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Centers for Medicare & Medicaid Services
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FACT SHEET

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CMS proposes payment changes for Medicare home health agencies for 2015

The Centers for Medicare & Medicaid Services (CMS) today announced proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year (CY) 2015 that would foster greater efficiency, flexibility, payment accuracy, and improved quality. Based on the most recent data available, CMS estimates that approximately 3.5 million beneficiaries received home health services from nearly 12,000 home health agencies, costing Medicare approximately $18 billion in 2013.

In the rule, CMS projects that Medicare payments to home health agencies in CY 2015 will be reduced by 0.30 percent, or -$58 million based on the proposed policies. The proposed decrease reflects the effects of the 2.2 percent home health payment update percentage ($427 million increase)and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($485 million decrease).

Background

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical therapy, speech-language pathology, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency (HHA).

Medicare pays home health agencies through a prospective payment system that pays higher rates for services furnished to beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating home health agencies. Home health payment rates are updated annually by the home health payment update percentage. The payment update percentage is based, in part,

on the home health market basket, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

Face-to-face encounter requirements

The Affordable Care Act mandates that the certifying physician or allowed non-physician provider (NPP) must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit. Current regulations require the encounter occur within 90 days before care begins or up to 30 days after care began. Documentation of the encounter must include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of skilled services.

In this rule, CMS is proposing three changes to the face-to-face encounter requirements. First, we are proposing to eliminate the narrative requirement currently in regulation. The certifying physician would still be required to certify that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility.

Second, for medical review purposes, we are proposing to only consider medical records from the patient's certifying physician or discharging facility in determining initial eligibility for the Medicare home health benefit.

Lastly, we are proposing that the physician claim for certification/re-certification of eligibility for home health services (not the face-to-face encounter visit) be considered a non-covered service if the HHA claim was non-covered because the patient was ineligible for the home health benefit.

Clarification on when documentation of a face-to-face encounter is required

The face-to-face encounter requirement applies to the physician's certification only, not the re-certification of eligibility for subsequent episodes. CMS previously clarified that the face-to-face encounter requirement applies to "initial episodes," the first in a series of episodes separated by no more than a 60-day gap. CMS is proposing to clarify that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care.

Recalibration of the HH PPS case-mix weights

CMS is proposing to recalibrate the HH PPS case-mix weights by adjusting the weights relative to one another, using CY 2013 home health claims data, to ensure that the case-mix weights reflect the most current utilization and resource data available.

Rate-setting changes

Core Based Statistical Area (CBSA) changes for the HH wage index

In Feb. 2013, the Office of Management and Budget (OMB) issued a bulletin that contained a number of significant changes related to the delineation of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and guidance on uses of the delineation of these areas. Based on our assessment working with other Medicare programs, CMS is proposing changes to the wage index based on the newest CBSA changes and OMB definitions for the CY 2015 HH PPS wage index. These changes will be made to the wage index using a blended wage index for a one-year transition. For each county, a blended wage index would be calculated as 50 percent of the CY 2015 wage index using the current OMB delineations and 50 percent of the CY 2015 wage index using the revised OMB delineations.

Home health payment update percentage

The Affordable Care Act requires that the market basket update for HHAs be adjusted by changes in economy-wide productivity for CY 2015 (and each subsequent calendar year). The CY 2015 home health market basket (2.6 percent) adjusted for multifactor productivity (0.4 percentage points) would result in a 2.2 percent payment update.

Rebasing the 60-day episode rate

The Affordable Care Act requires that beginning in CY 2014, CMS apply an adjustment to the national standardized 60-day episode rate and other applicable amounts to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. Additionally, CMS must phase-in any adjustment over a four year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year, and be fully implemented by CY 2017. CY 2015 will be the second year of the four year phase-in for rebasing adjustments to the HH PPS payment rates.

The rule implements increases to the national per-visit payment rates, a 2.82 percent reduction to the NRS conversion factor, and a reduction to the national, standardized 60-day episode rate of $80.95 for CY 2015. The proposed national, standardized 60-day episode payment for CY 2015 is $2,922.76.

<u>Home Health Quality Reporting Program (HH QRP) update</u>

The Home Health Conditions of Participations (CoPs) require HHAs to submit OASIS assessments as a condition of payment and also for quality measurement purposes. HHAs that do not submit quality measure data to CMS will see a two percent reduction in their annual payment update (APU). In this rule, CMS is proposing to establish a minimum submission threshold for the number of OASIS assessments that each HHA must submit. Beginning in CY 2015, the initial compliance threshold would be 70 percent. This means that HHAs 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. We are proposing to increase the threshold in 10 percent increments over the next two years to reach a maximum threshold of 90 percent. This proposal applies to the reporting period July 1, 2015 to June 30, 2016 to affect the APU in CY 2017.

Conditions of Participation for speech-language pathologists

CMS is proposing to revise the Home Health Conditions of Participation (CoPs) for speech language pathologist (SLP) personnel. We are proposing that a qualified SLP is an individual who meets one of the following requirements: a) has a masters' or doctoral degree in speech-language pathology, and is licensed as a speech-language pathologist by the state where they furnish services (CMS believes that all states license SLPs; therefore all SLPs would be covered by this option); or b) has successfully completed 350 clock hours of supervised clinical practicum (or be in the process of completing these hours), at least nine months of supervised full-time speech-language pathology experience, and has successfully completed a national examination approved by the Secretary. These requirements, which align with the requirements in the Social Security Act, would replace the current stringent requirements with a more flexible option that defers to State licensure requirements.

Home Health Value-based Purchasing Model

CMS is inviting comment on a value-based purchasing (VBP) model for HHAs in certain states that it is considering testing, to begin in CY 2016. We have already successfully implemented the Hospital Value-Based Purchasing (VBP) program where 1.25 percent of hospital payments in FY 2014 are tied to the quality of care that the hospitals provide. This percentage amount will gradually increase to two percent in FY 2017 and subsequent years. The HHA VBP model being considered would include a five to eight percent adjustment in payment made after each planned performance period in the projected five to eight states. A HHA VBP model presents an opportunity to test whether significantly larger incentives would lead to higher quality of care for beneficiaries. If CMS decides to move forward with the implementation of an HHA VBP model in CY 2016, it intends to invite additional comments on a more detailed model proposal to be included in future rulemaking.

For additional information about the Home Health Prospective Payment System, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html. The proposed rule can be viewed at https://www.federalregister.gov/public-inspection. Please be mindful this link will change once the proposed rule is published on July 7, 2014 in the Federal Register. CMS will accept comments on the proposed rule until Sept. 2, 2014.

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