Minnesota Home Care Association

CY2024 Proposed Home Health Prospective Payment System Rate Update

Payment Provisions

In 2023, CMS applied a 3.925% permanent rate reduction after originally proposing a 7.85% reduction. At the time, CMS explained that the lower adjustment would be applied because "we recognize the potential hardship of implementing the full -7.85%permanent adjustment in a single year."

As anticipated, the CY 2024 Proposed Rule came with rate cuts for providers. The proposed rate cut for 2024 is 5.653%. This represents the remainder of the original 7.85% rate reduction that CMS calculated as warranted under its methodology for 2020 and 2021 along with an additional 1.636% for 2022, totaling 9.36% overall from the beginning of PDGM. CMS states that "applying the full permanent adjustment of -5.635% in CY 2024 would potentially reduce any future permanent adjustments." After behavior adjustments applied to 30-day period payments, this is reduced to 5.1%. CMS also increased the outlier fixed dollar loss (FDL) threshold by a .2% increase.

The Proposed Rule provides for a 2024 payment update of 2.7%, which is based on a market basket increase of 3.0%minus a .3%productivity adjustment. **Overall, this will leave home health agencies facing a 2.2% cut in CY 2024.**

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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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

In addition to these cuts, CMS is proposing **to recalibrate the 432 PDGM case-mix weights, LUPA thresholds, functional levels, and comorbidity adjustment subgroups using 2022 data**. Detailed charts on all the recalibrated items can be found on pages 58-83 of the Proposed Rule.

CMS is also proposing to rebase and revise the home health market basket to reflect a 2021 base year (currently using a 2016 base year) using 2021 Medicare cost report data. CMS provides a detailed description of the methodology used to develop the proposed 2021-based home health market basket, including discussion of the proxies measuring labor price growth, where it will continue to use a blend of six different indices though they will be weighted differently. The proposed methodology is generally like the methodology used to develop the 2016-based home health market basket, and CMS provides data (See Table B32 on page 109 of the Proposed Rule) showing the resulting historical and forecasted annual changes of both the 2016 and 2021-based market baskets.

Home Health Quality Reporting System (HHQRS)

CMS is proposing quite a few changes to the HHQRS. The changes are the following:

Additions:

- **COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date**
- **Functional Discharge Score (DC Function).** This assessment-based outcome measure evaluates functional status by calculating the percentage of home health patients who meet or exceed an expected discharge function score. Under this proposal, HHAs would no longer be required to report a Self-Care Discharge Goal (that is, GG0130, Column 2) or a Mobility Discharge Goal (that is, GG0170, Column 2) on the OASIS beginning with patients admitted on April 1, 2024.

If both additions are finalized as proposed, HHAs would be required to report these OASIS assessment data beginning with patients discharged between January 1, 2024, and March 31, 2024, for the CY 2025 HH QRP.

Removal:

- **Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.** This proposed removal is due to the Functional Discharge Score addition.
- **M0110: Episode Timing**
- **M2220: Therapy Needs**

If all removal items are finalized as proposed, this would be effective January 1, 2025.

In addition to the changes above, **CMS is also proposing the public reporting of four measures**:

- Discharge Function
- Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider)
- Transfer of Health (TOH) Information to the Patient—Post-Acute Care (PAC)
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date.

CMS would begin displaying data with the January 2025 Care Compare refresh or as soon as technically feasible.

Home Health Value-Based Purchasing

CMS is proposing to remove five measures they finalized in the CY 2022 final rule. These measures are:

- OASIS-based Discharged to Community (DTC)
- OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care)
- OASIS-based Total Normalized Composite Change in Mobility (TBC Mobility)
- Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH)
- Claims-based Emergency Department Use without Hospitalization During the First 60 days of Home Health (ED Use)

The proposal includes replacing the above five measures with three additions:

- Claims-based Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies
- OASIS-based Discharge Functional Score (DC Function)
- Claims-based Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

A detailed chart of the above changes can be found on page 190 of the Proposed Rule. Because this proposal will now include fewer measures for your OASIS-based items, CMS will need to redistribute the weighted percentage for each of the items in the OASIS-based set. An example of this proposal can be found on page 200.

If finalized as is, these changes would begin with the CY 2025 performance year, thus all changes will affect the same payment year beginning with the CY 2027 payment year.

CMS is also proposing to amend § 484.375(b)(5) to specify that an HHA may request a reconsideration of the annual Total Performance Score (TPS) and payment adjustment within 7 days from when CMS gives notification that the reconsideration can be made.

Home Intravenous Immune Globulin (IVIG) Benefit

CMS is proposing regulations to implement coverage and payment of items and services related to administration of IVIG in a patient's home for a patient with a diagnosed primary immune deficiency disease (PIDD). Currently, Medicare pays for the IVIG product using the average sales price (ASP) methodology, and the items and services needed for in-home administration of IVIG for the treatment of PIDD are paid under a Medicare demonstration program. This demonstration program will end on December 31, 2023, and the Consolidated Appropriations Act (CAA), 2023 establishes permanent coverage and payment of the items and services needed for in-home administration beginning on January 1, 2024.

Lymphedema Therapy Benefit

Also in the CAA, 2023 is the addition of coverage under Medicare Part B for lymphedema compression treatment items. Specifically, coverage of standard and custom fitted gradient compression garments and other approved items that are prescribed by a physician or other specified health care professional to treat lymphedema.

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Coverage for Lymphedema therapy items will be provided under the Medicare durable medical equipment benefit, and therefore will not have any negative financial impact for home health agencies since items of DME are excluded from the Medicare home health consolidated billing rules.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Refill Policy

CMS is proposing to require documentation indicating that the beneficiary confirmed the need for the DMEPOS refill within the 30-day period prior to the end of the current supply. Additionally, they are proposing to codify our requirement that delivery of DMEPOS items (that is, date of service) be no sooner than 10 calendar days before the expected end of the current supply.

Hospice

This proposed rule came with several provisions that would impact hospice agencies. Please click here to review an analysis, by NAHC, outlining the proposed changes.