2019 Home Health PPS Rate Update

On November 13, 2018, CMS issued the Final Rule to update the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index for calendar year (CY) 2019. In summary, this final rule:

- Increases the Standardized PPS Base Rate by 1.661%, comprised of :
  - An decrease of 0.15% Wage Index Budget Neutrality factor
  - An increase of 2.2% Market Basket Update
  - An increase of 1.69% Case Mix Budget Neutrality recalibration

- Correspondingly decreases Case Mix Weights by 1.69%

- Reduced The Outlier Fixed Dollar Loss (FDL) ratio by .04, to 0.51; and the Loss Sharing factor of 80% remains unchanged

- Caps for EACH AGENCY'S outlier payments at 10% of total PPS payments

- Reinstated the rural add-on for the years 2019 to 2022, but with varying add-on rates based on a rural county population density.

Payments to home health agencies (HHAs) are estimated to increase by approximately 2.2%, or $420 million in CY 2019.

This rule also:

- Finalizes regulations changes regarding certifying and recertifying patient eligibility for Medicare home health services and remote patient monitoring;

- Finalizes the removal of seven measures from the Home Health Quality Reporting Program, including a regulatory change regarding OASIS data;

- Refines the Home Health Value-Based Purchasing (HHVBP) Model;

- Finalizes the definition of a “infusion drug administration calendar day” for the implementation of temporary transitional payments for home infusion therapy services for CYs 2019 and 2020, finalizes health and safety standards for home infusion therapy, and finalizes an accreditation and oversight process for home infusion therapy suppliers;

- Finalizes the implementation of the 30 day episodic Patient-Driven Groupings Model (PDGM) for CY 2020

Case Mix Recalibration to Average Weight of 1.0000

For CY 2019, a recalibration was made to increase the Standardized Episodic PPS Base Rate by 1.69% and correspondingly reducing Case Mix Weights by 1.69%.

Episodic Base Rate

The 2019 Episodic Base Rate is **$3,154.27** compared to $3,039.64 for 2018.

The rural add-on, which expired on January 1, 2018, is being reinstated for the years 2019 to 2022. However, the extension provides varying add-on amounts depending on the rural county classification by classifying each rural county into one of three distinct categories of (1) High Utilization, (2) Low Population Density and (3) All Other.

Low Utilization Payment Adjustments (LUPA)

The Low-Utilization Payment Adjustment for episodes consisting of four or fewer visits is paid the standardized per visit rates as follows:

	2019	2018
Skilled Nursing	$ 146.50	$ 143.40
Physical Therapy	160.14	156.76
Occupational Therapy	161.24	157.83
Speech Therapy	174.06	170.38
Medical Social Worker	234.82	229.86
Home Health Aide	66.34	64.94
Initial or Only Episode add-on payment:		-
Skilled Nursing is first skilled visit	123.81	121.19
Physical Therapy is first skilled visit	107.29	105.03
Speech Therapy is first skilled visit	109.07	106.76

As implemented in 2014, CMS will continue to use three LUPA add-on factors in calculating the LUPA add-on payment amount for LUPA episodes that are the only episode or the first episode in a sequence of adjacent episodes. In 2013 a single rate of $95.85 was made in addition to the initial visit rate. Effective in 2014, CMS finalized three LUPA add-on factors to be used in calculating the LUPA add-on payment amount: 1.8451 for skilled nursing, 1.6700 for physical therapy and 1.6266 for speech-language pathology **when that discipline is the first skilled visit in a LUPA episode** that occurs as the only episode or an initial episode in a sequence of adjacent episodes. For example, if the first skilled visit is a Skilled Nurse, the payment for that visit will be $264.59 (1.8451 multiplied by $143.40). Effectively, this translates to an equivalent add-on payment of $121.19, $105.03, and $106.76 for SN, PT, and ST, respectively (as reflected in the above table).

Effective for episodes ending on or after January 1, 2017, The LUPA rates will no longer be used in the Outlier computation. Instead, a 15-minute unit will be used in the computation, as further explained below in the Outlier section below.

Wage Index

The Standardized **Episodic Rate** and the Standardized **LUPA Rates** stated above are BEFORE applying the CBSA **Wage Index Adjustments.**

The **labor-related** share for episodic and LUPA rates changed from 78.535% to **76.1%**; meanwhile, the wage index has changed for all CBSA's. The *CBSA Tab* in the attached file list the wage index amounts for all Urban & Rural Counties for 2019.

Outliers

The Outlier Fixed Dollar Loss (FDL) factor changed from 55% to **51%** ($1,608.68) of the Episodic Rate and the Loss Sharing Ratio which remains at **80%.** As implemented in the 2010 final rule, outlier payments will continue to be "capped" at 10% of the AGENCY'S *Total PPS Payments*. The claims processing system would ensure that for each time a claim for a provider was processed, YTD outlier payments for that calendar year could never exceed 10% of YTD total PPS payments for that provider for that calendar year. The 10% payment cap is intended to penalize agencies that are abusing the outlier system and reward those that have not abused the system.

In 2017 CMS is changed the methodology used in computing outlier payments. Since the inception of PPS through 2016, The Wage Adjusted Standardized Cost used in the computation was based on per-visit LUPA rates by discipline. Effective for episodes ending in 2017, CMS modified the outlier methodology as to use a cost-per-15 minute unit approach. The per-unit amount was arrived at by dividing the LUPA rate by the average number of minutes per visit and then multiplying by 15 (minutes), as show in the table below:

Visit type	Cy 2019 National Per-visit Payment Rates	Average Minutes-per-visit	Cost-per-unit (1 Unit = 15 Minutes)
Skilled nursing	146.50	44.8	$ 49.05
Physical therapy	160.14	46.6	$ 51.55
Occupational therapy	161.24	47.1	$ 51.35
Speech-language pathology	174.06	48.1	$ 54.28
Medical social services	234.82	56.5	$ 62.34
Home health aide	66.34	63.0	$ 15.80

The table below illustrates how the 15-minute unit will be determined:

Time	Units
<23 minutes	1
23 minutes to <38 minutes	2
38 minutes to <53 minutes	3
53 minutes to <68 minutes	4
68 minutes to <83 minutes	5
83 minutes to <98 minutes	6
98 minutes to <113 minutes	7
113 minutes to <128 minutes	8
128 minutes to <143 minutes	9
143 minutes to <158 minutes	10

Non-Routine Supplies (NRS)

The Non-Routine Supply (NRS) Conversion Factor changes from $53.03 to $54.20; however, non-routine supply (NRS) relative weights will remain unchanged. After applying the relative weights for the severity levels, the NRS payment changed as follows:

	Relative Weight	2019	2018
Level 1	0.2698	$ 14.62	$ 14.31
Level 2	0.9742	52.80	51.66
Level 3	2.6712	144.78	141.65
Level 4	3.9686	215.10	210.45
Level 5	6.1198	331.69	324.53
Level 6	10.5254	570.48	558.16

Unlike the Episodic rate and the LUPA rates, the above NRS rates are NOT subject to wage adjustment.

Rural Add-on

As stated previously, the rural add-on, which expired on January 1, 2018, is being reinstated for the years 2019 to 2022.

Unlike previous rural add-ons, which were applied to all rural areas uniformly, the extension provides varying add-on amounts depending on the rural county FIPS classification by classifying each rural county into one of three distinct categories:

(1) Rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under part A of Medicare or enrolled for benefits under part B of Medicare only, but not enrolled in a Medicare Advantage plan under part C of Medicare (the "High utilization" category);

(2) Rural counties with a population density of 6 individuals or fewer per square mile of land area and are not included in the "High utilization" category (the "Low Population Density" category); and

(3) Rural counties and equivalent areas not in either the "High utilization" or "Low population density" categories (the "All Other" category).

The rural add-on percentages and duration of rural add-on payments are shown in the table below:

Category	CY 2019	CY 2020	CY 2021	CY 2022
High Utilization	1.5%	0.5%		
Low Population Density	4.0%	3.0%	2.0%	1.0%
All Other	3.0%	2.0%	1.0%	

Agencies will now be required to enter the FIPS state and county code on the claim in order to establish the rural add-on amount.

Home Health Groupings Model (HHGM)

In this final rule, CMS finalized the implementation of the Home Health Groupings Model (HHGM) for **CY 2020** payments. As compared to the current payment system, which is driven by OASIS, the new HHGM would use **30-day periods**, rather than 60-day episodes, and rely more heavily on clinical characteristics and other patient information (e.g., principal diagnosis, functional level, comorbid conditions, referral source, and timing) to place patients into payment categories. In summary, payments would be determined using a 4-step process, as outline below:

1. Episodes would be classified into four categories based on timing and source of admission.

    1. Community Early
    2. Community Late
    3. Institutional Early
    4. Institutional Late

    Higher reimbursement would go to "institutional" 30-day episodes (those with hospital, skilled nursing facility, and inpatient rehab facility stays within 14 days of home health admission) and those that are "early". Early is defined as the first or only episode in a series of nonadjacent episodes.

2. Episodes are then categorized into 12 clinical groupings or subgroupings based on principal diagnoses reported on the claim: Musculoskeletal Rehabilitation, Neuro/Stroke Rehabilitation, Wounds — Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care, Behavioral Health Care (including Substance Use Disorder), Complex Nursing Interventions, and seven Medication Management, Teaching and Assessment (MMTA) subgroups.

3. Episodes would then be assigned as Low, Medium, or High functional levels based on OASIS responses from 7 Oasis Functional Groups:

    1. M1800: Grooming
    2. M1810: Current Ability to Dress Upper Body
    3. M1820: Current Ability to Dress Lower Body
    4. M1830: Bathing
    5. M1840: Toilet Transferring
    6. M1850: Transferring and
    7. M1860: Ambulation and Locomotion

4. Adjustments are then made for comorbidities based on secondary diagnoses. PDGM will give episodes a "no" "low" or "high" comorbidity adjustment.

PDGM's four steps result in one of 432 Home Health Resource Groups, with a 30-day Episodic Federal Standard rate estimated to be $1,753.68. This would also be wage adjusted based on each agency's CBSA. This compares to 153 case mix groups under the current PPS system whose 60-day Episodic Base Rate is $3,154.27**.**

Currently, a 60-day episode with four or fewer visits triggers a Low Utilization Payment Adjustment (LUPA), in which the HHA is paid the national per visit amount by discipline, adjusted by the appropriate wage index. Under HHGM, LUPA threshold for each 30-day period of care will vary depending on the PDGM payment group to which it is assigned, ranging from two to six visits. LUPA thresholds for each PDGM payment group will be reevaluated every year based on the most current utilization data available.

I will follow this message at a later date with more in-depth information and a similar spreadsheet showing calculations for all 432 groups under the Home Health Grouping Model. It will also include a grouper calculator that hopefully you will find useful.

This message does NOT address every aspect of the Final Rule. I strongly encourage you go to the CMS website to read the rule for yourself. The final rule can be found at: *https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*

Attached is an **EXCEL SPREADSHEET** file to help you calculate the 2019 rates for your individual agency. It includes a number of tools I think you may find useful. The file contains the following ***TABS***:

HHRG: The spreadsheet allows you to enter up to Nine CBSA codes in the YELLOW shaded boxes so that you can view the HHRG and LUPA rates for a number of counties in your area. Input your County Code in cells M5 to V5 and the HHRG rates will be generated for each HHRG taking into account the wage index for your CBSA. If this is a rural agency you will need to enter the FIPS code in cells M7 to V7. The FIPS code can be obtained from the Rural Add-On Tab.

LUPA per visit rates are also generated. Simply go to the ***LUPA Rates*** tab and print. HOWEVER the NRS amount is NOT reflected into the computations on this ***HHRG*** tab. The advantage to this Tab vs. the ***HHRG w NRS*** tab is that you can generate rates for multiple CBSA's; however the disadvantage is the NRS amount is not reflected in the computation due to space limitations. The table takes into consideration the rural add-on which is based on the combination of the CBSA code 99900 or higher and the FIPS code.

HHRG w NRS: To generate a spreadsheet to include the Non-Routine Supply (NRS) enter a CBSA codes in the YELLOW shaded box so that you can view the HHRG with NRS Amount. Input your County Code in cells L5 and the HHRG rates along with a separate column for each NRS Level will be generated for each HHRG taking into account the wage index for your CBSA. If this is a rural agency you will need to enter the FIPS code in cells L7. Due to a limitation in the number of columns that can be printed and readable only ONE CBSA can be entered in this sheet.

LUPA Rates: Will compute automatically based on input in the ***HHRG Rates*** tab.

Outlier:: Computes outlier; you need to know the HIPPS code along with the CBSA and number of visits. Enter the HIPPS code (rather than the HHRG in Cell I14). You need to enter the **CBSA** code in cell C3**.**

CBSA: Reflects all the CBSA's in the Country.

Rural Add-On: Contains all of the FIPS codes which are used to determine the rural add-on amount.

HIPPS Code Ref: This table can be useful in correlating the HHRG to the HIPPS code.

2% Sequestration: All of the rate computations reflect the reimbursement rates before the 2% reduction.