CMS Estimates CY 2021 Home Health Agency Payments to Increase by 2.6 Percent; Proposes to Make Permanent COVID-19 Technology

On June 25, 2020, the Centers for Medicare and Medicaid Services (CMS) issued the calendar year (CY) 2021 home health prospective payment system and rate update proposed rule with comment period (fact sheet).

- **What it is.** The final rule affects payments to home health agencies (HHAs) beginning Jan. 1, 2021.

- **Why it is important for you.** CMS proposes to make updates to the home health payment rates for CY 2021. Specific policy changes include adopting the Office of Management and Budget's (OMB) statistical area delineations used in the home health wage index, simplifying conditions of participation requirements for new HHAs, updating payment rates for home infusion therapy services, and establishing Medicare enrollment standards for qualified home infusion therapy suppliers.

  Most notably, CMS proposes to make permanent its COVID-19 drive change for home health care providers included in the first COVID-19 interim final rule with comment period (IFC). Specifically, CMS proposes to permanently require that a home health plan of care must include any provision of remote patient monitoring or other services furnished via telecommunications systems, and that the plan of care must include how the use of this technology addresses patient-needs and goals included in the care plan.

  A telling line of detail from the agency involves its rationale for making permanent such changes. The agency states "because stakeholders have identified significant up-front costs in incorporating and evaluating various forms of telecommunications systems into home health care, this would allow HHAs to confidently plan for the continued inclusion telecommunications systems under the Medicare home health benefit and increase the tools available to promote patient involvement…"

  In short, to encourage providers to implement telehealth solutions as a means for addressing the COVID-19 pandemic, CMS is proposing to make the temporary flexibilities permanent so providers can realize the benefits of these upfront costs in the long-run. This line of thinking may speak more generally to the agency's overall perspective on these telehealth flexibilities across provider types, suggesting the agency may take a similar approach where it is able to under current regulatory authority.

- **Potential next steps**. Comments on the proposed rule must be received no later than **5:00pm ET on August 20, 2020.**

CMS projects that payments to HHAs will increase by 2.6 percent ($540 million) in CY 2021 compared with CY 2021. The 2.6 percent net rate update consists of:

- +2.7 percent market basket update as required by the BBA of 2018;
- -0.1 percent stemming from a revision to the rural add-on required by the BBA of 2018; and

See Table 17 on p. 126-127 of the public inspection copy for details on estimated impacts by HHA facility type and geography.

Highlights of today's proposed rule follow:

- **The Use of Technology under the Medicare Home Health Benefit –** CMS proposes to make permanent its temporary, COVID-19-driven change for home health care providers included in the first COVID-19 IFC (details on the first IFC here). Specifically, CMS proposes to permanently require that a home health plan of care must include any provision of remote patient monitoring or other services furnished via telecommunications systems, and that the plan of care must include how the use of this technology addresses patient needs and goals included in the care plan. While the use of these services cannot substitute a an in-person home visit – in accordance with section 1895(e)(1)(A) of the Social Security Act – CMS believes this change will encourage increased access to telehealth and remote patient monitoring technologies.

  On p. 57, CMS further specifies that HHAs should continue to report telehealth costs as "allowable costs on line 5 of the home health agency cost report."

- **Proposed CY 2021 PDGM LUPA Thresholds and PDGM Case-Mix Weights** – CMS proposes to maintain the CY 2020 low utilization payment adjustment (LUPA) threshold and case-mix weights under the Patient-Driven Groupings Model (PDGM) for CY 2021. The CY 2020 PDGM LUPA threshold and case mix weight for each home health resource group is provided in the final CY 2020 home health prospective payment rate update (see Table 16 on p. 60522 of the CY 2020 final rule). CMS explains that it lacks sufficient CY 2020 data to make any changes to the LUPA thresholds or case-mix weight for CY 2021.

- **Proposed Home Health Wage Index Changes** – CMS proposes to adopt OMB's statistical area delineations (OMB bullet No. 18-04) to account for "the reality of population shifts and labor market conditions" in the home health wage index.

  Beginning on p. 26, CMS discusses in detail the proposed new labor market delineations. For example, CMS proposes to continue to treat a Micropolitan Statistical Area – defined as having "at least one urban cluster that has a population of at least 10,000, but less than 50,000" – as rural and to include Micropolitan Statistical Areas in the calculation of each state's rural wage index. In

Tables 3-6 on pp. 27-31, CMS lists the counties that would change in status – urban counties becoming rural, rural counties becoming urban, urban counties moving to a different urban core-based statistical area (CBSA), and counties that would shift to a different CBSA.

To help mitigate any significant negative impacts, CMS proposes to phase in the revised OMB delineations over a two-year transition period. During CY 2021, CMS would apply a five percent cap on any decrease in a geographic area's wage index value from the wage index value from the prior calendar year. No cap would be applied to the reduction in the wage index for CY 2022.

The proposed wage index applicable to CY 2021 can be found here. CMS seeks comments on the proposed transition methodology.

- **Changes to the Condition of Participation (CoP) Requirements** – Beginning on p. 61, CMS proposes to remove the requirement that new home health agencies must successfully transmit test data to the Quality Improvement & Evaluation System (QIES) or CMS OASIS contractor as part of the initial process for becoming a Medicare-participating home health agency. The agency notes that due to the transition to a new data submission system and a simpler data submission process, the requirement is now obsolete. HHAs must still be able to submit assessment in order for the claims match process to occur and relay the data needed for payment under the PDGM system.

- **Home Infusion Therapy Services** – Beginning on p. 75, CMS codifies the implementation of the permanent payment system for home infusion therapy services as required by section 5012 of the 21st Century Cures Act. The proposed rule outlines the home infusion therapy policies finalized in the CY 2020 home health PPS final rule. This includes maintaining the three current payment categories associated with J-codes utilized under the temporary transitional payments for home infusion therapy services in CY 2020. Table 12 found on p. 88 lists the three categories infusion therapy service payment categories and corresponding J-codes.

  It also outlines the increase in CY 2021 payment amounts for infusion services based on the Physician Fee Schedule. Table 15 on p. 91 details the 5-hour payment amounts reflecting payment rates for CY 2020 and subsequent years. CMS estimates that updating the payment rates for home infusion therapy services, based on Physician Fee Schedule amounts for CY 2021, is "no more than a 1 to 2 percent increase or decrease" in payments to suppliers.

  Finally, CMS includes conforming regulations text changes that exclude home infusion therapy services from coverage under the Medicare home health benefit, as required by 21st Century Cures Act. See the full discussion beginning on p. 93.

- **Enrollment Standards for Qualified Home Infusion Therapy Suppliers** – Beginning on p. 98, CMS proposes enrollment requirements for home infusion therapy supplies to ensure that all suppliers are carefully screened for compliance; problematic suppliers are kept out of Medicare; and beneficiaries are protected. The agency proposes to define a "home infusion therapy supplier" as a supplier of home infusion therapy that meets the requirements that can be found on p. 105.

CMS then proposes that for a supplier to receive Medicare payment for home infusion services, they must qualify as a home infusion supplier; complete and submit Form-CMS-855B Application; and pay an application fee.

CMS also proposes that a home infusion therapy supplier must be currently accredited by a CMS-recognized home infusion therapy supplier accreditation organization in order to enroll and remain in Medicare. Additionally, regarding supplier standards, CMS proposes that suppliers must be compliant with section 414.1515 of the Social Security Act and all provisions of 42 CFR part 486, subpart I and must be enrolled in Medicare consistent with the provisions of section 424.68 of the Social Security Act and part 424, subpart P.

Finally, CMS proposes to add home infusion therapy suppliers to the types of suppliers that are subject to limited risk level of categorical screening and CMS may deny a supplier's enrollment application if the supplier does not meet all of the requirements.

CMS estimates that the average annual burden associated with home infusion therapy supplier enrollment over three years is 583 hours at the cost of $28,583. The agency also estimates a total application cost to enrollees of $364,800.

- **Home Health Quality Reporting Program** – CMS does not propose any changes to the Home Health Quality Reporting Program.