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CY 2019 Home Health Prospective Payment System Proposed Rule

OVERVIEW

On July 2nd, the Centers for Medicare and Medicaid Services (CMS) released a proposed rule that would update Medicare payment rates for home health agencies (HHAs) in CY 2019. Other policy and payment provisions of the rule include:

- Implementing the Patient-Driven Groupings Model (PDGM), a new case-mix methodology that would change the unit of payment from 60 days to 30 days in CY 2020;
- Paying for remote patient monitoring costs;
- Implementing a new home infusion therapy benefit, beginning in CY 2019;
- Reducing certain regulatory burdens for CY 2019;
- Updating the Home Health Quality Reporting Program (HH QRP) in CY 2021; and
- Soliciting information on interoperability requirements.

These provisions are explained in greater detail below. CMS will accept comments on the proposed rule until August 31st. The proposed rule is available here.

Payment Updates

For CY 2019, CMS estimates that the proposed rule would result in a 2.1%, or $400 million, increase in payments to HHAs. This reflects a 2.1% increase to the home health payment update percentage, a 0.1% increase due to decreasing the fixed-dollar-loss ratio so that no more than 2.5% of total payments are outlier payments, and a 0.1% decrease due to the Bipartisan Budget Act (BBA) rural-add on policy. Between CYs 2019 and 2022, the rural add-on payment will vary depending on county population density and home health utilization.

PDGM

HHAs are currently paid a standardized 60-day episode payment for covered services, adjusted for case-mix. To comply with provisions of the BBA, CMS is proposing the PDGM for CY 2020. The PDGM is very similar to the Home Health Groupings Model (HHGM), which was proposed, but not finalized by CMS last year. Both models would reduce the unit of payment for home health episodes from 60 days to 30 days and revise the case-mix system so that it excludes therapy thresholds and emphasizes the clinical characteristics of patients. Each 30-day period of care would be categorized as one of 216 different payment groups based on the patient's:

- Admission source and timing from claims;
- Clinical groupings from principal diagnosis reported on claims;
- Functional level from OASIS items; and
- Comorbidity adjustment from secondary diagnoses reported on claims.

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PDGM differs from HHGM in that it must be implemented in a budget-neutral manner. CMS estimated that HHGM would have resulted in a 4.3% decrease in payments to HHAs if implemented in a non-budget neutral manner or a 2.2% decrease in payments to HHAs if implemented in a partially-budget neutral manner in CY 2019.

The threshold for Low Utilization Payment Adjustment (LUPA) remains at four visits per episode. CY 2019 LUPA per visit rates would be increased by the 2.1 percent home health payment update and a regional wage index factor.

To assess the impact of the proposed PDGM, HHAs may request a Home Health Claims-OASIS Limited Data Set by following these instructions. More information on agency-level impacts, an expert panel's report to Congress, and an interactive Grouper Tool that will allow HHAs to determine case-mix weights for their patient population are available here.

Remote Patient Monitoring

Under the proposed rule, the costs of remote patient monitoring equipment and services would be allowable administrative costs if used by HHAs to augment the care planning process. Remote patient monitoring would be defined under the Medicare home health benefit as the collection of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the HHA. Since it is not considered a telehealth service, it would not be subject to Medicare telehealth site restrictions.

Home Infusion Therapy Benefit

To comply with the BBA, CMS is proposing temporary transitional payments for home infusion therapy services in CYs 2019 and 2020 before fully implementing the home infusion therapy benefit in CY 2021. Services may include: associated professional services for administering certain drugs and biologicals through a durable medical infusion pump, training and education, and remote monitoring and monitoring services.

CMS seeks comment on elements of the new benefit.

Regulatory Burden Reduction

In 2019, the proposed rule would offer regulatory relief to HHAs by:

- Removing the requirement that certifying physicians estimate how much longer skilled services are required when recertifying the need for continued home health care; and
- Allowing medical record documentation from HHAs to support Medicare home health eligibility determinations. CMS currently only considers medical records from prescribing physicians and acute or post-acute care facilities.

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HH QRP

The Improving Medicare Post-Acute Care Transformation Act requires post-acute care providers, including HHAs, to report standardized assessment data for the following domains: functional status changes, skin integrity and changes, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge options.

The rule proposes a new methodology for assessing measures that considers new measure removal factors. Based on the new measure removal methodology, CMS would remove the following quality measures from the HH QRP in CY 2021:

- 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 Home Health; and
- Rehospitalization During the First 30 Days of Home Health

Interoperability Request for Information

CMS is soliciting information on revisions to the Conditions of Participation to encourage providers to share data electronically. Specifically, CMS seeks suggestions for modifications to health and safety standards for providers and suppliers, such as requiring hospitals to electronically transfer medically necessary information to another facility or community provider upon patient transfer or discharge.