Public Policy

HCA Public Policy No.15-2018

TO: **HCA CHHA PROVIDER MEMBERS**

FROM: **PATRICK CONOLE, VICE PRESIDENT, FINANCE & MANAGEMENT**

RE: **CMS's CY 2019 HHPPS FINAL RULE – NEW CASE-MIX WEIGHTS & WAGE INDEX SUMMARY ATTACHED**

DATE: **NOVEMBER 8, 2018**

Overview

Last week, the U.S. Centers for Medicare and Medicaid Services (CMS) posted its final rule for the Calendar Year (CY) 2019 home health prospective payment system (HHPPS).

The final rule can be downloaded from the *Federal Register* website at https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24145.pdf.

All told, taking into account the various adjustments to the base episodic rate, CMS estimates an overall **2.2 percent increase in national Medicare home health payments (or $420 million)** in 2019.

However, CMS is moving forward with long-anticipated payment changes that were included in the February 2018 Bipartisan Budget Act (BBA) and now proposed and finalized by CMS in this rule. The model, named the **Patient Driven Groupings Model (PDGM)**, calls for a 30-day payment unit, distinct from the 60-day episodic system, beginning in **2020**, with related case-mix adjustments intended to treat early segments of the care episode differently from later ones under the CMS assumption that utilization tends to be higher during the first 30 days of an episode (compared to the last 30 days).

While the final rule states that these changes are budget-neutral, the new model still includes the risk of a significant "behavioral adjustment" based solely on assumptions of behavioral changes that home health agencies might undertake in the future. CMS originally proposed a 6.42 percent reduction in base payment rates for this purpose but the final rule does not include the actual CY 2020 rate adjustment, and instead notes that such an adjustment is required for the first year of PDGM. The cut, as originally proposed at 6.42 percent, was based on assumptions of "behavioral changes" by home health agencies but CMS provided no data or methodological forecasting to substantiate these assumptions.

In addition to the base payment rates, the final HHPPS rule includes some upside and downside adjustments affecting payments, similar to past years. This includes: a newly re-based market-basket update, another recalibration of the case-mix weights, application of the budget neutrality adjustment factor, Low Utilization Payment Adjustment (LUPA) payments, a newly tiered version of the home health rural add-on, with variations in the payment rate based

on whether a county is defined as "frontier" (a 4% add-on) or "high utilization" (a 2% add-on), with the remaining 1,162 counties receiving a 3% add-on and other rate adjustments. All of these calculations are detailed in this memo.

HCA submitted comments in August to CMS on all of these rate components and remains engaged in advocacy at the federal level on behalf of providers struggling with the rebasing cuts from the previous four years, sequestration cuts, and regulatory mandates such as the face-to face (F2F) physician encounter requirement that has burdened provider capacity to serve patients. While CMS's final rule includes a nominal change that is a step in the right direction to minimize the regulatory burden and required procedures for documenting F2F compliance, it is not the kind of fundamental relief which is needed – and which has been repeatedly sought by HCA and federal partners.

In its 2019 final rule, CMS also contains several important changes in benefits and process requirements, including: (1) the implementation of a new home infusion therapy benefit; (2) a new definition of remote patient monitoring in regulation for the Medicare home health benefit and the inclusion of remote patient monitoring as an allowable cost on the home health agency (HHA) cost report; (3) the elimination of requirements that certifying physicians must state how much longer care would be needed when recertifying the need for continued home care; and (4) allowing the incorporation of home health agency records into physician records, including through the use of the plan of care.

In addition, CMS is updating its home health value-based purchasing (HHVBP) program which is currently operating in nine randomly selected states. New York is still not one of the nine states (Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee). As detailed later in this memo, CMS is removing two OASIS-based measures from HHVBP, replacing three OASIS-based measures with two new proposed composite measures, rescoring the maximum number of improvement points, and reweighting the measures in the applicable measures set.

Also, as part of the Home Health Quality Reporting Program (HHQRP), CMS includes a discussion of the Meaningful Measures Initiative and the removal of seven measures to further the priorities of this initiative. In addition, CMS's HHQRP provisions include a discussion on social risk factors and an update on implementation efforts for certain provisions of the IMPACT Act. Lastly, the final rule clarifies the regulatory text to note that not all OASIS data is required for the HHQRP.

Other important highlights of the rule include:

- Changes regarding certifying and recertifying patient eligibility for Medicare home health services.
- Another recalibration of the HHPPS case-mix weights (CMWs), using the most current cost and utilization data. The CMWs in the recalibrated adjuster would result in a slight overall payment decrease, thereby necessitating a higher budget neutrality adjustment.
- Updated Tables for the final CY 2019 standardized 60-day episodic payment rate and LUPA Per-Visit rates.
- The final wage index for CY 2019, including a summary of those areas seeing increases or decreases in the wage index factor, as well as changes to the labor and non-labor share of the calculation.
- The new tiered version of the home health rural add-on.
- Changes to the fixed dollar loss (FDL) ratio used in the outlier calculation.

- OASIS requirements to avoid payment rate reductions in CY 2019.

- Details on the Home Health Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS).

Reimbursement Changes At-a-Glance

Under the 2019 final rule, CMS projects that total Medicare payments to HHAs in 2019 will be increased by **$420 million** nationally, based on the net impact of positive and negative rate adjustments. Specifically, this aggregate increase reflects the cumulative impact of the following:

- A 2.2 percent home health payment rate increase (a $420 million increase), using a newly re-based market basket update of 3.0 percent, minus a 0.8 percentage point for "multifactor productivity";

- A 0.1 percent increase in payments due to decreasing the FDL ratio so that CMS pays no more than 2.5 percent of total payments as outlier payments ($20 million increase); and

- A 0.1 percent decrease in payments due to the new rural add-on policy mandated by the BBA of 2018 for CY 2019 ($20 million decrease).

Final Rule in Detail

Implementation of the Patient Driven Groupings Model (PDGM) for CY 2020

Background

In addition to the CY 2019 rate-setting (summarized previously and described in greater detail later in this memo), the most sweeping and complex changes in reimbursement are for CY 2020 as described here.

Specifically, CMS has finalized case-mix methodology changes through the implementation of the PDGM in order to meet the requirement under Section 51001(b)(4) of the BBA of 2018 and to "better align payment with patient care needs and better ensure that clinically complex and ill beneficiaries have adequate access to home health care."

PDGM is a successor to the previously proposed Home Health Groupings Model (HHGM). The final PDGM shares many features of the alternative case mix-adjustment methodology for HHGM that CMS drafted in its CY 2018 HHPPS proposed rule. This HHGM proposal was later rejected following aggressive advocacy by HCA and others, along with hundreds of comments in the rule-making process, where we questioned the short timetable for implementation and expressed concerns that the model wasn't budget-neutral.

CMS will implement the PDGM for home health periods of care beginning on or after **January 1, 2020**. The implementation of PDGM will require provider education and training, updating and revising relevant manuals, and changing claims processing systems.

Change to 30 Day Payment Units

Under PDGM, CMS will use 30-day periods or units (rather than the 60-day episode used in the current payment system). PDGM also eliminates therapy visit numbers in determining payment, and relies more heavily on clinical characteristics and other patient information (for example, timing, diagnosis, functional level, comorbid conditions, admission source) to place patients into clinically meaningful payment categories. In total, there will be **432 home health resource groups (HHRGs).**

CMS's rationale for a 30-day unit of payment (rather than the current 60-day episodes) is based on CMS's finding that episodes have more visits, on average, during the first 30 days compared to the last 30 days. CMS also contends that costs are much higher earlier in the episode (and lesser later on). Thus, with the division into two 30-day periods, CMS believes it can more accurately apportion payments. In addition, with the removal of therapy thresholds from the case-mix adjustment methodology under the HHPPS, CMS says that a shorter period of care reduces the variation and improves the accuracy of the case-mix weights generated under the PDGM. Overall, CMS found that the average length of an episode of care was 47 days, but roughly a quarter of all 60-day episodes lasted 30 days or less.

RAPs and Split Percentage Approach for a 30-Day Unit of Payment

CMS is also finalizing the split-percentage proposal beginning January 1, 2020. This means that newly-enrolled HHAs (those certified for participation in Medicare effective on or after January 1, 2019) would not receive Request for Anticipated (RAP) payments beginning in CY 2020. HHAs that are certified for participation in Medicare effective on or after January 1, 2019 would still be required to submit a "no-pay" RAP at the beginning of care in order to establish the home health period of care, as well as every 30 days thereafter.

Existing HHAs (those that are certified for participation in Medicare effective prior to January 1, 2019) will continue to receive RAP payments upon implementation of the PDGM in CY 2020. For split-percentage payments to be made, existing HHAs would have to submit a RAP at the beginning of each 30-day period of care and a final claim would be submitted at the end of each 30-day period of care. For the first 30-day period of care, the split percentage payment would be 60/40 and all subsequent 30-day periods of care would be a split percentage payment of 50/50.

PDGM Behavioral Assumptions by CMS

CMS is finalizing the three behavioral assumptions as previously described in the proposed rule. CMS stated it "will update the CY 2020 30-day budget-neutral payment amount in the CY 2020 proposed rule using the most recent data available." CMS specifically noted that it does not believe the HHA payment reduction of 6.42 percent will cause revenue concerns, which it stated was supported by findings from the Medicare Payment Advisory Commission (MedPAC).

CMS stated it plans to analyze the impact of the assumed versus the actual behavior change after the implementation of the PDGM and the 30-day unit of payment to determine if any payment adjustment, either upward or downward, is warranted. CMS notes it will analyze "any actual, observed behavioral changes with respect to CYs 2020-2026 to make any payment adjustment beginning in CY 2022 at the earliest." CMS says the temporary and prospective adjustments outlined in the statute are "not meant to act as a cap" on overall home health expenditures. Further, CMS will analyze claims data from CY 2018 to determine any changes to the payment amount for CY 2020 and will include the amount in the CY 2020 HHPPS proposed rule.

To support HHAs in evaluating the effects of the proposed PDGM, CMS encourage HHAs to continue to review the list of diagnosis codes in the PDGM Grouper Tool posted with the final rule on the HHA Center webpage at the link below:

https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html

Cost Calculation

Costs during an episode/period of care will be estimated based on the concept of resource use, which measures the costs associated with visits performed during a home health episode/period. For the current HHPPS case-mix weights, CMS utilizes Wage Weighted Minutes of Care (WWMC), which draws on home health data from the Bureau of Labor Statistics (BLS). For PDGM, **CMS is shifting to a Cost-Per-Minute plus Non-Routine Supplies (CPM+NRS) approach, which uses information from the Medicare Cost Report and home health claims data**. The CPM+NRS approach incorporates a wider variety of costs (such as transportation) compared to the BLS estimates, and the costs are available for individual HHA providers while the BLS costs are aggregated for the home health care service industry.

Timing: "Early vs. Late"

Similar to the current payment system, 30-day periods under PDGM would be classified as "early" or "late" depending on when the 30-day increment occurs within a sequence. Presently, the first two 60-day episodes of a sequence are considered "early," while the third (and any subsequent) 60-day episode is considered "late." Under PDGM, the first 30-day period is classified as "early." All subsequent 30-day periods in the sequence (second or later) are classified as "late."

Admission Source Categories

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

Patient Clinical Groupings

PDGM will group 30-day periods into categories based on a variety of patient characteristics. The principal diagnosis reported will provide information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit. However, as part of the final rule, CMS has decided to divide the Medication Management, Teaching and Assessment (MMTA) clinical group into 7 sub-groups. These subgroups were selected based on public comments in response to the proposed rule which mainly focused on cardiac, oncology, infectious disease, and respiratory diagnoses. CMS created the additional subgroups based on data that showed above-average resource use for codes in those groups, and then combined certain groups that had a minimal number of codes.

Although it is categorizing patients into twelve groups according to the principal diagnosis, CMS notes that these groups do not reflect all the care being provided to the home health patient during a 30-day period of care. Home health care remains a multidisciplinary benefit. Additionally, as emphasized in the CY 2019 HHPPS final rule,

CMS will continue to examine trends in reporting and resource utilization to determine if future changes to the clinical groupings are needed after implementation of the PDGM in CY 2020.

The twelve clinical groups are as follows:

- Musculoskeletal Rehabilitation
- Neuro/Stroke Rehabilitation
- Wounds-Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care
- Complex Nursing Interventions
- Behavioral Health Care
- Medication Management, Teaching and Assessment (MMTA)
    - MMTA – Surgical Aftercare
    - MMTA – Cardiac/Circulatory
    - MMTA – Endocrine
    - MMTA – Gastrointestinal or Genitourinary (GI or GU)
    - MMTA – Infectious Disease/Neoplasms/Blood-Form Diseases
    - MMTA – Respiratory
    - MMTA – Other

Functional Impairment Levels and Corresponding OASIS Items

Under PDGM, each 30-day period will be placed into one of three functional impairment levels (**low, medium or high**). The PDGM will also use the same five OASIS items used in the current HHPPS to determine the functional case-mix adjustment (M1810, M1820, M1830, M1840, M1850, and M1860), but adds two additional OASIS items (M1800 and M1033) to determine the level of functional impairment.

The structure of categorizing functional impairment into "low, medium, and high" levels has been part of the home health payment structure since the implementation of the HHPPS, and the final functional level assignment under PDGM is very similar to the functional level assignment in the current payment system. Under PDGM, the level would indicate if a 30-day period is predicted to have higher costs or lower costs on average, given responses on certain functional OASIS items. CMS will assign roughly 33 percent of periods to each of the three functional levels. The criteria for assignment to each of the three functional levels may differ across each clinical group.

Comorbidity Adjustment

CMS has finalized the comorbidity adjustment as part of the overall case mix in PDGM. This includes the home health specific list of comorbidity subgroups and comorbidity subgroup interactions. One of the three mutually exclusive categories of comorbidity adjustment will be applied to each period: **no comorbidity adjustment, low comorbidity adjustment, and high comorbidity adjustment**.

A 30-day period of care can receive payment for a low comorbidity adjustment or a high comorbidity adjustment, but not both. A 30-day period of care can receive only one low comorbidity adjustment regardless of the number of secondary diagnoses reported on the home health claim that fell into one of the individual comorbidity subgroups.

CMS anticipates that it would annually recalibrate the PDGM case-mix weights, which would include the comorbidity adjustment.

LUPA Threshold, LUPA Add-On Factor and Outliers Under PDGM

Finally, for LUPAs under PDGM, CMS indicated the threshold would vary for a 30-day period under PDGM depending on the PDGM payment group to which it is assigned. For each payment group, CMS will use the10th percentile value of visits or 2 visits (whichever is higher) to create a payment-group-specific LUPA threshold. CMS will also continue to provide the LUPA add-on payment, partial episodic payment (PEP) and payment adjustments to account for high cost outliers under the new PDGM.

Other HHPPS Requirements are Unchanged

While the final PDGM would reflect significant changes in the case-mix adjustment methodology, the conditions for payment would remain the same for Medicare home health services, meaning all requirements would still need to be met in accordance with Section 424.22, according to CMS.

The comprehensive assessment will still be completed within 5 days of the start of care and completed no less frequently than during the last 5 days of every 60 days beginning with the start of care date, as currently required by federal regulations. In addition, the plan of care will still be reviewed and revised by the HHA and the physician responsible for the home health plan of care no less frequently than once every 60 days, beginning with the start of care date, as currently required by the federal Conditions of Participation (CoPs).

This also includes physician certification that: 1) the individual is in need of intermittent skilled nursing care, or physical therapy or speech-language pathology services, and is confined to the home; 2) a plan of care has been established and will be periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine; 3) the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine; and 4) a F2F patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of home health care and was performed by a physician or allowed non-physician practitioner. Likewise, under this new model, the Medicare beneficiary would retain all rights that now exist under the current HHPPS, including those related to beneficiary liability for services or any reduction or termination of services. These are issuance of the Advanced Beneficiary Notice (ABN) and the Home Health Change of Care Notice (HHCCN), when appropriate.

Questions to CMS and Appendix A

HCA members can submit specific questions to CMS about the PDGM at HomehealthPolicy@cms.hhs.gov .

Appendix A of this memo represents how each 30-day period of care would be placed into one of the 432 HHRGs under PDGM for CY 2020.

Certification and Recertification Changes for Medicare Home Health Eligibility

CMS's final rule makes a nominal change in the physician certification process, acting on a provision of the BBA of 2018. In the rule, CMS finalizes a proposal to allow for the home health record to be used along with the physician record when determining a patient's eligibility for the Medicare home health benefit. Specifically, it would allow CMS and its Medicare Administrative Contractors (MACs) to determine home health eligibility through a review of the entire patient medical record, including the HHA's patient record. In places where the physician's record may be insufficient to determine eligibility, the home health agency's record **may** be used as supporting material to attest eligibility for home health services.

The documentation from the HHA can be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient, thereby creating a clinically consistent picture that the patient is eligible for Medicare home health services as specified in Section 424.22 (a)(1) and (b). Also the certifying physician must **sign and date** the HHA documentation demonstrating that the documentation from the HHA was considered when certifying patient eligibility for Medicare home health services. HHA documentation can include, but is not limited to, the patient's plan of care required in accordance with Section 409.43 and/or the initial and/or comprehensive assessment of the patient required in accordance with Section 484.55.

HCA and the National Association for Home Care and Hospice (NAHC) strongly advocated that the BBA be modified so the physician certification documentation provisions used the term "shall" rather than "may" – i.e., to require the documentation. Unfortunately, this did not occur and HCA believes the term "may" will only codify CMS's existing standard, continuing to create unnecessary paperwork for providers.

Elimination of Recertification Requirement to Estimate How Much Longer Home Health Services will be Required

In the CY 2018 HHPPS proposed rule, CMS invited public comments about improvements that can be made to the health care delivery system that reduce unnecessary burdens for clinicians, other providers, patients and their families. Specifically, CMS asked the public to submit their ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to reduce burdens for HHAs, hospitals, physicians, and patients; improve the quality of care; decrease costs; and ensure that patients and their providers and physicians are making the best health care choices possible. CMS stated that it would not respond to the comment submissions in the CY 2018 final rule but, rather, would review and actively consider the comments as future regulatory proposals or sub-regulatory policy guidance.

Several commenters requested that CMS consider eliminating the requirement that the certifying physician include an estimate of how much longer skilled services will be required at each home health recertification, as set forth at Section 424.22(b)(2) and in sub-regulatory guidance in the Medicare Benefit Policy Manual (Chapter 7, Section 30.5.2). Commenters stated that this estimate is duplicative of the Home Health CoP requirements for the content of the home health plan of care, at 42 CFR 484.60(a)(2).

Based on these comments, CMS analyzed and determined that the estimate of how much longer skilled care will be required at each recertification is not currently used for quality, payment, or program integrity purposes. Given this consideration – along with the overlapping requirements of the Home Health CoPs, and to mitigate any potential denials of home health claims that otherwise would meet all other Medicare requirements – **CMS has finalized its proposal to eliminate the regulatory requirement at 42 CFR 424.22(b)(2) that the certifying physician, as part of the recertification process, provide an estimate of how much longer skilled services will be required.** All other recertification content requirements under Section 424.22(b)(2) would remain unchanged. CMS believes this change will reduce the the amount of time physicians spend on the recertification process and would result in an overall cost savings of $14.2 million.

Recalibration of the HHPPS Case-Mix Weights

In the CY 2015 final rule, CMS finalized a policy to annually recalibrate the HHPPS CMWs, adjusting the weights relative to one another, using the most current, complete data available (with the goal of having the average case-mix score of 1.0).

In CY 2019, CMS will recalibrate the HHPPS CMWs using the same methodology finalized in the CY 2008, 2012 and 2015 final rules.

CMS says the annual recalibration of the HHPPS CMWs ensures that the case-mix weights reflect current home health resource use and changes in utilization patterns.

To generate the final CY 2019 HHPPS case-mix weights, CMS analyzed CY 2017 home health claims data (as of June 30, 2018) with linked OASIS data. CMS states it will use CY 2017 home health claims data (as of June 30, 2018 or later) with OASIS data to generate the CY 2019 HHPPS case-mix weights in the CY 2019 HHPPS final rule.

CMS states that its recalibration of the CY 2019 CMWs results in a slight average CMW decrease. However, to achieve budget neutrality, CMS is applying a case-mix budget neutrality factor of 1.0169 to the final CY 2019 national, standardized 60-day episodic payment rate. This budget neutrality factor is calculated by applying the CY 2019 HHPPS CMWs (developed using CY 2019 home health claims data) to CY 2017 utilization (claims) data and setting this as a ratio to total payments when CY 2018 HHPPS case-mix weights (developed using CY 2016 home health claims data) are applied to CY 2017 utilization data.

In addition, CMS only used 'normal' episodes in its recalibration. Partial Episodic Payments (PEPs), LUPAs, outliers, and capped outlier episodes (that is, episodes which are paid as normal episodes but would have been outliers had the HHA not reached the outlier cap) were dropped from CMS 's data file.

It should also be reiterated that the recalibration results in some weights increasing while others decrease, primarily therapy-related episodes. However, the recalibration essentially focuses on therapy episodes. CMS is increasing CMWs by 3.75 percent for episodes with 0 to 5 therapy visits; decreasing CMWs by 2.5 percent for episodes with 14 to 15 therapy visits; decreasing weights by 5 percent for episodes with 20 or more therapy visits; and instituting gradual weight adjustments for episodes between those thresholds.

Appendix B of this memo offers a breakdown of the final 2019 CMWs.

Lastly, CMS states it will continue to monitor case-mix growth and may consider whether to propose nominal case-mix reductions in future rulemaking.

Market Basket Update

In the rule, CMS finalized its proposal to rebase and revise the home health market basket to reflect 2016 Medicare cost report data, the latest available and most complete data on the actual structure of HHA costs.

CMS explains how the terms "rebasing" and "revising," while often used interchangeably, denote different activities. The term "rebasing" means moving the base year for the structure of costs of an input price index (that is, in this exercise, CMS has decided to move the base year cost structure from CY 2010 to CY 2016) without making any other major changes to the methodology. The term "revising" means changing data sources, cost categories, and/or price proxies used in the input price index.

In the rule, CMS states it is rebasing the detailed wages and salaries and benefits cost weights to reflect 2016 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data on HHAs. The 2010-based home health market basket used 2010 BLS OES data on HHAs. CMS is proposing to break out the All Other (residual) cost category weight into more detailed cost categories, based on the 2007 Benchmark U.S. Department of Commerce,

Bureau of Economic Analysis (BEA) Input-Output (I-O) Table for HHAs. The 2010-based home health market basket used the 2002 I-O data.

CMS will also maintain its policy of using cost report data from only free-standing HHAs, which account for over 90 percent of HHAs, because CMS has determined that they better reflect the actual cost structure of all HHAs, since expense data for hospital-based HHAs can be affected by the allocation of overhead costs over the entire institution.

CMS also finalized its proposal to derive eight major expense categories (Wages and Salaries, Benefits, Contract Labor, Transportation, Professional Liability Insurance/PLI, Fixed Capital, Movable Capital, and a residual "All Other") from the 2016 Medicare HHA cost reports. CMS will eliminate the cost category "Postage," due to its small weight, and include these expenses in the "All Other (residual)" cost weight.

In its CY 2015 final rule (per ACA), CMS finalized its methodology for calculating and applying the multifactor productivity (MFP) adjustment to the annual market-basket update. ACA requires the annual home health market basket adjustment to reflect changes in economy-wide productivity. The statute defines the productivity adjustment as equal to the 10-year moving average of change in annual economy-wide private nonfarm business MFP.

The MFP is derived by subtracting the contributions of labor and capital input growth from output growth. The projections of the components of MFP are currently produced by IGI, a forecasting firm. Using IGI's third quarter 2018 forecast, the MFP adjustment for CY 2017 will be **0.8 percent**.

Thus, the calculation for the CY 2019 market-basket update of 3.0 percent, utilizing historical data through the third quarter of 2018, would then be reduced by the MFP adjustment of 0.8 percent, resulting in an MFP-adjusted home health market-basket increase of 2.2 percent.

Rural Add-On

The BBA of 2018 amended Section 421 (a) of the Medicare Modernization Act (MMA) by extending the rural add-on for five years. While the rural add-on will remain as a 3 percent increase for all home health services provided in rural areas for episodes and visits ending **before** January 1, 2019, CMS has proposed and finalized significant changes to the home health rural add-on between CY 2019 and CY 2022.

This extension of the rural add-on was implemented in CMS's Transmittal 2047 (March 20, 2018) which can be downloaded at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2047OTN.pdf.

Beginning in CY 2019 and onward, CMS will place rural counties into one of the following three categories for purposes of the home health rural add-on payment:

- **High Utilization** – For rural counties in the highest quartile of home health usage per 100 people, based on 2015 data, the rural add-on in those counties will be 1.5 percent in 2019; 0.5 percent in 2020; and 0 percent in 2021 and 2012.

- **Low Population Density** – For rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area (also known as "frontier counties") based on 2010 Census data, the rural add-on in those counties will be 4 percent in 2019; 3 percent in 2020; 2 percent in 2021; and 1 percent in 2022.

- **All Other** – For patients being serviced in all other rural counties (outside of the previous tiers mentioned above), the add-on will be 3 percent in 2019; 2 percent in 2020; 1 percent in 2021; and 0 percent in 2022.

The list of counties and equivalent areas used in CMS's analysis is based on the CY 2015 HHPPS wage index file.

Of the 3,246 total counties and equivalent areas that were used in CMS's analysis, 2,006 of these are considered rural for purposes of determining rural add-on payments for CY 2019 through CY 2022. CMS has determined that the 2,006 rural counties will include 510 counties in the "High Utilization" category, 334 counties in the low population or "frontier" category, and 1,162 counties in the "All Other" category.

Based on CMS's analysis, it has been determined that **Hamilton County** will fall under the "Low Population Density" or "frontier" category, while the remaining 23 rural counties in New York will fall under the "All Other" category.

Final 2019 HHPPS Episodic Rate

CMS's final 2019 national, standardized 60-day episodic payment rate is **$3,154.27**.

Table 1 shows how this rate is calculated. To determine this rate, CMS starts with the final 2018 average payment per episode ($3,039.64) and then applies a wage index neutrality factor (0.9985) to ensure budget neutrality in episodic payments using the 2019 wage index. CMS subsequently applies a CMW budget neutrality factor of 1.0169 to the 2018 national, standardized 60-day episodic payment rate. The original HHPPS rule required that the 60-day episodic base rate and other applicable amounts be standardized in a manner that eliminates the effects of variations in relative case mix and area wage adjustments among different HHAs, in a budget neutral manner.

Then, CMS applies the final 2019 home health market basket update of 2.2 percent as described on pages 6-7 of this memorandum. All of these calculations are shown below in Table 1.

Table 1: Final CY 2019 60-Day HHPPS Episodic Payment Update

CY 2018 National Standardized 60-Day Episode Payment Rate	Wage Index Budget Neutrality Factor (Multiply)	Case-Mix Weight Budget Neutrality Factor (Multiply)	CY 2019 Market Basket Update (Multiply)	CY 2019 Final National 60-Day Episodic Payment
$3,039.64	X 0.9985	X 1.0169	X 1.022	**$3,154.27**

When determining the actual final payment of a home health claim, this new 60-day base episodic rate still has to be adjusted by the applicable HHRG and wage index for the area in which the patient resides. The following are the steps HHAs should take to compute the case-mix and wage-adjusted 60-day episodic rate:

1. Multiply the national 60-day episodic rate by the patient's applicable new case-mix weight;

2. Divide the case-mix adjusted amount into a **NEW** labor portion (**76.1 percent**) and a **NEW** non-labor portion (**23.9 percent**);

3. Multiply the labor portion by the applicable wage index based on the site of the beneficiary's service; and

4. Add the wage-adjusted portion to the non-labor portion, yielding the case-mix and wage-adjusted 60-day episodic rate, subject to any additional applicable adjustments.

HHAs that did **not** submit the required amount of OASIS assessments (90 percent in CY 2019) for episodes beginning on or after July 1, 2017 and before July 1, 2018, would additionally see their market basket update reduced by 2 percent, which results in an overall 0.2 percent market basket update and a final CY 2019 national 60-day episodic payment rate of $3,092.55

Final 2019 National Per-Visit/LUPA Rates

To calculate the final CY 2019 national per-visit rates (aka LUPA rates), CMS first started with the final 2018 national per-visit rates. CMS then applied a wage index budget neutrality factor of 0.9996 to ensure budget neutrality for LUPA per-visit payments and next increased each of the six per-visit rates by the proposed and mandated market basket update of 2.2 percent, for HHAs that submit the required quality data.

CMS calculated the wage index budget neutrality factor by estimating total payments for LUPA episodes using the 2019 wage index and comparing it to simulated total payments for LUPA episodes with the 2018 wage index. CMS notes that the LUPA per-visit payments are not calculated using case-mix weights and, therefore, there is no case-mix standardization factor needed to ensure budget neutrality in LUPA payments. The final CY 2019 national per-visit rates are shown in Table 2.

Table 2: Final CY 2019 National Per-Visit / LUPA Rates

Disciplines	Current CY 2018 Per-Visit LUPA Rates	Wage Index Budget Neutrality Factor (Multiply)	Final CY 2019 Market Basket Update (Multiply)	Final CY 2019 Per-Visit LUPA Rates
Home Health Aide	$64.94	X 0.9996	1.022	$66.34
Skilled Nursing	$143.40	X 0.9996	1.022	$146.50
Physical Therapy	$156.76	X 0.9996	1.022	$160.14
Occupational Therapy	$157.83	X 0.9996	1.022	$161.24
Speech Therapy	$170.38	X 0.9996	1.022	$174.06
Medical Social Services	$229.86	X 0.9996	1.022	$234.82

To calculate the actual final payment, the above referenced national LUPA rates still need to be adjusted by the wage index factor based on the site of service of the beneficiary.

For HHAs that did **not** submit the required amount of OASIS assessment data (90 percent in CY 2019) for episodes beginning on or after July 1, 2017 and before July 1, 2018, Medicare would reduce their market basket update by 2 percent, resulting in an overall 0.2 percent market basket update.

No Changes to LUPA Add-on Factor Update

The final 2019 rule maintains the changes CMS made to the LUPA "add-on factor" in the 2014 final rule. This "add-on factor" applies to LUPA episodes that are the only episode or an initial episode in a sequence of adjacent

episodes (before adjusting for area wage differences). The three LUPA add-on factors are as follows: 1.8451 for Skilled Nursing (SN); 1.6700 for Physical Therapy (PT); and 1.6266 for Speech Language Pathology (SLP). These add-on factors are multiplied by the per-visit amount for each discipline as shown in the table above. For example, with LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit will be $270.31 (1.8451 multiplied by $146.50).

2019 NRS Calculation

CMS's final rule separates payments for NRS from the HHPPS base rate for episodes where supplies are provided to patients meeting certain characteristics.

To determine the 2019 NRS conversion factor, CMS starts with the 2018 NRS conversion factor ($53.03) and applies the final market-basket update percentage of 2.2 percent. CMS does not apply a standardization factor, given that the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The final NRS conversion factor for CY 2019 is shown in Table 3.

Table 3: Final 2019 NRS Conversion Factor

2018 NRS Conversion Factor	Final 2019 Market Basket Update (multiply)	Final 2019 NRS Conversion Factor
$53.03	X 1.022	$54.20

CMS's NRS case-mix system will continue using six severity group weightings with the low range (Severity 1) paying just $14.62 per episode and the high range (Severity 6) paying $570.48 per episode. These amounts are not subject to any further adjustment through application of the area wage index.

For HHAs that did not submit the required amount of OASIS assessment data for episodes beginning on or after July 1, 2017 and before July 1, 2018, Medicare would reduce the market basket update by 2 percent, resulting in an overall 0.2 percent market basket update in the calculation of the proposed 2019 NRS conversion factor.

Table 4 shows CMS's final 2019 Medical Supply Weights and the payment amounts for each of the six severity groups. Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor.

Table 4: Final 2019 NRS Weights

Severity Level	Points	Relative Weights	Payment
1	0	0.2698	$14.62
2	1 to 14	0.9742	$52.80
3	15 to 27	2.6712	$144.78
4	28 to 48	3.9686	$215.10
5	49 to 98	6.1198	$331.69
6	99+	10.5254	$570.48

Outlier Methodology and Finalized Update to the Fixed Dollar Loss (FDL) Ratio

CMS has finalized an important update to the outlier methodology for CY 2019.

In its CY 2017 final rule, CMS finalized significant but budget-neutral changes to its outlier methodology while maintaining that the total outlier fund will remain at 2.5 percent of the total home health services estimated expenditures. This total allowance is 2.5 percent of all HHPPS revenues (nationally). CMS's 2017 final rule also continued to impose a per-provider outlier cap of no more than 10 percent of total Medicare revenues.

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). Historically, CMS has used a value of 0.80 for the loss-sharing ratio which, CMS believes, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount.

A higher FDL ratio reduces the number of episodes that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio, and therefore, increases outlier payments for qualifying outlier episodes. Alternatively, a lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.

Simulating payments using preliminary CY 2017 claims data (as of June 30, 2018) and the CY 2018 HHPPS payment rates, CMS estimates that outlier payments in CY 2018 would comprise 2.30 percent of total payments. Based on simulations using CY 2017 claims data (as of June 30, 2018) and the final CY 2019 payment rates, CMS estimates that outlier payments would constitute approximately 2.32 percent of total HHPPS payments in CY 2019. CMS's simulations show that the FDL ratio would need to be changed from 0.55 to 0.51 to pay up to, but no more than, 2.5 percent of total payments as outlier payments in CY 2019.

Given the statutory requirement of a 2.5 percent limit, **CMS has finalized its proposal to lower the FDL ratio for CY 2019 from 0.55 to 0.51**. However, CMS notes that it is not making a change to the loss sharing ratio (0.80) for the sake of remaining consistent with payment of high-cost outliers in other Medicare payment systems (for example, IRF PPS, IPPS, etc.).

Also in the 2017 final rule, CMS reiterated that analysis of CY 2015 home health claims data found significant variation in the visit length by discipline for outlier episodes. Those agencies that had 10 percent of their total payments as outlier payments were providing shorter but more frequent skilled nursing visits than agencies with less than 10 percent of their total payments as outlier payments. Further analysis showed that the average number of skilled nursing visits per outlier episode (nationally) was significantly higher than the number of visits for the five other disciplines of care combined and, therefore, outlier payments were being predominately driven by the provision of skilled nursing services.

As a result of its analysis, CMS was concerned that the previous methodology for calculating outlier payments may have been creating a financial disincentive for providers to treat medically complex beneficiaries who require longer visits.

Therefore, CMS finalized in CY 2017 a change to the outlier methodology, using a cost-per-unit approach rather than a cost-per-visit approach. Under this approach, CMS now converts the national per-visit rates (See LUPA Rates on page 12) into per-15-minute unit rates. The new per-unit rates by discipline are then used, along with the visit length data by discipline reported on the home health claim in 15 minute increments (15 minutes = 1 unit), to

calculate the estimated cost of an episode to determine whether the claim will receive an outlier payment and the amount of payment for an episode of care.

CMS believes this change to the outlier methodology will result in more accurate outlier payments where the calculated cost per episode accounts for not only the number of visits during an episode of care, but also the length of the visits performed. This, in turn, may address some of the findings from CMS's home health study, where margins were lower for patients with medically complex needs that typically require longer visits, thus potentially creating an incentive to treat less complex patients.

CMS also implemented a cap on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier calculation purposes. Specifically, CMS now limits the amount of time per day (summed across the six disciplines of care) to 8 hours or 32 units per day when estimating the cost of an episode for outlier calculation purposes. CMS noted that this change is consistent with the definition of "part-time" or "intermittent" which limits the amount of skilled nursing and home health aide services combined to less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week).

In the CY 2017 final rule CMS stated that it did not propose to change the reporting of visits or visit length; the requirement to report visit length in 15-minute units is a statutory requirement that has been in place since the start of HHPPS in 2000. CMS encourages providers to continue to bill visits and visit length according to previous guidance.

Final 2019 Wage Index

In 2015, CMS finalized significant changes to the home health wage index. Specifically, CMS implemented a one-year blend of: 1) the wage indexes of the previously used Core Based Statistical Area (CBSA) designations; and 2) the new CBSAs designated by the Office of Management and Budget (OMB) in 2013. This one-year transition period expired at the end of CY 2015.

The HHPPS wage index for CY 2019 will continue to be fully based on the revised OMB delineations, as adopted in CY 2015 and then fully implemented in CY 2016.

However, effective for CY 2019, CMS has finalized its proposal to revise the labor-related share to reflect the 2016-based home health market basket compensation (Wages and Salaries plus Benefits) cost weight. (The current labor-related share is based on the compensation cost weight of the 2010-based home health market basket.) As a result, the final CY 2019 labor-related share will be **76.1 percent** and the non-labor-related share will be **23.9 percent**. (The current labor-related share is 78.5 percent and the non-labor-related share is 21.5 percent.)

Summary of Wage Index Changes

The revised OMB CBSA designations (using the 2013-14 pre-floor and pre-reclassification hospital wage index data) has resulted in significant changes for many HHAs in New York compared with their current 2018 wage index. What follows is a summary of these changes.

- There are 15 CBSA wage index designations for HHAs in New York. Eight CBSAs will see decreases in their final 2019 wage index. They include: Albany-Schenectady-Troy; Binghamton; Buffalo-Cheektowaga-

Niagara Falls; Ithaca; Kingston; New York City (NYC)-New Jersey-White Plains; Rochester; and the Utica-Rome designations.

- HCA is particularly disappointed that the Ithaca and Rochester area designations will see a -2.64 percent and -4.68 percent decrease while the Albany-Schenectady-Troy designation will see a -0.65 decrease and the NYC designation will see a -0.29 decrease in CY 2019. Both Albany and the NYC area designations have had repeated decreases over the past four to five years.

- Six CBSAs will see increases in their final 2019 wage index. They include: Dutchess-Putnam counties; Elmira; Glen Falls; Nassau-Suffolk; Syracuse; and Watertown-Fort Drum.

- The CY 2019 wage index for the 24 counties in New York's rural designation will remain the same.

Appendix C, attached to this Memorandum, includes a detailed New York State-specific summary of each current 2018 wage index, the final CY 2019 wage index, and the percentage difference between the two.

Updates to Value Based Purchasing Pilot Program

Beginning January 1, 2016, CMS implemented the home health Value Based Purchasing (VBP) pilot program in nine randomly selected states. The states are: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee. New York was not selected for participation in the pilot program and it appears that CMS will not be adding any new states to this pilot program, which ends in 2022.

The specific goals of the CMS's VBP model are to: (1) Provide incentives for better quality care with greater efficiency; (2) study new potential quality and efficiency measures for appropriateness in the home health setting; and (3) enhance the current public reporting process.

As part of its CY 2019 rule, CMS finalized the following proposed changes to the HHVBP program beginning in CY 2021 or Performance Year (PY) 4:

- Removes two OASIS-based measures (Influenza Immunization Received for Current Flu Season and Pneumococcal Polysaccharide Vaccine Ever Received) from the set of applicable measures;

- Replaces three OASIS-based measures (Improvement in Ambulation-Locomotion, Improvement in Bed Transferring, and Improvement in Bathing) with two composite measures on total normalized composite change in self-care and mobility; and

- Changes how CMS calculates the Total Performance Scores by changing the weighting methodology for the OASIS-based, claims-based, and HHCAHPS measures; and

- Changes the scoring methodology by reducing the maximum amount of improvement points an HHA could earn, from 10 points to 9 points, for PY 4 and subsequent performance years for all measures except for the Total Normalized Composite Change in Self-Care and Total Normalized Composite in Mobility measures, for which the maximum improvement points will 13.5.

Finalized Change Regarding Remote Patient Monitoring under the Medicare Home Health Benefit

Section 4012 of the federal 21st Century Cures Act directed CMS to provide information on the current use of and/or barriers to telehealth services. This directive, along with advancements in technology, prompted CMS to examine ways in which HHAs can integrate telehealth and/or remote patient monitoring into the care planning process. Telehealth services, under section 1834(m)(4) of the Act, include services such as professional consultations, office visits, pharmacologic management, and office psychiatry services furnished via a telecommunications system by a distant site physician or practitioner to a patient located at a designated "originating site."

For patients receiving care under the Medicare home health benefit, section 1895(e)(1)(A) of the Act prohibits payment for services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care certified by a physician. However, the statute does not define the term "telecommunications system" as it relates to the provision of home health care and CMS explicitly notes that an HHA is not prevented from providing services via a telecommunications system, assuming the service is not considered a home health visit for purposes of eligibility or payment.

Remote patient monitoring (which uses "digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations" is not considered a Medicare telehealth service as defined under current regulations in Section 1834(m) of the Act.

For example, remote patient monitoring allows the patient to collect and transmit his or her own clinical data, such as weight, blood pressure, and heart rate for monitoring and analysis. The clinical data is monitored without a direct interaction between the practitioner and beneficiary, and then reviewed by the HHA for potential consultation with the certifying physician for changes in the plan of care. Additionally, because remote patient monitoring is not statutorily considered a telehealth service, it would not be subject to the restrictions on originating site and interactive telecommunications systems technology. CMS believes remote patient monitoring could be beneficial in augmenting the home health services outlined in the patient's plan of care, without replicating or replacing home health visits.

In the rule, CMS has finalized its proposal to define remote patient monitoring under the Medicare home health benefit as "the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and transmitted by the patient or caregiver or both to the home health agency." CMS is adding this language to the regulations to ensure a more complete description of remote patient monitoring services, while also ensuring that such services cannot be reported as a visit without the provision of another skilled service. Thus, visits to a beneficiary's home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment are **not** separately billable without the provision of another skilled service. These services can be included in the expense of providing remote patient monitoring allowed as administrative costs. Additionally, CMS has finalized its proposal to amend the regulations at 42 CFR 409.46 to include the costs of remote patient monitoring as an allowable administrative cost (that is, operating expense), if remote patient monitoring is used by the HHA to augment the care planning process.

Home Health Quality Reporting Program (HHQRP) Update

OASIS Submission and Pay for Reporting

CMS's final rule will continue to reduce home health payment rates for HHAs that did not report OASIS quality data for episodes beginning on or after July 1, 2017 and before July 1, 2018. However, HHAs that became

Medicare certified on or after May 31 of the preceding year are not subject to the OASIS quality reporting requirement nor are they subject to any payment penalty for quality reporting purposes for the following year. For example, HHAs certified on or after May 31, 2018 are not subject to the 2 percentage point reduction to their market basket update for CY 2019. These exclusions only affect quality reporting requirements and payment reductions, and do not affect the HHA's reporting responsibilities.

CMS includes OASIS data and Home Healthcare Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS) data as part of the quality data submission mandate. If an HHA fails to submit the required OASIS and HHCAHPS data, payment rates are currently reduced 2 percent for an entire year.

However, in the CY 2015 final rule CMS set more specific requirements regarding the quantity of OASIS assessments:

- For episodes beginning on or after July 1, 2015 and before June 30, 2016, HHAs must successfully submit at least 70 percent of OASIS assessments or be subject to a 2 percentage point reduction to their market basket update for 2017;

- For episodes beginning on or after July 1, 2016 and before June 30, 2017, HHAs must successfully submit at least 80 percent of OASIS assessments or be subject to a 2 percentage point reduction to their market basket update for 2018; and

- **For episodes beginning on or after July 1, 2017 and before June 30, 2018, HHAs must successfully submit at least 90 percent of OASIS assessments or be subject to a 2 percentage point reduction to their market basket update for 2019**;

Successful submission of an OASIS assessment consists of the submission of the data into the Assessment Submission and Processing (ASAP) system with a receipt of no fatal error messages.

Error messages received during submission can be an indication of a problem that occurred during the submission process and could also be an indication that the OASIS assessment was rejected. Successful submission can be verified by ascertaining that the submitted assessment data resides in the national database after the assessment has met all of the quality standards for completeness and accuracy during the submission process. Should one or more OASIS assessments submitted by an HHA be rejected due to an IT/server issue caused by CMS, CMS may, at its discretion, excuse the non-submission of OASIS data. However, CMS states that such a scenario would rarely, if ever, occur. In the event that an HHA believes it was unable to submit OASIS assessments due to an IT/server issue on the part of CMS, the HHA should be prepared to provide any documentation or proof to demonstrate that no fault on its part contributed to the failure of the OASIS records to transmit to CMS.

Accounting for Social Risk Factors in the HHQRP Program

In the CY 2018 HHPPS final rule CMS discussed the importance of improving beneficiary outcomes, including reducing health disparities. CMS also discussed its commitment to ensuring that medically complex patients, as well as those with social risk factors, receive excellent care. CMS discussed how studies show that social risk factors, such as being near or below the poverty level, belonging to a racial or ethnic minority group, or living with a disability, can be associated with poor health outcomes and how some of this disparity is related to the quality of health care.

Within this context, reports by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine have examined the influence of social risk factors in CMS's VBP program. As CMS noted in the CY 2018 HHPPS final rule, ASPE's report to Congress, which was required by the IMPACT Act, found that dual eligibility was the most powerful predictor of poor health care outcomes among those social risk factors that it examined and tested. ASPE is continuing to examine this issue in its second report required by the IMPACT Act, which is due to Congress in the fall of 2019.

In the CY 2019 final rule, CMS states as a next step, that it is considering options to address health disparities among patient groups within and across hospitals by increasing the transparency of identified disparities as shown by quality measures. CMS is also considering how this work applies to other CMS quality programs in the future.

Removal Factors for Previously Adopted HHQRP Measures

In the CY 2017 HHPPS final rule, CMS adopted a process for retaining, removing, and replacing previously adopted HHQRP measures. To be consistent with other established quality reporting programs, CMS has finalized its proposal to replace the six criteria used when considering a quality measure for removal, as finalized in the CY 2017 HHPPS final rule, with the following seven measure-removal factors:

- Factor 1. Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

- Factor 2. Performance or improvement on a measure does not result in better patient outcomes.

- Factor 3. A measure does not align with current clinical guidelines or practice.

- Factor 4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.

- Factor 5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available.

- Factor 6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available.

- Factor 7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

CMS believes these measure removal factors are substantively consistent with the criteria CMS previously adopted (only CMS is changing the terminology to call them "factors") and appropriate for use in the HHQRP. However, even if one or more of the measure removal factors applies, CMS might nonetheless choose to retain the measure for certain specified reasons. Examples of such instances could include when a particular measure addresses a gap in quality that is so significant that removing the measure could result in poor quality, or in the event that a given measure is statutorily required. CMS can apply these factors on a case-by-case basis.

In the rule, CMS has also finalized its proposal to adopt an additional factor to consider when evaluating potential measures for removal from the HHQRP measure set:

- Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program.

Removal of HHQRP Measures Beginning with the CY 2021 HHQRP

To address the Meaningful Measures Initiative discussed in the CY 2019 proposed rule, CMS has finalized its proposal to remove the following **seven** measures from the HHQRP beginning with the CY 2021 HHQRP:

- Depression Assessment Conducted Measure-OASIS Item M1730 Depression Screening at Start of Care (SOC)/Resumption of Care (ROC);

- Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care Measure-OASIS Item M2401, Intervention Synopsis: Diabetic foot care at the time point of Transfer to an Inpatient Facility (TOC) and Discharge from Agency;

- Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate (NQF #0537) Measure-OASIS Item M1910: Falls Risk Assessment at SOC/ROC;

- Pneumococcal Polysaccharide Vaccine Ever Received Measure-OASIS Items M1051, Pneumococcal Vaccine and M1056, Reason Pneumococcal Vaccine not received at the time point of TOC and Discharge;

- Improvement in the Status of Surgical Wounds Measure-OASIS Items M1340, Does this patient have a Surgical Wound? and M1342, Status of Most Problematic Surgical Wound that is Observable, at the time points of SOC/ROC and Discharge;

- Emergency Department Use without Hospital Readmission during the First 30 Days of Home Health (NQF #2505) Measure; and

- Rehospitalization during the First 30 Days of Home Health (NQF #2380) Measure.

IMPACT Act Implementation Update

In the CY 2018 HHPPS final rule, CMS stated that it intends to specify two measures that would satisfy the domain of accurately communicating the existence and provision of the transfer of health information and care preferences under Section 1899B(c)(1)(E) of the IMPACT Act no later than January 1, 2019 and intends to adopt them for the CY 2021 HHQRP, with data collection beginning on or about January 1, 2020.

CMS now intends to specify the measures no later than January 1, 2020 and adopt the measures beginning in the CY 2022 HHQRP, with data collection at start of care (SOC), resumption of care (ROC) and Discharge beginning **January 1, 2021**.

HCA members can find additional information on CMS's pilot testing of this change at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-ActDownloads-and-Videos.html.

Form, Manner, and Timing of OASIS Data Submission

CMS's home health regulations, codified at Section 484.250(a) of the CoPs, require HHAs to submit OASIS assessments and HHCAHPS data to meet the quality reporting requirements of Section 1895(b)(3)(B)(v) of the Act. In the rule, CMS has finalized its proposal to revise Section 484.250(a) to clarify that not all OASIS data described in Section 484.55(b) and (d) are needed for purposes of complying with the requirements of HHQRP. OASIS data items may be submitted for other established purposes unrelated to the HHQRP, including payment, survey, the HHVBP Model, or care planning. Any OASIS data that are not submitted for the purposes of the HHQRP are not used for purposes of HHQRP compliance.

HHCAHPS

CMS's final rule maintains its existing policy of including the HHCAHPS home health survey as part of the 2019 annual payment update, with no changes.

All Medicare-certified HHAs must continue to provide their survey vendor with information about their survey-eligible patients every month in accordance with existing guidelines, and HHCAHPS survey data must be submitted and analyzed quarterly. CMS encourages HHAs to monitor their respective HHCAHPS vendors to assure they are submitting HHCAHPS data on time using the HHCAHPS Data Submission Reports.

The final rule also maintains the current guideline that all approved HHCAHPS survey vendors fully comply with all HHCAHPS oversight activities, and CMS plans to include this survey requirement in Section 484.250(c) of the CoPs.

HHCAHPS survey vendors are required to attend introductory trainings and all update trainings conducted by CMS and the HHCAHPS Survey Coordination Team, as well as pass a post-training certification test. There are still approximately 30 approved HHCAHPS survey vendors, listed at https://homehealthcahps.org.

HHAs and their vendors must still target at least 300 completed HHCAHPS surveys annually. Smaller agencies unable to reach the 300-survey threshold by sampling are expected to survey all HHCAHPS-eligible patients. HHAs with 59 or fewer Medicare and HHCAHPS-eligible patients between April 1, 2016 through March 31, 2017, can continue to file an annual application to become exempt from participation for CY 2019.

The following HHCAHPS reported measures will be continued for 2019:

- Patient care (Questions 9, 16, 19, 24);
- Communication between providers and patients (Questions 2, 15, 17, 18, 22, 23); and
- Specific care issues on medications, home safety and pain (Questions 3, 4, 5, 10, 12, 13, 14).

The two global ratings continue to be the overall rating of care and the patient's willingness to recommend the HHA to family and friends.

The HHCAHPS data collection period for 2019 will include the second quarter of 2017 through the first quarter of 2018. The HHCAHPS data collection period for the 2020 HHPPS will include the second quarter of 2018 through the first quarter of 2019.

CMS's rule exempts HHAs receiving Medicare certification on or after April 1, 2018 from the full HHCAHPS reporting requirement for 2019 because these HHAs were not Medicare-certified in the applicable data-collection period of April 1, 2017 through March 31, 2018. These HHAs would not need to complete a HHCAHPS Participation Exemption Request form for the CY 2018 Annual Payment Update (APU).

The HHCAHPS survey is currently available in English, Spanish, Chinese, Russian, and Vietnamese and CMS will continue to consider additional language translations.

New Home Infusion Therapy Services Temporary Transitional Payment and Home Infusion Therapy Benefit

Section 5012 of the 21st Century Cures Act creates a new separate Medicare benefit category for coverage of home infusion therapy services, including associated professional services for administering certain drugs and biologicals through a durable medical infusion pump, training and education, and remote monitoring and monitoring services, effective **January 1, 2021**.

This benefit would ensure consistency in coverage for home infusion benefits for all Medicare beneficiaries. Section 1861(iii) of the Act, as added by the Cures Act, sets forth elements for home infusion therapy suppliers in the following three areas: (1) ensuring that all patients have a plan of care established and updated by a physician that sets out the care and prescribed infusion therapy necessary to meet the patient-specific needs; (2) having procedures to ensure that remote monitoring services associated with administering infusion drugs in a patient's home are provided; and (3) having procedures to ensure that patients receive education and training on the effective use of medications and equipment in the home.

CMS has finalized its proposal to implement the following requirements for home infusion therapy suppliers:

- Ensure that all patients must have a plan of care established by a physician that prescribes the type, amount and duration of infusion therapy services furnished. The plan of care would specify the care and services necessary to meet the patient specific needs.

- Ensure that the plan of care for each patient is periodically reviewed by the physician.

- Ensure that patients have infusion therapy support services at all times through the provision of professional services, including nursing services, furnished in accordance with the plan of care on a 7-day-a-week, 24-hour-a-day schedule.

- Provide patient training and education.

- Provide remote monitoring and monitoring services for the provision of home infusion therapy and home infusion drugs.

Current regulations already require all home infusion therapy suppliers to be accredited to meet requirements established by private insurers and Medicare Advantage plans and CMS proposes to continue this requirement under its fee-for-service Medicare program.

For CYs 2019 and 2020, as required by Section 50401 of the BBA of 2018, CMS proposes the implementation of the temporary transitional payment for home infusion therapy services that would begin on January 1, 2019 and end the day before the full implementation of the new home infusion therapy benefit on January 1, 2021.

CMS is estimating that the net impact of this transitional payment will be approximately $60 million in increased Medicare payments to home infusion suppliers in CY 2019. This increase reflects the cost of providing infusion therapy services to existing DME home infusion therapy beneficiaries (at a 4-hour rate), as the temporary transitional payment applies only to **existing** Medicare qualified home infusion suppliers. DME suppliers enrolled as pharmacies that provide external infusion pumps and supplies are considered eligible home infusion suppliers, as are potential pharmacy suppliers that enroll and comply with the Medicare program's supplier standards and quality standards to become accredited for furnishing external infusion pumps and supplies.

HCA's Initial Analysis of the CY 2019 Final Rule

CMS's final rule specifically for CY 2019 includes both positive and negative changes. The overall 2.2 percent payment increase is helpful but can be offset if your agency is located in one of the eight NYS CBSAs that will see a decrease to the wage index in CY 2019.

The nominal physician certification process change is helpful but does not go far enough in that the home health agency's record **may** be used as supporting material to attest eligibility for home health services in cases where the physician's record may be insufficient to determine eligibility.

The elimination of the re-certification requirement to estimate how much longer home health services will be required is helpful to certifying physicians but also does not go far enough.

CMS's decision to making remote patient monitoring an allowable cost under the Medicare Home Health Benefit is helpful but, again, it does not go far enough, where actual direct reimbursement for such services is still not possible.

While the extension of the rural add-on is helpful in CY 2019, the three new rural category designations will lower the 3 percent add-on in subsequent years.

Lastly, the removal of seven HHQRP Measures beginning with the CY 2021 HHQRP is also helpful and will save HHAs across the nation an estimated $60 million annual.

However, CMS's decision to finalize PDGM and significantly change the case-mix methodology as well as the overall HHPPS payment methodology for **CY 2020** warrants ongoing review, analysis and advocacy by the entire home health industry, including the state and national home care associations and providers themselves.

As mentioned earlier in the memo, the new PDGM model still includes the risk of a significant "behavioral adjustment" based solely on assumptions of behavioral changes that home health agencies might undertake in the future. CMS originally proposed a 6.42 percent reduction in base payment rates for this purpose but the final rule does not offer the 2020 actual rates, and instead notes that such an adjustment is required for the first year of PDGM. The cut, as originally proposed at 6.42 percent, was based on assumptions of "behavioral changes" by home health agencies that have no basis in data or methodological forecasting by CMS.

Such a cut may have dire circumstances for many agencies, including those who are forecasted to have a net benefit over the full course of PDGM, even if CMS fulfills its assurance of budget-neutrality with restorations in the later years of PDGM implementation. HCA will need your support on legislation in the House and Senate to remove this

behavioral adjustment assumption and make other refinements to PDGM. Please stay tuned for further details and resources for your advocacy.

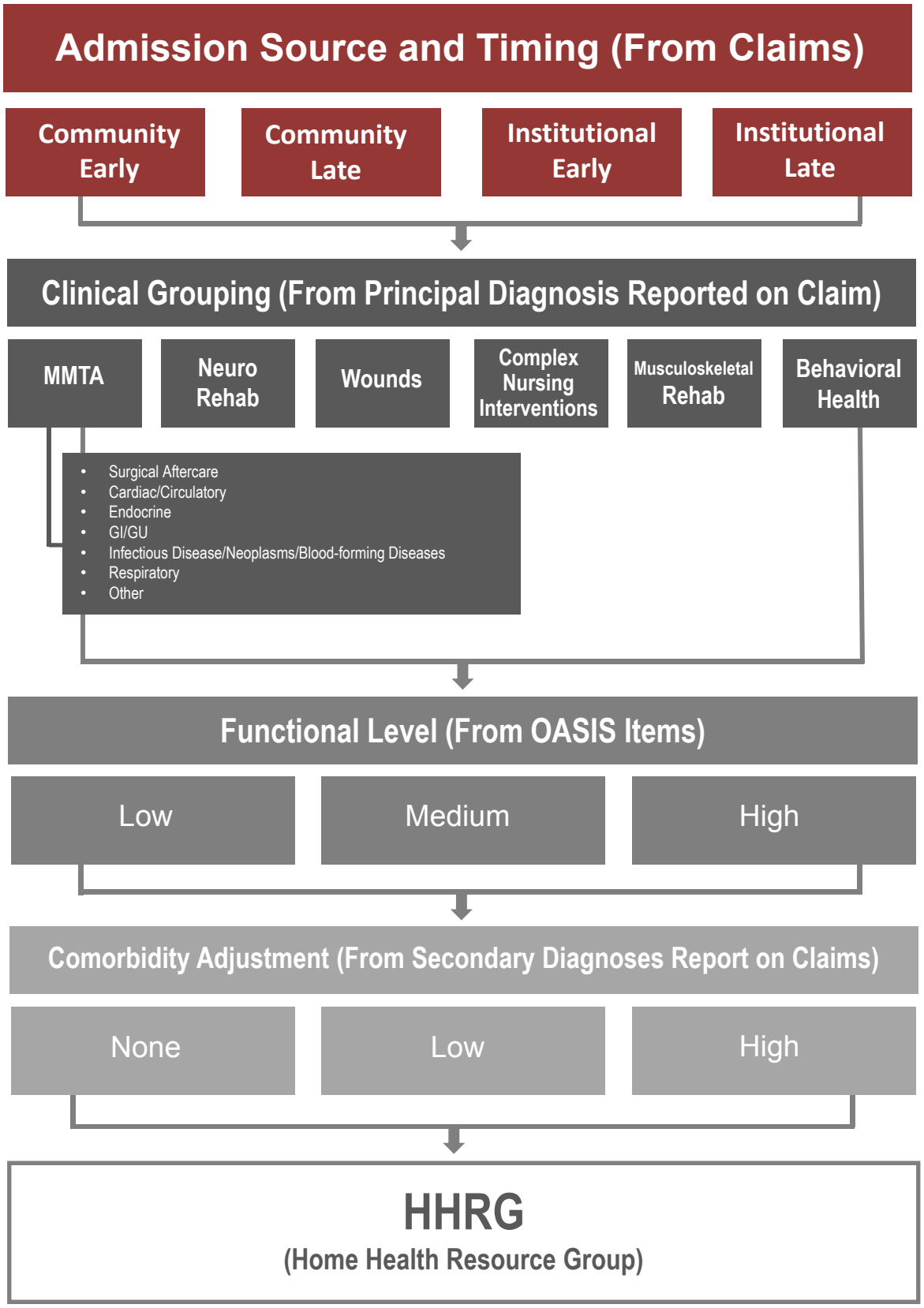
November 20 Statewide Call

To provide you with further insights on the rule's implications for you in 2019 and 2020, and to answer your questions, HCA is holding a statewide, members-only call on the final CY 2019 HHPPS payment rule on Tuesday, **November 20 from 10 to 11 a.m**.

Please register in advance and HCA will send you dial-in information before November 20. To register, complete the form at https://www.surveymonkey.com/r/2019HHPPS.

For further information on CMS's final 2019 HHPPS notice, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.

Appendix A



Under the Patient Driven Groupings Model, a 30-day period is grouped into one (and only one) subcategory under each larger colored category. A 30-day period's combination of subcategories places the 30-day period into one of 432 different payment groups.

Appendix B: Final CY 2019 Case-Mix Payment Weight

Paygroup	Description		Normalized Weight for Final Rule for CY2019
10111	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C1F1S1	0.5468
10112	**1st and 2nd Episodes, 6 Therapy Visits**	C1F1S2	0.6791
10113	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C1F1S3	0.8115
10114	**1st and 2nd Episodes, 10 Therapy Visits**	C1F1S4	0.9438
10115	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C1F1S5	1.0761
21111	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C1F1S1	1.2085
21112	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C1F1S2	1.3526
21113	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C1F1S3	1.4968
10121	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C1F2S1	0.6473
10122	**1st and 2nd Episodes, 6 Therapy Visits**	C1F2S2	0.7651
10123	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C1F2S3	0.8829
10124	**1st and 2nd Episodes, 10 Therapy Visits**	C1F2S4	1.0007
10125	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C1F2S5	1.1185
21121	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C1F2S1	1.2363
21122	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C1F2S2	1.3858
21123	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C1F2S3	1.5352
10131	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C1F3S1	0.6885
10132	**1st and 2nd Episodes, 6 Therapy Visits**	C1F3S2	0.8013
10133	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C1F3S3	0.9140
10134	**1st and 2nd Episodes, 10 Therapy Visits**	C1F3S4	1.0268
10135	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C1F3S5	1.1396
21131	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C1F3S1	1.2523
21132	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C1F3S2	1.3992
21133	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C1F3S3	1.5460
10211	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C2F1S1	0.5769
10212	**1st and 2nd Episodes, 6 Therapy Visits**	C2F1S2	0.7176
10213	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C2F1S3	0.8584
10214	**1st and 2nd Episodes, 10 Therapy Visits**	C2F1S4	0.9991
10215	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C2F1S5	1.1398
21211	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C2F1S1	1.2806
21212	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C2F1S2	1.4321
21213	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C2F1S3	1.5836
10221	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C2F2S1	0.6773
10222	**1st and 2nd Episodes, 6 Therapy Visits**	C2F2S2	0.8035
10223	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C2F2S3	0.9298
10224	**1st and 2nd Episodes, 10 Therapy Visits**	C2F2S4	1.0560
10225	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C2F2S5	1.1822
21221	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C2F2S1	1.3084
21222	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C2F2S2	1.4653
21223	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C2F2S3	1.6221
10231	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C2F3S1	0.7186
10232	**1st and 2nd Episodes, 6 Therapy Visits**	C2F3S2	0.8397
10233	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C2F3S3	0.9609
10234	**1st and 2nd Episodes, 10 Therapy Visits**	C2F3S4	1.0821

10235	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C2F3S5	1.2033
21231	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C2F3S1	1.3244
21232	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C2F3S2	1.4787
21233	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C2F3S3	1.6329
10311	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C3F1S1	0.6294
10312	**1st and 2nd Episodes, 6 Therapy Visits**	C3F1S2	0.7799
10313	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C3F1S3	0.9304
10314	**1st and 2nd Episodes, 10 Therapy Visits**	C3F1S4	1.0809
10315	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C3F1S5	1.2314
21311	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C3F1S1	1.3819
21312	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C3F1S2	1.5782
21313	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C3F1S3	1.7746
10321	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C3F2S1	0.7298
10322	**1st and 2nd Episodes, 6 Therapy Visits**	C3F2S2	0.8658
10323	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C3F2S3	1.0018
10324	**1st and 2nd Episodes, 10 Therapy Visits**	C3F2S4	1.1378
10325	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C3F2S5	1.2737
21321	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C3F2S1	1.4097
21322	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C3F2S2	1.6114
21323	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C3F2S3	1.8130
10331	**1st and 2nd Episodes, 0 to 5 Therapy Visits**	C3F3S1	0.7711
10332	**1st and 2nd Episodes, 6 Therapy Visits**	C3F3S2	0.9020
10333	**1st and 2nd Episodes, 7 to 9 Therapy Visits**	C3F3S3	1.0329
10334	**1st and 2nd Episodes, 10 Therapy Visits**	C3F3S4	1.1639
10335	**1st and 2nd Episodes, 11 to 13 Therapy Visits**	C3F3S5	1.2948
21331	**1st and 2nd Episodes, 14 to 15 Therapy Visits**	C3F3S1	1.4258
21332	**1st and 2nd Episodes, 16 to 17 Therapy Visits**	C3F3S2	1.6248
21333	**1st and 2nd Episodes, 18 to 19 Therapy Visits**	C3F3S3	1.8238
30111	**3rd+ Episodes, 0 to 5 Therapy Visits**	C1F1S1	0.4691
30112	**3rd+ Episodes, 6 Therapy Visits**	C1F1S2	0.6147
30113	**3rd+ Episodes, 7 to 9 Therapy Visits**	C1F1S3	0.7603
30114	**3rd+ Episodes, 10 Therapy Visits**	C1F1S4	0.9059
30115	**3rd+ Episodes, 11 to 13 Therapy Visits**	C1F1S5	1.0515
22111	**3rd+ Episodes, 14 to 15 Therapy Visits**	C1F1S1	1.1971
22112	**3rd+ Episodes, 16 to 17 Therapy Visits**	C1F1S2	1.3451
22113	**3rd+ Episodes, 18 to 19 Therapy Visits**	C1F1S3	1.4930
40111	**All Episodes, 20+ Therapy Visits**	C1F1S1	1.6409
30121	**3rd+ Episodes, 0 to 5 Therapy Visits**	C1F2S1	0.5514
30122	**3rd+ Episodes, 6 Therapy Visits**	C1F2S2	0.6936
30123	**3rd+ Episodes, 7 to 9 Therapy Visits**	C1F2S3	0.8358
30124	**3rd+ Episodes, 10 Therapy Visits**	C1F2S4	0.9780
30125	**3rd+ Episodes, 11 to 13 Therapy Visits**	C1F2S5	1.1202
22121	**3rd+ Episodes, 14 to 15 Therapy Visits**	C1F2S1	1.2624
22122	**3rd+ Episodes, 16 to 17 Therapy Visits**	C1F2S2	1.4031
22123	**3rd+ Episodes, 18 to 19 Therapy Visits**	C1F2S3	1.5439
40121	**All Episodes, 20+ Therapy Visits**	C1F2S1	1.6847
30131	**3rd+ Episodes, 0 to 5 Therapy Visits**	C1F3S1	0.5884
30132	**3rd+ Episodes, 6 Therapy Visits**	C1F3S2	0.7232
30133	**3rd+ Episodes, 7 to 9 Therapy Visits**	C1F3S3	0.8580
30134	**3rd+ Episodes, 10 Therapy Visits**	C1F3S4	0.9928

30135	**3rd+ Episodes, 11 to 13 Therapy Visits**	C1F3S5	1.1276
22131	**3rd+ Episodes, 14 to 15 Therapy Visits**	C1F3S1	1.2624
22132	**3rd+ Episodes, 16 to 17 Therapy Visits**	C1F3S2	1.4058
22133	**3rd+ Episodes, 18 to 19 Therapy Visits**	C1F3S3	1.5493
40131	**All Episodes, 20+ Therapy Visits**	C1F3S1	1.6928
30211	**3rd+ Episodes, 0 to 5 Therapy Visits**	C2F1S1	0.4930
30212	**3rd+ Episodes, 6 Therapy Visits**	C2F1S2	0.6480
30213	**3rd+ Episodes, 7 to 9 Therapy Visits**	C2F1S3	0.8030
30214	**3rd+ Episodes, 10 Therapy Visits**	C2F1S4	0.9579
30215	**3rd+ Episodes, 11 to 13 Therapy Visits**	C2F1S5	1.1129
22211	**3rd+ Episodes, 14 to 15 Therapy Visits**	C2F1S1	1.2679
22212	**3rd+ Episodes, 16 to 17 Therapy Visits**	C2F1S2	1.4236
22213	**3rd+ Episodes, 18 to 19 Therapy Visits**	C2F1S3	1.5794
40211	**All Episodes, 20+ Therapy Visits**	C2F1S1	1.7352
30221	**3rd+ Episodes, 0 to 5 Therapy Visits**	C2F2S1	0.5753
30222	**3rd+ Episodes, 6 Therapy Visits**	C2F2S2	0.7269
30223	**3rd+ Episodes, 7 to 9 Therapy Visits**	C2F2S3	0.8784
30224	**3rd+ Episodes, 10 Therapy Visits**	C2F2S4	1.0300
30225	**3rd+ Episodes, 11 to 13 Therapy Visits**	C2F2S5	1.1815
22221	**3rd+ Episodes, 14 to 15 Therapy Visits**	C2F2S1	1.3331
22222	**3rd+ Episodes, 16 to 17 Therapy Visits**	C2F2S2	1.4817
22223	**3rd+ Episodes, 18 to 19 Therapy Visits**	C2F2S3	1.6303
40221	**All Episodes, 20+ Therapy Visits**	C2F2S1	1.7790
30231	**3rd+ Episodes, 0 to 5 Therapy Visits**	C2F3S1	0.6123
30232	**3rd+ Episodes, 6 Therapy Visits**	C2F3S2	0.7565
30233	**3rd+ Episodes, 7 to 9 Therapy Visits**	C2F3S3	0.9006
30234	**3rd+ Episodes, 10 Therapy Visits**	C2F3S4	1.0448
30235	**3rd+ Episodes, 11 to 13 Therapy Visits**	C2F3S5	1.1889
22231	**3rd+ Episodes, 14 to 15 Therapy Visits**	C2F3S1	1.3331
22232	**3rd+ Episodes, 16 to 17 Therapy Visits**	C2F3S2	1.4844
22233	**3rd+ Episodes, 18 to 19 Therapy Visits**	C2F3S3	1.6357
40231	**All Episodes, 20+ Therapy Visits**	C2F3S1	1.7871
30311	**3rd+ Episodes, 0 to 5 Therapy Visits**	C3F1S1	0.5942
30312	**3rd+ Episodes, 6 Therapy Visits**	C3F1S2	0.7644
30313	**3rd+ Episodes, 7 to 9 Therapy Visits**	C3F1S3	0.9347
30314	**3rd+ Episodes, 10 Therapy Visits**	C3F1S4	1.1049
30315	**3rd+ Episodes, 11 to 13 Therapy Visits**	C3F1S5	1.2752
22311	**3rd+ Episodes, 14 to 15 Therapy Visits**	C3F1S1	1.4454
22312	**3rd+ Episodes, 16 to 17 Therapy Visits**	C3F1S2	1.6206
22313	**3rd+ Episodes, 18 to 19 Therapy Visits**	C3F1S3	1.7957
40311	**All Episodes, 20+ Therapy Visits**	C3F1S1	1.9709
30321	**3rd+ Episodes, 0 to 5 Therapy Visits**	C3F2S1	0.6765
30322	**3rd+ Episodes, 6 Therapy Visits**	C3F2S2	0.8433
30323	**3rd+ Episodes, 7 to 9 Therapy Visits**	C3F2S3	1.0102
30324	**3rd+ Episodes, 10 Therapy Visits**	C3F2S4	1.1770
30325	**3rd+ Episodes, 11 to 13 Therapy Visits**	C3F2S5	1.3438
22321	**3rd+ Episodes, 14 to 15 Therapy Visits**	C3F2S1	1.5106
22322	**3rd+ Episodes, 16 to 17 Therapy Visits**	C3F2S2	1.6787
22323	**3rd+ Episodes, 18 to 19 Therapy Visits**	C3F2S3	1.8467
40321	**All Episodes, 20+ Therapy Visits**	C3F2S1	2.0147

30331	**3rd+ Episodes, 0 to 5 Therapy Visits**	C3F3S1	0.7135
30332	**3rd+ Episodes, 6 Therapy Visits**	C3F3S2	0.8729
30333	**3rd+ Episodes, 7 to 9 Therapy Visits**	C3F3S3	1.0324
30334	**3rd+ Episodes, 10 Therapy Visits**	C3F3S4	1.1918
30335	**3rd+ Episodes, 11 to 13 Therapy Visits**	C3F3S5	1.3512
22331	**3rd+ Episodes, 14 to 15 Therapy Visits**	C3F3S1	1.5106
22332	**3rd+ Episodes, 16 to 17 Therapy Visits**	C3F3S2	1.6814
22333	**3rd+ Episodes, 18 to 19 Therapy Visits**	C3F3S3	1.8521
40331	**All Episodes, 20+ Therapy Visits**	C3F3S1	2.0228

Appendix C
Final CY 2019 Wage Index for Urban & Rural Areas

CY 2019 CBSA Code	Area	Current CY 2018 Wage Index - New CBSA Designations	Final CY 2019 Wage Index - New CBSA Designations	% Difference Final CY 2019 vs Current CY 2018 Wage Index
10580	**Albany - Schenectady- Troy**			
10580	Albany	0.8165	0.8112	**-0.65%**
10580	Rensselaer	0.8165	0.8112	**-0.65%**
10580	Saratoga	0.8165	0.8112	**-0.65%**
10580	Schenectady	0.8165	0.8112	**-0.65%**
10580	Schoharie	0.8165	0.8112	**-0.65%**
13780	**Binghamton**			
13780	Broome	0.8445	0.8359	**-1.02%**
13780	Tioga	0.8445	0.8359	**-1.02%**
15380	**Buffalo - Cheektowaga - Niagara Falls**			
15380	Erie	1.0596	1.0393	**-1.92%**
15380	Niagara	1.0596	1.0393	**-1.92%**
20524	**Dutchess - Putnam Counties**			
20524	Dutchess	1.1205	1.2263	**9.44%**
20524	Putnam	1.1205	1.2263	**9.44%**
21300	**Elmira**			
21300	Chemung	0.8502	0.8652	**1.76%**
24020	**Glen Falls**			
24020	Warren	0.8356	0.852	**1.96%**
24020	Washington	0.8356	0.852	**1.96%**
27060	**Ithaca**			
27060	Tompkins	0.9419	0.917	**-2.64%**
28740	**Kingston**			
28740	Ulster	0.8893	0.8819	**-0.83%**
35004	**Nassau - Suffolk**			
35004	Nassau	1.2781	1.2876	**0.74%**
35004	Suffolk	1.2781	1.2876	**0.74%**
35614	**NYC - Jersey City- White Plains, NY-NJ**			
35614	Bronx	1.2813	1.2776	**-0.29%**
35614	Kings	1.2813	1.2776	**-0.29%**
35614	Manhattan	1.2813	1.2776	**-0.29%**
35614	Queens	1.2813	1.2776	**-0.29%**
35614	Richmond	1.2813	1.2776	**-0.29%**
35614	Orange	1.2813	1.2776	**-0.29%**
35614	Rockland	1.2813	1.2776	**-0.29%**
35614	Westchester	1.2813	1.2776	**-0.29%**
35614	Bergen County - NJ	1.2813	1.2776	**-0.29%**
35614	Hudson County - NJ	1.2813	1.2776	**-0.29%**
35614	Middlesex County - NJ	1.2813	1.2776	**-0.29%**
35614	Monmouth County - NJ	1.2813	1.2776	**-0.29%**
35614	Ocean County - NJ	1.2813	1.2776	**-0.29%**
35614	Passaic County - NJ	1.2813	1.2776	**-0.29%**

Appendix C
Final CY 2019 Wage Index for Urban & Rural Areas

CY 2019 CBSA Code	Area	Current CY 2018 Wage Index - New CBSA Designations	Final CY 2019 Wage Index - New CBSA Designations	% Difference Final CY 2019 vs Current CY 2018 Wage Index
40380	**Rochester**			
40380	Livingston	0.8782		**#VALUE!**
40380	Monroe	0.8782	0.8579	**-2.31%**
40380	Ontario	0.8782	0.8579	**-2.31%**
40380	Orleans	0.8782	0.8579	**-2.31%**
40380	Wayne	0.8782	0.8579	**-2.31%**
40380	Yates	0.8782	0.8579	**-2.31%**
45060	**Syracuse**			
45060	Madison	1.0021	1.0053	**0.32%**
45060	Onondaga	1.0021	1.0053	**0.32%**
45060	Oswego	1.0021	1.0053	**0.32%**
46540	**Utica - Rome**			
46540	Herkimer	0.9321	0.8885	**-4.68%**
46540	Oneida	0.9321	0.8885	**-4.68%**
48060	**Watertown - Fort Drum, NY**			
48060	Jefferson	0.9055	0.9105	**0.55%**
99933	**Rural Areas (All other)**			
99933	Allegany	0.8499	0.8499	**0.00%**
99933	Cattaraugus	0.8499	0.8499	**0.00%**
99933	Cayuga	0.8499	0.8499	**0.00%**
99933	Chautauqua	0.8499	0.8499	**0.00%**
99933	Chenango	0.8499	0.8499	**0.00%**
99933	Clinton	0.8499	0.8499	**0.00%**
99933	Columbia	0.8499	0.8499	**0.00%**
99933	Cortland	0.8499	0.8499	**0.00%**
99933	Delaware	0.8499	0.8499	**0.00%**
99933	Essex	0.8499	0.8499	**0.00%**
99933	Franklin	0.8499	0.8499	**0.00%**
99933	Fulton	0.8499	0.8499	**0.00%**
99933	Genesee	0.8499	0.8499	**0.00%**
99933	Greene	0.8499	0.8499	**0.00%**
99933	Hamilton	0.8499	0.8499	**0.00%**
99933	Lewis	0.8499	0.8499	**0.00%**
99933	Montgomery	0.8499	0.8499	**0.00%**
99933	Otsego	0.8499	0.8499	**0.00%**
99933	St. Lawrence	0.8499	0.8499	**0.00%**
99933	Schuyler	0.8499	0.8499	**0.00%**
99933	Seneca	0.8499	0.8499	**0.00%**
99933	Steuben	0.8499	0.8499	**0.00%**
99933	Sullivan	0.8499	0.8499	**0.00%**
99933	Wyoming	0.8499	0.8499	**0.00%**