Medicare Home Health
Prospective Payment System

2022 Proposed Payment Rule Summary by the Wisconsin Hospital Association

Overview and Resources

On June 28, 2021 the Centers for Medicare and Medicaid Services (CMS) released its proposed calendar year (CY) 2022 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The proposed rule includes updates to the Medicare fee-for-service (FFS) HH PPS payment rates based on changes set forth by CMS and those previously adopted by the US Congress. Among the proposed updates are:

- Recalibration of the Patient-Driven Grouping Model (PDGM) case-mix weights, functional levels, and comorbidity adjustment subgroups;
- The expansion of the HH value-based purchasing (VBP) program to all Medicare-certified HHAs, with CY 2022 being the first performance year and CY 2024 being the first payment year;
- Updates to the HH quality reporting program (QRP), the IRF QRP, and the LTCH QRP;
- Making selected regulatory blanket waivers issued during the COVID-19 public health emergency (PHE) permanent;
- Updates to home infusion therapy payment categories and rates;
- Provisions regarding Medicare provider and supplier enrollment; and
- Provisions for Home Health and Hospice programs, as required by the Consolidated Appropriations Act (CAA) of 2021.

A copy of the *Federal Register* (FR) with this proposed rule and other resources related to the HH PPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

An online version of this proposed rule is available at https://www.federalregister.gov/public-inspection/2021-13763/medicare-and-medicaid-programs-cy-2022-home-health-prospective-payment-system-rate-update-home

A brief summary of the proposed rule is provided below. Program changes adopted by CMS are effective for services provided on or after January 1, 2022, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate to be an increase of $310 million in aggregate payments to HHAs in CY 2022 over CY 2021.

Comments are due to CMS by August 27, 2021 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1747-P."

Note: Text in italics is extracted from the July 7, 2021 *Federal Register (FR).*

HH PPS Payment Rates

FR pages 35,892, 35,909, and 35,910 – 35,913

The tables below show the proposed CY 2022 30-day standard payment rate compared to the final CY 2021 30-day standard payment rate and the components of the annual update factor:

	Final CY 2021	Proposed CY 2022	Percent Change

30-Day Period Standard Payment Rate	**$1,901.12**	**$2,013.43**	**+5.91%**

Proposed CY 2022 Update Factor Components	**30-Day Standard Rate**
Marketbasket (MB) Update	2.4%
Affordable Care Act (ACA)-Mandated Productivity MB Reduction	-0.6 percentage points
Wage Index Budget Neutrality	1.0013
Case-Mix Weight Recalibration Budget Neutrality	1.039
Overall Proposed Rate Update	**+5.91%**

CMS continues to monitor the impacts that the implementation of the Patient-Driven Grouping Model (PDGM) has on behavioral changes, which would affect aggregate spending, and is proposing to not make any other updates to the standardized 30-day payment rate aside from the routine updates shown above.

National Per-Visit Amounts

FR pages 35,892 and 35,911 – 35,913

CMS uses national per-visit amounts by service discipline to pay for "Low-Utilization Payment Adjustment" (LUPA) episodes as well as to compute outliers. LUPA payments are made when the number of visits is less than the LUPA threshold for their PDGM classification. This threshold is set at either 2 visits, or the 10th percentile value of visits, whichever is higher. CMS believes that visit patterns and some of the decreases in overall visits in CY 2020 may not be representative of the patterns in CY 2022, and that using CY 2020 data to set LUPA thresholds could cause an increase of thresholds when CY 2021 data are used for CY 2023 rulemaking. To mitigate potential future and short-term variability of LUPA thresholds, CMS is proposing to maintain LUPA thresholds finalized in the CY 2020 final rule. National per-visit payments include a wage index budget neutrality factor of 1.0014.

Per-Visit Amounts	Final CY 2021	Proposed CY 2022	Percent Change	Proposed CY 2022 with LUPA Add-On *
Home Health Aide	$69.11	$70.45	+1.94%	N/A
Medical Social Services	$244.64	$249.39		N/A
Occupational Therapy (OT)	$167.98	$171.24		$285.98 (1.6700 adj.)
Physical Therapy (PT)	$166.83	$170.07		$284.02 (1.6700 adj.)
Skilled Nursing (SN)	$152.63	$155.59		$287.09 (1.8451 adj.)
Speech Language Pathology (SLP)	$181.34	$184.86		$300.70 (1.6266 adj.)

* For OT, PT, SN, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue to use the LUPA add-on factors established in the CY 2014 final rule.

The CAA of 2021 included a provision allowing occupational therapists to conduct initial and comprehensive assessments to Home Health beneficiaries. CMS is proposing to allow these assessments when the plan of care does not initially include SN, but does include PT or SLP. Due to this, CMS is proposing to establish a LUPA add-on factor to be used for payment for the first occupational therapy visit in LUPA periods that occurs as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. Due to insufficient data regarding initial and comprehensive visits conducted by occupational therapists, CMS is proposing that the PT LUPA add-on factor be used as an appropriate proxy for the OT add-on factor, as their per-visit rates are similar.

CMS finalized, in the CY 2020 HH PPS Final Rule, the elimination of split-percentage payments for 30-day periods of care beginning on or after January 1, 2021. All HHAs would submit a "no-pay" Request for Anticipated Payment

(RAP) and receive the full 30-day period of care payment once the final claim is submitted to CMS, which will mirror CMS's finalized Notice of Admission (NOA) policy. Beginning in 2022, RAP will be eliminated and HHA's will be required to make one-time submissions of an NOA within 5 calendar days of the start of HH care to establish the start of the care period. This would include a verbal or written order from the physician that contains services required of the initial visit and that the HHA has conducted the initial visit.

Failure to submit timely NOAs would result in a reduction of the wage-adjusted 30-day period payment amount for those days of service from the start of care to the day before the NOA is submitted. CMS would reduce payment by 1/30th per day that the NOA is late. CMS had finalized that LUPA payments will not be made for tardy NOAs; that these days be a provider liability; that the reduction cannot exceed the total payment; and that the provider cannot bill the beneficiary for any penalized days. CMS is able to waive these penalties for extraordinary circumstances.

Wage Index and Labor-Related Share

FR pages 35,909 – 35,912

As has been the case in prior years, CMS is proposing to use the most recent inpatient hospital wage index, the FFY 2022 pre-rural floor and pre-reclassified hospital wage index to adjust payment rates under the HH PPS for CY 2022. The wage index is applied to the labor-related portion of the HH payment rate. CMS is maintaining the labor-related share at 76.1% for CY 2022, based on the FFY 2016 Medicare cost report.

CMS is proposing a wage index and labor-related share budget neutrality factor of 1.0013 for the standard rate and 1.0014 for the per-visit rates for CY 2022 to ensure that aggregate payments made under the HH PPS are not greater or less than would, otherwise, be made if wage adjustments had not changed. Due to the COVID-19 PHE, CMS did consider utilizing CY 2019 claims data to calculate this factor, but there were no significant differences between the factors calculated from CY 2019 data and those from the CY 2020 data.

For CY 2021, provider wage indexes changed depending on which CBSA they were assigned to and, in order to alleviate significant losses in revenue, CMS finalized a phase in period. Adopted delineations were effective beginning January 1, 2021 and included a 5% cap on the reduction of a provider's wage index for CY 2021, compared to its wage index for CY 2020, and CMS is proposing to use the full reduction of a provider's wage index, beginning in CY 2022, for affected providers.

A complete list of the wage indexes proposed for payment in CY 2022 is available on the CMS website at https://www.cms.gov/files/zip/cy-2022-proposed-home-health-wage-index.zip.

CMS proposes to adopt the updates in the March 6, 2020 OMB Bulletin 20-01, which was not issued in time for integration into the CY 2021 rule. However, the updates in this bulletin would not affect any geographic areas for purposes of the CY 2022 wage index calculation. This bulletin can be found at https://www.whitehouse.gov/wp-content/uploads/2020/03/Bulletin-20-01.pdf.

Patient-Driven Grouping Model (PDGM)

FR pages 35,880 – 35,909

CMS believes that recalibrating case-mix weights using CY 2020 data would better reflect PDGM utilization and patient resource use than weights set using simulated claims data of 60-day episodes grouped under the old Home Health Resource Group (HHRG) system. A budget neutrality factor of 1.0390 is proposed to be applied to the standardized 30-day period payment rate to ensure that PDGM case-mix weights are implemented in a budget neutral manner.

CMS is soliciting public comments on its preliminary analysis of the PDGM data, which compares simulated 30-day period claims for CYs 2018 and 2019 to CY 2020 claim data for all components of each HHRG to gauge overall utilization.

CMS is required to annually determine the impact of the differences between assumed and actual behavior changes on estimated expenditures from 2020 to 2026, which includes previously outlined assumed behaviors and other behavior changes not identified previously; as well as to adjust the standard payment amount to offset any change in estimated expenditure for a given year. The preliminary analysis done by CMS shows that a payment decrease would more appropriately account for behaviors reflected in CY 2020, which could be more variable as full claims data from CY 2020 and onwards are analyzed. CMS further states that not proposing any behavior adjustment for CY 2022 could result in larger, compounding payment adjustments in future years. As such, CMS is seeking comments on its repricing method for evaluating budget-neutrality when using CY 2020 claims data, with respect to behavior assumptions, as well as any alternate approaches to annually determine the difference between assumed and actual behavior changes and their effect on HH PPS expenditures.

Payment Add-On for Rural HH Agencies

FR pages 35,913 – 35,914

In the CY 2019 HH PPS final rule, CMS finalized rural add-on payments for episodes and visits ending during CY 2019 through CY 2022, as required by the Bipartisan Budget Act of 2018. This includes varying add-on amounts, depending on the rural county (or equivalent area), by classifying each into one of three distinct categories:

- High home health utilization category - rural counties and equivalent areas in highest quartile of all counties and equivalent areas based on number of Medicare home health episodes furnished per 100 Medicare beneficiaries, excluding areas with 10 or fewer episodes during 2015;
- Low population density category - rural counties and equivalent areas with a population density of 6 individuals or less per square mile and that are not included in the high utilization category; or
- All other rural counties and equivalent areas.

Categorization of counties (using FIPS county codes) for the rural add-on can be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/CY2019-CY2022-Rural-Add-On-Payments-Analysis-and-Designations.zip

The add-on percentages for CY 2022 are as follows:

Category	CY 2022
High utilization	0.0%
Low population density	1.0%
All other	0.0%

Outlier Payments

FR pages 35,914 – 35,915

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever an HHA's cost for an episode of care exceeds a fixed-loss threshold (the HH PPS payment amount for the episode plus a fixed dollar loss [FDL] amount).

Currently, there is a cap of 8 hours or 32 units per day (1 unit = 15 minutes, summed across the six disciplines of care) on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier. The discipline of care with the lowest associated cost per unit is first discounted in the calculation of episode cost, in order to cap the estimation of an episode's cost at 8 hours of care per day.

The FDL amount is an FDL ratio multiplied by the wage index-adjusted 30-day period payment. This is added to the HH PPS payment amount for that episode. If calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments is set aside for outliers. CMS is proposing a fixed-dollar loss ratio (FDL) of 0.41 for CY 2022.

Proposal to Expand the Home Health Value-Based Purchasing (HHVBP) Model

FR pages 35,916 – 35,948

On January 8, 2021, CMS announced the certification of the HHVBP for national expansion as well as its intent to expand the model through notice and comment rulemaking. In the original model, CMS implemented an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, which started January 1, 2016 and concludes December 31, 2022, with the last year of data collection having ended on December 30, 2020.

The Medicare-certified HHAs required to participate in the original demonstration are from 9 randomly selected states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. The demonstration program resembles the VBP Program for inpatient acute care hospitals. CMS found that this model resulted in an average 4.6% improvement in HHA quality scores while also saving Medicare an average of $141 million annually without denying or limiting coverage to beneficiaries.

CMS is proposing to expand the HHVBP model to all 50 states, the District of Columbia (DC), and all territories, starting in CY 2022 and would be budget neutral by cohort. Under this proposal, CY 2024 would be the first payment year with payment adjustments made based on CY 2022 performance for all HHAs certified before January 1, 2021, based on CMS Certification Numbers (CCN). Each HHA is proposed to have a reduction or increase of their Medicare payments by up to 5%, depending on the performance on specified quality measures relative to other similar competing HHAs. This adjustment percentage may change in future rulemaking as additional evaluation from the original model and the expansion becomes available.

Defining Cohorts for Benchmarking and Competition

FR pages 35,918 – 35,920

In the original HHVBP model, competing HHAs were grouped into cohorts by state and smaller- versus larger-volume for setting benchmarks and achievement thresholds for competition for payment adjustments. For the expansion, CMS is proposing to redefine the cohort structure to account for states, territories, and DC.

The larger-volume cohort would consist of HHAs that administer the Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey under the Home Health Quality Reporting Program (HH QRP) and the smaller-volume cohort would include HHAs exempt from submitting the HHCAHPS survey. An exempt HHA has fewer than 60 eligible unique HHCAHPS survey patients annually and submits their total survey patient count to CMS in order to be granted exemption status.

As such, CMS is proposing to establish cohorts prospectively with sufficient HHA counts in order to prevent the need to combine multiple cohorts retrospectively and to ensure each cohort has a sufficient number of HHAs for scoring purposes. It is estimated that a minimum of 20 HHAs in each cohort would be needed to ensure there are sufficient HHA counts at the end of a given performance year. To allow for these requirements and protections, it is being proposed that cohorts be based on all HHAs nationwide rather than by state, similar to the Skilled Nursing Facility (SNF) and Hospital VBP programs. Using the CY 2019 Home Health Care Compare Data, CMS found that, for CY 2020, 7,084 HHAs would fall into the larger-volume cohort and 485 would fall into the smaller-volume cohort.

CMS did consider and is seeking comments on an alternative approach of using state/territory-based cohorts rather than national volume-based cohorts, which would be similar to the original demonstration.

HHVBP Measures

FR pages 35,921 – 35,931

CMS considered the domains of the CMS Quality Strategy that map to the six National Quality Strategy (NQS) priority areas when choosing measures for the HHVBP expansion: Clinical quality of care; Care coordination; Population/community health; efficiency and cost reduction; safety; and Patient and caregiver-centered experience.

The proposed expanded measures mostly align with the HH QRP measures, though CMS intends to consider new measures for subsequent years in future rulemaking. A summary of the domains and measures is presented in the table below, with more detail included in Tables 26 and 27 and in the background on the composite measures on *FR* pages 35,923 – 35,927. Any measure that overlaps with those in the HH QRP would only need to be submitted once to fulfill data collection requirements of both programs, including the HHCAHPS survey.

Summary Table of Domains and Measures Proposed for the HH Value-Based Purchasing Program				
Category/Weight	**NQS Domain**	**Measure**	**In-Category Measure Weight**	**Minimum Case Count per Year**
OASIS-Based 35%	**Clinical Quality of Care**	Improvement in Dyspnea/Dyspnea	16.67%	20
	Communication & Care Coordination	Discharged to Community	16.67%	20
	Patient Safety	Improvement in Management of Oral Medications/Oral Medication	16.67%	20
	Patient and Family Engagement	Total Normalized Composite Change in Mobility/TNC Mobility (Composite Measure)	25%	20
		Total Normalized Composite Change in Self-Care/TNC Self-Care (Composite Measure)	25%	20
Claims-Based 35%	**Efficiency & Cost Reduction**	Acute Care Hospitalization During the First 60 Days of Home Health Use/ACH	75%	20
		Emergency Department Use without Hospitalization During the First 60 Days of Home Health/ED Use	25%	20
HHCAHPS-Based 30%	**Patient & Caregiver-Centered Experience**	Care of Patients/Professional Care	20%	40
		Communications between Providers and Patients/Communication	20%	40
		Specific Care Issues/Team Discussion	20%	40
		Overall rating of home health care/Overall Rating	20%	40
		Willingness to recommend agency/Willing to Recommend	20%	40

CMS intends to monitor quality measures for the expanded model and address any needed adjustments or modifications. Non-substantive changes are proposed to be incorporated using a sub-regulatory process to update measure specifications, including updates to the CMS website and sufficient lead time for HHAs to implement these changes. Substantive changes to a measure are proposed to use comment and rulemaking for adoption of changes. This is similar to the policy CMS adopted for the HH QRP in the CY 2015 HH PPS final rule.

CMS is also proposing eight factors to be considered when proposing to remove a measure:

- *"Factor 1. Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made (that is, topped out). To determine "topped-out" criteria, we will calculate the top distribution of HHA performance on each measure, and if the 75th and 90th percentiles are statistically indistinguishable, we will consider the measure topped-out.*
- *Factor 2. Performance or improvement on a measure does not result in better patient outcomes.*
- *Factor 3. A measure does not align with current clinical guidelines or practice.*
- *Factor 4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.*
- *Factor 5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available.*
- *Factor 6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available.*
- *Factor 7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.*
- *Factor 8. The costs associated with a measure outweigh the benefit of its continued use in the program."*

With respect to Factor 8, CMS is working to ensure that the overall cost burden of the program is minimized while promoting improved health outcomes for beneficiaries. Removal of a measure based on Factor 8 is being proposed to occur on a case-by-case basis, where costs outweigh the evidence supporting the continued use of the measure. CMS has identified several different types of costs associated with the expanded HHVBP model, which include, but are not limited to, the following:

- *"Provider and clinician information collection burden and burden associated with the submitting/reporting of quality measures to CMS.*
- *The provider and clinician cost associated with complying with other HH programmatic requirements.*
- *The provider and clinician cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within or across those programs.*
- *The cost to CMS associated with the program oversight of the measure, including measure maintenance and public display.*
- *The provider and clinician cost associated with compliance with other Federal and State regulations (if applicable)."*

Even if one or more measure removal factors apply, CMS may choose to retain the measure if there is a significant reason to do so. Additionally, CMS has the authority to explore new measures or remove a measure not captured in one of the previous factors through notice and comment rulemaking. If the collection of a particular measure is determined to cause possible patient safety concerns, CMS proposes to promptly suspend the measure and notify HHAs and the public and then, propose to remove or modify the measure in the next rulemaking cycle.

CMS seeks comments on if the expanded HHVBP model aligns with proposed changes of the HH QRP, specifically the proposed replacement of the Acute Care Hospitalization During the First 60 Days of Home Health (ACH) measure and the Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use) measure with the Home Health Within-Stay Potentially Preventable Hospitalization (PPH) for the HH QRP, beginning in CY 2023. Any future removal of measures would be proposed in future rulemaking.

In addition to its Request for Information on ways to close the health equity gap in post-acute care QRPs, CMS is seeking comments on the challenges in VBP frameworks in terms of promoting health equity and how health equity goals can be included in the expanded HHVBP.

Performance Standards and Scoring

FR pages 35,920 – 35,921 and 35,931 – 35,943

For HHAs certified by Medicare before January 1, 2019, due to the potential effects of the COVID-19 PHE on quality measure data for CY 2020, CMS proposes CY 2019 as the baseline period for the 2022 performance year/2024

payment year and subsequent years. CMS also proposes that, for future rulemaking, the baseline year may be updated for subsequent years and any additional measures may be added to the measure set.

For HHAs certified by Medicare on or after January 1, 2019, CMS proposes that the baseline year would be the HHA's first full CY of services beginning after the date of certification, with the COVID-19 exception for HHAs certified on January 1, 2019 through December 31, 2019, for which the baseline year would be CY 2021. These new HHAs are proposed to begin competing under the HHVP in the first full CY following their first full baseline year. The table below illustrates the proposed baseline, performance, and payment year, based on the Medicare certification date.

Medicare Certification Date	Baseline Year	Performance Year	Payment Year
Prior to January 1, 2019	**CY 2019**	**CY 2022**	**CY 2024**
January 1, 2019 - December 31, 2019	**CY 2021**	**CY 2022**	**CY 2024**
January 1, 2020 – December 31, 2020	**CY 2021**	**CY 2022**	**CY 2024**
January 1, 2021 – December 31, 2021	**CY 2022**	**CY 2023**	**CY 2025**

For the extended HHVBP, CMS is proposing to apply a performance scoring methodology similar to the original model, including the calculation of a total performance score (TPS) for each applicable measure for each competing HHA and would be calculated using the following steps:

Step 1: Determine Raw Quality Scores

Each HHA would receive a raw quality measure score for each measure during a performance year that the HHA meets the case count requirements (listed in the HHVBP measure section). Providers are proposed to report a minimum of 5 of the 12 possible measures in order to qualify to receive a TPS and the subsequent payment adjustment.

Step 2: Calculating the Achievement Score

To determine achievement points for each measure, CMS is proposing that HHAs would receive points along an achievement range between the achievement threshold, defined as the median of all HHA performance scores for the specified measure during the baseline year, and a benchmark, calculated as the mean of the top decile of all HHA performance scores on the specified quality measure during a baseline year. Both the achievement threshold and benchmark would be calculated separately for each cohort.

CMS proposes that the maximum achievement points be capped at 10 and the minimum be 0. It is also being proposed that achievement points be rounded to the third decimal point (thousandths).

The equation for the HHA achievement score for the expanded model is:

$$\textbf{HH Achievement Score} = 10 \times \frac{(\textit{HHA Performance Score} - \textit{Achievement Threshold})}{(\textit{Benchmark} - \textit{Achievement Threshold})}$$

Step 3: Calculating the Improvement Score

To determine improvement points for each measure, CMS is proposing to establish a unique improvement range between each HHA's baseline year score (improvement threshold) and the benchmark for the applicable measure, calculated for the applicable cohort.

CMS proposes that the maximum improvement points be capped at 9 and the minimum be 0. It is also being proposed that improvement points be rounded to the third decimal point (thousandths).

The equation for the HHA improvement score for the expanded model is:

$$\textbf{HH Improvement Score} = 9 \times \frac{(HHA\ Performance\ Score - HHA\ Improvement\ Threshold)}{(Benchmark - HHA\ Improvement\ Threshold)}$$

Step 4: Calculating the Performance Score
The final performance score for each measure by provider would be the higher of the achievement or improvement score.

Step 5: Weighting of Performance Scores to Calculate TPS
Each measure category would be subject to the following weights to calculate the TPS, which will range from a score of 0 to 100. To calculate the TPS, each measure category score will be subject to the measure specific weights, shown in the above table, then to the measure category weight, with the results of the three categories added together.

If an HHA does not meet the case count requirements for all measures in a single measure category, the remaining measure categories would be reweighted such that the proportional contribution remains consistent with the original weights. For example, if an HHA is missing the claims-based category, the OASIS-based (otherwise weighted 35%) and the HHCAHPS survey (otherwise weighted 30%) measure categories would be reweighted to 53.85 % and 46.15%, respectively. If two measure categories are missing, the remaining category would be weighted at 100%. The proposed reweighting process for within-category measure weights follows a similar process. This reweighting process is similar for any missing measures within a category.

Step 6: Calculate Payment Adjustment Percentages
The result of the above steps will then be used to calculate the payment adjustment percentage for each HHA. For the original model, CMS previously finalized the use of the Linear Exchange Function (LEF) to translate the TPS into a percentage of the value-based payment adjustment earned by each competing HHA. CMS is proposing to implement the LEF similarly in the expanded HHVBP model and includes the following proposals:

- HHAs that have a TPS that is average in relationship to other HHAs in their cohort would not receive any payment adjustment (LEF would intercept at 0%).
- Payment adjustments for each HHA with a score above 0% would be determined by the slope of the LEF. This slope would be set for the given performance year so that the estimated aggregate adjustments for that year are equal to 5% of the estimated aggregate base operating payment amount for the corresponding payment year, calculated separately for each cohort. This would make the program budget neutral by cohort such that all 5% payment reduction amounts are redistributed to HHAs, based on TPSs.

Reporting/Review, Correction, and Appeals Process

FR Pages 35,943 – 35,946

Each competing HHA is proposed to receive an interim performance report (IPR) on a quarterly basis, which would include performance compared to the benchmarks, achievement thresholds, and improvement thresholds for each measure. This report would contain interim quality measure performance data based on the 12 most recent months available. A preliminary IPR would be first sent to HHAs so that any recalculations can be requested before a final IPR is distributed. CMS expects the first IPR to be available in July 2022, and it is proposed to include expanded HHVBP performance results with comparison to other HHAs in the same cohort as well as its relative estimated ranking, measurement points, and TPS. The IPR is proposed to be available to HHAs through a CMS data platform, such as the Internet Quality Improvement and Evaluation System (iQIES).

An Annual TPS and Payment Adjustment Report (Annual Report) is being proposed to be made available around August of each year preceding the calendar year for which the payment adjustment would be applied, beginning in 2023. Each HHA would receive their own confidential report, which focuses on the HHA's payment adjustment for the upcoming CY. CMS proposes three versions: a Preview Annual Report, a Preliminary Annual Report (if applicable), and a Final Annual Report with the Preview and Preliminary reports both having 15-day review periods

for any necessary recalculations. A Preliminary report would not be provided if the HHA did not submit a recalculation request as a result of the Preview report. The Final Annual Report is proposed to be made available to all HHAs no later than 30 calendar days before the payment adjustment takes effect. An appeals process is being proposed for both the IPR and the Annual report, where providers would have 15 days from the date of the preliminary IPS or Preview Annual Report to request a recalculation of measure scores or dispute the application of the formula used to calculate the payment adjustment percentage in the Annual Report. Appeals must include a specific basis for the requested recalculation, and changes to underlying data would not be made.

To be consistent with the SNF VBP and the Hospital VBP, CMS is proposing to publish HHVBP performance information on the Care Compare website, including relevant definitions and methodology and HHA specific scoring data.

Lastly, CMS is proposing an extraordinary circumstances exception (ECE) policy, with respect to quality data requirements, in the event of extraordinary circumstances beyond control of the HHA, for the HHVBP that aligns with existing HH QRP exceptions and extension requirements. CMS is proposing to grant an exception as follows:

- *"An HHA that wishes to request an exception with respect to quality data reporting requirements must submit its request to CMS within 90 days of the date that the extraordinary circumstances occurred. Specific requirements for submission of a request for an exception would be available on the CMS website….*
- *CMS may grant an exception to one or more HHAs that have not requested an exception if: CMS determines that a systemic problem with CMS data collection systems directly affected the ability of the HHA to submit data; or if CMS determines that an extraordinary circumstance has affected an entire region or locale."*

Provisions under the Original HHVBP Model

FR pages 35,946 – 35,947

CMS is proposing to not use the CY 2020 (performance year 5) data for the purposes of payment adjustments under the HHVBP model due to exceptions and reporting challenges brought about by the COVID-19 PHE. As such, CMS is proposing to end the original model early with the CY 2021 payment year, meaning HHAs in the nine original model states would not have their claims payments adjusted for CY 2022. CMS will continue to provide HHAs the Interim Performance Reports and the Annual Reports with the calculated TPS and payment adjustments, using CY 2020 data. CMS further proposes to not publically report performance data for CY 2020 for the original HHVBP model.

HH Related Provisions

FR page 35,948

CMS believes that HHAs should educate and promote COVID-19 vaccination among their health care personnel (HCP) in order reduce the risk of the HCP carrying the infection to their patients. Data from influenza vaccination shows that provider uptake in vaccinations is associated with that provider recommending that vaccine to patients, which in turn can increase the uptake among the patient population. An overview of influenza care among HCPS can be found at https://www.cdc.gov/flu/toolkit/long-term-care/why.htm

CMS is also encouraging the continued effort for post-acute care (PAC) providers and health IT vendors to adopt interoperable health information technology and to promote nationwide health care exchange, including the exchange and reuse of PAC setting-specific datasets and the CMS Data Element Library. CMS is reminding stakeholders that, in the 21st Century Cures Act, policies deterring information blocking were put into place. Information blocking is defined as an unlawful practice that *"…is likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information."* In an effort to deter information blocking, *"health IT developers of certified health IT, health information networks and health information exchanges whom the HHS Inspector General determines, following an investigation, have committed information blocking, are*

subject to civil monetary penalties of up to $1 million." Penalties and disincentives for health care providers would need established through rulemaking.

HH Quality Reporting Program (HH QRP)

FR pages 35,948 – 35,956

CMS collects quality data from HHAs on processes, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

Summary Table of Measure Currently Adopted for the CY 2022 HH Quality Reporting Program	
Measures	**Data Source**
Improvement in Ambulation/Locomotion (NQF #0167)	OASIS
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	OASIS
Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	OASIS
Improvement in Bathing (NQF #0174)	OASIS
Improvement in Bed Transferring (NQF # 0175)	OASIS
Drug Regimen Review Conducted With Follow-Up for Identified Issues - Post Acute Care (PAC) HH QRP	OASIS
Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	OASIS
Improvement in Dyspnea	OASIS
Influenza Immunization Received for Current Flu Season	OASIS
Improvement in Management of Oral Medications (NQF #0176)	OASIS
Changes in Skin Integrity Post-Acute Care	OASIS
Timely Initiation Of Care (NQF #0526)	OASIS
Transfer of Health Information to Provider-Post-Acute Care	OASIS
Transfer of Health Information to Patient-Post-Acute Care	OASIS
Acute Care Hospitalization During the First 60 Days of HH (NQF #0171)	Claims-based
Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) (NQF #3477)	Claims-based
Emergency Department Use without Hospitalization During the First 60 Days of HH (NQF #0173)	Claims-based
Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) HH QRP	Claims-based
Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program	Claims-based
How well did the home health team communicate with patients	HHCAHPS

How do patients rate the overall care from the home health agency	HHCAHPS
How often the home health team gave care in a professional way	HHCAHPS
Did the home health team discuss medicines, pain, and home safety with patients	HHCAHPS
Will patients recommend the home health agency to friends and family	HHCAHPS

CMS is proposing the following measure updates to the HH QRP, beginning in CY 2023:

- Removal of the "Drug Education on all Medications provided to Patient/Caregiver" Measure
- Replacement of the "Acute Care Hospitalization During the First 60 Days of Home Health" Measure (NQF #0171) and the "Emergency Department Use Without Hospitalization During the First 60 Days of Home Health" Measure (NQF #0173) with the newly proposed "Home Health Within Stay Potential Preventable Hospitalizations" (PPH) Measure

CMS is proposing to begin publically reporting the following measures, beginning in April 2022:

- Percent of Residents Experiencing One or More Major Falls with Injury
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

In response to the COVID-19 PHE, CMS had published an interim final rule with comment period "Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program" (IFC-2), which delayed the compliance date for the following reporting requirements under the HH QRP:

- Reporting the Transfer of Health (TOH) Information to PAC and the TOH Information to Patient-PAC measures
- Reporting certain Standardized Patient Assessment Data Elements on January 1st of the year, that is, at least one full calendar year after the end of the COVID–19 Public Health Emergency (PHE).
- The adoption of the updated version of the Outcome and Assessment Information Set (OASIS) assessment instrument (OASIS-E), for which HHAs would report the Transfer of Health (TOH) measures 190 and certain Standardized Patient Assessment Data Elements

In order to support the need to collect this data and to balance the support that HHAs needed during the COVID-19-PHE, CMS is proposing to revise the compliance date of these requirements to January 1, 2023.

Change to the Conditions of Participation and Regulations

FR page 35,956 – 35,958

During the COVID-19 PHE, CMS issued numerous waivers, including selected requirements for conditions of participation (CoPs), for an HHA to participate in the Medicare program. Some of these waivers impacted the provision of patient care and, as such, CMS believes it is appropriate to make those policies permanent.

In order to implement policies required by the CAA, CMS is proposing to modify requirements for the initial assessment visit and comprehensive assessment by allowing occupational therapists to complete these assessments when occupational therapy is ordered with speech language pathology or physical therapy to establish program eligibility. This would not be permitted if skilled nursing services have been ordered. This would not change the requirements for establishing Medicare program eligibility.

CMS is proposing that HHAs be permitted to use interactive telecommunications systems to aid supervision, which will not exceed 2 virtual supervisory assessments per HHA in a 60-day period, regardless of the number of aides or patients associated with a given HHA. Interactive telecommunications systems are proposed to be defined as *"…multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."* If a

patient is receiving skilled care, the home health aide supervisor must complete a supervisory assessment of the aide services, either onsite or virtually, to ensure aides are furnishing safe and effective care, no less frequently than every 14 days. Any area of concern found by the supervising individual must be handled on site where the patient is receiving care while the aide is performing care.

For patients who are not receiving skilled care services, CMS is proposing to revise the supervisory requirements for aides by maintaining that a registered nurse (RN) make an in-person visit every 60 days, but removing the requirement that the RN directly observes the aide during these visits and that the aide be present. CMS is also proposing that an RN makes semi-annual (twice yearly) onsite visits to directly observe each home health aide while they are providing care and that this must be done for each aide in an HHA, regardless of how many patients are cared for by that aide.

For aides working in both skilled and non-skilled areas of care, CMS proposes that any deficiency in aide services and all related skills must result in the agency conducting retraining for the aide, the aide completing the retraining, and the agency conducting a competency evaluation for those skills deemed deficient by the RN.

In 2019, MedPAC reported that, between 1998 and 2017, home health visits declined by 88%. To ensure that aide services are meeting the needs of patients and that HHAs are maintaining safe, quality care, CMS seeks information about the adequacy of aide staffing as well as comments on the following:

- *"Whether home health agencies employ or arrange for (under contract) home health aides to provide aide services;*
- *The number of home health aides per home health agency (both directly employed and under contract), and whether the number has increased or decreased over the past 5-10 years;*
- *The average number of aide hours per beneficiary with aide service ordered on the plan of care;*
- *The effect of the public health emergency on the ability of HHAs to employ home health aides or arrange for (under contract) the provision of home health aide services."*

Home Infusion Therapy Services

FR pages 35,958 – 35,961

CMS is not proposing to make any changes to the three, previously finalized payment categories for CY 2022:

- Payment Category 1 – intravenous infusion drugs for therapy, prophylaxis, or diagnosis, including, but not limited to, antifungals and antivirals; inotropic and pulmonary hypertension drugs; pain management drugs; and chelation drugs;
- Payment Category 2 – subcutaneous infusions for therapy or prophylaxis, including, but not limited to, certain subcutaneous immunotherapy infusions; and
- Payment Category 3 – intravenous chemotherapy infusions, including certain chemotherapy drugs and biologicals.

J-Codes associated with each category can be found at https://www.cms.gov/files/document/mm11880.pdf. For these categories, CMS previously finalized that the payment amounts for the first visit be increased by an average difference between the PFS amounts for existing patients and new patient visits for a given year and each subsequent visit have a smaller payment amount, including a budget neutrality factor. For CY 2021, the first visit increase was 20% and the subsequent visit decrease was 1.3310%, including a CAA mandated 3.75% increase to PFS amounts for CY 2021. CMS proposes to maintain these adjustments when applied to the CY 2022 payment rates. However, CMS will remove the 3.75% increase to PFS rates and use unadjusted CY 2021 rates when calculating the CY 2022 payment amounts, which will be released in a forthcoming change request (CR).

For CY 2020, CMS finalized the adjustment of home infusion therapy payments to reflect differences in geographic wages, using the geographic adjustment factor (GAF) for CY 2021 and forward. The GAF is a weighted composite of each region's Geographic Practice Cost Indices (GPCIs), which include work, practice expense (PE), and malpractice (MP) and is calculated as:

$$GAF = (0.50886\ x\ Work\ GPCI) + (0.44839\ x\ PE\ GPCI)\ +\ (0.04295\ x\ MP\ GPCI).$$

The locally adjusted GAF is multiplied by the home infusion therapy payment based on the site of the beneficiary. The next full update to GPCIs and the GAFs will be in the CY 2023 Physician Fee Schedule (PFS) proposed rule. For CY 2022, there will be changes to GAF values for the majority for localities located in California, since CY 2022 is the last year of a 5-year incremental transition for these localities implemented in 2017 in accordance with the Protected Access to Medicare Act (PAMA) of 2014. A list of GAFs proposed in the CY 2022 PFS can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched.

CMS is proposing to continue to have the GAF adjustment be budget-neutral nationally, whenever there are changes to the GAFs, in order to eliminate the aggregate effects of the variations in the GAFs. For CY 2022, this factor would equal the ratio of the estimated national spending total, using the CY 2021 GAF, to the estimated national spending total, using the CY 2022 GAF, where the estimated spending totals would use home infusion utilization data for CY 2020. Since the CY 2022 GAF was not available for this proposed rule, CMS will calculate the CY 2022 GAF standardization factor in a forthcoming change request.

CMS previously finalized that, beginning in CY 2022, it would increase the single payment amount by the percent increase in the Consumer Price Index for all urban customers (CPI-U) for the 12-month period ending with June of the preceding year. This is then reduced by the 10-year moving average of economy-wide private nonfarm multifactor productivity (MFP), and may result in payments being lower than the preceding year. The CPI-U for the 12-month period ending in June 2021 was not available for this proposed rule. As such, CMS intends to update the productivity adjustment in the HH PPS final rule.

Medicare Provider and Supplier Enrollment Changes

FR pages 35,961 – 35,967

In a continued effort to prevent Medicare providers and suppliers from engaging in fraudulent, wasteful, and abusive behaviors, CMS is proposing several changes to their existing provider enrollment regulations which include:

- Extending the regulation and updating the regulation text for the effective date for billing privileges and retroactive billing for services to the following supplier types:
    - Part B hospital departments;
    - Clinical Laboratory Improvement Amendment labs;
    - Intensive cardiac rehabilitation facilities;
    - Mammography centers;
    - Mass immunizers/pharmacies;
    - Radiation therapy centers;
    - Physical therapists;
    - Occupational therapists; and
    - Speech language pathologists;
- Other regulatory code updates regarding effective dates;
- The inclusion of the following scenarios, in addition to the existing scenarios, where CMS can reject a provider's or supplier's enrollment application, for all CMS provider enrollment application submissions, if the provider or supplier fails to comply with regulations within a 30-day period:
    - *"The application is missing data required by CMS or the Medicare contractor to process the application (such as, but not limited to, names, social security number, contact information, and practice location information).*
    - *The application is unsigned or undated.*
    - *The application contains a copied or stamped signature.*
    - *The application is signed more than 120 days prior to the date on which the Medicare contractor received the application.*
    - *The application is signed by a person unauthorized to do so under 42 CFR Part 424, subpart P.218*
    - *For paper applications, the required certification statement is missing.*
    - *The paper application is completed in pencil.*

- *The application is submitted via fax or e-mail when the provider or supplier was not otherwise permitted to do so.*
- *The provider or supplier failed to submit all of the forms needed to process a Form CMS-855 reassignment package within 30 days of receipt….*
- *The provider or supplier submitted the incorrect Form CMS-855 application….";*

- The following situations where CMS or a contractor could, but are not required to, return an application to a supplier or provider:
  - *"The provider or supplier sent its paper Form CMS-855, Form CMS-588, or Form CMS-20134 application to the incorrect Medicare contractor for processing. (For example, the application was sent to Contractor X instead of Contractor Y.)*
  - *The Medicare contractor received the application more than 60 days prior to the effective date listed on the application. (This does not apply to (1) providers and suppliers submitting a Form CMS-855A application, (2) ambulatory surgical centers, or (3) portable x-ray suppliers.*
  - *The seller or buyer in a change of ownership submitted its Form CMS-855A or Form CMS-855B application more than 90 days prior to the anticipated date of the sale.*
  - *The Medicare contractor received an initial application more than 180 days prior to the effective date listed on the application from (1) a provider or supplier submitting a Form MS-855A application, (2) an ambulatory surgical center, or (3) a portable x-ray supplier.*
  - *The Medicare contractor confirms that the provider or supplier submitted an initial enrollment application prior to the expiration of the time period in which it is entitled to appeal the denial of its previously submitted application.*
  - *The provider or supplier submitted an initial enrollment application prior to the expiration of their existing reenrollment bar under § 424.535 or reapplication bar under § 424.530(f).*
  - *The application is not needed for (or is inapplicable to) the transaction in question.*
  - *The provider or supplier submitted a revalidation application more than 7 months prior to the provider's or supplier's revalidation due date.*
  - *A Medicare Diabetes Prevention Program (MDPP) supplier submitted an application with a coach start date more than 30 days in the future. (That is, the application lists an MDPP coach who will commence his or her services beginning at least 31 days after the date the Medicare contractor receives the application.)*
  - *The provider or supplier requests that their application be withdrawn prior to or during the Medicare contractor's processing thereof.*
  - *The provider or supplier submits an application that is an exact duplicate of an application that (1) has already been processed or (2) is currently being processed or is pending processing.*
  - *The provider or supplier submits a paper Form CMS-855 or Form CMS-20134 application that is outdated and/or has been superseded by a revised version.*
  - *The provider or supplier submits a Form CMS-855A or Form CMS-855B initial enrollment application followed by a Form CMS-855A or Form CMS-855B CHOW application. If the Medicare contractor:*
    - *Has not yet made a recommendation for approval concerning the initial application, both applications may be returned in this scenario.*
    - *Has made a recommendation for approval concerning the initial application, the Medicare contractor may return the CHOW application. If, per the Medicare contractor's written request, the provider or supplier fails to submit a new initial Form CMS-855A or Form CMS- 855B application containing the new owner's information within 30 days of the date of the letter, the Medicare contractor may return the originally submitted initial Form CMS-855A or Form CMS-855B application.";*
- Other proposals to the operational components of the return policy, including that a provider or supplier may not appeal a return of their enrollment application;
- The addition of the following grounds for deactivation (not revocation) of a provider's or supplier's billing privileges, which can be restored/reactivated once required information is submitted:
  - *"The provider or supplier is not in compliance with all enrollment requirements in Title 42.*

    - *The provider's or supplier's practice location is non-operational or otherwise invalid.*
    - *The provider or supplier is deceased.*
    - *The provider or supplier is voluntarily withdrawing from Medicare.*
    - *The provider is the seller in an HHA change of ownership under § 424.550(b)(1).";*
- Revision of regulatory language to account for the above additions and clarifications on the deactivation process;
- A provider or supplier may not receive payment for services or items furnished while payments are deactivated;
- Change in regulation text regarding attestation of HHA capital by a financial institution;
- Update in language in the "36-month rule" if there is a change in HHA ownership to allow the 2 consecutive years of ownership of cost reports to be from either the HHA's initial enrollment date or last change in majority ownership, whichever is later.

Survey and Enforcement Requirements for Hospice Programs

FR pages 35,967 – 35,979

The CAA established the following new hospice program survey and enforcement requirements, which would be effective on October 1, 2021 (unless otherwise noted):

- Public reporting of hospice program surveys by survey agencies (SA) and Accrediting Organizations (AO), and enforcement actions taken as a result of these surveys, on CMS's website *(FR page 35,970)*;
- Removal of the prohibition of public disclosure of hospice surveys performed by SAs, requiring AOs to use the same survey deficiency reports as SAs to report survey findings, specifically, Form CMS-2567, which CMS seeks public comment on how AOs can customize their proprietary systems to submit this form via electronic data exchange *(FR page 35,969)*;
- Programs must measure and reduce inconsistency in the application of survey results among all surveyors *(FR pages 35,973 – 35,974)*;
- The Secretary must provide training and testing of SA and AO hospice program surveyors;
- SA surveyors are prohibited from surveying hospice programs they have worked at in the last 2 years or in which they have financial interest (*FR pages 35,971 – 35,972)*;
- Hospice Program SAs and AOs must use a multidisciplinary team for surveys conducted with more than one surveyor and must include at least one RN *(FR pages 35,972 – 35,973)*;
- Each SA must establish a dedicated toll-free hotline to collect, maintain, and update information on hospice programs and to receive complaints (effective December 27, 2021) *(FR pages 35,970 – 35,971)*; and
- The Secretary must create a Special Focus Program (SFP) for poor performing hospice programs which would have authority to impose enforcement remedies for noncompliant programs and develop and implement remedies and procedures for appealing these remedies *(FR page 35,974)*.

CMS proposes to implement the CAA requirements in addition to developing a strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public.

CMS is proposing the definitions of the following terms as part of its new regulations for survey and certification of hospice programs: *abbreviated standard survey, complaint survey, condition-level deficiency, deficiency, noncompliance, standard-level deficiency, standard survey,* and *substantial compliance*. Details on these definitions can be found on *FR* pages 35,970 – 35,979.

CMS is proposing the definitions of the following terms as part of its new regulations for enforcement remedies for hospice programs with deficiencies: *directed plan of correction*, *immediate jeopardy*, *new admission*, *per instance*, *plan of correction*, *repeat deficiency*, *and temporary management*. Detail on these definitions, proposed general provisions, and related proposed regulatory provisions can be found on *FR* pages 35,970 – 35,979.

Requests for Information

FR pages 35,979 – 35,983

CMS is seeking or soliciting comment on the following topics for future proposals:

- Fast Healthcare Interoperability Resourced (FHIR) is support of digital quality measurement in post-acute care quality reporting programs (*FR pages 35,980 – 35,981).* Specifically, CMS seeks input on the following steps that would enable its quality measurement system to be fully digital:
    - *"What EHR/IT systems do you use and do you participate in a health information exchange (HIE)?*
    - *How do you currently share information with other providers and are there specific industry best practices for integrating SDOH screening into EHRs?*
    - *What ways could we incentivize or reward innovative uses of health information technology (IT) that could reduce burden for post-acute care settings, including but not limited to HHAs?*
    - *What additional resources or tools would post-acute care settings, including but not limited to HHAs, and health IT vendors find helpful to support testing, implementation, collection, and reporting of all measures using FHIR standards via secure APIs to reinforce the sharing of patient health information between care settings?*
    - *Would vendors, including those that service post-acute care settings, including but not limited to HHAs, be interested in or willing to participate in pilots or models of alternative approaches to quality measurement that would align standards for quality measure data collection across care settings to improve care coordination, such as sharing patient data via secure FHIR API as the basis for calculating and reporting digital measures?"*
- Closing the equity gap in post-acute care quality reporting programs. Specifically, CMS seeks comments on the possibility of expanding measure development and the collection of other Standardized Patient Assessment Data Elements (SPADEs) that address health equity gaps in the HH QRP in addition to those previously finalized *(FR pages 35,981 – 35,983).*

Revised Compliance Date for Certain Reporting Requirements Adopted for Inpatient Rehabilitation Facility (IRF) QRP and Long-Term Care Hospital (LTCH) QRP

FR pages 35,983 – 35,985

In IFC-2, CMS had delayed the requirement under the IRF and LTCH QRP for IRFs and LTCHs to begin reporting the "Transfer of Health (TOH) Information to Provider-PAC" and the "TOH information to Patient-PAC" measures as well as the requirement to report certain SPADEs to one full fiscal year after the end of the COVID-19 PHE. CMS also delayed the adoption of the updated version of the IRF Patient Assessment Instrument (PAI) V4.0 and the LTCH Continuity Assessment and Record of Evaluation (CARE) Data Set (LCDS) V5.0, which would be used to report the aforementioned delayed data elements for each setting's respective data elements. CMS proposes that the revised compliance date when IRFs and LTCHs would need to begin collecting data on these measures and SPADES, using the IRF PAI V4.0 and LCDS V5.0, respectively, would be October 1, 2022.

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