Medicare Home Health
Prospective Payment System

2023 Proposed Payment Rule Summary by the Wisconsin Hospital Association

Overview and Resources

On June 17, 2022 the Centers for Medicare and Medicaid Services (CMS) released its proposed calendar year (CY) 2023 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The proposed rule includes updates to the Medicare fee-for-service (FFS) HH PPS payment rates based on changes set forth by CMS and those previously adopted by the US Congress. Among the proposed updates are:

- Recalibration of the Patient-Driven Grouping Model (PDGM) case-mix weights, LUPA thresholds, functional levels, and comorbidity adjustment subgroups;
- Payment adjustments to reflect the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate payment expenditures under the HH PPS;
- Creation of a permanent 5% cap on wage index decreases;
- Updates to the expanded HH value-based purchasing (VBP) program;
- Updates to the HH quality reporting program (QRP); and
- Updates to home infusion therapy rates.

A link to this proposed rule and other resources related to the HH PPS are available on the CMS website https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

An online version of this proposed rule is available at https://www.federalregister.gov/public-inspection/2022-13376/medicare-program-calendar-year-2023-home-health-prospective-payment-system-rate-update-home-health.

A brief summary of the proposed rule is provided below. Program changes proposed by CMS are effective for services provided on or after January 1, 2023, unless otherwise noted. CMS estimates the overall economic impact of this proposed payment rate to be a decrease of $810 million in aggregate payments to HHAs in CY 2023 over CY 2022.

Comments on the proposed rule are due to CMS by August 16, 2022 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "1766-P."

Note: Text in italics are extracted from the proposed rule published in the June 23, 2022 *Federal Register*.

HH PPS Payment Rates

Federal Register pages 37,614 – 37,620, 37,625 – 37,626, 37,640 – 37,651, and 37,653 – 37,657

The tables below show the proposed CY 2023 30-day standard payment rate compared to the final CY 2022 30-day standard payment rate and the components of the annual update factor:

	Final CY 2022	Proposed CY 2023	Percent Change
30-Day Period Standard Payment Rate	**$2,031.64**	**$1,904.76**	**-6.25%**

Proposed CY 2023 Update Factor Components	30-Day Standard Rate
Marketbasket (MB) Update	3.3%
Affordable Care Act (ACA)-Mandated Productivity MB adjustment	-0.4 percentage points (PPTs)
Permanent Behavior Assumption Adjustment	0.9231
Wage Index Budget Neutrality	0.9975
Case-Mix Weights Recalibration Budget Neutrality	0.9895
Overall Proposed Rate Update	**-6.25%**

The proposed marketbasket update percentage is based on IHS Global Inc.'s first-quarter 2022 forecast with historical data through fourth-quarter 2021.

Behavioral Assumptions and Adjustments

Federal Register pages 37,614 – 37,620

Starting in CY 2020, CMS was required to change the unit of payment from a 60-day episode to a 30-day period of care. Part of this statute required CMS to make assumptions about behavior changes that could occur as a result of implementing a 30-day unit of payment and case-mix adjustment factors that eliminated the use of therapy thresholds, when calculating the CY 2020 standard payment amount. These behavior assumptions were finalized in the CY 2019 HH PPS final rule with comment period, and are as follows:

- *"Clinical Group Coding: The clinical group is determined by the principal diagnosis code for the patient as reported by the HHA on the home health claim. This behavior assumption assumes that HHAs will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group.*
- *Comorbidity Coding: The PDGM further adjusts payments based on patients' secondary diagnoses as reported by the HHA on the home health claim. The OASIS only allows HHAs to designate 1 principal diagnosis and 5 secondary diagnoses while the home health claim allows HHAs to designate 1 principal diagnosis and up to 24 secondary diagnoses. This behavior assumption assumes that by considering additional ICD–10– CM diagnosis codes listed on the home health claim (beyond the 6 allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment.*
- *LUPA Threshold: This behavior assumption assumes that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.*

In the CY 2020 HH PPS final rule, CMS interpreted actual behavior changes to encompass these three assumptions, as well as any other behavior changes not identified at the time that the CY 2020 30-day payment rate was established.

CMS is required by law to determine the impact of differences between assumed and actual behavior on estimated aggregate expenditures, beginning in CY 2020 and ending with CY 2026, and make permanent and temporary adjustments as necessary through notice and rulemaking. In the CY 2022 HH PPS proposed rule, CMS sought comments on its repricing method for evaluating budget-neutrality when using CY 2020 claims data, with respect to behavior assumptions, as well as any alternate approaches to annually determine the difference between assumed and actual behavior changes and their effect on HH PPS expenditures. These comments are summarized on Federal Register pages 37,615 – 37,616. The methodology presented on Federal Register pages 37,616– 37,620 incorporates feedback from these comments.

CMS analyzed the CY 2020 and CY 2021 30-day payment rates to account for changes in actual versus assumed behavior that would have caused payments to be different than what were finalized for those two years. Based on claims data, CMS found that the CY 2020 30-day payment rate with actual behavior changes would be $1,742.52, compared to $1,864.03 when using the assumed behavioral changes that had been adopted in the CY 2020 final

rule. Using this new CY 2020 rate, CMS recalculated a CY 2021 30-day payment rate of $1,777.19, using the adopted update factors and with assumed behavior changes from the CY 2021 final rule. CMS then analyzed CY 2021 claims data to determine a 30-day payment rate of $1,754.99 to account for actual behavior changes, which is -7.69% lower than the adopted CY 2021 rate of $1,901.12. As a result, CMS proposes to apply a permanent adjustment of 0.9231 to the CY 2023 base payment rate to prevent a compounding effect which could create a need for larger reductions in future years.

CMS analysis also found that, due to the updating of these rates for actual behavior in CYs 2020-2021, estimated payments for these two years were higher than they should have been. CMS estimates the overpayments to be $873 million for CY 2020 and $1.148 billion for CY 2021, also accounting for budget neutrality, for a combined $2.021 billion in temporary payment reconciliation. In order to avoid significant negative adjustments in a single year, CMS is proposing to only implement the permanent adjustment to the 30-day rate and seeks comments on how to best implement the temporary reconciliation adjustment.

National Per-Visit Amounts

Federal Register pages 37,625 – 37,626, 37,640 – 37,650, and 37,655 – 37,657

CMS uses national per-visit amounts by service discipline to pay for "Low-Utilization Payment Adjustment" (LUPA) periods of care as well as to compute outliers. LUPA payments are made when the number of visits is less than the LUPA threshold for their PDGM classification. This threshold is set at either 2 visits, or the 10th percentile value of visits, whichever is higher. CMS typically uses the most current utilization data available to set LUPA thresholds at the time of rulemaking.

After reviewing home health claims for CY 2020 and CY 2021, CMS believes that visit patterns have stabilized and that CY 2021 patterns will be more indicative of visit patterns in CY 2023 compared to using CY 2018 data pre-PDGM. As such, CMS proposes to update LUPA thresholds using CY 2021 home health claims data. Of these thresholds, 280 case-mix groups will have no change in threshold, 120 groups will have their threshold go down by one visit, 18 will go up by one visit, 12 go down by two visits, and 2 go down by three visits. A list of all proposed LUPA thresholds can be found in Table B26 on *Federal Register* pages 37,640 – 37,650 and on the CMS website https://www.cms.gov/files/zip/cy-2023-proposed-pdgm-case-mix-weights-and-lupa-thresholds.zip.

As with previous years, per-visit rates are not calculated using case-mix weights and do not require a corresponding budget neutrality adjustment to ensure budget neutrality. Additionally, the proposed permanent behavior assumption adjustment would not be applied to per-visit rates.

Per-Visit Amounts	Final CY 2022	Proposed CY 2023	Percent Change	Proposed CY 2023 with LUPA Add-On *
Home Health Aide	$71.04	$73.04	+2.82%	N/A
Medical Social Services	$251.48	$258.57		N/A
Occupational Therapy (OT)	$172.67	$177.54		$296.49 (1.6700 adj.)
Physical Therapy (PT)	$171.49	$176.32		$294.45 (1.6700 adj.)
Skilled Nursing (SN)	$156.90	$161.32		$297.65 (1.8451 adj.)
Speech Language Pathology (SLP)	$186.41	$191.66		$311.75 (1.6266 adj.)

* For OT, PT, SN, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue to use the LUPA add-on factors established in the CY 2014 final rule.

The Consolidated Appropriations Act (CAA) of 2021 included a provision allowing occupational therapists to conduct initial and comprehensive assessments to home health beneficiaries. CMS will allow these assessments when the plan of care does not initially include SN, but does include PT or SLP. Due to this, CMS established a LUPA add-on factor to be used for payment for the first 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. In CY 2022 rule making, CMS

stated that due to insufficient data regarding initial and comprehensive visits conducted by occupational therapists, the PT LUPA add-on factor of 1.6700 would be used as an appropriate proxy for the OT add-on factor until there is sufficient data to create a distinct OT add-on factor. CMS estimates that CY 2022 data will need to be available before a distinct OT add-on factor can be established. As such, CMS proposes to continue to use the PT LUPA add-on factor as a proxy for OT for CY 2023.

Wage Index and Labor-Related Share

Federal Register pages 37,651 – 37,653, 37,653 – 37,654, 37,654 – 37,654, and 37,655

As has been the case in prior years, CMS proposes to use the most recent inpatient hospital wage index, which is the FFY 2023 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2023. The wage index is applied to the labor-related portion of the HH payment rate. CMS previously finalized that for CY 2019 and subsequent years that the labor-related share would be set at 76.1%. CMS is not making any proposal to change the labor-related share for CY 2023.

CMS proposes the wage index and labor-related share budget neutrality factors to be 0.9975 for the standard rate and 0.9992 for the per-visit rates for CY 2023 to ensure that aggregate payments made under the HH PPS are not greater or less than would otherwise be made if wage adjustments had not changed.

In the past, CMS implemented wage index transition policies with limited duration in order to phase in significant changes to labor market areas with the intent to mitigate short-term negative impact to affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of HH PPS payments, CMS is proposing to apply a 5% cap on any decrease of the CY 2023 HH PPS wage index, and all future HH PPS wage indexes, compared with the previous year's final wage index. The cap is proposed to be applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if a HHA's prior CY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the HHA's capped wage index in the prior CY.

A complete list of the wage indexes proposed for CY 2023 is available on the CMS website at https://www.cms.gov/files/zip/cy-2023-proposed-hh-pps-wage-index.zip.

Patient-Driven Grouping Model (PDGM)

Federal Register pages 37,604 – 37,614, 37,620 – 37,625, and 37,626 – 37,651

CMS assigns HH stays into PDGM 30-day period of care groupings that are consistent with how clinicians differentiate between patients and the primary reason for needing home health care. Case-mix adjustments for home health payment are based solely on patient characteristics, relying more heavily on clinical characteristics and other patient information to place patients into 432 clinically meaningful payment categories.

Each year CMS recalibrates the PDGM case-mix weights to ensure that the case-mix weights reflect current home health resource use and change in utilization patterns. For CY 2023, CMS proposes to recalibrate case-mix weights based on data from CY 2021 as CMS believes that CY 2021 would be reflective of PDGM utilization and patient resource use. Compared to CY 2022 weights, 421 groups will see a +/- 5% difference, 10 groups will change between +5% and +10%, and 1 group will see a change of over +10% for CY 2023. A budget neutrality factor of 0.9895 is proposed to be applied to the standardized 30-day period payment rate to ensure that PDGM case-mix weights are implemented in a budget neutral manner.

CMS proposes to reassign 320 ICD-10-CM diagnosis codes to a different clinical group when listed as a principal diagnosis and 37 diagnosis codes to a different comorbidity subgroup when listed as a secondary diagnosis. Along with these reassignments, CMS proposes to establish a new comorbidity subgroup for certain neurological conditions and disorders. Based on a review of diagnosis codes where "unspecified" is used due to a lack of

information about location or severity of medical conditions, CMS is also proposing to reassign 159 codes to "no clinical group" as CMS believes that these 159 codes are not acceptable as principle diagnoses and that the reassignment will result in the most precise code being used. CMS also proposes the following reassignments of ICD-10-CM codes:

- code B78.9 strongyloidiasis, unspecified to be reassigned to clinical group K (MMTA - Infectious Disease,
- Neoplasms, and Blood-Forming Diseases) to be consistent with other strongyloidiasis codes;
- 144 diagnosis codes related to gout which have an anatomical site specified but not assigned to a clinical group to be reassigned to clinical group E (Musculoskeletal Rehabilitation);
- 12 diagnosis codes related to crushing injury of the face, skull, and head to be reassigned to clinical group B (Neurological Rehabilitation) due to being more consistent with other diagnosis codes in clinical group B; and
- 3 diagnosis codes related to lymphedema to be reassigned to clinical group C (Wounds) due to similarities these three codes have to diagnosis codes already in clinical group C.

Details on these proposed reassignments can be found in a supplemental file on the HH PPS webpage https://www.cms.gov/files/zip/cy-2023-proposed-reassignment-icd-10-cm-diagnosis-codes-hh-pdgm-clinical-groups-and-comorbidity.zip.

For CY 2023, CMS proposes to update functional impairment levels and functional points by clinical group using CY 2021 claims data. Tables B21 and B22 in *Federal Register* pages 37,627 – 37,628 show the proposed Outcome and Assessment Information Set (OASIS) points and thresholds for functional levels by clinical group, respectively, for CY 2023. CMS also proposes to update the comorbidity adjustment applicable to 30-day periods of care to include 23 low comorbidity adjustment subgroups and 94 high comorbidity subgroups. These groups are listed on tables B23 and B24, respectively, on *Federal Register* pages 37,630 – 37,637.

The proposed case-mix weights for CY 2023 are listed in Table B26 on *Federal Register* pages 37,640 – 37,650 and on the CMS website https://www.cms.gov/files/zip/cy-2023-proposed-pdgm-case-mix-weights-and-lupa-thresholds.zip.

Outlier Payments

Federal Register pages 37,657 – 37,658

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever an HHA's cost for an episode of care exceeds a fixed-loss threshold, defined as the HH PPS payment amount for the episode plus a fixed dollar loss (FDL) amount.

Currently, there is a cap of 8 hours or 32 units per day (1 unit = 15 minutes), summed across the six disciplines of care, on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier. The discipline of care with the lowest associated cost per unit is first discounted in the calculation of episode cost, in order to cap the estimation of an episode's cost at 8 hours of care per day.

The FDL amount is an FDL ratio multiplied by the wage index-adjusted 30-day period payment. This is added to the HH PPS payment amount for that episode. If calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments is set aside for outliers. CMS is proposing a FDL ratio of 0.44 for CY 2023, based on CY 2021 data.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

Federal Register pages 37,666 – 37,672

On January 8, 2021, CMS announced the certification of the HHVBP for national expansion as well as its intent to expand the model through notice and comment rulemaking. In the original model, CMS implemented an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, which started January 1, 2016 and concludes December 31, 2022, with the last year of data collection having ended on December 30, 2020.

The Medicare-certified HHAs required to participate in the original demonstration are from 9 randomly selected states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. The demonstration program resembles the VBP Program for inpatient acute care hospitals. CMS found that this model resulted in an average 4.6% improvement in HHA quality scores while also saving Medicare an average of $141 million annually without denying or limiting coverage to beneficiaries.

CMS will expand the HHVBP model to all 50 states, the District of Columbia (DC), and all territories, starting in CY 2023, and it will be budget neutral by cohort. Based on comments received, CMS previously finalized that CY 2025 will be the first payment year with payment adjustments made based on CY 2023 performance for all HHAs certified before January 1, 2021, based on CMS Certification Numbers (CCN). CY 2022 is a pre-implementation year which will allow HHAs to prepare and learn about the model with support from CMS. Each HHA will have a reduction or increase to their Medicare payments by up to 5%, dependent on their performance on specified quality measures relative to other similar, competing HHAs.

CMS is proposing to remove the existing baseline year definition: *"…the year against which measure performance in a performance year will be compared."* This definition would be replaced by two proposed definitions in an effort to lessen the confusion between the two types of baseline years used in the expanded HHVBP Model:

- HHA baseline year: *"…the calendar year used to determine the improvement threshold for each measure for each individual competing HHA…"*
- Model baseline year: *"…the calendar year used to determine the benchmark and achievement threshold for each measure for all competing HHAs."*

Performance Standards and Scoring

Federal Register pages 37,668 – 37,671

For HHAs certified by Medicare before January 1, 2019 and for HHAs certified during January 1, 2019 – December 31, 2021, CMS is proposing to change the HHA baseline year for all applicable measures used in the expanded Model, from CY 2019 and CY 2021 respectively, to CY 2022 beginning with the CY 2023 performance year. For any HHA certified on or after January 1, 2022, CMS proposes that the HHA baseline year be the first full CY of services beginning after the date of Medicare certification and the first performance year is the first full CY following the HHA baseline year. If this proposal is finalized, CMS intends to make HHA baseline data available as soon as administratively possible and would anticipate providing HHAs with their final individual improvement thresholds in the summer of CY 2023.

Medicare Certification Date	HHA Baseline CY	Performance CY	Payment CY
Prior to January 1, 2019	**2022**	**2023**	**2025**
January 1, 2019 - December 31, 2021	**2022**	**2023**	**2025**
January 1, 2022 – December 31, 2022	**2023**	**2024**	**2026**
January 1, 2023 – December 31, 2023	**2024**	**2024**	**2027**

Consistent with the proposal to update the HHA baseline year for HHA certified by Medicare prior to January 1, 2022, CMS is also proposing the change the Model baseline year from CY 2019 to CY 2022 for the CY 2023 performance year. If this proposal is adopted, CMS expects that HHAs would receive their final achievement thresholds and benchmarks in the July 2023 IPR in the summer of CY 2023.

Health Equity in the Expanded HHVBP Model – Request for Comments

Federal Register pages 37,671 – 37,672

CMS is requesting comments on what policy changes should be considered for incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that HHAs serve and tie health equity outcomes to the payment adjustments made based on HHA performance under the Model.

HH Quality Reporting Program (HH QRP)

Federal Register pages 37,659 – 37,666

CMS collects quality data from HHAs on processes, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

Summary Table of Measure Currently Adopted for the CY 2023 HH Quality Reporting Program	
Measures	**Data Source**
Improvement in Ambulation/Locomotion (NQF #0167)	OASIS
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	OASIS
Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	OASIS
Improvement in Bathing (NQF #0174)	OASIS
Improvement in Bed Transferring (NQF #0175)	OASIS
Drug Regimen Review Conducted with Follow-Up for Identified Issues - Post Acute Care (PAC) HH QRP	OASIS
Improvement in Dyspnea	OASIS
Influenza Immunization Received for Current Flu Season	OASIS
Improvement in Management of Oral Medications (NQF #0176)	OASIS
Changes in Skin Integrity Post-Acute Care	OASIS
Timely Initiation Of Care (NQF #0526)	OASIS
Transfer of Health Information to Provider-Post-Acute Care	OASIS
Transfer of Health Information to Patient-Post-Acute Care	OASIS
Acute Care Hospitalization during the First 60 Days of HH (NQF #0171)	Claims-based
Discharge to Community-Post Acute Care (PAC) Home Health (HH) Quality Reporting Program (QRP) (NQF #3477)	Claims-based
Emergency Department Use without Hospitalization during the First 60 Days of HH (NQF #0173)	Claims-based

Total Estimated Medicare Spending Per Beneficiary (MSPB)—Post Acute Care (PAC) HH QRP	Claims-based
Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program	Claims-based
Home Health Within Stay Potentially Preventable Hospitalization	Claims-based
How well did the home health team communicate with patients	HHCAHPS
How do patients rate the overall care from the home health agency	HHCAHPS
How often the home health team gave care in a professional way	HHCAHPS
Did the home health team discuss medicines, pain, and home safety with patients	HHCAHPS
Will patients recommend the home health agency to friends and family	HHCAHPS

CMS is proposing to end the suspension of non-Medicare/Medicaid OASIS data collection for purposes of the HH QRP. If adopted, all HHA's would be required to submit all-payer OASIS data beginning with the CY 2025 QRP program year, and would be phased in in two parts. For the CY 2025 HH QRP, reporting would be required for all patients discharged between January 1, 2024 and June 30, 2024. Beginning with the CY 2026 HH QRP, HHAs would be required to report OASIS data on all patients, regardless of payer, discharged during the applicable 12-month performance period (July 1, 2024 – June 30, 2025)

Request for Information – Health Equity in the HH QRP

Federal Register pages 37,664 – 37,666

CMS is seeking public comment on the following questions in an effort to advance health equity within the HH QRP for all patients 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:

- *"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 adopting a structural composite measure for the HH QRP that could include organizational activities to address access to and quality of HH care for underserved populations. The three domains under consideration for such a measure are on Federal Register pages 37,665 – 37,666.

Home Infusion Therapy Services – Annual Payment Updates

Federal Register pages 37,672 – 37,673

National home infusion therapy (HIT) services payment rates for initial and subsequent visits in each of the HIT payment categories for CY 2023 are required to be the CY 2022 rate adjusted by the percentage increase in the Consumer Price Index for all urban consumers for the 12-month period ending with June of the preceding year, which is then reduced by a productivity adjustment. These payment amounts are then adjusted using the

geographic adjustment factor (GAF). The GAF is a weighted composite of each region's Geographic Practice Cost Indices (GPCIs) which include work, practice expense (PE), and malpractice (MP). The GAF is calculated as:

$$GAF = (0.50886\ x\ Work\ GPCI) + (0.44839\ x\ PE\ GPCI)\ +\ (0.04295\ x\ MP\ GPCI).$$

The next full update to GPCIs and the GAFs will be in the CY 2023 Physician Fee Schedule (PFS) proposed rule. Once the CY 2023 PFS proposed rule is published in the Federal Register, a list of proposed GAFs can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched.

In future years, CMS will not include a section in the HH PPS rule on home infusion therapy if no changes are being proposed to the payment methodology. Rates will instead be updated each year in a change request and posted on the HIT website.

Data on the Use of Telecommunications Technology under the Medicare Home Health Benefit – Request for Comment

Federal Register pages 37,658 – 37,659

CMS believes that collecting data on the use of telecommunications technology on home health claims would allow for analysis of the characteristics of the beneficiaries utilizing remotely furnished services, including a broader understanding of the social determinants that affect who benefits most from these services and any barriers that may exist for subsets of beneficiaries. Additionally, in their March 2022 Report to the Congress, MedPAC recommended tracking the use of telehealth on home health claims in order to impact payment accuracy. As such, CMS is soliciting comments on the collection of such data on home health claims with a targeted start date for collection of January 1, 2023. This collection would begin on a voluntary basis, and would then become a reporting requirement by July 2023.

CMS is also soliciting comments on how appropriate the use of telecommunications technology would be for certain home health services, noting that such services would not be considered "visits" for purposes of eligibility or payment. CMS believes that certain forthcoming G-codes do not lend themselves to the use of this technology, due to the hands-on nature of the services. For other services, CMS intends to use comments received in order to clearly delineate when the use of such technology would be appropriate.

Lastly, CMS is soliciting comments on future refinement of these G-codes beginning July 1, 2023. Specifically, whether these codes should differentiate the type of clinician performing the service via telecommunications and whether these codes should differentiate the type of service being performed.

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