Medicare Home Health
Prospective Payment System

2020 Proposed Payment Rule Summary by the Wisconsin Hospital Association

Overview and Resources

On July 11, 2019, the Centers for Medicare and Medicaid Services (CMS) published its proposed calendar year (CY) 2020 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The proposed 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 proposed regulatory updates and policy changes are:

- Change in the HH unit of payment from 60-day episodes to 30-day episodes for CY 2020 and onwards;
- Implementation of payment and regulations for home infusion therapy services;
- Changes to the home health value-based purchasing (HHVBP) model, applicable to Home Health Agencies (HHAs) in selected states; and
- Changes to the home health quality reporting program (HH QRP) requirements.

A copy of the *Federal Register* (FR) with this proposed 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 proposed rule is available at https://federalregister.gov/d/2019-14913.

A brief summary of the proposed rule is provided below. Program changes adopted by CMS would be effective for services provided on or after January 1, 2020 unless otherwise noted. Comments on all aspects of the proposed rule are due to CMS by Monday, September 9, 2019 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1711-P."

Note: Text in italics is extracted from the July 18, 2019 *Federal Register*.

HH PPS Payment Rates

Federal Register pages 34604 – 34634, 34635 -34636

The tables below show the proposed CY 2020 conversion factor compared to the final CY 2019 conversion factor and the components of the update factor:

	Final CY 2019	Proposed CY 2020	Percent Change
60-Day Episode Rate	**$3,154.27**	**$3,221.43**	**+2.13%**
30-Day Episode Rate	**$1,754.37**	**$1,791.73**	**+2.13%**

Proposed CY 2020 Update Factor Component	Value
Marketbasket (MB) Update	+3.0%
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.4 Percentage points
Bipartisan Budget Act (BBA) of 2018 mandated 1.5% Market Basket Update	-1.07%
Wage Index Budget Neutrality	+0.62%
Overall Proposed Rate Update	**+2.13**%

Episodes which begin on or before December 31, 2019 and span the January 1, 2019 implementation date will be billed as a 60-day episode.

National Per-Visit Amounts

Federal Register Page 34633

CMS uses national per-visit amounts by service discipline to pay for "Low-Utilization Payment Adjustment" (LUPA) episodes as well as computing compute outlier calculations for both 60-day and 30-day episode payments. LUPA episodes are paid for 60-day episodes with 4 visits or less and 30-day episodes with a number of visits less than the PDGM LUPA threshold for their PDGM classification (2 visits or 10th percentile, whichever is higher). The proposed CY 2020 per-visit amounts include an update factor increase of 2.2% which includes an adjustment for wage index budget neutrality.

Per-Visit Amounts	Final CY 2019	Proposed CY 2020	Percent Change	Proposed CY 2020 With LUPA Add-On *
Home Health Aide	**$66.34**	**$67.77**	**+2.2%**	**N/A**
Medical Social Services	**$234.82**	**$239.89**		**N/A**
Occupational Therapy	**$161.24**	**$164.72**		**N/A**
Physical Therapy (PT)	**$160.14**	**$163.60**		**$273.21 (1.6700 adj.)**
Skilled Nursing (SN)	**$146.50**	**$149.66**		**$276.14 (1.8451 adj.)**
Speech Language Pathology (SLP)	**$174.06**	**$177.82**		**$289.24 (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 is proposing to continue the use of the LUPA add-on factors established in the CY 2014 final rule.

Non-routine Medical Supply (NRS) Conversion Factor 60-Day Episode

Federal Register Pages 34630-34632

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 proposed CY 2020 NRS conversion factor has an update factor increase of 1.5%. In CY 2020, the NRS payment amounts apply to only those 60-day episodes that begin on or before December 31, 2019 but span the implementation of the PDGM and the 60-day unit of payment on January 1, 2020 (ending on February 28, 2020). Under the PDGM, NRS payments are included in the 30-day base payment rate.

	Final CY 2019	Proposed CY 2020	Percent Change
NRS Conversion Factor for 60-day episodes	**$54.20**	**$55.01**	**+1.5%**

Severity Level	Points (Scoring)	Relative Weight (no change from prior years)	CY 2020 Proposed Payment Amount
1	**0**	**0.2698**	**$14.84**
2	**1 to 14**	**0.9742**	**$53.59**
3	**15 to 27**	**2.6712**	**$146.94**
4	**28 to 48**	**3.9686**	**$218.31**
5	**49 to 98**	**6.1198**	**$336.65**
6	**99+**	**10.5254**	**$579.00**

Wage Index and Labor-Related Share

Federal Register Pages 34628-34629

CMS is proposing to maintain the labor-related share at 76.1% for CY 2020 based on the 2016 Medicare cost report. The labor-related portion of the HH payment rate is adjusted for differences in area wage levels using a wage index.

There are no proposed major changes to the calculation of Medicare HH wage indexes. As has been the case in prior years, CMS is proposing to use the most recent inpatient hospital wage index, the FFY 2020 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2020. A complete list of the proposed wage indexes for payment in CY 2020 is available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CMS-1711-P-Home-Health-PPS-wage-index.zip. There was a minor calculation error in the file used to compute HH WI values and CMS will be posting the corrected WI values and payment rates in the final rule.

For rural areas that have no inpatient hospitals, and thus no hospital wage data on which to base the CY 2020 WI, CMS is proposing average the wage index from all contiguous Core Based Statistical Areas (CBSAs) to use as a reasonable proxy. CMS is seeking comments on concerns stakeholders may have regarding the WI used to adjust HH payments and suggestions for possible updates and improvements to the geographic adjustments of HH payments.

Payment Add-On for Rural HH Agencies

Federal Register Pages 34634 - 34635

CMS finalized, in the CY 2019 HH PPS final rule, rural add-on payments for episodes and visits ending during CYs 2019 through 2022 as required by the Bipartisan Budget Act of 2018. This includes varying add-on amounts depending on the rural county (or equivalent area) by classifying each into one of three distinct categories:

- *"High home health utilization category - rural counties and equivalent areas in highest quartile of all counties and equivalent areas based on number of Medicare home health episodes furnished per 100 Medicare beneficiaries excluding counties or equivalent areas with 10 or fewer episodes during 2015;*
- *Low population density category - rural counties and equivalent areas with a population density of 6 individuals or less per square mile of land area and that are not included in the high utilization category; or*
- *All other rural counties and equivalent areas."*

Categorization of counties (using FIPS county codes) for the rural add-on can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CY2019-CY2022-Rural-Add-On-Payments-Analysis-and-Designations.zip

The add-on percentages for CY 2020 through CY 2022 are as follows:

Category	CY 2020	CY 2021	CY 2022
High utilization	0.5%	0.0%	0.0%
Low population density	3.0%	2.0%	1.0%
All other	2.0%	1.0%	0.0%

Implementation of the Patient-Driven Groupings Model

Federal Register Pages 34604-34628, 34636-34640

As required by the Bipartisan Budget Act of 2018 in the CY 2019 final rule, CMS finalized the Patient-Driven Grouping Model (PDGM) that included case-mix methodology refinements and a change in the unit of payment from a 60-day episode of care to a 30-day period of care, implemented in a budget neutral manner, and effective January 1, 2020. CMS noticed costs are much higher earlier in the episode and lesser later on. Therefore, dividing a single 60-day episode into two 30-day periods more accurately apportions payments based on resource use.

"*The PDGM groups periods of care in a manner consistent with how clinicians differentiate between patients and the primary reason for needing home health care. The model also eliminates the use of therapy thresholds in the case-mix adjustment for determining payment, removing the financial incentive to overprovide therapy in order to receive higher payment.*" Case-mix adjustment for home health payment are based solely on patient characteristics, specifically relying more heavily on clinical characteristics and other patient information to place patients into 432 clinically meaningful payment categories.

In order to construct case-mix weights, the costs of providing care need to be determined. For the current case-mix weights, CMS uses Wage Weighted Minutes of Care, which uses data from the Bureau of Labor Statistics (BLS). For the PDGM, CMS adopted the use of Cost-Per-Minute plus Non-Routine Supplies (CPM + NRS) approach, which uses information from the home health cost reports. This approach incorporates a wider variety of costs and are available for individual HHA providers, while the BLS costs are aggregated. It also allows the NRS to be incorporated into the case-mix system, rather than maintaining a separate payment system.

Similar to the current model, 30-day periods under the PDGM are classified as "early" or "late" depending on when they occur within a sequence of 30-day periods. Under the current model, the first two 60-day episodes of a sequence of adjacent 60-day episodes are considered early, while the third and subsequent are considered late. In the PDGM, the first 30-day period is classified as early and all subsequent periods are late. A 30-day period is not considered early unless there was a gap of more than 60 days between the end of a prior period and the beginning of the next.

The current comprehensive assessment must be completed within 5 days of the start of care date and completed no less frequently than during the last 5 days of every 60 days beginning with the start of care date. In addition, the plan of care still must be reviewed and revised by the HHA and the physician responsible for the home health plan of care no less frequently than once every 60 days, beginning with the start of care date.

Under the PDGM, each period is classified into one of two admission source categories depending on what healthcare setting was utilized in the 14 days prior to home health:

Admission Source Category	30-Day Period Classification
Community	No acute or post-acute care stay occurred in the 14 days prior to the start of the 30-day period of care
Institutional	Acute or post-acute care stay occurred in the prior 14 days to the start of the 30-day period

PDGM then groups 30-day periods into one of twelve clinical groups based on principal diagnosis reported on the claim:

- Musculoskeletal Rehabilitation;
- Neuro/Stroke Rehabilitation;
- Wounds- Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care;
- Complex Nursing Interventions;
- Behavioral Health Care (including Substance Use Disorder); or
- Medical Management, Teaching and Assessment (MMTA) which includes
    - Surgical Aftercare;
    - Cardiac/Circulatory;
    - GI/GU;
    - Infectious Disease/Neoplasms/Blood-forming Diseases;
    - Respiratory; and
    - Other.

Each 30-day period is then placed into one of three functional levels with roughly 33% of periods within each clinical group to each functional level. Criteria for assignment to each of the three functional levels may differ across each clinical group. Afterwards, a comorbidity adjustment may be made depending on a patient's secondary diagnosis. The 30-day period may receive a "no", "low", or a "high" comorbidity adjustment. The LUPA threshold is the 10th percentile value of visits under the PDGM for each payment group (minimum threshold of at least 2 for each group).

Admission Source and Timing	Clinical Grouping (One of Six Groups From Principal Diagnosis)	Functional Level	Comorbidity Adjustment?	PDGM Classification
Community Early *(First 30-Day Period)*	Medication Management, Teaching and Assessment (MMTA), Neuro/Stroke Rehab, Wounds, Complex Nursing Interventions, Musculoskeletal (MS) Rehab, or Behavioral Health	Low	No	
			Low	
			High	
		Medium	No	
			Low	
			High	
		High	No	
			Low	
			High	
Community Late *(Subsequent 30-Day Periods)*	MMTA, Neuro/Stroke Rehab, Wounds, Complex Nursing Interventions, MS Rehab, or Behavioral Health	Low	No	
			Low	
			High	
		Medium	No	
			Low	
			High	
		High	No	
			Low	
			High	
Institutional Early *(First 30-Day Period*	MMTA, Neuro/Stroke Rehab, Wounds, Complex Nursing Interventions, MS Rehab, or Behavioral Health	Low	No	
			Low	
			High	
		Medium	No	
			Low	
			High	
		High	No	
			Low	
			High	
Institutional Late *(Subsequent 30-Day Periods)*	MMTA, Neuro/Stroke Rehab, Wounds, Complex Nursing Interventions, MS Rehab, or Behavioral Health	Low	No	
			Low	
			High	
		Medium	No	
			Low	
			High	
		High	No	
			Low	
			High	

In the PDGM the LUPA add-on policy, the partial episode payment adjustment policy, and the methodology used to calculate payments for high-cost outliers are the same as current except for occurring on a 30-day basis rather than a 60-day basis. In the event of a significant change in a patient's condition, two 30-day periods can have two different case mix groups to reflect the changes in condition.

CMS previously discussed the current split percentage payment approach to the 60-day episode and if it is still needed for HHAs when the unit of payment changes from 60-day episodes to 30-day periods of care. It is being proposed that split payment begin being phased out. In the CY 2019 final rule, CMS adopted its proposal to no longer allow newly-enrolled HHAs (certified for participation in Medicare on or after January 1, 2019) to receive Request for Anticipated Payment (RAP) payments beginning CY 2020 and therefore not participate in split percentage payments. Instead, newly-enrolled HHAs *"would submit a 'no-pay' RAP at the beginning of care in order to establish the home health period of care, as well as every 30-days thereafter."* However, existing HHAs continue to receive split percentage payments upon implementation of the PDPM. In the CY 2020 proposed rule, CMS is proposing to reduce both the initial episode split of 60/40 and the subsequent episode rate of 50/50 to 20/80 for all 30-day periods of care for existing HHAs. HHAs enrolled in Medicare on or after January 1, 2019 would continue to submit "no-pay" RAPs at the beginning of every 30-day period in CY 2020 in order to establish the start of the HH period. The split payment approach is as follows:

First Episode	Amount Paid (current)	Proposed
Beginning of Episode: Request for Anticipated Payment (RAP)	60% of the anticipated final claim	20% of the anticipated final claim
End of Episode	Remaining 40%	Remaining 80%

CMS is also proposing to fully eliminate split-percentage payments for all providers in CY 2021 and all HHAs would receive the full 30-day period of care payment once the final claim is submitted to CMS. Additionally, there is a proposal to require a one-time submission of a Notice of Admission (NOA) within 5 calendar days of the start of HH care to establish the start of the period. Failure to submit timely NOAs would result in a reduction of the full 30-day period payment amount for those days of service from the start of care to the day before the NOA is submitted. CMS would reduce payment by $1/30^{th}$ per day that the NOA is late. CMS is also proposing no LUPA payments for tardy NOAs. CMS proposes that these days be a provider liability, that the reduction cannot exceed the total payment, and that the provider cannot bill the beneficiary for any penalized days. CMS can waive this for extraordinary circumstances.

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 2020, CMS is proposing to generate the HH PPS case-mix weights using data from the CY 2018 HH claims (as of March 2019) linked to OASIS assessment data. Since this is the first year utilizing the PDGM case-mix, CMS is not proposing a case-mix budget neutrality adjustment to the 60-day or 30-day episode rate.

The proposed CY 2020 case-mix payment weights for the 30-day PDGM periods can be found on *Federal Register* pages 34619-34628. The proposed CY 2020 case-mix payment weights for 60-day periods are the same as finalized for CY 2019 and are listed in Table 6 of CY 2019 Final Rule.

Outlier Payments

Federal Register Pages 34635-34636

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).

Currently there is 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 is 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 a FDL ratio multiplied by the wage index-adjusted 60-day episode payment. This is added to the HH PPS payment amount for that episode. If 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. This process will continue for outlier payments in CY 2020 using the wage index-adjusted 30-day episode payment.

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 proposing not to update the FDL for 60-day episodes to span into 2020, keeping the rate at 0.51. For 30-day periods, CMS is proposing to set the FDL ratio to 0.63.

Home Infusion Therapy Services

Federal Register Pages 34686-34702

The Medicare Part B home infusion therapy benefit was established by the 21st Century Cures Act to cover professional services including nursing services furnished in accordance with the plan of care, patient training and education, remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

CMS is proposing to continue to define "Home Infusion Drugs" for CY 2020 and forward as "*parenteral drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit."* This definition does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list.

CMS finalized transitional payment for CY 2019 and CY 2020 as required by the Bipartisan Budget Act of 2018, in which payment for home infusion therapy is only for the day on which the nurse is in the patient's home when an infusion drug is being administered. Payment amounts during the transition period are equal to the amounts determined, for the corresponding year under the Physician Fee Schedule (PFS) using three payment categories:

- Payment Category 1 – intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including, but not limited to, antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs;
- Payment Category 2 - subcutaneous infusions for therapy or prophylaxis, including, but not limited to, certain subcutaneous immunotherapy infusions; and
- Payment Category 3 – intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.

These three categories are proposed to become permanent in CY 2021. Table 28 on *Federal Register* page 34696 shows the J-Codes associated with each category.

In the case that multiple drugs or biologicals from two different categories are administered concurrently to a patient on a single day, one payment for the highest category will be made. Payment categories for subsequent transitional home infusion drugs not otherwise classified will be determined by the DME MACs. The transitional payment only applies to existing Medicare qualified home infusion suppliers and is set, by law, as a single payment of 4 hours of infusion for a particular therapy in a calendar day without wage adjustments. HCPCS codes for transition home infusion drugs are listed in tables 55 and 56 in CY 2019 HH PR pages 32465 and 32466. For services per visit furnished January 1, 2021 and onwards, it is being proposed that home infusion payments be bundled and set at an amount equal to 5 hours of home infusion therapy for each infusion drug administration day. This is to ensure that payment covers differing patient needs and complexity of services provided while remaining a single payment. Proposed CPT codes for home infusion drug payments for 2021 are listed in table 29 on *Federal Register* page 34698.

The 21st Century Cures Act mandates the exclusion of home infusion therapy from HH PPS services, effective January 1, 2021. CMS clarified from the CY 2019 final rule that, home infusion therapy is not excluded from home health benefits during the transitional period. A home health agency may subcontract with an eligible infusion supplier but the service must be billed under the Medicare home health benefit and the supplier cannot bill for such services under the home infusion therapy benefit until January 1, 2021. More information can be found in the Frequently Asked Questions (FAQ) for home infusion therapy available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.html.

Additionally, CMS recognizes that the first visit by a home infusion therapy supplier may be longer or more resource intensive than subsequent visits. Thus, for CY 2021 and forward, CMS proposes to increase the payment amounts for the three payment categories for the first visit using the physician evaluation and management (E/M) payment amounts for a given year by the average difference between the PFS amounts of E/M existing payment visits and new patient visits for a given year, which would decrease subsequent payments in a budget-neutral manner. Changes or additions to the home infusion plan, even those that would change a payment category, would not trigger a first visit payment amount. A patient must be discharged for more than 60 days for a first visit to be billed again.

CPT Code	Description	2019 PFS Amount	5-hour Payment – First Visit	5-hour Payment – Subsequent Visit
96365	Ther, Proph, Diag IV/IN infusion 1hr	$72.80	$257.20 (category 1)	$154.70 (category 1)
96366	Ther, Proph, Diag IV/IN infusion add hr	$21.98		
96369	Sub Q Ther Inf 1 hr	$169.02	$374.94 (category 2)	$223.72 (category 2)
96310	Sub Q Ther Inf add hr	$15.86		
96413	Chemo Inf 1 hr	$143.08	$427.26 (category 3)	$256.99 (category 3)
96415	Chemo Inf add hr	$30.99		

CMS is proposing that, beginning CY 2021, qualified home infusion therapy suppliers would submit claims on the 837P/CMS-1500 claims form to the A/B MACs. DME suppliers who are enrolled as qualified infusion therapy suppliers would need to submit a claim for both the DME and the drug on the 937P/CMS-1500 to the A/B MAC as well as to the DME MAC. More detail is expected upon release of the CY 2020 HH PPS Final Rule.

CMS finalized in CY 2019 health and safety standards for home infusion therapy including an accreditation and oversight process for home infusion therapy suppliers. Specifically, CMS is requiring that home infusion therapy suppliers select a CMS-approved accredited organization (AO) and undergo an accreditation review process to demonstrate that the home infusion therapy program meets the accreditation organization's standards. Based on comments to the CY 2019 final rule, CMS is not requiring prior authorization for home infusion therapy or adjusting for high cost outlier payments.

CMS is soliciting comments regarding the "*appropriate form, manner, and frequency that any physician must use to provide notification of the treatment options available to his/her patient for the furnishing of infusion therapy (home or otherwise) under Medicare Part B"* as required by the Social Security Act (SSA).

Beginning in CY 2022, annual adjustments to the single payment amount, as specified by the SSA, will go into effect. CMS will increase the single payment amount by the percent increase in the Consumer Price Index for all urban customers (CPI-U) for the 12-month period ending with June of the preceding year. This is then reduced by the 10-year moving average of economy-wide private nonfarm multifactor productivity (MFP). This may result in a percentage less than 0.0, which may result in payments being lower than the preceding year.

Patient Eligibility and Plan of Care Requirements

Federal Register page 34691

CMS is proposing regulatory revisions to the home infusion therapy payment system beginning on January 1, 2021:

- Services must be furnished to an eligible beneficiary by, or under arrangement of a qualified home infusion therapy supplier that meets the qualified home infusion therapy supplier health and safety standards;
- Suppliers must ensure beneficiaries meet eligibility criteria for coverage of services and that plan of care requirements are met;
- Beneficiaries must be under the care of a physician, nurse practitioner, or physician assistant; and
- Beneficiaries must be under a plan of care established by a physician, including the frequency of the furnished services and the healthcare professional who will furnish each service.

Home Infusion Geographic Wage Adjustments

Federal Register Pages 34700-34701

CMS is proposing to adjust home infusion therapy payments to reflect differences in geographic wages using the geographic adjustment factor (GAF) for CY 2021 and forward. The GAF is a weighted composite of each region's Geographic Practice Cost Indices (GPCIs), which include work, practice expense (PE), and malpractice MP and is calculated as:

$$GAF = (.50886\ x\ Work\ GPCI) + (.44839\ x\ PE\ GPCI)\ +\ (.04295\ x\ MP\ GPCI).$$

The locally adjusted GAF is multiplied by the home infusion therapy payment based on the site of the beneficiary. The adjustment would be budget neutral nationally. A list of GAFs can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.html

Mandatory HH VBP Model Demonstration Project

Federal Register Pages 34641-34643

Background: CMS implemented an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, which started January 1, 2016 and concludes December 31, 2022. The Medicare-certified HHAs required to participate are from 9 randomly selected states: Arizona, Florida, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. 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, compared to the baseline period, as well as performance of their peers. The contribution amount is equal to the maximum payment adjustment.

Payment Period	Performance Period	HHVBP Payment Adjustment
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 program is budget neutral by state. Similar to the Hospital VBP program, this is redistributive and all HHAs in the mandated state contribute to the VBP pool; some will then get their contribution back or even more than what they contributed, and some lose money to the program.

In response to comments, CMS is proposing that total performance scores and percentile rankings be reported publically from the CY 2020 Performance Year (PY) 5 Annual Report for each HHA in the nine model states that qualified for a payment adjustment in CY 2020. CMS believes that this would enhance the quality of reporting, encourage HHAs to provide better quality of care, promote transparency, and allow beneficiaries to make better informed decisions. The list of finalized quality measures for PY 5 can be found in CY 2019 HH PR *Federal Register* pages 56533-56535 on table 38. Measures are weighted as follows:

Measure Category	Percentage of Total Points	Total Points
OASIS-based measures	35%	90
Claims-based measures	35%	
HHCAHPS	30%	
New Measures	100%	10

Updates to the HH Quality Reporting Program (HH QRP)

Federal Register Pages 34643-34684

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 options to improve health disparities among patient groups within and across hospitals by increasing transparency of disparities through quality measures and quality programs.

CMS continues to consider when evaluating measures for removal from the HH QRP Program measure set: the costs associated with a measure outweigh the benefit of its continued use in the program.

Summary Table of Measure Currently Adopted for the CY 2021 HH Quality Reporting Program	
Measures	**Data Source**
Improvement in Ambulation/Locomotion (NQF #0167)	OASIS
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	OASIS
Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).	OASIS
Improvement in Bathing (NQF #0174)	OASIS
Improvement in Bed Transferring (NQF # 0175)	OASIS
Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) HH QRP	OASIS
Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	OASIS
Improvement in Dyspnea	OASIS
Influenza Immunization Received for Current Flu Season (NQF #0522)	OASIS

Improvement in Management of Oral Medications (NQF #0176)	OASIS
Improvement in Pain Interfering with Activity (NQF #0177)	OASIS
Changes in Skin Integrity Post-Acute Care	OASIS
Timely Initiation Of Care (NQF #0526)	OASIS
Acute Care Hospitalization During the First 60 Days of HH (NQF #0171)	Claims-based
Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)	Claims-based
Emergency Department Use without Hospitalization During the First 60 Days of HH (NQF #0173)	Claims-based
Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) HH QRP	Claims-based
Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program	Claims-based
How well did the home health team communicate with patients	HHCAHPS
How do patients rate the overall care from the home health agency	HHCAHPS
How often the home health team gave care in a professional way	HHCAHPS
Did the home health team discuss medicines, pain, and home safety with patients	HHCAHPS
Will patients recommend the home health agency to friends and family	HHCAHPS

CMS is proposing to remove Question 10 from all HHCAHPS surveys, beginning July 1, 2020, which says, *"In the last 2 months of care, did you and a home health provider from this agency talk about pain?"* as well as the following measure from the CY 2022 HH QRP:

- Improvement in Pain Interfering with Activity (NQF #0177).

Questions and datasets referencing pain are being proposed to be removed in order to avoid potential unintended consequences from their inclusion.

CMS is proposing to adopt two process measures for the HH QRP beginning in CY 2022:

- Transfer of Health Information to Provider-Post-Acute Care (*FR Pages 34645-34648)*; and
- Transfer of Health Information to Patient-Post-Acute Care (*FR Pages 34648-34650l).*

These two process measures will be used to assess whether or not a current reconciled medication list is provided to the provider or entity upon a patient being discharged from a PAC facility.

CMS is also proposing to update specifications for the Discharge to Community- Post Acute Care HH QRP Measure to exclude baseline nursing facility (NF) residents, which aligns with the provisions proposed in FY 2020 rules for IRFs, LTCHs, and SNFs.

Proposed Standard Patient Assessment Data by Category

Federal Register Pages 34652-34686

For FFY 2019 and each subsequent year, HHAs must report standardized patient assessment data elements (SPADE). Previously, CMS had adopted SPADEs for the two categories:

- Functional Status: Data elements currently reported by HHAs to calculate the measure 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); and
- Medical conditions and comorbidities: the data elements used to calculate the pressure ulcer measures, Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short

Stay) (NQF #0678) and the replacement measure, Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.

CMS is seeking input on the value of including the following Standard Patient Assessment Data Elements (SPADEs) in the HH QRP 2022:

- Cognitive Function and Mental Status (*FR* pages 34652-34656);
- Special Services, Treatments, and Interventions Data (*FR* pages 34656-34672);
- Medical Condition and Comorbidity Data *(FR* pages 34672-34675);
- Impairment Data (*FR* pages 34675-34677); and
- Social Determinants of Health [New] (*FR* pages 34677-34684).

Beginning in CY 2022 HH QRP, CMS is proposing that HHAs must report data with respect to admissions and discharges between January 1, 2021 and June 30, 2021. Beginning in CY 2023 HH QRP, CMS is proposing HHAs must report data with respect to admissions and discharges that occur the successive calendar year. For the purposes of the HH QRP, CMS is proposing that HHAs must submit SPADEs with respect to start of care (SOC), resumption of care (ROC) and discharge. SPADEs for Hearing, Vision, Race, and Ethnicity will only be collected with regard to SOC.

In future rulemaking, CMS plans to propose to expand reporting of OASIS data used for the HH QRP to all patients, regardless of payer to add value to the program and provide a more accurate representation of the quality provided by HHAs. This would align HH QRP data requirements that are currently adopted for the LTCH QRP and Hospice QRP.

Therapy assistants allowed to perform maintenance therapy

Federal Register pages 34640-34641

CMS is proposing to allow therapist assistants, rather than only qualified therapists, to perform maintenance therapy under a program established by a qualified therapist under the HH benefit. Currently, the HH benefit allows therapist assistants to perform restorative therapy, but only a qualified therapist can perform maintenance therapy. This is consistent with other post-acute settings and allows HH agencies more options for resource utilization. A qualified therapist would still provide the initial assessment, plan of care, maintenance program development and modifications, and 30-day reassessment.

CMS Request for Information (RFI)

Federal Register Page 34651

With this proposed rule, CMS is issuing an RFI on *HH QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment.* They are seeking input on the importance, relevance, appropriateness, and applicability of the following measures and standardized patient assessment data elements (SPADEs):

Potentially-preventable hospitalizations	Quality Measures and Measure Concepts
Functional improvement and maintenance outcomes	
Opioid use and frequency	
Exchange in electronic health information and interoperability	
Cognitive complexity, such as executive function and memory	Standardized Patient Assessment Data Elements (SPADEs)
Dementia	
Bladder and bowel continence including appliance use and episodes of incontinence	

Care preference, advance care directives, and goals of cares	
Caregiver Status	
Veteran Status	
Health disparities and risk factors, including education, sex and gender identity, and sexual orientation	

Submissions will be considered in developing future measures and SPADEs.

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