2020

CMS Finalizes Calendar Year 2021 Payment and Policy Changes for Home Health Agencies - Summary

MTELEHEALTH

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CMS released the 2021 home health final rule on Thursday, October 29, 2020.

There were minimal changes compared to the home health proposed rule that was released in July 2020. Probably the best news in the rule was the 1.9% aggregate increase (or $390 million) in reimbursement that agencies will realize in 2021. Although the increase was less than the original 2.6% increase that was in the proposed rule.

Other highlights from the final rule are as follows:

- Patient-Driven Groupings Model (PDGM) remains in play with no changes to how HHRG (Home Health Resource Group) rates are determined.
- There were no changes to case mix rates and LUPA thresholds from 2020 to 2021.
- Behavioral adjustments that were realized in 2020 due to the implementation of PDGM remain intact. This was a controversial component of the final rule given that the preliminary PDGM data does not support that agencies have actually changed behaviors to support the negative adjustment.
- The delivery of infusion services under the Home Health benefit is drastically changing and now requires a rather costly home infusion therapy supplier enrollment as well as a decrease in reimbursement for these services.
- There are no changes to the quality reporting program for home health agencies.
- Some relief has been realized for Value Based Purchasing states through the public health emergency period where no aggregate increases or decreases in reimbursement will be realized.
- The provision of telehealth services remains the same as what has been realized through the public health emergency period. Telehealth services can be provided by home health agencies with appropriate physician collaboration and care planning, but no direct reimbursement can be realized by agencies providing these services.
- The split-percentage payment will now be 0% (was 20% in 2020) when home health agencies submit RAPs (Request for Anticipated Payment).
- The requirements for RAP submission have been updated to include the following which mirrors the Notice of Admission process that goes into effect 1/1/2022:

    - The appropriate physician's order (written or verbal) that is inclusive of services required for the initial visit. This order must be received and documented per the Home Health Conditions of Participation.
    - The initial visit within the 60-day certification period has to be made and the individual admitted to Home Health care.
- A non-timely submission payment reduction will occur when a home health agency does not submit a RAP within 5 calendar days from the start of care or any subsequent 30 day payment period.
    - The reduction in payment will be equal to 1/30th of the 30-day payment period amount for each day that the RAP is delayed not to exceed the total payment of the claim. Essentially any RAP that is delayed by 30 days or greater will receive $0 in reimbursement for that payment period.
    - Home Health agencies can submit RAPs for multiple 30-day payment periods at the same time to reduce administrative burden.
    - For payment periods resulting in a LUPA (Low Utilization Payment Adjustment), no per visit reimbursement will be provided for any visits that occur on days that fall within the period before the submission of the RAP.