PUBLICATION

Proposed CY 2022 Home Health PPS Rule Would Expand Value-Based Purchasing Model and Seeks to Gather Health Equity Data Through Quality Reporting Program

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On July 7, 2021, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule to update the Calendar Year (CY) 2022 Home Health Prospective Payment System (HH PPS) and Value-Based Purchasing (HH VBP) program. In the proposed rule, CMS notes that its experience with the home health value-based purchasing model has been successful enough to warrant adopting the model nationwide earlier than expected. The agency also seeks to gather information to guide its efforts in collecting health equity data that may influence policy development. The proposed rule impacts aspects of home health, hospice, long term care hospital, and inpatient rehabilitation facility care, reimbursement, data collection, and reporting. CMS is accepting comments on the proposed rule through August 27, 2021.

Early Expansion of the Home Health Value-Based Purchasing Model

CMS seeks to capitalize on the success of the CMS Innovation Center HH VBP Model by proposing to end the model in the original model states one year early and expand the model nationwide effective January 1, 2022. The model is designed to incentivize quality of care improvements for older adults and people with disabilities who depend on Medicare for care at home, without denying or limiting coverage or benefits for Medicare beneficiaries. In its last evaluation, the home health agency model participants showed an average 4.6 percent improvement in their quality scores and an average annual savings of $141 million to the Medicare program.

Payment Updates and Policy Changes

CMS proposes the following payment updates and policy changes for home health agencies and home infusion therapy suppliers for CY 2022:

- Patient-Driven Groupings Model (PDGM)

  In January 2020, Medicare implemented the PDGM and a 30-day unit of payment to better align the home health prospective payment system (HH PPS) with patient care needs and ensure that clinically complex beneficiaries had sufficient access to home health care. In implementing these changes, CMS finalized three behavioral assumptions regarding clinical group coding, comorbidity coding, and a low utilization payment amount (LUPA) that resulted in a reduction to the CY 2020 national standardized 30-day payment rate.

  In the proposed rule, CMS seeks comment on the method it describes to fulfill its statutorily mandated responsibility to determine the impact of the differences between the assumed behavior changes and the actual behavior changes, and to adjust the 30-day payment amount accordingly. Relatedly, CMS also proposes:

- recalibrating the PDGM-associated case-mix weights, functional levels, and comorbidity adjustments using the newer CY 2020 data to increase the payment accuracy for the types of patients served by home health agencies;
- maintaining the CY 2021 LUPA thresholds for CY 2022;
- conforming the regulation's language to allow for the implementation of a new statutory provision under which occupational therapists may conduct initial and comprehensive assessments for all Medicare beneficiaries through home health, provided that the plan of care does not initially include skilled nursing care, but does include either physical therapy or speech-language pathology; and
- utilizing a physical therapy LUPA add-on factor as a proxy for the average excess of minutes for the first LUPA periods where the initial and comprehensive visits are conducted by occupational therapists until a more accurate add-on factor may be established using CY 2022 data.

- Home Infusion Therapy Benefit for CY 2022

  CMS proposes fulfilling a separate statutory mandate by updating the home infusion therapy services payment rates for CY 2022. The agency also recommends updating the geographic adjustment factor used for wage adjustment, but maintaining the initial and subsequent visit payment policy finalized in the CY 2020 HH PPS final rule with comment period. Overall, CMS expects the economic impact of the updated home infusion therapy payment rates to be minimal.

Home Health Quality Reporting Program Proposals

CMS makes several proposals regarding the Home Health Quality Reporting Program (HH QRP), including proposed policies to advance health equity, consistent with President Biden's recent Executive Order 13985. The proposed rule includes two Requests for Information (RFI). The first RFI seeks feedback on methods to attain health equity through policy. The agency plans to improve data collection so that it may better measure and analyze disparities across its programs and policies to address significant and persistent inequities in health outcomes among Americans. The second RFI seeks feedback regarding CMS' future plans to define digital quality measures for the HH QRP and on the potential use of Fast Healthcare Interoperability Resources.

In addition, CMS makes several proposals regarding the operation of the HH QRP, specifically:

- improving the home health quality reporting program by removing or replacing certain quality measures;
- introducing a claims-based measure that addresses concerns surrounding attribution with a measure more strongly associated with desired patient outcomes; and
- beginning to collect data on the Transfer of Health Information to Provider-Post Acute Care measure and six categories of standardized patient assessment data elements to better support the coordination of care:

  - home health agencies would begin collecting the data effective January 1, 2023, and
  - long-term care hospitals and inpatient rehabilitation facilities would begin collecting the data effective October 1, 2022.

Home Health Conditions of Participation

The agency proposes to allow home health aides to use interactive telecommunications systems during the 14-day supervisory assessment only for unplanned occurrences that would otherwise interrupt scheduled on-site, in-person visits.

Survey and Enforcement Requirements for Hospice Programs

CMS proposes enhancing the hospice program survey process by changing the composition of survey teams, creating new enforcement mechanisms and authorities, and increasing the role of accrediting organizations (AOs). Specifically, CMS proposes:

- requiring the use of multidisciplinary survey teams;
- prohibiting surveyor conflicts of interest;
- establishing a hospice program complaint hotline;
- creating a Special Focus Program for poor-performing hospice programs;
- providing CMS the authority to impose new enforcement remedies on noncompliant hospice programs to encourage poor-performing hospice programs to come into substantial compliance with CMS requirements before CMS must terminate the hospice's provider agreement; and
- for AOs that accredit and "deem" hospice programs, such as the Accreditation Commission for Health Care, Community Health Accreditation Partner, and the Joint Commission:
  - expanding CMS-based surveyor training to AOs
  - requiring AOs with CMS-approved hospice programs to begin use of the Form CMS-2567.

Interested stakeholders must submit their comments either electronically via www.regulations.gov, or via regular, express, or overnight mail directly to CMS so that they are received by 5:00 p.m. ET on August 27, 2021.

For more information please contact anyone on Baker Donelson's Reimbursement team.