CY 2021 HH PPS Proposed Rule

On Thursday, June 25, CMS released the CY 2021 Home Health (HH) Prospective Payment System (PPS) Proposed Rule, which discusses proposed payment updates for 2021, changes regarding remote patient monitoring and the use of "telecommunications systems" during a HH episode, and the new Medicare Part B home infusion therapy benefit. Overall, the rule is light on change – with no proposed changes to PDGM or the HH quality reporting program (QRP). The comment period for this rule closes August 31, 2020.

Patient-Driven Groupings Model (PDGM)

CMS proposes to maintain the CY 2020 low utilization payment adjustment (LUPA) thresholds and case mix weights for all PDGM categories and proposes no changes to PDGM methodology.

Payment Updates

CMS proposes an increase of 2.7% ($540 million) for CY 2021 (3.1% market basket update minus a 0.4% multifactor productivity adjustment). Home Health Agencies (HHAs) who fail to submit quality data for the HH QRP would receive a 2% reduction in payment in CY 2021 (2.7% - 2% = 0.7%).

With respect to the implementation of PDGM, CMS states, "While we continue to monitor the impact of these changes on patient outcomes and Medicare expenditures, we believe it would be premature to release any information related to these issues based on the amount of data currently available and in light of the current public health emergency…" Therefore, CMS is proposing no changes to the 30-day payment amount in 2021 other than the "routine rate updates."

TABLE 7: CY 2021 National, Standardized 30-day Period Payment Amount

CY 2020 30-day Budget Neutral Amt	Wage Index Budget Neutrality Factor	CY 2021 Update	Proposed CY 2021 Rate
$1864.03	X 0.9987	X 1.027	$1911.87

TABLE 9: CY 2021 National Per Visit Rates

HH Discipline	CY 2020 Per Visit Rate	Wage Index Budget Neutrality Factor	CY 2021 Update	Proposed CY 2021 Per Visit Rate
HHA	$67.78	X 0.9988	X 1.027	$69.53
MSS	$239.92	X 0.9988	X 1.027	$246.10
OT	$164.74	X 0.9988	X 1.027	$168.98
PT	$163.61	X 0.9988	X 1.027	$167.83
SN	$149.68	X 0.9988	X 1.027	$153.54
SLP	$177.84	X 0.9988	X 1.027	$182.42

And, as outlined in the Bipartisan Budget Act of 2018, the rural add-on percentage for CYs 2019-2022 remains unchanged. Note the percentage for CY 2021 below:

TABLE 11: 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 Pop Density	4.0%	3.0%	2.0%	1.0%
All Other	3.0%	2.0%	1.0%	-

Requests for Anticipated Payment (RAPs)

In this rule, CMS reminds stakeholders of the policies finalized in last year's HH PPS final rule with respect to the submission of no-pay RAPs for CY 2021 and the implementation of the new one-time Notice of Admission (NOA) process starting in CY 2022.

Beginning in CY 2021, all HHAs will submit no-pay RAPs at the beginning of every 30-day period to establish the HH period. And, beginning CY 2022, all HHAs will submit a one-time Notice of Admission (NOA) to do the same. Both the no-pay RAP and the NOA must be submitted within 5 calendar days of the start of care (SOC) for the first 30-day period, and, for the no-pay RAP, within 5 calendar days of day 31 for the second 30-day period.

Failure to submit the no-pay RAP (or NOA) 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 (or NOA).

Changes to HH PPS Wage Index

In alignment with the FY 2021 SNF PPS and Hospice proposed rules, CMS proposes to adopt the Office of Management and Budget's (OMB's) updates to delineations of statistical areas including some new core-based statistical areas (CBSAs), urban counties (or county equivalents) that would become rural, rural counties (or county equivalents) that would become urban, and existing CBSAs that would be split apart. These delineations would be implemented for the HH wage index beginning CY 2021 (1/1/2021).

With the proposed changes, 34 counties currently classified as urban would change to rural and 47 counties currently classified as rural would change to urban. Several counties would change from one urban CBSA to another, and still others would be changed from urban to another newly proposed or modified CBSA. Typically, urban counties/county equivalents have a higher wage index than rural, so some of these changes will have a negative impact on HH payment in CY 2021, and some will have a positive impact.

To mitigate the potential negative impact of this change, CMS proposes a year-long transition plan for CY 2021. CMS will apply a 5% cap on any decrease in a HHA's geographic wage index from the prior year in CY 2021, phasing in the reduction over a two-year period (i.e., no cap in CY 2022). This allows HHAs with a positive impact to receive the full amount of their increase in CY 2021 while spreading out the negative impact for those HHAs hit the hardest over a two-year period.

Use of Technology Under the Medicare HH Benefit

CMS proposes making the current flexibilities with the use of technology in HH permanent after the end of the COVID-19 public health emergency (PHE). CMS references modifications to the HH plan of care requirements implemented in the first COVID-19 PHE interim final rule with comment period (IFC). These flexibilities include allowing the inclusion of remote patient monitoring or "other services furnished via a telecommunications

system" to be included in the individual patient's plan of care, but that these virtual services cannot substitute for a home visit and cannot be considered a home visit for the purposes of patient eligibility or payment.

In this proposed rule, CMS states, "We believe the provision of in-person visits and encounters using telecommunications technology can also apply outside of the PHE…We are proposing to permanently finalize the amendment to §409.43(a) as outlined in the first COVID-19 PHE IFC." CMS also proposes to allow HHAs to continue to report the costs of telehealth/telemedicine as "allowable administrative costs" on the HHA cost report.

Decisions regarding the use of telecommunications technology are determined based on patient needs identified during the comprehensive assessment and included as part of the patient's individualized plan of care. The plan of care must include both in-person and "virtual visits" and the frequency of each. As outlined in the first IFC, only in-person visits are reported on the HH claim and count toward the LUPA threshold.

CMS expects that services provided by telecommunications technology are services that could also be provided through an in-person visit. And, if there is a service which requires in-person, hands-on care (such as wound care), the HHA must make an in-person visit to render this service.

Quality Reporting Program (QRP)

CMS has proposed no changes or updates to the HH QRP in CY 2021.

Change to the Conditions of Participation (CoPs) OASIS Requirements

CMS proposes to remove the requirement that new HHAs successfully submit "test data" to the Quality Improvement & Evaluation System (QIES) or the CMS OASIS contractor as part of the initial process for becoming a Medicare-participating HHA. CMS states this "test submission" requirement is no longer necessary now that the new Internet Quality Improvement & Evaluation System (iQIES) is in place and the data submission process is simpler and requires the use of a valid CCN (vs. using a test or fake CCN as was used during the test submission process).

Home Infusion Therapy Services

In the CY 2020 Final Rule, CMS finalized several items related to the implementation of the permanent Medicare Part B benefit for coverage of home infusion therapy (HIT) services beginning 1/1/2021. The CY 2021 proposed rule confirms these items.

- A home infusion drug is a parenteral or biological administered via IV or subcutaneously for an administration period of 15 minutes or more in the individual's home. The drug must require infusion through an external infusion pump that is an item of DME covered under the Medicare Part B DME benefit. (Per the CY 2020 final rule, 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 this 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 HIT services is only made when a skilled professional is in the home on the day of the drug administration. HIT services may require some degree of care

coordination or monitoring outside of the infusion drug calendar day, but payment is only made on the date the professional services were furnished to administer the drug in the individual's home.

- Drugs identified for coverage of HIT 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.
- As outlined in the CY 2020 HH final rule, services covered under the HIT 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 & 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)

Interaction With The HH Benefit

A beneficiary is not required to be homebound to be eligible for the home infusion therapy benefit, and there may be instances where a beneficiary under a home health plan of care (i.e., a homebound patient) also requires home infusion therapy services. In this case, the beneficiary can utilize both benefits concurrently. And, the HHA and the HIT supplier may be the same entity in cases where the HHA is approved as a HIT supplier.

If a patient receiving HIT is also under a HH POC and receives a visit that is unrelated to HIT, payment would be covered by the HH PPS and billed on the HH claim. When the HHA is the qualified HIT supplier and conducts a home visit exclusively for purposes of furnishing items and services related to the administration of the home infusion drug, the HHA would submit a HIT services claim under the HIT benefit. If a home visit includes provision of both HH and HIT services (i.e., separate services) the HHA would submit claims under the HH PPS and the HIT benefits. However, in this case, the HHA must separate the time spent providing the HH and HIT services.

For more information, access the **Fact Sheet**.

Access the **Final Rule**.

Access the information about the **Home Infusion Therapy Benefit**.