Medicare Home Health Prospective Payment System
Final Rule Impact Analysis
Calendar Year 2019

-Version 1, December 2018-

Analysis Description

The calendar year (CY) 2019 Medicare Home Health (HH) Prospective Payment System (PPS) Final Rule Analysis is intended to show HH providers how Medicare fee-for-service (FFS) payments will change from CY 2018 to CY 2019 based on the policies set forth in the CY 2019 HH PPS final rule.

CY 2019 HH Final Rule Changes Modeled in this Analysis

- Marketbasket Update: 3.0% marketbasket increase to account for service cost inflation.
- ACA-Mandated Productivity Reduction: 0.8 percentage point multifactor productivity reduction, as established under the Affordable Care Act (ACA).
- Home Health Resource Group (HHRG) Case-Mix Budget Neutrality: 1.69% increase to the 60-day episode rate to maintain budget neutrality resulting from CMS' recalibration of the HHRG case-mix weights for CY 2019.
- Wage Index Budget Neutrality Adjustment: 0.15% (including all other budget neutrality) decrease in the rate due to wage index changes to maintain program budget neutrality.
- Wage Index and Labor Share Change: Updated wage index values based on the FFY 2019 inpatient hospital wage index without the rural floor or reclassifications. This impact includes the impact of any new core-based statistical area (CBSA) delineations and new wage data. CMS is decreasing the labor-related share from 78.535% for CY 2018 to 76.1% for CY 2019.
- Rural Add-On: CMS is adopting rural add-on payments for episodes and visits ending during CYs 2019 through 2022 as required by the Bipartisan Budget Act of 2018. This includes varying add-on amounts depending on the HHAs rural county classification by classifying each into one of three distinct categories with the following CY 2019 add-on percentages: high utilization (1.5%), low population density (4.0%), or all other (3.0%).

This analysis uses historical HH revenue from the Medicare cost report as its basis and does not estimate the impact of Home Health Agency (HHA) level changes due to volume or case-mix. This analysis does not estimate the HH specific revenue impacts of changes to HHRG weights, which may offset or exacerbate the case-mix budget neutrality impact shown in the analysis.

The values shown in the impact table do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2027. The estimated sequestration reduction applicable to HH PPS-specific payment has been calculated separately and is provided at the bottom of the impact table.

Beginning CY 2020, CMS is adopting a new case-mix adjustment methodology, the Patient-Driven Grouping Model (PDGM) to replace the current Home Health Resource Groups (HHRGs). The estimated change to HH PPS payments if PDGM was implemented today is shown.

For HHAs not in the CMS PDGM Agency-Level Impact File, the State percent change due to PDGM was used to estimate change in HH PPS payments.

This analysis also provides a report that breaks down the current 60-day episodes and the PDGM 30-day periods into PDGM clinical classifications for comparison using CY 2019 data. The episodes/periods are classified into one of two admission source categories; assigned as either a first or subsequent 30-day period; classified into one of 12 clinical groupings; given a functional level of low, medium or high; and assigned a comorbidity adjustment.

Impact of PDGM may differ on this report compared to other reports in this analysis due to data source and methodology used. On the PDGM Breakout reports, payments and volumes are calculated using the raw CY 2019 Final Rule PDGM OASIS Limited Data Set (LDS) and broken down into classification groups (not including comorbidity adjustments). Payment amounts do include outliers but do not include 10% outlier cap and therefore may be overestimated.

In PDGM, Medication, Management, Teaching and Assessment will be broken down into the following subgroups: Surgical Aftercare; Cardiac/Circulatory; Endocrine; GI/GU; Infectious Disease/Neoplasms/Blood-forming Diseases; Respiratory; or Other. For simplicity, in this analysis the 7 subgroups are combined into one MMTA classification.

Volumes less than 11 are redacted due to CMS privacy rules.

Data Sources

Estimated CY 2018 HH payments are derived from revenue data reported in the most recent Medicare cost report (2015, 2016, or 2017). Estimated CY 2019 HH payments are determined based on HH revenue from the cost report increased by the applicable update factor(s) as determined from year to year changes to the 60-day episode base rate.

Wage indexes, labor shares, and standard payment rates used in this analysis are from the CY 2018 HH PPS final rule and CY 2019 HH PPS final rule. The HHRG weights shown in the worksheet “HHRG Weight Changes” are from the CY 2018 HH PPS final rule and CY 2019 HH PPS final rule.

Percent impacts due to the PDGM on the HHA Report are from CMS’ CY 2019 Final Rule PDGM Agency-Level Impact file and applied to estimates of CY 2019 payments using the Medicare cost reports.

PDGM breakdown into classifications and impact of such is calculated using the CY 2019 Final Rule PDGM OASIS LDS.

Methods

The dollar impact of each component change has been calculated by first determining CY 2018 HH payments. Estimated payments are derived from the Medicare cost report as described above.

For each HH payment change component analyzed, the percent change for CY 2018 to CY 2019 is calculated and applied to estimated CY 2018 payments. The percentage impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the percent change due to the marketbasket update is applied to total CY 2018 payments. Then, the percent change resulting from the ACA-Mandated Productivity Reduction of the national 60-day episode rate is applied to the dollar result of the first change. This method continues for the remaining changes, creating a compounded effect. The difference between the results after each layered component is the impact of that component.

This analysis does NOT include impact estimates due to high cost outliers, estimates for payments for Managed Care patients, or any modifications in FFS payments as a result of HH participation in new payment models being tested under Medicare demonstration/pilot programs. Dollar impacts in this analysis may differ from those provided by other organizations/associations due to differences in source data and analytic methods.