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Medicare Home Health Prospective Payment System (HHPPS) Calendar Year (CY) 2013 Final Rule

COMPREHENSIVE SUMMARY

Introduction

On November 2, 2012, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the Medicare Home Health Prospective Payment System (HH PPS) Calendar Year (CY) 2013. The final rule finalizes a payment decrease of 1.32 percent for the home health 60- day episode for CY 2013. This reduction is made to account for growth in the aggregate case- mix that is unrelated to changes in patient's health status. Therefore, payments to home health agencies for CY 2013 are estimated to decrease by approximately $10 million.

In addition to the payment update, the rule contains extensive provisions the Medicare Conditions of Participation that are utilized by state surveyors to certify home health agencies, flexibilities for the physician face to face requirement and significant revisions to the current therapy functional reassessment requirements.

The final rule goes into effect on January 1, 2013.

Summary of Pertinent Provisions

Case- Mix Measurement

- CMS finalizes the 1.32 percent payment reduction to the CY 2013 national standardized 60-day episode base payment rate to account for increases in billed case-mix weights, resulting in overpayments that have occurred between 2000 to 2009, above real change in case- mix.
- CMS states that the Agency is in the process of finalizing its analysis for purposes of rebasing.

CY 2013 Rate Update

- CMS finalizes a CY 2013 market basket update of 2.3 percent for CY 2013 which is based on the IHS Global Insight forecast using the most recent available data.
- Section 3401(e) of the Affordable Care Act mandates that CMS reduce the updated market basket by 1 percentage point.
- Therefore, the final CY 2013 market basket update is 1.3 percent.

Outlier Policy

- In the CY 2011, CMS reduced payment rates by 5 percent, targeted up to 2.5 percent of the estimated total payments to be paid as outlier payments, and applied a 10 percent agency-level outlier cap. In addition, CMS must implement a Fixed Dollar Loss (FDL) ratio to ensure that the 2.5 percent target is not exceeded. For CY 2013, the FDL ratio is 0.45.

Home Health Care Quality Reporting for CY 2014 payment and subsequent years

- CMS will consider OASIS assessments submitted by HHAs to CMS in compliance with HHA Conditions of Participation and Conditions of Payment for episodes beginning on or after July 1, 2011 and before July 1, 2012 as fulfilling one portion of the quality reporting requirement for CY 2013.
- CMS plans to use this policy for each subsequent year beyond 2013 to consider OASIS assessments submitted for episodes beginning in the time frame between July 1 of the calendar year two years prior to the calendar year of the Annual Payment Update (APU) effective date and June 30 of the calendar year one year prior to the calendar of the APU effective date and received within 30 days of the end of that time period to meet the OASIS quality reporting requirement.
- CMS has corrected technical issues and will require reporting Acute Care Hospitalization and Emergency Department Use without Hospitalization.
- CMS finalizes that the claim based Acute Care Hospitalization measure will replace the OASIS based measure on the Home Health Compare.
- CMS maintains Home Health Care Consumer Assessment of Healthcare Providers and Systems (HH CAHPS) data requirements for CY 2013 as articulated in the CY 2012 HH PPS final rule, for continuous monthly data collection and quarterly data submission of HH CAHPS data.
- CMS codifies the current guideline that all approved HH CAHPS survey vendors fully comply with all HH CAHPS oversight activities.
- CMS finalizes its proposal to base the wage index adjustment to the labor portion of thigh PPS rates on the most recent pre-floor and pre- classified hospital wage index.
- For the wage index, CMS finalizes a labor-related share of the case-mix adjusted 60-day episode rate of 78.535 percent and anon- labor related share of 21.465 percent.

TABLE 12: CY 2013 National 60-Day Episode Payment Amount

CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the CY 2013 home health payment update of 1.3 percent	Reduce by 1.32 percent for nominal change in case-mix	CY 2013 National Standardized 60-Day Episode Payment Rate.
$2,138.52	X 1.013	X 0.9868	$2,137.73

TABLE 13: For HHAs that Do Not Submit the Quality Data –CY 2013 National 60-Day Episode Payment Amount

CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the CY 2013 home health payment update of 1.3 percent minus 2 percentage points (-0.7 percent)	Reduce by 1.32 percent for nominal change in case-mix	CY 2013 National Standardized 60-Day Episode Payment Rate.
$2,138.52	X 0.993	X 0.9868	$2,095.52

TABLE 14: CY 2013 National Per-Visit Payment Amounts

		For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
Home Health Discipline Type	CY 2012 Per-Visit Amounts Per 60-Day Episode	Multiply by the CY 2013 payment update of 1.3 percent	CY 2013 per-visit payment	Multiply by the CY 2013 payment update of 1.3 percent minus 2 percentage points (-0.7 percent)	CY 2013 per-visit payment
HH Aide	$51.13	X 1.013	$51.79	X 0.993	$50.77
MSS	$180.96	X 1.013	$183.31	X 0.993	$179.69
OT	$124.26	X 1.013	$125.88	X 0.993	$123.39
PT	$123.43	X 1.013	$125.03	X 0.993	$122.57
SN	$112.88	X 1.013	$114.35	X 0.993	$112.09
SLP	$134.12	X 1.013	$135.86	X 0.993	$133.18

TABLE 15: CY 2013 LUPA Add-On Amounts

	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
CY 2012 LUPA Add-On Amount	Multiply by the CY 2013 payment update of 1.3 percent	CY 2013 LUPA Add-On Amount	Multiply by the CY 2013 payment update of 1.3 percent minus 2 percentage points (-0.7 percent)	CY 2013 LUPA Add-On Amount
$94.62	X 1.013	$95.85	X 0.993	$93.96

TABLE 16: CY 2013 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

CY 2012 NRS Conversion Factor	Multiply by the CY 2013 payment update of 1.3 percent	CY 2013 NRS Conversion Factor
$53.28	X 1.013	$53.97

TABLE 17: CY 2013 NRS Payment Amounts for HHAs that DO Submit the Required Quality Data

Severity Level	Points (Scoring)	Relative Weight	CY 2013 NRS Payment Amount
1	0	0.2698	$14.56
2	1 to 14	0.9742	$52.58
3	15 to 27	2.6712	$144.16
4	28 to 48	3.9686	$214.19
5	49 to 98	6.1198	$330.29
6	99+	10.5254	$568.06

TABLE 18: CY 2013 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

CY 2012 NRS Conversion Factor	Multiply by the CY 2013 payment update of 1.3 percent minus 2 percentage points (-0.7 percent)	CY 2013 NRS Conversion Factor
$53.28	X 0.993	$52.91

TABLE 19: CY 2013 NRS Payment Amounts for HHAs that DO NOT Submit the Required Quality Data

Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	$14.28
2	1 to 14	0.9742	$51.54
3	15 to 27	2.6712	$141.33
4	28 to 48	3.9686	$209.98
5	49 to 98	6.1198	$323.80
6	99+	10.5254	$556.90

TABLE 20: CY 2013 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area

For HHAs that DO Submit Quality Data			For HHAs that DO NOT Submit Quality Data		
CY 2013 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 National Standardized 60-Day Episode Payment Rate	CY 2013 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 National Standardized 60-Day Episode Payment Rate
$2,137.73	X 1.03	$2,201.86	$2,095.52	X 1.03	$2,158.39

TABLE 21: CY 2013 Per-Visit Amounts for Services Provided in a Rural Area

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Home Health Discipline Type	CY 2013 per-visit rate	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 per-visit rate	CY 2013 per-visit rate	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 per-visit rate
HH Aide	$51.79	X 1.03	$53.34	$50.77	X 1.03	$52.29
MSS	$183.31	X 1.03	$188.81	$179.69	X 1.03	$185.08
OT	$125.88	X 1.03	$129.66	$123.39	X 1.03	$127.09
PT	$125.03	X 1.03	$128.78	$122.57	X 1.03	$126.25
SN	$114.35	X 1.03	$117.78	$112.09	X 1.03	$115.45
SLP	$135.86	X 1.03	$139.94	$133.18	X 1.03	$137.18

TABLE 22: CY 2013 LUPA Add-On Amounts for Services Provided in Rural Areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2013 LUPA Add-On Amount	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 LUPA Add-On Amount	CY 2013 LUPA Add-On Amount	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 LUPA Add-On Amount
$95.85	X 1.03	$98.73	$93.96	X 1.03	$96.78

TABLE 23: CY 2013 NRS Conversion Factor for Services Provided in Rural Areas

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2013 Conversion Factor	Multiply by the 3 Percent Rural Add-On	Rural CY 2013 Conversion Factor	CY 2013 Conversion Factor	Multiply by the 3 Percent Rural Add-On	CY Rural 2013 Conversion Factor
$53.97	X 1.03	$55.59	$52.91	X 1.03	$54.50

TABLE 24: CY 2013 NRS Payment Amounts for Services Provided in Rural Areas

		For HHAs that **DO** submit quality data (NRS Conversion Factor=$55.59)		For HHAs that DO **NOT** submit quality data (NRS Conversion Factor=$54.50)	
Severity Level	Points (Scoring)	Relative Weight	Total NRS Payment Amount for Rural Areas	Relative Weight	Total NRS Payment Amount for Rural Areas
1	0	0.2698	$15.00	0.2698	$14.70
2	1 to 14	0.9742	$54.16	0.9742	$53.09
3	15 to 27	2.6712	$148.49	2.6712	$145.58
4	28 to 48	3.9686	$220.61	3.9686	$216.29
5	49 to 98	6.1198	$340.20	6.1198	$333.53
6	99+	10.5254	$585.11	10.5254	$573.63

Home Health Face to Face Encounter

- CMS finalizes its proposal to allow a non-physician practitioner (NPP) in an acute or post-acute facility to perform the face-to-face encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the acute or post-acute facility, and allow such physician to inform the certifying physician of the patient's homebound status and need for skilled services.

Therapy Coverage and Reassessments

- CMS finalizes three revisions regarding the requirement that a qualified therapist complete a functional reassessment of the patient at the 13th and 19th visit and/or every 30 days.
- First, CMS finalized its proposal that if a qualified therapist missed a reassessment visit, therapy coverage would resume with the visit during which the qualified therapist completed the late reassessment, not the visit after the therapist completed the late reassessment.
- In the rule, CMS provides the following example: *If a patient receives occupational therapy on visit 11 (with reassessment requirements met) and on visit 14, speech-language pathology services on visit 13 (with reassessment requirements met) and 15, and physical therapy is provided on visit 12 (but did not meet reassessment requirements) and on visit 16 (assessment completed). Whether the CY 2013 HH PPS proposed rule would allow for ongoing coverage of occupational therapy and speech language pathology and would allow for coverage of physical therapy on visit 16, when the reassessment was completed. Under the scenario above, the proposal would allow for ongoing coverage of occupational therapy and speech-language pathology and would*

allow for coverage of physical therapy on visit 16, when the reassessment was completed. The physical therapy provided on visit 12 would be non-covered.

- Second, CMS finalized its proposal that in cases where multiple therapy disciplines are involved, if the required reassessment visit was missed for any one of the therapy disciplines for which therapy services were being provided, therapy coverage would cease only for that particular therapy discipline.
- Third, CMS clarifies that in cases where the patient is receiving more than one type of therapy, qualified therapists must complete their reassessment visits during the 11th, 12th, or 13th visit for the required 13th visit reassessment and the 17th, 18th, or 19th visit for the required 19th visit reassessment. However, CMS also states in instances where patients receive more than one type of therapy, if the frequency of a particular discipline, as ordered by a physician, does not make it feasible for the reassessment to occur during the specified timeframes without providing an extra unnecessary visit or delaying a visit, then it will still be acceptable for the qualified therapist from each discipline to provide all of the therapy and functionally reassess the patient during the visit associated with that discipline that is scheduled to occur closest to the 14th Medicare-covered therapy visit, but no later than the 13th Medicare-covered therapy visit.
- Likewise, a qualified therapist from each discipline must provide all of the therapy and functionally reassess the patient during the visit associated with that discipline that is scheduled to occur closest to the 20th Medicare-covered therapy visit, but no later than the 19th Medicare-covered therapy visit. In this instance, CMS has replaced the current requirement of "close to" with "closest to" which has potential implications for compliance. For example under the current "close to" language the PT may complete the functional reassessment on the 15th visit even though the PT may also return to treat the patient on the 18th visit and meet the compliance requirements. Under this new "closest to" language, in this instance, the PT would be required to complete the functional reassessment on the 18th visit to comply with the mandated functional reassessment requirement.

**** APTA is very concerned about the administrative implications that these provisions will have on therapists and HHAs to comply with the functional reassessment as the interpretation set forth in this final rule is significantly different than its current application. The association will provide educational opportunities in the coming weeks to provide clarity on how to comply with these provisions.***

Payment Reform: Home Health Study and Report

- To address issues regarding access to home health and cherry picking, the Affordable Care Act mandated a study on home health agency costs involved with providing access to care to low-income Medicare beneficiaries or in underserved areas as well as with high levels of severity.
- CMS awarded a contract in the fall of 2010 to conduct exploratory work for the study. This contract resulted in an extensive literature search of HH PPS vulnerabilities and access issues along with open door forums and technical expert panels.
- In September 2011, CMS awarded a study contract to develop an analytic plan, perform detailed analysis and recommendations. CMS is at the beginning of this contact and plans

to release more information at a later date. The final report is due to Congress no later than March 1, 2014. Congress also gave CMS the authority to conduct a separate demonstration to test recommendations stemming from the report.

International Classification of Diseases, 10th Edition (ICD 10) Transition Plan and Grouper Enhancements

- CMS finalizes its proposal to restrict M1024 to only permit fracture (V code) diagnoses codes which according to ICD-10 cannot be reported in a home health setting as a primary or secondary diagnosis.
- CMS finalizes its proposal to permit equivalent scoring in the HHRG logic when the Diabetes, Skin 1 or Neuro 1 codes are submitted immediately following the V-codes in the M1020 position without requiring utilization of the payment diagnosis field.
- CMS states that it will be modifying policy for the payment diagnosis field to reflect that when v-codes are reported as a primary or secondary diagnosis and paired with a fracture code in our pairing listing, the grouper will award points.
- CMS states that it will be modifying policy for the payment diagnosis field to permit the reporting of resolved conditions related to the plan of care that may be significant in describing the patient but will restrict the awarding of points to fracture conditions.

Quality Reporting for Hospices

- The Affordable Care Act mandates a quality reporting program for hospices. If hospices fail to report on the required measures they will receive a 2 percent reduction to the market basket for the applicable fiscal year. The performance measures must be endorsed by a consensus-based organization – this contract is currently held by the National Quality Forum (NQF). The statute mandates that CMS make the measures for the FY 2014 reporting year available no later than October 1, 2012.
- The statute mandates that the quality reporting program must make data available to the public. CMS states the development and implementation of a standardized data set must precede public reporting of hospice quality measures, and the Agency will announce the timeline for public reporting of data in future rulemaking.
- Currently, CMS has finalized two measures to satisfy the FY 2014 requirement: pain management (NQF #0209) and participation in a Quality Assessment and Performance Improvement (QAPI) program that includes at least three quality indicators related to patient care. For FY 2015, CMS proposes these same measures.
- CMS is considering a target date of for implementation of a standardized hospice data item set as early as CY 2014 and welcomes comments on the implementation of a hospice patient-level data item set in CY 2014. CMS is also considering implementation of measures based on an experience of care survey such as the Family Evaluation of Hospice Care Survey (FEHC).

Survey and Enforcement Requirements for Home Health Agencies

- CMS lays out extensive provisions that would add new sections to federal regulations regarding the survey and certification guidance and enforcement of compliance standards for HHAs that are not in substantial compliance with Medicare participation requirements.

The additions include:

- Standard surveys would be conducted no later than 36 months after the date of the last standard survey with the establishment of minimum requirements including patient or legal guardian consent.
- A partial extended survey may be conducted to identify deficiencies not determined in the standard survey, including violations of the Medicare Conditions of Participation (COP).
- An extended survey would review compliance with COPs and can be conducted at any time a deficiency is found. Must be conducted no later than 14 days after a standard survey is completed uncovering the deficiency.
- Standard surveys should be unannounced.
- A surveyor would be disqualified from surveying an HHA if he or she has certain employment arrangements or financial interest in the HHA.
- CMS will furnish HHAs with a detailed process for Informal Dispute Resolutions (IDR).
- CMS sets forth factors to determine sanctions based on the severity of the violation. These include government takeover and appointment of home health managers, suspension of payment for all new admissions and payment episodes, directive plan of correction and civil money penalties.
- Direct in-service training would be in situations where staff performance resulted in deficient practices.
- CMS holds the authority to terminate an HHA's provider agreement and HHAs have the right to appeal a decision to terminate such decision.

- The effective date of the civil money penalty (§ 488.845), suspension of payment for new admissions (§ 488.840), and Informal Dispute Resolution (IDR) provisions (§ 488.745) will be July 1, 2014.
- The effective date of all other survey and enforcement provisions in parts 488, 489, and 498 will be July 1, 2013.