The 2024 Proposed Rule for Home Health Payment

August 10, 2023

MONTHLY SUBSCRIBER WEBINAR

Annette Lee, RN, MS, COS-C, HCS-D

That time of year… Proposed Rule!

1.) Payment adjustments

Yearly adjustment increase, plus PDGM recalibration and rebasing of wage index

2.) HHQRP changes

3.) HHVBP changes

4.) Coverage changes

5.) Advocacy/Data/Request for Information

Payment Changes

- Payment increase of 2.7%
- Remainder of the "behavioral adjustment" from last year is an additional 5.63% reduction
- After the adjustment for the cost of inflation, the final impact for a 30-day Home Health PDGM base payment will be $1,974.38, a decrease from this year's base payment of $2010.69.

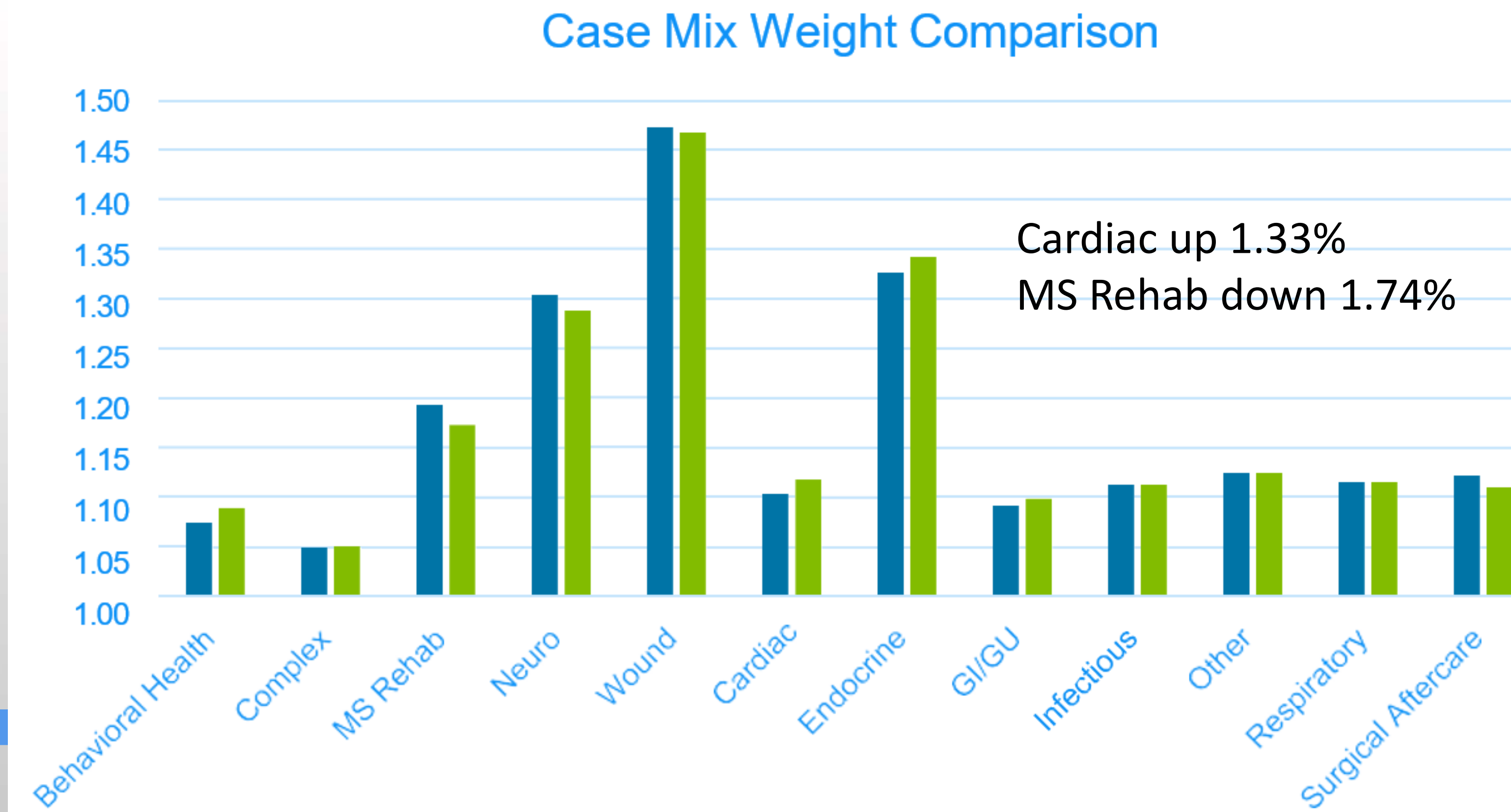
TABLE B34: CY 2024 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

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

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Recalibration

- CMS will also "recalibrate" the case-mix items to be more reflective of costs for agencies.



Little changes to functional points…

OASIS Item	OASIS Response	CY2023	CY2024
M1800	0 or 1	0	0
	2 or 3	3	3
M1810	0 or 1	0	0
	2 or 3	5	5
M1820	0 or 1	0	0
	2	4	**3**
	3	12	**11**
M1830	0 or 1	0	0
	2	2	**0**
	3 or 4	10	**7**
	5 or 6	17	**14**
M1840	0 or 1	0	0
	2, 3 or 4	6	6
M1850	0	0	0
	1	3	3
	2,3,4 or 5	6	6
M1860	0 or 1	0	0
	2	6	6
	3	5	**4**
	4,5, or 6	20	20
M1033	4 or more items checked	10	**11**

Easier to get to thresholds…

Clinical Group	Low 2023	Low 2024	Med 2023	Med 2024	High 2023	High 2024
MS Rehab	0 - 33	0-28	34 - 45	29-41	46+	42+
Neuro Rehab	0 - 35	0-34	36 - 51	35-49	52+	50+
Wound	0 - 33	0-28	34 - 51	29-49	52+	50+
Complex Nursing	0 - 33	0-28	34 - 54	29-52	55+	53+
Behavioral Health	0 - 31	0-28	32 - 43	29-41	44+	42+
MMTA Aftercare	0 - 33	0-28	34 - 43	29-39	44+	40+
MMTA Cardiac	0 - 31	0-28	32 - 43	29-41	44+	42+
MMTA Endocrine	0 - 30	0-27	31 - 43	28-39	44+	40+
MMTA GI/GU	0 - 33	0-31	34 - 49	32-46	50+	47+
MMTA Infection	0 - 33	0-28	34 - 45	29-43	46+	44+
MMTA Respiratory	0 - 33	0-29	34 - 46	30-44	47+	45+
MMTA Other	0 - 32	0-28	33 - 43	29-41	44+	42+

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Rebasing

- Wage index for your county's CBSA may have changed (check for your county in the Proposed Rule!
- Some winners- some losers
  - Max loss is 5%, per this maximum established loss from last year's rule

Winners	Losers -5%
Santa Fe, NM **+26.6%**	Amarillo, TX
Bellingham, WA **+10.5%**	Charleston, SC
Longview, TX **+10.0%**	Gulfport, MS
Fargo, ND **+9.7%**	Madison, WI
Tuscaloosa, AL **+7.8%**	Port St. Lucie, FL
Atlanta, GA **+5.8%**	Shreveport, LA

HHQRP Changes- Removing Process Measure

Admission and Discharge Functional Assessment and Care Plan that Addresses Function

ATTENTION! This means no more column 2 "Discharge goal" for GG0130 and GG0170!! That's correct-- we will no longer be required to report a Discharge Goal (that is, GG0130, Column 2 or GG0170, Column 2) on the OASIS beginning with patients admitted on April 1, 2024 (and this column will be removed at next OASIS revision).

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

This Photo by Unknown Author is licensed under CC BY-NC

Other OASIS Removals

- Proposed Removal of M0110, Episode Timing
- Proposed Removal of 2200 Therapy Needs.
  - These items have been obsolete for some time since our episode timing for payment is driven by the claims system, and we are no longer reimbursed based on therapy need.
  - Current OASIS guidance for these items states we should enter “NA”, because they are not applicable for Medicare patients

HHQRP Changes- Adding

- **CMS is proposing the public reporting of four measures:**

  (1) Discharge Function; CMS drives this based on our discharge GG self care and mobility items, and compares your patient's improvement to what was statistically expected for improvement, based on a number of other factors.

- (NOTE: Important to lessen our use of the "not attempted responses" now! Try to decrease your 07, 09, 10 and 88 scores as much as accurately possible!) CMS will "fill in the blank" if you use an NA code!

  (2) Transfer of Health (TOH) Information to the Provider — Post-Acute Care (PAC) Measure (TOH-Provider); (based on the current transfer OASIS item)

  (3) Transfer of Health (TOH) Information to the Patient — Post-Acute Care (PAC); (based on the current DC OASIS item)

  (4) COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date. A new OASIS item will have to be added, expected in January of 2025, simply asking "Is the patient up to date on COVID-19 vaccination-- ___ Yes ___No."

- TEP voted "no"- CMS moved forward with measure anyway for data purposes only

HHVBP Changes- Remove

- **CMS is proposing to remove five quality measures from HHVBP:**

  (1) OASIS-based Discharge to Community;

  (2) OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care);

  (3) OASIS-based Total Normalized Composite Change in Mobility (TNC Mobility);

  (4) Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH); and

  (5) Claims-based Emergency Department Use without Hospitalization During the First 60 Days of Home Health Use (ED Use).

HHVBP Changes- Add

- **In place of these retired measures, CMS is proposing to add the following measures:**

  (1) The claims-based Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies;

  (2) The OASIS-based Discharge Function Score (DC Function) measure; and

  (3) The claims-based Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

Potentially Preventable Hospitalizations

- CMS used Abt Associates to develop a new measure regarding **hospitalizations and observation stays** that would be more meaningful and impactful for home health agencies
- New PPH and potentially preventable observation stays (PPOBS) measures uses a list of diagnoses that home health most typically could have an impact in with good disease management, and case management that anticipates the needs of the patient
- https://www.cms.gov/files/document/proposed-pph-measure-specifications-cy22-hh-qrp-nprm.pdf
- FINALIZED in the Home Health Final Rule to begin collecting 1/1/2023
- PROPOSED in the HH Proposed Rule to take the place of current claims based measures of ACH and ED use

The Math…

- This measure calculates a risk-adjusted PPH rate for each HHA. This is derived by first calculating a standardized risk ratio – the predicted number of unplanned, potentially preventable hospital admissions or observation stays at the HHA divided by the expected number of admissions or observation stays for the same patients if treated at the average HHA.
- The standardized risk ratio is then multiplied by the mean potentially preventable admission or observation stay rate in the population (i.e., all Medicare FFS patients included in the measure) to generate the HHA-level standardized hospitalization rate of potentially preventable hospitalization.
- Measure uses 12-month CY data- and includes all Medicare stays, using full dates of service, plus one day after discharge.

The Exclusions

1) Stays where the patients are less than 18 years old.
   - Rationale: Patients under 18 years old are not included in the target population for this measure. Pediatric patients are relatively few and may have different patterns of care from adults.

2) Stays where the patients were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the HH admission date through the end of the home health stay.
   - Rationale: The adjustment for certain comorbid conditions in the measure requires information on acute inpatient claims for one year prior to the HH admission, and hospitalizations and observation stays must be observable in the observation window following discharge. Patients without Part A coverage or who are enrolled in Medicare Advantage plans will not have complete claims in the system.

3) Stays that begin with a Low Utilization Payment Adjustment (LUPA) claim.
   - Rationale: Home health stays designated as LUPAs are excluded because it is unclear that the initial HHA had an opportunity to impact the patient’s health outcomes.

More Exclusions…

4) Stays where the patient receives service from multiple agencies during the home health stay.

- Rationale: These home health stays are excluded because it is unclear that the initial HHA had an opportunity to impact the patient’s health outcomes.

5) Stays where the information required for risk adjustment is missing.

• Missing beneficiary’s birthday information;

• Beneficiary has gender other than male or female;

• Missing payment authorization code information;

• Beneficiary has Medicare Status Code other than the following: o 10: Aged without ESRD o 11: Aged with ESRD o 20: Disabled without ESRD o 21: Disabled with ESRD o 31: ESRD only

Selecting Diagnoses for “Preventable”

CMS sought clinical and TEP advice on why some rehospitalizations/ observation stays may have been prevented

- 1) Inadequate management of chronic conditions
- 2) Inadequate management of infections
- 3) Inadequate management of other unplanned events
- 4) Inadequate injury prevention

Excluded Diagnoses

- This measure is focused on inpatient admissions or observation stays that are potentially preventable (PP)
- **Planned** admissions are not counted in the numerator
- Planned inpatient admissions and observation stays are defined by the definition used for the Hospital Wide Readmission15 and "Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities16 measures"
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information- .html
- If an inpatient or outpatient claim contains a code for a procedure that is frequently a planned procedure, then that inpatient admission or observation stay is designated to be a planned inpatient admission or observation stay, and will not impact PPH

Risk Adjustment on the PPH Score

- Demographics:
  - Age, gender and “enrollment status” (Aged, disabled or ESRD)
  - ADL score: CMS using a composite of a number of ADLs from M1800s
- Proximal Hospitalizations:
  - Because beneficiaries who enter home health care from prior proximal hospitalizations may have different health statuses, this model takes into account beneficiaries’ immediate prior care setting, length of stay in proximal care (1-7 or 8 or more days) principal diagnoses, and procedures.
- Other care in last year
  - Number of: Acute discharges, ED visits, SNF visits, IRF and LTCH visits

Diagnoses Used for PPH (pp 21-37)

https://www.cms.gov/files/document/proposed-pph-measure-specifications-cy22-hh-qrp-nprm.

Table 1-1. Preliminary List of Conditions for Defining Potentially Preventable Admissions or Observation Stays with ICD-10 Codes (continued)

Conditions	Subconditions	ICD-10-CM	ICD-10-CM Description
Chronic obstructive pulmonary disease (COPD), continued	COPD* (PQI 05), continued	J42	Unspecified chronic bronchitis
		J430	Unilateral pulmonary emphysema [MacLeod's syndrome]
		J431	Panlobular emphysema
		J432	Centrilobular emphysema
		J438	Other emphysema
		J439	Emphysema, unspecified
		J440	Chronic obstructive pulmonary disease with acute lower respiratory infection
		J441	Chronic obstructive pulmonary disease with (acute) exacerbation
		J449	Chronic obstructive pulmonary disease, unspecified
		J470	Bronchiectasis with acute lower respiratory infection
		J471	Bronchiectasis with (acute) exacerbation
		J479	Bronchiectasis, uncomplicated
Congestive heart failure (CHF)		I09.81	Rheumatic heart failure
		I11.0	Hypertensive heart disease with heart failure
		I11.0	Hypertensive heart disease with heart failure
		I11.0	Hypertensive heart disease with heart failure
		I13.0	Hypertensive heart and chronic kidney disease

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Condition “Groups” in PPH Measure

1. Adult Asthma
2. CHF
3. COPD
4. Diabetes complications
5. Hypo/Hypertension
6. Influenza
7. Bacterial pneumonia
8. UTI/Kidney infection
9. C.Diff

- 10. Septicemia
- 11. Dehydration/Electrolyte issues
- 12. Skin/Subq Infections
- 13. Aspiration pneumonitis
- 14. Arrythmia
- 15. Intestinal impaction
- 16. Pressure Ulcers

Timeframes…

- CMS is proposing to make all changes to the applicable measure set discussed in this rule beginning with the CY 2025 performance (calendar) year, thus all changes will affect the same payment year beginning with the CY 2027 payment year.

  Since we would then have two less measures, CMS is proposing to adjust the weights for the measures in the OASIS-based and claims-based measure categories starting in CY 2025. Lastly, CMS is proposing to update the Model baseline year to CY 2023 for all measures starting in CY 2025.

Additional Changes…

- There were some additional changes related to:
- -- lymphedema therapy
- -- IVIG therapies being provided in the home setting
- --enrollment changes
- --Major hospice program integrity changes

Request for information

- CMS shared a number of concerns about utilization changes and the sharp decrease in aide utilization
- Requesting HHAs to provide feedback as to why
  - Staffing
  - Payment cuts
  - Change in patient

Actions of a Prudent Home Health Agency™

1. Know the changes
2. Review your current data- Medicare payments to calculate potential loss in 2024, CBSA wage index amount, case mix, functional domain and diagnoses impacts
3. Track and review rates for Medicare patient hospitalizations and observations throughout care
4. Plan how to impact these areas of need
5. Respond to CMS in Comments and RFI

Questions?

HOME HEALTH FUNDAMENTALS

KNOWLEDGE • EXPERTISE • COMMON SENSE

Annette Lee RN, MS, COS-C, HCS-D

Still to come this month...

Chart

OASIS IMPACTS FOR QUALITY AND PAYMENT

MEASURE	OASIS ITEMS	STAR RATING	PDGM	HHVBP 2023
Timely initiation of care	M0030/32, M0102, M0104	✓		
Hospitalization Risk	M1033 (If four or more risks indicated)		✓	
Improvement in Dyspnea	M1400	✓		✓
Improvement in Grooming	M1800		✓	✓
Improvement in Dressing Upper Body	M1810		✓	✓
Improvement in Dressing Lower Body	M1820		✓	✓
Improvement in Bathing	M1830	✓	✓	✓
Improvement in Toilet Transfer	M1840		✓	✓
Improvement in Toileting Hygiene	M1845			✓
Improvement in Bed Transferring	M1850	✓	✓	✓
Improvement in Ambulation/locomotion	M1860	✓	✓	✓
Improvement in Eating	M1870			✓
Improvement in Management of Oral Medications	M2020	✓		✓
Discharge to the Community	M2420			✓

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

FOR MORE INFORMATION: visit www.homehealthfundamentals.com

© 2022 ALL RIGHTS RESERVED - HOME HEALTH FUNDAMENTALS.

FYI:

Public Health Emergency (PHE) Extended

HOME HEALTH FUNDAMENTALS SUBSCRIBER EMAILS — AUGUST 2022

The Least You Need to Know:

The Public Health Emergency (PHE) was extended for another 90 days on July 15th, 2022. Since the beginning of the COVID-19 PHE, CMS has provided blanket waivers to provide flexibilities to meet the needs of the patients being served while facing a health and staffing crisis. The PHE will continue until at least October 13th, 2022, and the flexibilities of all of the federal waivers will continue at minimum at least 60 days after the end of the PHE.

Waivers include flexibilities such as:

- Ability to perform "initial assessment" of home bound status and immediate care needs telephonically to meet the timeframe of two days, per the Conditions of Participation (COPs).
- Waive onsite visits for the home health aide supervisory visits every two weeks per 484.80(h).
- Waive the 12 hours of yearly education for home health aides
- Extension of the timeframe for provision of medical records upon request to 10 days, instead of the four days required in the COPs.
- Allowance to narrow the scope of Quality Assessment Performance Improvement (QAPI) program to focus on items impacted during PHE, such as infection control.

HHF Hint: ***Currently, these remote visits do NOT go to the claim, nor is there payment by Medicare for remote visits/telehealth***

Actions of a Prudent Home Health Agency™

ONE. **Know the waivers available to you.** The prudent home health will continue to leverage these flexibilities when there are staffing shortages, cases of quarantining, etc.

TWO. **Review your current use, if any, of these flexibilities.** Are you using consistently? Could you return to "normal compliance"? What are the barriers?

THREE. **Create a plan to transition back to the traditional COPs without flexibilities by December 12th**—just in case the PHE is not extended and CMS is looking to resume "business as usual" within the 60 day window.

Links to More Information

COVID-19 Declaration Waivers - https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

CHECK IT OUT

22.8 FOR MORE INFORMATION: visit www.homehealthfundamentals.com

© 2022 ALL RIGHTS RESERVED · HHH FUNDAMENTALS. PERMISSION IS GRANTED TO SHARE FREELY WITHIN YOUR HOSPICE; ANY OTHER DISTRIBUTION IS A VIOLATION OF COPYRIGHT LAWS.

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

HOME HEALTH FUNDAMENTALS

KNOWLEDGE • EXPERTISE • COMMON SENSE

Contact Us

CALL US:
(561) 454-8121

EMAIL US:
heretohelp@homehealthfundamentals.com

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.