Medicare and Medicaid Programs; CY 2018 Home Health Prospective Payment System Rate Update and Proposed 2019 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements (CMS-1672-P)

Summary of Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) published in the July 28, 2017 *Federal Register* (81 FR 35270-35393) a calendar year proposed rule addressing the 2018 Home Health Prospective Payment System rate update;[1] 2019 case-mix adjustment methodology refinements, the Home Health Value-Based Purchasing model and home health quality reporting requirements. Page references given in this summary are to this published document, which is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1672-P.html.

Comments on the proposed rule are due by September 25, 2017.

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I. Summary (pages 35271-35272)

Update to Home Health Prospective Payment System (HH PPS): As required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS would update the national standardized 60-day episode rate by 1 percent for 2018. CMS would update the 2018 home health wage index using fiscal year (FY) 2014 hospital cost report data. The fixed-dollar loss ratio would remain at 0.55 for 2018 under its proposal.

[1] Henceforth in this document, a year is a calendar year unless otherwise specified.

Implementation of the Home Health Groupings Model (HHGM) for 2019: For home health services beginning on or after January 1, 2019, CMS proposes to revise its case-mix methodology and payment categories by using its home health groupings model (HHGM). This case-mix methodology groups home health patients into payment categories using primarily clinical characteristics and other patient information and eliminates therapy service use thresholds that are currently used to case-mix adjust payments. In addition, CMS proposes to change the unit of payment from a 60-day episode of care to a 30-day period of care. CMS proposes to implement this change in a non-budget neutral manner, which it estimates would result in a $950 million decrease (-4.3 percent) in payments to HHAs in 2019. **CMS seeks comments on specific alternatives to the proposed non-budget neutral approach.**

Home Health Value-Based Purchasing (HHVBP): Changes proposed to the HVBP program would increase the minimum number of surveys required for including patient experience of care measures in the HHVP score and eliminate one process of care measure. Payment adjustments under the HHVBP will begin with 2018 payment.

Home Health Quality Reporting Program (HH QRP): Policies are proposed for collection of standardized patient assessment data, elimination of 247 currently reported patient assessment data elements, updating public display of quality measure performance, and program procedures. One program measure would be replaced and two others added beginning in 2020. Comments are sought on adjusting HH QRP measures for social risk factors.

Impact: The HH PPS updates are estimated to reduce home health payments by a net of $80 million, or -0.4 percent, in 2018. If CMS adopts its home health groupings model (HHGM) in 2019, this is expected to reduce home health payments by $950 million (-4.3 percent) if implemented in a fully-budget neutral way, or by $480 million (-2.2 percent) if implemented in a partially budget neutral manner in 2019.

II. Background (pages 35273-35277)

CMS reviews the statutory and regulatory provisions for the HH PPS and updates to that system. It also reviews and highlights key aspects of the current system for payment of home health services. To adjust for case-mix in the current system, the HH PPS uses a 153-category case-mix classification system to assign patients to a home health resource group (HHRG). Patients are grouped into these payment categories based on clinical severity level, functional severity level, and service utilization. Therapy service use is measured by the number of therapy visits provided during the 60-day episode based on nine visit level categories ranging from 0-5 to 20 or more visits.

CMS also reviews updates to the HH PPS. Most recently, in the 2017 HH PPS final rule, CMS implemented the last year of the 4-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor. CMS also made changes to the methodology used to calculate outlier payments and changes in payment for furnishing Negative Pressure Wound Therapy.

CMS highlights concerns that have been raised about the use of therapy thresholds in the current payment system. CMS cites several studies that conclude that home health companies may be responding to financial incentives to put patients into higher payment categories by providing more therapy visits. In an analysis of home health data between 2008 and 2013, MedPAC reported a 26 percent increase in the number of episodes with at least 6 therapy visits, with only a 1 percent increase in the number of episodes with five or fewer visits.[2] A 2016 study by Fout et. al., found that the number of therapy visits increased sharply just over Medicare HH payment thresholds at 6, 7, and 16.[3] Furthermore, a Congressional investigation into therapy practices of the four largest publicly-traded home health companies found that three out of the four companies investigated "encourages therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns."[4]

After considering these findings, CMS states that this led it to further develop the Home Health Groupings Model (HHGM) proposal. This approach uses many of the same aspects of the current payment system, but includes proposals to change from a 60-day to a 30-day billing cycle and to eliminate the therapy thresholds in the case-mix system. CMS notes that it most recently posted a detailed technical report on the HHGM on its website in December 2016.[5] In addition, CMS states that it held an additional technical expert panel, clinical workgroup webinars, and a National Provider call (January 2017) to garner feedback from the industry and that it was positive.

This HHGM proposal is discussed in more detail in section III.E of the proposed rule and this summary.

III. Proposed Provisions: Payment under the Home Health Prospective Payment System (pages 35277-35332)

A. Monitoring for Potential Impacts – Affordable Care Act Rebasing Adjustments

CMS reports on its monitoring of the impact of rebasing adjustments finalized in the 2014 HH PPS final rule (See Tables 2-4 and Figures 2-4 on pages 35277-35282). It presents 2015 cost report and 2016 claims data and concludes that the rebasing adjustments made to HH PPS payment rates in 2014-2016 do not appear to have resulted in significant HHA closures or otherwise diminished access to home health services.

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[2] Medicare Payment Advisory Commission (MedPAC). "Home Health Care Services." *Report to Congress: Medicare Payment Policy*. Washington, D.C., March 2015. P. 223. Accessed on March 28, 2017 at: http://www.medpac.gov/docs/default-source/reports/mar2015_entirereport_revised.pdf?sfvrsn=0.

[3] Fout B, Plotzke M, Christian T. (2016). Using Predicted Therapy Visits in the Medicare Home Health Prospective Payment System. *Home Health Care Management & Practice, 29(2), 81-90.* http://journals.sagepub.com/doi/abs/10.1177/1084822316678384.

[5] [4] Committee on Finance, United States Senate. *Staff Report on Home Health and the Medicare Therapy Threshold*. Washington, D.C., 2011. Accessed on March 28, 2017 at https://www.finance.senate.gov/imo/media/doc/Home_Health_Report_Final4.pdf.

[5] Abt Associates. *Medicare Home Health Prospective Payment System: Case-Mix Methodology Refinements. Overview of the Home Health Groupings Model*. Cambridge, MA., November 18, 2016. Accessed on April 27, 2017 at: https://downloads.cms.gov/files/hhgm%20technical%20report%20120516%20sxf.pdf.

Its preliminary review of 2016 claims data shows that the number of episodes and home health users that received at least one episode of care remained virtually the same from 2015 to 2016. CMS notes that the number of HHAs billing Medicare continues to decline, but that there are still 2.9 HHAs per 10,000 FFS beneficiaries, compared with 1.9 in 2001 when the HH PPS was implemented. The portion of FFS beneficiaries using HH services has declined from 9.0 percent in 2012 to 8.7 percent in 2016.

Longer-term trends in the number of visits per episode are reviewed; they have dropped from 21.7 visits per episode in 2009 to 17.9 visits in 2015, with the most notable decreases occurring in skilled nursing and home health aide services. CMS also reviews trends in episode timing. Currently, the first two 60-day episodes of care are considered "early" and the third or later 60-day episodes are considered "late." CMS finds that the percentages of early episodes with 20+ therapy visits has been trending upward since 2009 while the percentage of late episodes with 20+ therapy visits has been trending downward. CMS also notes that the percentage of overall episodes with 20+ therapy visits increase from 4.6 percent in 2008 to 7.0 percent in 2016.

Finally, CMS reports on trends in episodes by admission source, and finds that the percentage of first or only episodes with a community admission source increased from 37.4 percent in 2008 to 42.6 percent in 2016. CMS notes that MedPAC reviewed data going back to 2002-2013. It found high rates of volume growth for patients residing in the community, and suggested the potential for overuse given the lack of cost sharing for home health care.

CMS states that it will continue to monitor the potential impact of rebasing.

B. Proposed 2018 HH PPS Case-Mix Weights

CMS proposes its annual recalibration of the HH PPS case-mix weights using 2016 claims data with linked OASIS data. CMS sets out the detailed methodology it uses to recalibrate the case-mix weights and the steps involved (see Tables 5-7 on 35282-35285). Table 8 (pages 35286-35288) presents the resulting proposed 2018 case-mix payment rates for each of the 153 payment groups.

CMS proposes a case-mix budget neutrality factor of 1.0159 for 2018, calculated as the ratio of total payments when 2018 case-mix weights are applied to 2016 utilization, to total payments when 2017 case-mix weights are applied to 2016 utilization.

C. Proposed 2018 Home Health Payment Rate Update

1. Proposed 2018 Home Health Market Basket Update

As specified in MACRA, which amended section 1895(b)(3)(B) of the Social Security Act, the market basket percentage increase is required to be 1 percent in 2018 for home health payments Absent this requirement, the proposed home health payment update for 2018 would have been 2.2 percent (HH market basket increase of 2.7 percent less 0.5 multifactor productivity (MFP) adjustment.

The 1.0 percent market basket update is reduced by 2.0 percentage points for HHAs that do not submit quality data required by the Secretary. Thus, the updates for 2018 would be:

For HHAs reporting the required quality data:	1.0 percent
For HHAs not reporting the required quality data:	-1.0 percent

2. Proposed 2018 Home Health Wage Index

CMS proposes to continue to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates. For 2018, CMS would use FY 2014 hospital cost report data as its source for the updated wage data. CMS will continue to use the Office of Management and Budget's (OMB's) February 28, 2013 revisions to the delineations of Metropolitan Statistical Areas (MSAs) and the creation of Micropolitan Statistical Areas, and Core-based Statistical Areas (CBSAs), and OMB's most recent update published July 15, 2015 in OMB Bulletin 15-01. The proposed wage index for 2018 is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1672-P.html.

3. Proposed 2018 Payment Update

CMS proposes two wage index budget neutrality adjustments. One that applies to the standardized episode payment rate for episodes other than those involving the Low-Utilization Payment Adjustment (LUPA); and the other that is specific to the national per visit rate for LUPA episodes.

- A wage index budget neutrality adjustment of 1.0001 would apply to the standardized episode payment rate, which is computed by dividing total payments for non-LUPA episodes using the proposed 2018 wage index by the total payments for such episodes using the 2017 wage index.
- A wage index budget neutrality adjustment of 1.0005 would apply to national per visit payments for LUPA episodes, computed by dividing total payments for LUPA episodes using the proposed 2018 wage index by the total payments for such episodes using the 2017 wage index.

The methodology and payment amounts for the national standardized 60-day episode payment and the national per visit amounts for HHAs submitting and not submitting quality data are reviewed. See Tables 9-16 on pages 35290-35292 for details on the updates; below is a summary of the proposed calculations.

Proposed 2018 60-day National, Standardized 60-Day Episode Payment Amount, for HHAs Submitting and Not Submitting Quality Data, and Those in Rural Areas		
	HHAs submitting quality data	HHAs not submitting quality data
Proposed National standardized amount (Tables 9,10)		
2017 amount	$2,989.97	
Wage index budget neutrality factor	x 1.0001	
Case-mix budget neutrality factor	x 1.0159	
Nominal case mix growth adjustment (1-0.0097)	x 0.9903	
HH payment update percentage	x 1.01	x 0.99
Proposed 2018 payment amount	**$3,038.43**	**$2,978.26**

A rural add-on payment will not apply for 2018. The MACRA provision (section 210) that had extended the rural add-on of 3 percent for 2016 and 2017 expired.

Computations are presented for the LUPA and the proposed the per-visit amounts for each type of service (these are amounts paid in lieu of the 60-day episode payment when there are four visits or fewer in an episode). CMS reminds the reader that the LUPA per-visit amounts are not calculated using case-mix rates. The proposed per-visit amounts for those HHAs submitting the required quality data is as follows:

Proposed 2018 National, Per-Visit Amounts for HHAs that do Submit Quality Data (see CMS Table 11)						
	Home health aide	Medical social services	Occu-pational therapy	Physical therapy	Skilled nursing	Speech-language pathology
2017 per visit rates	$64.23	$227.36	$156.11	$155.05	$141.84	$168.52
Wage index budget neutrality factor	1.0005					
Payment update	1.01					
Proposed 2018 per visit rates	**$64.90**	**$229.75**	**$157.75**	**$156.68**	**$143.33**	**$170.29**

As with the payments for a 60-day episode of care, HHAs that do not submit required quality data would have the payment update for per-visit services reduced from 1.0 percent to -1.0 percent (see Table 12), resulting in the following payment rates.

Proposed 2018 National, Per-Visit Amounts for HHAs that do not Submit Quality Data (see CMS Table 12)						
	Home health aide	Medical social services	Occupa-tional therapy	Physical therapy	Skilled nursing	Speech-language pathology
Proposed 2018 per visit rates	$63.62	$225.20	$154.63	$153.58	$140.49	$166.92

LUPA Add-On Factors: CMS proposes no changes in the LUPA add-on factors, which apply for the first or only visit in an episode. The per-visit adjusters for the initial visit are 1.8451 for skilled nursing, 1.6700 for physical therapy, and 1.6266 for speech-language pathology.

Proposed Non-routine Medical Supply (NRS) payment rates: CMS proposes to update the conversion factors for particular severity levels (the NRS conversion factor update).

Proposed CY 2018 NRS Conversion Factor for HHSs that do and do not Submit the Required Quality Data (Tables 13 and 15)		
	HHAs that submit quality data	HHAs that do not submit quality data
CY 2017 NRS Conversion Factor	$52.50	
Proposed CY 2018 Payment Update	1.01	0.99
Proposed CY 2018 NRS Conversion Factor	$53.03	$51.98

CMS proposes the NRS payment amounts for 2018 for each of the six severity levels based on that conversion factor for those that do and do not submit the required quality data (see Tables 14 and 16).

D. Payments for High-Cost Outliers Under the HH PPS

1. Background

In the 2017 HHS PPS final rule (81 FR 76702), CMS finalized changes to its methodology used to calculate outlier payments, switching from a cost-per-visit approach to a cost-per-unit approach. CMS now converts the national per-visit rates into per 15-minute unit rates. CMS also limits the amount of time per day (summed across the six disciplines of care) to 8 hours (32 units) per day when estimating the cost of an episode for outlier calculation purposes.

2. Fixed Dollar Loss (FDL) Ratio

CMS notes that the FDL ratio and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by statute (section 1895(b)(5)(A) of the Act). CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80 percent of the additional estimated costs above the outlier

threshold amount. In 2017, CMS raised the FDL ratio to 0.55 (from 0.45 in 2016). The FDL ratio is used in the calculation to determine the outlier threshold amount.[6]

Thus, for 2018 CMS proposes to maintain the FDL ratio of 0.55 with a loss-sharing ratio of 0.80. CMS believes that this is appropriate given the percentage of outlier payments projected for 2018 and the need to ensure that outlier payments do not exceed 2.5 percent of total payments. CMS states that it may update the FDL ratio in the final rule, based on the use of more complete claims data.

E. Proposed Implementation of the Home Health Groupings Model (HHGM) for 2019

1. Overview

Medicare payment for home health services provided during a 60-day episode of care are case-mix adjusted to account for the timing of the episode within a sequence of episodes, the patient's clinical status and functional status (based on information from the Outcome and Assessment Information Set (OASIS), and the amount of therapy services provided during the episode. The combination of episode timing, clinical and functional levels, and therapy services results in 153 home health resource groups (HHRGs) that are used to categorize each home health episode. Each HHRG is assigned a relative weight reflecting the average resource use of patients in that HHRG compared with the average resource use across all home health patients. This relative weight is used to case-mix adjust the episode's payment. Additional adjustments are made for geographic variations in wages, resource intensive (outlier) episodes, episodes with very few visits, transfers to other HHAs or to hospitals with a return to home health during the episode, and the expected use of non-routine medical supplies (NRS).

CMS' Report to Congress found that payment accuracy could be improved under the current payment system.[7] CMS reported the current home health PPS might discourage HHAs from serving patients with clinically complex and/or poorly controlled chronic conditions who require skilled nursing care but do not need therapy services. In addition, in its March 2017 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) reiterated a prior recommendation that CMS eliminate the use of the number of therapy visits as a payment factor in the home health PPS beginning in 2019.[8]

Based on this information, for 2019, CMS proposes to implement case-mix methodology refinements based on the Home Health Groupings Model (HHGM). CMS proposes to implement the HHGM for home health periods of care beginning on or after January 1, 2019. The HHGM uses 30-day periods rather than the 60-day episode in the current payment system.

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[6] The national, standardized 60-day episode payment is multiplied by the FDL ratio, and then wage adjusted. This amount is then added to the case-mix and wage-adjusted 60-day episode payment amount to determine the outlier threshold.

[7] *Report to Congress. Medicare Home Health Study: An Investigation on Access to Care and Payment for Vulnerable Patient Populations.* Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/HH-Report-to-Congress.pdf.

[8] MedPAC. "Home Health Care Services." Report to Congress: Medicare Payment Policy. Washington, DC, March 2017. P. 231. Available at http://www.medpac.gov/docs/default-source/reports/mar17_entirereport224610adfa9c665e80adff00009edf9c.pdf?sfvrsn=0.

Figure 5, reproduced below from the proposed rule, provides an overview of the structure of the HHGM model. Under the proposed HHGM model, each 30-day period of care would be placed into one of 144 home health resource groups (HHRGs).

- Early or Late Episode. The 30-day periods would be classified as "early" or "late" depending on when they occur within a sequence of 30-day periods. The first 30-day period would be classified as early and all subsequent 30-day periods in the sequence are classified as late. The comprehensive assessment would still be completed within 5 days of the start of care date and no less frequently than during the last 5 days of every 50 days beginning with the start of care date.

- Admission Source and Timing. Each period would be classified into one of two admission source categories: community or institutional. The 30-day period would be categorized as institutional if an acute or post-acute stay occurred in the prior 14 days to the start of the period of care. The 30-day period would be categorized as community if there was no acute or post-acute care stay in the 14 days prior to the start of the period of care.

- Clinical Grouping. Based on the principal diagnosis reported on claims, 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 proposed six clinical groups are Musculoskeletal Rehabilitation; Neuro/Stroke Rehabilitation; Wounds (post-op wound aftercare and skin/non-surgical wound care); Complex Nursing Interventions; Behavioral Health Care; and Medication Management, Teaching and Assessment (MMTA).

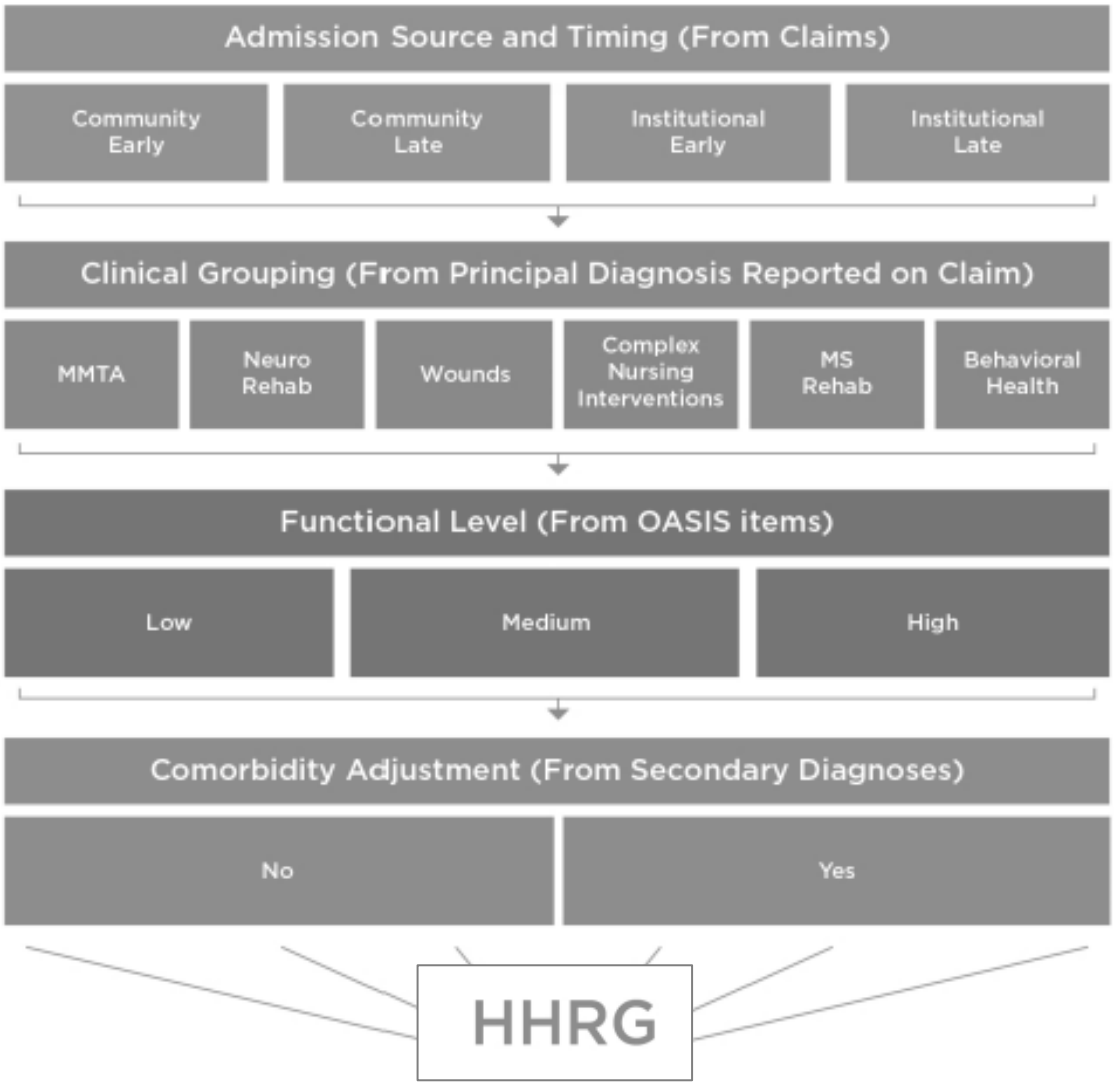
- Functional Level. Based on certain functional OASIS items, each 30-day period would be placed into one of three functional levels: low, medium, or high. The level would indicate if, on average, given its responses on certain functional OASIS items, a 30-day period is predicted to have higher costs or lower costs. CMS proposes that each of the six clinical groups would be further classified into one of the three functional levels with roughly 33 percent of periods in each level.

- Comorbidity Adjustment. Based on secondary diagnoses, CMS proposes that 30-day periods would receive a comorbidity adjustment if any diagnosis codes listed on the home health claim are included on a list of comorbidities that occurred in at least 0.1 percent of 30-day periods and associated with increased average resource use.

CMS also proposes changes in the Low-Utilization Payment Adjustment (LUPA) threshold. The LUPA add-on policy, the partial episode payment (PEP) adjustment policy, and the methodology used to calculate payments for high-cost outliers would remain unchanged except for occurring on a 30-day basis instead of a 60-day basis.

CMS notes that all the conditions for payment would remain the same for Medicare home health services. All the requirements would still need to be met in accordance with §424.

Figure 5: Structure of the Proposed Home Health Groupings Model (HHGM)[1]



[1]Under the HHGM, an episode is grouped into one (and only one) subcategory under each larger colored category. An episode's combination of subcategories groups the episodes into one of 144 different home health resource groups (HHRGs).

Analysis Used to Create the HHGM

CMS discusses the methodology it used to create the HHGM. CMS developed a data file based on 100 percent of health episode claims with through dates in 2017, processed by March 17, 2017, and accessed via the Chronic Conditions Data Warehouse (CCW). Original or adjusted claims processed after March 17, 2017 would not be reflected in this core file. The claims data provides episode-level data, visit-level data, and whether non-routine supplies (NRS) were provided during the episode and total charges for NRS. CMS supplemented the data with additional variables that were obtained from the CCW, such as information regarding other Part A and Part B utilization.

CMS discusses how it cleaned the data including accounting for potential data entry errors. CMS also applied a set of data cleaning exclusions to the episode-level file which excluded

episodes with no covered visits; episodes with any missing units or visit data; episodes with zero payments; episodes with no charges; and non-LUPA episodes missing an HHRG.

The analysis file also includes data on patient characteristics obtained from OASIS assessments. For constructing the core data file, CMS uploaded from the central CMS repository, 100 percent of the OASIS assessments submitted October 2015 through December 2016. Episodes that could not be linked with an OASIS assessment were excluded from the analysis file.

CMS discusses the variety of data sources it used to construct resource use. BLS data on average wages and fringe benefits were used to produce one version of the wage-weighted cost per minute for each home health discipline (see Table 17 in the proposed rule). Home Health Agency Medicare Cost Report (MCR) data were also used to construct a measure of resource use after trimming out HHAs whose costs were outliers. CMS used these data to provide a representation of the average costs of visits provided by HHAs in the six Medicare home health disciplines: skilled nursing; physical therapy (PT); occupational therapy (OT); speech-language pathology (SPL); medical social services; and home health aide services.

The 2016 analytic file included 6,293,442 episodes. After excluding 469,346 episodes (7.5 percent) the analysis file included 5,824,096 episodes. Episodes were excluded because they could not be linked to an OASIS assessment or because they met CMS' exclusion criteria. CMS converted these 60-day episodes into a final HHGM analytic file that included 10,231,507 30-day periods. CMS excluded 30-day periods missing diagnosis codes; periods where the diagnosis code did not link to a clinical group;; periods without nursing visit or therapy visit; and periods identified as LUPA. The final analytic sample included 8,642,107 30-day periods that were used for the analyses in the development of the HHGM.

CMS notes the analyses and the development of the HHGM has been shared with both internal and external stakeholders via technical expert panels, clinical workgroups, special open door forums, and the 2017 HHS PPS final rule (81 FR 76702). A detailed technical report that discusses all the components of the HHGM was posted on the CMS home health agency webpage in December 2016.[9] CMS held a National Provider call in January 2017, to obtain additional feedback.[10]

2. Methodology Used to Calculate the Cost of Care

As discussed below, CMS proposes to calculate the cost of a 30-day period of home health care under the HHGM using the cost per minute plus non-routine supplies (CPM+ NRS) approach. The current payment system uses the wage-weighted minutes of care (WWMC) approach based on data from the BLS.

[9] Abt Associates. "Overview of the HHGM." Medicare Home Health Prospective Payment System: Case-Mix Methodology Refinements. Cambridge, MA, November 18, 2016. Available at https://downloads.cms.gov/files/hhgm%20technical%20report%20120516%20sxf.pdf.

[10] CMS. "Certifying Patients for the Medicare Home Health Benefit." MLN Connects National Provider Call. Baltimore, MD, December 16, 2016. Information including transcript available at https://www.cmc.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2017-01-18-Home-health.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=descending.

CMS used the following data sources for calculating the measures of home health resource use:

- BLS Wage Estimates: For the WWMC methodology, wage and fringe data were obtained from the BLS by industry and occupation codes. These data provide nationwide average wage rates, and the average value of fringe benefits per hour of work for specific occupations.
- Home Health Medicare Cost Report (MCR) Data: All Medicare-certified HHAs must report costs through publically available home health cost reports maintained by the Health care Cost Report Information System (HCRIS). CMS notes these cost reports enable estimation of the cost per visit by provider and the estimated NRS cost to charge ratios. CMS used a trimming process to remove cost reports with missing or questionable data and extreme values.[11] CMS notes that it proxied opportunity costs by using hourly wage rates.
- Home Health Claims Data: Medicare home health claims are used in both the WWMC and CPM+NRS methods to obtain minutes of care by discipline of care.

The Wage-Weighted Minutes of Care (WWMC) approach determines resource use for each episode by multiplying utilization (in terms of the number of minutes of direct patient care provided by each discipline) by the corresponding opportunity costs of that care (represented by wage and fringe benefits rates from the BLS). CMS notes that in this analysis it proxied opportunity costs by using hourly wage rates. Table 18 in the proposed rule shows the occupational titles and corresponding mean hourly wage rate from the BLS and the corresponding opportunity costs. For home health disciplines that include multiple occupations (such as skilled nursing), the opportunity cost is generated by weighting the employer cost by the proportions of the labor mix.

For each home health period of care, the number of minutes of care provided (obtained from the home health claims) was weighted by the corresponding opportunity cost for each discipline providing the minutes. To obtain total costs for the 30-day period, the resulting wage-weighted minutes of care were summed. The mean total 30-day period costs were $374.52; the distribution ranged from a 5th percentile value of $73.87 to a 95th percentile value of $912.10 (Table 19).

In the current payment system, all episodes without a LUPA receive payment for NRS, regardless of whether or not the HHA provided NRS during the episode. NRS payments are determined using the presence of clinical factors associated with NRS provisions from the OASIS. CMS notes that two-thirds of episodes do not include provision of NRS.

Under the HHGM, CMS proposes to calculate the HHGM with a CPM+NRS methodology that is based on information from Medicare cost reports. CMS would group episodes into their case-mix group taking into account admission source, timing, clinical group, functional level, and comorbidity adjustment. The average resource use for each case-mix group would determine the group's case-mix weight. CMS determined resource use as the estimated cost of visits recorded

[11] Discussion of the trimming methodology is described in the report available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Anayses-in-Support-of-Rebasing-and -Updating-the-Medicare0Home-Health-Payment-Rates-Technical-Report.pdf.

on the home health claim plus the cost of NRS recorded on the claims. CMS calculated the cost of NRS by taking NRS charges on claims and converting them to costs using a NRS cost to charge ratio that is specific to each HHA. NRS costs are reflected in the average resource use that contributes to the case-mix weight. Under this methodology, CMS would return the NRS conversion factor ($53.06) to the base rate. If all episodes in a particular group have a high amount of NRS costs (all other factors are equal), the resource use will be higher relative to the average and the case-mix weight with correspondingly by higher.

Incorporating the NRS cost into the measure of overall resource use required adjusting the NRS charges submitted on claims based on the NRS cost-to-charge ratio from cost report data. In the proposed rule, CMS outlines the twelve steps used to generate the measure of resource use under the CPM+NRS approach. Under this approach the mean total 30-day period costs were $1,585.48; the distribution ranged from a 5th percentile value of $300.03 to a 95th percentile value of $3,908.93 (Table 20).

CMS discusses the differences in the estimates of costs for the two methods. CMS notes that because the cost estimates using the two approaches are measuring different items, they cannot be directly compared. The CPM+NRS method incorporates HHA-specific costs that represent the total costs during a 30-day period while the WWMC method provides an estimate of only the labor costs related to direct patient care from patient visits that are incurred during a 30-day period. The WWMC costs are not HHA-specific and do not account for any non-labor costs (such as transportation costs) or non-direct patient care labor costs (such as administration costs). CMS notes however, based on a high correlation coefficient between the two approaches for calculating resource use (correlation coefficient is equal to 0.8016), the relationship in relative costs is similar between the two methods.

CMS concludes that using cost report data to develop case-mix weights more evenly weights skilled nursing services and therapy services compare with using the BLS data. Table 21 (reproduced below) shows the ratios between the estimated costs per hour for each methodology for each of the home health disciplines.

Table 21: Relative Values in Costs per Hour by Disciplines (Skilled Nursing is Base)

Estimated Cost per Hour	Skilled Nursing	Physical Therapy	Occupational Therapy	Speech Therapy	Medical/ Social Service	Home Health Aide
CPM+NRS	1.00	1.14	1.16	1.24	1.36	0.41
WWMC	1.00	1.40	1.39	1.50	0.95	0.36

CMS proposes to calculate the cost of a 30-day period of home care under the HHGM using the CPM+NRS approach. CMS believes that using cost report data to calculate the cost of home health care better aligns the case-mix weights with the total relative cost of treating various patients.

3. Change from 60-day Billing to 30-day Billing Under the HHGM

CMS proposes using a 30-day period instead of the 60-day episodes in the current HH PPS.

CMS discusses the differences in resources used between the first 30-day period and the second 30-day period within a 60-day episode. Tables 22 and 23 in the proposed rule, demonstrate 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 than later on. CMS notes that although it also examined resource use in 15-day periods in a 60-day episode of care, it is not proposing to adjust payments every 15 days.

CMS found that approximately 25 percent of episodes are 30 days or less in length, with an average length of home health care approximately 46 days (Table 24). These episodes would convert to only one 30-day period under the HHGM. Any 60-day episode that is 31 days or more would produce two 30-day periods: a first period comprising 30 days in length and then a second period with the remaining days in the 60-day episode. CMS also found that reducing the unit of time from 60-day to 30-day episodes, improves the accuracy of payment (Tables 25 and 26). When a shorter, more constrained time period is used for payment, CMS found the HHGM's goodness of fit statistics (for example, R-squared) improved due to reduced variation in resource use.

CMS notes that the 60-day episode of payment was originally implemented in 2000, because most episodes in the HHA per-episode PPS demonstration ended in 60 days or less, the OASIS data would be captured on a 60-day cycle, and the Medicare plan of care/certification requirements would continue to be bimonthly. In the 2001 HH PPS, CMS reported that about 60 percent of episodes were completed within one 60-day episode and 73 percent within two 60-day episodes. CMS noted it would monitor the appropriateness of the 60-day unit of payment, and would consider modifying the episode definition if warranted (65 FR 41136). Based on 2016 data, CMS found more episodes were completed earlier in 2016 than in 2011: 73 percent of episodes were completed within one 60-day episode and 86 percent within two 60-day episodes.

Section 1895(b)(2) of the Act requires the Secretary to consider potential changes in the mix of services provided within that unit and their cost. As highlighted above, CMS' analyses shows evidence of a change in the mix of services under a 60-day episode of care and proposes to change the unit of payment from a 60-day episode of care to a 30-day episode of care.

a. National, Standardized 30-day Payment Amount

CMS proposes to implement the HHGM for a 30-day period of care beginning on or after January 1, 2019. CMS notes that 60-day episodes of care that begin on or before December 31, 2018 and end on or after January 1, 2019 will be paid using the current case-mix adjustment methodology (153 HHRG system) and a 2019 national, standardized 60-day episode payment amount and/or 2019 national per-visit amounts.

To calculate a national, standardized 30-day payment amount for 2019, CMS proposes to start with the 2019 national, standardized 60-day episode payment amount reflecting the HHA market basket update, add back the 2019 NRS conversion factor amount reflecting the HHA market basket update, and then divide the sum by two. To calculate a national, standardized 30-day payment amount for 2020 and subsequent years, CMS would update the national, standardized

30-day payment amount from the immediate preceding year by the home health payment update percentage required by the statute.

CMS provides the following example to illustrate the calculation. If the HHGM was going to be implemented in 2018, CMS would have calculated a proposed 30-day payment amount for 2018 by starting with the 2018 proposed national standardized 60-day episode payment amount of $3,038.43, add back the 2018 proposed NRS conversion factor amount of $53.03, and divide the sum by two to obtain a 30-day payment amount of $1,545.73.

CMS discusses alternative methodology it considered for determining the 30-day payment amount. In the first alternative, CMS calculated an estimated 30-day payment amount by taking the average number of visits per discipline per 30-day period of care in 2016 and multiplied those numbers by the FY 2001 per-visits amounts (including average NRS costs per visit) initially established under the HH PPS, adjusted for inflation and productivity. This methodology resulted in an estimated 30-day payment amount for 2018 of $1,494.64 (Table 28). This value is less than, but similar to CMS' proposed methodology, which resulted in a 30-day payment amount for 2018 of $1,545.73.

CMS also calculated an estimated 30-day payment amount by taking the average number of visits per discipline per 30 day period of care in 2016 and multiplied these numbers by the FY 2015 costs-per-visit, per discipline adjusted to include average NRS costs per visit, for outliers, and for inflation and productivity. This methodology resulted in an estimated 30-day payment amount for 2018 of $1,485.11 (Table 29). This value is also less than but similar to CMS' proposed methodology, which resulted in a 30-day payment amount for 2018 of $1,545.73.

CMS also proposes to implement the HHGM in a fully non-budget neutral manner beginning in 2019. CMS acknowledges it considered an alternative phased approach to lessen the economic impact for HHAs in transitioning to the HHGM. CMS considered a phased in approach that would apply a HHGM partial budget neutrality adjustment factor in 2019 that would reduce the estimated impact of the HHGM from an estimated -4.3 percent to -2.2 percent in the initial year of implementation. The HHGM partial neutrality adjustment factor would be removed in 2020.

CMS seeks comments on how to implement the HHGM. Specifically, whether to:

- Implement the HHGM in a fully non-budget neutral manner beginning in 2019;
- Implement the HHGM in 2019 with a HHGM partial budget neutrality adjustment factor applied and then subsequently removed in 2020; or
- Implement a HHGM partial budget neutrality adjustment factor in 2019, which is phased-out over a longer period of time.

b. Split Percentage Payment Approach for 30-day Periods of Care

CMS is not proposing a change to the split percentage approach that is currently used in the 60-day episode. The first bill, a Request for Anticipated Payment (RAP), is submitted at the beginning of the episode. The second, final bill is submitted at the end of the 60-day episode of care.

Under the HHGM, CMS proposes the initial payment for initial 30-day periods would be paid at 60 percent of the case-mix and wage-adjusted 30-day payment rate. The residual final payment would be paid at 40 percent. CMS proposes the initial payment for subsequent 30-day periods would be paid at 50 percent of the case-mix and wage-adjusted 30-day payment rate. The residual final payment for subsequent 30-day periods would be paid at 50 percent.

CMS notes that based on the current length of time HHAs take to submit RAPs, it might not need to continue the split payment approach to maintain adequate cash flow with a 30-day period of care. Specifically, CMS found that the median length of days for RAP submission is 12 days from the start of the episode and only approximately 5 percent of RAPs are not submitted until the end of an episode of care (Table 30). CMS states that eliminating RAP payments would address existing program integrity vulnerabilities.

CMS seeks comments about the split percentage payment approach:

- Whether the split payment approach would still be needed for HHAs to maintain adequate cash flow if the unit of payment changes to 30-day periods of care.
- Ways to phase-out the split percentage payment approach in the future if the proposed HHGM is finalized with the split percentage payment approach being initially maintained.
- If in the future the split percentage approach was eliminated, do HHAs need to submit a notice of admission within 5 days of the start of care to assure being established as the primary HHA for the beneficiary and so that claims processing systems would enforce the consolidated billing edits?

4. Episode of Timing Categories

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. CMS proposes the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late. Similar to the current definition of a "home health sequence", CMS proposes that a 30-day period could not be considered early unless there was a gap of more than 60 days between the end of one period and the start of another.

CMS discusses the evidence demonstrating that beneficiaries in their first 30-day period of care have different needs and patterns of resource use than those in the later 30-day periods. Several studies showed that more frequent skilled visits in the first few weeks of a home stay can provide benefit for certain diagnoses by reducing the likelihood of readmission to an institutional setting and ease the transition from hospital to home. CMS also discusses the practice of "frontloading" which is defined by the Visiting Nurse Associations of America as the practice of providing an intensity of visits during the first two to three weeks of the home health care episode for patients that have been determined to be at high risk for hospitalization.[12] Based on the literature describing the practice and improvements in overall outcomes from the practice of frontloading,

[12] Care-Initiation-Frontloading. (n.d.). Retrieved by CMS on March 20, 2017 from http://vnaablueprint.org/Care-Initiation-Frontloading.html.

CMS expects that HHAs would provide more frequent skilled services in the beginning portion of a home health stay. CMS also expects that beneficiaries would require more resources, particularly from skilled disciplines providing teaching and medication management, during the first 30 days of a home health admission.

CMS' evaluation of resource utilization from home health data demonstrated that HHAs provide more resources in the first 30-day period of home health (early) than in later periods of care (Table 28). Specifically, the median value of resource use for early episodes (the first 30-day period) was $1,848.12 while the median resource use for late episodes (subsequent 30-day periods) was $987.54.

To identify the first 30-day period within a sequence, the Medicare claims processing system would verify that the claim "From date" and "Admission date" match. If this condition was met, the claims processing systems would send the "early" indicator to the HH Grouper for the 30-day period of care. When the Common Working file receives the claim, the system would look back 60 days to ensure there is not a prior, related episode. If another related episode was identified, the claim would be returned to the shared systems for subsequent regrouping and re-pricing. Those periods that are not identified as the first 30-day period in a sequence of adjacent periods and separated by no more than a 60-day gap, would be categorized as "late" periods.

5. Admission Source Category

With the implementation of the HHGM, CMS proposes that each period of care would be classified into one of two admission source categories depending on what healthcare setting was utilized in the 14 days prior to home health: institutional or community.

CMS discusses the literature demonstrating the impact of beneficiary admission source, either from the community or institutional setting, on home resource use. The research showed that beneficiaries admitted directly or recently from an institutional setting (acute or PAC) have different care needs and higher resource use than those admitted from the community. MedPAC's analyses of 2013 HH claims, found that beneficiaries admitted from the community received more visits from home health aides than their non-community counterparts and averaged 2.6 60-day episodes. Beneficiaries admitted to home health from the institutional setting averaged only 1.4 60-day episodes. CMS concludes these findings suggest that beneficiaries admitted to home health from the community typically require less resources but for longer periods of time.

CMS' evaluation of resource utilization from home health data demonstrates a pattern of higher resource use for institutional admissions as compared to community admissions (Table 32). CMS examined average resource use by admission source based on the health care setting utilized in the 14 days prior to home health admission. For a 30-day period, the median value of resource use from institutional admissions was $2,772.04 while the median resource use for community admissions was $1,060.51. CMS states that the research combined with analyses of claims data indicates the need for differentiated payment amounts as determined by the health care setting utilized prior to home health admission.

Based on additional analyses of the claims data, CMS found that approximately 8 percent of home health admissions were from PAC settings across all 30-day periods of care. CMS reports states that when it created case-mix groups that differentiated between community, acute, and PAC admissions it found some case-mix groups with a very low number of 30-day periods. CMS believes this could result in substantial variability in the yearly average resource use. CMS is concerned this variability could introduce unnecessary instability in the case-mix weights and proposes to group patients admitted from acute care and PAC settings together as institutional admissions.

CMS also compared the use of a 14-day or 30 day "look-back" period for determining the admission source (Table 33). Given only a slight difference in resource use between beneficiaries in the 30 days prior instead of 14 days prior to home health admission, CMS proposes a 14-day look-back to align with OASIS items and limit burden on claims systems.

CMS proposes to establish two admission sources for grouping 30-day periods of care under the HHGM: institutional and community. The admission category would be determined by the health care setting utilized in the 14 days prior to the home health admission. The institutional category would include patients admitted from either acute care or PAC settings. CMS proposes this would include beneficiaries with any inpatient acute care hospitalizations, skilled nursing facility stays, inpatient rehabilitation facility stays, or long term care hospital stays within 14 days prior to home health admission.

- The institutional category would also include patients that had an acute hospital stay during a previous 30-day period of care and within 14 days prior to the subsequent, contiguous 30-day period of care for which the patient was not discharged from home health and readmitted to an acute hospital. CMS states this is based on the fact that HHAs have discretion as to whether they discharge the patient due to a hospitalization and then readmit the patient after hospital discharge.
- The institutional category would not categorize PAC stays that occur during a previous 30-day period and within 14 days of a subsequent, contiguous 30-day period of care. CMS expects the HHA to discharge the patient if the patient requires PAC in a different setting and then readmit the patient, if necessary, after discharge from the PAC.

CMS proposes that all other 30-day periods would be considered community admissions.

CMS discusses its plans to establish an evaluation process within the Medicare claims processing system to automatically check for the presence of an acute/post-acute claim occurring within 14 days of the home health admission on an ongoing basis. CMS proposes to create occurrence codes that would allow HHAs to manually indicate on home health claims an institutional admission source prior to an acute/post-acute Medicare claim, if any, being processed by Medicare systems.

CMS proposes that if an occurrence code were submitted on the home health claim, the claim would be categorized as an institutional admission. The Medicare systems would adjust community-admitted home health claims on a claim-by claim, flow basis if an acute/post-acute

Medicare claim for an institutional stay occurring within 14 days of the home health admission is received. A HHA would also be able to resubmit a claim that included an occurrence code, subject to the timely filing deadline, and payment adjustments would be made accordingly.

CMS proposes that if an occurrence code is submitted on a home health claim but the Medicare claim for an institutional stay is not subsequently submitted within the timely filing deadline and processed by the Medicare systems or if the claim for an institutional stay was submitted but denied for payment, it may conduct post-payment medical review of the home health claim.

6. Proposed Clinical Grouping

CMS proposes grouping 30-day periods into one of six clinical groups based on the principal diagnosis that describes the primary reason for which the beneficiary is receiving home health services. CMS believes the proposed groups reflect how clinicians differentiate between patients and the types of care they need to receive. To inform the development of the clinical groups, CMS conducted an extensive review of diagnosis codes to identify the primary reasons for home health services and developed six clinical groups that reflect the reported principal diagnosis, clinical relevance, and coding guidelines.[13] Table 34 (reproduced below) lists the six proposed clinical groups. Table 35 in the proposed rule, shows the distribution of episodes and the associated resources across the six clinical groups. Interested readers should review the proposed rule for more discussion about each proposed clinical group.

Table 34: Clinical Groups Used in the Home Health Grouping Model

Clinical Group	Primary Reason for the HH Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wound-Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions, including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	Assessment, evaluation, teaching and medication management for a variety of medical & surgical conditions not classified in one of the above listed groups.

Under the HHGM, CMS proposes that each 30-day period would be assigned to a clinical group according to the primary reason the patient was receiving home health. The primary reason would be derived from the principal diagnosis code on the home health claim.

[13] More information on the analysis and development of the groupings can be found in the HHGM technical report available on the HHA Center webpage at https://www.cms.gov/center/provider-Type/Home-Health-Agency-HHA-Center.html.

- If a 30-day period of care could not grouped based on the principal diagnosis, CMS proposes that the claim would remain a questionable encounter and be returned to the provider for more accurate or definitive coding.
- CMS would not use secondary diagnosis codes to assign the clinical group.

CMS plans to post a complete list of ICD-10 codes and their assigned clinical groupings at https://www.cms.gov/center/provider-Type/Home-Health-Agency-HHA-Center.html.

7. Functional Levels and Corresponding OASIS Items

CMS proposes each 30-day period would be placed into one of three functional levels. As discussed below, based on responses on certain functional OASIS items, a 30-day period would be predicted to have higher or lower costs. For each of the six clinical groups, the 30-day period would be further classified into one of three functional levels with roughly 33 percent of periods in each level. CMS notes the creation of this functional level is very similar to how the functional level is created in the current payment system.

CMS discusses its analyses of the OASIS items to identify OASIS items to use in the case-mix adjustment for the HHGM. This included feedback from a clinical workgroup comprised of physicians, nurses and therapists with substantial home health clinical expertise. CMS used 2013 data from the OASIS-C version and updated analyses for 2016 based on data from the OASIS C-1. On the basis of input from the clinical group and analytic results, CMS proposes the OASIS items listed in Table 36 (reproduced below) to be included as part of the functional payment adjustment. To facilitate the interpretation of the analyses of the functional items used to construct the case-mix weights for the HHGM, CMS converted the analysis into a table of points that it can use to calculate the functional score for a home health period.

Table 36: OASIS Points Table for Those Items Associated with Increased Resource Use Using a Reduced Set of OASIS Items, 2013 and 2016

Variable	Response Category	Points (2013)	Points (2016)	Percent of Periods in 2013 with this Response Category	Percent of Periods in 2016 with this Response Category
M1800: Grooming	1	3	4	41.5%	51.9%
M1810: Current Ability to Dress Upper Body	1	4	6	46.6%	55.6%
M1820: Current Ability to Dress Lower Body	1	7	6	52.1%	57.5%
	2	10	12	16.4%	19.6%
M1830: Bathing	1	6	4	24.4%	20.3%
	2	17	14	46.1%	51.6%
	3	25	22	19.1%	21.9%
M1840: Toilet Transferring	1	4	5	20.3%	28.2%

Variable	Response Category	Points (2013)	Points (2016)	Percent of Periods in 2013 with this Response Category	Percent of Periods in 2016 with this Response Category
M1850: Transferring	1	7	4	61.6%	47.7%
	2	13	9	29.2%	48.0%
M1860: Ambulation/ Locomotion	1	13	12	37.7%	29.0%
	2	17	15	33.0%	47.8%
	3	27	27	12.7%	14.2%
M1032 (M1033 for OASIS C-1): Risk of Hospitalization	4 or more items checked	12	11	12.6%	16.3%

CMS used the OASIS point data (Table 36) to create a functional score for each home health period of care in the HHGM. The sum of all the points associated with an OASIS item results in a functional score which is used in the HHGM to group home health periods into a functional level. CMS analyses of the data established three functional levels for each of the clinical groups – low, medium and high, with approximately one-third of home health periods from each of the clinical groups within each level.

As part of the HHGM case-mix adjustment, CMS proposes to assign points for each of the responses to the proposed OASIS functional items (Table 36) to sum up the points to create a functional score for the period of care. CMS proposes to use the three functional levels of low, medium and high based on the 2016 data for each of the clinical groups. Table 37 (reproduced below) shows the functional thresholds for each functional level by clinical group. Table 38 in the proposed rule shows the average resource use by clinical group and functional level for 2016.

Table 37: Thresholds for Functional Levels by Clinical Group, 2013 and 2016

Clinical Group	Level	Points (2013 Data)	Points (2016 Data)
MMTA	Low	0-36	0-36
	Medium	37-55	37-54
	High	56+	55+
Behavioral Health	Low	0-30	0-38
	Medium	31-55	37-57
	High	56+	58+
Complex Nursing Interventions	Low	0-33	0-36
	Medium	34-60	37-59
	High	61+	60+
Musculoskeletal Rehabilitation	Low	0-37	0-39
	Medium	38-55	40-55
	High	56+	56+
Neuro Rehabilitation	Low	0-48	0-49
	Medium	49-67	50-66
	High	68+	67
Wound	Low	0-41	0-42
	Medium	42-65	43-65
	High	66+	66+

CMS expects to make annual recalibration of the HHGM case-mix weights. If the HHGM is finalized, CMS plans to continue to analyze all of the components of the case-mix adjustment, including adjustment for functional status, and would make refinements as necessary to ensure that payment for home health periods are in alignment with costs.

8. Comorbidity Adjustments

CMS proposes to include a comorbidity adjustment category based on the presence of secondary diagnoses. Specifically, CMS proposes that 30-day periods would receive a comorbidity adjustment if any diagnosis codes listed on the home health claim are included on a list of comorbidities that occurred in at least 0.1 percent of 30-day periods and associated with increased average resource use.

CMS discusses the literature regarding the relationship between comorbidity and resource use and its analyses of the impact of the presence of comorbidities on resource utilization and costs. CMS considers a comorbidity as a condition(s) in which there is no direct correlation with the treatment of the principal diagnosis, but the presence of that condition(s) may impact the home health plan of care in terms of resource utilization and costs. CMS discusses how it developed subcategories, distinguished primarily by the first three characteristics of the ICD-10-CM diagnosis code, to represent related conditions within the same body system. The home health specific comorbidity list includes 13 broad body system based categories and 116 total subcategories using ICD-10-CM diagnosis codes. For example, the broad category for heart disease includes 11 subcategories.

On the basis of its analysis, CMS proposes that if a period had at least one secondary diagnosis reported on the home health claim that is in one of the 15 subcategories listed below, that period would receive a comorbidity adjustment to account for the higher costs associated with the comorbidity.

- Heart Disease 1: includes hypertensive heart disease.
- Cerebral Vascular Disease 4: includes sequelae of cerebrovascular disease.
- Circulatory Disease and Blood Disorders 9: includes venous embolisms and thrombosis.
- Circulatory Disease and Blood Disorders 10: includes varicose veins of lower extremities with ulcers and inflammation, and esophageal varices.
- Circulatory Disease and Blood Disorders 11: includes lymphedema.
- Endocrine Disease 2: includes diabetes with complications due to an underlying condition.
- Neoplasm 18: includes secondary malignant neoplasms.
- Neurological Disease and Associated Conditions 5: includes secondary parkinsonism.
- Neurological Disease and Associated Conditions 7: includes encephalitis, myelitis, encephalomyelitis, and hemiplegia, paraplegia, and quadriplegia.
- Neurological Disease and Associated Conditions 10: includes diabetes with neurological complications.
- Respiratory Disease 7: includes pneumonia, pneumonitis, and pulmonary edema.
- Skin Disease 1: includes cutaneous, abscesses, and cellulitis.
- Skin Disease 2: includes stage one pressure ulcers.

- Skin Disease 3: includes atherosclerosis with gangrene.
- Skin Disease 4: includes unstageable and stages two through four pressure ulcers.

CMS proposes that a period would receive only one comorbidity adjustment regardless of the number of secondary diagnoses reported on the home health claim that fell into one of the 15 subcategories. The comorbidity adjustment would be the same across all of the subcategories. If no reported diagnosis meets the comorbidity adjustment criteria, the period would not qualify for the payment adjustment. CMS notes that if the HHGM is finalized and implemented, it anticipates there may be behavioral shifts in secondary diagnosis reporting and the proposed comorbidity list and its associated subcategories may change over time to capture resource utilization associated with these or other conditions.

CMS examined resource use for periods with and without the comorbidity adjustment (Table 39). CMS found for a 30-day period, the median value of resource use without a comorbidity adjustment was $653.57 and the median value of resource use with the comorbidity adjustment was $803.15.

9. Changes in the Low-Utilization Payment Adjustment (LUPA) Threshold

Under the current payment system, if an HHA provides four visits or less in an episode, the provider is paid a standardized per visit payment instead of an episode payment for a 60-day episode of care. These payment adjustments are called Low-Utilization Payment Adjustments (LUPAs).

CMS proposes that the HHGM would still include LUPAs, but the approach to calculate the LUPA threshold would need to change to reflect the 30-day period instead of the 60-day episode. Specifically, CMS proposes the LUPA threshold would vary for a 30-day period depending on the HHGM payment group to which it was assigned. 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 proposes to set the LUPA threshold at the 10^{th} percentile value of visits with a minimum threshold of at least 2 visits for each group. CMS states that approximately 7 percent of 30-day periods would be LUPAs (assuming no behavior changes), which is similar to the current system in which 8 percent of episodes are considered LUPAs.

Table 40 in the proposed rule lists the LUPA thresholds based on the 2016 utilization data (available on March 17, 2017) for each proposed HHGM payment group. CMS proposes to update LUPA thresholds for the final rule.

10. HH PPS Case-Mix Weights Under the HHGM

Section 1895(b)(4)(B) of the Act requires the Secretary to establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services. CMS proposes a HHGM case-mix adjustment methodology, which sorts 30-day periods into different payment groups based on five categories: admission source, timing, clinical group, functional level, and comorbidity group. This results in

a total of 144 payment groups (CMS notes it would still refer to these payment groups as Home Health Resource Groups (HHRGs) under the HHGM.)

CMS discusses the methodology it used to determine case-mix weights under the HHGM. It determined the case-mix weight for each of the different HHGM payment groups by regressing resource use on a series of indicator variables for each of the five categories using a fixed effects model. CMS normalized the results from the fixed effects regression model to calculate the case-mix weight of all 30-day periods within a particular payment group. CMS used the case-mix weight to adjust the 30-day payment rate to determine each 30-day period payment. Table 41 in the proposed rule shows the coefficients of the payment regression used to generate the weights, and the coefficients divided by average resource use for HHGM payment groups.

The case-mix weight for each HHRG payment group (144 different HHRG payment groups under the HHGM) is provided in Table 42. The case-mix weight excludes LUPA episodes, outlier episodes, and episodes with partial episode payment (PEP) adjustments. CMS notes that 9 HHRG payment groups represent approximately 50.5 percent of the total episodes and 33 HHRG payment groups represent approximately 1.0 percent of the total episodes. The HHRG payment group with the smallest weight (0.5034) includes the five categories for community, late, behavioral health, low functional level, and with no comorbidity adjustment. The HHRG payment group with the largest weight (1.9533) includes the five categories for institutional admission, early, wound, high functional level, and with a comorbidity adjustment. CMS would update case-mix weights using the latest 2017 data for the 2019 HH PPS proposed rule.

11. Low-Utilization Payment Adjustment (LUPA) Add-On Payments and Partial Payment (PEP) Adjustments under the HHGM

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. CMS proposes that under the HHGM, the LUPA add-on factors will remain the same as the current payment system.

The current PEP adjustment is a proportion of the episode payment and is based on the span of days including the start-of-care date or first billable service date through and including the last billable service date under the original plan of care before the intervening event in a home health beneficiary's care. The intervening event is defined as a beneficiary elected transfer or a discharge and return to home health that would warrant, for payment, a new OASIS assessment, physician certification of eligibility, and a new plan of care.

For 30-day periods of care, CMS proposes to maintain the current process for PEP adjustments. When a new 30-day period begins due to an intervening event, CMS proposes the original 30-day period would be proportionally adjusted to reflect the length of time the beneficiary remained under the HHA care prior to the intervening event. The PEP is calculated by using the span of days as a proportion of 30. To obtain the 30-day payment, the proportion is multiplied by the original case-mix and wage index.

12. Payments for High-Cost Outliers Under the HHGM

CMS proposes to maintain the current methodology for payment of high-cost outliers under the HHGM but calculate payments for high-cost outliers on 30-day periods of care.

Using 2016 claims data and 2018 payment rates, CMS estimates that outlier payments under the proposed HHGM with 30-day periods of care would comprise approximately 4.50 percent of total HH PPS payments in 2018. To meet the statutory requirement to target up to, but no more that 2.5 percent of total payments as outlier payments, CMS estimates that the fixed dollar loss (FDL) ratio under the HHGM would need to change from 0.55 to 0.93. CMS notes it will update the estimate of outlier payments as a percent of total HH PPS payments using the most current data available at the time of 2019 rate-setting.

IV. Provisions of the Home Health Value-Based Purchasing (HHVBP) Model
(pages 35332-35340)

A. Background

The HHVBP Model was established in the 2016 HH PPS final rule (80 FR 68624) as a five-year test in nine states through the Center for Medicare and Medicaid Innovation (CMMI). The first payment adjustments under the HHVBP will apply to 2018 payments based on data for 2016 (performance year (PY) 1). The nine states were selected using a randomized selection methodology set forth in that rule; participation of all Medicare-certified HHAs providing services in those states and meeting data minimums[14] is mandatory. Several changes to the model were made in the 2017 HH PPS final rule (81 FR 76741-76752).

B. Changes to Quality Measures

CMS reviews the quality measures included in the HHVBP Model. The CY 2016 HH PPS final rule established a "starter set" of 24 quality measures already reported via the Outcome and Assessment Information Set (OASIS) patient assessment instrument.[15] Four of these measures were removed in the 2017 HH PPS final rule effective beginning with PY 1. The resulting current measure set includes 20 measures consisting of 9 process of care measures, 10 outcome measures, and 5 Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS) measures.

In this rule, CMS proposes two changes to the HHVBP measures. First, the minimum number of completed HHCAHPS surveys required for a score to be generated on the HHCAHPS measures would be increased from 20 to 40 completed surveys. This would apply to the calculation of the benchmark and achievement threshold and performance scores for all model years beginning with PY 1. This proposal would align the requirement for a score in the HHVBP Model to the

[14] HHAs must have a minimum of 20 episodes of care during a performance year to generate a performance score on at least five measures in order to have a payment adjustment percentage calculated.
[15] OASIS-C2 is the current version of OASIS. It was developed from OASIS-C1/ICD-10 to accommodate new data being collected for HH QRP in support of the IMPACT Act. The OASIS-C2 data item set was implemented on January 1, 2017.

40-survey minimum policy adopted for calculating patient survey star ratings on the *Home Health Compare* website. CMS says that the 40-survey minimum was chosen to balance the goal of providing star ratings that were meaningful and to minimize random variation with the goal of providing star ratings to as many HHAs as possible.

CMS notes that the Interim Performance Reports (IPRs) issued in October 2016, January 2017 and April 2017 were calculated using the 40-survey minimum, and that to allow HHAs a point of comparison, CMS will reissue these IPRs using the 20-survey minimum. HHAs will receive concurrent IPRs in July 2017 and concurrent total performance score and payment adjustment reports in August 2017 with the 40- and 20-survey minimum results included.

In reporting its analysis of the impact of the proposed change in the required minimum number of surveys using available data for 2015 and 2016, CMS says that the greatest change in state-specific achievement thresholds it estimated was 1.1 percent (in Arizona) for the "Willingness to Recommend the Agency" HHCAHPS measure. Changes in estimated benchmarks were greater, as low as -3.2 percent change (Nebraska) for the "Communications between Providers and Patients" measure. Differences in the statewide total performance scores between using the 40-survey and 20-survey minimums ranged from -0.4 percent (Washington) to +2.2 percent (Arizona). These figures could be different when complete data for 2016 is available. Table 60 in the impact analysis section of the proposed rule shows the impact of the proposal to change the minimum number of surveys for the HHCAHPS measures by state on performance scores and payment adjustments, stratified for larger- and smaller-volume HHAs.

The second proposed change would eliminate one process of care measure, "Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care" effective beginning with PY 3. The rationale offered for this proposal is that many providers have achieved full performance on this measure, for which the value across all participating HHAs averaged 95.6 percent in the January 2017 IPRs and the 10th percentile performance was 89 percent. In addition, CMS notes that its contractor's Technical Expert Panel (TEP) expressed concern that the measure does not capture whether the education provided by the HHA was meaningful.

Table 43 (pages 35335-6) describes the proposed remaining measure set, including details on data source, and the numerator and denominator for each measure. The table below provides a summary.

Proposed Measure Set for the HHVBP Model for PY 3 (From CMS Table 43)		
NQS Domains	**Measure Title**	**Measure Type**
Clinical Quality of Care	Improvement in Ambulation-Locomotion	Outcome
	Improvement in Bed Transferring	Outcome
	Improvement in Bathing	Outcome
	Improvement in Dyspnea	Outcome
Communication & Care Coordination	Discharged to Community	Outcome
	Advance Care Plan	Process

Proposed Measure Set for the HHVBP Model for PY 3 (From CMS Table 43)		
NQS Domains	**Measure Title**	**Measure Type**
Efficiency & Cost Reduction	Acute Care Hospitalization: Unplanned hospitalization during first 60 days of Home Health	Outcome
	Emergency Department Use without Hospitalization	Outcome
Patient Safety	Improvement in Pain Interfering with Activity	Outcome
	Improvement in Management of Oral Medications	Outcome
Population Community Health	Influenza Immunization Received for Current Flu Season	Process
	Pneumococcal Polysaccharide Vaccine Ever Received	Process
	Influenza Vaccination Coverage for Home Health Care Personnel	Process
	Herpes Zoster (shingles) Vaccination: Has the Patient Ever Received the Shingles Vaccination?	Process
Patient & Caregiver Centered Experience (HHCAHPS)	Care of Patients	Outcome
	Communications between Providers and Patients	Outcome
	Specific Care Issues	Outcome
	Overall Rating of Home Health Care	Outcome
	Willingness to Recommend the Agency	Outcome

C. Quality Measures for Future Consideration

CMS describes three measures or measure topics that it is considering for future inclusion in the HHVBP Model.

- A composite measure "Total Change in Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL) Performance by HHA Patients," which could replace "Changes in Daily Activity Function as Measured by AM-PAC" (NQF #430). The latter measure was in the starter set but removed because it required use of a proprietary data instrument. The potential composite would address all three potential outcomes for HHA patients: stabilization, decline, and improvement, and compare functioning reported at start/resumption of care to discharge across the 11 ADL/IADL items on the OASIS-C2 instrument. The proposed rule discusses the data items, calculation of the measure, and results of predictive models. One potential concern raised by CMS is building a measure on OASIS elements that could subsequently be changed.
- A composite functional decline measure, which could be the percentage of episodes in which there was a decline on one or more of eight ADL items. CMS discusses how such a measure might be constructed and risk-adjusted, and provides some analysis of functional decline by length of stay.

- Two behavioral health measures, one a composite measure "HHA Correctly Identifies Patient's Need for Mental or Behavioral Health Supervision," and the other "Caregiver Can/Does Provide for Patient's Mental or Behavioral Health Supervision Need." The proposed rule discusses how these measures might be constructed and risk-adjusted and results of related predictive modeling.

In addition to comments on these potential future measures, CMS is seeking comment on the interactions between the quality measures and the HHGM proposal discussed in section III above.

D. Impact Analysis

CMS does not believe the proposed changes in this rule would affect prior estimates of the overall impact of the HHVBP Model. In the 2017 HH PPS final rule, CMS estimated that model would reduce payments for 2018 through 2022 by approximately $378 million.

The proposed rule (pages 35387-8) includes estimates of the distribution of payment adjustments under the model using available data for 2015 and 2016 and taking into account the proposals in this rule to increase to 40 the minimum number of HHCAHPS surveys required for scores on those measures and to remove one measure beginning in PY3. Table 57, summarized below, displays the estimated distribution of possible payment adjustments being used across the five years of the model.

Payment adjustment distribution by percentile of quality TPS (from CMS Table 57)			
	Lowest, 10th percentile	50th percentile	Highest, 90th percentile
3% payment adjustment (year 1)	-1.5%	-0.1%	1.5%
5% payment adjustment (year 2)	-2.5%	-0.1%	2.6%
6% payment adjustment (year 3)	-2.9%	-0.2%	3.1%
7% payment adjustment (year 4)	-3.4%	-0.2%	3.6%
8% payment adjustment (year 5)	-3.9%	-0.2%	4.1%

Table 58 in the proposed rule shows the estimated distribution of payment adjustments by state and stratified by small/large volume HHAs. Table 59 shows the estimated distribution of payment adjustments across all states by HHA characteristics (size of HHA, percent of dual eligible beneficiaries, patient acuity, percent of rural beneficiaries, ownership, and free-standing versus facility-based HHAs). In that table, the average payment adjustment by patient acuity ranges from -0.3 percent (low acuity) to 0.4 percent (high acuity); differences shown for other characteristics are much smaller.

V. Updates to the Home Health Care Quality Reporting Program (HH QRP) (pages 35341-35378)

A. Background

CMS reviews background on the HH QRP, the Outcome and Assessment Information Set (OASIS) used for HHAs, and the pay-for-reporting program implemented in 2007, under which the market basket percentage increase is reduced by 2 percentage points for HHAs that do not report required quality data.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113-185) imposed new reporting requirements for post-acute care (PAC) providers, including HHAs. This includes standardized patient assessments for HHAs, SNFs, Inpatient Rehabilitation Facilities (IRFs) and Long-Term Care Hospitals (LTCHs).

B. Measuring and Accounting for Social Risk Factors

CMS seeks public comment on whether to account for social risk factors in the HH QRP, and if so, what combination of methods would be most appropriate (e.g., confidential reporting to providers of rates stratified by social risk factors; public reporting of stratified measure rates; and risk adjustment of measures as appropriate based on data and evidence). Discussion of recent reports by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering and Medicine is included, and CMS describes the National Quality Forum (NQF) trial period for adjustment of measures for social risk factors.[16] Two HH QRP measures are being addressed in the NQF trial (Rehospitalization During the First 30 Days of Home Health (NQF# 2380) and Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (NQF# 2505)). Social risk factors might include dual eligibility/low-income subsidy; race and ethnicity; and geographic area. CMS seeks comment not only on which factors might be used to adjust or stratify measures, but also whether existing sources of information are available or whether new data collection would be required, and on operational considerations. Any related changes to the HH QRP would be proposed through future rulemaking.

C. Removal of Data Elements from OASIS

CMS proposes to remove 247 data elements from 36 OASIS items because it says they are not used in the calculation of quality measures adopted for the HH QRP or for other purposes including payment, survey, the HHVBP Model or care planning. The list of items proposed for

[16] See Assistant Secretary for Planning and Evaluation, HHS. *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs.* December 2016. https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs and National Academies of Sciences, Engineering, and Medicine. 2017. *Accounting for social risk factors in Medicare payment.* Washington, DC: The National Academies Press. http://www.nationalacademies.org/hmd/Reports/2017/accounting-for-social-risk-factors-in-medicare-payment-5.aspx.

removal appears in Table 45 of the proposed rule and at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Proposed-Data-Elements-to-be-Removed-from-OASIS-on-January-1-2019.pdf.

D. Collection of Standardized Patient Assessment Data Under the HH QRP

The IMPACT Act requires that, beginning in FY 2019, HHAs must report standardized patient assessment data for at least the quality measures with respect to certain categories, summarized here as functional status; cognitive function; special services and interventions; medical conditions and comorbidities; impairments; and other categories deemed necessary and appropriate. The standardized patient assessment data must be reported at least with respect to the beginning of the home health episode (start or resumption of care) and at discharge, but the Secretary may require the data to be reported more frequently.

To implement this requirement, CMS proposes that "standardized patient assessment data" be defined as patient assessment questions and response options that are identical in all four post-acute care (PAC) assessment instruments, and to which identical standards and definitions apply. This would allow data to be shared electronically or otherwise among PAC provider types and provide for development of cross-cutting quality measures that consider patient characteristics rather than setting, as described in the IMPACT Act.

CMS says that the lack of standardization across the different PAC assessment instruments has inhibited comparison, and that standardizing the questions and response options across instruments will also enable the data to be interoperable and shared electronically or otherwise between PAC provider types. CMS intends to use the standardized patient assessment data for several purposes, including facilitating exchange among providers to enable high quality care and care coordination; calculation of quality measures, and identifying comorbidities that increase the medical complexity of an admission.

CMS describes its work with stakeholders and a TEP in identifying appropriate standardized patient assessment data. Data elements in the four existing PAC provider patient assessment instruments were considered, along with a literature search. Public meetings and public comment opportunities were provided. In its search, CMS sought data with the following attributes: (1) being supported by current science; (2) testing well in terms of their reliability and validity, consistent with findings from the Post-Acute Care-Payment Reform Demonstration (PAC PRD); (3) the potential to be shared (for example, through interoperable means) among PAC and other provider types to facilitate efficient care coordination and improved beneficiary outcomes; (4) the potential to inform the development of quality, resource use and other measures, as well as future payment methodologies that could more directly take into account individual beneficiary health characteristics; and (5) the ability to be used by practitioners to inform their clinical decision and care planning activities.

Elsewhere in the proposed rule, CMS also indicates that it considered clinical relevance, ability to support clinical decisions, care planning and interoperable exchange to facilitate coordination during transitions in care; the ability to capture medical complexity and risk factors to inform payment and quality; strong scientific reliability and validity; meaningful to inform longitudinal

analysis by providers; general consensus on usability; and the ability for the data to be collected once for multiple uses.

The specific data elements that HHAs would report as standardized patient assessment data are discussed in the proposed rule.[17] The table below summarizes this information. Some items are related to proposed new measures described in section V.F below. It lists the elements by category, identifies the current PAC patient assessment instruments that include the proposed elements (or similar ones) and indicates whether the data elements would be newly added to OASIS-C2. Beginning with the 2020 payment determination, HHAs would be required to report all but three of the elements at admission (start or resumption of care) and discharge. The three exceptions are the brief interview for mental status, hearing and vision elements, for which collection would only be required for assessments at admission, and not discharge. CMS previously adopted a policy under which the HH QRP reporting period is generally 12 months beginning in July, but for a new measure is the first two quarters of the calendar year. For example, the 2020 HH QRP reporting period for a new measure is January 1, 2019 through June 30, 2019. For that measure in 2021 the reporting period is July 1, 2019 through June 30, 2020. CMS proposes to extend this reporting period policy to reporting of standardized patient assessment data beginning with the 2019 HH QRP. In addition, CMS proposes that satisfactory reporting from January 1, 2018 through June 30, 2018 of the data elements used to report the current pressure ulcer measure (NQF #0678) would satisfy the statutory requirement for HHAs to report standardized patient assessment data elements for the 2019 HH QRP.

Proposals regarding data submission procedures for reporting standardized patient assessment data are discussed in item V.H below.

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to OASIS**
Functional Status		
Elements 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)	PAC-PRD version of the CARE Item Set	Add to OASIS elements assessing self-care and mobility; collection at follow up to meet HHA

[17] On July 31, 2017 CMS issued the FY 2018 final rules for payment under the IRF PPS and the SNF PPS. In those rules, CMS did not finalize all the new standardized patient assessment data that it had proposed because of concern about the burden that would have imposed on providers. Specifically, the standardized patient assessment data elements proposed for three of the five IMPACT Act categories were not finalized (Cognitive Function and Mental Status; Special Services, Treatments, and Interventions; and Impairments). Proposals for data elements regarding the other two categories were finalized (Functional Status and Medical Conditions and Co-Morbidities) because the proposed data for these categories are required for previously adopted or newly finalized measures. CMS says it intends to conduct a national field test that allows for stakeholder feedback on how to maximize the time that providers have available to prepare for reporting standardized patient assessment data for the three categories not being finalized. New proposals will be made no later than the 2020 proposed rules.

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to OASIS**
		CoPs; retain current OASIS functional assessment items
Elements addressing mobility and self-care from application of measures: NQF #2633 - Change in Self-Care Score for Medical Rehabilitation Patients; NQF #2634 - Change in Mobility Score for Medical Rehabilitation Patients; NQF #2635 - Discharge Self-Care Score for Medical Rehabilitation Patients; and NQF #2636 - Discharge Mobility Score for Medical Rehabilitation Patients	MDS 3.0 IRF PAI PAC-PRD	Add to OASIS
Cognitive Function and Mental Status		
Brief Interview for Mental Status (BIMS)	MDS 3.0 IRF-PAI PAC PRD	Add to OASIS; assess at admission only
Confusion Assessment Method	MDS 3.0 LCDS PAC PRD	Add to OASIS
Behavioral Signs and Symptoms	MDS 3.0 OASIS-C2 PAC PRD	Add to OASIS (MDS version)
Patient Health Questionnaire-2	MDS 3.0 OASIS-C2 PAC PRD	No change
Special Services, Treatments, and Interventions		
Cancer Treatment: Chemotherapy (IV, Oral, Other)	MDS 3.0 PAC PRD	Add to OASIS
Cancer Treatment: Radiation	MDS 3.0	Add to OASIS
Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)	MDS 3.0 OASIS-C2 PAC PRD	Expand OASIS element to include continuous and intermittent sub-elements
Respiratory Treatment: Suctioning (Scheduled, As Needed)	MDS 3.0 PAC PRD	Add to OASIS
Respiratory Treatment: Tracheostomy Care	MDS 3.0 PAC PRD	Add to OASIS
Respiratory Treatment: Non-invasive Mechanical Ventilator (BiPAP, CPAP)	LCDS MDS 3.0 OASIS-C2 PAC PRD	Expand and relabel OASIS elements
Respiratory Treatment: Invasive Mechanical Ventilator	LCDS MDS 3.0 PAC PRD	Add to OASIS

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to OASIS**
Other Treatment: Intravenous (IV) Medications (Antibiotics, Anticoagulation, Other)	MDS 3.0 OASIS-C2 PAC PRD	Add to OASIS, including sub-elements
Other Treatment: Transfusions	MDS 3.0 OASIS-C2 PAC PRD	Add to OASIS (MDS version)
Other Treatment: Dialysis (Hemodialysis, Peritoneal dialysis)	LCDS MDS 3.0 PAC PRD	Add to OASIS
Other Treatment: Intravenous (IV) Access (Peripheral IV, Midline, Central line, Other)	MDS 3.0 OASIS PAC PRD	Add to OASIS
Nutritional Approach: Parenteral/IV Feeding	LCDS MDS 3.0 IRF-PAI OASIS-C2 PAC PRD	No change except for renaming existing OASIS elements
Nutritional Approach: Feeding Tube	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	No change except for renaming existing OASIS elements
Nutritional Approach: Mechanically Altered Diet	MDS 3.0 OASIS-C2 IRF-PAI PAC PRD	Add to OASIS
Nutritional Approach: Therapeutic Diet	MDS 3.0 PAC PRD	Add to OASIS
Medical Condition and Comorbidity Data		
Elements to calculate the current and proposed pressure ulcer measures: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (NQF #0678) and Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	MDS 3.0 IRF-PAI OASIS	No change; elements already included in OASIS
Impairment		
Hearing	MDS 3.0 OASIS C-2 PAC PRD	Add to OASIS (MDS version)
Vision	MDS 3.0 OASIS C-2 PAC PRD	Add to OASIS (MDS version)
*This column reflects whether the proposed rule indicates that the specific elements proposed or similar or related elements are included in the current PAC assessment instruments or tested in the		

Proposed Standardized Patient Assessment Data Elements, by Category		
Data Elements	**Current Use/Test of Elements***	**Change to OASIS**
PAC PRD. The PAC instruments referenced are: Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI); Long-Term Care Hospital Continuity Assessment Record and Evaluation Data Set (LCDS); MDS for Skilled Nursing Facilities; and OASIS C-2 for home health agencies. The Continuity Assessment Record and Evaluation (CARE) Item Set is a standardized patient assessment tool developed as part of the PAC-PRD for use at acute hospital discharge and at post-acute care admission and discharge.		

E. Applying Certain HH QRP Policies to Standardized Patient Assessment Data

CMS proposes that the policy for retaining HH QRP measures until they are removed, suspended or replaced also be applied to the standardized patient assessment data adopted for the HH QRP. Similarly, the policy adopted for making nonsubstantive changes to HH QRP measures would also be changed to incorporate nonsubstantive updates to the standardized patient assessment data.

F. New Quality Measures Beginning with the 2020 HH QRP

CMS proposes to replace one HH QRP measure and add two new measures to the measure set beginning with the 2020 payment determination. Under previously finalized policy, CMS will retain the measures currently adopted for the HH QRP (currently totaling 28), until a measure is subsequently removed, suspended or replaced. A summary table at the end of this section shows the current and proposed measures. For the proposed replacement and new measures, specifications and information on standardized data elements are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Proposed-Measure-Specifications-and-Standardized-Data-Elements-for-CY-2018-HH-QRP-Notice-of-Proposed-Rule-Making.pdf.

1. Replacement of Pressure Ulcer Measure

The measure that would be replaced is *Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay)* (NQF #0678). The proposed replacement for that measure is *Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury*. This proposed measure is a modified version of the current pressure ulcer measure. Unlike the current measure, it includes new or worsened unstageable pressure ulcers, including deep tissue injuries, in the measure numerator. CMS believes this will increase measure scores and variability in measure scores making it easier to distinguish poor and high performing HHAs. It intends to submit the measure for NQF endorsement as soon as it is feasible. The Measure Applications Partnership (MAP) recommended conditional support for using the new measure in the HH QRP, and CMS says it intends to meet the MAP's conditions by offering additional training opportunities and educational materials prior to public reporting and by continuing to monitor and analyze the proposed measure. The proposed rule includes discussion of the development of this measure and results of analysis in various PAC settings.

Data for this measure would come from the OASIS, and the required items are already reported by HHAs through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. CMS notes that its proposal to eliminate duplicative data elements that were used for the current pressure ulcer measure would result in an overall reduced reporting burden on HHAs for the proposed replacement measure.

2. New Functional Status Measure

CMS proposes to add a new measure to the HH QRP that would address the IMPACT Act domain of functional status, cognitive function, and changes in function and cognitive function. 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) reports the percentage of patients with an admission and discharge functional assessment and treatment goal that addresses function. CMS discusses and cites literature on the need for the measure, background on functional status data collected by PAC providers, involvement of a TEP and stakeholders feedback on the measure. The measure has been endorsed by the NQF for the long-term care hospital setting. The MAP recommended support for addition of this measure to the HH QRP conditioned on NQF endorsement of the measure for the home health setting.

New functional status items would be added to OASIS for purposes of calculating performance on this measure. The new items would assess specific self-care and mobility activities, and would be based on functional items included in the PAC-PRD Continuity Assessment Record and Evaluation (CARE) Item Set.[18] The items would be reported at admission (start or resumption of care) and discharge. CMS reports on a recent field test capturing data from 12 HHAs, which found moderate to substantial reliability for the self-care and mobility items. Readers are directed for more information to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/CARE-Item-Set-and-B-CARE.html.

The new items are proposed for reporting in addition to continued reporting of the existing OASIS functional assessment items. CMS notes that the functional items differ from those currently included in OASIS with respect to data collection, rating scales used to score the patient's level of independence, and item definitions. **CMS does not believe the new items are duplicative of the existing OASIS item, but requests comments on opportunities to streamline reporting to avoid duplication and minimize burden.** The measure specifications describe the differences in the functional assessment items. The specifications are available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.

CMS proposes to add a subset of the functional assessment items to the OASIS with collection of the items at follow-up. CMS says that this would allow HHAs to fulfill the requirements in the

[18] See Barbara Gage and others. *Final Report on the Development of the CARE Item Set: Volume 1 of 3.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/Downloads/The-Development-and-Testing-of-the-Continuity-Assessment-Record-and-Evaluation-CARE-Item-Set-Final-Report-on-the-Development-of-the-CARE-Item-Set-Volume-1-of-3.pdf.

HHA Conditions of Participation (COPs) that suggest that information on patient health, including functional status, be collected on the comprehensive assessment.[19] CMS cites the final rule on HHA COPs that was issued on January 13, 2017. (82 FR 4504).

3. New Measure of Major Patient Falls

A measure is proposed for addition to the HH QRP beginning in 2020 to address the IMPACT Act domain "Incidence of Major Falls." The measure *Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay)"* (NQF #0674) has been implemented in the Nursing Home Quality Initiative for long-stay residents since 2011. It reports the percentage of residents who have experienced falls with major injury during episodes ending in a 3-month period. CMS would include an application of this measure in the home health setting, for which NQF endorsement has not been made, and intends to seek NQF endorsement for this setting as soon as it is feasible. The proposed rule discusses the clinical literature on patient falls, stakeholder feedback on the measure, and why CMS rejects related available measures in favor of this proposed measure.

The MAP conditionally supported using an application of this measure in the HH QRP but expressed concern that there could be potential difficulties in collecting falls data and more limited actionability in the home health setting. It suggested that CMS consider stratification of measure rates by referral origin when publicly reporting the measure results.

Two new falls-related items would be added to OASIS for purposes of implementing this measure. These would be collected at the end of care, which includes discharge from agency; death at home; and transfer to inpatient facility.

Summary Table: Measures Adopted and *Proposed* for the HH QRP

Short Name	**Measure Name & Data Source**
OASIS-based	
Pressure Ulcers	Percent of Patients or Residents with Pressure Ulcers that are New or Worsened (NQF # 0678) *Proposed for replacement with measure below*
	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury Proposed to replace above measure beginning with 2020 payment
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program
Ambulation	Improvement in Ambulation/Locomotion (NQF #0167)
Bathing	Improvement in Bathing (NQF #0174)
Dyspnea	Improvement in Dyspnea
Oral Medications	Improvement in Management of Oral Medication (NQF # 0176)
Pain	Improvement in Pain Interfering with Activity (NQF # 0177)
Surgical Wounds	Improvement in Status of Surgical Wounds (NQF #0178)
Bed Transferring	Improvement in Bed Transferring (NQF # 0175)

[19] The proposed rule does not cite any specific HHA COPs. 42 CFR 484.55 sets forth a COP on comprehensive assessment of patients.

Short Name	Measure Name & Data Source
Timely Care	Timely Initiation of Care (NQF # 0526)
Depression Assessment	Depression Assessment Conducted
Influenza	Influenza Immunization Received for Current Flu Season (NQF #0522)
PPV	Pneumococcal Polysaccharide Vaccine Ever Received (NQF # 0525)
Falls Risk	Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate (NQF # 0537)
Diabetic Foot Care	Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care (NQF # 0519)
Drug Education	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care
	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) *Proposed for addition beginning with 2020 payment*
	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF # 0674) *Proposed for addition beginning with 2020 payment*
Claims-based	
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) – Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
DTC	Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP)
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program
ACH	Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171)
ED Use	Emergency Department Use without Hospitalization During the First 60 Days of Home Health (NQF #0173)
Rehospitalization	Rehospitalization During the First 30 Days of Home Health (NQF # 2380)
ED Use without Readmission	Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (NQF # 2505)
HHCAHPs-based	
Professional Care	How often the home health team gave care in a professional way
Communication	How well did the home health team communicate with patients
Team Discussion	Did the home health team discuss medicines, pain, and home safety with patients
Overall Rating	How do patients rate the overall care from the home health agency
Willing to Recommend	Would patients recommend the home health agency to friends and family

G. HH QRP Measures and Measure Concepts Under Consideration for Future Years

CMS identifies four measures addressing functional outcomes across a home health episode that it is considering for future addition to the HH QRP. It says these measures would be standardized to measures finalized in other PAC quality reporting programs.

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

In addition, CMS says that it is considering the concept of within-stay potentially preventable hospitalizations for future development as claims-based measures for the HH QRP. Further, outcomes-based measures of functional status and other outcome measures will be considered for the IMPACT Act domain of functional status and cognitive function.

Feedback is invited on the importance, relevance, appropriateness and applicability of these potential measures and concept areas.

H. Form, Manner, and Timing of Data Submission under the HH QRP

1. Reporting of Patient Assessment Data

CMS makes several proposals related to reporting of standardized patient assessment data:

- New HHAs would begin reporting standardized patient assessment data on the same schedule previously adopted for reporting of standardized quality data under the HH QRP (80 FR 68624).
- The proposed standardized patient assessment data would be submitted via OASIS through the QIES ASAP system for HHA Medicare and Medicaid quality episodes that begin or end on or after January 1, 2019.
- As described earlier, the current schedule for reporting quality measure data would be applied to reporting standardized patient assessment data. Under that policy, the reporting period is generally 12 months beginning in July, but for a new measure is the first two quarters of the calendar year. Tables 49 and 50 in the proposed rule illustrate this policy.

2. Reporting for Proposed New Quality Measures

For the three proposed new measures described in section V.F above, CMS proposes that for 2020 payment, HHAs report data for Medicare and Medicaid quality episodes that begin or end during the period from January 1, 2019 through June 30, 2019. Beginning with 2021 payment, reporting would be for a 12-month period beginning July 1st of the year two years prior (i.e., July 1, 2019-June 30, 2020 for 2021 payment).

3. Request for Comment on Expanding Data Collection to All Patients Regardless of Payer

CMS seeks comments on whether it should require quality data reporting on all HHA patients, regardless of payer, where feasible, noting that claims-based measures rates would continue to be calculated only for Medicare beneficiaries. From public comment on previous rules, the MAP, and other sources CMS has received input that the OASIS data collection for the HH QRP should be extended to all patients regardless of payer. While Medicare and Medicaid account for about 75 percent of home health expenditures in 2014, CMS believes that expanding the patient population for which OASIS collects data would allow it to ensure that data are representative of all patients and allow it to better determine whether Medicare beneficiaries receive the same quality of care that other patients receive in the home health setting.

CMS recognizes that expanding data collection may create additional burden, but says that it has also been told that separating Medicare and Medicaid patients for OASIS reporting has work flow implications and burdens as well. It understands that it is common practice for HHAs to collect OASIS data on all patients, regardless of payer source.

I. Other Proposals Related to Data Submission

1. Data Submission Requirements

CMS previously established (80 FR 68703 through 68705) data submission thresholds under the HHA pay-for-reporting performance system. (An HHA that fails to meet the reporting requirements for a year receives a 2-percentage point reduction to the market basket increase that would otherwise apply.) Under those requirements, an HHA must score at least 70 percent on the Quality Assessments Only (QAO) metric for 2017, 80 percent for 2018, and 90 percent for 2019 (reporting period July 1, 2017 to June 30, 2018). The QAO metric calculates the percentage of an HHAs OASIS assessments that are considered quality assessments. (Quality assessments include matching start/resumption of care and end of care assessments for a patient.)

In this rule, CMS proposes to apply these threshold data completeness requirements to the submission of standardized patient assessment data beginning with the CY 2019 HH QRP.

2. HH QRP Submission Exceptions and Extensions

CMS proposes to establish at a new subsection 42 CFR 484.250(d) procedures and policies for exceptions and extensions of HH QRP data submission requirements in the case of extraordinary circumstances beyond the HHA's control (e.g., natural or man-made disasters). The proposed policies parallel those established for other Medicare quality reporting programs. A request for exception or extension would be made via email within 90 days of the extraordinary circumstance. It would be required to contain specified information, including evidence of the impact of extraordinary circumstances, which may include photographs, newspaper, and other media articles; and the date when the data submission is expected to resume (with justification). CMS may grant exceptions or extensions without a request if an entire region or location is affected, or if a systemic problem with CMS' data collection systems affected the ability of an

HHA to submit required data. Such a decision would be communicated through routine channels, including memos, emails and the HH QRP website.

Any exception or extension granted would apply only to the HH QRP and not to other programs, such as HHA survey and certification. CMS refers readers to OASIS requirements during Declared Public Health Emergencies, discussed in FAQs I-5, I-6, I-7, I-8 at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/downloads/AllHazardsFAQs.pdf.

3. HH QRP Submission Reconsideration and Appeals Procedures

CMS proposes what it describes as clarifications to previously finalized procedures for reconsiderations and appeals when an HHA is found to be out of compliance with the HH QRP requirements. The procedures would be codified in a new subsection 42 CFR 484.250(e). An HHA would receive a notice of non-compliance and would have 30 days to request reconsideration via email, including supporting documentation. CMS intends to provide a sample list of acceptable supporting documentation and instructions on the HH QRP website. Notices of the CMS decision would be made via the Certification and Survey Provider Enhanced Reports (CASPER) and the postal service. An HHA would have the right to appeal an adverse reconsideration decision to the Provider Reimbursement Review Board. CMS believes this approach would reduce the number of PRRB appeals by resolving issues earlier in the process.

J. Public Display of HH QRP Quality Measure Data

The statute requires that CMS provide for public display of HH QRP data. CMS reviews these requirements and previous related regulations, including policies that provide HHAs an opportunity to review and correct their performance data on IMPACT Act measures before they are publicly displayed.

CMS proposes to begin public reporting of data on five measures beginning in 2019. The measures are listed here along with the proposed reporting periods.

Measures Proposed for Public Reporting in 2019	
Measure	**Reporting Period**
Assessment-based Measures	
Percent of Residents or Patients with Pressure Ulcers that Are New or Worsened (Short Stay) (NQF #0678)	4 rolling quarters beginning with data collected for discharges in 2017
Drug Regimen Review Conducted with Follow-Up for Identified Issues-PAC HH QRP	
Claims-based Measures	
Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH QRP	1 year of claims data confidential feedback: 2015-2016 public reporting: 2016- 2017
Discharge to Community – (PAC) HH QRP	2 years of claims data confidential feedback: 2015-2016 public reporting: 2016- 2017

Measures Proposed for Public Reporting in 2019	
Measure	**Reporting Period**
Medicare Spending Per Beneficiary (PAC) HH QRP	3 years of claims data confidential feedback: 2014-2016 public reporting: 2015-2017

CMS also proposes that HHAs with fewer than 20 eligible cases during a performance period for a measure would be assigned to a separate category ("The number of patient episodes for this measure is too small to report") and performance would not be reported for that measure.

K. HHCAHPS Survey

CMS reviews previously finalized HH QRP requirements for HHA reporting of the HHCAHPS for payment in 2019 (81 FR 76789) and 2020 (81 FR 76789). These requirements are reiterated in the proposed rule. No changes are proposed to previously adopted policies for participation or implementation of the HCAHPS or for HCAHPS oversight activities.

In this rule, CMS proposes to update data collection periods and data submission deadlines for HHCAHPS reporting for the 2021 HHQRP. The data collection period would be April 2019 through March 2020. The quarterly reporting deadlines would be October 17, 2019 (2nd quarter 2019); January 16, 2020 (3rd quarter 2019); April 16, 2020 (4th quarter 2019); and July 16, 2020 (1st quarter 2020). HHAs with fewer than 60 HHCAHPS-eligible unduplicated or unique patients in the period of April 1, 2018 – March 31, 2019 would be exempt from the HHCAHPS data collection and submission requirements upon completion of the CY 2021 HHCAHPS Participation Exemption Request form and CMS verification of the HHA patient counts. The exemption form would need to be posted on https://homehealthcahps.org between from April 1, 2019 to March 31, 2020. HHAs receiving Medicare-certification on or after April 1, 2019 would be exempt from the HHCAHPS reporting requirement for the CY 2021 HH QRP without needing to complete the exemption request form.

L. Impact Analysis of HH QRP

CMS reports that 513 HHAs, or approximately 4.3 percent, of the 12,149 active Medicare certified HHAs, did not receive the full annual percentage increase for the CY 2017 annual payment update determination because they failed to meet the requirements of the HH QRP.

VI. Request for Information on CMS Flexibilities and Efficiencies (page 35378)

CMS is requesting ideas for payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences with the purpose of reducing burdens for hospitals, physicians, and patients. Responses could also include recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers and suppliers.

CMS is particularly interested in ideas for incentivizing organizations and the full range of relevant professionals and paraprofessionals to provide screening, assessment and evidence-based treatment for individuals with opioid use disorder and other substance use disorders, including reimbursement methodologies, care coordination, systems and services integration, use of paraprofessionals including community paramedics and other strategies. CMS notes it does not plan to respond to the comments it receives but will use these ideas as it considers future policies.

Respondents are admonished not to include any information that might be considered proprietary or confidential. Complete but concise responses are encouraged. CMS may publicly post the public comments it receives, or a summary of them.

VII. Collection of Information Requirements for HH QRP (pages 35378-35380)

CMS reports that as of April 2017, 12,149 HHAs report quality data. It reviews the proposed changes in reporting of OASIS data elements and finds that on net, the proposed rule would reduce the number of data elements. Based on the 18.2 million assessments completed in 2016, CMS estimates that the reductions would save HHAs $3,700 annually or $45 million nationally.

VIII. Regulatory Impact Analysis (pages 35380-35390)

CMS provides a regulatory impact analysis (RIA) because the proposed rule is a major rule that meets the threshold of an economic impact of $100 million or greater.

It first presents the regulatory impact of the changes in the HH PPS system on HHAs in 2018:

Summary of overall regulatory impact analysis		
Policy	**2018 impact**	
	Percentage	**Dollars**
HH PPS update	+ 1.0%	+$190 million
Nominal case-mix growth adjustment	-0.9%	-$170 million
Sunset of the rural add-on provision	-0.5%	- $100 million
Net impact	-0.4%	-$80 million

Table 54 on pages 35383-35384 provides details on the impact of each change by facility type and ownership, by rural and urban area, by census region and by facility size. As expected, based on the sunset of the rural add-on provision, rural facilities would experience the largest payment reductions ranging from 2.0 percent to 2.8 percent. CMS also notes that there are also negative estimated impacts attributed to the rural add-on provision for HHAs located in urban areas as well. HHAs located in urban areas could see a reduction in payments if they provide services to patients located in rural areas as payments to HHAs are based on the location of the beneficiary.

Given the proposed changes in 2019 to CMS' home health groupings model (HHGM) and proposed change of the unit of payment from a 60-day episode of care to a 30-day period of care,

CMS also prepared an impact analysis of how HHA revenues would likely be affected by these policy changes. Overall, before application of the home health payment update percentage for 2019, CMS estimates that aggregate payments in 2019 would:

- decrease by $950 million (-4.3 percent) if implemented in a fully non-budget neutral manner; and
- decrease by $480 million (-2.2 percent) if HHGM in 2019 is implemented in a partially non-budget neutral way. CMS states that it would use a partial budget neutrality adjustment factor in 2020 and subsequently remove it in 2020.

As noted earlier, CMS invites comments on whether to implement the HHGM in a fully non-budget neutral manner beginning in 2019, as proposed; whether to implement the HHGM in 2019 with a HHGM partial budget neutrality adjustment factor applied and then subsequently removed in CY 2020; or whether a HHGM partial budget neutrality adjustment factor should be applied and then phased-out over a longer period of time.

Table 55 on pages 35385-35386 provides details on the impact of each change by facility type and ownership, by rural and urban area, by census region and by facility size. CMS shows the impact by fully and partial budget neutral approaches. If implemented in a fully-budget neutral way, proprietary free-standing HH facilities (almost 80 percent of all facilities) would experience a reduction in payments of -5.7 percent. Government-based facilities would experience a 1.3 percent increase.

CMS provides at Tables 61 thru 63 on page 35390 the required accounting statements. Table 61 presents the accounting statement for HH PPS for 2018, setting out the $80 million in government savings in payments to HHAs. Table 62 provides the accounting statement for 2019 due to the implementation of the HHGM showing $950 million in government savings if implemented in a fully-budget neutral manner, and $480 million if implemented in a partially budget neutral way. Table 63 shows the estimated costs of $44.9 million to HHAs of submitting OASIS data for HH QRP classification for years 2018 to 2019.