FAQs from the webinar:

The 2022 home health proposed rule: A glimpse into the future of home health

Written by
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On Monday, June 28, 2021, the Centers for Medicare & Medicaid Services (CMS) released its 2022 home health proposed rule, which highlights the national expansion of the Home Health Value-Based Purchasing (VBP) Model to all 50 states as early as January 2022. Renowned home health consultant **Sharon Harder** and clinical expert **Jill Dyer**, BSN, RN, HCS-D, HCS-O recently presented a webinar unpacking the key elements of the proposed rule, including the VBP expansion, Quality Reporting Program changes, and infusion therapy payment updates. This webinar is available to watch on-demand. Now, Sharon and Jill provide answers to the most frequently asked questions from the webinar.

Home Health Value-Based Purchasing

Q: Will agencies in the nine states where VBP has been in effect since 2016 be penalized or rewarded for their 2020 results that would be expected to yield reimbursement adjustments in 2022?

A: The proposed rule establishes the CMS intent to end the VBP Model a year early such that calendar year 2020 performance data would not be used to calculate a payment adjustment that would materialize in 2022.

Q: Will the VBP program also extend to Medicare Advantage plans?
A: VBP metrics will be calculated based on data for traditional or fee-for-service Medicare patients. The VBP program will not extend to Medicare Advantage patients.

Q: Will the data that is used for calculation of VBP metrics be risk-adjusted?
A: Yes. According to the proposed rule, CMS is continuing with its approach to risk adjustment based on 'observed and predicted' values to arrive at the risk adjustment factor. This is designed to even the playing field between agencies that care for complex patients with chronic illness and those that provide services to less complex patient populations.

Q: Do the OASIS-based VBP measures account for episodes of care ending in recertifications, or only discharges?
A: The metrics will be calculated based on the difference between the start of care (SOC) or resumption of care (ROC) OASIS, whichever is more recent, as well as the Discharge or Transfer OASIS that is the final entry in the iQIES record. For example, if a patient is admitted in January and is on service for two certification periods *without* a transfer and subsequent ROC and *with* a discharge to the community, the OASIS assessments that would be used to influence the scoring would be the SOC and Discharge OASIS. The ROC would not apply for purposes of the measure and calculation. The piece to remember here is that an "episode of care" does not have the same meaning as a 60-day episode.

Q: When a patient's condition does not change between the SOC and Discharge OASIS, does the data from the episode of care "count" for purposes of the calculation? For example, a patient who has no dyspnea at the time of their admission with no change upon discharge.
A: All results are measured, meaning that there is no exclusion for assessments that do not establish a change between the admission/ROC and the patient's discharge

Q: How are patients who return to the hospital for a planned procedure viewed in terms of the hospitalization metric? For example, some of our patients have one knee replacement followed by a second, often within a 60-day period.

A: The claims-based hospitalization measure pertains only to unplanned admissions. Planned admissions, such as those related to your example of a joint replacement, are identified through the use of a modifier on the hospital claim. That modifier would exclude the claim from the data that is used to calculate the hospitalization rate.

Q: What if a patient goes to the emergency department (ED) and sits in observation status for five days but is never admitted? Is that considered an ED visit or hospitalization?
A: In this case, there would be no inpatient admission, so the hospitalization metric would not apply; however, there would be a claim for the patient's use of the ED and that would factor into the calculation for ED use.

Q: What will be the source of claims data that is used to measure hospitalizations and ED visits?
A: CMS maintains a database of all Medicare claims referred to as the Chronic Conditions Warehouse. This database includes not only home health claims, but also hospital inpatient and outpatient claims as well as claims data from other types of institutional providers. Hospitalization data will be taken from Part A inpatient claims and ED data will be derived from the Part B claims. Both will be compared to overlapping or adjacent home health claims.

Q: Is the competition model based on agencies in our state or on all agencies across the country?
A: The cohorts under the model program were based on each state; however, under the new VBP program proposed for 2022, the cohort is national, meaning that all agencies across the country would be compared to one another in terms of performance.

Q: How will the VBP program affect agencies that care for special needs patients who are unlikely to show improvement in their current functional status?
A: This is where the process of risk adjustment comes into play. Remember that all of the data used for the measurements will be risk-adjusted based on the characteristics of the patient population served by the agency compared to all others.

Notice of Admission

Q: How often does the Notice of Admission (NOA) need to be submitted?
A: The NOA will be submitted once during every episode of care (as defined), meaning every time there is a new SOC. The submission will not be repeated for recertification periods.

Q: Will our consent be used as the NOA?
A: No. The NOA will be submitted much like a claim with a particular Type of Bill (TOB) Code. The TOB Code will serve to designate it as an NOA that will not be associated with payment but will be used to calculate any applicable penalty on final bills for payment periods within a distinct episode of care or stay.

Q: Will we be paid for the NOA submission?
A: No. Just as advance payments have been discontinued for 2021, there will be no reimbursement for services other than as calculated based on final claim submissions. Remember that the penalty calculation related to submission of the NOA will mirror the penalty calculation now in effect for Requests for Anticipated Payment (RAPs). For every day that the NOA is "late" (meaning after day five) the penalty will be calculated as 1/30th of the anticipated payment multiplied by the number of days elapsed before the NOA is received and accepted.

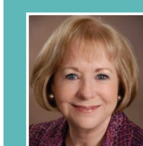
Therapy

Q: Could you provide a recap of the rules around Occupational Therapists (OTs) being able to perform comprehensive assessments?
A: Remember that for the duration of the public health emergency, CMS established a temporary waiver that enabled OTs to complete the comprehensive assessment. Under the proposed rule, the terms of the waiver would be made permanent, and the OT would be able to complete the assessment when OT services are ordered in conjunction with another therapy discipline and when there is no need for skilled nursing services. The statutory requirements related to completion of the comprehensive assessment have not changed in terms of when OT services can stand alone after the cessation of services provided by other disciplines.

Q: In a certification period where the certifying physician only anticipates a need for therapy services and it is later determined that the patient would benefit from skilled nursing services as well, is a follow-up OASIS required? Or is it acceptable to simply update the plan of care with nursing orders? Does adding skilled nursing later in the certification period without benefit of the additional follow-up OASIS put the agency at risk for scrutiny by CMS?
A: CMS has been clear that in situations where diagnosis coding changes are apparent or where additional services from other disciplines are required, the agency's overall policy will guide the need to conduct a follow-up assessment. If the patient's change in condition is significant enough to warrant a substantive change in the focus of care, then a follow-up assessment should be considered.

However, the agency's policies and procedures should guide the clinical evaluation of whether a follow-up assessment is needed – or not. The mere fact of adding on services in the midst of a certification period would not, in and of itself, put the agency at risk of CMS or contractor scrutiny unless there is a clear pattern that would be suggestive of program abuse. Our best advice is to establish a clear, defined, and reasonable process for determining when and how follow-up assessments are used in conjunction with either diagnostic coding changes or expansion of services with clear attention to documentation that follows.

About the authors



Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations ranging from a major healthcare professional association to large post-acute healthcare providers. As President of C3 Advisors, LLC, Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare market place.

Jill Dyer, BSN, RN, HCS-D, HCS-O is a senior-level home health executive with progressive management experience in home health. Jill is certified as a home care coding and OASIS specialist and is an accomplished nurse with more than 30 years of experience as a home health administrator, home health director of nursing, and nurse consultant for home health. Jill is the president of JID Consulting and Coding, LLC.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