

13 British American Blvd., Suite 2, Latham, New York 12110 Telephone (518) 867-8383 Web www.leadingageny.org

M E M O R A N D U M

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| TO:  | Community Services Members |
| **FROM:** | Cheryl Udell, Community Services Policy Analyst  |
| **DATE:** | August 18, 2017 |
| **SUBJECT:** | Home Health Agency Proposed Medicare Rule for 2018 |
| **ROUTE TO:** | Administrator/Director, CFO |

ABSTRACT: CMS releases HH PPS proposed rule for CY 2018.

**Introduction**

The Centers for Medicare and Medicaid Services (CMS) has issued the Medicare Home Health Prospective Payment System (HH PPS) proposed rule for Calendar Year (CY) 2018. The complete rule is published in the [*Federal Register*](https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-15825.pdf)*.* The final rule will likely be issued sometime in the last quarter of 2017.

**Public comments on the proposed changes must be received by CMS by 5 p.m. on Sept. 25, 2017**. Comments should reference file code *CMS-1672-P* and may be submitted electronically at <http://www.regulations.gov> by following the instructions under *More Search Options*.

For additional details on submitting comments, please refer to the [*Federal Register*](https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-15825.pdf)link referenced above.

CMS is proposing major changes that include a $950 million decrease in Medicare payments and in the methodology of how home health payments will be paid. They are proposing to change the unit of payment from 60-day episodes of care to 30-day periods of care. This proposed change is scheduled for CY 2019 under the Home Health Grouping Model (HHGM) and comprises approximately 30 percent of this proposed rule.

The proposed rule also includes proposed changes for the Home Health Value-Based Purchasing Model (HHVBP) and the Home Health Quality Reporting Program (HH QRP), as well as a Request for Information (RFI) to welcome feedback on positive solutions for program simplification, flexibility, and innovation.

In the CY 2015 proposed rule, the *Face-to-Face (F2F)* requirement was extensively covered with several proposals to reduce the burden to home health agencies (HHAs) and physicians, and to mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements. For the last three years, there has been no mention of the F2F requirement in the proposed or final HH PPS. LeadingAge NY will continue to work with LeadingAge National and other stakeholders to eliminate this mandate or work to reduce the all-or-nothing approach that CMS has taken.

**Overall Impact and Summary of Key Provisions**

CMS is proposing measures that equal a **0.4 percent decrease** in total Medicare payments to HHAs for CY 2018. Nationally, total Medicare revenue would be reduced by approximately **$80 million**. The proposed decrease reflects the effects of a 1 percent home health payment update percentage ($190 million increase); a -0.97 percent adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9 percent ($170 million decrease); and the sunset of the rural add-on provision ($100 million decrease). This is different from last year’s final HH PPS reduction of 0.7 percent, or $130 million.

### *CY 2018 HH PPS Case-Mix Weights*

To recalibrate the HH PPS case-mix weights for CY 2018, CMS proposes to use the same methodology finalized in past HH PPS rules, including the CY 2008, CY 2012, and the CY 2015 HH PPS final rules. Annual recalibration of the HH PPS case-mix weights ensures that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns. To generate the proposed CY 2018 HH PPS case-mix weights, CMS used CY 2016 home health claims data (as of March 17, 2017) with linked OASIS data. These data are the most current and complete data available now. CMS will use CY 2016 home health claims data (as of June 30, 2017) with linked OASIS data to generate the CY 2018 HH PPS case-mix weights in the CY 2018 HH PPS final rule. To ensure that the changes to case-mix weights are implemented in a budget-neutral manner, *CMS would apply a case-mix budget neutrality factor for CY 2018 of 1.0159 to the national, standardized 60-day episodic payment rate.*

See Appendix A for the CY 2018 Proposed Case-Mix Weights.

***CY 2018 Home Health Market Basket Update***

Prior to the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which amended section 1895(b)(3)(B) of the Social Security Act (the Act), the proposed home health update percentage for CY 2018 would have been based on the estimated home health market basket update of 2.7 percent (based on IHS Global Insight Inc.’s first-quarter 2017 forecast with historical data through fourth-quarter 2016). Due to the requirements specified at section 1895(b)(3)(B)(vi) of the Act prior to the enactment of MACRA, the estimated CY 2018 home health market basket update of 2.7 percent would have been reduced by a MFP adjustment as mandated by the Affordable Care Act (currently estimated to be 0.5 percentage point for CY 2018).

In effect, the proposed home health payment update percentage for CY 2018 would have been 2.2 percent. *However, section 411(c) of MACRA amended section 1895(b)(3)(B) of the Act, such that for home health payments for CY 2018, the market basket percentage increase is required to be 1 percent.*

As a reminder, section 1895(b)(3)(B) requires that the home health market basket percentage increase be decreased by 2 percentage points for those HHAs that do not submit quality data. *For HHAs that do not submit the required quality data for CY 2018, the home health payment update would be -1 percent (1 percent minus 2 percentage points).*

***CY 2018 Home Health Wage Index***

In 2015, CMS proposed and finalized changes to the wage index based on the newest Core Based Statistical Area (CBSA) changes for the HH PPS wage index and Office of Management and Budget (OMB) delineations, as described in [OMB Bulletin No. 13-01](https://obamawhitehouse.archives.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf). CMS believed that using the most recent OMB delineations would create a more accurate representation of geographic variation in wage levels. Therefore, in CY 2016, CMS finalized the wage index to be fully based on the revised OMB delineations adopted in CY 2015.

CMS has proposed to continue using the pre-floor, pre-reclassified hospital wage index as the wage adjustment to the labor portion of the HH PPS rates. For CY 2018, the updated wage data are for hospital cost reporting periods beginning on or after Oct. 1, 2013, and before Oct. 1, 2014 (FY 2014 cost report data). They would apply the appropriate wage index value to the labor portion of the HH PPS rates based on the site of service for the beneficiary (defined by section 1861(m) of the Act as the beneficiary’s place of residence).

The proposed CY 2018 wage index is available on the CMS website [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1672-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending), see Downloads.

See Appendix B for the Proposed CY 2018 Wage Index for New York.

**Adjustment to Reflect Nominal Case-Mix Growth**

CMS will implement a 0.97 percent reduction to the national, standardized 60-day episode rate in CY 2018 to account for nominal case-mix growth from 2012 to 2014. CY 2018 will be the third year of the three-year phase-in of the reduction to account for nominal case-mix growth. The 0.97 percent reduction to the national, standardized 60-day episode payment rate to account for nominal case-mix growth results in an estimated decrease in HH PPS payments for CY 2018 of 0.9 percent.

#### *National, Standardized 60-Day Episode Payment Rate*

To determine the CY 2018 national, standardized 60-day episode payment rate, CMS would apply a wage index budget neutrality factor; a case-mix budget neutrality factor; a reduction of 0.97 percent to account for nominal case-mix growth from 2012 to 2014; and the home health payment update percentage.

CMS calculated the wage index budget neutrality factor by simulating total payments for

non-LUPA episodes using the proposed CY 2018 wage index and comparing it to their simulation of total payments for non-LUPA episodes using the CY 2017 wage index. By dividing the total payments for non-LUPA episodes using the proposed CY 2018 wage index by the total payments for non-LUPA episodes using the CY 2017 wage index, CMS obtained a wage index budget neutrality factor of 1.0001. They then applied the wage index budget neutrality factor of 1.0001 to the calculation of the proposed CY 2018 national, standardized 60-day episode rate. *The proposed national, standardized 60-day episode payment for CY 2018 is $3,038.43.* See Table 1.

***Table 1: Proposed National, Standardized 60-Day Episode Payment for CY 2018***



Source: CMS

***CY 2018 National Per-Visit Rates***

The national per-visit rates are used to pay LUPAs (episodes with four or fewer visits) and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by either the type of visit or the home health discipline. They include: home health aide, medical social services, occupational therapy, physical therapy, skilled nursing, and speech-language pathology.

CMS calculated the CY 2018 national per-visit rates by starting with the CY 2017 national per

-visit rates. They then applied a wage index budget neutrality factor of 1.0005 to ensure budget neutrality for LUPA per-visit payments. Lastly, the per-visit rates for each discipline are updated by the proposed CY 2018 home health payment update percentage of 1 percent. The national per

-visit rates are adjusted by the wage index based on the site of service of the patient. The LUPA per-visit rates are not calculated using case-mix weights. See Table 2.

**Table 2: Proposed CY 2018 National Per-Visit Payment Amounts for HHAs That Do Submit the Required Quality Data** Source: CMS

The proposed CY 2018 per-visit payment rates for HHAs that do not submit the required

quality data are updated by the proposed CY 2018 home health payment update percentage of 1 percent minus 2 percentage points.

***CY 2018 Low-Utilization Payment Adjustment (LUPA) Add-On Factors – Same as Previous Years***

LUPA episodes that occur as the only episode or as an initial episode in a sequence of

adjacent episodes are adjusted by applying an additional amount to the LUPA payment before

adjusting for area wage differences. The LUPA in the proposed CY 2018 HH PPS is the same as the LUPA “add-on factor” in the CY 2014 HH PPS final rule. In the CY 2014 HH PPS, CMS changed the methodology for calculating the LUPA add-on amount by finalizing the use of three LUPA add-on factors:

* 1.8451 for Skilled Nursing (SN);
* 1.6700 for Physical and Occupational Therapy (PT/OT); and
* 1.6266 for Speech Language Pathology (SLP).

CMS then multiplied the per-visit amount for the first SN, PT, OT, or SLP visit in a LUPA episode that occurs as the only episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount. For instance, for a LUPA episode that occurs as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit would be $261.16 (1.8451 multiplied by $141.54), subject to the area wage adjustment. The LUPA per-visit rates are not calculated using case-mix weights.

***CY 2018 Non-Routine Medical Supply (NRS) Payment Rates***

To determine the proposed CY 2018 NRS conversion factor, CMS updated the CY 2017 NRS conversion factor ($52.50) by the proposed CY 2018 home health payment update percentage of 1 percent. They did not apply a standardization factor, as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed.

The proposed NRS conversion factor for CY 2018 is shown in Table 3.

**Table 3: Proposed CY 2018 NRS Conversion Factor for HHAs That Do Submit the Required Quality Data**  Source: CMS

For HHAs that do not submit the required quality data, CMS updated the CY 2017 NRS

conversion factor ($52.50) by the proposed CY 2018 home health payment update

percentage of 1 percent minus 2 percentage points.

***Rural Add-On No Longer Applies!***

As we reported last year, Section 3131(c) of the Affordable Care Act amended section 421(a) of the Medicare Modernization Act (MMA) to provide an increase of 3 percent of the payment amount for home health services furnished in a rural area for episodes and visits ending on or after April 1, 2010 and before Jan. 1, 2016. This had been extended for home health services provided in a rural area for episodes and visits ending before Jan. 1, 2018.

*Therefore, for episodes and visits that end on or after Jan. 1, 2018, a rural add-on payment will not apply.*

***CY 2018 Payment Changes for High-Cost Outliers – No Changes***

In CY 2017, CMS finalized the proposed change in the methodology used to calculate outlier payments, moving from a cost-per-visit approach to a cost-per-unit approach (1 unit = 15 minutes). They thought that this approach more accurately reflects the cost of an outlier episode of care and thus better aligns outlier payments with episode costs than the cost-per-visit approach.

In the past, CMS targeted up to 2.5 percent of estimated total payments to be paid as outlier payments and then applied the 10 percent agency-level outlier cap. The 10 percent cap was a result of excessive growth in outlier payments, primarily the result of unusually high outlier payments in a few areas of the country. This was the premise on which CMS based its proposed changes.

***Fixed Dollar Loss (FDL) Ratio and Loss-Sharing Ratio***

In past rules, CMS continued the Fixed Dollar Loss (FDL) ratio at the same amount of 0.45 and a loss-sharing ratio of 0.80. CMS believed this was appropriate given that the percentage of outlier payments is estimated. Given last year’s different outlier payment changes, CMS finalized a different FDL ratio.

CMS had stated that for a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of episodes that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio and therefore increase outlier payments for qualifying outlier episodes. Alternatively, a

lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.

CMS cited the statutory requirement to target up to, but no more than, 2.5 percent of total

payments as outlier payments. Therefore, they had proposed a change to the FDL ratio for CY

2017, as they believed that maintaining an FDL ratio of 0.45 with a loss-sharing ratio of 0.80 was no longer appropriate given the percentage of outlier payments projected for CY 2017.

CMS did not propose a change to the loss-sharing ratio (0.80) in order for the HH PPS to be consistent with the payment for high-cost outliers in other Medicare payment systems. Under the current outlier methodology, they suggested changing the FDL from 0.45 to 0.48 to pay up to, but no more than, 2.5 percent of total payments as outlier payments. Under the proposed outlier methodology, which would be cost per unit, CMS finalized an increase in the FDL ratio from 0.45 to **0.55** to pay up to, but no more than, 2.5 percent of total payments as outlier payments.

For this proposed rule, using preliminary CY 2016 claims data (as of March 17, 2017) and the proposed CY 2018 payment rate, CMS estimates that outlier payments would constitute approximately 2.47 percent of total HH PPS payments in CY 2018 under the current outlier methodology. Given the statutory requirement to target up to, but no more than, 2.5 percent of total payments as outlier payments, *CMS is not proposing a change to the FDL ratio for CY 2018, as they believe that maintaining an FDL ratio of 0.55 with a loss-sharing ratio of 0.80 is still appropriate given the percentage of outlier payments projected for CY 2018.*

***CY 2019 – Proposed Implementation of the Home Health Grouping Model (HHGM)***

In the proposed rule, CMS proposes case-mix methodology refinements, including a change in the unit of payment from 60-day episodes of care to 30-day periods of care, to be implemented for 30-day periods of care beginning on or after Jan. 1, 2019. This model would rely more heavily on clinical characteristics and other patient information (e.g., principal diagnosis, functional level, comorbid conditions, referral source, and timing) to place patients into what CMS considers “more meaningful” payment categories. The HHGM also would eliminate therapy service use thresholds that are currently used to case-mix adjust payments under the HH PPS. CMS has estimated that this could save as much as $950 million.

The proposed HHGM includes changes to the episode timing categories, the addition of an admission source category, the creation of six clinical groups used to categorize 30-day periods of care based on the patient’s primary reason for home health care, revised functional levels and corresponding OASIS items, the addition of a comorbidity adjustment, and a proposed change in the LUPA threshold. The LUPA add-on policy, the partial payment adjustment policy, and the methodology used to calculate payments for high-cost outliers would also be revised to be consistent with the proposed 30-day period of care.

Section II.D of the proposed CY 2018 HH PPS (page 24) states: “In this rule, we propose to better align payment with resource use so that it reduces HHAs’ financial incentives to select certain patients over others.”

In their Report to Congress, CMS found that payment accuracy could be improved under the current payment system, particularly for patients with certain clinical characteristics. Findings from the report suggest that the current home health payment system may discourage HHAs from serving patients with clinically complex and/or poorly controlled chronic conditions who do not need therapy services, but require skilled nursing care.

In addition, MedPAC believes that the Medicare home health benefit is ill-defined, and the current reliance on therapy service thresholds for determining payment is counter to the goals of a prospective payment system. Under the current payment system, HHAs receive higher payments for providing more therapy visits, which may incentivize unnecessary utilization. In their March 2017 Report to Congress, MedPAC reiterated their recommendation that CMS eliminate the use of the number of therapy visits as a payment factor in the home health PPS beginning in 2019.

CMS is proposing to implement the HHGM beginning on or after Jan. 1, 2019. The implementation of the HHGM will require provider education and training, updating and revising relevant manuals, and changing claims processing systems. Implementation starting in CY 2019 would provide an opportunity for CMS, its contractors, and the agencies themselves to prepare. This patient-centered model groups periods of care in a manner consistent with how clinicians differentiate between patients and the primary reason for needing home health care.

*Rationale for 30 Days*

CMS is proposing using 30-day periods rather than the 60-day episodes in the current

payment system. They found that episodes have more visits, on average, during the first 30 days compared to the last 30 days. Costs are much higher earlier in the episode and lesser later on; thus, CMS believes that dividing a single 60-day episode into two 30-day periods more accurately reflects payments.

The 30-day billing under the HHGM is discussed in detail in section III.E.3., on page 89.

*Episode Timing Classification*

Similar to the current payment system, 30-day periods under the HHGM would be

classified as “early” or “late” depending on when they occur within a sequence of 30-day

periods. Under the HHGM, the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. CMS is proposing to adopt this episode timing classification for 30-day periods with the implementation of the HHGM.

The comprehensive assessment would still 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, as currently required by §484.55, Condition of participation: Comprehensive assessment of patients.

The proposed episode timing classification is discussed in detail in section III.E.4., on page 109.

*Admission Source Category*

Under the HHGM, each period would be classified into one of two admission source categories – community or institutional – depending on what health care setting was utilized in the 14 days prior to home health. The 30-day period would be categorized as institutional if an acute or post-acute care stay occurred in the 14 days prior to the start of the 30-day period of care. The 30-day period would be categorized as community if there were no acute or post-acute care stay in the 14 days prior to the start of the 30-day period of care.

The proposed admission classification source is discussed in detail in section III.E.5, on page 111.

*Six Clinical Groups*

The HHGM would group 30-day periods into categories based on a variety of patient

characteristics. Within the HHGM, one of the steps in case-mix adjusting the 30-day payment

amount would include grouping periods into one of six clinical groups based on the principal

diagnosis listed on the home health claim. The principal diagnosis reported would provide information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. The proposed six clinical groups, which are discussed in detail in section III.E.6, on page 124, are:

* Musculoskeletal Rehabilitation
* Neuro/Stroke Rehabilitation
* Wounds- Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
* Complex Nursing Interventions
* Behavioral Health Care
* Medication Management, Teaching and Assessment (MMTA)

*Functional Levels*

Under the HHGM, each 30-day period would be placed into one of three functional

levels. The level would indicate if, on average, given its responses on certain functional OASIS

items, a 30-day period is predicted to have higher costs or lower costs. CMS is proposing classifying 30-day periods according to functional level. For each of the six clinical groups, they propose that periods would be further classified into one of three functional levels with roughly 33 percent of periods in each level. The creation of this functional level is very similar to how the functional level is created in the current payment system. The proposed functional levels and corresponding OASIS items are discussed in detail in section III.E.7, on page 137.

*Addition of Comorbidities Adjustments*

CMS examined differences in resource use based on patient characteristics in the development of the HHGM. They analyzed the presence of comorbidities as another factor that could impact resource utilization and costs. CMS points out that research has repeatedly shown that

comorbidity is associated with high health care utilization and expenditures. Additionally,

comorbidity is tied to worse health outcomes and the need for more complex treatment and

disease management. This, in turn, results in higher health care costs. Patients with

comorbidities tend to be high users of home health visits, and overall Medicare spending

increases with the number of chronic conditions. CMS then moved towards the development of a home health specific comorbidity list for the HHGM comorbidity adjustment that included chronic and acute comorbid conditions and 15 subcategories; see section III.E.8, on page 155-158.

*LUPA Thresholds*

An episode with four or fewer visits is paid the national per visit amount by discipline,

adjusted by the appropriate wage index based on the site of service of the beneficiary, instead of

the full episode amount. Such payment adjustments are called Low-Utilization Payment

Adjustments (LUPAs). While the proposed HHGM system would still include LUPA payments,

CMS is proposing that the approach to calculating the LUPA thresholds would change in the

HHGM because of the proposed change in the unit of payment from 60-day episodes to 30-day periods. Whereas LUPAs are paid for all episodes consisting of four or fewer visits under the current payment system, to receive the full episode amount under the HHGM (rather than receive a LUPA where the episode would be paid the national per visit amount by discipline), CMS is proposing to vary the LUPA threshold for a 30-day period under the HHGM depending on the HHGM payment group to which it is assigned. The 30-day periods have substantially more instances of four or fewer visits than 60-day episodes. To create LUPA thresholds, 30-day

periods (including those that were LUPAs in the current payment system) were grouped into the

144 different HHGM payment groups. For each payment group, CMS is proposing to set the LUPA threshold at the 10th percentile value of visits **or** two visits, whichever is higher.

**CMS is soliciting comments on these proposed payment methodology refinements.** This proposed change has many implications for HHAs. LeadingAge NY will be carefully analyzing what is being suggested, but we first need to confirm that CMS has the authority to propose implementing a 30-day period of care. Please send us your questions or concerns on this new proposed model.

See Appendix C for the Structure of the Proposed HHGM.

***Home Health Value-Based Purchasing Model (HHVBP)***

In the CY 2016 HH PPS final rule, CMS implemented the HHVBP Model to begin on Jan. 1, 2016. The purpose of the HHVBP Model was to improve the quality and delivery of home health care services to Medicare beneficiaries. The specific goals are to: (1) provide incentives for better quality care with greater efficiency; (2) study new potential quality and efficiency measures for appropriateness in the home health setting; and (3) enhance the current public reporting process.

Nine states were selected for inclusion in the HHVBP Model, representing each geographic

area across the nation. All Medicare-certified HHAs that provide services in Arizona, Florida,

Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington

are required to compete in the Model. New York was NOT selected; however, this model warrants attention given the ongoing development of New York’s VBP through Medicaid.

As finalized in the CY 2016 HH PPS final rule, the HHVBP will adjust Medicare payment rates

beginning in CY 2018 based on performance on applicable measures. Payment adjustments will be increased incrementally over the course of several years.

In the CY 2018 HHS PPS proposed rule, CMS proposes to refine the HHVBP Model. CMS proposes to revise the definition of “applicable measure” to specify that HHAs in the HHVBP would only have to submit a minimum of 40 completed Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) surveys for purposes of receiving a performance score for any of the HHCAHPS measures. They are also proposing to remove the Outcome and Assessment Information Set (OASIS)‑based measure, Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care, from the set of applicable measures.

***Home Health Quality Reporting Program (HHQRP) Provisions***

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act) amended Title XVIII of the Social Security Act (the Act) by adding new section 1899B, which requires HHAs, Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. The data must be standardized and interoperable so as to allow for the exchange of such data among providers. It also requires the modification of the PAC assessment instruments to provide for the submission and comparison of such standardized patient assessment data. These requirements are intended to enable interoperability as well as improve quality and discharge planning, among other purposes.

CMS is proposing to adopt for the **CY 2020** payment determination three measures to meet the requirements of the IMPACT Act. These three measures are assessment-based and are calculated using Outcome and Assessment Information Set (OASIS) data. The proposed measures are as follows:

* Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury;
* 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).

CMS is proposing the data elements used to calculate the existing and proposed replacement pressure ulcer measures to meet the definition of standardized patient assessment data for medical conditions and comorbidities. Additionally, CMS is proposing new, standardized data elements in four other categories: functional status; cognitive function and mental status; special services, treatments, and interventions; and impairment. Unless otherwise specified, this data would be collected at start or resumption of care and discharge. More information about the specifications for standardized measures and standardized data elements can be found [here](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html).

CMS also reviewed the OASIS-C2 item set to identify candidate items for removal. Based on this analysis, CMS is proposing to remove 247 data elements from 35 current OASIS items collected, beginning on Jan. 1, 2019. These OASIS items, or data elements within OASIS items, are not used in the calculation of quality measures already adopted in the HH QRP, nor are they used for previously established purposes unrelated to the HH QRP, including payment, survey, the HH VBP Model, or care planning. Because they will no longer be used in any manner, CMS is proposing to no longer collect them. A list of these changes can be found [here](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html). CMS is proposing to formalize its processes for requesting reconsideration of determinations regarding compliance with the HH QRP, as well as its policies for requesting exceptions and extensions of reporting timeframes.

*Social Risk Factors in the HH QRP*

CMS understands that social risk factors such as income, education, race and ethnicity, employment, disability, community resources, and social support (certain factors of which are also sometimes referred to as socioeconomic status (SES) factors or socio-demographic status (SDS) factors) play a major role in health. One of their core objectives is to improve beneficiary outcomes, including reducing health disparities, and they want to ensure that all beneficiaries, including those with social risk factors, receive high quality care.

CMS still seeks public comment on whether they should account for social risk factors in measures in the HH QRP, and if so, what method or combination of methods would be most appropriate for accounting for such factors.

***Request for Information***

CMS would like to start a national conversation about improving the health care delivery system, how Medicare can contribute to making the delivery system less bureaucratic and complex, and how they can reduce the burden for clinicians, providers, and patients in a way that increases quality of care and decreases costs – thereby making the health care system more effective, simple, and accessible while maintaining program integrity and preventing fraud.

CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to better accomplish these goals. Ideas could include recommendations regarding payment system re-design; elimination or streamlining of reporting; monitoring and documentation requirements; operational flexibility; and feedback mechanisms and data sharing that would enhance patient care, support the doctor-patient relationship in care delivery, and facilitate patient-centered care within hospices. Ideas could also include recommendations regarding when and how CMS issues regulations and policies and how they can simplify rules and policies for beneficiaries, clinicians, providers, and suppliers.

In responding to the RFI, CMS is asking for clear and concise proposals that include data and specific examples. If the proposals involve novel legal questions, analysis regarding CMS’ authority is welcome. CMS will not respond to RFI comment submissions in the final rule, but rather will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

***Conclusion***

The proposed rule focuses on many of the same areas of HH PPS case-mix weights, non-routine medical supplies (NRS), home health market basket, and per-visit payment rates. This year’s introduction of a new Home Health Grouping Model (HHGM) is of concern. Please share any concerns or questions that you have with this new model, such as access to care for vulnerable patients, the potential impact to providers with a high volume of therapy cases, the rationale for implementing a 30-day period of care, or comorbidity adjustments.

In September, LeadingAge NY will be participating, along with other state affiliates, on a call regarding our concerns with the CY 2018 HH PPS proposed rule. If you would like to participate in the call, please contact me. We will be carefully evaluating the proposed payment changes as well as the new proposed changes to the outlier payment model and fixed dollar loss ratio, and advocating to resume the rural add-on.

Please remember that public comments on the proposed changes must be received by CMS by

**5 p.m. on Sept. 25, 2017**. Comments should reference file code *CMS-1672-P* and may be submitted electronically at <http://www.regulations.gov> by following the instructions under *More Search Options*.

For additional details on submitting comments, please refer to the [*Federal Register*](https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-15825.pdf)link referenced above.

Please contact LeadingAge National at congress@leadingage.org and Cheryl Udell at cudell@leadingageny.org or 518-867-8871 to share your concerns and recommendations on the HH PPS proposed rule.

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| --- | --- | --- | --- |
| **Pay Group** | **Step (Episode and/or Therapy Visit Ranges)** | **Clinical and Functional Levels (1 = Low; 2 = Medium; 3= High)** |  **Proposed CY 2018 Weight** |
| 10111 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F1S1 | 0.5617 |
| 10112 | 1st and 2nd Episodes, 6 Therapy Visits | C1F1S2 | 0.6925 |
| 10113 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F1S3 | 0.8232 |
| 10114 | 1st and 2nd Episodes, 10 Therapy Visits | C1F1S4 | 0.9539 |
| 10115 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F1S5 | 1.0846 |
| 10121 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F2S1 | 0.6662 |
| 10122 | 1st and 2nd Episodes, 6 Therapy Visits | C1F2S2 | 0.7845 |
| 10123 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F2S3 | 0.9027 |
| 10124 | 1st and 2nd Episodes, 10 Therapy Visits | C1F2S4 | 1.0209 |
| 10125 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F2S5 | 1.1392 |
| 10131 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C1F3S1 | 0.7157 |
| 10132 | 1st and 2nd Episodes, 6 Therapy Visits | C1F3S2 | 0.8311 |
| 10133 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C1F3S3 | 0.9464 |
| 10134 | 1st and 2nd Episodes, 10 Therapy Visits | C1F3S4 | 1.0618 |
| 10135 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C1F3S5 | 1.1772 |
| 10211 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F1S1 | 0.5975 |
| 10212 | 1st and 2nd Episodes, 6 Therapy Visits | C2F1S2 | 0.7343 |
| 10213 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F1S3 | 0.8711 |
| 10214 | 1st and 2nd Episodes, 10 Therapy Visits | C2F1S4 | 1.0078 |
| 10215 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F1S5 | 1.1446 |
| 10221 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F2S1 | 0.702 |
| 10222 | 1st and 2nd Episodes, 6 Therapy Visits | C2F2S2 | 0.8263 |
| 10223 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F2S3 | 0.9506 |
| 10224 | 1st and 2nd Episodes, 10 Therapy Visits | C2F2S4 | 1.0749 |
| 10225 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F2S5 | 1.1991 |
| 10231 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C2F3S1 | 0.7514 |
| 10232 | 1st and 2nd Episodes, 6 Therapy Visits | C2F3S2 | 0.8729 |
| 10233 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C2F3S3 | 0.9943 |
| 10234 | 1st and 2nd Episodes, 10 Therapy Visits | C2F3S4 | 1.1157 |
| 10235 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C2F3S5 | 1.2372 |
| 10311 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F1S1 | 0.6412 |
| 10312 | 1st and 2nd Episodes, 6 Therapy Visits | C3F1S2 | 0.7929 |
| 10313 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F1S3 | 0.9446 |
| 10314 | 1st and 2nd Episodes, 10 Therapy Visits | C3F1S4 | 1.0963 |
| 10315 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F1S5 | 1.248 |
| 10321 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F2S1 | 0.7457 |
| 10322 | 1st and 2nd Episodes, 6 Therapy Visits | C3F2S2 | 0.885 |
| 10323 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F2S3 | 1.0242 |
| 10324 | 1st and 2nd Episodes, 10 Therapy Visits | C3F2S4 | 1.1634 |
| 10325 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F2S5 | 1.3026 |
| 10331 | 1st and 2nd Episodes, 0 to 5 Therapy Visits | C3F3S1 | 0.7952 |
| 10332 | 1st and 2nd Episodes, 6 Therapy Visits | C3F3S2 | 0.9315 |
| 10333 | 1st and 2nd Episodes, 7 to 9 Therapy Visits | C3F3S3 | 1.0679 |
| 10334 | 1st and 2nd Episodes, 10 Therapy Visits | C3F3S4 | 1.2043 |
| 10335 | 1st and 2nd Episodes, 11 to 13 Therapy Visits | C3F3S5 | 1.3406 |
| 21111 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F1S1 | 1.2154 |
| 21112 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F1S2 | 1.378 |
| 21113 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F1S3 | 1.5406 |
| 21121 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F2S1 | 1.2574 |
| 21122 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F2S2 | 1.4176 |
| 21123 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F2S3 | 1.5779 |
| 21131 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C1F3S1 | 1.2926 |
| 21132 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C1F3S2 | 1.4558 |
| 21133 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C1F3S3 | 1.6189 |
| 21211 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F1S1 | 1.2814 |
| 21212 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F1S2 | 1.4573 |
| 21213 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F1S3 | 1.6332 |
| 21221 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F2S1 | 1.3234 |
| 21222 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F2S2 | 1.497 |
| 21223 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F2S3 | 1.6705 |
| 21231 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C2F3S1 | 1.3586 |
| 21232 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C2F3S2 | 1.5351 |
| 21233 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C2F3S3 | 1.7116 |
| 21311 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F1S1 | 1.3997 |
| 21312 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F1S2 | 1.6178 |
| 21313 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F1S3 | 1.8359 |
| 21321 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F2S1 | 1.4418 |
| 21322 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F2S2 | 1.6575 |
| 21323 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F2S3 | 1.8732 |
| 21331 | 1st and 2nd Episodes, 14 to 15 Therapy Visits | C3F3S1 | 1.477 |
| 21332 | 1st and 2nd Episodes, 16 to 17 Therapy Visits | C3F3S2 | 1.6956 |
| 21333 | 1st and 2nd Episodes, 18 to 19 Therapy Visits | C3F3S3 | 1.9142 |
| 22111 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F1S1 | 1.23 |
| 22112 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F1S2 | 1.3877 |
| 22113 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F1S3 | 1.5455 |
| 22121 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F2S1 | 1.2549 |
| 22122 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F2S2 | 1.4159 |
| 22123 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F2S3 | 1.577 |
| 22131 | 3rd+ Episodes, 14 to 15 Therapy Visits | C1F3S1 | 1.3037 |
| 22132 | 3rd+ Episodes, 16 to 17 Therapy Visits | C1F3S2 | 1.4632 |
| 22133 | 3rd+ Episodes, 18 to 19 Therapy Visits | C1F3S3 | 1.6226 |
| 22211 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F1S1 | 1.2852 |
| 22212 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F1S2 | 1.4598 |
| 22213 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F1S3 | 1.6345 |
| 22221 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F2S1 | 1.31 |
| 22222 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F2S2 | 1.488 |
| 22223 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F2S3 | 1.666 |
| 22231 | 3rd+ Episodes, 14 to 15 Therapy Visits | C2F3S1 | 1.3588 |
| 22232 | 3rd+ Episodes, 16 to 17 Therapy Visits | C2F3S2 | 1.5352 |
| 22233 | 3rd+ Episodes, 18 to 19 Therapy Visits | C2F3S3 | 1.7117 |
| 22311 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F1S1 | 1.4954 |
| 22312 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F1S2 | 1.6816 |
| 22313 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F1S3 | 1.8678 |
| 22321 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F2S1 | 1.5202 |
| 22322 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F2S2 | 1.7098 |
| 22323 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F2S3 | 1.8993 |
| 22331 | 3rd+ Episodes, 14 to 15 Therapy Visits | C3F3S1 | 1.569 |
| 22332 | 3rd+ Episodes, 16 to 17 Therapy Visits | C3F3S2 | 1.757 |
| 22333 | 3rd+ Episodes, 18 to 19 Therapy Visits | C3F3S3 | 1.9449 |
| 30111 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F1S1 | 0.4628 |
| 30112 | 3rd+ Episodes, 6 Therapy Visits | C1F1S2 | 0.6163 |
| 30113 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F1S3 | 0.7697 |
| 30114 | 3rd+ Episodes, 10 Therapy Visits | C1F1S4 | 0.9232 |
| 30115 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F1S5 | 1.0766 |
| 30121 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F2S1 | 0.5455 |
| 30122 | 3rd+ Episodes, 6 Therapy Visits | C1F2S2 | 0.6874 |
| 30123 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F2S3 | 0.8293 |
| 30124 | 3rd+ Episodes, 10 Therapy Visits | C1F2S4 | 0.9711 |
| 30125 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F2S5 | 1.113 |
| 30131 | 3rd+ Episodes, 0 to 5 Therapy Visits | C1F3S1 | 0.5903 |
| 30132 | 3rd+ Episodes, 6 Therapy Visits | C1F3S2 | 0.733 |
| 30133 | 3rd+ Episodes, 7 to 9 Therapy Visits | C1F3S3 | 0.8757 |
| 30134 | 3rd+ Episodes, 10 Therapy Visits | C1F3S4 | 1.0183 |
| 30135 | 3rd+ Episodes, 11 to 13 Therapy Visits | C1F3S5 | 1.161 |
| 30211 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F1S1 | 0.4835 |
| 30212 | 3rd+ Episodes, 6 Therapy Visits | C2F1S2 | 0.6438 |
| 30213 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F1S3 | 0.8041 |
| 30214 | 3rd+ Episodes, 10 Therapy Visits | C2F1S4 | 0.9645 |
| 30215 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F1S5 | 1.1248 |
| 30221 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F2S1 | 0.5662 |
| 30222 | 3rd+ Episodes, 6 Therapy Visits | C2F2S2 | 0.7149 |
| 30223 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F2S3 | 0.8637 |
| 30224 | 3rd+ Episodes, 10 Therapy Visits | C2F2S4 | 1.0125 |
| 30225 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F2S5 | 1.1612 |
| 30231 | 3rd+ Episodes, 0 to 5 Therapy Visits | C2F3S1 | 0.611 |
| 30232 | 3rd+ Episodes, 6 Therapy Visits | C2F3S2 | 0.7605 |
| 30233 | 3rd+ Episodes, 7 to 9 Therapy Visits | C2F3S3 | 0.9101 |
| 30234 | 3rd+ Episodes, 10 Therapy Visits | C2F3S4 | 1.0597 |
| 30235 | 3rd+ Episodes, 11 to 13 Therapy Visits | C2F3S5 | 1.2093 |
| 30311 | 3rd+ Episodes, 0 to 5 Therapy Visits | C3F1S1 | 0.5993 |
| 30312 | 3rd+ Episodes, 6 Therapy Visits | C3F1S2 | 0.7785 |
| 30313 | 3rd+ Episodes, 7 to 9 Therapy Visits | C3F1S3 | 0.9577 |
| 30314 | 3rd+ Episodes, 10 Therapy Visits | C3F1S4 | 1.1369 |
| 30315 | 3rd+ Episodes, 11 to 13 Therapy Visits | C3F1S5 | 1.3162 |
| 30321 | 3rd+ Episodes, 0 to 5 Therapy Visits | C3F2S1 | 0.682 |
| 30322 | 3rd+ Episodes, 6 Therapy Visits | C3F2S2 | 0.8496 |
| 30323 | 3rd+ Episodes, 7 to 9 Therapy Visits | C3F2S3 | 1.0173 |
| 30324 | 3rd+ Episodes, 10 Therapy Visits | C3F2S4 | 1.1849 |
| 30325 | 3rd+ Episodes, 11 to 13 Therapy Visits | C3F2S5 | 1.3526 |
| 30331 | 3rd+ Episodes, 0 to 5 Therapy Visits | C3F3S1 | 0.7268 |
| 30332 | 3rd+ Episodes, 6 Therapy Visits | C3F3S2 | 0.8952 |
| 30333 | 3rd+ Episodes, 7 to 9 Therapy Visits | C3F3S3 | 1.0637 |
| 30334 | 3rd+ Episodes, 10 Therapy Visits | C3F3S4 | 1.2321 |
| 30335 | 3rd+ Episodes, 11 to 13 Therapy Visits | C3F3S5 | 1.4006 |
| 40111 | All Episodes, 20+ Therapy Visits  | C1F1S1 | 1.7032 |
| 40121 | All Episodes, 20+ Therapy Visits  | C1F2S1 | 1.7381 |
| 40131 | All Episodes, 20+ Therapy Visits  | C1F3S1 | 1.7821 |
| 40211 | All Episodes, 20+ Therapy Visits  | C2F1S1 | 1.8091 |
| 40221 | All Episodes, 20+ Therapy Visits  | C2F2S1 | 1.844 |
| 40231 | All Episodes, 20+ Therapy Visits  | C2F3S1 | 1.8881 |
| 40311 | All Episodes, 20+ Therapy Visits  | C3F1S1 | 2.0539 |
| 40321 | All Episodes, 20+ Therapy Visits  | C3F2S1 | 2.0889 |
| 40331 | All Episodes, 20+ Therapy Visits  | C3F3S1 | 2.1329 |



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