# OVERVIEW OF THE
# 2022 HOME HEALTH FINAL RULE CHANGES


SPEAKERS

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# VBP is Going Nationwide

- Value-based purchasing (VBP) is a program designed to incentivize quality care delivery from organizations by adjusting their Medicare reimbursement payments based on organizational performance data.
- The Centers for Medicare and Medicaid Services (CMS) has tested VBP in nine states since 2016. Between 2016 and 2018, quality scores for participating organizations improved by an average of 4.6 percent annually.
- Program evaluations showed significant savings, reporting an average annual savings of $141 million to Medicare.
- With positive results, CMS announced a nationwide rollout. The **maximum payment adjustment will be increased or decreased by 5 percent**.

# VBP Timeline

## 2020

CMS states that the VBP program will have a baseline year of 2019 and will intentionally avoid using 2020 performance data due to the COVID-19 public health emergency.

## 2021

The **Final Rule expands VBP nationwide but delays the first performance year by one year to 2023, and the data will impact payment adjustments in 2025.**

## 2022

Organizations should **use 2022 to focus on improving areas that will impact performance scores** and **not wait until 2023 to 'begin.'**

# Payment Rates Increasing

- Proposal allows a 1.8 percent Medicare payment increase totaling $330 million in 2022.
- The base rate will increase from $1,901.12 to $2,013.43. There will be a reduction in the rural add-on that takes effect in 2022 as CMS continues its rural add-on phase-out.
- Because of the $20 million rural add-on decrease, the **proposed aggregate increase in Medicare payment for 2022 will total 1.7 percent or $310 million**.

# Payment Rates Increasing

Home health providers will see higher Medicare reimbursement in 2022, with a **3.2 percent ($570 million) increase in total home health Medicare spending set out in the Final Rule**.

There were no changes made to the "phase-out" of the rural add-on in 2022. **2022 will be the last year of 'rural add-on.'**

- Providers in the "low population density" category will continue to receive a 1 percent add-on.

# NOA Requirements Begin

- A Notice of Admission (NOA) is a one-time submission that establishes the home health plan of care (POC). The NOA will begin in 2022. This new process will **eliminate the need for any type of RAP**.
- There is **required submission at the start of care only**. Organizations must submit an NOA to their Medicare Administrative Contractor (MAC) within five calendar days from the start of care date. This covers contiguous 30-day POCs until you discharge the patient from Medicare home health services.
- **If a patient is discharged and readmitted, a new NOA is required at the start of care**.
- **For all patients who are on service on January 1, 2022, organizations will need to submit a one-time NOA at the start of their first 30-day period in 2022**. This establishes a new artificial "admission" date within the Common Working File (CWF) without requiring an actual discharge or readmission on the part of the provider.

# NOA Requirements Begin

- You **must have a verbal or written order from the physician that contains the services required for the initial visit and you must have conducted an initial visit at the start of care**. The NOA only needs to contain **a primary diagnosis which can be generic**.
- **Untimely submissions of NOAs will result in a daily penalty equal to 1/30th reduction to the wage adjusted, 30-day period payment amount for each day from the home health start of care date until the date you submit the NOA.** This payment reduction also applies to outlier payments.
- An organization can request an exception for an NOA submitted outside the five-calendar day window for the following circumstances:
  - Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the agencies' ability to operate.
  - An event that produces a data filing problem due to a CMS or MAC system issue that is beyond your control.
  - You are newly Medicare-certified that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC.
  - Other circumstances that CMS or your MAC determines to be beyond your control.

# Case-Mix Weights and Groupings are Changing

As expected, there was a recalibration of Patient-Driven Groupings Model (PDGM) case-mix weights and some significant grouping changes for two important components of the PDGM payment model. There will be an **increase in low comorbidity subgroups from 13 to 20 and an increase in high comorbidity subgroup pairings from 31 to 87**.

- Functional Impairment Levels
- Comorbidity

The Low Utilization Payment Adjustment (LUPA) thresholds will remain the same in 2022. CMS used 2020 PDGM claims data with linked OASIS data (as of July 12, 2021) to recalibrate the case-mix weights.

# Case-Mix Weights and Groupings are Changing

There was an **increase in the functional impairment points for the Risk of Hospitalization OASIS item**.

There was a **decrease in points for Grooming, Bathing and Ambulation/Locomotion OASIS items**.

The **point thresholds were lowered for various clinical groupings** overall.

# COVID-19 Changes Become Permanent

14-day Aide Supervisory Visit:

- The Final Rule allows **one virtual supervisory visit per patient, per 60-day episode**.
- These virtual visits must only be used as needed and not as a routine part of supervision.
- **Must have very clear documentation as to why it was necessary to perform virtual supervision**—i.e., snowstorm, etc. Instances documented must relate to things outside the organizations' control, not for convenience. Surveyors will be instructed to watch this carefully.

**Aide competency assessments must be done when any patient safety issues are identified**.

# OT Initial Assessments Will Stay

**Occupational therapists (OT) can conduct the initial assessment visit and complete the comprehensive assessment:**

- **For therapy-only cases**
- **Must include an OT in the home health plan of care** with either physical therapy (PT) or speech therapy (ST) and only in cases in which skilled nursing services are not initially on the plan of care.
- **PT or ST must still determine eligibility.**

# COVID-19 Reporting Requirements

Mandatory **COVID-19 reporting requirements will continue** beyond the current COVID-19 public health emergency until December 31, 2024.

Infection control requirements have been extended for nursing homes which may impact hospice providers serving patients in these settings.

# LUPA Changes for OT

OT has only been allowed to conduct the initial assessment during the pandemic so there is not enough data to show the average excess of minutes for the first visit in LUPA periods where the initial and comprehensive assessments were conducted by occupational therapists.

CMS will use the physical therapy LUPA add-on factor as a substitution until data from 2022 becomes available and a more accurate OT add-on factor can be established for LUPA add-on payment amounts.

# LUPA Changes for OT

There will be a **LUPA add-on factor in calculating LUPA add-on payment amounts for occupational therapy visits**.

The add-on factor will **only apply to payments for the first skilled OT visit in LUPA periods occurring as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care**.

# Quality Reporting Program Updates Proposed

Home Health Quality Reporting (HHQRP) proposed changes include several changes to the OASIS as part of these efforts including, but not limited to:

- Removing Drug Education on Medications Provided to Patient/Caregiver measure
- Replacing Acute-Care Hospitalization During the First 60 Days of Home Health measure
- Removing Emergency Department Use Without Hospitalization During the First 60 Days of Home Health measure
- Replacing removed measures with claims-based measure Home Health Within–Stay Potentially Preventable Hospitalization
- Public reporting required of Percent of Patients Experiencing One or More Major Falls with Injury measure

# Additional Data Required at Transfer

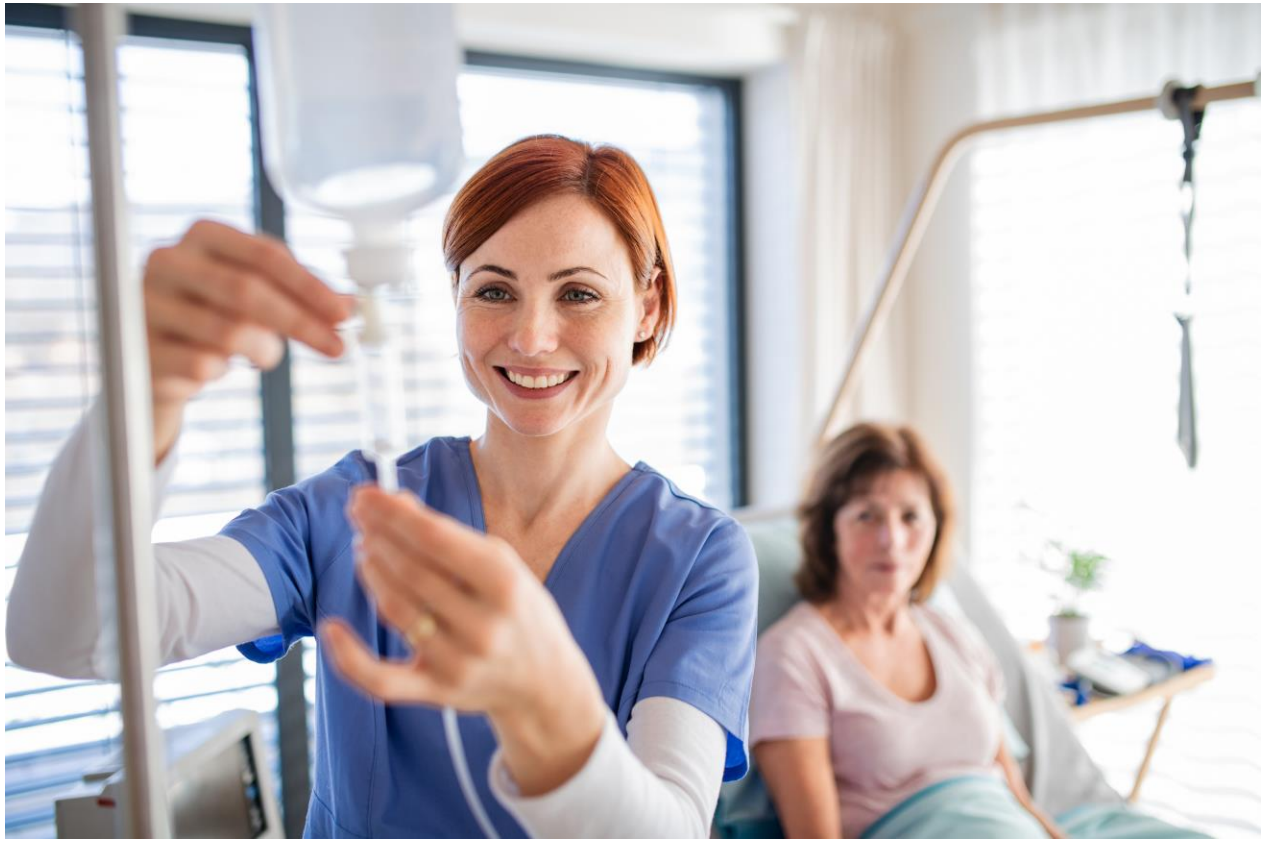
**OASIS-E is beginning in 2023.** Home health organizations will collect the Transfer of Health Information (TOH) to Provider Post-Acute Care measure, the Transfer of Health Information to Patient-PAC measure and certain Standardized Patient Assessment Data Elements (SPADES).

- **Begin collecting data on the two TOH measures beginning with discharges and transfers on January 1, 2023, on the OASIS-E**.
- **Begin collecting data on the six categories of Standardized Patient Assessment Data Elements on the OASIS-E**, with the start of care (SOC), resumption of care (ROC) and discharges (except for the hearing, vision, race and ethnicity Standardized Patient Assessment Data Elements which would be collected at the start of care only) beginning on January 1, 2023.

# Additional Data Required at Transfer

There is a **requirement to publicly report the percent of residents experiencing one or more major falls with injury measure** and application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function measures beginning in April 2022.

# Infusion Therapy Rates Changing



Rates are being updated with a **nominal increase using the same geographic factor used for wage adjustments**.

# References

- Office of the Federal Register, Current Public Inspection Issues
- Centers for Medicare and Medicaid Services, 2020 Final Rule, 9 November 2021
- MLM Matters, Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) - Manual Instructions, 9 June 2021
- CGS, The New 2022 Home Health Notice of Admission (NOA), 28 September 2021

# Support and Resources from Axxess

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