Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2024

MEDICARE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Overview and Resources

On June 26, 2024, the Centers for Medicare & Medicaid Services (CMS) released its proposed calendar year (CY) 2025 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. CMS estimates the overall economic impact of this proposed rule to be a decrease of $280 million in aggregate payments to Home Health Agencies (HHA) in CY 2025 over CY 2024, which includes a $595 million decrease due to the proposed permanent behavior adjustment and a $100 million decrease due to the proposed fixed-dollar loss (FDL) amount for outlier payments. Among the proposed updates are:

- Recalibration of the Patient-Driven Groupings Model (PDGM) case-mix weights, low utilization payment adjustment (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;
- Updating area wage indexes using county and Core-Based Statistical Area (CBSA) delineations based on Office of Management and Budget (OMB) Bulletin No. 23-01;
- Updates to the HH quality reporting program (QRP);
- Payment rates for the administration of Home Intravenous Immune Globulin (IVIG) items and Services;
- Updating HHA Conditions of Participation (CoP); and
- Long-Term Care (LTC) Requirements for Acute Respiratory Illness Reporting.

A link to this proposed rule and other resources related to the HH PPS are available on the CMS website. An online version of this proposed rule is available here. Comments on the proposed rule are due to CMS by August 26, 2024 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1803-P".

HH PPS Payment Rates

The tables below show the proposed CY 2025 30-day standard payment rate compared to the final CY 2024 30-day standard payment rate and the components of the annual update factor:

	Final CY 2024	Proposed CY 2025	Percent Change
30-Day Period Standard Payment Rate	**$2,038.13**	**$2,008.12**	**-1.47%**

Proposed CY 2025 Update Factor Components	**Change to 30-Day Standard Rate**
Market Basket (MB) Update	3.0%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.5 percentage points (PPT)

Permanent Behavior Assumption Adjustment	0.95933
Wage Index and Labor-Related Share Budget Neutrality	0.9985
Case-Mix Weights Recalibration Budget Neutrality	1.0035
Overall Proposed Rate Update	**-1.47%**

The proposed market basket update percentage is based on IHS Global Inc.'s 1Q 2024 forecast with historical data through 4Q 2023.

Behavioral Assumptions and Adjustments

The Consolidated Appropriations Act (CAA) of 2023 requires CMS 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. CMS is also required to provide both the data sets underlying the simulated 60-day episodes as well as time in order for stakeholders to make comments on the development of the HH PPS payment rate.

In the CY 2023 HH PPS final rule, CMS adopted the methodology to determine the impact on estimated expenditures between assumed and actual behavioral changes, which are used for evaluating the budget neutral 30-day payment rates for CYs 2020-2026 under the PDGM. These rates will be compared to what they would have been under the 153-group case-mix system and 60-day unit of payment that was in place prior to the establishment of the PDGM.

Due to an update of the OASIS instrument, CMS is proposing to add two assumptions when creating simulated 60-day episodes from 30-day periods. After analyzing 30-day payment rates for CYs 2020–2022 to account for changes in actual versus assumed behavior, CMS found that the rates should have been lower than the adopted rate (which was calculated using assumed behavior). Therefore, in CYs 2023 and 2024 CMS applied permanent adjustments of -3.925% and -2.890%, respectively, which amounted to half of the estimated required adjustment for each year to achieve parity with the 60-day episode payment rates.

Using this same methodology with CY 2023 claims, CMS has determined that the 30-day base payment rate for CY 2023 should have been $1,873.17 based on actual behavior, rather than the finalized rate of $2,010.69 based on assumed behaviors (which included the -3.925% adjustment applied to the CY 2023 payment rate). This results in an updated total permanent adjustment of -6.839% that would need to be applied to the CY 2025 payment rate to account for expenditures for CYs 2020-2023. Since a portion of this adjustment has already been accounted for in the CYs 2023 and 2024 rates, CMS proposes to apply the remaining permanent adjustment of 0.95933 (-4.067%) to the CY 2025 30-day rate.

The same CMS analysis also found that, by updating the HH PPS payments rates for actual behaviors in CYs 2020-2023, total estimated payments for these four years were higher than they should have been. CMS estimates these overpayments to be $873 million for CY 2020, $1.211 billion for CY 2021, $1.405 billion for CY 2022, and $966 million for CY 2023. This results in a combined $4.446 billion in temporary payment reconciliation, requiring a temporary adjustment to the 30-day payment rate as well. Similarly to CY 2024, CMS continues to believe that implementing both the permanent adjustment and temporary adjustment in the same year could adversely affect HHAs, especially given the magnitude of the two adjustments. As such, CMS proposes not to make the temporary adjustment for CY 2025 and will instead propose the adjustment factor in future rulemaking.

National Per-Visit Amounts

CMS uses national per-visit amounts by service discipline to pay for 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 two 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.

CMS proposes to update LUPA thresholds using CY 2023 home health claims data. Of these thresholds, 386 case-mix groups would have no change in threshold, 16 groups would increase by one visit, and 30 groups would have their threshold decrease by one visit. A list of all proposed LUPA thresholds can be found in on the CMS website.

The proposed CY 2025 national per-visit rates compared to the final CY 2024 national per-visit rates are shown below and are not subject to permanent behavior adjustment.

Per-Visit Amounts	Final CY 2024	Proposed CY 2025	Percent Change	Proposed CY 2025 with LUPA Add-On*
Home Health Aide	$76.23	$78.07	+2.41%	N/A
Medical Social Services	$269.87	$276.37		N/A
Occupational Therapy (OT)	$185.29	$189.75		$327.62 (1.7266 adj.)
Physical Therapy (PT)	$184.03	$188.46		$306.19 (1.6247 adj.)
Skilled Nursing (SN)	$168.37	$172.42		$297.03 (1.7227 adj.)
Speech Language Pathology (SLP)	$200.04	$204.86		$342.18 (1.6703 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.

As the LUPA add-on factors for PT, SN, and SLP have not been revised since the CY 2014 HH PPS final rule, CMS is proposing to update these factors using CY 2023 claims data to more accurately reflect current healthcare practices and costs. Using the same methodology as the CY 2014 rule, CMS proposes these add-on factors as 1.6247 for PT, 1.7227 for SN, and 1.6703 for SLP.

The CAA of 2021 included a provision allowing occupational therapists to conduct initial and comprehensive assessments to home health beneficiaries. CMS allows 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. CMS had previously been using the PT factor as a proxy for OT due to insufficient data regarding the average excess of minute for the first visit in LUPA periods when the initial and comprehensive assessments are conducted by OT. Now that sufficient claims data is available, CMS is proposing to establish an OT-specific LUPA add-on factor and discontinue using the PT factor as a proxy. Using the same methodology used to determine the PT, SN, and SLP add-on factors, CMS proposes the OT add-on factor to be 1.7266.

Wage Index and Labor-Related Share

As has been the case in prior years, CMS proposes to use the most recent inpatient hospital wage index, which is the Federal Fiscal Year (FFY) 2025 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2025. The wage index is applied to the labor-related portion of the HH payment rate. CMS previously finalized to use a labor-related share of 74.9% for CY 2024 and onwards.

On July 21, 2023, the OMB issued OMB Bulletin-23-01 that made a number of significant changes related to CBSA delineations. To align with these changes, CMS is proposing to adopt the newest OMB delineations for the FFY 2025 HH PPS wage index. If CMS adopts this proposal, 54 counties that are currently part of an urban CBSA would be considered located in a rural area (including one urban county in Connecticut that being redesignated to a newly proposed rural CBSA), listed in Table 27, and 54 counties that are currently located in rural areas would be considered located in urban areas, listed in Table 28.

For rural areas that do not have inpatient hospitals, CMS proposes to use the average wage index from all CBSAs which share a border with that county as a proxy.

Since CMS already applies a 5% cap on wage index loses from year-to-year, CMS does not believe any additional transition is necessary. However, some CBSAs and statewide rural areas could have more than one wage index value because of the potential for their constituent counties to have different wage index values as a result of application of the 5% cap. Therefore, CMS is proposing that in addition to the 5% cap applied to an entire CBSA or statewide rural area, the cap would also be applied at the county level. In addition, beginning CY 2025, counties that have a different wage index value than the CBSA or rural area into which they are designated after applying the 5% cap would use a 5-digit wage index transition code, beginning with "50". This would apply until the county's new CBSA-based wage index is at least 95% of the county's wage index from the previous year. A list of counties proposed to use wage index transition codes, and the proposed transition codes, can be found in Table 32.

The wage index and labor-related share budget neutrality factors for CY 2025 are proposed to be 0.9985 for the standard rate and 0.9991 for the per-visit rates. These factors ensure that aggregate payments made under the HH PPS are not greater or less than will otherwise be made if wage adjustments had not changed.

A complete list of the wage indexes proposed for CY 2025 is available on the CMS website.

Patient-Driven Groupings Model

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 in a budget neutral manner to ensure that the case-mix weights reflect current home health resource use and changes in utilization patterns. For CY 2025, CMS proposes to recalibrate case-mix weights based on CY 2023 claims data. Compared to CY 2024 weights, 430 groups would see less than a +/- 5% difference, and 2 groups would change between +5% and +10% for CY 2025. CMS is proposing a case-mix budget neutrality factor of 1.0035 to be applied to the standardized 30-day period payment rate.

The proposed case-mix weights for CY 2025 are listed in Table 25 and on the CMS website.

CMS proposes to update functional impairment levels and functional points by clinical group using CY 2023 claims data. Tables 20 and 21 show the proposed OASIS points and thresholds for functional levels by clinical group, respectively, for CY 2025. CMS is also proposing that the comorbidity adjustment applicable to 30-day periods of care be calculated using CY 2023 home health OASIS data, which would result in 22 low comorbidity adjustment subgroups and 90 high comorbidity subgroups. These groups are listed on Tables 22 and 23, respectively.

Outlier Payments

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 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 will 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 the home health 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 an FDL ratio of 0.38 for CY 2025, based on CY 2023 data.

Expanded Home Health Value-Based Purchasing Model

CMS previously adopted the expansion of the HHVBP model to all 50 states, the District of Columbia (DC), and all territories, starting with performance adjustments in CY 2025, which will be budget neutral by cohort. This will apply to all HHAs certified before January 1, 2022, and will be based on the HHAs' CMS Certification Numbers (CCN). CY 2022 was a pre-implementation year which allowed HHAs to prepare and learn about the model with support from CMS. Each HHA will have a reduction or increase to their Medicare payments of up to 5%, dependent on their performance on specified quality measures relative to other similar, competing HHAs in their cohort.

CMS is exploring the potential of adding a Health Equity Adjustment (similar to the SNF VBP) to the HHVBP model in the future.

Future Performance Measure Concepts for the Expanded HHVBP Model – Request for Information (RFI)

CMS requests comment on specific performance measures, as well as general comments on other future model concepts, that may be considered for inclusion in the expanded HHVBP model. The specific performance measures include a family caregiver measure, a claims-based falls with injury measure, a Medicare spending per Beneficiary measure, and function measures to complement existing cross-setting Discharge Function measures

Future Approaches to Health Equity in the Expanded HHVBP Model-Update

CMS states that it is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by their programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved. In previous rulemaking, RFIs were included so feedback could be gathered on what policy changes and actions should be considered in the HHVBP model to address these disparities and advance health equity. CMS considered the feedback received and has been exploring several approaches for integrating health equity concepts into the HHVBP model, which are evaluated to take into account the following considerations:

- Effectiveness: Does the approach further the model test? What would its impact on underserved communities be?
- Feasibility: How long would it take to implement the approach? Are the necessary data currently being collected? How many HHAs would be included?
- Reliability: Does the approach allow for reliable measurement of health equity within HHAs?
- Alignment: Is this approach aligned with other Medicare quality and VBP Program?

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 market basket update for the applicable year. CMS lists the measures in place for CY 2024 in Table 39.

In this proposed rule, CMS is proposing to add four new items and edit one item under the social determinants of health category to the OASIS-E Data Set, beginning January 1, 2027 for the CY 2027 HH QRP Program Year:

- Living Situation – "What is your living situation today?"
- Food – "Within the past 12 months, you worried that your food would run out before you got money to buy more."
- Food - "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."
- Utilities – "In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?"

CMS is also proposing to change the transportation item of the OASIS beginning in the CY 2027 HH QRP from "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" to "In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?" in order to distinguish the look back period and to simplify response options. In addition, the revised assessment item will be collected at admission only, which will decrease provider burden since the current assessment item is collected at both admission and discharge.

CMS previously ended the temporary suspension of OASIS data collection on non-Medicare/non-Medicaid HHA patients for the purposes of the HH QRP beginning with the CY 2027 program year. This requires submissions of all-payer OASIS data for patients discharged between July 1, 2025 and June 30, 2026, with a voluntary phase-in period beginning January 1, 2025. In this rule, CMS is proposing to change the beginning of data collection from the OASIS discharge time point to the start of care time point. The start of care is the first assessment that can be submitted for a non-Medicare/non-Medicaid patient, either on or after January 1, 2025 for the voluntary period or on/after July 1, 2025 for the mandatory period.

HH QRP Measure Concepts under Consideration for Future Years - RFI

CMS is seeking input on the following four concepts for the HH QRP:

- A composite of vaccinations which would represent overall immunization status of patients
- Depression for the HH QRP
- Pain management
- A measure concept related to substance use disorders

Disposable Negative Pressure Wound Therapy

Payments for disposable negative pressure wound therapy (dNPWT) devices are mandated by the CAA of 2023 to be paid separately from the HH benefit beginning CY 2024. Payment for the services to apply the device is included under the home health prospective payment system. This payment is calculated using the previous year's finalized payment, adjusted by the Consumer Price Index for All Urban Consumers (CPI-U) for the 12-month period ending with June of the preceding year, minus the productivity adjustment. Therefore, the payment amount for CY 2025 would be $270.09, updated by the percent increase of the CPI-U for the 12-month period ending June 2025, minus a productivity adjustment. CMS notes that the CPI-U was not available at the time of proposed rulemaking and that the payment amount will be calculated and included in the final rule.

Home Intravenous Immune Globulin Items and Services

The IVIG Demonstration Project was established in the Medicare IVIG Access Act of 2012 to evaluate the benefits of providing coverage and payment for these items and services as well as determine if the inclusion would improve access to home IVIG therapy. CMS proposes to update the finalized CY 2024 payment amount of $420.48 by the proposed CY 2024 HH payment rate update of 2.5%, to get a proposed CY 2025 payment amount of $430.99. The wage index budget neutrality factor is not included in this update as statute does not require this payment to be geographically wage adjusted.

Home Health Conditions of Participation Changes

In order to address concerns regarding the HHA referral and acceptance process and their implications for prospective and current patients, CMS is proposing to add a new standard to the HHA CoPs. The new standard would require HHAs to develop, implement, and maintain an acceptance to service policy that is applied consistently to each prospective patient referred for HH care. This policy would be reviewed annually and address the following criteria related to an HHA's capacity to provide patient care and to help inform an HHA's assessment of its capacity and suitability to meet the anticipated needs of a prospective patient:

- The anticipated needs of the referred prospective patient;
- The HHA's case load and case mix (volume and complexity of the patients currently receiving care from the HHA);
- The HHA's staffing levels; and
- the skills and competencies of the HHA staff.

CMS proposes that this policy be applied consistently to ensure that HHAs only accept patients for whom there is a reasonable expectation that the HHA can meet that patient's needs. It is also being proposed that HHAs make available to the public accurate information, to be reviewed annually or as necessary, regarding services offered by the HHA and any limitations that the HHA has to specialty services, service duration, or service frequency.

Request for Information

CMS requests information on the following topics with regard to HHA CoPs:

- Rehabilitative therapists conducting the initial and comprehensive assessment; and
- Plan of care development and scope of services home health patients receive.

Long-Term Care (LTC) Requirements for Acute Respiratory Illness Reporting

In an effort to continue data collections related to respiratory illnesses that were set forth in the various rules associated with the COVID-19 public health emergency (PHE), CMS is proposing to revise the

infection prevention and control requirements for LTC facilities to extend reporting in the National Healthcare Safety Network (NHSN) for a limited subset of the current COVID-19 elements and also require data related to influenza and RSV. Beginning January 1, 2025, facilities would be required to report information about COVID-19, influenza, and RSV in a standard format and frequency specified by the secretary. For this rulemaking cycle, CMS proposes that this reporting continue to be done weekly through the NHSN and capture the following data elements:

- Facility census (defined as the total number of residents occupying a bed at this facility for at least 24 hours during the week of data collection).
- Resident vaccination status for a limited set of respiratory illnesses including but not limited to COVID-19, influenza, and RSV.
- Confirmed, resident cases of a limited set of respiratory illnesses including but not limited to COVID-19, influenza, and RSV (overall and by vaccination status).
- Hospitalized residents with confirmed cases of a limited set of respiratory illnesses including but not limited to COVID-19, influenza, and RSV (overall and by vaccination status).

CMS is proposing that during a declared national, state, or local PHE for an acute respiratory illness, the Secretary may require facilities to report:

- Data up to a daily frequency without additional notice and comment rulemaking.
- Additional or modified data elements relevant to the PHE, including relevant confirmed infections among staff, supply inventory shortages, staffing shortages, and relevant medical countermeasures and therapeutic inventories, usage, or both.
- If the Secretary determines that an event is significantly likely to become a PHE for an infectious disease, the Secretary may require LTC facilities to report additional or modified data elements without notice and comment rulemaking.

CMS also seeks comments on the following, specifically focusing on how LTC facilities' experience with the COVID-19 PHE can help HHS collect data in such a way that would be beneficial to LTC facilities:

- If, in the event of a PHE, there should be limits to the data that can be required.
- Whether or how stakeholder feedback would be sought on additional elements would be handled without notice and comment rulemaking.
- How HHS should notify LTC facilities of new required infection disease data.
- What evidence HHS should provide to demonstrate that:
    - An event is significantly likely to become a PHE; or
    - The increased scope of required data will be used to protect resident and community health and safety.
- The utility and burden of specifically staffing and supply shortage data proposed to be collect during national, State, or local PHE for a respiratory infectious disease.

Provider Enrollment – Provisional End to Enhanced Oversight

CMS is proposing that providers and suppliers that reactivate their Medicare enrollment and billing privileges be treated similarly to new providers and suppliers. This would include being subject to additional oversight, which may include a provisional period of enhanced oversight for 30 days to one year after reactivation.

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