

Centers for Medicare & Medicaid Services (CMS)
CY 2019 Home Health Prospective System Rate Update and CY 2020 Case-Mix Adjustment
Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health
Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training
Requirements for Survey

On October 31, 2018, the Centers for Medicare & Medicaid Services (“CMS”) released a final rule which includes finalized CY 2019 Medicare payment updates, finalized quality reporting changes for home health agencies (“HHAs”), and finalized case-mix methodology refinements for the Patient Driven Groupings Model (“PDGM”) and a change in the home health unit of payment from 60 days to 30 days for CY 2020. The PDGM model for home health services will begin on or after January 1, 2020.

This final rule also discusses the implementation of temporary transitional payments for home infusion therapy services to begin on January 1, 2019 and summarizes public comments related to full implementation of the new home infusion therapy benefit in CY 2021.

CMS projects that Medicare payments to HHAs in CY 2019 will be increased by 2.2 percent, or \$420 million, based on the finalized policies. The increase reflects the effects of a 2.2 percent home health payment update percentage (\$420 million increase); a 0.1 percent increase in payments due to decreasing the fixed-dollar-loss (FDL) ratio in order to pay no more than 2.5 percent of total payments as outlier payments (a \$20 million increase); and a 0.1 percent decrease in payments due to the new rural add-on policy mandated by the Bipartisan Budget Act of 2018 for CY 2019 (\$20 million decrease).

The new rural add-on policy requires CMS to classify rural counties (and equivalent areas) into one of three categories based on: 1) high home health utilization; 2) low population density; and 3) all others. Rural add-on payments for CYs 2019 through 2022 vary based on counties’ (or equivalent areas’) category classification.

CMS requests comments on limited provisions of the rule, specifically related to the definition of “infusion drug administration calendar day” by December 31, 2018.

I. Payment Under the Home Health Prospective Payment System (HH PPS) for CY 2019

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

In the CY 2019 proposed rule CMS provided a summary of analysis on fiscal (FY) 2016 HHA cost report data and how such data, if used, would impact CMS’s estimate of the percentage difference between Medicare payments and HHA costs. In addition, CMS presented information on Medicare home health utilization statistics and trends that included HHA claims data through CY 2017. CMS stated in the final rule that it will continue monitoring the impacts due to the rebasing adjustments and other policy changes and will provide the industry with periodic updates.

B. CY 2019 HH PPS Case-Mix Weights

To generate the final CY 2019 HH PPS case-mix weights, CMS used CY 2017 home health claims data (as of June 30, 2018) with linked OASIS data. CMS stated that it would use CY 2017 home health claims data (as of June 30, 2018 or later) with linked OASIS data to generate the CY 2019 HH PPS case-mix weights for this final rule with comment period.

CMS is finalizing the recalibrated scores for the case-mix adjustment variables, clinical and functional thresholds, payment regression model, and case-mix weights as proposed. The CY 2019 scores for the case-mix variables, the clinical and functional thresholds, and the case-mix weights were developed using complete CY 2017 claims data as of June 30, 2018.

C. CY 2019 Home Health Payment Rate Update

1. Rebasing and Revising of the Home Health Market Basket

CMS is finalizing the proposed 2016-based home health market basket without modification. CMS is also finalizing the proposed labor related share of 76.1 percent and the non-labor-related share of 23.9 percent. CMS is also finalizing the CY 2019 HHA payment update at 2.2 percent (3.0 percent market basket update, less 0.8 percentage point MFP adjustment). CMS stated that it believes the market basket update of 3.0 percent reflects the expected compensation price increases that home health agencies will face in CY 2019.

2. CY 2019 Market Basket Update for HHAs

The current estimate of the CY 2019 HHA payment update is 2.2 percent (3.0 percent market basket update. For HHAs that do not submit the required quality data for CY 2019, the home health payment update would be 0.2 percent (2.2 percent minus 2 percentage points).

3. CY 2019 Home Health Wage Index

CMS finalized its proposal to continue to use the pre-floor, prereclassified hospital inpatient wage index as the wage adjustment to the labor portion of the HH PPS rates. CMS believes that wage index values are reflective of the labor costs in each geographic area as they reflect the costs included on the cost reports of hospitals in those specific labor market areas.

The final CY 2019 wage index is available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html>.

4. CY 2019 Annual Payment Update

a. CY 2019 National, Standardized 60-Day Episode Payment Rate

TABLE 16: CY 2019 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

| CY 2018 National, Standardized 60-Day Episode Payment | Wage Index Budget Neutrality Factor | Case-Mix Weights Budget Neutrality Factor | CY 2019 HH Payment Update | CY 2019 National, Standardized 60-Day Episode Payment |
|--|--|--|----------------------------------|--|
| \$3,039.64 | X 0.9985 | X 1.0169 | X 1.022 | \$3,154.27 |

b. Low-Utilization Payment Adjust (LUPA) Add-On Factors

LUPA add-on amount is calculated with the use of three LUPA add-on factors: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP. This number is then multiplied by the per-visit payment amount for the first SN, PT, or SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount.

c. CY 2019 Non-routine Medical Supply (NRS) Payment Rates

To determine the CY 2019 NRS conversion factor, CMS updated the CY 2018 NRS conversion factor (\$53.03) by the CY 2019 home health payment update percentage of 2.2 percent. CMS did not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed.

TABLE 20: CY 2019 NRS CONVERSION FACTOR

| CY 2018 NRS Conversion Factor | CY 2019 HH Payment Update | CY 2019 NRS Conversion Factor |
|--------------------------------------|----------------------------------|--------------------------------------|
| \$53.03 | X 1.022 | \$54.20 |

D. Rural Add-On Payments for CY 2019-2022

CMS is finalizing the policies for the provision of rural add-on payments for CY 2019 through CY 2022 in accordance with the BBA of 2018. This includes finalizing the designations of rural counties (or equivalent areas) into their respective categories as outlined in the Excel files published in conjunction with the CY 2019 HH PPS proposed rule:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>.

TABLE 25: HH PPS RURAL ADD-ON PERCENTAGES, CYs 2019-2022

| Category | CY 2019 | CY 2020 | CY 2021 | CY 2022 |
|------------------------|---------|---------|---------|---------|
| High utilization | 1.5% | 0.5% | | |
| Low population density | 4.0% | 3.0% | 2.0% | 1.0% |
| All other | 3.0% | 2.0% | 1.0% | |

E. Payments for High Cost Outliers Under the HH PPS

CMS plans to publish the cost-per-unit amounts for CY 2019 in the rate update change request, which is issued after the publication of the CY 2019 HH PPS final rule.

CMS finalized the change to the fixed-dollar loss (“FDL”) ratio or loss sharing ratio for CY 2019. CMS is establishing an FDL ratio of 0.51 with a loss-sharing ratio of 0.80 for CY 2019. CMS will continue to monitor outlier payments and continue to explore ways to maintain an outlier policy for episodes that incur unusually high costs.

F. Changes Regarding Certifying and Recertifying Patient Eligibility

CMS is finalizing its proposal to amend the regulations text at §424.22(c) to align with current subregulatory guidance to allow medical record documentation from the HHA to be used to support the basis for certification and/or recertification of home health eligibility.

Effective for recertifications made on and after January 1, 2019, CMS is finalizing its proposal to eliminate the regulatory requirement set forth at §424.22(b)(2) that requires the certifying physician, as part of the recertification process, to provide an estimate of how much longer skilled services will be required. All other recertification content requirements under §424.22(b)(2) would remain unchanged.

G. Remote Patient Monitoring

CMS is finalizing its proposal to define remote patient monitoring in regulation for the Medicare home health benefit and to include the cost of remote patient monitoring as an allowable cost on the HHA cost report.

CMS is finalizing the term “remote patient monitoring” as “the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency.”

CMS is also adding the following language to the regulations text to ensure a more complete description of remote patient monitoring services, while also ensuring that such services cannot be reported as a visit without the provision of another skilled service: Visits to a beneficiary's home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment, without the provision of another skilled service are not separately billable. These services do constitute services included in the expense of providing remote patient monitoring allowed as administrative costs.

Additionally, CMS is finalizing its proposal to amend the regulations to include the costs of remote patient monitoring as an allowable administrative cost (that is, operating expense), if remote patient monitoring is used by the HHA to augment the care planning process.

II. Implementation of the Patient Driven Groupings Model (“PDGM”) for CY 2020

A. Background

CMS is finalizing the change in the unit of payment from 60 days to 30 days, effective for 30-day periods of care that start on or after January 1, 2020, as proposed and in accordance with the provisions in the BBA of 2018. In addition, CMS is finalizing the PDGM, with modification (discussed below), also effective for 30-day periods of care that start on or after January 1, 2020.

B. Behavioral Assumptions

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

CMS stated it plans to analyze the impact of the assumed versus the actual behavior change after the implementation of the PDGM and the 30-day unit of payment to determine if any

payment adjustment, either upward or downward, is warranted. **CMS notes it will analyze “any actual, observed behavioral changes with respect to CYs 2020-2026 to make any payment adjustment beginning in CY 2022 at the earliest.”** CMS stated the temporary and prospective adjustments outlined in the statute are “not meant to act as a cap” on overall home health expenditures. Further, CMS will analyze claims data from CY 2018 to determine any changes to the payment amount for CY 2020 and will propose the amount in the CY 2020 HH PPS proposed rule.

CMS evaluated stakeholder concerns regarding the proposed behavioral adjustments but noted it was finalizing the proposal because it believes they are supported by law and data. CMS stated that the law requires that CMS analyze data for CYs 2020 through 2026, after implementation of the 30-day unit of payment and the alternate case-mix adjustment methodology, to annually determine the impact of the differences between assumed and actual behavioral changes on estimated aggregate expenditures and adjust the payment amount either upwards or downwards accordingly.

Therefore, CMS does not believe the law provides it the latitude to test behavioral assumptions prior to implementation of the 30-day unit of payment and the PDGM for CY 2020 given these requirements, in law, to make behavioral assumptions in calculating a 30-day budget-neutral payment amount for CY 2020 and to determine the impact on estimated aggregate expenditures of differences between the assumed and actual behavior changes once the data for CYs 2020 through 2026 become available to determine whether temporary and permanent adjustments are needed.

To support HHAs in evaluating the effects of the proposed PDGM, CMS will provide, upon request, a Home Health Claims-OASIS Limited Data Set (LDS) to accompany the proposed and final rules. The Home Health Claims-OASIS LDS file can be requested by following the instructions on the CMS website: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA-NewLDS.html>.

C. Budget Neutrality

CMS stated it is required to calculate a 30-day payment amount for CY 2020 in a budget neutral manner such that estimated aggregate expenditures under the HH PPS during CY 2020 are equal to the estimated aggregate expenditures that otherwise would have been made under the HH PPS during CY 2020 in the absence of the change to a 30-day unit of payment.

CMS said it is also required to calculate a budget-neutral 30-day payment amount before the the home health applicable percentage increase, the adjustment for case-mix changes, the adjustment if quality data is not reported, and the productivity adjustment. CMS noted however, this does not mean that the 30-day budget-neutral payment amount only pertains to payments made in CY 2020 as CMS is required to annually determine the impact of differences between assumed and actual behavior changes on estimated aggregate expenditures for CY

2020 through CY 2026 and adjust the payment amount upwards or downwards accordingly. Because CMS would propose the actual 30-day payment amount in the CY 2020 HH PPS proposed rule calculated using CY 2018 home health utilization data, CMS will calculate this amount before application of the proposed home health update percentage required for CY 2020.

D. Patient Driven Groupings Model (“PDGM”)

1. Costs

CMS is finalizing its proposal to adopt a Cost-per-Minute plus Non-Routine Supplies (CPM + NRS) approach in estimating resource use, which uses information from HHA Medicare cost reports.

2. Timing: “Early” vs. “Late”

CMS is finalizing its proposal to classify 30-day periods of care under the PDGM as “early” or “late” depending on when they occur within a sequence of 30-day periods. The first 30-day period would be classified as early and all subsequent 30-day periods in the sequence (second or later) would be classified as late and 30-day periods of care cannot be considered early unless there is a gap of more than 60 days between the end of one period and the start of another.

3. Admission Source Categories

CMS finalized its proposal that each 30-day period will be classified into one of two admission source categories—community or institutional-- depending on what healthcare setting was utilized in the 14 days prior to home health. The 30-day period would be categorized as institutional if an acute or post-acute care stay occurred within the prior 14 days to the start of the 30-day period of care. The 30-day period would be categorized as community if there was no acute or post-acute care stay in the 14 days prior to the start of the 30-day period of care.

4. Clinical Groupings

CMS is finalizing, with modification, its approach to grouping 30-day periods of care into clinical groups. CMS is finalizing twelve clinical groups, as shown in Table 27 below. The additional groups are a result of dividing the MMTA clinical group into 7 sub-groups. CMS will continue to examine trends in reporting and resource utilization to determine if future changes to the clinical groupings are needed after implementation of the PDGM in CY 2020.

TABLE 27: FINAL CLINICAL GROUPS USED IN THE PDGM

| Clinical Groups | The Primary Reason for the Home Health Encounter is to Provide: |
|---|--|
| Musculoskeletal Rehabilitation | Therapy (physical, occupational or speech) for a musculoskeletal condition |
| Neuro/Stroke Rehabilitation | Therapy (physical, occupational or speech) for a neurological condition or stroke |
| Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care | Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions |
| Behavioral Health Care | Assessment, treatment & evaluation of psychiatric conditions |
| Complex Nursing Interventions | Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies |
| Medication Management, Teaching and Assessment (MMTA) | |
| MMTA –Surgical Aftercare | Assessment, evaluation, teaching, and medication management for surgical aftercare |
| MMTA – Cardiac/Circulatory | Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions |
| MMTA – Endocrine | Assessment, evaluation, teaching, and medication management for endocrine related conditions |
| MMTA – GI/GU | Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions |
| MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases | Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases |
| MMTA –Respiratory | Assessment, evaluation, teaching, and medication management for respiratory related conditions |
| MMTA – Other | Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups |

Each 30-day period will be placed into one of three functional impairment levels. The level would indicate if, on average, given the HHA’s responses on certain functional OASIS questions, a 30-day period was predicted to have higher costs or lower costs. For each of the six clinical groups, CMS proposed that total periods would be further classified into one of three functional impairment levels with roughly 33 percent of total 30-day periods for all HHAs in each level.

A 30-day period will also receive a comorbidity adjustment category based on the presence of secondary diagnoses. Depending on patient’s secondary diagnoses, a 30-day period may receive “no” comorbidity adjustment, a “low” comorbidity adjustment, or a “high” comorbidity adjustment. For low-utilization payment adjustments (LUPAs) under the PDGM, the LUPA threshold would vary for a 30-day period under the PDGM depending on the PDGM payment group to which it was assigned. For each payment group, CMS will use the 10th percentile value of visits to create a payment group specific LUPA threshold with a minimum threshold of at least 2 visits for each group.

E. Split-Percentage Payment Approach for a 30-day Unit of Payment

CMS is finalizing the split-percentage proposal as proposed with an effective date of January 1, 2020. This means that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, would not receive RAP payments beginning in CY 2020.

HHAs that are certified for participation in Medicare effective on or after January 1, 2019, would still be required to submit a “no pay” RAP at the beginning of care in order to establish the home health period of care, as well as every 30-days thereafter.

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

CMS plans to continue to closely monitor RAP submissions, service utilization, payment, and quality trends which may change as a result of implementing of the PDGM and a 30-day unit of payment.

F. Functional Impairment Levels and Corresponding OASIS Items

CMS is finalizing the use of OASIS items: M1800, M1810, M1820, M1830, M1840, M1850, M1860 and M1033 for the functional impairment level case-mix adjustment under the PDGM. CMS is finalizing that a home health period of care receives points based on each of the responses associated with the functional OASIS items which are then converted into a table of points corresponding to increased resource use (see Table 28). The sum of all of these points results in a functional score which is used to group home health periods into a functional level with similar resource use.

CMS is finalizing three functional levels of low impairment, medium impairment, and high impairment with approximately one third of home health periods from each of the clinical groups within each functional impairment level (see Table 29). For the implementation of the PDGM in CY 2020, CMS will update the functional points and functional thresholds as previously described based on analysis of CY 2018 home health claims, and using the most current version of the OASIS data set, to reflect any changes in resource use associated with these variables. Once the PDGM is implemented in CY 2020, CMS will continue to analyze the impact of all of the PDGM case mix variables to determine if any additional refinements need to be made to ensure that all variables used as part of the overall case-mix adjustment appropriately align home health payment with the actual cost of providing home health care services.

G. Comorbidity Adjustment

CMS is finalizing the comorbidity adjustment as part of the overall case mix in the PDGM. This includes the home health specific list of comorbidity subgroups and comorbidity subgroup interactions. One of the three mutually exclusive categories of comorbidity adjustment will be applied to each period: No Comorbidity Adjustment, Low Comorbidity Adjustment, and High

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

The low comorbidity adjustment amount would be the same across the subgroups and the high comorbidity adjustment would be the same across the subgroup interactions. Upon implementation of the PDGM in CY 2020, CMS will analyze the most recently available claims to update the comorbidity list to include those comorbid conditions and interaction subgroups that represent more than 0.1 percent of periods and have at least as high as the median resource use. Likewise, CMS will continue to evaluate reported secondary diagnoses and interactions between comorbidities to identify their impact on resource costs to determine if any additional refinements to this case-mix adjustment variable are warranted.

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

H. Changes in the Low-Utilization Payment Adjustment (“LUPA”) Threshold

CMS is finalizing its proposal to vary the LUPA threshold for each 30-day period of care depending on the PDGM payment group to which it is assigned. CMS is finalizing that the LUPA thresholds for each PDGM payment group will be re-evaluated every year based on the most current utilization data available.

The LUPA thresholds for the PDGM payment groups with the corresponding HIPPS codes based on CY 2017 home health data are listed in Table 32. Because CMS proposes to implement the PDGM on January 1, 2020, LUPA thresholds for the PDGM payment groups with the corresponding HIPPS codes for CY 2020 will be updated in the CY 2020 HH PPS proposed rule using CY 2018 home health data.

I. Case-Mix Weights

CMS is finalizing its proposal to generate PDGM case-mix weights for each of the different PDGM payment groups by regressing resource use on a series of indicator variables for each of the five categories previously listed (timing, admission source, clinical grouping, functional level, and comorbidity) using a fixed effects model and annually recalibrating the PDGM case-mix weights to ensure that the case-mix weights reflect the most recent utilization data available at the time of annual rulemaking. CMS is not finalizing the discontinuation of the October release of the HH PPS Grouper software update given the potential for HIPAA violations. CMS will continue to release Grouper software in both October and January of each year.

J. LUPA Add-On Payments and Partial Payment Adjustments Under PDGM

CMS is finalizing its proposal to continue to multiply the per-visit payment amount for the first skilled nursing, physical therapy, or speech-language pathology visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care by the appropriate add-on factor (1.8451 for SN, 1.6700 for PT, and 1.6266 for SLP) to determine the LUPA add-on payment amount for 30-day periods of care under the PDGM. CMS is also finalizing its proposal to retain the current PEP policy and apply such policy to 30-day periods of care under the PDGM.

K. Payments for High-Cost Outliers Under the PDGM

CMS is finalizing its proposal to maintain the current methodology for payment of high-cost outliers upon implementation of the PGDM and that it will calculate payment for high-cost outliers based upon 30-day periods of care.

VIII. Home Health Value-Based Purchasing Model (“HHVBP”)

CMS is finalizing the following changes to the HHVBP Model, beginning with Performance Year 4:

- removal of two Outcome and Assessment Information Set (OASIS)-based measures, Influenza Immunization Received for Current Flu Season and Pneumococcal Polysaccharide Vaccine Ever Received, from the set of applicable measures;
- replacement of three OASIS-based measures with two new composite measures on total change in self-care and mobility;
- changes to how it calculates the Total Performance Scores by changing the weighting methodology for the OASIS-based, claims-based, and HHCAHPS measures; and
- a change to the scoring methodology by reducing the maximum amount of improvement points and HHA can earn.

VII. Home Health Quality Reporting Program (“HH QRP”) Provisions

CMS is finalizing its policy for removing previously adopted HH QRP measures based on eight measure removal factors.

CMS is also finalizing the removal of seven quality measures based upon one of these eight finalized measure removal factors:

1. HHAs will no longer be required to submit OASIS Item M1730, Depression Screening at SOC/ROC for the purposes of this measure beginning with Home Health quality episodes of care that begin on or after January 1, 2020. HHAs will, however, continue to submit data on M1730 at the time point of SOC/ROC as a risk adjuster for several other OASIS-based outcome measures currently adopted for the HH QRP.
2. CMS is removing the Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care Measure from the HH QRP. HHAs will no longer be required to submit OASIS Item M2401 row a, Intervention Synopsis: Diabetic foot care at the time point of Transfer to an Inpatient Facility (TOC) and Discharge from Agency — Not to an Inpatient Facility (Discharge) for the purposes of the HH QRP beginning January 1, 2020.
3. CMS is removing the Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate (NQF #0537) Measure from the HH QRP. HHAs will no longer be required to submit OASIS Item M1910, Falls Risk Assessment at SOC/ROC beginning January 1, 2020.
4. CMS is removing the Pneumococcal Polysaccharide Vaccine Ever Received Measure from the HH QRP. HHAs will no longer be required to submit OASIS Items M1051, Pneumococcal Vaccine and M1056, Reason Pneumococcal Vaccine not received at the time point of TOC and Discharge for the purposes of the HH QRP beginning January 1, 2020.
5. CMS is removing the Improvement in the Status of Surgical Wounds Measure from the HH QRP. HHAs will no longer be required to submit OASIS Items M1340, Does this patient have a Surgical Wound? and M1342, Status of Most Problematic Surgical Wound that is Observable, at the time points of SOC/ROC and Discharge for the purposes of this measure beginning January 1, 2020.
 - A. HHAs will still be required to submit data on Items M1340 and M1342 at the time point of SOC/ROC as risk adjusters for several other OASIS-based outcome measures currently adopted for the HH QRP and also at the time point of Discharge for the Potentially Avoidable Events measure Discharged to the Community Needing Wound Care or Medication Assistance that is used by HH surveyors during the survey process.
6. CMS is removing the Emergency Department (ED) Use without Hospital Readmission during the First 30 Days of HH (NQF #2505) Measure from the HH QRP beginning with the CY 2021 HH QRP.
7. CMS is removing the Rehospitalization during the First 30 Days of HH (NQF #2380) Measure from the HH QRP beginning with the CY 2021 HH QRP.

Lastly, CMS is finalizing an update to its regulations to clarify that not all OASIS data is used to determine whether an HHA has satisfied the HH QRP reporting requirements for a program year.

VI. Home Infusion

For CYs 2019 and 2020, CMS is implementing a temporary transitional payment for home infusion therapy services that pays eligible home infusion therapy suppliers for associated professional services for administering certain drugs and biologicals infused through a durable medical equipment pump, training and education, and remote monitoring and monitoring services. Section 5012 of the 21st Century Cures Act creates a new permanent Medicare benefit for home infusion therapy services beginning January 1, 2021.

The rule finalizes elements of the permanent home infusion benefit including the health and safety standards for home infusion therapy, an accreditation process for qualified home infusion therapy suppliers and an approval and oversight process for the organizations that accredit qualified home infusion therapy suppliers.

CMS is not including specific timeframes for the review of the plan of care and will defer to existing State laws and regulations.

In response to stakeholder feedback regarding CMS's interpretation of "infusion drug administration calendar day", including with respect to professional services that may be provided outside of the home and, as applicable, payment amounts for such services, CMS will monitor the effects on access to care of finalizing this definition and, if warranted and within the limits of its statutory authority, engage in additional rulemaking or guidance regarding this definition for temporary transitional payments. **CMS requests comments on this interpretation and on its potential effects on access to care.**

V. Changes to Accreditation Requirements for Certain Medicare Certified Providers and Suppliers

In the CY 2019 proposed rule CMS proposed to revise the regulations for Medicare-certified providers and providers to add two new requirements for the accrediting organizations ("AOs") that accredit certified providers and providers.

First, CMS is adopting, as proposed, a requirement for AOs of Medicare-certified providers and suppliers to include a written statement in their application which states that if a fully accredited and deemed facility in good standing provides written notification that they wish to voluntarily withdraw from the AO's CMS-approved accreditation program, the AO must continue the facility's current accreditation until the effective date of withdrawal identified by the facility or the expiration date of the term of accreditation, whichever comes first.

CMS is not finalizing its other proposal which would have modified the AO oversight regulations by adding new requirements for training for AO surveyors.

IX. Regulatory Burden Reduction

The cost impact related to OASIS item collection as a result of the implementation of the PDGM and finalized changes to the HH QRP as outlined above, is estimated to be a net \$60 million in annualized cost savings for home health agencies.