PREPARE FOR THE FUTURE

7 Things Changing in Healthcare 2023 You Should Know About

By The Remington Report Editorial Team

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Hospitals: New Social Determinants of Health Quality Measure: Starts 2023

Hospitals will be required to report what portion of their population is screened for various social determinant of health (SDOH) and how many screen positive in each category. CMS's new SDOH quality measures were published in the 2023 Medicare Hospital Inpatient Prospective Payment System rule, released on August 1.

Hospitals will capture screening and identification of patient-level, health-related social needs—such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

For greater insights into the SDOH quality measure, click here.

Health Plans: 2023 Social Determinants of Health Quality Measure Begin

The National Committee for Quality Assurance announced new and revised quality measures for health plans in the Healthcare Effectiveness Data and Information Set (HEDIS) for the measurement year 2023.

One of those measures is Social Need Screening and Intervention (SNS-E). The goal of this measure is to identify and address members' social determinants of health needs and to encourage health plans to assess and address the food, housing, and transportation needs of their patient populations. The screening looks at food, housing, and transportation needs. This measure helps health plans identify specific needs and connect members with resources necessary to address unmet social needs.

CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set

CMS released the first-ever Home-and Community-Based Services (HCBS) quality measure set to promote consistent quality measurement within and across state Medicaid HCBS programs. The measure set is intended to provide insight into the quality of HCBS programs and enable states to measure and improve health outcomes for people relying on long-term services and support (LTSS) in Medicaid.

The release of this voluntary measure set is also a critical step to promoting health equity among the millions of older adults and people with disabilities who need LTSS because of disabling conditions and chronic illnesses.

Nationally, over 7 million people receive HCBS under Medicaid, and Medicaid-funded HCBS accounts for $125 billion annually in state and federal spending. Implementation of the HCBS quality measure set will create opportunities for CMS

and states to promote more consistent use, within and across states, of nationally standardized quality measures in HCBS programs to promote health equity and reduce disparities in health outcomes among this population.

To review the HCBS quality measure, click here.

Medicare Managed Care Organizations: Federal and State Regulations for SDOH Screening and Technology Usage

States are increasingly requiring MCOs to incorporate methods to identify SDOH needs in screenings, covering areas such as housing, employment status, food insecurity, physical safety, and transportation needs. Additionally, some states are contractually requiring MCOs to either encourage or require their provider networks to incorporate SDOH needs screening into their practices. Louisiana and Ohio require MCOs to reimburse providers for SDOH screening and submitting applicable diagnosis codes (Z codes) on claims.

Main Trends in SDOH State Requirements

- Many states are requiring MCOs or provider networks to screen enrollees for SDOH needs.
- States are increasingly requiring MCO care management programs to incorporate SDOH, to coordinate with community-based organizations and to ensure referrals to social services and supports.
- Recent RFPs have included requirements that MCOs incorporate SDOH into their quality assessment and performance improvement (QAPI) programs and that MCOs provide SDOH training for staff.

The Bundled Payment Pilot Extended By 2 years

On October 13, 2022, CMS announced that the Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model will be extended for two years. The BPCI Advanced Model, which launched on October 1, 2018, was set to end on December 31, 2023, and will now conclude on December 31, 2025.

A bundled payment methodology involves combining the payments for physician, hospital, and other healthcare provider services into a single bundled payment amount.

BPCI Advanced is an Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program and tests whether linking payments for an episode of care will incentivize healthcare providers to invest in practice innovation and care redesign to improve care coordination and reduce expenditures while maintaining or improving the quality of care for Medicare beneficiaries

As of December 31, 2021, more than 1.2 million Medicare beneficiaries have received care from Participants in the BPCI Advanced Model, and over 1,800 Acute Care Hospitals (ACHs) in coordination with 69,867 physicians have engaged in care redesign activities because of participation in the BPCI Advanced Model.

Overall, in the first two model years, Medicare providers and suppliers in the BPCI Advanced Model have lowered healthcare spending without reducing quality.

For more details on the Bundled Payment Initiative, click here.

Medicare Advantage Value-Based Insurance Design Model VBID Hospice Benefit in 2023

The Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model tests a broad number of complementary MA health plan innovations designed to reduce Medicare program expenditures.

For the plan year 2023, the VBID Model has 52 participating Medicare Advantage Organizations (MAOs) with a total of 9.3 million enrollees projected to be enrolled in participating plan benefit packages (PBPs). More than six million of these enrollees are projected to receive additional Model benefits and/or rewards and incentives as part of the Model test in 2023.

Of the 52 MAOs participating in 2023, 15 are participating in the Hospice Benefit Component, six more than in 2021 and two more than in 2022. These 15 organizations will test the inclusion of the Part A hospice benefit in MA benefits through 119 PBPs (up from 53 PBPs in 2021 and 115 PBPs in 2022) and in 806 counties (up from 206 counties in 2021 and 461 counties in 2022).

In participating in this voluntary Model component, MAOs are incorporating the Medicare hospice benefit into MA-covered benefits while offering comprehensive palliative care services outside the hospice benefit for enrollees with serious illness.

In addition, participating MAOs can provide individualized, clinically appropriate transitional concurrent care through in-network providers and offer hospice-specific supplemental benefits. Each participating MAO prepared health equity plans on how they will address potential inequities and disparities in access, outcomes, and/or enrollee experience of care as it relates to their participation in the Hospice Benefit Component.

For additional information on the VBID model, click here.

The Expanded HHVBP Model

The expanded HHVBP Model began on January 1, 2022, and includes Medicare-certified HHAs in all 50 states, District of Columbia, and the U.S. territories. Calendar Year 2022 is the pre-implementation year.

The first full performance year for the expanded HHVBP Model is CY 2023, beginning January 1, 2023. Calendar Year 2025 will be the first payment year, with payment adjustment amounts determined on CY 2023 performance.

Data from the Outcome and Assessment Information Set, completed Home Health Consumer Assessment of Healthcare Providers and Systems surveys and, claims-based measures are used to calculate HHAs' performance.

For additional information on HHVBP, click here.