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
- https://public-inspection.federalregister.gov/2020-24146.pdf
- 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
  - https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1730-f
  - 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

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

CPT Code	Description	Proposed 2021 PFS Amount	5-hour Payment - First Visit	5-hour Payment - Subsequent Visits
96365	Ther, Proph, Diag IV/IN infusion 1 hr	$72.26	$188.85 (category 1)	$156.83 (category 1)
96366	Ther, Proph, Diag IV/IN infusion add hr	$21.61		
96369	Sub Q Ther Inf 1 hr	$156.46	$256.83 (category 2)	$213.27 (category 2)
96370	Sub Q Ther Inf add hr	$14.84		
96413	Chemo Inf 1 hr	$146.14	$319.80 (category 3)	$265.57 (category 3)
96415	Chemo Inf add hr	$30.65		

Note: Rates are calculated using proposed CY 2021 PFS rates.

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

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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