Medicare Home Health Prospective Payment System

Payment Rule Summary — FINAL CY 2018

Overview and Resources

On November 7, 2017, the Centers for Medicare and Medicaid Services (CMS) published its final calendar year (CY) 2018 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final rule includes updates of the Medicare fee-for-service (FFS) HH PPS payment rates based on regulatory changes, set forward by CMS and legislative changes previously adopted by the US Congress. Among the finalized regulatory updates and policy changes are:

- Implementation of the last year of the 3 year reduction to the national, standardized, 60-day episode payment rates of 0.97 percent to recoup overpayments for nominal case-mix growth between CY 2012 and CY 2014;
- Updates to the Home Health Resource Group (HHRG) weights;
- Expiration of the rural-add on for episodes and visits that end on or after January 1, 2018;
- Changes to the home health value-based purchasing (HHVBP) model with payment adjustments beginning January 1, 2018, applicable to Home Health Agencies (HHAs) in selected states; and
- Changes to the home health quality reporting program requirements.

A copy of the *Federal Register* (FR) with this final rule and other resources related to the HH PPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

An online version of the *Federal Register* with this final rule is available at https://federalregister.gov/a/2017-23935.

A brief summary of the final rule is provided below. Program changes adopted by CMS are effective for services provided on or after January 1, 2018 unless otherwise noted.

HH PPS Payment Rates

Federal Register pages 51690 – 51696

The Medicare Access and CHIP Reauthorization Act (MACRA) mandated the annual marketbasket update for FFY 2018, after applying the productivity adjustment, to be 1 percent.

The tables below show the final CY 2018 conversion factor compared to the final CY 2017 conversion factor and the components of the update factor:

	Final CY 2017	Final CY 2018	Percent Change

60-Day Episode Rate	$2,989.97	$3,039.64 (proposed at $3,038.43)	+1.66%

Final CY 2018 Update Factor Component	Value
Marketbasket (MB) Update	+2.5% (proposed at +2.7%)
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.6 percentage points (proposed at -0.5 percentage points)
MACRA Mandated 1.0% Marketbasket Update	-0.88% (proposed at -1.17%)
Nominal Case-Mix Growth Reduction	-0.97% (as proposed)
Case-Mix Budget Neutrality Adjustment	+1.6% (proposed at +1.59%)
Wage Index Budget Neutrality	+0.04% (proposed at +0.01%)
Overall Final Rate Update	**+1.66%** (proposed at +1.62%)

- **National Per-Visit Amounts**
  HH PPS payments for episodes with 4 visits or less are paid on a per visit basis. CMS uses national per-visit amounts by service discipline to pay for these "Low-Utilization Payment Adjustment" (LUPA) episodes. The national per-visit amounts are also used for outlier calculations. The adopted CY 2018 per-visit amounts include a rebasing increase of 3.5% of the CY 2010 national per-visit payment amounts, an update factor increase of 1.0%, and an adjustment for wage index budget neutrality.

Per-Visit Amounts	Final CY 2017	Final CY 2018	Percent Change	Final CY 2018 With LUPA Add-On *
Home Health Aide	**$64.23**	**$64.94**	**+1.10%** (proposed at +1.01%)	**N/A**
Medical Social Services	**$227.36**	**$229.86**		**N/A**
Occupational Therapy	**$156.11**	**$157.83**		**N/A**
Physical Therapy (PT)	**$155.05**	**$156.76**		**$261.79 (1.6700 adj.)**
Skilled Nursing (SN)	**$141.84**	**$143.40**		**$264.59 (1.8451 adj.)**
Speech Language Pathology (SLP)	**$168.52**	**$170.38**		**$277.14 (1.6266 adj.)**

* For SN, PT, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue the use of the LUPA add-on factors established in the CY 2014 final rule.

- **Non-routine Medical Supply (NRS) Conversion Factor**
  In CY 2008, CMS carved out the NRS component from the 60-day episode rate and established a separate national NRS conversion factor with 6 severity group weights to provide more adequate reimbursement for episodes with a high utilization of NRS. The final CY 2018 NRS conversion factor has an update factor increase of 1.01%.

	Final CY 2017	Final CY 2018	Percent Change
NRS Conversion Factor	**$52.50**	**$53.03** (as proposed)	**+1.01%**

Severity Level	Points (Scoring)	Relative Weight (no change from prior years)	CY 2018 Final Payment Amount
1	**0**	**0.2698**	**$14.31**
2	**1 to 14**	**0.9742**	**$51.66**
3	**15 to 27**	**2.6712**	**$141.65**
4	**28 to 48**	**3.9686**	**$210.45**
5	**49 to 98**	**6.1198**	**$324.53**
6	**99+**	**10.5254**	**$558.16**

Wage Index and Labor-Related Share

Federal Register pages 51690

CMS is maintaining the labor-related share at 78.535% for CY 2018. The labor-related portion of the HH payment rate is adjusted for differences in area wage levels using a wage index. CMS is not making any major changes to the calculation of Medicare HH wage indexes. As has been the case in prior years, CMS will use the most recent inpatient hospital wage index, the FFY 2018 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2018. A complete list of the adopted wage indexes for payment in CY 2018 is available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1672-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=ascending

Payment Add-On for Rural HH Agencies

Federal Register pages 51694

The ACA, by amending the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandated a 3.0% increase to the payments for HH PPS episodes and visits provided in rural areas between April 1, 2010 and January 1, 2016. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) amended the MMA again, extending the 3.0% increase to payments for HH PPS episodes and visits in rural areas for episodes and visits ending before January 1, 2018. Therefore, for episodes and visits that end on or after January 1, 2018, a rural add-on payment will not apply.

Reductions Due To Nominal-Case-Mix Growth

Federal Register pages 51680, 51696

Previously, CMS accounted for nominal case-mix growth through HHRG weight reductions, implemented from 2008 through 2013, in order to better align payment with real changes in patient severity. In the CY 2016 final rule, CMS finalized a total reduction of 2.88% to account for nominal case-mix growth from CY 2012 to CY 2014, to be implemented and distributed evenly over a 3 year period. CY 2018 will be the third year of the three-year phase-in of the 0.97% reduction to account for nominal case-mix growth to increase the accuracy of Medicare payments for the delivery of home health services and this reduction will remain separate from the CY 2014 rebasing adjustments.

HHRG Update

Federal Register pages 51683 - 51690

The HH PPS program uses a 153-category case-mix classification called Home Health Resource Groups (HHRGs). Patients' clinical severity level, functional severity level, and service utilization are extracted from the Outcome and Assessment Information Set (OASIS) instrument and used to assign HHRGs. Each HHRG has an associated

case-mix weight which is used in calculating the payment for an episode. According to CMS, the HHRG weights were designed to maintain a national average case-mix of about 1.0.

CMS recalibrates the case-mix weights each year using the most current data available. This annual recalibration guarantees that the case-mix weights will reflect the current status of home health resource use and changes in utilization. For CY 2018, CMS is recalibrating the HH PPS case-mix weights using cost and utilization data from CY 2016. Overall the impact of the change is negative; therefore, CMS is increasing the 60-day episode rate by 1.6% in order to maintain budget neutrality for the HH PPS program.

The final CY 2018 case-mix payment weights can be found on *Federal Register* pages 51687 –51689.

Outlier Payments

Federal Register pages 51696 - 51699

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever a HHA's cost for an episode of care exceeds a fixed-loss threshold (the HH PPS payment amount for the episode plus a fixed dollar loss [FDL] amount). In the CY 2017 final rule, CMS adopted a cost-per-unit calculation, rather than a cost-per-visit approach, in order to determine the cost of an episode.

In the CY 2017 final rule CMS also implemented a cap of 8 hours or 32 units per day (1 unit = 15 minutes, summed across the six disciplines of care) on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier. The discipline of care with the lowest associated cost per unit will be discounted first in the calculation of episode cost, in order to cap the estimation of an episode's cost at 8 hours of care per day.

The FDL amount is calculated as a FDL ratio multiplied by the wage index-adjusted 60-day episode payment rate. This is then added to the HH PPS payment amount for that episode. If the calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments are set aside for outliers. CMS is maintaining the FDL ratio of 0.55 (as proposed) in CY 2018.

Implementation of the Home Health Groupings Model (HHGM)

Federal Register pages 51699 - 516700

CMS is not finalizing the proposed major recalibration of the HH PPS through the implementation of the HHGM for home health periods of care beginning on or after January 1, 2019 due to public comments. Commenters were most concerned about the proposed change in the unit of payment from 60 days to 30 days and such change being proposed for implementation in a non-budget neutral manner. Commenters also expressed the desire for greater involvement in the development of the HHGM.

Mandatory HH VBP Model Demonstration Project

Federal Register pages 51700 - 51711

Background: CMS implemented an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, starting January 1, 2016 and concluding December 31, 2022. The Medicare-certified HHAs required to participate are from 9 randomly selected states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. The demonstration program resembles the VBP Program for inpatient acute care hospitals.

Payment adjustments for each year of the model are calculated based on a comparison of how well each of the competing Medicare-certified HHAs performed during each 1 year performance period, beginning in CY 2016, compared to the baseline year CY 2015, as well as performance of their peers. The contribution amount is equal to the maximum payment adjustment. CY 2018 is the first year that payment adjustments will be applied.

Payment Period	Performance Period	Aggregate HHVBP Payment Adjustment
CY 2018	January 1, 2016 – December 31, 2016	3% max
CY 2019	January 1, 2017 – December 31, 2017	5% max
CY 2020	January 1, 2018 – December 31, 2018	6% max
CY 2021	January 1, 2019 – December 31, 2019	7% max
CY 2022	January 1, 2020 – December 31, 2020	8% max

The HHVBP model will adjust Medicare HHA payments over the course of the model by up to 8% depending on the applicable performance year and the degree of quality performance demonstrated by each competing Medicare-certified HHA. The HHVBP program will be budget neutral by state. Similar to the Hospital VBP program, this is redistributive and all HHAs in the mandated state will contribute to the VBP pool; some will then get their contribution back or even more than what they contributed, and some may get less.

Quality Measures

Federal Register pages 51701 - 51711

CMS is removing the Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care measure for performance year 3 of the program.

The quality measures in performance year 1 of the HHVBP measure set include:

NQS Domain	Measure Type	Measure Title	Data Source
Clinical Quality of Care	**Outcome**	**Improvement in Ambulation-Locomotion (NQF0167)**	**OASIS (M1860)**
	Outcome	**Improvement in Bed Transferring (NQF0175)**	**OASIS (M1850)**
	Outcome	**Improvement in Bathing (NQF0174)**	**OASIS (M1830)**
	Outcome	**Improvement in Dyspnea**	**OASIS (M1400)**
	Process	**Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care *(proposal to remove for performance year 3)***	**OASIS (M2015)**
Communication & Care Coordination	**Outcome**	**Discharged to Community**	**OASIS (M2420)**
	Process	**Advance Care Plan (NQF0326)**	**Reported by HHAs through Web-based portal**
Efficiency & Cost Reduction	**Outcome**	**Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health (NQF0171);**	**CCW (Claims)**
	Outcome	**Emergency Department Use Without Hospitalization (NQF0173)**	**CCW (Claims)**

Patient Safety	**Outcome**	**Improvement in Pain Interfering with Activity (NQF0177)**	**OASIS (M1242)**
	Outcome	**Improvement in Management of Oral Medications (NQF0176)**	**OASIS (M2020)**
Population/Community Health	**Process**	**Influenza Immunization Received for Current Flu Season (NQF0522)**	**OASIS (M1046)**
	Process	**Pneumococcal Polysaccharide Vaccine Ever Received (NQF0525)**	**OASIS (M1051)**
	Process	**Influenza Vaccination Coverage for Home Health Care Personnel (NQF0431)**	**Reported by HHAs through Web-based portal**
	Process	**Herpes Zoster (Shingles) Vaccination Received by HHA Patients**	**Reported by HHAs through Web-based portal**
Patient & Caregiver Centered Experience	**Outcome**	**Willingness to recommend the agency**	**HHCAHPS**
	Outcome	**Communications between Providers and Patients**	**HHCAHPS**
	Outcome	**Care of Patients**	**HHCAHPS**
	Outcome	**Specific Care Issues**	**HHCAHPS**
	Outcome	**Overall Rating of Home Health Care**	**HHCAHPS**

CMS is considering the inclusion of the following measures for future program years:

- Composite Total ADL/IADL Change
- Composite Functional Decline
- HHA Correctly Identifies Patient's Need for Mental or Behavioral Health Supervision
- Caregiver Can/Does Provide for Patient's Mental or Behavioral Health Supervision Need

Inclusion/Exclusion Criteria

Federal Register pages 51701- 51703

Although every HHA in a selected state must participate in the HHVBP model, each HHA may not receive a payment adjustment every period due to an inadequate number of episodes of care to generate sufficient quality measure data. CMS is increasing the minimum number of completed Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) surveys from 20 to 40 completed HHCAHPS surveys for HHAs that have been certified for at least 6-months to better align the model with HHCAHPS policy for the Patient Survey Star Ratings on Home Health Compare, beginning with performance year one.

In order to receive a payment adjustment the HHA must meet this threshold in at least 5 of the Clinical Quality of Care, Care Coordination and Efficiency, and Person and Caregiver-Centered Experience measures. Otherwise a payment adjustment will not be made for that particular HHA. The HHA will still receive quality reports on any measures for which they have 20 episodes of care.

When there are fewer than 8 HHAs in the smaller-volume cohort in a state to compete in a fair manner and to mitigate outliers, these specific HHAs would be included in the state's larger-volume cohort without being measured on HHCAHPS. This is for purposes of calculating the total performance score and payment adjustment for those HHAs.

Scoring

Federal Register pages 51700 - 51701

As finalized in the CY 2017 final rule, CMS will calculate the benchmarks and achievement thresholds at the state level for all model years, beginning with CY 2016. The thresholds and benchmarks will be defined in each state based on a CY 2015 baseline period.

		Duration
Achievement threshold	**Median of HHA's performance on each measure**	**Baseline Period**
Benchmark	**Mean of top decile of HHA's performance on each measure**	

In the CY 2017 final rule CMS finalized that they will calculate the Linear Exchange Function at the state level.

Reporting/Review, Correction and Appeals Process

Federal Register pages 51700 - 51701

In the CY 2017 final rule CMS finalized that HHAs will have a 15-day period to review and correct information after quarterly reports and annual reports are released. Reconsideration requests are only available only for the annual report and must be submitted within 15 calendar days of release as well.

Updates to the HH Quality Reporting Program (HH QRP)

Federal Register pages 51711 - 51742

CMS collects quality data from HHAs on process, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

CMS is considering methods to account for social risk factors in the SNF QRP such as income, education, race and ethnicity, employment, disability, community resources, and social support. Public comments on this can be found on *Federal Register* pages 51713 – 51714.

To comply with the IMPACT act, in order to enable access to longitudinal information and to facilitate coordinated care, CMS is requiring that HHAs begin reporting standardized patient assessment data with respect to five specified patient assessment categories required by law for the CY 2019 HH QRP, including:

- Functional status
- Cognitive function
- Special services, treatments, and interventions
- Medical conditions and comorbidities
- Impairments
- Other categories deemed necessary

Due to the significant reporting burden, CMS is not finalizing the standard patient assessment data elements on the OASIS in 3 categories: Cognitive Function, Special Services, Treatments, and Interventions, and Impairments category requirements. CMS is finalizing the elements proposed to meet the Functional Status and Medical Conditions and Comorbidities categories.

In the CY 2015 final rule, CMS established a new pay-for-reporting performance standard to be phased in over 3 years for the submission of OASIS quality data. HHAs must meet a minimum reporting threshold, titled Quality Assessment Only (QAO), for OASIS data in order to avoid a 2% marketbasket reduction. In the CY 2016 final rule CMS implemented an increase in the minimum reporting threshold over 3 years:

$$QAO = \left(\frac{\text{\# of Quality Assessments Reported}}{\text{\# of Quality Assessments} + \text{\# of NonQuality Assessments}}\right) *100$$

Calendar Year	Performance Period	QAO Minimum Reporting Threshold
2017	**July 1, 2015 – June 30, 2016**	**70%**
2018	**July 1, 2016 – June 30, 2017**	**80%**
2019	**July 1, 2017 – June 30, 2018**	**90%**

CMS is removing 235 data elements from the current 33 OASIS items, effective January 1, 2019, since they are not needed to calculate quality measures, payments, or care planning.

CMS is applying these threshold requirements to the submission of standardized patient assessment data beginning with the CY 2019 HH QRP.

CMS is removing the current Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) measure and replacing it with a modified version of the measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury, for the FFY 2020 HH QRP.

In addition, CMS is adopting two more measures for CY 2020:

- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674); and
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).

Furthermore, CMS is considering 4 quality measures for future years:

- Application of Change in Self-Care Score for Medical Rehabilitation (NQF #2633);
- Application of Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634);
- Application of Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and
- Application of Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

Beginning with the CY 2019 HH QRP, CMS is adopting a process for HHAs to request and for CMS to grant exceptions and extensions for the reporting requirements of the HH QRP for one or more quarters when there are certain extraordinary circumstances beyond control of the HHA. The HHA must request an exception or extension within 90 days of the date that the extraordinary circumstances occurred.

CMS is also adopting a policy in which a HHA would receive a notification of noncompliance if CMS determines that the HHA did not submit data in accordance with the HH QRP reporting requirements for the applicable CY, beginning CY 2019. The HHA may then, within 30 days of receiving the notice, file a request for reconsideration if it believes that the finding of noncompliance is erroneous, has submitted a request for an extension or exception that has not yet been decided, or has been granted an extension or exception.

Lastly, CMS is finalizing if a HHA had fewer than 20 eligible cases for a measure, the HHA's performance on that measure would not be publicly reported for that performance period.

Home Health Care CAHPS Survey (HHCAHPS)

Federal Register pages 51742 - 51743

CMS requires monthly HHCAHPS data collection and reporting all 4 quarters of each year. CMS requires that all HHAs with fewer than 60 HHCAHPS-eligible unduplicated or unique patients in the previous year collection period are exempt from the HHCAHPS data collection and submission requirements. Also, if an HHA receives Medicare certification after the collection period, CMS automatically exempts them from the survey. CMS is continuing their home health quality measures reporting requirements for the CY 2021 Annual Payment Update (APU) period. Collection periods are below:

APU Period	Collection Period
CY 2017	April 2015 – March 2016
CY 2018	April 2016 – March 2017
CY 2019	April 2017 – March 2018
CY 2020	April 2018 – March 2019
CY 2021	April 2019 – March 2020

All the requirements for the HHCAHPS survey and which home health patients are ineligible for the HHCAHPS survey are detailed at http://homehealthcahps.org.

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