Home Health Billing Update 2025 & Beyond

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1

Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the NAHC/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E1 and Home Health Billing Answers, 2025.

Melinda A. Gaboury, COS-C
Chief Executive Officer

2

2025 Final Rule Recap Impact on Reimbursement

- CY 2025 Final Home Health Prospective Payment System Rate
- Final is -1.975% (4.067% was proposed) permanent PDGM Budget Neutrality Adjustment
- 2.7% net inflation rate update (3.2% – 0.5% productivity adjustment) was proposed at 2.5%
- Outlier FDL modified to 0.35 (2024 - 0.27) – proposed at 0.38
- Recalibrates all 432 case mix weights (separate budget neutrality of 1.0039%)
- Wage Index Changes lead to 0.9988% budget neutrality adjustment.
- Adds OT LUPA only add-on and modifies other LUPA add-ons – LUPA threshold update

3

Standard Base Rate

TABLE 21: CY 2025 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2024 National Standardized 30-Day Period Payment	CY 2025 Permanent BA Adjustment Factor	CY 2025 Case-Mix Weights Recalibration Neutrality Factor	CY 2025 Wage Index Budget Neutrality Factor	CY 2025 Final HH Payment Update	CY 2025 National, Standardized 30-Day Period Payment
$2,038.13	0.98025	1.0039	0.9988	1.027	$2,057.35

Proposed

TABLE 34: CY 2025 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2024 National Standardized 30-Day Period Payment	Permanent Adjustment Factor	Case-Mix Weights Recalibration Budget Neutrality Factor	Wage Index Budget Neutrality Factor	CY 2025 HH Payment Update Factor	CY 2025 National, Standardized 30-Day Period Payment
$2,038.13	0.95933	1.0035	0.9985	1.025	$2,008.12

4

PDGM – Clinical Groupings

- Medication Management, Teaching and Assessment (MMTA)
- MMTA – Surgical Aftercare
- MMTA – Cardiac/Circulatory
- MMTA – Endocrine
- MMTA – GI/GU
- MMTA – Infectious Diseases/Neoplasms
- MMTA – Respiratory
- MMTA – Other
- Neuro Rehab
- Wounds
- Complex Nursing Interventions
- Musculoskeletal (MS) Rehab
- Behavioral Health

5

Comorbidity Adjustment

- **Low comorbidity adjustment**: (22 subgroups proposed) There is a reported secondary diagnosis that falls within one of the home-health specific individual comorbidity subgroups associated with higher resource use, or;
  - 5.08% increase in case-mix from No to Low
- **High comorbidity adjustment**: (94 subgroups finalized – only 90 proposed) There are two or more secondary diagnoses reported that fall within the same comorbidity subgroup interaction that are associated with higher resource use.
  - 9.66% increase in case-mix from Low to High

6

HH PPS Final Low Comorbidity Adjustment Subgroups for CY 2025

Low Comorbidity Subgroup	Description
Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae
Circulatory 2	Hemolytic, Aplastic, and Other Anemias
Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension
Circulatory 9	Other Venous Embolism and Thrombosis
Circulatory 10	Varicose Veins and Lymphedema
Endocrine 3	Type 1, Type 2, and Other Specified Diabetes
Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease
Gastrointestinal 2	Intestinal Obstruction and Ileus
Heart 10	Dysrhythmias, includes Atrial Fibrillation and Atrial Flutter
Heart 11	Heart Failure
Neoplasms 1	Malignant Neoplasms of Lip, Oral Cavity and Pharynx, includes Head and Neck Cancers
Neoplasms 2	Malignant Neoplasms of Digestive Organs, includes Gastrointestinal Cancers
Neoplasms 17	Secondary neoplasms of respiratory and GI systems.
Neoplasms 18	Secondary Neoplasms of Urinary and Reproductive Systems, Skin, Brain, and Bone
Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
Neurological 10	Diabetes with neuropathy
Neurological 11	Disease of the Macula and Blindness/Low Vision
Neurological 12	Nondiabetic neuropathy
Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
Skin 4	Stages Two-Four and unstageable pressure ulcers by site

7

Patient Driven Groupings Model (PDGM)

Functional Level (OASIS Items) – (Low, Medium, High)

- Anticipates roughly 33% of periods of care will fall into each of the categories.
- M1800-M1860 (NOT M1845) and M1033 are OASIS-E Items will continue to determine the Functional Level
- GG items are not the same as the 1800 items - it is expected that they will eventually replace the M1800 items on the OASIS and in the PDGM calculations.
- GG items are currently used in RISK adjustment for outcomes calculations

8

Functional Impairment

TABLE 9: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY FUNCTIONAL IMPAIRMENT LEVEL, CYs 2018-2023

Functional Impairment Level	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023
Low	33.9%	31.9%	25.7%	23.2%	28.1%	29.8%
Medium	34.9%	35.5%	32.7%	32.6%	33.1%	31.8%
High	31.2%	32.6%	41.7%	44.2%	38.8%	38.3%

9

OASIS Points Table – Final Rule 2024		Response	2024 Points	2025 Proposed Points	% of Periods
M1800: Grooming		2,3	3	3	74.6%
M1810: Current Ability to Dress Upper Body		2,3	5	5	80.5%
M1820: Current Ability to Dress Lower Body		2	3	3	65.3%
		3	11	11	25.4%
M1830: Bathing		2	0	3	10.0%
		3,4	7	10	49.6%
		5,6	14	18	38.0%
M1840: Toilet Transferring		2,3,4	6	5	39.0%
M1850: Transferring		1	3	1	18.8%
		2,3,4,5	6	4	80.0%
M1860: Ambulation		2	6	6	13.8%
		3	4	2	65.2%
		4,5,6	20	18	17.8%
M1033: Risk of Hospitalization	4 or more marked	1-7	11	12	41.1%

10

CBSA Changes

- 54 urban counties in 2024 moved to rural in 2025 (25 states and PR)
- 54 rural counties in 2024 moved to urban in 2025 (25 states)
- Some counties moved from one CBSA to another CBSA
- Some counties that are being moved to a different URBAN CBSA

Finalized Last Year - 5% transition cap calculated at county level when moving from CBSA or rural designation to new CBSA or rural – Claims must use new transition code for affected counties

11

Case-Mix Weight Adjustments

- Recalibrate annually the PDGM case-mix weights using a fixed effects model with the most recent and complete utilization data available at the time of annual rulemaking.
- Used CY 2023 home health claims data with linked OASIS data
- Reflective of PDGM utilization and patient resource use expected for CY2025
- Budget neutrality adjustment of 1.0039% applied to base rate

12

LUPA STATS

LUPA Thresholds Updated – 8 case-mix groups saw a decline of 1 visit in the threshold

TABLE 23: CY 2025 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2024 Per-Visit Payment Amount	CY 2025 Wage Index Budget Neutrality Factor	CY 2025 Final HH Payment Update	CY 2025 Per-Visit Payment Amount
Home Health Aide	$76.23	0.9989	1.0270	$78.20
Medical Social Services	$269.87	0.9989	1.0270	$276.85
Occupational Therapy	$185.29	0.9989	1.0270	$190.08
Physical Therapy	$184.03	0.9989	1.0270	$188.79
Skilled Nursing	$168.37	0.9989	1.0270	$172.73
Speech-Language Pathology	$200.04	0.9989	1.0270	$205.22

13

LUPA Add-on Update 2025

LUPA Add-On %

- SN 1.7200
- PT 1.6225
- SLP 1.6696
- OT 1.7238

To calculate the payment, multiply the per-visit payment amount for the Start of Care visits - SN, PT, SLP or OT visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount.

For example, using the proposed CY 2025 per-visit payment rates for those HHAs that submit the required quality data, for LUPA periods that occur as the only period or an initial period in a sequence of adjacent periods, if the first skilled visit is SN, the payment for that visit would be $297.09 (1.7200 multiplied by $172.73), subject to area wage adjustment.

14

Notice of Medicare Non-Coverage

The new forms for use in 2025 have been released! These new forms have an expiration date of 11/30/2027…..you will need these new forms for any notifications issued in 2025 and beyond.

You can be cited if you are NOT using the new forms.

Also note that effective January 1, 2025, Medicare Advantage patients will now have the same immediate appeal rights through the QIO that Traditional Medicare patients have…..you will need to issue to all Medicare and Medicare Advantage patients at least 2 days prior to discharge.

15

dNPWT Devices

Beginning January 1, 2024, the separate payment for a dNPWT device is made to an HHA for an individual who is under a home health plan of care using Healthcare Common Procedure Coding System (HCPCS) code A9272. The code HCPCS A9272 is defined as a wound suction, disposable, includes dressing, all accessories and components, any type, each. The HHA reports the HCPCS code A9272 for the device only on the home health TOB 32X. The services related to the application of the device are included in the home health payment and are excluded from the separate payment amount for the device.

CY 2025 Disposable Negative Pressure Wound Therapy Rate (dNPWT)		
CY2024 dNPWT Payment Rate	**CY2025 dNPWT Payment Update (12-month CPI-U ending in June 2024 (3.0%) Reduced by Productivity Adjustment (0.6%))**	**CY2025 dNPWT Payment Rate**
$270.09	1.024	$276.57

16

Home Health Value Based Purchasing

17

Finalized Changes - 2025!

The HH Final Rule, released on Nov 1, 2023, finalized several changes to HHVBP, starting in CY2025:

- **Removal of 5 measures**, addition of **3 new measures** (starting in CY 2025)
- **Updated weights** for all measures, except HHCAHPS (starting in CY 2025)
- **Updated Baseline Year (2023)** for all measures (starting in CY 2025)
- Codify the measure removal factors (effective in CY 2024)

Public Reporting Update

CMS is including an update to remind HHAs and other stakeholders that **public reporting** of HHVBP performance data and payment adjustments will begin in December 2024.

18

Meure Category	Quality Measures	*Finalized Redistributions*			
		Current Measure Weights* (CY 2023, CY 2024)		Measure Weights Beginning CY 2025	
		Larger-Volume Cohort	Smaller-Volume Cohort	Larger-Volume Cohort	Smaller-Volume Cohort
OASIS-based Measures	Discharged to Community	5.83%	8.33%	-	-
	Improvement in Dyspnea	5.83%	8.33%	6.00%	8.57%
	Improvement in Management of Oral Medications	5.83%	8.33%	9.00%	12.86%
	TNC Change in Mobility	8.75%	12.5%	-	-
	TNC Change in Self-Care	8.75%	12.5%	-	-
	Discharge Function Score	-	-	20.00%	28.57%
	Sum of OASIS-based measures	**35.00%**	**50.00%**	**35.00%**	**50.00%**
Claims-based Measures	Acute Care Hospitalization	26.25%	37.50%	-	-
	Emergency Department Use	8.75%	12.50%	-	-
	Potentially Preventable Hospitalization	-	-	26.00%	37.14%
	Discharge to Community- Post Acute Care	-	-	9.00%	12.86%
	Sum of Claims-based measures	**35.00%**	**50.00%**	**35.00%**	**50.00%**
HHCAHPS Survey-based Measures	Care of Patients	6.00%	0.00%	6.00%	0.00%
	Communication Between Providers and Patients	6.00%	0.00%	6.00%	0.00%
	Specific Care Issues	6.00%	0.00%	6.00%	0.00%
	Overall Rating of Home Health Care	6.00%	0.00%	6.00%	0.00%
	Willingness to Recommend the Agency	6.00%	0.00%	6.00%	0.00%
	Sum of HHCAHPS Survey-based measures	**30.00 %**	**0.00%**	**30.00%**	**0.00%**
Sum	**Sum of All Measures**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**

19

Annual Payment Adjustment

Performance Year	CY 2023
Maximum Adjusted Payment Percentage	5.000%
Payment Year	CY 2025
Your HHA's Final TPS-Adjusted Payment Percentage	**-1.366%**

Annual Payment Adjustment Calculation

	(C1)	Step 1 (C2)	Step 2 (C3)	Step 3 (C4)	Step 4 (C5)	Step 5 (C6)	Step 6 (C7)	Step 7 (C8)
	Total Performance Score (TPS)	Prior Year Payment	Unadjusted Payment Amount *5% x (C2)*	TPS-Adjusted Payment Amount *(C1/100) x (C3)*	Linear Exchange Function (LEF) Ratio *Total (C3)/Total (C4)*	Final TPS-Adjusted Payment Amount *(C4) x (C5)*	TPS-Adjusted Payment Percentage *(C6)/(C2)*	Final TPS-Adjusted Payment Percentage *(C7) - 5%*
Your HHA:	20.685	$12,147,000	$607,350	$125,630	3.514	$441,416	3.634%	**-1.366%**
Your HHA's Cohort (all HHAs):	28.786	$16,533,718,824	$826,685,941	$235,281,179	3.514	$826,685,949	5.000%	-

20

Updated Resources for HHVBP

Resource Guide

https://www.cms.gov/priorities/innovation/media/document/hhvbp-exp-model-resource-index

New Email Address for Questions

HHVBPquestions@cms.hhs.gov

New FAQs Updated for 2025 Changes

https://www.cms.gov/priorities/innovation/media/document/hhvbp-exp-faqs

Technical Expert Panel Report for 2025 Changes

https://www.cms.gov/files/document/hhvbp-exp-tech-exp-panel-rpt.pdf

21

HHVBP - Future

Request for information related to future measure concepts

- Family caregiver measure
- Falls with injury (claims-based)
- Medicare spending per Beneficiary
- Function measures to complement existing cross-setting Discharge (DC) Function measure CMS is also interested in general comments on other future model concepts that may be considered for inclusion in the expanded HHVBP Model.

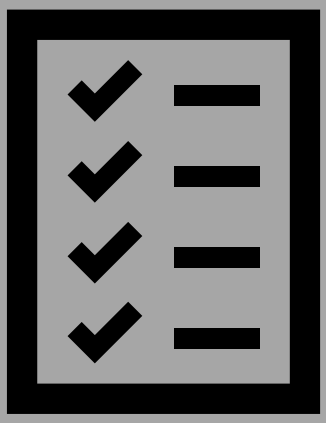
22

Managed Care Plans

23

When you receive the Referral

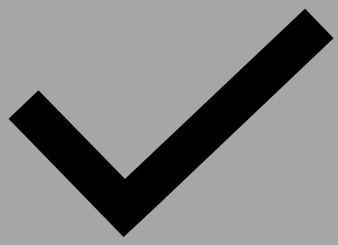
- Verify eligibility
  - Medicare verify- on every patient
  - Medicaid verification- every patient
  - Health plan verification
- Verify benefits
  - Confirm network status
  - Determine if authorization is required
  - Utilize payer portals



24

Verification

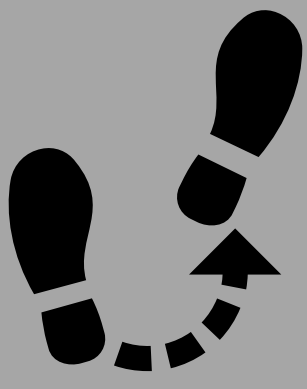
- Ensure policy is current
- Confirm services needed are covered
- Out of Network – check on cap of services
- Co-payments/ co-insurance
- Verify every client/ every time
- Check for open MSP (Medicare secondary payer)



25

Common missteps

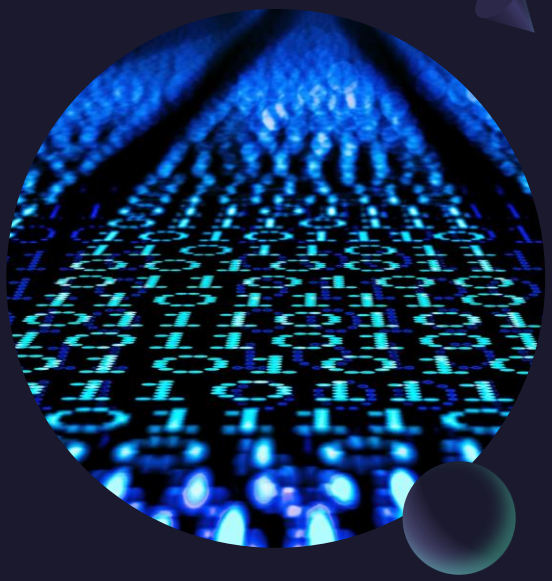
- Not having accurate client demographics
  - Discuss with client/ POA
- Not identifying primary care physicians
- Not using correct form or portal
- Not reading provider manual
- Not verifying benefits monthly



26

Authorizations

Pearls of Wisdom



27

27

Authorization

- Use correct form/portal or EVV
- Prior authorization vs. Advanced Notification
- Confirm codes in your agreement with codes on authorization
- Confirm skill levels authorized
- If you have non-routine supply orders, request authorization

28

Authorizations

- Track when re-authorizations are needed
- Receive authorization in writing
- Most require CPT/ HCPCS codes
- Ensure correct physician is identified (signing vs PCP)
- Confusing no prior auth required with no auth required

29

Authorizations

- Fill in any forms or information required completely
- Advocate for your clients- bullet points as to why you are asking for visits
- Learn the sweet spot per payer.
- Build relationships when possible
- Track when re-authorizations are needed

30

Five "Rights" of authorization

- Right Agency
- Right National Provider Identifier- NPI
- Right Patient
- Right Services & Codes
- Right Dates of Service

31

Common Information Needed

- Patient's full name
- Patient's address including where they will be receiving service
- Patient's date of birth
- Patient's preferred telephone number & alternate
- Diagnosis that supports need/ primary diagnosis
- Attestation for HH eligibility

32

Common Information Needed

- Start of Care Date
- Physician order with needed services clear
- Ordering physician Name/ telephone number/ NPI (will be PECOS verified)
- Primary care physician name/ number/ NPI
- Insurance plan number/ Group number

33

Continuation of Care for Skilled

- Some require OASIS & initial therapy evaluation- often with in 7 days of SOC
- OASIS if not already provided- if skilled
- Last 2 visit notes for each discipline seeing the patient
- Relevant clinical documentation to support services

34

Medicaid

- Build relationships with case managers
- Be compliant with EVV
- Any deviations from initial auth require prior authorization- i.e., an increase in hours

35

Letters of Agreement

- Handle as out of network
- Confirm eligibility/ benefits
- Collect co-pays/ co-insurance
- Is authorization also required?
- Confirm codes/ rates/ # of visits approved
- Send copy of LOA with claim

36

Case Management

Pro Tips

37

37

Case Management Pro Tips

- Team Collaboration
  - Weekly case conference
  - Do not wait until last covered visit to re-auth
  - If skilled patients- have systems in place for timely completion of clinician notes
  - Utilize EHR
  - Clear assignments to key staff

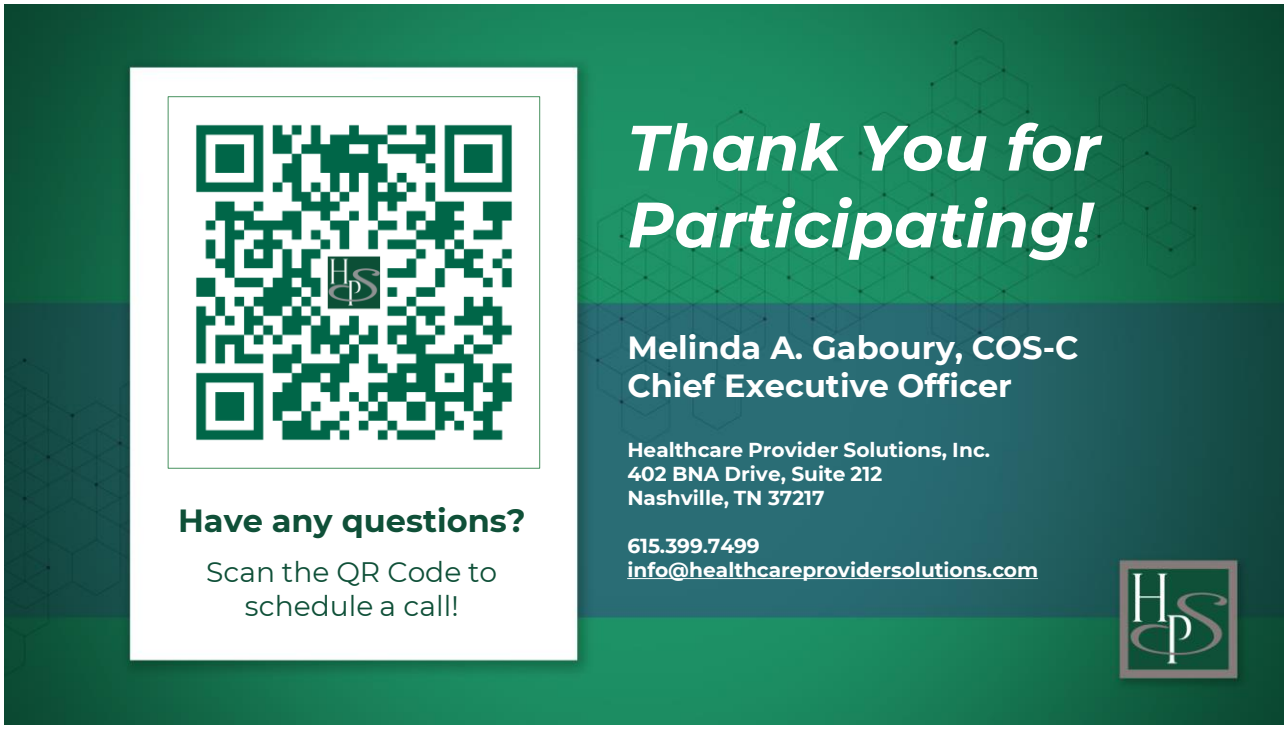
38

SUCCESS!

- Success is a team effort
- Identify areas that need improvement
- Be consistent
- Case management begins at referral
- Stay updated with health plan websites & email blasts
- Request provider training

39

40


Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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41