

A NEW HORIZON FOR HOME HEALTH

The CMS Proposed Rule & Patient-Driven Groupings Model (PDGM)

Simione Healthcare Consultants has completed an initial, comprehensive assessment of the proposed home health rule issued by the Centers for Medicare & Medicaid Services (CMS) on July 2, 2018. This overview includes highlights on the most significant anticipated changes to the home health payment system in two decades. The key areas involve: [rate changes for 2019, other proposed changes pertaining to home health operations, and changes for 2020 that include the Patient-Driven Groupings Model \(PDGM\)](#). The Simione team is ready to assist home health agencies in evaluating the proposed rule and supporting effective implementation for success in clinical, financial and administrative operations. Call 800-949-0388 and visit Simione.com. Home health organizations should refer to the proposed rule for verification of all information at <https://federalregister.gov/d/2018-14443>.



2019 Proposed Rate Changes

- Changes in National Standardized 60-day Episode Payment will be calculated as follows:

CY 2018 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2019 HH Payment Update	CY 2019 National, Standardized 60-Day Episode Payment
\$3,039.64	X 0.9991	X 1.0163	X 1.021	\$3,151.22

- The National Standardized 60-day Episode Payment will continue to be reduced by 2% in 2019 for agencies that do not submit quality data.
- The rate increase of 2.1% would result in \$400 million in new payments to HHAs.
 - This increase in payments is from the market basket increase of +2.8% less .7% for the multi-factor productivity.
 - The wage index update will now be using CY 2015 hospital cost report data.
- Several new factors are proposed to apply to the market basket index, including:
 - Rebase – move base year from CY 2010 to CY 2016 BLS OES HHA data
 - Revise – change data sources, cost categories and/or price proxies
 - Derive – 8 major expense categories with “All Other” further detailed into 9 cost categories
 - Result in – Only CY 2015 had any deviation with 2010 = 0.1 percentage point higher
- The labor-related share is a reduction from 78.5 in 2018 to 76.1 using 2016-based proposed home health market basket; non-labor share is 23.9. 2018 used the 2010-based HH market basket.
- Rural Add-on – changes equal a .10 decrease in payments, and an overall decrease of \$20 million
 - No longer applied uniformly – The percent and durations will vary from CY 2019 – CY 2022.

- The 2,006 rural counties will be placed into one of three categories:
 - **High utilization category** – based on number of Medicare HH episodes furnished per 100 Medicare beneficiaries. This top 25th percentile has a total of 510 counties. They will receive 1.5% in CY 2019 and 0.5% in CY 2020.
 - **Low population density category** – The 334 counties with fewer than six or fewer individuals per square mile will receive 4% in CY 2019, 3% in CY 2020, 2% in CY 2021 and 1% in CY 2022.
 - **All others** – These 1,162 counties will receive 3% in CY 2019, 2% in CY 2020, and 1% in CY 2021.
- Outlier payments = .10 increase due to the decrease in Fixed Dollar Loss (FDL) in order to target no more than 2.5% = \$20 million increase
 - The FDL ratio is dropping to .51 from .55, however not more than 2.5% of total payments as outlier payments in CY 2019
 - The loss sharing ratio stays the same at .80
 - The FDL may be adjusted in the final rule, because the outlier payment calculation will be updated.
- LUPA remains at 4 or fewer visits, and will be paid by the visit by discipline, and includes:
 - An add-on for initial or only episode in a sequence of adjacent episodes
 - A wage index budget neutrality factor of 1.0000 with a payment rate increase of 2.1%
 - National Per Visit amounts
 - A continued payment reduction of 2 percent for agencies that do not submit quality data

HH Discipline	CY 2018 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2019 Payment Update	CY 2019 Per-Visit Payment
Home Health Aide	\$64.94	X 1.0000	X 1.021	\$66.30
Medical Social Services	\$229.86	X 1.0000	X 1.021	\$234.69
Occupational Therapy	\$157.83	X 1.0000	X 1.021	\$161.14
Physical Therapy	\$156.76	X 1.0000	X 1.021	\$160.05
Skilled Nursing	\$143.40	X 1.0000	X 1.021	\$146.41
Speech-Language Pathology	\$170.38	X 1.0000	X 1.021	\$173.96

- No changes are proposed for non-routine supplies.
 - The payment rate is \$53.03 2018 conversion factor X 2019 HH payment update of 2.1% = \$54.14 2019 NRS conversion factor.
 - The 6 levels of severity continue with corresponding relative weight factors.
- The method for Partial Episode Payment (PEP) is unchanged: the beneficiary-elected transfer or discharge with goals met or no expectation of return to home health and beneficiary did transfer back to home health within the 60-day episode.
- The budget neutrality factor for case mix weight equals 1.0163, reflecting the recalibration to offset the case mix weight budget neutrality.
- The budget neutrality factor for wage index equals .9991.
- The proposed CY 2019 Case Mix Payment weights decreased from CY 2018 by .0211 or 1.8%.
- For rebasing and revising the home health market basket, the cost category weights in the current home health market basket are on CY 2010 data. The proposal is to rebase and revise to reflect 2016 Medicare cost report data. The change is +2.8 percent.
- The unit of payment for episodes of care for CY 2019 methodology is unchanged with RAP, and final payment and the split percentages (2 payments, initial and final) are the same.



Other Proposed Changes

Home Infusion Therapy Benefit

- Changes will ensure consistency in coverage for home infusion benefits for all Medicare beneficiaries.
- Payments will increase by \$60 million to home infusion therapy suppliers.
- Payments will include coverage of professional services, including nursing services furnished in accordance with the plan of care.
- Patient training and education (which was not covered under the DME benefit) is now covered, as well as patient monitoring furnished by a qualified home infusion supplier.
- Home infusion therapy suppliers must be accredited by an AO (Accrediting Organization).

Telehealth Costs

- The cost of patient monitoring is no longer non-reimbursable; it will be treated as allowable administrative costs, and it will not be separately billable.
- Telehealth will be covered as long as **remote patient monitoring** is used by the home health agency to augment the care planning process, and not to replace home health visits. Remote patient monitoring is defined as “the collection of physiologic data digitally stored and transmitted by the patient/caregiver or both to the home health agency”.

Documentation of Eligibility

- The physician recertification requirement has been eliminated, specifically the estimate as to how much longer home health services will be required.
- Medical record documentation from the HHA will be used to support the basis for certification and/or recertification of home health eligibility.

Home Health Value-Based Purchasing (HHVBP) Model

- The maximum payment adjustment for 2019 will be plus or minus 5%. It was 3 percent in 2018.
- Two outcomes & OASIS-based measures have been removed: influenza and pneumococcal. Three OASIS-based measures are replaced: improvement in ambulation, bed transferring & bathing, with 2 proposed composite measures in self-care and mobility. Maximum possible improvement points are reduced from 10 to 9. Changes in the weights for the performance measures allow for the OASIS and claims-based measures to each account for 35%.

Accreditation

- Changes for oversight for deemed-status Accrediting Organizations (AOs) will require:
 - That all AO surveyors complete the relevant program-specific CMS online surveyor trainings to reduce disparity between AO findings and validation surveys conducted by state survey agencies.
 - That AOs continue a provider’s current accreditation (if deemed status accreditation is voluntarily dropped) until the effective date of withdrawal identified by the provider or the expiration date of the term of accreditation, whichever comes first, if that provider’s Medicare certification is in good standing. CMS is proposing this change to ensure providers are not penalized because they choose to terminate accreditation during the certification/accreditation survey cycle.

Home Health Quality Reporting Program and OASIS

- CMS is proposing several changes related to implementation of the PDGM for CY 2020:
 - Removal of the previously adopted Home Health Quality Reporting Program (HH-QRP) measures and adoption of eight (8) measure removal factors to align with other QRPs
 - Removal of seven (7) measures beginning with the CY 2021 HH-QRP, and an update to regulations to clarify that not all OASIS data are required for the HH QRP
 - Use of 2 years (vs. 1 year) of data to calculate the Medicare Spending per Beneficiary measure display
 - CMS estimates that the cost impact related to OASIS item collection is \$60 million in annualized net cost savings to HHAs, discounted at 7 percent relative to year 2016, over a perpetual time horizon beginning in CY 2020. This is a result of the proposed PDGM implementation and changes to the HH QRP.
 - Changes to OASIS and QRP will impact agency OASIS data collection, publicly reported measures, and CMS reports used by state survey agencies.
 - CMS is not proposing changes to the Home Health Care Consumer Assessment of Healthcare Providers and Systems® (HCAHPS) Survey requirements for CY 2019.

Requests for Information (RFI)

- CMS is seeking feedback in two areas:
 - Promoting Interoperability and Electronic Healthcare Information Exchange
 - Revisions to the CMS Patient Health and Safety Requirements for hospitals and other Medicare/Medicaid participating providers and suppliers
 - Price Transparency: Improving Beneficiary Access to Home Health Charge Information
 - How to define “standard charges” in home health
 - If HHAs should be required to inform patients of out-of-pocket costs before services are furnished
 - How CMS can help beneficiaries understand how co-pays and coinsurance are applied to each covered service and better inform patients of financial obligations
 - How Medigap coverage will affect patients’ understanding of out-of-pocket costs before services are furnished



A Major Overhaul in 2020

The most significant change to home health prospective payments in 2020 will be implementation of the proposed **Patient-Driven Groupings Model (PDGM)**, which will align payment with resource use in a budget neutral way.

- CMS will be making assumptions about (and describe) behavioral changes related to:
 - Clinical Group Coding
 - Comorbidity Coding
 - LUPA Threshold
- Therapy thresholds will be eliminated.

- The 216 Payment Groups or HRGs, will include:
 - Early (first 30-day period) and Late (all subsequent periods)
 - Whether admission is from the community or an institution
 - Six clinical groups
 - Three functional levels of impairment
 - Three comorbidity adjustment categories
- Case mix weights will be based on costs of care with a change from the Wage-Weighted Minutes of Care (labor only) approach to Cost Per Minute + Non-routine Supplies (all costs).
 - Data sources will include cost reports and claims.
- The 30-Day Unit of Service will be synonymous with a 30-Day Unit of Payment. CMS will:
 - Develop 30-day payment amounts
 - Question the need to continue RAP due to cash flow and fraud concerns
 - If the RAP is eliminated, expect a possible “Notice of Admission” to establish the provider as primary and ensure that claims processing systems are updated to show the beneficiary is under a HH period of care. CMS is also considering a “No Pay RAP”.
 - Plans are similar to Hospice NOE/NOTR filing requirements. Providers should be aware of lessons learned during that implementation.
- An “early” 30-day period is the initial 30-day period in a sequence of adjacent 30-day periods. All subsequent periods would be considered “late”.
 - Adjacent or contiguous periods of care would be separated by no more than a 60-day period.
 - A new “early” would only exist if there is a 60-day gap between the end of one period and the start of another.
 - The Common Working File (CWF) will count from “day 30” – the only exception is a PEP. Then CWF will count from the day of last billable visit provided.
- The **Admission Source** is an indicator of where the patient was 14 days prior to the start of the 30-day period – community or institution.
- The PDGM will add functional items Section GG to OASIS effective 01/01/2019.
- The PDGM proposes three levels for the comorbidity case mix adjustment with a reported secondary diagnosis. These levels will determine if there is no adjustment, or a low or high comorbidity adjustment.
 - Considerations will include interactions between multiple comorbid conditions and the presence of individual comorbid conditions, as well as types of conditions most commonly seen in home health.
- LUPA thresholds for the 30-day period of care are proposed to vary by case mix group (216) – referencing the 10th percentile of visits or 2 visits, whichever is higher.
- LUPA add-on factors will remain the same.
- There will be an annual recalibration of PDGM case mix weights.
- PEP will remain the same. With an intervening event, the original 30-day period is proportionally adjusted using the span of days (first billable visit through the last billable service date).
- An outlier is proposed to maintain existing policy, except that payments will be determined on a 30-day basis.
- CMS also plans revisions to conform regulations for the PDGM, including sections that apply to the transition from a 60-day to a 30-day period.

Simione Healthcare Consultants advances quality and cost efficiency, providing reliable experts, technology and tools to grow and improve home- and community-based services.