Medicare Home Health
Prospective Payment System

Payment Rule Brief — PROPOSED RULE
Program Year: CY 2015

Overview, Resources, and Comment Submission

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) published the calendar year (CY) 2015 proposed payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The proposed rule reflects the annual update to the Medicare fee-for-service (FFS) HH rates and policies based on regulatory changes put forward by CMS and legislative changes previously adopted by Congress. Among other regular updates and policy changes, the rule would:

- Implement the second year of a four-year phase-in of rebasing adjustments to the HH payment rates (both positive and negative) mandated by the Affordable Care Act (ACA) of 2010;
- Change the Core-Based Statistical Area (CBSA) delineations—directly impacting the Medicare wage index used for payment purposes;
- Update the face-to-face encounter and therapy reassessment rules that define eligibility for the HH benefit; and
- Solicit industry comment on the establishment of a mandatory HH value-based purchasing (VBP) demonstration program in certain states beginning CY 2016.

A copy of the proposed rule Federal Register (FR) 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.

An online version of the proposed rule is available at https://federalregister.gov/a/2014-15736.

A brief summary of the proposed rule is provided below. Program changes adopted by CMS would be effective for services provided on or after January 1, 2015 unless otherwise noted. Comments on all aspects of the proposed rule are due to CMS by Tuesday, September 2 and can be submitted electronically at http://www.regulations.gov by using the website’s search feature to search for file code “1611-P.”

HH Payment Rates
FR pages 38,384-38,386 and 38,396-38,400

CMS is proposing to update the HH payment rates by several factors for CY 2015, including rebasing adjustments mandated by the ACA. CMS is proposing to implement the second year of a four-year phase-in of the rebasing adjustment by reducing the 60-day episode rate and Non-Routine Medical Supply (NRS) conversion factor and increasing the per-visit amounts. The following details the proposed updates to the HH payment rates for CY 2015.

- **National Standardized 60-Day Episode Payment Rate:** The proposed 60-day episode rate includes a:
  - budget neutrality (BN) increase of plus 0.12% (offsetting the proposed HH wage index changes);
  - BN increase of plus 2.37% (offsetting the proposed case-mix weight recalibration changes);
- rebasing reduction of minus $80.95 (-2.75%); and
- marketbasket (MB) increase of plus 2.2% (full 2.6% MB update minus an ACA-mandated productivity MB reduction of 0.4 percentage points).

<table>
<thead>
<tr>
<th>60-Day Episode Rate</th>
<th>Final CY 2014</th>
<th>Proposed CY 2015</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,869.27</td>
<td>$2,922.76</td>
<td>+1.9%</td>
</tr>
</tbody>
</table>

- **National Per-Visit Amounts:** 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 to pay for these “Low-Utilization Payment Adjustment” (LUPA) episodes. The national per-visit amounts are also used for outlier calculations. The proposed per-visit amounts include a rebasing increase of varying dollar amounts by visit type equating to a plus 3.26% adjustment and a MB increase of plus 2.2% (full 2.6% MB update minus an ACA-mandated productivity MB reduction of 0.4 percentage points).

<table>
<thead>
<tr>
<th>Per-Visit Amounts</th>
<th>Final CY 2014</th>
<th>Proposed CY 2015</th>
<th>Percent Change</th>
<th>Proposed CY 2015 With Add-On *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Aide</td>
<td>$54.84</td>
<td>$57.88</td>
<td>+5.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td>$194.12</td>
<td>$204.87</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>$133.30</td>
<td>$140.68</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Physical Therapy (PT)</td>
<td>$132.40</td>
<td>$139.73</td>
<td></td>
<td>233.35 (1.6700 adj.)</td>
</tr>
<tr>
<td>Skilled Nursing (SN)</td>
<td>$121.10</td>
<td>$127.81</td>
<td></td>
<td>235.82 (1.8451 adj.)</td>
</tr>
<tr>
<td>Speech Language Pathology (SLP)</td>
<td>$143.88</td>
<td>$151.85</td>
<td></td>
<td>247.00 (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 is proposing to 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 proposed NRS conversion factor includes a rebasing reduction of minus 2.82% and a MB increase of plus 2.2% (full 2.6% MB update minus an ACA-mandated productivity MB reduction of 0.4 percentage points).

<table>
<thead>
<tr>
<th>NRS Conversion Factor</th>
<th>Final CY 2014</th>
<th>Proposed CY 2015</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$53.65</td>
<td>$53.28</td>
<td>-0.7%</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>Proposed Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.2698</td>
<td>$14.37</td>
</tr>
<tr>
<td>2</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$51.91</td>
</tr>
<tr>
<td>3</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$142.32</td>
</tr>
<tr>
<td>4</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$211.45</td>
</tr>
<tr>
<td>5</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$326.06</td>
</tr>
<tr>
<td>6</td>
<td>99+</td>
<td>10.5254</td>
<td>$560.79</td>
</tr>
</tbody>
</table>
Payment Add-On for Rural HH Agencies

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 60-day episode rate, the national per-visit amounts, LUPA add-on payments, and the NRS conversion factor.

Effect of Sequestration

While the proposed rule does not specifically address the 2.0% sequester reductions to all lines of Medicare payments authorized by Congress and currently in effect through federal fiscal year (FFY) 2024, sequester will continue unless Congress intervenes. Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.

Wage Index and Labor-Related Share

For CY 2015, CMS is proposing updates to the CBSA delineations, the labor-markets that define a HHA’s Medicare wage index. Beyond the CBSA changes, CMS is not proposing any major changes to the standard calculation of wage index for HHAs. As has been the case in previous years, CMS would use the current year’s inpatient hospital wage index, the FFY 2015 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS based on the CBSA where the HH services are provided.

CMS’ proposed changes to the CBSA delineations would have a direct impact on the Medicare wage index used for payment purposes under the HH PPS. CMS last updated the CBSA delineations in 2005 (based on the 2000 Census). The CBSA changes proposed for 2015 (based on the 2010 Census) are not as substantial as those made in 2005 in terms of changes in the geographic make-up of the labor-market areas. However, under the new delineations there would be:

- newly created CBSAs;
- urban counties that would become rural;
- rural counties that would become urban; and
- existing CBSAs that would be split apart or incorporate additional counties.

The proposed CBSA changes would have both positive and negative impacts on HH payments. To mitigate the impact of the changes and maintain a reasonable wage index budget neutrality adjustment, CMS is proposing a 1-year transitional wage index for HHAs experiencing an increase or decrease in their wage index due solely to the newly proposed CBSA delineations (about 40% of hospital-based HHAs). The transition value would be for CY 2015 only, using 2015 wage data, with 50% based on the current CBSA delineations and 50% based on the new CBSA delineations. The transitional wage index would expire for CY 2016. At that point, the wage index values would be fully based on the new CBSA delineations. The transitional wage index proposed for HHAs is the same as the transition proposed for SNFs, but differs from the transition proposed for inpatient acute care, outpatient, and long-term care hospitals. For these payment systems, CMS proposed a transitional wage index value for hospitals experience a wage index reduction only.

The wage index, which is used to adjust payment for differences in area wage levels, is applied to the portion of the HH rates that CMS considers to be labor-related. CMS is proposing to maintain the labor-related share at 78.535% for CY 2015.
A complete list of the proposed 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/index.html.

HHRG Updates
FR pages 38,377-38,384

Under the HH PPS, a 153-category case-mix classification system is used to assign patients to a Home Health Resource Group (HHRG). The clinical severity level, functional severity level, and service utilization are computed from responses to selected data elements in the Outcome and Assessment Information Set (OASIS) assessment instrument and are used to place the patient into a particular HHRG. Each HHRG has an associated case-mix weight which is used in calculating the payment for an episode. According to CMS, the HH PPS was designed to maintain an average case-mix weight of about 1.0.

Last year, piggy-backing on the ACA mandate to rebase the HH payment rates, CMS used its administrative authority to adopt a significant across-the-board reduction (minus 25.7%) to the HHRG weights in an attempt to reset the average weight to 1.0. As required by law, this change was implemented in a budget neutral manner through a comparable increase to the 60-day episode rate.

Following up on its rebasing efforts from last year, for CY 2015, CMS is proposing to recalibrate the case-mix weights in an effort to align payments with current costs/utilization and maintain an average case-mix weight of 1.0 within the HH PPS. The proposed revisions are based on CY 2013 claims experience. Unlike last year’s across-the-board weight reduction, the proposed weight changes would be both positive and negative. However, overall the change would be negative as CMS is proposing to increase the 60-day episode rate by +2.37% to maintain HH program budget neutrality in response to the recalibration.

A comparison of the current HHRG payment weights to the newly proposed weights shows that the weights for about 80% of the HHRGs would change by less than +/-5%. Overall, the proposed weight changes range from minus 13.7% to plus 8.8%.

The proposed weights by HHRG are available on the CMS website at

The current weights by HHRG are available on the CMS website at

Outlier Payments
FR pages 38,400-38,401

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 0.45 fixed-dollar loss [FDL] ratio multiplied by the 60-day episode payment rate), the agency receives an outlier payment equal to 80% of the HHA’s costs over the fixed-loss threshold. Outlier payments are capped at 10% per HHA. By law, a target of 2.5% of total HH PPS payments are set aside for outliers. To maintain total outlier payments at 2.5% of total HH PPS payments, CMS is proposing to maintain an FDL ratio of 0.45 for CY 2015.
Face-to-Face Encounter Requirements
FR pages 38,370-38,377

Beginning in CY 2011, as a condition of payment under the HH PPS, the ACA requires a physician or specified non-physician practitioner to document that a face-to-face encounter occurred with the patient. Current regulations require that the face-to-face encounter be related to the primary reason the patient requires HH services and occur no more than 90 days prior to the start of HH care or within 30 days of the start of the HH care. In addition, as part of the certification of eligibility, the certifying physician 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 claims denials due to “insufficient documentation,” potential HH care access concerns, and other reasons, CMS is proposing to simplify the face-to-face encounter regulations. Beginning CY 2015, CMS is proposing to:

- eliminate the physician narrative requirement (except for patients needing skilled nursing services);
- for medical review purposes, review only the medical record from the certifying physician or the acute/post-acute care facility; and
- only pay for physician claims for certification/re-certification of eligibility for HH services only if the HH claim itself was covered.

CMS is also proposing to clarify when documentation of a face-to-face encounter is required. 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
FR pages 38,407-38,408

Current rules require therapy reassessments be performed on or close to the 13th and 19th therapy visits and at least once every 30 days. These assessments must be completed by a qualified therapist of the corresponding discipline for the type of therapy being provided. Since implementation of this policy in CY 2011, HH providers have expressed concern regarding the timing of the reassessments for multi-discipline therapy episodes and the potential risk of subsequent visits not being covered. In addition, CMS points to the establishment of payment policies that have mitigated the payment differentials at the 14 and 20 visit thresholds along with analysis that shows no significant change in the cases reaching the 14 and 20 visit thresholds. Pointing to these realities, CMS is proposing to simplify the therapy reassessment timeframes by requiring the reassessments to occur every 14 calendar days (as opposed to before the 14th and 20th visits and once every 30 calendar days). All other requirements related to therapy reassessments would remain unchanged. The requirement to perform a reassessment at least once every 14 calendar days would apply to all episodes regardless of the number of therapy visits provided.

Payment for Insulin Injections
FR pages 38,401-38,406

HH visits for the sole purpose of insulin injections are paid under the HH PPS only when patients are 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 identifying that a portion of these HH visits were unnecessary due to the lack of any secondary diagnoses on the HH claim to support that the patient was physically or mentally unable to self-inject, CMS states that they plan to monitor claims that are likely for the purpose of insulin injection assistance. CMS provides a list of conditions the agency expects to be listed on the claim and OASIS to support the need for skilled nursing visits for insulin injection assistance and is soliciting
industry comment as to whether this list is comprehensive (Table 28 on FR pages 38,404-38,406). The OIG report also identified excessive outlier payment for diabetic patients and CMS continues to monitor this issue.

Updates to the HH QRP

As previously adopted, for CY 2015 payment determinations under the HH Quality Reporting Program (QRP), CMS collects quality data from HHAs on process, outcomes, and patient experience of care data. 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—the reduction factor value is set in law.

Currently, process and outcomes measures used under the HH QRP are derived from the OASIS assessment instrument. HH Conditions of Participation (CoPs) require that all HH providers participating in Medicare and Medicaid collect and report OASIS data. As a result, 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. CMS also collects two outcomes measures from HH claims data.

Among other HH QRP updates, CMS is using the CY 2015 rulemaking process to propose a new performance standard for to the submission of OASIS quality data. This proposal is the result of an OIG study and recommendation. Beginning with CY 2017 payment determinations, successful participation in the HH QRP would depend on a HHA meeting a certain compliance threshold for the submission of OASIS quality assessments. CMS would assess compliance using the following formula:

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

CMS is proposing to phase up to a 90% compliance threshold as follows:

<table>
<thead>
<tr>
<th>Payment Determination Year</th>
<th>Compliance Threshold</th>
<th>OASIS Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2017</td>
<td>70% Compliance</td>
<td>July 2015 – June 2016</td>
</tr>
<tr>
<td>CY 2018</td>
<td>80% Compliance</td>
<td>July 2016 – June 2017</td>
</tr>
<tr>
<td>CY 2019 and beyond</td>
<td>90% Compliance</td>
<td>July 2017 – June 2018  (and subsequent annual July-June updates)</td>
</tr>
</tbody>
</table>

CMS has titled this Pay-for-Reporting performance requirement metric as the Quality Assessments Only (QAO) metric. CMS has defined seven types of OASIS assessments on FR pages 38,387-38,388 that would be used to calculate the QAO metric.

Beyond the new QAO metric, CMS is not proposing any additional measures for the HH QRP. CMS does reiterate and propose updates the data collection period for OASIS-based process and outcomes measures for CY 2015 payment determinations and beyond and the HHCAHPS data for CYs 2015, 2016, and 2017 payment determinations.

Mandatory HH VBP Demonstration Project for CY 2016

Using its waiver authority, CMS is considering the implementation of a mandatory HH VBP demonstration project for 5-8 states beginning CY 2016. As suggested by CMS, the demo would be similar to the ACA-mandated VBP Program for inpatient acute care hospitals that has been in place since FFY 2013 and could put between 5-8% of payment at risk—awarding both the achievement of high quality standards and HHA-specific
quality improvement. CMS is soliciting industry comment on the design of a HH VBP demo including how much
HH payment to put at risk under the program and the best approach for selecting states for participation in the
demo. If CMS decides to move forward with the demo in CY 2016, CMS plans to provide a detailed proposal
along with the opportunity for the industry to provide additional input/comment. An ACA-mandated report
from CMS on the development/design of a VBP Program for HH providers is available on the CMS website at
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-
NPRM.PDF.

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