CMS Proposed Rule Risks Stability of Home Health Care

The Centers for Medicare and Medicaid Services (CMS) issued its annual proposed rule regarding Medicare home health services payment rates for CY 2023. As usual, the rule also includes a hodgepodge of non-rate related proposals as well. This article provides a summary of the proposed rule.

Overall, the rule presents serious concerns for the home health community as it includes significant proposed rate reductions to account for the change in the payment model in 2020. Medicare law requires CMS to make permanent and temporary adjustments intended to ensure that the transition to the PDGM payment model is budget neutral in comparison to expected Medicare spending on the 2019 payment model. The outcome of the CMS analysis of the impact of the new payment model is a proposed 7.69% permanent rate adjustment based on the conclusion that HHAs were overpaid in 2020 and 2021 due to provider behavior changes in coding.

"We are extremely disappointed in the CMS proposed rule issued today. The stability of home health care is at risk because of CMS proposing the application of a fatally flawed methodology for assessing whether the PDGM payment model led to budget neutral spending in 2020 and later years," stated William A. Dombi, President of the National Association for Home Care & Hospice. "That has been made clear to CMS in the 2021 rulemaking and in multiple discussions since. With significantly rising costs for staff, transportation, and more, home health agencies across the country cannot withstand the impact of the proposed rate cut. Reliable analyses proves that PDGM underpaid home health agencies. We will be taking all steps to protect the home health benefit as this proposed rule advances and have fully prepared for Congressional action and more," Dombi added.

"What we see in the proposed rule is the equivalent of a declaration of war against home health agencies and the 3 plus million patients they serve. To believe this will have no impact on patients is to live in a bubble," Dombi stated.

The proposed rule includes the following:

- A net 2.9% inflation update (3.3% Market Basket Index – 0.4% Productivity Adjustment)

This is a strikingly low inflation update given that current inflation is at a 20-year high, nearing double digits.

- A 7.69% Budget Neutrality adjustment allegedly related to provider behavior changes triggered by PDGM
- An alleged $2 Billion overpayment in 2020 and 2021. CMS proposed withholding any adjustment at this time to reconcile the alleged overpayment.
- Recalibration of the 432 case mix weights.

Recalibration has been done annually to account for changes in case-specific resource and cost changes.

- Modification of the LUPA thresholds
- Institution of a five percent cap on negative changes in the area-specific wage index.

CMS originally applied a five percent negative change cap in 2021 with the new wage index. The cap was not applied in 2022. CMS now proposes to apply a cap prospectively on a permanent basis to prevent provider financial instability. However, certain areas had significant declines in their wage index in 2022 without the protection of a five percent cap. CMS does not propose to protect these providers for 2022 despite providing that protection to inpatient hospitals.

The outcome of these payment rate changes on 30-day period base rates and per-visit LUPA rates is as follows. HHAs that failed to provide required quality data have these rates reduced by two percent.

TABLE B27: CY2023 NATIONAL STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY2022 National Standardized 30-Day Period Payment	Permanent BA Adjustment Factor	Case-Mix Weights Budget Neutrality Factor	Wage Index Budget Neutrality Factor	CY2023 HH Payment Update	CY2023 National, Standardized 30-Day Period Payment
$2031.64	0.9231	0.9895	0.9975	1.029	$1904.76

TABLE B29: CY2023 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY2022 Per-Visit Payment Amount	Wage Index Budget Neutrality Factor	CY2023 HH Payment Update	CY2023 Per-Visit Payment Amount
HH Aide	$71.04	0.9992	1.029	$73.04
Medical Social Services	$251.48	0.9992	1.029	$258.57
Occupational Therapy	$172.67	0.9992	1.029	$177.54
Physical Therapy	$171.49	0.9992	1.029	$176.32
Skilled Nursing	$156.90	0.9992	1.029	$161.32
Speech-Language Pathology	$186.41	0.9992	1.029	$191.66

Other proposals in the rule include:

- A request for information regarding a data collection on the use of telecommunications
- Modified QRP measures
- Modified elements of the upcoming Home Health Value-Based Purchasing (HHVBP) demonstration program

- Deferring the Home Infusion Therapy benefit rate update to the Physician Fee Schedule issuance

Additionally, this rule discusses the future collection of data regarding the use of telecommunications technology during a 30-day home health period of care on home health claims, proposes changes to the Home Health Quality Reporting Program (HH QRP) requirements; requests information on health equity in the HH QRP and provides an update on advancing health information exchange.

HOME HEALTH QUALITY REPORTING PROGRAM AND SUBMISSION OF OASIS DATA FOR ALL PAYORS

CMS proposes to codify in regulations the factors adopted in the CY 2019 HH PPS final rule as the factors that will be considered when determining whether to remove measures from the HH QRP measure set. As a reminder, these are:

- Factor 1. Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- 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.

CMS is proposing to end the suspension of the collection of Outcome and Assessment Information Set (OASIS) data on non-Medicare and non-Medicaid patients, and to require HHAs to report all-payer OASIS data for purposes of the HH QRP for CY 2025. Specifically, for the CY 2025 HH QRP, the expanded reporting would be required for patients discharged between January 1, 2024, and

June 30, 2024. Beginning with the CY 2026 HH QRP, HHAs would be required to report assessment-based quality measure data and standardized patient assessment data on all patients, regardless of payer, for the applicable 12-month performance period (which for the CY 2026 program, would be patients discharged between July 1, 2024, and June 30, 2025).

Collecting OASIS data on all HHA patients, regardless of payer, would align data collection requirements under the HH QRP with the data collection requirements for the LTCH QRP and Hospice QRP. CMS indicated that it believes the most accurate representation of the quality of care furnished by HHAs is best captured by calculating the assessment-based measures rates using OASIS data submitted on all HHA patients, regardless of payer; new risk adjustment models with all-payer data would better represent the full spectrum of patients receiving skilled care in HHAs; and the submission of all-payer OASIS data would also enable CMS to meaningfully compare performance on quality measures across Post-Acute Care (PAC) settings. For example, Changes in Skin Integrity Post-Acute Care is currently reported by different PAC payers on different denominators of payer populations, and not having this for home health greatly inhibits CMS' ability to compare performance on this measure across PAC settings. sStandardizing the denominator for cross setting PAC measures to include all patients will enable to CMS to make these comparisons. CMS has implemented the QIES and iQIES provider data reporting systems to securely transfer and manage assessment data across QRPs, including home health. CMS systems can now support an extensive range of provider reports, including case-mix reports for private pay patients.

CMS has been laying the groundwork for the resumption of all-payer data submission for a while now by soliciting comments on such a change through proposed home health rules in recent years. Concerns raised in these comments include increased burden from requiring all-payer data submissions and appropriateness of collection and reporting private pay data among other concerns while some commenters supported the expanded collection. CMS believes the concerns raised have now been addressed and CMS systems are ready to support and utilize OASIS data for all payers. CMS stated that it appreciates that submitting OASIS data on all HHA patients regardless of payer source may create additional burden for HHAs, but also noted that the current practice of separating and submitting OASIS data on only Medicare beneficiaries has clinical and workflow implications with an associated burden. And, based on comments submitted in prior years' proposed rules, CMS understands that it is common practice for HHAs to collect OASIS data on all patients, regardless of payer source.

COMMENT SOLICITATION ON THE COLLECTION OF DATA ON THE USE OF TELECOMMUNICATIONS TECHNOLOGY UNDER THE MEDICARE HOME HEALTH BENEFIT

Data on the use of telecommunications technology during a 30-day period of care at the beneficiary level is not collected on the home health claim; however, the provision of services furnished via a telecommunications system must be included in the patient's plan of care. The plan of care must also describe how the use of such technology is tied to the patient-specific needs as identified in the comprehensive assessment and will help to achieve the goals outlined on the plan of care and these services cannot substitute for a home visit ordered as part of the plan of care and cannot be considered a home visit for the purposes of patient eligibility or payment. And, CMS does not review plans of care for information on telecommunications visits. Therefore, currently, the collection of data on the use of telecommunications technology is limited to overall cost data on a broad category of telecommunications services as a part of an HHA's allowable administrative costs on the HHA Medicare cost reports.

CMS is proposing to change this by establishing three new G-codes for use on home health claims to capture home health services delivered via telecommunications. CMS reiterates that the collection of information on the use of telecommunications technology does not mean that such services are considered "visits" for purposes of eligibility or payment, such data will not be used or factored into case-mix weights, or count towards outlier payments or the LUPA threshold per payment period. Collecting this type of data on home health claims would allow CMS to analyze the characteristics of the beneficiaries utilizing services furnished remotely, and would give CMS an understanding of the social determinants that affect who benefits most from these services, including what barriers may potentially exist for certain subsets of beneficiaries. In its March 2022 Report to the Congress MedPAC recommended tracking the use of telehealth in the home health care benefit on home health claims to improve payment accuracy.

CMS would establish G-codes for identifying when home health services are furnished using

- synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system;
- synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system; and

- the collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (remote patient monitoring).
    - CMS would capture the utilization of remote patient monitoring through the inclusion of the start date of the remote patient monitoring and the number of units indicated on the claim which may help CMS to understand in general how long remote monitoring is used for individual patients and for which conditions

Data collection using the G-codes would begin voluntarily by January 1, 2023 and become mandatory on claims by July of 2023.

Relative to use of telecommunications technology and collection of such data, CMS is interested in comments on:

- whether there are other common uses of telecommunications technology under the home health benefit that would warrant additional G-codes that would be helpful in tracking the use of such technology in the provision of care.
- the appropriateness of such technology for particular services in order to more clearly delineate when the use of such technology is appropriate. This may help inform how CMS' uses this analysis, for instance, connecting how such technology is impacting the provision of care to certain beneficiaries, costs, quality, and outcomes, and determine if further requirements surrounding the use of telecommunications technology are needed.
- whether the codes should differentiate the type of clinician performing the service via telecommunications technology, such as a therapist versus therapist assistant; and
- whether new G-codes should differentiate the type of service being performed through the use of telecommunications technology, such as: skilled nursing services performed for care plan oversight (for example, management and evaluation or observation and assessment) versus teaching; or physical therapy services performed for the establishment or performance of a maintenance program versus other restorative physical therapy services.

CMS indicated it would provide additional details of the G-codes with sufficient notice to enable HHAs to make the necessary changes in their electronic health records and billing systems. CMS also stated it would issue further program instruction prior to July 1, 2023 if the G-code description changes between January 1 and July 1 based on the comments to this proposed rule.

REQUEST FOR INFORMATION: HEALTH EQUITY IN THE HH QRP

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by CMS programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that enrollees need to thrive. In last year's home health rule, CMS sought and received comments regarding health equity. The comments were supportive of gathering standardized patient assessment data elements and additional Social Determinants of Health (SDOH) data to improve health equity. Many commenters shared that relevant data collection and appropriate stratification are very important in addressing any health equity gaps. These commenters noted that CMS should consider potential stratification of health outcomes. Stakeholders, including providers, also shared their strategies for addressing health disparities, noting that this was an important commitment for many health provider organizations. Commenters also shared recommendations for additional SDOH data elements that could strengthen their assessment of disparities and issues of health equity.

As CMS continues to consider health equity within the HH QRP, it is soliciting public comment on the following questions:

- What efforts does your HHA employ to recruit staff, volunteers, and board members from diverse populations to represent and serve underserved populations? How does your HHA attempt to bridge any cultural gaps between your personnel and beneficiaries/clients? How does your HHA measure whether this has an impact on health equity?
- How does your HHA currently identify barriers to access in your community or service area?
- What are barriers to collecting data related to disparities, social determinants of health, and equity? What steps does your HHA take to address these barriers?
- How does your HHA self-reported data such as race/ethnicity, veteran status, socioeconomic status, housing, food security, access to interpreter services, caregiving status, and marital status used to inform its health equity initiatives?
- How is your HHA using qualitative data collection and analysis methods to measure the impact of its health equity initiatives?

In addition, CMS is considering a structural composite measure for use in the HH QRP. The composite structural measure concept could include home health reported data on organizational activities to address underserved populations' access to home health care. For example, an HHA could receive a point for each domain where data are submitted to a CMS portal, regardless of the HHA's action in that domain (such as, reporting whether or not the HHA provided training for board members, leaders, staff and volunteers in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias). The data could reflect the HHA's completed actions for each corresponding domain (for a total of three points) in a reporting year. An HHA could submit information such as documentation, examples, or narratives to qualify for the measure numerator. **CMS is seeking comment on how to score a domain for an HHA that submitted data reflecting no actions or partial actions in the given domain.** Examples of the domains CMS is considering are described below. **CMS seeks comment on each of these domains, including specific suggestions on items that should be added, removed, or revised. Furthermore, CMS is soliciting public comments on publicly reporting a composite structural health equity quality measure; displaying descriptive information on Care Compare from the data HHAs provide to support health equity measures; and the impact of the domains and quality measure concepts on organizational culture change.**

- Domain 1: HHA's commitment to reducing disparities is strengthened when equity is a key organizational priority. Candidate domain 1 could be satisfied when an HHA submits data on their actions regarding the role of health equity and community engagement in their strategic plan. HHAs could self-report data in the reporting year about their actions in each of the following areas, and submission of data for all elements could be required to qualify for the measure numerator
    - HHA attests to whether its strategic plan includes approaches to address health equity in the reporting year.
    - HHA reports community engagement and key stakeholder activities in the reporting year.
    - HHA reports on any attempts to measure input from patients and caregivers about care disparities they may experience and recommendations or suggestions
- Domain 2: Training board members and staff in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias is an important step HHAs take to provide quality care to diverse populations. Candidate domain 2 could focus on HHAs' diversity, equity, inclusion and CLAS training for board members and staff by capturing the following self-reported actions

in the reporting year. Submission of relevant data for all elements could be required to qualify for the measure numerator.
    - HHAs attest as to whether their employed staff were trained in culturally sensitive care mindful of (SDOH in the reporting year and report data relevant to this training, such as documentation of specific training programs or training requirements.
    - HHAs attest as to whether they provided resources to staff about health equity, SDOH, and equity initiatives in the reporting year and report data such as the materials provided or other documentation of the learning opportunities.
- Domain 3: HHA leaders and staff can improve their capacity to address health disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. This candidate domain could capture activities related to organizational inclusion initiatives and capacity to promote health equity. Examples of equity-focused factors include proficiency in languages other than English, experience working with diverse populations in the service area, and experience working with individuals with disabilities. Submission of relevant data for all elements could be required to qualify for the measure numerator.
    - HHAs attest as to whether they considered equity-focused factors in the hiring of HHA senior leadership, including chief executives and board of trustees, in the applicable reporting year.
    - HHAs attest as to whether equity-focused factors were included in the hiring of direct patient care staff (for example, therapists, nurses, social workers, physicians, or aides) in the applicable reporting year.
    - HHAs attest as to whether equity focused factors were included in the hiring of indirect care or support staff (for example, administrative, clerical, or human resources) in the applicable reporting year.

This same RFI was also in the FY2023 hospice proposed rule.

ADVANCING HEALTH INFORMATION EXCHANGE

While there were no proposals related to health information exchange, CMS provided a summary of the Department of Health and Human Services' (HHS) initiatives designed to encourage and support the adoption of interoperable health information technology and to promote nationwide health information exchange to improve health care and patient access to their digital health information.

With respect the HHVBP expansion, CMS continues to estimate that it will save over $3B in Medicare spending over its term, through reduced hospitalizations. It is hard to imagine that outcome giving the multi-billion-dollar reduction in payment rates over that same term which undoubtedly will reduce the ability of HHAs to employ improved care.