Regulatory Update

Final Rule Summary

Medicare Home Health Prospective Payment System

Calendar Year 2015

November 2014

Florida Hospital Association

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Overview and Resources

The Centers for Medicare & Medicaid Services (CMS) has published the final calendar year (CY) 2015 payment rule for the Medicare home health prospective payment system (HHPPS). The final rule updates the Medicare fee-for-service (FFS) HHPPS payment rates and other regulatory changes, as well as implements policies as legislated by the U.S. Congress. Among the regulatory updates and policy changes are:

- Final CY2015 HHPPS market basket and productivity offsets of 2.6 percent and -0.5 percent respectively, for a net update factor of 2.1 percent;
- Final CY2015 HHPPS national, standardized episode payment rate of $2,961.38 – a 3.2 percent increase over the final CY2014 rate;
- Changes to the Core-Based Statistical Area (CBSA) delineations and implementation of final CY2015 HHPPS 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 HHPPS payment rates mandated by the Patient Protection and Affordable Care Act (PPACA) of 2010;
- Deferral of CMS' decision to require a minimum number of OASIS assessments as part of the home health pay-for-reporting program; and
- Updates to the therapy reassessment rules that define eligibility for the Medicare home health benefit.

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

A copy of the *Federal Register* with this final rule and other resources related to the HHPPS are available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html. An online version of the final rule is available at http://www.gpo.gov/fdsys/pkg/Federal Register-2014-11-06/pdf/2014-26057.pdf.

HHPPS Payment Rates
Federal Register pages 66088-66090

- **National Standardized 60-Day Episode Payment Rate**: The CY2015 60-day episode rate includes:

    - Update factor increase of 2.1 percent (2.6 percent market basket update minus an PPACA-mandated productivity reduction of 0.5 percent);
    - Wage index budget neutrality adjustment of 1.0024 (0.24 percent);
    - Case mix budget neutrality adjustment of 1.0366 (3.66 percent); and
    - Negative rebasing adjustment of -$80.95 (-2.75 percent).

	Final CY2014	Final CY2015	Percent Change
60-Day Episode Rate	$2,869.27	$2,961.38	+3.2

- **National Per Visit Amounts**
  HHPPS 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 CY2015 per visit amounts include a rebasing increase of 3.5 percent and an update factor increase of 2.1 percent.

Per visit Amounts	Final CY2014	Final CY2015	Percent Change	Final CY2015 With Add-On *
Home Health Aide	$54.84	$57.89	+5.6	N/A
Medical Social Services	$194.12	$204.91		N/A
Occupational Therapy	$133.30	$140.70		N/A
Physical Therapy (PT)	$132.40	$139.75		$233.38 (1.6700 adj.)
Skilled Nursing (SN)	$121.10	$127.83		$235.86 (1.8451 adj.)
Speech Language Pathology (SLP)	$143.88	$151.88		$247.05 (1.6266 adj.)

* 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 CY2008, 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 CY2015 NRS conversion factor includes a rebasing reduction -2.82 percent and an update factor increase of 2.1 percent.

	Final CY2014	Final CY2015	Percent Change
NRS Conversion Factor	$53.65	$53.23	-0.8

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

Payment Add-On for Rural Home Health Agencies
Federal Register pages 66090- 66092

The PPACA mandates a 3.0 percent increase to the payments for HHPPS episodes and visits provided in rural areas between April 1, 2010 and before January 1, 2016. This 3.0 percent 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
Federal Register page reference not available

All lines of Medicare payments authorized by Congress and currently in effect through federal fiscal year (FY) 2024 are subject to a 2.0 percent sequester reduction. Sequester will continue unless/until Congress intervenes. Sequester adjustments are not applied to payment rates; they are a 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
Federal Register pages 66083-66087

For CY2015, CMS will continue to use the pre-rural floor, pre-reclassification inpatient hospital wage indexes for the HHPPS payment program. The new CBSA delineations, adopted for the inpatient prospective payment system (IPPS) payment program, will be used for the CY2015 HHPPS 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 HHPPS payments. To mitigate the impact of the changes, CMS is applying a one-year phased-in, blended wage index, with 50 percent based on the current CBSA delineations and 50 percent 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 CY2015 wage indexes will be applied to an unchanged labor-related share of 78.535 percent. A complete list of the wage indexes to be used for payment in CY2015 along with detail on the transitional wage index calculation is available on the CMS Web site 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
Federal Register pages 66054-66072

The HHPPS 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 CY2015, CMS is recalibrating the HHRG weights in order to maintain an average case mix weight of 1.0. The revisions are based on CY2013 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 percent in order to maintain budget neutrality for the HHPPS program.

The final CY2015 weights by HHRG are available on the CMS Web site 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.

Outlier Payments
Federal Register pages 66092-66094

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 HHPPS payment amount for the episode plus a fixed dollar loss [FDL] amount).

For CY2015, 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 HHPPS payment amount for that episode. If the calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80 percent of the calculated excess costs over the fixed-loss threshold. Each HHA's outlier payments are capped at 10 percent of total PPS payments. By law, a target of 2.5 percent of total HHPPS payments are set aside for outliers.

Face-to-Face Encounter Requirements
Federal Register pages 66038 - 66054

Beginning in CY2011, the PPACA requires a physician or specified non-physician practitioner to document that a face-to-face encounter occurred prior to determining eligibility for home health care. Current regulations require that the face-to-face encounter be related to the primary reason the patient requires home health services and to occur no more than 90

days prior to or within 30 days from the start of home health 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 concerns regarding the face-to-face encounter documentation requirements along with a high proportion of home health claim denials due to "insufficient documentation," potential home health care access concerns, and other reasons, CMS is finalizing its proposal to simplify the face-to-face encounter regulations. For home health 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 of the home health start of care date;
- 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/recertification of eligibility for home health services <u>if</u> the home health claim itself is covered.

CMS clarifies that the face-to-face encounter requirement is applicable for certifications (not recertifications), 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
Federal Register pages 66101-66105

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 CY2011, home health 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 home health episodes ending on or after January 1, 2015, CMS will require therapy reassessments <u>at least</u> once every 30 calendar days rather than every 14 days. All other requirements related to therapy reassessments remain unchanged.

Payment for Insulin Injections
Federal Register pages 66094-66100

Home health visits for the sole purpose of providing insulin injections are only covered and paid under HHPPS 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 home health visits that lacking 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 home health visits for insulin injection assistance. There is no regulatory change regarding this issue at this time.

Updates to the Home Health Quality Reporting Program (HHQRP)
Federal Register 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 HHQRP are subject to a 2.0 percentage point reduction to the market basket update for the applicable year.

All of the process and most outcomes measures required under the HHQRP are derived from the OASIS assessment instrument. Since the Medicare Conditions of Participation (CoPs) require all home health providers that participate in Medicare and Medicaid to collect and report OASIS data to CMS, any home health provider that meets the current CoPs is currently deemed to be meeting the HHQRP reporting requirements for those measures. Home health providers must also collect patient experience of care data using the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey and CMS calculates two HHQRP outcomes measures from home health 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 two percent market basket 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:

> *[# of Quality Assessments / (# of Quality Assessments + # of Non-Quality Assessments) X 100]*

For episodes beginning on or after July 1, 2015 and before June 30, 2016, HHAs must score at least 70 percent on the QAO metric or be subject to the two percent market basket reduction. CMS had originally proposed a continued phase-in, up to 90 percent, 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 HHQRP quality measures. This sub-regulatory process will give CMS the leeway to make NQF-endorsed changes to existing HHQRP 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 HHQRP.

Mandatory HHVBP Demonstration Project for CY2016
Federal Register pages 66105-66106

Using its waiver authority, CMS is considering implementing a mandatory HHVBP demonstration program in five to eight states, to begin in CY2016. The demonstration program would resemble the VBP program for inpatient acute care hospitals. The HHVBP 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 five percent and eight percent of HHPPS payments at risk.

CMS received numerous comments on this proposal and will take them into consideration as it formulates a more detailed HHVBP program proposal for CY2016. 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 home health providers (as mandated by the PPACA) is available on the CMS Web site at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF.