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CMS Proposes Calendar Year 2022 Home Health Prospective Payment System Rate Update

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Today, the Centers for Medicare & Medicaid Services (CMS) took action to improve home health care for older adults and people with disabilities through a proposed rule that would accelerate the shift from paying for Medicare home health services based on volume to a system that pays for value and quality by proposing a nationwide expansion of the Home Health Value-Based Purchasing (HHVBP) Model. This rule also includes proposals and routine updates to the Medicare Home Health Prospective Payment System (HH PPS) and the home infusion therapy services payment rates for Calendar Year (CY) 2022, in accordance with existing statutory and regulatory requirements. This rule proposes to make permanent changes to the home health Conditions of Participation (CoP) that were implemented during the COVID-19 Public Health Emergency (PHE).

The proposed rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection/current

Proposed Home Health Value-Based Purchasing (HHVBP) Model Expansion

Under the authority of Section 1115A of the Social Security Act, the CMS Innovation Center (CMMI) implemented the HHVBP Model on January 1, 2016. This Model tests whether payment incentives can significantly change health care providers' behavior to improve quality of care, through payment adjustments based on quality performance during a given model performance year. The HHVBP Model's current participants were located in randomly selected states and comprise all Medicare-certified Home Health Agencies (HHAs) providing services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.

CMS is proposing to expand the CMS CMMI HHVBP Model nationwide. As a result of this proposed expansion, CMS is also proposing to end the existing HHVBP Model one year early for participants in the original model's nine states such that, if the proposed policies are finalized, CMS would not use CY 2020 data to make payment adjustments for current participants in CY 2022. The first performance year of the expanded HHVBP Model would be CY 2022, with quality performance data from that year used to calculate payment adjustments under the expanded Model in CY 2024.

The Third Annual Evaluation Report of the participants' performance from 2016-2018 showed an average 4.6% improvement in HHAs' quality scores as well as average annual savings of $141 million to Medicare. On January 8, 2021, CMS announced its intention to expand the Model no earlier than January 1, 2022, through notice and comment rulemaking, as required by statute. The evaluation findings, along with the CMS Chief Actuary's certification and determinations made by the Health and Human Services (HHS) Secretary, designated the HHVBP Model as eligible for expansion nationwide through rulemaking. The HHVBP Model's most recent findings can be viewed in the Fourth Annual Evaluation Report.

CY 2022 Proposed Payment Updates and Policy Changes Updates for Home Health Agencies and Home Infusion Therapy Suppliers

Proposals and Updates to the HH PPS for CY 2022

This rule proposes routine, statutorily required updates to the home health payment rates for CY 2022. CMS estimates that Medicare payments to HHAs in CY 2022 would increase in the aggregate by 1.7 percent, or $310 million, based on the proposed policies. This increase reflects the effects of the proposed 1.8 percent home health payment update percentage ($330 million increase) and a 0.1 percent decrease in payments due to reductions made in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018 for CY 2022 ($20 million decrease).

In this proposed rule, we discuss for the Medicare payment of home infusion therapy services payment adjustments, CMS is proposing to update the payment rates for CY 2022 as required by law. In addition, CMS is proposing to update the geographic adjustment factor used for wage adjustment and a proposal to maintain the percentages finalized for the initial and subsequent visit payment policy.

Patient-Driven Groupings Model (PDGM) and Behavioral Assumptions

Beginning on January 1, 2020, Medicare implemented the PDGM and a 30-day unit of payment, as required by law, for the HH PPS to better align with patient care needs and safeguard that clinically complex beneficiaries have adequate access to home health care. The law required CMS to make assumptions about behavior changes that could occur because of the implementation of the 30-day unit of payment and the PDGM and in the CY 2019 HH PPS final rule with comment period, CMS finalized three behavioral assumptions (clinical group coding, comorbidity coding, and a low utilization payment amount (LUPA) threshold). This resulted in a 4.36 percent reduction to the CY 2020 national, standardized 30-day payment rate. The law also requires CMS to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures beginning with 2020 and ending with 2026 and to make temporary and permanent increases or decreases, as needed, to the 30-day payment amount to offset such increases or decreases.

This proposed rule provides preliminary analyses of the first year of the PDGM including data on admission source, timing, clinical grouping, functional impairment level, comorbidity adjustment and the provision of therapy visits (physical, occupational, and speech). Additionally, CMS provides a detailed method on how it analyzed the difference between assumed and actual behavior changes. However, CMS is not proposing any specific method or behavior assumption payment adjustment in this proposed rule, rather it is soliciting comments on the described method and other possible methods to determine the impact of behavior changes on estimated aggregate expenditures.

Recalibration of PDGM Case-Mix Weights

Each of the 432 payment groups under the PDGM has an associated case-mix weight and LUPA threshold. CMS' policy is to annually recalibrate the case-mix weights using the most complete utilization data available at the time of rulemaking. In this proposed rule, CMS is proposing to recalibrate the case-mix weights, functional levels, and comorbidity adjustment subgroups using CY 2020 data to more accurately pay for the types of patients HHAs are serving. Additionally, CMS is proposing to maintain the CY 2021 LUPA thresholds for CY 2022.

Occupational Therapy LUPA Add-on Factor

Division CC, Section 115, of the Consolidated Appropriations Act, 2021 included provisions to allow Occupation Therapists (OTs) to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health benefit when the plan of care does not initially include skilled nursing care, but includes either Physical Therapy (PT) or speech-language pathology (SLP). Because of this change, we are proposing conforming regulation text changes to allow for this provision. Because OTs can now conduct the initial and comprehensive assessments, CMS also is proposing to establish a LUPA add-on factor for calculating the LUPA add-on payment amount for the first skilled occupational therapy visit in LUPA periods that occurs as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. Currently, there are no sufficient data regarding the average excess of minutes for the first visit in LUPA periods where the initial and comprehensive assessments are conducted by occupational therapists. Therefore, CMS is proposing to utilize the physical therapy LUPA add-on factor as a proxy until CY 2022 data is available to establish a more accurate occupational therapy add-on factor for the LUPA add-on payment amounts.

Proposals and Updates to the Home Infusion Therapy Benefit for CY 2022

CMS is proposing to update the home infusion therapy services payment rates for CY 2022 as required by law. In addition, CMS is proposing to update the geographic adjustment factor used for wage adjustment and to maintain the percentages finalized in the CY 2020 HH PPS final rule with comment period for the initial and subsequent visit payment policy. The overall economic impact of updating the payment rates for home infusion therapy services is expected to be minimal, based on the percentage increase in the consumer price index for all urban consumers (CPI-U) reduced by the productivity adjustment for CY 2022. The CPI-U for June 2021 was not yet available at the time of this proposed rule.

Home Health Quality Reporting Program

The HH QRP is a pay-for-reporting program. HHAs that do not meet reporting requirements must be subject to a two-percentage point (2%) reduction in their annual update.

Closing the Health Equity Gap - RFI

Consistent with Executive Order 13985 of January 20, 2021, entitled “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,” CMS is committed to pursuing a comprehensive approach to advancing equity for all. CMS seeks to address the significant and persistent inequities in health outcomes in the United States through improving data collection to better measure and analyze disparities across its programs and policies. CMS is working to make healthcare quality more transparent to consumers and providers, enabling them to make better choices as well as promoting provider accountability around health equity. We are seeking feedback in this RFI on ways to attain health equity for all patients through policy solutions. Our ongoing commitment to closing the health equity gap in HHAs has been demonstrated by the adoption of standardized patient assessment data elements which include several Social Determinants of Health (SDOH) that were finalized in the CY 2020 HH PPS final rule for the HH QRP. With this RFI, we are also

seeking comment on the possibility of expanding measure development, and the collection of other standardized patient assessment data elements that address gaps in health equity in the HH QRP.

CMS is proposing to improve the HH QRP by removing an OASIS-based measure which is no longer demonstrating meaningful differences in performance and by removing or replacing two claim-based measures with a claims-based measure that addresses concerns raised surrounding attribution with a measure more strongly associated with desired patient outcomes. CMS is also proposing that in supporting the coordination of care,HHAs begin collecting data on the Transfer of Health Information to Provider-Post Acute Care measure, the Transfer of Health Information to Patient-PAC measure, as well as six categories of standardized patient assessment data elements effective January 1, 2023 to position us with data to monitor outcomes across diverse populations. This proposal could also better position CMS to support the recent Executive Order 13985.

Fast Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs – RFI

CMS is working to further the mission to improve the quality of healthcare for beneficiaries through measurement, transparency, and public reporting of data. We believe that advancing our work with use of the FHIR standard offers the potential for supporting quality improvement and reporting which will improve care for our beneficiaries. We are seeking feedback on our future plans to define digital quality measures (dQMs) for the HH QRP. We also are seeking feedback on the potential use of FHIR for (dQMs) within the HH QRP aligning where possible with other quality programs.

Long Term Care Hospital (LTCH) Quality Reporting Program and Inpatient Rehabilitation Facility (IRF) Quality Reporting Program

CMS is proposing that LTCHs and IRFs begin collecting data on the Transfer of Health Information to Provider-Post Acute Care measure, the Transfer of Health Information to Patient-PAC measure and six categories of standardized patient assessment data elements effective October 1, 2022. This proposal could also better position CMS to support the recent Executive Order 13985of January 20, 2021, entitled “Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.”

<u>Home Health Conditions of Participation</u>

CMS is proposing to make permanent selected regulatory blanket waivers related to home health aide supervision and the use of telecommunication that were issued to Medicare participating home health agencies during the COVID-19 public health emergency (PHE). We believe the current 14-day on-site supervisory visit requirement when a patient is receiving skilled services is an important component to assessing the quality of care and services provided by the HHA aide, and to ensure that aide services are meeting the patient’s needs. While we are proposing to allow this telecommunications flexibility, we expect that in most instances, the HHAs would plan to conduct the 14-day supervisory assessment during an on-site, in person visit, and that the HHA would use interactive telecommunications systems option only for unplanned occurrences that would otherwise interrupt scheduled in-person visits. CMS is also proposing to update the home health Conditions of Participation to implement Division CC, section 115 of the Consolidated Appropriations Act, 2021 (CAA 2021) which requires CMS to permit an

occupational therapist to conduct the initial assessment visit and complete the comprehensive assessment under the Medicare program, but only when occupational therapy is on the home health plan of care with either physical therapy or speech therapy and skilled nursing services are not initially on the plan of care.

Survey and Enforcement Requirements for Hospice Programs

CMS continues to review and revise our health and safety requirements and survey processes to ensure that they are effective in driving quality of care for hospice programs. In this proposed rule, CMS includes provisions to implement Division CC, section 407(a) of the CAA, 2021 with respect to transparency, oversight, and enforcement of health and safety requirements for hospice programs.

These proposed provisions enhance the hospice program survey process by requiring the use of multidisciplinary survey teams, prohibiting surveyor conflicts of interest, expanding CMS-based surveyor training to accrediting organizations (AOs), and requiring AOs with CMS-approved hospice programs to begin use of the Form CMS-2567. Additionally, the proposed provisions establish a hospice program complaint hotline. Finally, the proposed provisions create a Special Focus Program (SFP) for poor-performing hospice programs and the authority for imposing enforcement remedies for noncompliant hospice programs. The CAA, 2021 provisions expanding requirements for AOs will apply to AOs that accredit and "deem" hospice programs. Currently there are three CMS-approved AOs for hospice programs: Accreditation Commission for Health Care (ACHC), Community Health Accreditation Partner (CHAP), and The Joint Commission (TJC). Half of all the Medicare-certified hospices have been deemed by these AOs.

For additional information about the Home Health Prospective Payment System, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/HomeHealthPPS/index.html and https://www.cms.gov/center/provider-Type/home- Health-Agency-HHA-Center.html.

For additional information about the Home Health Patient-Driven Groupings Model, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html.

For additional information about the Home Infusion Therapy Services benefit, visit
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion- Therapy/Overview.html.