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# Regulatory Advisory

**July 20, 2021**

# Home Health PPS Proposed CY 2022 Rule

## At A Glance

### At Issue

On June 28, the Centers for Medicare & Medicaid Services (CMS) issued its calendar year (CY) 2022 proposed rule for the home health (HH) prospective payment system (PPS). Comments on the proposed rule are due to CMS by Aug. 27.

### Our Take

We appreciate CMS' issuance of a streamlined rule, which allows HH agencies and their hospital and other partners to focus on the local response to the COVID-19 pandemic. While overall cases have slowed since their peak last winter, they are still significant. In fact, caseloads and hospitalizations are once again increasing in certain areas of the country. In addition, health care providers continue to treat the clinical needs of "long-haul COVID-19" patients, as well as prepare for a possible resurgence of the virus in response to new variants and the fall and winter seasons.

### Key Takeaways

CMS' proposed rule would:

- Increase net payments by 1.7% ($310 million) in CY 2022.
- Not alter the behavior offset amount implemented in CY 2020.
- Expand the HH Value-based Purchasing pilot to a mandatory nationwide model.
- Remove three and add one new quality measure.

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 in CY 2020 – especially given the complexities wrought by the pandemic. That said, we remain concerned about the prospective nature of the CY 2020 behavioral adjustment**.** With regard to the HH Value-based Purchasing (VBP) model, we are surprised at the speed with which the agency proposes to move forward with a nationwide expansion considering the modest results of the ongoing pilot; we will engage in further review of the proposed program.

### 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.
- ✓ Submit a comment letter on the proposed rule to CMS by Aug. 27 explaining this rule's potential impact on your patients, staff and facility.

### 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

CMS estimates that under its HH PPS proposed rule for CY 2021, HH agencies would receive a net payment increase of 1.7%, or $310 million, from CY 2021 payment levels, which accounts for the market-basket update and a reduction in rural add-on payments. Facility-based HH agencies, including hospital-based agencies, are projected to see the same 2% increase. These impact estimates do not take into account the home infusion or VBP proposed policies.

# Proposed CY 2022 Payment Update

**Proposed CY 2022 Rates**

30-day Episode Rates. For CY 2022, CMS is proposing that the 30-day episode rate increase by the 3.1% market basket, offset by a 0.4% productivity factor. In addition, the rate would be subject to a case-mix weight recalibration budget neutrality factor of 1.0390 and a wage index budget neutrality factor of 1.0013. CMS notes 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 proposing to use the most recent CY 2020 claims data. CMS' proposed 30-day episode payment amount for agencies that submit quality data are displayed in Table 19 in the rule, which is recreated here and shows the proposed CY 2022 30-day episode rate of $2,013.43.

**PROPOSED RULE TABLE 19: CY 2022 30-DAY PERIOD PAYMENT AMOUNT**

| CY 2021 30-day 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 | 1.0390 | 1.0013 | 1.018 | $2,013.43 |

Proposed Low Utilization Payment Adjustment (LUPA) Rates. CMS again proposes to extend the CY 2020 LUPA thresholds and apply them to CY 2022 in order to mitigate the impact of variability in LUPA thresholds 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 10$^{th}$ 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.

| Proposed 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 Proposed Per-visit Payment** |
| HH 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-Lang. Pathology | $181.34 | X 1.0014 | X 1.018 | $184.86 |

Agencies that do not submit required quality data would have the LUPA payments reduced from 1.8% to -0.2%.

Proposed New LUPA Add-on Factor for Occupational Therapists (OTs). Under 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. The add-on factors are 1.8451 for skilled nursing, 1.6700 for PT and 1.6266 for SLP. As required by law, CMS now proposes to allow OTs to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health 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 proposes to establish 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 proposes to 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 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 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's 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 2021 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 (HHRGs), 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 proposes to use actual CY 2020 data for 30-day episodes under PDGM, rather than simulated episodes.

## Area Wage Index

CMS proposes to continue to 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, using 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, CMS proposes to adopt the updates set forth in OMB Bulletin No. 20-01, though it notes that specific wage index updates would not be necessary for CY 2022 as a result of adopting these OMB updates.[1] The proposed CY 2022 wage index is available on the CMS website.

The proposed labor-related share for CY 2022 is 76.1%, the same as in CYs 2020 and 2021, and would 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.

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 proposes to keep this ratio for CY 2022. However, to align with the 2.5% target, the agency proposes lowering the FDL ratio from the current ratio of 0.56 to 0.41 for CY 2022, which will increase the number of outlier cases, relative to CY 2021.

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

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 plans to publish the cost-per-unit amounts for 2022 in a rate update change request to be issued after the publication of the 2021 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 home health periods fall within each level.

For 2022, CMS proposes to 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 2022. The updated OASIS functional points table and the table of functional impairment levels by clinical group for CY 2022 are listed in the proposed rule Tables 13 and 14, 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 an HH 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 proposes to use its initial PDGM methodology to initially 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 85 high-comorbidity adjustment interaction subgroups as shown in proposed rule Tables 15 and 16 in the rule.

### Rural Add-on Methodology

For CY 2022, Medicare rural add-on payments would be reduced by 0.1 percentage point ($20 million), relative to CY 2020, due to the phase-out of rural relief that was required by the Bipartisan Budget Act of 2018. This legislation changed the amount, structure and timeline for HH rural add-on payments 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, Table 23 from the rule is recreated, which includes the statutorily mandated schedule for rural add-on payments. These apply to both the 30-day episode and LUPA rates.

| Proposed Rule Table 23: 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. In addition, it prohibits administrative or judicial review of a rural classification for this policy. Further, each claim will be required to include a state and county code. CMS posted an Excel file with each HH agency's rural designation and related data in the downloads section associated with this proposed rule.

## *Initial Impact of the Patient-driven Groupings Model*

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 HHRGs:

- 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 CY 2020 PDGM Behavioral Offset. The implementation of PDGM in CY 2020 included a behavioral offset of 4.36%. **In this rule, CMS proposes no adjustment to that offset, and instead asks the field to provide feedback on a prospective adjustment methodology to consider for a future cycle of rulemaking.** 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 offset, 4.36%, while still very substantial, was a significant reduction from the initially proposed 8.01% cut.

CMS analyses reported in this rule show that the 2020 30-day base payment rate was approximately 6% higher than it would have been under the prior case-mix system. As such, to achieve budget neutrality for CY 2020, CMS states that temporary retrospective adjustments for 2020 and subsequent years will be necessary until a permanent prospective adjustment can be implemented in future rulemaking – which are not proposed in this rule. CMS found that a change in case-mix between the two systems is driving the increase in payment – in other words, the average case-mix weight was 6.53% higher under PDGM than it would have been for the same cases under the prior payment system.

The law provides CMS with flexibility for when and how to make prospective adjustments based on retrospective behavior to achieve budget neutrality for CY 2020. CMS anticipates further change to its analysis as more claims become available from 2020 and subsequent years. It is also further considering that the COVID-19 PHE is still ongoing. **For these reasons, the agency intends to propose *in the future* a retrospective payment adjustment methodology and, if appropriate, a temporary and permanent prospective payment adjustment. In addition, the agency notes that by not proposing any new adjustments for 2022, future adjustments could be larger.**

To help provide some context to the field, the rule shares the findings of CMS' preliminary monitoring of the impact of PDGM. For example, the agency found that for a sample of simulated 30-day episodes of care from CYs 2018 and 2019, when compared to CY 2020 first quarter actual claims, volume dropped for metrics such as: 30-day episodes, unique HH patients and average number of 30-day periods per unique patient. **Attachment A provides a comprehensive summary of these analyses of PDGM's effects on HH utilization and payment patterns, which was prepared for the AHA by Health Policy Alternatives.** CMS presents – but does not interpret or use as rationale for any proposals – these pre-PDGM versus PDGM comparisons of claims data, cost reports and patient assessment data. Rather, CMS calls for stakeholder comments on whether other analyses should be conducted to help examine the effects of PDGM on expenditures and utilization. In addition, the rule notes that CMS will continue to monitor the provision of HH services and overall HH payments to determine if refinements to the case-mix adjustment methodology may be needed in the future**. In addition, CMS invites comments on these preliminary data and whether there are other analyses that should be conducted to examine the effect of the PDGM on home health expenditures and utilization.**

The rule also notes that there may be other ways to determine the difference between "assumed" versus "actual" behavior change in CY 2020, such as analysis of nominal case-

 

mix growth or calculating the percent difference and percent change of payments between simulated 30-day periods of care and actual 30-day periods of care. **As such**, **CMS solicits comments on its methodology and alternative approaches to determining how behavior changes affect Medicare spending for HH services. Specifically, this rule solicits comments on how to determine the difference between "predicted" versus "actual" behavior change on CY 2020 aggregate HH PPS expenditures due to: (1) PDGM's new 30-day payment episode; versus (2) the PDGM case-mix system.**

## *Other Proposed Changes*

### Proposed New Hospice Survey and Enforcement Requirements

To implement the hospice-related provisions of The Consolidated Appropriations Act of 2021, this rule includes a substantial section on proposed requirements pertaining to the survey and certification accreditor applications, enforcement remedies for hospice programs with deficiencies, and related terminations and appeals requirements. This extensive section can be found on pages 35876 through 35979 of the rule. The rule asks that inquiries related to the proposed new hospice survey and enforcement requirements be emailed to CMS at QSOG_Hospice@cms.hhs.gov.

Current law allows hospice providers to demonstrate compliance through accreditation by an approved accrediting organization, instead of a state surveyor. As of March 2021, three hospice accreditation programs are approved and overseen by CMS, which survey over 5,000 Medicare-certified hospice programs.

Specifically, the rule proposes an extensive series of modifications, including the sample below,

Accrediting organizations would be required to:

- Amend the application and reapplication process, including requiring a statement acknowledging deficiencies in compliance with hospice conditions of participation (CoP) for Medicare.
- Provide by, Dec. 27, 2022, a toll-free hotline for hospices and maintain a unit for investigating HH agency complaints. More details are pending from CMS. In the meantime, the agency requests comments on the data elements and processes needed to assure confidentiality and immediate communication to facilitate prompt responses.
- Release deficiency reports for hospice program surveys conducted under their deeming authority to increase transparency for the hospice beneficiary community. CMS seeks comments on how to utilize and display these findings.
- As part of their application and reapplication process, submit a description of the content and frequency of the training provided to survey personnel. CMS proposes the following:

Hospice programs would be required to:

- Comply with the following definitions:

    - *Abbreviated standard survey*: A focused survey other than a standard survey that gathers information on hospice program's compliance with specific standards or CoPs. An abbreviated survey may be based on complaints received or other indicators such as media reports or OIG investigations.
    - *Complaint survey*: A survey that is conducted to investigate substantial allegations of noncompliance as defined in § 488.1.
    - *Conditional-level deficiency*: Noncompliance as described in §488.24 of Subpart M.
    - *Deficiency*: A violation of the Act and regulations in 42 CFR part 418, subparts C and D, determined as part of a survey, and can be either standard or condition-level.
    - *Noncompliance*: Any deficiency found at the condition-level or standard-level.
    - *Standard-level deficiency*: Noncompliance with one or more of the standards that make up each CoP for the hospice program.
    - *Standard survey*: A survey conducted in which the surveyor reviews the hospice program's compliance with a selected number of standards and/or CoPs to determine the quality of care and services furnished by a hospice program.
    - *Substantial compliance*: Compliance with all condition-level requirements as determined by CMS or the State.
- Comply with the following requirements for program surveys:
    - A standard survey would be conducted not later than 36 months after the date of the previous standard survey.
    - A survey could be conducted more frequently than 36 months to assure that hospice services comply with CoPs and confirm that the hospice program corrected previously cited deficiencies.
    - A standard or abbreviated standard survey would be conducted when complaint allegations against the hospice were reported to CMS, the state or local agency.
- Require all surveyors to take CMS-provided basic training currently available and additional training as specified by CMS. Until this rule is finalized, CMS will accept the current training that was previously reviewed and approved by CMS during the accrediting organization application process.
- Limit conflicts of interest by prohibiting surveyors with a financial interest in the program who have family with an affiliation or who are patients in the surveyed program, or who currently serve or within the previous two years have served on the staff of or as a consultant to the hospice program undergoing the survey.
- Disqualify individual surveyors who have an immediate family member who have a financial interest or ownership interest with the hospice program to be surveyed or have an immediate family member who is a patient of the hospice program to be surveyed.

CMS would be required to:

- Correct and remove condition-level deficiencies for a hospice program through an enforcement remedy, hospice provider termination or both.
- Provide training for state and federal surveyors, and any surveyor employed by an accrediting organization, by Oct. 1, 2021.

- Update hospice basic training to include enhanced guidance for surveyors that will emphasize assessment of quality of care, including requirements for disqualifying state and other surveyors from surveying a particular hospice.
- Collect recommendations on additional, relevant provider information that will assist the public in obtaining a more comprehensive understanding of a hospice's overall performance.

Survey teams would be required to:

- Use multidisciplinary survey teams consisting of more than one surveyor, with at least one person being a R.N. as of Oct. 1, 2021.
- Include diverse professional backgrounds among their surveyors to reflect the professional disciplines responsible for providing care to hospice patients. Multidisciplinary teams should include professionals included in hospice core services and may include physicians, nurses, medical social workers, or pastoral or other counselors. To help track compliance with this challenging provision, CMS proposes to collect the following: (1) the extent to which surveys are conducted by one professional, who by regulation must be a registered nurse; (2) the professional makeup of their current workforce; and (3) a timeframe estimate in which they could effectuate multidisciplinary teams if not already in place.
- Determine a plan of care for each patient and family that includes a physician, registered nurse (R.N.), medical social worker, and pastoral or other counselor.
- When the survey teams have more than one surveyor, the additional positions would be filled by professionals from among these disciplines. For hospice multidisciplinary survey teams, CMS is considering using the current guidance for long-term care facilities.

## Proposed HH CoP Changes

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 proposes to revise certain HH agency CoPs to make permanent some of the changes allowed under the waivers.

First, CMS proposes changes to allow flexibility related to HH aide supervision. Rather than requiring the 14-day supervisory assessment be conducted in person, CMS proposes to permit HH agencies to use interactive telecommunications systems for the purposes of aide supervision, on occasion, not to exceed two virtual supervisory assessments per agency in a 60-day period. In addition, CMS would remove the requirement that the supervising R.N. directly observe an aide (i.e., observe on site with the aide present) providing non-skilled services every 60 days. To ensure appropriate supervision, CMS would add a new requirement for the R.N. to make a semi-annual on-site visit to directly observe the aide. Finally, in addition to the current requirement of R.N.s to conduct, and the aide to complete, retraining and competency evaluations related to any skills deemed deficient, CMS would extend this requirement to "all related skills." For example, if a patient informs the R.N. that they almost fell when the aide was transferring them from a bed to a chair, the R.N. should assess the aide's skills in transferring a patient in other circumstances as well.

Second, CMS proposes to implement 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 PT or SLP, 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, PT or SLP; occupational therapy alone does not initially establish program eligibility. The proposed change would allow 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).

## *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-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 proposes 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).

**Finalized and Proposed Measures for the HH QRP, CY 2020 – CY 2023**

| Measure | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|
| Improvement in Ambulation/Locomotion | X | X | X | X |
| Improvement in Bathing | X | X | X | X |
| Changes in Skin Integrity Post-acute Care (PAC): Pressure Ulcer/Injury | X | X | X | X |
| Influenza Immunization Received for Current Flu Season | X | X | X | X |
| Improvement in Bed Transferring | X | X | X | X |
| Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care | X | X | X | - |
| Improvement in Dyspnea | X | X | X | X |
| Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) | X | X | X | X |
| Application of Percent of Long-term Care Home Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function | X | X | X | X |
| Improvement in Management of Oral Medications | X | X | X | X |
| Medicare Spending Per Beneficiary (MSPB) for PAC | X | X | X | X |
| Discharge to Community – PAC | X | X | X | X |

| Measure | CY 2020 | CY 2021 | CY 2022 | CY 2023 |
|---|---|---|---|---|
| Potentially Preventable 30-day Post-discharge Readmission Measure | X | X | X | X |
| Drug Regimen Review Conducted with Follow-up for Identified Issues | X | X | X | X |
| Improvement in Pain Interfering with Activity | X | X | | |
| Timely Initiation of Care | X | X | X | |
| Acute Care Hospitalization During the First 60 Days of HH | X | X | X | - |
| Emergency Department (ED) Use without Hospitalization During the First 60 Days of HH | X | X | X | - |
| CAHPS Home Health Survey (five component questions) | X | X | X | X |
| Depression Assessment Conducted | X | | | |
| Diabetic Foot Care and Patient/Caregiver Education Implemented during All Episodes of Care | X | | | |
| Multifactor Fall Risk Assessment Conducted for All Patients Who Can Ambulate | X | | | |
| Pneumococcal Polysaccharide Vaccine Ever Received | X | | | |
| Improvement in the Status of Surgical Wounds | X | | | |
| ED Use without Hospital Readmission during the First 30 Days of HH | X | | | |
| Rehospitalization during the First 30 Days of HH | X | | | |
| Transfer of Health Information to Provider | | | X | X |
| Transfer for Health Information to Patient | | | X | X |
| HH Within Stay Potentially Preventable Hospitalization | | | | Y |

*X = Adopted and Required for HH agencies*
*Y = Proposed*
*- =Proposed for Removal*

### *CY 2023 Measurement Proposals*

Removal of Drug Education on All Medications Provided to Patient/Caregiver Measure. CMS proposes to 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; in fact, the mean and median performance scores in CY 2019 were 97.1% and 99.2%. In addition, the agency believes the Improvement in Management of Oral Medications measure in the HH QRP better addresses the topic of medication management. If finalized, HH agencies would no longer be required to submit OASIS item M2016 beginning Jan. 1, 2023, and the measure would no longer be publicly reported on *Care Compare* after Oct. 1, 2023.

Replacement of Measures with HH Within Stay Potentially Preventable Hospitalization Measure. CMS proposes to 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 proposes to remove the ED Use Without Hospitalization During the First 60 Days of HH measure based on concerns regarding a HH agency's ability to prevent an ED visits, especially for visits not resulting in hospitalization; experts have suggested that there are several drivers of ED use outside the control of a HH agency. Similarly, CMS would

remove the Acute Care Hospitalization During the First 60 Days of HH 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 proposed for adoption is HH 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 a 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, “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. In developing this definition, the measure developer used the Agency for Healthcare Research and Quality’s *Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*, which consists of conditions for which hospitalization can potentially be prevented, given good outpatient care and early intervention.

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 proposes to begin public reporting of 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 (LTCH) 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 HH, Inpatient Rehabilitation Facilities (IRF), and LTCH Measures and SPADEs*

In the CY 2020 HH PPS final rule and the FY 2020 IRF PPS and IPPS/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 COVID-19 PHE, 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 proposes to 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 analyses of these measures and SPADEs, see AHA's CY/FY 2020 Regulatory Advisories for HH agencies, IRFs and LTCHs.

### *CMS Requests for Information*

Fast Healthcare Interoperability Resource (FHIR). CMS is considering adopting the following standardized definition of digital quality measures (dQMs) in alignment across quality programs:

"Digital Quality Measures (dQMs) are quality measures that use one or more sources of

health information that are captured and can be transmitted electronically via interoperable systems. A dQM includes a calculation that processes digital data to produce a measure score or measure scores. Data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRs, instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated health data), health information exchanges (HIEs) or registries, and other sources."

CMS also seeks feedback on the potential use of FHIR for dQMs within the HH QRP aligning with other quality programs. FHIR is a free and open source standards framework that establishes a common language and process for all health information technology. CMS believes that using FHIR-based standards to exchange clinical information through application programming interfaces (APIs) would allow clinicians to submit digitally quality information one time that can then be used in many ways. The agency relates that it is currently evaluating the use of FHIR-based APIs to access patient assessment data collected and maintained through the Quality Improvement and Evaluation System (QIES) systems.

CMS states that it is considering the future development and staged implementation of a cohesive portfolio of dQMs across quality programs, agencies and private payers. This would require standardization of measures and data elements. In this RFI, CMS seeks feedback on the steps that would enable transformation of CMS' quality measurement enterprise to be fully digital.

Health Equity. CMS requests information on revising several CMS programs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for providers and patients. Specifically, the agency seeks recommendations for quality measures or measurement domains that address health equity as well as the collection of other SPADEs that address gaps in health equity in the HH QRP. In addition, CMS requests feedback on how the agency can promote health equity in outcomes among HH residents by stratifying quality measure results by social risk factors and what challenges exist for effective capture, use and exchange of health information including data on race, ethnicity and other social determinants of health.

## *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 proposes 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 beginning Jan. 1, 2022, (i.e., performance in CY 2022 would inform the preliminary payment adjustment on CY 2024 payments). In a January 2021 announcement, CMS voiced its intent to expand the model through notice and comment rulemaking. The model had been approved for expansion based on three factors, which CMS believes the model's evaluation has demonstrated:

1. Improved quality of care without increased spending: CMS believes that a 4.6% improvement in HH agencies' quality scores and an average annual savings to Medicare of $141 million suggest the model has met this objective.
2. Impact on Medicare Spending: The CMS Chief Actuary has certified that expansion of the HH VBP Model would produce Medicare savings if expanded to all states.
3. No alteration in coverage or provision of benefits: The model does not make any changes to coverage or provision of benefits, and therefore CMS believes the expansion would not deny or limit coverage or provision of benefits.

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

Cohorts. CMS proposes to group HH agencies into nationwide cohorts by size. HH agencies in the "larger-volume" cohort would be those agencies that administer the HH Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey as required by the HH QRP, and agencies in the "smaller-volume" cohort would be those agencies exempt from submitting the HHCAHPS survey due to low volumes. As under the original model, CMS proposes to 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 HH Compare Star Ratings.

Measures. CMS proposes to assess performance on eight quality measures; only four of these measures are endorsed by the National Quality Forum. All of these measures are currently collected under the HH QRP, and thus HH agencies participated in the HH VBP model would not be required to submit additional data.

To calculate a Total Performance Score (TPS), CMS would take the weighted sum of the measures in each of three categories, and then the weighted sum of each category. CMS proposes 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% |
| HHCAHPS Survey | Professional Care | 20% |
| | Communication | 20% |
| | Team Discussion | 20% |
| | Overall Rating | 20% |
| | Willingness to Recommend | 20% |
| Claims | Acute Care Hospitalization During the First 60 Days of HH Use | 75% |
| | Emergency Department Use without Hospitalization During the First 60 Days of HH Use | 25% |

In this same rule, CMS proposes to remove these 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 proposes to waive parts of the pre-rulemaking process for the selection of quality and efficiency measures. Specifically, the agency would 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 makes this proposal 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 proposes a scoring methodology similar to what is currently used in the original model. In summary, HH agencies would receive a TPS ranging from zero to 100. The TPS would be the weighted sum of the performance scores for each applicable quality measure; performance scores would be calculated as either achievement (performance compared to a cohort-specific benchmark) or improvement (performance

[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.

compared to the agency's performance on the same measure in the baseline year), whichever is greater.

*Achievement Score.* Agencies would receive points for each measure based on their performance relative to a score range. The "achievement threshold" of this range would be the median (50th percentile) of all cohort-specific HH agency performance scores on the measure during the baseline year; the benchmark of the range would the mean of the 90th percentile of all HH agency performance on the measure during the baseline year. Scores at or above the benchmark would yield a maximum 10 points for the measure; scores at or below the threshold would yield zero points. Scores between the threshold and benchmark would receive between zero and 10 points. CMS proposes to 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 would 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 would receive between zero and nine points. If its score is below its baseline performance – meaning its performance worsened – it would receive zero points. CMS proposes to 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 would contribute 35% of the TPS each; HHCAHPS survey-based measures would contribute 30%. If an HH agency is missing all measures from single category, the weights for the remaining two categories would be redistributed proportionally.

Payment Adjustment. CMS proposes a maximum payment adjustment (upward or downward) of 5%, and would begin the expanded VBP model with this adjustment. Under the original model, payment adjustments began at 3% and increased each year of the program to a maximum of 8% in 2022. To translate the TPS into a payment adjustment, CMS proposes to use a linear exchange function (LEF), which plots each HH agency's TPS along a line relative to the TPSs of other HH agencies. The slope of the line would 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 proposed to calculate payment adjustments:

TABLE 32: 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 would have to 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 would have to provide a minimum of 20 home health episodes of care per year and, therefore, have at least 20 cases in the measure denominator. For the HHCAHPS survey measures, the HH agency would have to 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 would be paid for services in an amount equivalent to the amount that would have been paid if the program did not exist.

*Timing.* CMS proposes to use CY 2019 as the baseline year for the CY 2022 performance year/CY 2024 payment year and subsequent years (meaning that performance in CY 2023 for payment in CY 2025 would also be compared to performance in CY 2019). The agency may propose to update the baseline year through future rulemaking. CMS proposes 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 would 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). CMS proposes that new HH agencies would 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 2022, and the first payment adjustments would be made in CY 2024.

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

*Preview Reports and Appeals Process.* CMS proposes to provide two types of preview reports to HH agencies. One would be 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 would receive both a preliminary and final version of the interim report to allow for recalculation requests.

In addition to the interim performance reports, CMS proposes to distribute an annual TPS and payment adjustment report in approximately August of each year preceding the payment adjustment year. This report would focus on the HH agency's payment adjustment percentage, and would 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 proposes to 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 would have to include a specific basis for their request; CMS would not make any changes to underlying measure data, and would not provide HH agencies with the underlying source data utilized to generate performance measure scores.

*Public Reporting.* CMS proposes to report publicly performance data under the HH VBP model beginning with CY 2022 performance. On or after Dec. 1, 2023, CMS would 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. The quality measure results would also continue to be reported on *Care Compare*, but would differ in their reporting periods from those used in the HH VBP model; CMS explains that it believes "this would be clear and transparent for the public."

Current Model. The last year of data collection for the original HH VBP model ended on Dec. 31, 2020; the last payment adjustment is scheduled to affect payments for CY 2022. However, due to measure reporting exceptions and other effects of the COVID-19 pandemic, CMS proposes 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 proposes to end the original model early; under this proposal, CY 2021 payments would be the last affected under the original HH VBP model, and CMS would 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, and 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 proposes to 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 provide an update on the consumer price index productivity adjustment in the CY 2022 HH PPS final rule.

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 proposes to maintain the methodology it 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 1.3310%. 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.

## *Next Steps*

The AHA hosted a member call to discuss this rule and gather input for our comment letter to CMS. Related materials and a recording of this call will be available in the HH section here.

Submitting Comments. The AHA urges all HH agencies to submit comments to CMS by Aug. 27. Comments may be submitted electronically at www.regulations.gov. Follow the instructions for “Comment or Submission” and enter the file code “CMS-1747-P.”

Questions. Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about the payment and hospice 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.

# *Attachment A*

**CMS Analyses of the Impact of the Initial Implementation of PDGM**

The following summary of CMS' evaluation of the effects of PDGM on HH utilization and payment patterns was prepared for the AHA by Health Policy Alternatives. The rule notes that CMS will continue to monitor the provision of HH services and overall HH payments to determine if refinements to the case-mix adjustment methodology may be needed in the future. **CMS invites comments on these preliminary data and whether there are other analyses that should be conducted to examine the effect of the PDGM on HH expenditures and utilization.**

1. Monitoring the Effects of the Implementation of PDGM

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 for directly determining payment and developing 432 case-mix adjusted payment groups in place of 153 groups. In the CY 2020 HH PPS final rule[3], CMS stated it would continue to monitor how the PDGM, including the variables that determine the case-mix weights, affect the provision of home health care and would implement any future refinements, if needed.

CMS believes that stakeholders want information about how HH utilization patterns may have changed under the PDGM. CMS notes that adjusting to the new payment system takes time and that any emergent trends from implementation of the PDGM may be impacted by the COVID-19 PHE. Preliminary utilization patterns are discussed below.

a. Claims Data Overview used in PDGM Monitoring

CMS discusses the analysis it performed for monitoring PDGM implementation. CMS used 2018 HH data to divide 60-day episodes of care into two simulated 30-day periods of care that were used to set payment rates in the 2020 HH PPS final rule.[4] CMS also used 2019 HH data (used for routine rate setting updates for 2021) to divide 60-day episodes of care into two simulated 30-day periods of care. The simulated data in these analytical files represent pre-PDGM utilization. CMS refers readers to the 2019 HH PPS proposed rule for a detailed description of how these analytical files were created.[5] CMS used 2020 claims data as of March 30, 2021, to analyze changes post-implementation of the PDGM and the 30-day unit of payment.

b. Routine PDGM Monitoring

Section 1895(b)(3)(D) of the Act requires CMS to annually determine the impact of assumed versus actual behavioral changes on aggregate expenditures under the HH PPS

[3] 84 FR 60513
[4] 84 FR 60518
[5] 83 FR 32382 – 32388.

for 2020 through 2026. Analysis for routine monitoring may include, but not be limited to, analyzing: overall total 30-day periods of care and average periods of care per HH patient; the distribution of visits in a 30-day period of care; the percentage of periods that receive a LUPA; the percentage of 30-day periods of care by clinical group, comorbidity adjustment, admission source, timing and functional impairment level; and the proportion of 30-day periods of care with and without any therapy visits.

CMS notes the beginning of 2020 included ongoing 60-day episodes of care that began in 2019 and ended in 2020. Depending on the length of the remainder of the episode, these 60-day episodes were simulated into one or two 30-day periods of care and are included in the analysis. Approximately 6.1% of the 30-day periods of care in 2020 data were simulated because the original 60-day episode of care began in 2019 and ended in 2020.

*(1) Utilization*. To evaluate utilization, CMS compared the simulated 30-day periods in its analytical files to actual 2020 PDGM claims. CMS examined utilization for 2018 simulated 30-day periods of care, 2019 simulated 30-day periods of care and 2020 actual 30-day periods of care.

CMS notes this preliminary data indicates the number of 30-day periods of care decreased between 2018 and 2020, while the average number of 30-day periods of care per unique HH patient is similar. In addition, on average, the total number of visits decreased by 1.27 visits per 30-day period of care between 2018 and 2020. The percentage of 30-day periods of care that are LUPAs increased from 6.7% in 2018 to 8.6% in 2020. Tables 2, 3 and 4, reproduced below, provide additional information.

**Table 2: Overall Utilization of Home Health Services, CYs 2018-2020**

| | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 |
|---|---|---|---|
| 30-Day Periods of Care | 9,336,898 | 8,744,171 | 8,165,402 |
| Unique HH AGENCY Users | 2,980,385 | 2,802,560 | 2,786,662 |
| Average Number of 30-Day Periods of Care Per Unique HH AGENCY User | 3.13 | 3.12 | 2.93 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH Limited Data Set (LDS) file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the Chronic Conditions Data Warehouse (CCW) Virtual Research Data Center (VRDC) on March 30, 2021. | | | |
| Notes: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in this analysis. All 30-day periods of care claims were included (e.g., LUPAs, PEPs and outliers). | | | |

**Table 3: Utilization of Visits Per 30-Day Periods of Care by Home Health Discipline, CYs 2018-2020**

| Discipline | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 |
|---|---|---|---|
| Skilled Nursing | 4.53 | 4.49 | 4.35 |
| Physical Therapy | 3.30 | 3.33 | 2.71 |
| Occupational Therapy | 1.02 | 1.07 | 0.78 |
| Speech Therapy | 0.21 | 0.21 | 0.16 |
| Home Health Aide | 0.71 | 0.67 | 0.54 |
| Social Worker | 0.08 | 0.08 | 0.06 |

| | | | |
|---|---|---|---|
| Total (all disciplines) | 9.86 | 9.85 | 8.59 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | |
| Notes: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in this analysis. All 30-day periods of care claims were included (e.g., LUPAs, PEPs and outliers). | | | |

**Table 4: The Proportion of 30-Day Periods of Care That are LUPAs and the Average Number of LUPAs and the Average Number of Visits by Home Health Discipline for LUPA Home Health Periods, CYs 2018-2020**

| Discipline | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 |
|---|---|---|---|
| Total percentage of overall 30-day periods of care that are LUPAs | 6.7% | 6.8% | 8.6% |
| Discipline (Average # of visits for LUPA home health periods) | | | |
| Skilled Nursing | 1.15 | 1.14 | 1.19 |
| Physical Therapy | 0.43 | 0.46 | 0.53 |
| Occupational Therapy | 0.07 | 0.07 | 0.08 |
| Speech Therapy | 0.02 | 0.02 | 0.02 |
| Home Health Aide | 0.01 | 0.01 | 0.01 |
| Social Worker | 0.01 | 0.01 | 0.01 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | |
| Notes: The average (CY 2018 to CY 2020) number of visits per 30-day periods of care across all claims for skilled nursing is 4.46, for PT is 3.13, for OT is 0.97, for SLP is 0.19, for aide is 0.65 and for social worker is 0.07. There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in this analysis. All 30-day periods of care claims were included (e.g., LUPAs, PEPs and outliers). | | | |

*(2) Analysis of 2019 Cost Report Data for 30-Day Periods of Care.* CMS examined 2019 HH agency Medicare cost reports (the most recent and complete cost report data available) and 2020 30-day period of care HH claims to estimate 30-day period of care costs. CMS excluded LUPAs and PEPs in the average number of visits. Table 5, reproduced below, shows the estimated average costs for 30-day periods of care by discipline with non-routine supplies (NRS) and the total 30-day period of care costs with NRS for 2020.

**Table 5: Estimated Costs for 30-Day Periods of Care in CY 2020**

| Discipline | 2019 Average Costs Per Visit with NRS | 2020 Average Number of Visits | 2020 Market Basket Update | 2020 Estimated 30-Day Period Costs |
|---|---|---|---|---|
| Skilled Nursing | $142.75 | 4.66 | 1.026 | $682.51 |
| Physical Therapy | $160.85 | 2.92 | 1.026 | $481.89 |
| Occupational Therapy | $160.14 | 0.85 | 1.026 | $139.66 |
| Speech Therapy | $181.27 | 0.17 | 1.026 | $31.62 |
| Home Health Aide | $238.66 | 0.06 | 1.026 | $14.69 |
| Social Worker | $72.20 | 0.59 | 1.026 | $44.31 |
| Total (all disciplines) | | | | $1,394.68 |
| Source: 2019 Medicare cost report data obtained on Jan. 26, 2021. Home health visit information came from episodes ending or on before Dec. 31, 2019 (obtained from the CCW VRDC on July 13, 2020). | | | | |

| Table 5: Estimated Costs for 30-Day Periods of Care in CY 2020 | | | | |
|---|---|---|---|---|
| **Discipline** | **2019 Average Costs Per Visit with NRS** | **2020 Average Number of Visits** | **2020 Market Basket Update** | **2020 Estimated 30-Day Period Costs** |
| Note: The 2020 average number of visits excludes LUPAs and PEPs | | | | |

CMS notes the 2020 national, standardized 30-day period payment was $1,864.03, which is approximately 34% more than the estimated 2020 30-day period cost of $1,394.68. In addition, using the actual 2020 claims data, the average number of visits in a 30-day period was 9.25 visits – a decrease of approximately 10.5 from the estimated number of visits for a 30-day period of care in 2017. CMS acknowledges that with the PHE, the 2019 data on the Medicare cost reports may not reflect the associated changes such as increased telecommunications technology costs and personal protective equipment costs. CMS will update the estimated 30-day period of care costs in 2020 in future rulemaking.

*(3) Clinical Groupings and Comorbidities.* Each 30-day period of care is grouped into one of 12 clinical groups describing the primary reason patients are receiving HH services. Table 6, reproduced below, shows the distribution of the 12 clinical groups over time. The average case-mix weight for each clinical group includes all possible comorbidity adjustments, admission source and timing, and functional impairment levels.

| Table 6: Distribution of 30-Day Periods of Care by the 12 PDGM Clinical Groups, CYs 2018-2020 | | | | |
|---|---|---|---|---|
| **Clinical Grouping** | **CY 2018 (Simulated)** | **CY 2019 (Simulated)** | **CY 2020** | **Average Case-mix Weight for Each Group** |
| Behavioral Health | 1.7% | 1.5% | 2.3% | 0.8243 |
| Complex | 2.6 | 2.5 | 3.5 | 0.8574 |
| MMTA - Cardiac | 16.5 | 16.1 | 19.0 | 0.9202 |
| MMTA - Endocrine | 17.3 | 17.4 | 7.2 | 1.0161 |
| MMTA – GI/GU | 2.2 | 2.3 | 4.7 | 0.9793 |
| MMTA - Infectious | 2.9 | 2.7 | 4.8 | 0.9805 |
| MMTA - Other | 4.7 | 4.7 | 3.1 | 0.9711 |
| MMTA - Respiratory | 4.3 | 4.1 | 7.8 | 0.9906 |
| MMTA – Surgical Aftercare | 1.8 | 1.8 | 3.5 | 1.0701 |
| MS Rehab | 17.2 | 17.3 | 19.4 | 1.1174 |
| Neuro | 14.4 | 14.5 | 10.5 | 1.1603 |
| Wound | 14.5 | 15.1 | 14.2 | 1.1923 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | | |
| Note: The average case-mix weight for each clinical group includes all 30-day periods regardless of other adjustments (for example admission source, timing, comorbidities, etc.) | | | | |

Thirty-day periods of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on HH claims; the comorbidity adjustment can be a low- or high-comorbidity adjustment. Table 7, reproduced below, shows the distribution of 30-day periods of care by comorbidity adjustment category. The average case-mix weight

for each comorbidity adjustment includes all possible clinical groupings, admission source and timing, and functional impairment levels.

| Table 7: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category for 30-Day Periods, CYs 2018-2020 | | | | |
|---|---|---|---|---|
| **Comorbidity Adjustment** | **CY 2018 (Simulated)** | **CY 2019 (Simulated)** | **CY 2020** | **Average Case-mix Weight for Each Group** |
| None | 55.6% | 52.0% | 49.2% | 1.0058 |
| Low | 35.3 | 38.0 | 36.9 | 1.0446 |
| High | 9.2 | 10.0 | 114.0 | 1.1683 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | | |
| Note: The average case-mix weight for each clinical group includes all 30-day periods regardless of other adjustments (for example admission source, timing, comorbidities, etc.) | | | | |

*(4) Admission Source and Timing.* Each 30-day period of care is classified into one of two admission source categories depending on what health care setting was utilized in the 14 days prior to receiving home health care. Thirty-day periods of care are classified as "early" or "late" depending on when they occur within a sequence of 30-day periods of care. The first 30-day period of care is classified as early and all subsequent 30-day periods of care in the sequence are classified as late. Table 8, reproduced below, shows the distribution of 30-day periods of care by admission source and timing over time. The average case-mix weight for each admission source and period timing includes all possible clinical groupings, comorbidity adjustment and functional impairments.

| Table 8: Distribution of 30-Day Periods of Care by Admission Source and Period Timing. CYs 2018-2020 | | | | | |
|---|---|---|---|---|---|
| **Admission Source** | **Period Timing** | **CY 2018 (Simulated)** | **CY 2019 (Simulated)** | **CY 2020** | **Average Case-mix Weight for Each Group** |
| Community | Early | 13.5% | 13.8% | 12.5% | 1.2584 |
| Community | Late | 61.1 | 60.9 | 61.9 | 0.8504 |
| Institutional | Early | 18.6 | 18.4 | 19.9 | 1.4234 |
| Institutional | Late | 6.8 | 5.8 | 5.8 | 1.3303 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | | | |

*(5) Functional Impairment Level.* Each 30-day period of care is placed into a functional level based on responses to certain OASIS functional items associated with grooming, bathing, dressing, ambulating, transferring and risk for hospitalization. The functional impairment level remains the same for the first and second 30-day periods of care unless here has been a significant change in condition that warranted an "other follow-up" assessment prior to the second 30-day period of care. Table 9, reproduced below, shows the distribution of 30-day periods by functional status. The average case-mix weight for each functional impairment level includes all possible clinical groupings, comorbidity adjustments, admission source and period timing.

| Table 9: Distribution of 30-Day Periods of Care by Functional Impairment Level, CYs 2018-2020 | | | | |
|---|---|---|---|---|
| **Functional Impairment Level** | **CY 2018 (Simulated)** | **CY 2019 (Simulated)** | **CY 2020** | **Average Case-mix Weight for Each Group** |
| Low | 33.9% | 31.9% | 25.6% | 0.8392 |
| Medium | 34.9 | 35.5 | 32.7 | 1.0373 |
| High | 31.2 | 31.6 | 41.7 | 1.1724 |
| Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021. | | | | |

The functional impairment level is currently determined by responses to OASIS items M1800-M1860 and M1032. Section 1899B(b)(1)(A) of the Act requires the Secretary to require HH agencies to report standardized patient assessment data beginning no later than Jan. 1, 2019. The standardized patient assessment data categories include functional status; CMS finalized adding the functional items, Section GG, "Functional Abilities and Goals" to the OASIS data set, effective Jan. 1, 2019. Although CMS does not yet have the data to determine the effect of these newly added items on resource cost utilization during a HH period of care, it examined the correlation between the current functional items used for payment and the analogous GG items (see Figure 2 in the proposed rule). CMS' preliminary analysis shows there is a correlation between the current responses to the M1800-1860 items and the GG items. CMS will continue to monitor the GG items to determine the correlation between the current functional items used to case-mix home health payments and the GG items.

*(6) Therapy Visits.* Beginning in CY 2020, section 1895(b)(4)(B)(ii) of the Act eliminated the use of therapy thresholds in calculating payments for 2020 and subsequent years. CMS examined the proportion of simulated 30-day periods with and without any therapy visits for 2018 and 2019, prior to the removal of therapy thresholds. CMS also examined the proportion of actual 30-day periods of care with and without therapy visits for 2020, after the removal of therapy thresholds. Table 10, reproduced below, shows the proportion of 30-day periods of care for various therapy options. CMS also examined the proportion of 30-day periods of care by the number of therapy visits provided during 30-day periods of care (see Figure 3 in the proposed rule). CMS' preliminary analysis shows there have been changes in the distribution of both therapy and non-therapy visits in 2020.

| Table 10: Proportion of 30-Day Periods of Care with Only Therapy, At Least One Therapy Visits, and No Therapy Visits for CYs 2018-2020 | | | |
|---|---|---|---|
| **30-Day Period Visit Type** | **CY 2018 (Simulated)** | **CY 2019 (Simulated)** | **CY 2020** |
| Therapy Only | 13.5% | 14.4% | 15.2% |
| Therapy + Non-therapy | 48.2% | 48.4% | 42.2% |
| No Therapy | 38.3% | 37.2% | 42.6% |
| Total 30-Day Periods | 9,336,898 | 8,744,171 | 8,165,402 |

Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021.

CMS also examined the proportion of 30-day periods of care with and without skilled nursing, social work or HH aide visits for 2018, 2019 and 2020 (see Tables 11 and 12, reproduced below).

**Table 11: Proportion of 30-Day Periods of Care with Only Skilled Nursing, Skilled Nursing + Other Visit Type, and No Skilled Nursing Visits for CYs 2018-2020**

| 30-Day Period Visit Type | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 |
|---|---|---|---|
| Skilled Nursing Only | 33.8% | 33.1% | 38.6% |
| Skilled Nursing + Other | 51.6% | 51.5% | 45.2% |
| No Skilled Nursing | 14.7% | 15.5% | 16.2% |
| Total 30-Day Periods | 9,336,898 | 8,744,171 | 8,165,402 |

Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021.

**Table 12: Proportion of 30-Day Periods of Care with and without Home Health Aide and/or Social Worker Visits for CYs 2018-2020**

| 30-Day Period Visit Type | CY 2018 (Simulated) | CY 2019 (Simulated) | CY 2020 |
|---|---|---|---|
| Any HH Aide and/or Social Worker | 16.6% | 15.9% | 13.1% |
| No HH Aide and/or Social Worker | 83.4% | 51.5% | 86.9% |
| Total 30-Day Periods | 9,336,898 | 8,744,171 | 8,165,402 |

Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data comes from the HH LDS file. CMS applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was assessed from the CCW VRDC on March 30, 2021.