American Hospital Association

Special Bulletin

Tuesday, July 3, 2018

CMS Proposes Home Health PPS CY 2019 Update and CY 2020 Redesign

The Centers for Medicare & Medicaid Services (CMS) yesterday issued a proposed rule that would update home health (HH) prospective payment system (PPS) payments for calendar year (CY) 2019 and change the HH quality reporting program (QRP). In addition, in accordance with the statutory mandate in the Bipartisan Budget Act of 2018 (BiBA), the rule proposes a complete redesign of the payment system for CY 2020 that follows a regulatory proposal last year to overhaul this payment system, which received an extensive response from the HH field.

The AHA will be closely evaluating CMS's proposed model to overhaul the HH PPS in CY 2020 to determine the extent to which it includes changes recommended in response to CMS's prior iteration of the reform model.

CMS will accept comments on this rule through August 31. Watch for detailed Regulatory Advisory in the coming weeks. In addition, AHA's HH members will receive separate invitations to calls to discuss the proposed rule and help AHA prepare its comment letter.

Key Take-aways

CMS proposes to:

- Increase net HH payments by 2.1 percent in CY 2019, including for facility-based agencies.
- Overhaul the HH PPS in CY 2020 by replacing the current therapy-based payment system with a new model that would be budget-neutral overall, but increase payments for facility-based HH agencies by almost 4 percent.
- Remove seven quality measures from the HH Quality Reporting Program.
- Remove/replace five measures in the HH Value-based Purchasing Program and adjust performance calculation.
- Create safety and payment standards for new home infusion therapy services.
- Add new requirements for all accreditation organizations.

CY 2019 Proposed Payment Update

The CY 2019 payment provisions in this proposed rule are straightforward with minimal material policy changes. **Specifically, CY 2019 payments would increase by a net 2.1 percent, or $400 million, after all policy changes, compared to 2018 payment levels.** This increase includes:

- A 2.7 percent market basket update;
- A statutorily-mandated productivity adjustment of negative 0.7 percent;
- A 0.1 percent 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; and
- A 0.1 percent 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 PROPOSALS

Proposed Changes to the Home Health Quality Reporting Program (HH QRP): CMS proposes to replace the criteria currently used to consider a HH QRP quality measure for removal with the eight criteria that currently are used in the other post-acute care quality reporting programs. These criteria would continue to be applied on a case-by-case basis and would 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 become 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 proposed criteria, CMS identifies and proposes to remove seven quality measures from the HH QRP beginning with the CY 2021 program year. The measures proposed for removal 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

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

Proposed 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 proposed rule, CMS establishes health and safety standards for this therapy as well as regulations for the approval and oversight of accrediting 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.

Proposed 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 January 1, 2016. CMS proposes to 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 proposes to replace three other OASIS-based measures with two composite measures. The measures that would be replaced are:

- Improvement in Bathing, Improvement in Bed Transferring, and
- Improvement in Ambulation-Locomotion.

In their place CMS would adopt:

- Total Normalized Composite Change in Self-Care, and
- Total Normalized Composite Change in Mobility.

These two measures would be calculated based on existing Activities of Daily Living (ADL) items that HH agencies already collect.

CMS also proposes to reweight the measures used in the HHVBP program. Currently, OASIS-based measures, claims-based measures, and HHCAHPS measures are all weighted equally. Under this proposal, claims-based measures would be weighted more than the others. 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.

Proposed Changes to 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 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 adds two new requirements for AOs:

- First, if a fully accredited facility in good standing provides written notification that they wish 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 proposal 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.

- Second, CMS also proposes new requirements for training for AO surveyors. If finalized, AO surveyors would 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.

CY 2020 Proposed Redesign of the HH PPS

The BiBA requires CMS to redesign the HH PPS in a budget-neutral manner by CY 2020. This includes by moving from 60-day to 30-day episodes of care and basing payments on a clinical profile of the patient rather than their therapy volume, as currently done. In response to this mandate, CMS has proposed a reform model, the Patient-Driven Groupings Model (PDGM), which appears very similar to the model proposed, but later withdrawn, in CY 2018 rulemaking. Specifically, CMS states in the proposed rule that "PDGM removes the current incentive to overprovide therapy, and instead, is designed to reflect our focus on relying more heavily on clinical characteristics and other patient information to allow payments to more closely coincide with patients' needs."

It appears that, like its prior iteration, the PDGM would rely on clinical characteristics and other patient information, rather than on the current therapy thresholds, to place patients into meaningful payment categories. 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 (community versus institutional referrals) and timing of the episode (first versus subsequent episode in a sequency);
- Clinical groups:
    - 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 levels (low, medium, high); and
- Comorbidity adjustment (non, low, high).

In addition, in response to the CY 2018 proposed rule's inappropriately brief mention of the agency's methodology for including a behavior adjustment in its impact analysis, this rule provides more detail about CMS's anticipated behavioral response from the field. Specifically, CMS projects that HH agencies would change their documentation and coding practices; the number of co-morbidity adjustments would increase overall payments; and low-volume cases would receive more visits. The rule notes CMS's intention to consider a behavioral adjustment in the future based on its observations of the field's actual behavior.

Finally, CMS states in the rule that it plans to release provider-level impact estimates for PDGM as well as a report on a technical expert panel's insights on the proposal. In addition, the agency will issue an interactive grouper that allows providers to determine case-mix weights for their patient populations. CMS will share these resources with providers at https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html.

In the weeks ahead, as we prepare for discussions with members and our comment letter to CMS, the AHA will closely examine PDGM's structure, the overall readiness of the proposal, and any concerns raised in CY 2018 rulemaking that still apply to PDGM.

NEXT STEPS

Watch for a more detailed Regulatory Advisory and an invitation to an AHA members-only call to discuss the proposed rule. Comments on the proposed rule are due to CMS by August 31. If you have further questions on the payment provisions, 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.