

**Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements
(CMS-1730-P)**

Summary of Proposed Rule

On June 30, 2020, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule addressing updates to the Home Health Prospective Payment System (HH PPS) rates for calendar year 2021,¹ home infusion therapy services requirements, and related matters (85 FR 39408). Among other things, the proposed rule would provide for a 2.7 percent update to the HH PPS rates, adopt new wage area delineations, make permanent changes with respect to including telecommunication services in the home health plan of care that were adopted for purposes of the COVID-19 public health emergency, and create new enrollment requirements for qualified home infusion therapy providers. No changes are proposed to requirements under the Home Health Quality Reporting Program for 2021. **The deadline for public comment is August 31, 2020.**

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¹ Henceforth in this document, a year is a calendar year unless otherwise specified.

I. Overview

CMS reviews the statutory and regulatory history of the HH PPS from 1997. Most recently, beginning on or after January 1, 2020, Medicare makes payment under the HH PPS based on a national, standardized 30-day period payment rate that is adjusted for the applicable case-mix and wage index. The national, standardized 30-day period rate includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine supplies (NRS), previously paid through a separate adjustment, are now part of the national, standardized 30-day period rate. Durable medical equipment provided as a home health service is not included in the national, standardized 30-day period payment.

The Patient Driven Groupings Model (PDGM), also implemented beginning January 1, 2020, is a new patient case-mix adjustment methodology that shifts the focus from volume of services to a model that relies more on patient characteristics. It uses timing of episode, admission source, clinical groups based on principal diagnosis, and level of functional impairment to case-mix adjust payments resulting in 432 unique case-mix groups. Patient characteristics and other clinical information is drawn from Medicare claims and the Outcome and Assessment Information Set (OASIS). In the proposed rule, CMS details how timing, admission source, clinical grouping, functional impairment level, and comorbid conditions are used to establish the PDGM case-mix weights.

For low-utilization episodes, HHAs are paid national per-visit rates based on the discipline(s) providing the services; this payment adjustment is referred to as a low-utilization payment adjustment (LUPA). The national, standardized 30-day episode payment rate is also adjusted for certain intervening events that are subject to a partial episode payment (PEP) adjustment. In addition, an outlier adjustment may be available for certain cases that exceed a specific cost threshold.

For 2020 through 2022, payment for home health services provided to beneficiaries residing in rural counties will be increased based on rural county classification (high utilization; low population density; or all others (section 50208 of the Bipartisan Budget Act (BBA) of 2018).

II. Payment Under the Home Health Prospective Payment System

A. 2020 PDGM Low-Utilization Payment Adjustment (LUPA) Thresholds and PDGM Case-Mix Weights

As discussed further below, CMS proposes to maintain for 2021 the LUPA thresholds and PDGM case-mix weights that were finalized for 2020. As noted, these factors are shown in Table 16 of the 2020 HH PPS final rule. In addition, CMS has reposted them on its HHA Center webpage: <https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center>.

1. 2021 PDGM LUPA Thresholds.

Low utilization payment adjustments (LUPAs) are paid when a certain visit threshold for a payment group during a 30-day period of care is not met.² LUPA thresholds are set at the 10th percentile value of visits or 2 visits, whichever is higher for each payment group. That is, the LUPA threshold for each 30-day period of care varies based on the PDGM payment group to which it is assigned. If the LUPA threshold is met, the 30-day period of care is paid the full 30-day period payment. If a 30-day period of care does not meet the PDGM LUPA visit threshold, then payment is made using the per-visit payment amount.

CMS adopted a policy that the LUPA thresholds would be updated each year based on the most current utilization data available. However, because 2020 is the first year of implementation of the PDGM and the 30-day period of care, CMS says does not have sufficient data to update the thresholds for 2021. Therefore, CMS proposes to maintain the thresholds adopted for 2020, as shown in Table 16 of the HH PPS final rule for 2020 (84 FR 60522). Those thresholds were based on 2018 Medicare home health claims as of July 31, 2019, linked to OASIS assessment data.

2. 2021 PDGM Case-Mix Weights.

For 2020, CMS determined the PDGM case-mix weights using a data file based on home health 30-day periods of care, as reported in the 2018 Medicare home health claims available as of July 31, 2019, linked to OASIS assessment data to obtain patient characteristics. The claims data provide visit-level data and data on whether NRS were provided during the period and the total NRS charges. CMS determined the case-mix weight for each of the 432 different PDGM payment groups by regressing resource use on a series of indicator variables for each of the categories using a fixed effects model, as discussed in detail in the proposed rule. The case-mix weight is then used to adjust the base payment to determine each 30-day period's payment. Table 15 in the 2020 HH PPS final rule (84 FR 60521) shows the coefficients of the payment regression used to generate the weights, and the coefficients divided by average resource use for PDGM payment groups. The final 2020 case-mix weights that CMS proposes to maintain for 2021 are provided in Table 16 of the 2020 HH PPS final rule (84 FR 60522).

Although CMS plans to annually recalibrate the case-mix weights using the most current data available, it proposes to continue to use the 2020 case-mix weights for the 2021 HH PPS due to limited data for 2020. As with the proposal to maintain the LUPA thresholds into 2021, CMS believes this will be less burdensome to HHAs and software vendors who are still learning the new case-mix methodology.

B. Home Health Wage Index

CMS proposes to update the home health wage index to reflect updates to the Office of Management and Budget (OMB) designations of Metropolitan and Micropolitan Statistical

² The thresholds previously in place for 60-day episodes of care resulted in LUPAs accounting for about 7 to 8 percent of episodes, and CMS set 30-day thresholds to achieve about the same percentage of LUPA episodes under the PDGM.

Areas.³ In particular, for 2021, the wage index would reflect changes included in OMB Bulletin No. 18-04, issued on September 14, 2018. That bulletin is available at <https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf>. Further, CMS notes that on March 6, 2020, OMB issued OMB Bulletin 20-01—available on the web at <https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf>—but says it was not issued in time for development of this proposed rule. CMS plans to assess the changes in that latest bulletin and propose adoption of any updates in the 2022 HH PPS proposed rule.

The changes included in OMB Bulletin No 18-04 would result in new Core Based Statistical Areas (CBSAs), changing 34 urban counties to rural, 47 rural counties to urban, and splitting some existing CBSAs. Tables 3, 4, and 6 in the proposed rule detail these substantive changes; Table 5 identifies areas where only the CBSA name or number would change, without affecting assignment of a wage index.

To mitigate any negative impact of these changes in the wage index, CMS proposes to adopt the changes in OMB Bulletin 18-04 beginning with the 2021 HH PPS wage index, and to provide for a 5 percent cap on decreases in any HHA’s wage index for 2021 when compared to 2020. The cap would provide for a transition to the new wage index areas. No cap would be applied in FY 2022. Readers are referred to the proposed rule wage index table available on the HHA Center webpage, which shows the current and revised wage areas, counties included in the revised area, and the proposed wage index for the area for 2021.

Table 17 in the proposed rule, reproduced in section V of this summary, shows the impact of the proposed adoption of the new wage area delineations by type of HHA.

C. 2021 Home Health Payment Rate Updates

1. CY 2021 Home Health Market Basket Update for HHAs

Unlike for 2020, there is no specific statutory market basket update for the HH PPS for 2021. The update will equal the projected increase in the market basket adjusted for changes in economy-wide productivity. Based on IHS Global Insight Inc.’s first-quarter 2020 forecast for 2021 with historical data through fourth-quarter 2019, the proposed HH PPS market basket update is as follows:

Market Basket Update	Change (in %)
Market basket forecast	3.1
Multifactor productivity	-0.4
Net update for HHAs reporting quality data	2.7
Net update for HHAs NOT reporting quality data	0.7

³ OMB defines a Micropolitan Statistical Area as an area ‘associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. Under previously adopted policies, CMS treats these as rural areas for purposes of the hospital and home health wage indexes.

More recent forecasts for 2021 will be used for the final rule, if available. As noted below, the final update factor also includes budget neutrality adjustments for the wage index and case-mix recalibration.

2. CY 2021 Home Health Wage Index

CMS proposes to continue to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates for 2021, using FY 2017 hospital cost report data as its source for the updated wage data. As discussed above, CMS is proposing to transition to adoption of revisions to the delineations of Metropolitan Statistical Areas (MSAs) and the creation of Micropolitan Statistical Areas, and CBSAs set forth in OMB Bulletin No. 18-04, issued on September 14, 2018. For urban areas without an inpatient hospital, CMS proposes to continue to use the average wage index from all other urban areas in the state; this currently involves only Hinesville, GA. For rural Puerto Rico, the most recently available wage index for the area would continue to be used.

3. CY 2021 Annual Payment Update

a. Background. CMS discusses the methodology it uses to compute the case-mix and wage-adjusted 30-day period rates as set forth in §484.215. It first multiplies the national, standardized 30-day period rate by the patient's applicable case-mix weight. It then divides the case-mix adjusted amount into labor (76.1 percent) and non-labor (23.9 percent) portions. The labor portion is multiplied by the appropriate wage index based on the site of service and summed to the non-labor portion.

Next, CMS may adjust the resulting 30-day case-mix and wage-adjusted payment based on the information submitted on the claim to reflect:

- A LUPA is provided on a per-visit basis (§§484.205(d)(1) and 484.230).
- A partial episode payment (PEP) adjustment (§§484.205(d)(2) and 484.235).
- An outlier payment (§§484.205(d)(3) and 484.240).

Implementation of the PDGM and the 30-day unit of payment began in 2020, and CMS is required to annually analyze data (for 2020 through 2026) to assess the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. For 2021, CMS is not proposing to make any additional changes to the 30-day payment rate other than the routine updates described further below. It continues to monitor the impact of the case-mix and unit of payment changes on patient outcomes and program expenditures, but believes that it would be premature to release information based on the limited data available and in light of the COVID-19 public health emergency. In future rulemaking, CMS plans to consider analysis of actual versus assumed behavior change to determine whether any changes need to be made to the national, standardized 30-day period payment rate.

b. 2021 National, Standardized 30-Day Period Payment Amount. To determine the 2021 national, standardized 30-day period payment rate, CMS applies a wage index budget neutrality factor and the home health payment update percentage. (No case-mix budget neutrality adjustment is necessary because CMS proposes to maintain the 2020 case-mix weights for 2021.)

In future years CMS will apply a case-mix budget neutrality factor to account for changes between the previous year's PDGM case-mix weights and the recalibrated weights.) The following table shows the proposed standardized amounts, as displayed in proposed rule Tables 7 and 8.

Proposed 2021 National, Standardized 30-Day Episode Payment Amount, for HHAs Submitting and Not Submitting Quality Data		
	HHAs submitting quality data	HHAs not submitting quality data
2020 30-day budget neutral standardized amount	\$1,864.03	
Wage index budget neutrality factor	x 0.9987	
HH payment update percentage	x 1.027	x 1.007
2021 30-day payment amount	\$1,911.87	\$1,874.64

c. *2021 National Per-Visit Rates for 30-Day Periods of Care.* Computations are presented for the 2021 proposed per-visit amounts for each type of service. These amounts are used for LUPAs and in outlier calculations. The proposed per-visit amounts for those HHAs submitting the required quality data (Table 9 in the proposed rule) are as follows:

Proposed 2021 National, Per-Visit Payment Amounts for HHAs that Submit Quality Data				
HH Discipline	CY 2020 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2021 HH Payment Update	CY 2021 Per-Visit Payment
Home Health Aide	\$67.78	X 0.9988	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

HHAs that do not submit required quality data would have the payment update for per-visit services reduced from 2.7 percent to 0.7 percent, resulting in the following payment rates:

Proposed 2021 National, Per-Visit Amounts for HHAs that Do Not Submit 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

CMS reminds stakeholders that as adopted in the 2020 HH PPS final rule (84 FR 60544), for 2021 all HHAs (both existing and newly-enrolled HHAs) must submit a “no-pay” Request for Anticipated Payment (RAP) at the beginning of each 30-day period. This will establish the home health period of care in the common working file and also trigger the consolidated billing edits. A payment reduction is applied if the HHA does not submit the RAP within 5 calendar days from the start of care. The reduction equals one-thirtieth of the wage and case-mix adjusted 30-day period payment amount, including any outlier payment, for each day from the home health start of care date until the date the HHA submitted the RAP. For LUPA 30-day periods for which an HHA fails to submit a timely RAP, no LUPA payments will be made for days that fall within the period from the start of care prior to submission of the RAP. These days would be a provider liability; the payment reduction cannot exceed the total payment of the claim; and the provider may not bill the beneficiary for these days. Beginning in 2022, HHAs will submit a one-time Notice of Admission (NOA) that includes similar information to the 2021 RAP. The NOA will establish the home health period of care and covers all contiguous periods of care until the patient is discharged from Medicare home health services, and similar penalties for failure to timely submit the NOA will apply.

d. LUPA Add-on Factors. Under previously adopted policy, to determine the LUPA add-on payment for a 30-day period of care, CMS multiplies the per-visit payment amount for the first skilled nursing, physical therapy, or speech-language pathology visit in a LUPA period that is the first 30-day period of care or the initial 30-day period of care in a sequence of adjacent periods. The add-on factors are 1.8451 for skilled nursing, 1.6700 for physical therapy, and 1.6266 for speech-language pathology.

e. Rural Add-On Payments for 2021 and 2022. Section 50208(a)(1)(D) of the BBA of 2018 provides rural add-on payments for episodes and visits ending during 2019 through 2022. In the 2019 HH PPS final rule (83 FR 56443), CMS finalized policies for 2019 through 2022 for these rural add-on payments. The three categories for purposes of rural add-on payments are: (1) High utilization category: rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare home health episodes furnished per 100 individuals; (2) Low population density category: rural counties and equivalent areas with a population density of six individuals or fewer per square mile of land area; and (3) All other category: rural counties and equivalent areas not in the above categories.⁴

The HH PRICER module within CMS’ claims processing system applies the rural add-on amounts prior to applying any case-mix and wage index adjustments. Table 11 of the proposed rule lists the 2019 through 2022 rural add-on payments outlined in law.

Category	2019	2020	2021	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

⁴ The data used to categorize each county or equivalent area and an Excel file containing the rural county or equivalent area name, its Federal Information Processing Standards (FIPS) state and county codes, and its designation into one of the three rural add-on categories is available on the CMS webpage for this proposed rule: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html>

f. Payments for High-Cost Outliers Under the HH PPS. Under the HH PPS, outlier payments are made for episodes whose estimated costs exceed a threshold amount. The outlier threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and a wage-adjusted fixed-dollar loss (FDL) amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated cost for the episode that surpasses the wage-adjusted threshold; this proportion is referred to as the loss-sharing ratio.

CMS notes that the FDL ratio and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the aggregate level of 2.5 percent of estimated total payments as required by statute. CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes are proposed to the loss-sharing ratio for 2021.

For 2021 payment, CMS proposes to “maintain the fixed-dollar loss ratio of 0.63, as finalized for CY 2020.” Note that although CMS proposed an FDL ratio of 0.63 for 30-day periods of care for 2020, it finalized an FDL ratio of 0.56 based on the most recent data available for the final rule (84 FR 60544).

In the proposed rule, CMS reviews the history of HH PPS policy regarding outlier payments. In the 2017 HHS PPS final rule (81 FR 76702), CMS finalized changes to its methodology used to calculate outlier payments, switching from a cost-per-visit approach to a cost-per-unit approach. CMS now converts the national per-visit rates into per 15-minute unit rates. CMS also limits the amount of time per day (summed across the six disciplines of care) to 8 hours (32 units) per day when estimating the cost of an episode for outlier calculation purposes. CMS will publish the cost-per-unit amounts for 2021 in the rate update change request to be issued after the publication of the 2021 HH PPS final rule.⁵

D. Use of Technology Under the Medicare Home Health Benefit

HHAs can furnish services via a telecommunications systems, as long as such services do not: (1) substitute for in-person home health services ordered as part of a plan of care certified by a physician; and (2) are not considered a home health visit for purpose of eligibility or payment. In the 2019 HH PPS final rule (83 FR 56527), CMS finalized that remote patient monitoring is one type of service that can be furnished via a telecommunications system to augment a home health plan of care without substituting for an in-person visit. Remote patient monitoring was defined as the collection of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the HHA. The costs of remote patient monitoring are considered allowable administrative costs if the monitoring is used by the HHA to augment the care planning process. In the first COVID-19 Public Health Emergency (PHE) Interim Final Rule with Comment Period (85 FR 19230) CMS amended the regulations at §409.43(a) on an interim basis, to provide HHAs with the flexibility to use various types of telecommunications systems, in addition to remote patient monitoring, in conjunction with the provision of in-person visits. Specifically:

- The plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system, and that these services cannot

⁵ The per-unit amounts for 2020 are found in the November 8, 2019 HH PPS change request: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4453CP.pdf>

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 the technology must be related to the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit or when there is a home visit.

In addition, on an interim basis, HHAs can report the costs of telecommunications technology as allowable administrative and general costs by identifying the costs using a subscript between line 5.01 through line 5.19. Stakeholders have informed CMS that these technologies are important components of home health services provided outside the PHE.

In addition, section 3707 of the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act (Pub. L. 116-136) requires the Secretary of HHS to consider ways to issue guidance encouraging the use of telecommunications, including remote monitoring, consistent with the plan of care, for home health services.

CMS provides a payment example for a scenario involving a patient recently discharged from the hospital after coronary bypass surgery and receiving home health skilled nursing visits three times a week for medication management, teaching and assessment. The example illustrates that the use of technology is not a substitute for the provision of in-person visits as ordered on the plan of care. The patient develops respiratory symptoms, has a confirmed COVID-19 diagnosis, and the patient's home health plan of care is updated to include an in-person skilled nursing visit once a week to assess the respiratory condition and a video consultation twice a week between the skilled nurse and the patient for medication management, teaching and assessment, as well as to obtain oxygen saturation readings that the patient provides to the nurse. If the primary reason for home health care was to manage the symptoms resulting from COVID-19, this 30-day period of care would be grouped into the Medication, Management, Teaching and Assessment (MMTA) – Respiratory clinical group, and it would be an early 30-day period of care with an institutional admission source. Assuming a medium functional impairment level with “low” comorbidities, the LUPA threshold would be 4 visits. If the patient continued to receive the original 3 in-person skilled nursing visits per week (12 visits total in the 30-day period) rather than the once per-week in-person skilled nursing visits (4 visits total in the 30-day period) as ordered in the plan of care, the HHA would receive the full 30-day payment amount.

CMS believes that the provision of in-person visits and telecommunications technology is an important part of home health services and proposes to permanently finalize the amendments to §409.43(a) to provide HHAs with the flexibility to use various types of telecommunications systems, in addition to remote patient monitoring, in conjunction with the provision of in-person visits. CMS also proposes to amend the allowable administrative costs in §409.46(e) to include not only the costs of telehealth/telemedicine but also other communications or monitoring services, consistent with the plan of care for the individual.

CMS stresses that access to telecommunications technology must be inclusive and that section 504 of the Rehabilitation Act and the Americans with Disabilities Act protect qualified

individuals with disabilities from discrimination based on disability in the provision of benefits and services. CMS notes that any concerns related to potential discrimination issues should be referred to the Office of Civil Rights. In addition, the home health CoPs (§ 484.50(f)(1)) require that information must be provided to people 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.⁶

III. Other Home Health Related Provisions

A. Home Health Care Quality Reporting Program (HH QRP)

CMS provides background on the HH QRP, the pay-for-reporting program implemented in 2007 under which the market basket percentage increase is reduced by 2 percentage points for HHAs that do not report required quality data. The previously adopted and finalized measures are shown in the following table. No changes to the HH QRP are proposed in this rule.

Summary Table: Measures for the 2021 and 2022 HH QRP
(2022 changes noted *in italics*)

Short Name	Measure Name & Data Source
OASIS-based	
Ambulation	Improvement in Ambulation/Locomotion (NQF #0167)
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF #0674)
Application of Functional Assessment	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
Bathing	Improvement in Bathing (NQF #0174)
Bed Transferring	Improvement in Bed Transferring (NQF #0175)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program
Drug Education	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care
Dyspnea	Improvement in Dyspnea
Influenza	Influenza Immunization Received for Current Flu Season (NQF #0522)
Oral Medications	Improvement in Management of Oral Medication (NQF #0176)
Pain	Improvement in Pain Interfering with Activity (NQF #0177) <i>Removed in 2022</i>
Pressure Ulcers	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury\
Timely Care	Timely Initiation of Care (NQF #0526)
<i>Transfer of Health Information</i>	<i>Transfer of Health Information to the Patient-PAC Measure - Added in 2022</i> <i>Transfer of Health Information to the Provider-PAC Measure - Added in 2022</i>
Claims-based	
ACH	Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171)
DTC	Discharge to Community-Post Acute Care (PAC) HH QRP*
ED Use	Emergency Department Use without Hospitalization During the First 60 Days of Home Health (NQF #0173)
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) –PAC HH QRP

⁶Appendix B of the State Operations Manual (regarding Home Health services) provides examples of auxiliary aids and services, and is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf.

Short Name	Measure Name & Data Source
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program
HHAHPs-based	
Communication	How well did the home health team communicate with patients
Overall Rating	How do patients rate the overall care from the home health agency
Professional Care	How often the home health team gave care in a professional way
Team Discussion	Did the home health team discuss medicines, pain, and home safety with patients
Willing to Recommend	Would patients recommend the home health agency to friends and family
*Baseline NF residents excluded from this measure beginning with the 2021 HH QRP.	

B. Change to the Conditions of Participation (CoPs) OASIS Requirements

CMS proposes to remove obsolete regulatory text in the CoP for reporting OASIS information. Specifically, §484.45(c)(2) which requires HHAs to successfully transmit test data to the Quality Improvement & Evaluation System Assessment Submission & Processing System or CMS OASIS contractor would be removed. Before obtaining a CMS Certification Number (CCN), HHAs would submit data using test or fake CCNs. CMS says this requirement is no longer relevant because the new internet-based CMS data submission system, Internet Quality Improvement & Evaluation System (iQIES), has simplified data submission and no longer supports the use of test or fake CCNs. CMS believes that because 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, they will have a strong incentive to successfully submit their OASIS assessments in the absence of this regulatory requirement.

IV. Home Infusion Therapy

Sections A through C below describes provisions of the 2021 HH PPS proposed rule that are unchanged (except for updates to payment amounts or other minor changes) from policy CMS adopted in the 2020 HH PPS rule.

A. Medicare Coverage of Home Infusion Therapy Services

1. Background

The 21st Century Cures Act established a new Medicare home infusion therapy benefit effective January 1, 2021. At the same time, the 21st Century Cures Act changed payment for home infusion drugs from 95 percent of the October 2003 average wholesale price (AWP) to the latest quarter's average sales price plus 6 percent effective January 1, 2017. This statutory change resulted in a large reduction in payment for home infusion drugs. Specialty pharmacies have indicated that they used the margins from 95 percent of AWP to furnish home infusion therapy services. The Balanced Budget Act of 2018 later established a home infusion therapy services benefit transitional payment beginning January 1, 2019, effective two years earlier than the permanent home infusion therapy benefit.

Under the home infusion therapy benefit, Medicare Part B will cover professional services, including nursing services, training and education (not otherwise paid for as durable medical

equipment (DME))⁷, remote monitoring, other monitoring services and home infusion drugs furnished by a qualified home infusion therapy supplier in the individual’s home. The patient must be under a plan of care established by a physician and under the care of a physician, nurse practitioner, or physician assistant. A home infusion drug is a parenteral drug or biological administered for 15 minutes or more through DME. A “qualified home infusion therapy supplier” is a pharmacy, physician, or other provider of services or supplier licensed by the state in which supplies or services are furnished.

Beginning January 1, 2021, a single payment will be made to a qualified home infusion therapy supplier. The single payment amount must be adjusted to reflect wages and other costs that may vary by region, patient acuity, and the complexity of drug administration. The single payment may be adjusted to reflect outlier situations. All payment adjustments are budget neutral. CMS is required to apply an annual update based on the Consumer Price Index for all urban consumers (CPI-U) beginning January 1, 2022. Total payment for a calendar day cannot exceed the amount that would be paid under the Medicare physician fee schedule in a physician’s office for 5 hours of infusion therapy.

Under the transitional payment system, Medicare could pay for self-administered drugs and biologicals covered under the DME local coverage determination (LCD) for External Infusion Pumps (L33794). However, the statute prohibits payment for home infusion therapy for a self-administered drug or biological under the permanent payment system.

Under the transitional payment system in effect for 2019 and 2020, home infusion drugs are assigned to three payment categories based on the HCPCS code for the drug administration.

Category 1: Intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs (both initial and subsequent injection/hour).

Category 2: Subcutaneous infusions for therapy or prophylaxis, including certain subcutaneous immunotherapy infusions (both initial and subsequent injection/hour).

Category 3: Intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals (both initial and subsequent injection/hour).

The home infusion therapy payment category for additions to LCD L33794 and compounded infusion drugs not otherwise classified will be determined by the DME Medicare Administrative Contractors (MAC).

⁷ CMS distinguishes home infusion therapy from DME. Home infusion therapy services are professional services (such as nursing services) furnished in the patient’s home associated with home infusion therapy as well as the home infusion drugs themselves. Medicare Part B will cover a limited number of home infusion drugs as DME if: (1) the drug is necessary for the effective use of an external infusion pump classified as DME and (2) the pump is reasonable and necessary for administration of the drug and the drug is reasonable and necessary for the treatment of an illness or injury. The infusion pump must be appropriate for use in the home.

Each payment category is paid at amounts consistent with how the HCPCS codes for the drug administration are paid using the Physician Fee Schedule (PFS). If drugs and biologicals from two different payment categories are administered to an individual concurrently on a single infusion drug administration calendar day, one payment for the highest payment category is made.

2. Summary of 2019 and 2020 Home Infusion Therapy Provisions

CMS created a new HCPCS G-code for each of the three payment categories and finalized the billing procedure for the temporary transitional payment for eligible home infusion suppliers. The eligible home infusion supplier submits, in line-item detail on the claim, a G-code for each infusion drug administration calendar day on which professional services were furnished in person. The claim should include the length of time, in 15-minute increments, for which professional services were furnished.

CMS indicates that section 1834(u)(7)(E)(i) of the Act restricts payment to the date on which professional services were furnished. The 2019 final rule defined “infusion drug administration calendar day” as the day on which home infusion therapy services are furnished by skilled professional(s) in the individual’s home. This definition applies for both the transitional and the permanent home infusion therapy benefit. This policy is controversial and has been the subject of litigation. CMS will monitor the effects of this definition on access to care and, if warranted and within the limits of its statutory authority, engage in additional rulemaking guidance regarding this definition.

B. Home Infusion Therapy Services for 2021 and Subsequent Years

1. Scope of Benefit and Conditions for Payment

a. Home Infusion Drugs. For 2019 and 2020, the term “transitional home infusion drug” includes the HCPCS codes for the drugs and biologicals covered under the LCD L33794. In the 2020 HH PPS final rule with comment period (84 FR 60618), CMS indicated that “home infusion drugs” for the permanent benefit are defined as parenteral drugs and biologicals administered intravenously or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit.

Consistent with the definition of “home infusion therapy,” the home infusion therapy payment explicitly and separately pays for the professional services related to the administration of the drugs identified on the DME LCD for external infusion pumps. Services covered under the home infusion therapy benefit are intended to provide teaching and training on the provision of home infusion drugs besides the teaching and training under the DME benefit.

b. Patient Eligibility and Plan of Care Requirements. The Medicare statute requires that the beneficiary must be under the care of a physician, nurse practitioner, or physician assistant to be eligible for home infusion therapy. In coordination with the furnishing of home infusion drugs, the statute further requires the beneficiary to be under a plan of care that is established by a physician, prescribes the type, amount, and duration of infusion therapy services to be furnished,

and is periodically reviewed. CMS set out these requirements in 42 CFR § 486.520 as *conditions of coverage* for home infusion therapy suppliers to furnish services to Medicare beneficiaries. In the 2020 HH PPS final rule, CMS adopted these same requirements as *conditions of payment* for Medicare to pay for a specific instance of home infusion therapy.

c. 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 it furnishes items or services that 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 by the Secretary; and
- meet such other requirements as the Secretary determines appropriate.

CMS does not enumerate a list of “professional services” that may be necessary for the care of an individual patient. The rule specifies that no payment can be made for Medicare services under Part B that are not reasonable and necessary for the diagnosis or treatment of illness.

Payment for an infusion drug administration calendar day is a bundled payment, which reflects not only the visit itself, but any necessary follow-up work (which could include visits for venipuncture), or care coordination provided by the qualified home infusion therapy supplier on days in which professional services are not being provided in the home. Care coordination furnished by the DME supplier responsible for furnishing equipment and supplies, including the home infusion drug, is paid for under the DME benefit. Care coordination furnished by the physician who establishes the plan of care is separately billable under the PFS.

d. Home Infusion Therapy and the Interaction with Home Health. Effective January 1, 2021, home infusion therapy is excluded from the definition of the home health benefit. A beneficiary may utilize both benefits concurrently. CMS provides the following billing guidance if the HHA providing services under the Medicare home health benefit is also the same entity furnishing services as the qualified home infusion therapy supplier:

- If the home visit is exclusively for the purpose of furnishing home infusion therapy services, the HHA would submit a claim for payment as a home infusion therapy supplier and receive payment under the home infusion therapy services benefit.
- If the home visit includes the provision of home health services in addition to, and separate from, items and services related to home infusion therapy, the HHA would submit both a home health claim and a home infusion therapy services claim, and must separate the time spent performing services covered under the HH PPS from the time spent performing services covered under the home infusion therapy services benefit.
- If the home visit is exclusively for the purposes of providing services furnished under the home health benefit, the HHA would submit a claim for payment as an HHA under the home health benefit.

2. Notification of Infusion Therapy Options Available Prior to Furnishing Home Infusion Therapy Services

For home infusion therapy services effective beginning in 2021, physicians are to continue with the current practice of discussing options available for furnishing infusion therapy under Part B and annotating these discussions in their patients' medical records prior to establishing a home infusion therapy plan of care.

3. Payment Categories and Amounts for Home Infusion Therapy Services for 2021

In the 2020 HH PPS final rule, CMS adopted a policy to carry forward the three temporary transitional payment categories for use with the home infusion therapy services payment in 2021, except it caps payment equal to 5 hours of infusion per day rather than 4 hours. The law indicates that the payment cannot exceed 4 hours per day under the transitional system and 5 hours per day under the permanent system. As is occurring under the transitional payment system, subsequent drugs added to the DME LCD for external infusion pumps, and compounded infusion drugs not otherwise classified, as identified by HCPCS codes J7799 and J7999, will be grouped into the appropriate payment category by the DME MACs.

Payment for an infusion drug administration calendar day would not vary within each category but would vary between categories. CMS indicates that the values of the CPT infusion code amounts, in accordance with the different payment categories, reflect variations in nursing utilization, patient acuity, and complexity of drug administration, as they are directly proportionate to the clinical labor involved in furnishing the infusion services in the patient's home. The rule states that this policy is consistent with the statutory requirement to vary payment by patient acuity and the complexity of drug administration

CMS adopted a policy in the 2020 HH PPS final rule to increase the payment amounts for each of the three payment categories for the first visit by the relative difference in payment for a new patient versus an established patient evaluation and management service for a given year. Overall, this adjustment would be budget-neutral. Using a 2020 PFS base rate of \$160.22, this proposal results in a 60 percent increase in the first visit payment amount and a 3.72 percent decrease in subsequent visit amounts.

CMS plans to monitor home infusion therapy service lengths of visits, both initial and subsequent, in order to evaluate whether the data substantiates the increase to the initial visit payment amount or if it should be reevaluated.

The below table provides the payment amounts for home infusion therapy for each of the three categories based on the 2020 PFS. Final 2021 payments for home infusion therapy will be based on the 2021 PFS and are not yet available.

INFUSION DRUG J-CODES PAYMENT CATEGORIES FOR 2021

HCPCS	Drug	Codes	First Visit¹	Subsequent Visit¹
Category 1		96365, 96366	\$256.35	\$154.26
J0133	Injection, acyclovir, 5 mg			
J0285	Injection, amphotericin b, 50 mg			
J0287	Injection, amphotericin b lipid complex, 10 mg			
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg			
J0289	Injection, amphotericin b liposome, 10 mg			
J0895	Injection, deferoxamine mesylate, 500 mg			
J1170	Injection, hydromorphone, up to 4 mg			
J1250	Injection, dobutamine hydrochloride, per 250 mg			
J1265	Injection, dopamine hcl, 40 mg			
J1325	Injection, epoprostenol, 0.5 mg			
J1455	Injection, foscarnet sodium, per 1000 mg			
J1457	Injection, gallium nitrate, 1 mg			
J1570	Injection, ganciclovir sodium, 500 mg			
J2175	Injection, meperidine hydrochloride, per 100 mg			
J2260	Injection, milrinone lactate, 5 mg			
J2270	Injection, morphine sulfate, up to 10 mg			
J3010	Injection, fentanyl citrate, 0.1 mg			
J3285	Injection, treprostinil, 1 mg			
Category 2		96369, 96370	\$358.59	\$215.78
J1555	JB* Injection, immune globulin (cuvitru), 100 mg			
J1561	JB* Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg			
J1562	JB* Injection, immune globulin (vivaglobin), 100 mg			
J1569	JB* Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg			
J1575	JB* Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin			
Category 3		96413, 96415	\$424.43	\$255.40
J9000	Injection, doxorubicin hydrochloride, 10 mg			
J9039	Injection, blinatumomab, 1 microgram			
J9040	Injection, bleomycin sulfate, 15 units			
J9065	Injection, cladribine, per 1 mg			
J9100	Injection, cytarabine, 100 mg			
J9190	Injection, fluorouracil, 500 mg			
J9360	Injection, vinblastine sulfate, 1 mg			
J9370	Injection, vincristine sulfate, 1 mg			

* The JB modifier indicates a subcutaneous route of administration.

¹For each of the payment categories, CMS proposes to pay 1 unit of the initial infusion hour and 1 unit for each subsequent hour up to a total time of 5 hours. Payment amounts are based on 2020 PFS payments amounts.

There are several drugs that are paid for under the transitional benefit that are not defined as home infusion drugs under the permanent benefit beginning with 2021. CMS indicates the following drugs would be excluded from the permanent benefit:

Hizentra: The product is listed as on a self-administered drug (SAD) exclusion list by the MACs. SAD drugs are excluded from the permanent home infusion therapy benefit but not the temporary one.

Ziconotide and Floxuridine: These are given via intrathecal and intra-arterial routes respectively and the statute only allows drugs administered via subcutaneous and intravenous routes to be considered home infusion drugs for the permanent benefit.

C. Required Payment Adjustments for 2021 Home Infusion Therapy Services

1. Home Infusion Therapy Geographic Wage Index Adjustment

CMS adopted a policy in the 2020 HH PPS to adjust the single payment amount by the PFS geographic adjustment factor (GAF)—a weighted composite of each PFS locality’s physician work, practice expense (PE), and malpractice (MP) geographic practice cost index (GPCI). The GAF is calculated by multiplying the physician work, PE and MP GPCIs by the corresponding national cost share weight: work (50.886 percent), PE (44.839 percent), and MP (4.295 percent). The GAF is updated at least every 3 years per statute and reflects a 1.5 work GPCI floor for services furnished in Alaska as well as a 1.0 PE GPCI floor for services furnished in frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming).

The policy applies the GAF to the home infusion therapy single payment amount based on the zip code of where the beneficiary is receiving the service. 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> (penultimate link at the bottom of the page).

Application of the GAF is budget neutral so there is no overall cost impact. If the rates were set using 2020 payment amounts and GAFs, the budget neutrality factor would be 0.9957. The budget neutrality adjustment was determined as the ratio of the estimated unadjusted national spending total to the estimated GAF-adjusted national spending total. The rule details how CMS determined estimated national spending using 2019 utilization.

2. Payment Update

Consistent with the statute, CMS will increase the single payment amount annually beginning in 2022 by the percentage increase in the CPI-U, reduced by the 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.

D. Proposed Enrollment Standards for Qualified Home Infusion Therapy Suppliers

A “qualified home infusion therapy supplier”

- 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.

Under this last provision, CMS is establishing enrollment criteria to protect the Medicare program from fraud, waste, and abuse. CMS outlines its enrollment authority and actions that it has taken to prevent unqualified and potentially fraudulent individuals and entities from being able to enroll and inappropriately bill Medicare.

CMS proposes to incorporate the statutory definition of “home infusion therapy supplier” into its regulations as enrollment requirements (those criteria listed in B.2.c above). A “home infusion therapy supplier” must enroll in Medicare and adhere to all enrollment requirements. The proposal requires a home infusion therapy supplier to submit Form CMS-855B, certify that it meets and will continue to meet the specific requirements and standards for enrollment, and pay an application fee of \$595. Consistent with the statute and regulations previously adopted, CMS proposes to incorporate accreditation requirements into the enrollment regulations specifying that a home infusion therapy supplier must be currently and validly accredited by a CMS-recognized home infusion therapy supplier accreditation organization in order to enroll and remain enrolled in Medicare.

Similarly, CMS proposes to adopt the home infusion therapy supplier standards as enrollment requirements. These supplier standards would include that patients must have a plan of care established by a physician that prescribes the type, amount, and duration of the home infusion therapy services to be furnished as well as specific services that the home infusion therapy supplier must furnish.

CMS proposes to designate home infusion therapy suppliers as subject to “limited risk” categorical enrollment screening (as opposed to “moderate risk” or “high risk”). This designation requires the following screening functions for an initial enrollment application, a revalidation application, or an application to add a new practice location:

- Verifies that the provider or supplier meets all applicable federal regulations and state requirements for their provider or supplier type;
- Conducts state license verifications; and
- Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider or supplier type.

If the home infusion therapy supplier does not meet all of the requirements for enrollment, CMS will deny its application. CMS is proposing that a home infusion therapy supplier may appeal the denial of its enrollment application.

CMS proposes that upon and after enrollment, a home infusion therapy supplier must:

- Remain currently and validly accredited; and
- Remain in full compliance with all enrollment requirements, requirements for establishing and maintaining Medicare billing privileges, plan of care requirements and conditions of coverage.

If accreditation requirements, enrollment requirements, requirements for establishing and maintaining Medicare billing privileges, plan of care requirements or conditions of coverage are

not met, CMS may revoke a home infusion therapy supplier’s enrollment. A home infusion therapy supplier may appeal the revocation of its enrollment.

Consistent with existing enrollment provisions, CMS proposes that the effective date of a home infusion therapy supplier’s enrollment will be the later of: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date that the supplier first began furnishing services at a new practice location. Covered services may be billed retrospectively when the supplier has met all program requirements (including state licensure requirements), and services were provided at the enrolled practice location for up to:

- Thirty days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries; or
- Ninety days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, precluded enrollment in advance of providing services to Medicare beneficiaries.

V. Regulatory Impact Analysis

CMS estimates that the net impact of the HH PPS policies in this final rule is an increase of 2.6 percent, or \$540 million, in Medicare payments to HHAs for 2020. The overall impact of the changes in the HH PPS system on payments to HHAs in 2021 is summarized in the following table.

Summary of Overall Impact of Proposed HH PPS Changes		
Policy	2021 impact	
	Percentage	Dollars
HH PPS update	+ 2.7%	+\$560 million
Statutory rural add-on provision	-0.1%	- \$20 million
Net impact	+2.6%	+\$540 million

Table 17, reproduced below from the proposed rule, provides details on the impact by facility type and ownership, by rural and urban area, by census region and by facility size. It breaks out the payment effects of the 2021 wage index update, the change in the wage index resulting from the updated OMB delineations, the rural add-on payment, and the 2021 update percentage.

With respect to home infusion therapy, CMS estimates the overall impact on payments to eligible home infusion therapy suppliers in 2021 from updating the payment rates based on the 2021 Physician Fee Schedule amounts will be an increase or decrease of \$1 million or less (1 to 2 percent). The proposed requirement that new home infusion therapy suppliers submit form CMS-855B is estimated to result in an average annual aggregate burden on a total of 700 suppliers of \$28,583 over three years. In addition, CMS estimates the enrollment application fee would result in an aggregate cost to 600 suppliers of \$364,800 in the first year and an annual average aggregate cost of \$142,527 over three years, on the assumption that 50 new suppliers are added in each of the second and third years.

TABLE 17: ESTIMATED HHA IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTY, CY 2021

	Number of Agencies	CY 2021 Updated Wage Index (CY2020 Payments)	OMB Delineations with 5 percent Cap		CY 2021 Rural Add-On	CY 2021 HH Payment Update Percentage	Total Impact
All Agencies	9,758	0.0%	0.0%		-0.1%	2.7%	2.6%
Facility Type and Control							
Free-Standing/Other Vol/NP	961	-0.1%	0.0%		-0.1%	2.7%	2.5%
Free-Standing/Other Proprietary	7,867	0.0%	0.0%		-0.1%	2.7%	2.6%
Free-Standing/Other Government	196	0.3%	0.1%		-0.3%	2.7%	2.8%
Facility-Based Vol/NP	514	0.1%	0.1%		-0.2%	2.7%	2.7%
Facility-Based Proprietary	57	-0.2%	0.3%		-0.2%	2.7%	2.6%
Facility-Based Government	163	-0.1%	0.1%		-0.3%	2.7%	2.4%
Subtotal: Freestanding	9,024	0.0%	0.0%		-0.1%	2.7%	2.6%
Subtotal: Facility-based	734	0.1%	0.1%		-0.2%	2.7%	2.7%
Subtotal: Vol/NP	1,475	0.0%	0.0%		-0.1%	2.7%	2.6%
Subtotal: Proprietary	7,924	0.0%	0.0%		-0.1%	2.7%	2.6%
Subtotal: Government	359	0.1%	0.1%		-0.3%	2.7%	2.6%
Facility Type and Control: Rural							
Free-Standing/Other Vol/NP	228	0.1%	0.0%		-0.7%	2.7%	2.1%
Free-Standing/Other Proprietary	814	0.2%	0.0%		-0.5%	2.7%	2.4%
Free-Standing/Other Government	131	0.2%	0.1%		-0.8%	2.7%	2.2%
Facility-Based Vol/NP	233	0.1%	0.0%		-0.7%	2.7%	2.1%
Facility-Based Proprietary	26	0.5%	0.5%		-0.6%	2.7%	3.1%
Facility-Based Government	125	0.3%	0.0%		-0.7%	2.7%	2.3%
Facility Type and Control: Urban							
Free-Standing/Other Vol/NP	733	-0.1%	0.0%		-0.1%	2.7%	2.5%
Free-Standing/Other Proprietary	7,053	0.0%	0.0%		-0.1%	2.7%	2.6%
Free-Standing/Other Government	65	0.4%	0.1%		-0.1%	2.7%	3.1%
Facility-Based Vol/NP	281	0.1%	0.1%		-0.1%	2.7%	2.8%
Facility-Based Proprietary	31	-0.5%	0.2%		-0.1%	2.7%	2.3%
Facility-Based Government	38	-0.4%	0.1%		-0.1%	2.7%	2.3%
Facility Location: Urban or Rural							
Rural	1,557	0.2%	0.0%		-0.6%	2.7%	2.3%
Urban	8,201	0.0%	0.0%		-0.1%	2.7%	2.6%
Facility Location: Region of the Country (Census Divisions)							
New England	335	-1.1%	-0.1%		-0.1%	2.7%	1.4%
Mid Atlantic	452	0.5%	0.3%		-0.1%	2.7%	3.4%
East North Central	1,740	0.0%	-0.1%		-0.1%	2.7%	2.5%
West North Central	648	-0.5%	0.0%		-0.3%	2.7%	1.9%
South Atlantic	1,566	0.1%	0.0%		-0.1%	2.7%	2.7%
East South Central	381	0.0%	0.0%		-0.3%	2.7%	2.4%
West South Central	2,378	0.2%	0.0%		-0.1%	2.7%	2.8%
Mountain	683	-0.2%	0.0%		-0.1%	2.7%	2.4%
Pacific	1,535	0.1%	0.1%		0.0%	2.7%	2.9%
Outlying	40	-1.1%	-0.2%		-0.1%	2.7%	1.3%
Facility Size (Number of 60-day Episodes)							

	Number of Agencies	CY 2021 Updated Wage Index (CY2020 Payments)	OMB Delineations with 5 percent Cap		CY 2021 Rural Add-On	CY 2021 HH Payment Update Percentage	Total Impact
< 100 episodes	2,578	-0.1%	0.0%		-0.1%	2.7%	2.5%
100 to 249	2,087	-0.1%	0.0%		-0.1%	2.7%	2.5%
250 to 499	2,004	-0.1%	0.0%		-0.1%	2.7%	2.5%
500 to 999	1,612	0.0%	0.0%		-0.1%	2.7%	2.6%
1,000 or More	1,477	0.0%	0.0%		-0.1%	2.7%	2.6%

Source: CY 2019 Medicare claims data for episodes ending on or before December 31, 2019 for which we had a linked OASIS assessment (as of March 13, 2020)

Notes: This analysis omits 710,316 simulated 30-day periods not grouped under the PDGM (either due to a missing SOC OASIS, because they could be assigned to a clinical grouping, or had missing therapy/nursing visits). Additionally, another 38,192 periods were excluded with missing wage index information, a further 7 periods were excluded with missing NRS weights, and 2,040 periods with a missing urban/rural indicator. The standard 30-day payment amount used to achieve impact neutrality does not incorporate any behavioral assumptions. PDGM impacts were modeled using CY2020 payment parameters, wage indexes, and rural add-on policy, with a 30-day standard amount of \$1,864.03.

REGION KEY:

New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Middle Atlantic=Pennsylvania, New Jersey, New York.

South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin

East South Central=Alabama, Kentucky, Mississippi, Tennessee

West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

West South Central=Arkansas, Louisiana, Oklahoma, Texas

Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

Pacific=Alaska, California, Hawaii, Oregon, Washington

Other=Guam, Puerto Rico, Virgin Islands