CMS CY2024 Home Health Payment Proposed Rule

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Landscape Factors

- PDGM started 1/1/2020
  - Covid-19 pandemic hits March 2020
- Significantly affected the delivery of Medicare home health services
  - Reduced therapy visits
  - Reduced overall visits
  - 30-day episode resets care planning
  - LUPA rates increase
  - 432 case mix categories complicates care management
- HHAs decrease
  - 2019 11.732
  - 2023 11506
  - 2023 w/o CA 11321
- Medicare Advantage enrollment and home health increases as a proportion of HHA patient census

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Medicare HH 2024 Proposed Rule

- **CY 2024 Proposed Home Health Prospective Payment System Rate Update and….. Much More**
- **https://www.govinfo.gov/content/pkg/FR-2023-07-10/pdf/2023-14044.pdf**
- **($375M) expected spending decrease**
- **2.7% net inflation rate update**
- **$35 million increase in outlier spending**
- **5.653% permanent PDGM Budget Neutrality Adjustment**
- **Maintains PDGM case mix model**
  - **Recalibrates all 432 case mix weights and LUPA thresholds**
  - **Outlier FDL modified to 0.31 (increases # of outlier periods**
  - **Rebase and revised Market Basket Index formula**
- **Home Health Value Based Purchasing demo (HHVBP) modified slightly**
- **QRP modified**
- **Provider enrolment rule changes; Hospice provisions; Miscellaneous**

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TABLE A1: SUMMARY OF COSTS, TRANSFERS, AND BENEFITS

Provision Description	Costs and Cost Savings	Transfers	Benefits
CY 2024 HH PPS Payment Rate Update		The overall economic impact related to the changes in payments under the HH PPS for CY 2024 is estimated to be -$375 million (-2.2 percent). The $375 million decrease in estimated payments for CY 2024 reflects the effects of the CY 2024 proposed home health payment update percentage of 2.7 percent ($460 million increase), an estimated 5.1 percent decrease* that reflects the effects of the permanent behavioral assumption adjustment (-$870 million) and an estimated 0.2 percent increase that reflects the effects of an updated FDL ($35 million increase). *The estimated 5.1 percent decrease related to the proposed behavioral assumption adjustment includes all payments, while the proposed -5.653 percent BA adjustment only applies to the national, standardized 30-Day period payments and does not impact payments for 30-day periods which are LUPAs.	To ensure that home health payments are consistent with statutory payment authority for CY 2024.

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2024 Proposed Payment Rates

- Base payment rates are increased by a net Market Basket Index of 2.7%
  - An annual inflation update of 3.0%
  - Reduced by a 0.3 Productivity Adjustment to net at 2.7%
- 2022 PDGM 7.85% Budget Neutrality Adjustment (BNA) increased to 9.36% with added 1.636% for 2022 leading to proposed -5.653% adjustment for 2024

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2024 Proposed Payment Rates

TABLE B34: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2023 National Standardized 30-Day Period Payment	Permanent BA Adjustment Factor	Case-Mix Weights Recalibration Budget Neutrality Factor	Wage Index Budget Neutrality Factor	Labor-Related Share Budget Neutrality Factor	CY 2024 HH Payment Update Factor	CY 2024 National, Standardized 30-Day Period Payment
$2,010.69	0.94347	1.0121	1.0015	0.9998	1.027	$1,974.38

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2024 Proposed LUPA Rates

TABLE B36: CY 2024 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2023 Per-Visit Payment Amount	Wage Index Budget Neutrality Factor	Labor-Related Share Budget Neutrality Factor	CY 2024 HH Payment Update Factor	CY 2024 Per-Visit Payment Amount
Home Health Aide	$73.93	1.0015	0.9999	1.0270	$76.03
Medical Social Services	$261.72	1.0015	0.9999	1.0270	$269.16
Occupational Therapy	$179.70	1.0015	0.9999	1.0270	$184.81
Physical Therapy	$178.47	1.0015	0.9999	1.0270	$183.55
Skilled Nursing	$163.29	1.0015	0.9999	1.0270	$167.93
Speech-Language Pathology	$194.00	1.0015	0.9999	1.0270	$199.52

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PDGM Budget Neutrality Adjustment

- **CMS maintained its 2023 methodology**
  - **NAHC believes that the methodology is noncompliant with Medicare law**
  - **CMS applied HHPPS-HHRG payment model to 2020 through 2022 claims**
  - **With PDGM-induced reductions in therapy services, HHPPS-HHRG model would have resulted in less spending than occurred under 2020- 2022 PDGM**
  - **NAHC calculates an underpayment with a true budget neutrality analysis**

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"Clawback" Risk

- CMS calculates the "overpayments: from 2020-2022 at $3,439,284,729 due to time-lag in data that prevented an earlier budget neutrality calculation
- 2020 $873,073,121
- 2021 $1,211,002,953
- 2022 $1,355,208,655

- No payment adjustments at this time are scheduled

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Final Inflation Update

- Proposed CY 2024 home health market basket update of 3.0 percent rebased and revised formula
- Based on IHS Global Inc.'s first-quarter 2023 forecast with historical data through fourth-quarter 2022
- Reduced by a productivity adjustment, currently estimated to be 0.3 percentage point for CY 2024
- Proposed net update percentage for CY 2024 is a 2.7 percent increase
- Labor share decreased from 76.1% to 74.9%

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PDGM Case Mix Weights Recalibrated

- Recalibrate annually the PDGM case-mix weights using a fixed effects model with the most recent and complete utilization data available at the time of annual rulemaking.
- Reflects current home health resource use and changes in utilization patterns.
- Used CY 2022 home health claims data with linked OASIS data
- Reflective of PDGM utilization and patient resource use expected for CY2024

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Area Wage Index Changes

- Beginning in CY 2023, CMS applies a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline.
- a geographic area's wage index for CY 2024 would not be less than 95 percent of its final wage index for CY 2023, regardless of whether the geographic area is part of an updated CBSA
- As usual, wage index is a key factor to consider in determining individual HHA impact
- https://www.cms.gov/medicare/medicare-fee-service-payment/homehealthpps/home-health-prospective-payment-system/cms-1780-p

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LUPA

- All 432 LUPA thresholds have been subject to modification
- LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care by the appropriate add-on factor
  - 1.8451 for SN
  - 1.6700 for PT
  - 1.6266 for SLP
  - OT same as PT until data becomes available
- Example: using the proposed CY 2024 per-visit payment rates for HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods, if the first skilled visit is SN, the payment for that visit would be $309.85 (1.8451 multiplied by $167.93), subject to area wage adjustment.

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Outlier

- loss-sharing ratio of 0.80--- Medicare pays 80 percent of the additional estimated costs that exceed the outlier threshold amount
  - Using CY 2022 claims data (as of March 17, 2023)
  - statutory requirement that total outlier payments do not exceed 2.5 percent of the total payments
- proposing an FDL ratio of 0.31 for CY 2023 (down from 0.35)
- Results in an increase in outlier episodes
- CMS will update the FDL, if needed, when more complete CY 2022 claims data is available

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CY2024 Medicare Home Health Rule Action Plan

- Coordinated submission of comments and recommendations on the proposed rule
  - Market Basket Index update
  - Case mix weight recalibration
  - Budget neutrality evaluation
- Enlist White House engagement
- Congressional action to eliminate or reduce permanent and temporary rate adjustments; See, S.2137
- NAHC v. Becerra, US District Court for the District of Columbia

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Disposable Negative Pressure Wound Therapy (dNPWT)

- CAA, 2023
- Beginning January 1, 2024
- Device and professional service will be billed separately on the home health claim type of bill (TOB) 32x rather than bundled on TOB 34x
- Nursing and therapy visits provided for dNPWT billed separately and included as HH visits
- HCPCS A9272 is defined as a wound suction, disposable, includes dressing, all accessories and components, any type, each.
- dNPWT priced using the Medicare PFS

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HH QRP

- CY 2025 HH QRP
- Two new measures
- Remove one existing measure
- Remove of two OASIS items
- Begin public reporting of four measures in the HH QRP
- Update on closing the health equity gap
- Codifying into regulation the 90 percent data submission threshold policy

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HH QRP

- Two new measures
  - Discharge (DC) functional score
  - COVID-19 vaccine
- DC Functional Score
  - Calculates the percent of HH patients who achieve a risk adjusted expected function score at discharge.
  - Functional status is measured through Section GG of OASIS assessment related to self-care (GG0130) and mobility (GG0170).
  - Risk adjustment model controlling for admission function score, age, and patient clinical characteristics
  - Begin reporting with discharges - January 1, 2024
- $\frac{\text{\# of HHA's episode where the observed discharge score} \geq \text{expected discharge score}}{\text{Total number of HHA episodes}} * 100$

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HH QRP

COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- **CMS Measures Under Consideration (MUC) List**
- **No exclusions**
- **CDC "up to date" definition potential change**
- **Not consensus-based entity (CBE) endorsed**
- **CDC "up to date" definition potential change**
- **Requires a new item to the OASIS**
- **Begin reporting with discharges -January 1, 2025**

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HH QRP

Measure removed –CY 2025 HH QRP

"Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function"

- **Topped out**
- **Replace with DC Functional score**

End reporting: April 2024

- **Self-Care Discharge Goals (GG0130, Column 2)**
- **Mobility Discharge Goals (GG0170, Column 2)**

Data items removed from OASIS effective January 1, 2025

- **M0110 Episode Timing**
- **M2200 Therapy Need**

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HH QRP

Public Reporting –

January 2025 Care Compare refresh or as soon as feasible

- **Transfer of Health Information to the Patient Post-Acute Care**
- **Transfer of Health Information to the Provider Post-Acute Care**
- **DC Functional Score**

January 2026 Care Compare refresh or as soon as feasible

- **COVID-19 vaccination**

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HH QRP

Update on health equity in HH QRP

- **Request for information in the CY 2023 rate update rule**
- **Technical expert panel convened for development of health equity quality measure in HH & H**
- **Anticipated future health equity activities , pursue additional SDOH and continue with quality measure development**

Codify into regulation the 90 percent data submission threshold

- **Propose to codify our requirement that HHAs must meet or exceed a data submission threshold set at 90 percent of all required OASIS and submit the data through the CMS designated data submission systems.**
  - **§ 484.245 (2)(ii) Data completion thresholds.**
    (A) A home health agency must meet or exceed the data submission threshold set at 90 percent of all required OASIS or successor instrument records within 30-days of the beneficiary's admission or discharge and submitted through the CMS designated data submission systems

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HH QRP Request for Information

- **Aligns with National Quality Strategy**
- **Streamline measures across programs – "Universal Foundation" of quality measures**
- **Seeking input on gaps in HH QRP measures**
- **Seeking input on measures for the HHQRP**

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HH QRP Request for information

1.Principles for Selecting and Prioritizing HH QRP Measures

CMS identified a set of principles to guide future HH QRP measure set development and maintenance

Actionability, Comprehensiveness and Conciseness, Focus on Provider Responses to Payment, Alignment with CMS Statutory Requirements and Key Program Goals

- **To what extent do you agree with the principles for selecting and prioritizing measures?**
-
- **Are there principles that you believe CMS should eliminate from the measure selection criteria?**
- **Are there principles that you believe CMS should add to the measure selection criteria?**
- **How can CMS best consider equity in measures?**

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HH QRP Request for Information

2. HH QRP Measurement Gaps: Measurement gaps identified in the domains of cognitive function, behavioral health, chronic conditions and pain management.

- Input on the identified measurement gaps(cognitive function, behavioral and mental health, , and chronic conditions and pain management.)
- Are there gaps in the other HH QRP measures

3. Measures and Measure Concepts Recommended for Use in the HH QRP

- Are there measures that are either currently available for use, or that could be adapted or developed for use in the HH QRP program to assess performance in the areas of: cognitive functioning; behavioral and mental health; chronic conditions; pain management; or other areas not mentioned in this RFI**.**

4. Input on data available to develop measures, approaches for data collection, perceived challenges, or barriers, and approaches for addressing challenges, including existing measure

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Home Health Value Based Purchasing Program (HHVBP)

Beginning with reporting year 2025/ payment year 2027

- **Change the baseline year to CY 2023**
- **Remove the following measures:**

  (1) OASIS-based Discharged to Community (DTC);

  (2) OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care);

  (3) OASIS based Total Normalized Composite Change in Mobility (TNC Mobility);

  (4) Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH); and

  5) Claims-based Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use).

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Home Health Value Based Purchasing Program (HHVBP)

Proposing to add the following measures:

- **Claims-based：**

  Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies;

  Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

- **OASIS based:**

  Discharge Function Score measure (proposed new measure)

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Home Health Value Based Purchasing Program (HHVBP)

TABLE D4. PROPOSED MEASURE WEIGHT REDISTRIBUTIONS FOR HHAS IN THE LARGER-VOLUME AND SMALLER-VOLUME COHORT

	Proposed Redistributions			
	Current Measure Weights		Proposed Measure Weights	
Measure	Larger-Volume Cohort	Smaller-Volume Cohort	Larger-Volume Cohort	Smaller-Volume Cohort
OASIS-Based Measures				
Discharged to Community	5.833	8.333	-	-
Improvement in Dyspnea	5.833	8.333	6.000	8.571
Improvement in Management of Oral Medications	5.833	8.333	9.000	12.857
Total Normalized Composite (TNC) Change in Mobility	8.750	12.500	-	-
Total Normalized Composite (TNC) Change in Self-Care	8.750	12.500	-	-
DC Function	-	-	20.000	28.571
Sum of OASIS-based Measures	**35.000**	**50.000**	**35.000**	**50.000**
Claims-based Measures				
Acute-Care Hospitalizations (ACH)	26.250	37.500	-	-
Emergency Department Use Without Hospitalization (ED)	8.750	12.500	-	-
Potentially Preventable Hospitalization	-	-	26.000	37.143
Discharge to Community (DTC-PAC)	-	-	9.000	12.857
Sum of Claims-based Measures	**35.000**	**50.000**	**35.000**	**50.000**
HHCAHPS Survey-based Measures				
Care of Patients	6.000	0.000	6.000	0.000
Communications Between Providers and Patients	6.000	0.000	6.000	0.000
Specific Care Issues	6.000	0.000	6.000	0.000
Overall Rating of Home Health Care	6.000	0.000	6.000	0.000
Willingness to Recommend the Agency	6.000	0.000	6.000	0.000
Sum of HHCAHPS Survey-based Measures	**30.000**	**0.000**	**30.000**	0.000
Sum of All Measures	**100.000**	**100.000**	**100.000**	**100.000**

Note: The weights of the measure categories, when one category is missing, are based on the relative weight of each category when all measures are used. For example, if an HHA is missing the HHCAHPS category, the remaining two measure categories (OASIS-based and claims-based) represent 50 percent.

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Home Health Value Based Purchasing Program (HHVBP)

Appeals:

- **Proposing to amend § 484.375(b)(5) to specify that an HHA may request Administrator review of a reconsideration decision within 7 days from CMS' notification to the HHA contact of the outcome of the reconsideration request.**
- **Proposing that the CMS Administrator may decline to review the reconsideration decision, render a final determination, or choose to take no action on the request for administrative review. Reconsideration decisions are considered final if the CMS Administrator declines an HHA's request for review or if the CMS Administrator does not take any action on the HHA's request for review within 14 days.**

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Intravenous Immune Globulin (IVIG)

- **Demonstration project since 2014**
- **CAA, 2023 permanent program**
- **Effective 1/2024**
- **Coverage and payment of items and services related to administration of IVIG in a patient's home (bundled payment)**
- **Dx of primary immune deficiency disease(PIDD)**
- **Covered under DMEPOS benefit, not HIT benefit**
- **Standard copays and deductibles apply**
- **Patients under a Medicare home health POC not eligible**

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Lymphedema Therapy Benefit

- **New Part B benefit category- CAA, 2023,**
- **Effective 1/2024**
- **Covers standard and custom fitted gradient compression garments and other approved items (bundled)**
- **Enrolled DMEPOS supplier**
- **DMEPOS Quality standards apply**
- **Subject to competitive bidding competitive**
- **Billed to DME MAC**

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Lymphedema Therapy Benefit

Gradient compression stockings/wraps as surgical supplies for statis venous ulcers

- **New HCPCS codes for gradient compression stockings/wrap to reflect surgical dressings (current: A6531, A6532, and A6545)**
- **New HCPC codes and pricing for lymphedema items**

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Other DMEPOS Issues

- CMS is proposing making conforming changes required by the CAA, 2023 related to paying for DME items and services with the end of the PHE.
- Adding the definition of brace to the regulations at 42 CFR 410.2 to improve clarity and transparency regarding coverage and payment.
- Codifying into regulation documentation requirements for DMEPOS suppliers for refills to the original order

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Provider Enrollment

- § 424.527(a) New provider defined for provisional period of enhanced oversight (PPEO)
  - A newly enrolling Medicare provider or supplier
  - A certified provider or certified supplier undergoing a change of ownership
  - A provider or supplier (including an HHA or hospice) undergoing a 100 percent change of ownership via a change of information.
- § 424.527(b) The effective date of the PPEO's commencement is the date on which the new provider or supplier submits its first claim rather than the date the first service was performed or the effective date of the ownership change

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Provider Enrollment

- Propose in new § 489.52(b)(4) that a provider may request a retroactive termination date, but only if no Medicare beneficiary received services from the facility on or after the requested termination date.
- Propose to revise § 424.540(a)(1) to change the 12-month time frame to 6 month for deactivations related to non-billing.
- Propose to add new § 424.518(c)(1)(viii) that would incorporate within the high-screening category revalidating DMEPOS suppliers, HHAs, OTPs, MDPPs, and SNFs for which CMS waived the FBCBC requirement when they initially enrolled in Medicare (e.g. PHE).

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Provider Enrollment

Establish a revised paragraph that would include within the moderate-risk category revalidating DMEPOS suppliers, HHAs, OTPs, MDPPs, SNFs, and hospices that underwent FBCBCs:

(1) when they initially enrolled in Medicare; or

(2) upon revalidation after CMS waived the FBCBC requirement provider or supplier initially

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Provider Enrollment

- **Proposed to extend the maximum length of a reapplication bar under § 424.530(f) to 10 years from 3 years – denials**
- **Propose that a provider or supplier that is currently subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs.**
- **Propose that Medicare does not pay for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a provider or supplier that is currently under a reapplication bar**

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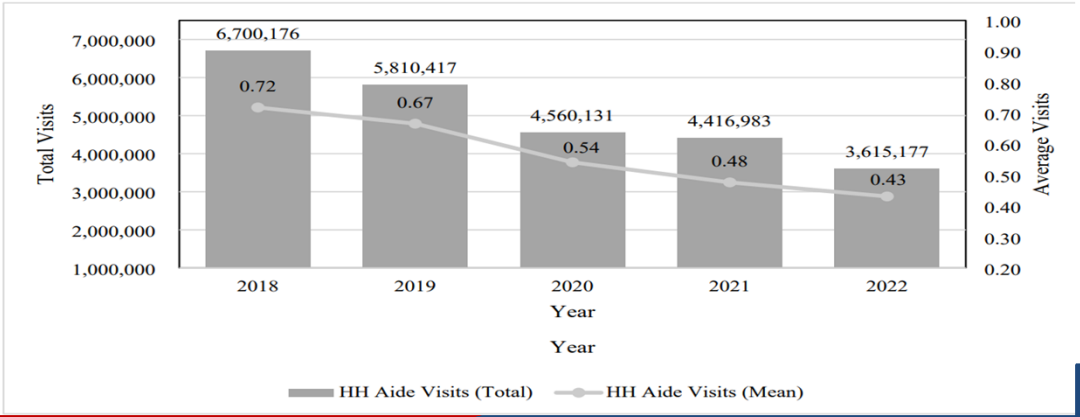
Request for Information – Access to Home Health Aide Services

- Home health aide utilization continues to

FIGURE B4: TOTAL OF HOME HEALTH AIDE VISITS AND AVERAGE NUMBER OF HOME HEALTH AIDE VISITS BY 30-DAY PERIOD FOR CYs 2018-2022



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Request for Information - Home Health Aides

- **Why is utilization of home health aides continuing to decline**
- **To what extent are higher acuity individuals eligible for Medicare having more difficulty accessing home health care services, specifically home health aide services?**
- **What are notable barriers or obstacles that home health agencies experience relating to recruiting and retaining home health aides?**
  - **What steps could home health agencies take to improve the recruitment and retention of home health aides?**
- **Are HHAs paying home health aides less than equivalent positions in other care settings .if so , why**
- **In what ways could HHAs ensure that home health aides are consistently paid wages that are commensurate with the impact they have on patient care that they provide to Medicare beneficiaries**
- **How effective is the coordination between Medicare and Medicaid to ensure adequate access to home health aide services? Please share insights on the level of utilization of Medicaid benefits by dually eligible beneficiaries for additional home health aide services that are not being provided by Medicare.**
- **Are physicians' plans of care less reliant on home health aide services in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons for why such services are not provided?**
- **What are the consequences of beneficiary difficulty in accessing home health aide services**

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CMS CY 2024 Home Health Proposed Rule

QUESTIONS ??

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