

Public Policy

HCA Public Policy No.6-2019



TO: HCA CHHA PROVIDER MEMBERS

FROM: PATRICK CONOLE, VICE PRESIDENT, FINANCE & MANAGEMENT

RE: CMS's CY 2020 HHPPS PROPOSED RULE – NEW CASE-MIX WEIGHTS & WAGE INDEX SUMMARY ATTACHED

DATE: JULY 19, 2019

Overview

Last week, the U.S. Centers for Medicare and Medicaid Services (CMS) posted for public inspection its calendar year (CY) 2020 proposed Home Health Prospective Payment System (HHPPS) rule for Medicare home health services.

The proposed rule can be read from the Federal Register website at: <https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14913.pdf>.

All told, taking into account the various adjustments to the base episodic rate, CMS estimates an overall **1.3 percent increase in national Medicare home health payments (or \$250 million)** in 2020.

As expected, CMS is moving forward with long-anticipated payment changes that were included in the February 2018 Bipartisan Budget Act (BBA) and finalized by CMS in its CY 2019 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 on January 1, 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). This represents the biggest change to Medicare home health payments since the inception of HHPPS 20 years ago.

While the proposed rule maintains that these changes are budget-neutral, the new model still includes a significant “behavioral adjustment” based solely on assumptions of behavioral changes that home health agencies might undertake in the future. In 2019, CMS was proposing an estimated -6.42 percent reduction in base payment rates for this purpose **but the CY 2020 proposed rule goes further with a stunning -8.01 percent downward adjustment**. This cut would apply in three parts, affecting: clinical group coding (-5.91 percent); comorbidity coding (-0.37 percent); and presumed extra visits by agencies seeking to surpass the Low Utilization Payment Adjustment (LUPA) threshold (-1.86 percent).

While these separate reductions add up to -8.14 percent, CMS explains that there are "overlap and interactions between the behavior assumptions," resulting in CMS's estimate of a cumulative -8.01 percent decrease when all of these factors are combined.

HCA and colleague associations have argued that there is no reasonable statistical justification for such cuts, which are based entirely on unforeseeable predictions. The now-deeper reductions in the newly announced 2020 proposal will only further destabilize the home health sector from the outset at a time when agencies are working to adapt to an entirely new model.

Legislative action is all the more imperative, as HCA works to further mobilize a bipartisan group of Congressional Representatives to advance S.433/H.R.2573. That bill restricts such reimbursement adjustments, allowing such changes only after behavioral changes do, indeed, occur, rather than merely anticipating or assuming prospectively that behavior will change. The bill also limits "behavioral-adjustment" rate changes (up or down) to 2 percent per year under PDGM, a major difference from what CMS is now proposing at -8.01 percent. HCA has been working doggedly to engage our provider members in advocacy on this bill and to secure co-sponsorship from New York's Congressional Delegation.

In addition, the rule includes several important policy changes, summarized in further detail later in this memo. These include: changes to the Home Health Quality Reporting Program (HHQRP); a continuation of the changes implemented last year to the home infusion therapy benefit; and a proposal for public reporting of certain performance data under the Home Health Value-Based Purchasing (HHVBP) Model, which is currently operating in nine model states (New York is not one of them).

Other important highlights of the rule include:

- A continuation of the CY 2019 HHPPS rates for home health episodes of care that begin anytime in 2019 but carry-over into CY 2020 (includes a mandated 1.5 percent market basket update).
- Major revisions to the Request for Anticipated Payment (RAP) process and the implementation of a Notice of Admission (NOA) process beginning in CY 2021.
- Another recalibration of the PDGM case-mix weights (CMWs), using the most current cost and utilization data.
- Updated Tables for the CY 2019 standardized 60-day episodic payment rate and LUPA Per-Visit rates (in cases where episodes span the calendar years between the current HHPPS and the new PDGM methodology), as well as new Tables for the CY 2020 PDGM 30-day unit payment structure.
- The proposed wage index for CY 2020, 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 continuation of the newly tiered version of the home health rural add-on.
- Changes to the fixed dollar loss (FDL) ratio used in the outlier calculation.

- The elimination of one question in the Home Health Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS).

Important note: as a reminder, all references to a 60-day episodic rate calculation in CY 2020 (as distinct from 30 days) applies to those episodes that span PDGM implementation – that is, episodes beginning in 2019 and ending in 2020, with an end date no later than **February 28, 2020**.

Overall Payment Impact At-a-Glance

Under the 2020 proposed rule, CMS projects that total Medicare payments to home health agencies in 2020 will be increased by \$250 million nationally, based on the net impact of a positive and negative adjustment. Specifically, this aggregate increase reflects the cumulative impact of the following:

- A 1.5 percent home health payment rate increase (a \$290 million increase), as required by the BBA of 2018; and
- A 0.2 percent decrease in CY 2020 payments due to the rural add-on percentages changes mandated by the BBA of 2018 (a \$40 million decrease).

Proposed Rule in Detail

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

Background

Prior iterations of the PDGM payment structure have been advanced since 2017. PDGM became formally required by Congress under Section 51001 of the BBA of 2018.

In accordance with the BBA, CMS included PDGM in last year's CY 2019 rule for implementation in CY 2020 and the proposal being advanced for the CY 2020 rule largely keeps the PDGM model intact by maintaining the following core features to be implemented on **January 1, 2020**:

- 30-day payment units
- Major revisions to the RAP process
- Behavioral assumptions by CMS
- New cost calculations under PDGM
- Timing: Early vs. Late
- Admission source categories
- Patient Clinical Groupings
- Functional Impairment Levels
- A comorbidity adjustment
- Variances in the LUPA thresholds

What follows is a summary of each of these features.

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 HHPPS, CMS says that a shorter period of care reduces the variation and improves the accuracy of the case-mix weights generated under 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.

Major RAP Payment Changes

CMS is proposing to undo and phase-out the current split-percentage payment approach involving RAPs.

Under the current practice: 1) a RAP is submitted at the beginning of the initial episode for 60 percent of the anticipated final claim payment amount; 2) the final claim is submitted at the end of the 60-day episode while the entire payment amount is paid and the initial RAP payment is recouped; and 3) all subsequent episodes of continuous home health care are paid at a 50/50 percentage payment split.

This approach is vital for agency cash flow; yet, CMS's proposed rule points to several integrity issues and scenarios where RAPs are abused.

Under CMS's proposed phase-out, existing providers would see a reduction in their RAP payments to 20 percent in 2020. **RAPs would be eliminated completely in 2021 for all providers**, and CMS is proposing that home health agencies submit a Notice of Admission within the first five days of admission to establish their "ownership" of the patient.

HCA opposes this change at a time when providers are otherwise managing a transition to PDGM and experiencing a cascade of other obstacles in the initiation of payment for services (such as the Medicare face-to-face requirement and delays in signed physician orders). CMS already has the tools to address abuses of RAP payments in post-payment review and audits, and we believe CMS should focus those tools where problems most clearly exist, rather than upsetting a cash-flow mechanism necessary for payment predictability in the initiation of services.

In last year's rule, CMS also finalized a provision that newly-enrolled home health agencies (those certified for participation in Medicare effective on or after January 1, 2019) would not receive RAP payments beginning in CY 2020. However, agencies 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.

PDGM Behavioral Assumptions by CMS

Last year, CMS finalized the three behavioral assumptions as previously described in the memorandum. In 2019, CMS was proposing an estimated -6.42 percent reduction in base payment rates for this purpose but the CY 2020 proposed rule goes further with a stunning **-8.01 percent** downward adjustment.

In the rule, CMS reiterates its plan to analyze the impact of the assumed versus the actual behavior change after the implementation of 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 2019 to determine any changes to the payment amount for CY 2021.

CMS’s HHA Center webpage (<https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html>) offers a list of diagnosis codes for providers to analyze reimbursement impacts based on the latest claims data available.

Cost Calculation

Costs during an episode/period of care will be estimated based on the concept of resource use. This concept 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 home health agency providers, while the BLS costs are aggregated industrywide.

Timing: “Early vs. Late”

Similar to the current payment system, PDGM’s 30-day periods 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 30-day 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.

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 CY 2019 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 reiterates that these groups do not reflect all the care being provided to the home health patient during a 30-day period of care, as 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 PDGM in CY 2020.

The twelve clinical groups, including the MMTA subgroupings, 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). PDGM will also use the same five OASIS items from 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 HHPPS. Thus, these final functional level assignments under PDGM are very similar to 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

Last year, CMS 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 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.

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

For LUPAs under PDGM, CMS states that the threshold will 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 the 10th percentile value of visits or two 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: Unchanged

While PDGM will 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 must still be completed within five days of the start of care and completed no less frequently than during the last five 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 home health agency and the physician responsible for the plan of care at least 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 face-to-face (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 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.

2019 Case-Mix Weights & CY 2020 Recalibrated PDGM 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 2020, CMS will recalibrate the PDGM CMWs using the same methodology finalized in the CY 2008, 2012 and 2015 final rules. CMS says the annual recalibration of the CMWs ensures that the case-mix weights reflect current home health resource use and changes in utilization patterns.

However, these recalibrated case-mix weights for CY 2020 are not applicable for those 60-day episodes of care that begin on or before **December 31, 2019** and end on or after **January 1, 2020**. In these cases, CMS is not proposing to separately recalibrate the CMWs for those 60-day episodes that span the January 1, 2020 implementation date. Instead, CMS is proposing that these 60-day episodes would be paid the national, standardized 60-day episode payment amount (See Table 1) and will be case-mix adjusted using the existing CY 2019 CMWs as listed in Appendix B.

CMS believes that this is a reasonable approach for case-mix adjusting these 60-day episodes of care that span the January 1, 2020 implementation date. For those 60-day episodes that end after January 1, 2020, but where there is a continued need for home health services, CMS is proposing that any subsequent periods of care would be paid the 30-day national, standardized payment amount (See Table 2) with the appropriate CY 2020 PDGM CMWs applied (See Appendix C).

CMS is soliciting comments on this proposal regarding payment for those 60-day episodes of care that span the implementation date of PDGM and the change to a 30-day unit of payment. HCA members that have thoughts or concerns on this matter should e-mail HCA's Patrick Conole at pconole@hcanys.org who will be submitting comments to CMS on behalf of the membership.

To generate the CY 2020 PDGM CMWs, CMS utilized a data file based on home health 30-day periods of care, as reported in CY 2018 Medicare home health claims (as of March 2019) linked to OASIS assessment data to obtain patient characteristics. CMS says these data are the most current and complete data available at this time. The claims provide visit-level data and data on whether Non-Routine Supplies (NRS) were provided during the period and the total charges of NRS. CMS determined the CMWs for each of the 432 different PDGM payment groups by regressing resource use on a series of indicator variables for each of the categories using a fixed effects model as described in great detail in the proposed rule.

Again, **Appendix C** of this memo offers a breakdown of the proposed 2020 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 2019, CMS finalized its proposal to rebase and revise the home health market basket to reflect 2016 Medicare cost report data, the latest and most complete data available on the actual structure of home health agency costs.

CMS explains how the terms “rebasings” and “revising,” while often used interchangeably, denote different activities. The term “rebasings” 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 last year’s final rule, CMS stated it was rebasing the detailed wages and salaries and benefits cost weights to reflect 2016 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) data on home health agencies.

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

CMS also finalized last year 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 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 the Affordable Care Act, or 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.

As a result, the proposed home health update percentage for CY 2020 would have been based on the estimated home health market basket update of 3.0 percent (based on IHS Global Insight Inc.’s first-quarter 2019 forecast with historical data through fourth quarter 2018) then reduced by a MFP adjustment currently estimated to be 0.4 percent for an overall market basket of 2.6 percent in CY 2020.

However, Section 53110 of the BBA of 2018 made a one-year amendment such that for home health payments for CY 2020, **the home health market basket update is required to be 1.5 percent.** The MFP adjustment is not applied to the BBA-mandated 1.5 percent payment update. However, the BBA of 2018 still requires that the home health update be decreased by 2 percentage points for those home health agencies that do not submit quality data as

required by CMS. For agencies that do not submit the required quality data for CY 2020, the home health payment update would be -0.5 percent (1.5 percent minus 2 percentage points).

Tiered Rural Add-On Continues

The BBA of 2018 amended Section 421 (a) of the Medicare Modernization Act (MMA) by extending the rural add-on for five years. In last year's final rule, CMS 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), available at: <https://www.cms.gov/Regulations-andGuidance/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 will be 1.5 percent in 2019; **0.5 percent in 2020**; and 0 percent in 2021 and 2022.
- **Low Population Density** – For rural counties and equivalent areas with a population density of six individuals or fewer per square mile of land area (also known as “frontier counties”) based on 2010 Census data, the rural add-on 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.

Based on HCA'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.

Proposed CY 2020 HHPPS Rates

CY 2020 National, Standardized 60-Day Episode Payment Rate for Episodes that Span CYs

As finalized in the CY 2019 final rule and also described in this proposed rule, the unit of home health payment will change from a 60-day episode to a 30-day period effective for those 30-day periods beginning on or after January 1, 2020. **However, the standardized 60-day payment rate will apply to case-mix adjusted episodes (that is, not LUPAs) beginning on or before December 31, 2019 and ending on or before February 28, 2020. As such, the latest date such a 60-day crossover episode could end on is February 28, 2020.**

To determine the CY 2020 national, standardized 60-day episode payment rate for those 60-day episodes that span the implementation date of PDGM, CMS applied a wage index budget neutrality factor and the home health market basket update percentage.

CMS is not proposing to update the case-mix weights for the 153-group case-mix methodology in CY 2020. Because CMS is proposing to continue the CY 2019 case-mix weights, CMS does not have to apply a case-mix weight budget neutrality factor to the CY 2020 60-day episode payment rate.

To calculate the wage index budget neutrality factor, CMS simulated total payments for non-LUPA episodes using the proposed CY 2020 wage index and compared it to the simulation of total payments for non-LUPA episodes using the CY 2019 wage index. This results in a wage index budget neutrality factor of 1.0062. CMS then applies the wage index budget neutrality factor of 1.0062 to the calculation of the CY 2019 national, standardized 60-day episode payment rate.

Next, CMS updates the 60-day payment rate by the CY 2020 home health market basket update percentage of 1.5 percent as required by the BBA of 2018. The CY 2020 national, standardized 60-day episode payment rate is calculated in Table 1 – again, this is for episodes that span the implementation of PDGM (that is, episodes beginning in 2019 and ending in 2020).

Table 1: Proposed CY 2020 60-Day HHPPS Episodic Payment Update			
CY 2019 Standardized 60-Day Episodic Payment	Wage Index Budget Neutrality Factor (Multiply)	CY 2020 Market Basket Update (Multiply)	CY 2020 Proposed National 60-Day Episode Payment
\$3,154.27	X 1.0062	X 1.015	\$3,221.43

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 home health agencies 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 the 2019 updated labor portion (76.1 percent) and 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.

Home Health Agencies that did not submit the required amount of OASIS assessments (90 percent in CY 2020) for episodes beginning on or after July 1, 2018 and before July 1, 2019 would additionally see their market basket update reduced by 2 percent, which results in an overall -0.5 percent market basket update and a final CY 2020 national 60-day episodic payment rate of **\$3,157.96**

CY 2020 National, Standardized 30-Day Payment Rate

To calculate the CY 2020 proposed budget-neutral 30-day payment amounts, both with and without behavior assumptions, CMS first calculated the total, aggregate amount of expenditures that would occur under the current case-mix adjustment methodology and the 60-day episode unit of payment using the CY 2019 payment parameters (for example, CY 2019 payment rates, case-mix weights and outlier fixed-dollar loss ratio). That resulted in a total aggregate expenditures target amount of \$16.2 billion.

CMS then calculated what the 30-day payment amount would need to be set at in CY 2020, with and without behavior assumptions, while taking into account needed changes to the outlier fixed-dollar loss ratio under the PDGM in order to pay out no more than 2.5 percent of total HHPPS payments as outlier payments (see the outlier section of this memo) and in order for Medicare to pay out \$16.2 billion in total expenditures in CY 2020 with the application of a 30-day unit of payment under PDGM.

If no behavior assumptions were made, CMS estimates that the CY 2020 30-day payment amount needed to achieve budget neutrality would be \$1,907.11. However, when CMS applies its clinical group and comorbidity coding assumptions, and the LUPA threshold assumption, this results in the need to decrease the CY 2020 estimated budget-neutral 30-day payment amount to \$1,754.37 (an 8.01 percent decrease from \$1,907.11).

To calculate the wage index budget neutrality factor, CMS simulated total payments for non-LUPA episodes using the proposed CY 2020 wage index and compared it to a simulation of total payments for non-LUPA episodes using the CY 2019 wage index. Next, CMS divided the total payments for non-LUPA episodes using the CY 2020 wage index by the total payments for non-LUPA episodes using the CY 2019 wage index. The result is a wage index budget neutrality factor of 1.0062. CMS then applies the wage index budget neutrality factor of 1.0062 to the calculation of the CY 2019 national, standardized 30-day period payment rate.

CMS notes that in past years, a case-mix budget neutrality factor was annually applied to the HHPPS base rate to account for the change between the previous year's case-mix weights and the newly recalibrated case-mix weights. Since CY 2020 is the first year of PDGM, there is no way to do a case-mix budget neutrality factor in this manner. However, in future years under PDGM, CMS will apply a case-mix budget neutrality factor with the annual payment update in order to account for the change between the previous year's PDGM case-mix weights.

Finally, CMS updates the 30-day payment rate by the CY 2020 home health market basket update of 1.5 percent as required by the BBA of 2018. The CY 2020 national, standardized 30-day period payment rate is calculated in Table 2.

CY 2019 Standardized 30-Day Episodic Payment	Wage Index Budget Neutrality Factor (Multiply)	CY 2020 Market Basket Update (Multiply)	CY 2020 Proposed National 30-Day Episode Payment
\$1,754.37	X 1.0062	X 1.015	\$1,791.73

When determining the actual final payment of a home health claim, this new 30-day payment 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 home health agencies should take to compute the case-mix and wage-adjusted 30-day episodic rate:

1. Multiply the national 30-day episodic rate by the patient's applicable new case-mix weight;
2. Divide the case-mix adjusted amount into the labor portion (76.1 percent) and 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 30-day payment rate.

Home health agencies that did not submit the required 90 percent of OASIS assessments for episodes beginning on or after July 1, 2018 and before July 1, 2019, would additionally see their market basket update reduced by 2 percent, which results in an overall -0.5 percent market basket update and a final CY 2020 national 30-day payment rate of **\$1,756.42**

Unfortunately, CMS's proposed rule did not provide a calculation table for subsequent or late 30-day payments, which are expected to be significantly lower (at a standardized rate in the \$1,200 to \$1,300 range) than the first or early 30-day payment. HCA has submitted questions to CMS and our colleagues at the National Association for Home Care (NAHC) and will update the membership as additional information becomes available, including in the form of an updated version of this memo.

Proposed 2020 National Per-Visit/LUPA Rates

To calculate the proposed CY 2020 national per-visit rates (aka LUPA rates), CMS first started with the final 2019 national per-visit rates. CMS then applied a wage index budget neutrality factor of 1.0065 to ensure budget neutrality for LUPA per-visit payments and next increased each of the six per-visit rates by the mandated market basket update of 1.5 percent, for home health agencies that submit the required quality data.

CMS calculated the wage index budget neutrality factor by estimating total payments for LUPA episodes using the 2020 wage index and comparing it to simulated total payments for LUPA episodes with the 2019 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 proposed CY 2020 national per-visit rates are calculated in Table 3.

HH Disciplines	CY 2019 LUPA Rates	Wage Index Budget Neutrality Factor (Multiply)	2020 Market Basket Update (Multiply)	Proposed CY 2020 Per Visit (LUPA) Rates
Home Health Aide	\$66.34	1.0065	1.015	\$67.77
Skilled Nursing	\$146.50	1.0065	1.015	\$149.66
Physical Therapy	\$160.14	1.0065	1.015	\$163.60
Occupational Therapy	\$161.24	1.0065	1.015	\$164.72
Speech Therapy	\$174.06	1.0065	1.015	\$177.82
Medial Social Services	\$234.82	1.0065	1.015	\$239.89

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.

These LUPA rates would also be used in applicable cases that start in 2019 but cross over into CY 2020.

For home health agencies that did not submit the required amount of OASIS assessment data (90 percent in CY 2019) for episodes beginning on or after July 1, 2018 and before July 1, 2019, CMS would reduce their market basket update by 2 percent, resulting in an overall -0.5 percent market basket update.

No Changes to LUPA Add-on Factor Update

The proposed CY 2020 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 Table 3.

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 \$276.14 (1.8451 multiplied by \$149.66).

Proposed 2020 NRS Conversion Factor (only applies to 60-day episodes)

CMS’s proposed rule continues to separate payments for NRS from the 60-day HHPPS base rate for episodes where supplies are provided to patients meeting certain characteristics in cases where episodes span the PDGM implementation date. Again, the NRS conversion factor will only apply to case-mix adjusted episodes (that is, not LUPAs) **beginning on or before December 31, 2019 and ending on or before February 28, 2020.**

To determine the 2020 NRS conversion factor, CMS starts with the 2019 NRS conversion factor (\$54.20) and applies the mandated market-basket update percentage of 1.5 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 4.

Table 4: Proposed 2020 NRS Conversion Factor		
2019 NRS Conversion Factor	Proposed 2020 Market Basket Update (multiply)	Proposed 2020 NRS Conversion Factor
\$54.20	X 1.015	\$55.01

CMS's NRS case-mix system will continue using six severity group weightings with the low range (Severity 1) paying just \$14.55 per episode and the high range (Severity 6) paying \$567.63 per episode. These amounts are not subject to any further adjustment through application of the area wage index.

For home health agencies that did not submit the required amount of OASIS assessment data for episodes beginning on or after July 1, 2018 and before July 1, 2019, CMS would reduce the market basket update by 2 percent, resulting in an overall -0.5 percent market basket update in the calculation of the proposed 2020 NRS conversion factor.

Table 5 shows CMS's proposed 2020 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 5: Proposed CY 2020 NRS Weights			
Severity Level	Points	Relative Weights	Payment
1	0	0.2698	\$14.55
2	1 to 14	0.9742	\$52.54
3	15 to 27	2.6712	\$144.06
4	28 to 48	3.9686	\$214.03
5	49 to 98	6.1198	\$330.04
6	99+	10.5254	\$567.63

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

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.

In its 2019 final rule, CMS finalized a FDL ratio of 0.51 to pay up to, but no more than, 2.5 percent of total payments as outlier payments. For CY 2020, CMS is not proposing to update the FDL ratio for those 60-day episodes that span the implementation date of PDGM; CMS will keep the FDL ratio for 60-day episodes in CY 2020 at 0.51.

However, for this CY 2020 proposed rule, simulating payments using preliminary CY 2018 claims data (as of January 2019) and the CY 2019 HHPPS payment rates, CMS estimates that outlier payments in CY 2019 would comprise 2.42 percent of total payments for those 60-day episodes that span into 2020 and are paid under the national, standardized 60-day payment rate (with an FDL of 0.51) and 2.5 percent of total payments for PDGM 30-day periods using the 30-day budget-neutral payment amount as detailed in this proposed rule (with an FDL of 0.63). Given the statutory requirement that total outlier payments not exceed 2.5 percent of the total payments estimated to be made under the HHPPS, CMS is proposing that the FDL ratio for 30-day periods of care in CY 2020 would need to be set at 0.63 for 30-day periods of care based on CMS's simulations looking at both the 60-day episodes that would span into CY 2020 and the 30-day periods.

CMS indicates that its CY 2020 final rule will update the estimates of outlier payments as a percent of total HHPPS payments using the most current and complete year of HHPPS data (CY 2018 claims data as of June 30, 2019 or later). At that time, CMS may adjust the final FDL ratio accordingly.

Proposed 2020 Wage Index

In 2015, CMS finalized significant changes to the home health wage index, transitioning from the wage indexes of the previously used Core Based Statistical Area (CBSA) designations to the new CBSAs designated in 2013 by the Office of Management and Budget (OMB).

The proposed wage index for CY 2020 will continue to be fully based on the revised OMB delineations, as adopted in CY 2015 and then fully implemented in CY 2016. Also in 2019, CMS 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 labor-related share was changed to 76.1 percent, resulting in a non-labor-related share of 23.9 percent. CMS is proposing to maintain these percentages for CY 2020.

Most importantly, CMS's proposed rule "solicits comments on the wage index used to adjust home health payments and suggestions for possible updates and improvements to the geographic adjustment of home health payments."

HCA has repeatedly taken issue with CMS's wage index due to the distorted market-area definitions that CMS uses in these calculations and the incompatibilities between hospital cost-reporting and labor mix as compared to other settings. We will use this opportunity to further press our call for reform of the wage index.

Summary of Proposed 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 home health agencies in New York compared to 2019. What follows is a summary of these changes.

- There are 15 CBSA wage index designations in New York. **Eleven** CBSAs will see decreases in their proposed 2020 wage index. They include: Binghamton; Dutchess-Putnam; Elmira; Glen Falls; Ithaca; Nassau-Suffolk; New York City (NYC)-New Jersey-White Plains; Rochester; Syracuse; Watertown-Fort Drum; and the Rural Area designations.
- HCA is particularly disappointed that the Glen Falls area designation is proposed to see a staggering -8.58 percent decrease while the Syracuse area designation is proposed to see a -2.43 percent decrease. And once again the NYC area designation is proposed to see another wage index decrease (-1.07 percent).
- Only four CBSAs in New York are proposed to see increases in their 2020 wage index. They include: Albany-Schenectady-Troy; Buffalo-Cheektowaga-Niagara Falls; Kingston; and Utica-Rome.

Appendix D, attached to this Memorandum, includes a detailed New York State-specific summary of each current 2019 wage index, the proposed CY 2020 wage index, and the percentage difference between the two.

Updates to Value Based Purchasing (VBP) Pilot Program

For 2020, CMS is proposing public reporting of performance reports stemming from the Value Based Purchasing Model that has been in effect in nine states since 2018. (New York is not one of the states.)

Under this model, all Medicare-certified agencies in the demonstration states (Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington) must participate and are subject to payment adjustments based on a total performance score (TPS) comprised of OASIS measures, completed HHCAHPS surveys, selected claims data and three new measures.

Maximum upward or downward adjustments have begun being phased-in over a five-year period. This process began with a 3 percent maximum upward-downward adjustment in 2018, gradually increasing annually and culminating in an 8 percent threshold in 2022.

In the CY 2019 rule, CMS made significant changes to the HHVBP model. These include the removal of two OASIS-based measures, replacement of three OASIS-based measures with two new proposed composite measures, a rescoring of the maximum number of improvement points, and reweighting of the measures in the applicable measures set.

CMS's plan for public reporting is not new. CMS sought input, in prior rulemaking, on the nature of any HHVBP public reporting design, including which elements to report from an agency's "Annual Total Performance Score and Payment Adjustment Report."

For 2020, CMS proposes to publicly report HHVBP performance for year 5 only. The following two points of data would be publicly reported on the CMS website: 1) the home health agency's TPS from performance year 5; and 2) the agency's corresponding performance year 5 TPS percentile ranking.

While this public reporting initiative **would not apply to New York State providers**, the framing of the data has ramifications for public perception of home care outcomes and performance generally. We will be consulting colleague associations in the demo states on their response to the public reporting initiative and closely scrutinizing CMS's analysis.

Home Health Quality Reporting Program (HHQRP) Update

As in prior years, agencies that do not submit certain Home Health Quality Reporting (HHRQP) data – including OASIS and HHCAHPS data – are subject to a 2 percent reduction.

For the CY 2022 HHQRP, CMS proposes to remove one measure: National Quality Forum (NQF) No. 0177, or “Improvement in Pain Interfering with Activity.”

CMS indicates that this measure is being removed “in an effort to mitigate any potential unintended, over-prescription of opioid medications” that may stem from this measure. CMS says it is not aware of scientific studies making this connection but is nevertheless making this decision for CY 2022 out of “an abundance of caution.”

This change would affect providers in CY 2021 as they collect OASIS items in 2021 for purposes of 2022 reporting. Home health agencies would continue to be required to submit data on this measure through CY 2020 (OASIS Item M1242, Frequency of Pain Interfering with Patient’s Activity or Movement) but would no longer be required to do for the purposes of the HHQRP beginning January 1, 2021.

For similar reasons, CMS is also proposing to remove a pain management question from all HHCAHPS surveys beginning July 1, 2020. This item, question 10, asks: “In the last 2 months of care, did you and a home health provider from this agency talk about pain?” The question is one of seven in the “Special Care Issues” composite measure.

CMS is also proposing to add two process measures for the CY 2022 HHQRP regarding the transfer of health information and care preferences to beneficiaries and families during transition from a post-acute provider to another applicable setting.

The two measures are “Transfer of Health Information to Provider/Post-Acute Care” and “Transfer of Health Information to Patient/Post-Acute Care.”

CMS points to the literature in finding that “poor” communication – such as incomplete medication information – often results in patient complications, readmissions and other adverse events that contribute to the \$25-\$45 billion in wasteful spending on failures in care coordination.

- For the first of these measures, the proposed denominator is the total number of quality episodes ending in discharge/transfer to an “admitting provider” (a short-term general hospital, intermediate care, home under care of another organized home health service organization or a hospice, a hospice in an institutional facility, a SNF, an LTCH, an IRF, an inpatient psychiatric facility, or a critical access hospital). The proposed numerator is the number of episodes indicating a current reconciled medication list was provided to the admitting provider at the time of discharge/transfer.
- For the second of these measures, the proposed denominator is the total number of quality episodes ending in discharge to a private home/apartment without any further services, a board and care home, assisted living, a group home or transitional living. The numerator is the number of quality episodes with an OASIS discharge assessment indicating a current reconciled medication list was provided to the patient, family, and/or caregiver at the time of discharge.

Future Measures and Measure Concepts

CMS's proposed rule also seeks input on future quality measures and measure concepts in the following areas: potentially-preventable hospitalizations; functional improvement and maintenance outcomes; opioid use and frequency; and exchange of electronic health information and interoperability. CMS also seeks input on the following standardized patient assessment data elements (SPADES) under consideration for HHQRP in later years: cognitive complexity, such as executive function and memory; dementia; bladder and bowel continence including appliance use and episodes of incontinence; bare preferences, advance care directives, and goals of care; caregiver status; veteran status; and health disparities and risk factors, including education, sex and gender identity, and sexual orientation.

None of these measures are slated for finalization in this rulemaking period and CMS says it will not be responding to comment submissions, but will be "using this input to inform our future measure and SPADE development efforts."

No Proposed Changes to the Home Infusion Therapy Services and Temporary Transitional Payment

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.

In last year's final rule, CMS 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. 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 has implemented 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 four-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.

The following is how the home infusion therapy coordinates with the home health benefit:

- Professional service associated with this new home infusion therapy benefit must be provided by the home infusion therapy supplier under Part B, **not home health** (2021).
- If a beneficiary is receiving home health service by a home health agency that is also a qualified home infusion supplier, CMS will permit the agency to bill for the infusion therapy services separately under new Part B home infusion benefit (2021).
- During the transitional period (CYs 2019-20) home health continues to provide infusion therapy for patients under a home health plan of care (POC).

Proposed Regulatory Change to Allow Therapist Assistants to Perform Maintenance Therapy

According to CMS regulations in Section 409.44, in order for therapy visits to be covered in the home health setting one of three criteria must be met: 1) there must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition; 2) the unique clinical condition of a patient requires the specialized skills, knowledge, and judgment of a qualified therapist to design or establish a safe and effective maintenance program required in connection with the patient's specific illness or injury; 3) or the unique clinical condition of a patient requires the specialized skills of a qualified therapist to perform a safe and effective maintenance program required in connection with the patient's specific illness or injury.

Furthermore, the regulations state that where the clinical condition of the patient is such that the complexity of the therapy services required to maintain function involves the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) or the clinical condition of the patient is such that the complexity of the therapy services required to maintain function must be delivered by the therapist himself/herself

(and not an assistant) in order to ensure the patient's safety and to provide an effective maintenance program, then those reasonable and necessary services shall be covered.

In the proposed rule, CMS states its belief that it would be appropriate to allow therapist assistants to perform maintenance therapy services under a maintenance program established by a qualified therapist under the home health benefit, if acting within the therapy scope of practice defined by state licensure laws. The qualified therapist would still be responsible for the initial assessment; plan of care; maintenance program development and modifications; and reassessment every 30 days, in addition to supervising the services provided by the therapist assistant.

CMS believes this would allow home health agencies more latitude in resource utilization. Furthermore, allowing assistants to perform maintenance therapy would be consistent with other post-acute care settings, including SNFs. Thus, CMS is proposing to modify the regulations in Section 409.44 to allow therapist assistants (rather than only therapists) to perform maintenance therapy under the Medicare home health benefit. CMS is soliciting comments regarding this proposal and also asks for feedback on whether this proposal would require therapists to provide more frequent patient reassessment or maintenance program review when the services are being performed by a therapist assistant. CMS is also soliciting comments on whether CMS should revise the description of the therapy codes to indicate maintenance services performed by a physical or occupational therapist assistant (G0151 and G0157) versus a qualified therapist, or simply remove the therapy code indicating the establishment or delivery of a safe and effective physical therapy maintenance program, by a physical therapist (G0159). Finally, CMS welcomes comments on the importance of tracking whether a visit is for maintenance or restorative therapy or whether it would be appropriate to only identify whether the service is furnished by a qualified therapist or an assistant.

HHCAHPS

What is staying the same

All Medicare-certified providers 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 agencies to monitor their respective HHCAHPS vendors to assure they are submitting HHCAHPS data on time using the HHCAHPS Data Submission Reports.

CMS's CY 2020 proposed 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>.

Home health agencies 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. Home health agencies with 59 or fewer Medicare and HHCAHPS-eligible patients between April 1, 2017 through March 31, 2018, can continue to file an annual application to become exempt from participation for CY 2020.

What is changing

However, as noted earlier in this memo, CMS is proposing one change in CY 2020 – to remove Question 10 from all HHCAHPS Surveys (both mail surveys and telephone surveys). The question says: “In the last 2 months of care, did you and a home health provider from this agency talk about pain?” It is one of seven questions (they are questions 3, 4, 5, 10, 12, 13 and 14) in the “Special Care Issues” composite measure, beginning July 1, 2020. The “Special Care Issues” composite measure also focuses on home health agency staff discussing home safety, the purpose of the medications that are being taken, side effects of medications, and when to take medications. In the initial development of the HHCAHPS Survey, this question was included in the survey since home health staff talk about pain to identify any emerging issues (for example, wounds that are getting worse) every time they see their home health patients.

CMS is proposing to remove pain questions from the HHCAHPS Survey and pain items from the OASIS data sets to avoid potential unintended consequences that may arise from their inclusion in CMS surveys and datasets (i.e., as noted earlier regarding opioid use). The reason that CMS is proposing removing this particular pain question is consistent with the proposed removal of pain items from OASIS and also consistent with the removal of pain items from the Hospital CAHPS Survey. The removal of pain questions from CMS surveys and removal of pain items from CMS data sets is to avoid potential unintended consequences that arise from their inclusion in CMS surveys and datasets.

Comment Period & Issuance of the CY 2020 Final Rule

CMS’s proposed rule will be open for public comment until 5 p.m. on **September 9, 2019**. HCA will submit comments on behalf of the membership. Members are encouraged to share with HCA their concerns by e-mailing Patrick Conole at pconole@hcanys.org.

HCA is particularly interested in hearing your comments, concerns or suggestions with CMS’s proposal to phase-out (in CY 2020) and ultimately eliminate the RAP payment beginning in CY 2021, suggestions on how to improve the home health wage index and CMS’s proposal to update the FDL ratio used in the outlier calculation. Most significantly, we also seek your input and impact projections on CMS’s proposed behavioral adjustments, particularly the change from a -6.42 percent adjustment to an even more severe -8.01 percent adjustment. These adjustments are a main target of HCA’s federal advocacy and we have recently posted tools on our *Legislative Action Center* for HCA members to gain support from Congress on legislation that would mitigate these destabilizing cuts. Please visit our Action Center today at <https://p2a.co/CrvM1NC> and look for the campaign titled “Urgent: S.433/H.R. 2573 Imperative as Home Care Faces 8% Cuts.”

Providers interested in submitting their own comments are encouraged to do so electronically and should refer to File Code CMS-1711-P. Electronic comments on the proposed rule can be sent to <http://www.regulations.gov> (follow the instructions under the “More Search Options” tab). Providers preferring to submit comments by regular mail should send them to: CMS, Department of Health and Human Services, Attention: CMS-1711-P, Mail Stop C4-26-05, 7500 Security Blvd., Baltimore, MD 21244-1850.

HCA will share with the membership our comments to CMS shortly after they are submitted. HCA expects CMS to post the final rule towards the end of October. HCA will provide the membership with a follow-up *Public Policy Memorandum* when this occurs.

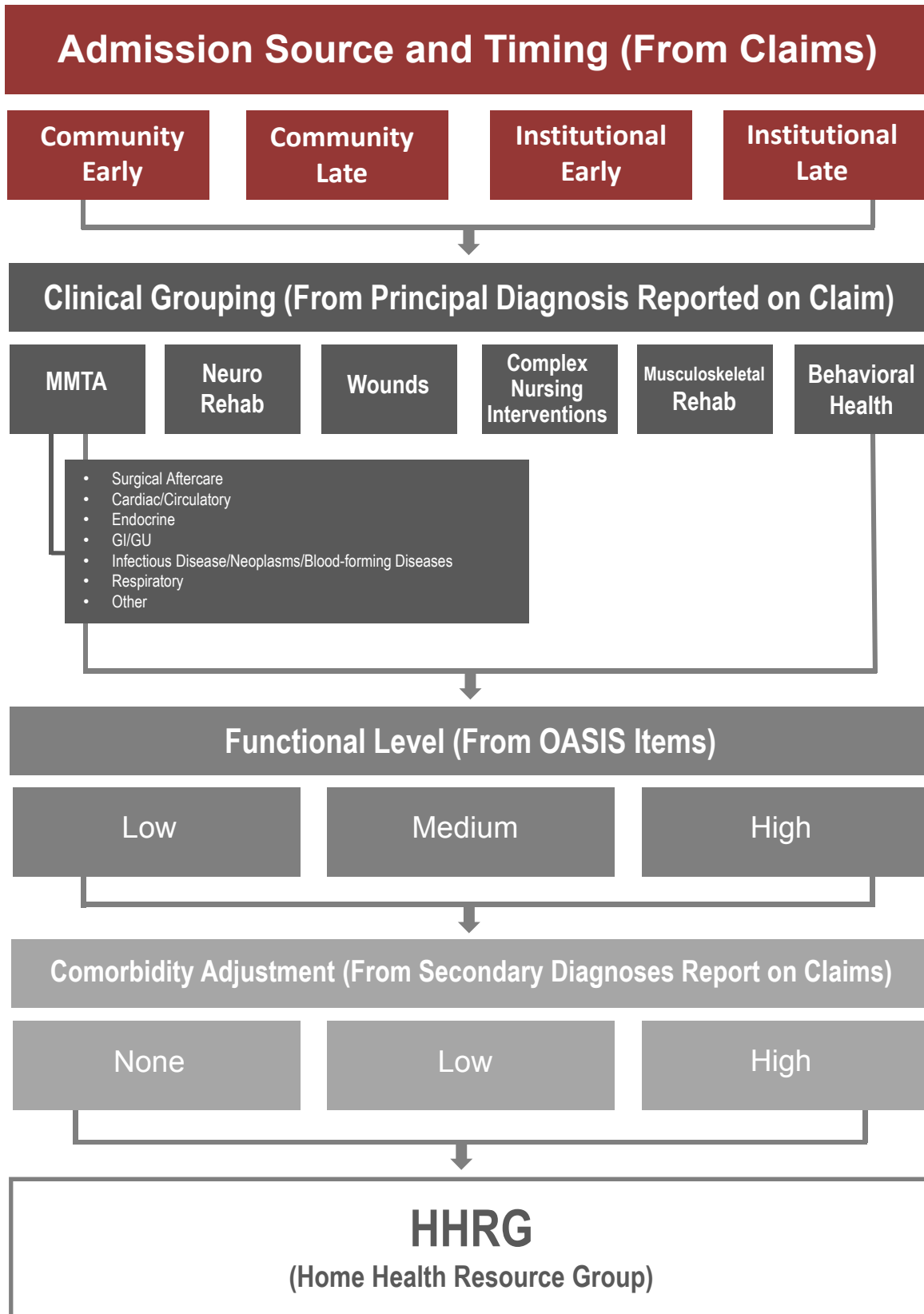
Two PDGM Sessions at September Finance Retreat

HCA is finalizing the program for our highly anticipated Senior Financial Managers Retreat in New Paltz on **September 5 and 6**. It will contain two sessions on PDGM, including a final-stage PDGM readiness checklist to help ensure that you've considered what's necessary to succeed, plus a comparative analysis of financial outcomes (pre- and post-PDGM) based on benchmark data using 2017-2018 claims data.

All HCA member CEOs, CFOs, finance managers and others with budgeting responsibility and finance planning roles should attend. Please save the dates and be on the lookout for registration information soon.

For further information on CMS's CY 2020 HHPS proposed rule, 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 - 2019 Case Mix Weights

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

CY 2020 Proposed: PDGM Home Health Resource Groups (HHRGs): Case-Mix Weights & LUPA Thresholds

HIPPS	Clinical Group and Functional Level	Timing and Admission Source	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	LUPA Visit Threshold (10th percentile or 2 - whichever is higher)	CY 2020 Proposed Case- Mix Weights
1FC11	Behavioral Health - High	Early - Community	0	4	1.1824
1FC21	Behavioral Health - High	Early - Community	1	4	1.2424
1FC31	Behavioral Health - High	Early - Community	2	4	1.3719
2FC11	Behavioral Health - High	Early - Institutional	0	4	1.359
2FC21	Behavioral Health - High	Early - Institutional	1	4	1.419
2FC31	Behavioral Health - High	Early - Institutional	2	4	1.5485
3FC11	Behavioral Health - High	Late - Community	0	2	0.7723
3FC21	Behavioral Health - High	Late - Community	1	2	0.8324
3FC31	Behavioral Health - High	Late - Community	2	3	0.9619
4FC11	Behavioral Health - High	Late - Institutional	0	3	1.2208
4FC21	Behavioral Health - High	Late - Institutional	1	4	1.2808
4FC31	Behavioral Health - High	Late - Institutional	2	3	1.4103
1FA11	Behavioral Health - Low	Early - Community	0	3	0.9291
1FA21	Behavioral Health - Low	Early - Community	1	4	0.9892
1FA31	Behavioral Health - Low	Early - Community	2	3	1.1187
2FA11	Behavioral Health - Low	Early - Institutional	0	3	1.1058
2FA21	Behavioral Health - Low	Early - Institutional	1	3	1.1658
2FA31	Behavioral Health - Low	Early - Institutional	2	3	1.2953
3FA11	Behavioral Health - Low	Late - Community	0	2	0.5191
3FA21	Behavioral Health - Low	Late - Community	1	2	0.5791
3FA31	Behavioral Health - Low	Late - Community	2	2	0.7086
4FA11	Behavioral Health - Low	Late - Institutional	0	2	0.9675
4FA21	Behavioral Health - Low	Late - Institutional	1	2	1.0275
4FA31	Behavioral Health - Low	Late - Institutional	2	2	1.157
1FB11	Behavioral Health - Medium	Early - Community	0	4	1.0946
1FB21	Behavioral Health - Medium	Early - Community	1	4	1.1546
1FB31	Behavioral Health - Medium	Early - Community	2	4	1.2841
2FB11	Behavioral Health - Medium	Early - Institutional	0	4	1.2712
2FB21	Behavioral Health - Medium	Early - Institutional	1	4	1.3312
2FB31	Behavioral Health - Medium	Early - Institutional	2	4	1.4607
3FB11	Behavioral Health - Medium	Late - Community	0	2	0.6845
3FB21	Behavioral Health - Medium	Late - Community	1	2	0.7445
3FB31	Behavioral Health - Medium	Late - Community	2	2	0.874
4FB11	Behavioral Health - Medium	Late - Institutional	0	3	1.1329
4FB21	Behavioral Health - Medium	Late - Institutional	1	3	1.193
4FB31	Behavioral Health - Medium	Late - Institutional	2	3	1.3224
1DC11	Complex - High	Early - Community	0	3	1.2037
1DC21	Complex - High	Early - Community	1	2	1.2637
1DC31	Complex - High	Early - Community	2	2	1.3932
2DC11	Complex - High	Early - Institutional	0	4	1.3803
2DC21	Complex - High	Early - Institutional	1	4	1.4403
2DC31	Complex - High	Early - Institutional	2	4	1.5698
3DC11	Complex - High	Late - Community	0	2	0.7936
3DC21	Complex - High	Late - Community	1	2	0.8536
3DC31	Complex - High	Late - Community	2	2	0.9831
4DC11	Complex - High	Late - Institutional	0	3	1.2421
4DC21	Complex - High	Late - Institutional	1	3	1.3021
4DC31	Complex - High	Late - Institutional	2	3	1.4316
1DA11	Complex - Low	Early - Community	0	3	0.9589
1DA21	Complex - Low	Early - Community	1	3	1.019
1DA31	Complex - Low	Early - Community	2	2	1.1485
2DA11	Complex - Low	Early - Institutional	0	3	1.1356
2DA21	Complex - Low	Early - Institutional	1	4	1.1956
2DA31	Complex - Low	Early - Institutional	2	4	1.3251
3DA11	Complex - Low	Late - Community	0	2	0.5489
3DA21	Complex - Low	Late - Community	1	2	0.6089
3DA31	Complex - Low	Late - Community	2	2	0.7384
4DA11	Complex - Low	Late - Institutional	0	2	0.9973
4DA21	Complex - Low	Late - Institutional	1	2	1.0573

4DA31	Complex - Low	Late - Institutional	2	2	1.1868
1DB11	Complex - Medium	Early - Community	0	3	1.1547
1DB21	Complex - Medium	Early - Community	1	3	1.2147
1DB31	Complex - Medium	Early - Community	2	3	1.3442
2DB11	Complex - Medium	Early - Institutional	0	4	1.3313
2DB21	Complex - Medium	Early - Institutional	1	4	1.3913
2DB31	Complex - Medium	Early - Institutional	2	4	1.5208
3DB11	Complex - Medium	Late - Community	0	2	0.7446
3DB21	Complex - Medium	Late - Community	1	2	0.8046
3DB31	Complex - Medium	Late - Community	2	2	0.9341
4DB11	Complex - Medium	Late - Institutional	0	3	1.193
4DB21	Complex - Medium	Late - Institutional	1	3	1.253
4DB31	Complex - Medium	Late - Institutional	2	3	1.3825
1GC11	MMTA - Surgical Aftercare - High	Early - Community	0	4	1.2257
1GC21	MMTA - Surgical Aftercare - High	Early - Community	1	5	1.2857
1GC31	MMTA - Surgical Aftercare - High	Early - Community	2	5	1.4152
2GC11	MMTA - Surgical Aftercare - High	Early - Institutional	0	4	1.4023
2GC21	MMTA - Surgical Aftercare - High	Early - Institutional	1	5	1.4623
2GC31	MMTA - Surgical Aftercare - High	Early - Institutional	2	5	1.5918
3GC11	MMTA - Surgical Aftercare - High	Late - Community	0	2	0.8156
3GC21	MMTA - Surgical Aftercare - High	Late - Community	1	2	0.8756
3GC31	MMTA - Surgical Aftercare - High	Late - Community	2	2	1.0051
4GC11	MMTA - Surgical Aftercare - High	Late - Institutional	0	4	1.2641
4GC21	MMTA - Surgical Aftercare - High	Late - Institutional	1	4	1.3241
4GC31	MMTA - Surgical Aftercare - High	Late - Institutional	2	4	1.4536
1GA11	MMTA - Surgical Aftercare - Low	Early - Community	0	3	0.9036
1GA21	MMTA - Surgical Aftercare - Low	Early - Community	1	4	0.9636
1GA31	MMTA - Surgical Aftercare - Low	Early - Community	2	4	1.0931
2GA11	MMTA - Surgical Aftercare - Low	Early - Institutional	0	3	1.0802
2GA21	MMTA - Surgical Aftercare - Low	Early - Institutional	1	4	1.1402
2GA31	MMTA - Surgical Aftercare - Low	Early - Institutional	2	4	1.2697
3GA11	MMTA - Surgical Aftercare - Low	Late - Community	0	2	0.4935
3GA21	MMTA - Surgical Aftercare - Low	Late - Community	1	2	0.5535
3GA31	MMTA - Surgical Aftercare - Low	Late - Community	2	2	0.683
4GA11	MMTA - Surgical Aftercare - Low	Late - Institutional	0	3	0.942
4GA21	MMTA - Surgical Aftercare - Low	Late - Institutional	1	3	1.002
4GA31	MMTA - Surgical Aftercare - Low	Late - Institutional	2	4	1.1315
1GB11	MMTA - Surgical Aftercare - Medium	Early - Community	0	4	1.0669
1GB21	MMTA - Surgical Aftercare - Medium	Early - Community	1	4	1.127
1GB31	MMTA - Surgical Aftercare - Medium	Early - Community	2	5	1.2564
2GB11	MMTA - Surgical Aftercare - Medium	Early - Institutional	0	4	1.2435
2GB21	MMTA - Surgical Aftercare - Medium	Early - Institutional	1	5	1.3036
2GB31	MMTA - Surgical Aftercare - Medium	Early - Institutional	2	5	1.4331
3GB11	MMTA - Surgical Aftercare - Medium	Late - Community	0	2	0.6569
3GB21	MMTA - Surgical Aftercare - Medium	Late - Community	1	2	0.7169
3GB31	MMTA - Surgical Aftercare - Medium	Late - Community	2	2	0.8464
4GB11	MMTA - Surgical Aftercare - Medium	Late - Institutional	0	3	1.1053
4GB21	MMTA - Surgical Aftercare - Medium	Late - Institutional	1	4	1.1653
4GB31	MMTA - Surgical Aftercare - Medium	Late - Institutional	2	4	1.2948
1HC11	MMTA - Cardiac - High	Early - Community	0	5	1.2458
1HC21	MMTA - Cardiac - High	Early - Community	1	5	1.3058
1HC31	MMTA - Cardiac - High	Early - Community	2	5	1.4353
2HC11	MMTA - Cardiac - High	Early - Institutional	0	4	1.4224
2HC21	MMTA - Cardiac - High	Early - Institutional	1	4	1.4824
2HC31	MMTA - Cardiac - High	Early - Institutional	2	5	1.6119
3HC11	MMTA - Cardiac - High	Late - Community	0	2	0.8357
3HC21	MMTA - Cardiac - High	Late - Community	1	2	0.8957
3HC31	MMTA - Cardiac - High	Late - Community	2	3	1.0252
4HC11	MMTA - Cardiac - High	Late - Institutional	0	4	1.2841
4HC21	MMTA - Cardiac - High	Late - Institutional	1	4	1.3442
4HC31	MMTA - Cardiac - High	Late - Institutional	2	4	1.4737
1HA11	MMTA - Cardiac - Low	Early - Community	0	4	0.9886
1HA21	MMTA - Cardiac - Low	Early - Community	1	4	1.0487
1HA31	MMTA - Cardiac - Low	Early - Community	2	4	1.1782
2HA11	MMTA - Cardiac - Low	Early - Institutional	0	4	1.1652
2HA21	MMTA - Cardiac - Low	Early - Institutional	1	4	1.2253
2HA31	MMTA - Cardiac - Low	Early - Institutional	2	4	1.3548

3HA11	MMTA - Cardiac - Low	Late - Community	0	2	0.5786
3HA21	MMTA - Cardiac - Low	Late - Community	1	2	0.6386
3HA31	MMTA - Cardiac - Low	Late - Community	2	3	0.7681
4HA11	MMTA - Cardiac - Low	Late - Institutional	0	3	1.027
4HA21	MMTA - Cardiac - Low	Late - Institutional	1	3	1.087
4HA31	MMTA - Cardiac - Low	Late - Institutional	2	3	1.2165
1HB11	MMTA - Cardiac - Medium	Early - Community	0	5	1.1315
1HB21	MMTA - Cardiac - Medium	Early - Community	1	5	1.1915
1HB31	MMTA - Cardiac - Medium	Early - Community	2	5	1.321
2HB11	MMTA - Cardiac - Medium	Early - Institutional	0	4	1.3081
2HB21	MMTA - Cardiac - Medium	Early - Institutional	1	5	1.3681
2HB31	MMTA - Cardiac - Medium	Early - Institutional	2	5	1.4976
3HB11	MMTA - Cardiac - Medium	Late - Community	0	2	0.7214
3HB21	MMTA - Cardiac - Medium	Late - Community	1	2	0.7814
3HB31	MMTA - Cardiac - Medium	Late - Community	2	3	0.9109
4HB11	MMTA - Cardiac - Medium	Late - Institutional	0	3	1.1699
4HB21	MMTA - Cardiac - Medium	Late - Institutional	1	3	1.2299
4HB31	MMTA - Cardiac - Medium	Late - Institutional	2	4	1.3594
1IC11	MMTA - Endocrine - High	Early - Community	0	5	1.3884
1IC21	MMTA - Endocrine - High	Early - Community	1	5	1.4485
1IC31	MMTA - Endocrine - High	Early - Community	2	5	1.578
2IC11	MMTA - Endocrine - High	Early - Institutional	0	4	1.565
2IC21	MMTA - Endocrine - High	Early - Institutional	1	5	1.6251
2IC31	MMTA - Endocrine - High	Early - Institutional	2	4	1.7546
3IC11	MMTA - Endocrine - High	Late - Community	0	3	0.9784
3IC21	MMTA - Endocrine - High	Late - Community	1	3	1.0384
3IC31	MMTA - Endocrine - High	Late - Community	2	3	1.1679
4IC11	MMTA - Endocrine - High	Late - Institutional	0	3	1.4268
4IC21	MMTA - Endocrine - High	Late - Institutional	1	3	1.4868
4IC31	MMTA - Endocrine - High	Late - Institutional	2	4	1.6163
1IA11	MMTA - Endocrine - Low	Early - Community	0	4	1.1216
1IA21	MMTA - Endocrine - Low	Early - Community	1	4	1.1817
1IA31	MMTA - Endocrine - Low	Early - Community	2	4	1.3111
2IA11	MMTA - Endocrine - Low	Early - Institutional	0	3	1.2982
2IA21	MMTA - Endocrine - Low	Early - Institutional	1	4	1.3583
2IA31	MMTA - Endocrine - Low	Early - Institutional	2	4	1.4878
3IA11	MMTA - Endocrine - Low	Late - Community	0	2	0.7116
3IA21	MMTA - Endocrine - Low	Late - Community	1	2	0.7716
3IA31	MMTA - Endocrine - Low	Late - Community	2	3	0.9011
4IA11	MMTA - Endocrine - Low	Late - Institutional	0	3	1.16
4IA21	MMTA - Endocrine - Low	Late - Institutional	1	3	1.22
4IA31	MMTA - Endocrine - Low	Late - Institutional	2	3	1.3495
1IB11	MMTA - Endocrine - Medium	Early - Community	0	5	1.2833
1IB21	MMTA - Endocrine - Medium	Early - Community	1	5	1.3434
1IB31	MMTA - Endocrine - Medium	Early - Community	2	4	1.4729
2IB11	MMTA - Endocrine - Medium	Early - Institutional	0	4	1.4599
2IB21	MMTA - Endocrine - Medium	Early - Institutional	1	4	1.52
2IB31	MMTA - Endocrine - Medium	Early - Institutional	2	5	1.6495
3IB11	MMTA - Endocrine - Medium	Late - Community	0	3	0.8733
3IB21	MMTA - Endocrine - Medium	Late - Community	1	3	0.9333
3IB31	MMTA - Endocrine - Medium	Late - Community	2	3	1.0628
4IB11	MMTA - Endocrine - Medium	Late - Institutional	0	3	1.3217
4IB21	MMTA - Endocrine - Medium	Late - Institutional	1	3	1.3817
4IB31	MMTA - Endocrine - Medium	Late - Institutional	2	4	1.5112
1JC11	MMTA - GI/GU - High	Early - Community	0	4	1.1957
1JC21	MMTA - GI/GU - High	Early - Community	1	3	1.2557
1JC31	MMTA - GI/GU - High	Early - Community	2	3	1.3852
2JC11	MMTA - GI/GU - High	Early - Institutional	0	4	1.3723
2JC21	MMTA - GI/GU - High	Early - Institutional	1	4	1.4323
2JC31	MMTA - GI/GU - High	Early - Institutional	2	4	1.5618
3JC11	MMTA - GI/GU - High	Late - Community	0	2	0.7856
3JC21	MMTA - GI/GU - High	Late - Community	1	2	0.8456
3JC31	MMTA - GI/GU - High	Late - Community	2	2	0.9751
4JC11	MMTA - GI/GU - High	Late - Institutional	0	3	1.2341
4JC21	MMTA - GI/GU - High	Late - Institutional	1	3	1.2941
4JC31	MMTA - GI/GU - High	Late - Institutional	2	4	1.4236
1JA11	MMTA - GI/GU - Low	Early - Community	0	3	0.9567

1JA21	MMTA - GI/GU - Low	Early - Community	1	3	1.0167
1JA31	MMTA - GI/GU - Low	Early - Community	2	3	1.1462
2JA11	MMTA - GI/GU - Low	Early - Institutional	0	3	1.1333
2JA21	MMTA - GI/GU - Low	Early - Institutional	1	4	1.1933
2JA31	MMTA - GI/GU - Low	Early - Institutional	2	4	1.3228
3JA11	MMTA - GI/GU - Low	Late - Community	0	2	0.5466
3JA21	MMTA - GI/GU - Low	Late - Community	1	2	0.6066
3JA31	MMTA - GI/GU - Low	Late - Community	2	2	0.7361
4JA11	MMTA - GI/GU - Low	Late - Institutional	0	3	0.9951
4JA21	MMTA - GI/GU - Low	Late - Institutional	1	3	1.0551
4JA31	MMTA - GI/GU - Low	Late - Institutional	2	3	1.1846
1JB11	MMTA - GI/GU - Medium	Early - Community	0	4	1.1091
1JB21	MMTA - GI/GU - Medium	Early - Community	1	4	1.1691
1JB31	MMTA - GI/GU - Medium	Early - Community	2	4	1.2986
2JB11	MMTA - GI/GU - Medium	Early - Institutional	0	4	1.2857
2JB21	MMTA - GI/GU - Medium	Early - Institutional	1	4	1.3457
2JB31	MMTA - GI/GU - Medium	Early - Institutional	2	4	1.4752
3JB11	MMTA - GI/GU - Medium	Late - Community	0	2	0.699
3JB21	MMTA - GI/GU - Medium	Late - Community	1	2	0.759
3JB31	MMTA - GI/GU - Medium	Late - Community	2	2	0.8885
4JB11	MMTA - GI/GU - Medium	Late - Institutional	0	3	1.1475
4JB21	MMTA - GI/GU - Medium	Late - Institutional	1	3	1.2075
4JB31	MMTA - GI/GU - Medium	Late - Institutional	2	4	1.337
1KC11	MMTA - Infectious - High	Early - Community	0	3	1.2278
1KC21	MMTA - Infectious - High	Early - Community	1	3	1.2878
1KC31	MMTA - Infectious - High	Early - Community	2	3	1.4173
2KC11	MMTA - Infectious - High	Early - Institutional	0	3	1.4044
2KC21	MMTA - Infectious - High	Early - Institutional	1	4	1.4644
2KC31	MMTA - Infectious - High	Early - Institutional	2	4	1.5939
3KC11	MMTA - Infectious - High	Late - Community	0	2	0.8177
3KC21	MMTA - Infectious - High	Late - Community	1	2	0.8777
3KC31	MMTA - Infectious - High	Late - Community	2	2	1.0072
4KC11	MMTA - Infectious - High	Late - Institutional	0	3	1.2661
4KC21	MMTA - Infectious - High	Late - Institutional	1	3	1.3261
4KC31	MMTA - Infectious - High	Late - Institutional	2	3	1.4556
1KA11	MMTA - Infectious - Low	Early - Community	0	3	0.9853
1KA21	MMTA - Infectious - Low	Early - Community	1	3	1.0453
1KA31	MMTA - Infectious - Low	Early - Community	2	4	1.1748
2KA11	MMTA - Infectious - Low	Early - Institutional	0	3	1.1619
2KA21	MMTA - Infectious - Low	Early - Institutional	1	3	1.2219
2KA31	MMTA - Infectious - Low	Early - Institutional	2	4	1.3514
3KA11	MMTA - Infectious - Low	Late - Community	0	2	0.5752
3KA21	MMTA - Infectious - Low	Late - Community	1	2	0.6352
3KA31	MMTA - Infectious - Low	Late - Community	2	2	0.7647
4KA11	MMTA - Infectious - Low	Late - Institutional	0	2	1.0236
4KA21	MMTA - Infectious - Low	Late - Institutional	1	3	1.0836
4KA31	MMTA - Infectious - Low	Late - Institutional	2	3	1.2131
1KB11	MMTA - Infectious - Medium	Early - Community	0	3	1.1174
1KB21	MMTA - Infectious - Medium	Early - Community	1	4	1.1774
1KB31	MMTA - Infectious - Medium	Early - Community	2	4	1.3069
2KB11	MMTA - Infectious - Medium	Early - Institutional	0	4	1.294
2KB21	MMTA - Infectious - Medium	Early - Institutional	1	4	1.354
2KB31	MMTA - Infectious - Medium	Early - Institutional	2	5	1.4835
3KB11	MMTA - Infectious - Medium	Late - Community	0	2	0.7073
3KB21	MMTA - Infectious - Medium	Late - Community	1	2	0.7674
3KB31	MMTA - Infectious - Medium	Late - Community	2	2	0.8968
4KB11	MMTA - Infectious - Medium	Late - Institutional	0	3	1.1558
4KB21	MMTA - Infectious - Medium	Late - Institutional	1	3	1.2158
4KB31	MMTA - Infectious - Medium	Late - Institutional	2	4	1.3453
1AC11	MMTA - Other - High	Early - Community	0	5	1.2701
1AC21	MMTA - Other - High	Early - Community	1	5	1.3302
1AC31	MMTA - Other - High	Early - Community	2	5	1.4597
2AC11	MMTA - Other - High	Early - Institutional	0	5	1.4468
2AC21	MMTA - Other - High	Early - Institutional	1	5	1.5068
2AC31	MMTA - Other - High	Early - Institutional	2	5	1.6363
3AC11	MMTA - Other - High	Late - Community	0	2	0.8601
3AC21	MMTA - Other - High	Late - Community	1	3	0.9201

3AC31	MMTA - Other - High	Late - Community	2	3	1.0496
4AC11	MMTA - Other - High	Late - Institutional	0	4	1.3085
4AC21	MMTA - Other - High	Late - Institutional	1	4	1.3685
4AC31	MMTA - Other - High	Late - Institutional	2	3	1.498
1AA11	MMTA - Other - Low	Early - Community	0	4	1.0062
1AA21	MMTA - Other - Low	Early - Community	1	4	1.0662
1AA31	MMTA - Other - Low	Early - Community	2	4	1.1957
2AA11	MMTA - Other - Low	Early - Institutional	0	3	1.1828
2AA21	MMTA - Other - Low	Early - Institutional	1	4	1.2428
2AA31	MMTA - Other - Low	Early - Institutional	2	4	1.3723
3AA11	MMTA - Other - Low	Late - Community	0	2	0.5961
3AA21	MMTA - Other - Low	Late - Community	1	2	0.6562
3AA31	MMTA - Other - Low	Late - Community	2	3	0.7856
4AA11	MMTA - Other - Low	Late - Institutional	0	3	1.0446
4AA21	MMTA - Other - Low	Late - Institutional	1	3	1.1046
4AA31	MMTA - Other - Low	Late - Institutional	2	3	1.2341
1AB11	MMTA - Other - Medium	Early - Community	0	5	1.1456
1AB21	MMTA - Other - Medium	Early - Community	1	5	1.2056
1AB31	MMTA - Other - Medium	Early - Community	2	5	1.3351
2AB11	MMTA - Other - Medium	Early - Institutional	0	5	1.3222
2AB21	MMTA - Other - Medium	Early - Institutional	1	5	1.3822
2AB31	MMTA - Other - Medium	Early - Institutional	2	5	1.5117
3AB11	MMTA - Other - Medium	Late - Community	0	2	0.7355
3AB21	MMTA - Other - Medium	Late - Community	1	2	0.7955
3AB31	MMTA - Other - Medium	Late - Community	2	3	0.925
4AB11	MMTA - Other - Medium	Late - Institutional	0	3	1.1839
4AB21	MMTA - Other - Medium	Late - Institutional	1	3	1.244
4AB31	MMTA - Other - Medium	Late - Institutional	2	4	1.3735
1LC11	MMTA - Respiratory - High	Early - Community	0	4	1.2081
1LC21	MMTA - Respiratory - High	Early - Community	1	4	1.2681
1LC31	MMTA - Respiratory - High	Early - Community	2	4	1.3976
2LC11	MMTA - Respiratory - High	Early - Institutional	0	4	1.3847
2LC21	MMTA - Respiratory - High	Early - Institutional	1	4	1.4447
2LC31	MMTA - Respiratory - High	Early - Institutional	2	4	1.5742
3LC11	MMTA - Respiratory - High	Late - Community	0	2	0.798
3LC21	MMTA - Respiratory - High	Late - Community	1	2	0.8581
3LC31	MMTA - Respiratory - High	Late - Community	2	3	0.9876
4LC11	MMTA - Respiratory - High	Late - Institutional	0	3	1.2465
4LC21	MMTA - Respiratory - High	Late - Institutional	1	4	1.3065
4LC31	MMTA - Respiratory - High	Late - Institutional	2	3	1.436
1LA11	MMTA - Respiratory - Low	Early - Community	0	4	0.9655
1LA21	MMTA - Respiratory - Low	Early - Community	1	4	1.0255
1LA31	MMTA - Respiratory - Low	Early - Community	2	4	1.155
2LA11	MMTA - Respiratory - Low	Early - Institutional	0	4	1.1421
2LA21	MMTA - Respiratory - Low	Early - Institutional	1	4	1.2021
2LA31	MMTA - Respiratory - Low	Early - Institutional	2	4	1.3316
3LA11	MMTA - Respiratory - Low	Late - Community	0	2	0.5554
3LA21	MMTA - Respiratory - Low	Late - Community	1	2	0.6155
3LA31	MMTA - Respiratory - Low	Late - Community	2	2	0.745
4LA11	MMTA - Respiratory - Low	Late - Institutional	0	3	1.0039
4LA21	MMTA - Respiratory - Low	Late - Institutional	1	3	1.0639
4LA31	MMTA - Respiratory - Low	Late - Institutional	2	3	1.1934
1LB11	MMTA - Respiratory - Medium	Early - Community	0	4	1.1041
1LB21	MMTA - Respiratory - Medium	Early - Community	1	5	1.1641
1LB31	MMTA - Respiratory - Medium	Early - Community	2	5	1.2936
2LB11	MMTA - Respiratory - Medium	Early - Institutional	0	4	1.2807
2LB21	MMTA - Respiratory - Medium	Early - Institutional	1	5	1.3407
2LB31	MMTA - Respiratory - Medium	Early - Institutional	2	5	1.4702
3LB11	MMTA - Respiratory - Medium	Late - Community	0	2	0.694
3LB21	MMTA - Respiratory - Medium	Late - Community	1	2	0.7541
3LB31	MMTA - Respiratory - Medium	Late - Community	2	2	0.8835
4LB11	MMTA - Respiratory - Medium	Late - Institutional	0	3	1.1425
4LB21	MMTA - Respiratory - Medium	Late - Institutional	1	3	1.2025
4LB31	MMTA - Respiratory - Medium	Late - Institutional	2	4	1.332
1EC11	MS Rehab - High	Early - Community	0	5	1.3424
1EC21	MS Rehab - High	Early - Community	1	5	1.4024
1EC31	MS Rehab - High	Early - Community	2	5	1.5319

2EC11	MS Rehab - High	Early - Institutional	0	6	1.519
2EC21	MS Rehab - High	Early - Institutional	1	6	1.579
2EC31	MS Rehab - High	Early - Institutional	2	6	1.7085
3EC11	MS Rehab - High	Late - Community	0	2	0.9323
3EC21	MS Rehab - High	Late - Community	1	2	0.9923
3EC31	MS Rehab - High	Late - Community	2	3	1.1218
4EC11	MS Rehab - High	Late - Institutional	0	4	1.3807
4EC21	MS Rehab - High	Late - Institutional	1	4	1.4407
4EC31	MS Rehab - High	Late - Institutional	2	5	1.5702
1EA11	MS Rehab - Low	Early - Community	0	5	1.0847
1EA21	MS Rehab - Low	Early - Community	1	5	1.1447
1EA31	MS Rehab - Low	Early - Community	2	5	1.2742
2EA11	MS Rehab - Low	Early - Institutional	0	5	1.2613
2EA21	MS Rehab - Low	Early - Institutional	1	5	1.3213
2EA31	MS Rehab - Low	Early - Institutional	2	5	1.4508
3EA11	MS Rehab - Low	Late - Community	0	2	0.6746
3EA21	MS Rehab - Low	Late - Community	1	2	0.7347
3EA31	MS Rehab - Low	Late - Community	2	3	0.8642
4EA11	MS Rehab - Low	Late - Institutional	0	4	1.1231
4EA21	MS Rehab - Low	Late - Institutional	1	4	1.1831
4EA31	MS Rehab - Low	Late - Institutional	2	4	1.3126
1EB11	MS Rehab - Medium	Early - Community	0	5	1.1912
1EB21	MS Rehab - Medium	Early - Community	1	5	1.2512
1EB31	MS Rehab - Medium	Early - Community	2	5	1.3807
2EB11	MS Rehab - Medium	Early - Institutional	0	5	1.3678
2EB21	MS Rehab - Medium	Early - Institutional	1	6	1.4278
2EB31	MS Rehab - Medium	Early - Institutional	2	6	1.5573
3EB11	MS Rehab - Medium	Late - Community	0	2	0.7811
3EB21	MS Rehab - Medium	Late - Community	1	2	0.8411
3EB31	MS Rehab - Medium	Late - Community	2	3	0.9706
4EB11	MS Rehab - Medium	Late - Institutional	0	4	1.2295
4EB21	MS Rehab - Medium	Late - Institutional	1	4	1.2896
4EB31	MS Rehab - Medium	Late - Institutional	2	4	1.4191
1BC11	Neuro - High	Early - Community	0	5	1.4555
1BC21	Neuro - High	Early - Community	1	5	1.5155
1BC31	Neuro - High	Early - Community	2	5	1.645
2BC11	Neuro - High	Early - Institutional	0	5	1.6321
2BC21	Neuro - High	Early - Institutional	1	6	1.6921
2BC31	Neuro - High	Early - Institutional	2	5	1.8216
3BC11	Neuro - High	Late - Community	0	2	1.0454
3BC21	Neuro - High	Late - Community	1	3	1.1054
3BC31	Neuro - High	Late - Community	2	3	1.2349
4BC11	Neuro - High	Late - Institutional	0	4	1.4938
4BC21	Neuro - High	Late - Institutional	1	4	1.5539
4BC31	Neuro - High	Late - Institutional	2	4	1.6833
1BA11	Neuro - Low	Early - Community	0	5	1.1925
1BA21	Neuro - Low	Early - Community	1	5	1.2526
1BA31	Neuro - Low	Early - Community	2	5	1.3821
2BA11	Neuro - Low	Early - Institutional	0	5	1.3691
2BA21	Neuro - Low	Early - Institutional	1	5	1.4292
2BA31	Neuro - Low	Early - Institutional	2	5	1.5587
3BA11	Neuro - Low	Late - Community	0	2	0.7825
3BA21	Neuro - Low	Late - Community	1	2	0.8425
3BA31	Neuro - Low	Late - Community	2	2	0.972
4BA11	Neuro - Low	Late - Institutional	0	3	1.2309
4BA21	Neuro - Low	Late - Institutional	1	4	1.2909
4BA31	Neuro - Low	Late - Institutional	2	4	1.4204
1BB11	Neuro - Medium	Early - Community	0	5	1.3508
1BB21	Neuro - Medium	Early - Community	1	5	1.4109
1BB31	Neuro - Medium	Early - Community	2	5	1.5404
2BB11	Neuro - Medium	Early - Institutional	0	6	1.5275
2BB21	Neuro - Medium	Early - Institutional	1	6	1.5875
2BB31	Neuro - Medium	Early - Institutional	2	6	1.717
3BB11	Neuro - Medium	Late - Community	0	2	0.9408
3BB21	Neuro - Medium	Late - Community	1	2	1.0008
3BB31	Neuro - Medium	Late - Community	2	3	1.1303
4BB11	Neuro - Medium	Late - Institutional	0	4	1.3892

4BB21	Neuro - Medium	Late - Institutional	1	4	1.4492
4BB31	Neuro - Medium	Late - Institutional	2	5	1.5787
1CC11	Wound - High	Early - Community	0	5	1.4985
1CC21	Wound - High	Early - Community	1	5	1.5585
1CC31	Wound - High	Early - Community	2	5	1.688
2CC11	Wound - High	Early - Institutional	0	4	1.6751
2CC21	Wound - High	Early - Institutional	1	5	1.7351
2CC31	Wound - High	Early - Institutional	2	5	1.8646
3CC11	Wound - High	Late - Community	0	3	1.0884
3CC21	Wound - High	Late - Community	1	3	1.1484
3CC31	Wound - High	Late - Community	2	3	1.2779
4CC11	Wound - High	Late - Institutional	0	3	1.5368
4CC21	Wound - High	Late - Institutional	1	4	1.5969
4CC31	Wound - High	Late - Institutional	2	4	1.7263
1CA11	Wound - Low	Early - Community	0	5	1.2207
1CA21	Wound - Low	Early - Community	1	5	1.2808
1CA31	Wound - Low	Early - Community	2	4	1.4103
2CA11	Wound - Low	Early - Institutional	0	4	1.3974
2CA21	Wound - Low	Early - Institutional	1	4	1.4574
2CA31	Wound - Low	Early - Institutional	2	4	1.5869
3CA11	Wound - Low	Late - Community	0	2	0.8107
3CA21	Wound - Low	Late - Community	1	3	0.8707
3CA31	Wound - Low	Late - Community	2	3	1.0002
4CA11	Wound - Low	Late - Institutional	0	3	1.2591
4CA21	Wound - Low	Late - Institutional	1	3	1.3191
4CA31	Wound - Low	Late - Institutional	2	3	1.4486
1CB11	Wound - Medium	Early - Community	0	5	1.3743
1CB21	Wound - Medium	Early - Community	1	5	1.4343
1CB31	Wound - Medium	Early - Community	2	5	1.5638
2CB11	Wound - Medium	Early - Institutional	0	5	1.5509
2CB21	Wound - Medium	Early - Institutional	1	5	1.6109
2CB31	Wound - Medium	Early - Institutional	2	5	1.7404
3CB11	Wound - Medium	Late - Community	0	3	0.9642
3CB21	Wound - Medium	Late - Community	1	3	1.0242
3CB31	Wound - Medium	Late - Community	2	3	1.1537
4CB11	Wound - Medium	Late - Institutional	0	4	1.4126
4CB21	Wound - Medium	Late - Institutional	1	4	1.4727
4CB31	Wound - Medium	Late - Institutional	2	4	1.6022

Appendix D

Proposed CY 2020 Wage Index for Urban & Rural Areas

CY 2020 CBSA Code	Area	Current CY 2019 Wage Index - New CBSA Designations	Proposed CY 2020 Wage Index - New CBSA Designations	% Difference Proposed CY 2020 vs Current CY 2019 Wage Index
10580	Albany - Schenectady- Troy			
10580	Albany	0.8112	0.8200	1.08%
10580	Rensselaer	0.8112	0.8200	1.08%
10580	Saratoga	0.8112	0.8200	1.08%
10580	Schenectady	0.8112	0.8200	1.08%
10580	Schoharie	0.8112	0.8200	1.08%
13780	Binghamton			
13780	Broome	0.8359	0.8230	-1.54%
13780	Tioga	0.8359	0.8230	-1.54%
15380	Buffalo - Cheektowaga - Niagara Falls			
15380	Erie	1.0393	1.0436	0.41%
15380	Niagara	1.0393	1.0436	0.41%
20524	Dutchess - Putnam Counties			
20524	Dutchess	1.2263	1.2158	-0.86%
20524	Putnam	1.2263	1.2158	-0.86%
21300	Elmira			
21300	Chemung	0.8652	0.8532	-1.39%
24020	Glen Falls			
24020	Warren	0.8520	0.7789	-8.58%
24020	Washington	0.8520	0.7789	-8.58%
27060	Ithaca			
27060	Tompkins	0.9170	0.9122	-0.52%
28740	Kingston			
28740	Ulster	0.8819	0.8835	0.18%
35004	Nassau - Suffolk			
35004	Nassau	1.2876	1.2814	-0.48%
35004	Suffolk	1.2876	1.2814	-0.48%
35614	NYC - Jersey City- White Plains, NY-NJ			
35614	Bronx	1.2776	1.2639	-1.07%
35614	Kings	1.2776	1.2639	-1.07%
35614	Manhattan	1.2776	1.2639	-1.07%
35614	Queens	1.2776	1.2639	-1.07%
35614	Richmond	1.2776	1.2639	-1.07%
35614	Orange	1.2776	1.2639	-1.07%
35614	Rockland	1.2776	1.2639	-1.07%
35614	Westchester	1.2776	1.2639	-1.07%
35614	Bergen County - NJ	1.2776	1.2639	-1.07%
35614	Hudson County - NJ	1.2776	1.2639	-1.07%
35614	Middlesex County - NJ	1.2776	1.2639	-1.07%
35614	Monmouth County - NJ	1.2776	1.2639	-1.07%
35614	Ocean County - NJ	1.2776	1.2639	-1.07%
35614	Passaic County - NJ	1.2776	1.2639	-1.07%

Appendix D

Proposed CY 2020 Wage Index for Urban & Rural Areas

CY 2020 CBSA Code	Area	Current CY 2019 Wage Index - New CBSA Designations	Proposed CY 2020 Wage Index - New CBSA Designations	% Difference Proposed CY 2020 vs Current CY 2019 Wage Index
40380	Rochester			
40380	Livingston	0.8579	0.8425	-1.80%
40380	Monroe	0.8579	0.8425	-1.80%
40380	Ontario	0.8579	0.8425	-1.80%
40380	Orleans	0.8579	0.8425	-1.80%
40380	Wayne	0.8579	0.8425	-1.80%
40380	Yates	0.8579	0.8425	-1.80%
45060	Syracuse			
45060	Madison	1.0053	0.9809	-2.43%
45060	Onondaga	1.0053	0.9809	-2.43%
45060	Oswego	1.0053	0.9809	-2.43%
46540	Utica - Rome			
46540	Herkimer	0.8885	0.9181	3.33%
46540	Oneida	0.8885	0.9181	3.33%
48060	Watertown - Fort Drum, NY			
48060	Jefferson	0.9105	0.9068	-0.41%
99933	Rural Areas (All other)			
99933	Allegany	0.8499	0.8431	-0.80%
99933	Cattaraugus	0.8499	0.8431	-0.80%
99933	Cayuga	0.8499	0.8431	-0.80%
99933	Chautauqua	0.8499	0.8431	-0.80%
99933	Chenango	0.8499	0.8431	-0.80%
99933	Clinton	0.8499	0.8431	-0.80%
99933	Columbia	0.8499	0.8431	-0.80%
99933	Cortland	0.8499	0.8431	-0.80%
99933	Delaware	0.8499	0.8431	-0.80%
99933	Essex	0.8499	0.8431	-0.80%
99933	Franklin	0.8499	0.8431	-0.80%
99933	Fulton	0.8499	0.8431	-0.80%
99933	Genesee	0.8499	0.8431	-0.80%
99933	Greene	0.8499	0.8431	-0.80%
99933	Hamilton	0.8499	0.8431	-0.80%
99933	Lewis	0.8499	0.8431	-0.80%
99933	Montgomery	0.8499	0.8431	-0.80%
99933	Otsego	0.8499	0.8431	-0.80%
99933	St. Lawrence	0.8499	0.8431	-0.80%
99933	Schuyler	0.8499	0.8431	-0.80%
99933	Seneca	0.8499	0.8431	-0.80%
99933	Steuben	0.8499	0.8431	-0.80%
99933	Sullivan	0.8499	0.8431	-0.80%
99933	Wyoming	0.8499	0.8431	-0.80%