CODINGDEPARTMENT.COM
Clinical Compliance Coupled with Cost Savings

CMS Posts Final CY 2025
HH PPS Payment Update Rule

The Final Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies FINAL (CMS-1803-F) was posted on the Federal Register Public Inspection desk on 11/1/2024

Providers are strongly encouraged to review the rule in its entirety as details of each rate adjustment is not included in this summary. This update is for home health and also includes updates on intravenous immune globulin (IVIG) items and services' payment rate for CY 2025 for Durable Medical Equipment (DME) suppliers.

These regulations are effective on January 1, 2025 .

Key takeaways of the final rule

Payment update information:

CMS states the final actions in this rule would help improve patient care and protect the Medicare program's sustainability for future generations.

- This rule finalizes a permanent prospective adjustment of -1.975% (half of the calculated permanent adjustment of -3.95%) to the CY 2025 home health payment rate to account for the impact of implementing the Patient-Driven Groupings Model (PDGM).
  - In the final rule, CMS projected a 1.7% decrease in payments for 2025, or about $280 million aggregate reduction compared to 2024 levels. Within that proposal, there was also a permanent prospective adjustment to the CY 2025 home health payment rate of -4.067%.
  - It is the third straight year that CMS has implemented permanent cuts to home health payments

- This rule includes a 0.5% rate update or $85 million, compared to 2024 aggregate payments
  - The final CY 2025 home health payment update of 2.7% ($445 million increase), which is offset by an estimated 1.8% decrease that reflects the permanent behavior adjustment ($295 million decrease) and an estimated 0.4% decrease that reflects the updated FDL ($65 million decrease)
    - The law requires CMS to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures, beginning with 2020 and ending with 2026, and to make temporary and permanent increases or decreases, as needed, to the 30-day payment amount to offset such increases or decreases.

    - For the CY 2025 HH PPS final rule, CMS used CY 2023 claims, and the methodology finalized in the CY 2023 HH PPS final rule, to determine that Medicare is still paying more under the new system than it would have under the old system. A total permanent behavior adjustment of -3.95% is needed to be applied to the 30-day base payment rate to account for overpayments in CY 2023, as well as the remaining adjustment of 2.890% that CMS delayed finalizing in CY 2024.

  - In response to commenter concerns that this would impose too large a reduction in a single year, CMS is finalizing only half of the adjustment (1.975%) to the CY 2025 payment rate.
  - This adjustment will continue to satisfy the statutory requirements in section 1895(b)(3)(D) of the Act to offset any increases or decreases resulting from the impact of differences between assumed behavior and actual behavior changes on estimated aggregate expenditures, reduce the need for any future large permanent behavior adjustments, and help slow the accrual of the temporary payment adjustment amount.
  - The final permanent behavior adjustment is also anticipated to lessen any potential temporary adjustments in future years.
  - The final rule does provide the calculated temporary behavior adjustment dollar amount (approximately $971 million) based on an analysis of CY 2023 claims.
  - The law provides CMS the discretion to make any future permanent or temporary behavior adjustments in a time and manner determined appropriately through analysis of estimated aggregate expenditures through CY 2026.
  - **CMS estimates that Medicare payments to HHAs in CY 2025 would increase in the aggregate by 0.5%, or $85 million, compared to CY 2024, based on the finalized policies**

- After consideration of the public comments received, CMS is finalizing the CY 2025 home IVIG items and services payment rate of $431.83 ($420.48 updated by the final home health payment update percentage of 2.7 percent ($420.48 * 1.027 = $431.83)). The final home IVIG items and services payment rate will be posted in the Billing and Rates section of the CMS' Home Infusion Therapy (HIT) webpage (found at Home Infusion Therapy/Home IVIG Services | CMS)

- CMS is finalizing and adopting the most recent Office of Management and Budget (OMB) Core-Based Statistical Area (CBSA) delineations for the home health wage index; an occupational therapy (OT) LUPA add-on factor and updated physical therapy (PT), speech-language pathology (SLP), and skilled nursing (SN) LUPA add-on factors; and an updated CY 2025 fixed-dollar loss ratio (FDL) for outlier payments.
  - After consideration of public comments, CMS is finalizing the proposal to redesignate 54 urban counties as rural for purposes of the HH PPS wage index beginning in CY 2025

- LUPA Thresholds
  - CMS is finalizing the proposal to update the LUPA thresholds for CY 2025 using CY 2023 claims data (as of July 11, 2024).
  - The final LUPA thresholds for the CY 2025 PDGM payment groups with the corresponding Health Insurance Prospective Payment System (HIPPS) codes and the case-mix weights are available in the final rule and on the HHA Center webpage, located at https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center

- CY 2025 Functional Impairment Levels
  - For CY 2025, CMS final using CY 2023 claims data to update the functional points and functional impairment levels by clinical group.
  - They are finalizing the functional points and functional impairment level updates for CY 2025 as final, using updated CY 2023 claims data (as of July 11, 2024).

- Comorbidity adjustment
  - CMS final using CY 2023 claims data to update the functional points and functional impairment levels by clinical group.
  - CMS is finalizing the updated comorbidity adjustment subgroups and the high comorbidity adjustment interactions using CY 2023 home health data.

- Case-mix weights
  - CMS invited public comments on the CY 2025 final case-mix weights and final case-mix weight budget neutrality factor.
  - They did not receive any comments on the final case-mix weight budget neutrality factor.
  - CMS is finalizing the recalibrated case-mix weights for CY 2025, updated with claims data as of July 11, 2024, and the proposal to implement the changes to the PDGM case-mix weights in a budget-neutral manner by applying a case-mix budget neutrality factor to the CY 2025 national, standardized 30-day period payment rate.
  - The final case-mix budget neutrality factor for CY 2025 will be 1.0039.

- CY 2025 National Per-Visit Rates for 30-day Periods of Care
  - CMS is finalizing the updates to the CY 2025 national, standardized 30-day period payment rates and the CY 2025 national per-visit payment amounts as final, using the updated market basket amount.
  - The CY 2025 per-visit payment rates for HHAs that do not submit the required quality data are updated by the final CY 2025 home health payment update percentage of 2.7 percent minus 2 percentage points

Collection of Additional Data Elements During a PHE

CMS final that during a declared national, State, or local PHE for respiratory infectious disease (or if the Secretary determines a significant threat for one exists) the Secretary may require facilities to report specific information.

- CMS is finalizing the proposal to require additional reporting during a declared national, State, or local PHE for an acute infectious illness.
- They have withdrawn the proposal to require additional reporting if the Secretary determines that an event is “significantly likely” to become a PHE for an infectious disease.
- During a declared national, State, or local PHE for an acute infectious illness the Secretary may require reporting of data elements relevant to confirmed infections for staff, supply inventory shortages, staffing shortages, and relevant medical countermeasures and therapeutic inventories, usage, or both.

Home Health CoP Changes

CMS finalizes changes to §484.105, Acceptance-to-service policy with revisions.

After consideration of public comments, CMS is finalizing the acceptance-to-service policy with revisions.

Specifically…

- They are updating the frequency with which HHAs must review the publicly facing information regarding their services provided and any service limitations to ensure this information is up to date and accurate.
- They are revising § 484.105(i)(2), to require HHAs to review the publicly facing information as frequently as services are changed, but no less often than annually Revised regulatory text
- 484.105 Condition of participation: Organization and administration of services.

(i) HHA acceptance-to-service. A HHA must do both of the following:

1. Develop, implement, and maintain through an annual review, a patient acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care, which addresses criteria related to the HHA's capacity to provide patient care, including, but not limited to, all of the following:
   i. Anticipated needs of the referred prospective patient.
   ii. Caseload and case mix of the HHA.
   iii. Staffing levels of the HHA.
   iv. (Skills and competencies of the HHA staff.

2. Make available to the public accurate information regarding the services offered by the HHA and any limitations related to types of specialty services, service duration, or service frequency.
   i. Review the information specified in paragraph (i)(2)(i) of this section as frequently as the services are changed, but no less often than annually.

Crosswalk for Mapping OASIS-D Data Elements to The Equivalent OASIS-E Data Elements

CMS is finalizing the following assumptions for the OASIS-D to OASIS-E crosswalk:

- If the simulated 60-day episode matches an SOC or ROC assessment, then CMS will not impute the 13 items. If the simulated 60-day episode matches to an OASIS-E follow-up assessment, then they will look back for the most recent 30-day period that is linked to a SOC or ROC assessment and impute the 13 responses for follow-up using the responses at the most recent SOC or ROC assessment.
  - They will limit the look-back period to 12 months. For example, a simulated 60-day episode that began on June 1, 2023, and linked to a follow-up assessment will be limited to a 30-day period that ended on or after June 1, 2022, and linked to a SOC or ROC assessment. If they cannot find a SOC or ROC assessment in that period, CMS will exclude the claim from the analysis.

- If the simulated 60-day episode matches an OASIS-D assessment, then they will use the OASIS-D for the three items (therapies (M1030), vision (M1200), and the frequency of pain interfering with activity (M1242)) responses.
  - If the simulated 60-day episode matches an OASIS-E assessment, CMS will apply the mapping for the therapies, vision, and pain items as shown in figures 4 – 6 to impute responses as these responses are required for accurate payment calculation under the prior 153-group system.
  - When necessary, they will also apply the same 12-month look-back period as described in the previous assumption.

Home Health Quality Reporting Program (QRP)

1. Four new items as standardized patient assessment data elements CMS finalizes the collection of four new items as standardized patient assessment data elements in the social determinants of health (SDOH) category and modifies one item collected as a standardized patient assessment data element in the SDOH category beginning with the CY 2027 HH QRP. The four assessment items finalized for collection are:

   - One living situation item
   - Two food items
   - One utility item
   - They also finalized a policy to modify the current transportation item beginning with the CY 2027 HH QRP.

CMS also final an update to the removal of the suspension of OASIS all-payer data collection to change all-payer data collection to begin with the start of care OASIS data collection timepoint instead of discharge timepoint.

2. HH QRP Quality Measure Concepts Under Consideration for Future Years

In consideration of the feedback, CMS received from interested parties through these activities, CMS is seeking input on four concepts for the HH QRP.

- One is a composite of vaccinations,78 which could represent overall immunization status of patients such as the Adult Immunization Status measure79 in the Universal Foundation.
- A second concept on which CMS sought feedback is the concept of depression for the HH QRP, similar to the Clinical Screening for Depression and Follow-up measure80 in the Universal Foundation.
- Third, CMS sought feedback on the concept of pain management.
- Finally, CMS seeks input on a measure concept relating to substance use disorders, such as the Initiation and Engagement of Substance Use Disorder Treatment measure included in the Universal Foundation of Quality Measures.

CMS will not be responding to specific comments in response to the RFI in this final rule, but they invited public comment on these four measure concepts and intend to use this input to inform future quality measure development efforts.

3. Future Health Equity Measures in the HHVBP

CMS expressed appreciation for the comments received and will take them into account, as appropriate, as they continue to work to develop policies, quality measures, and measurement strategies on health equity.

In this RFI, CMS was seeking information related to future measure concepts for the expanded HHVBP Model. Specifically, on the following performance measures.

- Family caregiver measure
- Falls with injury (claims-based)
- Medicare spending per Beneficiary
- Function measures to complement existing cross-setting Discharge (DC) Function measure

Requests for Information (RFI)

1. RFI Regarding Rehabilitative Therapists Conducting the Initial and Comprehensive Assessment

In the final rule, CMS sought information from stakeholders on whether they should shift its longstanding policy and permit rehabilitative therapists to conduct the initial and comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care. However, CMS did not provide a summary of comments in the final rule.

Plan of Care Development and Scope of Services Home Health Patients Receive

CMS provided a summary of the comments received but did not provide any responses. They did note that they may use this feedback to inform additional rulemaking

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

The current LTC requirements for reporting COVID-19-related data expire on December 31, 2024, except for reporting COVID-19 resident and staff vaccination status.

Given the utility of LTC facility data, CMS finalized to replace these requirements with streamlined continued data reporting requirements for certain respiratory illnesses.

CMS also finalized additional, related data elements that could be activated in the event of a future acute respiratory illness PHE.

However, they are not finalizing our proposal to increase data reporting if a significant threat for a PHE for an acute infectious illness exists.

Medicare Provider Enrollment

CMS finalizes their proposal to expand the definition of “new provider or supplier” (solely for purposes of applying a PPEO) to include providers and suppliers that are reactivating their Medicare enrollment and billing privileges.

References:

Review the final rule on the Federal Register Public Inspection desk:

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Me dicare & Medicaid Services 42 CFR Parts 424, 483, and 484 [CMS-1803-F]

For further information, see the CMS summary of the HHA Final rule:

Calendar Year (CY) 2025 Home Health Prospective Payment System Final Rule Fact Sheet (CMS-1803-F)