Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

JUNE 2022

CY 2023 MEDICARE HOME HEALTH PPS PROPOSED RULE – CMS-1766-P

On June 23, the Centers for Medicare & Medicaid Services (CMS) published its annual proposed rule updating the Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2023 (Jan. 1, 2023 through Dec. 31, 2023). Comments are due on Aug. 16.

Proposed Rate Update

CMS proposed a net rate update of -4.2%. This reflects a market basket update of 3.3%, a 0.4 percentage point productivity decrease, an estimated negative 6.9% adjustment reflecting the effects of the proposed prospective permanent behavior adjustment of -7.69% ($1.33 billion decrease), and an estimated 0.2% decrease reflecting the proposed update to the fixed-dollar loss ratio (FDL) used in determining outlier payments ($40 million decrease). Home health agencies (HHAs) that do not submit required quality data are subject to a 2 percentage point reduction in their payment rate, resulting in a net rate update of -6.2%.

Proposed CY 2023 Payment Rates for 30-Day Periods

CY 2022 30-Day Payment	CY 2023 30-Day Payment	CY 2023 30-Day Payment, No Quality Data
$2,031.64	$1,904.76	$1,867.74

Proposed CY 2023 National Per-Visit Payment Amounts

HH Discipline	CY 2022 Per-Visit Payment	CY 2023 Per-Visit Payments	CY 2023 Per Visit Payments, No Quality Data
Home Health Aide	$71.04	$73.04	$71.62
Medical Social Services	$251.48	$258.57	$253.54
Occupational Therapy	$172.67	$177.54	$174.08
Physical Therapy	$171.49	$176.32	$172.89
Skilled Nursing	$156.90	$161.32	$158.19
Speech-Language Pathology	$186.41	$191.66	$187.94

CMS is required to ensure that estimated aggregate expenditures under the HH PPS during CY 2020 are equal to the estimated aggregate expenditures that otherwise would have been made during CY 2020 absent the implementation of the Patient Driven Groupings Model (PDGM). CMS must also determine, annually, the impact of differences between assumed and actual behavior changes (i.e., utilization) on estimated aggregate expenditures under the HH PPS from 2020 through 2026. In this proposed rule, CMS calculated a permanent behavior adjustment, proposing a -7.69% permanent adjustment to the CY 2023 base payment rate. CMS also calculated a temporary adjustment of approximately $2 billion to reconcile retrospective

overpayments in CYs 2020 and 2021, but solicits comments on how best to collect these overpayments.

Use of Telecommunications Technology

CMS currently collects aggregate cost data on the use of telecommunications technology as part of the HHA Medicare cost report, but does not collect such information at the claim level. In this proposed rule, CMS solicits comments on the collection of claim-level telecommunications data, with goals to begin voluntary collection of such data on Jan. 1, 2023 and mandatory collection beginning July 2023. CMS intends to use three G-codes, identifying HH services furnished using synchronous real-time two-way audio and video telecommunications; HH services furnished using synchronous telephone or other real-time interactive audio-only telecommunications; and the collection of physiologic data digitally stored and/or transmitted by the patient to the HHA (i.e. remote patient monitoring).

LUPA Thresholds and Case Mix Weights

CMS proposed updating low utilization payment adjustment (LUPA) thresholds using CY 2021 Medicare HH claims linked to Outcome and Assessment Information Set (OASIS) data. CMS justifies using post-PDGM implementation data, stating visit data from CYs 2020 and 2021 were stable and case-mix group LUPA thresholds were largely unchanged.

See Table B26 in the proposed rule for the CY 2023 proposed LUPA thresholds with their corresponding Health Insurance Prospective Payment System (HIPPS) codes and case mix weights.

High Cost Outliers and FDL Ratio

CMS proposed a fixed-dollar loss (FDL) ratio of 0.44 for CY 2023, an increase from the CY 2022 FDL of 0.40. By law, CMS limits outlier payments to 2.5% of total HH PPS payments.

Diagnosis Code Reassignments

CMS proposed reassigning 320 diagnosis codes to a different clinical group when listed as a principal diagnosis, and 37 diagnosis codes to a different comorbidity subgroup when listed as a secondary diagnosis. CMS also proposed establishing a new comorbidity subgroup for certain neurological conditions and disorders. A list of these proposed reassignments is here.

Wage Index

CMS proposed a permanent 5% cap on negative wage index changes, meaning an HHA's wage index would not be less than 95% of its wage index from the previous year regardless of the circumstances causing a wage index decline. This policy as proposed will be budget neutral. CMS stated this policy will maintain the HH PPS wage index as a relative measure of the value of labor in a given labor market area, increase the predictability of HH PPS payments, and mitigate instability and significant negative impacts to providers resulting from significant changes to wage index.

CMS proposed continued use of the inpatient hospital wage index data in developing HH payments. As finalized in CY 2019, the labor-related share is 76.1%. The proposed CY 2022 HH wage indexes for Illinois core-based statistical areas (CBSAs) are below:

CY 2023 Proposed Illinois HH Wage Indexes by CBSA

CBSA	Proposed Wage Index
Bloomington	0.9251
Cape Girardeau	0.8055
Carbondale-Marion	0.8357
Champaign-Urbana	0.8918
Chicago-Naperville-Evanston	1.0505
Danville	0.9376
Decatur	0.8702
Elgin	1.0297
Kankakee	0.9194
Lake County	0.9833
Peoria	0.8520
Rock Island-Moline	0.7954
Rockford	0.9621
Springfield	0.8679
St. Louis	0.9510
Rural	0.8436

HH QRP

HHAs that do not successfully participate in the HH quality reporting program (QRP) are subject to a 2 percentage point reduction to their market basket update. Measures currently adopted for the CY 2023 HH QRP are listed in Table C1 in the proposed rule.

CMS proposed discontinuing the long-standing suspension on collecting all-payer OASIS data. CMS stated that collecting all-payer OASIS data aligns the HH QRP with data collection requirements for the Long-Term Care Hospital and Hospice QRPs. CMS also believes all-payer data provides a more accurate representation of the quality of care furnished by HHAs.

CMS proposed collecting all-payer OASIS data for the HH QRP beginning with the CY 2025 HH QRP program year, and stated it would use OASIS data to calculate all measures for which OASIS is the data source. This means expanded reporting would be required for patients discharged between Jan. 1, 2024 and June 30, 2024. All-payer reporting for full 12-month performance periods would begin with the CY 2026 HH QRP (patients discharged between July 1, 2024 and June 30, 2025).

Finally, CMS proposed codification of the eight HH QRP measure removal factors outlined in the CY 2019 HH PPS final rule. These factors include:

- Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.
- Performance or improvement on a measure does not result in better patient outcomes.
- A measure does not align with current clinical guidelines or practice.
- A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.

- A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
- The costs associated with a measure outweigh the benefit of its continued use in the program.

Home Infusion Therapy Services

Once finalized, home infusion therapy service rate updates will be posted to CMS' website. Unless proposing a payment methodology change, CMS will no longer include a section in the HH PPS rule on home infusion therapy. Instead, rates will be updated each year in a Change Request and posted to the website.

HH VBP Model

In the CY 2022 HH PPS final rule, CMS finalized the expansion of the Home Health Value-Based Purchasing (HH VBP) Model to all Medicare-certified HHAs in all 50 states and the District of Columbia beginning Jan. 1, 2022. All HHAs certified to participate in the Medicare program prior to Jan. 1, 2022 are required to participate and are eligible to receive an annual Total Performance Score based on their CY 2023 performance.

CMS also proposed replacing the term *baseline year* with the terms *HHA baseline year* and *Model baseline year*. The HHA baseline year will be the calendar year used to determine the improvement threshold for each measure for each individual competing HHA. The Model baseline year will be the calendar year used to determine the benchmark and achievement threshold for each measure for all competing HHAs.

CMS also proposed changing the calendar years associated with the HHA and Model baseline years. The HHA baseline year for HHAs certified prior to Jan. 1, 2019 or from Jan. 1, 2019 through Dec. 31, 2021 would be 2022. The HHA baseline year for HHAs certified beginning Jan. 1, 2022 or after would be the first full calendar year of services beginning after the date of Medicare certification.

Proposed HHA Baseline, Performance and Payment Years

Medicare-Certification Date	HHA Baseline Year	Performance Year	Payment Year
Prior to Jan. 1, 2019	2022	2023	2025
Jan. 1, 2019 – Dec. 31, 2021	2022	2023	2025
Jan. 1 – Dec. 31, 2022	2023	2024	2026
Jan. 1 – Dec. 31, 2023	2024	2025	2027

CMS also proposed changing the Model baseline year from CY 2019 to CY 2022 for the CY 2023 performance year and subsequent years.

Finally, CMS requests comments on specific actions it can take through the national HHVBP Model to address healthcare disparities and advance health equity.

RFI on Health Equity in the HH QRP

Similar to last year, CMS requests information on how to address health equity in the HH QRP. Specific areas of interest include: efforts made to recruit staff, volunteers, and board members from diverse populations; identifying barriers to accessing care in the community served by an HHA; barriers to collecting data related to disparities and social determinants of health; and how HHAs use such information to inform health equity initiatives.

CMS is also considering adopting a structural composite measure for the HH QRP. This measure might include organizational activities to address access to and quality of HH care for underserved populations, and the measure would include HHA reported data on activities to address underserved populations' access to HH care. An HHA would receive a point for each domain where data are submitted, for a total of three points across three domains. The domains address organization priorities around reducing disparities; training board members, leaders, and other staff in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias; and setting an organization culture of equity.

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Sources:

Centers for Medicare & Medicaid Services. CY 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements. CMS-1766-P. Available from: https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1766-p. Accessed June 24, 2022.

Centers for Medicare & Medicaid Services. CY 2023 Proposed HH PPS Downloads. Available from: https://www.cms.gov/medicaremedicare-fee-service-paymenthomehealthppshome-health-prospective-payment-system-regulations/cms-1766-p. Accessed June 24, 2022.