July 17, 2023 | Volume 48, Issue 28

Home Health Line

Regulatory news, benchmarks and best practices

Special Issue

decisionhealth
an hcpro brand

2024 proposed rule

CMS proposes 2.2% cut, changes to quality reporting, HHVBP measures

CMS is planning for a 2.2% reduction in home health payments in 2024, amounting to a $375 million reduction in payments overall when compared to 2023.

CMS released its payment projection June 30 in the 2024 proposed rule for the Home Health Prospective Payment System Rate Update. Providers have until August 29 to submit comments.

Industry leaders see the reduction in payments as another hurdle making it harder for homebound patients to get the care they need.

"Overall spending on Medicare home health is down, fewer patients are receiving care, patient referrals are being rejected because providers cannot afford to provide the care needed within the payment rates and providers have closed their doors or restricted service territory to reduce care costs," says William Dombi, president of the National Association for Home Care & Hospice (NAHC).

The payment decrease includes a permanent 5.65% cut in national, standardized 30-day period payments in response to behavioral adjustments due to utilization under PDGM.

According to CMS, the overall payment decrease reflects the effects of:

- A 5.1% decrease based on the permanent behavioral assumption adjustment, including LUPAs (a $870 billion decrease).
- A proposed increase of 2.7% in the home health payment update percentage (a $460 million increase).

- An estimated 0.2% increase that reflects the effects of an updated fixed-dollar loss ratio (FDL) used in determining outlier payments (a $35 million increase).

Payment adjustments for inflation are not keeping up with the real-world costs to providers, says Joanne Cunningham, CEO of the Partnership for Quality Home Healthcare.

"Agencies cannot absorb compounding cuts in this environment," she says. "This latest round of proposed cuts will further exacerbate an already fragile economic environment in the home health sector."

In the rule, CMS noted that there is still more than $3.4 billion that it expects to eventually claw bank from agencies for what it considers to be overpayments in the first three years under PDGM.

HHVBP measure changes

The rule proposes removing five measures from the Home Health Value-Based Purchasing model beginning in 2025.

The changes would align the measures used in the HHVBP model with the measures in the quality reporting program, CMS notes in the rule.

"This alignment will support comparisons of provider quality and streamline home health providers' data capture and reporting processes," CMS states.

If finalized, "Change in Mobility" and "Change in Self-Care," both based on M items, would be removed from the OASIS-based measures for HHVBP. They would be replaced with the new "Discharge Function Score" measure, based on GG items, that is proposed for inclusion in the HHQRP in the rule (*see story, p. 3*). Among the reasons, CMS notes that it's a single measure reflecting self-care and mobility, as opposed to two separate measures.

Agencies need to remember that these don't go into effect until 2025, so it's important to continue to focus on the measures that will currently impact HHVBP results, says Charles Breznicky, clinical director with SimiTree Healthcare Consulting in Hamden, Conn.

"Once this year wraps up, agencies should take the opportunity to evaluate how their field staff are conducting their assessments and develop strategies to improve the accuracy of these assessments," he says. "Starting in 2024, agencies can then begin to focus on the GG items."

"Discharged to Community" would be removed as an OASIS-based measure and it would be added as a claims-based measure.

The shift to the claims-based measure will expand the data used from one year to two years, CMS notes. It also aligns risk-adjustment, exclusions and measure intent with other post-acute settings.

The rule also would replace the claims-based "Acute Care Hospitalizations" and "Emergency Department Use Without Hospitalization" with the already collected "Potentially Preventable Hospitalization" (PPH) measure.

This change will be a bit more challenging for agencies, Breznicky says.

decisionhealth an hcpro brand

SUBSCRIBER INFORMATION

Have questions on a story? Call or email us.

EDITORIAL

Have questions on a story? Call toll-free: **1-855-CALL-DH1**

***HOME HEALTH LINE* TEAM**

Maria Tsigas, x6023
Product Director
mtsigas@decisionhealth.com

Megan Herr, x4062
Content Specialist
mherr@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@decisionhealth.com

Sarah Schock, x6033
Content Specialist
sschock@decisionhealth.com

Greg Hambrick X6024
Associate Content Manager
ghambrick@decisionhealth.com

Join our DecisionHealth — Home Care Matters community!

www.facebook.com/DecisionHealthPAC
www.twitter.com/DH_HomeCare
www.linkedin.com/groups/12003710

PLEDGE OF INDEPENDENCE

At DecisionHealth, the only person we work for is you, the provider. *Home Health Line* is not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the healthcare industry. For nearly three decades, we've been independently watching out for the financial health of healthcare providers, and we'll be there for you and your peers for decades to come.

WEBSITE

www.homehealthline.com

SUBSCRIPTIONS

Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email customer@decisionhealth.com.

ADVERTISING

To inquire about advertising in HHL, call Amy Roadman, 1-855-CALL-DH1 x8119.

Home Health Line is a registered trademark of DecisionHealth.
Home Health Line is published 48 times/year by
DecisionHealth, 5511 Virginia Way, Suite 150
Brentwood, Tennessee 37027. ISSN 0893-8121.
Price: $687/year. © 2023 DecisionHealth

decisionhealth an hcpro brand

"As of now, agencies can try to target patients with specific characteristics, such as clinical grouping or risk factors, and develop strategies to reduce hospitalizations for those patients," he says. With PPH, agencies are going to have to look at their overall hospitalization reduction strategy.

The rule would adjust the baseline year for HHVBP measures from 2022 to 2023 starting with the 2025 performance year.

CMS reminds providers that HHVBP performance data will be publicly reported on or after December 1, 2024.

Home health aide use questions

CMS also is seeking comments related to a continued decrease in home health aide services used as part of the home health benefit.

The total number of home health aide visits has dropped from 6.7 million in 2018 to 3.6 million in 2022, according to CMS.

"CMS wants to ensure that all Medicare beneficiaries receiving care under the home health benefit are afforded all covered services for which they quality," the rule states.

Questions posed in the rule seek to get provider and community feedback on potential reasons for the decline, including barriers to recruitment and retention, the impact of lower wages and the changing role that aides play in physician plans of care. — *Greg Hambrick* (*ghambrick@decisionhealth.com*) ■

More info: See the final rule at *https://tinyurl.com/3vckp5t8*.

Benchmark of the Week

National standardized 30-day period payment amount

After increasing in 2021 and 2022, the national average for the 30-day period payment amount is expected to see its second consecutive decrease in 2024.

2020	$1,864.03
2021	$1,901.12
2022	$2,031.64
2023	$2,010.69
2024	$1,974.38

Source: *2024 HHPPS Proposed Rule*

Proposed rule: Quality measures

New Discharge Function Score proposed for quality reporting

CMS is looking to add a new measure in the Home Health Quality Reporting Program (HHQRP) that will be based on how your patients improve on functional items during their home health stay.

Included in the proposed home health payment rule, the Discharge Function Score (DC Function) would measure the proportion of that agency's episodes where a patient's observed discharge score meets or exceeds his or her expected discharge score, CMS states.

If finalized later this year, the measure will be added to Care Compare in January 2025 and will replace two function-based measures in Home Health Value-Based Purchasing *(see story, p. 1)*.

"The good news is that organizations will get credit for the patients that stay the same or have improvement, so this also seems to be a move to give credit for the maintenance of function as well," adds Sherri Parson, chief compliance officer/director of operations with Infusion Health in Ypsilanti, Mich.

This measure determines how successful the agency is at achieving expected functional ability at discharge and provides actionable feedback to improve the quality of care delivered while eliminating any additional data collection, she says.

Measure provides meaningful info

This measure is to be calculated entirely using data already collected, meaning there will be no additional burden on agencies.

Functional status is measured through Section GG of OASIS assessments, which evaluates a patient's capacity to perform daily activities related to self-care (GG0130) and mobility (GG0170).

The expected discharge score will incorporate risk-adjustment controls, including admission function score, age and patient clinical characteristics.

The Discharge Function Score will give more meaningful information to CMS, Parson says.

"For years now, HHS and the National Academy of Science has identified the functional scores as indicators for poorer outcomes for patients," she says. "CMS

had told us last year that they had wanted to use the GG items in HHQRP and HHVBP but didn't have the data to do that due to so many not attempted codes."

CMS hopes this measure will promote wellness and encourage adequate therapy to help prevent rehospitalization and other adverse outcomes and increase the transparency of quality of care in the home health setting and across post-acute care.

In addition to adopting the DC Function measure, CMS is also proposing to remove the measure "Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function" (Application of Functional Assessment/Care Plan) from the HHQRP in CY2025. — *Megan Herr* (*mherr@decisionhealth.com*) ■

Editor's note: To view the CY2024 Home Health Prospective Payment System proposed rule, visit *https://tinyurl.com/3vckp5t8*.

Proposed rule: Hospice

Special focus program would take aim at poorly performing hospices

CMS' plan to target poor-performing hospices with the Hospice Special Focus Program (SFP) could have a big impact on providers not already focused on compliance and quality. But for those hospices that are already playing by the rules and meeting patient and caregiver needs, this may be welcome news.

The Home Health Prospective Payment System Rate Update proposed rule, released June 30, included an outline for the Hospice SFP, which involves increased monitoring for certain hospices, with the threat of potential removal from the Medicare program.

"The addition of the Special Focus Program will allow those who need to improve to be identified and given the opportunity [and assistance] to address concerns," says Joanne Ford RN CDP, director of hospice clinical operations at Corridor in Overland Park, Kan.

"For agencies providing quality care the SFP will be another opportunity to showcase their compliance with multiple standards that reflect high quality care," she says.

The proposed rule also calls for a Hospice Informal Dispute Resolution (IDR) process for condition-level deficiencies, similar to existing processes in home health. Both the SFP and IDR are expected to begin in 2024.

Check your HQRP data

CMS proposes to use the November 2023 HQRP data to determine the 2024 pool of SFP eligible hospices.

"This means the hospices HQRP performance prior to calendar year 2023 is considered," warns Katie Wehri, director of regulatory affairs at the National Association for Home Care & Hospice, based in Washington, D.C.

"Hospices will be able to see CMS' calculation of this HQRP data in August when the provider preview reports are made available to hospices and can review their own data now to see where they think they may fall," she continues.

While it may be too late for hospices to avoid being selected for the SFP, here are some tips to mitigate future risk, Wehri says:

- **Resolve complaints.** Hospices should work to ensure that they do not have any substantiated complaints or quality-of-care condition-level survey deficiencies.
- **Focus on quality of care.** Performance on the 11 quality-of-care conditions of participation is where hospices should be focused on right now.
- **Focus on low HQRP data.** Looking beyond 2024, hospices should review their HQRP data, especially if scores are low, and work on improving these.

"Focusing on best practices and measurable outcomes will put hospices in the best position for enactment of the Special Focus Program," Ford says.

An active quality program that evaluates root cause for areas of concern will be more critical than ever in preparing for the SFP, she says.

These are the same target areas agencies should be focusing on to prepare for surveys.

"If you prepare well for surveys now, it will keep you safe from the Special Focus Program," agrees Beau Sorensen, director of finance and operations at First Choice Home Health and Hospice in Orem, Utah.

CMS plans to publicly report general information about the SFP program and hospices selected for SFP, according to the proposed rule.

How will poor performance be measured in hospice SFP?

As proposed in the home health rule, the criteria for Special Focus Program (SFP) inclusion will involve hospice surveys and Hospice Quality Reporting Program data to determine poor performing hospices.

Specifically, CMS will be looking for quality-of-care condition-level deficiencies over the three previous years, as well as substantiated complaints in hospices surveys.

From Care Compare, CMS is focusing on five measures:

- Hospice Care Index overall score
- Help for Pain and Symptoms
- Getting Timely Help
- Willingness to Recommend this Hospice
- Overall Rating of this Hospice

As proposed, the results from all sources will factor into a single score for every hospice. SFP designation will be considered for the 10% of hospices with the worst scores. The exact number of hospices included in the SFP will be determined annually, according to CMS.

A hospice in the SFP would be surveyed "not less than once every six months," according to CMS, along with other progressive enforcement remedies, as appropriate.

Generally, a hospice would graduate out of the SFP if it has no condition-level deficiencies for any two SFP surveys in an 18-month period and if there is no pending complaint survey at an immediate jeopardy or condition level.

After completing the SFP, a hospice would receive a one-year post SFP survey and then would return to the regular 36-month cycle.

Hospices that fail any two SFP surveys or have a pending complaint investigation at the immediate injury or condition level would be considered for termination from the Medicare program. — *Greg Hambrick* (*ghambrick@decisionhealth.com*)

Dispute condition-level deficiencies

CMS is establishing the IDR to provide hospices with an avenue to informally dispute condition-level deficiencies. Remember in addition to hospices in SFP, this would be available to all hospices following a complaint or validation survey.

"The condition-level deficiencies may be an impetus for enforcement findings, so having this IDR process is important and has been one NAHC has requested of CMS for some time," Wehri explains.

The IDR process would be available for disputing condition-level deficiencies found during surveys — it cannot be used to appeal a hospices' designation as an SFP participant, according to the proposed rule.

There are several things hospices should keep in mind when submitting an IDR:

- **File the IDR in a timely manner.** Agencies will have just 10 calendar days to file an IDR after a survey deficiency is identified. The timeframe for filing an IDR request will be the same as it is for submitting a plan of correction, Wehri says.
- **File a plan of correction.** A plan of correction will still need to be filed and include a correction plan for the disputed deficiencies.
- **Be patient.** "Hospices should not count on a condition-level deficiency being overturned just because it is disputed and should not expect that the survey agency will be able to hold an IDR hearing immediately," Wehri warns. "It may take some time and the hospice may have to begin implementation of its plan of correction before an IDR hearing is held."
- **Involve legal counsel.** This is a legal process and an attorney can help you determine the value of your evidence and advise you on whether or not you should move ahead through the IDR process, Sorensen says.
- **Gather concise evidence.** Make sure your evidence is clear and directly talks about the deficiency at hand, instead of talking about things that aren't relevant, like quality of care, Sorensen recommends. "You're trying to overturn the initial ruling, and the best way to do that is to make sure your arguments are relevant and have evidence behind them."

  In order for the determination of the surveying body to be overturned, agencies will need to have a preponderance of evidence that tips the scales in their favor, such as evidence of bias or things surveyors may have missed, Sorensen adds.

It's important to note that the IDR process may not be used to delay the formal imposition of enforcement remedies (i.e. civil monetary penalties, directed plan of correction, etc.) or to challenge any other aspect of the survey process, Wehri explains.

The IDR process can, however, help minimize survey deficiencies by creating an opportunity to have condition-level survey deficiencies removed, she says.

"Hospices now have an opportunity to present their reasoning and evidence for why the citation should not have occurred and to do it with the survey agency instead of the surveyor making the citation," Wehri says. — *Sarah Schock* (*sschock@decisionhealth.com*) ■

Proposed rule: OASIS-E

CMS proposes new question for COVID-19, other OASIS-E updates

Agencies likely will have a new OASIS item in 2025 to track patients' COVID-19 vaccination status if proposed changes are finalized later this year.

The proposed OASIS item will measure whether a patient's COVID-19 vaccination is up to date, according to measure specifications shared with the 2024 proposed payment rule.

The proposed response options would be either:

- "0- No, patient is not up to date"
- "1- Yes, patient is up to date"

"I think the tracking of the COVID-19 vaccination status will become commonplace like the influenza vaccine status," says Lisa McClammy, senior clinical education consultant with MAC Legacy in Denton, Texas. "We have seen so many changes in our practice related to the COVID-9 pandemic, and tracking vaccination status may help identify trends in COVID-19 cases."

The information can be helpful in identifying vulnerable individuals and encouraging those individuals to keep their vaccination current, she adds.

This also will be useful for the agency to track any COVID-19 cases and trends, McClammy says.

Get ready for new OASIS item

While this COVID-19 vaccination item does not yet exist on the OASIS instrument, the item would be added to the OASIS by 2025 and collected at the transfer, discharge and death at home to capture this information across all Medicare-certified home health agencies, according to CMS.

Agencies would be able to use all sources of information available to obtain the vaccination data, such as patient interviews, medical records, proxy response and vaccination cards provided by the patient/caregivers.

With new OASIS comes new HHQRP measure

Data from the new OASIS item would feed the proposed quality measure, COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date" (Patient/Resident COVID-19 Vaccine), the proposed rule states.

The new COVID-19 vaccine measure would report the percentage of home health quality episodes in which patients were up to date with their COVID-19 vaccinations as defined by Centers for Disease Control and Prevention (CDC) guidelines on current vaccination.

According to the rule, the new measure would be publicly reported beginning with the January 2026 refresh of Care Compare, or as soon as technically feasible, and then updated quarterly.

The measure would use information from the OASIS to obtain raw rates of the number of home health quality episodes in which patients were up to date with their COVID-19 vaccination.

CMS plans to remove episode timing, therapy needs

CMS also proposes to remove two OASIS items, M0110 (Episode timing) and M2220 (Therapy Needs), effective Jan. 1, 2025.

Industry experts were happy to see the proposed changes for M0110 and M2200 as neither of those items have contributed to payment since PDGM took effect.

"It makes sense to eliminate M0110 since the data from this item are no longer used in payment, and many folks still remain confused with the changes in guidance between OASIS-D1 and OASIS-E," notes Ohio-based independent home health and coding expert Brandi Whitemyer. The OASIS-E manual is clear that this item is not used in the PDGM payment model, she says, with early/late determinations for PDGM claim payment only taken from claims.

M2200 (Therapy need) is also no longer used to affect payment with PDGM, and the current guidance allows for the agency to code this item as not applicable, notes McClammy, adding that she hopes the removal will help clear up any confusion.

"M2200 is almost impossible to get correct as it basically boils down to a guess and relies on best intentions,"

says Anna Powers, vice president of clinical services at HealthRev Partners in Ozark, Mo. "A patient's disease process or rehabilitation almost never follows the textbook, so it is hard to determine what their need will be. All we can do is make an educated guess." — *Megan Herr* (*mherr@decisionhealth.com*) ■

Editor's note: To view the CY2024 Home Health Prospective Payment System proposed rule, visit *https://tinyurl.com/bdzczcce*. View CMS' COVID vaccine measure specifications at *https://tinyurl.com/ᵊ38hswmnc*.

Medicaid

Stakeholder comments show concern for payment provisions

Industry leaders are concerned about CMS' plans for staff payment requirements and transparency provisions for Home and Community Based Services (HCBS) that were included in the Ensuring Access to Medicaid Services proposed rule.

Generally, there were mixed reactions to the proposed rule, according to some of the 2,235 comments submitted prior to the deadline July 3.

Many commentors made it clear that what is proposed will be unsustainable for many agencies, especially smaller and rural agencies.

The provision requires that at least 80% of Medicaid payments for personal care, homemaker and home health aide services be spent on compensation for direct care workers.

"Unfortunately, this aspect of the rule does not address the chronic underfunding of Medicaid HCBS and instead attempts to reallocate the use of current Medicaid reimbursements," writes the National Association for Home Care & Hospice (NAHC) and the Home Care Association of America (HCAOA) in a joint comment.

Previous efforts to enhance direct care worker (DCW) compensation included funding to support the HCBS system and ensure that the policy proposals were achievable. This will not be the case with this provision.

"It is therefore disappointing that this rule does not address the inadequacy of HCBS funding and instead would impose arbitrary limits on providers' administrative expenses – many of which are due to state and federal requirements and are not within the control of the providers themselves," continues NAHC and HCAOA in their comment.

The groups also took umbrage with CMS' definition of "overhead" costs as described in the rule.

"This is an unfair characterization that grossly misrepresents the forces driving home care agency expenditures and disregards the many state and federal regulations imposed upon HCBS providers," they write in the comment. NAHC and HCAOA propose that CMS consider a comprehensive list of overhead expenses included in their comment.

One size does not fit all

NAHC and HCAOA are not alone in thinking that this provision will unfairly affect smaller and rural agencies.

"Providers are different sizes and operate in different geographic areas, so a one-size-fits-all approach is not appropriate," wrote The American Health Care Association (AHCA) and National Center for Assisted Living (NCAL) in a joint comment.

Some states will also be more negatively impacted by this rule than others.

"We strongly believe that CMS' uniform approach is flawed and fails to take into account the unique challenges that different states face," writes Bobby Lolley, RN, executive director of the Home Care Association of Florida (HCAF).

For context, Florida's reimbursement rate for home health aide visits, at $18.04 per visit, is among the lowest in the nation, significantly lagging behind neighboring and other populous states, he notes.

Associations are also questioning the method used by CMS to determine the 80% rule.

"Of particular concern is the lack of data used to produce the calculation for an 80% payment threshold," write leaders of the Texas Association for Home Care and Hospice (TAHC&H) in their comment.

"Due to insufficient data and absent a full understanding of the state-by-state payment rate structures and regulatory requirements for these programs, it would be reckless of CMS to apply this mandate to states universally," TAHC&H continues.

"TAHC&H does not believe that mandating 80% of payment reimbursements to direct care workers

will ensure higher wages for workers. Instead we have serious concerns that this will force providers to make cuts to other essential programs, such as direct care worker support systems, day-to-day operations and processes, or alternatively, shut down entirely," the comment continues.

DCW reporting might be too burdensome

Commentors agree that there is a lack of consistent, reliable information regarding the Reporting on Proportion of Payments to DCWs *(42 CFR §441.311(e))*, however, many feel that this will place a time burden on agencies.

"We recognize and agree that there is a lack of consistent, reliable information regarding the proportion of Medicaid payments that are provided to DCWs as compensation. . . We therefore support the concept of increasing the availability and transparency of this information," writes NAHC and HCAOA.

However, there is concern that CMS is underestimating the amount of time that it will take agencies to collect and analyze this data.

"Adhering to the proposed reporting requirements in this section would require comprehensive Medicaid cost reporting in a manner that most providers are not currently able to provide," warns NAHC and HCAOA. "Significant administrative effort and expense would be necessary to collect this information, and we do not believe that it is feasible in the current Medicaid structure."

NAHC and HCAOA instead recommend that CMS commission national studies to evaluate existing Medicaid payment rates, current DCW payment rates and the proportion that are passed through to DCWs.

"Performing this type of analysis, using statistically significant national and state sample sizes, would provide a more achievable approach without the substantial burden on providers and states that would accompany an annual, universal, cost reporting mandate," they write in the comment.

Agencies support Medicaid rate transparency

One thing agencies overwhelmingly support in the comments is CMS' proposed transparency about payment rates.

CMS proposes to rescind *§ 447.203(b),* a provision requiring agencies to maintain documentation of payment rates and make it available to the U.S. Department of Health and Human Services upon request and replace it with new requirements to ensure fee-for-service Medicaid payment rate adequacy, including a new process to promote payment rate transparency.

"Requiring states to make consolidated, easy-to-understand information readily available will better inform the public, providers and participants about the payment rates for Medicaid services," write NAHC and HCAOA.

However, commentors also think that CMS needs to rethink the methodology behind disclosing payment rates.

"Just posting rates alone is not comparing apples to apples across states as definitions and service definitions may be different," writes TAHC&H in their comment.
— *Sarah Schock* (*sschock@decisionhealth.com*) ■

Benchmark of the Week

Breakdown of 30-day periods by PDGM clinical group

MS rehab saw a 1 percentage point climb in the distribution of 30-day periods among clinical groupings in 2022, according to CMS data shared in the 2024 proposed payment rule. Respiratory, which increased significantly since the start of the pandemic, had only a slight decrease in total periods.

Clinical grouping	2022	2021	2020	2019*
Behavioral health	2.3%	2.4%	2.3%	1.5%
Complex nursing	3.2%	3.3%	3.5%	3.3%
MMTA - Cardiac	17.9%	18.5%	18.9%	16.1%
MMTA - Endocrine	6.8%	6.9%	7.2%	17.4%
MMTA - GI/GU	4.9%	4.7%	4.7%	2.3%
MMTA - Infectious	4.6%	4.6%	4.8%	2.7%
MMTA - Other	3.5%	3.6%	3.1%	4.7%
MMTA - Respiratory	7.8%	8.0%	7.8%	4.1%
MMTA - Surgical aftercare	3.4%	3.4%	3.6%	1.8%
MS rehab	20.8%	19.8%	19.4%	17.3%
Neuro rehab	11.0%	10.9%	10.5%	14.5%
Wounds	13.7%	13.9%	14.2%	15.1%

**2019 numbers are based on CMS simulations of 30-day periods*