Home Health Proposed PPS Final Rule for CY 2022

The **CY 2022 Home Health Prospective Payment System Rate Update (CMS-1747-P)** was released on June 28, 2021 and is applicable to Medicare home health services. This document summarizes portions of the proposed changes to home health care agencies. Sixty days are allowed for comments—electronic or mail—and must be received no later than 5pm on August 27, 2021. For detailed information regarding CMS-1747-P, use this address: https://www.federalregister.gov/documents/2021/07/07/2021-13763/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home

Payment (HH PPS)

- **National, Standardized Prospective Payment Rates:**
  - Payment adjustment from 2021 rates reflect wage adjustments which results in payment changes to all 432 case-mix weights
  - CY 2022 national standardized 30-day period payment = $2,013.43 (an increase of $112.31 from CY 2021) for agencies who submit quality data
  - CY 2022 national standardized 30-day payment = $1973.88 (an increase of $72.76 from CY 2021) for agencies who do not submit quality data
- **LUPAs**
  - Paid per visit rate if LUPA threshold is not met
  - CY 2022 rates for agencies submitting quality data:
    - Aide: $70.45
    - MSW: $249.39
    - OT: $171.24
    - PT: $170.07
    - SN: $155.59
    - SLP: $184.86
  - For agencies not submitting quality data, update percentage is 1.8% minus 2% points *(Table 22 on page 74 of HH Proposed Rule)*
  - LUPA payments for SN, PT, SLP and OT performance of initial and comprehensive assessment receive an add-on payment amount (SN: 1.8451 multiplied by national visit rate; PT, SLP, and OT: 1.6700 multiplied by national visit rate)
- **Rural Add-On Percentage**
  - Areas designated as low population density will receive a 1% add-on
- **Outlier adjustment:**
  - Fixed Dollar Loss (FDL) Ratio reduced from 0.80 to 0.41

Notice of Admission (NOA)

- **One-time NOA** will be submitted for the 30-day period establishing the HH period of care and covers all contiguous 30-day periods of care until the patient is discharged from Medicare HH services
- To begin on **January 1, 2022**
- **Failure to submit NOA** within 5 calendar days of start of care will result in a one-thirtieth payment reduction for each day from the start of care until the date the NOA is submitted (includes outlier payment amounts)
  - **Start of Care date** will be counted as Day 0 when calculating 5 day window
- **LUPAs and NOAs:** in the event of a LUPA in the 30-day period and a late NOA, visits performed prior to NOA submission will not be paid
- **No RAPs** will be submitted
- **Certain exceptions** apply to late filing of NOA due to catastrophic events inflicting damage to the operation of the HH agency, systems issue of CMS or Medicare contractors which are beyond the control of the HH agency, or certain situations involving a newly Medicare-certified HH

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Allowed Practitioners

- As established in the CY 2021 HH PPS Final rule, allowed practitioners (nurse practitioners, clinical nurse specialists, and physician's assistants) may certify, establish and periodically review the plan of care, and supervise the provision of items and services for beneficiaries under the Medicare home health benefit
- **Face-to-Face (F2F) Encounters:** may be performed by an allowed practitioner to certify eligibility
    - Only patients who are directly admitted to home health from an acute or post-acute facility may have a different certifying physician from the physician or non-physician practitioner who performed the F2F

HH Value-Based Purchasing (HHVBP) Model

- **Expansion to all 50 States, District of Columbia and territories** on January 1, 2022
    - CY2022 would be the first performance year and CY 2024 would be the first payment year with adjustments based on CY 2022 performance
    - The baseline year would be CY 2019 to provide a basis from which each respective HHA's performance would be measured
    - Newly Medicare-certified HHAs on or after January 1, 2019 would use CY 2021 as the baseline due to the pandemic and disruption of services in CY 2020 *(see Table 25 on page 101 in Proposed Final Rule)*
- **Reduction or increase of up to 5% to Medicare payments** depending on HHA's performance on specified quality measures relative to its peers
- **For comparison to peers**, CMS proposes to divide agencies into two groups (or cohorts).
    - Larger-volume cohorts are those HHAs who are required to submit an HHCAHPS survey for the calendar year.
    - Smaller-volume cohorts are those HHAs who have fewer than 40 eligible HHCAHPS survey patients annually (proposed change from minimum of 60 to 40 eligible surveys)
    - Cohorts must have a minimum of eight HHAs for comparison
- **Proposed Quality Measures and Data Source**
    - Improvement in Dyspnea (OASIS M1400)
    - Discharged to Community (OASIS M2420)
    - Improvement in Management of Oral Medications (OASIS M2020)
    - Total Normalized Composite Change in Mobility (OASIS M1840, M1850, M1860)
    - Total Normalized Composite Change in Self-Care (OASIS M1800, M1810, M1820, M1830, M1845, M1870)
    - Acute Care Hospitalization During the First 60 Days of HH Use (claims based data)
    - Emergency Department Use without Hospitalization During the First 60 Days of HH (claims based data)
    - HHCAHPS Survey (CAHPS data) *(See Tables 26 and 27 on pages 105-108 in Proposed Final Rule)*
- **CY 2023:** Proposed removal of Acute Care Hospitalization and Emergency Department Use to be replaced with Home Health Within-Stay Potentially Preventable Hospitalization (PPH)
- **HHAs would not be required to submit additional data through OASIS.** OASIS data submitted according to § 484.250(a) and 484.55(b)(c)(d) would suffice for 12 months of data for calculation of Quality Measures
- **A minimum of 20 HH episodes of care per year and minimum of 40 HHCAHPS surveys** received in the performance year will be required; failure to meet these parameters will result in the HHA not receiving a payment adjustment based on that performance year *(see Table 29 on page 142 in Proposed Final Rule for further clarification of weighting and re-weighting of quality measures)*
- *Scoring methodology can be found in the Proposed HH Final Rule 2022*
- **HHVBP Model results will be publicly reported** on a CMS website on or after December 1, 2023; results would not affect star ratings

LUPA Thresholds (PDGM)

- **No changes in thresholds for CY 2022** due to the Public Health Emergency of CY 2020 causing alterations in overall visits
- **Thresholds will be re-evaluated for CY 2023** using data from CY 2021

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Functional Impairment Levels (PDGM)

- OASIS points based on CY 2020 data

OASIS Item	Responses	Points (CY 2020)
M1800: Grooming	0 or 1	0
	2 or 3	3
M1810: Current Ability to Dress Upper Body	0 or 1	0
	2 or 3	6
M1820: Current Ability to Dress Lower Body	0 or 1	0
	2	5
	3	12
M1830: Bathing	0 or 1	0
	2	1
	3 or 4	9
	5 or 6	17
M1840: Toilet Transfer	0 or 1	0
	2, 3, or 4	5
M1850: Transferring	0	0
	1	3
	2, 3, 4, or 5	7
M1860: Ambulation/Locomotion	0 or 1	0
	2	6
	3	6
	4, 5, or 6	19
M1032: Risk of Hospitalization	Three or fewer items marked (excluding responses 8, 9, or 10)	0
	Four or fewer items marked (excluding responses 8, 9, or 10)	12

HH Quality Reporting Program (HH QRP)

- **Twenty measures continue** from CY 2020 HH PPS Final Rule
- **CY 2023:**
  - Removal of Drug Education item beginning January 1, 2023
  - Removal of ACH in First 60 Days of HH and Emergency Department Use Without Hospitalization During First 60 Days of HH to be replaced with Home Health Within Stay Potentially Preventable Hospitalization Measure (PPH)
    - Measure is calculated using a calendar year of Medicare FFS data
    - Agency would need a minimum of 20 eligible HH stays for public reporting

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OASIS-E

- **Most likely to begin use January 1, 2023** (must be one full year following Public Health Emergency)
- Draft of updated version likely to be released in early 2022
- Transfer of Health Information to Provider Post-Acute Care measure, Transfer of Health Information to Patient-PAC measure, and certain Standardized Patient Assessment Data Elements would be collected with the OASIS-E start of care, resumption of care, and discharges

Proposed Changes to HH CoPs

- **Medicare, Medicaid, and CHIP programs:** Where requirements were temporarily waived or modified to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in the emergency area during the emergency period, providers can be reimbursed and exempted from sanctions (absent of any determination of fraud or abuse)
- Some waivers of the HH Medicare program may be appropriate as a permanent policy
    - **Supervision of home health aides (484.(h)(1)(2):**
        - **Aides caring for a patient with skilled care from nurses or therapists:** Supervision must be performed no less than every 14 days either onsite or by using interactive telecommunications systems (not to exceed twice in a 60-day episode); virtual supervision may only be performed when unplanned occurrences would interrupt the scheduled on-site in-person visit
            - No change to annual on-site , in person, supervisory visit to observe each HH aide while he/she is performing patient care activities
        - **Aides caring for a patient who is <u>not</u> receiving skilled care services:** on-site supervisory visit by RN every 60 days (aide does not need to be present)
            - Semi-annual in-person assessment for each aide while he/she is performing care
        - **RN/qualified professionals identification of deficiency in aide services:** proposed addition that aide will complete retraining and a competency evaluation related to "all related deficient skills"
    - **HH initial assessment and comprehensive assessment** may be performed by the OT where OT is ordered with another rehab therapy service but no skilled nursing services are ordered
        - No change in services that can initially establish eligibility for Medicare home health care
- **Adequacy of HH aide staffing:** CMS seeks comments on-
    - If agency employs or contracts with HH aide services;
    - Number of HH aides employed or contracted and whether this number has increased or decreased over the past 5-10 years;
    - Average number of aide hours per beneficiary ordered on the plan of care;
    - Effect of public health emergency on ability to employ/contract HH aides

Home Infusion Therapy Payment Categories

- No proposed changes to three categories of payment
- A geographic adjustment factor and consumer price index will be applied for CY 2022
- CY 2021 unadjusted rates will be used for CY 2022 payment (removal of 3.75% increase used in CY 2021)
- *See Table 34 on page 210 for payment rates*

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Medicare Provider and Supplier Enrollment Changes

- **Effective Dates clarifications to be included in 42 CFR 424** including effective date of billing privileges
  - Applies to home infusion therapy suppliers (as well as other non-home health providers)
  - Allows the provider to "back bill" for services
  - Clarification of "deactivation" of billing privileges in § 424.540
- **HHA Change of Ownership**
  - Change to language of § 424.550(b)(2)(i) clarifying details of the 36-month rule

Extra Information & Tips for Agencies

- This proposed rule is heavily influenced by COVID-19 PHE and the disruption it caused to agencies during CY 2020.
- At minimum, read sections of the 387 pages of the proposed rule which apply to you. The information in this tool are summaries of the most important changes, but further information may be useful in the proposed rule.
- Begin preparing for possible changes such as OASIS items to ensure assessing clinician accuracy.
- Examine your CY 2019's quality measures which will be used as a baseline for the HHVBP model. Educate staff on measures to improve outcomes where needed.
- Look at your HHCAHPS survey return and results for past years. Strategize on methods to improve return rate and results.
- Submit comments to CMS where rules are overly burdensome or need adjustments. Deadline is August 27, 2021.