CMS Home Health Final Rule Includes Big Rate Cut

Source: NAHC, November 1, 2023

- **Rule contains important hospice provisions. Scroll down to learn more.**

The Centers for Medicare and Medicaid Services (CMS) issued the Final Rule regarding Medicare home health services payment rates for CY 2024. As usual, the rule also includes a hodgepodge of non-rate related proposals as well. This article provides a summary of the Final Rule. NAHC will be providing more detail over the next week as the rule is further analyzed along with a nationwide webinar.

Overall, the Final Rule presents serious concerns for the home health community as CMS proposes further, significant rate reductions to account for the change in the payment model in 2020. Medicare law requires CMS to make permanent and temporary adjustments intended to ensure that the transition to the PDGM payment model is budget neutral in comparison to expected Medicare spending if the 2019 payment model were in place through 2026.

CMS originally proposed a 7.85% permanent rate adjustment in 2023 based on the conclusion that HHAs were overpaid in 2020 and 2021 due to provider behavior changes in coding and services provided. Ultimately, CMS applied a 3.925% permanent rate 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 percent permanent adjustment in a single year."

The Proposed Rule included a 2024 rate reduction at 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. An early CMS analysis indicates that the additional 2022 element to the proposed permanent adjustment is due to further visit decreases in a 30-day episode, particularly with therapy services.

With the Final Rule, CMS calculates a permanent adjustment of 9.48% with 5.779% needed on top pf the 2023 3.925% cut. However, out of concern for the impact of the full rate cut on home health agencies, CMS institutes a rate reduction of 2.890% which is equal to one half of the full adjustment.

CMS did not take any action on the $3,489,523,364 in temporary adjustments (up from the proposed $3,439,284,729) to address alleged overpayments in 2020-

2022. CMS did not propose to collect any of the alleged overpayment in 2024. The Final Rule maintains this position.

CMS proposed a cost inflation update at 2.7% (3.0% Market Basket Index – 0.3% Productivity Adjustment). The combination of the proposed permanent adjustment and the inflation update would have resulted in a base PDGM 30-day payment rate of $1974.38 in contrast to the 2023 base rate at $2010.69. The proposed rate change also included the budget neutrality adjustments for case mix weight recalibration, and wage index rebasing and revising. The proposed rate changes would have resulted in a net decrease in expected Medicare expenditures in 2024 of $375 million.

With the Final Rule, the net inflation update is set at 3.0% (3.3% Market Basket Index – 0.3% Productivity Adjustment). This results in a 2024 base PDGM 30-day payment rate of $2,038.15. (a base rate increase from the proposed rule of $27.46). This rate change leads to an increase in expected Medicare expenditures in 2024 of $140 million.

The Centers for Medicare and Medicaid Services (CMS) issued the Final Rule regarding Medicare home health services payment rates for CY 2024. Overall, the Final Rule presents serious concerns for the home health community as CMS institutes significant rate reductions that will begin on January 1, 2025. These rate cuts would bring the total to 6.815% over 2023 and 2024 with more cuts looming for 2025. Originally, CMS proposed a total of 9.36% cuts overall and 5.653% in 2024.

On top of the rate cuts, CMS alleges that home health agencies have been overpaid $3,439,284,729 in 2020-2022 under the payment model that began in 2020. Annual spending on Medicare home health services ranged between $15 and $16 billion in each of those years. At the same time, CMS is applying an inflation update of just 3.0% despite its 5.2% forecasting error in the past few years.

“We continue to strenuously disagree with CMS’s rate setting actions, including the budget neutrality methodology that CMS employed to arrive at the rate adjustments,” stated NAHC President William A. Dombi. “We recognize that CMS has reduced the proposed 2024 rate cut. However, overall spending on Medicare home health is down, 500,000 fewer patients are receiving care annually since 2018, patient referrals are being rejected more than 50% of the time because providers cannot afford to provide the care needed within the payment rates, and providers have closed their doors or restricted service territory to reduce care costs. If the payment rate was truly excessive, we would not see these actions occurring. The fatally flawed payment methodology that CMS continues to insist on applying is having a direct and permanent effect on access to care. When you add in the impact of shortchanging home health agencies on an accurate cost

inflation update of 5.2% over the last two years, the loss of care access is natural and foreseeable."

"We now implore Congress to correct what CMS has done and prevent the impending harm to the millions of highly vulnerable home health patients that depend and will depend in the future on this essential Medicare benefit. Fortunately, longstanding advocates for home health care, Senator Debbie Stabenow (D-MI) and Senator Susan Collins (R-ME) have introduced S. 2137 to eliminate the rate cuts. We urge the Congress to support this legislation and enact it into law before the end of the year. The 2024 rate cuts must not take effect" Dombi added.

FINAL RULE DETAILS

The Final Rule includes the following:

- A net 3.0% inflation update (3.3%% Market Basket Index — 0.3% Productivity Adjustment)

Note: CMS refuses to recognize its unprecedented forecasting error in CY2022 and 2023 rates where the inflation update fell short of reality by a cumulative 5.2%. That error will impact base rates permanently if not corrected. All Medicare sectors have suffered from the CMS forecasting error with CMS rejected all calls for correcting the error with an adjustment.

- A 2.890% Budget Neutrality permanent adjustment to account for one-half of the remaining 3.925% adjustment from CY2023 plus the additional 2022 adjustment of 1.636%.
- A $3,489,523,364 alleged overpayment in 2020-2022. CMS has not scheduled a collection of the alleged overpayment in 2024 or any other year yet.
- Recalibration of the 432 case mix weights as CMS has done multiple times in recent years. The recalibration leads to a separate budget neutrality adjustment in the payment rates of +1.0124%.
- Overall, CMS estimates that the Final Rule will **increase** CY2024 Medicare spending by $140 million ($525 million inflation update – $455 million rate adjustment + $ 70 million outlier FDL change).

The outcome of these payment rate changes on 30-day period base rates and per-visit LUPA rates is as follows. HHAs that failed to provide required quality data have these rates reduced by two percent.

TABLE B24: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2023 National Standardized 30-Day Period Payment	CY 2024 Permanent BA Adjustment Factor	CY 2024 Case-Mix Weights Recalibration Neutrality Factor	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 National, Standardized 30-Day Period Payment
$2,010.69	0.97110	1.0124	1.0012	0.9998	1.030	$2,038.13

TABLE B26: CY 2024 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2023 Per-Visit Payment Amount	CY 2024 Wage Index Budget Neutrality Factor	CY 2024 Labor-Related Share Neutrality Factor	CY 2024 HH Payment Update	CY 2024 Per-Visit Payment Amount
Home Health Aide	$73.93	1.0012	0.9999	1.030	$76.23
Medical Social Services	$261.72	1.0012	0.9999	1.030	$269.87
Occupational Therapy	$179.70	1.0012	0.9999	1.030	$185.29
Physical Therapy	$178.47	1.0012	0.9999	1.030	$184.03
Skilled Nursing	$163.29	1.0012	0.9999	1.030	$168.37
Speech-Language Pathology	$194.00	1.0012	0.9999	1.030	$200.04

Disposable Negative Pressure Wound Therapy (dNPWT)

The Consolidated Appropriations Act, (CAA) 2023 included technical amendments for the payment of dNPWT. The Act modifies the methods for calculating separate payments for dNPWT devices for each of the next three years. Additionally, beginning January 1, 2024, payment for the device will be made separately from the nursing and therapy services associated with furnishing the device. Nursing and therapy visits provided for dNPWT will be billed separately on the home health claim type of bill (TOB) 32x. Beginning in calendar year (CY) 2024 and each subsequent year, claims for the separate payment amount of an applicable dNPWT device using Healthcare Common Procedure Coding System (HCPCS) code A9272 would be reported on claims submitted using the TOB 32x. That is, claims with a date of service on or after January 1, 2024 for an applicable dNPWT device will no longer be submitted on TOB 34X. CMS will be issuing billing instructions. .

Home Health Value Based Purchasing Program (HHVBP)

CMS finalized its proposal to remove five measures from the current applicable measure set and add three measures starting in CY 2025. Due to the net change in the number of measures proposed, CMS finalized adjusting the weights for the

measures in the OASIS-based and claims-based measure categories starting in CY 2025. Lastly, CMSfinalized changing the baseline year to 2023 beginning with performance year 2025.

Specifically, CMS finalized its proposal to remove the following measures from the applicable measure set: 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 (TNC Mobility); claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH); and) claims-based Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use).

CMS is finalized adding the following measures: the claims-based Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies; the OASIS based Discharge Function Score (DC Function) measure; and the claims-based Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

All changes to the measure set begins with the CY 2025 performance year, thus all changes will affect the payment year beginning with the CY 2027 payment year.

CMS finalized its proposal 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.

Medicare Home Intravenous Immune Globulin (IVIG) Items and Services

The CAA 2023 added coverage and payment of items and services related to administration of IVIG in a patient's home of a patient with a diagnosed primary immune deficiency disease furnished on or after January 1, 2024

Payment for these items and services is required to be a separate bundled payment made to a supplier for all administration items and services furnished in the home during a calendar day. The standard Part B coinsurance and the Part B deductible will be applied. In addition, the statute states that the separate bundled payment for these IVIG administration items and services does not apply for individuals receiving services under the Medicare home health benefit.

CMS clarified that HHAs must provide home health items and services included on the plan of care either directly or under arrangement and must bill and be paid under the HH PPS for such covered home health services. Thus, if an HHA is unable to furnish the items and services related to the administration of IVIG (as indicated in the plan of care) in the home, they are responsible for arranging

these services (including arranging for services in an outpatient facility) and are required to bill these services as home health services under the HH PPS. NAHC will be requesting further clarification regarding this decision.

Home Health Quality Reporting Program (HHQRP)

CMS finalized its proposal to adopt two new measures and remove one existing measure. Along with the removal of two OASIS items. Additionally, CMS is proposing to begin public reporting of additional measures in the HH QRP.

CMS is finalizing the adoption of the Discharge Function Score (DC Function) measure in the HH QRP beginning with the CY 2025 HHQRP. 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. CMS will replace the topped-out, cross-setting Application of Functional Assessment/Care Plan process measure. HHAs would no longer be required to report a Self-Care Discharge Goal (that is, GG0130, Column 2) or a Mobility Discharge Goals (that is, GG0170, Column 2) on the OASIS beginning with patients admitted on April 1, 2024.

HHAs will 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.

CMS finalized its proposal to adopt the COVID-19 Vaccine: Percent of Patients/Residents who are Up to Date (Patient/Resident COVID-19 Vaccine) measure for the HH QRP beginning with the CY 2025 HH QRP, even though the definition by the Centers for Disease Control and Prevention for “up to date” COVID-19 vaccinations has potential to change.

CMS finalized removing two OASIS items, the M0110 – Episode Timing and M2220- Therapy Needs effective January 1, 2025.

CMS finalized publicly displaying data for the measures: (1) Transfer of Health (TOH) Information to the Provider—Post-Acute Care (PAC) Measure (TOH-Provider); and (2) Transfer of Health (TOH) Information to the Patient—Post-Acute Care (PAC) Measure (TOH-Patient). CMS would begin displaying data with the January 2025 Care Compare refresh or as soon as technically feasible.

CMS finalized codifying the 90 percent data submission threshold policy in the Code of Federal Regulations. CMS removed the confusing phrase within “…..30 days of admission and discharge” from the regulatory language.

HHQRP Request for information (RFI)

CMS provided a summary of the comments received on their HHQRP RFI

Lymphedema Therapy Benefit

Also in the CAA, 2023 is the addition of coverage under Medicare 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 a new Medicare Part B benefit. CMS did not address our comments on whether regarding lymphedema garments and wraps would fall under our consolidated billing, However, the general discussion in the rule points to separate payments under Part B for the lymphedema garments. NAHC will continue to seek clarification.

Provider enrollment

CMS finalized the following revisions to the Medicare provider enrollment requirements:

1.§ 424.502 Definitions. Revises managing employee to include hospice and SNF Medical director and administrator.

2. § 424.518 Screening levels for Medicare providers and suppliers. Revised to accommodate PHE waiver for fingerprint based criminal background checks for newly enrolled high risk providers.

3. § 424.527 Provisional period of oversight. Codifies who is subject to a provisional period of oversight and the effective date.

4. § 424.530 Denial of enrollment in the Medicare program. reapplication bar changed to 10 years from 3 years. 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, and Medicare will not pay for services ordered.

5. § 424.540(a)(1) change the 12-month time frame to 6 months for deactivations related to non-billing.

6. § 424.542 Prohibition on ordering, certifying, referring, or prescribing based on felony conviction.

7. § 424.550 Prohibitions on the sale or transfer of billing privileges. Applies the 36-month rule to hospice providers.

HOSPICE PROVISIONS

Hospice Special Focus Program (SFP)

CMS is pushing ahead with the SFP as proposed – program becomes effective beginning the effective date of the final rule, with implementation occurring during CY 2024.

NAHC is deeply concerned that CMS has decided to push ahead with its proposed structure and implementation timeline for the hospice special focus program (SFP), ignoring all the commonsense suggested changes NAHC and others requested throughout our engagement with the agency. By implementing the SFP using a flawed algorithm, CMS will fail in its efforts to identify hospices most appropriate for additional oversight and support, and risk reducing access to higher-quality care by directing patients and families to hospices that perform most poorly relative to health and safety requirements. It is unfortunate to see CMS apparently prioritizing speed to implementation over actually getting the SFP structure right.

While NAHC remains strongly supportive of the SFP's goal to improve poor performing hospices' quality of care through increased scrutiny and technical assistance, we are adamant that CMS must ensure the design of the program actually works to achieve that goal. Sadly, the SFP CMS is finalizing with today's rule falls far short and will likely result in hospices that *should* be in the program being able to stay under its radar, while at the same time unfairly creating bias against hospices that serve more patients and invest the resources to report full quality data.

Over the last few months, NAHC and our members, in partnership with the other leading national hospice associations, have been educating CMS and members of Congress on concerns with the proposed SFP algorithm, and how, if implemented, it would have negative unintended consequences on patient access to high-quality end-of-life care. Despite letters sent to CMS from both the hospice community and a bipartisan group of congressional members asking for a pause in the SFP's implementation to make sure it works as intended, the agency is needlessly rushing out the door a flawed design that differs significantly from what its own Technical Expert Panel (TEP) was presented with.

NAHC will continue to advocate for the necessary changes to the SFP structure to ensure the final program is one that aligns with congressional intent, is free of bias, and is truly capable of identifying the poorest-performing providers.

As a reminder, and as finalized with this rule, hospices will be identified for potential SFP enrollment if they (1) have data from any of the below data sources (see table F1); (2) are listed as an active provider [that is, have billed at least one

claim to Medicare FFS in the last 12 months]; and (3) operate in the United States, including the District of Columbia and U.S. territories.

TABLE F1. PROPOSED PRIMARY MEDICARE DATA SOURCES AND INDICATORS IN THE SPECIAL FOCUS PROGRAM

Data Source	Hospice Surveys	Hospice Quality Reporting Program (HQRP)	
		Claims Data	CAHPS® Hospice Survey Measures
Indicators	Quality-of-Care Condition-Level Deficiencies	Hospice Care Index (HCI)	Help for Pain and Symptoms
			Getting Timely Help
	Substantiated Complaints		Willingness to Recommend this Hospice
			Overall Rating of this Hospice

Survey data will be from the last 3 years of available data; HCI will be the score from the most recent eight quarters of Medicare claims data; CAHPS data will be the most recently available pulled from the Provider Data Catalog. The SFP algorithm will identify the bottom 10% of hospices based on these inputs into the algorithm. From that bottom 10%, CMS will then pick specific hospices to enter into the SFP program.

CMS <u>did not</u> address any of NAHC and the broader hospice community's recommendations for how to improve the SFP, including:

- Scaling the survey data by hospice size
- Accounting for the large number of hospices that do not have reportable HCI scores or data for the 4 CAHPS measures
- Reducing the weight given to CAHPS data in the SFP algorithm
- Providing transparency into exactly how SFP hospices will be chosen from the list of bottom 10% performers
- Providing SFP hospices with technical assistance to support quality improvement
- Going back to the SFP TEP to address technical shortcomings of the proposed design
- Giving hospices a preview period so they could better understand their SFP scores before the program was fully implemented

NAHC is disappointed that CMS is proceeding with such a flawed SFP. We will continue to advocate through all channels for necessary improvements.

***<u>Hospice Informal Dispute Resolution</u>* <u>(IDR)</u>**

CMS is finalizing the hospice IDR as proposed.

The IDR process for hospice programs, like that of HHAs, is for condition-level survey findings which may be the impetus for an enforcement action. Standard-level findings alone do not trigger an enforcement action and are not accompanied by appeal and hearing rights. The finalized IDR process would provide hospice programs an informal opportunity to resolve disputes regarding survey findings for those hospice programs seeking recertification from the SA, CMS, or reaccreditation from the AO for continued participation in Medicare.

Additionally, the finalized IDR may be initiated for programs under SA monitoring (either through a complaint investigation or validation survey) and those in the SFP. For hospice programs deemed through a CMS-approved AO, the AO would receive the IDR request from their deemed hospice program, following the same process and coordinating with CMS regarding any enforcement actions

The purpose of the finalized IDR process would be to provide an opportunity to settle disagreements at the earliest stage, prior to a formal hearing, and to conserve time and money resources potentially spent by the hospice, the SA, and CMS. The finalized IDR process may not be used to refute an enforcement action or selection into the SFP.

NAHC recommended that CMS institute a timeline for survey entities to complete the IDR process and recommended 30 calendar days from the date the dispute is filed. Following the rule's finalization, CMS will publish guidance for the hospice IDR process, similar to the guidance established for the HHA IDR, to include timeframes for the process and for completing the IDR as expeditiously as possible.

NAHC also recommended that CMS develop a process to track providers utilizing the IDR process and the final resolutions, and that CMS ensure the final IDR resolution, if changed from the initial findings in the CMS-2567, is reflected in a revised CMS-2567 and posted to the tracking process. CMS' response was that the national surveyor database (iQIES) tracks the IDR process, and if findings are changed due to IDR, a revised CMS-2567 will be sent to the provider and updated in the national database.

Prohibiting a hospice that is undergoing a change in majority ownership (CIMO) by sale within 36 months after the effective date of the hospice's initial enrollment in Medicare, or within 36 months after the hospice's most recent CIMO, from conveying the provider agreement and Medicare billing privileges to the hospice's new owner (The "36-month" rule)

CMS is finalizing the hospice 36-month rule proposal without modification.

Given concerns about lack of scrutiny on new hospice owners, as well as issues with entities and individuals "flipping" Medicare certifications before a hospice has ever seen a Medicare beneficiary or hired an employee, CMS is extending the "36-month" rule that applies to home health agencies to hospices.

Just as in home health, there will be several exceptions to the 36-month rule for hospices. Specifically, even if an hospice undergoes a CIMO, the requirement in § 424.550(b)(1) that the hospice enroll as a new hospice and undergo a survey or accreditation *does not apply if any of the following four exceptions are implicated*:

- The hospice submitted 2 consecutive years of full cost reports since initial enrollment or the last CIMO, whichever is later.
- A hospice's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation.
- The owners of an existing HHA are changing the hospice's existing business structure (for example, from a corporation to a partnership (general or limited)), and the owners remain the same.
- An individual owner of an hospice dies

Moving initially enrolling hospices and those submitting applications to report any new owner into the "high-risk" screening category

CMS is finalizing the hospice high-risk screening proposal without modification

Given ongoing and recent concerns about hospice program integrity issues, CMS will now subject initially enrolling hospices and those submitting applications to report any new owner to the "high-risk" screening requirements. In addition to all the other requirements that the lower-tier "moderate-risk" providers must undergo, "high-risk" hospices will now also be required to submit a set of fingerprints for a national background check from all individuals who have a 5 percent or greater direct or indirect ownership interest in the hospice. CMS will also conduct a fingerprint-based criminal history record check of the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System on these 5 percent or greater owners.

Hospices can be "deactivated" for 6 months of non-billing (as opposed to prior standard of 12 months)

"Deactivation" means that the provider's or supplier's billing privileges are stopped but can be restored (or "reactivated") upon the submission of information required under § 424.540. A deactivated provider or supplier is not revoked from Medicare and remains enrolled. Per § 424.540(c), deactivation does not impact the provider's or supplier's existing provider or supplier agreement; the deactivated provider or supplier may also file a rebuttal to the action in accordance with § 424.546. Nonetheless, the provider's or supplier's ability to bill Medicare is halted pending its compliance with § 424.540's requirements for reactivation.

Due to its recent concerns with fraud and program integrity issues in certain areas, CMS is reducing the 12-month timeframe for deactivation currently in § 424.540(a)(1) to 6 months. CMS states in the final rule that one of its concerns involves the following situation: a provider that (1) establishes multiple enrollments with multiple billing numbers; (2) abusively or inappropriately bills under one billing number; (3) receives an overpayment demand letter or becomes the subject of investigation; (4) voluntarily terminates the billing number in

question; and then (5) begins to bill via another of its billing numbers that is dormant (for example, 6 consecutive months without billing) but nevertheless active, repeating the same improper conduct as before. The problem in this case is that CMS cannot deactivate the dormant billing number (hence rendering it unusable and inaccessible pending a reactivation) under § 424.540(a)(1) because the applicable 12-month period has not yet expired. CMS feels that it must be able to move more promptly to deactivate these "spare" billing numbers so the latter cannot be inappropriately used or accessed.

Adding hospice administrators and medical directors to the definition of "managing employee"

CMS is finalizing the change to this definition as proposed with one exception.

Providers and suppliers are required to report their managing employees via the applicable Medicare enrollment application to enroll in Medicare. We currently define a "managing employee" in § 424.502 as a "general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier (either under contract or through some other arrangement), whether or not the individual is a W-2 employee of the provider or supplier."

CMS states that, in their experience overseeing the Medicare provider enrollment process, hospice administrators and medical directors indeed exercise managing control over the hospice, and they have long required that they be reported as managing employees. Accordingly, CMS is adding the following language immediately after (and in the same paragraph as) the current managing employee definition: "*For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director*."