Medicare Home Health
Prospective Payment System

Payment Rule Brief — Final Rule
Program Year: CY 2013

Overview

On November 8, 2012, the Centers for Medicare and Medicaid Services (CMS) officially released the calendar year (CY) 2013 final payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final rule reflects the annual update to the Medicare fee-for-service (FFS) HH payment rates and policies based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress.

A copy of the final rule Federal Register and other resources related to the HH PPS are available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1358-F.html.

An online version of the final rule Federal Register is available https://federalregister.gov/a/2012-26904.

A brief of the final rule along with Federal Register (FR) page references for additional details are provided below. Program changes adopted by CMS are effective for HH episodes and visits ending on or after January 1, 2013 unless otherwise noted.

HH Payment Rates

Marketbasket Update
CMS is adopting its proposal to rebase, using CY 2010 Medicare cost report data, and revise the inputs that make up the HH marketbasket. As a result, CMS is adopting a marketbasket update of 2.3% for CY 2013 (proposed at 2.5%). CMS estimates the marketbasket update would have been 2.1% without the rebasing and revisions.

The Affordable Care Act (ACA) of 2010 requires CMS to reduce the HH marketbasket by 1.0 percentage point for CYs 2011, 2012, and 2013. As a result the ACA-adjusted marketbasket update for CY 2013 is 1.3% (FR pages 67,080-67,092).

Coding Adjustment
CMS has the authority to adjust HH payment rates to eliminate the effect of payment changes due to coding improvements or classification of discharges that the agency believes are not reflective of real changes in patient case mix. Based on an analysis conducted in 2007 and subsequent analyses that have sought to distinguish between case-mix increases attributable to real changes in clinical condition versus increases driven by coding improvements or the “nominal” case mix change, CMS has applied the following permanent coding adjustment reductions to the national 60-day standardized episode payment rate since CY 2008:

<table>
<thead>
<tr>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-2.75%</td>
<td>-2.75%</td>
<td>-2.75%</td>
<td>-2.71%</td>
<td>-3.79%</td>
</tr>
</tbody>
</table>
Last year, CMS proposed and adopted a policy to apply a -1.32% coding adjustment to the 60-day episode rate in CY 2013. However, citing an updated analysis in the proposed rule, CMS believed the appropriate coding adjustment for CY 2013 should be -2.18%. CMS is finalizing its proposal to implement the previously adopted -1.32% coding adjustment for CY 2013. CMS notes a desire to remain conservative due to the potential effect of the recalibration of weights in CY 2012 on case-mix as reasoning for adopting the 1.32% reduction as opposed to the 2.18% reduction (FR pages 67,071-67,079).

National 60-Day Standardized Episode Payment Rate
As described above, CMS is adopting rate updates that include a full marketbasket, an ACA-mandated pre-determined marketbasket reduction, and a coding adjustment. The following table shows the final national 60-day episode payment rate compared to the rate currently in effect (FR pages 67,099-67,100).

<table>
<thead>
<tr>
<th>60-Day Episode Rate</th>
<th>Final CY 2012</th>
<th>Final CY 2013</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,138.52</td>
<td>$2,137.73</td>
<td>-0.04%</td>
</tr>
</tbody>
</table>

National Per-Visit Amounts and LUPA Add-On Amount
Payments for HH episodes with four visits or fewer are made outside of the 60-day episode rate. CMS uses national per-visit amounts by service discipline and a low utilization payment adjustment (LUPA) add-on to pay for these episodes. The national per-visit amounts are also used for outlier calculations. CMS is updating the per-visit amounts and the LUPA add-on by 1.3% (these amounts are not subject to the 1.32% coding reduction). The following table shows the final per-visit amounts by discipline and the LUPA add-on amount compared to the amounts currently in effect (FR page 67,100-67,102).

<table>
<thead>
<tr>
<th>Per-Visit Amounts</th>
<th>Final CY 2012</th>
<th>Final CY 2013</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$51.13</td>
<td>$51.79</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$180.96</td>
<td>$183.31</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$124.26</td>
<td>$125.88</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>$123.43</td>
<td>$125.03</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$112.88</td>
<td>$114.35</td>
<td>+1.3%</td>
</tr>
<tr>
<td>Speech Language Pathology Therapy</td>
<td>$134.12</td>
<td>$135.86</td>
<td>+1.3%</td>
</tr>
<tr>
<td>LUPA Add-On Amount</td>
<td>$94.62</td>
<td>$95.85</td>
<td>+1.3%</td>
</tr>
</tbody>
</table>

NRS Conversion Factor
Prior to 2008, HH PPS payments for non-routine medical supplies (NRS) had been included in the national 60-day episode payment rate. The amount related to NRS was calculated using cost data from facilities’ audited cost reports. In CY 2008, CMS carved out the NRS component from the 60-day episode rate and established a separate national NRS conversion factor with six severity group weights to provide more adequate reimbursement for episodes with a high utilization of NRS. CMS is updating the NRS conversion factor by 1.3% (the conversion factor is not subject to the 1.32% coding reduction). The final NRS conversion factor and the final payment amounts for the various severity levels are shown below (FR page 67,102-67,103).

<table>
<thead>
<tr>
<th>NRS Conversion Factor</th>
<th>Final CY 2012</th>
<th>Final CY 2013</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$53.28</td>
<td>$53.97</td>
<td>+1.3%</td>
</tr>
</tbody>
</table>
### Rural Add-On

The ACA implemented a 3.0% increase to the payment amount for HH services provided in a rural area for episodes and visits ending on or after April 1, 2010 and before January 1, 2016. This 3.0% add-on is not subject to budget neutrality and is applied to the national standardization 60-day episode rate, the national per-visit amounts, LUPA add-on payments, and the NRS conversion factor *(FR pages 67,103-67,105)*.

### Sequestration Reductions

Absent from the final rule is guidance as to how CMS will implement the 2.0% sequestration reduction to all lines of Medicare payment set to take effect in 2013. Sequestration reductions were authorized by Congress as part of the Budget Control Act (BCA) of 2011. It is believed that the 2.0% downward reduction will be applied at remittance (the time Medicare contractors pay each Medicare FFS claim) and will be incorporated into the cost report settlement *(no FR reference)*.

### Wage Index and Labor-Related Share

#### Wage Index

The labor-related portion of the HH payment rates are adjusted for differences in area wage levels using a wage index. The wage index for HH providers is calculated using acute inpatient PPS wage data, without geographic reclassifications, and without applying the rural floor. This is the same wage index that is used for skilled nursing facilities and long-term care hospitals. A complete list of the final HH wage indexes for payment in CY 2013 is available on the CMS Web site at: [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1358-F.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1358-F.html) *(FR page 67,097-67,099)*.

#### Labor-Related Share

CMS is adopting its proposal to increase the labor-related share from 77.082% for CY 2012 to 78.535% for CY 2013. This change is directly related to CMS’ rebasing and revision to the HH marketbasket. An increase in the labor-related share will decrease payments to HHS with a wage index less than 1.0 and increase payments for those with wage indexes greater than 1.0 *(FR pages 67,090)*.

### Outlier Payments

Outlier payments provide additional payment for extremely high-cost cases. Currently, if a HHA’s costs for an episode of care (measured by the number of visits multiplied by the wage index-adjusted national per-visit amount) exceeds the fixed-loss threshold (measured by the case-mix and wage-adjusted payment for the episode plus a 0.67 fixed-dollar loss [FDL] ratio times the national standardized 60-day episode payment rate), the agency receives an outlier payment equal to 80% of the HHA’s costs over the fixed-loss threshold.

A regulatory change to the outlier policy made by CMS in CY 2010 was adopted as law under the ACA. The CY 2010 policy reduced the HH outlier pool from 5% of total HH payments to 2.5% and required that a cap of no more than...
10% per agency for outlier payments be applied. To meet the target outlier pool of 2.5% of total HH payments for CY 2013, CMS originally proposed to maintain the current FDL ratio of 0.67. However, due to claims processing errors and updated analysis, CMS is adopting a FDL ratio of 0.45 for CY 2013 (FR pages 67,079-67,080).

**HH QRP**

The Deficit Reduction Act (DRA) of 2005 required CMS to implement a quality data pay-for-reporting program for providers paid under the HH PPS. HH providers that fail to successfully participate in the HH Quality Reporting Program (QRP) receive reduced payments through a reduction of 2.0 percentage points to the HH marketbasket update.


Currently, process and outcomes measures used under the HH QRP are derived from the Outcome and Assessment Information Set (OASIS) assessment instrument. HH Conditions of Participation (CoPs) require that all HH providers participating in Medicare and Medicaid collect and report OASIS data. Therefore, HH providers that meet the current HH CoPs during defined time periods are deemed to have successfully participated in one portion of the HH QRP. HH providers must also collect patient experience of care data using the HH Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey.

For CY 2013 payment determinations, HH providers must have met the OASIS reporting requirements for episodes beginning on or after July 1, 2011 and before July 1, 2012. In addition, HH providers must have submitted, through an approved HHCAHPS survey vendor, HHCAHPS survey data collected between April 1, 2011 and March 31, 2012. HH providers that met these requirements are deemed to have successfully participated in the CY 2013 HH QRP. Each year, CMS updates the HH pay-for-reporting program measures and policies.

**CY 2014 and CY 2015 Payment Determinations**

For the process and outcome measures, CMS will continue to reconcile the OASIS submissions with claims data to verify full compliance with the OASIS portion of the quality reporting requirements on an annual cycle July 1 through June 30.

For the HHCAHPS measures, CMS will continue the April through March data collection timeframe. The table below lists the HHCAHPS data collection and submission timeframes for CY 2014 and 2015 payment determinations.

<table>
<thead>
<tr>
<th>CY 2014 Collection and Submission Requirements</th>
<th>CY 2015 Collection and Submission Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHCAHPS Data Collection Period</td>
<td>Submission Deadline to the HHCAHPS Data Center</td>
</tr>
<tr>
<td>2nd Quarter 2012 Data</td>
<td>October 18, 2012</td>
</tr>
<tr>
<td>3rd Quarter 2012 Data</td>
<td>January 17, 2013</td>
</tr>
<tr>
<td>4th Quarter 2012 Data</td>
<td>April 18, 2013</td>
</tr>
<tr>
<td>1st Quarter 2013 Data</td>
<td>July 18, 2013</td>
</tr>
</tbody>
</table>

As is the case for CY 2013 payment determinations, certain HH providers will be exempt from the HHCAHPS reporting requirements for CY 2014 and CY 2015 payment determinations. CMS exempts the following HH providers from the HHCAHPS reporting requirements (the CY 2013 exemption criteria was established last year):

- HH providers receiving Medicare certification on or after April 1, 2012 for CY 2014 payment determinations (April 1, 2013 for CY 2015 payment determinations); or
• HH providers that have fewer than 60 HHCAHPS eligible unduplicated or unique patients in the period April 1, 2011 through March 31, 2012 for CY 2014 payment determinations (April 1, 2012 through March 31, 2013 for CY 2015 payment determinations).

For HHAs with fewer than 60 HHCAHPS eligible unique patients, the deadline to apply for a survey exemption is January 17, 2013 for CY 2014 payment determinations (January 16, 2014 for CY 2015 payment determinations). The form HH providers must use to submit patient counts for this exemption is available online at https://www.homehealthcahps.org (FR pages 67,092-67,099).

Survey and Enforcement Requirements

The Omnibus Budget Reconciliation Act (OBRA) of 1987 established requirements for surveying HH providers to determine compliance with the Medicare HH CoPs. The law also provides CMS with the authority to utilize varying enforcement mechanisms to terminate participation and/or to impose alternative sanctions if HH providers are not in compliance with the participation requirements.

In the proposed rule, CMS put forward various proposals to codify longstanding CMS HH survey and enforcement policy that has yet to be formalized in regulation. Because these policies have been informally in place for years, HH providers may already be familiar with many of the survey types and alternative sanctions put forward for formal adoption by CMS in the proposed rule.

In the final rule, CMS adopted, in some cases with modification, most of the survey and enforcement proposals put forward. The rule provides full survey and certification guidance to both HH providers and surveyors including definitions for types of surveys and survey frequency, surveyor qualifications, and the how HH providers can file Informal Dispute Resolutions (an informal compliance decision appeal). The final rule also lays out enforcement actions when a provider is found not to be in compliance with the CoPs, including alternative sanctions beyond termination of a HH provider agreement and when those sanctions can be enforced. The alternative actions include:

• tiered civil money penalties (required by the OBRA);
• suspension of payment for all new admissions and episodes (required by the OBRA);
• temporary management of the HHA (required by the OBRA);
• directed plan of correction (CMS discretion); and
• directed in-service training (CMS discretion)

Complete details on CMS’ adopted policies to fully implement the survey and enforcement requirements applicable to HH providers are available on Federal Register pages 61,136-61,156.

Most of the survey and enforcement provisions will be effective July 1, 2013 (FR pages 61,136-61,156).

Face-to-Face Encounters

The ACA established a policy that requires the physician who certifies a patient as eligible for Medicare HH services to have a face-to-face encounter with the patient. The law allows this requirement to be satisfied by a non-physician practitioner (NPP) when the NPP is working for or in collaboration with the physician. CMS implemented this requirement for CY 2012.

In response to industry questions, CMS is adopting its proposed technical modification to the face-to-face encounter rules implemented last year. The change will provide more flexibility to HH providers and relates to NPP face-to-face encounters and patients that are admitted to HH following care in an acute or post-acute care
facility. Specifically, CMS will now allow an NPP in an acute or post-acute facility to perform the face-to-face encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in an acute or post-acute facility, and allow such physician to inform the certifying physician of the patient’s need for skilled HH services.

CMS believes this change will result in more efficient care coordination between the acute or post-acute NPP and physician and the certifying physician and improve transition of care from the acute or post-acute care setting to the HH setting (FR pages 67,106-67,108).

Therapy Coverage and Reassessments

In CY 2011, CMS clarified and expanded policies related to how therapy services are to be provided and documented. Currently, patients receiving therapy services are required to have their function periodically reassessed by a qualified therapist using objective measures any time after the 10th visit but no later than the 13th visit, and no later than the 19th visit. Under current rules, if a qualified therapist misses a required reassessment visit for any of the therapy disciplines for which therapy services are being provided, the visits are not be covered until all missed reassessments are completed.

In response to industry concerns and to ensure beneficiary access to therapy services, CMS is adopting its proposal to make its rules related to how therapy services are to be provided and documented more flexible. The change allows coverage of therapy services to resume with the visit during which the qualified therapist completes a late reassessment rather than the visit after the therapist completes a late reassessment. When multiple therapy disciplines are involved, if a reassessment visit is missed for any one of the therapy disciplines, CMS is adopting its proposal to end coverage for the therapy discipline where the reassessment visit was missed only; coverage for the remaining disciplines would continue as long as those reassessments were completed (FR pages 67,108-67,110).

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