



Home Health Regulatory Update: CY 2020 HH Proposed Rule (CMS-1711-P)

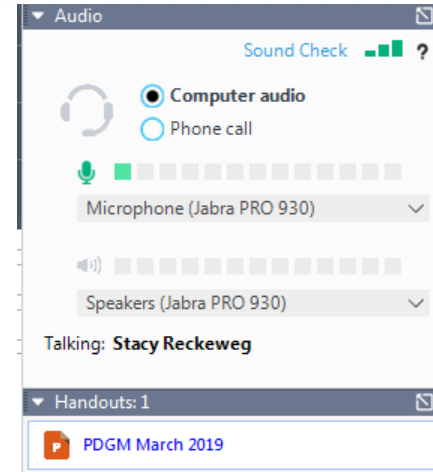
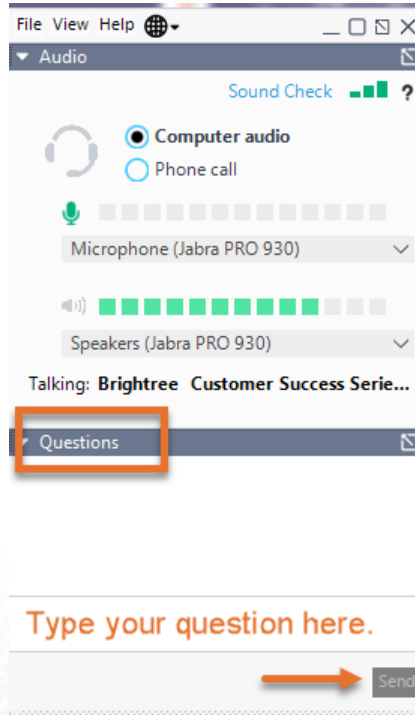
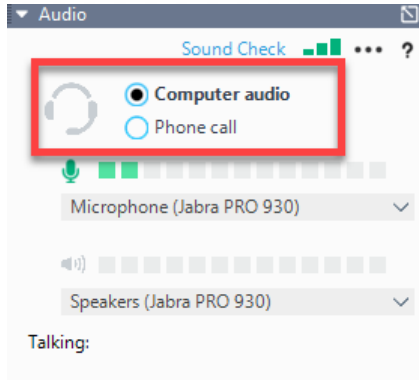
Presenters:

Brandy Shifteh and Carolyn Dean

Regulations Compliance Management



August 15th, 2019



I. HH CY 2020 HH Proposed Rule

- ❖ CY 2020 Payment Update
- ❖ Requirements for Implementation of the Patient-Driven Groupings Model (PDGM)
 - New PDGM Proposals: Split-Percentage Changes and the New Notice of Admission (NOA) Requirement
 - Cash Flow Impact Considerations
 - PDGM Transition Implementation
- ❖ Other Proposed CY 2020 Rule Provisions
 - Proposed Modifications to Payment Regulations Related to the Content of the HH Plan of Care
 - Proposed Changes Related to Therapy Assistants & Maintenance Therapy
 - Proposed Public Reporting Under the Home Health Value-Based Purchasing (HHVBP) Model
- ❖ Proposed Home Health Quality Reporting Program (HHQRP) Requirements
- ❖ Updates on Provisions for Phase-In Implementation of Home Infusion Therapy Through 2021

II. Other Important CMS Transmittals & Reminders:



CY 2020 Payment Update

Proposed CY 2020 (PDGM) Base Payment Rates

- CY 2020 HH PPS Rates have MBI of 1.5% (inflation update) over CY 2019 for episodes ending on/after 1/1/20
- 60-Day payment amount increased from \$3154.27 to \$3221.43 for episodes that span 1/1/20 implementation date (thru 2/28/20) (Table 15)
- 30-Day payment amount (PDGM Base Rate) \$1791.73 (for new 1/1/20 payment periods) (Table 21)
 - CY 2020 estimated 30-day budget neutral payment amount \$1754.37 (pre-required 1.5% update in BiBA 2018)

TABLE 15: CY 2020 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2019 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	CY 2020 HH Payment Update	CY 2020 National, Standardized 60-Day Episode Payment
\$3,154.27	X 1.0062	X 1.015	\$3,221.43

TABLE 21: CY 2020 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2020 30-day Budget Neutral (BN) Standard Amount	Wage Index Budget Neutrality Factor	CY 2020 III Payment Update	CY 2020 National, Standardized 30-Day Period Payment
\$1,754.37	X 1.0062	X 1.015	\$1,791.73

- Updated by the CY 2020 HH payment update percentage of 1.5%
- LUPA per visit rates are not calculated using case mix weights
- LUPA calculation and LUPA add-on factors remain the same as CY 2019, using CY 2020 proposed visit rates
 - SN 1.8451
 - PT 1.6700
 - SLP 1.6266
- LUPA add-on payment calculation example for a first SN visit: $\$149.66 \times 1.8451 = \276.14

TABLE 23: CY 2020 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2019 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2020 IIII Payment Update	CY 2020 Per-Visit Payment
Home Health Aide	\$66.34	X 1.0065	X 1.015	\$ 67.77
Medical Social Services	\$234.82	X 1.0065	X 1.015	\$239.89
Occupational Therapy	\$161.24	X 1.0065	X 1.015	\$164.72
Physical Therapy	\$160.14	X 1.0065	X 1.015	\$163.60
Skilled Nursing	\$146.50	X 1.0065	X 1.015	\$149.66
Speech-Language Pathology	\$174.06	X 1.0065	X 1.015	\$177.82

- CMS updated the CY 2019 NRS conversion factor \$54.20 to \$55.01 (Table 17)
- Using the CY 2020 NRS conversion factor, the payment amounts for six severity levels were updated (Table 18)
 - Applies only to those 60-day episodes that begin on or before 12/31/19, but span PDGM implementation (thru 2/28/20)
- Under PDGM, NRS payments are included in the 30-day base payment rate

TABLE 17: CY 2020 NRS CONVERSION FACTOR

CY 2019 NRS Conversion Factor	CY 2020 HH Payment Update	CY 2020 NRS Conversion Factor
\$54.20	X 1.015	\$55.01

TABLE 18: CY 2020 NRS PAYMENT AMOUNTS

Severity Level	Points (Scoring)	Relative Weight	CY 2020 NRS Payment Amounts
1	0	0.2698	\$14.84
2	1 to 14	0.9742	\$53.59
3	15 to 27	2.6712	\$146.94
4	28 to 48	3.9686	\$218.31
5	49 to 98	6.1198	\$336.65
6	99+	10.5254	\$579.00

Year	Low Population Density (counties with 6 or fewer people per square mile- 334 rural counties)	High Utilization Counties (top quartile of utilization on average- 510 rural counties)	All other rural areas (1162 rural counties)
2019	4%	1.5%	3%
2020	3%	0.5%	2%
2021	2%	None	1%
2022	1%	None	None

- Fixed-dollar loss ratio (FDL) updated from 0.51 to 0.63 for CY 2020
30-Day payment periods
 - Decrease volume of outlier claims
- FDL ratio for transitional 60-day episodes in CY2020 at 0.51
- Cost per 15 minute unit outlier methodology remains same as CY 2019
 - Providers should assume new outlier per unit rate changes to be posted in future CMS Change Request (CR) after final rule publishes

- Proposed rule continues to plan for behavioral adjustment to base rates to account for assumed diagnosis and visit volume changes:
 - Clinical Group Coding
 - Comorbidity Coding
 - LUPA Thresholds
- Increases adjustment from 6.42% to 8.01%
- CMS soliciting comments and reiterates consequences of under/over-estimating reductions necessary to offset behavior changes/maintain budget neutrality
- NAHC Advocacy
- Bipartisan Bills S.433 and H.R.2573

CMS' Home Health Agency (HHA) Center webpage: <https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>

CY 2020 HH PPS Proposed Rule: <https://www.federalregister.gov/documents/2019/07/18/2019-14913/medicare-and-medicaid-programs-cy-2020-home-health-prospective-payment-system-rate-update-home>

CMS Press Release: <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-steps-strengthen-medicare-new-home-infusion-therapy-benefit-and-new>

CMS Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/cms-proposes-calendar-year-2020-and-2021-new-home-infusion-therapy-benefit-and-payment-and-policy>

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Requirements for Implementation of the Patient-Driven Groupings Model (PDGM)

- 30-Day Payment Periods
- Therapy Utilization Domain Eliminated
- 432 Payment Groups
- Episode Timing: Early or Late (Claims-Based)
- Admission Source: Community or Institutional (Claims Based)
- Six Clinical Groupings (plus sub-groups in MMTA) (Claims-Based)
- Functional Impairment Level (OASIS-Based)
- Comorbidity Adjustment (secondary diagnosis) (Claims-Based)
- LUPA Range of 2-6 Visits per Payment Period
- Bundled Services/Supplies
- Case-mix Weights Recalibrated from 2018 Version
- **HEALTHCARE*first* PDGM Webinar:** <https://www.healthcarefirst.com/webinar-replays/>

Split Percentage Changes CY 2020 / RAP Phase Out CY 2021

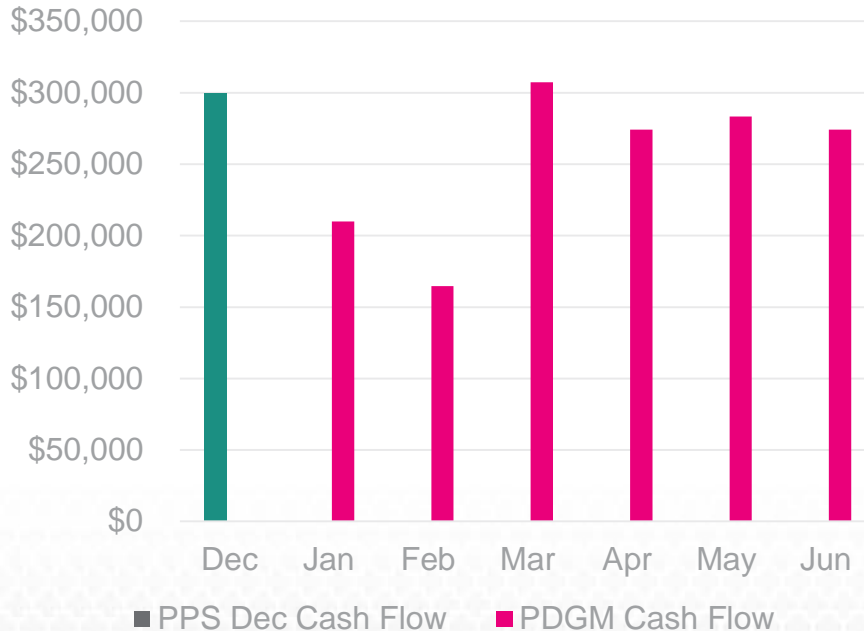
- Reduction of split-percentage payment in CY 2020 from current 60/50 upfront, to 20% upfront-Existing HHAs
 - New HHAs –No-pay RAPs 2020
- Elimination of split-percentage payments in CY 2021 (RAP Phase Out)-All HHAs
- CMS views that 30-day billing obviates need for RAP

Replace RAPS with New NOA Requirement CY 2021

- One-time submission of NOA within 5 calendar days of SOC
- Would be used to trigger consolidated billing edits
- Would allow other providers/CMS claims processing systems to know patient under HH period of care
- Penalty for late NOA proportionate to degree of lateness (1/30th rate reduction each late day)
- The reduction (R) to the full 30-day period payment amount would be calculated as follows:
 - The number of days (d) from the start of care until the NOA is submitted divided by 30 days;
 - The fraction from step 1 is multiplied by the case-mix and wage-adjusted 30-day period payment (P) amount
 - The formula for the reduction would be $R = (d/30) \times P$
- No LUPA payments made for days within period of care prior to late NOA submission
- HHAs able to request waiver if exceptional circumstances

- Anticipate a temporary decrease in cash flow
- Standard payment RAP will decrease from \$1932.86 (60%) for a PPS episode to \$358.35 (20%) per PDGM payment period
- Cash flow decrease month will depend on agency claim delays
 - Days to RAP, Days to Final Claim
- For projected case mix change use the CY 2020 PDGM Agency Level Impacts on the CMS Home Health Agency (HHA) Center webpage:
<https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>

Cash Flow Impact Under PDGM

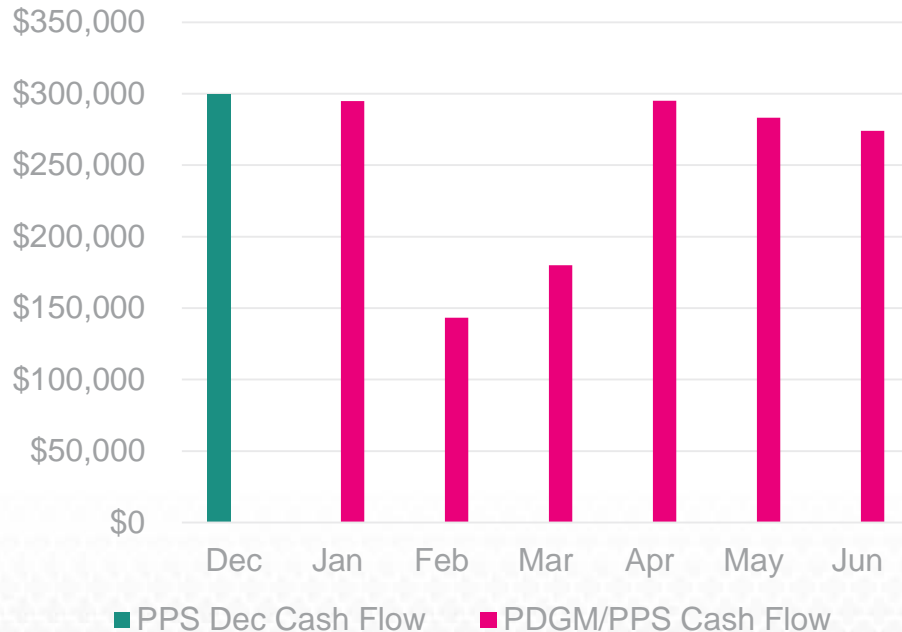


Best Case Scenario

Assumptions:

- RAP delay = 7 days
- Final delay = 14 days
- Days to pay RAP = 5
- Days to pay Final = 14
- Case mix impact = 0%
- Periods per patient = 1.7
- RAP % (as proposed) = 20%
- New episodes per day = 3

Cash Flow Impact Under PDGM



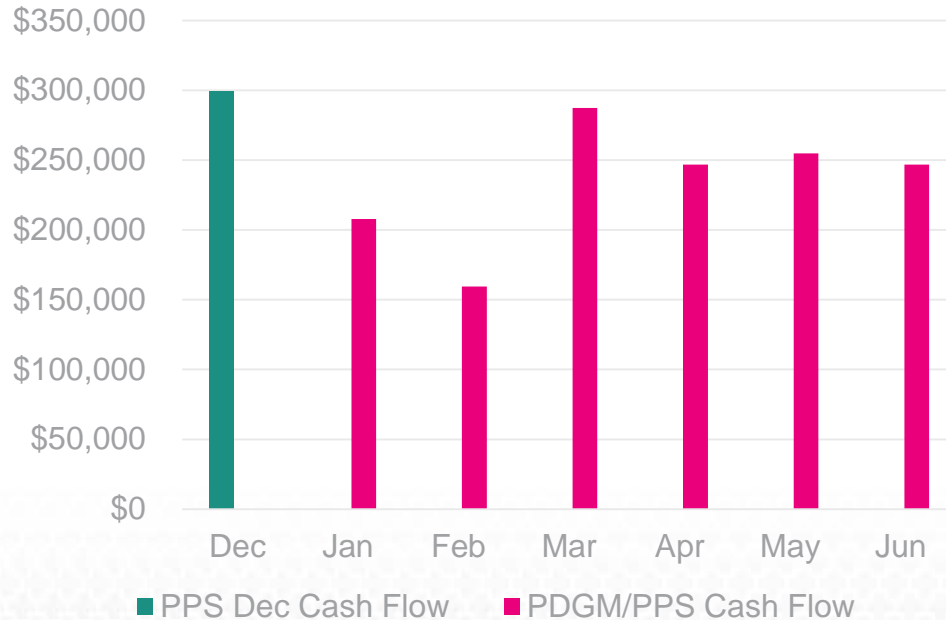
Best Case Scenario

(with late claims billing)

Assumptions

- **RAP delay = 25 days**
- **Final delay = 45 days**
- Days to pay RAP = 5
- Days to pay Final = 14
- Case mix impact = 0%
- Periods per patient = 1.7
- RAP % (as proposed) = 20%
- New episodes per day = 3

Cash Flow Impact Under PDGM



Negative Case Mix Scenario

Assumptions

- RAP delay = 7 days
- Final delay = 14 days
- Days to pay RAP = 5
- Days to pay Final = 14
- **Case mix impact = (10%)**
- Periods per patient = 1.7
- RAP % (as proposed) = 20%
- New episodes per day = 3

HH Episodes Begin and End CY 2019	HH Episodes Begin CY 2019 End CY 2020	HH Episodes Begin CY 2020 And Later	Special Guidance for Re-certifications 12/27-12/31/19 <i>(For assessments needing to provide HIPPS code for PDGM episode that begins 1/1/2020 or later)</i>
<ul style="list-style-type: none"> ▪ Use CY 2019 Payment Rates & PPS Model Payment Rules ▪ CMS will look at Claim “From” date and “Claim “Through” date of 12/31/19 and prior ▪ 2019 Grouper and OASIS D 	<ul style="list-style-type: none"> ▪ Use CY 2020 Payment Rates & PPS Model Payment Rules ▪ CMS will look at Claim “From” date of 12/31/19 and prior, and claim “Through” date of 1/1/20 and later ▪ 2019 Group and OASIS-D 	<ul style="list-style-type: none"> ▪ Use CY 2020 Payment Rates & PDGM Model Payment Rules ▪ CMS will look at Claim “From” date equal to 1/1/20 and later ▪ 2020 Grouper and OASIS-D1 	<ul style="list-style-type: none"> ▪ Use OASIS D-1 ▪ Enter M0090 date of 1/1/20 ▪ Do not transmit OASIS until 1/1/2020 ▪ CMS will alert State surveyors of this one-time exemption

CMS' PDGM Overview Document: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Overview-of-the-Patient-Driven-Groupings-Model.pdf>

CMS' HHA Center webpage: <https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html>

CMS' PDGM webpage: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html>

CY 2019 HH PPS final rule: <https://www.federalregister.gov/documents/2018/11/13/2018-24145/medicare-and-medicaid-programs-cy-2019-home-health-prospective-payment-system-rate-update-and-cy>

CR 11081: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4228CP.pdf>

CR 11272: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4294CP.pdf>

CY 2020 HH Proposed Rule: <https://www.federalregister.gov/documents/2019/07/18/2019-14913/medicare-and-medicaid-programs-cy-2020-home-health-prospective-payment-system-rate-update-home>



Other Proposed CY 2020 Rule Provisions

Proposed Modifications to Payment Regulations Related to the Content of the HH Plan of Care

- Proposing to revise condition for payment requirements for Medicare Plan of Care items requirements listed at 409.43(a)
- Specifically, CMS Proposes for HH services to be covered:
 - Individual plan of care must specify the services necessary to meet patient-specific needs identified in comprehensive assessment
 - In addition, plan of care must include identification of responsible discipline(s), frequency and duration of all visits
 - As well as those items listed in 484.60(a) ***that establish the need for such services***
- Proposed newly added items remain a CoP but not condition for payment; best addressed through survey process rather than claims denials:
 - Risk for ER visits/hospital admission and all necessary interventions to address underlying risk factors
 - Information related to advance directives

- Proposal to allow therapy assistants to furnish maintenance therapy services under a maintenance program established by a qualified therapist
 - According to individual state practice requirements
- Qualified therapist still responsible for:
 - Initial assessment
 - Plan of care
 - Maintenance program development and modifications
 - Reassessment every 30 days
 - Supervising services provided by therapy assistant
- CMS soliciting comments on proposal and importance of tracking whether a visit is for maintenance or restorative therapy versus just identifying if the service was provided by a qualified therapy assistant or therapist

- Proposal to publicly report Total Performance Score (TPS) and TPS Percentile Ranking from Performance Year 5 (PY5) Annual Report for each HHA in the nine HHVBP Model states
 - Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee & Washington
- Data to be public after December 1, 2021
- CMS' HHVBP Model webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/HHVBP.html>

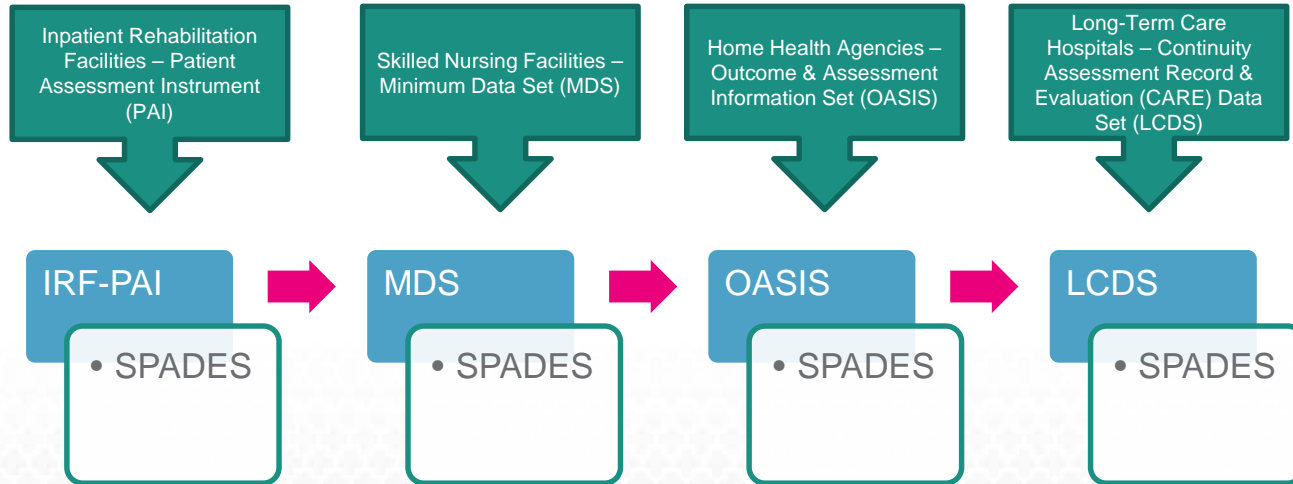


Proposed Home Health Quality Reporting Program (HHQRP) Requirements

- Removal of One Measure beginning CY 2022
 - Improvement in Pain Interfering with Activity Measure
- Removal of Question #10 from HHCAHPS beginning July 1, 2020
 - “In the last two months, did you and a home health provider from this agency talk about pain?”
- Adoption of Two Measures beginning CY 2022
 - Transfer of Health Information to Provider -Post-Acute Care (PAC)
 - Transfer of Health Information to Patient –Post Acute Care (PAC)
- Modification of One Existing Measure beginning CY 2021
 - Update specs for Discharge to Community (DTC) –Post-Acute Care (PAC) to exclude nursing facility (NF) residents
- Adoption of New Standardized Assessment Data Elements (SPADES) beginning CY 2022

Proposed Standardized Patient Assessment Data Elements (SPADES)

IMPACT Act requires standardized patient assessment data elements (SPADES) to be collected across post-acute care (PAC)



Collection CY 2021, Reporting in HHQRP CY 2022

1. Functional Status (Collected from GG items)
2. Cognitive Function and Mental Status
3. Special Services, Treatments, and Interventions Data
4. Medical Conditions and Comorbidities Data
5. Impairment Data
- 6. *New Category*: Social Determinants of Health**

**NOTE* 2-5 (above) were originally proposed in 2018 HH PPS rule for reporting beginning in 2019, but not finalized at that time*

- Request for Information (RFI) for input on importance, relevance, appropriateness and applicability of each of the measures, measure concepts, and SPADES under consideration
 - CMS does intend to use this input to inform their future measure and SPADE development efforts
- CMS will not be responding to comment submissions, nor finalizing in this CY 2020 final rule

TABLE 27: FUTURE MEASURES, MEASURE CONCEPTS, AND STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS (SPADEs) UNDER CONSIDERATION FOR THE HH QRP

Quality Measures and Measure Concepts
Potentially-preventable hospitalizations
Functional improvement and maintenance outcomes
Opioid use and frequency
Exchange of electronic health information and interoperability
Standardized Patient Assessment Data Elements (SPADEs)
Cognitive complexity, such as executive function and memory
Dementia
Bladder and bowel continence including appliance use and episodes of incontinence
Care preferences, advance care directives, and goals of care
Caregiver Status
Veteran Status
Health disparities and risk factors, including education, sex and gender identity, and sexual orientation

- Proposed to codify requirements that apply to HHQRP in a single section of their regulations (**New**- 484.245), titled “Home Health Quality Reporting Program”
- Future Considerations: CMS plans to propose expansion of reporting of OASIS data used for HHQRP to include data on all patients, regardless of payer in future rule-making – CMS requests input:
 - Do you agree there is a need to collect OASIS data for the HH QRP on all patients regardless of payer?
 - What percentage of your HHA’s patients are you not currently reporting OASIS data for the HH QRP?
 - Are there burden issues that need to be considered specific to the reporting of OASIS data on all HH patients, regardless of their payer?
 - What differences, if any, do you notice in patient mix or in outcomes between those patients that you currently report OASIS data, and those patients that you do not report data for the HH QRP?
 - Are there other factors that should be considered prior to proposing to expand the reporting of OASIS data used for the HH QRP to include data on all patients, regardless of their payer?
- NAHC Survey (includes CMS questions): <https://www.surveymonkey.com/r/Q8GR88J>

Proposed Specifications for HHQRP Quality Measures and Standardized Patient Assessment Data Elements:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Proposed-Specifications-for-HH-QRP-Quality-Measures-and-SPADE.pdf>

CMS' Home Health Quality Measures webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Measures.html>

CMS' IMPACT Act Downloads and Videos webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-Downloads-and-Videos.html>

CMS' Home Health Quality Reporting Program webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html>



Updates on Phase-In Implementation of Home Infusion Therapy Through 2021

- Section 5012 of the 21st Century Cures Act:
Permanent benefit beginning in CY 2021
- Section 50401 of the BBA of 2018:
Temporary transitional payments in CY 2019
and CY 2020



- Payment made to eligible home infusion therapy suppliers
 - Professional services for administering certain drugs and biologicals infused through a durable medical equipment pump, training and education, and remote monitoring and monitoring services.
- CR10836: Billing instructions for the temporary payments under Medicare Part B
- CY 2020 Proposed Rule:
 - CY 2020 transitional payment rates: Publish with CY 2020 physician fee schedule final rule
 - Clarification: Home infusion therapy not excluded from home health benefit until January 1, 2021

CR 10836: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018-Transmittals-Items/R4112CP.html?DLPage=1&DLEntries=10&DLFilter=10836&DLSort=1&DLSortDir=ascending>

- New Medicare Provider Type designation: Home Infusion Therapy
 - Providers must enroll in Medicare Part B under the new provider type designation
 - Providers must become accredited as a home infusion therapy provider
 - HHA's must meet new requirements in CY 2021 to continue providing services
- Covers acute and chronically ill beneficiaries receiving infusion therapy associated professional services for certain drugs and biologicals administered intravenously, or subcutaneously through a pump that is an item of DME.
 - Professional services: nursing, PoC, training and education, remote patient monitoring, availability 24/7, patient must be under the care of a physician, NP or PA
 - Infusion pump and supplies would remain under the Medicare Part B DME benefit
- Single payment for drug administration calendar day
- 20% co-pay applies

- CY 2020 Home Health Proposed Rule :
 - CMS is soliciting comments on definition of Home Infusion Drug
 - CMS is soliciting comments on physician notification
 - Patient eligibility and plan of care requirements as a condition of payment
 - Payment proposals and clarifications:
 - Carry forward 3 transitional payment categories
 - **Higher payment for first home infusion therapy visit (similar to a LUPA add-on)**
 - **Set payment amount for infusion drug calendar equivalent to 5 hours of infusion vs 4 hours**
 - **Visit must be within 30 days of associated drug**
 - Use the GAF to wage adjust home infusion therapy services payment
 - No prior authorization or outlier payments
 - Separate billing for Part B DME supplier claims and Home Infusion Therapy professional services claims
 - **CR with billing and policy instructions will be released after publication of the CY 2020 final rule**

- Monitor for the release of enrollment, accreditation, policy and billing requirements
 - The Joint Commission recently submitted the first CMS accreditation application
 - AO's must apply by February, 2020
- NAHC plans legislative action advocating against carve out from home health
 - Suggest HHAs be allowed to bill under 34X type of bill

CMS Infusion Therapy Link: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.html>

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Other Important CMS Transmittals & Reminders

- Implementation effective with PDGM (January 1, 2020)
- No revised version of OASIS D Manual for 2020
 - Zip file posted on CMS OASIS Data Sets Webpage (OASIS D1 revisions)
 - <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/oasis-data-sets.html>
- No new questions!
- 2 existing items added to Follow-Up time point for data collection
 - M1033 Risk for Hospitalization & M1800 Grooming
- Data collection at certain time points for 23 existing items is optional

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D1-Update-Memorandum.pdf>

Start of Care/Resumption of Care (SOC/ROC)

- M1910 Fall risk Assessment

Transfer (TRN) and Discharge (DC)

- M2401a Intervention Synopsis: Diabetic Foot Care
- M1051 Pneumococcal Vaccine
- M1056 Reason Pneumococcal Vaccine not received



Follow-Up (FU)

- M1021 Primary Diagnosis
- M1023 Other Diagnoses
- M1030 Therapies
- M1200 Vision
- M1242 Frequency of Pain Interfering with Activity
- M1311 Current Number of Unhealed Pressure Ulcers at Each Stage
- M1322 Current Number of Stage 1 Pressure Injuries
- M1324 Stage of Most Problematic Unhealed Pressure Ulcer-Stageable
- M1330 Does this patient have a Stasis Ulcer
- M1332 Current Number of Stasis Ulcers that are Observable
- M1334 Status of Most Problematic Stasis Ulcer that is Observable
- M1340 Does this patient have a Surgical Wound
- M1342 Status of the Most Problematic Surgical Wound-Observable
- M1400 Short of Breath
- M1610 Urinary Incontinence or Urinary Catheter Presence
- M1620 Bowel Incontinence Frequency
- M1630 Ostomy for Bowel Elimination
- M2030 Management of Injectable Medications
- M2200 Therapy Need

- CMS website at:
<https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html>
- 71,932 codes in 2019 ICD-10 CM
- 72,184 codes in 2020 ICD-10CM
 - 273 additions
 - 21 deletions
 - 30 revisions
- Effective for dates of service 10/1/2019 through 9/30/2020



- Bipartisan legislation introduced June 5, 2019
- Proposes permitting occupational therapists to conduct the initial assessment visit/complete comprehensive assessment for certain rehab cases
- If referral order by physician:
 - does not include skilled nursing care;
 - includes occupational therapy; AND
 - includes physical therapy or speech therapy

S.1725 link: <https://www.congress.gov/bill/116th-congress/senatebill/1725?q=%7B%22search%22%3A%5B%22S.1725%22%5D%7D&s=1&r=1>

HR 3127 link: <https://www.congress.gov/bill/116th-congress/house-bill/3127?q=%7B%22search%22%3A%5B%22HR+3127%22%5D%7D&s=3&r=1>

- Bipartisan legislation introduced January 31, 2019
- Allows Medicare home health payment for services ordered by a:
 - Nurse practitioner
 - Clinical nurse specialist
 - Certified nurse-midwife
 - Physician assistant

S.296 Link: <https://www.congress.gov/bill/116th-congress/senate-bill/296?q=%7B%22search%22%3A%5B%22S.296%22%5D%7D&s=1&r=1>

H.R. 2150 Link: <https://www.congress.gov/bill/116th-congress/house-bill/2150>

- Proposed rule was set to expire on November 3, 2018
 - November 2, 2018: CMS filed a one-year extension
 - November 3, 2019: final rule deadline date
- Incorporates requirements of the Post-Acute Care Transformation Act of 2014 to utilize quality and resource measures in discharge planning and modify CoPs to:
 - Inform patients/caregivers on discharge planning options/settings
 - Establish a discharge planning process which includes patient preferences and goals
 - Facilitate discharge/transfer by sending necessary medical information to receiving facilities
- Discharge Planning Process: Finalized with HH revised CoPs January 13, 2018

Proposed Rule link: <https://www.federalregister.gov/documents/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals>

- Medicare Advantage CY 2019 (CMS-4182-F):
 - Beginning CY 2019
 - Expands definitions of “primarily health related”
 - Allows optional supplemental benefits such as non-skilled care services
 - <https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare>
- Bi-Partisan Budget Act of 2018 (Section 50322):
 - Beginning CY 2020
 - Expands optional supplemental benefits to chronically ill (i.e., palliative care services)
 - <https://www.govinfo.gov/content/pkg/PLAW-115publ123/html/PLAW-115publ123.htm>
- Proactively seek opportunities with MA plans in your area

- CMS-3346-P: Medicare and Medicaid - Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction
 - Published in Federal Register on September 20, 2018
 - Proposes to revise certain CoPs and CfCs:
 - **Patient rights (§ 484.50(a)(3)) and (c)(7))-HHA Requirements for Verbal Notification of Patient Rights and Responsibilities:** *Delete verbal notification requirements of all patient rights*
 - **Home Health Agency (HHA) Requirements for Providing Patients with Copies of Clinical Records (§ 484.110(e)):** *Remove provision of the copy of a clinical record upon request by the next home visit and replace within 4 business days*
 - **Home Health Aide Services (§ 484.80(h)(3)):** *Eliminate requirement to conduct a full competency evaluation and replace with retraining and competency evaluation for identified deficient skills*
 - **Various Emergency Preparedness training and plan flexibilities**

CMS-3346-P Link: <https://www.federalregister.gov/documents/2018/09/20/2018-19599/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and>

- Home Health demonstration: Test processes for identifying and preventing fraud
- Illinois, Ohio, Texas, North Carolina, and Florida.
 - Illinois implementation: June 1, 2019
 - Ohio: **September 30, 2019**
 - Other states: TBD
- Three Choices:
 - Choice 1: Pre-claim review
 - Choice 2: Post-payment review
 - Choice 3: Minimal review with 25% payment reduction

CMS RCD Link: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services.html>

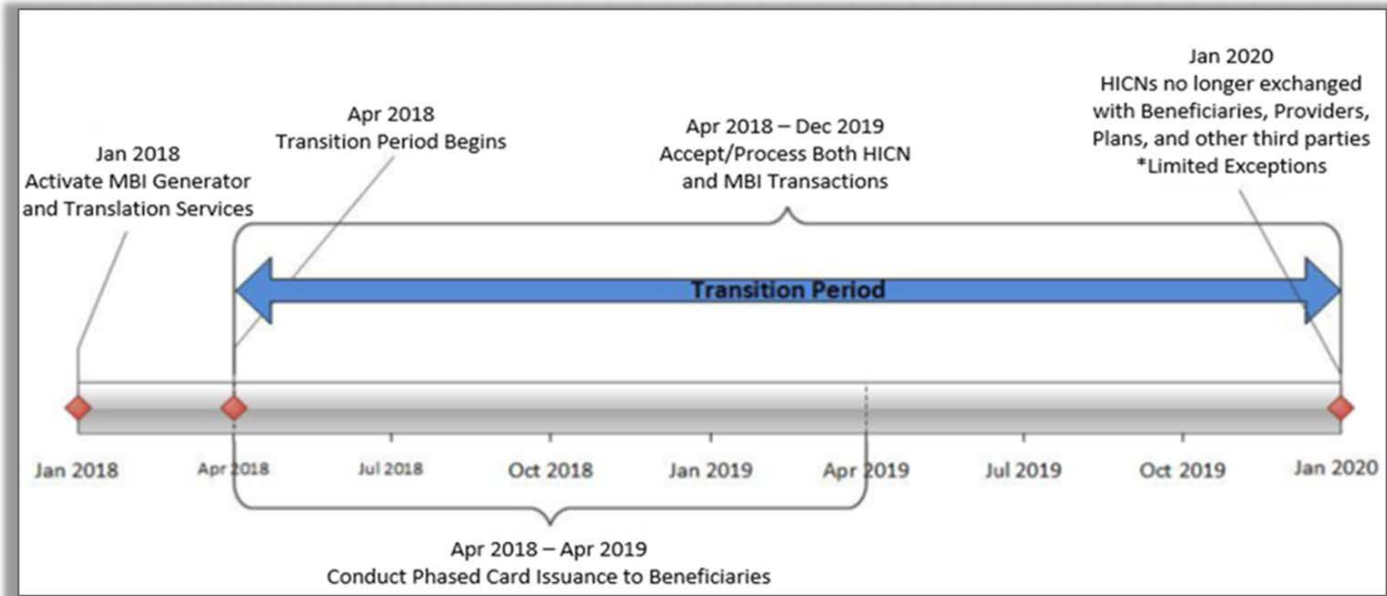
- Section 12006: Requires state Medicaid plans implement an EVV system
 - Personal Care: January 1, 2019
 - H.R. 6042: extended personal care date to January 1, 2020
 - Home Health Services: January 1, 2023
- States that do not meet EVV requirements are subject to a reduction in the FMAP
- July, 2019: States can file a good faith effort exemption request
 - If approved, exemption is good for 1 year
- Agencies:
 - Keep abreast of state plans
 - Attend stakeholder engagement meetings and trainings
 - Share information learned with Account Management

Medicaid.gov EVV link: <https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html>

- Signed into law on October 24, 2018
- Has over 100 provisions related to substance use-disorder prevention, opioid recovery and treatment provisions. Examples:
 - Mandatory ePrescribe for controlled substances beginning 1/1/21
 - State mandated drug prescription monitoring programs for at-risk beneficiaries beginning 1/1/22
 - Requires HHS to provide guidance on display of drug abuse/controlled substances in medical record history of EHR systems within one year from enactment of this act

H.R. 6 Link: <https://www.congress.gov/bill/115th-congress/house-bill/6>

Reminder: SSRNI Transition Deadline is Approaching!



MLN Article: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE18006.pdf>

