Treatments, and Interventions	Cancer Treatment: Chemotherapy (IV, Oral, Other)	No	MDS	Yes (sub)	1-4 (1 principal; 3 sub)
	Cancer Treatment: Radiation	No	MDS	No	1
	Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	Yes[1]	MDS	Yes*	1-2 (1 principal; 2 sub either/or)
	Respiratory Treatment: Suctioning (Scheduled, As needed)	No	MDS	Yes*	1-2 (1 principal; 2 sub either/or)
	Respiratory Treatment: Tracheostomy Care	No	MDS	Yes*	1
	Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	Yes[1]	LCDS (principal) MDS	Yes*	1-3 (1 principal; 2 sub)
	Respiratory Treatment: Invasive Mechanical Ventilator	No	LCDS MDS	Yes*	1
	Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	Yes (principal only)	MDS	Yes (sub)	1-4 (1 principal; 3 sub)
	Other Treatment: Transfusions	Yes	MDS	Yes	1
	Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	No	LCDS (principal) MDS	Yes (sub)	1-2 (1 principal; 2 sub either/or)

	Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	No	No	Yes*	1-5 (1 principal; 4 sub)
	Nutritional Approach: Parenteral/IV Feeding	Yes	LCDS IRF-PAI MDS	Yes*	1
	Nutritional Approach: Feeding Tube	Yes	MDS	Yes*	1
	Nutritional Approach: Mechanically Altered Diet	No	MDS	Yes*	1
	Nutritional Approach: Therapeutic Diet	No	MDS	Yes*	1
Medical Condition & Comorbidity	Percent of Resident or Patients with Pressure Ulcers that are New or Worsened	Yes	LCDS IRF-PAI MDS	n/a	1
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	No	Revised Measure	n/a	1
Impairment	Hearing	Yes[1]	MDS	Yes	1
	Vision	Yes[1]	MDS	Yes	1
Range of Patient Assessment Items (i.e., how many boxes to fill per patient)					**38-53**

[1]Proposed for removal from OASIS-C2 in this proposed rule.

*Item tested in PAC PRD not identical to item proposed; advisors agreed that element deemed feasible in PAC PRD is related or equivalent to proposed data element and thus reasonable for inclusion as a patient assessment data element.

HOME HEALTH VALUE-BASED PURCHASING PROGRAM (HH VBP)

The HH VBP program was finalized in the CY 2016 HH PPS final rule, which is summarized in our 2015 Regulatory Advisory. Additional program logistics were finalized in the CY 2017 HH PPS final rule, which is summarized in our 2016 Regulatory Advisory. All Medicare-certified HH agencies providing services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington are required to participate in the model. In this proposed rule, CMS would alter the minimum required number of patient surveys for measure calculation, and would remove one measure from the program.

Minimum Number of Completed Home Health Care Consumer Assessment of Healthcare Providers and System (HHCAHPS) Surveys

As finalized in the CY 2016 HH PPS final rule, agencies needed to demonstrate at least 20 episodes of care during a performance year to generate a performance score on HHCAHPS surveys for at least five measures. If an agency did not collect at least 20 completed HHCAHPS surveys, it would not be included in the calculation of performance for all participants and would not have a payment adjustment percentage calculated.

However, CMS proposes to increase the minimum number of surveys from 20 to 40. CMS states that this would better align the HH VBP model with the HHCAHPS policy for the Patient Survey Star Ratings on the *Home Health Compare* website, which uses a minimum of 40 surveys to calculate star ratings. In addition, CMS believes that using more surveys to calculate measures would result in meaningful and less random variations in measure performance by HH agencies.

CMS analyzed the possible impact of using 40 surveys to calculate measures instead of 20 and found that achievement thresholds—which are calculated as the median of all HH agencies' performance on the specified quality measures during the 2015 baseline year for each state—would not change by more than ±1.1 percent. However, benchmarks—the mean of the top decile of performance on the measures during the baseline year—could change by -3.2 percent. Overall, CMS contends that this proposed increase in the minimum number of surveys would result in an average change in the statewide total performance score for larger volume HHAs by -0.4 to +2.2 percent. These changes vary by state. CMS admits that these estimates may not reflect the actual changes in scores as the data used in their analysis did not cover the full 2016 calendar year.

Removal of Drug Education Measure

CMS proposes to remove one OASIS-based quality measure from the program beginning in performance year 3 (CY 2018), Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care. In its monitoring efforts, CMS has determined that many providers have achieved full performance on this measure. In addition, a technical expert panel (TEP) expressed concern that this measure does not capture the quality of the education provided by the HH agency to the patient or caregiver.

Measures for Future Consideration

CMS is identifying measures for possible inclusion in the VBP program in future rulemaking in response to several stakeholder comments that the measures currently used in the model do not reflect the patient population served. Specifically, these stakeholders voiced concerns that the measures are primarily focused on outcomes and clinical improvement and do not address patients with chronic illness or deteriorating/terminal illness. Thus, in order to highlight the value of stabilization measures in the program, CMS is considering measures in the following domains:

Total Change in Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) Performance by HHA Patients. This composite measure assesses total change in ADL/IADL by capturing all three potential outcomes for home health patients: stabilization, decline and improvement. The measure would report the average, normalized, total improved functioning across the 11 ADL/IADL items currently in the OASIS-C2. The measure would then be calculated by comparing scores from SOC/ROC to scores at discharge, and average the result across all eligible episodes to provide a total measure score for the agency. The measure would be risk-adjusted using other OASIS items to account for case-mix variation and other factors beyond the agency's control.

Composite Functional Decline. This measure determines the percentage of episodes where there was a decline on one or more of the eight ADL items used in the measure. Similar to the composite ADL decline measure currently used in the Skilled Nursing Facility QRP, this measure would be based on the difference between the predicted outcome for an individual agency and the national predicted outcome. Both predicted outcomes would be based on a logistic regression model constructed using length of stay and other patient characteristics.

HHA Correctly Identifies Patient's Need for Mental or Behavioral Health Supervision. Recognizing that the HH VBP does not include behavioral health measures, CMS is considering this outcome measure assessing whether the HH agency has correctly identified whether or not the patient needs mental or behavioral health supervision based on the OASIS SOC/ROC assessment item that asks about Types and Sources of Assistance: Supervision and Safety. An algorithm would determine if a patient needed mental or behavioral health supervision based on whether the agency noted certain conditions in OASIS (e.g., was discharged from a psychiatric hospital prior to home care, is diagnosed with mental illness, is confused, etc.). The outcome measure would be defined as the agreement between the algorithm's determination and the agency's coding of the need for supervision.

Caregiver Can/Does Provide for Patient's Mental or Behavioral Health Supervision Need. This measure would report the percentage of episodes where patients with identified mental or behavioral health supervision needs have their needs met or could have their needs met by the patient's caregiver with additional training (if needed). This measure would rely upon a similar algorithm and agreement calculation as in the previous measure.

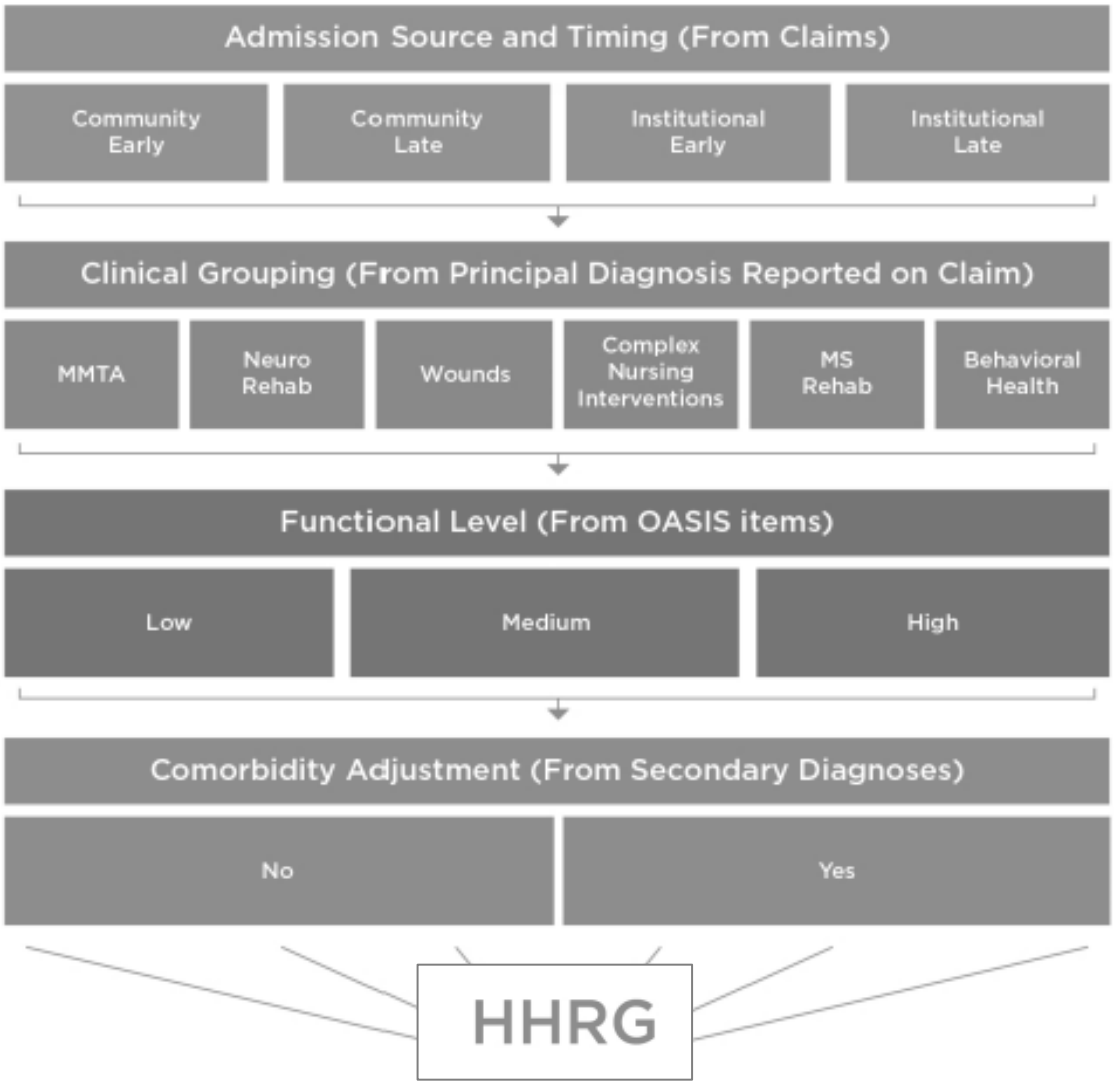
PROPOSED HH PPS REFINEMENTS FOR CY 2019

CMS proposes a major redesign of the HH PPS, effective Jan. 1, 2019. The rule discusses research by CMS and the Medicare Payment Advisory Commission (MedPAC) that provide a rationale for this change based on findings that HH PPS accuracy could be improved by reducing the influence of therapy visits in the payment setting process. Under its proposal, the current HH PPS model would be replaced with the Home Health Groupings Model (HHGM), which is a five-tiered case-mix system that would be paired with 30-day, rather than the current 60-day, episodes of care.

HHGM Clinical Elements

HHGM uses five clinical elements, described below, to set payments for each patient. The proposed case-mix methodology would be used to assign patients to one of the 144 HHGM payment units, which would retain the current payment system's term of home health resource groups (HHRG). The current HH PPS has 153 HHRG units. Figure 5 in the rule, reproduced below, outlines the structure of the HHGM model.

Figure 5: Structure of the Proposed Home Health Groupings Model (HHGM)[1]



[1]Under the HHGM, an episode is grouped into one (and only one) subcategory under each larger colored category. An episode's combination of subcategories groups the episodes into one of 144 different home health resource groups (HHRGs).

Timing of Episode. The 30-day episode would be classified as "early" or "late" depending on when it occurs within a sequence of episodes. Specifically, the first 30-day period would be classified as "early" and all subsequent 30-day periods in the sequence classified as "late."

Admission Source. Each period would be classified into one of two admission source categories: community or institutional. The 30-day period would be categorized as "institutional" if an acute or post-acute stay occurred 14 days prior to the start of the period of care. The 30-day period would be categorized as "community" if there was no acute or post-acute care stay in the 14 days prior to the start of the period of care. CMS proposes to automatically classify all claims as community but to create occurrence codes that allow agencies to manually flag a claim as institutional. CMS also discusses plans for an evaluation process within the claims processing system to automatically

check for the presence of an acute/post-acute claim discharge within 14 days of the home health admission. Finally, CMS proposes that post-payment medical review may be conducted if a claim for the prior institutional stay was not submitted timely or if the claim was denied.

Clinical Grouping. Based on the principal diagnosis reported on a HH claim, the 30-day payment amount would be grouped into one of six clinical groups:

- musculoskeletal rehabilitation;
- neuro/stroke rehabilitation;
- wounds (post-op wound aftercare and skin/non-surgical wound care);
- complex nursing interventions;
- behavioral health care; or
- medication management, teaching and assessment (MMTA).

CMS believes these proposed groups reflect how clinicians differentiate between patients and the types of care they need to receive. Table 35 in the proposed rule shows the distribution of episodes and the associated resources across the six clinical groups. CMS plans to post a complete list of ICD-10 codes and their assigned clinical groupings at https://www.cms.gov/center/provider-Type/Home-Health-Agency-HHA-Center.html.

Functional Level. The six clinical groups would be further classified into one of the three functional levels (low, medium or high) with roughly 33 percent of episodes in each level. On the basis of input from a clinical group and analytic results, functional assessment would be based on particular OASIS items (specifically grooming; current ability to dress upper body; bathing; toilet transferring; transferring; ambulation/locomotion; risk of hospitalization). Tables 36 and 37 in the rule provide CMS's rating system, which converts points on these metrics into a functional score that is factored into the patient's HHGM case-mix weight for an episode.

Comorbidity Adjustment. Under the HHGM, 30-day episodes would receive one standard comorbidity adjustment if the claim has at least one of the qualifying secondary diagnosis listed below. CMS defines a comorbidity as a condition in which there is no direct correlation with the treatment of the principal diagnosis, but the presence of that condition(s) may impact the home health plan of care in terms of resource utilization and costs.

- Heart Disease 1: includes hypertensive heart disease.
- Cerebral Vascular Disease 4: includes sequelae of cerebrovascular disease.
- Circulatory Disease and Blood Disorders 9: includes venous embolisms and thrombosis.
- Circulatory Disease and Blood Disorders 10: includes varicose veins of lower extremities with ulcers and inflammation, and esophageal varices.
- Circulatory Disease and Blood Disorders 11: includes lymphedema.
- Endocrine Disease 2: includes diabetes with complications due to an underlying condition.
- Neoplasm 18: includes secondary malignant neoplasms.

- Neurological Disease and Associated Conditions 5: includes secondary parkinsonism.
- Neurological Disease and Associated Conditions 7: includes encephalitis, myelitis, encephalomyelitis, and hemiplegia, paraplegia, and quadriplegia.
- Neurological Disease and Associated Conditions 10: includes diabetes with neurological complications.
- Respiratory Disease 7: includes pneumonia, pneumonitis, and pulmonary edema.
- Skin Disease 1: includes cutaneous, abscesses, and cellulitis.
- Skin Disease 2: includes stage one pressure ulcers.
- Skin Disease 3: includes atherosclerosis with gangrene.
- Skin Disease 4: includes unstageable and stages two through four pressure ulcers.

Proposed New Methodology for Calculating the Cost of Care

Under the current system, CMS uses the "wage-weighted minutes of care" (WWMC) approach that relies on Bureau of Labor Statistics data, with data related to the minutes and discipline of care collected from HH claims. However, CMS states that this approach relies on data that are not agency specific, estimate labor costs for only direct patient care, and do not account for any non-labor costs (such as transportation) or non-direct patient care labor costs (such as administrative costs). Further, the current approach pays non-routine supply (NRS) costs for all episodes, although two-thirds of episodes do not provide NRS.

Therefore, the agency proposes a new methodology to estimate the costs of care for HH agencies. Specifically, the proposed cost estimating methodology under HHGM uses cost per minutes (CPM) data from cost reports and claims data that are converted into facility-specific estimates of NRS costs. The cost reports enable the estimation of the cost per visit by provider and the estimated NRS cost-to-charge ratios. CMS concludes that the CPM + NRS model more evenly weights skilled nursing services and therapy services when compared to the current approach. Table 21 in the rule compares the relative values in costs per hour and by discipline, under the two methodologies.

Proposed Change from a 60-day to 30-day Episode of Care

CMS is pursuing its stated goal of improving payment accuracy by proposing to replace the current 60-day episode with a 30-day episode. CMS found that a 30-day episode improves the accuracy of payment, and states that over time, the proportion of episodes of 30 day or less in length has steadily grown and is now 25 percent of all episodes (data on episode length are shown in the rule's Table 24). See Tables 22 and 23 in the rule for more detail on visits in different portions of an episode, by discipline, which show a concentration of visits during the initial 15- and 30-day periods.

The rule briefly describes two methodologies CMS used to estimate 30-day payments for CY 2018, neither of which uses current payments as a baseline. In the first approach, the agency multiplied the per-visit costs (plus NRS costs) for the first year of the HH PPS (FY 2001) by CY 2016 average number of visits per discipline per 30-day period, which were adjusted for inflation and productivity to CY 2018 amounts. The second methodology multiplied the CY 2016 average number of visits by discipline by

average cost per visit in the FY 2015 cost reports, trended forward to 2018, plus outlier payments. As shown in Tables 28 and 29 of the rule, these calculations produce 30-day payment amounts of $1,494.64 and $1,485.11, respectively, both of which are less than half of the proposed CY 2018 60-day payment. The rule recommends the first methodology for CY 2019, which would be used as a baseline for CY 2020 payments. The gap between 30-day payments under the current and proposed approaches would reduce overall payments in CY 2019, as discussed below in the "Proposed Implementation" section.

HHGM's LUPA Approach

CMS proposes that, under the HHGM, the LUPA payment add-on elements would remain the same. However, because CMS projects that the proportion of LUPA claims would increase with a 30-day threshold, the agency is proposing a new approach for identifying LUPA claims. Rather than the current four-day threshold, LUPA thresholds would vary per HHGM payment group. To calculate LUPA thresholds under the proposed model, all 30-day episodes in the 2016 utilization data were grouped into the 144 different HHGM payment groups. For each payment group, CMS proposes a LUPA threshold at the 10th percentile value of visits with a minimum threshold of at least two visits for each group. Under this methodology, CMS estimates that 7 percent of 30-day periods would be LUPAs, which is similar to the 8 percent rate under the current system. Table 40 in the rule lists the proposed LUPA thresholds for each proposed HHGM payment group. Further, CMS proposes that, consistent with the current approach, LUPA episodes that occur as the only episode or as an initial episode in a sequence of adjacent episodes would be adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences.

Case-mix Weights under the HHGM

The case-mix weight for each of the 144 HHRG payment units in the HHGM model is provided in Table 42 in the rule. These weights exclude LUPA episodes, outlier episodes, and episodes with partial episode payment adjustments. CMS notes that nine HHRG payment groups represent approximately 50.5 percent of the total episodes and 33 HHRG payment groups represent approximately 1.0 percent of the total episodes. The HHRG payment group with the smallest weight (0.5034) is for cases that are late, community, behavioral health, low functional level, and with no comorbidity adjustment. The HHRG payment group with the largest weight (1.9533) is for cases that are early, institutional admission, wound, high functional level, and with a comorbidity adjustment. For the CY 2019 HH PPS proposed rule, CMS states it would update case-mix weights using the most recently available data.

Partial Episode Payment (PEP) Adjustments under the HHGM

CMS proposes to maintain the current process for PEP adjustments. As such, the PEP adjustment would continue to be a proportion of the episode payment and be based on the span of days including the start-of-care date or first billable service date through and including the last billable service date under the original plan of care before the intervening event in a home health beneficiary's care. The intervening event would still be defined as a beneficiary-elected transfer or a discharge and return to home health that would warrant, for payment, a new OASIS assessment, physician certification of eligibility and a new plan of care.

High-cost Outliers under the HHGM

CMS proposes to maintain the current methodology for payment of high-cost outliers under the HHGM, but would calculate them using 30-day periods of care. Using 2016 claims data and 2018 payment rates, CMS estimates that HHGM outlier payments would comprise approximately 4.50 percent of total HH PPS payments in 2018. To meet the statutory requirement to target up to, but no more that 2.5 percent of total payments as outlier payments, CMS estimates that the fixed-dollar loss (FDL) ratio under the HHGM would need to change from 0.55 to 0.93. CMS notes it will update the estimate of outlier payments as a percent of total HH PPS payments using the most current data available at the time of 2019 rate-setting.

Proposed Implementation

The rule discusses several approaches for implementing the HHGM:

- One approach is immediate implementation with no phase-in assistance. This approach, without accounting for the annual update, would reduce CY 2019 payments by 4.3 percent, or $950 million.
- Another approach is a partial phase-in assistance in CY 2019, with full implementation in CY 2020. The payment cut under this approach would be 2.2 percent in CY 2019, or $480 million.

The rule also mentions the possibility of a longer phase-in with two years of partial relief, as well as a staggered approach with implementation of the 30-day episode in CY 2019 followed by the case-mix methodology in CY 2020.

NEXT STEPS

The AHA will host a member call on Thursday, Aug. 24 at 4:00 p.m. ET to discuss the provisions of this proposed rule and to gather input from the field for AHA's comment letter to CMS. AHA members may register here. Related materials and a recording of this call will be available at www.aha.org/postacute in the HH section.

Submitting Comments. The AHA urges all HH agencies to submit comments to CMS. Comments are due Sept. 25 and may be submitted electronically at www.regulations.gov. Follow the instructions for "Comment or Submission" and enter the file code "CMS-1672-P." You also may mail written comments (an original and two copies) to CMS; instructions are in the first page of the proposed rule.

Questions. If you have further questions regarding the proposed rule's payment provisions, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. Questions regarding the quality provisions should be directed to Caitlin Gillooley, associate director, at cgillooley@aha.org.

Item	Definition	SOC	ROC	FU	Transfer	Death at Home	Discharge	Items Added for Standardized Patient Assessment, SOC	Items Added for Standardized Patient Assessment, ROC	Items Added for Standardized Patient Assessment, Discharge
M0903	Date of last (most recent) home visit				1	1	1			
M1011	List each inpatient diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes)	6	6	6						
M1017	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes)	6	6							
M1018	Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)	6	6							
M1025	Optional Diagnoses (not used for payment)	12	12	12						
M1034	Overall Status	1	1							
M1036	Risk factors	4	4							
M1200	Vision	1	1	1				1	1	n/a
M1210	Ability to Hear	1	1					1	1	n/a
M1220	Understanding of Verbal Content	1	1							
M1230	Speech and Oral (Verbal) Expression of Language	1	1				1			
M1240	Pain Assessment	1	1							
M1300	Pressure Ulcer Assessment: Risk of Developing Pressure Ulcer	1	1							
M1302	Risk of Developing Pressure Ulcers	1	1							
M1320	Status of Most Problematic Pressure Ulcer that is Observable	1	1				1			
M1322	Current Number of Stage 1 Pressure Ulcers						1			
M1332	Current Number of Stasis Ulcer(s) that are Observable						1			
M1350	Skin Lesion or Open Wound	1	1							
M1410	Respiratory Treatments	3	3					5	5	5
M1501	Symptoms in Heart Failure Patients				1		1			
M1511	Heart Failure Follow-up				5		5			
M1610	Urinary Incontinence or Urinary Catheter Presence						1			
M1615	When does Urinary Incontinence occur	1	1				1			
M1730	Depression Screening (PHQ-2)	3	3					2	2	2
M1750	Psychiatric Nursing Services	1	1							
M1880	Ability to Plan and Prepare Light Meals	1	1				1			
M1890	Ability to Use Telephone	1	1				1			
M1900	Prior Functioning ADL/IADL	4	4							
M2030	Management of Injectable Medications	1	1	1			1			
M2040	Prior Medication Management	2	2							
M2102	Types and Sources of Assistance	6	6				3			
M2110	How Often does patient receive ADL/IADL assistance	1	1							
M2250	Plan of Care Synopsis	7	7							
M2310	Reason for Emergent Care				15		15			
M2430	Reason for Hospitalization				20					
TOTALS		**75**	**75**	**20**	**42**	**1**	**34**			