WellSky

The CY 2023 Home Health Proposed Rule: **Key facts, action items, and FAQs**

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Published by the Centers for Medicare & Medicaid Services (CMS) on June 23, the CY 2023 home health proposed rule has concerned providers and could pose a potential risk to the stability of home healthcare. CMS is proposing to permanently reduce home health reimbursement rates by 7.69 percent, which equates to a $1.33 billion cut in 2023. Additionally, CMS has proposed collecting over $2 billion in alleged overpayments at a future date. Because of this, it is crucial for providers to make their voices heard by contacting members of Congress to support the Senate and House bills which oppose the cuts to home health.

Cindy Campbell (MHA-Healthcare Informatics, BSN, RN, COQS, CHHCM, Director of Operational Consulting at WellSky) recently presented a webinar about the proposed rule, which is available to watch-on-demand. In this tip sheet, she lays out key facts about the rule, answers frequently asked questions from the webinar, and highlights actions you can take now to potentially prevent the payment cuts.

Key facts:

The overall impact of the proposed rule for CY 2023 is estimated to be about an $810 million *reduction* in payment to home health, reflected in the following changes:

- A 2.9 percent increase due to payment updates
- A 0.2 percent decrease due to the updated Fixed Dollar Loss
- An attempt to achieve budget neutrality for the PDGM on a prospective basis
- A 6.9 percent decrease that reflects the effects of the proposed prospective, permanent behavioral assumption adjustment of -7.69 percent
- A permanent, budget-neutral approach to smooth year-to-year changes in the hospital wage index with a permanent 5 percent cap on negative wage index changes, regardless of the underlying reason for the decrease

The following updates are also proposed:

- The baseline year of Home Health Value-Based Purchasing would now be 2022 (as opposed to 2019)
- OASIS would be gathered on all payer types by 2025

There are several potential negative economic impacts of the proposed rule:

- The proposed takeback of CMS's reported "overpayment to industry" (under PDGM, as it relates to the behavioral adjustment) is estimated to be between $2-3 billion.
- Unprecedented proposed cuts will potentially impact access to home health services, limiting the number of people that can be cared for in the home.
- Decreasing payments to home health jeopardizes access to essential healthcare services utilized by our most vulnerable populations. Negatively impacting access to home health could drive up costs to CMS, because of potential access to care and negative impacts on increased hospitalizations and emergent care, as well as expanded use of short-term skilled nursing stays.
- The methodology for calculating the behavioral adjustment has led the National Association for Home Care & Hospice (NAHC) to suggest that CMS has erroneously "rebased rates," as opposed to achieving an agreed upon standard for measurement of behavioral adjustment.
- Industry and patient advocacy have motivated new legislation to freeze the payment cuts to home health until a resolution is found in how behavioral adjustments are measured and used to establish budget neutrality.

Preserving Access to Home Health Act of 2022 [S. 4605 / H.R. 8581]

Bills have been introduced in the U.S. House and Senate to ensure stability in payments to Medicare home health agencies. These bills, known as the **Preserving Access to Home Health Act [S. 4605 / H.R. 8581]**, would specifically block CMS from reducing payments to home health agencies until 2026. Passage of the bills would prevent the 7.69 percent payment reduction proposed by CMS in the CY 2023 home health proposed rule. WellSky and the National Association for Home Care & Hospice (NAHC) strongly support these bills, and we urge you to **make your voice heard.**

2 steps to make your voice heard and help stop cuts to home health

1. Advocate for the home health industry — and by extension, your agency — by contacting your senators and representatives to support the **Preserving Access to Home Health Act of 2022 [S. 4605 / H.R. 8581**]. Additionally, invite your congressperson to go on a home health visit so that they can see the value you provide to their constituents.

2. Send NAHC's pre-drafted letter to your officials — with just one click — **here**.

Tip: *Encourage every one of your team members to send the letter. If all teammates contact their respective representatives, our collective voice may have more of an impact.*

Frequently asked questions about the proposed rule

Q: Can you clarify who CMS is collecting OASIS data on and whether we need to send OASIS to Medicare even if they're not the payer? Additionally, will OASIS have to be completed on clients who are receiving non-skilled services only, like non-Medicaid personal care services?

A: We believe CMS is proposing to collect OASIS on all home health patients, regardless of payer. Therefore, personal care services would not be included in this data request.

The OASIS instrument provides CMS with key information about who home health serves and the difference home health makes by serving them. It is proposed that agencies submit OASIS for all payers as of 2025, as CMS wants to understand the industry and who it serves, despite payer designation. We do not know how this data collection, proposed for 2025, will impact risk-adjustment and outcomes at this point, but we know our industry serves patients impacted by payer standards – and differentiating these may point out inherent challenges within some payer groups as it relates to top outcome achievement.

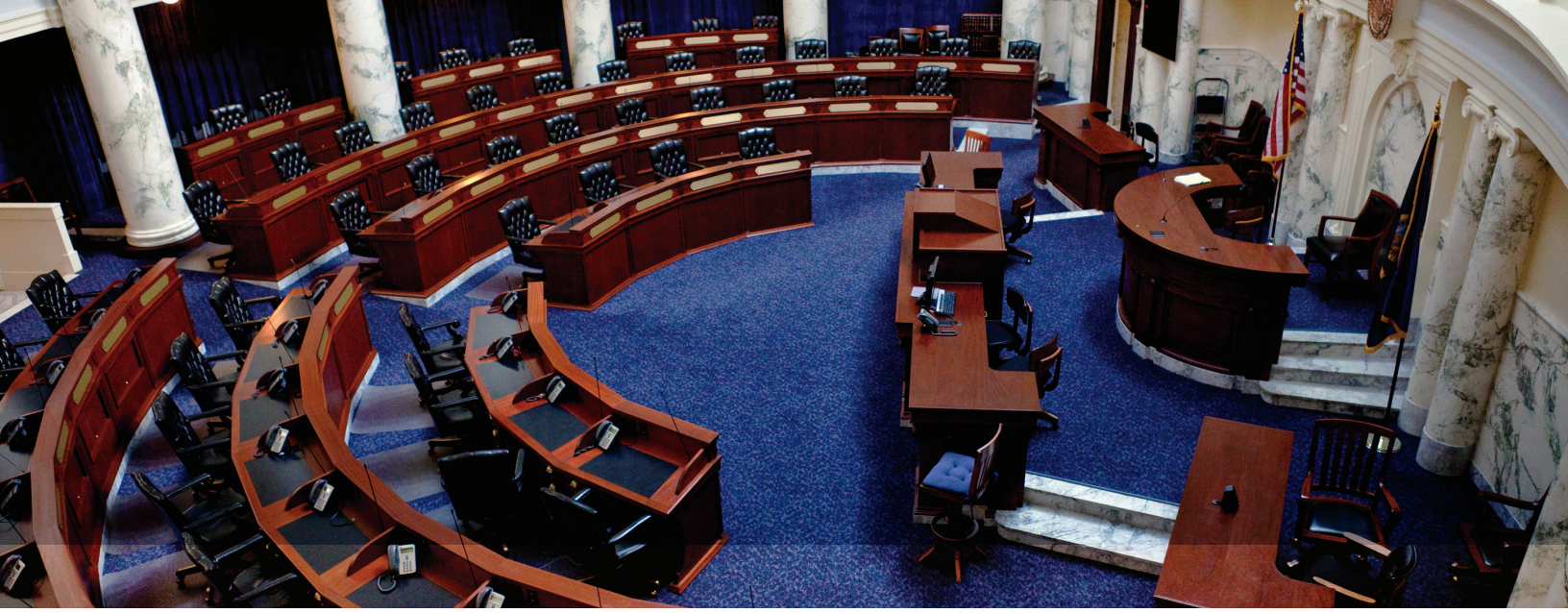
Q: Therapy utilization continues to decrease and agencies continue to ration care. Will this continue to lead to reductions in reimbursement?

A: Visit reductions did drive the proposed cut to reimbursement, though the methodology used by CMS is widely seen as erroneous, hence the proposed legislation.

Agencies are learning how to best use visits and technology to achieve the lowest hospitalization within the most efficient use of resources (visits and technology). Rationing of care may get confused with best practice utilization management. With that said, the impact of reduced therapy visits within the shift from PPS to PDGM fueled much of CMS's methodology when proposing payment cuts. This is important to understand, further, when thinking about support for stopping these cuts to home health.

CMS used the change in therapy visits provided as a rationale for changing episodic reimbursement. Home health providers and advocates believe the extrapolated behavioral assumptions were erroneously generated here, given the intent of the design of PDGM. We know the foundational shift from Prospective Payment System (PPS) to Patient-Driven Groupings Model (PDGM) reimbursement was to provide care based on patient need, as opposed to planning care within the potential of payment incentives. The PPS model rewarded more visits being provided, such as pre-existent therapy thresholds and incentives. As the industry strives to understand how to achieve the top outcome, within the most efficient use of visits and integrated technology, CMS may learn how to best reimburse care within specific patient groups. In the meantime, industry pushback to reimbursement cuts based on the drop in therapy use between PPS and PDGM is strong – given the imposition of what we believe to be an erroneous behavioral adjustment.

Providers are encouraged to continue seeking efficiencies in when and how to deploy interventions for those they serve. As we tie those interventions to the outcomes achieved, we as an industry can collectively learn how best to serve our patients.



Q: Does CMS plan to address the fact that functional impairment levels went up, but therapy utilization went down significantly?

A: CMS's goal is to achieve the objective of an equal distribution of low, medium, and high functional points. Thus, we see a rebasing of the functional impairment distribution in response to this finding. The correlation of reduced therapy visits speaks to the transition from PPS to PDGM and was not a factor in the readjustment of functional impairment.

The influence of payment incentive inherent in therapy utilization under PPS, as it compares to PDGM and patient centered care, is important to note as impacting the reduction in therapy visits.

Q: How do you gain points when discharging to the community?

A: Discharged to Community (DTC) is an applicable OASIS-based measure in the calculation of your agency's Total Performance Score (TPS). Per the CY 2023 proposed rule, your performance in this measure in 2023 will be compared to your performance in CY 2021. This comparison will lead to either improvement or achievement points for the DTC measure, which will then be combined with your points for the other applicable measures. It will then be weighted and ultimately contribute to your TTPS. (The DTC measure calculation specifications from CMS can be found here.)

Q: Is HHRG cost standard or is this something we can customize?

A: The HHRGs are set by CMS. The costs of providing the care within the HHRG are up to the agency, as the capture of the patient's acuity and resultant care plan becomes customized to that specific person. How you approach the provision of a skilled, intermittent home health plan of care for a specific clinical group — or PDGM HHRG patient cohort — is up to you. Achieving the best outcome (lowest hospitalization rate) with the most efficient use of visits and integrated technology is ideal. Integrated use of predictive analytics, remote patient monitoring, and virtual telecommunication technologies are helping agencies to reduce the cost of care while leveraging innovative approaches to connectivity and best practice utilization management.

Q: Does home health have representation on the MedPAC?

A: In the current Medicare Payment Advisory Commission (MedPAC) member group, there is more than one individual representing health systems, in which home health is included.

Q: Since the end of the Emergency Temporary Standard (ETS), we had to cease voice-only telehealth in California. In January 2023, are we able to resume voice-only visits to fulfill frequency?

A: CMS stated in the interim final rule that telehealth visits must be included on the home health plan of care, along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care. Outside of this, there are no specific requirements related to the contents of a telehealth visit. In the CY 2021 HHPPS rate update, CMS implies that visit frequency must also reflect virtual visits.

Section III.D. of this proposed rule proposes to permanently finalize the changes to § 409.43(a) as finalized in the first COVID–19 PHE IFC (85 FR 19230), to state that the plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system and 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.

(More examples are seen on page 39427-8)

This visit frequency does not count toward PDGM LUPA thresholds, nor does it impact episodic payment. The visit frequency must reflect virtual visits. This holds true in the CY 2023 proposed rule. We do advise that you check your state regulation to see if California-specific regulation varies from Federal.

CMS has begun to recognize the importance of virtual care delivery since the onset of the public health emergency and has formally requested recommendations to better capture and differentiate the use of virtual care technologies in home health. Moving to minimally capture the use of telecommunications technology and report the cost of this technology in care at home incrementally moves CMS toward better understanding the home health industry's need to innovate through demographic challenges to the demand/supply equation. In the CY 2023 proposed rule, CMS has asked for comments related to how to capture virtual visits and telehealth encounters – finally recognizing the need to understand how the industry used virtual care options during the public health emergency. Savvy leaders know that advancing use of telecommunications, analytics, and virtual care delivery will continue to be instrumental to providing care in the home. In collaboration with NAHC, WellSky is submitting comments related to this data capture.

(As this question was submitted in reference to California, we recommend you check your state-specific guidelines for home health to ensure you plan and act in compliance with your state's regulations.)

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.