

Revisions to the home health prospective payment system in 2020 (cont.)

of the episode: prior hospitalization or institutional post-acute care on the one hand, or admission from the community on the other.

- **Clinical category**—The new system would create 12 clinical categories based on patients' reported conditions or treatments: need for musculoskeletal rehabilitation; neuro/stroke rehabilitation; wound care; behavioral health care; complex care; and medication management, teaching, and assessment.
- **Functional/cognitive level**—Similar to the existing system, the PDGM would classify patients' cognitive and physical functioning using information from the Outcomes Assessment Information Set, known as OASIS, home health patient assessment.
- **Presence of comorbidities**— The PDGM will adjust payment for commonly occurring comorbidities in home health care. There would be a three-tiered adjustment for selected comorbidities.

CMS analyzed the PDGM's likely impact in the 2019 home health payment rule, finding that, in general, funds would be redistributed from HHAs that provide more therapy to those that provide relatively more nursing. Specifically:

- Payments in 2020 would increase by 2.9 percent for nonprofit agencies and 3.9 percent for facility-based HHAs.
- Payments would fall by 0.4 percent for freestanding agencies and fall by 1.2 percent for for-profit HHAs.
- HHAs in urban areas would see a 0.6 percent payment decrease, while those in rural areas would see a 4.0 percent increase.
- Payments would rise for smaller providers and fall for larger providers. For example, payments would increase by 1.9 percent for the 2,841 HHAs with less than 100 episodes in annual volume and would drop 0.2 percent for larger HHAs with more than a 1,000 episodes a year. ■

the PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced Budget Act of 1997 led HHAs to reduce costs and utilization without a measurable difference in the quality of patient care.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first full year of the PPS, average Medicare margins for freestanding HHAs equaled 23 percent (Figure 9-1, p. 235).¹ The high margins in the first year suggest that the PPS established a base rate well in excess of costs. The base rate assumed that the average number of visits

per episode between 1998 and 2001 would decline about 15 percent, while the actual decline was about 32 percent (Table 9-2, p. 235). Between 2001 and 2017, the number of visits per episode declined. The number of therapy services per episode increased, but this increase has been more than offset by the decline in all other service types (nursing, home health aide, and medical social services). In addition, HHAs have been able to hold the rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the home health payment update (data not shown). Consequently, HHAs were able to garner extremely high average payments relative to the cost of services provided. Between 2001 and 2016, freestanding HHA margins averaged 16.3 percent (Figure 9-1, p. 235).