The CY 2023 Home Health Final Rule: FAQ

Written by
Cindy Campbell, MHA-Healthcare Informatics, BSN, RN, COQS, CHHCM
Director of Operational Consulting at WellSky

The Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2023 final rule for home health on October 31, 2022. In response to industry advocacy efforts, CMS raised the home health inflation update to 4%, imposing only half of the proposed, unprecedented 8% negative adjustment in 2023 (but promising further payment adjustment in subsequent years). While it is good news for 2023, advocacy against further cuts must continue — and now, more than ever, your agency needs data-driven, strategic leadership to succeed.

Home health regulatory and consulting expert Cindy Campbell recently presented an important webinar that provided in-depth coverage of the final rule and its effect on home health providers. Now is the time to ensure understanding of these changes and plan your actions so that your agency is fully equipped to succeed in 2023. You can watch the on-demand webinar here.

In this new tip sheet, Cindy lays out key facts and answers frequently asked questions about the home health final rule.

Outcome and Assessment Information Set (OASIS) FAQ

Q: How can agencies prepare for the OASIS requirement for all payers?

A: Managing OASIS-related costs, competency, and culture are important considerations now and in the future as OASIS becomes required for all payers. These steps can help organizations with both the transition to OASIS-E and the future move to all payer OASIS submission:

1. Proactively position the OASIS as a tool to guide the assessment of the home health patient's risk; this will help lay a foundation for risk-aligned, best-practice care management.

   For example, the clinical acuity of patients discharged to home health has gone up since the onset of the pandemic. Systematically identifying risks that are unique to the home health patient through a standardized assessment can affect care planning, and, ultimately, the patients' ability to safely remain in the home. When captured accurately, the OASIS provides this necessary data, allowing for more robust insights and **better clinical outcomes.**

Again, positioning the OASIS for all as a tool to better serve those under our care assists in proactively managing the messaging and motivating clinician buy-in. The industry will benefit from greater insights gained as it relates to outcomes and expenditure during a period of growing demand.

2. Establish a clear method for teaching, measuring, and sustaining clinician competency in the assessment/OASIS-walk and for accurate capturing of data elements at the point of care; **this is key to greater accuracy, risk prediction, and care management efficacy.** This will help you build accuracy in your transition to OASIS-E now, and as you prepare clinicians for future expanded capture of OASIS data.

   Mastering a quick assessment methodology followed by documentation in the home or directly adjacent to the visit also builds a heathier life-work balance for the clinician. This can be a gamechanger for clinicians, unlocking the door to more efficient and satisfying work. Leveraging these habits now will help with clinician engagement and competence, **serving current retention and future workforce stability.** As OASIS becomes mandated for all payers, having a well-adhered-to method and discipline can help you navigate the change.

Q: Will the expansion of OASIS include those receiving charity care? How does this align with the focus on health equity?

A: CMS has required OASIS to be collected on all patients regardless of payer, which would **include care provided as charity.** As health equity becomes more important, being able to then advocate for the release of outcome data, categorized by payer (or lack of payer) could become potent information used on behalf of more equitable healthcare delivery. The National Association for Home Care & Hospice (NAHC) has been advocating for the release of outcome data, categorized by payer, for a long time. Given the new mandate of OASIS for all payers, I support this and encourage this to be a continued goal in our collective industry and for patient advocacy.

Q: Did CMS realize that not all patients could have an OASIS completed on them? (For instance, contract work done by the agency for infusion pharmacies that is years' long and doesn't fit into a home health model.)

A: First, let's deal with contract work for infusion. If the agency is acting in the capacity of a staffing agency for the infusion company, this rule would not apply as it would if the patient is admitted to the home health agency. If admitted under the Home Health benefit, we would be required. CMS is aware of the different scenarios which may arise, and we will continue to learn, together, as we progress.

Q: Will workers compensation patients be included when exporting all OASIS? Their assessments/ treatments are very specific and only related to their workers compensation case/injury.

A: Yes, these patients would be required under OASIS for all, regardless of payer.

Q: Do Medicaid-serving agencies have to report non-skilled patients on their OASIS data in January 2025?

A: No, the OASIS will only be required for patients served under a Medicare-certified agency receiving skilled-intermittent services. Non-skilled patients do not require OASIS.

Q: Are we required to collect the OASIS on therapy-only patients for other payers?

A: Yes, as you are now required to collect on Medicare therapy-only patients.

Q: We have been collecting OASIS for all our Medicare Advantage patients. Because Managed Care is based on authorizations, how is this going to impact outcomes for home health agencies when OASIS becomes a requirement in the future?

A: All payers may positively or negatively impact outcome payments. Being able to filter outcomes by payer type will better help both providers and payers. Advocates for the industry are seeking to have CMS stratify this data by payer — and I continue to support this. Sophisticated software platforms and applied analytics may help the provider, now, to identify payer-trended outcome status.

Q: Regarding the quality reporting program: will all OASIS information need to be extracted to CMS regardless of the payer type, starting on June 1, 2025? Do we need to export the OASIS gathered from other payers to CMS?

A: To best answer this, we are quoting directly from the final rule fact sheet from CMS:

> "Consistent with the two-quarter phase-in that we typically use when adopting new reporting requirements for the HHAs, we proposed that for the CY 2025 HH QRP, the expanded reporting would be required for patients discharged between January 1, 2024 and June 30, 2024.
>
> After consideration of the comments on this proposal, we are finalizing that the new OASIS data reporting will be required beginning with the CY 2027 program year, with data for that program year required for patients discharged between July 1, 2025 and June 30, 2026.
>
> Consistent with the two-quarter phase-in that we typically use, HHAs will have an opportunity to begin submitting this data for patients discharged between January 1, 2025 through June 30, 2025, but we will not use that data to make a compliance determination.
>
> Beginning with the CY 2027 program year, HHAs will be required to report OASIS data on all patients, regardless of payer, for the applicable 12-month performance period (which for the CY 2027 program year, would be patients discharged between July 1, 2025 and June 30, 2026)."

General Home Health Final Rule FAQ

Q: How can agencies more appropriately pay clinicians in a "job-seeker's market" while inflation is high?

A: As we face clinician salary increases of 10% or more in specific markets, we must be as competitive as possible with respect to wages and benefits. Consider how you are working to retain and increase the engagement of your current clinical workforce. Providing adequate training, coaching, and guidance to build competence, while enhancing clinical skillsets, can yield a culture which attracts and supports those motivated to provide care in the home setting.

As an example, how are you really preparing your clinicians for success in the field? Do you rely on anecdotal and variable experience and competence to train the trainer, with respect to understanding OASIS assessment methods, data capture, regulations required, how to best document in an efficient manner, etc.? I've witnessed too many clinicians at high risk of burnout and turnover due to just these types of issues.

We must continue to advocate for fair rates for market basket/inflation updates, and though we're appreciative of the 4% increase, the staffing shortages have pushed our wages to new highs. Building a

new teammate's confidence, competence, and engagement becomes even more essential to mitigate turnover.

Q: Where do we stand on Medicare, Medicaid, and Speech Therapy being reimbursed for telehealth?

A: Under Medicare Part A billing, visits provided via telehealth technology, or virtually, may not count toward Low Utilization Payment Adjustment (LUPA) visit thresholds. Orders for care provided virtually must be clearly written with noted adherence to orders/capture of the visit and route by which it was performed.

With respect to Medicaid waivers: State-specific guidance should be sought to clarify restrictions/ requirements.

The public health emergency — now extended — established waivers for the provision of home telehealth services and coverage. This may apply to you as a Speech-Language Pathologist (SLP), should you practice and bill outside of the Part A Home Health benefit:

Under "Flexibility for Medicare Telehealth Services", regarding Eligible Practitioners:

This was updated in November 2022: Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals who can furnish distant site telehealth services to include all those who are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. This waiver will end 151 days after the conclusion of the PHE.

Additionally reported by the American Speech-Language-Hearing Association (ASHA):

"In response to the spread of COVID-19, the Centers for Medicare & Medicaid Services (CMS) allowed audiologists and speech-language pathologists (SLPs) to provide select telehealth services to Medicare Part B (outpatient) beneficiaries for the duration of the federally-declared public health emergency (PHE).

CMS announced the telehealth expansion in an April 30, 2020, press release and its COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers [PDF].

The original expansion included a limited set of eligible audiology and speech-language pathology telehealth services. CMS subsequently expanded the list of Current Procedural Terminology (CPT) codes on March 30, 2021, resulting in a more comprehensive list of eligible telehealth services provided by audiologists and SLPs. Medicare Part C (Medicare Advantage plans) may also reimburse for telehealth services provided by audiologists and SLPs during the public health emergency. Check with the plan directly for coding and billing guidelines".

Q: What is the baseline year?

A: The baseline year for Home Home Health Value-Based Purchasing (HHVBP) is 2022, establishing a foundation for comparison to the first performance year (2023) and the potential for improvement points in the Total Performance Score (TPS).

Q: What is the latest status of the preservation of home health access bill? When do we expect it to be voted on?

A: The 2022 Congress did not pass key elements of the Preserving Access to Home Health Act of 2022 (S.4605, H.R.8581). As a new congressional year begins, continued advocacy for industry is a top priority for WellSky. We are working closely with NAHC's Advocacy and Public Policy Committees and will keep you apprised of further efforts for grassroots advocacy of industry.

Q: Does the net annual payment update offset the 3.925% reduction?

A: The 3.925% reduction is only half of the anticipated published cut to the base rate, temporarily postponed by CMS at this time. Additionally, CMS presented the multi-billion-dollar clawback as reasonable, given their perceived industry behavioral adjustment, reflecting a drop in therapy utilization between the Prospective Payment System (PPS) and Patient-Driven Groupings Model (PDGM). These combined factors far outweigh the market basket update of 4%.

Q: Why are agencies that don't serve Medicare patients getting put on the list for a 2% cut if their performance was not rated on Medicaid at all?

A: CMS requires you to follow the same standards for Medicaid patients within a Medicare-certified agency. We would encourage you to reach out to NAHC's regulatory division should the following not answer your concern (which can then be taken to CMS directly, if indicated):

WellSky believes the 2% cut to which you are referring to may be the imposed cut when agencies do not submit the required quality data. Transparency in quality reporting and outcome data is a key element within maintaining quality program integrity.

The following is from Table 18 in the Final Rule:

The CY 2023 national, standardized 30-day period payment rate for a HHA that does not submit the required quality data is updated by the CY 2023 home health payment update of 4.0 percent minus 2 percentage points and is shown in Table 18.

Table 18—CY 2023 National, Standardized 30-Day Period Payment Amount for HHAS That Do Not Submit the Quality Data

CY 2022 National Standardized 30-Day Period Payment	CY 2023 Permanent BA Adjustment Factor	CY 2023 Case-Mix Weights Recalibration Neutrality Factor	CY 2023 Wage Index Budget Neutrality Factor	CY 2023 HH Payment Update Minus 2 Percentage Points	CY 2023 National, Standardized 30-Day Period Payment
$2,031.64	0.96075	0.9904	1.0001	1.020	$1,972.02

Q: For the average 30-day payment listed, is that the average for the first 30 days? Or both the first and second?

A: The payment listed is for the base payment rate to each 30-day period, which is further adjusted for case mix weight by the factors integrated into PDGM (e.g., early vs. late, institutional vs. community referral, co-morbidities, clinical group and functional limitation).

Q: Why does CMS have access to everyone's health information?

A: Transparency in reporting, as well as quality outcomes relative to costs, is needed to safeguard Medicare funds and protect beneficiaries.

Additionally, CMS stated the following in the final rule, regarding privacy safeguards:

"We stated in the CY 2023 HH PPS proposed rule that the concerns raised surrounding privacy outlined previously have been mitigated. We also stated that we take the privacy and security of individually identifiable health information of all patients very seriously. CMS data systems conform to all applicable federal laws, regulations and standards on information security and data privacy. The systems limit data access to authorized users and monitor such users to help protect against unauthorized data access or disclosures. CMS anticipates updating the current provider data reporting system in iQIES to address the addition of private payer patients."

Q: Where can we find the G-codes for telehealth?

A: This guidance is taken directly from CMS: Telehealth Home Health Services: New G-Codes

"Starting on or after January 1, 2023, you may voluntarily report the use of telecommunications technology in providing HH services on HH payment claims. We'll require this information on HH claims starting on July 1, 2023. You'll submit the use of telecommunications technology on the HH claim using the following 3 G-codes:

- G0320: Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system
- G0322: The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (for example, remote patient monitoring)

Q: What is the status of the Remote Patient Monitoring (RPM) telecommunication codes that were established during the PHE? Will the codes remain as-is?

A: You should report on the use of remote patient monitoring (that spans a number of days) as a single line item showing the start date of monitoring and the number of days of monitoring in the units field. You'll submit services provided via telecommunications technology in line-item detail.

Report each service as a separate dated line under the appropriate revenue code for each discipline providing the service. You must document how telecommunications technology helps to achieve the goals outlined on the plan of care.

You can only report the previous three G-codes on Type of Bill 032x. You should only report these codes with revenue codes 042x, 043x, 044x, 055x, 056x, and 057x.

Q: Can you give me more information on face-to-face (F2F) and progress notes. Do all the dates need to match F2F and the progress notes?

A: The date of the F2F encounter should be noted in the certification statement. If a progress note is used to capture the F2F requirements, then this date should match the F2F encounter date. The F2F encounter documentation requirements state that:

- F2F documentation must be signed and dated by the provider who performed the visit, which is usually an office visit note, an inpatient progress or consult note, or discharge H&P/summary
- F2F is required to be related to the primary reason for home health
- F2F encounters must support the patient's homebound status
- F2F encounter documentation is required to support a Skilled Need or Medical Necessity
- F2F encounters must occur within 90 days prior or 30 days after the SOC date

Here is another resource for face-to-face documentation that may be found within your Medicare Administrative Contractor (MAC), as an example.

Q: Is there any guidance for how to adequately fill out a revisit note? What are some of the requirements?

A: With respect to a foundational approach to visit documentation, keep the following in mind:

- Teach clinicians to document at the point of care or adjacent to the visit. Establishing dynamic documentation serves the patient best, as higher accuracy is achieved when information is fresh in the mind of the clinician. Clinicians are better served, life-work balance is optimized, engagement increased, and interdisciplinary communication better supported, as well as the needs of patients served, as an interdisciplinary team.
- Be sure to reflect the medical necessity for the visit, including skilled monitoring and skilled intervention provided during the visit. Note aligned assessment and patient clinical status.
- Medical necessity is critical when justifying each note. Note the skilled interventions within the context of goals: what are you working toward and what is the patient's progress toward achieving those goals?
- Notes aligned with physician orders should be clear — specific adherence to treatments ordered, description of what was provided, patient response and assessment of their status in relation to this treatment should be in alignment with goals noted (e.g., specific measurement of wounds and description of healing progression).
- Interventions and the patient's response should be noted, as well as any variance from expected outcomes (e.g., medications, procedures, protocols) and what actions were taken.
- Note any communication with the MD/practitioner overseeing the plan of care and or coordination of care with other team members.

In essence, each note should be able to stand alone as a reflection of care provided to a patient who is homebound and is receiving the clinically skilled intervention or observation of a home health professional. This answer is not intended to be comprehensive, and further reference may be found at your MAC. A solid example can be seen on the CGS website.

Q: Are you providing more education around Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPs) improvement? How can we better advocate for regions that historically have lower scores as compared to the national average (for example, all agencies in the District of Columbia are below the national average significantly — and the HHCAHPS account for 30% of the total performance score (TPS)?

A: Yes! There are very specific methods agencies may adopt to enhance both the CAHPS response rates and responses rendered by patients served. I encourage you to go over recommendations provided in this HHVBP guidance white paper, as well as more specific training for improving customer satisfaction within the WellSky Learning Center.

Q: Though CMS publicly speaks about enhancing quality of care, adding further documentation and reporting requirements reduces the time clinicians are able to spend in direct patient care. Will this be addressed?

A: I agree it can seem paradoxical to meet both the intent of regulation through clinical assessment and intervention/support while fully complying with regulatory requirements; however, it is important to look to mitigate that through establishing other core competencies which save on clinicians' time.

About the author

Cindy Campbell, MHA-Healthcare Informatics, BSN, RN, COQS, CHHCM, is a nationally recognized home health leader and management consultant. She supports home health providers across the country, guiding them toward best practice structure, clinical modeling, and revenue cycle process efficiencies. She is a passionate advocate for shifting advanced levels of care to the home – the least restrictive setting, with the lowest cost, that yields the greatest patient satisfaction. Cindy's focus is grounded in patient experience and outcomes, with an emphasis on integrating and leveraging innovative technology into advancing clinical models to better manage patients where they live.

About WellSky®

WellSky is a technology company leading the movement for intelligent, coordinated care. Our next-generation software, analytics, and services power better outcomes and lower costs for stakeholders across the health and community care continuum. In today's value-based care environment, WellSky helps providers, payers, health systems, and community organizations solve tough challenges, improve collaboration for growth, harness the power of data analytics, and achieve better outcomes by further connecting clinical and social care. WellSky serves more than 20,000 client sites — including the largest hospital systems, blood banks, cell therapy labs, blood centers, home health and hospice franchises, post-acute providers, government agencies, and human services organizations. Informed by more than 40 years of providing software and expertise, WellSky anticipates clients' needs and innovates relentlessly to ultimately help more people thrive.

Learn more at **WellSky.com.**