FEDERAL HEALTH POLICY STRATEGIES

FROM: FHP Strategies

TO: Partnership for Quality Home Health Care

DATE: November 2, 2021

RE: Calendar Year 2022 Home Health Prospective Payment System Rate Update, Home Infusion Therapy Services, and Quality Reporting Requirements (CMS-1747-F); Final Rule – **Key Policy Proposals**

This afternoon, the Centers for Medicare & Medicaid Services (CMS) released the *Calendar Year (CY) 2022 Home Health Prospective Payment System Rate Update, Home Infusion Therapy Services, and Quality Reporting Requirements Final Rule*. As noted below, the rule contains final policies related to the Medicare home health benefit for CY 2022 on payment and quality related programs and responds to public comments on the Proposed Rule. **The Final Rule is effective on January 1, 2022.**

Major Provisions of the Final Rule

- ***General:*** This Final Rule establishes routine updates to the home health prospective payment system, including the Home Health Patient Directed Groupings Model (PDGM). Consistent with the Proposed Rule, the Final Rule does not provide relief for the -4.36 percent behavioral adjustment applied by CMS to the rates in CY 2020 and CY 2021. As a result, this reduction to the rates will continue to apply in CY 2022. The rule also finalizes a national expansion of the home health value-based purchasing model starting in CY 2023, and finalizes several changes related to quality reporting. While CMS included several requests for information (RFIs) in the proposed rule, including seeking feedback on ways to advance health equity for all patients and Healthcare Interoperability Resources (FHIR) in support of Digital Quality Measurement in Quality Reporting Programs, the agency did not respond substantively to comments on these areas, consistent with other final payment rules issued this year.

- ***Annual Payment Update:*** The Final rule provides for an annual payment update of 2.6 percent which is based on a market basket increase of 3.1 percent minus a .5 percent productivity adjustment. The final update of 2.6 percent compares favorably to the proposed update of 1.8 percent in the earlier Proposed Rule. Under current law, for CY 2022, there will also be a 1 percent rural add-on for low population density rural areas.

- ***Impact Analysis:*** Overall, CMS estimates that Medicare payments to HHAs in CY 2022 would increase in the aggregate by $570 million (3.2 percent). The $570 million increase in estimated payments for CY 2022 reflects the effects of the CY 2022 home health payment update percentage of 2.6 percent ($465 million increase), an estimated 0.7 percent increase that reflects the effects of the updated fixed-dollar loss ratio for outlier payments ($125 million increase) and an estimated 0.1 percent decrease in payments due to the continued phase-out of the rural add-on percentages for CY 2022 ($20 million decrease).

- ***Behavioral Adjustments:*** The home health payment rates included in the CY 2022 Proposed Rule continued to reflect application of the -4.36 percent behavioral adjustment originally put in place for CY 2020. While a number of commenters presented data and analysis to refute these adjustments and the underlying assumptions made by CMS, the Final Rule continues to apply this reduction for CY 2022 without modification with CMS noting its discretion under the statute to make both temporary and permanent adjustments to the payment rates and the need to propose any specific changes through notice and comment rulemaking.

- ***Annual Determination of Budget Neutral Payments Under PDGM:*** In the proposed Rule, CMS solicited comments on an analysis and methodology for determining budget neutral payments based on the difference between assumed and actual behavior changes under PDGM compared to the former 153 group home health payment model. CMS presented analyses in the Proposed Rule which the agency believed support that "an additional payment decrease would more appropriately account for behaviors reflected in CY 2020." CMS also noted that it determined that the CY 2020 30-day base payment rate was approximately "6 percent higher than it should have been". Stakeholders submitted significant technical and policy comments on CMS' methodology. In the Final Rule, CMS acknowledges these comments and indicates that it will consider all alternative approaches as it continues to develop and refine a methodology for annually determining the difference between assumed versus actual behavior changes on estimated aggregate expenditures. CMS concludes by saying that the methodology and any associated payment adjustment will be made through future notice and comment rulemaking.

- ***Case Mix Weights:*** CMS also proposed to recalibrate the case-mix weights using CY 2020 data consistent with past practice. A number of commenters had expressed concerns with using the 2020 data and recommended that CMS maintain the existing case mix weights. In the Final Rule, CMS finalized its proposal to recalibrate the case mix weights, functional levels and comorbidity subgroups using the 2020 data noting that the agency believes that prolonging recalibration could lead to more significant variation in the case-mix weights than what is observed using CY 2020 utilization data.

- ***Low Utilization Payment Adjustments (LUPAs):*** CMS finalized its proposals to maintain the existing LUPA thresholds for CY 2022 (and thus not update based on 2020 data) and establish a LUPA add-on factor for calculating a LUPA add-on payment amount for the first skilled occupational therapy visit in a LUPA period 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.

- ***Wage Index:*** CMS finalized a routine update to the wage index in this Final Rule based on its existing policy and regulations. While a number of commenters supported continuation of the CY 2021 core-based statistical area (CBSA) transition under which a 5 percent cap is applied on any decrease in a home health agency's wage index compared to its wage index for the prior calendar year, CMS did not adopt this change. For CY 2022, CMS will be terminating this transition, as finalized in the CY 2021 final rule, and applying 100 percent of the updated wage index values to all providers.

- ***The Use of Technology under the Medicare Home Health Benefit:*** CMS finalized its proposal to make permanent the regulatory 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). CMS noted in the proposed rule that its expectation is that in-person supervisory visits should be the normal practice and that use of telecommunications would be for unplanned occurrences. In the Final Rule, CMS modified this restriction and will now apply a patient level limit for the virtual nurse aide supervisory visit of one per patient per 60-day episode and only in the rare circumstance, from an unplanned occurrence where an onsite visit cannot be coordinated within the 14-day time period.

- ***Home Health Value-Based Purchasing (VBP):*** In January 2021, CMS announced that the Home Health Value-Based Purchasing (HHVBP) Model had been certified for expansion beginning as early as CY 2022. The CY 2022 Proposed Rule included a proposal to expand the HHVBP model nationwide beginning in CY 2022 which was adopted in today's Final Rule. However, CMS will be delaying implementation for one-year such that CY 2023 will be the first performance year and CY 2025 the first payment year, with a maximum payment adjustment, upward or downward, of 5 percent. CMS is also finalizing the expanded VBP model to generally use benchmarks, achievement thresholds, and improvement thresholds based on CY 2019 data. Under the Final Rule policies, CMS will assess achievement or improvement of performance based on designated quality measures and home health providers will compete nationally in their applicable size cohort, smaller-volume providers or larger-volume providers. All providers certified to participate in the Medicare program prior to January 1, 2022, would be required to participate and would be eligible to receive an annual Total Performance Score based on their CY 2023 performance. Finally, CMS is finalizing its proposal to end the original HHVBP model one year early and not use CY 2020 performance data for providers in the nine original states to apply payment adjustments for the CY 2022 payment year.

- ***Quality Reporting:*** CMS Finalized a number of proposed updates to the Home Health Quality Reporting Program (QRP), including its proposal that home health providers collect the Transfer of Health (TOH) Information to Provider Post-Acute Care measure, the Transfer of Health Information to Patient-PAC measure, and certain Standardized Patient Assessment Data Elements beginning January 1, 2023. CMS will require that providers begin collecting

data on the two TOH measures beginning with discharges and transfers on January 1, 2023 on the OASIS-E. CMS also finalized that providers will collect data on the six categories of Standardized Patient Assessment Data Elements (SPADES) on the OASIS-E, with the start of care, resumption of care, and discharges (except for the hearing, vision, race, and ethnicity SPADES) which would be collected at the start of care only) beginning on January 1, 2023.

We hope you find this memorandum useful.
If you have any questions or comments, please let us know.