



EDUCATIONAL RESOURCES

# CY 2021 HOME HEALTH PROPOSED RULE

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*CHANGE IS THE ONLY CONSTANT IN LIFE.*

*-HERACLITUS*

# OBJECTIVES

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- Home Health Prospective Payment System (HH PPS)
- Use of Technology – Telehealth
- Changes to CoP OASIS Requirements
- Home Infusion Therapy Services
- Enrollment Standards for Qualified Home Infusion Therapy Suppliers



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# HOME HEALTH PROSPECTIVE PAYMENT SYSTEM – (HH PPS)

# CY 2021 PROPOSED RULE

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- A sigh of relief!
  - With limited amount of PDGM data, CMS is proposing limited reimbursement changes for CY 2021

# CY 2021

- Medicare increased spending - \$540 million
- Proposed Reimbursement – **Changes**
  - Market Basket increase 2.7%
  - Wage Index
    - Adopt the new OMB statistical area delineations
    - 1-year cap on wage index decreases in excess of 5%
- Proposed Reimbursement - **No Change**
  - PDGM case mix - no change
  - LUPA threshold – no change
  - LUPA add-on continues
  - Outlier ratio - no change

# MARKET BASKET INCREASE

- 2.7% increase - Quality Data submitted
- 0.7% increase - Quality Data NOT submitted
  - 2.7% basket increase – 2.0% decrease for not submitting quality data = 0.7%

# PDGM 30-DAY PERIOD PAYMENT AMOUNT

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- No Changes CY 2021
- BBA of 2018
  - Required analysis of data for CYs 2020 – 2026 after PDGM implementation
  - New PDGM case-mix adjustment methodology to determine the impact of the differences between assumed behavior changes and actual behavior changed



# PDGM 30-DAY PERIOD PAYMENT AMOUNT

- CMS CY 2021 proposed rule statements:
  - CMS states it is monitoring the impact of these changes on patient outcomes & Medicare expenditures
  - States it is premature to release any information related to these issues based on the amount of data currently available and due to PHE from COVID-19 pandemic.
  - Therefore, not proposing any additional changes to the national, standardized 30-day payment rate other than routine rate updates.
  - In the future CMS plan is to determine whether any changes need to be made to the national, standardized 30-day payment rate based on analysis of the actual versus assumed behavior change.

# CY 2021 – STANDARDIZED 30-DAY PAYMENT QUALITY DATA SUBMITTED

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

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

# 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**

<b>CY 2020 National, Standardized 30-Day Period Payment</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>CY 2021 HH Payment Update Minus 2 Percentage Points</b>	<b>CY 2021 National, Standardized 30-Day Period Payment</b>
\$1,864.03	X 0.9987	X 1.007	\$1,874.64

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

- Table 9: CY 2021 National Per-Visit Payment Amounts

<b>HH Discipline</b>	<b>CY 2020 Per-Visit Payment</b>	<b>Wage Index Budget Neutrality Factor</b>	<b>CY 2021 HH Payment Update</b>	<b>CY 2021 Per-Visit Payment</b>
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

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

- Table 10: CY 2021 National Per-Visit Payment Amounts for HHs 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 0.9988	X 1.007	\$68.17
Medical Social Services	\$239.92	X 0.9988	X 1.007	\$241.31
Occupational Therapy	\$164.74	X 0.9988	X 1.007	\$165.69
Physical Therapy	\$163.61	X 0.9988	X 1.007	\$164.56
Skilled Nursing	\$149.68	X 0.9988	X 1.007	\$150.55
Speech- Language Pathology	\$177.84	X 0.9988	X 1.007	\$178.87

# CY 2021 - LUPAS

- LUPA Add-on

- No changes from CY 2020

CMS example using the proposed CY 2021 per-visit

- Payment rates for those HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods

1<sup>ST</sup> skilled visit is SN

Visit reimbursement would be \$283.30

(1.8451 multiplied by \$153.54), subject to area wage adjustment.

# CY 2021 – RURAL ADD ON

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

**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

# 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



# CY 2021 – OUTLIERS – NO CHANGE

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- Outlier
  - Maintain the fixed-dollar loss ratio of 0.63, as finalized for CY 2020

# 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 within 5 calendar days from the SOC
  - Failure to submit within 5 calendar days will result in payment reduction 1/30th each day from SOC until RAP is submitted
  - 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

# MLN MATTERS ARTICLE - MM11855

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- MLN Matters Article MM11855 Explains the Penalty for delayed RAP submission Implementation
- <https://files.constantcontact.com/b476ed6c001/2e865a98-df9c-4ce2-aa8e-6acc66258722.pdf>

# CY 2022 - NOTICE OF ADMISSION (NOA)

- One-time Notice of Admission to establish HH period within 5 calendar days from SOC
- Failure to submit within 5 calendar days will result in payment reduction 1/30th each day from SOC until NOA submitted
- LUPA 30-Day Period of Care
  - If HHA 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



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# USE OF TECHNOLOGY - TELEHEALTH

# USE OF TECHNOLOGY - TELEHEALTH

- The proposed rule proposes to permanently finalize the changes to §409.43(a) as finalized in the first COVID-19 PHE IFC (85 FR 19230), to state:
  - The 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.
  - These 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.

# USE OF TECHNOLOGY - TELEHEALTH

- The use of telecommunications technology is determined based on patient needs identified during the comprehensive assessment;
- Included as part of the individualized plan of care established and reviewed by the physician who establishes the plan of care.
- 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.

# USE OF TECHNOLOGY - TELEHEALTH

- HHA cannot discriminate against any individual who is unable or unwilling to receive home health services that could be provided via telecommunications technology.
  - In those circumstances, the HHA must provide such services through in-person visits
- Access to telecommunications technology must be inclusive, especially for those patients who may have disabilities where the use of technology may be more challenging.
- The home health CoPs at § 484.50(f)(1) require that information must 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 Americans with Disabilities Act and section 504 of the Rehabilitation Act.
- This means that the HHA must meet these requirements to ensure access to and use of telecommunications as required by law.



# USE OF TECHNOLOGY - TELEHEALTH

- The proposed rule states:
  - “Telecommunications technology, as indicated on the plan of care, can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY) technology; and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician.”
- This statement needs further clarification for agencies to determine the methods they will use for telehealth after the pandemic.
- In its comments to CMS, the National Association for Home Care & Hospice is seeking clarification since during the PHE telephonic visits are allowed, but do not seem to meet CMS’ definition of telecommunication.

# USE OF TECHNOLOGY - TELEHEALTH

- Administrative costs
  - The costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs.
  - Visits to a patient's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service, are not separately billable.
- CMS is proposing to:
  - Allow HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the HH agency cost report.
  - Modify the instructions regarding this line on the cost report to reflect a broader use of telecommunications technology.
- CMS proposes to amend § 409.46(e) to include not only remote patient monitoring, but other communications or monitoring services, consistent with the plan of care for the individual.



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# CONDITIONS OF PARTICIPATION (CoPS) – OASIS REQUIREMENTS

# COPS – OASIS REQUIREMENTS

- CMS is proposing to remove the requirement at §484.45(c)(2) that new home health agencies must successfully transmit test data to the Quality Improvement & Evaluation System (QIES) or CMS OASIS contractor as part of the initial process for becoming a Medicare-participating home health agency.
  - New HHAs do not yet have a CMS Certification Number (CCN).
  - The new data submission system, Internet Quality Improvement & Evaluation System (iQIES), no longer has the ability to use test or fake CCNs and has rendered the requirement at §484.45(c)(2) obsolete.
- 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.
- This link to the payment process gives HHAs strong incentive to ensure that they can successfully submit their OASIS assessments in the absence of this regulatory requirement.



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# HOME INFUSION THERAPY SERVICES

# 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.
- Section 50401 of 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.
- Transitional payment system ends the day before the full implementation of the home infusion therapy services benefit on January 1, 2021.
- CMS established regulatory authority for the oversight of national accrediting organizations (AOs) that accredit home infusion therapy suppliers, and their CMS-approved home infusion therapy accreditation programs.

# 21ST CENTURY CURES ACT - HIT

- Effective January 1, 2021, section 5012 of the 21st Century Cures Act created a separate Medicare Part B benefit category under section 1861(s)(2)(GG) of the Act 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.

# 21ST CENTURY CURES ACT PROVISIONS (HIT)

- Services explicitly covered by Cures Act are necessary for the safe and effective administration of home infusion drugs.
- Section 1834(u)(1) of the Act requires the Secretary to implement a payment system, beginning January 1, 2021, - 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 (HIT)

- 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 CURES ACT PROVISIONS (HIT)

- 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.
- The Act amended section 1861(m) **excluded** home infusion therapy from the HH PPS beginning on January 1, 2021.
- The Act specifies that annual updates to the single payment are required to be made, beginning January 1, 2022.

# 21ST CENTURY CURES ACT PROVISIONS (HIT)

- Patient must be under care of applicable provider:
  - physician,
  - nurse practitioner, or
  - physician assistant
- Patient must receive therapy in the individual's home.
- 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.

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# QUALIFIED HOME INFUSION THERAPY SUPPLIERS AND 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 (HIT) SUPPLIERS AND 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 (HIT) SUPPLIERS AND 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.
- The qualified home infusion therapy supplier is responsible for furnishing the necessary services to administer the drug in the home.

# QUALIFIED HOME INFUSION THERAPY (HIT) SUPPLIERS AND PROFESSIONAL SERVICES

- The home infusion therapy supplier must be in the patient's home, 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 (HIT) 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.
  - Any care coordination, or visits made for venipuncture, provided by the qualified home infusion therapy supplier that occurs outside of an infusion drug administration calendar day would be included in the payment for the visit.
- 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 AND 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 AND INTERACTION WITH THE HOME HEALTH BENEFIT

- 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:
  - If a patient receiving home IVs under a HH POC and 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 IVs, 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 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.

# HOME INFUSION THERAPY AND INTERACTION WITH THE HOME HEALTH BENEFIT

- DME is excluded from the consolidated billing requirements governing the HH PPS and therefore, the DME items and services (including the home infusion drug and related services) will continue to be paid for outside of the HH PPS.
- *If the qualified home infusion therapy supplier is not the same entity as the home health agency furnishing the home health services, the HHA would continue to bill under the HH PPS on the home health claim, and the qualified HIT supplier would bill for the services related to the administration of the home infusion drugs on the home infusion therapy services claim.*

# PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HOME INFUSION THERAPY SERVICES CY 2021

- This permanent payment system would become effective for HIT items and services furnished on or after January 1, 2021.
- When home infusion drugs or biologicals from two different payment categories are administered to an individual on a single infusion drug administration calendar day, one payment for the highest payment category will be made.
- The single payment for each infusion drug administration calendar day in the individual's home must take into account:
  - Variation in utilization of nursing services by therapy type.
  - Reflect patient acuity and complexity of drug administration.
- CMS believes the best way to develop a single payment that reflects utilization and patient acuity is to develop payment groups for similar therapy types.

# PAYMENT CATEGORIES & PAYMENT AMOUNTS FOR HOME INFUSION THERAPY SERVICES CY 2021

- Identified HCPCS codes for transitional home infusion drugs are assigned to three payment categories, as identified by their corresponding HCPCS codes, with associated J-codes, for which a single amount to be paid for HIT services furnished on each infusion drug administration calendar day.
  - 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 HOME INFUSION THERAPY SERVICES 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, because it is on a SAD exclusion list, services related to the administration of this biological are not covered under the benefit in 2021.
  - 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 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

# CY 2021 PAYMENT AMOUNTS FOR HOME INFUSION THERAPY SERVICES

- First Visit Payment Increased
- CMS proposes to increase the payment amounts for each of the three payment categories for the first HIT visit by the qualified home infusion therapy supplier in the patient's home resulting in a small decrease to the payment amounts for the second and subsequent visits, using a budget neutrality factor.
- Using the CY 2020 PFS rates, this results in a 60% increase in the first visit payment amount and a 3.72% decrease in subsequent visit amounts.



# CY 2021 PAYMENT AMOUNTS FOR HOME INFUSION THERAPY SERVICES

- The payment amounts for this proposed rule are estimated using CY 2020 rates because the CY 2021 PFS rates are not available at the time of this rule making.
- The final home infusion 5-hour payment amounts will be released in a CR when the final CY 2021 PFS rates are posted.
- CMS plan 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.

# CY 2021 PAYMENT AMOUNTS FOR HOME INFUSION THERAPY SERVICES

**TABLE 15: 5-HOUR PAYMENT AMOUNTS REFLECTING PAYMENT RATES FOR FIRST AND SUBSEQUENT VISITS**

Description	2020 PFS Amount	5-hour Payment - First Visit	5-hour Payment - Subsequent Visits
Ther, Proph, Diag IV/IN infusion 1 hr	\$72.18	\$256.35 (category 1)	\$154.26 (category 1)
Ther, Proph, Diag IV/IN infusion add hr	\$22.01		
Sub Q Ther Inf 1 hr	\$162.04	\$358.59 (category 2)	\$215.78 (category 2)
Sub Q Ther Inf add hr	\$15.52		
Chemo Inf 1 hr	\$142.55	\$424.43 (category 3)	\$255.40 (category 3)
Chemo Inf add hr	\$30.68		

**Note:** Rates are calculated using CY 2020 PFS rates

# PAYMENT ADJUSTMENTS FOR CY 2021 HOME INFUSION THERAPY SERVICES

- Home Infusion Therapy Geographic Wage Index Adjustment
- The Act requires that the single payment amount be adjusted to reflect a geographic wage index and other costs that may vary by region.
- 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 submitted on the 837P/CMS-1500 professional and supplier claims form.
- The list of GAFs by locality for this proposed rule is available as a downloadable file at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview>

# PROPOSED HIT SERVICES EXCLUDED FROM THE MEDICARE HOME HEALTH BENEFIT

- CMS states that these services may include, for example the following:
  - 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;

# PROPOSED HIT SERVICES EXCLUDED FROM THE MEDICARE HOME HEALTH BENEFIT

- CMS states that these services may include, for example the following:
  - 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.

# PROPOSED HIT SERVICES EXCLUDED FROM THE MEDICARE HOME HEALTH BENEFIT

- 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.
- Many home health agencies will probably become accredited and enroll as qualified home infusion therapy suppliers.
- A home health agency can provide both home health services and home infusion therapy services, so it is necessary to exclude the provision of home infusion drugs from the services covered under the home health benefit.
- When a home health agency is furnishing services to a patient receiving an infusion drug not defined as a home infusion drug at § 486.505, those services may still be covered as home health services.

# PROPOSED HIT SERVICES EXCLUDED FROM THE MEDICARE HOME HEALTH BENEFIT

- CMS proposes to amend § 409.49 to exclude services covered under the home infusion therapy services benefit from the home health benefit.
- Any services that are covered under the home infusion therapy services benefit as outlined at § 486.525, including any home infusion therapy services furnished to a Medicare beneficiary that is under a home health plan of care, are excluded from coverage under the Medicare home health benefit.
- Excluded home infusion therapy services pertain to the items and services for the provision of home infusion drugs, as defined at § 486.505.
- Services for the provision of drugs and biologicals not covered under this definition may continue to be provided under the Medicare home health benefit.



EDUCATIONAL RESOURCES

# ENROLLMENT STANDARDS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS



# PROPOSED ENROLLMENT STANDARDS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

- Part 486, subpart I, 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 criteria--section 1861(iii)(3)(D)(i) of the Act:
  - 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 designated by the Secretary in accordance with section 1834(u)(5) of the Act.
  - Meets such other requirements as the Secretary determines appropriate.
    - This final criterion, which reflects section 1861(iii)(3)(D)(i)(IV) of the Act, is of particular importance for purposes of this section V.B. of this proposed rule. One of our 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. CMS believes that section 1861(iii)(3)(D)(i)(IV) of the Act permits the Secretary to take steps in this direction with respect to home infusion therapy suppliers.

# PROPOSED ENROLLMENT STANDARDS FOR QUALIFIED HOME INFUSION THERAPY SUPPLIERS

- Under § 424.510, a provider or supplier must complete, sign, and submit to its assigned MAC the appropriate Form CMS-855 application in order to enroll in the Medicare program and obtain Medicare billing privileges.
- CMS believes that the provider enrollment process is invaluable in helping to ensure that:
  - 1) all potential providers and suppliers are carefully screened for compliance with all applicable requirements;
  - 2) problematic providers and suppliers are kept out of Medicare; and
  - 3) beneficiaries are protected from unqualified providers and suppliers.
- Given CMS' responsibility in preventing waste and abuse in the Medicare program, CMS believes that the safeguards that Medicare enrollment furnishes are needed with respect to home infusion therapy suppliers.

# CONCLUSION

- With limited PDGM data, CMS is proposing limited reimbursement changes for CY 2021
- RAP must be submitted within 5 calendar days from the SOC
  - Failure to submit within 5 calendar days will result in payment reduction 1/30<sup>th</sup> each day from SOC until RAP submitted
  - 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
- Proposal to make some telehealth changes permanent that were instituted during the Covid-19 PHE without reimbursement / or counting towards LUPA threshold

# CONCLUSION

- Proposal to remove the requirement that new home health agencies must successfully transmit test data to the Quality Improvement & Evaluation System (QIES) or CMS OASIS contractor as part of the initial process for becoming a Medicare-participating home health agency
- 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.

# REFERENCE

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- <https://www.federalregister.gov/documents/2020/06/30/2020-13792/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home>



EDUCATIONAL RESOURCES

# QUESTIONS?





EDUCATIONAL RESOURCES

# THANK YOU

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