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M E M O R A N D U M

TO: Community Services Members

FROM: Cheryl Udell, Community Services Policy Analyst

DATE: August 10, 2012

SUBJECT: **Home Health Agency Proposed Medicare Rule for 2013**

ROUTE TO: Administrator/Director, CFO

ABSTRACT: CMS releases HHA PPS proposed rule for CY 2013.

Introduction

The Centers for Medicare and Medicaid Services (CMS) has issued the Home Health Agency Prospective Payment System (HHA PPS) proposed rule for Calendar Year (CY) 2013. The complete rule is published in the *Federal Register*. The final rule will likely be issued sometime in the last quarter of 2012.

Public comments on the proposed changes must be received by CMS by 5 p.m., Sept. 4, 2012. Comments should reference file code *CMS-1358-P* and may be submitted electronically at http://www.regulations.gov by following the instructions under *More Search Options*.

For additional details on submitting comments please refer to the *Federal Register* link referenced above for detailed instructions.

Overall Impact

CMS is proposing measures that equal a **0.1 percent decrease** in total Medicare payments to HHAs for CY 2013. Nationally, total Medicare revenue would be reduced by approximately $20 million.

The rule proposes to rebase and revise the home health market basket. The CY 2013 home health market basket would result in a labor-related share of 78.535 percent, and a non labor-related share of 21.465 percent.

Affordable Care Act

With this proposed rule, CMS is following through on several changes first implemented with previous years' final rules and requirements of the *Affordable Care Act* (ACA). CMS is applying the ACA mandated **1 percent** efficiency reduction to the CY 2013 **2.5 percent market basket index,** resulting in a **1.5 percent** increase for HHA next year**.**

Survey

This proposed rule establishes requirements for unannounced, standard and extended surveys of HHAs, and provides a number of alternatives or intermediate sanctions that could be imposed if HHAs were out of compliance with Federal requirements. In accordance with the new proposal, surveyors would be allowed to impose a financial requirement on non-compliant providers and require that they work toward correcting areas in which they are deficient.

Face-to-Face

In addition, CMS is also proposing changes in the Face-to-Face (F2F) encounter requirements which include:

- Adding flexibility to allow Non-physician Practioners (NPP) who attend to home health patients in an acute or post-acute setting to perform F2F encounters in collaboration with or under the supervision of the physician who has privileges and cared for the patient in acute or post-acute setting.
- Previously a NPP included a nurse practitioner or clinical nurse specialist or a certified nurse-midwife or physician assistant. In a recent June 2012 Question and Answer document, a resident who is not Medicare-enrolled can perform the F2F encounter, but only under the supervision of a teaching physician who has privileges at the acute or post-acute facility.

Therapy

CMS is proposing three changes:

- 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 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.
- Questions regarding acceptable visit ranges for the required 13th and 19th reassessment continue; therefore, CMS is proposing to clarify that in cases where the patient is receiving more than one type of therapy, qualified therapists could 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.

Additional Highlights

Following is a list of additional highlights from the proposed rule detailed in this memo:

- Market Basket Index (MBI)
- Rural Add-on
- Wage Index
- The Low Utilization Payment Adjustment (LUPA)
- Fixed Dollar Loss Ratio (FDL) and Outlier Policy
- The Non-routine Medical Supply (NRS) conversion factor
- Recalibration
- Survey Changes
- OASIS-C and Home Health Compare
- Technical corrections on therapy services and G- Codes
- Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

MBI

In addition to the net inflationary adjustment of 1.5 percent noted above, rates are also impacted by a negative1.32 percent recalibration due to case mix creep. As a result, the base average 60-day episodic payment rate increased by $3.43 per episode to $2,141.95 for 2013 (see Table 1).

TABLE 1: Proposed CY 2013 National 60-Day Episode Payment Amount

CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the proposed CY 2013 home health paymentupdate of 1.5 percent	Reduce by 1.32 percent for nominal change in case-mix	Proposed CY 2013 National Standardized 60-Day Episode Payment Rate.
$2,138.52	X 1.015	X 0. 9868	$2, 141.95

Source: CMS Proposed HHA PPS for CY 2013

Penalty for Failing to Report Quality Data

Starting in 2007, CMS began applying a 2 percent reduction in the MBI for those agencies that failed to submit the required quality data. For 2013, CMS is continuing to use the OASIS assessments as the required quality data submission. Applying the 2 percent reduction to those agencies that failed to meet the reporting requirement for the period of July 1, 2011 through July 1, 2012, results in a net negative 0.5 percent adjustment (see Table 2.)

Table 2. Proposed CY 2013 National 60-Day Episode Payment with 2 % Penalty

CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the proposed CY 2013 home health payment update of 1.5 percent minus 2 percentage points (-0.5 percent)	Reduce by 1.32 percent for nominal change in case-mix	Proposed CY 2013 National Standardized 60-Day Episode Payment Rate.
$2,138.52	X 0.995	X 0.9868	$2099.74

Source: CMS Proposed HHA PPS for CY 2013

This base 60-day episode rates calculated above are further adjusted by the regional wage index (see below); the applicable HHRG; and the rural home health add-on of 3 percent as found in Table 3.

Rural Add-on

As mandated under ACA, the home health rural add-on for episodes and visits furnished in rural areas beginning on or after April 1, 2010 and before Jan. 1, 2016 is reinstated. The 3 percent add-on applies to the 60-day episode rates listed above, the LUPA and the NRS conversion factor for services provided in non-Core Based Statistical Areas (non-CBSA).

Table 3. Calculation of Proposed Home Health 3 Percent Rural Add-on

For HHAs that DO Submit Quality Data			For HHAs that DO NOT Submit Quality Data		
Proposed CY 2013 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Proposed Rural CY 2013 National Standardized 60-Day Episode Payment Rate	Proposed CY 2013 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Proposed Rural CY 2013 National Standardized 60-Day Episode Payment Rate
$2,141.95	X 1.03	$2,206.21	$2,099.74	X 1.03	$2,162.73

Source: CMS Proposed HHA PPS for CY 2013

Wage Index

CMS continues to utilize a wage index in order to account for differences in area wage levels, based upon hospital wage data. Any wage index must be applied in a manner that does not result in aggregate payments that are greater or less than what would otherwise be made in the absence of the wage adjustment. The CY 2013 home health market basket would result in a labor-related share of 78.535 percent and a non labor-related share of 21.465 percent.

Table 4 provides a break down of wage index changes for 2013 for the 13 New York CBSAs and non-CBSA counties. The state wide average change in wage index is a 0.16 percent, with nine

out of the 14 regions showing a positive change. There is wide variation around this average, and the **very dramatic negative adjustment for the Kingston region** is of concern.

Table 4. CY 2013 Proposed HHA PPS Wage Index Changes by NY Region
Please see appendix on page 12 for county breakdown of payment localities

	Albany Wage Index	**Binghamton Wage Index**	**Buffalo Wage Index**	**Elmira Wage Index**	**Glens Falls Wage Index**	**Ithaca Wage Index**	**Kingston Wage Index**
CY 2012	0.8680	0.8731	0.9750	0.8522	0.8504	0.8819	0.9170
CY 2013	0.8715	0.8727	0.9958	0.8383	0.8359	0.9233	0.8965
% CHANGE	0.40%	-0.05%	2.13%	-1.63%	-1.71%	4.69%	-2.24%
	Nassau-Suffolk Wage Index	**New York Metro Wage Index**	**Poughkeepsie Wage Index**	**Rochester Wage Index**	**Syracuse Wage Index**	**Utica Wage Index**	**Non-Urban Wage Index**
CY 2012	1.2416	1.3052	1.1339	0.8602	0.9776	0.8441	0.8152
CY 2013	1.2682	1.2924	1.1350	0.8714	0.9851	0.8672	0.8217
% CHANGE	2.14%	-0.98%	0.10%	1.30%	0.77%	2.74%	0.80%

LUPA

CMS is proposing to continue paying for episodes with four or fewer visits by adding **$96.04** to LUPA (as adjusted by the wage index) for single episodes and initial episodes in a sequence of adjacent episodes.

Table 5. Calculation of Proposed 2013 LUPA

	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 proposed CY 2013 payment update of 1.5 percent	Proposed CY 2013 LUPA Add-On Amount	Multiply by the proposed CY 2013 payment update of 1.5 percent minus 2 percentage points (-0.5 percent)	Proposed CY 2013 LUPA Add-On Amount
$94.62	X 1.015	$96.04	X 0.995	$94.15

Source: CMS Proposed HHA PPS for CY 2013

In calculating the 2013 national per visit rates for LUPA episodes and to compute the imputed costs in the outlier calculations, the 2012 national per visit rates for each discipline are updated by the net 1.5 percent MBI (for HHAs that submit required quality data). The negative 1.32

recalibration does not apply as these factors are not subject to case mix adjustment. The six home health disciplines that factor into the calculation are listed in Table 6, which provides the corresponding data with the rural add-on.

Table 6. Proposed CY 2013 Medicare per Visit LUPA Rates (before wage index adjustment)

		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 proposed CY 2013 payment update of 1.5 percent	Proposed CY 2013 per-visit payment	Multiply by the proposed CY 2013 payment update of 1.5 percent minus 2 percentage points (-0.5 percent)	Proposed CY 2013 per-visit payment
HH Aide	$51.13	X 1.015	$51.90	X 0.995	$50.87
MSS	$180.96	X 1.015	$183.67	X 0.995	$180.06
OT	$124.26	X 1.015	$126.12	X 0.995	$123.64
PT	$123.43	X 1.015	$125.28	X 0.995	$122.81
SN	$112.88	X 1.015	$114.57	X 0.995	$112.32
SLP	$134.12	X 1.015	$136.13	X 0.995	$133.45

Source: CMS Proposed HHA PPS for CY 2013

Table 7. Proposed CY 2013 Medicare per Visit LUPA Rates (before wage index adjustment) with Rural Add-on.

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Home Health Discipline Type	Proposed CY 2013 per-visit rate	Multiply by the 3 Percent Rural Add-On	Proposed Rural CY 2013 per-visit rate	Proposed CY 2013 per-visit rate	Multiply by the 3 Percent Rural Add-On	Proposed Rural CY 2013 per-visit rate
HH Aide	$51.90	X 1.03	$53.46	$50.87	X 1.03	$52.40
MSS	$183.67	X 1.03	$189.18	$180.06	X 1.03	$185.46
OT	$126.12	X 1.03	$129.90	$123.64	X 1.03	$127.35
PT	$125.28	X 1.03	$129.04	$122.81	X 1.03	$126.49
SN	$114.57	X 1.03	$118.01	$112.32	X 1.03	$115.69
SLP	$136.13	X 1.03	$140.21	$133.45	X 1.03	$137.45

Source: CMS Proposed HHA PPS Rule for CY 2013

Revision of the Fixed Dollar Loss Ratio

The wage-adjusted Fixed Dollar Loss ratio (FDL) amount represents the amount of loss that an agency must bear before an episode becomes eligible for outlier payments. CMS proposes keeping the FDL unchanged at **0.67 percent**, which translates to an approximate $1,435.11 (before wage adjustment) threshold that HHA must incur before triggering an outlier payment.

The FDL is calculated by multiplying the 2013 average episodic payment amount of $2,141.95 by the 0.67.

Outlier Payments

Outlier payments are made in addition to the regular 60-day case-mix and wage-adjusted episode payments for cases that incur unusually large costs due to the unique needs of a specific client. The estimated total outlier payments are limited to no more than 2.5 percent of the total estimated HHA PPS payments in a given calendar year. As noted above, the FDL represents the threshold loss amount the HHA must bear in order to trigger the outlier or loss-sharing payment.

As established in the CY 2010 final rule, the outlier fund remains at 2.5 percent of the total home health estimated expenditures (down from the previous cap of 5 percent.) This decreased amount results in fewer dollars to compensate HHAs in dealing with the needs of patients with more extensive and complex needs.

Accordingly, a relatively high FDL reduces the number of episodes qualifying for outlier payments, but allows for a higher per episode payment. A lower FDL allows for more episodes to qualify for the outlier payment, but the amount of payment per episode must be lower in order to stay within the cap. When initially set in 2000 the FDL was 1.13. CMS has been periodically monitoring outlier payments and recommending adjustments.

NRS

In 2008, CMS separated payments for the NRS from the PPS base rate, and substituted a case mix adjusted add-on for clients meeting certain criteria. The proposed conversion factor for 2013 is $54.08.

Table 8. Calculation of NRS Conversion Factor

CY 2012 NRS Conversion Factor	Multiply by the proposed CY 2013 payment update of 1.5 percent	Proposed CY 2013 NRS Conversion Factor
$53.28	X 1.015	$54.08

Source: CMS HHS PPS Proposed Rule for CY 2013

Table 9. Calculation of NRS Conversion Factor for HHAs Not Submitting Quality Data

CY 2012 NRS Conversion Factor	Multiply by the proposed CY 2013 payment update of 1.5 percent minus 2 percentage points (-0.5 percent)	Proposed CY 2013 NRS Conversion Factor
$53.28	X 0.995	$53.01

Source: CMS HHA PPS Proposed Rule for CY 2013

Using the conversion factor of $54.08, CMS calculates the following payment amounts per severity level:

Table 10. NRS Payment Amounts per Severity Level

Severity Level	Points (Scoring)	Relative Weight	Proposed CY 2013 NRS Payment Amount
1	0	0.2698	$14.59
2	1 to 14	0.9742	$52.68
3	15 to 27	2.6712	$144.46
4	28 to 48	3.9686	$214.62
5	49 to 98	6.1198	$330.96
6	99+	10.5254	$569.21

Source: CMS HHA PPS Proposed Rule for CY 2013

Recalibration

As noted above, CMS devotes a major portion of the proposed rule to the issue of "case mix creep." CMS contends that since the inception of PPS in 2000, there has been almost a 20 percent increase in overall case mix. In this proposed rule, CY 2013 CMS has identified a 19.03% nominal case-mix growth from 2000-2009, finalized a 3.79 % payment reduction in 2012 and a 1.32% payment reduction for CY 2013.

Surveys

CMS has attempted several proposals since Aug. 2, 1991 to establish survey and enforcement requirements. In response to the August 2008 Office of Inspector General (OIG) Report, ''Deficiency History and Recertification of Medicare Home Health Agencies'' (OEI–09–06–00040), CMS noted that the Aug. 2, 1991 proposed rule would require substantial revisions and republication to implement the alternative sanctions. Due to the considerable length of time that has passed since the publication of Aug. 2, 1991 proposed rule, CMS is now publishing a new proposed rule which has numerous proposed changes.

Technical Changes to Surveys

- Sections 4022 and 4023 of OBRA '87 amended the Act by adding sections 1891(c) through (f) to establish requirements for surveying and certifying HHAs, as well as to establish the authority of the Secretary to utilize varying enforcement mechanisms to terminate participation and to impose alternative sanctions if HHAs were found out of compliance with the CoPs.

- CMS is proposing to add new subparts I and J to 42 CFR part 488 to implement these sections of the Act. New subpart I would provide survey and certification guidance while new *subpart J would outline the basis for enforcement of compliance standards* for HHAs that are not in substantial compliance with Medicare participation requirements.

    - Subpart I – includes basis and scope, definitions of the types and frequencies of surveys, surveyor qualifications and informal dispute resolutions.
    - Subpart J – definitions, general provisions and factors to consider in selecting sanctions. The list of available sanctions is outlined in 488.820, 488.825, 488.830, 488.835, 488.840, and 488.845 – civil money penalties (CMPs). The range is from $500 - $10,000 per day.

OASIS-C

CMS is seeking to continue their policy of a 2 percent reduction in MBI for those providers failing to submit required quality data.

For CY 2013, CMS is proposing to consider OASIS assessments submitted by HHAs to CMS in compliance with HHA Conditions of Participation and Conditions for 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. This time period would allow for 12 full months of data collection and would provide the time necessary to analyze and make any necessary payment adjustments to the payment rates for CY 2013. CMS is proposing to continue this pattern for each subsequent year beyond CY 2013.

Due to technical issues with Home Health Compare files, CMS will delay the reporting of both "Emergency Department Use Without Hospitalization" and "Acute Care Hospitalization" until such time as the technical issues are resolved. The OASIS-based Acute Care Hospitalization measure will continue to be made available to the public via Home Health Compare until it is replaced with the claims-based measure.

Technical Corrections to Therapy Services

The proposed rule contains technical corrections/clarifications regarding the provision of therapy services, including:

- CMS is proposing to revise the regulations at §409.44(c)(2)(i)(E) to state 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 late reassessment. Minimal changes to claims submissions are expected as a result of this policy change. However, LeadingAge New York will monitor claims for unintended consequences, including possible up-coding associated with therapy-related home health resource groups (HHRGs) pre and post-implementation.

- Another proposal will revise regulations §409.44(c)(2)(i)(E) to state 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. Therefore, as long as the required therapy reassessments were completed timely for the remaining therapy disciplines, therapy services would continue to be covered for those therapy disciplines.

- CMS is clarifying §409.44(c)(2)(i)(C)(2) and §409.44(c)(2)(i)(D)(2) that the therapist's visit need only be "close to" the 13th and 19th visits. However, due to the industry's need for additional guidance, to provide more precise guidance, LeadingAge New York proposes to revise the regulations §409.44(c)(2)(i)(C)(1) and §409.44(c)(2)(i)(D)(1) to clarify that in cases where the patient is receiving more than one type of therapy, qualified therapists could 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.

Technical Corrections to G-Code Descriptions

- In Change Request 7182, CMS finalized these new and revised G-codes. These codes included G0158, which had as its description, "Services performed by a qualified occupational *therapist* assistant in the home health or hospice setting, each 15 minutes." In G0158, the new description would instead include the terminology, "occupational *therapy* assistant," making it also consistent with §484.4.
  Source: CMS HHA PPS Proposed Rule for CY 2013

CAHPS

CMS proposes continuing its existing policy on CAHPS. All Medicare HHAs will continue to provide their survey vendor with patient data on a monthly basis, with CAHPS data submitted and analyzed quarterly. Agencies with fewer that 60 patients can continue to submit for the exemption from the reporting requirement.

CMS is proposing only one change for the CY 2013 rule, which will codify the HHCAHPS guideline that HHAs ensure that survey vendors fully comply with all HHCAHPS requirements.

HHAs should learn about the survey and view the HHCAHPS Survey Web site at https://homehealthcahps.org.

Home health agencies can also send an email to the HHCAHPS Survey Coordination Team at HHCAHPS@rti.org or call 1-866-354-0985 for more information about HHCAHPS.

Conclusion

The proposed rule raises several concerns, not the least of which are the types of surveys and number of alternatives or intermediate sanctions that could be imposed if HHAs were out of compliance with Federal requirements. In accordance with the new proposal, surveyors would be allowed to impose a financial requirement on non-compliant providers and require that they work toward correcting areas in which they are deficient. The fines could range from $500 to $10,000 per day.

The second area of concern is the F2F encounters. Allowing the flexibility of a NPP to conduct the F2F encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in acute or post-acute setting, at first look seems fine. However, if the NPP could conduct the F2F encounter and report back to the physician and sign the certificate would be more efficient, especially in rural areas.

The cuts are being proposed by CMS at the same time that Congress is debating major cuts to social safety net spending, including Medicare, Medicaid and Social Security. To add to the perfect storm, we are all aware of the changes impacting home health providers resulting from our recent State budget process.

Please contact LeadingAge at congress@leadingage.org and let them know what the cuts would mean in terms of financial viability, the ability to continue to employ staff and the ability to maintain quality and access to services.

For comments or questions regarding the HHA PPS proposed rule, please contact Cheryl Udell at cudell@leadingageny.org (ext. 151) or Patrick Cucinelli at pcucinelli@leadingageny.org (ext. 145).

Appendix

Table 11. Payment Localities

Payment Locality	Counties
Albany-Schenectady-Troy	Albany, Rensselaer, Saratoga, Schenectady, Schoharie
Binghamton	Broome, Tioga
Buffalo-Niagara Falls	Erie, Niagara
Elmira	Chemung
Glens Falls	Warren, Washington
Ithaca	Tompkins
Kingston	Ulster
Nassau-Suffolk	Nassau, Suffolk
New York	Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, Westchester (NJ – Bergen, Hudson, and Passaic)
Poughkeepsie	Dutchess, Orange
Rochester	Livingston, Monroe, Ontario, Orleans, Wayne
Syracuse	Madison, Onondaga, Oswego
Utica-Rome	Herkimer, Oneida
Non-Urban	All Other Counties