Home Health CY 2020 Proposed and Final Rule Crosswalk

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Section	CY 2020 Home Health Proposed Rule	Starting Page Number	CY 2020 Home Health Final Rule	Starting Page Number
Resources	Issued: July 11, 2019	N/A	Issued: October 31, 2019; Published November 8, 2019	N/A
	CY 2020 HH PPS Proposed Rule Link (CMS-1711-P)	N/A	CY 2020 Home Health Final Rule Link	N/A
	CY 2020 HH Proposed Rule Fact Sheet Link	N/A	CY 2020 HH Final Rule Press Release	N/A
	CY 2020 PDGM Agency Level Impacts Index Files	N/A	CY 2020 HH Final Rule Fact Sheet	N/A
	CY 2020 HH PPS Wage Index	N/A	CMS Home Health Agency (HHA) Center Webpage	N/A
	CY 2020 PDGM Case Mix Weights and LUPA Thresholds	N/A	Other PDGM Rate Transmittals: • CR 11081 • CR 11272 • CR 11395 • CR 11527	N/A
	CY 2019-CY 2022 Rural Add-On Payment Designations	N/A		
	CY 2020 Home Health Proposed Rule Submitted Comments	N/A		
Behavioral Adjustment	**Section III.B: Implementation of a 30-Day Unit of Payment for CY 2020** The proposed rule implements the change in the unit of payment from 60-day episodes of care to 30-day periods of care, and proposes a 30-day payment amount for CY 2020, which includes the behavioral adjustment, reducing the initial 30-day base rate from -6.42% last year to utilize an -8.01% reduction in 2020.	34614	**Section III.B: Implementation of a 30-Day Unit of Payment for CY 2020** • Finalized with changes: • Based on the comments received and reconsideration as to frequency of the assumed behaviors during the first year of the transition to a new unit of payment and casemix adjustment methodology, CMS is finalizing a -4.36% (significantly less than the initial -8.01% proposed) behavior change assumptions adjustment in order to calculate the 30-day payment rate in a budget-neutral manner for CY 2020. This adjustment will be made using the three behavior assumptions finalized in the CY 2019 HH PPS final rule.	60511
Annual Payment Update	**Section III.E.1: Proposed CY 2020 Home Health Market Basket Update for HHAs** • Estimated increase in aggregate by 1.3% or $250 million • Reflects the 1.5% home health payment (market basket update) percentage ($290 million increase) and a 0.2% decrease in aggregate payments due to reductions made by the new rural add-on policy mandated in 2018 for CY 2020.	34628	**Section III.E.1: Finalized CY 2020 Home Health Market Basket Update for HHAs** • Finalized with no changes: • Estimated increase in aggregate by 1.3%, or $250 million • Reflects the 1.5% home health payment update percentage ($290 million increase) and a 0.2% aggregate decrease (-$40 million) in payments due to reductions made by the new rural add-on policy mandated in 2018 for CY 2020.	38487
Wage Index	**Section III.E.2: CY 2020 Home Health Wage Index** • Contain multiple changes; files are expansive and can be viewed on CMS HHA Center Webpage	34628 34629	**Section III.E.2: CY 2020 Home Health Wage Index** • Finalized with no changes: • Finalized wage index files can be viewed on CMS HHA Center Webpage	38492

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<tr><th>Section</th><th>CY 2020 Home Health Proposed Rule</th><th>Starting Page Number</th><th>CY 2020 Home Health Final Rule</th><th>Starting Page Number</th></tr>
<tr><td>60-Day Episode Payment Rate</td><td>Section III.E.4.b: CY 2020 National Standardized 60-Day Episode Payment Rate
The proposed national, standardized 60-day episode amount of $3,221.43 for agencies that submit the required quality data.
Note: this would be used for episodes that span the January 1, 2020 implementation date (through 2/28/20) and is referenced in Table 15 of the proposed rule.
Table 15: CY 2020 National Standardized 60-Day Episode Payment Amount<table><tr><th>CY 2019 National, Standardized 60-Day Episode Payment</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 HH Payment Update</th><th>CY 2020 National, Standardized 60-Day Episode Payment</th></tr><tr><td>$3,154.27</td><td>X 1.0062</td><td>X 1.015</td><td>$3,221.43</td></tr></table></td><td>34630

34630</td><td>Section III.E.4.b: CY 2020 National Standardized 60-Day Episode Payment Rate
Finalized with changes
Final standardized 60-day episode amount of $3,220.79 for agencies that submit the required quality data.
Note: this would be used for episodes that span the January 1, 2020 implementation date (through 2/28/20) and is referenced in Table 17 of the final rule.
Table 17: CY 2020 National Standardized 60-Day Episode Payment Amount<table><tr><th>CY 2019 National, Standardized 60-Day Episode Payment</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 HH Payment Update</th><th>CY 2020 National, Standardized 60-Day Episode Payment</th></tr><tr><td>$3,154.27</td><td>X 1.0060</td><td>X 1.015</td><td>$3,220.73</td></tr></table></td><td>38503

38503</td></tr>
<tr><td>30-Day Payment Amount</td><td>Section III.E.4.d: CY 2020 National., Standardized 30-Day Payment Amount
The proposed new national, standardized 30-day period payment amount (PDGM Base Rate) is $1,791.73 for agencies that submit the required quality data.
Note: This would be used for new payment periods starting on/after January 1, 2020
Table 21: CY 2020 National, Standardized 30-Day Period Payment Amount<table><tr><th>CY 2020 30-Day Budget Neutral (BN) Standard Amount</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 Payment Update</th><th>CY 2020 National, Standardized 30-Day Period Payment</th></tr><tr><td>$1,754.37</td><td>X 1.0062</td><td>X 1.015</td><td>$1,791.73</td></tr></table></td><td>34632</td><td>Section III.E.4.d: CY 2020 National, Standardized 30-Day Payment Amount
Finalized with changes:
Final standardized 30-day period payment amount (PDGM base rate) of $1,864.03 for agencies that submit the required quality data.
Note: This would be used for new payment periods starting on/after January 1, 2020 and is referenced in Table 23 of the final rule.
Table 23: CY 2020 National, Standardized 30-Day Period Payment Amount<table><tr><th>CY 2020 30-Day Budget Neutral (BN) Standard Amount</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 Payment Update</th><th>CY 2020 National, Standardized 30-Day Period Payment</th></tr><tr><td>$1,824.99</td><td>X 1.0063</td><td>X 1.015</td><td>$1,864.03</td></tr></table></td><td>60538</td></tr>
<tr><td>NRS</td><td>Section III.E.4.c: CY 2020 Non-Routine Medical Supply (NRS) Payment Factor and Payment Amounts
CMS updated the CY 2019 NRS Conversion factor of ($54.20) by a percentage of 1.5 percent (to $55.01) (Table 17-proposed rule)
Using the CY 2020 NRS conversion factor, the payment amounts for the six severity levels (Table 18-proposed rule) would only be used for transition episodes that span PDGM implementation, and apply to only those 60-day episodes that begin on or before December 31, 2019 but span the implementation of the PDGM and the 30-day unit of payment on January 1, 2020 (ending on February 28, 2020).</td><td>34630</td><td>Section III.E.4.c CY 2020 Non-Routine Medical Supply (NRS) Payment Factor and Payment Amounts
Finalized with no changes:
CMS finalized CY 2019 NRS Conversion factor of ($54.20) by a percentage of 1.5 percent (to $55.01) (Table 19 in final rule)
Finalized CY 2020 NRS payment amounts (table 20-final rule) for the six severity levels to be used for transition episodes and apply to only those 60-day episodes that begin on or before December 31, 2019 but span the implementation of the PDGM and the 30-day unit of payment on January 1, 2020 (ending on February 28, 2020).</td><td>60537</td></tr>
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<tr><th>Section</th><th>CY 2020 Home Health Proposed Rule</th><th>Starting Page Number</th><th>CY 2020 Home Health Final Rule</th><th>Starting Page Number</th></tr>
<tr><td>NRS (continued)</td><td>• Under the PDGM, NRS payments are included in the 30-day base payment rate.
Table 17: CY 2020 NRS Conversion Factor<table><tr><th>CY 2019 NRS Conversion Factor</th><th>CY 2020 HH Payment Update</th><th>CY 2020 NRS Conversion Factor</th></tr><tr><td>$54.20</td><td>X 1.015</td><td>$55.01</td></tr></table>
Table 18: CY 2020 NRS Payment Amounts<table><tr><th>Severity Level</th><th>Points (Scoring)</th><th>Relative Weight</th><th>CY 2020 NRS Payment Amounts</th></tr><tr><td>1</td><td>0</td><td>0.2698</td><td>$14.84</td></tr><tr><td>2</td><td>1 to 14</td><td>0.9742</td><td>$53.59</td></tr><tr><td>3</td><td>15 to 27</td><td>2.6712</td><td>$146.94</td></tr><tr><td>4</td><td>28 to 48</td><td>3.9686</td><td>$218.31</td></tr><tr><td>5</td><td>49 to 98</td><td>6.1198</td><td>$336.65</td></tr><tr><td>6</td><td>99+</td><td>10.5254</td><td>$579.00</td></tr></table></td><td>34630

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Table 20: CY 2020 NRS Payment Amounts<table><tr><th>Severity</th><th>Points (Scoring)</th><th>Relative Weight</th><th>CY 2020 NRS Payment Amounts</th></tr><tr><td>1</td><td>0</td><td>0.2698</td><td>$14.84</td></tr><tr><td>2</td><td>1 to 14</td><td>0.9742</td><td>$53.59</td></tr><tr><td>3</td><td>15 to 27</td><td>2.6712</td><td>$146.94</td></tr><tr><td>4</td><td>28 to 48</td><td>3.9686</td><td>$218.31</td></tr><tr><td>5</td><td>49 to 98</td><td>6.1198</td><td>$336.65</td></tr><tr><td>6</td><td>99+</td><td>10.5254</td><td>$579.00</td></tr></table></td><td>60537

60537</td></tr>
<tr><td>Per-Visit Rates</td><td>Section III.E.4.e: CY 2020 National Per-Visit Rates for Both 60-Day Episodes of Care and 30-Day Periods of Care
• Updated by CY 2020 HH payment update of 1.5% (Table 23-proposed rule)
• LUPA add-on factors remain same as CY 2019, using CY 2020 proposed visit rates (SN 1.8451, PT 1.6700, SLP 1.6266).</td><td>34632</td><td>Section III.E.4.e: CY 2020 National Per-Visit Rates for Both 60-Day Episodes of Care and 30-Day Periods of Care
• Finalized with changes:
• Finalized CY 2020 National per-visit rates were updated by the CY 2020 HH payment update of 1.5% (Table 25-final rule).
• LUPA Add-on factors remain same as CY 2019, to be used with final CY 2020 visit rates (SN 1.8451, PT 1.6700, SLP 1.6266).</td><td>60539</td></tr>
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<tr><th>Section</th><th>CY 2020 Home Health Proposed Rule</th><th>Starting Page Number</th><th>CY 2020 Home Health Final Rule</th><th>Starting Page Number</th></tr>
<tr><td>Per-Visit Rates (continued)</td><td>
Table 23: CY 2020 National Per-Visit Payment Rates
<table>
<tr><th>HH Discipline</th><th>CY 2019 Per-Visit Payment</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 Payment Update</th><th>CY 2020 Per-Visit Payment</th></tr>
<tr><td>Home Health Aide</td><td>$66.34</td><td>X 1.0065</td><td>X 1.015</td><td>$67.77</td></tr>
<tr><td>Medical Social Services</td><td>$234.82</td><td>X 1.0065</td><td>X 1.015</td><td>$239.89</td></tr>
<tr><td>Occupational Therapy</td><td>$161.24</td><td>X 1.0065</td><td>X 1.015</td><td>$164.72</td></tr>
<tr><td>Physical Therapy</td><td>$160.14</td><td>X 1.0065</td><td>X 1.015</td><td>$163.60</td></tr>
<tr><td>Skilled Nursing</td><td>$146.50</td><td>X 1.0065</td><td>X 1.015</td><td>$149.66</td></tr>
<tr><td>Speech-Language Pathology</td><td>$174.06</td><td>X 1.0065</td><td>X 1.015</td><td>$177.82</td></tr>
</table>
</td><td>34632</td><td>
Table 25: CY 2020 National Per-Visit Payment Rates
<table>
<tr><th>HH Discipline</th><th>CY 2019 Per-Visit Payment</th><th>Wage Index Budget Neutrality Factor</th><th>CY 2020 Payment Update</th><th>CY 2020 Per-Visit Payment</th></tr>
<tr><td>Home Health Aide</td><td>$66.34</td><td>X 1.0066</td><td>X 1.015</td><td>$67.78</td></tr>
<tr><td>Medical Social Services</td><td>$234.82</td><td>X 1.0066</td><td>X 1.015</td><td>$239.92</td></tr>
<tr><td>Occupational Therapy</td><td>$161.24</td><td>X 1.0066</td><td>X 1.015</td><td>$164.74</td></tr>
<tr><td>Physical Therapy</td><td>$160.14</td><td>X 1.0066</td><td>X 1.015</td><td>$163.61</td></tr>
<tr><td>Skilled Nursing</td><td>$146.50</td><td>X 1.0066</td><td>X 1.015</td><td>$149.68</td></tr>
<tr><td>Speech-Language Pathology</td><td>$174.06</td><td>X 1.0066</td><td>X 1.015</td><td>$177.84</td></tr>
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</td><td>60539</td></tr>
<tr><td>Rural Add-On Payments</td><td>
Section III.E.4.f.2: Rural Add-On Payments for CYs 2020 Through 2022

CY 2019 final rule implemented brand-new methodology for calculating rural add-on as mandated by Bipartisan Budget Act of 2018
Rural add-on payments vary by county category classification (low population density, high home health utilization, and all other rural areas, until the rural add-on payment is phased out in 2022)
Nothing new was proposed to be different from CY 2019 Final Rule percentages; this table is provided for reference purposes only.

<table>
<tr><th>Year</th><th>Low Population Density (counties with 6 or fewer people per square mile- 334 rural counties)</th><th>High Utilization Counties (top quartile of utilization on average- 510 rural counties)</th><th>All other rural areas (1162 rural counties)</th></tr>
<tr><td>2019</td><td>4%</td><td>1.5%</td><td>3%</td></tr>
<tr><td>2020</td><td>3%</td><td>0.5%</td><td>2%</td></tr>
<tr><td>2021</td><td>2%</td><td>None</td><td>1%</td></tr>
<tr><td>2022</td><td>1%</td><td>None</td><td>None</td></tr>
</table>
</td><td>34634</td><td>
Section III.E.4.f.2: Rural Add-On Payments for CYs 2020 Through 2022

Previously finalized; no changes:
The new rural add-on methodology implemented in CY 2019 will remain under PDGM.
Rural add-on payments vary by county category classification (low population density, high home health utilization, and all other rural areas, until the rural add-on payment is phased out in 2022)
Nothing new was proposed/finalized to be different from CY 2019 Final Rule percentages; this table is provided for reference purposes only.

<table>
<tr><th>Year</th><th>Low Population Density (counties with 6 or fewer people per square mile- 334 rural counties)</th><th>High Utilization Counties (top quartile of utilization on average- 510 rural counties)</th><th>All other rural areas (1162 rural counties)</th></tr>
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<tr><td>2020</td><td>3%</td><td>0.5%</td><td>2%</td></tr>
<tr><td>2021</td><td>2%</td><td>None</td><td>1%</td></tr>
<tr><td>2022</td><td>1%</td><td>None</td><td>None</td></tr>
</table>
</td><td>60541</td></tr>
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LUPA and PEP	**Section III.E.4.g: Low-Utilization Payment Adjustment (LUPA) Add-On Factors and Partial Payment Adjustments** • Proposed CY 2020 HH PPS case-mix weights and LUPA thresholds: also contain multiple changes. These files are expansive and can be viewed on the CMS Home Health Agency (HHA) Center webpage. • As finalized in CY 2019 HH PPS Final Rule, (83 FR 56516), CMS finalized their policy that process for Partial Episode Payment (PEP) Adjustments for 30-day periods of care will remain the same as the process for 60-day episodes.	34635	**Section III.E.4.g: Low Utilization Payment Adjustment (LUPA) Add-On Factors and Partial Episode Payments** • LUPA/PEP Finalized with no changes; Case mix weights have been updated • Finalized CY 2020 PPS case mix weights and LUPA thresholds file can be viewed on the CMS Home Health Agency (HHA) Center webpage. • As finalized in CY 2019 HH PPS Final Rule, (83 FR 56516), CMS finalized their policy that process for Partial Episode Payment (PEP) Adjustments for 30-day periods of care will remain the same as the process for 60-day episodes.	60542
Outliers	**Section III.F.1: Proposed Payment for High-Cost Outliers Under the HH PPS** • New Proposal CY 2020: Update the fixed-dollar loss ratio from 0.51 to 0.63 for CY 2020 30-day payment periods in order to increase outlier payments as a percentage of total payments so that this percentage is closer to, but not more than the maximum allowed, 2.5 percent budget amount. CMS invites comments to this change. • CY 2019 HH final rule finalized policy to maintain current methodology for payment of high-cost outliers upon implementation of PDGM in CY 2020 and will calculate payment for outliers based on 30-day periods of care. • FDL ratio for transitional 60-day episodes in CY 2020 at 0.51 • Loss sharing ratio remains at 0.80 for the HH PPS to remain consistent with payments for high-cost outliers in other Medicare payment systems (for example, IRF PPS, IPPS, etc.) • CMS plans to publish the cost-per-unit amounts for CY 2020 in the rate update change request, which is issued after the publication of the CY 2020 HH PPS final rule.	34635	**Section III.F.1: Proposed Payment for High-Cost Outliers Under the HH PPS** • Finalized with changes: • Finalized the fixed-dollar loss ratio (FDL) from 0.51 to 0.56 for CY 2020 30-day payment periods. • CY 2019 HH final rule finalized policy to maintain current methodology for payment of high-cost outliers upon implementation of PDGM in CY 2020 and will calculate payment for outliers based on 30-day periods of care. • Finalized keeping the FDL ratio for transitional 60-day episodes in CY 2020 at 0.51. • Loss sharing ratio finalized/remains at 0.80 for the HH PPS to remain consistent with payments for high-cost outliers in other payment systems. • Cost per 15-minute unit outlier methodology remains same as CY 2019, but the public should assume new outlier per unit rate changes will be posted in a future CMS Change Request, as CMS will continue to monitor the visit length by discipline as more recent data becomes available.	60542
Split Percentage Payments and Final Rule Title Correction	**Section III.G.1: Proposed Changes to the Split Percentage Payment Approach for HHAs in CY 2020 and Subsequent Years** • For existing HHAs (certified prior to January 1, 2019): (1) to reduce the split-percentage payment from the current 60/50 percent to 20 percent in CY 2020 for all 30-day HH periods of care (both initial and subsequent periods of care); and (2) full elimination of the split-percentage payments for all providers in CY 2021. • Newly enrolled HHAs (certified January 1, 2019 or later) will not receive split percentage payments (as finalized in 2019 HH Final Rule) and will still be required to submit “no pay” RAPs at the beginning of a period of care, and every 30 days thereafter, until RAPs are completely phased out.	34636	**Section III.G: Proposed Changes to the Split Percentage Payment Approach for HHAs in CY 2020 and Subsequent Years** • Finalized as proposed with updates: • Finalized proposal to decrease the upfront split-percentage payment in CY 2020 for 30- day periods of care beginning on and after January 1, 2020 from 60/50 percent to 20 percent for each 30-day period, for existing HHAs, meaning HHAs certified for participation in Medicare effective on or before December 31, 2018. • HHAs certified for participation in Medicare on or after January 1, 2020 are required to submit a “no pay” RAP for each 30-day period of care in CY 2020. • Finalized to lower split percentage payment from 20 percent to zero for all HHAs (existing agencies as well as newly enrolled agencies who receive no split-percentage payments in CY 2020) and for all 30-day periods of care beginning on or after January 1, 2021. • CY 2021 all HHAs will submit ‘no-pay’ RAPs at beginning of each 30-day period.	60544

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Split Percentage Payments and Final Rule Title Correction (continued)			• Advance submission of RAPs for both the first and second 30-day periods of care (for a 60-day certification) will be allowed in CY 2021. • In CY 2021 there will be a non-timely submission reduction in payment amount tied to late submission of "no-pay" RAPs when not submitted within 5 calendar days for first 30-day period, and within 5 calendar days of day 31 for the second 30-day period. - Reduction will be calculated same way as the NOA non-timely filling policy (below).	60544
	Section III.G.2: CY 2019 HH PPS Final Rule Title Correction • Proposing to make a correction to the regulations text at § 484.205(g)(2)(iii) to accurately reflect the finalized policy that newly-enrolled HHAs will not receive split-percentage payments beginning in CY 2020.	34637	**Section III.G.2: CY 2019 HH PPS Final Rule Title Correction** • Finalized as proposed with no changes	60549
New Notice of Admission	**Proposed Notice of Admission (NOA) Requirement for CY 2021** • Beginning in CY 2021, HHAs submit a one-time submission of a notice of admission (NOA) within five calendar days of the start of care to establish that the beneficiary is under a Medicare home health period of care. • NOA process would be through an EDI submission, similar to that used for the hospice notice of election (NOE). • Failure to submit a timely NOA would result in reduction to 30-day Medicare payment amount, from start of care to the NOA filing date. • The payment reduction would be applied to the case-mix and wage-index adjusted 30-day period payment amount, including NRS, which would be a 1/30 reduction off of the full 30-day period payment amount for each day until the date the NOA is submitted (that is, from the start of care date through the day before the NOA is submitted, as the day submitted would be counted as a covered day). • The reduction (R) to the full 30-day period payment amount would be calculated as follows: - The number of days (d) from the start of care until the NOA is submitted divided by 30 days; - The fraction from step 1 is multiplied by the case-mix and wage-adjusted 30-day period payment (P) amount). - The formula for the reduction would be R = (d/30) x P. • For periods of care in which a HHA fails to submit a timely NOA, no LUPA payments would be made for days that fall within the period of care prior to the submission of the NOA - These days would be considered provider liability, the payment reduction could not exceed the total payment of the claim, and the provider may not bill the beneficiary for these days. • Once the NOA is received, all claims for both initial and subsequent episodes of care would compare the receipt date of the NOA to the HH period of care start date to determine whether a late NOA reduction applies.	34639	**Notice of Admission (NOA) Requirement for CY 2021** • Finalized with changes: • NOA requirement implementation delayed to 2022. • In CY 2022, CMS is eliminating the requirement to submit RAPs and is finalizing the implementation of a one-time NOA submission policy for all HHAs. • NOA process would be through an EDI submission, similar to that used for the hospice notice of election (NOE). • Required to submit a one-time submission of a notice of admission (NOA) within five calendar days of the start of care to establish that the beneficiary is under a Medicare home health period of care and covers contiguous 30-day periods of care until the individual is discharged from Medicare home health services. • NOA submission criteria will require HHAs having a verbal or written order from the physician that contains the services required for the initial visit, and that the HHA has conducted an initial visit at the start of care. • The NOA would be used to trigger consolidated billing edits and would allow for other providers and the CMS claims processing systems to know that the beneficiary is in a HH period of care. • Once the NOA is received, all claims for both initial and subsequent episodes of care would compare the receipt date of the NOA to the HH period of care start date to determine whether a late NOA reduction applies. • Failure to submit a timely NOA would result in a reduction in payment amount and would be equal to a 1/30th reduction to the wage-adjusted 30- day period payment amount for each day from the home health start of care date until the date the HHA submitted the NOA. Reduction calculation was finalized as proposed. • For periods of care in which HHA fails to submit a timely NOA, no LUPA payments would be made for days that fall within the period of care prior to the submission of the NOA. - These days would be considered provider liability, the payment reduction could not exceed the total payment of the claim, and the provider may not bill the beneficiary for these days.	60549

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New Notice of Admission (continued)	• If an exceptional circumstance is experienced by the HHA, the agency can request a waiver of the payment consequences due to an exceptional circumstance, by which the HHA would fully document and furnish any requested documentation to CMS through their corresponding MAC, for a determination of exception.	34639	• If an exceptional circumstance is experienced by the HHA, the agency can request a waiver of the payment consequences due to an exceptional circumstance, by which the HHA would fully document and furnish any requested documentation to CMS through their corresponding MAC, for a determination of exception.	60549
Proposed Regulatory Change: Therapist Assistants	**Section III.H: Proposed Regulatory Change to Allow Therapy Assistants to Perform Maintenance Therapy** • Would allow therapy assistants to furnish maintenance therapy services under a maintenance program established by a qualified therapist. • Qualified therapist still responsible for initial assessment, Plan of Care, maintenance program development/modifications, reassessment every 30 days and supervising services provided by therapy assistant. • CMS soliciting comments on proposal and importance of tracking whether a visit is for maintenance or restorative therapy versus just identifying if a qualified therapy assistant or therapist provided the service.	34640	**Section III.H: Proposed Regulatory Change to Allow Therapy Assistants to Perform Maintenance Therapy** • Finalized with one modification: • CMS is finalizing the proposed regulations text at § 409.44(c)(2)(iii)(C)(1) and (2) with a modification to reflect that all therapist assistants, rather than only physical therapist assistants, can perform maintenance therapy. • Qualified therapist still responsible for initial assessment, Plan of Care, maintenance program development/modifications, reassessment every 30 days and supervising services provided by therapy assistant.	60549
Proposed Changes to POC Regulations	**Section III.I: Proposed Changes to the Home Health Plan of Care Regulations at 409.43** • Revise condition of payment requirements for Medicare Plan of Care item requirements listed at 409.43(a). • Plan of Care must include those items listed at 484.60(a) that establish the need for service, of which newly added items: Risk for ER visits/hospital admission and all necessary interventions to address underlying risk factors; and information related to advance directives, would be exempt from being a requirement for payment (however, will remain a condition of participation).	34641	**Section III.I: Proposed Changes to the Home Health Plan of Care Regulations at 409.43** • Finalized with no changes: • CMS is finalizing the change to the regulations text at § 409.43(a) to state that for HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in § 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care. - Thus, the home health plan of care must include those items listed in 484.60(a) that establish the need for service (of which the newly added items: Risk for ER visits/hospital admission and all necessary interventions to address underlying risk factors; and information related to advance directives, will be exempt from being a requirement for payment, but will remain a condition of participation). - While these newly added plan of care items at 484.60(a) remain a condition of participation (CoP), CMS believes that violations for missed required items are best addressed through the survey process, rather than through claims denials for otherwise eligible periods of care.	60550

Section	CY 2020 Home Health Proposed Rule	Starting Page Number	CY 2020 Home Health Final Rule	Starting Page Number
HHVBP	**Section IV.B: Public Reporting of Total Performance Scores and Percentile Rankings Under the HHVBP Model** • Publicly report the Total Performance Score (TPS) and Total Performance Score Percentile Ranking from the final CY 2020 Performance Year 5 Annual Report for each HHA in the nine Model states that qualified for a payment adjustment for CY 2020. • Data would be made public after December 1, 2021, the date by which CMS intends to complete the CY 2020 Annual Report appeals process and issuance of the final Annual Report to each HHA. • CMS is also considering making this data available on the HHVBP Model page of the CMS innovation website.	34642	**Section IV.B: Public Reporting of Total Performance Scores and Percentile Rankings Under the HHVBP Model** • Finalized with no changes: • CMS will publicly report the Total Performance Score (TPS) and Total Performance Score Percentile Ranking from the final CY 2020 Performance Year 5 Annual Report for each HHA in the nine Model states that qualified for a payment adjustment for CY 2020. - CMS finalized their proposed amendment to § 484.315 to reflect this policy. • CMS expects that the data would be made public (on the HHVBP Model page of the CMS Innovation Center website) after December 1, 2021, the date by which CMS intends to complete the CY 2020 Annual Report appeals process and issuance of the final Annual Report to each HHA.	60551
HHQRP	**Section V: Proposed Updates to the Home Health Care Quality Reporting Program (HH QRP)**	34643	**Section V: Finalized Updates to the Home Health Care Quality Reporting Program (HH QRP)**	60554
	Section V.D.1: CMS Proposal to Remove Improvement in Pain Interfering with Activity Measure (NQF #0177) • Would allow therapy assistants to furnish maintenance therapy services under a maintenance program established by a qualified therapist. • Qualified therapist still responsible for initial assessment, Plan of Care, maintenance program	34644	**Section V.D.1: CMS Proposal to Remove Improvement in Pain Interfering with Activity Measure (NQF #0177)** • Finalized with no changes: • CMS is finalizing the removal of Improvement in Pain Interfering with Activity Measure (NQF #0177) from the HHQRP beginning with CY 2022. - HHAs will no longer be required to submit OASIS item M1242: Frequency of Pain Interfering with Patient's Activity or Movement, beginning January 1, 2021. - Data for this measure will be publicly reported on HH Compare until April 2020.	60555
	Section V.E. Proposed New and Modified HH QRP Quality Measures Beginning with the CY 2022 HH QRP • Proposed 2 new measures: - (1) Proposed Transfer of Health Information to the Provider-Post-Acute Care (PAC) Measure - (2) Proposed Transfer of Health Information to the Patient-Post-Acute Care (PAC) Measure ▫ These proposed measures are designed to improve patient safety by ensuring that the patient's medication list is accurate and complete at the time of transfer or discharge. Data would be collected in 2021 for HHQRP reporting in 2022 • Proposal to update existing measure: - (3) Proposed Update to the Discharge to Community (DTC)-Post-Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) Measure ▫ Update proposed to exclude baseline nursing facility (NF) residents from the measure beginning with CY 2021 HHQRP	34645	**Section V.E. Proposed New and Modified HH QRP Quality Measures Beginning with the CY 2022 HH QRP** • Finalized with no changes: • Finalized proposal to add two new measures CY 2022: - (1) Proposed Transfer of Health Information to the Provider-Post-Acute Care (PAC) Measure - (2) Proposed Transfer of Health Information to the Patient-Post-Acute Care (PAC) Measure • CMS finalized that these two measures would be adopted beginning with CY 2022 HHQRP and that HHAs will report the data on these measures using the OASIS. • HHAs will be required to collect data on these measures for patients beginning with patients discharged or transferred on or after January 1, 2021. • Finalized proposal to update existing measure. • CMS is finalizing the proposal to update the specifications for the Discharge to Community (DTC) - Post Acute Care (PAC) HH QRP measure to exclude baseline nursing facility (NF) residents from the measure beginning with CY 2021 HHQRP	60557

Section	CY 2020 Home Health Proposed Rule	Starting Page Number	CY 2020 Home Health Final Rule	Starting Page Number
HHQRP (continued)	**Section V.F: HH QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years: Request for Information** • CMS seeking input on importance, relevance, appropriateness, and applicability of each of the measures, standardized patient assessment data elements (SPADES), and measure concepts under consideration listed in Table 27 (page 34651) for future years in the HH QRP	34651	**Section V.F: HH QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years: Request for Information** • CMS will not be responding to comment submissions regarding this RFI, nor will CMS be finalizing any of these measures, measure concepts, or SPADES under consideration in tis CY 2020 final rule; however, CMS intends to use the input to inform future measure and SPADE development efforts.	60565
	Section V.G: Proposed Standardized Patient Assessment Data Reporting Beginning with the CY 2022 HH QRP • CMS is proposing to adopt a number of standardized patient assessment data elements (SPADEs) to fulfill IMPACT Act requirements. These SPADEs are designed to assess (1) functional status; (2) cognitive function and mental status; (3) special service, treatments and interventions, (4) medical conditions and comorbidities; (5) impairments, and (6) social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, and social isolation). The addition of these SPADEs to the Outcome and Assessment Information Set (OASIS) will in part improve coordination of care and facilitate communication between HHAs and other members of the healthcare community, which is in alignment with CMS's strategic initiative to improve interoperability. • In the CY 2018 HH PPS proposed rule, CMS proposed to adopt SPADES that would satisfy the first 5 categories listed above, however only finalized the adoption of SPADES for two of the first five categories described in section 1899(b)(1)(B) of the Act; CMS is now proposing to adopt many of the same SPADES previously proposed, along with other SPADES, of which HHAs would be required to report beginning with the 2022 HHQRP: • Proposed Specifications for HH QRP Measures and Standardized Patient Assessment Data Elements (SPADES) are available on the CMS website.	34652	**Section V.G: Proposed Standardized Patient Assessment Data Reporting Beginning with the CY 2022 HH QRP** • All SPADES were finalized as proposed (no changes) beginning with the CY 2022 HHQRP. • HHAs will be required to report the data using the OASIS and be required to collect the SPADES for episodes beginning or ending on or after January 1, 2021. • CMS also finalized that HHAs that submit the Hearing, Vision, Race, Ethnicity, Preferred Language and Interpreter Services SPADES with respect to SOC will be deemed to have submitted those SPADES with respect to SOC, ROC and Discharge because it is unlikely that the assessment of those SPADES with respect to SOC, will differ from the assessment of the same SPADES with respect to ROC or Discharge. • HHAs will be required to report the remaining SPADES for the CY 2022 HHQRP at SOC, ROC and Discharge timepoints between January 1, 2021 and June 30, 2021. • Following the initial reporting period for the CY 2022 HHQRP, subsequent years for the HHQRP would be based on 12 months of such data reporting beginning July 1, 2021 through June 30, 2022 for the CY 2023 HHQRP. • Additional details related to the new measures, SPADE descriptions and requirements can be found on the CMS document, titled "Proposed Specifications for HH QRP Quality Measures and Standardized Patient Assessment Data Elements (SPADES)" • CMS will be posting all updated specifications for finalized measures and SPADES to their Home Health Quality Measures webpage prior to implementation.	60566
Codification of HHQRP	**J. Proposed Codification of the Home Health Quality Reporting Program Requirements** • To promote alignment of the HH QRP and the SNF QRP, IRF QRP, and LTCH QRP regulatory text, CMS believes that with the exception of the provision governing the 2 percentage point reduction to the update of the unadjusted national standardized prospective payment rate, it is appropriate to codify the requirements that apply to the HH QRP in a single section of their regulations. Accordingly, CMS is proposing to amend 42 CFR chapter IV, subchapter G by creating a new 484.245, titled "Home Health Quality Reporting Program".	34684	**J. Finalized Codification of the Home Health Quality Reporting Program Requirements** • Finalized with no changes: • With the exception of the provision governing the 2-percentage point reduction to the update of the unadjusted national standardized prospective payment rate, CMS is finalizing as proposed, to amend 42 CFR chapter IV, subchapter G by creating a new 484.245, titled "Home Health Quality Reporting Program".	60608

Section	CY 2020 Home Health Proposed Rule	Starting Page Number	CY 2020 Home Health Final Rule	Starting Page Number
HHCAHPS	**K. Home Health Care Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey (HHCAHPS)** • Proposal to remove question # 10 from HHCAHPS beginning July 1, 2020. ("In the last two months of care, did you and a home health provider from this agency talk about pain")	34685	**K. Home Health Care Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey (HHCAHPS)** • CMS did not finalize their proposal to remove Question 10, regarding pain communication, from the all HHCAHPS surveys based upon comments received the pointed out the monitoring of pain was critical and concerns that removal of the item would potentially affect the validity of the survey.	60609
RFI	**4. Input Sought to Expand the Reporting of OASIS Data Used for the HHQRP to Include Data on All Patients Regardless of Their Payer** • CMS plans to propose to expand the reporting of OASIS data used for the HHQRP to include data on all patients, regardless of their payer in future rule-making and is seeking input on the following questions (it is currently proposed in CY 2020 Proposed Rules for SNF and IRF QRP) to assist CMS with a future proposal: - Do you agree there is a need to collect OASIS data for the HH QRP on all patients regardless of payer? - What percentage of your HHA's patients are you not currently reporting OASIS data for the HH QRP? - Are there burden issues that need to be considered specific to the reporting of OASIS data on all HH patients, regardless of their payer? - What differences, if any, do you notice in patient mix or in outcomes between those patients that you currently report OASIS data, and those patients that you do not report data for the HH QRP? - Are there other factors that should be considered prior to proposing to expand the reporting of OASIS data used for the HH QRP to include data on all patients, regardless of their payer?	34685	**4. Input Sought to Expand the Reporting of OASIS Data Used for the HHQRP to Include Data on All Patients Regardless of Their Payer** • CMS acknowledge appreciation for all of the feedback/comments that they received regarding this RFI and stated they will take it into consideration in future policy and propose it in future rulemaking by where HHAs may be required to collect and submit data on HH patients regardless of payer.	60610
Home Infusion Therapy Services	**Section VI: Medicare Coverage of Home Infusion Therapy Services** **Section VI.4 Summary of Temporary Transitional Payments CY 2019 and 2020** • Only eligible home infusion suppliers can bill for temporary transitional payments; which are existing DME suppliers that are enrolled in Medicare part B as pharmacies • CY 2019 HH PPS Final Rule finalized implementation of home infusion therapy services temporary transitional payments. • Temporary transitional payments began on January 1, 2019 and will end the day before the full implementation of the home infusion therapy benefit on January 1, 2021. • Change Request CR10836, provides the detailed billing instructions (including HCPCS codes and units) to be billed on the Medicare Part B claim for the home infusion drugs and professional services. • CMS will update the temporary transitional payments based on CPT code payment amounts with the CY 2020 physician fee schedule final rule. • CMS provided clarification that during the transitional period, that home infusion therapy is not excluded from home health services until January 1, 2021.	34686 34689	**Section VI: Medicare Coverage of Home Infusion Therapy Services** **Section VI.4: Summary of Temporary Transitional Payments CY 2019 and 2020** • Previously finalized; contains updates to rates • CMS is updating the temporary transitional payments based on the CPT code payment amounts in the CY 2020 PFS. At the time of publication of this final rule, CMS does not yet have the CY 2020 PFS rates. CMS will publish these updated rates in the CY 2020 PFS Final Rule and will publish the updated CY 2020 Temporary Transitional Payment rates in the January 2020 DMEPOS fee schedule file.	60611 60614

Section	CY 2020 Home Health Proposed Rule	Starting Page Number	CY 2020 Home Health Final Rule	Starting Page Number
Home Infusion Therapy Services (continued)	• For home infusion therapy services furnished in CYs 2019 and 2020, if a patient who is considered homebound and is under a Medicare home health plan of care, the home health agency should continue to furnish the professional services related to the administration of transitional home infusion drugs, in accordance with the Home Health CoPs and other regulations, as home health services.	34689	• CMS clarified the home infusion therapy benefit and interaction with home health clearly indicate that home infusion therapy is not excluded from home health services until January 1, 2021. A home health agency may subcontract with an eligible home infusion supplier in CYs 2019 and 2020 to furnish home infusion therapy services to a beneficiary under a home health plan of care; however, such services would be considered home health services and should be billed by the home health agency under the Medicare home health benefit and not the home infusion therapy benefit. In addition, the eligible home infusion supplier cannot bill for such services under the home infusion therapy benefit as such services are covered as home health services under the Medicare home health benefit.	60614
	Section VI.4 Summary of CY 2021 Home Infusion Therapy Provisions • For home infusion therapy services furnished on/after January 1, 2021, CMS proposes "home infusion drugs" are parental drugs and biologicals administered intravenously or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit • Medicare payment for home infusion therapy is for services furnished in coordination with the furnishing of the infusion drugs and biologicals specified on the DME LCD for External Infusion Pumps.	34690	**Section VI.4.C: Home Infusion Therapy Services for CY 2021 and Subsequent Years** **(2) Home Infusion Drugs** • Finalized with updated details: • Finalized definition: home infusion drugs are parenteral drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit. • (3) Patient Eligibility and Plan of Care Requirements: CMS finalized, as proposed, a new 42 CFR part 414, subpart P, to implement the home infusion therapy services conditions for payment: - CMS is conforming regulations text, at 414.1505, requiring that home infusion therapy services be furnished to an eligible beneficiary by, or under arrangement with, a qualified home infusion therapy supplier that meets the health and safety standards for qualified home infusion therapy suppliers at 486.520(a) through (c). - CMS is finalizing at 414.1510 that, as a condition for payment, qualified home infusion therapy suppliers ensure that eligibility and plan of care requirements are met. - CMS is finalizing at 414.1510 to require that a beneficiary must be under the care of an applicable provider (defined as a physician, nurse practitioner, or physician assistant). - CMS is finalizing at 414.1510, to require that a beneficiary must be under a plan of care, established by a physician. - CMS will require at 414.1515, that the plan of care must contain those items listed in 486.520(b). The PoC must include type of home infusion therapy services, physician orders for services, frequency of services, and the professional who furnishes the services. - CMS is amending the regulations at § 486.505 to change the term "nurse provider" to "nurse practitioner." - CMS is also amending § 414.1550(a)(1) and (2) to include "or service." • *Although these changes were not proposed in the proposed rule, CMS is adopting the changes here under a ''good cause'' waiver of proposed rulemaking. The specific changes CMS is making in the regulations are simply technical corrections in the language and do not reflect any additional substantive changes.*	60615

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<tr><th>Section</th><th>CY 2020 Home Health Proposed Rule</th><th>Starting Page Number</th><th>CY 2020 Home Health Final Rule</th><th>Starting Page Number</th></tr>
<tr><td>Home Infusion Therapy Services (continued)</td><td>Section VI.4.D: Proposed Payment Categories and Amounts for Home Infusion Therapy Services for CY 2021
Proposal to carry forward the three temporary transitional payment categories for home infusion therapy services payment in CY 2021.</td><td>34695</td><td>Section VI.4.D: Proposed Payment Categories and Amounts for Home Infusion Therapy Services for CY 2021
Finalized with no changes:
CMS finalized to carry forward the three temporary transitional payment categories for home infusion therapy services CY 2021 payment as depicted in Table 30 of the final rule</td><td>60625</td></tr>
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<table>
<tr><th>J-Code</th><th>Drug</th></tr>
<tr><td colspan="2">Category 1</td></tr>
<tr><td>J0133</td><td>Injection, acyclovir, 5 mg</td></tr>
<tr><td>J0285</td><td>Injection, amphotericin b, 50 mg</td></tr>
<tr><td>J0287</td><td>Injection, amphotericin b lipid complex, 10 mg</td></tr>
<tr><td>J0288</td><td>Injection, amphotericin b cholesteryl sulfate complex, 10 mg</td></tr>
<tr><td>J0289</td><td>Injection, amphotericin b liposome, 10 mg</td></tr>
<tr><td>J0895</td><td>Injection, deferoxamine mesylate, 500 mg</td></tr>
<tr><td>J1170</td><td>Injection, hydromorphone, up to 4 mg</td></tr>
<tr><td>J1250</td><td>Injection, dobutamine hydrochloride, per 250 mg</td></tr>
<tr><td>J1265</td><td>Injection, dopamine hcl, 40 mg</td></tr>
<tr><td>J1325</td><td>Injection, epoprostenol, 0.5 mg</td></tr>
<tr><td>J1455</td><td>Injection, foscarnet sodium, per 1000 mg</td></tr>
<tr><td>J1457</td><td>Injection, gallium nitrate, 1 mg</td></tr>
<tr><td>J1570</td><td>Injection ganciclovir sodium, 500 mg</td></tr>
<tr><td>J2175</td><td>Injection, meperidine hydrochloride, per 100 mg</td></tr>
<tr><td>J2260</td><td>Injection, milrinone lactate, 5 mg</td></tr>
<tr><td>J2270</td><td>Injection, morphine sulfate, up to 10 mg</td></tr>
<tr><td>J2274</td><td>Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg</td></tr>
<tr><td>J3010</td><td>Injection, fentanyl citrate, 0.1 mg</td></tr>
<tr><td>J3285</td><td>Injection, treprostinil, 1 mg</td></tr>
</table>
*The JB modifier indicates that the route of administration is subcutaneous
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<tr><td>J0895</td><td>Injection, deferoxamine mesylate, 500 mg</td></tr>
<tr><td>J1170</td><td>Injection, hydromorphone, up to 4 mg</td></tr>
<tr><td>J1250</td><td>Injection, dobutamine hydrochloride, per 250 mg</td></tr>
<tr><td>J1265</td><td>Injection, dopamine hcl, 40 mg</td></tr>
<tr><td>J1325</td><td>Injection, epoprostenol, 0.5 mg</td></tr>
<tr><td>J1455</td><td>Injection, foscarnet sodium, per 1000 mg</td></tr>
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<tr>
<td>Home Infusion Therapy Services (continued)</td>
<td>
<table>
<tr><th>J-Code</th><th>Drug</th></tr>
<tr><td colspan="2">Category 2</td></tr>
<tr><td>J1555 JB*</td><td>Injection, immune globulin (cuvitru), 100 mg</td></tr>
<tr><td>J1561 JB*</td><td>Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg</td></tr>
<tr><td>J1562 JB*</td><td>Injection, immune globulin (vivaglobulin), 100 mg</td></tr>
<tr><td>J1569 JB*</td><td>Injection, immune globulin (gammagard liquid), non-lyophilized, (e.g. liquid), 500 mg</td></tr>
<tr><td>J1575 JB*</td><td>Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin</td></tr>
<tr><td colspan="2">Category 3</td></tr>
<tr><td>J9000</td><td>Injection, doxorubicin hydrochloride, 10 mg</td></tr>
<tr><td>J9039</td><td>Injection, blinatumomab, 1 microgram</td></tr>
<tr><td>J9040</td><td>Injection, bleomycin sulfate, 15 units</td></tr>
<tr><td>J9065</td><td>Injection, cladribine, per 1 mg</td></tr>
<tr><td>J9100</td><td>Injection, cytarabine, 100 mg</td></tr>
<tr><td>J9190</td><td>Injection, fluorouracil, 500 mg</td></tr>
<tr><td>J9360</td><td>Injection, vinblastine sulfate, 1 mg</td></tr>
<tr><td>J9370</td><td>Injection, vincristine sulfate, 1 mg</td></tr>
</table>
*The JB modifier indicates that the route of administration is subcutaneous

Section VI.4.D.1:

Proposing a single unit of payment equal to five hours of infusion therapy services in a physician's office.
Proposing increasing payment amounts for the first visit by the relative payment for a new patient rate over an existing patient rate using the physician evaluation and management (E/M) payment amounts for a given year.

If a patient receiving home infusion therapy services is discharged, the home infusion therapy services claim must show a patient status code to indicate a discharge with a gap of more than 60 days in order to bill a first visit again if the patient is readmitted.
Suppliers would not be able to bill for the initial visit amount for those patients who have been receiving services under the temporary, transitional payment, and have billed a G-code within the past 60 days.

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<tr><td>J9039</td><td>Injection, blinatumomab, 1 microgram</td></tr>
<tr><td>J9040</td><td>Injection, bleomycin sulfate, 15 units</td></tr>
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<tr><td>J9100</td><td>Injection, cytarabine, 100 mg</td></tr>
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<tr><td>J9360</td><td>Injection, vinblastine sulfate, 1 mg</td></tr>
<tr><td>J9370</td><td>Injection, vincristine sulfate, 1 mg</td></tr>
</table>
*The JB modifier indicates that the route of administration is subcutaneous

Section VI.4.D.:

Finalized with updated rates:
CMS finalized the proposal to increase the payment amounts for each of the three payment categories for the first visit by the relative payment for a new patient rate over an existing patient rate using the physician evaluation and management (E/M) payment amounts for a given year, in a budget neutral manner, resulting in a small decrease to the payment amounts for any subsequent visits.
Payment will be made for each infusion drug administration calendar day in accordance with the definition finalized in the CY 2019 final rule with comment period (83 FR 56583).
CMS finalized that each category payment will be in accordance with the six CPT infusion codes under the PFS and equal to 5 hours of infusion services in a physician's office.
Table 32 in the final rule illustrates the 5-hour payment rates (using the proposed CY 2020 PFS amounts) reflecting the increased payment for the first visit and the decreased payment for all subsequent visits.

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<tr>
<td>Home Infusion Therapy Services (continued)</td>
<td>
<table>
<tr><th colspan="5">Table 31: 5-Hour Payment Amounts Reflecting Payment Rates for First and Subsequent Visits</th></tr>
<tr><th>CPT Code</th><th>Description</th><th>2019 PFS Amount</th><th>5-hour Payment -First Visit</th><th>5-hour Payment -Subsequent Visits</th></tr>
<tr><td>96365</td><td>Ther, Proph, Diag IV/IN infusion 1 hr</td><td>$72.80</td><td>$257.20 (category 1)</td><td>$154.70 (category 1)</td></tr>
<tr><td>96366</td><td>Ther, Proph, Diag IV/IN infusion add hr</td><td>$21.98</td><td></td><td></td></tr>
<tr><td>96369</td><td>Sub Q Ther Inf 1 hr</td><td>$169.02</td><td>$371.94 (category 2)</td><td>$223.72 (category 2)</td></tr>
<tr><td>96370</td><td>Sub Q Ther Inf add hr</td><td>$15.86</td><td></td><td></td></tr>
<tr><td>96413</td><td>Chemo Inf 1 hr</td><td>$143.08</td><td>$427.26 (category 3)</td><td>$256.99 (category 3)</td></tr>
<tr><td>96415</td><td>Chemo Inf add hr</td><td>$30.99</td><td></td><td></td></tr>
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<td>34699</td>
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<tr><th colspan="5">Table 31: 5-Hour Payment Amounts Reflecting Payment Rates for First and Subsequent Visits</th></tr>
<tr><th>CPT Code</th><th>Description</th><th>2020 Proposed PFS Amounts</th><th>5-hour Payment -First Visit</th><th>5-hour Payment -Subsequent Visits</th></tr>
<tr><td>96365</td><td>Ther, Proph, Diag IV/IN infusion 1 hr</td><td>$71.45</td><td>$255.25 (category 1)</td><td>$153.54 (category 1)</td></tr>
<tr><td>96366</td><td>Ther, Proph, Diag IV/IN infusion add hr</td><td>$22.02</td><td></td><td></td></tr>
<tr><td>96369</td><td>Sub Q Ther Inf 1 hr</td><td>$161.32</td><td>$357.44 (category 2)</td><td>$215.00 (category 2)</td></tr>
<tr><td>96370</td><td>Sub Q Ther Inf add hr</td><td>$15.52</td><td></td><td></td></tr>
<tr><td>96413</td><td>Chemo Inf 1 hr</td><td>$141.47</td><td>$422.70 (category 3)</td><td>$254.26 (category 3)</td></tr>
<tr><td>96415</td><td>Chemo Inf add hr</td><td>$30.68</td><td></td><td></td></tr>
</table>

The actual home infusion payment rates will be updated in next year's rule using the CY 2021 PFS amounts.
CMS finalized use of the GAF to geographically adjust the home infusion therapy services payment amounts in CY 2021. The list of GAFs by locality for this final rule is available as a downloadable file.
CMS believes that prior authorization for home infusion therapy services is not necessary currently, as services are contingent on the requirements under the DME benefit. CMS will monitor the provision of the home infusion therapy services and revisit if needs arise.
CMS believes that high cost outlier payments are not appropriate at this time and plans to monitor the need for such payments and if necessary, address outlier situations in future rule making.
CMS will require Part B DME supplier claims and Home Infusion therapy professional services claims to be submitted on separate claims to separate MACs. Supplier claims would be submitted to the DME MACs and infusion therapy professional services claims to Part A/B MACs.
CMS will issue a Change Request (CR) providing more detailed instruction regarding billing and policy information for home infusion therapy services prior to implementation of the CY 2021 home infusion benefit.

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<td>60629</td>
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This "Home Health CY 2020 Proposed to Final Rule Crosswalk" document was developed using the published CMS Home Health CY 2020 Proposed (CMS-1711-P) and CMS Home Health CY 2020 Final (CMS-1711-F) rules. The information in this document is aimed to help your agency obtain a high-level overview of the proposed rule provisions compared to the final rule provisions, and is to be used for informational purposes only, as the information provided should be individually verified by the recipient. The recipient should seek as appropriate, regulatory and legal advice on impact of the foregoing CMS rules.