Illinois Health and Hospital Association

RULE SUMMARY

NOVEMBER 2024

MEDICARE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Overview and Resources

On Nov. 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released its final calendar year (CY) 2025 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final 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 adopted 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;
- Updates to 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;
- Updates to the HHA Conditions of Participation (CoP); and
- Long-Term Care (LTC) Requirements for Acute Respiratory Illness Reporting.

Program changes will be effective for discharges on or after Jan. 1, 2025, unless otherwise noted. **CMS estimates the overall impact of this final rule to be an increase of $85 million in aggregate payments to Home Health Agencies (HHAs) in CY 2025 over CY 2024, which includes a $305 million decrease due to the adopted permanent behavior adjustment and a $70 million decrease due to the adopted fixed-dollar loss (FDL) amount for outlier payments.**

A link to this final rule and other resources related to the HH PPS are available on the CMS website. An online version of this final rule is available here.

HH PPS Payment Rates

The table below shows the final CY 2025 30-day period standard payment rate compared to the final CY 2024 30-day standard payment rate:

	Final CY 2024	Final CY 2025	Percent Change
30-Day Period Standard Payment Rate	$2,038.13	$2,057.35	+0.94%

The following table provides details for the adopted annual updates to the HH 30-day period standard payment rate for CY 2025.

Final CY 2025 Update Factor Component	Change to 30-Day Period Standard Rate
Market Basket (MB) Update	3.2%

Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.5 percentage points (PPTs)
Permanent Behavior Assumption Adjustment	-1.975%
Wage Index and Labor-Related Share Budget Neutrality	-0.12%
Case-Mix Weights Recalibration Budget Neutrality	+0.39%

The adopted market basket update percentage is based on IHS Global Inc.'s third quarter 2024 forecast with historical data through second quarter 2024.

Behavioral Assumptions and Adjustments

Starting in CY 2020, CMS is required by the Bipartisan Budget Act of 2018 to use a 30-day period of care as the unit of payment in place of the prior 60-day episode of care. Part of this statute requires 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.

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 finalizing the addition of two assumptions when creating simulated 60-day episodes from 30-day periods.

After analyzing 30-day period standard payment rates for CYs 2020 – 2022 to account for changes in actual versus assumed behavior, CMS found that the actual rates should have been lower than the adopted rates (which were calculated using assumed behavior). Therefore, in CYs 2023 and 2024 CMS applied permanent adjustments of –3.925% and –2.890%, respectively, to each year's 30–day period standard rate. These adjustments 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 $1,875.46 based on actual behavior, rather than the adopted 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 –6.726% that needs 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 is finalizing that the remaining permanent adjustment for CY 2025 will be –3.95% (proposed at –4.067%). However, due to commenter concerns, CMS will only apply half of this adjustment to the CY 2025 30–day period standard rate, similarly to the final rules for CYs 2023 and 2024. The resulting adjustment of –1.975% to be applied

to the CY 2025 30–day payment rate will not adjust the rate fully to account for the differences in behavior changes. As such there may be a need for further adjustments to the base rate in future rulemaking.

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 $971 million (proposed at $966 million) for CY 2023. This results in a combined $4.460 billion (proposed at $4.446 billion) in temporary payment reconciliation, requiring an additional temporary adjustment to the 30–day payment rate. Similarly to CY 2024, CMS believes 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 will not make the temporary adjustment for CY 2025 and will instead propose the adjustment factor in future rulemaking. CMS does note that the delay in implementing the full permanent adjustment will continue to increase the total temporary dollar reconciliation amount.

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 will update LUPA thresholds using CY 2023 home health claims data. Of these thresholds, 388 case–mix groups will have no change in threshold (proposed at 386), 33 groups will increase by one visit (proposed at 16), and 11 groups will have their threshold decrease by one visit (proposed at 30). A list of all adopted LUPA thresholds can be found in on the CMS website.

The adopted CY 2025 national per–visit rates compared to the final CY 2024 national per–visit rates are shown below. These rates are not subject to the permanent behavior adjustment or case–mix budget neutrality.

Per-Visit Amounts	Final CY 2024	Final CY 2025	Percent Change	Final CY 2025 with LUPA Add–On
Home Health Aide	$76.23	$78.20	+2.59%	N/A
Medical Social Services	$269.87	$276.85		N/A
Occupational Therapy (OT)	$185.29	$190.08		$327.66 (1.7238 adj.)
Physical Therapy (PT)	$184.03	$188.79		$306.31 (1.6225 adj.)
Skilled Nursing	$168.37	$172.73		$297.10 (1.7200 adj.)
Speech Language Pathology (SLP)	$200.04	$205.22		$342.64 (1.6696 adj.)

The LUPA add–on is used 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 adopting an update to 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 is finalizing these add–on factors as 1.6225 for PT (proposed at 1.6247), 1.7200 for SN (proposed at 1.7227), and 1.6696 for SLP (proposed at 1.6703).

The CAA of 2021 includes 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 minutes for the first visit in LUPA periods when the initial and comprehensive assessments are conducted by an OT. Now that sufficient claims data are available, CMS will 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 is adopting the OT add–on factor to be 1.7238 (proposed at 1.7266).

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 an FDL amount.

Currently, there is a cap of eight hours or 32 units per day (one 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 eight 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 the 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 adopting an FDL ratio of 0.35 (proposed at 0.38) for CY 2025, based on CY 2023 data.

Wage Index and Labor-Related Share

As has been the case in prior years, CMS will use the most recent inpatient hospital wage index, which is the Federal Fiscal Year (FFY) 2025 pre–rural floor and pre–reclassification 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 adopted the use of a labor–related share of 74.9% for CY 2024 and onwards.

On July 21, 2023, the OMB issued OMB Bulletin No. 23–01 that made several significant changes related to CBSA delineations. To align with these changes, CMS is adopting the newest OMB delineations for the FFY 2025 HH PPS wage index. In adopting these delineations, 54 counties that are currently part of an urban CBSA will be considered located in a rural area (including one urban county in Connecticut that

being redesignated to a newly adopted rural CBSA), listed in Table 14 on page 88409, and 15 counties that are currently located in rural areas will be considered located in urban areas, listed in Table 15 on page 88411.

For rural areas that do not have inpatient hospitals, CMS is adopting the use of the average wage index from all CBSAs which share a border with that county as a proxy. Under the new OMB delineations, rural North Dakota will become a rural area without a hospital from which wage data can be derived. Using this methodology, CMS calculates a wage index of 0.8334 for rural North Dakota.

Since CMS already applies a 5% cap on wage index loses from year to year (described above), CMS does not believe any additional wage index transition is necessary. However, some CBSAs and statewide rural areas have more than one wage index value because of their constituent counties having different wage index values as a result of the application of the 5% cap. Therefore, CMS is finalizing that, in addition to the 5% cap applied to an entire CBSA or statewide rural area, the cap will 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 will use a five–digit wage index transition code, beginning with "50". This will 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 required to use these wage index transition codes, and the adopted transition codes, can be found in Table 19 on page 88420. The wage index and labor–related share budget neutrality factors for CY 2025 will be 0.9988 (proposed at 0.9985) for the standard rate and 0.9989 (proposed at 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 adopted 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 reasons for needing home health care. Case–mix adjustments for home health payments are based solely on these 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 is recalibrating case–mix weights based on CY 2023 claims data as of July 11, 2024. Compared to CY 2024 weights, 430 groups will see less than a +/– 5% difference, and 2 groups will change between +5% and +10% for CY 2025 (as proposed). CMS is adopting a case–mix budget neutrality factor of 1.0039 (proposed at 1.0035) to be applied to the standardized 30–day period payment rate.

The final case–mix weights for CY 2025 are listed in Table 12 on pages 88389–88401 and on the CMS website https://www.cms.gov/files/zip/cy-2025-final-hh-pdgm-case-mix-weights-and-lupa-thresholds.zip.

CMS is updating functional impairment levels and functional points by clinical group using CY 2023 claims data. Tables 7 and 8, on pages 88375–88376 show the adopted OASIS points and thresholds for functional levels by clinical group, respectively, for CY 2025. CMS is also adopting that the comorbidity adjustment applicable to 30–day periods of care be calculated using CY 2023 home health OASIS data,

which will result in 22 low comorbidity adjustment subgroups (as proposed) and 94 high comorbidity subgroups (proposed at 90). These groups are listed on tables 9 and 10, respectively, on pages 88378–88383.

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. This will apply to all HHAs certified before January 1, 2022, will be based on the HHAs' CMS Certification Numbers (CCN), and will be budget neutral by cohort. 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 requested 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. Comments received by CMS and their responses can be found on the pages listed above.

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 consider the following:

- 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 Programs?

Home Health Quality Reporting 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 26 on page 88432, which are also listed below.

Measures	Data Source
Improvement in Ambulation/Locomotion (CBE #0167)	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 (CBE #2631)	OASIS
Improvement in Bathing (CBE #0174)	OASIS
Improvement in Bed Transferring (CBE #0175)	OASIS
Drug Regimen Review Conducted with Follow–Up for Identified Issues–Post Acute Care (PAC) HH QRP	OASIS
Discharge Function Score	OASIS
Improvement in Dyspnea	OASIS
Influenza Immunization Received for Current Flu Season	OASIS
Improvement in Management of Oral Medications (CBE #0176)	OASIS
Changes in Skin Integrity PAC	OASIS
Timely Initiation of Care (CBE #0526)	OASIS
Transfer of Health Information to Provider–PAC	OASIS
Transfer of Health Information to Patient–PAC	OASIS
COVID–19 Vaccine: Percent of Patients/Residents Who Are Up to Date	OASIS
Discharge to Community– PAC HH QRP (CBE #3477)	Claims–based
Total Estimated Medicare Spending Per Beneficiary (MSPB)–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 adopting the addition of four new items and editing 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 changing 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 as 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 adopting 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 sought 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; and
- 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 is equal to CY 2024 rate of $270.09, updated by a 3.0% increase of the CPI–U for the 12–month period ending June 2024, minus a 0.6 ppt productivity adjustment. This results in a CY 2025 dNPWT payment rate of $276.57.

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 is updating the finalized CY 2024 payment amount of $420.48 by the adopted CY 2025 HH payment rate update of 2.7%, to get a final CY 2025 payment amount of $431.83 (proposed at $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 adding a new standard to the HHA CoPs. The new standard will 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 will be reviewed annually and addresses 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.

This policy will 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.

CMS is also finalizing, with revision, that HHAs must make accurate information regarding services offered by the HHA; and any limitations that the HHA has to specialty services, service duration, or service frequency available to the public. In the final rule, CMS added that HHAs are required to review public facing information as frequently as services are changed, but no less often than annually.

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 will 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 respiratory syncytial virus (RSV). Beginning January 1, 2025, facilities will 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 is adopting 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 adopting 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."*

Based on comments received, CMS is withdrawing their proposal that "*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.*"

Provider Enrollment – Provisional End to Enhanced Oversight

Providers and suppliers that reactivate their Medicare enrollment and billing privileges be treated similarly to new providers and suppliers. This includes 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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