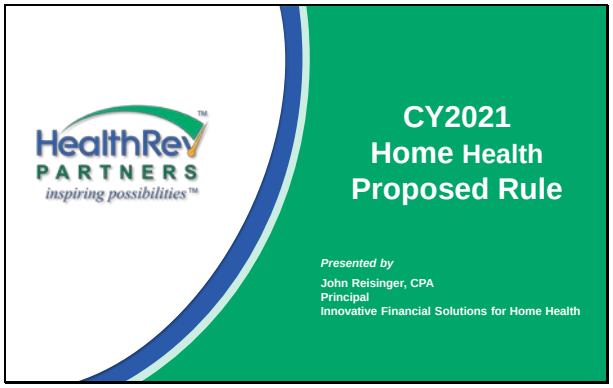


Introduction

- We're here to discuss the CY2021 HH PPS Proposed Rule
  - The HH PPS Proposed Rule is an annual occurrence
  - Changes can vary year to year
  - Sometimes, changes can be punitive
  - This is Year 2 under PDGM
  - Just about any time CMS proposes a new rule or a change to an existing rule, we, the industry have an opportunity to address those proposals via participating in the Rule-Making Process by submitting Comments

The Rule-Making Process

- Interested Parties can submit comments
  - Not a commonly known right that we have
  - And history has shown we can impact the proposals
    - But rarely to the level that we'd wish
    - Because of far too few comments submitted and/or too much copying-and-pasting of comments that are submitted
  - Industry participation needs to increase
    - From 2008 thru 2017, there were an avg of 185 comments!
    - Not very impressive
    - Especially when there were 12-13k+ agencies for most of that time!

The Rule-Making Process

- When you comment, you can comment on one, or multiple topics & issues contained in the Proposed Rule
- So for CY2021, that could include commenting on:
  - Telehealth/Remote Patient Monitoring
  - The changes to the service areas of over 100 counties
  - A Home Health-specific Wage Index
  - The Outlier Provision
  - And anything else identified in the CY2021 Proposed Rule
  - And we'll touch on each of these during this presentation

The Rule-Making Process

- In commenting, please refer to file code CMS–1730–P
- Comments can be submitted:
  - Via USPS *(regular mail)* or by
  - Express or Overnight mail
  - Electronically *(@ https://www.regulations.gov/) until 11:59pm ET*
    - You can type comment(s) directly here, or
    - You can drag and drop a WORD or PDF document
    - *Electronically is best*, and
- And, you can submit your comment(s) anonymously

The Rule-Making Process

- DATES: To be assured consideration, written and mailed comments must be received at one of the addresses identified below, no later than 5 p.m. on August 24, 2020. *
- Regular Mail Address:

Centers for Medicare & Medicaid Services
Dept of Health and Human Services
Attention: CMS–1730–P
P.O. Box 8013
Baltimore, MD 21244–8013

Express/Overnight Address:

Centers for Medicare & Medicaid Services
Dept of Health and Human Services
Attention: CMS–1730–P, Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

The Rule-Making Process

- Following is what you see going via the electronic route.

- Click on the Comment Now! and you'll be taken to the following page:

The Rule-Making Process

- Again, the easiest and least costly method is electronically – see the following:
- You can type your comments directly,
- Or, you can drag-and-drop your word or PDF file here.
- Very simple, very easy, and very beneficial for the industry!
- Advocate for yourself, your agency and make a difference!

The Rule-Making Process

- Update: CMS is implementing a Beta site – see the following:

- Looks the same, but the landing page has changed!

The Rule-Making Process

- The primary landing page looks like this:

- Not a big deal so far. Click on the Comment button, and

The Rule-Making Process

You land here:

It's easy enough to submit your comments here as well!

Typing here, or by Dragging & Dropping

The Rule-Making Process

- Good news is:
- You can still submit anonymously!
  - No name, and
  - No email
- I've tried, it works

The Rule-Making Process

- As of 10:18am ET on 8/17/20, there are 32 comments submitted thus far!
- That's not many! See the following:

Caveat:

If the industry doesn't significantly work to get what it wants …

… how can it ever expect to get what it wants???

In some ways, the HH industry is the biggest obstacle it faces to fair treatment!

The Rule-Making Process

- We've spent some time on the Rule-Making process because it is far more important than what any associations and most agencies seem to realize.
- Here, we have an opportunity to impact our own future:
  - You can do nothing and live with the outcome *(& don't complain)*, or
  - You can make an effort and advocate for our industry and try to improve our industry's future!
- btw: I will point out several areas worthy of comment throughout today's presentation – my recommendation though:
  - *Just re-word enough to make the comment(s) your own!*

Preview of the Proposed Rule

- This Proposed Rule is a pretty passive proposal by CMS, considering the recent past
- CMS is projecting an increase of $540 million in payments to home health
  - That's an increase of 2.6% for CY2021
  - So, can all Home Health Agencies expect to receive a 2.6% increase in their payments for CY2021?
    - NO!
      - They cannot

Preview of the Proposed Rule

- Some will see an increase in the 2.6% range,
- But most will not!
  - Some, will actually realize a greater increase in their pmts,
  - While others will realize an increase much less than that,
  - And some, will actually see their PPS payment rates decrease in CY2021
- Many things cause this discrepancy at the agency level

Preview of the Proposed Rule

- This year the biggest impact has to do with the changes occurring with the Wage Indices for home health; which we'll discuss shortly
  - This is why it is risky to assume that your agency*(s)* should expect a change in the PPS payment rates as identified by CMS in either the Proposed or Final Rule
  - And, why I have always recommended that agencies have an analysis done on what this impact is projected to be for the upcoming year on their agency's Medicare revenues
  - A little work upfront can save significant headaches later on!

The Significant Changes Proposed by CMS

- For CY2021 CMS is proposing no changes for the following:
  - The LUPA Thresholds
  - The LUPA Add-on $ Amounts,
  - The various aspects of the Outlier Provision, and
  - The 432 PDGM Case-Mix Weights
    - Recently, CMS has been updating and changing the current Case-Mix Weights on an annual basis
    - So this is something out of the ordinary
    - But, holding the other three fixed, not so out of the ordinary

The Significant Changes Proposed by CMS

- Following are the changes we'll go over today:
  - the Wage Index Changes
  - the PPS Payment Update
  - the Rural Add-on Payments
  - Outliers
  - RAP Submissions for CY 2021 *and*
  - The Use of Technology under the Medicare Home Health Benefit

Next: Wage Index Changes

- CMS is proposing to implement the Micropolitan Statistical Area sub-category of the CBSA that has been developed by the OMB
  - OMB defines a "Micropolitan Statistical Area" as a "CBSA" associated w/at least one urban cluster that has a population of at least 10k, but less than 50k
  - CMS believes the best course of action is to treat these "Micropolitan Statistical Areas" as "rural" and include them in the calculation of each state's home health rural wage index
  - CMS continues: "*Thus, the HH PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in non-Metropolitan Statistical Areas (MSA)…"*
- The result of which will be:

Wage Index Changes

- Some Urban Counties Becoming Rural
  - 34 Counties would change to rural status if proposal is finalized
  - See Table 3 of the Proposed Rule
- Some Rural Counties Becoming Urban
  - 47 Counties would change to urban status if proposal is finalized
  - See Table 4 of the Proposed Rule
- Some Urban Counties Would Be In a CBSA that Changed Name or #
  - 31 Counties would be in a CBSA that changed name or number
  - See Table 5 of the Proposed Rule, and
- 19 Counties would Change to a Different CBSA (see Table 6)

Wage Index Changes

- So, what's the big deal that nobody is talking about?
  - Every one of these changes will cause a change in the Wage Index for the counties affected, impacting the associated revenue for all services provided in those counties!
    - Some, it will benefit – will likely see an increase > CMS projection
    - Others it will hurt – will see changes < CMS projection,
    - With some, being really hurt – will see reductions in pmt rates
    - That's why CMS proposed putting a cap of 5% on the amount a counties Wage Index could decrease from 2020 to 2021; assuming the county was impacted by one of those moves!
  - See the following:

Wage Index Changes

- Following is a summary of the changes for two CBSAs for CY2021:
  - CBSA # 1

			Pmt Rates
# that Increased	0	0	432
# that Decreased	0	0	0
# that Stayed the Same	432	432	0
	432	432	432
		MIN	16.4%
		AVG	16.4%
		MAX	16.4%

  - CBSA # 2

			Pmt Rates
# that Increased	0	0	0
# that Decreased	0	0	432
# that Stayed the Same	432	432	0
	432	432	432
		MIN	-5.5%
		AVG	-5.5%
		MAX	-5.5%

- Although a 5.5% cut in revenues is not catastrophic in and of itself, it's a whole lot worse when you're expecting a 2.6% increase!
- So which CBSA would you rather be?

Wage Index Changes

- Another issue germane to the Wage Index for Home Health is that Home Health DOES NOT have its own Wage Index!
- Never has!
  - Hospitals do!
  - SNFs do!
  - Hospices do! etc…
  - But there's no home health (HH) specific Wage Index!
  - Does that seem right to you?
- CMS uses Inpatient Hospital Wage Data in developing a wage index to be applied to HH payments!

Wage Index Changes

- If you believe that the cost of labor for like-kind staff is basically the same for hospitals and HHAs, then this should be OK by you
- But if you believe that there's a difference in the cost of labor and in the ability to attract and retain quality staff between Hospitals and HH, then you cannot think that this is fair to HH
  - If you think like this, this would be a good topic to comment on
  - Maybe submit a comment that is something like:

    "Why does home health not have its own wage index? CMS has developed a wage index for hospitals, SNFs, hospice, etc…; it's high-time that CMS create a home health specific wage index."

Next: the Payment Update

- CMS has proposed a Net Market Basket Update of +2.7% for all agencies submitting the required quality data
  - The proposed update for those agencies not submitting the required quality data is: +0.7%
    - The 2.7% previously noted,
    - Less 2 percentage points (2.7% - 2.0%)
- So, the Nat'l Std 30-day pmt rate for CY2021 is: $1,911.87
  - Was $1,864.03 for CY2020 *(diff is the budget neutrality factor)*
- 30-day pmt rate for those not submitting … is: $1,874.64

Next: the Payment Update

- Following are the LUPA per-Visit Rates as Proposed for '21:

  For Agencies:

Submitting ① Quality Data	Disc	Not Submitting ② Quality Data
$ 153.54	SN	$ 150.55
167.83	PT	164.56
168.98	OT	165.69
182.42	ST	178.87
246.10	MSS	241.31
69.53	HHA	68.17

① see Table 9

② see Table 10

the Payment Update

- I've noted several times now that CMS is projecting that HH spending for CY2021 will increase 2.6%
- But I also noted that it was unwise for any agency to assume that the Medicare pmt rates for their agency would increase along that same CMS projected rate …
- Think about this: When you hear anyone talk about the Proposed Rule *(ever!)*, have you ever heard them say anything besides what CMS projects the change in HH spending to be?
  - And, did you think that's what it would be for your agency?

the Payment Update

- I have never heard anyone ever say anything different; they've only ever referenced the projected change in HH spending as though that's what everyone could expect for their agency!
  - You have to look between the numbers & words to see what the impact really is; to have read & understood the rule
  - Just like you have to look beyond your Total Revenues, Total Expenses and Net Income/Loss to really understand how your agency is doing both operationally & financially
  - Most just don't make the effort to attain that level of understanding
  - So, be careful who you listen to!

the Payment Update

- There's generally a difference between what the change in HH spending is proposed to be in any given year as compared to how its going to impact any given agency that same year!
  - Some agencies will do better
  - Some will do worse
  - And some, will do a lot worse!
- To emphasize, I will reiterate the changes in Medicare revenue noted for two CBSA/Service Areas for CY2021.

The Payment Update

- As previously shown on slide 23:
  - CBSA # 1 is projected to realize an increase of 16.4% in all 432 PPS Payment Rates, while
  - CBSA # 2 is projected to realize a decrease of 5.5% in all 432 PPS Payment Rates,
  - Even though CMS projected that CY2021 HH Spending was going to increase by 2.6%
    - So 1 area does 13.8 % points better than CMS' projection, and
    - Another area does 8.1 % points worse
  - Therefore, do not take the CMS projection as a given!

the Payment Update

- I haven't run scenarios for all 460+ CBSA/Service Areas, but I would expect that the impact to most Service Areas will fall somewhere in this range.
  - A few Service Areas might exceed either extreme
  - Because of some of the more intricate changes CMS is proposing; specifically, the changes previously with the Wage Indices
  - However, most agencies will NOT see an increase of 2.6% in their payment rates for CY2021!
    - In fact, I believe that only two CBSA/Service Areas will!

the Payment Update

- How do you identify what the impact to Medicare Revenues will be for CY2021?
  - Well, this is an easier year than most for doing this type of comparison
  - As the only things really changing are the:
    - Market-Basket Update, and
    - The Wage-Indices
      - But there are some complications in this area because of those counties changing Service Areas

the Payment Update

- Unlike every other year under PPS,
- You can easily calculate the change for CY2021 by calculating the 30-day payment rates for CY2021 and comparing to CY2020
  - I've been doing this since Year 2 of PPS *(i.e., 2001)*, and
  - I have always been confounded why this isn't an industry std!
  - This is one of those financial-fundamentals that's greatly lacking in the home health industry *(and there are a great many!)*
- There's more to this analysis as well, but I am not looking to teach other consultants, etc… what they should be doing

Next: The Rural Add-on Payments

- Next is the Rural Add-on and that rate is also changing for CY2021; but changing following what was proposed and finalized back in 2018 – see the following:

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

  - I would think that counties that switched from Urban to Rural per this rule would be "High utilization"; receiving no Add-on pmt in 2021

The Rural Add-on Payments

- And CY2022 is the last year of the Rural Add-on!
- This is not a CMS doing, as the Rural Add-on only exists because of Congressional legislation
- Therefore, over the next year, all agencies that provide services in any rural counties should write their members of Congress urging them '*to extend the Rural Add-on payment for home health, or potentially risk losing coverage for the seniors living in those counties*'.

Next: Outliers

- No changes proposed for the Outlier Provision
- However, it's the lack of industry-wide understanding of the impacts of this provision that has me bringing it up here!
- First off, for full disclosure, I am against the Outlier Provision and wish it would be eliminated
  - More on that in a little bit, but
  - Let's see how you feel about it once you have a better understanding of how this provision impacts your agency's …
- That being said, let me ID the particulars of this provision

Outliers

- Following are aspects that are not changing:
  - The Fixed Dollar Loss (FDL) is remaining at 0.63 *(63%)*
    - This is the '*theoretical*' amount of loss you must incur before loss-sharing kicks-in
  - The Loss-Sharing Ratio is remaining at 0.80 *(80%)*
    - This is the portion of the loss in excess of the FDL that Medicare will reimburse
    - This is your Outlier Payment
  - Still using a Per-Unit approach
    - This became effective in CY2017
    - Prior to that had been based on a Per-Visit approach

Outliers

- *Aspects that are not changing (cont'd)*:
  - The calculation of episode costs is based on Imputed Costs *(theoretical)*
    - The costs for the episodes is NOT based on your actual costs,
    - It based on your visits and the LUPA Per Visit Rates
      - Meaning, if your actual CPVs > LUPA Rates, your actual loss even after Outlier Pmts will be > the 63% FDL
      - I have actually seen agencies target Outliers, thinking profitable!
    - And the cost of Chargeable Medical supplies are excluded/ignored!
  - The Outlier CAP for any agency remains at 10%
    - i.e., Outlier Pmts cannot exceed 10% of your total Medicare Payments, inclusive of the Outlier Pmts
    - Any Outlier losses in excess of 10% are lost

Outliers

- *Aspects that are not changing (cont'd)*:
  - The amount withheld from total HH spending to fund the Outlier provision each year since CY2011 has been 5%
    - This means if the Outlier provision did not exist, every PPS payment that you receive would be 5% higher *(but, no Outlier pmts)*
    - This is a vestige of the PPACA
  - The total amount of Outlier Pmts to the industry for the year is targeted *(i.e., capped)* at 2.5%
    - This too is a vestige of the PPACA

Outliers

- Did you catch that legislated discrepancy?
- 5% withhold, versus
- 2.5% cap in Outlier Pmts!
  - It is this discrepancy that causes me to dislike the Outlier Provision
    - The 5% withheld to fund the provision,
    - Yet, there is a cap of 2.5% in total Outlier pmts to HH,
    - ½ (i.e., 50%) of what is withheld to fund the Outlier Provision vanishes – is never returned to HH!
- What's that in $'s?

Outliers

- Let's estimate that avg HH spending = $18 billion
- We get:
  - 5% withheld to fund provision: $900,000,000 *(18,000,000,000 x 0.05)*
  - 2.5% cap in Outlier payments: 450,000,000 *(18,000,000,000 x 0.025)*
  - Difference *(the discrepancy)*: $450,000,000
  - That's $450 million
  - And, that's the ballpark # that's been extracted from HH spending every year since CY2011
- What do you think of that aspect of the Outlier Provision?

Outliers

- What do you think of that aspect of the Outlier Provision?
  - Make you a fan?
  - Make you a foe?
- Additionally, I would recommend everyone go back and take a look at their prior Cost Reports as well to see how they fared:
  - How much did you receive in Outlier Pmts? *versus*
  - How much was withheld from your agency to fund the provision?
  - My expectation is that the vast majority of HHAs throughout the industry have had their Medicare cash-flows reduced because of the Outlier Provision!

Outliers

- Here's another reason that most do not correctly understand the Outlier Provision.
  - What most seem to understand are the Outlier payments that they receive during the year
    - These are tangible $ amounts, and
    - These $ amounts can be seen by everyone, and
    - they provide some level of comfort that this '*so-called*' safety-net is working
    - So they provide some sense of security
    - But, is it a false sense of security?

Outliers

- The aspect of the Outlier Provision that most don't really understand is the impact the funding mechanism for the Outlier Payments has on their Medicare revenues!
  - And that is because nobody sees its impact on their cash-flows,
  - Because it's done before Medicare payments are made.
  - As previously noted, the bucket from which Outlier Pmts come from is funded by reducing every episodic pmt that an agency receives by 5%

Outliers

- So, if the Outlier Provision did not exist:
  - You would receive 5% more for every episodic payment, but
  - You would no-longer receive any Outlier payments!
- Most are afraid of this loss of Outlier pmts; but, if they actually compared:
  - What they lose in cash-flow to fund the Outlier Provision,
  - To what they actually receive in Outlier pmts
  - They would likely see that the Outlier Provision is actually reducing their overall Medicare cash-flow, while providing a false sense of security through at least some Outlier pmts!

Outliers

- In other words, they would have been better off receiving the increased pmt rate for all episodic pmts while also no-longer receiving any Outlier pmts!
- Have you ever taken a look at this for your agency(s)?
- And, you really should look at this over the last 10 *(even 20)* years to get a real feel for what that impact has been.
  - You may have had a year, or 3 that you actually benefitted,
  - But chances are great, that over the life of the Outlier Provision, it has been detrimental to your overall cash-flows!

Outliers

- Consider the following as extracted from Cost Reports:

Following is a look at 2 yrs for this agency:

	Year 1	Year 2
• Total Outlier Pmts:	$ 71,209	$127,053
• Reduction to fund:	173,663	220,864
• Difference:	-102,454	- 93,811

- In Yr 1 they rec'd over $71k in Outlier Pmts!
- In Yr 2 they rec'd over $127k in Outlier Pmts!
- That's obviously a lot in Outlier Pmts!
  - **Do they want to give this up?**
  - **Should they?**
- You might want to do or have done for you something similar so you can identify how this provision has impacted your agency(s)!

Outliers

- If you think that maybe the Outlier Provision is more a detriment to your agency and the industry, then maybe consider submitting a comment to CMS; something like:

  "… as the provision for outlier payments is optional …, we respectfully request that you eliminate the outlier provision as a factor in home health and add back the 5% of funds currently withheld to fund outliers …"

Next: RAP Submissions for CY 2021

• BIG Changes coming in CY2021

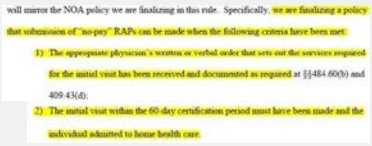
- First, there will be no payment associated w/the RAP
- The RAP will change its name to a **no-Pay RAP**
- HHAs will submit no-Pay RAPs for all 30-day pay periods beginning on/after 1/01/21, and
- And will submit no-Pay NOAs for all 30-day pay periods beginning on/after 1/01/22
  - NOA = Notice of Admission

RAP Submissions for CY 2021

- All no-Pay RAPs and no-Pay NOAs must be submitted w/in 5 calendar days from the SoC or financial penalties will apply:
  - For a RAP submitted on Day 6, a 20% penalty would apply *(6/30)*,
  - For a RAP submitted on Day 10, a 33.33% penalty would apply *(10/30)*, and
  - For a RAP submitted on/after Day 30, a 100% penalty would apply *(30/30)*
- >>> Submit your no-Pay RAPs timely! *(i.e., days 1 thru 5)*

RAP Submissions for CY 2021

- To minimize the documentation burden going forward, since there is no payment associated w/the no-Pay RAP, CMS has lessened the documentation requirements – see the following:

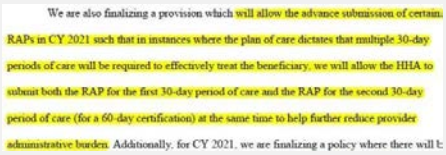


will mirror the NOA policy we are finalizing in this rule. Specifically, we are finalizing a policy that submission of "no-pay" RAPs can be made when the following criteria have been met:

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 §§484.60(b) and 409.43(d);
2) The initial visit within the 60-day certification period must have been made and the individual admitted to home health care.

RAP Submissions for CY 2021

- Additionally, CMS states:



We are also finalizing a provision which will allow the advance submission of certain RAPs in CY 2021 such that in instances where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the beneficiary, we will allow the HHA to submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification) at the same time to help further reduce provider administrative burden. Additionally, for CY 2021, we are finalizing a policy where there will b

- So CMS is trying to make some things easier for us.

RAP Submissions for CY 2021

- Also, consider the timeliness of submitting your final claims
  - This impacts cash-flow, so is vital to an agency's health
  - The longer this takes, the slower your cash conversion process
- You want to work with your policies & procedures, along w/your staff to minimize the # of days after the EoE that you bill
- The elimination of a partial-payment associated with the RAP is going to emphasize the importance of billing timely
- And you also want to have a conscious, diligent effort to reduce your Days of A/R *(aka DSO)* to the 35-40 range
  - Soon even lower; maybe in the 30–35 day range : time will tell

Next: The Use of Technology

- Our last area of discussion is the section CMS identified as:
- **The Use of Technology under the Medicare Home Health Benefit**
- This is Telehealth/Remote Patient Monitoring
- Note the following as excerpted from the Proposed Rule:
  - w/respect to HH svc furnished during the PHE for COVID-19, *"that the Secretary shall consider ways to encourage the use of telecommunications systems, including for remote patient monitoring …, consistent with the PoC for the individual, including by clarifying guidance and conducting outreach, as appropriate. …"*
  - A positive sounding position by CMS!

The Use of Technology

- Another excerpt from the Proposed Rule:
- When COVID started: "… *the POC 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 POC*."
  - Again, sounds positive, but HHA's have been able to utilize remote-patient monitoring for over 20 years!

The Use of Technology

- Additional Excerpt from the Proposed Rule:
  - "… we are proposing to permanently finalize the amendment to 409.43(a) as outlined in the first COVID-19 PHE IFC (85 FR 19230). We are also proposing to allow HHAs to continue to report the costs of telehealth/telemedicine as allowable administrative costs on line 5 of the home health agency cost report. We propose to modify the instructions regarding this line on the cost report to reflect a broader use of telecommunications technology. Additionally, we propose 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. Because stakeholders have identified significant up-front costs in incorporating and evaluating various forms of telecommunications systems into home health care, this would allow HHAs to confidently plan for the continued inclusion of telecommunications systems under the Medicare home health benefit and increase the tools available to promote patient involvement and autonomy and potentially more efficient home health care."

The Use of Technology

- 42 CFR 409.43(a)
- The big change here is highlighted in yellow
- It has to do w/our ability to use telehealth/remote patient monitoring
- Originally, for the PHE (Public Health Emergency)
- Proposing to make permanent!

§ 409.43 - Plan of care requirements.

(a) Contents. An individualized plan of care must be established and periodically reviewed by the certifying physician or allowed practitioner, as defined at § 484.2 of this chapter.

(1) The HHA must be acting upon a plan of care that meets the requirements of this section for HHA services to be covered.

(2) For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment.

(3) The plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits, as well as those items listed in § 484.60(a) of this chapter that establish the need for such services. All care provided must be in accordance with the plan of care. During a PHE, as defined in § 400.200 of this chapter, the plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and such services must be tied to the patient-specific needs as identified in the comprehensive assessment, 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. The plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

The Use of Technology

- Following is a partial excerpt of 42 CFR 409.46:

§ 409.46 - Allowable administrative costs.

Services that are allowable as administrative costs but are not separately billable include, but are not limited to, the following *(sub-sections (a) thru (d) seem consistent w/past requirements)*:

(e) Remote patient monitoring. Remote patient monitoring is defined as the collection of physiologic data (for example, ECG, blood pressure, or glucose monitoring) digitally stored and transmitted by the patient or caregiver or both to the home health agency. If remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the remote patient monitoring equipment, without the provision of a skilled service are not separately billable.

The Use of Technology

- So everything is sounding good so far regarding potential opportunities for utilizing Telehealth/Remote Patient Monitoring services in home health going forward, and
- Our brethren; including Hospitals, SNFs, Outpatient Therapy facilities, etc…, have all been granted with the ability to treat certain *(if not most)* Telehealth/Remote Patient Monitoring interactions with the Medicare beneficiary as Allowable, Chargeable Visits as part of their operations!
  - All very positive sounding

The Use of Technology

- And then we read the following in the Proposed Rule:
- *"These services cannot substitute for a home visit as ordered as part of the POC and cannot be considered a home visit ordered for the purpose of eligibility or pmt …"*

  and
- *"… Although section 1895(e)(1)(A) of the Act prohibits payment for services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care, we understand that there are ways in which technology can be further utilized to improve patient care, better leverage advanced practice clinicians, and improve outcomes while potentially making the provision of home health care more efficient. We acknowledged that technology has become an integral part of medicine across the entire spectrum of healthcare, and that telemedicine, in particular has the potential to play a large role in enhancing the delivery of healthcare in the home. In the first COVID-19 PHE IFC, …"*

The Use of Technology

- And all the sudden, the proposed changes are a whole lot less positive for the home health industry!
  - Although the allowability to treat Telehealth costs as Allowable Administrative Costs is a positive:
    - This is not due to the pandemic, which most of the reading makes it sound like, as it has been in the works since 2018!
    - And, it would be MUCH more beneficial if these costs could be attributed to the Cost Centers/Disciplines utilizing telehealth, as opposed to treating as an Admin cost that gets allocated to all Cost Centers; including non-allowable Cost Centers!
      - *Potential Comment here!*

The Use of Technology

- However, CMS is not allowing the home health industry to treat Telehealth/Remote Patient Monitoring patient encounters as an allowable, chargeable patient visit *(can this be a skilled svc?)*
- Whereas, Hospitals, SNFs, Outpatient Rehab Facilities, etc… can treat as an allowable, chargeable patient visit
- Does this seem fair, reasonable and/or consistent to you?
  - *It does not to me, and*
  - *That's what makes this an issue worthy of comment*

The Use of Technology

- Following are a couple potential comments for this area:

Primary

We request that home health be able to treat the Telehealth/Remote Patient monitoring visits as allowable chargeable visits as part of the Medicare Home Health Benefit.

Secondary

We request that home health be able to attribute the costs of providing Telehealth/Remote Patient monitoring to the disciplines involved in providing that service as opposed to treating as an Admin cost.

Summary

- And that concludes our detailed look at the CY2021 Proposed Rule
- We've discussed the following areas:
  - The Wage Index Changes
  - the PPS Payment Update
  - the Rural Add-on Payments
  - Outliers
  - RAP Submission Changes for CY 2021 and
  - The Use of Technology under the Medicare Home Health Benefit

Summary

- And we started, with a discussion on the importance of increased industry participation in the Rule-Making Process
  - That we need to increase the couple 100 comments
  - To several thousand comments submitted by the industry each and every year
    - Because both the quantity and
    - The quality of the comments submitted make a diff!
  - And we also talked about numerous issues worthy of comment from this year's Proposed Rule

Summary

- Including:
  - Telehealth/Remote Patient Monitoring
    - Two potential comments here!
  - The changes to the service areas of over 100 counties
  - Creating a Home Health specific Wage Index
  - The Outlier Provision
  - And anything else identified in the Proposed Rule

Summary

- Conclusion
- Thank you for your time!

Q & A

Contact Information

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