Medicare Home Health
Prospective Payment System

Payment Rule Summary — FINAL CY 2015

Overview and Resources

The Centers for Medicare and Medicaid Services (CMS) have published the final calendar year (CY) 2015 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final rule updates the Medicare fee-for-service (FFS) HH PPS payment rates and other regulatory changes, as well as implements policies as legislated by the US Congress. Among the regulatory updates and policy changes are:

- Final CY 2015 HH PPS market basket and productivity offsets of 2.6% and -0.5% respectively, for a net update factor of 2.1%
- Final CY 2015 HH PPS national, standardized episode payment rate of $2,961.38 — a 3.2% increase over the final CY 2014 rate.
- Changes to the Core-Based Statistical Area (CBSA) delineations and implementation of final CY 2015 HH PPS wage indexes that reflect a 50:50 blend of wage indexes calculated according to the old and new area definitions;
- Implementation of the second year of a four-year phase-in for rebasing adjustments to the HH PPS payment rates mandated by the Affordable Care Act (ACA) of 2010;
- Deferral of CMS’ decision to require a minimum number of OASIS assessments as part of the HH pay-for-reporting program; and
- Updates to the therapy reassessment rules that define eligibility for the Medicare HH benefit.

A copy of the Federal Register (FR) with this final rule and other resources related to the HH PPS are available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html.


Program changes are effective for services provided on or after January 1, 2015 unless otherwise noted.

HH PPS Payment Rates
FR pages 66088 - 66090

- **National Standardized 60-Day Episode Payment Rate**
  The CY 2015 60-day episode rate includes:
  - Update factor increase of 2.1% (2.6% market basket update minus an ACA-mandated productivity reduction of 0.5%);
  - Wage index budget neutrality (BN) adjustment of 1.0024 (0.24%);
  - Case-mix BN adjustment of 1.0366 (3.66%); and
  - Negative rebasing adjustment of -$80.95 (-2.75%)
• **National Per-Visit Amounts**

HH PPS payments for episodes with four visits or less are paid on a per visit basis. CMS uses national per-visit amounts by service discipline to pay for these “Low-Utilization Payment Adjustment” (LUPA) episodes. The national per-visit amounts are also used for outlier calculations. The CY 2015 per-visit amounts include a rebasing increase of 3.5% and an update factor increase of 2.1%.

<table>
<thead>
<tr>
<th>Per-Visit Amounts</th>
<th>Final CY 2014</th>
<th>Final CY 2015</th>
<th>Percent Change</th>
<th>Final CY 2015 With Add-On *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>$57.89</td>
<td>+5.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>$204.91</td>
<td>N/A</td>
<td>$233.38 (1.6700 adj.)</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>$140.70</td>
<td>N/A</td>
<td>$235.86 (1.8451 adj.)</td>
</tr>
<tr>
<td>Physical Therapy (PT)</td>
<td>$132.40</td>
<td>$139.75</td>
<td>N/A</td>
<td>$247.05 (1.6266 adj.)</td>
</tr>
<tr>
<td>Skilled Nursing (SN)</td>
<td>$121.10</td>
<td>$127.83</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Speech Language Pathology (SLP)</td>
<td>$143.88</td>
<td>$151.88</td>
<td>N/A</td>
<td>$247.05 (1.6266 adj.)</td>
</tr>
</tbody>
</table>

* For SN, PT, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue the use of the LUPA add-on factors established last year.

• **NRS Conversion Factor**

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. The CY 2015 NRS conversion factor includes a rebasing reduction -2.82% and an update factor increase of 2.1%.

<table>
<thead>
<tr>
<th>NRS Conversion Factor</th>
<th>Final CY 2014</th>
<th>Final CY 2015</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$53.65</td>
<td>$53.23</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Points (Scoring)</th>
<th>Relative Weight (no change from prior years)</th>
<th>Final Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.36</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.86</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$142.19</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$211.25</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$325.76</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$560.27</td>
</tr>
</tbody>
</table>

### Payment Add-On for Rural HH Agencies

*FR pages 66090-66092*

The ACA mandates a 3.0% increase to the payments for HH PPS episodes and visits provided in rural areas between April 1, 2010 and before January 1, 2016. This 3.0% add-on is not subject to budget neutrality and is applied to the 60-day episode rate, the national per-visit amounts, LUPA add-on payments, and the NRS conversion factor.
Effect of Sequestration

All lines of Medicare payments authorized by Congress and currently in effect through federal fiscal year (FFY) 2024 are subject to a 2.0% sequester reduction. Sequester will continue unless/until Congress intervenes. Sequester adjustments are not applied to payment rates; they area reduction to the Medicare claim payment after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary adjustments.

Wage Index and Labor-Related Share

For CY 2015, CMS will continue to use the pre-rural floor, pre-reclassification inpatient hospital wage indexes for the HH PPS payment program. The new CBSA delineations, adopted for the inpatient PPS payment program, will be used for the CY 2015 HH PPS wage indexes. The CBSA changes include:

- newly created CBSAs;
- some formerly urban counties are now rural;
- some formerly rural counties are now urban; and
- some CBSAs have split or now incorporate additional counties.

Depending upon the labor area, these CBSA changes can have a positive, negative or no impact on HH PPS payments. To mitigate the impact of the changes, CMS is applying a 1-year phased-in, blended wage index, with 50% based on the current CBSA delineations and 50% based on the new CBSA delineations (both using the 2015 wage index data). The blend will have no impact on wage index adjustments for CBSAs in which there is no change.

The CY 2015 wage indexes will be applied to an unchanged labor-related share of 78.535%

A complete list of the wage indexes to be used for payment in CY 2015 along with detail on the transitional wage index calculation is available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1611-F.html?DLPage=1&DLSort=2&DLSortDir=descending.

HHRG Updates

The HH PPS program uses a 153-category case-mix classification called Home Health Resource Groups (HHRGs). Patients’ clinical severity level, functional severity level, and service utilization are extracted from the Outcome and Assessment Information Set (OASIS) instrument and used to assign HHRGs. Each HHRG has an associated case-mix weight which is used in calculating the payment for an episode. According to CMS, the HHRG weights were designed to maintain an average case-mix of about 1.0.

For CY 2015, CMS is recalibrating the HHRG weights in order to maintain an average case-mix weight of 1.0. The revisions are based on CY 2013 claims and yield increases and decreases to the HHRG weights. Overall the impact of the change is negative; therefore, CMS is increasing the 60-day episode rate by 3.66% in order to maintain budget neutrality for the HH PPS program.

Outlier Payments

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases (requiring more visits than typical) within the constraints of a per episode payment system. An additional outlier payment is provided whenever a HHA’s cost for an episode of care (calculated using the number of visits in the episode multiplied by a wage index-adjusted national per-visit amount) exceeds the fixed-loss threshold (the HH PPS payment amount for the episode plus a fixed dollar loss [FDL] amount).

For CY 2015, CMS will continue to use a ratio of 0.45 to determine the FDL amount. The ratio is multiplied by the wage index-adjusted 60-day episode payment rate then added to the HH PPS payment amount for that episode. If the calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA’s outlier payments are capped at 10% of total PPS payments. By law, a target of 2.5% of total HH PPS payments are set aside for outliers.

Face-to-Face Encounter Requirements

Beginning in CY 2011, the ACA requires a physician or specified non-physician practitioner to document that a face-to-face encounter occurred prior to determining eligibility for HH care. Current regulations require that the face-to-face encounter be related to the primary reason the patient requires HH services and to occur no more than 90 days prior to, or within 30 days from the start of HH care. As part of the certification process, the certifying practitioner must document the date of the encounter and include a narrative explanation of why the patient is homebound and in need of either intermittent skilled nursing services or therapy services.

Citing industry concerns regarding the face-to-face encounter documentation requirements along with a high proportion of HH claim denials due to “insufficient documentation,” potential HH care access concerns, and other reasons, CMS is finalizing its proposal to simplify the face-to-face encounter regulations. For HH episodes beginning on or after January 2015:

- the requirement for a face-to-face encounter narrative is eliminated (except for patients needing skilled nursing services);
- practitioners must still certify that a face-to-face encounter occurred no more than 90 days prior to, or within 30 days from the start of HH care;
- for medical review purposes, only the medical record from the certifying physician or the acute/post-acute care facility will be reviewed; and
- CMS will only pay for physician claims for certification/re-certification of eligibility for HH services if the HH claim itself is covered.

CMS clarifies that the face-to-face encounter requirement is applicable for certifications (not re-certifications), rather than initial episodes. A certification is considered to be any time that a new start of care OASIS is completed to initiate care.

Therapy Reassessment Timeframes

The current rules require that therapy reassessments be performed on or close to the 13th and 19th therapy visit and at least once every 30 days. These assessments must be completed by a qualified therapist in the discipline for the type of therapy being provided. Since implementation of this policy in CY 2011, HH providers have expressed concerns regarding the timing of the reassessments for multi-discipline therapy episodes and
the potential risks for subsequent visits not being covered. In addition, CMS acknowledges the establishment of payment policies that have mitigated the payment differentials at the 14th and 20th visit and analysis that shows no significant change when cases reach the 14th and 20th visit thresholds.

CMS is adopting its proposal to eliminate the requirement for therapy reassessments on or close to the 13th and 19th visit and is revising its proposal for assessments every 14 days. Effective for HH episodes ending on or after January 1, 2015, CMS will require therapy reassessments at least once every 30 calendar days rather than every 14 days. All other requirements related to therapy reassessments remain unchanged.

Payment for Insulin Injections
FR pages 66094 - 66100

HH visits for the sole purpose of providing insulin injections are only covered and paid under HH PPS when the patient is physically or mentally unable to self-inject and there is no other person who is able/willing to inject the patient. Citing an August 2013 Office of the Inspector General (OIG) report, that identified a portion of HH visits that lacked sufficient supporting documentation to warrant coverage, CMS intends to monitor claims for insulin injection assistance and is compiling a list of diagnosis codes that would indicate the medical necessity for HH visits for insulin injection assistance. There is no regulatory change regarding this issue at this time.

Updates to the HH Quality Reporting Program (HH QRP)
FR pages 66073 - 66083

CMS collects quality data from HHAs on process, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

All of the process and most outcomes measures required under the HH QRP are derived from the OASIS assessment instrument. Since the Medicare Conditions of Participation (CoPs) require all HH providers that participate in Medicare and Medicaid to collect and report OASIS data to CMS, any HH provider that meets the current CoPs is currently deemed to be meeting the HH QRP reporting requirements for those measures. HH providers must also collect patient experience of care data using the HH Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey and CMS calculates two HH QRP outcomes measures from HH claims data – no reporting required.

In this final rule, CMS is establishing a new pay-for-reporting performance standard for the submission of OASIS quality data. HHAs must meet a minimum reporting threshold for OASIS data in order to avoid the 2% marketbasket reduction. The minimum threshold has been titled the Quality Assessment Only (QAO) formula, because it only considers assessments that contribute, or could contribute, to creating a quality episode of care. CMS has defined seven types of OASIS assessments that will be used to calculate the QAO metric. The QAO formula is as follows:

\[
\text{QAO} = \left( \frac{\text{# of Quality Assessments}}{\text{# of Quality Assessments} + \text{# of Non-Quality Assessments}} \right) \times 100
\]

For episodes beginning on or after July 1, 2015 and before June 30, 2016, HHAs must score at least 70% on the QAO metric or be subject to the 2% marketbasket reduction. CMS had originally proposed a continued phase-in, up to 90%, over several years for the QAO metric; however, in this final rule, CMS is deferring its decision on setting minimum QAO thresholds for subsequent years.

CMS is also adopting a “sub-regulatory” process to incorporate non-substantive updates to HH QRP quality measures. This sub-regulatory process will give CMS the leeway to make NQF-endorsed changes to existing HH QRP measures. NQF decisions are open and transparent; HHAs have access to information about recommended changes as they are announced.
CMS is not adopting any additional measures for the HH QRP.

**Mandatory HH VBP Demonstration Project for CY 2016**

*FR pages 66105 - 66106*

Using its waiver authority, CMS is considering implementing a mandatory HH VBP demonstration program in 5 to 8 states, to begin in CY 2016. The demonstration program would resemble the VBP Program for inpatient acute care hospitals. The HH VBP demonstration program that is under consideration would recognize both the achievement of high quality standards and improvement in quality performance. CMS is interested in testing a larger incentive/penalty range for HHAs, proposing to put between 5% and 8% of HH PPS payments at risk.

CMS received numerous comments on this proposal and will take them into consideration as it formulates a more detailed HH VBP program proposal for CY 2016. CMS will invite additional comments once that detailed proposal is published in future rule-making.

A report on the development/design of a VBP program for HH providers (as mandated by the ACA) is available on the CMS website at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF).

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