HOME HEALTH PPS PROPOSED RULE CY2021: SOME GOOD NEWS

On June 25, 2020, CMS released the pre-publication copy of the CY2021 Home Health PPS Proposed Rule (the "Proposed Rule"). Compared to prior years, this year's rule is surprisingly brief. Of course, COVID-19 Pandemic has already resulted in significant compliance challenges for the industry. The Proposed Rule addresses the annual payment update.

CY2021 ADJUSTMENTS BASED UPON INDUSTRY BEHAVIORAL CHANGES

One area that the industry had anticipated with great concern was how CMS's analysis of "behavioral changes" under Patient-Driven Groupings Model ("PDGM") would impact the home health rates for FY2021. CMS is required to assess behavioral changes and adjust payments to address actual versus assumed behavior changes. Many of us had anticipated that the COVID-19 Pandemic would make it difficult for CMS to assess behavioral changes because COVID-19 created significant utilization changes, primarily reduced visit volume, that would skew CMS's data. This suspicion has proven to be accurate, as CMS notes, "it would be premature to release any information related to these issues based on the amount of data currently available and in light of the current public health emergency resulting from the COVID-19 pandemic outbreak." As a result, CMS will be making no changes to the national standardized 30-day payment to address behavioral changes. The CY2021 Proposed Ruled will only address routine rate updates. CMS promises to assess the need for changes to the rate based upon behavioral change in future rulemakings.

RATE UPDATE

With behavioral adjustments off the table, CMS's proposed rule outlines the proposed rate adjustments for CY2021. Because 2020 was the first year of PDGM, CMS is not proposing to recalibrate case mix weights for 2021. CMS calculates the update using the home health payment update of 2.7%.

CY 2020 30-Day Budget Neutral (BN) Standard Amount	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update	CY 2021 National, Standardized 30-Day Period Payment
$1,864.03	X 0.9987	X 1.027	$1,911.87

Using the 2.7% update and the required budge neutrality factor, CMS calculates that the standardized 20-day episodic payment for 2021 will be $1,911.87.

Agencies that do not submit their quality data will receive a standardized episodic payment amount of $1,874.64, which reflects the 2% penalty amount for failing to submit quality data.

The Low Utilization Payment Adjustment ("LUPA") payments also receive a 2.7% increase.

HH Discipline	CY 2020 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update	CY 2021 Per-Visit Payment
Home Health Aide	$67.78	X 0.9988	X 1.027	$69.53

Medical Social Services	$239.92	X 0.9988	X 1.027	$246.10
Occupational Therapy	$164.74	X 0.9988	X 1.027	$168.98
Physical Therapy	$163.61	X 0.9988	X 1.027	$167.83
Skilled Nursing	$149.68	X 0.9988	X 1.027	$153.54
Speech-Language Pathology	$177.84	X 0.9988	X 1.027	$182.42

As with the episodic payments, agencies that fail to submit their quality data will see their rates reduced by 2%.

Overall, CMS projects that this update will increase Medicare home health spending by 2.6%. The difference between the 2.7% increase and the 2.6% overall increase in spending is due to the changes resulting from the continued phaseout of the Rural Add On.

As outlined in last years PPS Rule, CMS is phasing out the Rural Add ON. This was required by section 50208 of the Balanced Budget Act of 2018. In the FY2020 PPS final rule, CMS finalized the following schedule of Rural Add On Percentages from CY2019 – CY2022:

TABLE 11: HH PPS RURAL ADD-ON PERCENTAGES, CYs 2021-2022

Category	CY 2019	CY 2020	CY 2021	CY 2022
High Utilization	1.5%	0.5%	None	None
Low Population Density	4.0%	3.0%	2.0%	1.0%
All Other	3.0%	2.0%	1.0%	None

OUTLIER PAYMENTS

CMS proposes to set the Loss Sharing Ratio at 0.80. This means that Medicare will pay 80% of the additional estimated costs that exceed the outlier threshold. With the loss sharing ratio set at 0.80, Medicare must then set the Fixed Dollar Loss Ratio ("FDL") at a level to keep the total outlier spending below 2.5% of the total Medicare home health reimbursement, as required by the Affordable Care Act. Because of the 2.5% cap, CMS proposes to keep the FDL at 0.63 for FY2021.

TECHNOLOGY AND THE MEDICARE HOME HEALTH BENEFIT

In the Interim Final Rule regarding the COVID-19 Public Health Emergency ("IFR"), CMS changed the plan of care requirements at 42 C.F.R. § 409.43(a) to address the use of technology in home health. The IFR made it clear that CMS agreed that the use of technology in home health was appropriate. The IFR specifically allowed for it but required that the plan of care include a description of any "remote patient monitoring or other services furnished via a telecommunications system." It also required the plan of care "describe how the use of such technology is tied to the patient-specific needs … and will help to achieve the goals outlined on the plan of care."

CMS notes that it has received feedback from the industry that remote patient monitoring and other telecommunications technologies can play an important role in home health, beyond the current pandemic. CMS agrees. CMS acknowledges that "there are ways in which technology can be further utilized to improve patient care, better leverage advanced practice clinicians, and improve outcomes while

potentially making the provision of home health care more efficient."

Because of this potential broader benefit, CMS is proposing to make the changes from the IFR permanent. CMS is also proposing to continue to allow agencies to report the costs of telehealth/telemedicine as allowable administrative costs. In order to increase the utilization of technology in home health, CMS proposes to modify the cost report instructions to reflect a broader use of telecommunications technology and to modify 42 C.F.R. § 409.46(e) to include not only remote patient monitoring but also other forms of communication or monitoring services that are consistent with the patient's plan of care.

This change is a direct result of the pandemic. CMS hopes that these changes will allow agencies to "confidently plan for the continued inclusion of telecommunications systems under the Medicare home health benefit." CMS believes this is necessary because of the significant up-front costs incurred by stakeholders in evaluating and implementing these systems. This is a significant indication that the future for remote patient monitoring and telehealth in home health is bright. However, until Congress changes the Social Security Act, agencies cannot be reimbursed for remote patient visits.

HOME INFUSION THERAPY SUPPLIER

CMS announces its proposal to end the temporary transitional home infusion payments and the start of the permanent benefit. One key announcement contained in the proposed rule relates to drugs that are covered under the temporary transitional payment system that will cease being covered on January 1, 2021. Some of the drugs that were eligible for temporary transitional payments are excluded from the Home Infusion Benefit because they are listed on a "self-administered drug" ("SAD") exclusion list. Similarly, several drugs that were covered under the temporary transitional payment are excluded from the benefit because they are administered intrathecally or intra-arterially. Drugs that were eligible for temporary transitional payments, but which are excluded drugs under the Benefit include: Hizentra (SAD), Ziconotide, Floxuridine, intrathecally administered Morphine (J2274)

CMS also proposes to add home infusion therapy supplier standards to the conditions of payment. A number of these standards, such as the requirement to be accredited, are contained in the statute and were set forth in other regulations previously. For purposes of screening, CMS has determined to place home infusion therapy suppliers in the "limited risk" category. CMS is also proposing to add provider appeal provisions related to enrollment denials.

PRACTICAL TAKEAWAYS

The Proposed Rule contains a number of items of good news for the industry:

- A 2.7% rate increase;
- No behavioral adjustments; and
- Making the remote patient monitoring/technology changes set out in the IFR permanent.

CMS decision to make the IFR changes permanent should cause many agencies to take additional steps to implement remote patient monitoring and other technologies. CMS has come to recognize the many benefits of this technology. Agencies will want to be positioned to take advantage of future changes by looking to implement this technology now.

If you have questions or would like additional information about this topic, please contact:

- Robert Markette at (317) 977-1454 or rmarkette@hallrender.com;
- Todd Selby at (317) 977-1440 or tselby@hallrender.com;
- Brian Jent at (317) 977-1402 or bjent@hallrender.com;
- Sean Fahey at (317) 977-1472 or sfahey@hallrender.com; or
- Your regular Hall Render attorney.

More information about Hall Render's Post-Acute and Long-Term Care services can be found here.