The Proposed HH PPS Rule for CY2022

A review of the changes from an Industry-Wide Perspective down to the agency level.

Advanced Planning does make a difference!

1

Intro

- This presentation is primarily going to be about the changes to HH PPS/PDGM
  - It's projected effect on the industry overall,
  - The significant areas of change, as well as
  - The projected impact at the agency level
    - Which should be your primary concern
- Based on that premise – see the following poll questions

2

Poll Question 1:

Note: Every CBSA/Service Area has 432 HIPPS Codes/unique pmt rates

- CMS identified an increase of 1.7% in this Proposed Rule.
  Q: What is this a proposed increase of?
  a) Each of the 432 pmt rates for all CBSA/Service Areas
  b) The Avg change of all 432 pmt rates for each CBSA/SA's
  c) The Nat'l, Std, 30-day pmt rate for the 432 pmt calc's or
  d) Total Home Health Spending
- And, as a follow-up, see Poll Question # 2

3

Poll Question 2:

- Based on the preceding question, what should I expect the change in my Medicare revenue to be?
  a) A 1.7% increase (↑) for all my 30-day pmt periods
  b) An avg ↑ of 1.7% for all my 30-day pmt rates *(some better, some worse)*
  c) No change in my avg pmt rate for all my 30-day pmt periods, or
  d) This does not give me enough information – I must have it calculated for my agency each year to identify

Thursday, August 19, 2022 4

4

The Polling Questions

- 1) What is the 1.7% an increase of?
  a) All 432 pmt rates per CBSA/SA
  b) The avg change for all pmt rate changes
  c) The Nat'l, Std, 30-day pmt rate, or
  d) Total Home Health Spending
- 2) Do you know what to expect for your agency?
  a) All 432 pmt rates per CBSA/SA will increase 1.7%
  b) The avg change for all pmt rate changes will be 1.7% *(some↑, some↓)*
  c) No change in my pmt rates, or
  d) I cannot tell by the 1.7% comment, I must calculate for my agency

Thursday, August 19, 2022 5

5

Agency-Specific Considerations

- Let's look at this from an agency-level perspective:
- When we look at it by CBSA/SA on a case-by-case basis, one CBSA out there will see an individual pmt rate increase by as much as **35.7%**
  - Having 424 *(of 432)* rates increase between **0.9%** to **35.7%**
  - And only 8 rates decreasing somewhere between **0.16%** to **14.2%**

Thursday, August 19, 2022 6

6

Agency-Specific Considerations

- Conversely, a different CBSA/SA is projected to have A MAX Increase of only **3.5%**, with
  - Having only 2 (of its 432) rate increases: **3.5%** & **3.2%**
  - Meaning 430 of its payment rates will decrease, ranging between **0.07%** to **34.6%**
- Which CBSA/SA would you rather operate in?
- Do you know the changes for your CBSAs/SAs?

Thursday, August 19, 2022 7

7

Agency-Specific Considerations

- To take that a step further,
- The Avg CBSA Service Area throughout the program will see changes ranging from:
  - A **MAX Inc of approx. 22.7%** for a 30-day pmt
  - To a MAX Dec of approx. 22.4%
  - So, hard to say whether these agencies/locations will be winners or losers!
  - Are you OK with that uncertainty?

Thursday, August 19, 2022 8

8

Agency-Specific Considerations

- And that's based on an increase in HH Spending of 1.7%
- This variability is more the norm than the exception to the rule for the changes for each year's Proposed/Final Rule
  - And Proposed Increases often decrease at the FINAL Rule:
    - the CY2021 Projected Increase @ Proposed was 2.6%
    - the CY2021 Projected Increase @ FINAL was 1.9%
    - A 27% reduction to the original, proposed increase!

Thursday, August 19, 2022 9

9

Agency-Specific Considerations

- So, bearing that in mind, do you think you should determine what the impact to your payment rates will be for CY2022?
  - And every year per the Proposed/FINAL Rules hereafter?
- IMO, this is something that every agency should be doing every year! And should have been …
  - Just as all HHAs should analyze their Resource Utilization
  - And should be doing Monthly Financial-Operational Analyses
    - *To understand what your financials are trying to tell you!*

10

Proposed Changes for the HH PPS/PDGM

- The preceding was looking at the projected Medicare Revenue impacts at the agency level per this P Rule
- Now, we're going to dig into the Rule itself and look at the changes proposed for CY2022
- The first section we'll look at are the Proposed Changes to HH PPS *(PDGM)*

11

Home Health Spending

- Home Health spending is projected to increase $310M
  - a 1.7% increase (↑) from 2021 *(from HH spending)*
  - **Note: *That's <u>NOT</u> a 1.7% ↑ in agency-level revenues!!!***
    - It never has been throughout the entirety of PPS!
    - Some HHAs' will see an increase around this rate
    - But most agencies will not
      - Some will see an increase, but less than @ the 1.7% level
      - While many others will actually realize a reduction in their Medicare revenues for CY2022!

12

Proposed Changes for the HH PPS/PDGM

- As previously noted, the only way to identify what the projected impact to your agency will be is to have it calculated
- There are a lot of moving parts impacting this change each year and that is what is presented in the Proposed and FINAL Rules each year
- As they say: "*The devil is in the details!*"
- So, let's get into some details …

Thursday, August 19, 2022 13

13

Behavior Assumption Adjustment

- 1st: CMS' "*Behavior Assumption Adjustment*"
  - Originally proposed to be @ 8.01%
  - Finalized @ 4.36%, back in CY2020
- This was a continuation of CMS' "*Nominal Change in the Case-Mix Weight Adjustment*" which CMS used from 2008 thru 2019 to cut HH spending by over 20%!
- Watch out for it to re-appear in the near future:

Next, we calculated what the CY 2020 30-day periods of care base payment rate and FDL should have been, to achieve the estimated aggregate payments for the simulated 60-day episodes in CY 2020. We then calculated a percent change between the payment rates. In other words, we divided the CY 2020 repriced 30-day base payment rate by the actual CY 2020 base-payment rate minus one. We determined the CY 2020 30-day base payment rate was approximately 6 percent higher than it should have been, and would require temporary retrospective adjustments for CY 2020 and subsequent years until a permanent prospective adjustment could be implemented in future rulemaking.

Thursday, August 19, 2022 14

14

No-Pay RAPs Change to Notice of Admission

- More or less a formality now is the change from a No-Pay RAP to the NOA starting Jan 1, 2022:

We are reminding stakeholders of the policies finalized in the CY 2020 HH PPS final rule with comment period (84 FR 60544) and the implementation of a new one-time Notice of Admission (NOA) process starting in CY 2022. In

  - One change of significance though is as follows:

an NOA for CYs 2022 and beyond would mirror that of the RAP in CY 2021. Starting in CY 2022, HHAs will submit a one-time NOA that establishes the home health period of care and covers all contiguous 30-day periods of care until the individual is discharged from Medicare home health services.

- Additionally, the late-filing penalty still applies to the NOAs – see the following:

Thursday, August 19, 2022 15

15

NOA Late Filing Penalty information

the individual is discharged from Medicare home health services. Also, for the one-time NOA for CYs 2022 and beyond, we finalized a payment reduction if the HHA does not submit the NOA for CYs 2022 and beyond within 5 calendar days from the start of care. That is, if an HHA fails to submit a timely NOA for CYs 2022 and beyond, the reduction in payment amount would be equal to a one-thirtieth reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date until the date the HHA submitted the NOA. In other words, the one-thirtieth reduction would be to the 30-day period adjusted payment amount, including any outlier payment, that the HHA otherwise would have received absent any reduction. For LUPA 30-day periods of care in which an HHA fails to submit a timely NOA, no LUPA payments would be made for days that fall within the period of care prior to the submission of the NOA. We stated that these days would be a provider liability, the payment reduction could not exceed the total payment of the claim, and that the provider may not bill the beneficiary for these days.

Example

1/1/2022 = Day 0 (start of the first 30- day period of care)

1/6/2022 = Day 5 (An NOA submitted on or before this date would be considered "timely-filed".)

1/7/2022 and after = Day 6 and beyond (An NOA submitted on and after this date will trigger the penalty.) In the event that the NOA is not timely-filed, the penalty is calculated from the first day of that 30-day period (in the example, the penalty calculation would begin with the start of care date of January 1, 2022, counting as the first day of the penalty) until the date of the submission of the NOA.

Thursday, August 19, 2022 16

16

Market-Basket Update

- The Market-Basket Update (MBU) is our inflation adjusted update for the upcoming year.
- There's a lot in here we could talk about, what with the annual economy-wide private nonfarm business multifactor productivity (MFP) adjustment per §1895 of the Affordable Care Act, alone – do you know this?
- The MBU for CY2022 starts @ +2.4%
- Less the MFP rate of **-0.6%**
- So, the net MBU for CY2022 is proposed to be +1.8%
  - What will it be at FINAL?

Thursday, August 19, 2022 17

17

The Home Health Wage-Index

- Next, let's look at the HH Wage Index
  - First, we don't have an HH-specific Wage Index (WI)
  - CMS uses Inpatient Hospital data to determine our WI
    - Do you think that reasonably represents HH?
  - There are 465 CBSA/SAs covered by Medicare
  - The WI is CMS' approach to try to make the payment rates equivalent in all 465 CBSA/SAs, when considering the labor-rate differences in these CBSA/SAs

Thursday, August 19, 2022 18

18

The Home Health Wage-Index

- Of the 465 CBSA/SAs:
  - 226 are proposed to have an increase in their WI
  - 234 are proposed to see a decrease
  - With the WI for 5 CBSA/SAs not changing in CY2022
- When it comes to Medicare payment rates *(ceteris paribus)*,
  - CBSA/SAs w/an ↑ in their WI will obviously do better, and
  - CBSA/SAs w/a ↓ in their WI will do worse
- What's the impact at your CBSA/SA(s)?

Thursday, August 19, 2022

19

19

LUPA Thresholds

- Next, LUPAs
- Certainly, a whole lot more complex under PDGM
- The thresholds are proposed remain the same for CY2022
- 432 HIPPS Codes with the following LUPA Thresholds:

# @ 2	94
# @ 3	130
# @ 4	128
# @ 5	72
# @ 6	8
	432

no changes!

Thursday, August 19, 2022

20

20

LUPA Thresholds

- **Q:** Is it important to know the LUPA Thresholds?
  - Absolutely!
  - You should never have controllable LUPA encounters!
- And it is important that you track and trend your LUPA encounter rates annually
- Historically, LUPA episodes/encounters accounted for approx. 7% of all episodes in HH
  - See excerpt from the Proposed Rule on the next slide

Thursday, August 19, 2022

21

21

LUPA Thresholds

- Note that CMS identifies that the LUPA rate was:
  - 6.7% for 2018*
  - 6.8% for 2019*, and
  - 8.6% for 2020 – does this seem realistic?
    - Remember COVID-19?

* See CMS' notes → → →

TABLE 4: THE PROPORTION OF 30-DAY PERIODS OF CARE THAT ARE LUPAs AND THE AVERAGE NUMBER OF VISITS BY HOME HEALTH DISCIPLINE FOR LUPA HOME HEALTH PERIODS, CYs 2018-2020

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020
Total percentage of overall 30-day periods of care that are LUPAs	6.7%	6.8%	8.6%
Discipline (Average # of visits for LUPA home health periods)			
Skilled Nursing	1.15	1.14	1.19
Physical Therapy	0.43	0.46	0.53
Occupational Therapy	0.07	0.07	0.08
Speech Therapy	0.02	0.02	0.02
Home Health Aide	0.01	0.01	0.01
Social Worker	0.01	0.01	0.01

Source: Analysis of data for CY 2018 through CY 2020. CY 2018 and CY 2019 data came from the Home Health LDS file and we applied the three behavioral assumptions to half the claims (randomly selected). CY 2020 was accessed from the CCW VRDC on March 30, 2021.
Notes: The average (CY 2018 to CY 2020) number of visits per 30-day periods of care across all claims for skilled nursing is 4.46, for physical therapy is 3.13, for occupational therapy is 0.97, for speech therapy is 0.19, for home health aid is 0.65, and for social worker is 0.07. There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in this analysis.

Thursday, August 19, 2022 22

22

Case-Mix Weights

- As previously noted, each CBSA/SA has 432 unique Case-Mix Weights (CMW)
- Which is associated with a unique HIPPS Code, and
- Each creates a unique payment rate
- Consequently, each CBSA/SA has:
  - 432 HIPPS Codes, each with
  - Its own, unique Case-Mix Weight,
  - And unique payment rate

Thursday, August 19, 2022 23

23

Case-Mix Weights

- So, any change in the CMWs impacts the associated revenue for each HIPPS Code
- It was just a few years ago (2018?) that CMS unilaterally decided that they would review and possibly adjust the CMWs on an annual basis
  - Prior to that they generally did that kind of review every 3-5 or so years
- Do you think this potential change every year will really give CMS and the industry a good perspective on the accuracy of the CMWs developed?
  - I wonder about this!

Thursday, August 19, 2022 24

24

Case-Mix Weights

- Again, under PDGM, there are 432 CMWs
- For CY2022:
  - 223 are proposed to increase,
    - With the MAX Increase being **+15.94%**, and
  - 209 are proposed to decrease
    - With the MAX Decrease being **-26.73%**
- As this affects the Medicare pmt rates,
  - An increase in the CMW is a positive, whereas
  - A Decrease in the CMW is a negative

25

National, Standardized 30-day Payment Rate

- Next, we're going to look at the 30-day pmt rate
- Remember, an Episode is still for 60-days,
  - As it coincides with the OASIS
- And pre-PDGM, there was one payment rate for each 60-day episode
- Now, under PDGM, there are two 30-day payment periods possible for each 60-day episode
- And the calculation of the payment rates starts with the National, Standardized 30-day Payment Rate

26

National, Standardized 30-day Payment Rate

TABLE 19: CY 2022 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2021 National Standardized 30-Day Period Payment	Case-Mix Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 National, Standardized 30-Day Period Payment
$1,901.12	1.0390	1.0013	1.018	$2,013.43

and

TABLE 20: CY 2022 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2021 National Standardized 30-Day Period Payment	Case-Mix Weights Recalibration Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update Minus 2 Percentage Points	CY 2022 National, Standardized 30-Day Period Payment
$1,901.12	1.0390	1.0013	0.998	$1,973.88

27

National, Standardized 30-day Payment Rate

- The preceding 30-day rates must then be adjusted for:
  - Labor *(76.1%)* and non-Labor *(23.9%)*,
  - The CBSA/SA's Wage Index, and
  - The patient-encounter's Case-Mix Weight
- And the prescribed calculations identify what the Medicare payment rate will be for that *(and every)* 30-day payment period for any agency.

Note: The above mechanics are also used to calculate the Per-Visit LUPA Rates for every CBSA/SA

28

National Per Visit Rates (LUPA Rates)

- Next, we'll look at the LUPA Rates for CY2022
- Each CBSA/SA will have its own Per Visit LUPA Rates
  - **Note:** These come into play for calculating both:
    - The LUPA Revenue for a LUPA situation, and
    - The imputed costs for an Outlier situation *(more on this later)*
- As with the 30-day payment rates, CMS identifies LUPA Per Visit Rates for HHAs that DO and those that DON'T submit the required quality data

29

National Per Visit Rates (LUPA Rates)

- For HHAs that DO submit the required quality data:

TABLE 21: CY 2022 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2021 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update	CY 2022 Per-Visit Payment
Home Health Aide	$69.11	X 1.0014	X 1.018	$70.45
Medical Social Services	$244.64	X 1.0014	X 1.018	$249.39
Occupational Therapy	$167.98	X 1.0014	X 1.018	$171.24
Physical Therapy	$166.83	X 1.0014	X 1.018	$170.07
Skilled Nursing	$152.63	X 1.0014	X 1.018	$155.59
Speech-Language Pathology	$181.34	X 1.0014	X 1.018	$184.86

30

National Per Visit Rates (LUPA Rates)

- For HHAs that DO NOT submit the required quality data:

TABLE 22: CY 2022 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline	CY 2021 Per-Visit Rates	Wage Index Budget Neutrality Factor	CY 2022 HH Payment Update Minus 2 Percentage Points	CY 2022 Per-Visit Rates
Home Health Aide	$69.11	X 1.0014	X 0.998	$69.07
Medical Social Services	$244.64	X 1.0014	X 0.998	$244.49
Occupational Therapy	$167.98	X 1.0014	X 0.998	$167.88
Physical Therapy	$166.83	X 1.0014	X 0.998	$166.73
Skilled Nursing	$152.63	X 1.0014	X 0.998	$152.54
Speech- Language Pathology	$181.34	X 1.0014	X 0.998	$181.23

31

LUPA Add-on

- CMS has historically paid what they call the:
  LUPA Add-on
- The LUPA Add-on is an additional $ amount, over and above the LUPA Per Visit Rate to try to offset the administrative costs an agency will incur but not have the full 30-day payment to cover those costs
- The LUPA Add-on is an inflationary-type factor applied to the LUPA Per Visit Rate of the 1st visit's discipline LUPA Rate

32

LUPA Add-on

- The original LUPA Add-on factors are remaining the same for CY2022, and they are:
  - 1.8451 for SN,
  - 1.6700 for PT, and
  - 1.6266 for ST
- For example, assume that 3 visits were done for this 30-day pmt period which resulted in a LUPA *(w/a SN (1st) and 2 PT visits)*, the LUPA revenue calculation would be as follows:

33

LUPA Add-on

- LUPA Rev cal'c – Order of visits: SN, PT, PT
- The wage adjusted LUPA Rates are:
  - SN – $132.13
  - PT – 144.42
- The revenue calculation:
  - 1st Visit: $132.13 x 1.8451 *(the add-on factor)* = $243.79 +
  - PT Visits: $144.42 x 2 *(for 2 PT visits)* = 288.84
  - For a Total LUPA Revenue *(including add-on)* of: $532.63

Thursday, August 19, 2022

34

34

LUPA Add-on

- However, there is a change this year
- OT has now been approved to complete the 1st, assessment visit *(as long as SN is not in the original POC and PT and/or ST are also involved)* and hence, CMS has established an OT LUPA Add-on factor
- CMS feels there currently is a lack of data to establish a true OT LUPA Add-on rate, so they propose to use the PT rate *(1.6700)* until they have more data to calculate a more accurate OT LUPA Add-on factor.

Thursday, August 19, 2022

35

35

Rural Add-on

- CY2022 is the last year of the Rural Add-on
  - This provision is scheduled to sunset on Dec. 31, 2022

TABLE 23: HOME HEALTH 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

- As this is for CY2022, only the Low Population density category will receive a Rural Add-on

Thursday, August 19, 2022

36

36

Rural Add-on

- If you believe that the Rural Add-on is necessary for services provided in Rural America
- Then you should submit a comment to this Proposed Rule requesting that the Rural Add-on be extended *(probably for all 3 rural categories)* and
- You MUST contact your Federal Senators and Representatives, requesting them to have CMS extend/re-establish the Rural Add-on as part of the Home Health Benefit!

Thursday, August 19, 2022

37

37

Outliers

- Outliers: a benefit at what cost?
- I considered a couple of polling questions here, but decided against due to time constraints
- But I had considered because of the utter lack of understanding of how the Outlier Provision works and its impact on your Medicare Revenues/Cash-flow
- **Issue**: Almost everyone thinks the Outlier Provision is good because they receive and see that they receive Outlier payments

Thursday, August 19, 2022

38

38

Outliers

- What they don't realize is that all of their Medicare payments are 5% less than what they would have been if the Outlier Provision did not exist. Consider this:
  - Projected HH Spending *(HHS)* is reduced 5% to fund Outliers
  - Outlier pmts to the industry are capped @ 2.5% of HHS
  - So that means that 2.5% of potential funds to the HH industry are eliminated from HHS before any monies are ever paid to the industry!

Thursday, August 19, 2022

39

39

Outliers

- And that 2.5% of this lost HHS *(i.e., a cut)* was due to a section of the Affordable Care Act and has been occurring since 2011
  - This will be YR 12 of this disparity
  - Which costs the industry approx. $450 million per year!

As we noted in the CY 2011 HH PPS final rule (75 FR 70397 through 70399), section 3131(b)(1) of the Affordable Care Act amended section 1895(b)(3)(C) of the Act to require that the Secretary reduce the HH PPS payment rates such that aggregate HH PPS payments were reduced by 5 percent. In addition, section 3131(b)(2) of the Affordable Care Act amended section 1895(b)(5) of the Act by redesignating the existing language as section 1895(b)(5)(A) of the Act and revised the language to state that the total amount of the additional payments or payment adjustments for outlier episodes could not exceed 2.5 percent of the estimated total HH PPS payments for that year. Section 3131(b)(2)(C) of the Affordable Care Act also added section 1895(b)(5)(B) of the Act, which capped outlier payments as a percent of total payments for each HHA for each year at 10 percent.

40

Outliers

- Back to the agency-specific perspective
- As I previously noted, most operators think that the Outlier provision is good because most do receive at least some Outlier pmts during the year
  - Outlier encounters guarantee a loss for most all HHAs for that 30-day service period, even after the Outlier pmt
    - Unless your CPVs are less than your LUPA per visit rates *(which, for almost all HHAs is not the case)*, and
    - You provide no chargeable Med Supplies during the encounter as the cost of Med Supp are ignored in the Outlier cal'c!
      - Think about Wound Care, Diabetic, Ostomy and other type of pts …

41

Outliers

- Also, you must consider the Outlier pmts received vs how much was withheld *(5%)* to fund the Outlier provision
  - 95+% of all HHAs have more withheld to fund the Outlier provision than they receive in Outlier payments
  - However, they don't see the 5% that's withheld,
  - They only see the Outlier pmts that they receive
  - So, they think the Outlier Provision is beneficial for them
  - In other words, they may receive $15k in Outlier pmts and think it's good; while …

42

Outliers

- failing to consider the $100k in potential Medicare revenues withheld to fund the Outlier provision
- So, even though the HHA received $15k in Outlier payments, they still lost $85k in potential Medicare revenue because of the Outlier provision
- Meaning, had the Outlier provision not existed:
  - They would have lost the $15k in Outlier Pmts, but
  - Would have realized an increase in their Medicare revenues of $100k
  - A net pick-up of $85k!

43

Outliers

- That's why I say: *"a benefit at what cost?"*
- Everyone should look back at their last handful of Cost Reports to see what the impact has been to them
- And, if you, like I expect 95+% of all HHAs are losing monies due to the Outlier Provision
- Consider submitting a comment to CMS for this Proposed Rule requesting that *'CMS eliminate the Outlier Provision as part of the HH reimbursement'*

44

Outliers

- A couple more points on the Outlier Provision and it's calculation:
  - An HHA's actual costs for an encounter are not considered in the Outlier calculations
    - 1st: any/all cost for Med Supp are ignored, and
    - Imputed Costs are used *(Disc Visits x LUPA Rate = encounter costs)*
  - The Fixed-Dollar Loss *(FDL)* is set @ 41% for CY2022, and
  - The Loss-Sharing Ratio remains @ 80%

45

Outliers

- See the following:

(2) Fixed Dollar Loss (FDL) Ratio for CY 2022

For a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of periods that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio, and therefore, increase outlier payments for qualifying outlier periods. Alternatively, a lower FDL ratio means that more periods can qualify for outlier payments, but outlier payments per period must be lower.

The FDL ratio and the loss-sharing ratio are selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, we have used a value of 0.80 for the loss-sharing ratio, which, we believe, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs that exceed the outlier threshold amount. Using CY 2020 claims data (as of March 30, 2021), and given the statutory requirement that total outlier payments does not exceed 2.5 percent of the total payments estimated to be made under the HH PPS, we are proposing a FDL ratio of 0.41 for CY 2022.

- Next, we'll look at changes w/Allowed Practitioners

46

Allowed Practitioners

- This is something that the industry has been working on expanding for years
- Apparently, it took the COVID-19 pandemic for the '*powers that be'* *(i.e., CMS)* to finally see the value in these sought-out changes *(reforms?)*!
- IMO, this would be a good area for comment, and one in which we could thank CMS for this advancement which should only further improve our ability to provide timely, quality care to the Medicare beneficiary – see the following:

47

Allowed Practitioners

6. Conforming Regulations Text Changes Regarding Allowed Practitioners

As stated in the May 2020 COVID-19 interim final rule with comment period (85 FR 27550), we amended the regulations at parts 409, 424, and 484 to implement section 3708 of the CARES Act. This included defining a nurse practitioner (NP), a clinical nurse specialist (CNS), and a physician's assistant (PA) (as such qualifications are defined at §§ 410.74 through 410.76) as "allowed practitioners" (85 FR 27572). This means that in addition to a physician, as defined at section 1861(r) of the Act, 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. Additionally, we amended the regulations to reflect that we would expect the allowed practitioner to also perform the face-to-face encounter for the patient for whom they are certifying eligibility; however, if a face-to-face encounter is performed by a physician or an allowed non-physician practitioner (NPP), as set forth in § 424.22(a)(1)(v)(A), in an acute or post-acute facility, from which the patient was directly admitted to home health, the certifying allowed practitioner may be different from the provider physician or allowed practitioner that performed the face-to-face encounter. These regulations text changes are not time limited to the period of the COVID-19 PHE.

When implementing plan of care changes in the CY 2021 HH PPS final rule (85 FR 70298), the term "allowed practitioner" was inadvertently deleted from the regulation text at § 409.43. Therefore, in this proposed rule we are proposing conforming regulations text changes at § 409.43 to reflect that allowed practitioners, in addition to physicians, may establish and periodically review the plan of care.

48

Home Health Value Based Performance Model

- The last area of this Proposed Rule that I want to talk about is the HH VBP Model
- The HH VBP demo started in 9 states *(AZ, FL, IA, MA, MD, NE, NC, TN & WA)* in 2016
- The 1st two years *(2016 & 2017)* were just collecting data
- The next 3 *(2018-2020)* were collecting data as well as having impacts to revenue, and
- The last 2 *(2021 & 2022)* were going to be the last two-years of revenue impacts

49

Home Health Value Based Performance Model

- CMS noted in Jan 2021, that the HH VBP demo had thus far seen a 4.6% improvement in HH quality scores as well as an average annual savings to Medicare of $141 million
- CMS is proposing to expand the HH VBP Model to all 50 states, D.C., and territories covered by the Medicare program starting Jan 1, 2022
- CMS proposes to initially have the revenue impact under the nation-wide HH VBP Model be up to +/- 5% of Medicare payments to any/all HHAs

50

Home Health Value Based Performance Model

- Following are additional proposals for this expansion:
  - 2022 would be the 1st Performance Year *(for all)*, and
  - 2024 would be the start of the Payment Adjustments, and would be based on the HHA's performance in CY2022
  - And that Pmt Rate Adj Factor could go up or down each year, based on the agency's Performance results of two year's prior, meaning:
    - 2022 Performance impacts 2024 Rev,
    - 2023 Performance impacts 2025 Rev, & so on …

51

Home Health Value Based Performance Model

- And CMS would consider adjusting the Rev Adj Factor in future proposed rules
- Each HHA *(distinct CCN)* would have its own unique Pmt Rate Adjustment Factor associated with it for each year, and that factor would be applied to all Medicare revenues received that year *(including Outlier & LUPA pmts)*
  - These Revenue Adjustment Factors could range between
    - +5.0% to -5.0%
    - And any rate in-between

Thursday, August 19, 2022 52

52

Home Health Value Based Performance Model

- Most HHAs would realize an adjustment to their PPS Pmt Rates each year, somewhere in-between +5.0 to -5.0%
  - With some HHAs having a Rev Adj Factor of 0.00% in a given year
- One big difference between the current demo and the expansion as proposed by CMS is:
  - As opposed to the current demo which is segregated by state
    - Each state having its own LARGE and SMALL Cohort *(group)*
    - So currently, there are 18 Cohorts *(9 Large and 9 Small Cohorts)*

Thursday, August 19, 2022 53

53

Home Health Value Based Performance Model

- CMS is proposing that there only be two Cohorts nationwide
  - One Cohort *(group)* for all HHAs in the LARGE group, and
  - One Cohort for all the HHAs in the SMALL group

We are proposing to establish nationwide volume-based cohorts for the expanded HHVBP Model, such that HHAs nationwide would compete within either the larger-volume cohort or the smaller-volume cohort. We propose to codify this policy at § 484.370, and to codify the proposed definitions of smaller-volume cohort and larger-volume cohort at § 484.345. Under this proposal, HHAs currently participating in the original HHVBP Model would no longer compete within just their State. We are also requesting comment on the alternative approach of applying State/territory-based cohorts only, without volume-based cohorts, which we may finalize after consideration of comments received.

We seek public comment on these proposals.

- Whether an HHA belongs to the LARGE or the SMALL Cohort would be based on HHCAHPS & OASIS submissions

Thursday, August 19, 2022 54

54

Home Health Value Based Performance Model

- If adopted, this proposal WILL NOT impact Medicare payments in CY2022 or CY2023
  - As those years will be deemed Performance Years
- HHAs' would start to see the impact to their Medicare payments beginning in CY2024, and every year after
- There's a lot to this proposal, and HHAs operating in the 9 demo states have an advantage as they, for the most part, already understand the rules of the game

55

Home Health Value Based Performance Model

- But to go into the requisite detail to cover all aspects of this proposal would require a separate 60- to 90-minute presentation on its own
- The details of this proposal can be found in § III of the CY2022 Proposed HH PPS Rule
  - In the bookmarked PDF version of this Proposed Rule, that's on pages 53 thru 94 *(of the 200 pg doc)*
- Next, well look at other areas of the Proposed Rule in which CMS is proposing some changes

56

Other Ares of this Proposed Rule

- Other Areas Updated, but not reviewed in this presentation include:
  - HH QRP - **§ IV** *of Proposed Rule*
  - Home Infusion Therapy Services - **§ V** *of Proposed Rule*
  - Medicare Provider and Supplier Enrollment Changes - **§ VI** *of Proposed Rule*, and
  - Survey and Enforcement Requirements for Hospice Programs - **§ VII** *of Proposed Rule*

57

The Rule-Making Process

- Lastly, I want to conclude with a brief overview of the Rule-Making Process
- In a nutshell, the Rule-Making Process is where the regulatory body overseeing a segment of governmental spending *(CMS for us in Medicare)*, proposes a rule change
- If the rule is material enough, then it must be put out to the public for an open comment period
- This is almost always the case for any proposed changes that come from CMS

Thursday, August 19, 2022

58

58

The Rule-Making Process

- Generally, we *(i.e., stakeholders and any interested parties)* are given 30-60 days to review and comment on the Proposed Rule
  - Commenting works!
  - We don't always get everything we want, but it does have an impact on the FINAL Rule
- Once the open comment period has closed, CMS reviews the submitted comments, addresses those comments and submits their FINAL Rule

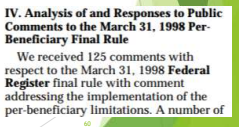
Thursday, August 19, 2022

59

59

The Rule-Making Process

- Unfortunately, the HH Industry stakeholders have been far too lax in taking advantage of this opportunity to positively impact its own future!!!!!
- Going back to 1998, when CMS proposed introducing the *'Per-Beneficiary Cost Limit' (PBL)* as part of the Interim Payment System there were only 125 comments submitted



IV. Analysis of and Responses to Public Comments to the March 31, 1998 Per-Beneficiary Final Rule

We received 125 comments with respect to the March 31, 1998 **Federal Register** final rule with comment addressing the implementation of the per-beneficiary limitations. A number of

Thursday, August 19, 2022

60

60

The Rule-Making Process

- 125 comments at a time when there were over 12,500 operating, Medicare Certified HHAs
  - Over the next 5+ years *(by the end of 2003)*, the introduction of the PBL had caused almost 40% of all HHAs at the start of 1998 to have closed or de-certified!
  - Do you think that 1,000s of HHA owners/operators had wished in 1999-2003 that they had submitted comments in 1998 to try to reduce the dire impact the changes proposed in 1998 ultimately had on their agency's?

61

The Rule-Making Process

- In 2014, CMS proposed rebasing HH reimbursement; which was the biggest proposed change to HH reimbursement since the inception of PPS back in 2000
  - There were only 100 comments submitted
  - 2014 was the 1st year since 2003 that there were fewer certified HHAs at the end of the year than at the start
  - And that trend continues even now
- 2016 – Pre-Claim Review *(was: Prior Authorization Demo)*
  - Approx. 200 Comments submitted

62

The Rule-Making Process

- For CY2020 – PDGM was proposed
  - 1,345 comments submitted
  - Over 11,500 certified HHAs, let alone all other stakeholders
  - And most of those comments were NOT by HHAs!
- As I have spoken around the country *(in person & virtual)* for years, I have always been surprised at the # of individuals in HH that did not know that this opportunity existed

63

The Rule-Making Process

- You can submit comments
  - As a representative for your agency(s)
  - As an individual
  - Even anonymously
  - I have even seen beneficiaries that have submitted
- Comments can be:
  - Mailed
  - Overnighted
  - An even submitted electronically, the easiest, by far!

Thursday, August 19, 2022 64

64

The Rule-Making Process

- Following is how you can submit:

Dates

To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 27, 2021.

Addresses

In commenting, please refer to file code CMS-1747-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1747-P, P.O. Box 8013, Baltimore, MD 21244-8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1747-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION section.

Thursday, August 19, 2022 65

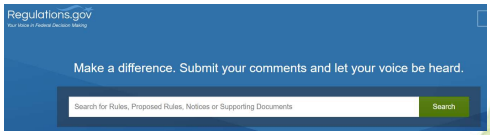
65

The Rule-Making Process

- Note: The electronic submission has a link that you can access via the Proposed Rule

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the "Submit a comment" instructions.

- This link takes you to:

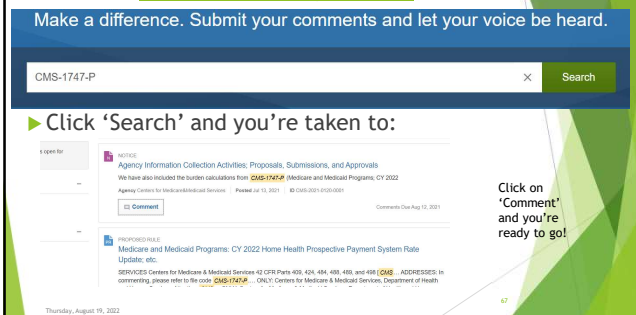


- Just type in "CMS-1747-P" and click 'Search'

Thursday, August 19, 2022 66

66

The Rule-Making Process



- Click 'Search' and you're taken to:

Click on 'Comment' and you're ready to go!

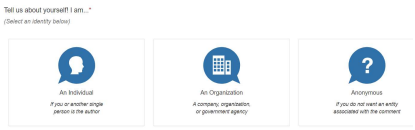
Thursday, August 19, 2022

67

67

The Rule-Making Process

- You can type your comment directly on this page, or
- You can drop an attachment *(up to 20)* on to this page *(this is generally how I do it)*
- And, as previously noted



Thursday, August 19, 2022

68

68

The Rule-Making Process

- This is real advocacy for the industry
- And it does make a difference
- And, you can be selfish, in that your comments can be based solely on your considerations for your agency only; not necessarily for the industry, because generally
  - I believe what is good for the specific agency, is also likely good for the industry
- So, I would request that you consider submitting comments this year, and as long as you are in HH!

Thursday, August 19, 2022

69

69

The Rule-Making Process

- **Some areas that could warrant comments include:**
- The difference between Assumed and Actual Behavioral Changes which CMS used in CY2020 to reduce HH Spending by 4.86% (originally proposed a 8.01% reduction) (§ II, pgs 21-24)
- CMS's annual recalibration of:
  - Case-Mix Weights (§ II, pgs 32-44)
  - Functional Levels (§ II, pgs 17-19 and 25-27), and
  - Comorbidity Adjustments (§ II, pgs 27-31)
- OT LUPA Add-on – this could be a positive comment for CMS proposing to allow OT's to perform assessments (§ II, pg 50 & § IV, pg 107)
- The Elimination of the Rural-Add on after CY2022 (as noted in webinar) (§, pgs 50-51)
- Allowed Practitioners – another positive comment in which we could thank CMS for allowing NPs, CNS & PAs to be deemed Allowed Practitioners permanently (II XX, pg 53)
- The Outlier Provision -maybe check to see if this provision actually helps or hurts your agencies cash-flows (as identified in my webinar presentation) (§ II, pgs 51-53)
- Nationwide expansion of the HH Value-Based Purchasing Model (§ III, pgs 53-94)
- HH QRP (§ IV, pgs 94-107)
- Modification to aide supervision (§ IV, pgs 105-107)
- Adequacy of Aide Staffing (§ IV, pg 107)

70

Summary

- So, we identified all, and discussed most of the areas in which CMS is proposing changes for CY2022, including:
  - The various payment provisions under HH PPS:
    - HH Spending
    - No-Pay RAPs
    - Case-Mix Weights
    - LUPAs
    - Outliers
    - Market Basket Update
    - HH Wage Index
    - 30-day Pmt Rates
    - Rural Add-on, and

71

Summary

- We also discussed proposed changes to:
  - Allowed Practitioners, and
  - Program-wide expansion of the HH VBP Model
- Identified other areas of change not covered here:
  - HH QRP
  - Home Infusion Therapy Services
  - Medicare Provider & Supplier Enrollment Changes &
  - Survey & Enforcement Requirements for Hospice

72

Summary

- And I closed out the presentation taking about the Rule-Making Process
  - How Rules are first proposed by CMS
  - That we/interested stakeholders then have a limited time to submit comments to try to influence the rule
    - Which I recommend everyone to take advantage of
  - And CMS's review of the comments submitted, and
  - Ultimately, CMS's publication of the FINAL Rule

73

Q&A

- Thank-you for your time and attention!
- Now is the opportunity for attendees to submit their questions or comments regarding the HH PPS Proposed Rule for CY2022.
  - In general, or
  - Agency specific

74

Contact Information

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75