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Regulatory Advisory

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Home Health PPS Final CY 2022 Rule

At A Glance

At Issue

The Centers for Medicare & Medicaid Services (CMS) Nov. 9 published its calendar year (CY) 2022 final rule for the home health (HH) prospective payment system (PPS). Most provisions in the rule will take effect Jan. 1.

Our Take

We appreciate CMS' issuance of a streamlined rule, which allows HH agencies and their hospital and other local partners to focus on their response to the COVID-19 pandemic. While virus surges continue in many communities, in others, the HH agencies are now reacting to the clinical needs of "long-haul COVID-19" and other patients while preparing for a possible resurgence of the virus during the fall and winter seasons.

In addition, the AHA supports CMS' caution in determining how best to ensure that the new HH PPS case-mix system was implemented in a budget-neutral manner — especially given the complexities wrought by the pandemic. That said, we remain concerned about the prospective nature of the CY 2020 behavioral adjustment, especially given that analyses conducted thus far indicate a substantial gap between CMS' and stakeholders' findings. Specifically, CMS found that Medicare overpaid for HH services in CY 2020, while analysis by HH stakeholders found an underpayment for that year. Moving forward, we urge CMS to partner with stakeholders to transparently evaluate projected versus actual payments that year. In addition, we appreciate that CMS will delay the expansion of the HH Value-based Purchasing (VBP) model for one year as we suggested, but continue to be concerned by other details of the model's design.

Key Takeaways

CMS's final rule:

- Increases net payments by 3.2% ($570 million).
- Does not alter the behavior offset amount implemented in CY 2020.
- As required by law, allows occupational therapists to conduct initial and comprehensive patient assessments.
- Finalizes certain COVID-19 public health waivers related to the virtual supervision of HH aides.
- Delays for one year the nationwide expansion of the HH VBP pilot.

What You Can Do

- ✓ Share this advisory with your senior management team to examine the impact these payment changes would have on your organization in CY 2022.
- ✓ In the HH section of AHA's post-acute webpage, review the materials and video of the Nov. 9 member call, during which the provisions of this rule were discussed.

Further Questions

For questions on proposed payment changes, please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org. For quality-reporting or VBP questions, please contact Caitlin Gillooley, senior associate director, at cgillooley@aha.org.

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Overview

The Centers for Medicare & Medicaid Services (CMS) estimates that under this final rule for calendar year (CY) 2022, home health (HH) agencies will receive a net payment increase of 3.2%, or $570 million, over CY 2021 payment levels, which accounts for the market-basket and outlier payments increase and a reduction for productivity and rural add-on payments. Facility-based HH agencies, including hospital-based agencies, will see an average increase of 3.8%, mostly due to their higher average case-mix weights. These impact estimates do not take into account the home infusion or Value-based Purchasing (VBP) proposed policies.

Final CY 2022 Payment Update

Final CY 2022 Rates

30-day Episode Rates. For CY 2022, CMS finalized a 30-day episode rate increase based on the 3.1% market basket, offset by a -0.5% productivity factor. As discussed below, the market-basket increase also will be adjusted for increases for outlier and rural cases. In addition, the rate would be subject to a case-mix weight recalibration budget neutrality factor of 1.0396 and a wage index budget neutrality factor of 1.0019. CMS noted that to calculate the wage index budget neutrality factor, it compared the use of CY 2019 versus CY 2020 data to assess the potential impact of the COVID-19 public health emergency (PHE) and found a small difference, thus CMS used CY 2020 claims data for this rule. CMS' final 30-day episode payment amounts for agencies that submit quality data are provided below, including the final 30-day episode rate of $2,031.64.

FINAL RULE TABLES 16 & 17: CY 2022 30-DAY PERIOD PAYMENT AMOUNT

Final Rule Tables 16 and 17: CY 2022 30-day Period Payment Amount				
CY 2021 30day Period Payment	**Case-mix Weights Recalibration Neutrality Factor**	**Wage Index Budget Neutrality Factor**	**CY 2022 HH Payment Update**	**CY 2022 30-day Period Payment**
$1,901.12	1.0396	1.0019	1.26	$2,031.64

Final Low Utilization Payment Adjustment (LUPA) Rates. For CY 2022, as proposed, CMS again will use the CY 2020 LUPA thresholds to mitigate the impact of variability due to the COVID-19 PHE. Under the patient-driven groupings model (PDGM), the LUPA methodology was altered and now sets a threshold for each payment unit at the 10th percentile of visits or two visits, whichever is higher. If the LUPA threshold is met, the case will be paid the full 30-day period payment; if not, the LUPA per-visit rates will apply. The proposed per-visit rates from Table 21 in the rule, recreated below, reflect the latest HH claims linked to Outcome and Assessment Information Set (OASIS) assessment data,

which are updated annually to reflect the most recent utilization data. The LUPA amounts also are used in outlier calculations.

Final Rule's CY 2022 National, Per-visit Payment Amounts for Agencies that Submit Quality Data				
HH Discipline	**CY 2021 Per-visit Rates**	**Wage Index Budget Neutrality Factor**	**CY 2022 HH Payment Update**	**CY 2022 Final Per-visit Payment**
HH Aide	$69.11	X 1.0019	X 1.026	$71.04
Medical Social Services	$244.64	X 1.0019	X 1.026	$251.48
Occupational Therapy	$167.98	X 1.0019	X 1.026	$172.67
Physical Therapy	$166.83	X 1.0019	X 1.026	$171.49
Skilled Nursing	$152.63	X 1.0019	X 1.026	$156.90
Speech-Lang. Pathology	$181.34	X 1.0019	X 1.026	$186.41

Agencies that do not submit required quality data would have the LUPA payments reduced from 2.6% to 0.6%.

New LUPA Add-on Factor for Occupational Therapists (OTs). Under previously adopted policy, to determine the LUPA add-on payment for a 30-day period of care, CMS multiplies the per-visit payment amount for the first skilled nursing, physical therapist (PT) or speech-language pathology (SLP) visit that is the initial or first in a sequence of 30-day episodes by these add-on factors: 1.8451 for skilled nursing, 1.6700 for PT and 1.6266 for SLP. As required by law, this final rule implements the authority for OTs to conduct initial and comprehensive assessments for all Medicare beneficiaries under the HH benefit when the plan of care does not initially include skilled nursing care but does include either PT or SLP. Because of this change, CMS will use a LUPA add-on factor for only the first skilled OT LUPA for the only or initial 30-day episode. Because CMS lacks sufficient data to estimate an OT-specific LUPA add-on factor, it will utilize the PT LUPA add-on factor of 1.6700 as a proxy until it has CY 2022 data.

Request for Anticipated Payment (RAP) and Notice of Admission (NOA). CMS reminds stakeholders that beginning in CY 2021, all HH agencies were required to submit a "no-pay" RAP at the beginning of each 30-day period. A RAP notifies CMS of the commencement of an HH episode in the common working file and also triggers the related consolidated billing edits. A payment reduction is applied if a RAP is not submitted within five calendar days from the start of care. The reduction equals one-thirtieth of the wage and case-mix adjusted 30-day period payment amount, including any outlier payment, for each day from the HH start of care date until the date the HH agency has submitted the RAP. For LUPA 30-day periods for which an agency fails to submit a timely RAP, no LUPA payments will be made for days that fall within the period from the start of care prior to submission of the RAP. These days would be a provider liability; the payment reduction cannot exceed the total payment of the claim; and the provider may not bill the beneficiary for these days.

Beginning in 2022, HH agencies also must submit a one-time NOA that includes similar information to the RAP. The NOA will establish the HH period of care and covers all contiguous periods of care until the patient is discharged from Medicare HH services. Similar penalties for failure to timely submit the NOA will apply. There are certain exceptions to the timely filing consequences of the RAP requirements, which include fires, floods, earthquakes and other damaging events; issues with CMS or Medicare contractor systems; and other situations CMS determines to be out of the HH agency's control.

Non-routine Supplies Conversion Factor. Under PDGM, non-routine supplies payments are now included in the 30-day base payment rate.

Case-mix Weights

PDGM categorizes patients into one of 432 payment units, known as HH resource groups, using patient assessment data collected with the OASIS tool and other data. Since CY 2015, CMS annually recalibrates the HH case-mix weights based on the most recent, complete year of claims and patient assessment data. To recalibrate the CY 2022 weights, CMS used actual CY 2020 data for 30-day episodes under PDGM, rather than simulated episodes. The agency acknowledges the impact of the PHE on the CY 2020 weights, but determined that it is more important to use actual PDGM case-mix weights as its base, rather than pre-PDGM data that reflect payment policy incentives, such as the prior therapy-based payment criteria. Table 15 in the rule provides the final case-mix weights for CY 2022.

Area Wage Index

CMS will use the pre-floor, pre-reclassified inpatient PPS wage index as the wage index to adjust the labor portion of HH PPS rates for CY 2022, relying on FY 2018 hospital cost report data as its source for the updated wage data. Consistent with its longstanding policy of adopting the Office of Management and Budget (OMB) delineation updates, this final rule adopts the updates set forth in OMB Bulletin No. 20-01, though it notes that specific wage index updates will not be necessary for CY 2022 as a result of adopting these OMB updates.[1] The final CY 2022 wage index is available on the CMS website.

The labor-related share for CY 2022 will remain 76.1%, the same as in CYs 2020 and 2021, and will be implemented in a budget neutral manner.

High-cost Outliers

HH PPS outlier payments are made for 30-day episodes with estimated costs that exceed a threshold loss. The outlier threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and a wage-adjusted fixed-dollar loss (FDL) amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated cost for the episode that surpasses the wage-adjusted threshold; this proportion is referred to as the loss-sharing ratio.

[1] OMB Bulletin No. 20-01 made minor updates including one new Micropolitan Statistical Area and changes to New England City and Town Area delineations.

By law, an FDL ratio and the loss-sharing ratio must be set so that total outlier payments do not exceed the 2.5% of aggregate payments. CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80% of the additional estimated costs above the FDL threshold — and the agency will keep this ratio for CY 2022. However, to meet the 2.5% target using CY 2020 claims, the agency will lower the FDL ratio from the current ratio of 0.56 to 0.40 for CY 2022, which will increase the number of outlier cases, relative to CY 2021.

Under PDGM, high-cost outliers for 30-day episodes are calculated on a cost-per-unit approach. Specifically, CMS converts the national per-visit rates into per 15-minute unit rates when estimating outlier costs and payments. CMS also limits the amount of time per day (summed across the six disciplines of care) to eight hours (32 units). CMS notes that it will publish the cost-per-unit amounts for 2022 in a rate update change request to be issued after the publication of the 2022 HH PPS final rule.

Functional Impairment Levels

Under the PDGM, the functional impairment-related case-mix adjustment is determined by responses to certain OASIS items associated with activities of daily living and risk of hospitalization. An HH period of care receives points based on responses from these functional OASIS items, which are converted to a table of points. The sum of all these points is used to group HH periods into low, medium and high functional impairment levels, designed so that about one-third of HH periods fall within each level.

For 2022, as proposed and as supported by the Medicare Payment Advisory Commission, CMS will use the 2020 claims data to update the functional points and functional impairment levels by clinical group and the same methodology previously finalized to update the functional impairment levels for CY 2021. The updated OASIS functional points table and the table of functional impairment levels by clinical group for CY 2022 are listed in the final rule Tables 2 and 3, respectively.

Comorbidity Groups

Thirty-day episodes of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on HH claims. These diagnoses are based on a list of clinically and statistically significant secondary diagnoses subgroups with similar resource use. A single comorbidity adjustment is applied to the episode if either of the following is present: (1) a “low comorbidity adjustment” will be applied if one secondary diagnoses is present that is associated with higher resource use; or (2) a “high comorbidity adjustment” will be applied if two or more qualifying secondary diagnoses are present.

For 2022, CMS will continue to use its initial PDGM methodology to establish the comorbidity subgroups using 2020 data to update the case-mix system’s comorbidity subgroups, which would add 20 low-comorbidity adjustment subgroups and 87 high-comorbidity adjustment interaction subgroups as shown in proposed rule Tables 4 and 5 in the rule.

Rural Add-on Methodology

For CY 2022, Medicare rural add-on payments will be reduced by 1.0 percentage point ($20 million), relative to CY 2020, per the terms of the rural relief authorized by the Bipartisan Budget Act of 2018. This legislation changed the amount, structure and timeline for HH rural add-on payments only for CYs 2019 through 2022 based on an HH agency's rural county designation, as shown below, with no add-on payments authorized for CY 2023 and beyond. Specifically, the law established the following rural add-on payment categories:

- High utilization: Rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare HH episodes furnished per 100 individuals;
- Low-population density: Rural counties and equivalent areas with a population density of six individuals or fewer per square mile of land area; and
- All other: Rural counties and equivalent areas not in the above categories.

Below are the statutorily mandated schedules for rural add-on payments. These apply to both the 30-day episode and LUPA rates.

HH Rural Add-on Percentages, 2019-2022				
Category	**2019**	**2020**	**2021**	**2022**
High utilization	1.5%	0.5%	n/a	n/a
Low-population density	4.0%	3.0%	2.0%	1.0%
All other	3.0%	2.0%	1.0%	n/a

The statute requires that each rural designation for this policy would apply for the four-year period, although only providers in the low-population density category would receive a payment add-on in each of the four years. CMS posted an Excel file with each HH agency's rural designation and related data in the downloads section associated with this rule.

Initial Impact of the PDGM

In compliance with the Balanced Budget Act of 2018, CMS implemented the PDGM and a 30-day payment episode on Jan. 1, 2020. The PDGM case-mix system bases payments on the clinical characteristics of the patient instead of the patient's therapy volume. Specifically, it uses five clinical elements to set payments for each patient, with each 30-day episode assigned to one of 432 payment units called HH resource groups:

- Admission source (institutional or community);
- Admission timing (early or late-episode);
- Principal diagnosis;
- Clinical functional impairment level; and
- Comorbidity adjustment.

CMS' goal for CY 2020 was to set the initial PDGM 30-day episode payment amount at budget-neutral levels relative to what payments would have been paid using a 60-day episode and the prior case-mix system. This amount was set prospectively, based on assumptions about behavior changes by providers in CY 2020 in response to the shift to the 30-day payment and new case-mix system.

No Change to the Initial PDGM Behavioral Offset. The implementation of PDGM in CY 2020 included a behavioral offset of 4.36%. **In this rule, CMS implements no adjustment to the CY 2020 offset.** We note that the CY 2020 behavior adjustment was a top PDGM implementation concern of AHA and the HH field, as we did not support the use of a prospective adjustment that lacked actual evidence as its foundation. However, we were pleased that the finalized CY 2020 offset, 4.36%, while still very substantial, was a significant reduction from the initially proposed 8.01% cut.

In the proposed rule, CMS had asked the field to provide feedback on a prospective adjustment methodology to consider for a future cycle of rulemaking. The agency's discussion and analyses indicate that in the future — perhaps in its rulemaking for CY 2023 — temporary retrospective adjustments and/or another permanent prospective adjustment will be needed to adjust for inaccuracies in the initial offset. CMS' perspective and related analyses pertaining to this likely future adjustment are summarized in AHA's Regulatory Advisory on the CY 2022 HH PPS proposed rule, including an attachment with key analyses.

HH Quality Reporting Program (QRP)

Section 1895(b)(3)(B)(v)(II) of the Social Security Act requires that CMS establish the HH QRP. Starting in CY 2007, HH agencies that fail to meet all HH QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction in payments. A detailed summary of the Social Security Act's statutory authority can be found on CMS' HH QRP website.

CMS finalizes its proposals to remove one measure, replace two measures with one new measure, begin public reporting for two measures beginning in 2022, and revise the effective date for reporting of two quality measures and several standardized patient assessment data elements (SPADEs).

Table 1: Finalized and Proposed Measures for the HH QRP, CY 2021-CY 2023

Measure	CY 2021	CY 2022	CY 2023
Improvement in Ambulation/Locomotion	X	X	X
Improvement in Bathing	X	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X	X

Measure	CY 2021	CY 2022	CY 2023
Influenza Immunization Received for Current Flu Season	X	X	X
Improvement in Bed Transferring	X	X	X
Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	X	X	
Improvement in Dyspnea	X	X	X
Application of Percent of residents experiencing one or more falls with major injury (Long stay)	X	X	X
Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function	X	X	X
Improvement in Management of Oral Medications	X	X	X
Medicare spending per beneficiary (MSPB) for post-acute care (PAC)	X	X	X
Discharge to community – PAC	X	X	X
Potentially preventable 30-day post-discharge readmission measure	X	X	X
Drug regimen review conducted with follow-up for identified issues	X	X	X
Improvement in Pain Interfering with Activity	X		
Timely Initiation of Care	X	X	
Acute Care Hospitalization During the First 60 Days of HH	X	X	
Emergency Department Use without Hospitalization During the First 60 Days of HH	X	X	
CAHPS Home Health Survey (five component questions)	X	X	X
Transfer of Health Information to Provider		X	X
Transfer for Health Information to Patient		X	X
Home Health Within Stay Potentially Preventable Hospitalization			X

X = Adopted and Required for HH agencies

CY 2023 Measurement Provisions

Removal of Drug Education on All Medications Provided to Patient/Caregiver Measure. CMS will remove this process measure, which assesses the percentage of episodes during which the patient/caregiver was provided specific information on the patient's drug therapy, beginning with the CY 2023 HH QRP. CMS notes that HH agencies across the country have high and unvarying performance on this measure. HH agencies will no longer be required to submit OASIS item M2016 beginning Jan. 1, 2023, and the measure will no longer be publicly reported on *Care Compare* after Oct. 1, 2023.

Replacement of Measures with HH Within Stay Potentially Preventable Hospitalization Measure. CMS will remove two measures and replace them with a new measure that better addresses high-priority patient safety issues beginning with the CY 2023 HH QRP. CMS will remove the Emergency Department (ED) Use Without Hospitalization During the First

60 Days of Home Health measure based on concerns regarding an HH agency's ability to prevent an ED visit, especially for visits not resulting in hospitalization; experts have suggested that there are several drivers of ED use outside the control of an HH agency. Similarly, CMS will remove the Acute Care Hospitalization During the First 60 Days of Home Health measure as stakeholders have noted the difficulty in determining appropriate attribution for hospitalization between different providers and settings, especially when evaluating all-cause hospitalization that does not require the reason for admission to be related to the reason the patient is receiving HH care.

The new measure adopted in their place is Home Health Within Stay Potentially Preventable Hospitalization (referred to as PPH). It uses claims data to assess the agency-level risk-adjusted rate of potentially preventable and unplanned inpatient hospitalization or observation stays for Medicare fee-for-service beneficiaries that occur within an HH stay, defined as a sequence of HH payment episodes that are within two days or fewer from an adjacent payment episode. CMS believes this measure is more strongly associated with desired patient outcomes because it assesses observation stays instead of just ED use and focuses on the subset of inpatient hospitalizations that could have been avoided with appropriate HH agency intervention.

According to the specifications of the PPH measure, a "potentially preventable hospitalization" is defined as one where, for certain diagnoses, proper management and care of the condition by the HH agency combined with appropriate, clearly explained and implemented discharge instructions and referrals can potentially prevent a patient's admission. The measure derives a risk-adjusted PPH rate for each HH agency by calculating a standardized risk ratio of the predicted number of unplanned, potentially preventable hospital admissions or observation stays for the HH agency to the expected number of admissions or observation stays for the same patients if treated at the "average" HH agency. This ratio is then multiplied by the mean potentially preventable admission or observation stay rate of all Medicare fee-for-service patients included in the measure. Exclusions include patients under 18 years old, stays where the patient was not continuously enrolled in Part A fee-for-service Medicare for the 12 months prior to the HH admission date through the end of the HH stay, stays that begin with a LUPA claim, stays where the patient receives services from multiple HH agencies, and stays where the information required for risk adjustment is missing. The measure is risk-adjusted for demographics (age, sex, enrollment status and activities of daily living scores), care received during the prior proximal hospitalization and other care received within one year of the HH stay.

Public Reporting Proposals. CMS will begin publicly reporting two measures beginning in April 2022. These measures, Percent of Residents Experiencing One or More Major Falls with Injury and Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function, were adopted in the CY 2018 HH PPS final rule beginning with the CY 2020 HH QRP.

Updated Reporting Timeline for Measures and SPADEs

In the CY 2020 HH PPS final rule and the FY 2020 inpatient rehabilitation facility (IRF) PPS and inpatient PPS/long-term care hospital (LTCH) PPS final rules, CMS adopted two new quality measures and several SPADEs. The quality measures, Transfer of Health Information (TOH) to the Patient and TOH to the Provider, and the SPADEs (including seven elements regarding social determinants of health) were originally scheduled for implementation on Jan. 1, 2021, for HH agencies and Oct. 1, 2020, for IRFs and LTCHs. However, in light of the challenges associated with the PHE for COVID-19, CMS issued an interim final rule in May 2020 that delayed the compliance date for reporting these measures and SPADEs until Jan. 1 (for HH agencies) and Oct. 1 (for IRFs and LTCHs) of the year that is at least one full calendar year after the end of the PHE. In turn, CMS delayed the releases of the updated versions of the patient assessment instruments for which providers would report the measures and SPADEs: OASIS-E for HH agencies, IRF Patient Assessment Instrument (PAI) V.4.0 for IRFs, and LTCH CARE Data Set (LCDS) V.5.0 for LTCHs.

Upon reflection, however, CMS now believes that HH agencies, IRFs and LTCHs are able to begin reporting of these measures and SPADEs sooner than established in the May 2020 interim final rule. The agency cites flexibilities and assistance granted by CMS during the PHE as well as the promising trends in COVID-19 vaccination and death rates in its belief that providers "are in a better position to accommodate reporting of the TOH measures and certain (Social Determination [sic] of Health) Standardized Patient Assessment Data Elements." In other words, providers now have the administrative capacity to attend training, train their staff and work with their vendors to incorporate the updated assessment instruments.

Based on this rationale, CMS will require data collection for the TOH measures and certain SPADEs in the updated versions of the patient assessment instruments beginning Jan. 1, 2023, for HH agencies and Oct. 1, 2022, for IRFs and LTCHs. For details and analysis of these measures and SPADEs, see AHA's CY/FY 2020 Regulatory Advisories for HH agencies, IRFs and LTCHs.

HH Value-based Purchasing Program (VBP)

The HH VBP model was adopted as a demonstration in the CY 2016 HH PPS final rule, which you can read about in detail in our 2015 Regulatory Advisory. Additional program logistics were finalized in the CY 2018 HH PPS final rule, which you can read about in detail in our 2017 Regulatory Advisory. In this model, hereafter referred to as the original model, all Medicare-certified HH agencies providing services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee and Washington were required to participate in the model.

In this rule, CMS finalizes its proposal to expand the HH VBP model nationwide, with mandatory participation for all Medicare-certified HH agencies in all 50 states, the District of

Columbia and territories. However, CMS will require participation beginning Jan. 1, 2023, (i.e., performance in CY 2023 would inform the preliminary payment adjustment on CY 2025 payments) rather than Jan. 1, 2022, as originally proposed. The agency explains that it will use CY 2022 as a "pre-implementation year" to provide HH agencies with technical assistance and guidance in preparation for the onset of the program.

The national HH VBP model is similar to the original model. A summary of the elements of the program follow.

Cohorts. CMS will group HH agencies into nationwide cohorts by size. HH agencies in the "larger-volume" cohort are those agencies that administer the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey as required by the HH QRP, and agencies in the "smaller-volume" cohort are those agencies exempt from submitting the HHCAHPS survey due to low patient volume. As under the original model, CMS will set the minimum volume for an HHCAHPS survey measure at 40 completed surveys in the performance year.

The original model defined cohorts by state as well as by size (for example, HH agencies in Maryland were divided into smaller- and larger-volume cohorts for comparison, but were not compared to smaller- and larger-volume cohorts in Iowa). However, the inclusion of all 50 states, the territories and the District of Columbia would lead to state-level cohorts with insufficient numbers of HH agencies for statistically sound comparisons. In addition, using nationwide cohorts would make the HH VBP consistent with the SNF and Hospital VBP programs as well as the Home Health Compare Star Ratings.

Measures. CMS will assess performance on eight quality measures. All of these measures are based on data currently collected by HH agencies, and thus HH agencies participating in the HH VBP model will not be required to submit additional data.

To calculate a Total Performance Score, or TPS, CMS will take the weighted sum of the measures in each of three categories, and then the weighted sum of each category. CMS will use the following measures and weights for measures within each category:

Measure Category	**Quality Measures**	**Within-Category Weight**
OASIS	Total Normalized Composite Change in Mobility[2]	25%
	Total Normalized Composite Change in Self-Care	25%
	Improvement in Dyspnea	16.67%
	Discharged to Community	16.67%
	Improvement in Management of Oral Medications	16.67%
	Professional Care	20%

[2] The Total Normalized Composite Mobility and Self-Care measures were included in the original HH VBP model measure set, finalized in CY 2019. Details on these measures can be found in AHA's Regulatory Advisory on the CY 2019 HH PPS Final Rule.

HHCAHPS Survey	Communication	20%
	Team Discussion	20%
	Overall Rating	20%
	Willingness to Recommend	20%
Claims	Acute Care Hospitalization During the First 60 Days of Home Health Use	75%
	Emergency Department Use without Hospitalization During the First 60 Days of Home Health Use	25%

In this same rule, CMS finalizes the removal of two claims-based measures from the HH QRP beginning CY 2023. The agency seeks public comment on whether it should also remove these measures from the HH VBP model in the future.

CMS will waive parts of the pre-rulemaking process for the selection of quality and efficiency measures. Specifically, the agency will skip the convening of multi-stakeholder groups to provide input to the Secretary on the measures, transmitting input from these groups to the Secretary, consideration of the input by the Secretary, publication in the Federal Register of the rationale on the measures not endorsed for use, and execution of an impact assessment every three years on the use of the measures. CMS waives these steps because "the timeline associated with completing the steps described by these provisions would impede our ability to support testing new measures in a timely fashion" and because doing so would allow flexibility that "would be a key lever to adapt the Model to the unpredictable changes led by beneficiary preference, industry trends, and unforeseen nationwide events that HH agencies are particularly sensitive to."

Scoring Methodology. CMS will use a scoring methodology similar to what is currently used in the original model. In summary, HH agencies will receive a TPS ranging from zero to 100. The TPS is the weighted sum of the performance scores for each applicable quality measure; performance scores will be calculated as either achievement (performance compared to a cohort-specific benchmark) or improvement (performance compared to the agency's performance on the same measure in the baseline year), whichever is greater.

Achievement Score. Agencies will receive points for each measure based on their performance relative to a score range. The "achievement threshold" of this range is the median (50th percentile) of all cohort-specific HH agency performance scores on the measure during the baseline year; the benchmark of the range is the mean of the 90th percentile of all HH agency performance on the measure during the baseline year. Scores at or above the benchmark yield a maximum 10 points for the measure; scores at or below the threshold yield zero points. Scores between the threshold and benchmark garner between zero and 10 points. CMS will calculate the achievement score using the following formula:

$$\text{Achievement Score} = 10 \times \left(\frac{HHA\ Performance\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold} \right)$$

Improvement Score. Similar to the achievement score, HH agencies will receive points for each measure based on their performance on a range relative to their performance in the baseline year. If the HH agency's score is greater than its baseline year score (the "improvement threshold") but below the benchmark (which is the same as for the achievement score), it will receive between zero and nine points. If its score is below its baseline performance — meaning its performance worsened — it will receive zero points. CMS will calculate the improvement score using the following formula:

$$\text{Improvement Score} = 9 \times \left(\frac{HHA\ Performance\ Score - HHA\ Improvement\ Threshold}{Benchmark - HHA\ Improvement\ Threshold} \right)$$

Claims- and OASIS-based measures contribute 35% of the TPS each; HHCAHPS survey-based measures contribute 30%. If an HH agency is missing all measures from a single category, the weights for the remaining two categories will be redistributed proportionally.

Payment Adjustment. CMS will impose a maximum payment adjustment (upward or downward) of 5% at the onset of the expanded model (as opposed to a gradual increase in maximum payment adjustment, as in the original model). To translate the TPS into a payment adjustment, CMS will use a linear exchange function, which plots each HH agency's TPS along a line relative to the TPSs of other HH agencies. The slope of the line will be set so that the total payments are equal to 5% of the total base operating payment amount for the corresponding payment year.

CMS provides the following example to demonstrate the methodology used to calculate payment adjustments:

TABLE 31: 5-PERCENT REDUCTION SAMPLE

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
HHA	TPS	Prior Year Aggregate HHA Payment Amount*	5-Percent Payment Reduction Amount (C2*5 percent)	TPS Adjusted Reduction Amount (C1/100)*C3	Linear Exchange Function (LEF) (Sum of C3/ Sum of C4)	Final TPS Adjusted Payment Amount (C4*C5)	Quality Adjusted Payment Rate (C6/C2)	Final Percent Payment Adjustment +/- (C7-5%)
	(C1)	(C2)	(C3)	(C4)	(C5)	(C6)	(C7)	(C8)
HHA1	38	$100,000	$5,000	$1,900	1.931	$3,669	3.669%	-1.331%
HHA2	55	$145,000	$7,250	$3,988	1.931	$7,701	5.311%	0.311%
HHA3	22	$800,000	$40,000	$8,800	1.931	$16,995	2.124%	-2.876%
HHA4	85	$653,222	$32,661	$27,762	1.931	$53,614	8.208%	3.208%
HHA5	50	$190,000	$9,500	$4,750	1.931	$9,173	4.828%	-0.172%
HHA6	63	$340,000	$17,000	$10,710	1.931	$20,683	6.083%	1.083%
HHA7	74	$660,000	$33,000	$24,420	1.931	$47,160	7.146%	2.146%
HHA8	25	$564,000	$28,200	$7,050	1.931	$13,615	2.414%	-2.586%
Sum			$172,611	$89,379		$172,611		

*Example cases.

To receive a payment adjustment, HH agencies must meet minimum thresholds to report measures and meet these thresholds for a minimum of five measures in the program. For the measures included in the claims-based and OASIS-based measure categories, HH agencies must provide a minimum of 20 HH episodes of care per year and, therefore, have at least 20 cases in the measure denominator. For the HHCAHPS survey measures, the HH agency must have submitted a minimum of 40 completed HHCAHPS surveys. HH agencies unable to meet the minimum thresholds for at least five measures for a performance year will be paid for services in an amount equivalent to the amount that would have been paid if the program did not exist.

Timing. CMS will use CY 2019 as the baseline year for the CY 2023 performance year/CY 2025 payment year and subsequent years (meaning that performance in CY 2024 for payment in CY 2026 will also be compared to performance in CY 2019). The agency may propose to update the baseline year through future rulemaking. CMS explains that it will use CY 2019 because it believes performance in CY 2020 is not indicative of normal HH agency performance.

For HH agencies that are certified by Medicare on or after Jan. 1, 2019, ("new HH agencies") the baseline year will be the HH agency's first full calendar year of services beginning after the date of Medicare certification, with the exception of HH agencies certified in CY 2019, for which the baseline year would be CY 2021 (again, to skip CY 2020 performance likely affected by the COVID-19 pandemic). New HH agencies will begin competing in the HH VBP model in the first full calendar year following the full calendar year baseline year — for example, an HH agency certified in March 2020 would have a baseline year of CY 2021; the first performance year for this agency would be CY 2023, and the first payment adjustments would be made in CY 2025.

Other Details. In addition to methodological provisions, CMS also finalizes several programmatic details for the HH VBP model.

Preview Reports and Appeals Process. CMS will provide two types of preview reports to HH agencies. One is an interim performance report, distributed quarterly, containing information on an agency's quality measure performance based on the 12 most recent months of data available as well as its relative estimated ranking among its cohort and TPS. HH agencies will receive both a preliminary and final version of the interim report to allow for recalculation requests. CMS notes that it plans to provide sample interim performance reports for learning purposes only (i.e., no payment adjustment will be made) to HH agencies based on CY 2022 data.

In addition to the interim performance reports, CMS will distribute an annual TPS and payment adjustment report in approximately August of each year preceding the payment adjustment year. This report will focus on the HH agency's payment adjustment percentage, and will be provided in three versions: a preview report, a preliminary report if an agency requests a recalculation and a final report after all reconsideration requests are processed.

CMS will use these preview reports to provide HH agencies with two separate opportunities to review scoring information and request recalculations if a discrepancy is identified due to a CMS error in calculations. Agencies requesting recalculation must include a specific basis for their request; CMS will not make any changes to underlying measure data, and will not provide HH agencies with the underlying source data utilized to generate performance measure scores.

Public Reporting. CMS will begin publicly reporting performance data under the HH VBP model beginning with CY 2023 performance. On or after Dec.1, 2024, CMS will establish a separate HH VBP website to display measure benchmarks and achievement thresholds by cohort, as well as data for each HH agency that qualified for a payment adjustment, including the agency's measure results and improvement thresholds, TPS, TPS percentile ranking and payment adjustment.

Current Model. The last year of data collection for the original HH VBP model ended on Dec. 31, 2020; the last payment adjustment was scheduled to affect payments for CY 2022. However, due to measure reporting exceptions and other effects of the COVID-19 pandemic, CMS will not to use the CY 2020 data to inform payment adjustments for the HH agencies in the nine states participating in the original model. Instead, CMS will end the original model early. CY 2021 payments will be the last affected under the original HH VBP model, and CMS will not publicly report performance data for CY 2020.

Home Infusion Therapy Services Benefit

Section 5012 of the 21st Century Cures Act of 2016 (Cures Act) established a new home infusion therapy benefit. The Cures Act defines a "home infusion drug" as a drug or biological administered intravenously or subcutaneously for an administration period of 15 minutes or more, in the patient's home, through a pump that is an item of durable medical equipment (DME). This definition does not include insulin pump systems or any self-administered drug or biological on a self-administered drug exclusion list.

The benefit covers the nursing, patient training and education, and monitoring services associated with administering infusion drugs in a patient's home. The infusion pump and supplies (including home infusion drugs) will continue to be covered under the DME benefit. For details on the payment provisions and safety standards adopted at the onset of this benefit, see AHA's CY 2019 Proposed Rule Regulatory Advisory. For details on the previously codified policies pertaining to the permanent payment system, see AHA's CY 2021 Final Rule Regulatory Advisory.

In this rule, CMS will continue to apply the geographic adjustment factor (GAF) — an adjustment to take variations in wage index by region — with a budget neutrality factor whenever there are changes to the GAF in order to eliminate large scale variations. CMS will calculate the factor that will be used in updating payment amounts for CY 2022 and will issue this information to home infusion therapy providers in a forthcoming change request.

In addition, CMS will update the consumer price index adjustment to 5.4% and the productivity adjustment to 0.3%, for a net payment rate update of 5.1%.

In the CY 2021 final rule, CMS stated that it would increase the payment amount for the first home infusion therapy visit to take the more time- and resource-intensive nature of these preliminary visits into account; the agency also stated it would reduce the payment amounts for subsequent visits accordingly. In this rule, CMS finalizes its proposal to maintain the methodology used to calculate the payment adjustments in the previous year's rule; the initial home infusion therapy service visit payment amount would be increased by 20%, and the subsequent visits would be decreased by 1.33%. The agency will release the final payment amounts in a forthcoming change request and post them on the Home Infusion Therapy Billing and Rates webpage.

Other Provisions

Conditions of Participation. During the COVID-19 PHE, CMS issued a number of waivers to alleviate regulatory burden and expand health care system capacity. In this rule, CMS finalizes revisions to certain HH agency Conditions of Participation (CoPs) to make permanent some of the changes allowed under the waivers.

First, CMS proposes changes to allow flexibility related to HH aide supervision. Aides caring for patients receiving skilled care from nurses or therapists currently have an onsite supervisory visit every 14 days. In this rule, CMS finalizes its proposal to permit HH agencies to use interactive telecommunications systems for the purposes of aide supervision, on occasion. In the proposed rule, CMS would limit the use of virtual supervisory assessments to two per agency in a 60-day period; however, in response to public comments that this requirement would be difficult to track at the agency level, CMS will instead limit virtual assessments to one per patient per 60-day episode. The agency reiterated that it expects these virtual assessments to be rare and only used when an onsite visit cannot be coordinated within the 14-day time period due to unplanned occurrences.

In addition, CMS removes the requirement that the supervising registered nurse (RN) directly observe an aide (i.e., observe onsite with the aide present) providing non-skilled services every 60 days. Stakeholders found the requirement burdensome, especially for patients who receive services from multiple aides, each of whom would need to schedule separate supervisory assessments. Instead, CMS will require the RN to make a semi-annual onsite visit to directly observe the aide; CMS modifies its proposal to require the visit be conducted with each patient for whom the aide cares, rather than with any one patient. Finally, in addition to the current requirement of RNs to conduct, and the aide to complete, retraining and competency evaluations related to any skills deemed deficient, CMS extends this requirement to "all related skills." For example, if a patient informs the

RN that they almost fell when the aide was transferring them from a bed to a chair, the RN should assess the aide's skills in transferring a patient in other circumstances as well.

Second, CMS implements a provision of the Consolidated Appropriations Act of 2021 permitting an occupational therapist to conduct the initial assessment visit and comprehensive assessment under the Medicare program when occupational therapy is on the HH plan of care with either physical therapy or speech therapy, but skilled nursing services are not initially on the plan of care. Eligibility for Medicare HH care is established based on the need for skilled nursing, physical therapy or speech language pathology; occupational therapy alone does not initially establish program eligibility. The change allows an occupational therapist to conduct assessments even if skilled nursing services are not initially on the plan of care (as long as another rehabilitation therapy service is ordered).

Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment provisions in this rule. Questions pertaining to quality measurement, CoPs and home infusion should be shared with Caitlin Gillooley, senior associate director, at cgillooley@aha.org.