American Hospital Association®

Regulatory Advisory

November 20, 2014

HOME HEALTH PPS: FINAL RULE FOR CY 2015

AT A GLANCE

The Issue:
On Nov. 6, the Centers for Medicare & Medicaid Services (CMS) published its calendar year (CY) 2015 final rule for the home health (HH) prospective payment system (PPS). Under the final rule, HH agencies will receive an overall net payment reduction of 0.3 percent (or $60 million) as compared to CY 2014. Hospital-based HH agencies will, on average, see a slight increase in payment of 1.5 percent above CY 2014 levels. These payment changes reflect reductions due to the implementation of the second year of the four-year phase-in of the HH PPS rebasing adjustments.

In addition to updating the HHS PPS payment rates, this final rule, among other changes:

- streamlines the face-to-face encounter requirements;
- simplifies the timeline for therapy reassessments; and
- implements a data completeness standard for the HH quality reporting program (HH QRP).

Our Take:
The AHA welcomes the streamlining of the HH face-to-face encounter requirement, which should facilitate quicker transitions from hospitals and other health settings to home care. However, we are concerned about the ability of HH agencies to comply with the requirements to acquire documentation from the certifying physician, which can be an administratively burdensome and slow process. We are pleased that CMS has implemented a 30-day interval for therapy reassessments, in alignment with AHA's recommendation. The AHA also is pleased that CMS is gradually phasing in the HH QRP's data completeness threshold, and will give HH agencies the opportunity to appeal a finding of non-compliance.

What You Can Do:

✓ Share this advisory with your senior management team to examine the impact of these payment changes on your organization for CY 2015.

Further Questions:
Please contact Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org, or for questions about the quality provisions, Akin Demihin, senior associate director of policy, at (202) 626-2365 or ademehin@aha.org.

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BACKGROUND

On Nov. 6, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register its calendar year (CY) 2015 final rule, for the home health (HH) prospective payment system (PPS). CMS estimates that HH agencies will receive an overall update of negative 0.3 percent, a $60 million decrease from CY 2014 payment levels. Facility-based HH agencies, such as hospital-based agencies, will see an average increase of 1.5 percent above 2014 levels, due to case mix differences.

CY 2015 Payment Update

The overall payment update for HH agencies is composed of several distinct parts, and the overall impact on individual agencies depends on how an agency fares with each of these elements: the market basket update, the rebasing of payments, the case-mix adjustment and the area wage index.

Market-Basket Update

The HH PPS standard rates are updated annually using a HH-specific market basket. For CY 2015, HH agencies that report quality data will receive a 2.6 percent market-basket update. Agencies that do not report quality data will have a decrease of 2.0 percentage points in their market-basket update, meaning their update will be 0.6 percent. All agencies then will have their market-basket update reduced by 0.5 percentage points, which is a productivity cut mandated by the Affordable Care Act (ACA).

Rebasing of Payments

As required by the ACA, CMS is rebasing HH PPS payments via a four-year process initiated in CY 2014. The stated purpose of this rebasing is to adjust for changes in HH service delivery that have occurred over time, such as a reduction in the number of visits per HH episode, changes in the mix and intensity of services provided and the average cost of providing an episode of care. By law, the per-year payment reduction due to this rebasing cannot exceed 3.5 percent of total 2010 payments. The rebasing process for CY 2015 reduces the 60-day episode rate and the non-routine supplies

(NRS) conversion factor, and increases the per-visit rates, which are used for low-volume episodes. Overall, the CY 2015 rebasing cut is -2.4 percent, which reduces HH payments by $450 million relative to CY 2014 payment levels. The rebasing adjustments include a 3.5 percent reduction to the standardized 60-day episode rate (-$80.95), a 3.5 percent increase to the national per-visit payment amounts (ranging from +$1.79 to +$6.34), and a 2.82 percent reduction of the NRS conversion factor.

60-day Episode Rate. For CY 2015, CMS finalized a 60-day episode rate of $2,961.38, which includes the noted rebasing cut. Overall, however, the 2015 rate is an increase from the CY 2014 rate of $2,869.27, due to positive adjustments to the 2015 rate for changes to the wage index and case-mix weights, which maintain budget neutrality with the 2014 rate. CMS notes that the annual statutory cap for the rebasing cut, which is 3.5 percent of the 2010 60-day episode rate, prevents CMS from proposing a larger cut. The agency says a larger cut is needed to more closely align payments to the cost of the average 60-day episode.

Low-utilization Payment Adjustment (LUPA) Rates. Episodes with four or fewer visits are subject to a LUPA and are paid on a per-visit basis per type of service. Included in the table below are the current CY 2014 and final CY 2015 per-visit rates used to pay LUPA episodes. Both the current and 2015 per-visit amounts include an increase compared to the previous year due to the rebasing process, which increased these per-visit rates.

	CY 2014 Per-Visit Rates	**Final CY 2015 Per-Visit Rates**
HH Aide	$54.84	$57.89
Medical Social Services	$194.12	$204.91
Occupational Therapy	$133.30	$140.70
Physical Therapy	$132.40	$139.75
Skilled Nursing	$121.10	$127.83
Speech-language Pathology	$143.88	$151.88

Non-routine Supplies Conversion Factor. NRS are defined in the Medicare Benefits Policy Manual and include, for example, dressings for wounds, syringes, intravenous supplies and catheters. Payment rates for NRS are established by applying a conversion factor to the relative weight assigned to each of the six NRS severity levels. The final CY 2015 rates for the six NRS severity levels, which are calculated using the final NRS conversion factor of $53.23, are listed in Table 27 of the final rule and range from $14.36 to $560.27. The final rates were reduced by a negative 2.82 percent rebasing adjustment to the conversion factor.

Case-mix Adjustment

The HH PPS uses the home health resource groups (HHRG) along with the patient assessment data collected using the Outcome and Assessment Information Set (OASIS) tool to categorize patients for payment purposes. In CY 2014, in a change that accompanied the statutorily mandated rebasing of HH PPS payments, the HHRG

weights were reset by lowering the average weight to 1.00. This was accomplished by decreasing each weight by the same factor (1.3464) to maintain the same relative values between the weights. In addition, a budget-neutrality adjustment of 1.0237 was applied to the weights.

Similarly, for CY 2015, CMS recalibrated the weights for 60-day episodes in a budget-neutral manner to align payments with the most current HH service utilization data. The agency used CY 2013 claims data for 60-day episodes in place of the 2005 data used for the last update. The weights for CY 2015 are found in Table 15 of the final rule. Under this rule, CMS will now annually recalibrate the case-mix weights ever year with more current data.

Area Wage Index

In the fiscal year (FY) 2015 inpatient PPS final rule, CMS applies updated labor market boundaries to the area wage index. These boundaries are based on new core-based statistical area (CBSA) definitions, which have been updated by the Office of Management and Budget (OMB) using 2010 Census population data. The HH PPS final rule implements the proposed rule's recommendation to incorporate these new CBSA boundaries into the CY 2015 HH PPS wage index. It also applies a one-year transition to the implementation of these new labor markets, by using wage indices that consist of a 50/50 blend of the wage index values using OMB's previous labor market delineations and the wage index values using OMB's updated labor market delineations. Tables 13 and 14 in the proposed rule listed the 37 counties that change to rural status and the 105 counties that change to urban status, respectively, as a result of the updated labor markets. The CY 2015 wage index update will be applied in a budget-neutral manner, with a budget-neutrality factor of 1.0012 applied to the 60-day episode rates.

Labor-related Share

The HH final rule maintains a labor-related share of 78.535 percent for the case-mix adjusted 60-day episode rate, as set in the CY 2013 HH PPS final rule.

High-cost Outliers

CMS is not making any changes to the HH PPS high-cost outlier policy in CY 2015. The agency estimates that outlier payments will comprise approximately 2.25 percent of total HH PPS payments in CY 2015. The agency also notes that the statute requires the outlier pool for the HH PPS to *not exceed* 2.5 percent.

Rural Add-on

Under the ACA, rural HH episodes and visits receive a 3 percent payment add-on through Jan. 1, 2016. The final rule implements this rural add-on.

OTHER POLICY CHANGES

Face-to-Face Encounter

Per the ACA, in January 2011, CMS implemented a face-to-face encounter requirement for patients beginning HH services. The goal of this policy was to have a non-HH provider verify eligibility for Medicare's HH benefit. Today, this encounter with a physician or certified provider (including a nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the certifying physician in accordance with state law) must occur between 90 days prior to the initiation of services or 30 days after the start of services, and must include a narrative explanation of the patient's homebound status and need for either intermittent skilled-nursing or therapy services.

The final rule makes three changes to the face-to-face encounter policy:

- The final rule eliminates the requirement for a narrative to be included in the certification, with an exception. A narrative will still be required for HH patients needing skilled nursing services for management and evaluation of those patients' care plans, which the agency notes should be a rare occurrence as only 1.5 percent of all HH visits were for management and evaluation. The final rule cites Chapter 7 of the Medicare Benefits Policy Manual for guidance on how to identify whether the patients are subject to this infrequent exception.

- For determining the medical necessity of HH coverage, the final rule requires that documentation from the certifying physician's medical records and/or the acute/post-acute care facility's medical records be used as the basis for certification of home health eligibility. The rule "…remind[s] certifying physicians and acute/post-acute care facilities of their responsibility to provide the medical record documentation that supports the certification of patient eligibility for the Medicare HH benefit. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as through provider-specific probe review."

- For determining coverage for payment of physician claims for certification/recertification of eligibility for home health services, Medicare will not cover the physician claim if the related HH claim was not covered because of insufficient documentation to support the patient's eligibility for the Medicare HH benefit. This change will be implemented through future sub-regulatory guidance.

The regulation also clarifies that a face-to-face encounter is required for all HH certifications, but not for re-certifications. A certification occurs when a Start of Care (SOC) OASIS is completed to initiate care. This standard applies for the initial commencement of care and if an SOC OASIS occurs for a patient who is discharged and readmitted during the same 60-day episode of care.

The AHA welcomes the streamlining of the HH face-to-face encounter requirement, which should facilitate quicker transitions from hospitals and other health settings to homecare. However, we are concerned about the ability of HH agencies to comply with the requirements to acquired documentation from the certifying physician, which can be an administratively burdensome and slow process.

Therapy Reassessment Time Frames

The final rule changes the requirement for HH agencies to perform therapy reassessments on or close to the thirteenth and nineteenth therapy visits, and at least once every 30 days. **Instead, therapy reassessments will be required every 30 days, in alignment with the recommendation of the AHA.** A therapist from the therapy discipline being provided must conduct these assessments, with results on effectiveness of the treatment (or lack thereof) documented in the medical record.

Coverage of Insulin Injections

Medicare covers HH visits for the sole purpose of insulin injections only for patients who are physically or mentally unable to self-inject and when no other person is available to assist. In an August 2013 report, the Department of Health and Human Services Office of Inspector General (OIG) found that some portion of these visits was unnecessary because the patient could self-inject. This final rule also cites separate analyses that found for episodes with greater than $10,000 in outlier payments, patients received an average of 160 skilled nursing visits, with many of these visits having a primary diagnosis of diabetes or long-term use of insulin. CMS's analysis also found that these cases had disproportionately high concentrations in five states.

At this time, CMS is not proposing any changes to insulin injection coverage. However, the agency presents in Table 34 of the final rule a list of ICD-9-CM codes that the agency believes indicate a potential inability to self-inject insulin. This list, which was initially developed by CMS and contractors, may be expanded via a future proposal to include additional ICD-9-CM codes recommended by the AHA and other stakeholders. However, the final rule also states that CMS does not intend for a list of codes to be used as the sole means to identify beneficiaries eligible for this coverage. The agency plans to continue monitoring this issue and may provide additional sub-regulatory guidance to encourage the use of insulin injection pens to reduce expenses and increase patient adherence to treatment plans.

HH QUALITY REPORTING PROGRAM

The Deficit Reduction Act of 2005 required CMS to establish a program under which HH agencies must report data on quality of care in order to receive the full annual update to the HH PPS payment rate. Since CY 2007, HH agencies failing to report the data have incurred a reduction in their annual payment update factor of 2.0 percentage points. No new measures were added to the HH Quality Reporting Program (HH QRP) in this rule.

However, CMS finalizes a new minimum data submission threshold for OASIS assessments used to calculate HH QRP measures.

OASIS Data Completeness Standards

HH agencies are required to submit OASIS assessments for both payment and quality measurement purposes. In the rule, CMS indicates that in order to appropriately calculate quality measures using OASIS data, it needs to match OASIS assessments completed at the start or resumption of HH agency care with OASIS assessments completed at the time of patient transfer or discharge. Taken together, these matched OASIS assessments create what the agency terms an OASIS "quality assessment." To date, the agency has not implemented a standard measuring whether HH agencies report sufficiently complete data to create OASIS quality assessments. However, a 2012 OIG report recommended that CMS implement data completeness standards for OASIS assessments, and impose on those HH agencies that fail to meet the standards the 2 percent annual payment update reduction permitted under the statute.

In response to the OIG recommendation, CMS finalizes a "minimum data submission threshold" – or data completeness threshold – that assesses whether HH agencies have submitted sufficient data to calculate measures. **For the CY 2017 payment determination, HH agencies will be required to submit complete OASIS quality assessments on a minimum of 70 percent of patients with episodes of care occurring during the applicable data reporting period. HH agencies that do not meet the data completeness standard will be subject to a 2.0 percentage point reduction to their annual payment updates.** The reporting period for CY 2017 is Jul. 1, 2015 through Jun. 30, 2016. CMS has the authority to establish data submission requirements under the statute, which requires HH agencies to submit measure data "in a form and manner, and at a time, specified by the Secretary [of Health and Human Services]."

However, CMS does not finalize its proposal to increase the minimum data threshold to 80 percent for CY 2018 payment determinations, and 90 percent for CY 2019 payment determinations and beyond. Instead, the agency indicates it will monitor HH agency compliance with the 70 percent threshold, and use it to inform future increases to the threshold. CMS also states it will provide HH agencies with preview reports showing their "hypothetical performance" on the new data completeness using data from the "pre-implementation reporting period" (i.e., Jul. 1, 2014 – Jun. 30, 2015).

CMS will use a mathematical formula to calculate whether HH agencies have met the data completeness standards for quality assessments. The formula is as follows:

$$\text{Compliance} = \frac{\text{Number of quality assessments}}{(\text{Number of quality assessments} + \text{Number of non-quality assessments})} \times 100$$

In the context of the formula, "quality assessments" are any one of the six OASIS assessment types listed in the table below, while "non-quality assessments" do not fit in any of the categories below.

OASIS Quality Assessments

- A start-of-care (SOC) or resumption-of-care (ROC) OASIS assessment that has a matching end-of-care (EOC) assessment within the applicable data reporting period. EOC assessments are conducted at the time of transfer to an inpatient facility, patient death or discharge from HH care.
- A "late SOC/ROC" assessment is completed in the final 60 days of the applicable data reporting period, and could be used for a matching EOC assessment in a subsequent reporting period.
- An "early EOC" assessment that occurs within the first 60 days of an applicable reporting period.
- A "pseudo SOC/ROC" episode, which is an SOC/ROC assessment followed by one or more follow-up assessments.
- An "EOC pseudo episode" assessment, which is an EOC assessment preceded by one or more follow up assessments.
- An SOC/ROC assessment that is part of a known "one-visit" episode. A one-visit episode is a HH visit whose OASIS assessment data indicate that a subsequent visit is not required.

The AHA is pleased that, in response to our comments, CMS clarifies that HH agencies can appeal a finding of non-compliance with the data completeness threshold. Specifically, CMS states that HH agencies found non-compliant with the standard can use the annual "reconsideration" process to appeal the finding. Each year, CMS reviews whether HH agencies have met all of the data submission requirements for the HH QRP, and sends notices to those HH agencies found to be non-compliant. The affected HH agencies then have 30 days to submit a "reconsideration request" providing evidence that demonstrates compliance with reporting requirements.

Updates to National Quality Forum (NQF) -endorsed HH QRP Measures

Several measures in the HH QRP are NQF-endorsed. The NQF endorsement process includes a three-year "measure maintenance" process that provides for minor annual updates to measure specifications, as well as a comprehensive review for continued NQF endorsement at the end of the three-year cycle. CMS finalizes its proposal to incorporate any non-substantive updates to NQF-endorsed measures using a sub-regulatory process. Specifically, the measure changes would be posted to the CMS HH QRP website. CMS indicates that the determination of "substantive" versus "non-substantive" updates will be made on a measure-by-measure basis.

HH Value-based Purchasing (VBP) Demonstration

In the proposed rule, CMS solicited comment on a HH VBP demonstration project it is considering for implementation in CY 2016. In the final rule, CMS does not finalize any aspects of the HH VBP demonstration, but suggests it will use the feedback obtained from comments in shaping any future HH VBP demonstration. The agency also indicates it will solicit comment on a more detailed HH VBP model in future rulemaking.

FURTHER QUESTIONS

If you have further questions, please contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org, or for questions about the quality provisions, Akin Demehin, AHA senior associate director or policy, at (202) 626-2365 or ademehin@aha.org.