CY 2019 Home Health PPS Final Rule

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AHA Policy

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CY 2019 Final Rule

- **AHA Regulatory Advisory:**
- **Published in Nov 13 Federal Register**
  - https://www.gpo.gov/fdsys/pkg/FR-2018-11-13/pdf/2018-24145.pdf
- **Final Net Update: +2.2%, $420 million**
  - Same for facility-based agencies
  - Includes:
    - + 3.0% market basket
    - - 0.8% productivity adjustment
    - +1.0% increase in high-cost outlier payments
    - -1.0% decrease due to new rural health payment methodology

- **Final rates:**
  - 60-day episode: $3,092.55 (increase from $3,039.64 in CY 2018)
  - NRS conversion factor: $54.20 for the 6 severity levels (CY 2017 factor: $53.03)
    - Table 21: Range of $14.62 for lowest severity level; $570.48 for highest.
  - LUPA: All LUPA rates are increased (See AHA advisory page 2 for CY 2019 rates)
- **High-Cost Outliers:**
  - Federal Statute: Outlier payments limited to 2.5% of aggregate HH payments
  - To comply, the fixed dollar loss ratio would be reduced from 0.55 to 0.51

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- **New Rural Add-on Methodology for CYs 2019 through 2022**
- **Bipartisan Budget Act of 2018**

Table 26: HH PPS Rural Add-on Percentages, 2019-2022				
Category	**2019**	**2020**	**2021**	**2022**
High utilization	1.5%	0.5%		
Low-population density	4.0%	3.0%	2.0%	1.0%
All other	3.0%	2.0%	1.0%	

- **High-utilization Counties/equivalent Areas**: Currently 510 rural counties/areas. Highest quartile based on the number of Medicare HH episodes per 100 individuals;
- **Low-population-density Counties/equivalent Areas**: Currently 334 rural counties/areas. Population density of 6 individuals or fewer per square mile of land area; and
- **All-other Counties/equivalent Areas**: Currently 1,162 rural counties/areas. Those rural counties and equivalent areas not in the above categories.
- **Designations**: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.
  - 2,006 rural designations (out of 3,245 counties/areas) based on 2015 wage index, claims data, and data from the Medicare beneficiary summary file; and 2010 Census data.

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Certifying/Re-certifying Eligiblity

- **Per the Bipartisan Budget Act of 2018, the rule allows the use of documentation in the HH medical record in addition to that of the certifying physician (or of the acute or post-acute care facility).**
  - Allows medical record documentation from the HH agency if the following requirements are met:
    - The documentation from the HH agency can be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient; and
    - The certifying physician signs and dates the HH agency documentation demonstrating that the documentation from the HH agency was considered when certifying patient eligibility for Medicare home health services.
- **Per BiBA, the rule eliminates the recertification requirement to estimate the duration of HH services.**
  - Responds to field's request for burden reduction;
  - Duplicative with other HH COP requirements re the plan of care.
  - Estimated to save $14.2 million worth of physicians time.

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PDGM Legislative Mandate

- **The Balanced Budget Act of 2018 required CMS to redesign the HH PPS to include:**
  - 30-day unit of service
  - Budget-neutral implementation
  - Eliminate the use of therapy thresholds in case-mix adjustment
  - Calculate behavior adjustments for 2020-2026
  - Make 1+ permanent and 1+ temporary behavioral adjustments

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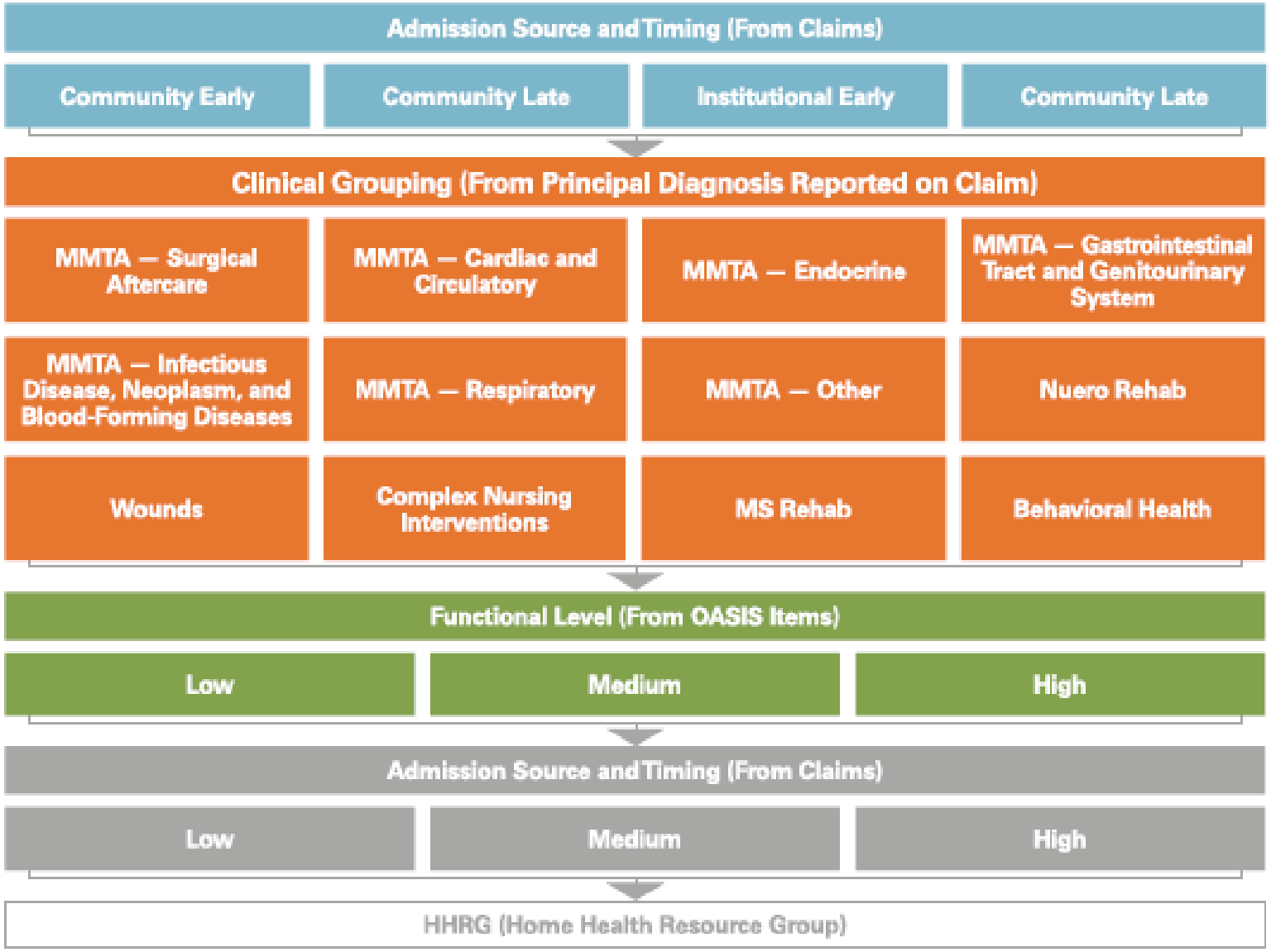
PDGM Final Framework



PDGM Proposal

Prospective Behavioral Adjustment

3 Projected Behavior Changes:

- Clinical group coding: Agencies will place the highest paying diagnosis as the principal diagnosis code. *(Proposed rule: -4.28)*
- Comorbidity coding: Since comorbidities can increase payment by up to 20%, coding will change to increase payment. *(Proposed rule: -0.38)*
- LUPA threshold: For 1/3 of cases, agencies would add extra visits to achieve a full 30-day payment. *(Proposed rule: -1.75%)*

PDGM Proposal – Selected Payment Provisions

- **Case-mix Weights:**
  - 432 possible HHRGs
  - 2020 weights to be proposed next year
  - Smallest weights: community and late admission; behavior health, low functional level, and no comorbidity.
  - Largest weights: institutional and early admission, wound, high functional impairment, interactive comorbidity adjustment.
- **LUPAs:** Limited to cases below 10th percentile (per HHRG) and at least two visits.
- **NRS:** Only paid to cases with NRS and based on provider-specific cost report data
- **High-cost outliers:**
  - Applies current methodology to 30-day unit and same 2.5% limit for total outlier payments.
- **PEP:** Current methodology applied to 30-day payment.
- **RAPs:** *Agencies certified after Dec 31, 2018* will not receive RAP payments. At later point, this change may be applied to other agencies

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Home Health Quality Reporting & VBP

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Finalized Measure Removal Criteria

1. Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
2. Performance or improvement on a measure does not result in better patient outcomes.
3. Measure does not align with current clinical guidelines or practice.
4. A more broadly applicable measure on the topic is available.
5. A measure that is more proximal in time to desired patient outcomes on the topic is available.
6. A measure more strongly associated with desired patient outcomes on the topic is available.
7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
8. The costs associated with a measure outweigh the benefit of its continued use in the program.

HH Final Rule: Measures Removed

- Depression Assessment Conducted
  - **Still required for risk adjustment**
- Diabetic Foot Care and Patient/Caregiver Education
- Multifactor Fall Risk Assessment
- Improvement of Surgical Wounds
  - **Still required for risk adjustment**
- ED Use Without Readmission in First 30 Days
- Rehospitalization in First 30 Days
- Pneumococcal Polysaccharide Vaccine

Topped Out

More applicable measure available

Inconsistent with clinical guidelines

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HH VBP: New Composite Measures

- Replaces Improvement in Bathing, Bed Transferring, and Ambulation-Locomotion measures
- Incorporates those OASIS items with 6 others to create two new measures:
  - Total Normalized Composite **Change in Self-Care**
    - Grooming, upper body/lower body dressing, bathing, toileting hygiene, eating
  - Total Normalized Composite **Change in Mobility**
    - Toilet transferring, bed transferring, ambulation/locomotion
- Calculates absolute change for each OASIS item at episode level
  - Normalizes scores; sums normalized scores
  - Averages scores for all episodes
  - Risk-adjustment with national and HHA-specific predicted values

HHA Risk-Adjusted Score = HHA Observed + (National Predicted – HHA Predicted)

HH VBP: Changes in Measure Weights

	Measure	Current Weights	New Weights
OASIS	Flu Vaccine	6.25%	0% (Measure Removed)
	Pneumococcal Vaccine	6.25%	0% (Measure Removed)
	Improve Bathing	6.25%	7.5 (Now Composite Self-Care)
	Improve Bed Transfer	6.25%	7.5% (Now Composite Mobility)
	Improve Ambulation	6.25%	
	Improve Oral Meds	6.25%	5%
	Improve Dyspnea	6.25%	5%
	Improve Pain	6.25%	5%
	Discharge to Community	6.25%	5%
Claims	Hospitalizations	6.25%	26.25%
	Outpatient ED	6.25%	8.75%
HHCAHPS	Care of Patients	6.25%	6%
	Communication	6.25%	6%
	Discussion of Specific Care Issues	6.25%	6%
	Overall Rating	6.25%	6%
	Willingness to Recommend	6.25%	6%

HH VBP: Scoring Changes

- Currently: up to **10** points for either achievement or improvement, whichever is higher
- Finalized for year 4 (2019): only **9** points for improvement (still 10 for achievement)
- Rationale:
  - Should focus more on achievement than rely on improvement
  - Providers have had enough time to get their acts together

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New
Home Infusion Benefit

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Home Infusion Therapy Provisions

- Established by 21st Century Cures Act
- Covers professional services associated with HIT therapy, including nursing services
  - Drugs, supplies, equipment covered by DME
- Full benefit starts 2021; until then, temporary transitional payment based on HCPCS codes + G-codes
- **Payment unit finalized as drug administration calendar day**
  - Agency will “monitor effects on access to care”
- HHAs must bill separately for HIT and HHA services if providing both

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Questions
&
Discussion

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AHA Post-Acute Resources:

www.aha.org/postacute

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