CMS Finalizes Payment Rate Update to Home Health for 2022

- **Home health payment rates increased by 2.6%**
- **CMS does not increase or decrease behavioral adjustment**
- **432 case mix weights recalibrated using 2020 data**
- **CMS refuses to continue the 5% cap on negative wage index changes**
- **HHVBP demonstration expansion nationwide delayed for one year**
- **Read Administrations statement on improving home health services for older adults & people with disabilities**

The 2022 final Medicare home health rates represent an increased inflation rate update of 2.6% in comparison to the proposed 1.8%, and recalibration of the case mix weights while maintaining the Low Utilization Payment Adjustment (LUPA) threshold amounts. The rule also includes a scheduled phasing-out of the rural add-on, and the continuation of outlier payment standards, with the decreased Fix Loss Ratio for outlier eligibility at 0.40 for 2022.

The most notable difference between the proposed and final policies is a one-year delay in expanding the Home Health Value Based Purchasing (HHVBP) demonstration to the entire nation. Instead of the proposed start on January1, 2022 as the first performance year and CY 2024 as the first payment year, the Centers for Medicare & Medicaid Services (CMS) delayed the first performance year 2023 and 2025 to the first year affected by the 5-percent at-risk payment adjustment. CMS rejected the call to use state-by-state performance comparisons and finalized the proposed small and large provider national cohort approach. CMS also rejected the recommendation that the HHVBP use a “shared savings” methodology that would provide financial bonuses tied the amount of Medicare savings achieved by high performing providers.

Additionally, CMS finalized its proposal to end the original HHVBP Model one year early. CY 2020 performance data for the HHAs in the nine original Model States will not be used to apply payment adjustments for the CY 2022 payment year. CMS also decided not to publicly report CY 2020 (performance year 5) annual performance data under the original HHVBP Model.

Although NAHC advocated for CMS to roll back the 2020 behavioral adjustment, CMS continues to apply the 4.36% adjustment. This “inaction” is consistent with CMS’s general approach of instituting limited changes until full 2020 data is available for evaluation.

“The Center for Medicare & Medicaid Services’ (CMS) 528-page is a combination of significant and minor changes in the home health payment model and conditions of participation along with the expected expansion of the Home Health Value-Based Purchasing (HHVBP) and establishment of enhanced survey and certification standards

for hospices," said **NAHC President Bill Dombi**, in reaction to release of the final rule. "As expected, CMS has tweaked quality measures for home health and updated the home infusion therapy payment under Medicare Part B.

"All told," continued Dombi, "the final rule is a combination of standard adjustments, reasonable policy actions during a continued Public Health Emergency, sensible postponements in policy reforms, and unfortunate rejections of some recommendations, such as a consistent wage index policy, that would protect access to care. NAHC agrees that CMS needed to be cautious at this unsettled time, and we recommended CMS avoid taking premature steps that could disrupt a fragile health care system based on a myriad of assumptions and limited data from a chaotic period. In that respect, NAHC appreciates that CMS is avoiding taking potential actions without reliance on comprehensive data."

2022 Reimbursement Policies

- Base payment rates are increased by a net Market Basket Index of 2.6%. An annual inflation update of 3.1% is reduced by a 0.5% Productivity Adjustment to net at 2.6%. The proposed inflation update was 1.8%. The end results is that:
    - The base 30-day payment rate is increased from $1901.12 to $2031.64 after application of wage index budget neutrality factor of 1.0009 and case mix recalibration neutrality factor of 1.0396. HHAs that do not submit required quality data have that rate reduced by 2%.
- The LUPA per visit rates are set at:
    - Home Health Aide $71.04
    - Medical Social Services $251.48
    - Occupational Therapy $172.67
    - Physical Therapy $171.49
    - Skilled Nursing $156.90
    - Speech-Language Pathology $186.49

- LUPA rates are also reduced by 2% for those HHAs that did not submit required quality data.
- The LUPA add-on for LUPA only patient continues. Each discipline would get its own add-on rate. CMS is proposing to add a LUPA add-on factor for occupational therapists (OT) in response to the statutory change that permits OTs to conduct initial comprehensive assessment in certain circumstances.
- The area Wage Index that applies based on the patient's residence changed significantly in 2021 to reflect updated census information. Due to that significant change, CMS capped any reduction in the wage index for 2021 at 5%. However, the 5% cap will be lifted in CY 2022. This will have a serious negative affect in certain geographic areas such as central New Jersey and Massachusetts.
- The Outlier Fixed Dollar Loss is proposed to change to 0.40. That would mean that more periods will be eligible for outlier payments in CY 2022.
- The rural add-on phase-out continues
    - High Utilization areas—- 0% add-on
    - Low Population Density areas—1% add-no

- All other areas——0% add-on

The final rule does not include a methodology for evaluating whether the new PDGM payment model was “budget neutral” in 2020 in comparison to the estimated level of spending that would have occurred if the 2019 payment model was still in place. With the proposed methodology, CMS calculated that HHAs were “overpaid” by 6% in 2020. NAHC had fiercely challenged the validity and reliability of that draft assessment methodology. In response, CMS indicated that it was not establishing any methodology at this time and would do so in the future through public notice and comment formal rulemaking.

CMS also had proposed to recalibrate all 432 case mix weights in PDGM using 2020 data on the use of clinical resources in home health 30-day periods along with data on other PDGM measures such as the site of referral and patient functional status. NAHC protested that recalibration, arguing that 2020 was a unique year in health care delivery and that no payment model should be based on any data from that chaotic year. CMS rejected these concerns and decided to finalize the proposed case mix weight recalibrations. The recalibration is done in a budget neutral manner, leading to a 1.096 adjustment to payment rates. That adjustment is expected to lead to the same overall spending under Medicare as would occur without recalibration. However, while most HHAs will see little impact in the aggregate, some will experience higher or lower payments than would have happened without recalibration. NAHC holds to its position that applying 2020 service utilization to set 2022 case mix weights falls short on logic.

CMS also reminds stakeholders of the policies finalized in the CY 2020 HH PPS final rule with the implementation of a new one-time Notice of Admission (NOA) process starting in CY 2022. CMS did take the opportunity to express the exceptions to the NOA policy. Recently, NAHC conveyed to CMS that the application of the RAP notice requirement led to financial penalties on claims that should have been excepted from the policy.

HHVBP Expansion

CMS proposed to expand the current 9-state demonstration Home Health Value Based Purchasing (HHVBP) program to all 50 states. In doing so, CMS proposed to apply the HHVBP in two cohorts: a national cohort of all HHAs other than very small HHAs and a small HHA national cohort. This proposal contrasted with the current demonstration that applied HHVBP on a individual state-specific basis. CMS proposed a number of other changes including setting 5% as the amount of payment at risk or subject to a bonus based on performance outcomes.

NAHC supported the expansion with a number of qualifications. First, NAHC expressed that a start date of January 1 was too short a time for HHAs to put together any operation adjustments needed to manage the HHVBP demonstration. In addition, NAHC recommended that CMS share the savings with all HHAS that contribute to the

savings on Medicare spending even if the HHA did not qualify for bonus payments in the competition between HHAs. NAHC also suggested that a use of state-based performance assessments in the earlier stages of the nationwide demonstration was more appropriate given the wide geographic variation in care practices in all health care sectors. Finally, NAHC recommended that CMS adjust the performance measures to reflect the entire scope of the home health benefit, particularly the patient population with chronic illnesses and those whose care goals are for maintenance or stabilization of their condition rather than improvement.

In response, CMS agreed to postpone the start date of the nationwide HHVBP. CY 2022 will be a pre-implementation year, with CY 2023 as the first performance year and CY 2025 as the first payment year. The maximum payment adjustment, upward or downward, of 5-percent remains.

However, CMS rejected the recommendation to apply a state-specific comparison of HHA performance for purposes of evaluating which HHAs qualify for bonuses or penalties, arguing that it would not make much difference and that larger numbers of participants in the “small” cohort was needed to be effective.

With respect to the recommendation to share Medicare savings with any HHA that contributes to Medicare savings, CMS alleges that such an element was not within the scope of the demonstration project. NAHC will continue to work to secure such a change as the project unfolds.

The measures used in the HHVBP demonstration remain unchanged from what CMS proposed and will be drawn from claims, OASIS and HHCAHPs based measures. CMS finalized that the expanded Model would use benchmarks, achievement thresholds, and improvement thresholds based on CY 2019 data to assess achievement or improvement of HHA performance on applicable quality measures. While CMS did not make any adjustments in the measures proposed for a nationwide HHVBP to reflect patients with goals of maintenance or slowed deterioration in their condition, CMS did strongly acknowledge that such patients are within the scope of the home health benefit. CMS explained that the risk adjustment accommodates the performance impact with patients that are not expected to improve.

Additionally, CMS finalized ending the original HHVBP Model one year early. CY 2020 performance data for the HHAs in the nine original Model States will not be used to apply payment adjustments for the CY 2022 payment year. CMS will also not publicly report CY 2020 (performance year 5) annual performance data under the original HHVBP Model.

Regulatory Changes: Payment Policies, Conditions of Participation, Provider Enrollment, and Home Infusion Therapy (HIT)

When implementing plan of care changes in the CY 2021 HH PPS final rule, the term "allowed practitioner" was inadvertently deleted from the regulation text at § 409.43. Therefore, CMS finalized text changes at § 409.43 to reflect that allowed practitioners, in addition to physicians, may establish and periodically review the plan of care. And finalizing conforming regulation text changes to permit the occupational therapist to complete the initial and comprehensive assessments for Medicare patients when ordered with another rehabilitation therapy service (speech language pathology or physical therapy) that establishes program eligibility, in the case where skilled nursing services are also not ordered.

Several changes to the home health Condition of Participation for home care aide supervisory visits are also finalized. First, CMS finalized their proposal to revise the home health aide supervision requirements to allow for virtual visits through real-time, audio-visual technology. However, in response to public comments, CMS is revising the frequency of the visit from 2 visits every 60 days per agency to permit the one virtual supervisory visit per **patient** per 60-day episode. This visit must only be done in rare instances for circumstances outside the HHA's control and must have documentation in the medical record detailing such circumstances.

Second, CMS is revising the language at § 484.80(h)(2) to clarify that the every 60 day home care aide supervisory visit for patients not receiving skilled services is conducted on each patient and not on each aide caring for that patient. The proposed change would remove the language from 42 CFR 484.80(h)(2) that states, "in order to observe and assess each home health aide while he or she is performing care," and replacing it with "to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs". Lastly, CMS is finalizing the assessment of deficient skills at § 484.80(h)(3) as proposed.

CMS is also finalizing a number of provisions regarding Medicare provider and supplier enrollment and two regulatory clarifications related to HHA changes of ownership and HHA capitalization requirements.

Further, CMS is proposing to update the HIT payment rates for CY 2022.

Home Health Quality Reporting

This final rule updates the HH QRP by removing an OASIS-based measure, the Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care measure, from the HH QRP beginning with the CY2023 HH QRP. HHAs will no longer be required to submit OASIS Item M2016, Patient/Caregiver Drug Education Intervention for the purposes of this measure beginning January 1, 2023, and data for this measure would be publicly reported on Care Compare through October 1, 2023, after which it would be removed from the site.

This rule also finalizes to replace 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 with the Home Health Within Stay Potentially Preventable measure and as proposed, beginning with the CY 2023 HH QRP.

CMS will 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. Finally, this proposed rule proposes revisions for certain HHA QRP reporting requirements. This proposed rule would also revise similar compliance dates for certain IRF QRP and LTCH QRP requirements.

CMS finalized its proposal 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 measure beginning in April 2022. An agency's performance on these measures is currently available in the agency's confidential feedback reports. HHAs' HH QRP measure scores for these two measures would additionally be made available for review on the HH Provider Preview Report, which would be issued in January 2022, three months in advance of the inaugural display of these measures on Care Compare.

Due to the Public Health Emergency (PHE), in May 2020 through an interim final rule with comment (IFC) CMS delayed the requirement for HHAs to begin reporting the Transfer of Health (TOH) Information to PAC and the TOH Information to Patient-PAC measures and the requirement for HHAs to begin reporting certain Standardized Patient Assessment Data Elements to January 1st of the year that is at least one full calendar year after the end of the COVID–19 PHE. CMS also delayed the adoption of the updated version of the Outcome and Assessment Information Set (OASIS) assessment instrument (OASIS-E) for which HHAs would report the TOH measures and certain Standardized Patient Assessment Data Elements (SPADEs) to January 1 of the of the year that is at least one full calendar year after the end of the COVID–19 PHE. CMS is finalizing its proposal to revise the compliance date from the IFC to January 1, 2023, even though there is not a set end date for the PHE. CMS reiterated that it would provide the training and education for HHAs to be prepared for this implementation and stated it would release a draft of the updated version of the OASIS instrument, OASIS-E, in early 2022 if the January 1, 2023 date is finalized as proposed.