PUBLICATION

New Horizons Calling for Action Under Home Health Agency Final Rule

December 13, 2018

On November 13, 2018, CMS/HHS published in the Federal Register the Home Health Final Rule. 83 FR 56406 (Nov. 13, 2018). We provided an overview of the proposed rule in Payment Matters on September 14, 2018. Home health agencies will need to revise current policies and practices to respond to these changes.

The final rule with comment period addresses the following:

- Permits qualified home infusion suppliers to provide home infusion therapy services under the new home infusion benefit and introduces a transitional payment for home infusion therapy services for CYs 2019 and 2020. The Rule also spells out the health and safety standards for the services and establishes the accreditation and oversight process for home infusion suppliers. CMS has finalized approval and oversight standards for home infusion therapy accrediting organizations (AOs). It also requests comments on the definition of "infusion drug administration calendar day" at § 486.505 and discussed in Section VI.D of the Rule. Comments are due on or before December 31, 2018. The effective date of the rule is January 1, 2019.

- Updates case mix rates for CY 2019 and rebases the home health market basket, updates payment rates, reduces the labor related share, updates the home health wage index, and reduces the fixed-dollar loss ratio from 0.55 – 0.51 for CY 2019 in order to increase outlier payments so that this percentage is closer to but no more than 2.5 percent.

- Finalizes the methodology for the rural add on payments for CY 2019 through 2022. Each county is now classified into one of three categories for calculating the add on: (1) high utilization; (2) low population density; and (3) other. It also finalizes changes regarding certifying and recertifying patient eligibility for home health services. These changes are addressed in our previous overview. The Rule changes the definition of "remote patient monitoring" making it a home health benefit and includes the cost of monitoring as an allowable administrative cost. Home health agencies must properly document the provision of remote patient monitoring and capture administrative costs for cost reporting purposes.

- Finalizes the Home Health Value Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP) requirements. Beginning with performance year (PY) 4, the HHVBP will remove two Outcome and Assessment Information Set (OASIS) based measures, replace three OASIS-based measures with two new composite measures on total normalized composite change in self-care and mobility and change how CMS calculates the Total Performance Scores by changing the weighting methodology for the OASIS-based, claims-based, and HHCAHPS measures, and change the scoring methodology by reducing the maximum amount of improvement points a home health agency can earn from ten points to nine points.

- Updates the HH QRP by adopting eight measure removal factors, removing seven measures, and updating its regulations to clarify that not all OASIS data are required for the HH QRP. CMS is also providing an update on the implementation of certain provisions of the IMPACT Act, and finalizing its

proposal to increase the number of years of data used to calculate the Medicare Spending per Beneficiary measure for purposes of display from one year to two years.

- The effective date for the Patient Driven Groupings Model (PDGM), case-mix methodology refinements that eliminate the use of therapy thresholds for case-mix adjustment purposes, and the change in the unit of payment from the 60-day episode of care to 30 days is January 1, 2020. The delay in implementation of these changes will allow home health agencies to transition to properly document, code, and bill for each episode of care. The revenue cycle managers will have to adjust to the shortened time sequence for dropping clean claims.

- An episode of care will be assigned to one of the clinical groupings and the diagnosis must match. Coding and OASIS accuracy are essential to properly assign a clinical grouping to allow a claim to be processed. Home health agencies' quality review committees should carefully review visit frequencies by clinical groups. Further, a home health agency must now identify its admission source as either institutional or community. A community admission includes any beneficiary admission with no acute or PAC stay in the 14 days prior to the start of a 30-day episode of care. Emergency department or observational stays will be classified as a community admission. CMS will develop automated systems to evaluate the admission classification and repeated improper coding could lead to audits. There will also be a separate LUPA threshold for each 30-day episode of care. The threshold will vary depending on the PDGM payment grouping.

For assistance in reviewing and revising policies and practices at your home health agency, please contact any member of Baker Donelson's Reimbursement Team.