# Tips for Submitting Comments on Proposed Rule CMS-1766-P

(CY 2023 Home Health Prospective Payment System Proposed Rule)

The proposed Calendar Year 2023 Home Health Prospective Payment System proposed rule was published to the Federal Register on June 23, 2022. LeadingAge will be submitting comments on the proposed rule, and we encourage members to do so as well, paying particular attention to the behavioral assumptions CMS is using to cut payment. We have compiled the following tips and links to help. This document leads with a summary of the key components of the rule and is followed by some specific ideas about how to comment using your agency's unique data and experience.

## How to Write Your Comments

The first step is to introduce yourself, your home health agency, and sharing why this rule matters to you. You might share a little about the agency you work for, the beneficiaries and community you serve, or the job you do at the home health agency. Generally, it's best to share high level information and, if necessary, get appropriate permissions before sharing any identifying information. Don't feel obligated to comment on every aspect of the rule. Choose what matters most to you, whether that is 1 issue or 4 issues. Identify the issue, tell why you support or oppose the specific issue, and offer an alternative to issues you oppose. Explain how your alternative will help meet the same objective more effectively. Hit the sweet spot of concise and constructive. Provide enough information to make your point. Remember, you are shaping policy, not simply casting a vote.

***Why Your Comments Matter:*** In CY 2020, CMS initially proposed a -8.01% cut. After advocacy and comments from the field, CMS backed down and finalized a -4.36% cut.

## How to Submit Your Comments

Comments must be received by CMS by Tuesday, August 16, 2022, at 5pm ET. Remember to reference file code CMS-1766-P in your comments. Comments can be submitted 1 of 3 ways:

**Electronically:** Comments can be submitted electronically via the Federal Register. Access the rule here, then click on "Submit a Formal Comment" near the top of the page. You may type your comments directly into the text box, or you may attach a file containing your comments.

**By regular mail:** Comments may be submitted by mail and must be received before the close of the comment period. Mail written comments to:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1766-P

P.O. Box 8013
Baltimore, MD 21244-8050

**By express or overnight mail:** Comments may be submitted by express or overnight mail to:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1766-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

## Summary of Main Points of the Rule to Inform Comments

***Temporary Retrospective and Permanent Prospective Adjustment***
CMS conducted a required analysis of the new payment model to determine its budget neutrality in comparison to the expected Medicare spending on the previous payment model from CY2019. CMS determined aggregate Medicare expenditures for CY2020 and CY2021 exceeded their assumed behavioral changes. In order to meet the budget neutrality requirement, CMS contends that they need to implement both a temporary retrospective payment adjustment and a permanent prospective payment adjustment. To reconcile the differences between CY2020 and CY2021 assumed behavior vs. actual behavior, CMS would need to apply a -7.69% permanent adjustment to the CY2023 base payment rate in addition to a temporary adjustment of $2 billion to reconcile retrospective overpayments from the first two years of PDGM. As proposed, only the permanent adjustment would be implemented for CY2023 – CMS is taking comments on how to collect the retrospective overpayment.

CMS proposes to only apply the permanent adjustment of -7.69% to the CY2023 national, standardized 30-day period payment; the payment adjustment would not apply to periods that do not meet the Low Utilization Payment Adjustments (LUPA) threshold. CMS solicits comments on how to collect the temporary payment adjustment of $2 billion for CY2020 and CY2021. CMS is also open to additional empirical evidence to support COVID-19 PHE effects on provider behavior which may change the payment adjustments.

In addition to the proposed permanent negative adjustment, CMS proposes a 2.9 percent market basket increase for the home health payment update for CY 2023.

CMS estimates that the aggregate impact to home health agencies in CY2023 would be a decrease of -4.2%, or -$810 million compared to CY 2022. This decrease reflects the effects of the proposed 2.9% home health market basket update ($560 million increase), an estimated 6.9% decrease that reflects the effects of the proposed prospective permanent behavioral assumption adjustment of -7.69% ($1.33 billion decrease), and an estimated 0.2% decrease that reflects the effects of a proposed update to the fixed-dollar loss ratio (FDL) used in determining outlier payments ($40 million decrease) which is discussed in more detail below.

For HHAs that do not submit the required quality data for CY 2023, the home health payment update would be 0.9 percent (2.9 percent minus 2 percentage points). The proposed rule would also include a permanent 5-percent cap on wage index decreases.

***Reassignment of PDGM Diagnosis Codes***

CMS proposes make the following changes to clinical groupings and comorbidity subgroups:

- Reassign 320 diagnosis codes to different clinical groups when listed as a principal diagnosis
- Reassign 37 diagnostics codes to a different comorbidity subgroup when listed as a secondary diagnosis
- Removal of 159 ICD-10-CM diagnosis codes from being accepted as the principal diagnosis to "no clinical group" since each has another ICD-10-CM code which more clearly specified the diagnosis
- New comorbidity subgroup for certain neurological conditions related to non-diabetic neuropathy

These can be reviewed in Table 1.C of the CY 2023 Proposed Reassignment of ICD– 10–CM Diagnosis Codes supplemental file **here**.

**Proposed CY2023 PDGM LUPA Thresholds and PDGM Case-Mix Weights**

CMS proposes recalibration of the 432 case mix weights which is done annually to account for changes in case-specific resource and cost.

CMS is proposing to update the Low Utilization Payment Adjustment (LUPA) thresholds for CY 2023 using data from CY 2021. CMS did not find much variation in the updated LUPA thresholds.

- 280 case-mix groups had no change in their LUPA threshold
- 120 case-mix groups had their LUPA threshold go down by one visit
- 18 case-mix groups had their LUPA threshold go up by a visit
- 12 case-mix groups had their LUPA threshold go down by two visits
- 2 case-mix groups had their LUPA threshold go down by three visits

The proposed LUPA thresholds for the CY2023 PDGM payment groups with the corresponding Health Insurance Prospective Payment System (HIPPS) codes and the case-mix weights are listed in Table B26 **here**. If your agency had a higher number of LUPAs in specific case-mix groups, please tell CMS how these changes will positively or negatively impact your agency.

***Functional Impairment Level Changes***

CMS proposes to update OASIS functional points as follows:

- M1810: Current Ability to Dress Upper Body – Response 2 or 3 – decreased from 6 to 5 points
- M1820: Current Ability to Dress Lower Body – Response 2 – decreased from 5 to 4 points
- M1830: Bathing – Response 2 – increased from 2 to 1 point
- M1850: Transferring – Response 2, 3, 4 or 5 – decreased from 7 to 6 points
- M1860: Ambulation/Locomotion – Response 2 and 3 decreased by 1 point and response 4, 5 or 6 increased by 1 point
- M1033: Risk of Hospitalization – Four or more items – decreased from 12 to 10

The updated OASIS functional points table and the table of functional impairment levels by clinical group for CY2023 are listed in Tables B21 and B22 of the rule. Each of the 12 clinical groups' functional impairment levels decreased.

***Comorbidity Adjustment Subgroup Changes***

For CY 2023, CMS proposes to use the same methodology used to establish the comorbidity subgroups to update the comorbidity subgroups using CY2021 home health data. The comorbidity subgroups for CY2023 reflect the proposed coding changes detailed above and include:

- 23 low comorbidity adjustment subgroups as identified in Table B23
- 94 high comorbidity adjustment interaction subgroups as identified in Table B24

A full review of these adjustments, including the updated diagnosis codes in each subgroup, is available **here**.

***Collection of Data on Use of Telecommunications Technology under Medicare Home Health Benefit***

Currently, telecommunications technology is statutorily prohibited from being used as a substitute for in-person home health services; services provided using telecommunications technology (rather than in-person) are not considered a home health visit for the purposes of payment including meeting LUPA thresholds. In CY2022, CMS did finalize policy that allows for home health agencies to use telecommunications technology as part of the plan of care but not as a visit eligible for payment. 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 agency's administrative costs on line 5 of the HHA Medicare cost reports. In CY2019, CMS began factoring these costs into per visit costs.

Beneficiary level data on the uses of telecommunications technology during a 30-day period of care is not currently collected on the home health claim. Collecting this data on claims could allow CMS to analyze the characteristics of beneficiaries utilizing services furnished remotely and give a broader understanding of who benefits most from these services, including barriers to these services for certain subsets of beneficiary. In March 2022, MedPAC also recommended tracking the use of telehealth in home health care on claims to improve payment accuracy.

CMS recognizes the COVID-19 PHE has made significant changes in home health agencies' utilization of telecommunications technology and is therefore soliciting comments on the collection of such data on home health claims. CMS would aim to begin collecting voluntary data by January 1, 2023, and to require this information be reported on claims by July of 2023.

CMS is soliciting 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 requesting comments on whether there are other common uses of telecommunications technology under the home health benefit that would warrant additional G-codes. CMS stated they believe 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 is also soliciting comments regarding the appropriateness of such technology for particular services.

Additional instruction on how G-codes are to be used will be forthcoming, but each code will need to report services in line-item detail and each service must be reported as a separate line under the appropriate revenue code. While CMS does not plan on limiting the use of these G-codes to any particular discipline, they would not anticipate use of such technology would be reported under certain revenue codes such as the wound care.

Beginning July 1, 2023, CMS will solicit comments on future refinement of these G-codes. Specifically, whether the codes should differentiate the type of clinician performing the service via telecommunications technology (e.g., a therapist vs. therapist assistant) and whether new G-codes should differentiate the type of service being performed through the use of telecommunications technology (e.g., physical therapy for maintenance vs. other restorative physical therapy).

CMS clarified that this comment solicitation does not mean that telehealth services are considered "visits" for purposes of eligibility or payment. Additionally, data collected in this effort will not be used or factored into case-mix weights, count towards outlier payments, or the LUPA threshold per payment period.

***Changes to Home Health Quality Reporting Program***

CMS proposes to end the suspension of the collection of OASIS data on non-Medicare and non-Medicaid patients and require home health ageinces to report all-payer OASIS data for the purpose of the Home Health Quality Reporting Program (HHQRP) beginning in CY2025. CMS' goal is to have OASIS measures reported for all patients for all payer sources and improve the HHQRP ability to assess quality and foster better quality of care regardless of pay source. CMS is also interested in comparing standardized outcome measures across post-acute care settings in line with the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

This would mean for the CY2025 HHQRP, the expanded reporting would be required for all patients discharged between January 1, 2024, and June 30, 2024. For the CY2026 HHQRP, agencies would be required to report assessment-based quality measure data and standardized patient assessment data on all patients, regardless of payer, for the applicable 12-month performance period (patients discharged between July 1, 2024, and June 30, 2025).

CMS included statutorily required cost estimates for expanding the collection of OASIS for all home health patients regardless of payer, these costs are available at the end of the rule.

***Request for Information on Health Equity***

Based on the feedback received from the CY2022 HH PP final rule request for information on health equity, CMS is asking for public comment on specific work home health agencies conducted around health equity using the following questions:

- 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/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?

Additionally, CMS is considering a structural composite measure based on organizational activities to address access to and quality of home health care for underserved populations. CMS is interested in developing health equity measures based on information collected by home health agencies that is not currently available on claims, assessments, or other publicly available data.

Home health agencies could receive a point for each domain where data are submitted to a CMS portal, regardless of the action (such as training in culturally and linguistically appropriate services, health equity, and implicit bias). The data could reflect the home health agency's completed actions for each corresponding domain (for a total of three points, one per proposed domain) in a reporting year. A home health agency could also submit documentation, examples, or narratives to qualify for the measure numerator. CMS is also seeking comment on how to score a domain for a home health agency that submitted data reflecting no actions or partial actions in a given domain.

CMS is interested in public comments on publicly reporting a composite structural health equity quality measure, displaying descriptive information on Care Compare from the data home health agencies proved to support health equity measures, and the impact of the domains and quality measure concepts on organizational culture change. CMS is seeking comment on each of the domains being considered below, including specific suggestions on items that should be added, removed, or revised.

*Domain 1:* HHAs' commitment to reducing disparities is strengthened when equity is a key organizational priority. Candidate domain 1 could be satisfied if an HHA submits data on actions it is taking with respect to health equity and community engagement in their strategic plan. HHAs could report data in the reporting year about their actions in each of the following areas, and submission of data for all elements could be required to qualify for the measure numerator.

- HHAs attest to whether their strategic plan includes approaches to address health equity in the reporting year.

- HHAs report community engagement and key stakeholder activities in the reporting year.
- HHAs report on any attempts to measure input they solicit from patients and caregivers about care disparities they may experience as well as recommendations or suggestions for improvement.

*Domain 2:* Training HHA board members, HHA leaders, and other HHA staff in culturally and linguistically appropriate services (CLAS), health equity, and implicit bias is an important step the HHA can take to provide quality care to diverse populations. Candidate domain 2 could focus on HHAs' diversity, equity, inclusion training for board members and staff by capturing the following reported actions in the reporting year. Submission of relevant data for all elements could be required to qualify for the measure numerator.

- HHAs attest as to whether their employed staff were trained in culturally sensitive care mindful of SDOH in the reporting year. HHAs could report data relevant to this training, such as documentation of specific training programs or training requirements.
- HHAs attest as to whether they provided resources to staff about health equity, SDOH, and equity initiatives in the reporting year and report data such as the materials provided or other documentation of the learning opportunities.

*Domain 3:* HHA leaders and staff can improve their capacity to address health disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. This candidate domain could capture activities related to organizational inclusion initiatives and capacity to promote health equity. Examples of equity-focused factors include proficiency in languages other than English, experience working with diverse populations in the service area, and experience working with individuals with disabilities. Submission of relevant data for all elements could be required to qualify for the measure numerator.

- HHAs attest as to whether they considered equity-focused factors in the hiring of HHA senior leadership, including chief executives and board of trustees, in the applicable reporting year.
- HHAs attest as to whether equity-focused factors were included in the hiring of direct patient care staff (for example, therapists, nurses, social workers, physicians, or aides) in the applicable reporting year.
- HHAs attest as to whether equity focused factors were included in the hiring of indirect care or support staff (for example, administrative, clerical, or human resources) in the applicable reporting year.

***Changes to Expanded Home Health Value Based Purchasing Model***

CMS is proposing two key updates to the Home Health Value Based Purchasing (HHVBP) Model prior to the first year of data collection in CY2023 and is seeking feedback on how to incorporate health equity in future years of the model.

CMS proposes to change the baseline HHVBP year from CY2019 to CY2022 for the performance year starting in CY2023. This decision reflects the continuing effects of the COVID-19 public health emergency (PHE). CMS conducted a measure-by-measure comparison of performance for CY2019 to CY2021 for the expanded HHVBP Model's measure set relative to the historical trends of those measures. The two claims-based measures in the set (Acute Care Hospitalization During the First 60 Days of Home Health

Use measure and the Emergency Department Use without Hospitalization During the First 60 Days of Home Health measure) deviated significantly from previous trends with a drop of 9 percent and 15 percent in CY 2020, respectively, relative to CY2019 (Table D2 PGS. 139-140). Analysis also found measure averages remained lower in CY 2021 as compared to historic trends that occurred prior to the pandemic. In the five years prior to 2020, both measures demonstrated stable trends, varying +/- 5 percent from year to year, which highlights the significance of the change. These two measures alone make up 35 percent of the total performance score used to determine payment adjustments under the Model.

Based on these trends, CMS proposes to use CY2022 as the baseline year since it was the first year where the vast majority of beneficiaries were vaccinated and there were viable treatments available. Additionally, healthcare providers had nearly two years of experience managing COVID -19 patients.

However, because not all the CY2022 baseline data is available yet, CMS would not anticipate providing agencies with the final achievement thresholds and benchmarks until the July 2023 interim performance report (IPR). This is consistent with the rollout of the original HHVBP Model in which benchmarks and achievement thresholds using 2015 data were made available to agencies during the summer of the first performance year (CY2016).

As CMS continues to develop policies for the expanded HHVBP Model, they are requesting public comments on policy changes that to consider on the topic of health equity. Specifically, CMS is requesting comments on whether they should consider incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that agencies serve around the country and tie health equity outcomes to the payment adjustments they make based on agency performance under the Model. CMS provided several examples of how this could be implemented:

- Adjustments could be made at the measure level in forms such as stratification (for example, based on dual status or other metrics),
- New measures could be adopted around social determinants of health (SDOH).
- Adjustments could be incorporated at the scoring level in forms such as modified benchmarks, points adjustments, or modified payment adjustment percentages (for example, peer comparison groups based on whether the home health agency includes a high proportion of dual eligible beneficiaries or other metrics).

## Proposals for Consideration in Your Comments

Below LeadingAge has provided information on sections of the proposed regulations members may be interested in commenting on along with what specific questions and information they should provide in their comment letters to CMS.

***Proposed Payment Changes:*** LeadingAge encourages providers to use the following paragraphs to respond to CMS' behavioral assumption adjustments **in addition to** using agency specific data to highlight how CMS' assumptions do not apply to all agencies *[see the green box on page 10 for more details on structuring your agency's arguments]*.

CMS is required by Congress to annually adjust payments in home health to achieve budget neutrality. For CY2021 and CY2022, CMS decided not to conduct behavioral assessment due to the unknown impact of COVID-19. The statute is very clear and directs CMS to look at aggregate expenditures in home health. From their perspective, the statute leaves no room for risk adjustment for patient populations that have more acute needs such as dual eligible individuals.

The behavioral assumptions CMS used to calculate the devastating cuts in this proposed rule are erroneous and do not represent the work of nonprofit, mission-driven providers. Our nonprofit, mission driven agency is committed to making decisions based on clinical needs and quality outcomes – not, as CMS assumes, to make more money. Prior to Patient-Driven Groupings Model (PDGM) going into effect, industry surveys showed nonprofit providers made no plans to adjust their operations based on the change in payment, especially in regard to providing therapy visits.

The cost of doing business is rising as inflation drives up prices for all kinds of goods and services–like personal protective equipment, medical supplies, and other basics. Home health providers cannot cut PPE or wound care supplies from their budgets. The price of gas, which careworkers need to travel to appointments, has hit record highs. These rising expenses, coupled with a tight labor market, force providers to make hard decisions. CMS assumes a 2.9% inflation factor. Our members report that labor costs overall – including wage increases due to a competitive labor market, plus signing and referral bonuses – have risen well beyond 2.9%. Add significant hikes in the price of gas, personal protective equipment and other critical resources and supplies, and the impact of payment cuts becomes clear. They will be devastating.

Agencies are also increasingly serving complex Medicare beneficiaries, many of whom increased in acuity during the pandemic due to putting off preventative treatement and care during state mandated shutdowns. CMS has not accurately taken into account the increasing acuity of the home health population.

CMS has asked for feedback on the application of $2 billion temporary adjustment to all agencies. Any adjustments that do not include risk analysis and identification of the agencies with the most significant behavioral adjustments is inappropriate and will put underserved communities at risk. Correcting their own mistake by making funding cuts at a time when home health agencies are already in the red trying to pay for increased personal protective equipment, inflated staffing costs will not help improve quality of care for Medicare beneficiaries.

**USING YOUR AGENCY DATA EFFECTIVELY**

The key to responding to this proposed rule is contradicting CMS' behavioral assumptions. CMS' cuts are based on four behavioral assumptions of providers after PDGM implementation. Many agencies pay for data analytics tools, now is the time to use those to make your case. Below are examples of how you might use data to contradict CMS' broad brush stroke approach – but if your data shows something else compelling to contradict these assumptions, these are not the only points to make:

1. CMS Assumption: HHAs will change their coding and documenting practices to "up-code" a patient's primary diagnosis into a higher-paying clinical group.
   ***Sample Response: Our agency did not change diagnosis coding practices after the implementation of PDGM. Looking at our data from CY2019 compared to CY2020 and CY2021; we maintained the same diagnosis coding mix.*** **(INSERT DATA)**

2. CMS Assumption: HHAs would include more secondary diagnosis on claims, beyond the 6 typically allowed in the OASIS, to ensure comorbidity adjustments.
   ***Sample Response: Our agency did not change secondary diagnosis coding practices in order to ensure comorbidity adjustments. Based on our review of data from CY2019 compared to CY2020 and CY2021, we did not include more secondary diagnosis on claims.*** **(INSERT DATA)**

3. CMS Assumption: HHAs would work to avoid a third of LUPAs which were only 1 or 2 visits away from the LUPA threshold by providing an additional 1 or 2 more visits.
   ***Sample Response: CMS' data does not show a reduction in LUPAs for CY2020 and 2021; this is consistent with our agency's experience. (DISCUSSION OF PANDEMIC IMPACT ON LUPAs & INSERT RELEVANT LUPA RATE DATA)***

   ***Sample Response: CMS assumes that a reduction in LUPAs equates with behavior that needs to be factored into a behavioral adjustment. Our agency worked to reduce LUPAs by (INSERT AGENCY ACTIVITY) and it had positive impacts on patient care (PROVIDE EXAMPLES).***

4. CMS Assumption: HHAs decreased therapy visits in response to their reduction in payment.
   ***Sample Response: Our agency did not reduce therapy visits for patients. Our data shows from CY2019 compared to CY2020 and CY2021 we did not reduce therapy visits for patients.*** **(INSERT DATA)**

***Collection of Data on Use of Telecommunications in Home Health:*** CMS is soliciting comments on the use of three new G-codes identifying when home health services are furnished using the following technologies:

- 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).

As these G-codes are expected to be proposed by next year, LeadingAge urges providers to review and reasons to the request for information in the rule to help inform future rulemaking. As a reminder, this comment solicitation does not mean that telehealth services are considered "visits" for purposes of eligibility or payment.

**Among the many key factors CMS offers for consideration, providers may wish to provide feedback on the following topics based on their current use of telehealth and their patient population:**
*Telehealth Usage* - Are there other common uses of telecommunications technology that would need a G-Code to be captured on claims?

*Guardrails for Telehealth Usage* - Are there any home health services that technology would not be appropriate for (e.g., home health aide services, wound care)? Reporting on each G-code will require line-item detail including the revenue code, are there any revenue codes which should not reported using G-codes (e.g., wound care)?

*Specificity of Services* - Should the G-codes differentiate the type of clinician preforming the service via telehealth (e.g., a therapist vs. therapist assistant)? Should the G-codes differentiate the type of service being performed through the use of telecommunications technology (e.g., physical therapy for maintenance vs. other restorative physical therapy)?

***All Payer OASIS Collection in 2025:*** CMS proposes to end the suspension of the collection of OASIS data on non-Medicare and non-Medicaid patients and require home health ageinces to report all-payer OASIS data for the purpose of the Home Health Quality Reporting Program (HHQRP) beginning in CY2025.

**Providers may wish to contribute feedback on the following topics:**
1. Does your agency currently conduct OASIS on all patients regardless of payer?
2. What proportion of your episodes are for private insurance (non-Medicare, Medicaid, or related managed care)?
3. How significant a burden would adding OASIS for all patients regardless of payer?

***Home Health Value Based Purchasing Baseline Year Adjustment:*** LeadingAge encourages providers to comment in the following way to CMS' proposal to move the baseline year for the expanded Home Health Value Based Purchasing (HHVBP) model from CY2019 to CY2022.

**LeadingAge believes moving the demonstration initial start date back to CY2024 will provide a level playing field for all providers:**
The rule proposes to change the HHVBP baseline year from CY2019 to CY2022. While CMS' rationale for moving the baseline year to CY2022 is based on trends clearly showing the impact of COVID-19 on hospitalizations and ED visits for home health beneficiaries, not all the CY2022 baseline data is available yet. CMS would not anticipate providing agencies with the final achievement thresholds and

benchmarks until July 2023. CMS claims this is consistent with the rollout of the original HHVBP Model in which benchmarks and achievement thresholds were available during the summer of the first CY2016. However, in the origional model, providers only risked no payment adjustment in the first two years and CMS did not propose reducing the payment adjustment in this proposed rule. Given this is the first year of implementation is universal, unlike the original demonstration which only impacted providers in nine states, it seems prudent to delay the expansion of HHVBP for one year to ensure accuracy of baseline data and to create an even playing field for all providers.

***Home Health Value Based Purchasing and Health Equity:*** As CMS continues to develop policies for the expanded HHVBP Model, they are requesting public comments on policy changes on health equity. Specifically, CMS is requesting comments on whether they should consider incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that agencies serve around the country and tie health equity outcomes to the payment adjustments they make based on agency performance under the Model. CMS provided several examples of how this could be implemented.

**LeadingAge encourages providers to comment on which proposed adjustments might better support their patient populations:**

- Adjustments could be made at the measure level in forms such as stratification (for example, based on dual status or other metrics),
- New measures could be adopted around social determinants of health (SDOH),
- Adjustments could be incorporated at the scoring level in forms such as modified benchmarks, points adjustments, or modified payment adjustment percentages (for example, peer comparison groups based on whether the home health agency includes a high proportion of dual eligible beneficiaries or other metrics).

***Health Equity Request for Information****:* CMS is soliciting feedback from providers on how they integrate health equity efforts in their agency. CMS recently announced a Technical Expert Panel which will utilize this feedback to develop future quality metrics for home health as well as hospice agencies.

**Provide examples of how your home health agency works on health equity issues in your community by answering as many of the following CMS questions as you are able:**

- 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/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?

## Resources to Assist You as You Write

Find the proposed rule here.

Read the CMS fact sheet here.

Read the LeadingAge summary of provisions and analysis here.

Read LeadingAge's Home Health Member Network presentation here.

Read LeadingAge's talking points on the rule here.