Medicare Program; Calendar Year 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements (CMS-1766-P) Summary of Proposed Rule

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I. Introduction

On June 23, 2022 the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule addressing updates to the Home Health Prospective Payment System (HH PPS) rates for calendar year 2023,[1] home infusion therapy services requirements, and related matters (85 FR 37600). Among other changes, this rule proposes a permanent budget neutral approach to smooth year-to-year changes in the hospice wage index by applying a permanent cap on negative wage index changes greater than a 5 percent decrease from the prior year. CMS also proposes to apply a permanent prospective payment adjustment to the home health 30-day period payment rate to account for any changes in aggregate expenditures resulting

[1] Henceforth in this document, a year is a calendar year unless otherwise specified.

from the difference between assumed behavior changes and actual behavior changes, due to implementation of the Patient-Driven Groupings Model (PDGM) and 30-day unit of payment.

CMS estimates that the net impact of the proposed policies would decrease Medicare payments to home health agencies (HHAs) in 2023 by -4.2 percent (-$810 million). This decrease reflects the effects of the proposed 2.9 percent home health payment update, an estimated 6.9 percent decrease from the proposed prospective, permanent behavioral assumption adjustment of -7.69 percent[2], and an estimated 0.2 percent decrease from the proposed update to the fixed-dollar loss ratio (FDL) used in determining outlier payments.

For the Home Health Quality Reporting Program (HH QRP), CMS proposes to require reporting of all-payer patient assessment data beginning with payment year CY 2025. For the Expanded Home Health Value-Based Purchasing (HHVBP) Model, CMS proposes to modify the baseline and Model year definitions that are used when determining benchmarks and setting achievement and improvement thresholds. For both programs, CMS requests feedback about ways to address disparities and advance health equity.

The deadline for public comment is August 16, 2022.

II. Payment Under the Home Health Prospective Payment System

A. Overview

CMS reviews the statutory and regulatory history of the HH PPS from 1997. Most recently, as required by the Bipartisan Budget Act of 2018 (BBA of 2018) on January 1, 2020, CMS implemented the home health Patient Driven Groupings Model (PDGM) and a 30-day unit of payment.

Medicare makes payment under the HH PPS based on a national, standardized 30-day period payment rate that is adjusted for the applicable case-mix and wage index. The national, standardized 30-day period rate includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine supplies (NRS), previously paid through a separate adjustment, are now part of the national, standardized 30-day period rate. Durable medical equipment provided as a home health service is not included in the national, standardized 30-day period payment. The 30-day period payment rate does not include payment for certain injectable osteoporosis drugs and negative pressure wound therapy (NPWT) using a disposable device; these drugs and services must be billed by the HHA while a patient is under a home health plan of care.

The PDGM is a patient case-mix adjustment methodology that shifts the focus from volume of services to a model that relies more on patient characteristics. It uses timing of episode,

[2] CMS proposes a permanent behavior adjustment of -7.69 percent which applies only to the national, standardized 30-day period payments and does not impact payments for 30-day periods that are LUPAs. The estimated -6.9 percent includes all payments.

admission source, clinical groups based on principal diagnosis, level of functional impairment, and comorbidity to case-mix adjust payments resulting in 432 home health resource groups (HHRG). Patient characteristics and other clinical information is drawn from Medicare claims and the Outcome and Assessment Information Set (OASIS). Each HHRG has an associated case-mix weight that is used in calculating the payment for a 30-day period of care.

For low-utilization episodes, HHAs are paid national per-visit rates based on the discipline(s) providing the services; this payment adjustment is referred to as a low-utilization payment adjustment (LUPA). The national, standardized 30-day episode payment rate is also adjusted for certain intervening events that are subject to a partial episode payment (PEP) adjustment. In addition, an outlier adjustment may be available for certain cases that exceed a specific cost threshold.

B. Proposing Provisions for Payment Under the HH PPS

1. Monitoring the Effects of the Implementation of PDGM

a. Routine PDGM Monitoring

Section 1895(b)(3)(D) of the Act requires CMS to annually determine the impact of assumed versus actual behavioral changes on aggregate expenditures under the HH PPS for 2020 through 2026. Analysis for routine monitoring may include, but not be limited, to analyzing: overall total 30-day periods of care and average periods of care per HHA user; the distribution of visits in a 30-day period of care; the percentage of periods that receive a LUPA; the percentage of 30-day periods of care by clinical group, comorbidity adjustment, admission source, timing, and functional impairment level; and the proportion of 30-day periods of care with and without any therapy visits.

In this proposed rule, CMS examines simulated data for 2018 and 2019 and actual data for 2020 and 2021 for 30-day periods of care. As discussed below, CMS provides interpretation of results for 2020 and CY 2021. CMS refers readers to the 2022 HH PPS final rule[3] for a discussion about the simulated data for 2018 and 2019.

1. Utilization

Tables B2, B3, and B4 in the proposed rule (reproduced below) show the average utilization.

- Table B2 indicates the average number of 30-day periods of care per unique HHA user is similar per 30-day period of care between 2020 and 2021.
- Table B3 indicates that the number of 30-day periods of care decreased between 2018 and 2021.
- Table B4 shows the proportion of 30-day periods of care that are LUPAs and the average number of visits per discipline of those LUPA 30-day periods of care over time.

[3] 86 FR 35881

Table B2: Overall Utilization of Home Health Services, 2018-2021				
Volume of Periods and Number of Beneficiaries	**CY2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
30-Day Periods of Care	9,336,898	8,744,171	8,423,688	8,962,690
Unique Beneficiaries	2,980,385	2,802,560	2,850,916	2,944,305
Average Number of 30-Day Periods per Unique Beneficiary	3.13	3.12	2.95	3.04
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health Limited Data Set (LDS). PDGM data for 2020 was accessed from the Chronic Conditions Data Warehouse (CCW) Virtual Research Data Center (VDRC) on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

Table B3: Utilization of Visits Per 30-Day Periods of Care by HH Discipline, 2018-2021				
Discipline	**CY 2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Skilled Nursing	4.53	4.49	4.35	4.05
Physical Therapy	3.30	3.33	2.70	2.73
Occupational Therapy	1.02	1.07	0.79	0.77
Speech Therapy	0.21	0.21	0.16	0.15
Home Health Aide	0.72	0.67	0.54	0.47
Social Worker	0.08	0.08	0.06	0.05
Total (all disciplines)	**9.86**	**9.85**	**8.60**	**8.22**
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

Table B4: The Proportion of 30-Day Periods of Care That Are LUPAs and the Average Number of Visits by HH Discipline for LUPA HH Periods, 2018-2021				
	CY 2018 (Simulated)	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Total LUPA % of Overall 30-day Periods	6.7%	6.8%	8.7%	7.8%
Discipline (Average # visits for LUPA home health periods)				
Skilled Nursing	1.15	1.14	1.19	1.12
Physical Therapy	0.43	0.46	0.53	0.55
Occupational Therapy	0.07	0.07	0.08	0.08
Speech Therapy	0.02	0.02	0.02	0.02
Home Health Aide	0.01	0.01	0.01	0.01

Table B4: The Proportion of 30-Day Periods of Care That Are LUPAs and the Average Number of Visits by HH Discipline for LUPA HH Periods, 2018-2021				
	CY 2018 (Simulated)	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Social Worker	0.01	0.01	0.01	0.01
Total	**1.69**	**1.71**	**1.84**	**1.78**
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

(2) Analysis of 2020 Cost Report Data for 30-Day Periods of Care

CMS examined 2020 HHA Medicare cost reports (the most recent and complete cost report data available) and 2021 30-day period of care home health claims, to estimate 30-day period of care costs. CMS excluded LUPAs and PEPs in the average number of visits. Table B5, reproduced below, shows the estimated average costs for 30-day periods of care by discipline with non-routine supplies (NRS) and the total 30-day period of care costs with NRS for 2021.

Table B5: Estimated Costs for 30-Day Periods of Care in CY 2021				
Discipline	**2020 Average Costs per visit with NRS**	**2021 Home Health Payment Update**	**2021 Average Number of Visits**	**2021 Estimated 30-Day Period Costs**
Skilled Nursing	$154.77	1.02	4.30	$678.82
Physical Therapy	$170.04	1.02	2.93	$508.18
Occupational Therapy	$165.86	1.02	0.84	$142.11
Speech Pathology	$192.39	1.02	0.16	$31.40
Medical Social Services	$264.92	1.02	0.06	$16.21
Home Health Aides	$82.25	1.02	0.52	$43.63
Total				**$1,420.35**
Source: 2020 Medicare cost report data obtained on January 18, 2022. Home health visit information came from 30-day periods of care with a through date in 2021 (obtained from the CCW VDRC on March 21, 2022).				
Notes: The 2021 average number of visits excludes LUPAs and PEPs.				

CMS notes the 2021 national, standardized 30-day period payment was $1,901.12, which is approximately 34 percent more than the estimated 2021 30-day period cost of $1,420.35. In addition, using the actual 2021 claims data, the average number of visits in a 30-day period (excluding LUPAs and PEPs) was 8.81 visits – a decrease of approximately 16 percent from the estimated number of visits for a 30-day period of care in 2017. CMS acknowledges that with the PHE, the 2020 data on the Medicare cost reports may not reflect the associated changes such as increased telecommunications technology costs and personal protective equipment costs.

CMS notes that MedPAC assumed a cost growth of 3.47 percent for both 2021 and 2022.[4] MedPAC noted that for more than a decade, payments under the HH PPS have significantly

[4] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch8_SEC.pdf

exceeded HHA's costs because agencies reduced episode costs by reducing the average number of visits per episode and cost growth in recent years has been lower than annual payment updates.

(3) Clinical Groupings and Comorbidities

Each 30-day period of care is grouped into one of 12 clinical groups describing the primary reason patients are receiving home health services. Table B6, reproduced below, shows the distribution of the 12 clinical groups over time.

Table B6: Distribution of 30-Day Periods of Care by the 12 PDGM Clinical Groups, 2018-2021

Clinical Grouping	CY 2018 (Simulated)	CY2019 (Simulated)	CY 2020	CY 2021
Behavioral Health	1.7%	1.5%	2.3%	2.4%
Complex Nursing	2.6%	2.5%	3.5%	3.3%
MMTA – Cardiac	16.5%	16.1%	18.9%	18.5%
MMTA – Endocrine	17.3%	17.4%	7.2%	6.9%
MMTA – GI/GU	2.2%	2.3%	4.7%	4.7%
MMTA – Infectious	2.9%	2.7%	4.8%	4.6%
MMTA – Other	4.7%	4.7%	3.1%	3.6%
MMTA – Respiratory	4.3%	4.1%	7.8%	8.0%
MMTA – Surgical Aftercare	1.8%	1.8%	3.6%	3.4%
MS Rehab	17.1%	17.3%	19.4%	19.8%
Neuro Rehab	14.4%	14.5%	10.5%	10.9%
Wounds	14.5%	15.1%	14.2%	13.9%

Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.

Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.

Thirty-day periods of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on home health claims; the comorbidity adjustment can be low or a high comorbidity adjustment, or no comorbidity adjustment. Table B7, reproduced below, shows the distribution of 30-day periods of care by comorbidity adjustment category.

Table B7: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category for 30-Day Periods. 2018-2021

Comorbidity Adjustment	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021
None	55.6%	52.0%	49.2%	49.6%
Low	35.3%	38.0%	36.9%	36.9%
High	9.2%	10.0%	14.0%	13.5%

Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.

Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.

(4) Admission Source and Timing

Each 30-day period of care is classified into one of two admission source categories (community or institutional) depending on what healthcare setting was utilized in the 14 days prior to receiving home health care.[5] Thirty-day periods of care are classified as "early" or "late" depending on when they occur within a sequence of 30-day periods of care. The first 30-day period of care is classified as early and all subsequent 30-day periods of care in the sequence are classified as late. Table B8, reproduced below, shows the distribution of 30-day periods of care by admission source and timing over time.

Table B8: Distribution of 30-Day Periods of Care by Admission Source and Period Timing, 2018-2021

Admission Source	Period Timing	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021
Community	Early	13.5%	13.8%	12.4%	11.6%
Community	Late	61.1%	60.9	61.8%	63.9%
Institutional	Early	18.6%	118.4%	20.0%	18.6%
Institutional	Late	6.8 %	6.9%	5.8%	5.9%

Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.

Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.

(5) Functional Impairment Level

Each 30-day period of care is placed into a functional level based on responses to certain OASIS functional items associated with grooming, bathing, dressing, ambulating, transferring, and risk for hospitalization.[6] The functional impairment level remains the same for the first and second 30-day periods of care unless here has been a significant change in condition that warranted an "other follow-up" assessment prior to the second 30-day period of care. Table B9, reproduced below, shows the distribution of 30-day periods by functional status.

[5] Thirty-day periods of care for beneficiaries with any inpatient acute care hospitalizations, inpatient psychiatric facility stays, skilled nursing facility stays, inpatient rehabilitation facility stays, or long-term care hospital stays within 14-days prior to a HH admission are designated as institutional stays. The institutional source category also includes patients with an acute care hospital stay during a previous 30-day period of care and within 14 days prior to the subsequent, contiguous 30-day period of care and for which the patient was not discharged from home health and readmitted.

[6] A detailed description of these response categories can be found in the technical report, "Overview of the HH Groupings Model" posted on the HHA web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM)

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Table B9: Distribution of 30-Day Periods of Care by Functional Impairment Level, 2018-2021				
Functional Impairment Level	**CY 2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Low	33.9%	31.9%	25.7%	23.2%
Medium	34.9%	35.5%	32.7%	32.6%
High	31.2%	32.6%	41.75	44.2%
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

(6) CY 2023 Discussion and Analysis of GG Items

The functional impairment level is currently determined by responses to OASIS items M1800-M1860 and M1032. Section 1899B(b)(1)(A) of the Act requires the Secretary to require HHAs to report standardized patient assessment data beginning no later than January 1, 2019. The standardized patient assessment data categories include functional status; CMS finalized adding the functional items, Section GG, "Functional Abilities and Goals" to the OASIS data set, effective January 1, 2019. For payment purposes under the PDGM, CMS did not have the data to determine the effect, if any, of these newly added items on resource costs during a home health period of care. The GG functional items are not currently used to determine the functional impairment level under the PDGM. For case-mix purposes, CMS continues to use the M1800-1860 items.

CMS examined the correlation between the current functional items used for payment and the analogous GG items (see Figure B2 in the proposed rule). CMS' analysis shows there is a correlation between the current responses to the M1800-1860 items and the GG items. CMS notes however, that certain information in the M1800 items is collected at follow-up but is not collected at follow-up for the GG items. In addition, CMS states that ongoing analysis of the GG items shows a significant amount of "Activity not Attempted" (ANA) responses which is difficult to map to corresponding M1800-1860 item responses.

(7) Therapy Visits

Beginning in 2020, section 1895(b)(4)(B)(ii) of the Act eliminated the use of therapy thresholds in calculating payments for 2020 and subsequent years. CMS examined the proportion of simulated 30-day periods with and without any therapy visits for 2018 and 2019, prior to the removal of therapy thresholds. CMS also examined the proportion of actual 30-day periods of care with and without therapy visits for 2020 and 2021, after the removal of therapy thresholds. Table B10, reproduced below, shows the proportion of 30-day periods of care for various therapy options. CMS also examined the proportion of 30-day periods of care by the number of therapy visits provided during 30-day periods of care (Figure 3B in the proposed rule). CMS' analysis shows there have been changes in the distribution of both therapy and non-therapy visits in 2021 compared to 2020.

Table B10: Proportion of 30-Day Periods of Care with Only Therapy, At Least One Therapy Visits, and No Therapy Visits for CYs 2018-2021				
30-Day Period Visit Type	**CY 2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Therapy Only	13.5%	14.4%	15.2%	17.8%
Therapy + Non-therapy	48.2%	48.4%	42.2%	42.3%
No Therapy	38.3%	37.2%	42.6%	39.9%
Total 30-Day Periods	**9,336,898**	**8,744,171**	**8,165,402**	**8,962,690**
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

CMS also examined the proportion of 30-day periods of care with and without skilled nursing, social work, or home health aide visits for 2018 - 2021 (Tables B11 and B12, reproduced below).

Table B11: Proportion of 30-Day Periods of Care with Only Skilled Nursing, Skilled Nursing + Other Visit Type, and No Skilled Nursing Visits for 2018-2021				
30-Day Period Visit Type	**CY 2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2022**
Skilled Nursing Only	33.8%	33.1%	38.5%	36.2%
Skilled Nursing + Other	51.6%	51.5%	45.3%	44.9%
No Skilled Nursing	14.7%	15.5%	16.2%	18.9%
Total 30-Day Periods	**9,336,898**	**8,744,171**	**8,423,688**	**8,962,690**
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

Table B12: Proportion of 30-Day Periods of Care with and without Home Health Aide and/or Social Worker Visits for 2018-2021				
30-Day Period Visit Type	**CY 2018 (Simulated)**	**CY 2019 (Simulated)**	**CY 2020**	**CY 2021**
Any HH Aide and/or social worker	16.6%	15.9%	13.2%	12.2%
No HH aide and/or social worker	83.4%	84.1%	86.8%	87.8%
Total 30-Day Periods	**9,336,898**	**8,744,171**	**8,165,402**	**8,962,690**
Source: Simulated PDGM data with behavioral assumptions for 2018 and 2019 came from the Home Health LDS. PDGM data for 2020 was accessed from the CCW VDRC on July 12, 2021. PDGM data for 2021 was accessed from the CCW VRDC on March 21, 2022.				
Note: There are approximately 540,000 60-day episodes that started in 2019 and ended in 2020 that are not included in the analysis.				

CMS will continue to monitor the provision of home health services and overall home health payments to determine if refinements to the case-mix adjustment methodology may be needed in the future.

2. Proposed Methodology for Behavioral Assumptions and Adjustments under the HH PPS

a. Background and Comment Solicitation from the 2022 HH PPS Proposed Rule

(1) Background

As directed by section 1895(b)(2)(B) of the Act, beginning in 2020, CMS adopted a 30-day period of home health service in place of a 60-day period. Section 1895(b)(4)(B) of the Act further required CMS to eliminate use of therapy thresholds in assigning an episode to a case mix adjusted payment group. For 2020, section 1895(b)(3)(A)(iv) of the Act required CMS to adopt the change to a 30-day episode of care as budget neutral taking into account behavior changes from the new period of service and eliminating the use of therapy thresholds to assign a case to a payment group.

Section 1895(b)(3)(A)(iv) of the Act requires CMS to make a prospective adjustment for 2020 to maintain budget neutrality, while section 1895(b)(3)(D)(i) of the Act requires CMS to revisit the adjustment retrospectively for each year beginning with 2020 and ending with 2026. If CMS' retrospective review reveals that behavioral changes were different than assumed in the prospective adjustment, CMS is required to make both permanent and temporary adjustments to the home health rate to ensure aggregate spending neither increased or decreased as a result of the new unit of payment and elimination of therapy thresholds. The temporary adjustment is made to either recoup or repay past over or underspending, while the permanent adjustment ensures that future spending neither increased nor decreased relative to continuing the prior policies.

CMS applied a prospective budget neutrality adjustment including its behavior assumption of -4.36 percent when setting the 2020 30-day payment rate of $1,864.03.

(2) Summary of the Comment Solicitation from the 2022 Proposed Rule

The majority of commenters on the 2022 HH PPS proposed rule were supportive of forgoing any payment adjustment in 2022 based on the difference between assumed versus actual behavior. Several commenters provided an independent analysis of the actual versus assumed behavioral changes, which questioned whether CMS behavior assumptions were accurate. These commenters stated that the magnitude of coding the highest-paying clinical diagnosis was overstated, the actual change in coding practices did not manifest as CMS assumed, and that assumption of low utilization payment adjustments (LUPA) was overstated. They recommended that CMS remove these behavior assumptions and not apply the future planned negative 4.36 percent payment adjustment for rate setting in 2022. Other commenters believe that reported comorbidity levels have increased because HHAs are more comprehensively recoding these secondary diagnoses on home health claims, whereas others believe the increased acuity is due to the COVID-19 PHE.

Most commenters disagreed with the methodology set out in the proposed rule. Reasons included exclusions applied to the data when simulating 60-day episodes claims from 30-day periods, the impact of the COVID-10 PHE, the lack of comparability between case-mix models, and the removal of patient incentives for therapy visits. MedPAC, on the other hand, supported the method presented in the proposed rule for computing the budget neutral amount, stating that the method was reasonable and would satisfy the statutory requirement.

In its response, CMS reiterates that it is required by statute (1895(b)(3)(A)(iv)) to make behavioral assumptions when calculating the budget-neutral 30-day payment rate. It further states that its best reading of the law requires it to retrospectively determine if the 30-day payment amount in 2020 resulted in the same estimated aggregate expenditures that would have been made if the change in the unit of payment and the PDGM case-mix adjustment methodology had not been implemented. Further, if the estimated aggregate expenditures are determined not to be equal, CMS is required, by law, to make permanent and temporary adjustments to the PDGM payment rate so that the expenditures across the two payment systems would be equal.

b. Proposed Methodology

The proposed rule provides a detailed explanation of CMS' methodology and assumptions to determine whether further budget neutrality adjustments are needed for the change to a 30-day unit of payment. In summary, CMS simulated home health payments for a 60-day episode of care with 153 pre-PDGM payment groups and compared it to actual payments using a 30-day episode of care with 432 PDGM payment groups. It describes in this section the exclusions and assumptions made when simulating 60-day episodes from actual 30-day periods.

To calculate a permanent prospective adjustment, CMS determines what the 30-day base payment amount should have been in order to achieve the same estimated aggregate expenditures as obtained from the simulated 60-day episodes. This is the recalculated base payment rate. The percent change between the actual 30-day base payment rate and the recalculated 30-day base payment rate would be the permanent prospective adjustment.

To calculate a temporary retrospective adjustment for each year, CMS would determine the dollar amount difference between the following:

- Estimated aggregate expenditures from estimated aggregate expenditures from all 30-day periods using the *recalculated* 30-day base payment rate, and
- The aggregate expenditures for all 30-day periods using the *actual* 30-day base payment rate for the same year.

The temporary adjustment is applied on a prospective basis and applies only with respect to the year for which such temporary increase or decrease is made.

c. 2020 Results and 2021 Preliminary Results

(1) 2020 Results

Using its methodology, CMS simulated 60-day episodes using actual 2020 30-day periods to determine what the 2020 permanent and temporary payment adjustments should be to offset such

increase or decreases in estimated aggregate expenditures. The proposed rule details the exclusions and assumptions that CMS needed to make to undertake this analysis. After all exclusions and assumptions were applied, the final dataset included 7,618,061 actual 30-day periods of care and 4,463,549 simulated 60-day episodes of care for 2020.

CMS determined that a permanent prospective adjustment of -6.52 percent to the 2020 30-day payment rate would be required to offset for such increases in estimated aggregate expenditures in future years. It also calculates that a temporary adjustment of $873 million would be required to achieve budget neutrality. Table B13 (reproduced below) details these results.

Table B13: CY 2020 Proposed Permanent and Temporary Adjustments

	Budget-neutral 30-day Payment Rate with Assumed Behavior Changes	Budget-neutral 30-day Payment Rate with Actual Behavior Changes	Adjustment
Base Payment Rate	$1,864.03	$1,742.52	**Permanent** -6.52%
Aggregate Expenditures	$15,170,223,126	$14,297,150,005	**Temporary** -$873,073,121

Source: 2020 Home Health Claims Data. Periods that begin and end in 2020 accessed on the CCW July 12, 2021.

(2) 2021 Preliminary Results

CMS notes that its 2021 analysis presented in the proposed rule is preliminary and will be updated in the final rule as more data become available in the latter half of 2021. It followed the same methodology described previously. After all exclusions and assumptions were applied, the final dataset included 7,494,836 actual 30-day periods of care and 4,431,238 simulated 60-day episodes of care for 2021.

CMS determined that a permanent prospective adjustment of -1.26 percent to the 2021 30-day payment rate would be required to offset for such increases in estimated aggregate expenditures in future years. It also calculates that a temporary adjustment of $1.148 billion would be required to achieve budget neutrality. Table B14 (reproduced below) details these results.

Table B14: CY 2021 Proposed Permanent and Temporary Adjustments

	Budget-neutral 30-day Payment Rate with Assumed Behavior Changes	Budget-neutral 30-day Payment Rate with Actual Behavior Changes	Adjustment
Base Payment Rate	$1,777.19	$1,754.88	**Permanent** -1.26%
Aggregate Expenditures	$16,491,173,256	$15,343,249,798	**Temporary** -$1,147,923,458

Source: 2021 Home Health Claims Data. Periods that begin and end in 2021 accessed on the CCW March 21, 2022.
Note: The estimated aggregate expenditures for assumed behavior ($16.5 billion), uses the 2021 payment rate of $1,901.12 as this is what CMS actually paid in 2021.

d. Proposed 2023 Permanent and Temporary Adjustments

CMS calculates the 2023 permanent and temporary adjustments by combining the 2020 and 2021 permanent and temporary adjustments. It would need to apply a -7.69 percent permanent adjustment to the 2023 base payment rate as well as implement a temporary adjustment of appropriately $2.0 billion to reconcile retrospective overpayments in 2020 and 2021. It notes that applying the full permanent and temporary adjustment immediately would result in a significant negative adjustment in a single year.[7] Thus, CMS proposes initially to apply only the permanent adjustment of -7.69 percent to the 2023 base payment rate.

Detailed results are shown in Table B15 and B16.

Table B15: Total Permanent Adjustment for CYs 2020 and 2021		
Actual 2021 Base Payment Rate (Assumed Behavior)	**Recalculated 2021 Base Payment Rate Behavior (Actual Behavior)**	**Total Permanent Prospective Adjustment**
$1,901.12	$1,754.88	-7.69%
Source: 2021 Home Health Claims Data. Periods that begin and end in 2021 accessed on the CCW March 21, 2022.		

Table B16: Total Temporary Adjustment for CYs 2020 and 2021		
CY 2020 Temporary Adjustment	**CY 2020 Temporary Adjustment**	**Total Temporary Adjustment Dollar Amount for CYs 2020 and 2021**
-$873,073,121	-$1,147,923,458	-$2,020,996,579
Source: 2020 Home Health Claims Data, with periods that begin and end in 2020 accessed on the CCW July 12, 2021. 2021 Home Health Claims data, with periods that end in 2021 accessed on the CCW March 21, 2022.		

CMS seeks comments on the application of only the permanent payment adjustment to the 2023 30-day payment rate. In addition, it solicits comments on how best to collect the temporary payment adjustment of approximately $2.0 billion for CYs 2020 and 2021. CMS reminds readers it will update these permanent and temporary adjustments in the final rule to reflect more complete claims data for 2021.

3. Proposed Reassignment of Specific ICD-10-CM Codes Under the PDGM

a. Methodology for ICD-10-CM Diagnosis Code Assignments

In the HH PPS grouper software (HHGS), CMS assigns ICD-10-CM diagnosis codes as either a principal diagnosis code for grouping home health periods into clinical groups, a secondary

[7] HPA estimates that the percentage decrease in HHAs' payments would be about 11 percent from the temporary adjustment (a $2 billion decrease from overall estimated HHA payments of $18.8 billion) if implemented in 2023. Combined, the permanent and temporary adjustment would be about an 18 percent decrease in overall HHA payments in 2023.

diagnosis for a comorbidity subgroup, or designated as "not assigned" (NA) to a clinical group or comorbidity subgroup. The ICD-10-CM diagnosis code list is updated each fiscal year and the HH PPS is generally subject to a minimum of two HHGS releases, one in October and one in January in each year. In addition, updates to the HHGS may occur on the first of each quarter because of the creation of new ICD-10-CM diagnosis codes for emergency use or a new or revised edit may be added to be Medicare Code Editor (MCE).

Although CMS does not review all ICD-10-CM diagnosis codes each year, it does review codes in response to public comments and updates to the MCE. CMS states that any addition or removal of a specific diagnosis code to the ICD-10-CM code set or minor tweaks to a diagnosis code descriptor would generally not require rule making and may occur at any time. However, if assignment or reassignment of an ICD-10-CM diagnosis code may affect payment, CMS believes it is appropriate to propose these changes through notice and comment rulemaking. For review of reassignment of diagnosis codes, CMS uses the expert opinion of its clinical reviewers (e.g., nurse consultants and medical officers) and current ICD-10-CM coding guidelines to determine if the specific ICD-10-CM diagnosis code is significantly similar or different to the existing clinical group and/or comorbidity subgroup assignment. If an ICD-10-CM diagnosis code does not meet the clinical criteria for reassignment to a different comorbidity subgroup, then CMS will not make a reassignment. When an ICD-10-CM diagnosis code does meet the clinical criteria for a comorbidity subgroup reassignment, CMS will evaluate the resource consumption associated with the diagnosis code, the current assigned comorbidity subgroup, and the proposed (reassigned) comorbidity subgroup.[8]

b. Proposed ICD-10-CM Diagnosis Code Reassignments to a PDGM Clinical Group or Comorbidity Subgroup

CMS proposes reassignment of 320 diagnosis codes to a different clinical group when listed as a principal diagnosis, reassignment of 37 diagnosis codes to a different comorbidity subgroup when listed as a secondary diagnosis, and the establishment of a new comorbidity subgroup for certain neurological conditions and disorders. These proposals are posted as a supplemental file ("CY 2023 Proposed Reassignment of ICD-10-CM Diagnosis Codes for HH PDGM Clinical Groups and Comorbidity Subgroups") on the HH PPS Regulations and Notices webpage.[9] The following tables are included in the supplemental file:

- Table 1.A - Unspecified Diagnosis
- Table 1.B - Gout Related Diagnosis Codes
- Table 1.C - G Diagnosis Codes Related to Specified Neuropathy or Unspecified Neuropathy

The summary below provides a high-level discussion of CMS' proposals; readers are advised to review the proposed rule for more detailed information. **CMS solicits comments on all of the proposed clinical group and comorbidity subgroup reassignments.**

[8] The methodology used to calculate resource consumption is discussed in the 2019 HH final rule (83 FR 56450).
[9] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices

(1) Proposed Clinical Group Reassignment of Certain Unspecified Diagnosis Codes. In the 2019 HH final rule[10], CMS stated that whenever possible, the most specific code that describes a medical disease, condition, or injury should be used. "Unspecified" codes are generally used when there is lack of information about location or severity of medical conditions in the medical record. CMS expects a provider to use a precise code whenever more specific codes are available and expects HHA to follow-up with the referring provider to ensure the care plan is sufficient and has the necessary information for coding.

In the FY 2022 Inpatient PPS, CMS finalized the implementation of a new MCE to expand the list of unacceptable principal diagnosis codes for "unspecified" ICD-10-CM diagnosis codes when there are other diagnosis codes available that further specify the anatomical site. CMS reviewed this list and identified 159 ICD-10-CM diagnosis codes currently accepted as a principal diagnosis that have more specific codes available. CMS believes these codes are not acceptable as principal diagnoses and proposes to assign them to "no clinical group" (NA).

CMS also proposes the following reassignments for "unspecified" ICD-10-CM diagnosis codes:

- B78.9 (Strongyloidiasis, unspecified) reassigned to clinical group K (MMTA-Infectious Disease, Neoplasms, and Blood-Forming Diseases) and
- N83.201 (Unspecified ovarian cyst, right side) reassigned to clinical group J (MMTA-Gastrointestinal Tract and Genitourinary System).

(2) Proposed Clinical Group Reassignment of Gout-Related Codes. CMS proposes to reassignment 144 gout-related ICD-10-CM diagnosis codes to clinical group E (Musculoskeletal Rehabilitation).

(3) Proposed Clinical Group Reassignment of Crushing Injury-Related Codes. CMS identified 12 ICD-10-CM diagnosis codes related to crushing injury of the face, skull, and head that warrant reassignment (Table B18 in the proposed rule). CMS proposes to reassign these diagnosis codes to clinical group B (Neurological Rehabilitation).

(4) Proposed Clinical Group Reassignment of Lymphedema-Related Codes. CMS received questions about the clinical group assignments of three lymphedema codes (Table B19 in the proposed rule). CMS proposes to reassign these diagnosis codes to clinical group C (Wounds).

(5) Proposed Behavioral Health Comorbidity Subgroups. CMS proposes to reassign diagnosis code F60.5 (Obsessive-compulsive personality disorder) to behavior 5 (Phobias, Other Anxiety and Obsessive-Compulsive Disorders) when listed as a secondary diagnosis.

(6) Proposed Circulatory Comorbidity Subgroups. CMS proposes to assign diagnosis code Q82.0 (Hereditary lymphedema) to circulatory 10 (Varicose Veins and Lymphedema) when listed as a secondary diagnosis.

[10] 83 FR 56473

(7) Proposed Neoplasm Comorbidity Subgroups.

(i) Malignant Neoplasm of Upper Respiratory. In response to questions related to upper respiratory malignant neoplasms, CMS reviewed 14 ICD-10-CM diagnosis codes (Table B20 in the proposed rule). Based on its review, CMS proposes to reassign diagnosis codes C30.0, C30.1, C31.0, C31.1 - C31.3, C31.8, C31.9, C32.0 - C32.2 from neoplasm 6 (Malignant Neoplasms of Trachea, Bronchus, Lung, and Mediastinum) to neoplasm 1 (Malignant Neoplasm of Lip, Oral Cavity and Pharynx including Head and Neck Cancers) when listed as a secondary diagnosis.

(ii) Malignant Neoplasm of Unspecified Adrenal Gland. CMS proposes to reassign diagnosis codes C74.00 (Malignant neoplasm of cortex of unspecified adrenal gland) and C74.90 (Malignant neoplasm of unspecified part of unspecified adrenal gland) from "NA" to neoplasm 15 (Malignant Neoplasm of Adrenal Gland, Endocrine Glands and Related Structures) when listed as secondary diagnoses.

(8) Proposed New Neurological Comorbidity Subgroup. CMS believes a new neurological comorbidity subgroup to include ICD-10-CM diagnosis codes related to nondiabetic neuropathy is appropriate. CMS proposes 18 ICD-10-CM diagnosis codes for potential reassignment to a proposed new comorbidity subgroup, neurologic 12 (Nondiabetic Neuropathy) (Table 1.C of the supplemental file). CMS notes that of the 18 codes, 11 were not currently assigned a comorbidity group and seven codes were assigned to neurological 11 comorbidity subgroup. CMS also proposes to change the description of comorbidity subgroup, neurological 11 from "Diabetic Retinopathy and Macular Edema" to "Disease of the Macular and Blindness/Low Vision".

(9) Proposed Respiratory Comorbidity Subgroups.

(i) J18.2 Hypostatic Pneumonia, Unspecified Organism. CMS proposes to reassign J18.2 to respiratory 2 (Whooping Cough and Pneumonia) when listed as a secondary diagnosis.

(ii) J98.2 Interstitial Emphysema and J98.2 Compensatory Emphysema. CMS proposes to reassign diagnosis codes J98.2 and J98.3 to respiratory 4 (Bronchitis, Emphysema, and Interstitial lung disease) when listed as a secondary diagnosis.

(iii) U09.9 Post COVID-19 Condition, Unspecified. CMS proposes to reassign diagnosis code U09.9 to respiratory 10 (2019 Novel Coronavirus) when listed as a secondary diagnosis.

4. 2023 PDGM Low-Utilization Payment Adjustment (LUPA) Thresholds and PDGM Case-Mix Weights

a. 2023 PDGM LUPA Thresholds

Low utilization payment adjustments (LUPAs) are paid when a certain visit threshold for a payment group during a 30-day period of care is not met. LUPA thresholds are set at the 10th percentile value of visits or 2 visits, whichever is higher for each payment group. That is, the LUPA threshold for each 30-day period of care varies based on the PDGM payment group to which it is assigned. If the LUPA threshold is met, the 30-day period of care is paid the full 30-

day period payment. If a 30-day period of care does not meet the PDGM LUPA visit threshold, then payment is made using the per-visit payment amount.

CMS adopted a policy that the LUPA thresholds would be updated each year based on the most current utilization data available. However, to mitigate any potential future and significant short-term variability in the LUPA thresholds due to the COVID-19 PHE, CMS maintained the thresholds adopted for 2020 for 2022. For 2023, CMS proposes to update the LUPA thresholds using 2021 home health claims (as of March 21, 2022) linked to OASIS assessment data, as it believes that these data will be more indicative of visit patterns in 2023.

The proposed LUPA thresholds for the 2023 PDGM payment groups with the corresponding HIPPS codes and the case-mix weights are listed in Table B26 of the proposed rule. **CMS solicits comment on the proposed updates to the LUPA thresholds for 2023.**

b. 2023 Functional Impairment Levels

Under the PDGM, the functional impairment level is determined by responses to certain OASIS items associated with activities of daily living and risk of hospitalization. A home health period of care receives points based on responses from these functional OASIS items, which are converted to a table of points. The sum of all these points is used to group home health periods into low, medium, and high functional impairment levels, designed so that about one-third of home health periods fall within each level.

For 2023, CMS proposes to use the 2021 claims data to update the functional points and functional impairment levels by clinical group and to use the same methodology previously finalized to update the functional impairment levels for CY 2023. The updated OASIS functional points table and the table of functional impairment levels by clinical group for CY 2023 are listed in Tables B21 and B22, respectively. **CMS solicits comment on the updates to functional points and the functional impairment levels by clinical group.**

c. 2023 Comorbidity Groups

Thirty-day periods of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on home health claims. These diagnoses are based on a home health list of clinically and statistically significant secondary diagnosis subgroups with similar resource use. A comorbidity adjustment is applied to the 30-day period of care when there is the following: (1) low comorbidity adjustment – a reported secondary diagnoses on the health-specific comorbidity subgroup list that is associated with higher resource use; or a (2) high comorbidity adjustment – two or more secondary diagnoses on the home health-specific comorbidity subgroup list.

For 2023, CMS proposes to use the same methodology used to establish the comorbidity subgroups to update the comorbidity subgroups using 2021 home health data. Using these data, CMS proposes to update the comorbidity subgroups to include 23 low comorbidity adjustment subgroups and 94 high comorbidity adjustment interaction subgroups as identified in Tables B23 and B24 in the proposed rule. **CMS invites comment on the proposed updates to the low**

comorbidity adjustment subgroups and the high comorbidity adjustment interactions for 2023.

d. 2023 PDGM Case-Mix Weights

The PDGM case-mix methodology (as finalized in the 2019 HH PPS final rule) results in 432 unique case-mix groups called home health resource groups (HHRGs). CMS annually recalibrates the PDGM case-mix weights using a fixed effects regression model with the most recent and complete utilization data available at the time of annual rulemaking. For 2023, CMS proposes to generate the recalibrated case-mix weights using 2021 home health claims data with linked OASIS assessment data (as of March 2021). CMS believes that recalibrating the case-mix weights using data from 2021 would be reflective of PDGM utilization and patient resource use for 2023. These weights will be updated based on more complete 2021 claims data for the final rule.

Table B25 in the proposed rule shows the coefficients of the payment regression used to generate the weights, and the coefficients divided by average resource use for PDGM payment groups. The proposed 2023 case-mix weights are provided in Table B26 in the proposed rule and will also be posted on its HHA Center webpage.

To determine the case-mix budget neutrality factor for 2023, CMS continues its practice of using the most recent complete home health claims data at the time of rulemaking, which is 2021 data. CMS calculates a case-mix budget neutrality factor for 2023 of 0.9895.

5. 2023 Home Health Payment Rate Updates

a. 2023 Home Health Market Basket Update for HHAs

The update will equal the projected increase in the market basket adjusted for changes in economy-wide productivity. Based on IHS Global Insight Inc.'s first-quarter 2022 forecast for 2023 with historical data through fourth-quarter 2021, the proposed HH PPS market basket update is as follows:

Market Basket Update	**Change (in %)**
Market basket forecast	3.3
Total factor productivity	-0.4
Net update for HHAs reporting quality data	**2.9**
Net update for HHAs NOT reporting quality data	**0.9**

More recent forecasts for 2023 will be used for the final rule, if available. As noted below, the final update factor also includes budget neutrality adjustments for the wage index and case-mix recalibration.

b. 2023 Home Health Wage Index

CMS proposes to continue to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates for 2023, using FY 2019 hospital cost report data as its source for the updated wage data. CMS also proposes for 2023 and subsequent years, to apply a permanent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. It believes that a more permanent approach is needed to smooth year-to-year changes in providers' wage indexes that could occur due to external factors beyond a provider's control, such as COVID-19 PHE. It further proposes that if a geographic area's prior calendar year wage index is calculated based on the 5-percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index. This 5-percent cap on negative wage index changes would be implemented in a budget neutral manner, but CMS anticipates that effect of this proposed policy on the wage index budget neutrality factor would be small.

The proposed wage 2023 wage index is available on the CMS website at: https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.

c. 2023 Annual Payment Update

(1) Background
CMS discusses the methodology it uses to compute the case-mix and wage-adjusted 30-day period rates as set forth in §484.220. It first multiplies the national, standardized 30-day period rate by the patient's applicable case-mix weight. It then divides the case-mix adjusted amount into labor (76.1 percent) and non-labor (23.9 percent) portions. The labor portion is multiplied by the appropriate wage index based on the site of service and summed to the non-labor portion.

Next, CMS may adjust the resulting 30-day case-mix and wage-adjusted payment based on the information submitted on the claim to reflect:

- A LUPA provided on a per-visit basis (§§484.205(d)(1) and 484.230).
- A partial episode payment (PEP) adjustment (§§484.205(d)(2) and 484.235).
- An outlier payment (§§484.205(d)(3) and 484.240).

Implementation of the PDGM and the 30-day unit of payment began in 2020, and CMS is required to annually analyze data (for 2020 through 2026) to assess the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. As discussed above, for 2023 CMS is proposing to apply a permanent behavioral adjustment factor.

(2) 2023 National, Standardized 30-Day Period Payment Amount
To determine the 2023 national, standardized 30-day period payment rate, CMS proposes to apply a permanent behavioral adjustment factor, case-mix weights recalibration budget neutrality factor, a wage index budget neutrality factor, and the home health payment update percentage. The permanent behavior adjustment of -7.69 percent has the largest effect on the calculation of the proposed standardized amount.

The following table shows the proposed standardized amounts, as displayed in Tables B27 and B28.

Proposed 2023 National, Standardized 30-Day Episode Payment Amount, for HHAs Submitting and Not Submitting Quality Data		
	HHAs submitting quality data	HHAs not submitting quality data
2022 30-day budget neutral standardized amount	$2,031.64	
Permanent behavior adjustment factor	x 0.9231	
Case-mix weights recalibration neutrality factor	x 0.9895	
Wage index budget neutrality factor	x 0.9975	
HH payment update percentage	x 1.029	x 1.009
2023 30-day payment amount	**$1,904.76**	**$1,867.74**

(3) 2023 National Per-Visit Rates for 30-Day Periods of Care

Computations are presented for the 2023 proposed per-visit amounts for each type of service. These amounts are used for LUPAs and in outlier calculations. The proposed per-visit amounts for those HHAs submitting the required quality data (Table B29 in the proposed rule) are as follows:

Proposed 2023 National, Per-Visit Payment Amounts for HHAs that Submit Quality Data				
HH Discipline	**CY 2022 Per-Visit Rates**	**Wage Index Budget Neutrality Factor**	**CY 2023 HH Payment Update**	**CY 2023 Per-Visit Payment**
Home Health Aide	$71.04	X 0.9992	X 1.029	$73.04
Medical Social Services	$251.48	X 0.9992	X 1.029	$258.57
Occupational Therapy	$172.67	X 0.9992	X 1.029	$177.54
Physical Therapy	$171.49	X 0.9992	X 1.029	$176.32
Skilled Nursing	$156.90	X 0.9992	X 1.029	$161.32
Speech-Language Pathology	$186.41	X 0.9992	X 1.029	$191.66

HHAs that do not submit required quality data would have the payment update for per-visit services reduced from 2.9 percent to 0.9 percent, resulting in the following payment rates (Table B30 in the proposed rule):

Proposed 2023 National, Per-Visit Amounts for HHAs that Do Not Submit Quality Data				
HH Discipline	**CY 2022 Per-Visit Rates**	**Wage Index Budget Neutrality Factor**	**CY 2023 HH Payment Update Minus 2 Percentage Points**	**CY 2023 Per-Visit Rates**
Home Health Aide	$71.04	X 0.9992	X 1.009	$71.62
Medical Social Services	$251.48	X 0.9992	X 1.009	$253.54
Occupational Therapy (OT)	$172.67	X 0.9992	X 1.009	$174.08
Physical Therapy (PT)	$171.49	X 0.9992	X 1.009	$172.89
Skilled Nursing	$156.90	X 0.9992	X 1.009	$158.19
Speech-Language Pathology (SLP)	$186.41	X 0.9992	X 1.009	$187.94

(4) LUPA Add-on Factors

Under previously adopted policy, to determine the LUPA add-on payment for a 30-day period of care, CMS multiplies the per-visit payment amount for the first skilled nursing, PT, or SLP visit in a LUPA period that is the first 30-day period of care or the initial 30-day period of care in a sequence of adjacent periods. The add-on factors are 1.8451 for skilled nursing, 1.6700 for PT, and 1.6266 for SLP.

(5) Occupational Therapy LUPA Add-On Factor

CMS finalized changes to regulations at §§484.55(a)(2) and 484.55(b)(3) to implement requirements of CAA 2021 in the 2022 HH PPS final rule. These revisions allow OTs to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health benefit when the plan of care does not initially include skilled nursing care, but includes either PT or SLP. Because of this change, CMS established a LUPA add-on factor for calculating the LUPA add-on payment amount for the first skilled OT visit in LUPA periods that occurs as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. Because CMS did not have sufficient data to estimate an OT specific LUPA add-on factor, CMS finalizes the PT LUPA add-on factor of 1.6700 as a proxy until it has 2022 data. CMS continues to believe that this add-on factor is the most appropriate until it has 2022 data to propose a LUPA add-on factor specific to OT in future rulemaking.

d. Payments for High-Cost Outliers Under the HH PPS

Under the HH PPS, outlier payments are made for episodes whose estimated costs exceed a threshold amount. The outlier threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and a wage-adjusted fixed-dollar loss (FDL) amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated cost for the episode that surpasses the wage-adjusted threshold; this proportion is referred to as the loss-sharing ratio.

CMS notes that the FDL ratio and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the aggregate level of 2.5 percent of estimated total HH PPS payments as required by statute. CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes are proposed to the loss-sharing ratio for 2023.

For 2023 payment, CMS proposes an FDL ratio of 0.44 for 2023 based on analysis of 2021 claims data (as of March 21, 2022). In the proposed rule, CMS also reviews the history of HH PPS policy regarding outlier payments. In the 2017 HHS PPS final rule (81 FR 76702), CMS finalized changes to its methodology used to calculate outlier payments, switching from a cost-per-visit approach to a cost-per-unit approach. CMS now converts the national per-visit rates into per 15-minute unit rates. CMS also limits the amount of time per day (summed across the six disciplines of care) to 8 hours (32 units) per day when estimating the cost of an episode for

outlier calculation purposes. CMS will publish the cost-per-unit amounts for 2023 in the rate update change request to be issued after the publication of the 2023 HH PPS final rule.[11]

C. Comment Solicitation on the Collection of Data on the Use of Telecommunications Technology under the Medicare Home Health Benefit

1. Background

CMS reviews its policies that have expanded the use of telecommunications technology under the Medicare home health benefit. In the CY 2019 HH PPS final rule with comment (83 FR 56406), CMS finalized the definition of "remote patient monitoring" in regulation at 42 CFR §409.46(e) as the collection of physiologic data (for example, electrocardiogram (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the HHA. It also finalized in regulation at §409.46(e) that the costs of remote patient monitoring are considered allowable administrative costs (operating expenses) if remote patient monitoring is used by the HHA to augment the care planning process (83 FR 56527).

CMS also expanded the use of telecommunications technology in response to the COVID-19 PHE. In the first COVID-19 PHE interim final with comment period (IFC) (85 FR 19230), CMS changed the plan of care requirements at §409.43(a) on an interim basis, for the purposes of Medicare payment, to state that the plan of care must include any provision of remote patient monitoring or other services furnished via a telecommunications system. 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. The amended plan of care requirements also states that 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. The CY 2021 HH PPS final rule with comment period (85 FR 70298) finalized these changes on a permanent basis, as well as amended §409.46(e) to include not only remote patient monitoring, but other communication or monitoring services consistent with the plan of care for the individual, on the home health cost report as allowable administrative costs.

CMS notes that 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 administrative costs on line 5 of the HHA Medicare cost reports. These data are not currently collected on the home health claims and CMS does not routinely review plans of care to determine the extent to which these services are actually being provided. CMS believes that collecting data on the use of telecommunications technology on home health claims would allow it to analyze the characteristics of the beneficiaries' utilizing services furnished remotely and would give CMS a broader understanding of the social determinants that affect who benefits most from these services, including what barriers may potentially exist for certain subsets of

[11] The per-unit amounts for 2022 are found in the November 19, 2021 HH PPS change request: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11099cp

beneficiaries.

2. Comment Solicitation

CMS solicits comments on collection of data on the use of telecommunications technology on home health claims. It aims to begin collecting such data by January 1, 2023 on a voluntary basis by HHAs and will begin to require this information be reported on claims by July of 2023. Specifically, CMS solicits comments on the use of three new G-codes 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, that is, 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. CMS is also 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.

CMS states that it plans to issue instructions that these forthcoming G-codes are to be used to report services in line-item detail and each service must be reported as a separate line under the appropriate revenue code (04x – Physical Therapy, 043x – Occupational Therapy, 044x - Speech-Language Pathology, 055x – Skilled Nursing, 056x – Medical Social Services, or 057x- Home Health Aide). It does not plan to limit the use of these G-codes to any particular discipline, but that it would not anticipate use of such technology would be reported under certain revenue codes such as 027x or 0623 – Medical Supplies, or revenue code 057x – Home Health Aide. It is also interested in comments from the public on its belief that, due to the hands-on nature of home health aide services, the use of telecommunications technology would generally not be appropriate for such services. CMS also seeks comments on the appropriateness of such technology for particular services in order to more clearly delineate when the use of such technology is appropriate. For example, such technology would not be appropriate for wound care that requires in-person, hands-on care from a skilled nurse.

CMS also solicits comments on future refinement of these G-codes beginning July 1, 2023. Specifically, 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 emphasizes that the collection of this information does not mean that such services are considered “visits” for purposes of eligibility or payment.

III. Home Health Quality Reporting Program (HH QRP)

A. Background and Overview

The HH QRP is a pay-for-reporting program authorized under section 1895(b)(3)(B)(5) of the Act. Under this program the annual market basket percentage increase is reduced by 2 percentage points for HHAs that do not report required quality data. CY 2007 was the first year in which payments were affected by the program. The program was modified by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act, P.L. 113-185), which added requirements for HHAs to begin entering standardized patient assessment data elements (SPADEs) into the Outcome and Assessment Information Set (OASIS). The SPADEs are grouped into categories, one of which aggregates social determinants of health (SDOH) and currently includes SPADEs for race, ethnicity, language preference, health literacy, transportation needs, and social isolation. As previously finalized, required reporting of these SDOH category SPADEs by HHAs will begin January 1, 2023.

For the CY 2025 program (payment) year, CMS proposes to begin requiring quality data collection and submission for all HHA patients, regardless of payer. CMS also proposes to codify the program's measure removal factors and to make several technical changes to the regulation text. Further, CMS provides updates on several health information technology (IT) developments with potential applicability to all of the post-acute care (PAC) quality reporting systems (including OASIS). Finally, CMS issues a Request for Information (RFI) concerning health equity considerations relevant to the HH QRP. CMS requests comments on all proposals.

No changes are proposed to the current HH QRP measure set, and no changes are proposed to existing program policies other than the proposal for OASIS data submission regardless of payer. The measure set applicable for program year CY 2023 is provided as a table at the end of this summary section. More information on the HH QRP can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits.

B. All-Payer OASIS Data Submission

CMS proposes to require HHAs to submit all-payer OASIS data for purposes of the HH QRP beginning with the CY 2025 program year. The requirement will be phased in. For program year CY 2025, all-payer OASIS data will be required for two quarters (discharges between January 1, 2024 and June 30, 2024). Four-quarter (full year) reporting will begin with program year CY 2026 (i.e., discharges between July 1, 2024 and June 30, 2025 for program year 2026 and advancing annually by 1 year for each subsequent program year).

CMS would operationalize the all-payer OASIS data requirement by ending the suspension of data collection from non-Medicare/Medicaid HHA cases. Suspension of data collection was enacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The MMA also required the HHS Secretary to study and report back about issues that had been raised by stakeholders before proposing new all-payer data collection regulations. The Secretary submitted the required study to the Congress in December 2006 but opted not to

proceed with new regulatory proposals. Since that time, CMS has implemented secure, robust OASIS data reporting systems; revised and expanded the HH QRP measure set; and solicited stakeholder feedback about all-payer data collection through comment requests issued during several HH PPS rulemaking cycles.

CMS believes that resuming all-payer OASIS data collection as proposed in this rule would:

- be responsive to stakeholder calls for increased data standardization across PAC settings, including from the NQF-convened Measure Applications Partnership (MAP);
- be consistent with similar requirements in the CMS quality programs for long-term acute care hospitals (LTCH QRP) and hospice providers (HQRP);[12]
- provide a fuller, more accurate representation of HHA quality of care for use in beneficiary healthcare decision making, policy development, and health services research; and
- enhance identification of outcomes disparities across PAC settings and patient subsets.

CMS acknowledges the time and cost burden for HHAs that would be added by the expanded reporting but believes the burden may be partially offset by no longer having to reliably separate out Medicare patient data for reporting. Later in the preamble, CMS provides added time and cost burden estimates of 296.3 hours per HHA per year (3,364,285 hours across all 11,354 HHAs) and $23,529.82 per HHA per year ($267.2 million across all HHAs).[13]

C. Codifying HH QRP Measure Removal Factors

CMS proposes to codify factors finalized during the CY 2019 HH PPS rulemaking cycle to be used as guides to decision making about removing measures from the HH QRP measure set. The 8 factors, listed below, would be added at §484.245 as new paragraph (b)(3) and would align the HH QRP regulations with those of other PAC settings.

1. Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made ("topped out").
2. Performance or improvement on a measure does not result in better patient outcomes.
3. A measure does not align with current clinical guidelines or practice.
4. A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
5. A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
6. A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
7. Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
8. The costs associated with a measure outweigh the benefit of its continued use in the program.

[12] All-payer reporting also has been proposed for the IRF QRP beginning with FY 2023.
[13] The time and cost burden estimates are based on full-year (four-quarter) required reporting.

D. Regulation Text Technical Changes

CMS proposes technical changes to §484.245 that would consolidate statutory references to data submission and would clarify that certain submission requirements apply only to HH Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.

E. Advancing Health Information Exchange

In the CY 2022 HH PPS proposed rule, CMS discussed several ongoing HHS initiatives to advance health information exchange within the post-acute care (PAC) settings and within the larger health care environment. The agency now provides updates about selected activities.

Post-Acute Care Interoperability Workgroup (PACIO). The PACIO Project continues to develop Fast Healthcare Interoperability Resources (FHIR®) implementation guides and new use cases such as advance directives, and reassessment timepoints. CMS again strongly encourages hospices and other PAC providers to participate in PACIO.

CMS Data Element Library (DEL). The CMS DEL serves as the authoritative resource for PAC assessment data elements and their associated mappings to health IT standards (e.g., SNOMED). CMS states that the latest DEL standards are now available in the 2022 ONC Interoperability Standards Advisory (https://www.healthit.gov/isa).

Trusted Exchange Framework and Common Agreement (TEFCA). This trusted exchange framework and common agreement is intended to enable the nationwide exchange of electronic health information across health information networks and provide a way to enable bi-directional health information exchange in the future. CMS notes that TEFCA Version 1 was released January 18, 2022, and is available for download at https://www.healthit.gov/sites/default/files/page/2022-01/Common_Agreement_for_Nationwide_Health_Information_Interoperability_Version_1.pdf. Incorporated by reference into the Common Agreement is the Qualified Health Information Network Technical Framework Version 1, establishing the technical infrastructure model, which follows a network-of-networks structure. The Technical Framework is available at https://rce.sequoiaproject.org/wp-content/uploads/2022/01/QTF_0122.pdf.

F. Request for Information (RFI): Health Equity in the HH QRP

During CY 2022 HH PPS rulemaking, CMS requested information about approaches to identifying healthcare disparities in the agency's quality reporting and value-based purchasing programs, including the HH QRP. In the current rule, CMS seeks feedback on additional questions related to advancing health equity in the HH QRP.

By way of background, CMS states that prior research has uncovered disparities in the provision of home health services, which have been amplified by the COVID-19 PHE. Black, Hispanic, and lower-income patients have reduced access to high-quality HHAs, and HHAs serving higher

proportions of Black and low-income older adults furnish lower quality care. Home health disparities also have been linked to neighborhood-level factors.

1. Agency Level Experiences

CMS first asks for input from the field as follows:

- 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 or clients? How does your HHA measure whether this has an impact on health equity?
- How does your HHA currently identify barriers to access to care in your community or service area?
- What are the barriers to collecting data related to disparities, SDOH, and equity? What steps does your HHA take to address these barriers?
- How does your HHA collect self-reported demographic information such as information on race and ethnicity, disability, sexual orientation, gender identity, veteran status, socioeconomic status, and language preference?
- How is your HHA using collected information such as housing, food security, access to interpreter services, caregiving status, and marital status to inform its health equity initiatives?

2. Structural Measure of HHA Commitment to Equity

CMS also discusses future adoption into the HH QRP of a composite structural measure to assess commitment at the agency level to an organizational culture of equity. CMS suggests a measure format having 3 domains and multiple elements within each domain. To satisfy a domain, an HHA would need to show evidence of activities for all domain elements through some combination of attestation and documentation submitted via a CMS portal. Completion of a domain would be worth 1 point, so that a total of 3 points would be available for the measure. The potential measure's domains and their associated elements are collated in the table below, created by HPA based on their descriptions by CMS in section III.G. of the rule.[14]

Table: Potential Composite Structural Measure--Home Health Agency Commitment to Health Equity	
Attestation	**Elements**
Domain 1: Equity is a strategic priority	
Attest that the HHA has a strategic plan for advancing healthcare equity and that the plan includes all of the associated elements.	The plan includes approaches to address equity during the QRP reporting period. The agency reports community engagement and key stakeholder activities. The agency seeks input from patients and caregivers about care disparities and suggestions for improvement by the agency.

[14] The format of this table follows that for a similar structural equity measure proposed for adoption into the Hospital Inpatient Quality Reporting Program in the FY 2023 IPPS proposed rule (86 FR 28495).

Domain 2: Appropriate training is provided	
Attest that training is provided throughout the organization.	Agency board members, leaders, and staff all receive diversity, equity, and inclusion training. Employed staff are trained to provide culturally and linguistically appropriate care. Resource materials about health equity, SDOH and agency equity initiatives are provided to agency staff.
Domain 3 Organizational culture of equity	
Attest that agency leadership and staff demonstrate routine and thorough attention to equity and setting an organizational culture of equity.	Equity-focused factors are considered in the hiring of senior leadership, direct patient care staff, and indirect care/support staff.

G. Summary Table of HH QRP Measures

The table below lists the HH QRP measures that have been finalized for the CY 2023 program year, as shown in Table C1 of the rule, with additional context provided by HPA. (Added material is italicized.)

Table: HH QRP Measures for the 2023 Program Year	
Short Name	**Measure Full Name & Data Source**
OASIS-based	
Ambulation	Improvement in Ambulation/Locomotion (NQF #0167)
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (NQF #0674)
Application of Functional Assessment	Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
Bathing	Improvement in Bathing (NQF #0174)
Bed Transferring	Improvement in Bed Transferring (NQF #0175)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program
Drug Education	*Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care – Previously finalized for removal beginning in CY 2023*
Dyspnea	Improvement in Dyspnea
Influenza	Influenza Immunization Received for Current Flu Season (NQF #0522)
Oral Medications	Improvement in Management of Oral Medication (NQF #0176)
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care
Timely Care	Timely Initiation of Care (NQF #0526)
Transfer of Health Information *	Transfer of Health Information to the Patient-PAC Measure
Transfer of Health Information *	Transfer of Health Information to the Provider-PAC Measure
** Compliance date delayed due to COVID-19 PHE; reporting will begin January 1, 2023.*	
Claims-based	
ACH	*Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171) – Replaced by PPH measure beginning CY 2023*
ED Use	*Emergency Department Use without Hospitalization During the First 60 Days of Home Health (NQF #0173) – Replaced by PPH measure beginning CY 2023*
PPH	Home Health Within Stay Potentially Preventable Hospitalization *PPH measure replaces ACH and ED Use measures beginning CY 2023*
DTC	Discharge to Community-Post Acute Care (PAC) HH QRP

Table: HH QRP Measures for the 2023 Program Year	
Short Name	**Measure Full Name & Data Source**
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) –PAC HH QRP
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for Home Health Quality Reporting Program
HHCAHPS-based (CAHPS Home Health Care Survey NQF #0517)	
Communication	How well did the home health team communicate with patients
Overall Rating	How do patients rate the overall care from the home health agency
Professional Care	How often the home health team gave care in a way
Team Discussion	Did the home health team discuss medicines, pain, and home safety with patients
Willing to Recommend	Would patients recommend the home health agency to friends and family

IV. Home Health Value-Based Purchasing Model (HHVBP Model)

A. Background and Overview

The CMS Center for Medicare and Medicaid Innovation (CMMI, Innovation Center) tested the "original" Home Health Value-Based Purchasing Model (HHVBP-O) in 9 states during calendar years 2016 through 2021. Payments were adjusted based on performance on the model's measures as summed into a Total Performance Score (TPS). The model produced average annual savings to Medicare of $141 million with an average TPS increase of 4.6 percent and without evidence of adverse risks. The model's results met statutory criteria to be certified for expansion, as announced by CMS on January 8, 2021. Final payment adjustments under the HHVBP-O model were made during CY 2021.

The Expanded HHVBP Model (HHVBP-E) began nationwide testing January 1, 2022, starting with a "pre-implementation year" of CY 2022 during which agencies can familiarize themselves with the expanded model and their performances will not trigger future payment adjustments. Beginning with performance year CY 2023, measures will be scored and TPSs calculated annually and will trigger payment adjustments two years after each performance year. Payment adjustments will range from -5% to +5% for all model test years. The model requires all Medicare-certified HHAs to participate and they are termed "competing HHAs."

In this rule, CMS proposes changes to the HHVBP-E model that would revise certain time period definitions, revise the HHA baseline year, and change the Model baseline year. No changes are proposed to the model's measure set, listed in a table at the end of this summary section. Other than proposed changes to the model's baseline year time periods, no policy changes are proposed in this rule. All proposals are open to comment. CMS also seeks input through an RFI about future approaches to health equity relevant to the expanded model. Additional information about the HHVBP-E model is available at https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model.

As a CMMI model, the HHVBP-E is not subject to the Paperwork Reduction Act, so no burden estimate is provided in this rule. CMS has previously estimated total Fee-For-Service Medicare savings from the model at $3.376 billion over 5 years (CY 2023 through CY 2027). This estimate is unchanged by provisions in this rule if finalized.

B. Proposals Related to the Expanded HHVBP Model's Baseline Years

1. Definitions

Definitions for the expanded HHVBP model are found at §484.345, where *Baseline year* means the year against which measure performance in a performance year will be compared. To enhance clarity, CMS proposes to remove this definition and add two definitions—*HHA baseline year* and *Model baseline year*—applicable for CY 2023 and subsequent years. *HHA baseline year* would mean the calendar year used to determine the improvement threshold for each measure for each individual competing HHA. *Model baseline year* would mean the calendar year used to determine the benchmark and achievement threshold for each measure for all competing HHAs. CMS also proposes to make conforming changes to the regulation text.

2. HHA Baseline Year Changes

CMS proposes to update the HHA baseline years for all competing HHAs, starting with model performance year CY 2023. The HHA baseline year would become CY 2022 for all measures for agencies certified prior to January 1, 2022 and the first performance year for these agencies would remain unchanged—CY 2023. For any new HHA certified on or after January 1, 2022, CMS proposes that for all measures (1) the HHA baseline year would be the first full calendar year of services beginning after that HHA's certification date and (2) the new HHA's first performance year would be the first full calendar year following the baseline year. CMS also proposes to make conforming changes to the regulation text.

The proposed changes are based on analyses by CMS of HHA performance on each of the model's measures for the CY 2019 through CY 2021 period compared to historical trends. CMS found significant deviations from the previously stable, historical rates for two claims-based measures that together account for 35 percent of an agency's TPS. (Details of the analysis, tabular and graphic, are provided in section IV.B.2.b. of the rule.) CMS notes that during earlier phases of the PHE, patients often were discharged to home health care rather than to institutional PAC settings, skewing the home health patient population.

CMS believes that CY 2022 data would more fairly represent HHA baseline performances when used for TPS calculations than would data from years more heavily impacted by the COVID-19 PHE. CMS alternatively considered using CY 2021 as the new HHA baseline year or making no baseline year changes, as well as making measure-specific baseline year changes. CMS believes its proposal is straightforward and provides for use of the most representative data as a baseline. The proposed changes are shown below (from Table D3 of the rule with minor modifications).

TABLE: PROPOSED HHA BASELINE, PERFORMANCE, AND PAYMENT YEARS			
Date HHA certified	**HHA baseline year**	**Performance Year**	**Payment Year**
Prior to January 1, 2022	2022	2023	2025
January 1 – December 31, 2022	2023	2024	2026
January 1 – December 31, 2023	2024	2025	2027

3. Model Baseline Year Changes

Beginning with model performance year 2023, CMS proposes to update the Model baseline year from CY 2019 to CY 2022. Model baseline year data are used when setting measure-specific benchmarks and achievement thresholds. CMS chose CY 2022 to allow use of the most recent data available while avoiding use of data from the most acute phase of the COVID-19-PHE when making HHA payment adjustments.

C. Request for Comment on a Future Approach to Health Equity in the Expanded HHVBP Model

CMS reprises its definition of health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." CMS also notes its ongoing work to close the health equity gap by undertaking initiatives throughout its quality enterprise to identify and address disparities. CMS indicates interest in stakeholder input about actions to advance equity and reduce disparities as part of the expanded HHVBP model.

CMS specifically requests comments about making changes to the HHVBP-E model that would tie home health agency outcomes to the model's payment adjustments and reflect the diversity of the home health patient population. In particular, CMS asks for comments on approaches to accounting for disparities through quality program elements such as:

- At the measure-level (e.g., stratification based on demographic or social risk factors);
- At the scoring-level (e.g., modified benchmarks or adjustment percentages, measure points adjustments, comparing results within HHA peer groups based on agency demographic or social risk factors); and
- At the program-level (e.g., adding new equity-focused measures).

D. Expanded HHVBP Model Quality Measure Set

Table: Quality Measure Set for the Expanded HHVBP Model	
Short Name	**Measure Name & Data Source**
OASIS-based	
Dyspnea	Improvement in Dyspnea
DTC	Discharged to Community
Oral Medications	Improvement in Management of Oral Medication (NQF #0176)
TNC Mobility	Total Normalized Composite Change in Mobility
TNC Self-Care	Total Normalized Composite Change in Self-Care
Claims-based	
ACH	Acute Care Hospitalization During the First 60 Days of Home Health (NQF #0171)

ED Use	Emergency Department Use without Hospitalization During the First 60 Days of Home Health (NQF #0173)
Table: Quality Measure Set for the Expanded HHVBP Model	
Short Name	**Measure Name & Data Source**
HHCAHPS-based (NQF #0517)	
Communication	How well did the home health team communicate with patients
Overall Rating	How do patients rate the overall care from the home health agency
Professional Care	How often the home health team gave care in a professional way
Team Discussion	Did the home health team discuss medicines, pain, and home safety with patients
Willing to Recommend	Would patients recommend the home health agency to friends and family

V. Home Infusion Therapy

As required by section 1843(u)(3) of the Act and 42 CFR §414.1550, the national home infusion therapy (HIT) services payment rates for the initial and subsequent visits in each of the home infusion therapy payment categories for CY 2023 are required to be the CY 2022 rate adjusted by the percentage increase in the Consumer Price Index (CPI) for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year reduced by a productivity adjustment factor. The single payment amounts are also adjusted for geographic area wage differences using the geographic adjustment factor (GAF). The GAF is a weighted composite of each PFS locality's physician work, practice expense (PE), and malpractice (MP) geographic practice cost index (GPCI). The GAF is updated at least every 3 years per statute and is implemented over a 2-year phase-in. The GPCIs were lasted updated in 2020 and are scheduled to be updated in the 2023 PFS proposed rule.

Application of the GAF is budget neutral so there is no overall cost impact. Proposed 2023 GAFs are not yet available, so CMS is not providing the proposed budget neutrality adjustment. CMS will include this information in a forthcoming change request to implement the 2023 home infusion therapy payment amounts.

CMS notes that the updated GAFs, national home infusion therapy payment rates, and locality-adjusted home infusion therapy payment rates will be posted on CMS' Home Infusion Therapy Services once these rates are finalized. In the future, CMS states it will no longer include a section in the HH PPS rule on home infusion therapy if no changes are being proposed to the payment methodology. Instead, the rates will be updated each year in a Change Request and posted on its website.

VI. Regulatory Impact Analysis

CMS estimates that the net impact of the HH PPS policies in this proposed rule is a decrease of 4.2 percent, or $810 million, in Medicare payments to HHAs for 2023. The overall impact of the changes in the HH PPS system on payments to HHAs in 2023 is summarized in the following table.

Summary of Overall Impact of Proposed HH PPS Changes		
Policy	**2023 impact**	
	Percentage	**Dollars**
HH PPS update	+ 2.9%	+$560 million
Permanent behavioral adjustment	-6.9%	-$1.33 billion
Updated FDL	-0.2%	-$40 million
Net impact	**-4.2%**	**-$810 million**

Table F5, reproduced below from the proposed rule, provides details on the impact by facility type and ownership, by rural and urban area, by census region and by facility size. The combined effects of all of the changes vary by specific types of providers and by location. It breaks out the payment effects of the permanent behavioral adjustment, the case-mix weights recalibration budget neutrality factor, the 2023 wage index update, the FDL update, and the 2023 update percentage. The permanent behavior adjustment impact reflected in column 3 does not equal the proposed -7.69 percent permanent behavior adjustment. CMS explains that the -6.9 percent reflected in column 3 includes all payments, while the proposed -7.69 percent behavior adjustment only applies to the national, standardized 30-day period payments and does not impact payments for 30-day periods that are LUPAs. Proprietary free-standing urban HH facilities (about 73 percent of all facilities) would experience an average decrease of payments of 4.4 percent. Voluntary/Non-profit HHAs would experience a 4.5 percent decrease. Government-based facilities would experience a 3.7 percent decrease.

CMS examined alternatives to the proposed -7.69 percent permanent payment adjustment, including a phase-in approach (spreading out over several years) or delaying the permanent adjustment to a future year. It believes that neither approach would be appropriate as the phase-in or delay would likely lead to the need for larger reduction to the payment rate in future years to maintain budget neutrality. It also considered proposing to implement the one-time temporary adjustment to reconcile retrospective overpayments in 2020 and 2021. It remains concerned, however, that implementing both the permanent and temporary adjustments to the 2023 payment rate may adversely affect HHAs given the potentially large reduction in payments in one year.

Table F5: Estimated HHA Impacts by Facility Type and Area of the Country, CY 2023

	Number of Agencies	Permanent Behavior Adjustment	CY 2023 Case-Mix Weights Recalibration Neutrality Factor	CY 2023 Updated Wage Index with 5-Percent Cap	CY 2023 Proposed HH Payment Update[2] Percentage	Fixed-Dollar Loss (FDL) Update	Total
All Agencies	**9,461**	**-6.9%**	**0.0%**	**0.0%**	**2.9%**	**-0.2%**	**-4.2%**
Facility Type and Control							
Freestanding/Other Vol/NP	928	-6.7%	0.1%	-0.5%	2.9%	-0.2%	-4.5%
Freestanding/Other Proprietary	7,703	-7.0%	-0.1%	0.2%	2.9%	-0.2%	-4.2%
Freestanding/Other Government	172	-6.8%	0.3%	0.1%	2.9%	-0.2%	-3.7%
Facility-Based Vol/NP	466	-6.5%	0.2%	-0.4%	2.9%	-0.3%	-4.1%
Facility-Based Proprietary	48	-6.9%	0.1%	-0.2%	2.9%	-0.2%	-4.3%
Facility-Based Government	144	-6.8%	0.2%	0.1%	2.9%	-0.2%	-3.8%
Subtotal: Freestanding	8,803	-7.0%	0.0%	0.1%	2.9%	-0.2%	-4.1%
Subtotal: Facility-based	658	-6.6%	0.2%	-0.3%	2.9%	-0.3%	-4.1%
Subtotal: Vol/NP	1,394	-6.7%	0.2%	-0.4%	2.9%	-0.3%	-4.2%
Subtotal: Proprietary	7,751	-7.0%	-0.1%	0.2%	2.9%	-0.2%	-4.2%
Subtotal: Government	316	-6.8%	0.2%	0.1%	2.9%	-0.2%	-3.8%
Facility Type and Control: Rural							
Freestanding/Other Vol/NP	221	-6.8%	0.2%	-0.4%	2.9%	-0.2%	-4.3%
Facility-Based Proprietary	32	-6.8%	0.1%	-0.3%	2.9%	-0.2%	-4.3%
Facility-Based Government	37	-6.9%	0.0%	-0.2%	2.9%	-0.2%	-4.4%
Facility-Based Vol/NP	204	-6.6%	0.3%	-0.3%	2.9%	-0.3%	-4.0%
Facility-Based Proprietary	16	-7.3%	0.2%	0.4%	2.9%	-0.1%	-3.9%
Facility-Based Government	107	-6.7%	0.4%	0.6%	2.9%	-0.3%	-3.1%
Facility Type and Control: Urban							
Freestanding/Other Vol/NP	707	-6.7%	0.1%	-0.5%	2.9%	-0.2%	-4.5%
Free-Standing/Other Proprietary	6,918	-7.0%	-0.1%	0.0%	2.9%	-0.2%	-4.4%
Free-Standing/Other Government	54	-6.9%	0.3%	-0.1%	2.9%	-0.2%	-4.0%
Facility-Based Vol/NP	262	-6.5%	0.2%	-0.4%	2.9%	-0.3%	-4.1%
Facility-Based Proprietary	32	-6.8%	0.1%	-0.3%	2.9%	-0.2%	-4.3%
Facility-Based Government	37	-6.9%	0.0%	-0.2%	2.9%	-0.2%	-4.4%
Facility Location: Urban or Rural							
Rural	1,451	-7.0%	0.1%	0.8%	2.9%	-0.2%	-3.4%
Urban	8,010	-6.9%	0.0%	-0.1%	2.9%	-0.2%	-4.3%
Facility Location: Region of the Country (Census Region)							
New England	327	-6.7%	0.1%	-1.0%	2.9%	-0.3%	-5.0%
Mid Atlantic	413	-6.8%	0.2%	-0.4%	2.9%	-0.2%	-4.3%
East North Central	1,553	-6.9%	-0.1%	-0.5%	2.9%	-0.2%	-4.8%
West North Central	610	-6.7%	-0.1%	-0.6%	2.9%	-0.3%	-4.7%
South Atlantic	1,568	-7.0%	0.0%	-0.5%	2.9%	-0.2%	-4.8%
East South Central	363	-7.2%	0.0%	1.1%	2.9%	-0.1%	-3.3%
West South Central	2,128	-7.0%	0.0%	1.2%	2.9%	-0.2%	-3.1%
Mountain	693	-6.8%	-0.1%	-0.3%	2.9%	-0.2%	-4.6%
Pacific	1,763	-6.9%	0.0%	0.5%	2.9%	-0.2%	-3.7%
Outlying	43	-7.0%	1.1%	-0.5%	2.9%	-0.2%	-3.7%
Facility Size (Number of 30-day Periods)							
< 100 periods	2,016	-6.9%	0.2%	-0.1%	2.9%	-0.2%	-4.1%
100 to 249	1,380	-6.9%	0.2%	0.1%	2.9%	-0.2%	-3.9%
250 to 499	1,671	-6.9%	0.0%	0.2%	2.9%	-0.2%	-4.0%
500 to 999	1,912	-6.9%	-0.1%	0.2%	2.9%	-0.2%	-4.1%
1,000 or More	2,482	-6.9%	0.0%	0.0%	2.9%	-0.2%	-4.2%