PUBLICATION

Home Health Payment Rule Published

November 20, 2017

On November 1, 2017, CMS released the Final Rule for the 2018 home health prospective payment system rate update, including the CY 2019 case mix adjustment methodology refinements. CMS also made changes to the Value Based Purchasing Model (HHVPM) model and the quality reporting program. CMS did not finalize the home health groupings model, instead opting to seek more stakeholder input. The Final Rule was published in the Federal Register on November 7, 2017. 82 F. R. 51676-51752 (November 7, 2017). The regulations are effective January 1, 2018.

CMS had previously published the Final Rule on home health conditions of participation on January 13, 2017. 82 F. R. 4505-4591 (January 13, 2017). CMS has extended the effective date for compliance with the conditions of participation to January 13, 2018.

Case Mix Update

The home health prospective payment system (HH PPS) payment rates include national, standardized 60-day episode payment rates, national per visit rates, and a non-routine medical supply conversion factor. CMS projects the net impact of the changes will be a reduction of 0.4 percent in the CY 2018 rates. This impact takes into account a one percent CY 2018 HH PPS payment update, the sunset of the rural add-on, the updated case mix weights using current cost and utilization data, and a reduction to the national standardized 60-day episode payment resulting in a -0.97 percent adjustment to account for case mix growth unrelated to increases in patient acuity. CMS also updated the wage index. The fixed dollar loss ratio remains 0.55, to pay up to, but no more than, 2.5 percent of total payments as outlier payments.

(HHVPM)

CMS began testing the HHVPM Model in 2016. Beginning in CY 2018, CMS will adjust Medicare payment rates based on performance on applicable measures. Payment adjustments will be allowed to move a maximum of three percent upward and downward in 2018, five percent upward and downward in 2019, six percent upward and downward in 2020, seven percent upward and downward in 2021 and eight percent upward and downward in 2022.

CMS finalized the quality measures in 2016, but will remove four measures for PY 1 (Performance Year 1 and subsequent years) and one OASIS based measure in PY 3 (Performance Year 3). There will be 19 quality measures in PY 3. The quality measures focus on six priority areas, including (1) clinical quality of care; (2) care coordination; (3) population & community health; (4) person- and caregiver-centered experience and outcomes; (5) safety; and (6) efficiency and cost reduction.

CMS is using 40 or more completed Home Health Care Consumer Assessment of Health Care Providers and System (HHCAHPS) surveys using quality measure scores and performance scores to calculate payments. Home health agencies will receive one report with quality measure scores and total performance scores, and may submit recalculation and reconsideration requests and will have appeal rights. CMS changed the definition of "applicable measure" to mean "a measure for which a competing HHA has provided a minimum of 40 completed surveys for HHCAHPS measures, for purposes of receiving a performance score for any the HHCAHPA measures beginning with the PY1."

The Home Health Quality Reporting Program (HH QRP)

The HH QRP began in 2007. In this rule, CMS removed 235 data elements from 33 OASIS items effective January 1, 2019, finalized its definition of "standardized patient assessment data" and finalized that CMS will apply its policy for adopting changes to HH QRP measures to the standardized patient assessment data that it adopts for the HH QRP. It replaced one measure and adopted two new quality measures. Currently, the HH QRP has 23 measures, but these will be updated in CY 2020. Failure to submit data required will result in a reduction of the annual update to the standard federal rate for discharges occurring during such fiscal year by two percentage points. CMS also finalized the data submission requirements. A HHA may request an exception or extension to the reporting requirements as set forth in the regulations. HHAs that do not meet the reporting requirements may request reconsideration and may appeal the results to the Provider Reimbursement Review Board.