



EDUCATIONAL RESOURCES

HOME HEALTH FINAL RULE CY 2021

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EDUCATIONAL RESOURCES

"CHANGE IS THE ONLY
CONSTANT IN LIFE".

— HERACLITUS

OVERVIEW

✓ Home Health Payment Rate Updates

✓ Use of Telecommunications Technology

✓ Care Planning for Medicare Home Health Services

✓ Home Infusion Therapy Services

✓ RAPs



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HOME HEALTH PAYMENT RATE UPDATES

CY 2021 HOME HEALTH PAYMENT RATE UPDATES – MARKET BASKET UPDATE

- The proposed rule set the update at 2.7% - using a market basket increase of 3.1 % and a Multifactor Productivity Adjustment (MFP) of 0.4 % point.
- The final rule however, results in a reduction of the annual update of payment rates to 2.0 % - market basket increase of 2.3 %- less 0.3 % points Multifactor Productivity Adjustment - MFP.
- This lower update (2.3 %) for CY 2021, relative to the proposed rule (3.1 %), is primarily driven by slower anticipated compensation growth for both health-related and other occupations - as labor markets are expected to be significantly impacted during the recession that started in February 2020 and throughout the anticipated recovery.

CY 2021 HOME HEALTH PAYMENT RATE UPDATES

- For those home health agencies that *do not* submit quality data as required, they will continue to have their home health payment update percentage decreased by 2.0 percentage points.
- The home health payment update percentage would be 0.0 percent (2.0 percent minus 2.0 percentage points).

CY 2021 – STANDARDIZED 30-DAY PAYMENT QUALITY DATA SUBMITTED

TABLE 7: CY 2021 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

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 0.9999	X 1.020	\$1,901.12

CY 2021 – STANDARDIZED 30-DAY PAYMENT QUALITY DATA NOT SUBMITTED

TABLE 8: CY 2021 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2020 National, Standardized 30-Day Budget Neutral (BN) Period Payment	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update Minus 2 Percentage Points	CY 2021 National, Standardized 30-Day Period Payment
\$1,864.03	X 0.9999	X 1.000	\$1,863.84

CY 2021 – LUPAS PER VISIT PAYMENT AMOUNT – QUALITY DATA SUBMITTED

TABLE 9: CY 2021 NATIONAL PER-VISIT PAYMENT AMOUNTS

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 0.9997	X 1.020	\$69.11
Medical Social Services	\$239.92	X 0.9997	X 1.020	\$244.64
Occupational Therapy	\$164.74	X 0.9997	X 1.020	\$167.98
Physical Therapy	\$163.61	X 0.9997	X 1.020	\$166.83
Skilled Nursing	\$149.68	X 0.9997	X 1.020	\$152.63
Speech-Language Pathology	\$177.84	X 0.9997	X 1.020	\$181.34

CY 2021 – LUPAS PER VISIT PAYMENT AMOUNT – QUALITY DATA NOT SUBMITTED

TABLE 10: CY 2021 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline	CY 2020 Per-Visit Rates	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update Minus 2 Percentage Points	CY 2021 Per-Visit Rates
Home Health Aide	\$67.78	X 0.9997	X 1.000	\$67.76
Medical Social Services	\$239.92	X 0.9997	X 1.000	\$239.85
Occupational Therapy	\$164.74	X 0.9997	X 1.000	\$164.69
Physical Therapy	\$163.61	X 0.9997	X 1.000	\$163.56
Skilled Nursing	\$149.68	X 0.9997	X 1.000	\$149.64
Speech- Language Pathology	\$177.84	X 0.9997	X 1.000	\$177.79

CY 2021 – RURAL ADD ON

- Rural Add-on Payments for CYs 2019 through CY 2022

TABLE 11: HH PPS RURAL ADD-ON PERCENTAGES, CYs 2019-2022

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

WAGE INDEX

- Labor Market Delineations
 - Urban Counties Becoming Rural
 - 34 counties would change to rural status
 - Rural Counties Becoming Urban
 - 47 counties designated rural would change to urban
 - Urban Counties Moving to a Different Urban CBSA
 - Several urban counties would shift from one urban CBSA to another urban CBSA
 - Some CBSAs have counties that would split off to become part of or to form entirely new labor market areas
- Transition
 - 5% Cap on any decrease in a geographic area's wage index from prior calendar year
- Check to see if your agency will be affected



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USE OF TELECOMMUNICATIONS TECHNOLOGY

TELEHEALTH – COVID WAIVERS

- Allows home health agencies to provide all necessary telehealth during emergency period
 - Technology used to minimize the risk of exposure to clinicians, patients and the public during the PHE for the COVID-19 pandemic.
- Acknowledges that the use of telehealth technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.
- Telehealth must be ordered by physician or allowed practitioner and be on the plan of care.
- Plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and describe how the use of such technology is tied to the patient-specific needs as identified in the comprehensive assessment and will help to achieve the goals outlined on the plan of care.
- Telehealth services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment.

TELEHEALTH FINAL RULE

- CMS proposed to:
 - Finalize the amendment to § 409.43(a) as set out in the March 2020 COVID-19 IFC beyond the period of the COVID-19 PHE.
 - Allow home health agencies to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report to reflect a broader use of telecommunications technology.
 - Specifically, CMS proposed to amend § 409.46(e) to include not only remote patient monitoring, but other communication or monitoring services, consistent with the plan of care for the individual.

TELEHEALTH FINAL RULE

- CMS reminded home health agencies:
 - Access to telecommunications technology must be accessible, including for patients with disabilities.
 - Home health CoPs at § 484.50(f)(1) require that information be provided to persons with disabilities in plain language and in a manner that is accessible and timely, including accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the ADA, section 1557 of the ACA, and section 504 of the Rehabilitation Act.
 - Appendix B of the State Operations Manual (regarding home health services) provides detailed examples of “auxiliary aids and services”

TELEHEALTH FINAL RULE

- CMS reiterated the expectation that:
 - Services provided by telecommunications technology are services that could also be provided through an in-person visit.
 - If there is a service that cannot be provided through telecommunications technology (for example, wound care which requires in-person, hands-on care), the HHA must make an in-person visit to furnish such services).
 - HHAs cannot discriminate against any individual who is unable or unwilling to receive home health services provided via telecommunications technology.
 - In those circumstances, the HHA must provide such services through in-person visits.

TELEHEALTH FINAL RULE

- Telecommunications technology to provide services in the home has the potential to:
 - improve efficiencies,
 - expand the reach of healthcare providers,
 - allow more specialized care in the home, and
 - allow home health agencies to see more patients or to communicate with patients more often.

TELEHEALTH FINAL RULE

- CMS expects physicians and allowed practitioners to only order services to be furnished via telehealth, including remote patient monitoring, when
 - it is in the best interest of each individual patient and
 - after it has been determined that the patient would benefit from services furnished in this manner, as in-person care in the patient's home is the hallmark of the home health benefit.
- CMS plans to monitor and analyze the cost report data and, as with all allowable administrative costs, and expects HHAs to be diligent and accurate in their reporting of these costs.

TELEHEALTH FINAL RULE – AUDIO ONLY VISITS APPROVED

- CMS clarified that audio-only (telephone) technology may continue to be utilized to furnish skilled home health services after the expiration of the PHE.
 - Audio-only telephone calls are not considered a visit for purposes of eligibility or payment and cannot replace in-person visits as ordered on the plan of care.
- Like telecommunications technology, if audio-only services are ordered by the physician or allowed practitioner to furnish a skilled service, this must be included on the plan of care.
- The home health agency and patient's physician/practitioner must determine whether such audio-only technology can meet the patient's needs.

TELEHEALTH FINAL RULE

- Any provision of remote patient monitoring or other services furnished via a telecommunications system or audio-only technology:
 - Must be included on the plan of care
 - Cannot substitute for a home visit ordered as part of the plan of care
 - Cannot be considered a home visit for the purposes of eligibility or payment

TELEHEALTH FINAL RULE

- Requires that telecommunications technology or audio-only technology be tied to the patient-specific needs as identified in the comprehensive assessment.
- However, *will not require* on the plan of care, a description of how technology will help to achieve the goals outlined on the plan of care.
- CMS expects to see documentation of how such services will be used to help achieve the goals outlined on the plan of care throughout the medical record when such technology is used.



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CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

- The CARES Act allowed regulatory discretion regarding the requirements for nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs).
- That is, NPs, CNSs and PAs (as those terms are defined in the Act), would be able to practice at the top of their state licensure to certify eligibility for home health services, as well as establish and periodically review the home health plan of care.
- However, stated in the CARES Act is that NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs services.
- HHAs or other practitioners should check with the relevant state licensing authority websites to ensure that practitioners are working within their scope of practice and prescriptive authority.

CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

- May 2020 COVID-19 waivers, CMS amended the regulations to define an NP, a CNS, and a PA as an “allowed practitioner”.
- This means that in addition to a physician an “allowed practitioner” may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit.
- CMS amended the regulations so that they would expect the allowed practitioner to also perform the face-to-face encounter for the patient they are certifying eligibility.
- However, if a face-to-face encounter is performed by an allowed non-physician practitioner (NPP) in an acute or post-acute facility, from which the patient was directly admitted to home health, the certifying practitioner may be different from the provider performing the face-to-face encounter.
- These regulation changes were not time limited to the period of the COVID-19 PHE.

CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

- CMS inadvertently did not update the regulations in the CARES Act with the May 2020 COVID-19 IFC waivers regarding the “allowed practitioners” who can certify and establish home health services.
- Therefore, in the final rule CMS finalized regulation text changes at § 409.64(a)(2)(ii), 410.170(b), and 484.110 regarding allowed practitioner certification as a condition for payment for home health services.



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HOME INFUSION THERAPY

HOME INFUSION THERAPY SERVICES

- On December 13, 2016, the 21st Century Cures Act was enacted into law.
- Section 5012 of this new law established a new Medicare home infusion therapy benefit.
- The BBA of 2018 was amended that established a home infusion therapy services *temporary transitional payment* for eligible home infusion suppliers for certain items and services furnished of transitional home infusion drugs beginning January 1, 2019.
- The Transitional payment system ends the day before the full implementation of the home infusion therapy services benefit on January 1, 2021.
- CMS gave regulatory authority for oversight of HIT suppliers to the accrediting organizations (AOs) that have their program approved by CMS.

21ST CENTURY CURES ACT – HIT

- Effective January 1, 2021, the 21st Century Cures Act created a separate Medicare Part B benefit category for coverage of home infusion therapy services needed for the safe and effective administration of certain drugs and biologicals administered:
 - Either intravenously, or subcutaneously with an administration period of 15 minutes or more.
 - At an individual's home through a DME *pump*.
- The infusion pump and supplies (including home infusion drugs) will continue to be covered under the Part B DME benefit.
- Drugs not included in home infusion benefit:
 - Drugs that are identified on the self-administered drug exclusion list, which is set by Medicare Administrative Contractors (MACs).
 - Insulin pumps.
- 20% Co-pay under the Medicare Part B benefit

21ST CENTURY CURES ACT PROVISIONS – HOME INFUSION THERAPY

- Services explicitly covered by Cures Act are: Necessary for the safe and effective administration of home infusion drugs.
- A single payment is made to a qualified home infusion therapy supplier for the items and services.
 - Professional services, including nursing services, furnished in accordance with the plan.
 - Training and education (not otherwise paid for as durable medical equipment).
 - Remote monitoring and other monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier; which are furnished in the home.

21ST CENTURY CURES ACT PROVISIONS – HOME INFUSION THERAPY

- The single payment:
 - Must take into account types of infusion therapy, including variations in utilization of services by therapy type.
 - Is required to be adjusted to reflect geographic wage index and other costs that may vary by region, patient acuity and complexity of drug administration.
 - May be adjusted to reflect outlier situations and other factors as deemed appropriate by the Secretary, which are required to be done in a budget-neutral manner.

21ST CENTURY ACT PROVISIONS

- The single payment amount for each infusion drug administration calendar day, including the required adjustments and the annual update, cannot exceed the amount determined under the fee schedule for infusion therapy services if furnished in a physician's office.
- This statutory provision limits the single payment amount so that it cannot reflect more than 5 hours of infusion for a particular therapy per calendar day.
- Patient must be under care of applicable provider:
 - physician,
 - nurse practitioner, or
 - physician assistant
- Patient must receive therapy in the individual's home.

21ST CENTURY CURES ACT PROVISIONS – HOME INFUSION THERAPY

- Patient has to be under a physician established plan of care that prescribes the type, amount and duration of infusion therapy services that are to be furnished and must be periodically reviewed by a physician.
- The skilled services provided on an infusion drug administration calendar day must be so inherently complex that they can only be safely and effectively performed by, or under the supervision of, professional or technical personnel.
- CMS doesn't specify the disciplines that may provide the home infusion therapy services; they say the provider must be furnishing services within the scope of his/her practice.

QUALIFIED HOME INFUSION THERAPY SUPPLIERS & PROFESSIONAL SERVICES

- A “qualified home infusion therapy supplier” is a:
 - pharmacy,
 - physician, or
 - other provider of services or supplier licensed by the State in which the pharmacy, physician, or provider of services or supplier furnishes items or services.

QUALIFIED HOME INFUSION THERAPY SUPPLIERS & PROFESSIONAL SERVICES

- The qualified home infusion therapy supplier must:
 - furnish infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs;
 - ensure the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis;
 - be accredited by an organization designated;
 - meet other requirements as deemed appropriate, taking into account the standards of care for home infusion therapy established by Medicare Advantage (MA) plans under Part C and in the private sector.
- The supplier may subcontract with a pharmacy, physician, other qualified supplier or provider of medical services, in order to meet these requirements.

QUALIFIED HOME INFUSION THERAPY SUPPLIERS & PROFESSIONAL SERVICES

- Payment to a qualified HIT supplier is for an infusion in the individual's home, only for the date when services were to administer the drugs to the individual.
- It is necessary for the qualified home infusion therapy supplier to be in the patient's home, on occasions when the drug is being administered, in order to provide an accurate assessment to the physician responsible for ordering the home infusion drug and services.
- The services provided would include:
 - patient evaluation and assessment;
 - training and education of patients and their caretakers,
 - assessment of vascular access sites and obtaining any necessary bloodwork; and
 - evaluation of medication administration.

QUALIFIED HOME INFUSION THERAPY SUPPLIERS AND PROFESSIONAL SERVICES

- Visits made only for venipuncture on days where there is no administration of the infusion drug would not be separately paid because the single payment includes all services for administration of the drug.
- Payment for an infusion drug administration calendar day is a bundled payment, which reflects not only the visit itself, but any necessary follow-up work (which could include visits for venipuncture), or care coordination provided by the qualified home infusion therapy supplier.
- The home infusion benefit is a separate payment in addition to the existing payment made under the DME benefit;
 - Professional services covered under the DME benefit are not covered under the home infusion benefit.
 - The services are billed and paid for under separate payment systems.

HOME INFUSION THERAPY & INTERACTION WITH THE HOME HEALTH BENEFIT

- Because a qualified HIT supplier is not required to become accredited as a Part B DME supplier or to furnish the home infusion drug, and because payment is determined by the provision of services furnished in the patient's home, CMS acknowledged the potential for overlap between the new home infusion therapy services benefit and the home health benefit.
- CMS stated that a beneficiary is *not required to be considered homebound* in order to be eligible for the home infusion therapy services benefit;
 - however, there may be instances where a beneficiary under a home health plan of care also requires home infusion therapy services.
- Because the Act excludes home infusion therapy from home health services effective on January 1, 2021, CMS stated that a beneficiary *may utilize both benefits concurrently*.

HOME INFUSION THERAPY & INTERACTION WITH THE HOME HEALTH BENEFIT

- Since the HHA & the HIT supplier furnish services in the individual's home, and could be the same agency, the best process for payment for furnishing home infusion therapy services to beneficiaries who qualify for both benefits is:
 - If a patient receiving home IV's under a HH POC & receives a visit that is unrelated to home infusion therapy, then payment for the home health visit would be covered by the HH PPS and billed on the home health claim.
 - If the patient receives a visit exclusively for administration of IV's, the HHA would submit a home infusion therapy services claim under the home infusion therapy services benefit only.
 - If the home visit includes both home health services in addition to, and separate from IV services, the HHA would submit both a home health claim under the HH PPS and a home infusion therapy services claim under the HIT services benefit.
- The agency must separate the time spent furnishing services covered under the HH PPS from the time spent furnishing services covered under the home infusion therapy services benefit.

PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HIT SERVICES FOR CY 2021

- There are 3 payment categories with associated J-codes –
 - a single amount to be paid for HIT services furnished on each infusion drug administration calendar day.
- Payment amount for each of these 3 categories is different, though each category has its associated single payment amount.
- There are only 32 drugs that are covered as part of these categories

PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HIT SERVICES FOR CY 2021

- The single payment amount (per category) reflects variations in nursing utilization, complexity of drug administration, and patient acuity, as determined by the different categories based on therapy type
 - Payment category 1 includes certain intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs.
 - Payment category 2 includes subcutaneous infusions for therapy or prophylaxis, including certain subcutaneous immunotherapy infusions.
 - Payment category 3 includes intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.
 - The payment category for subsequent transitional home infusion drug additions to the LCD and compounded infusion drugs not otherwise classified, as identified by HCPCS codes J7799 and J7999, will be determined by the DME MACs.

PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HIT SERVICES FOR CY 2021

- There are some drugs that are paid for under the transitional benefit but are not a part of the permanent benefit beginning with 2021. *The following are not or will no longer be covered.*
 - Insulin pump systems
 - A self-administered drug or biological on a self-administered drug exclusion list. For example, Hizentra, a subcutaneous immunoglobulin, is listed on a self-administered drug (SAD) exclusion list by the MACs. HIT services related to the administration of Hizentra are covered under the temporary transitional payment; since it is on a SAD exclusion list, services related to the administration of this biological are not covered under the benefit in 2021.

PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HIT SERVICES FOR CY 2021

- There are some drugs that are paid for under the transitional benefit but are not a part of the permanent benefit beginning with 2021. *The following are not or will no longer be covered.*
 - Intrathecal administration- HIT services related to the administration of Ziconotide and Floxuridine are also excluded, these drugs are given via intrathecal and intra-arterial routes; they do not meet the definition of home infusion drug. Home infusion services related to the intrathecal administration of Morphine is excluded because intrathecal administration does not meet the definition of a home infusion drug under the permanent benefit.
 - Infusion drugs not otherwise classified are assigned to the most appropriate category. If the Medicare Administrative Contractor that processes DME claims determines them to be covered drugs.

INFUSION DRUG J-CODES

TABLE 13: INFUSION DRUG J-CODES ASSOCIATED WITH HOME INFUSION THERAPY SERVICE PAYMENT CATEGORIES FOR CY 2021

J-Code	Drug
Category 1	
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin b, 50 mg
J0287	Injection, amphotericin b lipid complex, 10 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg
J0289	Injection, amphotericin b liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine hydrochloride, per 250 mg
J1265	Injection, dopamine hcl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1457	Injection, gallium nitrate, 1 mg
J1570	Injection, ganciclovir sodium, 500 mg

INFUSION DRUG J-CODES

TABLE 13: INFUSION DRUG J-CODES ASSOCIATED WITH HOME INFUSION THERAPY SERVICE PAYMENT CATEGORIES FOR CY 2021

J-Code	Drug
J2175	Injection, meperidine hydrochloride, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, treprostinil, 1 mg
Category 2	
J1555 JB*	Injection, immune globulin (cuvitru), 100 mg
J1558 JB*	Injection, immune globulin (xembify), 100 mg
J1561 JB*	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg
J1562 JB*	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB*	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1575 JB*	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
Category 3	
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg

*The JB modifier indicates that the route of administration is subcutaneous.

CY 2021 PAYMENT AMOUNTS FOR HIT SERVICES – 5 HOUR PAYMENT AMOUNTS

- 5-hour payment amounts reflect the increased payment for the first visit and the decreased payment for all subsequent visits.
- CMS plans on monitoring HIT service lengths of visits, both initial and subsequent, to evaluate whether the data substantiates the increase or whether they should re-evaluate whether, or how much, to increase the initial visit payment amount.

TABLE 16: 5-HOUR PAYMENT AMOUNTS REFLECTING PAYMENT RATES FOR FIRST AND SUBSEQUENT VISITS

CPT Code	Description	Proposed 2021 PFS Amount	5-hour Payment - First Visit	5-hour Payment - Subsequent Visits
96365	Ther, Proph, Diag IV/IN infusion 1 hr	\$72.26	\$188.85 (category 1)	\$156.83 (category 1)
96366	Ther, Proph, Diag IV/IN infusion add hr	\$21.61		
96369	Sub Q Ther Inf 1 hr	\$156.46	\$256.83 (category 2)	\$213.27 (category 2)
96370	Sub Q Ther Inf add hr	\$14.84		
96413	Chemo Inf 1 hr	\$146.14	\$319.80 (category 3)	\$265.57 (category 3)
96415	Chemo Inf add hr	\$30.65		

Note: Rates are calculated using proposed CY 2021 PFS rates.

PAYMENT ADJUSTMENTS FOR CY 2021 HOME INFUSION THERAPY SERVICES

- Home Infusion Therapy Geographic Wage Index Adjustment
- The Geographic Adjustment Factor (GAF) to adjust home infusion therapy payments is based on differences in geographic wages.
- The appropriate GAF value is applied to the HIT single payment amount based on the site of service of the beneficiary and the adjustment will happen on the PFS based on the beneficiary zip code professional and supplier claims form.
- The list of GAFs by locality for this final rule is available as a downloadable file at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-InfusionTherapy/Overview.html>

HIT SERVICES – PROFESSIONAL SERVICES, TRAINING & EDUCATION (NOT COVERED UNDER THE DME BENEFIT), & REMOTE MONITORING SERVICES FOR THE PROVISION OF HOME INFUSION DRUGS:

- Training and education on care and maintenance of vascular access devices-- –
 - Hygiene Education;
 - Instruction on what to do in the event of a dislodgement or occlusion;
 - Education on signs and symptoms of infection;
 - Teaching and training on flushing and locking the catheter.

HIT SERVICES – PROFESSIONAL SERVICES, TRAINING & EDUCATION (NOT COVERED UNDER THE DME BENEFIT), & REMOTE MONITORING SERVICES FOR THE PROVISION OF HOME INFUSION DRUGS

- Dressing changes and site care.
- Patient assessment and evaluation:
 - Review history and assess current physical and mental status, including obtaining vital signs; Assess any adverse effects or infusion complications;
 - Evaluate family and caregiver support ;
 - Review prescribed treatment and any concurrent oral and/or over-the-counter treatments;
 - Obtain blood for laboratory work

HIT SERVICES – PROFESSIONAL SERVICES, TRAINING & EDUCATION (NOT COVERED UNDER THE DME BENEFIT), & REMOTE MONITORING SERVICES FOR THE PROVISION OF HOME INFUSION DRUGS:

- Medication and disease management education–
 - Instruction on self-monitoring;
 - Education on lifestyle and nutritional modifications;
 - Education regarding drug mechanism of action, side effects, interactions with other medications, adverse and infusion-related reactions;
 - Education regarding therapy goals and progress;
 - Instruction on administering pre-medications and inspection of medication prior to use;
 - Education regarding household and contact precautions and/or spills;

HIT SERVICES – PROFESSIONAL SERVICES, TRAINING & EDUCATION (NOT COVERED UNDER THE DME BENEFIT), & REMOTE MONITORING SERVICES FOR THE PROVISION OF HOME INFUSION DRUGS:

- Remote monitoring services.
- Monitoring services:
 - Communicate with patient regarding changes in condition and treatment plan;
 - Monitor patient response to therapy; and
 - Assess compliance.
- The preceding list is not all-inclusive, as the physician is responsible for ordering the reasonable and necessary services for the safe and effective administration of the home infusion drug.

HOME INFUSION THERAPY SERVICES EXCLUDED FROM THE MEDICARE HOME HEALTH BENEFIT

- Exclude home infusion therapy from the definition of home health services, effective on January 1, 2021.
- While patients needing home infusion therapy are not required to be eligible for the home health benefit, they can use both the home infusion therapy and home health benefits concurrently.
- Home health agencies may become accredited and enroll as qualified home infusion therapy suppliers.
- When a home health agency is furnishing services to a patient receiving an infusion drug not defined as a home infusion drug, those services may still be covered as home health services.



EDUCATIONAL RESOURCES

ENROLLMENT REQUIREMENTS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

ENROLLMENT REQUIREMENTS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

- CMS outlines standards for home infusion therapy suppliers and specifies a definition of “qualified home infusion therapy supplier” at § 486.505.
- A supplier of home infusion therapy must meet all the following:
 - Furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs.
 - Ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis.
 - Is accredited by an organization approved by CMS.
 - Meets such other requirements as CMS determines appropriate:
 - One of CMS’ principal oversight roles is to protect the Medicare program from fraud, waste and abuse. This is accomplished in part through the careful screening and monitoring of prospective and existing providers and suppliers.

ENROLLMENT REQUIREMENTS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

- Approved Accrediting Organizations:
 - Accreditation Commission for Health Care (ACHC)
 - Community Health Accreditation Partner (CHAP)
 - National Association of Boards of Pharmacy (NABP)
 - The Compliance Team (TCT)
 - The Joint Commission (TJC)
 - Utilization Review Accreditation Commission (URAC)

ENROLLMENT REQUIREMENTS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

- A home infusion supplier must:
 - complete and submit the Form CMS-855B application to its applicable MAC
 - certify via the Form CMS-855B that it meets and will continue to meet the specific requirements and standards for enrollment
 - Pay Application Fee - \$595
 - Be accredited as such by a CMS-recognized home infusion therapy supplier accreditation organization in order to enroll and remain enrolled in Medicare
 - Be compliant with conditions of payment related to Plan of care requirements, Requirement for Payment, and be enrolled in Medicare
 - Successfully complete the limited categorical risk level of screening under § 424.518



EDUCATIONAL RESOURCES

RAP SUBMISSION

CY 2021 – RAP SUBMISSION

- Agencies ***Will Not*** get a RAP payment starting in 2021
- **No pay RAP submission – both new and existing HHAs**
 - All 30-day periods beginning on or after January 1, 2021
- **RAP must be submitted & accepted within 5 calendar days of the first day of the 30-day payment period**
 - Failure to submit within 5 calendar days will result in payment reduction 1/30th each day from day 1 of the period until the day before the RAP is accepted
 - LUPA 30-Day Period of Care
 - If HHA fails to submit a timely RAP, no LUPA payments for days that fall within the period of care prior to the submission of the RAP

CY 2022 – NOTICE OF ADMISSION (NOA)

- **One-time** Notice of Admission to establish HH period within 5 calendar days from SOC
 - Establishes the home health period of care and covers all contiguous 30-day periods of care until the patient is discharged
- Failure to submit within 5 calendar days will result in payment reduction 1/30th each day from SOC until the day before the NOA is accepted
- LUPA 30-Day Period of Care
 - If the home health agency fails to submit a timely NOA, no LUPA payments for days that fall within the period of care prior to the submission of the NOA

INFORMATION REQUIRED FOR RAP SUBMISSION

- The information an agency needs to submit a RAP beginning January 2021 will be less than in 2020.
- Agencies are to submit the RAP when:
 - **1.** The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented as required at 42 Code of Federal Regulations (CFR) Sections § 484.60(b) and § 409.43(d); and
 - **2.** The initial visit within the 60-day certification period has been made and the individual is admitted to home health care [84 FR 60548].

INFORMATION REQUIRED FOR RAP SUBMISSION

- Coding, OASIS and the plan of care will not be required to be complete in order to submit a RAP in 2021.
- There is a requirement that a HIPPS code be present on the RAP.
 - CMS has clarified that any HIPPS code may be used.
 - Consider having a standard HIPPS code in your billing system to be used on all RAPs.
- The HIPPS code on RAPs in 2021 will need to match the HIPPS codes on the final claims and a generic HIPPS code is recommended on the Final as well - - no impact to reimbursement due to the MAC calculating the HIPPS code that you are paid for.
- The info needed to submit a RAP in calendar year 2021 will mirror the one-time NOA process which begins in 2022.

RAP SUBMISSION

- When the plan of care dictates multiple 30-day periods of care will be required to effectively treat the patient, HHAs will be allowed to submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time.

RAP – AGENCY SUBMISSION VS MAC ACCEPTANCE

- Agency submission and MAC acceptance dates are different
 - Hospices have the same issue with the Notice of Election (NOE) process that has been in place for several years.
- The RAP penalty begins at the start of the period through the day before the RAP is accepted.
- The date the agency files the RAP is not considered - - It is the date the RAP is accepted at the MAC.

RAP – BILLING

- The RAP will show in the Return to Provider (RTP) file if it is not accepted.
- Agencies should check RAP acceptance dates daily to verify that each one was received.
- Expect the MACs to take about 24 hours to accept the RAP if it's submitted correctly.

CY 2021 – RAP SUBMISSION EXAMPLE

- Example:

- 1/1/2021 = Day 0 (start of the first 30-day period of care)
- 1/6/2021 = Day 5 (A “no-pay” RAP submitted and accepted on or before this date would be considered “timely-filed”.)
- 1/7/2021 and after = Day 6 and beyond (A “no-pay” RAP submitted on and after this date will trigger the penalty.)

CY 2021 – RAP SUBMISSION

- If a home health agency gets their “no-pay” RAP accepted one day late (with an acceptance date 6 days after the first day of the period), the result would be a 20% reduction to the 30-day payment amount
- No LUPA payments are made that fall within the late period
- The payment reduction cannot exceed the total payment of the claim
- The non-covered days are a provider liability
- The provider must not bill the beneficiary for the non-covered days

CIRCUMSTANCES FOR EXCEPTION TO FILING LATE RAP

- The four circumstances that may qualify the home health agency for an exception to the consequences of filing the RAP more than 5 calendar days after the home health period of care. From date are as follows:
 1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the home health agency's ability to operate
 2. An event that produces a data filing problem due to a CMS or MAC systems issue that is beyond the control of the home health agency
 3. A newly Medicare-certified home health agency that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC
 4. Other circumstances determined by the MAC or CMS to be beyond the control of the home health agency

EXCEPTION REQUEST FOR FILING LATE RAP

- MACs will accept the KX modifier when reported with the Health Insurance Prospective Payment System (HIPPS) code on the revenue code 0023 line of Type of Bill (TOB) 032x (other than 0322 and 0320) as an indicator that a home health agency requests an exception to the late RAP penalty.
- The home health agency should provide sufficient information in the Remarks section of its claim to allow the MAC to research the exception request.
- If the remarks are not sufficient, the MAC will request documentation from the home health agency.

INSTRUCTIONS FOR REMARKS

- Conditional – If the RAP that corresponds to a claim was filed late and the home health agency is requesting an exception to the late-filing penalty (see section 40.1 of the manual revision of CR 11855), enter information supporting the exception category that applied to the RAP.
- If the RAP that corresponds to a claim was originally received timely, but the RAP was canceled and resubmitted to correct an error, enter remarks to indicate this condition, (for example, “Timely RAP, cancel and rebill”). Append modifier KX to the HIPPS code reported on the revenue code 0023 line. Home health agencies should resubmit corrected RAPs promptly (generally within 2 business days of canceling the original RAP).
- Remarks are otherwise required only in cases where the claim is cancelled or adjusted.

TIGHT DEADLINE

- The admission is usually complete in 24 to 48 hours, but then takes another two to three days for all post-admit review and coding.
- Items required for the RAP will allow that submission while the coding, OASIS review and plan of care development continues.
- A major timeliness concern is that the five days for RAP acceptance is calendar days. Therefore, weekends and holidays will count, showing that all RAPs must be submitted as early as possible in order to get acceptance by day five after the start-of-care or “from date.”

TIPS TO SPEED UP WORKFLOW

- Document SOC visits in the EMR the same day.
 - Good goal for admitting clinicians.
- This doesn't mean that all documentation needs to be completed.
- The OASIS comprehensive assessment can be completed within five days after the SOC date to ensure collaboration, proper diagnosis coding and subsequent plan of care after the SOC visit is done.
- Create a policy for your agency that requires this to be done by day three, for instance, so that acceptance occurs prior to the day five limit.
- This will then apply to all 30-day periods and recertifications.

TIPS TO SPEED UP WORKFLOW

- Submit the RAP by day three.
- After the SOC visit is done, create a clear path for the biller to get this information including the initial order (written or verbal) and file the RAP as soon as possible.
- The biller should then check the RTP file daily on all RAPs for MAC acceptance.
- Use dashboards to keep track of it all
 - Initial visit/SOC visit
 - RAP submission
 - daily check of RTP file and RAP acceptance date.
- The administrator can then quickly identify any delays and act on them prior to the deadline to avoid penalties.

TIPS TO PREVENT PENALTIES

- Be sure staff understand deadlines and penalties.
- The five days are **calendar** days.
- Have mechanisms in place to ensure that all RAPs are filed expediently.
- Make sure RAPs aren't submitted late over weekends but are submitted with enough time to have MAC acceptance.
- Check RTP files daily for RAP rejections.
- Diligence to track the days in order to avoid any penalties in reimbursement.
- Talk to your EMR vendor to see what/if software updates will be made for this change.

CONCLUSION

- Annual update of payment rates to 2.0%
- Telehealth changes permanent that were instituted during the COVID-19 PHE without reimbursement / or counting towards LUPA threshold
- In addition to a physician, as defined at section 1861(r) of the Act, an “allowed practitioner”, nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), may certify, establish and periodically review the plan of care, as well as supervise the provision of items and services for beneficiaries under the Medicare home health benefit.
- Audio Only – telephone – telehealth visits are allowed, as appropriate

CONCLUSION

- Home Infusion Therapy (HIT) - New benefit under Medicare Part B effective January 1, 2021
 - Coverage of certain drugs and biologicals, administered IV or SQ, over period of 15 minutes or longer, in the patient's home, through pump that is DME item. Payment is for professional service, training and education, and monitoring that is needed to administer the infusion in the patient's home.
- **RAP must be submitted within 5 calendar days from the beginning of the 30-day period**
 - Failure to get it accepted within 5 calendar days will result in payment reduction 1/30th each day from the beginning of the 30-day period until the day before the RAP is accepted
 - LUPA 30-Day Period of Care
 - If the home health agency fails to submit a timely RAP, no LUPA payments for days that fall within the period of care prior to the submission of the RAP

REFERENCES

- <https://www.federalregister.gov/documents/2020/11/04/2020-24146/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home>

<https://www.cms.gov/files/document/mm11855.pdf>



EDUCATIONAL RESOURCES

QUESTIONS?



EDUCATIONAL RESOURCES

THANK YOU

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