Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

DECEMBER 2021

CY 2022 MEDICARE HH PPS FINAL RULE – CMS-1747-F

On Nov. 9, the Centers for Medicare & Medicaid Services (CMS) published its annual final rule updating the Home Health Prospective Payment System (HH PPS) effective Jan. 1, 2022 through Dec. 31, 2022.

CY 2022 Final Payment Rate

CMS estimated an overall calendar year (CY) 2022 rate update of 3.2% or $570 million. This includes a 3.1% market basket update, the Affordable Care Act (ACA)-mandated productivity market basket reduction of 0.5 percentage points, a 0.7% increase for high-cost outlier cases and a, 0.1% reduction due to the rural add-on phase-out required by the Bipartisan Budget Act of 2018. Home health agencies (HHAs) that do not submit required quality data are subject to a 2.0 percentage point reduction in their payment rate, resulting in a 0.6% update.

Final CY 2022 Payment Rates for 30-Day Periods

CY 2021 30-Day Payment	CY 2022 30-Day Payment	CY 2022 30-Day Payment, No Quality Data
$1,901.12	$2,031.64	$1,992.04

Final CY 2022 National Per-Visit Payment Amounts

HH Discipline	CY 2021 Per-Visit Payment	CY 2022 Per-Visit Payments	CY 2022 Per Visit Payments, No Quality Data
Home Health Aide	$69.11	$71.04	$69.66
Medical Social Services	$244.64	$251.48	$246.58
Occupational Therapy	$167.98	$172.67	$169.31
Physical Therapy	$166.83	$171.49	$168.15
Skilled Nursing	$152.63	$156.90	$153.84
Speech-Language Pathology	$181.34	$186.41	$182.77

Low Utilization Payment Adjustment (LUPA) Thresholds and Patient-Driven Grouping Model (PDGM) Case Mix Weights

CMS will use CY 2020 LUPA thresholds for CY 2022 payment purposes due to the COVID-19 public health emergency (PHE) (see Table 17 in the CY 2020 HH PPS final rule). CMS recalibrated the case-mix weights using CY 2020 data, located in Table 15 of the CY 2022 final rule.

High Cost Outliers and Fixed-Dollar Loss Ratio

A limit of 2.5% of total HH PPS payments are set aside for outliers. CMS caps each HHA's outlier payments at 10% of total PPS payments. CMS finalized a fixed-dollar loss ratio of 0.40 for CY 2022.

Payment Add-On for Rural HHAs

In the CY 2019 HH PPS final rule, CMS finalized rural add-on payments for CYs 2019 through 2022. CMS placed counties into one of three categories for rural add-on payments: (1) high HH utilization (0% add-on for CY 2022); (2) low population density (1% add-on for CY 2022); or (3) all other rural counties and equivalent areas (0% add-on for CY 2022). All rural counties in Illinois are in category 3, meaning rural Illinois HHAs will not receive a rural add-on payment in CY 2022.

Wage Index

CMS applied the federal fiscal year (FFY) 2022 pre-rural floor, pre-reclassified inpatient hospital wage index to the labor-related portion of the HH PPS payment rate. The labor-related share is 76.1%. The final CY 2022 HH wage indexes for Illinois core-based statistical areas (CBSAs) are below:

CY 2022 Final Illinois HH Wage Indexes by CBSA

CBSA	Final Wage Index
Bloomington	0.9269
Cape Girardeau	0.8282
Carbondale-Marion	0.8179
Champaign-Urbana	0.8680
Chicago-Naperville-Evanston	1.0372
Danville	0.9407
Decatur	0.8353
Elgin	1.0232
Kankakee	0.8914
Lake County	1.0047
Peoria	0.8457
Rock Island-Moline	0.8373
Rockford	0.9901
Springfield	0.9136
St. Louis	0.9583
Rural	0.8401

Notice of Admission Process (NOA)

Beginning CY 2022, HHAs will submit a one-time NOA that establishes the home health period of care and covers all contiguous 30-day periods of care until the HHA discharges the beneficiary from Medicare home health services. CMS also finalized a payment reduction if the HHA does not submit the NOA within five calendar days from the start of care. The payment reduction

equals one-thirtieth of the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date until the HHA submits the NOA. For LUPA 30-day periods of care, providers will not receive LUPA payments for days prior to the submission of the NOA. The provider is liable for these days and may not bill the beneficiary for unreimbursed days due to untimely NOA submissions. The payment reduction will not exceed the total claim.

HH Quality Reporting Program (QRP)

HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to their market basket update. For CY 2022, the HH QRP includes the 20 measures listed in Table 28 of the CY 2020 HH PPS final rule.

Beginning CY 2023, CMS will remove the Drug Education on all Medications Provided to Patient/Caregiver measure from the HH QRP. In addition, CMS will replace two measures, (1) Acute Care Hospitalization during the First 60 days of Home Health (NQF # 0171) and (2) Emergency Department Use without Hospitalization during the First 60 Days of Home Health (NQF # 0173), with the Home Health within Stay Potentially Preventable Hospitalization measure.

Beginning April 2022, CMS will publicly report two measures: (1) Percent of Residents Experiencing One or More Major Falls with Injury and Application of Percent of Long-Term Care Hospital Patients with an Admission and (2) Discharge Functional Assessment and a Care Plan that Addresses Function (NQR #2631).

In addition, CMS revised the effective date of the Transfer of Health Information (TOH) to the Provider-Post Acute Care (PAC), TOH Information to the Patient-PAC, and certain Standardized Patient Assessment Data Elements (SPADEs). These measures were delayed due to COVID-19 PHE. CMS will require reporting of these QRP measures beginning Jan. 1, 2023.

Changes to Conditions of Participation (CoPs)

CMS issued numerous waivers specific to CoPs during the COVID-19 PHE. CMS made many of these waivers permanent in the CY 2022 HH PPS final rule.

Specifically, if a patient is receiving skilled care, the home health aide supervisor must complete a supervisory assessment of aide services, either onsite or virtually, to ensure aides are furnishing safe and effective care. This must happen no less frequently than every 14 days. Any areas of concern must be handled on site where the patient is receiving care while the aide is furnishing said care. CMS finalized that HHAs be permitted to use interactive telecommunications systems to aid supervision, which will not exceed one virtual supervisory assessment per patient in a 60-day period. This visit is only to be done in rare instances where an onsite visit cannot be coordinated within the 14-day time period, which is outside of the HHA's control. The details of these circumstances must be documented in the patient's medical record. Interactive telecommunications systems are defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting tow-way, real-time interactive communication between the patient and distant site physician or practitioner.

For patients who are not receiving skilled care services, CMS revised supervisory requirements for aides by maintaining that a registered nurse (RN) make an in-person visit every 60 days, but

removing the requirement that the RN directly observes the aide during these visits and that the aide be present. RNs must also make twice-yearly onsite visits to directly observe each home health aide while they are providing care for each aide in an HHA and for each patient that aide is providing services to.

For aides working in both skilled and non-skilled areas of care, CMS adopted that any deficiency in aide services and all related skills must result in the agency retraining the aide and conducting a competency evaluation for those skills deemed deficient by the RN.

Additionally, CMS will allow occupational therapists (OTs) to complete the initial assessment visit and comprehensive assessment for Medicare patients when occupational therapy is ordered with another qualifying rehabilitation therapy service (i.e. speech language pathology or physical therapy) and when skilled nursing care is not initially in the plan of care.

Occupational Therapy LUPA Add-on Factor

As stated above, CMS will allow OTs to conduct initial and comprehensive assessments for all Medicare beneficiaries when the plan of care does not initially include skilled nursing care, but does include either physical therapy (PT) or speech language pathology (SLP). CMS established a LUPA add-on factor to be used for payment for the first OT visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. However, there is insufficient data regarding initial and comprehensive visits conducted by OTs. Therefore, for CY 2022, CMS will use the PT LUPA add-on factor of 1.6700 as a proxy until there are sufficient CY 2022 data to calculate an accurate OT LUPA add-on factor.

Home Infusion Therapy Services

CMS did not change the three home infusion therapy service payment categories finalized in the CY 2020 HH PPS final rule. The J-Codes associated with each category are in the MLN Matters article entitled "Billing for Home Infusion Therapy Services On or After January 1, 2021."

The CY 2022 Physician Fee Schedule (PFS) included relevant Geographic Adjustment Factor (GAFs) values that are on the Medicare PFS website. CMS will remove the 3.75% increase from the PFS amounts used for the CY 2021 home infusion therapy payment rates and use unadjusted CY 2021 rates for the CY 2022 payment amounts. Beginning in CY 2022, CMS will update the payment amount using the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the 12-month period ending June of the previous year, and then reduced by the multifactor productivity adjustment. Final home infusion therapy 5-hour payment amounts can be found on Table 36 of the CY 2022 Final Home Health Rule.

Home Health Value-Based Purchasing (HHVBP) Model Expansion

On Jan. 8, 2021, CMS announced the national expansion of the HHVBP model to all applicable Medicare-certified HHAs. The first performance year for the expanded HHVBP model is CY 2023, with payment adjustments occurring in CY 2025. CMS will use CY 2022 as a pre-implementation year for all HHAs, allowing time to learn and prepare for this model.

Each HHA will have a reduction or increase to their Medicare payments by up to 5%, depending on its performance on specified quality measures relative to other HHAs. This adjustment

percentage may change in future rulemaking as the original model and the expansion are evaluated.

Measured by both achievement and improvement, HHAs that deliver higher quality care in a given performance year measured against a baseline year relative to peers nationwide could receive a higher payment than they would otherwise be paid. HHAs that do not perform as well as their peers would receive a lower payment.

CMS presents a timeline for the CY 2023 performance year and CY 2025 payment year in Table 32 of the CY 2022 HH final rule. Tables 25 and 26 in the CY 2022 HH final rule show the adopted measures that align with the HH QRP measures. Any HHVBP measures that overlap with an HH QRP measure should be submitted once to meet the data collection requirement for both programs.

Requests for Information

In the CY 2022 HH PPS proposed rule, CMS requested comment on several issues including: Fast Health Interoperability Resourced (FHIR) standards, full digitization of quality measurement, closing the equity gap via post-acute quality reporting programs, and expanding the SPADES measure set to address heath quality. CMS will consider received comments in future rulemaking.

Sources:

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