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2019 Home Health Prospective Payment System (HH PPS) Final Rule

OVERVIEW

On October 31st, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will update Medicare payment rates for home health agencies (HHAs) in CY 2019. The rule will implement a new case-mix methodology, allow for the payment of remote patient monitoring, ease certain regulatory burdens, and update the Home Health Quality Reporting Program (HH QRP). CMS estimates that the rule will result in a 2.2%, or $420 million, increase in payments to HHAs.

Provisions of the rule are explained in greater detail below. The final rule is available here.

Patient-Driven Groupings Model (PDGM)

HHAs are currently paid a standardized 60-day episode payment for covered services, adjusted for case-mix. To comply with the Bipartisan Budget Act, CMS will implement the PDGM in 2020. The PDGM will 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 will be categorized based on the patient's:

- *Admission Source and Timing* – Admission source will be either Institutional or Community and timing will be considered Early for the first 30-day period or Late for all subsequent 30-day periods
- *Clinical Groupings* – Will be based on a principal diagnosis of: Musculoskeletal Rehabilitation; Neuro/Stoke Rehabilitation; Wound Care; Behavioral Health Care; Complex Nursing Interventions; or Medication Management, Teaching and Assessment (MMTA):
  - The final rule includes seven clinical sub-groups for MMTA: Surgical Aftercare, Cardiac/Circulatory, Endocrine, Gastrointestinal/Genitourinary, Infectious Disease/Neoplasms/Blood-Forming Diseases, Respiratory, and Other
- *Functional Impairment Levels* – Will be categorized High impairment, Medium impairment, or Low impairment according to Outcome and Assessment Information Set (OASIS) items
- *Comorbidity Adjustment* – Will be categorized as No adjustment, Low adjustment, or High adjustment based on a secondary diagnosis of home health specific comorbidities

The Low Utilization Payment Adjustment (LUPA) threshold will also vary for each 30-day period depending on which PDGM payment group a patient is assigned to. To determine the LUPA add-on payment, CMS will continue to multiply the per-visit payment amount for the first skilled nursing, physical therapy, or speech-language pathology visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care.

The proposed rule included a 6.42% payment reduction to account for behavior changes that could occur following the implementation of PDGM. CMS finalized the policy of applying a negative payment adjustment, but did not finalize an amount. The payment reduction, along with reimbursement weights and a base payment, will be outlined in the CY 2020 HH PPS proposed rule.

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More information, including agency-level impacts and an interactive Grouper Tool that allows HHAs to determine case-mix weights for their patient populations, is available here. Upon request, CMS will also provide Home Health Claims-OASIS Limited Data Set files to help stakeholders assess the impact of the PDGM. Instructions for requesting the file are available here.

Remote Patient Monitoring

Under the final rule, the costs of remote patient monitoring equipment and services will 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. However, remote patient monitoring must be accompanied by the provision of another skilled service. Visits to a beneficiary's home for the sole purpose of remote patient monitoring, without the provision of another skilled service, would not be separately billable.

Since this benefit is not considered a telehealth service, it would not be subject to Medicare telehealth restrictions.

Home Infusion Therapy Benefits

To comply with the BBA, CMS is finalizing temporary transitional payments for home infusion therapy services in 2019 and 2020, before fully implementing the benefit in 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.

The rule also establishes safety standards, accreditation and approval processes, and oversight for home infusion therapy suppliers.

Regulatory Burden Reduction

The final rule seeks to offer HHAs regulatory relief in 2019 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 to 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 finalized a new measure evaluation and removal methodology. Based on the new methodology, CMS will remove the following measures from the HH QRP in 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 Readmissions During the First 30 Days of Home Health; and
- Rehospitalization During the First 30 Days of Home Health.

The final rule will also replace the following measures:

- Three OASIS-based measures (Improvement in Ambulation-Locomotion, Improvement in Bed Transferring, and Improvement in Bathing) will be replaced with two composite measures (Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility); and
- The Improvement in Ambulation-Locomotion, Improvement in Bed Transferring, and Improvement in Bathing measures will be replaced with the the Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility measures.