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CMS Proposed Rule Impacting Home Health Agencies -- July 7, 2014

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The Centers for Medicare & Medicaid Services (CMS) on July 1, 2014 released the proposed rule for Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies (CMS-1611-P) that contains some very important changes, especially to the face-to-face requirements. The proposed rule will be published in the Federal Register on July 7, 2014.

In the proposed rule, CMS projects that Medicare payments to home health agencies in CY 2015 will be reduced by 0.30 percent, or -$58 million. There were a number of important changes in the proposed rule, especially concerning the regulations for the home health face to face physician encounter requirement.

The proposed rule:

- Decreases payment due to 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). Of course, this decrease does not take into account the additional 2 percent decrease due to sequestration. 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. CY 2015 will be the second year of the four year phase-in for rebasing adjustments to the HH PPS payment rates.
- 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.
- Changes the current regulations that requires the face to face encounter to include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of skilled services. LeadingAge is pleased that CMS has proposed 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. This requirement was a duplication of the information that the physician had already documented in the patient's record. CMS is also 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. CMS is 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.

- Clarifies 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.
- Re-calibrates 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.
- Changes to the wage index based on the newest Core Based Statistical Area (CBSA) changes for the HH wage index (CBSA) changes and Office of Management and Budget 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.
- Establishes a minimum submission threshold for the number of OASIS assessments that each HHA must submit for the Home Health Quality Reporting Program (HH QRP) update. HHAs that do not submit quality measure data to CMS will see a two percent reduction in their annual payment update (APU). 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. CMS is 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.
- Revises the Home Health Conditions of Participation (CoPs) for speech language pathologist stating that a qualified speech language pathologist (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 or 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.
- Encourages stakeholders to comment on a value-based purchasing (VBP) model for Home Health Agencies that CMS plans to test in certain states beginning in CY 2016. CMS has 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.

LeadingAge is in the process of reviewing the proposed rule, and we encourage home health members to submit comments. LeadingAge believes that some of the changes to the face to face encounter requirement are positive, and will reduce errors and excessive, unnecessary documentation. We are also pleased that CMS is moving closer to a quality-based reimbursement system. CMS will accept comments on the proposed rule until Sept. 2, 2013.