Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

NOVEMBER 2020

FFY 2021 MEDICARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE – CMS-1735-F

On Nov. 4, the Centers for Medicare & Medicaid Services (CMS) published its annual final rule updating the Home Health Prospective Payment System (HH PPS) effective Jan. 1, 2021 through Dec. 31, 2021.

Medicare began making national, standardized case-mix and wage index adjusted 30-day period payment rate HH PPS payments on Jan. 1, 2020. Payments account for the CY 2019 HH PPS final rule Patient-Driven Groups Model (PDGM) case-mix methodology, and include six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payments for non-routine supplies are included in the 30-day period, but payments for durable medical equipment are not.

CY 2021 HH PPS Final Payment Rate (*pp.70312-70318)*

CMS finalized an overall CY 2021 rate update of 2.0% (2.3% market basket update minus the ACA-mandated productivity market basket reduction of 0.3 percentage points). CMS will also adjust payments by a budget neutrality factor of 0.9999 to account for the wage index. Home health agencies (HHAs) that do not submit required quality data are subject to a 2.0 percentage point reduction, resulting in a 0% rate update.

Proposed CY 2021 Payment Rates for 30-Day Periods

CY 2020 30-Day Payment	CY 2021 30-Day Payment (proposed)	CY 2021 30-Day Payment, No Quality Data (proposed)
$1,864.03	$1,901.12 ($1,911.87)	$1,863.84 ($1,874.64)

CY 2021 National Per-Visit Payment Amounts

HH Discipline	CY 2020 Per-Visit Payment	CY 2021 Per-Visit Payments (proposed)	CY 2021 Per Visit Payments, No Quality Data (proposed)
Home Health Aide	$67.78	$69.11 ($69.53)	$67.76 ($68.17)
Medical Social Services	$239.92	$244.64 ($246.10)	$239.85 ($241.31)
Occupational Therapy	$164.74	$167.98 ($168.98)	$164.69 ($165.69)
Physical Therapy	$163.61	$166.83 ($167.83)	$163.56 ($164.56)
Skilled Nursing	$149.68	$152.63 ($153.54)	$149.64 ($150.55)
Speech-Language Pathology	$177.84	$181.34 ($182.42)	$177.79 ($178.87)

CY 2021 PDGM Low-Utilization Payment Adjustment (LUPA) Thresholds and PDGM Case-Mix Weights *(pp. 70319-70320)*

LUPA thresholds are set at the higher of either the 10th percentile of visits or two visits for each payment group. The LUPA threshold for each 30-day period varies depending on the assigned PDGM payment group. If a 30-day period of care meets the LUPA threshold, CMS pays the full 30-day period case-mix adjustment payment amount. If a 30-day period of care does not meet the LUPA threshold, CMS pays the CY 2021 per-visit payment amount.

In the CY 2019 HH PPS final rule, CMS finalized annual reevaluations for LUPA thresholds for each PDGM payment group using the most current utilization data available at the time of rulemaking. CMS also decided to recalibrate PDGM case-mix weights annually using a fixed effects model and the most recent, complete utilization data available at the time of rulemaking. CY 2020 was the first year of the new case-mix adjustment methodology and 30-day unit of payment; therefore, CMS did not propose any changes to the LUPA thresholds or PDGM case-mix weights for CY 2021. Instead, CMS will maintain the LUPA thresholds and PDGM case-mix weights finalized and shown in Table 16 of the CY 2020 HH PPS final rule for CY 2021 payment purposes.

CMS finalized the below add-on factors for per visit payment amounts for the first skilled nursing, physical therapy, or speech-language pathology visits 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.

Final Add-On Factors for Per Visit Payment Amounts

HH Discipline	CY 2021 LUPA Add-On (Adjustment Factor)
Physical Therapy	$278.61 (1.6700)
Skilled Nursing	$281.62 (1.8451)
Speech-Language Pathology	$294.97 (1.6266)

High Cost Outliers and Fixed-Dollar Loss Ratio (*pp. 70321-70322*)

CMS caps each HHA's outlier payments at 10% of total PPS payments. By law, CMS sets aside a limit of 2.5% of total HH PPS payments for outliers. CMS finalized maintaining the fixed-dollar loss ratio of 0.56 (proposed at 0.63) for CY 2021.

Payment Add-On for Rural HHAs (*pp. 70320-70321*)

CMS finalized rural add-on payments for periods ending during CYs 2021 and 2022 in the CY 2019 HH PPS final rule. CMS categorized counties for the rural add-on as: (1) high HH utilization; (2) low population density; or (3) all other rural counties and equivalent areas. All rural counties in Illinois are in the "all other" category through CY 2022, meaning rural Illinois HHAs will not receive a rural add-on payment. More information, including county classifications, are on CMS' website.

Wage Index (*pp. 70306-70312*)

CMS finalized using the federal fiscal year (FFY) 2021 pre-rural floor, pre-reclassified inpatient hospital wage index to adjust payment rates under the HH PPS for CY 2021. CMS applies the wage index to the labor-related portion of the HH payment rate. CMS finalized maintaining a labor-related share of 76.1% for CY 2021 (based on the FFY 2016 Medicare cost report).

CMS adopted updates to the Core-Based Statistical Areas (CBSAs) for all providers based on the delineations published in the September 2018 Office of Management and Budget (OMB) Bulletin No. 18-04. This reassigns or alters some counties, which may affect the wage index for some providers. To alleviate significant losses in revenue caused by this change, CMS finalized a two-year transition period, adopting these new CBSA assignments effective Jan. 1, 2021 along with a 5% cap on the reduction of a provider's wage index for CY 2021 compared to its wage index for CY 2020. The full reduction will be in effect for CY 2022.

Illinois Counties with New CBSA under OMB Bulletin No. 18-04

County	Current CBSA	New CBSA	Wage Index with 5% Cap
DeWitt	Bloomington, IL	Rural	0.8773
Ford	Champaign-Urbana, IL	Rural	0.8297
Fulton	Rural	Peoria, IL	0.8644
Johnson	Rural	Carbondale, IL	0.8184
Cook	Chicago-Naperville-Arlington Heights, IL	Chicago-Naperville-Evanston, IL	1.0442
DuPage	Chicago-Naperville-Arlington Heights, IL	Chicago-Naperville-Evanston, IL	1.0442
Grundy	Chicago-Naperville-Arlington Heights, IL	Chicago-Naperville-Evanston, IL	1.0442
Kendall	Chicago-Naperville-Arlington Heights, IL	Elgin, IL	1.0559
McHenry	Chicago-Naperville-Arlington Heights, IL	Chicago-Naperville-Evanston, IL	1.0442
Will	Chicago-Naperville-Arlington Heights, IL	Chicago-Naperville-Evanston, IL	1.0442

CY 2021 Illinois HH Wage Indexes by CBSA

Core-Based Statistical Area	Proposed Wage Index with 5% Cap
Bloomington	0.9114
Cape Girardeau	0.8019
Carbondale-Marion	0.8184
Champaign-Urbana	0.8655
Chicago-Naperville-Evanston	1.0442
Danville	0.9032
Decatur	0.8326
Elgin	1.0559
Kankakee	0.9068
Lake County	1.0192
Peoria	0.8644
Rock Island-Moline	0.8606
Rockford	0.9693
Springfield	0.9256
St. Louis	0.9317
Rural	0.8297

Requests for Anticipated Payment and Notice of Admission Process (*pp. 70318-70320)*

In the CY 2020 HH PPS final rule, CMS finalized policies specific to Requests for Anticipated Payment (RAP) and the Notice of Admission (NOA) Process for the CY 2021 payment year. CMS lowered the up-front payment for RAPs to 0% for all 30-day periods of care beginning on or after Jan. 1, 2021. For CY 2021, all HHAs (both existing and newly enrolled) will submit a RAP at the beginning of each 30-day period to establish the home health period of care in the common working file, and trigger consolidated billing edits. Beginning in 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 discharge.

For both the submission of the RAP in CY 2021 and the one-time NOA for CYs 2022 and beyond, CMS finalized a payment reduction if the HHA does not submit these documents within five calendar days from the start of care. The payment reduction is equal to a one-thirtieth

reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submits the RAP or NOA. For LUPA 30-day periods of care in which an HHA fails to submit a timely RAP or NOA, providers will receive no LUPA payments for days that fall within the period of care prior to submission.

Use of Technology under the Medicare Home Health Benefit (*pp. 70322-70325)*

In response to the COVID-19 pandemic, CMS made several interim changes regarding use of technology under the Medicare HH benefit. In this rule, CMS finalized use of telecommunications technology as part of the home health plan of care as long as the use of such technology does not substitute for ordered in-person visits. Providers must link the use of telecommunications or audio-only technologies to patient-specific needs as identified in the comprehensive assessment; however, a description of how such technology helps to achieve goals outlined in the plan of care is not necessary. Additionally, CMS finalized allowing HHAs to report telehealth and telemedicine beyond the public health emergency as allowable costs on line 5 of the HHA cost report.

HH Quality Report Program (QRP) (*pp. 70326-70328*)

CMS did not propose or finalize any changes or updates to the HH QRP for CY 2021. The quality measure currently adopted for the CY 2022 HH QRP are included in Table 12 of the final rule on *Federal Register* page 70327. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to their market basket.

Proposed Changes to the Conditions of Participation (CoPs) OASIS (*p. 70328-70330*)

CMS made recent enhancements to the system HHAs use to submit OASIS data. The new system, entitled internet Quality Improvement & Evaluation System (iQIES), is internet-based and no longer supports the use of test or fake CMS Certification Numbers (CCNs). Instead, HHAs are no longer limited to two users for submission of assessment data, and the iQIES system requires users to include a valid CCN with their iQIES user role request. This makes it impossible for new HHAs that do not yet have a CCN to submit test data. HHAs must be able to submit assessments in order for the claims match process to occur and relay the data needed for payment under the PDGM system. CMS states that the link to the payment process gives HHAs strong incentive to ensure that they can successfully submit their OASIS assessments.

Home Infusion Therapy Services (*pp. 70330-70347*)

CMS finalized several provisions specific to home infusion therapy services in the CY 2019 and CY 2020 HH PPS final rules. These provisions go into effect Jan. 1, 2021.

CMS finalized three payment categories that become permanent in CY 2021:

- Payment Category 1 – intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including, but not limited to, antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs;
- Payment Category 2 - subcutaneous infusions for therapy or prophylaxis, including, but not limited to, certain subcutaneous immunotherapy infusions; and
- Payment Category 3 – intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.

See Table 13 for the J-Codes associated with each category.

For services per visit furnished Jan. 1, 2021 and after, home infusion payments will continue to be bundled and set at an amount equal to five hours of home infusion therapy for each infusion drug administration day. See Table 14 for finalized CPT codes for CY 2021 home infusion drug payments. CY 2021 payment rates are not yet available; the final CY 2021 Physician Fee Schedule (PFS) will include finalized rates.

For home infusion therapy services beginning in CY 2021, physicians should continue the current practice of discussing options for infusion therapy for Part B and noting these discussions in the patient's records prior to establishing a plan of care. CMS may consider additional requirements if this practice is found insufficient for providing infusion therapy options in the future.

In this CY 2021 final rule, CMS excluded home infusion therapy services covered under the home infusion therapy benefit from the home health benefit. Additionally, CMS will increase payment amounts for the three payment categories for the first visit of a given year by the relative payment rate for a new patient rate over an existing patient using the physician evaluation and management (E/M) payment amounts, decreasing subsequent payments in a budget-neutral manner. A patient must be discharged for more than 60 days for a first visit to be billed again.

Beginning in CY 2022, CMS will increase the single payment amount by the percent increase in the Consumer Price Index for all urban customers (CPI-U) for the 12-month period ending with June of the preceding year. This is then reduced by the 10-year moving average of economy-wide private nonfarm multifactor productivity (MFP). This may result in payments being lower than the preceding year.

Contact:

Please contact IHA

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Centers for Medicare & Medicaid Services. Home Health Agency CBSA Designations. Available from: https://www.cms.gov/files/zip/cy-2021-hh-pps-wage-index.zip-0. Accessed November 12, 2020.