PUBLICATION

Proposed Home Health Regulations Add a Number of Key Substantive Changes

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In its proposed HH PPS regulations published in the Federal Register on July 12, 2018, CMS would implement substantive changes for home health agencies. The proposed rule would rebase the market basket and update the payment rates, decrease the labor related share and increase the wage index, change the home health units of payment from 60 to 30 days, make case mix updates and methodology refinements, propose a new methodology for applying rural add-on payments, and reduce the fixed dollar loss ratio in order to increase outlier payments. CMS also proposes changes to the Home Health Value Based Purchasing Model and Home Health Quality Reporting Program, which are not the subject of this article.

The proposed rule would establish a transitional payment for home health infusion therapy services beginning January 1, 2019, add health and safety standards for home infusion therapy services, an accreditation and oversight process for suppliers, and add a home health care infusion therapy benefit for CY 2021 and subsequent years.

CMS also proposes to make changes to the home health certification and recertification process which has been the subject of many audits across the country. Currently, the regulations as supplemented by the sub-regulatory guidance, which has been highly controversial, requires documentation in the certifying physician's medical record and/or the acute/post-acute care facilities record to be used as the basis for certification for home health eligibility. The documentation must substantiate the need for skilled services, homebound status, and contain the actual face-to-face encounter visit that demonstrates the encounter was timely made, related to the primary reason the patient required home health services and was performed by an allowed provider type. Now effective January 1, 2019, CMS proposes in addition to using the documentation in the certifying physician's medical record or the post-acute care facility record the home health agency may use its records to support homebound status and skilled care need. This would include the HHA plan of care, and the initial and comprehensive assessment when the physician signs and dates the plan of care. This documentation could be used in conjunction with the physician and/or post-acute care facility medical record. The documentation from the home health agency must be corroborated by the physician/post-acute care medical records and the home health record documentation must be signed and dated by the appropriate provider type.

CMS also proposes changes to home health remote patient monitoring, permitting the home health agency to provide this benefit, defined as "the collection of physiologic data digitally stored and/or transmitted by the patient and/or the caregiver to the HHA" and used by the HHA to augment the care planning process, may be reported on the HHA cost report as an allowable administrative cost (an operating expense). This operating cost could then be factored into the costs per visit. CMS is also soliciting comments on the proposed definition of "remote patient monitoring".

CMS Proposed Rule 1689-P (83 Fed. Reg. 32340 July 12, 2018) can be found at https://www.gpo.gov/fdsys/pkg/FR-2018-07-12/pdf/2018-14443.pdf