WASHINGTON

perspectives

An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

October 31, 2020

CMS Releasing Final Calendar Year 2021 PPS Updates – Home Health Issued

The Centers for Medicare and Medicaid Services (CMS) have issued their final calendar year (CY) 2021 update to the home health prospective payment system (HH PPS). The rule is effective January 1, 2021.

The rule will update the payment rates and the wage index for home health agencies (HHAs); set forth the case-mix weights for 2021; and specify the CY 2021 fixed-dollar loss ratio (FDL) for outlier payments. The rule also will adopt revised Office of Management and Budget (OMB) statistical area delineations described in a September 14, 2018 OMB Bulletin No. 18-04 effective beginning in CY 2021. This rule includes a cap on wage index decreases in excess of 5.0 percent for CY 2021. The rule also includes changes to the home health regulations regarding the use of telecommunications technology; implements the permanent home infusion therapy services benefit and supplier enrollment requirements for CY 2021; finalizes a policy to align the Home Health Value-Based Purchasing (HHVBP) Model data submission requirements with any exceptions or extensions granted for purposes of the Home Health Quality Reporting Program (HH QRP) during the COVID-19 Public Health Emergency (PHE).

The 190-page rule is currently on display at the ***Federal Register.*** A copy is available at: https://public-inspection.federalregister.gov/2020-24146.pdf. Publication is slated for November 4.

Comment

The overall economic impact of the HH PPS payment rate update is now estimated at an increase in payments of $390. The proposed update was an estimated $540 million.

Again, this is another rule that has no table of contents. However, CMS has provided helpful "final decision" paragraphs. We are including many.

CY 2021 Home Health Payment Rate Updates

1. Market Basket

The final home health update percentage for CY 2021, is based on an estimated home health market basket update of 2.3 percent. It was proposed at 2.7 percent. CMS says "this lower update (2.3 percent)

for CY 2021, relative to the proposed rule is primarily driven by slower anticipated compensation growth for both health-related and other occupations as labor markets are expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery."

The 2.3 percent update is further reduced by a multi-productivity factor of 0.3 percent, netting an overall increase of 2.0 percent.

Section 1895(b)(3)(B)(v) of the Act requires that the home health update be decreased by 2.0 percentage points for those HHAs that do not submit quality data. For HHAs that do not submit the required quality data, the home health payment update will be 0.0 percent (2.0 percent minus 2.0 percentage points).

CMS will maintain the current labor amounts of 76.1 percent and the non-labor related share of 23.9 percent.

Final Decision*: After consideration of public comments, CMS is finalizing the home health payment update percentage for CY 2021 based on the most recent forecast of the HHA market basket percentage increase and MFP adjustment at the time of rulemaking. Based on IGI's third-quarter 2020 forecast (with historical data through second-quarter 2020) of the HHA market basket percentage increase and IGI's September 2020 macroeconomic forecast of MFP, the home health payment update percentage for CY 2021 will be 2.0 percent (2.3 percent HHA market basket percentage increase less 0.3 percentage point MFP adjustment) for HHAs that submit the required quality data and 0.0 percent (2.0 percent minus 2.0 percentage points) for HHAs that do not submit quality data as required by the Secretary.*

2. CY 2021 Home Health Wage Index

a. Implementation of New Labor Market Delineations

CMS proposed to implement new OMB delineations as described in a September 14, 2018 OMB Bulletin No. 18-04 for the home health wage index effective beginning in CY 2021. CMS is adopting its proposed changes.

A copy of the September 2018 bulletin is available at: https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.

Urban Counties Becoming Rural

A total of 34 counties (and county equivalents) that are currently considered urban will be considered rural beginning in CY 2021. Refer the rule's Table 3 for a list of these counties.

Rural Counties Becoming Urban

A total of 47 counties (and county equivalents) that are currently designated rural will be considered urban beginning in CY 2021. Refer the rule's Table 4 for a list of these counties.

Urban Counties Moving to a Different Urban CBSA

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties will shift from one urban CBSA to another urban CBSA. Refer the rule's Table 5 for a list of these areas.

Counties That Will Change to a Different CBSA

In some cases, a CBSA will lose counties to another existing CBSA. The rule's Table 6 lists the urban counties that will move from one urban CBSA to a newly or modified CBSA if CMS adopts the new OMB delineations.

b. Transition Period

CMS says it believes that using the new OMB delineations will create a more accurate payment adjustment for differences in area wage levels. The agency will include a cap of 5.0 percent on any overall decrease in a geographic area's wage index value. This adjustment will only be for CY 2021.

Comment

CMS notes that in the absence of a HH-specific wage data that accounts for area differences, using inpatient hospital wage data is appropriate and reasonable for the HH PPS.

Final Decision*: After considering the comments received in response to the proposed rule, we are finalizing our proposal to use the FY 2021 pre-floor, pre-reclassified hospital wage index data as the basis for the CY 2021 HH PPS wage index.*

Final Decision: *We are finalizing our proposal to adopt the revised OMB delineations from the September 14, 2018 OMB Bulletin 18–04 and apply a 1-year 5 percent cap on wage index decreases as proposed, meaning the counties impacted will receive a 5 percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior calendar year for CY 2021 effective January 1, 2021.*

The final CY 2021 wage indexes are available on the CMS website at: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

Current Payment System of Home Health Services Beginning in CY 2020 and Subsequent Year Employing the HH Patient Driven Grouping Model (PDGM)

In the CY 2019 HH PPS final rule, CMS finalized case-mix methodology refinements through the Patient-Driven Groupings Model (PDGM) for home health periods of care beginning on or after January 1, 2020.

To adjust for case-mix for 30-day periods of care beginning on and after January 1, 2020, the HH PPS uses a 432-category case mix classification system to assign patients to a home health resource group (HHRG) using patient characteristics and other clinical information from Medicare claims and the Outcome and Assessment Information Set (OASIS) assessment instrument.

Each HHRG has an associated case-mix weight that is used in calculating the payment for a 30-day period of care. For periods of care with visits less than the low-utilization payment adjustment (LUPA) threshold for HHRG, Medicare pays national per-visit rates based on the discipline(s) providing the services.

Case-mix weights are generated for each of the different PDGM payment groups by regressing resource use for each of five categories using a fixed effects model.

CY 2021 Annual Payment Update

CY 2021 National, Standardized 30-Day period Payment Amount

The CY 2021 national standardized 30-day episode payment rate is as follows.

CY 2020 30-day Budget Neutral (BN) Standard Amount	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update	CY 2021 National, Standardized 30-Day Period Payment
$1,864.03	X 0.9999	X 1.0200	$1,901.12

The proposed amount was $1,911.87.

The CY 2021 30-day national standardized 30-day episode payment amount for HHAs that DO NOT submit quality data is as follows.

CY 2020 National, Standardized 30-Day Episode Payment	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update Minus 2.0 Percentage Points	Proposed CY 2021 National, Standardized 30-Day Episode Payment
$1,864.03	X 0.9999	X 1.0000	$1,863.84

CY 2021 National Per-Visit Rates for 30-day Periods of Care

The CY 2021 national per-visit rates for HHAs that submit required quality data are updated by the CY 2021 HH payment update percentage of 2.0 percent and are shown in the table below.

CY 2021 National Per-Visit Rates for 30-day Periods of Care

HH Discipline	CY 2020 Per-Visit Payment	Wage Index Budget Neutrality Factor	Proposed CY 2021 HH Payment Update	Proposed CY 2021 Per-Visit Payment
Home Health Aide	$67.78	X 0.9997	X 1.0200	$69.11
Medical Social Services	$239.92	X 0.9997	X 1.0200	$246.64
Occupational Therapy	$164.74	X 0.9997	X 1.0200	$167.98
Physical Therapy	$163.61	X 0.9997	X 1.0200	$166.83
Skilled Nursing	$149.68	X 0.9997	X 1.0200	$152.63
Speech-Language Pathology	$177.84	X 0.9997	X 1.0200	$181.34

Comment

CMS has two different area wage index budget neutrality factors. One is for the national, standardized 30-day period payment amount – 0.9999. The second is for the national per-visit payment amounts – 0.9997. The tables above show each.

Final Decision*: After considering the comments received in response to the proposed CY 2021 annual payment update, we are finalizing the CY 2021 national, standardized 30-day payment rates, the per-visit payment rates and the home health payment update percentage of 2.0 percent for CY 2021.*

We are not making any changes to the policies previously finalized in the CY 2020 HH PPS final rule regarding the behavior assumptions adjustment. In accordance with section 1895(b)(3)(D) of the Act, we will analyze data for CYs 2020 through 2026, after implementation of the 30-day unit of payment and new case-mix adjustment methodology under the PDGM, to annually determine the impact of the differences between assumed and actual behavior changes on estimated aggregate expenditures and, at a time and manner determined appropriate by the Secretary, make permanent and temporary adjustments to the 30-day payment amounts. Any future changes to the national, standardized 30-day period payment rates to account for differences in assumed versus actual behavior change, as a result of the implementation of the 30-day unit of payment and the case-mix adjustment methodology under the PDGM, are required to go through notice and comment rulemaking as required by 1895(b)(3)(D)(ii) and (iii) of the Act.

We are not making any changes to the split-percentage payment policy finalized in the CY 2020 HH PPS final rule. That is, for CY 2021, all HHAs will submit a ''no-pay'' Request for Anticipated Payment (RAP) at the beginning of each 30-day period to allow the beneficiary to be claimed in the CWF and also to trigger the consolidated billing edits.

Rural Add-On Payments for CY 2021 and CY 2022

Section 50208(a)(1)(D) of the BBA of 2018 added a new subsection (b) to section 421 of the ***Medicare Modernization Act*** to provide rural add-on payments for episodes or visits ending during CYs 2019 through 2022.

It also mandated implementation of a new methodology for applying those payments. Unlike previous rural add-ons, which were applied to all rural areas uniformly, the extension provided varying add-on amounts depending on the rural county (or equivalent area) classification by classifying each rural county (or equivalent area) into one of three distinct categories: (1) rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals who are entitled to, or enrolled for, benefits under Part A of Medicare or enrolled for benefits under Part B of Medicare only, but not enrolled in a Medicare Advantage plan under Part C of Medicare (the "High utilization" category); (2) rural counties and equivalent areas with a population density of 6 individuals or fewer per square mile of land area and are not included in the ''High utilization'' category (the ''Low population density'' category); and (3) rural counties and equivalent areas not in either the ''High utilization'' or ''Low population density'' categories (the ''All other'' category).

The CY 2020 through 2022 rural add-on percentages outlined in law are shown below.

Category	CY 2020	CY 2021	CY 2022
High utilization	0.5%	None	None
Low population density	3.0%	2.0%	1.0%
All other	2.0%	1.0%	None

Final Decision: *Policies for the provision of rural add-on payments for CY 2019 through CY 2022 were finalized in the CY 2019 HH PPS final rule with comment period, in accordance with section 50208 of the BBA of 2018. The data used to categorize each county or equivalent area are available in the downloads section associated with the publication of this rule at: https:// www.cms.gov/Medicare/Medicare-Feefor-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.*

Payments for High-Cost Outliers under the HH PPS

Final Decision: *We are finalizing the fixed-dollar loss ratio of 0.56 for CY 2021 to ensure that total outlier payments not exceed 2.5 percent of the total payments estimated to be made under the HH PPS.*

The Use of Telecommunications Technology under the Medicare Home Health Benefit

Final Decision: *We are finalizing the proposal to require that any provision of remote patient monitoring or other services furnished via a telecommunications system or audio-only technology must be included on the plan of care and cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of eligibility or payment.*

We will still require that the use of such telecommunications technology or audio-only technology be tied to the patient-specific needs as identified in the comprehensive assessment, but we will not require as part of the plan of care, a description of how such technology will help to achieve the goals outlined on the plan of care. We expect to see documentation of how such services will be used to help achieve the goals outlined on the plan of care throughout the medical record when such technology is used. We are also finalizing the regulation text changes allowing a broader use of telecommunications technology to be considered allowable administrative costs on the home health cost report.

Home Health Quality Reporting Program (HH QRP)

There were no proposals or updates in the proposed rule for the Home Health Quality Reporting Program. The HH QRP currently includes 20 measures for the CY 2022 program year, as outlined in Table 28 of the CY 2020 HH PPS final rule.

Finalization of the Provisions of the May 2020 Interim Final Rule with Comment Period Relating to the Home Health Value-Based Purchasing Model (HHVBP)

Final Decision: *After consideration of the comments received, we are finalizing without modification the policy to align HHVBP Model data submission requirements with any exceptions or extensions granted for purposes of the HH QRP during the COVID-19 PHE, as described in the May 2020 COVID-19 IFC. We are also finalizing without modification the policy for granting exceptions to the New Measures data reporting requirements under the HHVBP Model during the COVID-19 PHE, including the codification of these changes at § 484.315(b), as described in the May 2020 COVID-19 IFC.*

Medicare Coverage of Home Infusion Therapy Services

Effective January 1, 2021, section 5012 of the ***21st Century Cures Act*** (Cures Act) created a separate Medicare Part B benefit category under section 1861(s)(2)(GG) of the Act for coverage of home infusion therapy services needed for the safe and effective administration of certain drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual, through a pump that is an item of DME.

Payment Categories and Payment Amounts for Home Infusion Therapy Services for CY 2021

Section 1834(u)(7)(C) of the Act established three payment categories, with an associated J-code for each transitional home infusion drug, for the home infusion therapy services temporary transitional payment. Payment category 1 comprises certain intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including, but not limited to, antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs. Payment category 2 comprises subcutaneous infusions for therapy or prophylaxis, including, but not limited to, certain subcutaneous immunotherapy infusions. Payment category 3 comprises intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.

The rule's Table 13 provides the list of J-codes associated with the infusion drugs that fall within each of the payment categories.

Final Decision*: At this time, we will not create a mandatory form nor require a specific manner or frequency of notification of options available for infusion therapy under Part B prior to establishing a home infusion therapy plan of care, as we believe that current practice provides appropriate notification. However, if current practice is later found to be insufficient in providing appropriate notification to patients of the available infusion options under Part B, we may consider additional requirements regarding this notification in future rulemaking.*

CY 2021 Payment Amounts for Home Infusion Therapy Services

The table below shows the payment categories with the CPT codes and units for such codes for home infusion therapy services in CY 2021 and subsequent calendar years.

Payment Categories for Home Infusion Therapy Services Payment for CY 2021

CPT CODE	DESCRIPTION	UNITS
CATEGORY 1		
96365	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)- up to one hour	1
96366	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)- each additional hour	4
CATEGORY 2		
96369	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)- up to one hour	1
96370	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)- each additional hour	4
CATEGORY 3		
96413	Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration- up to one hour	1
96415	Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration- each additional hour	4

The rule's table 16 shows the 5-hour payment amounts (using CY 2021 PFS rates) reflecting the increased payment for the first visit and the decreased payment for all subsequent visits. The payment amounts for this final rule are estimated using CY 2021 rates because the CY 2021 PFS rates are not available at the time of this rule-making. The final home infusion 5-hour payment amounts will be released on the Physician Fee Schedule when the final CY 2021 PFS rates are posted.

Table 16: 5-Hour Payment Amounts Reflecting Payment Rates for First and Subsequent Visits

Description	2020 Proposed PFS Amounts	5-hour Payment – First Visit	5-hour Payment – Subsequent Visits
Ther, Proph,Diag IV/IN infusion 1 hr	$72.18	$256.35	$154.26
Ther, Proph,Diag IV/IN infusion add hr	$22.01		
Sub Q Ther Inf 1 hr	$162.04	$358.59 (category 2)	$215.78 (category 2)
Sub Q Ther Inf add hr	$15.52		
Chemo Inf 1 hr	$142.55	$424.43 (category 3)	$255.40 (category 3)
Chemo Inf add hr	$30.68		

Final Decision: *The payment policies for the permanent home infusion therapy services benefit were finalized in the CY 2020 HH PPS final rule. We will maintain the three payment categories currently being utilized under the temporary transitional payments for home infusion therapy services and each category payment amount will be in accordance with the six CPT infusion codes under the PFS and equal to 5 hours of infusion services in a physician's office. We will increase the payment amounts for each of the three payment categories for the first visit by the relative payment for a new patient rate over an existing patient rate using the Medicare physician evaluation and management (E/M) payment amounts for a given year, in a budget neutral manner, resulting in a small decrease to the payment amounts for any subsequent visits. Payment will be made for each infusion drug administration calendar day in accordance with the definition finalized in the CY 2019 final rule.*

Home Infusion Therapy Geographic Wage Index Adjustment

CMS will the use the Geographic Adjustment Factor (GAF) to adjust home infusion therapy payments based on differences in geographic wages. A list of GAFs by locality for this final rule is available as a downloadable file at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview.html.

Home Infusion Therapy Services Excluded from the Medicare Home Health Benefit

***Final Decision**: In accordance with the conforming amendment in section 5012(c)(3) of the 21st Century Cures Act, which amended section 1861(m) of the Act to exclude home infusion therapy from the definition of home health services, we are finalizing as proposed our amendment to § 409.49 to exclude services covered under the home infusion therapy services benefit from the home health benefit. Any services that are covered under the home infusion therapy services benefit as outlined at § 486.525, including any home infusion therapy services furnished to a Medicare beneficiary that is under a home health plan of care, are excluded from coverage under the Medicare home health benefit.*

Excluded home infusion therapy services only pertain to the items and services for the provision of home infusion drugs, as defined at § 486.505. Services for the provision of drugs and biologicals not covered under this definition may continue to be provided under the Medicare home health benefit, and paid under the home health prospective payment system.

Comment

The home infusion therapy material extends some 60 pages, 23 percent of the entire rule. The issue of Home Infusion Therapy Services is much more involved than the material above would suggest.