



HH PPS
CY 2021 Proposed Rule

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AHA Policy

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CY 2021 Proposed Rule

- **See AHA Regulatory Advisory**
 - HH section at www.aha.org/postacute
- **Issued on by CMS**
 - Final Net Update: +2.6%, \$540 million
 - + 2.7% market basket
 - -0.1% decrease due to altered rural add-on formula (-\$40 million)
- **Proposed rates:**
 - Proposed 30-day episode: \$1,911.87, an increase from the CY 2020 rate of \$1,864.03.
 - LUPA: New policy began in CY 2020
 - **Policy Goal**: Keep LUPAs at 7-8% of total episodes (same as under 60-day episodes)
 - For each HHRG, the LUPA threshold is 10th percentile of visits/episode or 2 visits – whichever is greater. Cases below the threshold are paid LUPA per-visit rates
 - **COVID**: During pandemic, LUPA volume is increasing as % of total episodes. Some reporting an increase from 7% to 14%.



No Change to PDGM Behavioral Offset

- CY 2020 Proposed Rule.
 - CMS proposed a 8.1% behavioral offset.
 - AHA (and the HH field) opposed a prospective adjustment that was not based on actual evidence.
- CY 2020 Final Rule.
 - The final rule included a PDGM behavioral offset of 4.36%.
 - While still a large offset, we were pleased with this significant reduction.
- CY 2021 Proposed Rule.
 - CMS does not alter the CY 2020 offset;
 - The agency lacks the claims and cost report data to evaluate service utilization and provider behavior under PDGM.
 - AHA: COVID-19's impact has made the future evaluation of projected versus actual behavior even more complex, insofar as it pertains to any future behavioral offset changes.
- Moving forward. CMS will determine whether any change is needed, based on analysis of projected versus actual behavior.



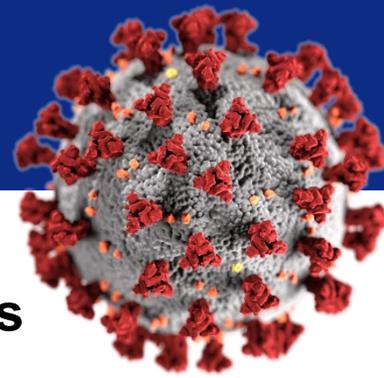
Rural Add-on

- **New Rural Add-on Methodology for CYs 2019 through 2022**
- **Bipartisan Budget Act of 2018**

Category	2019	2020	2021	2022
High utilization	1.5%	0.5%		
Low-population density	4.0%	3.0%	2.0%	1.0%
All other	3.0%	2.0%	1.0%	

- **High-utilization Counties/equivalent Areas:** Currently 510 rural counties/areas. Highest quartile based on the number of Medicare HH episodes per 100 individuals;
- **Low-population-density Counties/equivalent Areas:** Currently 334 rural counties/areas. Population density of 6 individuals or fewer per square mile of land area; and
- **All-other Counties/equivalent Areas:** Currently 1,162 rural counties/areas. Those rural counties and equivalent areas not in the above categories.
- **Designations:** <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1689-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>.
 - 2,006 rural designations (out of 3,245 counties/areas) based on 2015 wage index, claims data, and data from the Medicare beneficiary summary file; and 2010 Census data.

PDGM & COVID-19



- **During initial stage of pandemic many beneficiaries refused care.**
 - Applies to all PAC settings and general acute-care hospital;
 - Visits per HH episode have dropped, even with 30-day episode;
 - Cost per case goes up.
- **Combined effect of both PDGM and COVID make 2020 a difficult year for policymaking.**
 - How to assess PDGM case-mix system?
 - How to incorporate 2020 data in determination of necessity for a future behavioral offset for new system?
 - How to interpret any increase in case-mix? Isolate cause and effect?
 - Impact on function-item in PDGM?
 - How to ensure budget-neutral implementation in CY 2020?
 - Which data exclusions make sense?
 - Data exclusions for VBP and QRP?
- **Support CMS's decision not to alter PDGM at this time, given pandemic disruptions.**

Proposed OASIS Testing Requirements

- Currently, new HHAs are required to send test data to QIES using a fake CCN, limited to 2 users
- Last year, CMS upgraded to internet-based QIES; no limits to users but requires valid CCN
- Thus, new HHAs cannot use fake CCN to submit test data– **would no longer be required to send test data**

Home Infusion Therapy

- Reiterates home infusion therapy supplier policies finalized in previous (CY 19 and 20) rules
- Establishes enrollment policies for suppliers:
 - Accreditation
 - Comply with standards, enrollment, and screening requirements
 - Enroll using form CMS-855B and pay application fee

Comment Letter

Final Rule with Comment Period

- **DEADLINE:** Comments due to CMS by Aug. 24.
- **Preliminary Topics for Draft Letter:**
 - Thanks for streamlined rule
 - Now is not the time for PDGM changes
 - Still thinking about how to account for 2020 drop in Medicare adequate spending and increases in case-mix? What do they mean relative to PDGM budget neutrality?
 - Any advantage to not waiting on the 2020 budget neutrality question.
 - Conclude that PDGM was implemented in a budget neutral manner.
 - Sharing data from other stakeholders
 - IMPACT Act Reset
 - LUPA increase
 - Interim approach during the PHE?
 - Home infusion
 - Quality
 - What else?

Questions & Discussion

AHA Post-Acute Resources:

www.aha.org/postacute

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Home Health PPS Proposed CY 2021 Rule

At A Glance

At Issue

On June 30, the Centers for Medicare & Medicaid Services (CMS) issued its calendar year (CY) 2021 [proposed rule](#) for the home health (HH) prospective payment system (PPS). Comments on the proposed rule are due to CMS by Aug. 24.

Our Take

The AHA appreciates the rule's streamlined provisions, which help HH agencies focus on their COVID-19 responses. In addition, we support the proposal to permanently expand the types of telecommunication technologies used to provide telehealth implemented during the COVID-19 public health emergency (PHE).

However, we remain concerned about CMS's continued application of the substantial prospective behavioral adjustment, which was implemented to offset the cost of the new case-mix system that began Jan. 1, 2020. **This offset was not based on actual data. In fact, the concurrent impact of the new case-mix system and disruptions caused by the COVID-19 pandemic virtually eliminate the possibility that this prospective adjustment will align with actual behavior in CY 2020. As such, the offset should be reconsidered using prompt, thorough evaluation of HH service delivery, including COVID-19-related changes.**

What You Can Do

- ✓ Share this advisory with your senior management team to examine the impact these payment changes would have on your organization in CY 2021.
- ✓ **Participate in the AHA-member call on this rule on Tuesday, Aug 4, at 2 p.m. ET.** Click [here](#) to register in advance.
- ✓ Submit a comment letter on the proposed rule to CMS by Aug. 24 explaining this rule's potential impact on your patients, staff and facility.

Further Questions

Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with questions.

Key Takeaways

CMS's proposed rule would:

- Increase net payments by 2.6% (\$540 million).
- Continue application of the behavior offset finalized last year, which CMS states is necessary for a budget-neutral implementation of the new case-mix system.
- Permanently expand the types of telecommunication technologies used for telehealth, which were implemented during the COVID-19 public health emergency.
- Update the geographic areas used to set area wage index payment adjustments;
- Modify the home infusion policy;
- Make no material changes to the HH value-based purchasing or quality report programs

Overview

CMS estimates that under its home health PPS [proposed rule](#) for CY 2021, HH agencies would receive a net payment increase of 2.6%, \$540 million, from CY 2020 payment levels, which accounts for the market-basket update and a reduction in rural add-on payments. Facility-based HH agencies, including hospital-based agencies, are projected to see the same 2.6%%increase. These impact estimates do not take into account the home infusion or value based purchasing (VBP) proposed policies. In this streamlined rule, CMS proposes no material changes to the HH PPS case-mix system, called the patient-driven health groupings model (PDGM), the HH quality reporting program (QRP), or the HH VBP program.

Proposed CY 2021 Payment Update

Proposed CY 2021 Rates

30-day Episode Rates. For CY 2021, CMS is proposing that the 30-day episode rate be increased by a 3.1% market basket, and offset by a 0.4% productivity factor. This would result in rate of \$1,911.87, an increase from the CY 2020 rate of \$1,864.03.

Low Utilization Payment Adjustment (LUPA) Rates. CMS proposes to extend the CY 2020 LUPA thresholds into 2021, because of limited data available under the PDGM as a result of PDGM implementation and the COVID-19 PHE. Under the PDGM, the LUPA methodology was altered and now sets a threshold for each payment unit at the 10th percentile of visits or two visits, whichever is higher. If the LUPA threshold is met, the case will be paid the full 30-day period payment; if not, the LUPA per-visit rates will apply. The proposed per-visit rates from Table 9 in the rule, recreated below, reflect the latest HH claims linked to OASIS assessment data, which are updated annually to reflect the most recent utilization data.

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

We note that our members have reported an increase in LUPA cases during the pandemic, resulting from new service utilization patterns.

Non-routine Supplies Conversion Factor. Under PDGM, non-routine supplies payments are included in the 30-day base payment rate.

Case-mix Weights

PDGM categorizes patients into one of 432 payment units, known as HH resource groups (HHRG), using patient assessment data collected with the OASIS tool and other data. Since CY 2015, CMS annually has recalibrated the HH case-mix weights based on the most recent, complete year of claims data. However, for 2021, CMS proposes to continue to use the 2020 case-mix weights because the most recent year of complete data are from before implementation of the PDGM. As with the proposal to maintain the LUPA thresholds into 2021, CMS believes this will be less burdensome to HH agencies and software vendors who are still learning the new case-mix methodology.

Area Wage Index

The rule proposes to update the area wage index geographic areas, as revised by the Office of Management and Budget in September 2018 and shown in Table 5 in the rule. The new boundaries would result in the reclassification of 34 urban counties to rural, and 47 rural counties to urban. The rule would cap wage index decreases at no more than 5% in CY 2021; no cap is proposed for CY 2022. The payment system uses the pre-floor, pre-reclassified inpatient PPS wage indices.

The proposed labor-related share for CY 2021 is 76.1%, the same as in CY 2020, and would be implemented in a budget neutral manner.

High-cost Outliers

Under PDGM, high-cost outliers for 30-day episodes are calculated on a cost-per-unit approach. Specifically, CMS converts the national per-visit rates into per 15-minute unit rates when estimating outlier costs and payments. CMS also limits the amount of time per day (summed across the six disciplines of care) to eight hours (32 units). CMS notes that it plans to publish the cost-per-unit amounts for 2021 in a rate update change request to be issued after the publication of the 2021 HH PPS final rule.

By law, a fixed dollar loss (FDL) ratio and the loss-sharing ratio must be set so that total outlier payments do not exceed the 2.5% of aggregate payments. CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80% of the additional estimated costs above the FDL threshold. For 30-day episodes in CY 2021, CMS proposes to maintain the CY 2020 FDL ratio at 0.56.

Rural Add-on Methodology

For CY 2021, Medicare rural add-on payments would be reduced by 0.1 percentage point, relative to CY 2020, due to the phase-out required by the Bipartisan Budget Act of 2018. This legislation changed the amount, structure and timeline for HH rural add-on payments for CYs 2019 through 2022 based on a HH agency's rural county designation, with no add-on payments authorized for CY 2023 and beyond. Specifically, the law established the following rural add-on payment categories:

- High-utilization category: Rural counties and equivalent areas in the highest quartile of all counties and equivalent areas based on the number of Medicare HH episodes furnished per 100 individuals;
- 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
- All-other category: Rural counties and equivalent areas not in the above categories.

Below, Table 26 from the rule is recreated, which includes the statutorily-mandated schedule for rural add-on payments. These apply to both the 30-day episode and LUPA rates.

Table 26: HH PPS Rural Add-on Percentages, 2019-2022				
Category	2019	2020	2021	2022
High utilization	1.5%	0.5%	n/a	n/a
Low-population density	4.0%	3.0%	2.0%	1.0%
All other	3.0%	2.0%	1.0%	n/a

The statute requires that each rural designation for this policy would apply for the four-year period, although only providers in the low-population density category would receive a payment add-on in each of the four years. In addition, it prohibits administrative or judicial review of a rural classification for this policy. Further, each claim will be required to include a state and county code. CMS posted an [Excel file](#) with each HH agency’s rural designation and related data in the downloads section associated with this proposed rule.

Patient-driven Groupings Model and BNA

In compliance with the Balanced Budget Act of 2018, CMS implemented the PDGM and a 30-day payment episode on Jan. 1, 2020. The PDGM case-mix system bases payments on the clinical characteristics of the patient instead of the patient’s therapy volume. Specifically, it uses five clinical elements to set payments for each patient, with each 30-day episode assigned to one of 432 payment units called home health resource groups (HHRG):

- Admission source (institutional or community);
- Admission timing (early or late episode);
- Principal diagnosis;
- Clinical functional impairment level; and
- Comorbidity adjustment.

CMS’s goal for CY 2020 was to set the initial PDGM 30-day episode payment amount at budget-neutral levels relative to what payments would have been paid using a 60-day episode and the prior case-mix system. This amount was set prospectively, based on assumptions about behavior changes by providers in CY 2020 in response to the shift to the 30-day payment and new case-mix system.

No Change to CY 2020 PDGM Behavioral Offset. The implementation of PDGM included a behavioral offset of 4.36%. **In this rule, CMS maintains last year’s application of such a behavioral offset, as the agency states that it lacks the claims and cost report data to evaluate actual service utilization and provider behavior under PDGM.** In future rulemaking, CMS plans to determine whether any change is needed, based on analysis of projected versus actual behavior.

Leading up to PDGM implementation, this behavioral adjustment was a critical concern of the AHA and the HH field; we opposed using a prospective adjustment that was not based on actual evidence. **While we were pleased that the finalized offset was a significant reduction from the initially proposed 8.01% cut, COVID-19’s impact has made the future evaluation of projected versus actual behavior even more complex, insofar as it pertains to any future behavioral offset changes.**

AHA will join the HH field in emphasizing the importance of carefully evaluating how, and the degree to which, HH service utilization was disrupted by the COVID-19 pandemic, and the resulting effect on PDGM implementation (including the size of the CY 2020 offset), access to care and other impacts.

Other Proposed Changes

Proposed Extension of Telecommunications Use

CMS proposes to permanently extend the use of telecommunications technologies, as described below, that were implemented during the COVID-19 PHE. Under this proposed extension, which would begin Jan. 1, 2021, HH agencies could continue to use these technologies to provide telehealth under the Medicare home health benefit after the emergency declaration ends. Eligible services must be outlined in the plan of care with a described connection to a specific clinical goal, explaining how the technology would facilitate treatment outcomes.

Importantly, such services could not be substituted for medically necessary, in-person home care and could not be considered home visits for purposes of determining eligibility for, or payment of, HH services. However, this rule proposes to allow agencies to continue to report the costs of telecommunications technology as allowable administrative costs on the HH agency cost report beyond the COVID-19 PHE. The rule notes that this proposed extension would advance CMS’s goal of facilitating provider planning for telecommunications systems’ ongoing, and even expanded, use to increase access to care and advance patient engagement and autonomy.

Based on prior rulemaking, HH agencies have been allowed to 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. As an example provided by CMS, remote patient monitoring can be furnished via telecommunications, which are defined as the collection of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the HH agency. The costs of remote patient monitoring are

considered allowable administrative costs if the monitoring is used by the HH agency to augment the care planning process.

CMS implemented the following flexibilities under the PHE. Specifically, in addition to remote patient monitoring provided in conjunction with the provision of in-person visits, it allowed that:

- 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 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; and
- 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.

HH Quality Measurement Changes

CMS proposed no changes to the HH quality reporting and value-based purchasing programs.

OASIS Test Data for New HH Agencies. CMS proposes to remove a HH agency Condition of Participation (CoP) that requires HH agencies applying for participation in the Medicare program to transmit test data to the Quality Improvement and Evaluation System (QIES). New HH agencies were asked previously to submit data to the QIES under a “test” CMS certification number (CCN) since those agencies do not have active CCNs. However, CMS recently updated the QIES system in a way that simplifies reporting, making it impossible to submit data under test CCNs. CMS indicates that the QIES system’s enhancements, along with the agency’s other requirements to submit OASIS data for quality and payment purposes, make the test data CoP infeasible, redundant and unnecessary.

Proposed Home Infusion Changes

For CY 2021, the rule proposes Medicare enrollment policies for qualified home infusion therapy suppliers. It also proposes updates to the CY 2021 home infusion therapy services payment rates using CY 2021 physician fee schedule (PFS) amounts.

As required by the 21st Century Cures Act of 2016, a new Medicare home infusion therapy benefit will take effect Jan. 1, 2021. In addition, effective Jan. 1, 2017, this legislation implemented a new payment rate based on the latest quarter’s average sales price plus 6%, which resulted in a large reduction in payment for home infusion drugs. Subsequently, the Balanced Budget Act of 2018 established transitional payments for home infusion therapy services for CYs 2019 and 2020.

The Cures Act defines a “home infusion drug” as a drug or biological administered intravenously or subcutaneously for an administration period of 15 minutes or more, in the patient’s home, through a pump that is an item of durable medical equipment (DME). This

definition does not include insulin pump systems or any self-administered drug or biological on a self-administered drug exclusion list. The benefit covers the nursing, patient training and education, and monitoring services associated with administering infusion drugs in a patient's home. The infusion pump and supplies (including home infusion drugs) will continue to be covered under the DME benefit. In addition, the home infusion therapy payment explicitly and separately pays for the professional services related to the administration of the drugs identified on the DME local coverage determination 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.

Effective Jan. 1, 2021, home infusion therapy is excluded from the definition of the home health benefit. A beneficiary may utilize both benefits concurrently. This rule provides billing guidance for agencies furnishing both services:

- If the home visit is exclusively for the purpose of furnishing home infusion therapy services, the HH agency 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 HH agency 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; and
- If the home visit is exclusively for the purposes of providing services furnished under the home health benefit, the HH agency would submit a claim for payment as an HH agency under the home health benefit.

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.

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% increase in the first visit payment amount and a 3.72% 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 table below provides the proposed CY 2021 payment amounts for home infusion therapy for each of the three categories based on the CY 2020 PFS. Final payments for home infusion therapy will become available when the CY 2021 PFS rule is finalized.

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*. Medicare administrative contractors list this item as a self-administered drug, which is excluded from the permanent home infusion therapy benefit but not the temporary one.
- *Ziconotide and Floxuridine*. These products 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.

Next Steps

The AHA will host a member call on Tuesday, Aug. 4, at 2 p.m. ET to discuss this rule and gather input for our comment letter to CMS. AHA members may register [here](#). Related materials and a recording of this call will be available at: www.aha.org/postacute in the HH section.

Submitting Comments. The AHA urges all HH agencies to submit comments to CMS by Aug. 24. Comments may be submitted electronically at: www.regulations.gov. Follow the instructions for “Comment or Submission” and enter the file code “CMS-1730P.” You also may mail written comments (an original and two copies) to CMS using the instructions in the first page of the proposed rule.

Questions. Please contact Rochelle Archuleta, director of policy, at rarchuleta@aha.org with any questions about this rule.

August 3, 2020

CMS Releases Skilled Nursing Facility PPS Final Rule for FY 2021

The Centers for Medicare & Medicaid Services (CMS) July 31 issued the [final rule](#) for the skilled nursing facility (SNF) prospective payment system (PPS) for fiscal year (FY) 2021. The final rule increases SNF payments by 2.2% (\$750 million) in FY 2021, with larger updates for hospital-based providers. The rule will take effect Oct. 1.

AHA Take: We appreciate that this streamlined rule allows hospital-based SNFs and others in the field to focus on their local COVID-19 response efforts.

The rule makes required payment updates and minimal changes to the SNF value-based purchasing (VBP) program. With regard to the redesigned SNF PPS payment model implemented last October, AHA is pleased that the agency made no material changes at this early stage of implementation. However, CMS did report that it is closely monitoring implementation of the payment-driven patient model (PDPM).

Highlights from the final rule follow.

FY 2021 Payment Update. The rule increases net payments to SNFs by 2.2% (\$750 million) in FY 2021 relative to FY 2020. This includes a 2.2% market-basket update plus a zero percentage point change for productivity, reflective of the COVID-19 virus' disruptions. No adjustment was proposed for prior market baskets forecast errors.

Payment-driven Patient Model (PDPM). On Oct. 1, 2019, CMS implemented the new Payment-driven Patient Model for the SNF PPS, which bases payments on a composite profile of each patient, rather than volume of therapy services. In this rule, the agency made no PDPM-related change to weights and no budget-neutrality adjustments. Instead, CMS states that it plans to continue monitoring provider behavior under PDPM, including patient outcomes and aggregate SNF PPS payments, and may consider future

Key Takeaways

The final rule:

- Increases SNF payments by 2.2% (\$750 million) in FY 2021, with larger updates for hospital-based providers
- Makes no material changes to the PDPM case-mix system implemented in October 2019
- Makes no material changes to the SNF quality reporting program
- Makes no changes to the measures, scoring or payment policies for the SNF value-based purchasing program.

PDPM-related offsets. The new model, which is significantly different from the prior payment model, is described in our FY 2019 SNF PPS final rule [Regulatory Advisory](#).

SNF Quality Reporting Program (QRP). CMS did not make any proposals or updates related to the SNF QRP.

SNF VBP Program. CMS did not propose any changes to the measures, scoring or payment policies for the SNF VBP; rather, the agency makes nominal updates to the program, including codifying changes made in previous rules. In the FY 2017 SNF PPS final rule, CMS finalized its proposal to use the SNF 30-day Potentially Preventable Readmission (SNFPPR) measure in the VBP program as soon as practicable, as required by statute; the agency has not yet transitioned to using this measure in the program.

In the FY 2020 SNF PPS final rule, CMS changed the name of the measure to “Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge;” this is intended to minimize confusion with another measure that also assesses potentially preventable readmissions in SNFs, but during a different time window (30-days post-SNF discharge). In this rule, CMS amends the codified definition of “SNF Readmission Measure” to reflect the name change. The agency also states that it intends to submit the measure for endorsement by the National Quality Forum, and subsequently determine appropriate time for starting the measure’s use in the SNF VBP program.

In addition, CMS finalized its proposal to apply the 30-day Phase One Review and Correction deadline to the baseline period quality measure quarterly report (which already applies to the performance period quality measure quarterly report).

CMS establishes that it will use FY 2019 as the baseline period for the FY 2023 program under the previously finalized policy. It also provides the final achievement threshold and benchmark standards for performance on the 30-Day All-Cause Readmission Measure (SNFRM). Please see AHA’s FY 2016 [Regulatory Advisory](#) for details on the SNF VBP scoring methodology. The estimated standards are:

- Achievement: 0.79270
- Benchmark: 0.83028

NEXT STEPS

AHA’s SNF members will receive an invitation for a conference call to discuss the rule.

Please contact Rochelle Archuleta, AHA director of policy, at (202) 626-2320 or rarchuleta@aha.org with any questions.