VNAA Brief Summary of Medicare Home Health Rule for 2015


The rule proposes multiple changes to the home health payment rates as well as significant changes in other home health policies including face-to-face documentation, therapy assessment schedules, and requirements for OASIS data submission. The proposed rule also introduces CMS’ preliminary plan for a value based purchasing pilot in 2016 and requests industry input on the approach being considered.

Below is a summary of the key policies in the proposed rule. Please note comments are due August 30, 2014.

**Rebasing**
CMS discusses the impact of the rebasing cuts that began in 2014 and presents data that suggests average payments still exceed average costs. CMS states that while data may support a larger reduction, legislation limits rebasing reductions for CY2015 to 3.5 percent. Based on this analysis, CMS proposes to implement the statutory 3.5 percent rebasing reduction for CY2015.

**Face to Face**
Acknowledging vocal concern from home health providers about the impact of on access to care, CMS discusses the impact of the face-to-face physician documentation requirement. CMS data shows a reduction in average home health utilization since the face-to-face requirement was put in place, but argues that it is impossible to separate the impact of the face-to-face requirement from other changes that could have reduced home health use.

CMS characterizes the reduction in utilization as minor and illustrates that in several states utilization actually has increased. It illustrates this with data from California, Alabama, Massachusetts, New Jersey and Virginia. It concludes that face-to-face could have been a contributing factor where utilization reductions have taken place, but any reduction solely due to face-to-face is indistinguishable from other causes. CMS indicates that its monitoring of home health agency utilization will continue.

CMS proposes changes in the face-to-face documentation requirements designed to reduce burden and increase compliance. CMS proposes to:

- Eliminate the additional narrative documentation requirement on physician certification except the clinical justification narrative needed for those cases in which home health skilled nursing services are being certified for management and evaluation of a patient’s plan of care.
- Use the physician documentation in the patient’s medical record in lieu of the “narrative”, citing the claim by home health agencies that the additional narrative requirement duplicated documentation that exists in the patient’s medical record.
• Deny payment for both the Medicare home health episode claim and physician’s Medicare claim for physician certification payment in the case where the physician’s medical record does not contain adequate documentation to support the certification.

**Case Mix Weights**
CMS proposes to recalibrate the case mix weights based on updated data on resource use. Based on this data, the proposal would modify OASIS and claims variables used for determining the Home Health Resource Groups (HHRGS) and the related payment weights. These adjustments would impact the overall payments made in aggregate. To address this, CMS applies a budget neutrality factor to assure that the overall impact on payments is budget neutral. Tables 8 and 11 in the proposed rule include information that can simulate the impact of the recalibration on payments to specific agencies.

**Home Health Market Basket Increase**
CMS proposes a total home health market basket increase for 2015 of 2.2 percent (currently estimated at 2.6 percent minus .4 percent for productivity increases). This is subject to last minute revision based on data that may become available between now and the final rule. This market basket increase will reduce by two percent for agencies that fail to report quality data as required.

**Quality Reporting Requirement**
Starting in July 2015, CMS proposes to establish a minimum threshold of the number of OASIS assessments that an agency must submit in a given year. Beginning in CY2015, the initial compliance threshold would be 70 percent. To meet this threshold, agencies would be required to submit both admission and discharge OASIS assessments for a minimum of 70 percent of all patients with episodes of care occurring during the reporting period. Failure to submit this information would result in a two percent market basket adjustment in CY2017. CMS proposes to increase this reporting threshold by 10 percent per year to be 90 percent by CY2017.

CMS also proposes to continue the requirement regarding completion of the experience of care survey (HHCAHPS) and updates the schedule for mandatory reporting. It reiterates its monitoring and appeals process, as well as reminds agencies of their obligation to assure their HHCAHPS vendor is reporting the agency’s data properly.

**Home Health Wage Index**
CMS makes a significant change in the payment system by adopting new Core Based Statistical Areas (CBSA) designations for the application of the home health wage index. CBSAs are the groupings of counties into either urban statistical areas or the non-urban area of each state. There are new CBSAs, 37 urban counties have become rural, 105 counties have become urban, and 46 existing CBSAs have been changed or split. The Tables 13, 14 and 15 detail these change on pages 85-91 of the posted proposed rule or pages 38392-38395 of the published proposed rule.

CMS is proposing to phase in the new wage index values over two years by blending 50 percent of the new wage index with 50 percent of what the wage index would otherwise have been absent CBSA changes. In 2015, this blending cushions the impact on those agencies disadvantaged by the changes but reduces the positive impact on those agencies benefitting from the CBSA changes. CMS also applies a budget neutrality factor to the standardized rate to accommodate the impact of these changes on overall Medicare home health payments.
The wage index tables used to find the proposed new wage index ratio(s) are not included in the proposed rule but is available under “Downloads” on the CMS website.

**CMS Proposed Rates**

**CMS includes information on calculations related to home health payment rates. These calculations include:**

- **Standardized Episode Rate:** CMS calculates the proposed 2015 Standardized Episode Rate to be $2922.76 by starting with the 2014 rate of $2869.27 and applying a +.12 percent budget neutrality factor for wage index changes, a +2.37 percent budget neutrality factor for case mix weight recalibration, a -$80.95 for 2015 rebasing and a +2.2 percent for the home health market basket.

- **Per Visit Rate:** CMS also calculates the proposed Per Visit Rates at: HH Aide: $57.88; MSS: $204.87; OT: $140.68; PT: $139.73; SN: $127.81; SLP: $151.85 by applying negative and positive rebasing adjustments and the market basket to the 2014 rates in Table 18 on page 97 of the posted proposed rule and page 38397 of the published proposed rule.

- **Non-Routine Supply Rates:** CMS calculates the proposed 2015 Non Routine Supply Rates for each severity level (SL) as SL1: $14.37; SL2: $51.91; SL3: $142.32; SL4: $211.45; SL5: $326.06; SL6: $560.79.

- **Rural Add-On:** CMS applies the three percent rural add-on required by law to the above rates for 2015 as reflected in Tables 24, 25, and 26 on pages 101-102 of the posted proposed rule or pages 38399-38400 of the published proposed rule.

- **Outlier Payments:** CMS estimates outlier payments at a point close enough to the 2.5 percent aggregate cap to propose that there be no changes in outlier policy for 2015.

**Non-self-injecting diabetics**

CMS provides an analysis of the impact of coverage of home health services for non-self-injecting, insulin dependent diabetics that suggests that many patients receiving these services may not require them. CMS highlights the high percentage of outlier patients that fall into this category (44 percent) and the percentage that list no complications as secondary diagnoses that would justify coverage (16 percent). CMS notes the concentration of such claims in proprietary agencies (81 percent) and their concentration in Florida (27 percent), Texas (24 percent) and California (15 percent). CMS lists secondary diagnoses that it believes would support the need for skilled nursing for non-self-injecting diabetics (Table 28 pages 115-118 of the posted proposed rule and page 38406 of the published proposed rule). CMS does not propose changes but requests comments on the table.

**ICD-10**

CMS formally advises agencies that the ICD-10 coding conversion is postponed until October 1 2015 and suggests further updates will be forthcoming throughout the year.

**Therapy Assessments**
CMS proposes performing therapy assessments on a simple schedule of at least every 14-calendar days. This is a significant change to the current scheduling rules that require maintaining a running count of therapy assessments.

**Value Based Purchasing (VBP) demo**

CMS discusses a preliminary approach to value based purchasing (VBP) in home health. CMS does not formally propose a home health VBP program in the proposed rule, but indicates a home health VBP proposal could be included in rulemaking as early as CY2015 for CY2016 implementation. CMS lays out a possible approach and seeks comment in this proposed rule.

The proposal is based in part on the prior study on its report to Congress on home health VBP, the home health VBP demonstration and experience in hospital VBP, in which hospitals currently have 1.25 percent of their payment at risk based on measured quality.

CMS believes the home health demonstration illustrates that a higher percentage risk/reward must be applied to influence home health agency behavior, and suggests a range of five to eight percent.

In the proposal, there would be rewards for both attainment and improvement above a threshold level of quality based on multiple quality standards. Agency payment rates would reduce to fund the VBP reward pool and those agencies that attain the quality level necessary for reward would receive those dollars back plus additional reward. Agencies that fall below the quality threshold would be penalized and not receive all their dollars back. The amount of reward or penalty would be proportional to the level of quality achieved relative to agencies within each state. CMS proposes that the system be mandatory and apply to all agencies in five to eight states initially. CMS seeks comments on all aspects of this plan including whether all states should be included or how states should be selected for initial participation.

**Health Information Technology (HIT)**

CMS promotes health information exchange (HIE) and highlights that the Office of the National Coordinator for Health Information Technology has proposed a voluntary certification for technology used by providers such as home health agencies that are not eligible under law for incentive payments for electronic health records (EHR) incentive programs. CMS states that the use of EHR certification by HHAs can help agencies with internal care delivery practices, support management of care across the continuum, and enable the reporting of electronically specified clinical quality measures.

**Speech-Language Pathology Services**

CMS proposes revisions to the existing standard at 42CFR484.4 that defines qualifications for speech-language pathologists who provide services under the home health benefit. State licensure would be required and, in the unlikely circumstance that state licensure should cease to exist, outlines specific education and experience requirements.

**Technical Changes**

CMS also proposes a technical change to correct an inadvertent regulatory omission and clarifies “...if a beneficiary is discharged with goals met and or no expectation of a return to home healthcare and returns to the same HHA during the 60-day episode a new start of care would be initiated (rather than an update to the comprehensive assessment) and thus the second episode would be considered a certification, not a recertification and would be subject to [42CFR] 424.22(a)(1) [certification with narrative].”
CMS makes a technical change to 42CFR250(a)(1) to clarify that when OASIS is referenced it is the current OASIS not a particular version of OASIS such as OASIS-C.

**Appeals**

CMS proposes to modify the appeals mechanism for violations of the home health Conditions of Participation resulting in the imposition of civil monetary penalties (CMPs). The change would require that “…when the administrative law judge or state hearing officer (or higher administrative authority) finds noncompliance supporting the imposition of a CMP, he or she must retain some amount of penalty consistent with the ranges of penalty amounts established at [42CFR] 488.845(b).” CMS proposes several other technical adjustments to related provisions to correct a typo, replace it with the correct reference to the scope of CMP for home health and specifically reference HHAs.

**Impact of Proposed Rule**

CMS includes estimates of paper work reduction impacts as well as overall financial impacts of the payment changes proposed in this rule. While these aggregate impacts do not accurately reflect the impact on any one agency, the data show some important trends. This rule is projected to increase payments to non-profit, freestanding agencies by .6 percent and non-profit facility-based agencies by .6 percent, while reducing payment to for-profit, freestanding agencies by .6 percent and for-profit, facility-based agencies by .2 percent. Payments tend to be reduced for agencies in the south and increase in other areas. Smaller volume agencies tend to see decreases in payment while larger volume agencies tend to see increases. Table 34, Pages 149-50 of the posted Proposed Rule and Pages 38415-38416 of the published Proposed Rule reflect these and other estimates of impact.

**Conclusion**

The complexity and number of changes in this proposed rule make estimating the financial impact of on any particular agency very difficult. Agencies that have the capacity to simulate these changes are likely to achieve the best projections using historical data from their own agency applied to the new wage index areas, wage index values, case mix scoring and weights, and payment levels. VNAA urges those with the capacity to do such simulations do so as quickly as possible and share any significant impacts with VNAA. This will enable VNAA to include specific information on VNAA member impacts in its comment letter to CMS and contacts in Congress.