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# CMS Finalizes Payment Cuts for Home Health Agencies for CY 2025

On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2025 Home Health Prospective Payment System final rule for home health agencies (HHAs). CMS released a fact sheet accompanying the final rule. This final rule includes the annual payment update, changes to the home health conditions of participation, updates to the quality reporting program and the value-based purchasing model, and updates to provider and supplier enrollment requirements.

This final rule is scheduled to be published in the *Federal Register* on November 7, 2024.

## CMS PREDICTS $85 MILLION INCREASE IN HOME HEALTH PAYMENTS IN CY 2025

The Home Health Prospective Payment System (PPS) provides a standardized case-mix and area-wage adjusted payment to home health agencies for 30-day periods. This bundled payment includes six home health service types, including skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services, as well as non-routine supplies.

For CY 2025, CMS finalizes a .5 percent increase in home health payments, or $85 million, relative to CY 2024. This reflects an estimated 1.8 percent, or $305 million, decrease associated with the behavioral assumption adjustment (also known as the permanent adjustment), an estimated 0.4 percent, or $79 million, decrease associated with a proposed fixed-dollar loss ratio (FDL), and a 2.7 percent, or $460 million, home health PPS annual payment update increase.

**Table 1. Home Health PPS Payment Impacts for CY 2025**

| CY 2025 Annual Update | CY 2025 FDL | Behavioral Assumption Adjustment | CY 2025 Economic Impact |
|---|---|---|---|
| 2.7% (+$460 million) | -0.4% (-$70 million) | -1.8% (-$305 million) | **0.5% ($85 million)** |

## In Response to Comments, CMS Only Finalizes Half of Remaining Permanent Adjustment

In CY 2020, CMS implemented the Patient-Driven Groupings Model (PDGM) for home health agency payment, as required by statute.[1] The goal of the PDGM is to better align payments with patient care needs, especially for beneficiaries that require more skilled nursing care rather than therapy. When implementing the law, CMS had to make assumptions about behavior changes that could occur due to the implementation of the 30-day unit of payment and the PDGM.[2] CMS annually determines the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures and adjusts payment accordingly.

In the CY 2023 Home Health PPS final rule,[3] CMS determined that Medicare paid more to home health agencies in CYs 2020 and 2021 under the PDGM than the old payment system. In response, CMS indicated a negative 7.85 percent adjustment would need to be made to the 30-day payment rate. However, to mitigate the impact of such a large adjustment, CMS finalized a phased-in permanent adjustment, reducing it by half to negative 3.925 percent.

In the CY 2024 Home Health PPS final rule[4], CMS once again only finalized half of the remaining negative 5.779 percent permanent adjustment, reducing it to negative2.890 percent. For CY 2025, CMS originally proposed to apply all of the remaining permanent adjustment (negative 3.95 percent). However, commenters expressed concerns about the industry's ability to weather the full adjustment amid increasing costs, labor shortages, and increasing referral rejections from HHAs. In response, CMS will only

[1] 42 U.S.C. 1395fff(b)(2)
[2] CMS finalized three behavioral assumptions in the CY 2019 Home Health PPS final rule with comment period, including clinical group coding, comorbidity coding, and the Low Utilization Payment Adjustment threshold.
[3] 87 FR 66796
[4] 88 FR 77697

finalize half of the remaining permanent adjustment for CY 2025 and will apply an adjustment of negative 1.975 percent to the 30-day base payment rate.

The final national standardized 30-day period payment rate for CY 2025 is $2,057.35.

## CMS UPDATES CORE-BASED STATISTICAL AREAS USED FOR WAGE INDEX

CMS finalizes its proposal to update the home health wage index using the Office of Management and Budget's (OMB) most recent Core-Based Statistical Areas (CBSAs) delineations, which are based on 2020 Decennial Census data. CMS believes that adopting these new delineations will result in wage index values more accurately representing the actual local costs of labor. Due to this update, 54 counties currently part of an urban Core-Based Statistical Area (CBSA) will be considered located in a rural area[5], and another 54 currently part of a rural CBSA will be considered located in an urban area[6]. Wage index decreases are capped at 5 percent for a given year.

## CMS RECALIBRATES CASE-MIX WEIGHTS USING CY 2023 CLAIMS DATA

Under the PDGM, there are 432 payment groups with each having an associated case-mix weight and Low Utilization Payment Adjustment (LUPA) threshold. CMS annually recalibrates the case-mix weights and LUPA thresholds using the most recent and complete utilization data available to ensure they reflect current home health resource use and changes in utilization patterns.

For CY 2025, CMS finalizes its proposal to recalibrate the LUPA thresholds, PDGM case-mix weights, functional levels, and comorbidity adjustment subgroups using CY 2023 claims data.[7] The final case-mix budget neutrality factor for CY 2025 will be 1.0039.

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[5] See Table 14 on page 102 of the unpublished final rule

[6] See Table 15 on page 105 of the unpublished final rule

[7] See Table 12 on page 70 of the unpublished final rule for final case-mix weights and LUPA thresholds for each HHRG payment group.

## CMS FINALIZES A 2.7 PERCENT INCREASE TO PAYMENTS FOR HOME IVIG

The payment rate for home intravenous immune globulin (IVIG) and services is subject to annual updates based on the home health payment rate update percentage. Division FF, section 4134 of the Consolidated Appropriations Act, 2023 (CAA, 2023) expanded Medicare coverage to include IVIG administration in the homes of patients with primary immune deficiency disease (PIDD), effective January 1, 2024.[8]

For CY 2025, CMS finalizes a payment rate for home IVIG items and services of $431.83 per visit, which reflects the CY 2024 IVIG items and services payment rate of $420.48 updated by the 2.7 percent final home health payment increase. This differs from the proposed rate of $430.99 per visit, which reflected the proposed home health payment update percentage of 2.5 percent. CMS estimates that this payment update will result in a total cost increase of $250,000 for the Medicare fee-for-service program.

## CHANGES FINALIZED FOR HOME HEALTH CONDITIONS OF PARTICIPATION

Sections 1861(o) and 1891 of the Social Security Act grant the Secretary of the HHS authority to define the conditions of participation (CoPs) that HHAs must meet to qualify for Medicare participation. These standards apply both to HHAs as entities and to the services provided to individual patients. Currently, HHAs must provide skilled nursing services and at least one other therapeutic service on a visiting basis in patients' residences, tailored to meet their specific needs. However, the variability in services among HHAs presents challenges for patients and caregivers in finding an HHA that meets their exact care requirements.

To address these challenges and enhance patient care outcomes, CMS finalizes its proposal to require HHAs to develop and maintain an "acceptance to service policy" for prospective patients referred for home health care. This policy will involve an annual review and assessment of factors such as current case load, case mix, staffing levels, and staff competencies, enabling HHAs to make informed decisions about accepting new patients.

Additionally, HHAs must publicly disclose accurate information about the services they offer, including any limitations related to specialty services, service duration, or

[8] The amendment added coverage under section 1861(s)(2)(Z) of the Act and established a separate bundled payment system for IVIG administration items and services, distinct from the IVIG product payment.

frequency. This transparency aims to assist referring entities, caregivers, and patients in selecting an HHA that aligns with their specific care needs and geographic location.

CMS received mixed feedback on this policy. Some commenters felt this policy would improve access and equity by ensuring HHAs only accept patients they can adequately serve, while others argued it could limit access and increase administrative burdens without addressing staffing challenges. CMS acknowledged these concerns but maintained that the policy would enhance timely care and workload distribution by standardizing patient acceptance.

## CMS FINALIZES CHANGES TO PROVIDER AND SUPPLIER ENROLLMENT POLICIES

Section 1866(j)(3)(A) of the Social Security Act directs the HHS Secretary to establish procedures for ensuring enhanced oversight of new providers and suppliers. CMS typically oversees newly enrolled HHAs under a provisional period of enhanced oversight (PPEO) to monitor for fraud, waste, and abuse.

CMS finalizes its proposal to include providers and suppliers that are reactivating their Medicare enrollment and billing privileges under the "new provider and supplier" category. CMS may impose a PPEO for 30 days to one year for reactivating providers and suppliers.

## CMS FINALIZES FOUR NEW SDOH MEASURES UNDER THE HOME HEALTH QUALITY REPORTING PROGRAM, MODIFICATIONS TO ONE EXISTING MEASURE

Under the Home Health Quality Reporting Program (HH QRP), HHAs must submit certain required data for the measurement of health care quality. HHAs that fail to submit this data have their annual payment update reduced by 2 percentage points.

CMS finalizes its proposal to add four new social determinants of health (SDOH) assessment items to the Outcome and Assessment Information Set (OASIS), the instrument used to collect and report assessment data for the HH QRP, and to modify one existing item.

These new measures and modification are intended to better standardize the collection of SDOH data across programs, with all the changes being based on measures currently collected in the Accountable Health Communities (AHC) Health related social needs

(HRSN) Screening Tool. CMS finalized identical changes to the Inpatient Rehabilitation Facility Quality Reporting Program (QRP) and the Skilled Nursing Facility Quality Reporting Program (SNF QRP) in their respective rules. These changes will go into effect beginning with the CY 2027 HH QRP.

In addition, the agency finalizes updates to OASIS all-payer data collection, and responds to feedback received on future HH QRP quality measure concepts.

## New SDOH Measures to be Collected Using the OASIS

### Living Situation

CMS believes that HHAs could use housing information on a patient's living situation to better inform discharge planning and ensure that referrals to address this SDOH are not lost when care is transitioned.

The finalized measure will ask patients "What is your living situation today?" CMS finalizes the following response options: (1) I have a steady place to live; (2) I have a place to live today, but I am worried about losing it in the future; (3) I do not have a steady place to live; (4) Patient unable to respond; and (5) Patient declines to respond.

### Food

Food insecurity is associated with several negative health outcomes, including cardiovascular disease. CMS aims to increase coordination between HHAs and providers to address food insecurity during transitions of care. This information could also be used to refer patients to government programs such as the Supplemental Nutrition Assistance Program (SNAP).

Accordingly, CMS finalizes two food related measures that would be asked to patients:

1. "Within the past 12 months, you worried that your food would run out before you got money to buy more."
2. "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."

Patients will choose one of the following proposed options to respond: (1) Often true; (2) Sometimes true; (3) Never True; (4) Patient declines to respond; and (5) Patient unable to respond.

### Utilities

The inability to cover the cost of utilities places patients at risk of living without adequate heat or air conditioning. These living conditions can lead to negative health outcomes such as increased risk of respiratory conditions. Accordingly, CMS believes

HHAs should have access to information regarding a patient's utility insecurity so that they can help connect patients to programs that address this SDOH, such as the Low-Income Home Energy Assistance Program (LIHEAP), which helps pay for heating and cooling.

This measure will ask patients, "In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?"

Patients will choose one of the following proposed options to respond: (1) Yes; (2) No; (3) Already shut off; (4) Patient unable to respond; and (5) Patient declines to respond.

### Modifications to the Transportation Measure

CMS finalizes its proposal to modify the existing transportation item to better align this item with the AHC HRSN Screening Tool. The modifications would make the lookback period for the measure clearer and simplify the response options available to patients.

This measure will be modified from reading, "Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?" to "In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?"

Patients will choose one of the following options to respond: to: (0) Yes; (1) No; (7) Patient declines to respond; and (8) Patient unable to respond.

### Updates to OASIS All-Payer Data Collection

CMS finalized requirements for HHAs to submit all-payer OASIS data beginning with the CY 2027 HH QRP in the CY 2023 HH PPS final rule. This rule also finalized the end of the temporary suspension of OASIS data collection for patients who were not enrolled in Medicare or Medicaid. To add clarity to these changes, CMS finalizes its proposal to establish that data collection will begin with the start of care (SOC) time point, as opposed to the OASIS discharge time point. To provide data for the CY 2027 program year, HHAs must collect data for non-Medicare/non-Medicaid patients beginning July 1, 2025, for the mandatory period.

### CMS Will Consider Feedback on Future HH QRP Quality Measure Concepts

CMS sought feedback on four concepts that could be incorporated into the HH QRP to better align the program with CMS's Universal Foundation of quality measures: a composite vaccination measure similar to the Adult Immunization Status measure in the Universal Foundation, a depression related measure similar to the Clinical Screening for Depression and Follow-up measure in the Universal Foundation, the concept of pain management, and a measure of substance use disorder similar to the

Initiation and Engagement of Substance Use Disorder Treatment measure in the Universal Foundation. CMS did not respond to comments but will incorporate them into future measure development.

## CMS CONSIDERS FEEDBACK ON MEASURE CONCEPTS FOR EXPANDED HOME HEALTH VALUE-BASED PURCHASING MODEL

In the CY 2022 HHA Final Rule,[9] CMS finalized its expansion of the Home Health Value-Based Purchasing (VBP) Model; requiring HHAs in all 50 states, the District of Columbia, and U.S. territories to participate, with a pre-implementation year beginning in 2022. CY 2023 was the first performance year, which will impact payment during CY 2025 with a maximum payment adjustment, upward or downward, of 5 percent.

CMS views the expanded VBP Model as an opportunity to improve quality of care and adopt measures that address critical gaps in care. Accordingly, the agency sought general comments on future model concepts, as well as feedback on the following specific performance measures that could be included in the expanded VBP Model:

- A measure that addresses HHAs ability to meet caregiver needs,
- A claims-based measure of falls with injury,
- A measure of Medicare spending per beneficiary (MSPB), and
- Measures that would complement the existing cross-setting Discharge (DC) Function measure by better capturing daily living elements like bathing and dressing.

Commenters were generally supportive of caregiver needs measure and the DC function measure but had mixed reactions to the falls with injury measure and MSPB measure. For all of the measures, commenters had potential concerns. CMS also received feedback on other measures to potentially include in the expanded VBP model, such as advance care planning and interoperability. Additionally, some stakeholders were concerned about burden and duplicative reporting. Any future changes to this measure set will be carried out via rulemaking.

The final rule also includes an update on potential approaches to integrate a health equity adjustment into the VBP Model. While CMS did not propose any health equity

[9] 86 FR 62240.

changes to the model in this rule, the agency reiterates its intention to establish a health equity adjustment (HEA) that rewards HHAs for providing high quality care to underserved populations. This adjustment will not be finalized until at least two years of performance data are gathered under the program so that the agency can better understand the program's impact on health equity outcomes.

Stakeholders generally supported CMS's efforts to advance health equity. While supportive, commenters also noted concerns such as challenges with implementation and the potential for disincentivizing HHAs to treat certain patients. Some stakeholders suggested CMS expand the use of the SNF VBP Program HEA to the HHVBP.

Comments in response to the RFI and health equity update will be shared with the Expanded Home Health Value-Based Purchasing (HHVBP) Model's Implementation and Monitoring technical expert panel (TEP) and used to inform future measure development and policy.

## CMS SOUGHT COMMENTS ON TWO REQUESTS FOR INFORMATION

In this final rule, CMS sought public comment the following two topics:

1. Feasibility of rehabilitative therapists conducting the comprehensive assessment for cases that have both therapy and nursing services ordered as part of the plan of care.
2. HHA scope of services and how these services interact with HHA operations.

### RFI to Allow Rehabilitation Therapist to Conduct the Comprehensive Assessment

The CoPs in § 484.55(a)(1) mandate that a registered nurse must perform an initial assessment visit within 48 hours of referral or the patient's return home, or no later than 5 days after the start of care date ordered by the physician or practitioner.

Rehabilitation professionals (occupational therapists (OT), physical therapists (PT), or speech-language pathologists (SLP)) may conduct the initial and comprehensive assessments when therapy services are the sole services ordered.

CMS waived the requirements in § 484.55(a)(2) and (b)(3) at the beginning of the COVID-19 public health emergency (PHE), allowing rehabilitation professionals to conduct the initial and comprehensive assessment when both nursing and therapy services are ordered. CMS sought comment regarding revising the policy to expand

coverage permanently. In response to comments regarding appropriate patient placement with a HHA, CMS acknowledged the skills and clinical knowledge of a nurse may be important to this process but that other clinicians, such as rehabilitation therapists, may be appropriate as well. Further, CMS noted their belief that it is best to allow the HHA the flexibility to determine which staff members should be included in the process of determining whether an HHA can serve a patient.

### RFI to Evaluate HHA Scope of Services and HHA Operations

CMS sought comment on the communications that occur between patients' physicians and allowed practitioners in establishing and reviewing the plan of care. CMS also solicited comments on how physicians and allowed practitioners make sure patients receive the correct mix, duration, and frequency of services to meet outcomes and goals identified by the patient and the HHA. Several commenters noted that there are often communication gaps between patients, referral sources, and HHAs. In response, CMS noted HHAs are responsible for their own policies and share patient care responsibilities with the practitioners that oversee the HHA plan of care.

## ACUTE RESPIRATORY ILLNESS DATA REPORTING TO REPLACE COVID-19 REPORTING STANDARDS

CMS finalizes a new data reporting standard, to replace current COVID-19 reporting standards for Long-Term Care (LTC) Facilities that sunset in December 2024, with a new standard that addresses a broader range of respiratory illnesses. The proposed data elements include facility census; resident vaccination status for COVID-19, influenza, and respiratory syncytial virus (RSV); confirmed resident cases of COVID-19, influenza, and RSV (overall and by vaccination status); and hospitalized residents with confirmed cases of COVID-19, influenza, and RSV (overall and by vaccination status). The measures are required for reporting beginning January 1, 2025. CMS sought feedback on ways to minimize the reporting burden on HHAs. Many commenters recommended that CMS scale back the frequency of reporting as compared to the current weekly reporting. In response, CMS reiterated their belief of the importance of weekly reporting at this time and noted that the finalized requirements, such as the creation of one simplified reporting form, are streamlined compared to current post COVID-19 PHE requirements. CMS also noted that there are ongoing projects with LTC industry stakeholders to modernize data collection methods. Several commenters also noted the need for HHS to invest in the infrastructure needed to make reporting of these values less burdensome and CMS acknowledged the agency's ongoing efforts to do so in response.

CMS also finalized that, in the event of a future national public health emergency for an acute respiratory illness, there may be additional data elements required to be reported. CMS is not finalizing their proposal to increase data reporting if a significant threat for a public health emergency for an acute infectious illness exists.

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