1. **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.**

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](https://public-inspection.federalregister.gov/2023-14044.pdf) of the Proposed Rule. See below for snips from webinars-





**MHCA Medicare Workgroup Comments-Payment Provisions**

-Do you believe the cuts are not warranted –why? We do not agree with the rationale of CMS to cut home health payment by 2.2%. We don’t believe HHA’s should be financially punished for the payment model that CMS created with PDGM. The cost to provide care is higher that it has ever been due to increased wages, supplies, mileage, and other health care disrupters.

Healthcare disruptors are **companies that are shifting the healthcare industry by making big changes that significantly redefine the way care is delivered**. That means integrating new technologies, streamlining processes, and simply refusing to do things the way they've always been done.

 \*CMS’s reasoning- They believe overall, particularly therapy, visits have decreased for 30-day episodes (changes agencies have made since PDGM). Do we have agency data this is not the case? There could be multiple reasons therapy visits have decreased in the past few years, and they are not because reputable agencies are trying to “game” the system. Therapy utilization may have decreased due to staffing issues and/or the issue facing our agency with patients that have same-day surgeries (i.e. ortho patients). These patients typically are on home care services for only a week before they go to outpatient therapy. In addition, Covid impacted utilization of all services as we were trying to minimize staff and patient exposure, and also attempting to conserve PPE. Some visits were done using telehealth.

Thoughts on other reasons for change that are not attributed to Behavioral adjustments made by agencies in response to change to PDGM?

-Comment on your agency’s expenses have increased since PDGM began- Inflation, cost of supplies, salaries, benefits, travel, and recruiting and retaining of staff.

\*Some thoughts on the first group discussion for the first two questions-

* More complex patients now that would have normally gone to post-acute facilities are being admitted to home care-
* Increases in staffing costs (e.g. increases to recruit and retain staff, to remain competitive not only with other agencies, but other businesses as a whole; still have staff working below license to provide aide services due to inability to fill all aide positions), supply costs, regulatory costs (EVV,OASIS-E)

 \*use some data from MHCA 2022 proposed rule comment letter. See URL below-<https://www.mnhomecare.org/resource/resmgr/cms/MHCA_Proposed_Rule_Comment_L.pdf>

-CMS has asked if this one-time cut would be easier vs multiple smaller cuts. What is your position on this? Obviously we would rather have the multiple smaller cuts.

-Any comments on the recalibration of the 432 PDGM case-mix weights, LUPA thresholds, functional levels, and comorbidity adjustment subgroups? No comments

1. **Home Health Quality Reporting System**

CMS is proposing several changes to the HHQRS, including:

**Adding:**

* **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.

**Removing:**

* **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.

Additional information on Functional Discharge Score:

CMS reasoning behind wanting this measure-

Measuring functional status of HH patients can provide valuable information about an HHA’s quality of care. A patient’s functional status is associated with institutionalization, higher risk of falls and falls-related hip fracture and death greater risk of undernutrition, higher emergency department admissions, higher risk of readmissions following home care, and higher prevalence of hypertension and diabetes. Predictors of poorer recovery in function include greater age, complications after hospital discharge, and residence in a nursing home. Understanding factors associated with poorer functional recovery facilitates the ability to estimate expected functional outcome recovery for patients, based on their personal characteristics.

Assessing functional status as a health outcome in HH can thus provide valuable information in determining treatment decisions throughout the care continuum, the need for therapy service, and discharge planning as well as provide information to consumers about the effectiveness of the care delivered.

How this would be calculated

This measure adds no additional provider burden since it would be calculated using data from the OASIS that are already reported to the Medicare program for payment and quality reporting purposes.

Additional CMS document on discharge functional score-

[HH QRP Discharge Function Score Measure – Technical Report (cms.gov)](https://www.cms.gov/files/document/hh-discharge-function-score-measure-technical-report.pdf)

**MHCA Medicare Workgroup Comments-Quality Reporting**

-Comments on Covid addition

 \*Initial group thoughts: up-to-date definition is hard to keep track of. Should be responsibility of primary care providers, not home health, MICC tracks this, we don’t need this. What is CMS going to do with this information? How is this meaningful? State already tracks COVID vaccination in MIIC system. Duplicating work already done at state level; would be time consuming to track accurately, would only capture data for portion of population. Who is responsible for determining definition of up-to-date? Would this be self-reported or does this have to be verified? To many variables to obtain reliable data from patients/caregivers based on limited definitions currently available. Would increase staff time and cost, with no identified purpose or benefit.

-Comments on Discharge functional score?

-Any concerns or other comments regarding removals/additions? No further comments.

Initial group thoughts

* no concerns with removing episode timing and therapy need OASIS items as they are no longer used for anything
* question the value of publically reporting the Transfer of Health (TOH) Information and COVID-19 vaccine measures – how does this impact consumer decision making regarding home care services

Other comments regarding QRS: No further comments

1. **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.

\*More information on the PPH measure is here [Specifications for the Home Health Within-Stay Potentially Preventable Hospitalization Measure for the Home Health Quality Reporting Program (cms.gov)](https://www.cms.gov/files/document/hh-qrp-specificationspotentiallypreventablehospitalizations.pdf)

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](https://public-inspection.federalregister.gov/2023-14044.pdf).

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.

**MHCA Medicare Workgroup Comments-VBP**

-Agree/disagree with the changes. Other ideas on weighed distribution? No new comments

Comments/Concerns with new proposed Discharge Function (DC Function) measure?

Comments/Concerns with new proposed PPH measure?

1. **Other Provisions:**

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.

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. We support this.

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.

**MHCA Medicare Workgroup Comments-Other Items**

If an area impacts your agency/you have working knowledge around these items, do you agree/disagree with the following proposals and why?

IVIG benefit – No comments

**Comments/Concerns?**

Lymphedema benefit- We support this

**Comments/Concerns?**

DMEPOS benefit – No comment

**Comments/Concerns?**

dNPWT – We don’t agree with the payment changes.

**Comments/Concerns?**

1. **Hospice**

[NAHC\_Hospice\_Specific\_Provis.pdf (ymaws.com)](https://cdn.ymaws.com/www.mnhomecare.org/resource/resmgr/docs/2023_articles/NAHC_Hospice_Specific_Provis.pdf)

For hospice providers wishing to add comments, please review the above attachment and provide feedback wherever possible.

**Comments/Concerns?**

**Hospice Special Focus Program-** We believe that the SFP is punitive to hospices and that in some cases, the intense oversight and financial burden of hosipices included in the SFP would lead to agency closure. As an industry, we believe there are many hospices that struggle to keep up with the overly burdensome regulations that CMS requires. In some cases, the hospice may be excellent at providing care, but may struggle with regulatory compliance. These hospices would benefit from guidance and help from CMS and/or their MAC, but the enforcement remedies in the Proposed Rule are not sustainable for the average hospice. We recognize there are hospices engaging in fraudulent behavior. However, there are other ways that regulatory bodies can identify these bad actors versus the punitive approach that CMS is proposing with the SFP.