CY 2020 HH PPS Proposed Rule

On Friday, July 12, CMS released the CY 2020 Home Health (HH) PPS Proposed Rule, which outlines proposed payment updates, modifications in the HH VBP and QRP programs, updates to coverage of home infusion services, and some clarifications associated with the implementation of the Patient-Driven Groupings Model (PDGM) on January 1, 2020. The comment period closes September 9, 2019.

Patient-Driven Groupings Model (PDGM)

CMS reiterated implementation of PDGM on January 1, 2020, with no substantive changes to the model itself.

PDGM Categories Affecting Payment remain as clarified in the CY 2019 HH PPS Final Rule:

1. Timing of 30-day period – Early vs. Late
2. Admission Source – Institutional vs. Community
3. Clinical Grouping – 12 Clinical Categories
4. Functional Level – Low / Medium / High
5. Comorbidity Adjustment – None / Low / High

For more information on PDGM and the five categories affecting payment, read Casamba's PDGM Summary document found **here**.

Comments and clarifications found in the CY 2020 proposed rule related to PDGM are outlined in the sections that follow:

TIMING

Under PDGM, the first 30-day period of care will be classified as early and all subsequent 30-day periods of care in the sequence (second or later) will be classified as late. A 30-day period will not be considered early unless there is a gap of more than 60 days between the end of one period of care and the start of another.

Other HH requirements will continue on a 60-day basis. Specifically, certifications and recertifications continue on a 60-day basis and the comprehensive assessment will still be completed within five days of the start of care (SOC) date and completed no less frequently than during the last five days of every 60 days thereafter.

ADMISSION SOURCE

CMS clarifies the following regarding the institutional admission source category:

- "The institutional admission source category will also include patients who had an acute hospital stay during a previous 30-day period of care and within 14 days of a subsequent, contiguous 30-day period and for which the patient was not discharged and readmitted…as we acknowledge that HHAs [home health agencies] have discretion as to whether they discharge the patient due to a hospitalization and then readmit the patient after hospital discharge."

- "However, we will not categorize post-acute care stays, meaning SNF, IRF, LTCH, or IPF stays, that occur during a previous 30-day period of care and within 14 days of a subsequent, contiguous 30-day period of care as institutional…as we would expect the HHA to discharge the patient if the patient required post-acute care in a different setting…and then readmit the patient, if necessary, after discharge from such setting. All other 30-day periods of care would be designated as community admissions."

Note: This appears to be a change from previous clarifications from CMS about late institutional periods after a post-acute inpatient stay. In a PDGM presentation on February 12, 2019, CMS stated the following: "A post-acute stay in the 14 days prior to a late home health 30-day period would not be classified as an institutional admission unless the patient had been discharged from home health prior to post-acute stay (which is what we would expect to occur)."

Classification of admission source will be determined by the Medicare Claims Processing System for final claim payment. This allows CMS the opportunity and flexibility to verify admission source and correct any improper payments.

HHAs will be allowed to manually indicate an institutional admission source on the claim using new occurrence codes:

- Occurrence code 61: Acute hospital discharge within 14 days prior to the "From Date" of any HH claim
- Occurrence code 62: SNF, IRF, LTCH, or IPF (i.e., post-acute) discharge within 14 days prior to the "Admission Date" of the first HH claim

If no occurrence code is present on the claim, the period will be categorized as community, but may be adjusted once any institutional claims are processed.

CLINICAL GROUPING

A change in the principal diagnosis during a 30-day period may change the clinical grouping for the next 30-day period. However, this does not mean that a new OASIS ("other follow up") must be completed just to make the diagnosis on the claim match the OASIS. However, if the patient had a significant change in condition before the start of a subsequent, contiguous 30-day period, the HHA is required to update the comprehensive assessment.

Currently, billing instructions say the principal diagnosis on the OASIS and the claim must match. These instructions will be updated to allow for the clinical judgment of the HH provider to determine the need for an "other follow up" assessment to make a diagnosis match. For claims with "From" dates on or after January 1, 2020, the ICD-10-CM code and principal diagnosis used for payment grouping will come from the claim and not the OASIS. The claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Regardless of clinical group assignment, HHAs are required to ensure that the individualized HH POC addresses all care needs, including the disciplines to provide such care. (*Note:* This speaks to the

question regarding whether or not a patient in a clinical group other than Musculoskeletal rehab or Neuro/Stroke Rehab can receive PT, OT or ST. The answer is YES. Regardless of clinical group, HH is an interdisciplinary service, and patients should receive the care they need.)

FUNCTIONAL LEVEL

Functional impairment level will remain the same for the first and second 30-day periods of care unless there has been a significant change in condition that warrants an "other follow up" assessment prior to the second 30-day period.

COMORBIDITY ADJUSTMENT

CMS will update the comorbidity subgroups and interactions subgroups using the most recent available claims data in the CY 2020 HH PPS final rule.

LUPA THRESHOLDS

Low utilization payment amount (LUPA) thresholds remain as finalized in the CY 2019 HH PPS final rule. Each home health resource group (HHRG) will have its own LUPA threshold, ranging between 2 and 6 visits, based on the 10th percentile value of visits or two visits, whichever is higher. The LUPA thresholds will be reevaluated each year based on the most current utilization data available at the time of rulemaking. Under PDGM, if the LUPA threshold is met, the 30-day period of care will be paid at the full 30-day period payment. If the threshold is not met, payment will be made per visit. For example, if the LUPA threshold is four, and a 30-day period of care has four or more visits, it is paid the full 30-day payment period amount.

BEHAVIORAL ASSUMPTIONS

As required by the Bipartisan Budget Act (BBA) of 2018, CMS is required to calculate budget neutral 30-day payment amounts for the implementation of PDGM before the annual HH percentage increase, adjustment for case-mix changes, adjustment if quality data is not reported, and the productivity adjustment. CMS is also required to make "assumptions about behavior changes" that could occur with the implementation of the 30-day unit of payment and/or as a result of the PDGM case-mix adjustment factors.

In this rule, CMS confirms the three behavioral assumptions initially presented in the CY 2019 HH PPS Proposed Rule:

- *Clinical Group Coding* – CMS assumes that HHAs will change documentation and coding practices and will put the highest paying diagnosis code as the principal diagnosis to have the 30-day period be placed into a higher paying clinical group.
- *Comorbidity Coding* – While the OASIS only allows HHAs to designate one primary and five secondary diagnoses, the HH claim allows one principal diagnosis and 24 secondary diagnoses. Therefore, CMS assumes that by taking into account the additional ICD-10-CM codes listed on the claim (beyond the six allowed on the OASIS), more 30-day periods will receive a comorbidity adjustment than would be the case if only the OASIS data was used for payment.

- *LUPA Threshold* – CMS assumes that for one third of LUPAs that are 1-2 visits away from the LUPA threshold, HHAs will provide "1-2 extra visits" to receive the full 30-day payment vs. the per visit LUPA amount.

CMS estimated that without the behavioral assumptions, the 30-day payment amount needed to achieve budget neutrality in CY 2020 would be $1907.11. Applying these three assumptions, results in the need to decrease the CY 2020 estimated budget-neutral 30-day payment amount to $1,754.37 (an 8.01% decrease).

TABLE 12: CY 2020 Proposed, Estimated 30-day Budget-Neutral Payment Amounts

Behavioral Assumption	30-day Budget Neutral Standard Amount	% Change from No Behavioral Assumptions[1]
No Behavioral Assumptions	$1907.11	
LUPA Threshold	$1871.67	-1.86%
Clinical Group Coding[2]	$1794.42	-5.91%
Comorbidity Coding	$1900.05	-0.37%
Clinical Group + Comorbidity + LUPA	$1754.37	-8.01%

Notes:

[1]Adding all percent decreases for each behavior assumption results in a total % decrease of -8.14%. However, there is overlap and interactions between the assumptions, and when combined, the budget-neutral payment amount results in a -8.01% decrease.

[2]Clinical group coding assumption has a higher % decrease in this year's proposed rule compared to CY 2019 HH Proposed Rule. This is because the CY 2019 clinical coding assumption was based on the 6 proposed clinical groups, and the CY 2020 assumption is based on the finalized 12 clinical groups.

CMS notes they are required by the BBA of 2018 to analyze data for calendar years 2020-2026 to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. The data from CY 2020-2026 will be used to determine whether or not a prospective adjustment (an increase or decrease) is needed no earlier than in 2022-2028 rulemaking. CMS will analyze data after implementation of PDGM to determine if there are any notable or consistent trends to warrant whether any changes to the national, standardized 30-day payment rate should be made earlier than CY 2022.

IMPLEMENTATION OF PDGM

Because CY 2020 is the first year of PDGM and the change to the 30-day unit of payment, there will be a transition period to account for HH episodes of care that span the implementation date of January 1, 2020.

For 60-day episodes (not LUPA episodes) that begin on or before December 31, 2019 and end on or after January 1, 2020, payment made under the Medicare HH PPS will be the CY 2020 national, standardized 60-day episode payment amount. This rate will apply to case mix adjusted episodes beginning on or before December 31, 2019 and ending on or before February 28, 2020.

For HH periods of care that begin on or after January 1, 2020, the unit of service will be a 30-day period, and payment will be made under the CY 2020 national, standardized prospective 30-day payment amount.

The end date of the 60-day episode or 30-day period as reported on the claim determines the CY rates Medicare will use to pay the claim.

Payment Updates:

The rule proposes an aggregate increase of 1.3% ($250 million) for CY 2020 (a 1.5% increase by law, with a 0.2% decrease due to the rural add-on percentages). HHAs who fail to submit quality data for the HH Quality Reporting Program will receive a 2% reduction in payment in CY 2020.

There will be no updates in CY 2020 to the case-mix weight for the current 153 HHRGs which will be used for payment of 60-day episodes (not LUPAs) that begin on or before December 31, 2019 and end on or before February 28, 2020 (i.e., episodes that span the January 1 PDGM transition date).

TABLE 15: CY 2020 National, Standardized 60-day Episode Payment Amount

CY 2019	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Rate
$3154.27	X 1.0062	X 1.015	$3221.43

TABLE 17: CY 2020 Non-routine Supplies (NRS) Conversion Factor

CY 2019 NRS	CY 2020 Update	CY 2020 NRS
$54.20	X 1.015	$55.01

TABLE 21: CY 2020 National, Standardized 30-day Period Payment Amount

CY 2020 30-day Budget Neutral Amt	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Rate
$1754.37	X 1.0062	X 1.015	$1791.73

(Note: Under PDPM, NRS payments are included in the 30-day period base payment rate)

TABLE 23: CY 2020 National Per Visit Rates

HH Discipline	CY 2019 Per Visit Rate	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Per Visit Rate
HHA	$66.34	X 1.0062	X 1.015	$67.77
MSS	$234.82	X 1.0062	X 1.015	$239.89
OT	$161.24	X 1.0062	X 1.015	$164.72
PT	$160.14	X 1.0062	X 1.015	$163.60
SN	$146.50	X 1.0062	X 1.015	$149.66
SLP	$174.60	X 1.0062	X 1.015	$177.82

Rural add-ons, as amended by the BBA of 2018, continue into 2020 with the add-on percentage varying by rural category as defined in the CY 2019 Final Rule.

Category	CY 2020	CY 2021	CY 2022
High Utilization	0.5%	-	-
Low Pop Density	3.0%	2.0%	1.0%
All Other	2.0%	1.0%	-

The partial episode payment (PEP) adjustment process for the 30-day payment periods will remain the same as the current process for 60-day episodes. CMS will maintain the current methodology for payment of high cost outliers upon implementation of PDGM in 2020.

Split Percentage Payments

CMS is proposing several changes and updates to the split percentage payment, or request for anticipated payment (RAP) process, beginning in 2020. For HHAs certified before January 1, 2019, the split percentage payment will be reduced from the current 60% or 50% (depending on if a first or later period) to 20% for all 30-day periods in CY 2020, with full elimination of the split percentage payment in 2021. HHAs enrolled in Medicare after January 1, 2019 ("newly-enrolled HHAs") will submit no-pay RAPs at the beginning of every 30-day period in CY 2020.

Beginning in 2021, CMS proposes that all HHAs submit a one-time Notice of Admission (NOA) within five calendar days of the start of care (SOC) to establish that the beneficiary is under a Medicare HH period of care. The NOA would only be submitted at the beginning of the first 30-day period. However, if the beneficiary was discharged from HH and readmitted, a new NOA would need to be submitted within five calendar days. Failure to submit a timely NOA would result in a decreased Medicare payment from SOC to NOA filing date (similar to hospice NOE process).

Therapist Assistants and Maintenance Therapy

CMS proposes to allow PTAs and OTAs to perform maintenance therapy under the HH benefit, similar to what is allowed under Medicare Part A in the SNF. (Currently, skilled maintenance therapy can only be provided by a licensed therapist in the HH setting.) Additionally, CMS is seeking comments regarding the revision of the HCPCS codes to indicate maintenance provided by an assistant, or alternatively, removal of the codes indicating maintenance by a therapist. CMS welcomes comments on the importance of tracking maintenance vs. restorative visits and the possible effects on quality of care.

HH Value-Based Purchasing (VBP) Model

The HH VBP Model currently applies to nine states: AZ, FL, IA, MD, MA, NE, NC, TN and WA. Payment adjustments are based on the HHA's Total Performance Score (TPS), which is calculated based on quality measures reported from the OASIS, HH CAHPS and the claim, as well as three measures for which points are achieved for reporting data.

CMS is proposing to publicly report two data points from performance year (PY) five (CY 2020) of the HH VBP:

- HHA Total Performance Score
- HHA's corresponding PY five TPS percentile ranking

The data would begin to be reported after December 1, 2021, and would be limited to one year's worth of data.

CMS reiterates their belief that public reporting of competing HHA's scores under the HH VBP Model will support efforts to empower consumers by providing more information to help them make health care decisions, while also encouraging providers to strive for higher levels of quality.

HH Quality Reporting Program (QRP)

In consideration of CMS's Meaningful Measures Initiative, CMS is proposing to remove the Improvement in Pain Interfering with Activity Measure (NQF #1077) from the HH QRP beginning CY 2022 (i.e., HHAs would no longer submit this measure effective January 1, 2021), in an effort to mitigate any potential unintended over-prescription of opioids which may be inadvertently driven by this measure.

CMS proposes two new process measures for CY 2022 (data collection January 1, 2021 – June 30, 2021):

- 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 a patient is discharged from the current post-acute setting. Calculated as the proportion of quality episodes (SOC, ROC, Transfer or DC OASIS) with a DC/transfer assessment indicating a current reconciled medication list was provided to the admitting provider at the time of discharge/transfer.

"Admitting" provider as captured by the current discharge location items on the OASIS:

- Short-term general hospital
- Intermediate care (developmental or intellectual disabilities providers)
- Home under the care of another organized home health service organization or hospice
- Hospice in an institutional facility
- SNF
- IRF
- LTCH
- Inpatient psychiatric facility (IPF)
- CAH

- Transfer of Health Information to the Patient – Post-Acute Care: Assesses whether or not a current reconciled medication list was provided to the patient, family, or caregiver when the patient is discharged from a PAC setting to a private home/apartment without any further services, a board and care home, ALF, a group home, or transitional living. Calculated as the proportion of quality episodes (SOC, ROC, Transfer or DC OASIS) with a DC assessment indicating a current reconciled medication list was provided to the patient, family or caregiver at the time of discharge.

CMS proposes to update the specifications of the DC to Community (DTC – PAC HH QRP) measure to exclude baseline nursing facility (NF) residents beginning with the CY 2021 HH QRP. Baseline NF residents are defined as HH patients who had a long-term NF stay in the 180 days preceding their hospitalization and HH episode, with no intervening community discharge between the NF stay and qualifying hospitalization. This proposed update aligns the HH QRP with the FY 2020 PPS proposed rules for skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF) and long-term acute care hospitals (LTCH).

CMS also proposes to collect multiple new Standardized Patient Assessment Data Elements (SPADEs) as part of the HH QRP in its continued effort to obtain meaningful data that is assessed, collected and measured in the same way across all PAC venues. In this proposed rule, CMS clarifies that data collection of the new SPADEs for the CY 2022 HH QRP will be January 1, 2021 – June 30, 2021; for CY 2023, data collection will be July 1, 2021 – June 30, 2022; and for CY 2024, July 1, 2022 – June 30, 2023.

CMS suggests SPADEs in five categories will be submitted at Start of Care (SOC), Resumption of Care (ROC) and Discharge (DC), except for hearing, vision, race and ethnicity, which will be collected on SOC only. The five categories and corresponding SPADEs are:

- Cognitive Function and Mental Status:
  - Brief Interview for Mental Status (BIMS) to assess cognition: Currently, the BIMS is used in the SNF Minimum Data Set (MDS) and the IRF Patient Assessment Instrument (PAI).
  - Confusion Assessment Method (CAM) to assess delirium: Currently, the CAM is used in the MDS and the Long-Term Care Hospital CARE Data Set (LCDS) to assess acute changes in mental status, inattention, disorganized thinking, and altered level of consciousness.

- PHQ-2 to 9 (Patient Health Questionnaire) to assess depression: The PHQ-2 has two items and will serve as a gateway item (an embedded skip pattern) to the PHQ-9. If positive responses are entered to the PHQ-2, then the clinician will go on to complete PHQ-9. The PHQ-2 is already used in the OASIS; the PHQ-9, in the MDS.

- Special Services, Treatments and Interventions: Some of these items are already present on post-acute assessment tools such as the MDS and/or the OASIS, some will need to be added or clarified.
  - Cancer treatment: Chemotherapy (IV, Oral, Other)
  - Cancer treatment: Radiation
  - Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High Concentration Oxygen Delivery Systems)
  - Respiratory Treatment: Suctioning (Scheduled, As Needed)
  - Respiratory Treatment: Tracheostomy Care
  - Respiratory Treatment: Non-invasive Mechanical Ventilation (BiPAP, CPAP)
  - Respiratory Treatment: Invasive Mechanical Ventilator
  - IV Medications: (Antibiotics, Anticoagulants, Vasoactive Medications, Other)
  - Transfusions
  - Dialysis (Hemodialysis, Peritoneal Dialysis)
  - IV Access (Peripheral IV, Midline, Central Line)
  - Nutritional Approach: Parenteral/IV Feeding
  - Nutritional Approach: Feeding Tube
  - Nutritional Approach: Mechanically Altered Diet
  - Nutritional Approach: Therapeutic Diet
  - High Risk Drug Classes: Use and Indications - Assess whether or not a resident is taking any medications in these 6 classes, and if so, are there indications for this medication in the medical record.
    - Anticoagulants
    - Antiplatelets
    - Hypoglycemics (including insulin)
    - Opioids
    - Antipsychotics
    - Antibiotics

- Medical Condition and Comorbidity Data: Pain Interference (vs. pain intensity or frequency)
  - Pain Effect on Sleep
  - Pain Interference with Therapy Activities
  - Pain Interference with Day-to-Day Activities

- Impairment Data:
  - Hearing (aligns with current MDS Item B0200)
  - Vision (similar item in use in the OASIS)

- Social Determinants of Health (SDOH): All of these elements are in use in the current OASIS.
  - Race
  - Ethnicity
  - Preferred Language
  - Interpreter Services
  - Health Literacy
  - Transportation
  - Social Isolation

CMS is also seeking input and comments on their plan to expand reporting of OASIS data for the HH QRP to include data on all patients regardless of payer in future rulemaking.

HH Care Consumer Assessment of Healthcare Providers and Services (CAHPS®)

CMS proposes to remove question #10 from all HH CAHPS surveys, which says, "In the last 2 months of care, did you and a home health provider from this agency talk about pain?" Again, CMS is trying to avoid potential unintended consequences related to opioid use that may arise from inclusion of this type of information in CMS surveys and datasets.

Medicare Coverage of Home Infusion Services

CMS also outlines many continued proposals for the January 1, 2021 implementation of a separate Medicare Part B benefit for coverage of home infusion services that are not covered under the Part B DME benefit, as mandated in the 21st Century Cures Act. CMS discusses that the HH benefit and the home infusion benefit are distinct, and in the transitional years of CY 2019 and 2020, a HHA may provide the professional services related to home infusion services and bill under the HH benefit, but the receipt of HH services is not necessary for a beneficiary to be eligible to receive home infusion therapy services under the home infusion benefit.

To read the **CMS Fact Sheet**

To access the **Proposed Rule**