CY2021 Home Health Final Rule
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Medicare HH 2021 Final Rule

• CY 2021 Home Health Prospective Payment System Rate Update and Quality Reporting Requirements-Final Rule
• 2.0% rate update (net at 1.9% after budget neutrality adjustment with wage index)
  – Maintains PDGM case mix model and LUPA thresholds
  – New wage index areas with 5% cap on reductions
  – Outlier standards maintained
  – No new behavioral adjustment
• Telehealth use standards made permanent
• 2021 Home infusion therapy payment standards and supplier requirements clarified
• HHVBP minor modifications
• $390M increase in Medicare spending expected

• Should bring a degree of stabilization and predictability
2021 Final Payment Rates

- Base payment rates are increased by a net Market Basket Index of 2.0%
  - An annual inflation update of 2.3%
  - Reduced by a 0.3% Productivity Adjustment to net at 2.0%
  - Wage index neutrality adjustment at 0.9999
  - Proposed increase of 2.7% reduced due to use of more recent 2Q2020 data
- No change in 2020 behavioral adjustment (4.36%) as CMS wants full year of data to assess whether budget neutrality
- Medicare home health services spending projected to increase by $390 million in CY 2021
- The base 30-day payment rate is increased from $1864.03 to $1901.12
  - Wage index budget neutrality factor of 0.9999 for 30-day episodes; 0.9997 for LUPA rates
  - HHAs that did not submit required quality data have rates reduced by 2%

2021 Final Payment Rates

- The LUPA per visit rates are set at:
  - SN $152.63
  - PT $166.83
  - SLP $181.34
  - OT $167.98
  - MSW $244.64
  - HHA $69.11
- LUPA rates are also reduced by 2% for those HHAs that did not submit required quality data.
- The LUPA add-on for LUPA only patient continues.
  - For example: SN as the first LUPA visit, the add-on results in a first visit payment of $281.62
  - Each discipline would get its own add-on rate
2021 Final Payment Rates

- Area Wage Index that applies based on the patient's residence has changed significantly to reflect update census information
  - New CBSA inclusions and exclusions
  - New Rural and non-rural areas
  - Some CBSAs and rural areas will have more than one county-based wage index value
- Due to the significant change, CMS proposes to cap any reduction in the wage index at 5% for 1 year
- There is no cap on wage index increases

2021 Final Payment Rates

- Outlier standards unchanged
  - Fixed Dollar Loss ratio stays a 0.56
  - Means that no increase or decrease in the national volume of outlier episodes is expected
- Rural add-on phase-out continues
  - High Utilization areas — 0% add-on
  - Low Population Density areas — 2% add-on
  - All other areas — 1% add-on
- PDGM case mix weights unchanged from 2020
- LUPA thresholds stay at the 2020 levels
No-Pay RAP and NOA

- RAP phase-out continues
- CMS continues policy on 2021 No-Pay RAP and 2022 Notice of Admission
- 5-day window for timely submission
- Penalty for late submission applied starting with day 1 of the episode
  - number of days since episode start to submission date / 30 x Episode Payment

Telehealth

- Permanently allows the use of remote patient monitoring, other telecommunications, or audio-only technology
- Tied to patient specific needs identified in the comprehensive assessment
- Do not need to describe in the POC how the use of telehealth will help to achieve goals, but expect to see such throughout the medical record
- Cannot substitute for an ordered home visit
- Cannot be considered a home visit for eligibility or payment
- Continue to report as administrative cost
Telehealth

- The CARES Act requires the Secretary to encourage the use of telecommunications systems including remote patient monitoring and other communications or monitoring services...

RULE CHANGE
§409.46 Telecommunications technology

- (e) Telecommunications technology. Telecommunications technology, as indicated on the plan of care, can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY); and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician. The costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service, are not separately billable.

HHVBP

- Modifications to align HHVBP Model data submission requirements with any exceptions or extensions granted for HH QRP during PHE
- Modification of policy for granting exceptions to the New Measures data reporting during PHE
Home Infusion Therapy Supplier

- New Part B benefit-coverage and payment finalized in the 2019-20 HHPPS rules
- Covers the professional services related to HIT for Part B drugs- infused via a pump
- HIT suppliers must be accredited by a Medicare approved AO
- HHAs may become HIT supplier
- HHAs may contract with a HIT supplier
- Skilled services related to Part B infusion drugs carved out of the home health benefit beginning 1/1/2021
  - Services related to drugs outside this benefit may continue under HH benefit
- Currently DME suppliers with pharmacies are able to bill under the new benefit

Home Infusion Therapy

- Maintain definition of covered “home infusion drugs”
- Three payment categories
- Category payment amount consistent with six CPT infusion codes, equal to 5 hours in a physician’s office
- First visit subject to payment increase, reduces rate for later visits
- Payment for each infusion drug administration calendar day
- Rates adjusted geographically using GAF
- Rates updated annually by (CPI-U – productivity adjustment)
Home Infusion Therapy Supplier

Rule outlines the provider enrollment requirements
- Accredited by a CMS approved accrediting organization
- Comply with the conditions for payment and coverage under §414.1500-1550 and §486.500-525
- Submit Form CMS-855B application
- Subject to the application fee (2020 - $595.00)
- Limited risk level category for screening
- Same appeal rights for enrollment denials and revocations

HHAs should begin working with DME and HIT supplier

TABLE 16: 5-HOUR PAYMENT AMOUNTS REFLECTING PAYMENT RATES FOR FIRST AND SUBSEQUENT VISITS

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Proposed 2021 PFS Amount</th>
<th>5-hour Payment - First Visit</th>
<th>5-hour Payment - Subsequent Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>96365</td>
<td>Ther, Proph, Diag IV/IN infusion 1 hr</td>
<td>$72.26</td>
<td>$188.65 (category 1)</td>
<td>$156.83 (category 1)</td>
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<td>96366</td>
<td>Ther, Proph, Diag IV/IN infusion add hr</td>
<td>$21.61</td>
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<td></td>
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<tr>
<td>96369</td>
<td>Sub Q Ther Inf 1 hr</td>
<td>$156.46</td>
<td>$256.63 (category 2)</td>
<td>$213.27 (category 2)</td>
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<tr>
<td>96370</td>
<td>Sub Q Ther Inf add hr</td>
<td>$14.84</td>
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<td></td>
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<tr>
<td>96412</td>
<td>Chemo Inf 1 hr</td>
<td>$146.14</td>
<td>$319.80 (category 3)</td>
<td>$265.57 (category 3)</td>
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<tr>
<td>96415</td>
<td>Chemo Inf add hr</td>
<td>$30.65</td>
<td></td>
<td></td>
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</tbody>
</table>

Note: Rates are calculated using proposed CY 2021 PFS rates.
Quality Reporting Program & OASIS

• No changes to HH QRP for CY2021
• Change in OASIS testing for new agencies
  – Eliminate the testing requirement due to iQIES
• Reminders
  – OASIS-E delayed until January 1st of the year that is at least 1 full calendar year after the end of the COVID-19 PHE
  – 20 measures for CY2022 HH QRP finalized last year

Q & A
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Upcoming Events

**NAHC/HHFMA**
Using Technology to Enhance Wound Care Delivery
November 10, 2020  |  2:00-3:00pm Eastern

Home Care Industry Legislative Update Webinar Series
November 11, 2020  |  12:00-2:00pm Eastern

**NAHC Private Duty Home Care Certification**
November 12, 2020  |  3:00-4:00pm Eastern

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