

Friday, November 1, 2019

## CMS Issues CY 2020 Final Rule with Comment Period for Home Health Payment System

The Centers for Medicare & Medicaid Services (CMS) Oct. 31 issued a [final rule with comment period](#) that updates the home health (HH) prospective payment system (PPS) for calendar year (CY) 2020. In accordance with the Bipartisan Budget Act of 2018 (BBA of 2018), last year's rulemaking finalized a redesign of the home health payment system, which will begin in CY 2020. This rule adds more detail to the new model, including a behavioral offset.

**While we support the general approach of the redesigned home health PPS, and are pleased that CMS has reduced its behavioral offset from -8.01% to -4.36%, we remain concerned that CMS is proceeding with a prospective behavioral adjustment that is not based on actual evidence.**

Watch for a detailed Regulatory Advisory in the coming weeks. In addition, AHA's home health members will receive a separate invitation to a member call to discuss the final rule with comment period.

Highlights of the rule follow.

### FINAL CY 2020 PAYMENT UPDATE

The CY 2020 payment provisions in this rule are straightforward, with minimal material policy changes. **Specifically, CY 2020 payments will increase by a net 1.3%, or \$250 million, after all policy changes, compared to CY 2019 payment levels.** This increase includes:

- A 1.5% market-basket update.
- A 0.2 percentage point cut due to the new rural add-on payment methodology required by BBA of 2018, which applies varying add-on payments for CYs 2019 through 2022 based on a home health agency's rural county designation.

### *Key Takeaways*

The final rule with comment period would:

- Increase net payments by 1.3% (\$250 million).
- Implement a redesigned payment system in CY 2020, as previously finalized.
- Implement a 4.36% cut to attempt budget-neutral implementation of the new payment system.
- Remove one and add two new quality measures.
- Require the reporting of several standardized patient assessment data elements.

## CY 2020 REDESIGN OF THE HH PPS

The BBA of 2018 required CMS to redesign the HH PPS in a budget-neutral manner by CY 2020. This includes a transition from a 60-day to 30-day episode of care and a shift to a new case-mix system that bases payment on a broad clinical profile of the patient.

In response to this mandate, last year's rulemaking finalized the Patient-Driven Groupings Model (PDGM), which relies on a comprehensive assessment of patients' clinical characteristics, rather than therapy utilization, to set payments. Specifically, patients will be assigned to a PDGM payment category based on these key elements of the patient's clinical profile:

- *Admission source.* Institutional referrals will be paid more than community-based referrals.
- *Timing of the episode.* The first episode will be paid more than subsequent episodes in a sequence.
- *Primary diagnosis.* The patient's primary diagnosis will influence the payment amount, with diagnoses organized in these six categories:
  1. Medication management, teaching and assessment;
  2. Neuro/stroke rehabilitation;
  3. Wounds (post-op wound aftercare and skin/non-surgical wound care);
  4. Complex nursing interventions;
  5. Musculoskeletal rehabilitation; or
  6. Behavioral health.
- *Functional level.* A payment add-on will be made based on a patient's functional level, depending on whether the functional level is considered low, medium or high. The three functional level categories will be based on the distribution of levels found in the claims for a preceding year, with those levels divided into approximately even thirds.
- *Comorbidity.* Patients with one qualifying secondary diagnosis will receive a "low" comorbidity adjustment, and those with at least two qualifying conditions will receive a "high" comorbidity adjustment.

**Final Behavioral Adjustment.** CMS is required to implement the PDGM in a budget-neutral fashion. To do so, it finalized a prospective behavioral adjustment based on three assumptions of how HH agency behavior will change under the new model:

- *Clinical Group Coding.* CMS assumes that HH agencies will change their documentation and coding practices and designate the highest-paying diagnosis as the principal diagnosis code. Under the PDGM, this would result in a 30-day period being placed in a higher-paying clinical group.

- *Comorbidity Coding.* Since the PDGM adjusts payments based on secondary diagnoses reported on the HH claim, more 30-day periods of care will receive a comorbidity adjustment than if the model only used the more limited Outcome and Assessment Information Set (OASIS) diagnosis codes, which is current practice. Under the PDGM, the comorbidity adjustment can increase payments.
- *LUPA Threshold.* CMS assumes that under PDGM, HH agencies will provide one to two extra visits for about one-third of low-volume episodes to qualify for a full 30-day episode payment.

**In a significant change from the proposed rule, which recommended a behavioral adjustment of negative 8.01% to account for the above provider responses, CMS finalized a much smaller behavioral adjustment of negative 4.36%.** The proposed adjustment was the subject of intense opposition from the field, including AHA, due to the lack of a precedent for accurate, prospective behavioral adjustments. To explain its shift, CMS stated, “We continue to believe that the behavior assumptions are valid ones and supported by evidence as described in the CY 2019 final rule ... and the CY 2020 proposed rule. However, given the scale of the payment system changes, we agree that it might take HHAs more time before they fully implement the behavior assumed by CMS.” CMS also said it made the change due to analysis from its own actuaries, who determined by looking at claims during the inpatient PPS transition to Medicare Severity-Diagnosis Related Groups that coding and documentation changes were only about half of what was initially expected. The agency went on to say, “We believe it is reasonable to apply the three previously outlined behavior change assumptions to only half of the 30-day periods in our analytic file (randomly selected). Note that since payment is made for 30-day periods, it is more accurate to apply the behavior assumptions to half the 30-day periods than to assume the magnitude of the behaviors would be halved. Therefore, taking this approach means that the resulting adjustment to the 30-day payment amount needed to maintain budget neutrality, as required by law, is an adjustment of -4.36%.” In other words, while CMS will still apply all three assumptions for establishing a 30-day payment rate, the agency changed its assumption regarding the frequency with which those behaviors would occur in the first year of implementation.

Moving forward, CMS states that it plans to continue monitoring provider behavior in response to PDGM and the shorter payment period to determine if the 4.36% offset actually achieves budget neutrality in CY 2020. The rule also notes that if CMS finds that it underestimated or overestimated this offset, it would adjust the CY 2021 30-day payment amount through another behavioral offset. Any such CY 2021 and/or subsequent adjustments would be proposed through rulemaking.

**Estimating PDGM Impact.** To assist providers in understanding the impact of the new 30-day payment unit and payment model, CMS has posted several resources on its website: <https://www.cms.gov/center/provider-type/home-health-agency-hha-center.html>. Specifically, among other resources, this link includes CY 2020 provider-level impacts, an updated interactive grouper tool, and instructions for requesting a HH claims-OASIS limited data set (LDS) file. This webpage also includes materials from CMS’s Aug. 21, 2019 call with HH agencies that address PDGM operational issues and are designed to help agencies prepare to implement the new model.

**Maintenance Therapy.** The final rule allows therapist assistants to perform maintenance therapy for HH beneficiaries in accordance with individual state practice requirements. The agency notes that this change is consistent with regulations for skilled nursing facilities, where therapist assistants can perform maintenance therapy; allows therapist assistants to practice at the top of their state licensure; and provides HH agencies the flexibility to use either therapists or therapist assistants to meet the maintenance therapy needs of their patients.

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## **FINAL HH QUALITY MEASUREMENT CHANGES**

**HH Quality Reporting Program (QRP).** CMS will adopt two new process measures for the CY 2022 HH QRP. These measures satisfy the Improving Medicare Post-Acute Care Transformation (IMPACT) Act-required domain of “Transfer of Health Information.” One measure, “Transfer of Health Information to the Provider—Post-Acute Care,” assesses whether or not a current reconciled medication list is given to the subsequent provider when an episode ends in discharge/transfer to an “admitting provider,” including a hospital, intermediate care, home under care of another home health agency or hospice, or another post-acute care provider. The other, “Transfer of Health Information to the Patient—Post-Acute Care,” assesses whether the same information is provided to the patient, family or caregiver when the patient is discharged from a home health agency to a private home without any further services, a board and care home, assisted living, a group home or transitional living. Home health agencies will be required to begin data collection for both measures on Jan. 1, 2021. Neither measure has been endorsed by the National Quality Forum.

CMS will also modify the existing measure, “Discharge to Community,” to exclude patients who had long-term nursing facility stays before their home health agency episode with no intervening community discharge from the measure calculation. CMS makes this change because these “baseline nursing facility residents” are far less likely to return to the community following home health discharge, and thus unfairly skew measure performance.

In addition, CMS will remove one quality measure from the HH QRP. Acting in an “abundance of caution” and in alignment with the agency’s roadmap to promote appropriate stewardship of opioids, CMS believes that inclusion of the measure, “Improvement in Pain Interfering with Activity,” may result in unintended consequences regarding inappropriate utilization of opioids. Home health agencies will no longer be required to submit OASIS item M1242 beginning Jan. 1, 2021, and data for the measure will no longer be publicly reported on *HH Compare* after April 2020.

CMS did not finalize its proposal to remove one question from the HH Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey that is related to pain. CMS initially proposed to remove the question, “In the last 2 months of care, did you and a home health provider from this agency talk about pain?” to avoid the same potential unintended consequences as with the aforementioned pain quality measure. However, in response to many public comments opposing the removal of the question, most focusing on the critical need to monitor pain in the HH setting, CMS will retain the question.

**Standardized Patient Assessment Data Elements (SPADES).** CMS finalized its proposal for home health agencies to begin reporting several SPADES at start of care, resumption of care and discharge beginning Jan. 1, 2021. Home health agencies already collect some of these data elements through the SNF MDS, but many more elements (or parts or versions of elements) will be added to the instrument. Most of these SPADES are the same that were proposed for implementation in the FY 2018 home health PPS proposed rule, but subsequently were not finalized following public comments voicing concerns about the speed and magnitude of the additions as well as the lack of facility-specific testing for several elements. CMS believes that since that time, home health agencies have had sufficient time to prepare for new reporting requirements, and further testing of the SPADES supports their use across post-acute care providers.

In addition to the SPADEs that meet the IMPACT Act-required domains, CMS also adds a new domain regarding social determinants of health (SDOH) and seven new data elements to inform that domain. All elements were finalized for adoption as proposed, with technical changes to the SDOH elements on Ethnicity, Preferred Language and Interpreter Services, the latter two of which will only be required for reporting upon admission (instead of both admission and discharge). HH agencies will be required to report this data with respect to admissions and discharges that occur between Jan. 1, 2021, and June 30, 2021, for the CY 2022 HH QRP, and then for each calendar year thereafter.

**HH Value-based Purchasing (HH VBP).** CMS will publicly report the Total Performance Scores (TPS) and the TPS Percentile Rankings from the fifth year (CY 2020) of the HH VBP demonstration. Nine states participate in this model, and CMS expects the data for these states to be made public after Dec. 1, 2021.

**Home Infusion Therapy Benefit.** Following the establishment of a temporary transitional payment that began for this new Medicare benefit on Jan. 1, 2019, CMS sets forth routine updates to these payments for CY 2020 and finalizes payment provisions for these services for CY 2021 and beyond. The rule also makes a number of revisions to the regulations to implement the payment system beginning Jan. 1, 2021. The revised regulations reflect proposals for the implementation of the benefit that were finalized in the CY 2019 home health PPS final rule.

CMS finalizes its proposal that the permanent payment system (i.e., what will be used after the temporary transitional payment period expires at the end of CY 2020) use the same design as the temporary transitional payment system, which groups home infusion drugs by J-code into payment categories reflecting similar therapy types. The agency states that this will result in payment categories reflecting variations in infusion drug administration services, including the utilization of nursing services, patient acuity and the complexity of drug administration. Under this system, CMS will pay a single amount for each infusion drug administration calendar day in the beneficiary's home based on the payment category for that specific drug. CMS states that this single amount will cover all services associated with drug administration, including professional services (like nursing), training and education, and monitoring/remote monitoring.

Unlike the transitional payment system, however, CMS will set the single payment amount equal to five hours (instead of four) of infusion therapy services in a physician's office for

each infusion drug administration calendar day, as proposed. Also, CMS will increase the payment amounts for the first visit by the average difference between the payments for existing patient and new patient visits as paid in the physician fee schedule. This will result in a small decrease to the payment amounts for the second and subsequent visits. Finally, CMS will apply a specific geographic wage adjustment — the geographic adjustment factor — in a budget-neutral fashion to account for wage differences and other costs that may vary by region.

## **NEXT STEPS**

Watch for a more detailed Regulatory Advisory and an invitation to an AHA members-only call to discuss the final rule with comment to collect input for AHA's comment letter. Through Dec. 30, CMS will receive comments that exclusively pertain to the durable medical equipment benefit provision in the rule.

If you have further questions on the payment provisions, contact Rochelle Archuleta, director of policy, at [rarchuleta@aha.org](mailto:rarchuleta@aha.org); for questions on quality provisions, contact Caitlin Gillooley, senior associate director of policy, at [cgillooley@aha.org](mailto:cgillooley@aha.org).