CY 2020 HH PPS Final Rule

On Thursday, October 31st, CMS released the CY 2020 Home Health (HH) Prospective Payment System (PPS) Final Rule, which discusses finalized payment updates, modifications in the HH Value-based Purchasing (VBP) and Quality Reporting (QRP) programs, updates to coverage of home infusion services, and clarifications associated with the implementation of the Patient-Driven Groupings Model (PDGM) on January 1, 2020.

PATIENT-DRIVEN GROUPINGS MODEL (PDGM):

CMS reiterated implementation of PDGM on January 1, 2020, with no substantive changes to the model itself. PDGM Categories Affecting Payment remain as clarified in the CY 2019 HH PPS Final Rule:

1. Timing of 30-day period – Early vs. Late
2. Admission Source – Institutional vs. Community
3. Clinical Grouping – 12 Clinical Categories
4. Functional Level – Low / Medium / High
5. Comorbidity Adjustment – None / Low / High

Timing

Under PDGM, the first 30-day period of care will be classified as early and all subsequent 30-day periods of care in the sequence (second or later) will be classified as late. A 30-day period will not be considered early unless there is a gap of more than 60 days between the end of one period of care and the start of another.

Other HH requirements will continue on a 60-day basis. Specifically, certifications and recertifications continue on a 60-day basis, and the comprehensive assessment will still be completed within 5 days of the start of care (SOC) and no less frequently than during the last 5 days of every 60 days thereafter.

Admission Source

Each 30-day period of care will be classified as either Community or Institutional, depending on the health care setting utilized in the 14 days prior to home health. If the beneficiary has had an inpatient institutional stay (i.e., acute care hospital, inpatient rehab facility (IRF), skilled nursing facility (SNF), inpatient psychiatric facility (IPF), or long-term acute care hospital (LTCH)) within 14-days prior to a HH admission, the 30-day period will be classified as institutional.

CMS states the institutional admission source category will also include patients who had an acute care hospital stay during a previous 30-day period of care and "within 14 days prior to the start of a subsequent, contiguous 30-day period of care and for which the patient was not discharged from home health and readmitted (that is, the "admission date" and "from date" for the subsequent 30-day period of care do not match), as *we acknowledge that HHAs [home health agencies] have the discretion as to whether they discharge the patient due to a hospitalization* and then readmit the patient after hospital discharge."

However, post-acute care stays (i.e., SNF, IRF, LTCH, IPF) that occur during a previous 30-day period of care "and within 14 days of a subsequent, contiguous 30-day period of care will not be categorized as institutional, "as *we would expect the HHA to discharge the patient if the patient required post-acute care in a different setting*, or inpatient psychiatric care, and then readmit the patient, if necessary after discharge from such setting. All other 30-day periods of care would be designated as community admissions."

Classification of admission source will be determined by the Medicare Claims Processing System for final claim payment. This allows CMS the opportunity and flexibility to verify admission source and correct any improper payments. For purposes of a request for anticipated payment (RAP), only the final claim will be adjusted to reflect the admission source.

HHAs will be allowed to manually indicate an institutional admission source on the claim using occurrence codes:

- Occurrence code 61: Acute hospital discharge within 14 days prior to the "From Date" of any HH claim
- Occurrence code 62: SNF, IRF, LTCH, or IPF (i.e., post-acute) discharge within 14 days prior to the "Admission Date" of the first HH claim

If no occurrence code is present on the claim, the period will be categorized as community, but may be adjusted once institutional claims are processed.

Clinical Grouping

A change in the principal diagnosis during a 30-day period may change the clinical grouping for the next 30-day period. This does not mean that a new OASIS ("other follow up") must be completed just to make the diagnosis on the claim match the OASIS. However, if the patient had a significant change in condition before the start of a subsequent, contiguous 30-day period, the home health agency (HHA) is required to update the comprehensive assessment.

Currently, billing instructions state the principal diagnosis on the OASIS and the claim must match. CMS states these instructions will be updated to allow for the clinical judgment of the HH provider to determine the need for the "other follow up" assessment to make the diagnoses match. For claims with "From" dates on or after January 1, 2020, the ICD-10-CM code and principal diagnosis used for payment grouping will come from the claim and not the OASIS. The claim and OASIS diagnosis codes will no longer be expected to match in all cases.

Regardless of clinical group assignment, HHAs are required to ensure that the individualized HH plan of care (POC) addresses all care needs, including the disciplines to provide such care. (Note: This speaks to the question regarding whether or not a patient in a clinical group other than Musculoskeletal rehab or Neuro/Stroke Rehab can receive PT, OT, or ST. The answer is YES. Regardless of clinical group, HH is an interdisciplinary service, and patients should receive the care they need.)

In response to stakeholder comments, **CMS agreed to assign dysphagia codes R13.10 – R13.19 to the Neuro Rehab clinical group** as CMS believes the intensity of SLP services would be similar to those with dysphagia resulting from a neurological diagnosis. CMS states

they will monitor the use of these codes to determine their impact on resource utilization. (Previously, these codes did not map to any clinical group.)

CMS also states that while there are certain diagnosis codes not assigned to a clinical group under PDGM, claims submitted with these codes in the primary position will not be denied but will be returned to the provider for more definitive coding.

Functional Level

Functional impairment level will remain the same for the first and second 30-day periods of care unless there has been a significant change in condition that warrants an "other follow up" OASIS assessment prior to the second 30-day period.

Comorbidity Adjustment

CMS will update the comorbidity subgroups and interactions subgroups using the most recent available claims data in the Interactive Grouper Tool, to be posted on the HHA Center webpage and in the downloadable HH PPS grouper that will accompany the publication of the Final Rule.

LUPA THRESHOLDS

Low utilization payment amount (LUPA) thresholds remain as finalized in the CY 2019 HH PPS Final Rule – i.e., the 10th percentile value of visits or two visits for each payment group (i.e., each HHRG), whichever is higher. The LUPA thresholds will be reevaluated each year based on the most current utilization data available at the time of rulemaking. Under PDGM, if the LUPA threshold is met, the 30-day period of care will be paid at the full 30-day period payment. If the threshold is not met, payment will be made per visit. For example, if the LUPA threshold is 4, and a 30-day period of care has 4 or more visits, it is paid the full 30-day payment period amount.

Behavioral Assumptions

The Bipartisan Budget Act (BBA) of 2018 required CMS to calculate budget neutral 30-day payment amounts for the implementation of PDGM before the annual HH percentage increase, adjustment for case-mix changes, adjustment if quality data is not reported, and the productivity adjustment. The BBA also required CMS to make "assumptions about behavior changes" that could occur with the implementation of the 30-day unit of payment and/or as a result of the PDGM case-mix adjustment factors.

In the CY 2020 Final Rule, CMS confirms the three behavioral assumptions initially presented in last year's Proposed Rule:

1. *Clinical Group Coding* – CMS assumes that HHAs will change documentation and coding practices and will put the highest paying diagnosis code as the principal diagnosis to have the 30-day period be placed into a higher paying clinical group.
2. *Comorbidity Coding* – While the OASIS only allows HHAs to designate one primary and five secondary diagnoses, the HH claim allows one principal diagnosis and 24 secondary diagnoses. Therefore, CMS assumes that by taking into account the additional ICD-10-

CM codes listed on the claim (beyond the six allowed on the OASIS), more 30-day periods will receive a comorbidity adjustment than would be the case if only the OASIS data was used for payment.

3. *LUPA Threshold* – CMS assumes that for one-third of LUPAs that are 1-2 visits away from the LUPA threshold, HHAs will provide "1-2 extra visits" to receive the full 30-day payment vs. the per visit LUPA amount.

In response to comments received from stakeholders, CMS stated that given the scale of the payment system changes, CMS agrees that it might take HHAs more time to fully implement the behavior changes assumed by CMS. Therefore, CMS feels it is reasonable to apply the behavior changes to *only half* of the 30-day periods in the analytics file. **This means the resulting payment adjustment to maintain budget neutrality will be -4.36%, as opposed to the -8.01% outlined in the CY 2020 Proposed Rule**. The finalized CY 2020 30-day budget neutral payment amount with the -4.36% adjustment is $1824.99 (as opposed to $1754.37 presented in the Proposed Rule).

CMS reminds providers they are required by the BBA of 2018 to analyze data for CYs 2020-2026 to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. The data from CY 2020-2026 will be used to determine whether or not a prospective adjustment (increase or decrease) is needed no earlier than in 2022-2028 rulemaking to better align payment with the costs of providing care. CMS will analyze data after implementation of PDGM to determine if there are any notable or consistent trends to warrant whether any changes to the national, standardized 30-day payment rate should be made earlier than CY 2022.

Implementation of PDGM

Because CY 2020 is the first year of PDGM and the change to the 30-day unit of payment, there will be a transition period to account for HH episodes of care that span the implementation date of January 1, 2020.

For 60-day episodes (not LUPA episodes) that begin on or before December 31, 2019, and end on or after January 1st, payment made under the Medicare HH PPS will be the CY 2020 national, standardized 60-day episode payment amount. This rate will apply to case mix adjusted episodes beginning on or before December 31, 2019, and ending on or before February 28, 2020.

For HH periods of care that begin on or after January 1, 2020, the unit of service will be a 30-day period and payment will be made under the CY 2020 national, standardized prospective 30-day payment amount.

The end date of the 60-day episode or 30-day period as reported on the claim determines the CY rates Medicare will use to pay the claim.

PAYMENT UPDATES:

CMS finalized an increase of 1.3% ($250 million) for CY 2020. HHAs who fail to submit quality data for the HH Quality Reporting Program (QRP) will receive a 2% reduction in payment in CY 2020 (1.5% - 2% = -0.5%).

CMS finalized there will be no updates in CY 2020 to the case-mix weights for the current 153 home health resource groups (HHRGs) which will be used for payment of 60-day episodes that begin on or before December 31, 2019, and end on or before February 28, 2020 (i.e., episodes that span the PDGM transition date).

Modifications/adjustments to CY 2020 rates in the Final Rule (as compared to the Proposed Rule) are indicated below in red.

TABLE 17: CY 2020 National, Standardized 60-day Episode Payment Amount

CY 2019	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Rate
$3154.27	X 1.0060	X 1.015	~~$3221.43~~ $3220.79

TABLE 19: CY 2020 Non-routine Supplies (NRS) Conversion Factor

CY 2019 NRS	CY 2020 Update	CY 2020 NRS
$54.20	X 1.015	$55.01

TABLE 21: CY 2020 National, Standardized 30-day Period Payment Amount

CY 2020 30-day Budget Neutral Amt	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Rate
~~$1754.37~~ $1824.99	X 1.0063	X 1.015	~~$1791.73~~ $1864.03

(Note: Under PDPM, NRS payments are included in the 30-day period base payment rate)

TABLE 25: CY 2020 National Per Visit Rates

HH Discipline	CY 2019 Per Visit Rate	Wage Index Budget Neutrality Factor	CY 2020 Update	CY 2020 Per Visit Rate
HHA	$66.34	X 1.0066	X 1.015	$67.78
MSS	$234.82	X 1.0066	X 1.015	$239.92
OT	$161.24	X 1.0066	X 1.015	$164.74
PT	$160.14	X 1.0066	X 1.015	$163.61
SN	$146.50	X 1.0066	X 1.015	$149.68
SLP	$174.60	X 1.0066	X 1.015	$177.84

TABLE 27: HH PPS Rural Add-on Percentages, CYs 2020 – 2022

Category	CY 2020	CY 2021	CY 2022
High Utilization	0.5%	-	-
Low Pop Density	3.0%	2.0%	1.0%
All Other	2.0%	1.0%	-

Lupa Add-On Factor

For the first skilled nursing (SN), PT, or SLP visit in LUPA periods that occur as the only or initial 30-day period of care, the per visit rate will be multiplied by a LUPA add-on factor, as is the current process.

The LUPA add-on factors for CY 2020 are:

- SN: 1.8451
- PT: 1.6700
- SLP: 1.6266

Partial Episode Payment Adjustment

The partial episode payment (PEP) adjustment process for the 30-day payment periods in CY 2020 will remain the same as the current process for 60-day episodes.

The PEP adjustment is defined as a proportion of the period payment based on the span of days including the SOC date through and including the last billable date of service under the original plan of care before an "intervening event," defined as:

- Beneficiary-elected transfer
- Discharge and return to HH that would warrant, for purposes of payment, a new OASIS, physician certification, and a new POC

When a new 30-day period begins due to an intervening event as defined above, the original 30-day period will be proportionally adjusted to reflect the length of time the beneficiary remained under the HHA's care. The proportional payment (i.e., the PEP) is calculated by using the span of days as a proportion of the 30-day period, multiplied by the original case-mix weight.

High Cost Outliers

CMS will maintain the current methodology for payment of high cost outliers upon implementation of PDGM in 2020. The finalized fixed dollar loss (FDL) ratio for 60-day episodes spanning January 1, 2020 will equal 0.51; for 30-day periods, 0.56.

Split Percentage Payments (i.e., Requests for Anticipated Payment)

For HHAs certified before January 1, 2019, CMS finalized that **split percentage payments will be reduced from the current 60% or 50% to 20% in CY 2020 for all 30-day periods**. HHAs enrolled in Medicare after January 1, 2019, (i.e., "newly-enrolled HHAs") will submit no-pay

requests for anticipated payment (RAPs) at the beginning of every 30-day period in CY 2020, with full elimination of split percentage payments for all HHAs in CY 2021.

Beginning in CY 2021, all HHAs will submit no-pay RAPs at the beginning of every 30-day period, and these no-pay RAPs must be submitted within five calendar days of the SOC for the first 30-day period, and within five calendar days of day 31 for the second 30-day period.

- **Failure to submit the no-pay RAP timely will result in a late submission penalty** equal to a 1/30th reduction to the wage adjusted 30-day period payment amount for each day from SOC through the date the HHA submits the late no-pay RAP.
- CMS finalized revised (i.e., shortened) requirements for submission of the no-pay RAP. Specifically, a no-pay RAP may be submitted when:
  - The physician's written or verbal order that sets out the services required for the initial visit has been received and documented as required, and
  - The initial visit within the 60-day certification period has been made and the individual has been admitted to HH care.
- CMS also finalized a provision allowing the "advance submission" of certain RAPs in 2021, such that where the POC dictates that multiple periods of care will be required to treat the beneficiary, HHAs can submit the no-pay RAP for the first 30-day period and the no-pay RAP for the second 30-day period (i.e., for the 60-day episode) at the same time to reduce provider burden.

Beginning CY 2022, CMS finalized that all HHAs will submit a one-time Notice of Admission (NOA) within 5 calendar days of the SOC to establish that the beneficiary is under a Medicare HH period of care. CMS proposed to implement the NOA in 2021, but in the Final Rule, CMS delayed implementation of this change until 2022.

- **Failure to submit a timely NOA will result in a late submission penalty**, i.e., decreased Medicare payment from SOC to NOA filing date (similar to hospice Notice of Election (NOE) process). Again, the payment penalty will be equal to a 1/30th reduction to the wage adjusted 30-day period payment amount for each day from SOC through the date the HHA submits the late NOA.
- Requirements for the submission of the NOA mirror CMS's requirements for the no-pay RAP:
  - The physician's written or verbal order that contains the requirements for the initial visit has been received, and
  - The HHA has conducted an initial visit at SOC.

CMS states they will finalize exceptions to the timely filing consequences in future rule-making.

THERAPIST ASSISTANTS AND MAINTENANCE THERAPY:

CMS finalized their decision to allow physical and occupational therapist assistants to perform skilled maintenance therapy under the HH benefit, similar to maintenance therapy provided under Medicare Part A in the SNF. The requirements for a 30-day reassessment by the therapist remain unchanged. CMS will consider any changes to HCPCS coding for therapy visits in later rulemaking.

HH VALUE-BASED PURCHASING (VBP) PROGRAM:

CMS finalized the public reporting of the Total Performance Score (TPS) and Total Performance Score Percentile Ranking from the final performance year five (CY 2020) Annual Report for each HHA in the nine HH VBP Model states (AZ, FL, IA, MD, MA, NE, NC, TN, WA) that qualified for a payment adjustment for CY 2020. CMS expects this data will be made available on the HH VBP Model page of the CMS Innovation Center website after December 1, 2021.

HH QUALITY REPORTING PROGRAM (QRP):

Improvement in Pain Interfering with Activity Measure

CMS finalized the removal of the Improvement in Pain Interfering with Activity Measure (NQF #1077) beginning with the CY 2022 HH QRP under measure removal factor #7: collection or public reporting of a measure leads to negative unintended consequences other than patient harm. HHAs will no longer be required to submit OASIS Item M1242, Frequency of Pain Interfering with Patient's Activity or Movement, for the purposes of this quality measure beginning January 1, 2021. Data for this measure will be publicly reported on HH Compare until April 2020.

Transfer of Health Information Measures

CMS finalized the adoption of 2 new process measures for CY 2022 (data collection January 1 – June 30, 2021):

1. **Transfer of Health Information to the Provider – Post-Acute Care**: Assesses whether or not a current *reconciled medication list* is given to the subsequent provider when a patient is discharged from the current post-acute setting. Calculated as the proportion of quality episodes (SOC, Resumption of Care (ROC), Transfer or Discharge (DC) OASIS) with a DC/transfer assessment indicating a current reconciled medication list was provided to the admitting provider at the time of discharge/transfer.

   "Admitting" provider as captured by the current discharge location items on the OASIS:
   - Short-term general hospital
   - Intermediate care (developmental or intellectual disabilities providers)
   - Home under the care of another organized home health service organization or hospice
   - Hospice in an institutional facility
   - SNF
   - IRF

- LTCH
- IPF
- Critical Access Hospital (CAH)

2. **Transfer of Health Information to the Patient – Post-Acute Care:** Assesses whether or not a current *reconciled medication list* was provided to the patient, family, or caregiver when the patient is discharged from a post-acute care setting to a private home/apartment without any further services, a board and care home, assisted living facility, a group home, or transitional living. Calculated as the proportion of quality episodes (SOC, ROC, Transfer or DC OASIS) with a DC assessment indicating a current reconciled medication list was provided to the patient, family, or caregiver at the time of discharge.

In the Final Rule, CMS gives "guidance" as to the definition of a reconciled medication list (although they state this is not a list of requirements and is not an exhaustive list):

- A list of current prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route to the patient at the time of discharge or transfer
- Current medications should include 1) those that are active, including medications that will be discontinued after discharge, and 2) those held during the stay and planned to be continued/resumed after discharge
- A reconciled medication list "often includes other information" about the patient and each medication that helps to improve patient safety, such as:
    - Information about the patient – name, date of birth, active diagnoses, known medication and other allergies, known drug sensitivities and reactions
    - Each medication – name, strength, dose, route of administration, frequency or timing, purpose/ indication, any special instructions (e.g., crush medication), and for any held medications, the reason for holding and when to resume
- Additional information may be application and important to include in the medication list, such as the patient's weight and height (and dates taken), preferred language, patient's ability to self-administer, when the last dose was administered by the discharging provider, and when the final dose should be administered

Providers will begin to report these measures for patients discharged or transferred on January 1, 2021 (collection period of January 1 – June 30, 2021) for the CY 2022 QRP. Following this initial reporting period for CY 2022, subsequent years for the HH QRP would be based on 12 months of data reporting, beginning with July 1, 2021 – June 30, 2022, for the CY 2023 HH QRP.

Discharge to Community Measure

CMS finalized updates to the specifications of the Discharge to Community (DTC – PAC HH QRP) measure to exclude baseline nursing facility (NF) residents and align with proposed (and finalized) changes for IRF, SNF, and LTCH, beginning with the CY 2021 HH

QRP. The DTC – PAC HH QRP measure (NQF #3477) assesses successful discharge to the community from a home health agency, with successful discharge to the community including no unplanned re-hospitalizations and no death in the 31 days following discharge. Baseline NF residents are defined as HH patients who had a long-term NF stay in the 180 days preceding their hospitalization and HH episode, with no intervening community discharge between the NF stay and qualifying hospitalization.

Standardized Patient Assessment Data Elements (Spades) for the CY 2022 HH QRP

CMS proposed to collect multiple new SPADEs as part of the HH QRP in its continued effort to obtain meaningful data that is assessed, collected, and measured in the same way across all post-acute care venues. (Note: These SPADEs were finalized in the FY 2020 SNF PPS Final Rule.)

CMS finalized SPADEs in five categories to be submitted at SOC, ROC, and DC, except hearing, vision, race, ethnicity, preferred language and interpreter services, which will be collected on SOC only:

1. Cognitive Function and Mental Status:
   - Brief Interview for Mental Status (BIMS) to assess cognition: Currently used in the SNF Minimum Data Set (MDS) and IRF Patient Assessment Instrument (PAI)
   - Confusion Assessment Method (CAM) to assess delirium: Currently used in the MDS and LTCH long-term care data set (LCDS), the CAM assesses acute changes in mental status, inattention, disorganized thinking, and altered level of consciousness.
   - PHQ-2 to 9 (Patient Health Questionnaire) to assess depression: PHQ-2 has two items and will serve as a gateway item (i.e., embedded skip pattern) to the PHQ-9. If there are positive responses to the PHQ-2, the assessor goes on to complete the PHQ-9. The PHQ-2 is already used in the OASIS; the PHQ-9, in the MDS.

2. Special Services, Treatments, and Interventions:
   1) Cancer treatment: Chemotherapy (IV, Oral, Other)
   2) Cancer treatment: Radiation
   3) Respiratory Treatment: Oxygen Therapy (Intermittent, Continuous, High Concentration Oxygen Delivery Systems)
   4) Respiratory Treatment: Suctioning (Scheduled, As Needed)
   5) Respiratory Treatment: Tracheostomy Care
   6) Respiratory Treatment: Non-invasive Mechanical Ventilation (BiPAP, CPAP)
   7) Respiratory Treatment: Invasive Mechanical Ventilator
   8) IV Medications: (Antibiotics, Anticoagulants, Vasoactive Medications, Other)
   9) Transfusions
   10) Dialysis (Hemodialysis, Peritoneal Dialysis)
   11) IV Access (Peripheral IV, Midline, Central Line)
   12) Nutritional Approach: Parenteral/IV Feeding
   13) Nutritional Approach: Feeding Tube
   14) Nutritional Approach: Mechanically Altered Diet

15) Nutritional Approach: Therapeutic Diet
16) High Risk Drug Classes: Use and Indications - Assess whether or not a resident is taking any medications in these 6 classes, and if so, are there indications for this medication in the medical record.
    - Anticoagulants
    - Antiplatelets
    - Hypoglycemics (including insulin)
    - Opioids
    - Antipsychotics
    - Antibiotics

3. Medical Condition and Comorbidity Data: Pain Interference
    - Pain Effect on Sleep
    - Pain Interference with Therapy Activities
    - Pain Interference with Day-to-Day Activities

4. Impairment Data
    - Hearing (aligns with current MDS Item B0200), to be collected at SOC only
    - Vision (Ability to See in Adequate Light) is in use in the MDS, and will replace M1200, Vision on the OASIS, to be collected at SOC only

5. Social Determinants of Health (SDOH) – all elements are in use in the current OASIS
    1) Race, to be collected at SOC only
    2) Ethnicity, to be collected at SOC only
    3) Preferred Language
    4) Interpreter Services
    5) Health Literacy
    6) Transportation
    7) Social Isolation

CMS finalized that HHAs would begin data collection of these new SPADEs for the CY 2022 HH QRP for episodes beginning or ending on or after January 1, 2021. And, CMS finalized that HHAs that submit Hearing, Vision, Race, Ethnicity, Preferred Language, and Interpreter Services SPADEs with respect to SOC will be "deemed to have submitted those SPADEs with respect to SOC, ROC, and DC," as it is unlikely the assessment of these elements would differ from SOC to ROC or DC. The data collection period for CY 2022 will be January 1 – June 30, 2021; for CY 2023, data collection will be FY 2021 (July 1, 2021 – June 30, 2022); for CY 2024, FY 2022 (July 1, 2022 – June 30, 2023).

In the Proposed Rule, CMS requested input and comments on their plan to expand reporting of OASIS data for the HH QRP to include data on all patients regardless of payer, where feasible. In the Final Rule, CMS states they plan to consider expanding the reporting of OASIS data used for the HH QRP to include data on all patients regardless of payer in future rulemaking. (Note:

Collecting data on all patients regardless of payer was also proposed, but not finalized, in the FY 2020 rules for SNF and IRF.)

HH Care Consumer Assessment of Healthcare Providers and Services (CAHPS®):

CMS proposed to remove question #10 from all HH CAHPS surveys, which says, "In the last 2 months of care, did you and a home health provider from this agency talk about pain?" However, after receiving comments from multiple stakeholders opposed to removing this question, CMS has decided not to remove it.

MEDICARE COVERAGE OF HOME INFUSION THERAPY SERVICES:

Background: The 21st Century Cures Act established a new home infusion therapy services benefit under Medicare Part B to be effective January 1, 2021. This benefit covers the professional services (including nursing services) furnished in accordance with the plan of care, patient training and education (not otherwise covered under the DME benefit), remote monitoring, and other monitoring services for the provision of home infusion drugs furnished by a qualified home infusion therapy supplier. The Bipartisan Budget Act of 2018 established a home infusion therapy services "temporary transitional payment" system for certain items and services furnished in coordination with the rendering of transitional home infusion drugs beginning January 1, 2019, and ending December 31, 2020 (i.e., for the 2-year period leading up to the January 1, 2021, implementation date as required by the 21st Century Cures Act).

In this year's Final Rule, CMS finalized several items related to the implementation of the permanent Medicare Part B benefit for coverage of home infusion therapy services beginning January 1, 2021.

- A home infusion drug is a parenteral or biological administered via IV or subcutaneously, and must require infusion through an external infusion pump. If the drug/biological can be infused through a disposable pump or by a gravity drip, it does not meet this criterion.
- The drug cannot be on the self-administered drug exclusion list. Drugs are on the self-administered drug exclusion list if more than 50% of Medicare beneficiaries are able to self-administer the drug (as described in the Medicare Benefit Policy Manual, Chapter 15, §50.2).
- *Infusion drug administration calendar day* is defined as the day on which home infusion therapy services are furnished by skilled professionals in the patient's home on the day of drug administration.
    - **The single, bundled payment for home infusion therapy services is only made when a skilled professional is in the home on the day of the drug administration**.
- Drugs identified for coverage of home infusion therapy services are paid under the Part B DME benefit, therefore, services related to furnishing the drug, remote or otherwise, are paid under the DME benefit. This includes services by the DMEPOS supplier, such as preparation and dispensing of the drugs, and education and training on how to effectively and safely use the DME equipment.

- **Services covered under this "new" home infusion therapy benefit are distinct from those paid under the DME benefit** and may include the following:
  - Training and education on care and maintenance of vascular access devices (e.g., hygiene education, what to do in the event of a dislodgement or occlusion, education on signs and symptoms of infection, flushing/locking the catheter, dressing changes/site care)
  - Patient assessment and evaluation (e.g., review of patient history and assessment of current physical and mental status – including vital signs, assessment of adverse effects, evaluation of family/caregiver support, obtaining blood for lab work)
  - Medication and disease management education (e.g., instruction on self-monitoring, lifestyle and nutritional modifications, drug mechanism of action, side effects/interactions/adverse reactions, home infusion therapy goals and progress, education on administration of pre-meds)
  - Remote patient monitoring services
  - Other monitoring services (e.g., communication with patient regarding changes in condition and treatment plan, patient response to therapy, assessing compliance)

For more information on the home infusion therapy benefit, read Casamba's summary document **Here**.

For more information on the CY 2020 Home Health Final Rule, access **CMS's Fact Sheet**.

Access the **Final Rule**.