# Issue Brief

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

The Centers for Medicare & Medicaid Services issued a proposed calendar year 2022 update to the home health prospective payment system (HH PPS). The 387-page rule is currently on display at the *Federal Register.* A copy is available at https://public-inspection.federalregister.gov/2021-13763.pdf. Publication is slated for July 7. A comment period closing Aug. 27 is provided.

This proposed rule would set forth routine updates to the home health and home infusion therapy services payment rates for CY 2022. The rule also provides monitoring and analysis of the Patient-Driven Groupings Model (PDGM), proposes to recalibrate the PDGM case-mix weights, functional levels and comorbidity adjustment subgroups.

Additionally, the proposal would utilize the physical therapy low utilization payment adjustment (LUPA) add-on factor to establish the occupational therapy add-on factor for the LUPA add-on payment amounts.

The proposal would expand the Home Health Value-Based Purchasing (HHVBP) Model, beginning Jan. 1, 2022, to the 50 states, territories and District of Columbia. The rulemaking also proposes to end the original HHVBP Model one year early for the home health agencies (HHAs) in the nine original Model States, such that CY 2020 performance data would not be used to calculate a payment adjustment for CY 2022 under the original Model.

The proposal would make changes to the Home Health Quality Reporting Program (QRP) to remove one measure, remove two claims-based measures and replace them with one claims-based measure, publicly report two measures, proposes a modification to the effective date for the reporting of the Transfer of Health to Provider-Post Acute Care and Transfer of Health to Patient-Post Acute Care (TOH) measures and Standardized Patient Assessment Data Elements.

In addition, the rulemaking proposes to make permanent selected regulatory blanket waivers related to home health aide supervision that were issued to Medicare participating home health agencies during the COVID-19 public health emergency, and would update the home health conditions of participation to implement Division CC, section 115 of the *Consolidated Appropriations Act* (CAA) regarding occupational therapists completing initial and comprehensive assessments.

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## COMMENTS

CMS says the FY 2022 overall economic impact of the HH PPS payment rate update is an estimated increase in payments of $310 million, adopting a proposed mandatory home health value-based system for all will result in an estimated $3.154 billion savings to Medicare between 2022 and 2026.

### Summary of Costs, Transfers and Benefits

| Provision Description | Costs and Cost Savings | Transfers | Benefits |
|---|---|---|---|
| CY 2022 HH PPS Payment Rate Update | | The overall economic impact of the HH PPS payment rate update is an estimated $310 million (1.7%) in increased payments to HHAs in CY 2022. | To ensure home health payments are consistent with statutory payment authority for CY 2022. |
| HHVBP | | The overall economic impact of the HHVBP Model for CYs 2022 through 2026 is an estimated $3.154 billion in total savings to FFS Medicare from a reduction in unnecessary hospitalizations and SNF usage as a result of greater quality improvements in the HH industry. As for payments to HHAs, there are no aggregate increases or decreases expected to be applied to the HHAs competing in the model. | |
| HH QRP | The total savings beginning in CY 2023 is an estimated $2,762,277 based upon the removal of one OASIS-based measure, item M2016. | | |
| Changes to the Home Health Conditions of Participation | CMS does not anticipate any costs or cost savings associated with our proposed Conditions of Participation provisions. | | |
| Medicare Coverage of Home Infusion Therapy | | 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 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. | To ensure that payment for home infusion therapy services are consistent with statutory authority for CY 2022. |
| Provider and Supplier Enrollment Processes | CMS does not anticipate any costs or cost savings associated with the proposed Medicare provider and supplier enrollment provisions. | The overall impact of the proposed provider enrollment provisions would be a transfer of $54,145,000 from providers/suppliers to the Federal government. This would result from the proposed provision prohibiting payment for services and items furnished by a deactivated provider or supplier. | |
| Survey and Enforcement Requirements for Hospice Programs | CMS estimates that the proposal presented in the preamble of this proposed rule to implement Division CC, section 407 of CAA 2021 would result in an estimated cost of approximately $5.5 million from FY 2021 through FY 2022. | CMS does not anticipate any transfers associated with the proposed Medicare survey and enforcement requirements for hospice programs. | To ensure a comprehensive strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public. |

This is another rule with a limited and helpful table of contents.

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Note, the 60-day comment period has started with the rule being placed on public display.

## Proposed CY 2022 Home Health Payment Rate Updates

***Market Basket***

The estimated CY 2022 home health market basket update is currently estimated at 2.4%. The 2.4% is reduced by a productivity adjustment, as mandated by the *Affordable Care Act* currently estimated to be 0.6 percentage points for CY 2022. In effect, the proposed home health payment update percentage for CY 2022 is 1.8%.

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 -0.2% (1.8% minus 2.0 percentage points).

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

## Proposed CY 2021 Home Health Wage Index

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."

CMS will use the FY 2022 pre-floor, pre-reclassified hospital wage index data as the basis for the CY 2022 HH PPS wage index.

The proposed CY 2022 wage indexes are available on the CMS website at https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

***Current HHA System***

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 Jan. 1, 2020.

The PDGM made several changes to the HH PPS, including replacing 60-day episodes of care with 30-day periods of care, removing therapy volume from directly determining payment, and developing 432 case-mix adjusted payment groups in place of the previous 153 groups.

The proposed rule updates the case-mix weights. These are being reported in a separate *Washington Perspectives*.

## Proposed CY 2022 National, Standardized 30-Day Period Payment Amount

The proposed CY 2022 national standardized 30-day episode payment rate would be as follows.

| CY 2021 National Standardized 30-day Period Payment | Case-MIX Weights Recalibration Neutrality Factor | Wage Index Budget Neutrality Factor | CY 2022 HH Payment Update | CY 2022 National, Standardized 30-Day Period Payment |
|---|---|---|---|---|
| $1,901.12 | 1.0390 | X 1.0013 | X 1.018 | $2,013.43 |

The proposed CY 2022 30-day national standardized 30-day episode payment amount for HHAs that DO NOT submit quality data is as follows.

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| CY 2021 National Standardized 30-day Period Payment | Case-MIX Weights Recalibration Neutrality Factor | Wage Index Budget Neutrality Factor | CY 2022 HH Payment Update Minus 2.0% | CY 2022 National, Standardized 30-Day Period Payment |
|---|---|---|---|---|
| $1,901.12 | 1.0390 | X 1.0013 | X 0.998 | $1,973.88 |

## COMMENT

On page 71 of the display copy, CMS says, "the proposed case-mix weights budget neutrality factor for CY 2022 is 1.0344." On page 72, CMS is using 1.0390 for the Case-Mix Weights Recalibration Neutrality

Factor in calculating the CY 2022 national, standardized 30-day period payment rate. The math is correct in the above tables applying the 1.0390 factor. Which is correct?

### Proposed CY 2022 National Per-Visit Payment Amounts Rates

The CY 2022 national per-visit rates for HHAs that submit required quality data are updated by the CY 2022 HH payment update percentage of 1.8% and are shown in the table below.

### Proposed CY 2022 National Per-Visit Payment Amounts

| HH Discipline | CY 2021 Per-Visit Payment | Wage Index Budget Neutrality Factor | Proposed CY 2022 HH Payment Update | Proposed CY 2022 Per-Visit Payment |
|---|---|---|---|---|
| Home Health Aide | $69.11 | X 1.0014 | X 1.018 | $70.45 |
| Medical Social Services | $244.64 | X 1.0014 | X 1.018 | $249.39 |
| Occupational Therapy | $167.98 | X 1.0014 | X 1.018 | $171.24 |
| Physical Therapy | $166.83 | X 1.0014 | X 1.018 | $170.07 |
| Skilled Nursing | $152.63 | X 1.0014 | X 1.018 | $155.59 |
| Speech-Language Pathology | $181.34 | X 1.0014 | X 1.018 | $184.86 |

### Rural Add-On Payments for 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 six 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

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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 |

### Proposed Payments for High-Cost Outliers under the HH PPS

CMS is proposing a Fixed Dollar Loss (FDL) ratio of 0.41 for CY 2022. This is a decrease from the current FDL ratio of 0.56.

## COMMENT

CMS says that "for a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of periods that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio, and therefore, increase outlier payments for qualifying outlier periods. Alternatively, a lower FDL ratio means that more periods can qualify for outlier payments, but outlier payments per period must be lower."

### Conforming Regulations Text Changes Regarding Allowed Practitioners

CMS is proposing conforming regulations text changes at section 409.43 to reflect that allowed practitioners, in addition to physicians, may establish and periodically review the plan of care.

### Home Health Value-Based Purchasing Model

CMS is proposing to expand the HHVBP Model to all Medicare-certified HHAs in the 50 states, territories, and District of Columbia beginning Jan. 1, 2022 with CY 2022 as the first performance year and CY 2024 as the first payment year, based on HHA performance in CY 2022. The rule also proposes to end the original HHVBP Model one year early for the HHAs in the nine original Model States (Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington), such that CY 2020 performance data would not be used to calculate a payment adjustment for CY 2022.

"The original Model has resulted in an average 4.6% improvement in home health agencies' quality scores as well as average annual savings of $141 million to Medicare."

CMS is proposing to use the section 1115A(d)(1) of the Act waiver authority to apply a reduction or increase of up to 5% to Medicare payments to Medicare-certified HHAs delivering care to beneficiaries in the 50 states, District of Columbia and the territories, depending on the HHA's performance on specified quality measures relative to its peers.

### Defining Cohorts for Benchmarking and Competition

CMS says "a key consideration in defining the cohorts is ensuring sufficient HHA counts within each cohort."

CMS is proposing to redefine the cohort structure to account for States, territories, and the District of Columbia with smaller numbers of HHAs, while also allowing for the use of volume-based cohorts in determining benchmarks, achievement thresholds, and payment adjustments.

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CMS is proposing to establish nationwide volume-based cohorts for the expanded HHVBP Model, such that HHAs nationwide would compete within either the larger-volume cohort or the smaller-volume cohort. Under this proposal, HHAs currently participating in the original HHVBP Model would no longer compete within just their state.

The table below identifies the counts of HHAs in each of the potential cohorts, if CMS were to apply separate state-and-volume-based cohorts for each state, territory, and the District of Columbia under the expanded Model.

## HHA Counts in State/Territory/District of Columbia- And Volume-Based Cohorts Based on CY 2019 Home Health Care Compare Data

| State | Large HHAs | Small HHAs | All HHAs | State | Large HHAs | Small HHAs | All HHAs |
|---|---|---|---|---|---|---|---|
| AK | 12 | 1 | 13 | MT | 22 | 2 | 24 |
| AL | 114 | 1 | 115 | NC | 152 | 4 | 156 |
| AR | 90 | 2 | 92 | ND | 12 | - | 12 |
| AZ | 106 | 2 | 108 | NE | 40 | 8 | 48 |
| CA | 993 | 76 | 1,069 | NH | 20 | 1 | 21 |
| CO | 105 | 4 | 109 | NJ | 42 | - | 42 |
| CT | 74 | - | 74 | NM | 58 | 4 | 62 |
| DC* | 7 | - | 7 | NV | 97 | 8 | 105 |
| DE | 12 | - | 12 | NY | 105 | - | 105 |
| FL | 677 | 54 | 731 | OH | 287 | 10 | 297 |
| GA | 99 | - | 99 | OK | 183 | 10 | 193 |
| GU* | 4 | - | 4 | OR | 43 | 1 | 44 |
| HI | 14 | - | 14 | PA | 229 | 12 | 241 |
| IA | 94 | 7 | 101 | PR | 33 | - | 33 |
| ID | 42 | 1 | 43 | RI | 18 | - | 18 |
| IL | 399 | 64 | 463 | SC | 63 | - | 63 |
| IN | 138 | 11 | 149 | SD | 19 | 4 | 23 |
| KS | 84 | 5 | 89 | TN | 112 | 1 | 113 |
| KY | 90 | - | 90 | TX | 982 | 97 | 1,079 |
| LA | 167 | - | 167 | UT | 68 | 6 | 74 |
| MA | 127 | 5 | 132 | VA | 187 | 6 | 193 |
| MD | 49 | 2 | 51 | VI* | 1 | - | 1 |
| ME | 19 | 1 | 20 | VT | 10 | - | 10 |
| MI | 322 | 54 | 376 | WA | 57 | - | 57 |
| MN | 97 | 9 | 106 | WI | 73 | - | 73 |
| MO | 123 | 9 | 132 | WV | 50 | 1 | 51 |
| MP* | 2 | - | 2 | WY | 16 | 2 | 18 |
| MS | 45 | - | 45 | All | 7,084 | 485 | 7,569 |

**These territories and the District of Columbia fall short of the original HHVBP Model's minimum of 8 HHAs to compose their own cohort even where the volume-based cohorts are combined.*

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## COMMENT

There is much more to this item than the information cited above. The proposal spans some 82 pages and as such requires an in-depth review. Subjects include scoring, benchmarking, and achievement. This is probably the most complex aspect of the rule.

### Proposed Home Health Quality Reporting Program

The HH QRP currently includes 20 measures for the CY 2022 program year.

CMS proposes to remove the Drug Education on all Medications Provided to Patient/Caregiver measure.

If finalized as proposed, HHAs would no longer be required to submit OASIS Item M2016, Patient/Caregiver Drug Education Intervention for the purposes of this measure beginning Jan. 1, 2023.

CMS proposes to remove the Acute Care Hospitalization during the First 60 Days of Home Health (NQF #0171) measure and Emergency Department Use Without Hospitalization During the First 60 days of Home Health (NQF #0173) measure and replace them with the Home Health Within-Stay Potentially Preventable Hospitalization claims-based measures beginning with the CY 2023 HH QRP.

### Proposed Schedule for Publicly Reporting Quality Measures Beginning with the CY 2022 HH QRP

CMS proposes to publicly report the Percent of Residents Experiencing One or More Major Falls with Injury measure and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631) measure beginning in April 2022.

### Proposal to Collect the Transfer of Health Information to Provider-Post Acute Care (PAC) measure, the Transfer of Health Information to Patient-PAC measure, and Certain Standardized Patient Assessment Data Elements Beginning January 1, 2023

CMS is revising the date for the collection of data on the Transfer of Health Information to Provider-PAC measure and Transfer of Health Information to Patient-PAC measure, and certain Standardized Patient Assessment Data Elements on the updated version of the OASIS assessment instrument referred to as OASIS-E. This revised date of Jan. 1, 2023, which is a two-year delay from this original compliance date finalized in the CY 2020 HH PPS final rule "balances the support that HHAs needed during much of the COVID-19 PHE as CMS provided flexibilities to support HHAs along with the need to collect this important data."

### Proposed Changes to the Home Health Conditions of Participation

CMS is proposing that HHAs be permitted to use interactive telecommunications systems for purposes of aide supervision, on occasion, not to exceed two virtual supervisory assessments per HHA in a 60-day period.

CMS is proposing the define interactive telecommunications systems as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

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### Permitting Occupational Therapists to Conduct the Initial Assessment Visit and Complete the Comprehensive Assessment for Home Health Agencies Under the Medicare Program

CMS is proposing to add additional language that allows the occupational therapist to complete the initial assessment for Medicare patients when skilled nursing is not initially on the plan of care, but occupational therapy is ordered with another rehabilitation therapy service (speech language pathology or physical therapy) that establishes program eligibility as a need for occupational therapy alone would not initially establish program eligibility under the Medicare home health benefit.

### Home Infusion Therapy Services: Annual Payment Updates for CY 2022

The Medicare home infusion therapy services benefit covers the professional services, including nursing services, furnished in accordance with the plan of care, patient training and education not otherwise covered under the durable medical equipment benefit, remote monitoring, and monitoring services for the provision of home infusion therapy furnished by a qualified home infusion therapy supplier.

In the CY 2020 HH PPS final rule, CMS finalized its proposal to maintain three payment categories that were utilized under the temporary transitional payments for home infusion therapy services. The three payment categories group home infusion drugs by J-code based on therapy type. Payment category 1 comprises certain intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including 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 certain subcutaneous immunotherapy infusions. Payment category 3 comprises intravenous chemotherapy infusions and other highly complex intravenous infusions.

CMS is not proposing to make any changes to the three payment categories in CY 2022.

While CMS is proposing to update the home infusion therapy services payment rates for CY 2022, as required by law, the consumer price index for all urban consumers (CPI-U) "was not yet available at the time of this proposed rule." Nonetheless, CMS says it expects any changes to be minimal.

Section 1834(u)(1)(B)(I) of the Act requires that the single payment amount be adjusted to reflect a geographic wage index and other costs that may vary by region. CMS use of the geographic adjustment factor (GAF) to adjust home infusion therapy payments for differences in geographic area wages rates based on the location of the beneficiary.

The CY 2022 proposed GAFs will be available on the physician fee schedule website when released at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched.

### Survey and Enforcement Requirements for Hospice Programs

CMS is piggybacking on this HHA proposed rule to propose changes to the Hospice Program.

CMS is including provisions to implement Division CC, section 407(a) of the CAA, 2021 with respect to transparency,

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oversight, and enforcement of health and safety requirements for hospice programs.

These proposed provisions require the use of multidisciplinary survey teams, prohibiting surveyor conflicts of interest, expanding CMS-based surveyor training to accrediting organizations, 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 for poor-performing hospice programs and the authority for imposing enforcement remedies for noncompliant hospice programs.

Currently there are three CMS-approved AOs for hospice programs: Accreditation Commission for Health Care, Community Health Accreditation Partner and The Joint Commission. Half of all the Medicare-certified hospices have been deemed by these AOs.

*Analysis provided for MHA by Larry Goldberg, Goldberg Consulting*