Overview

On July 13, the U.S. Centers for Medicare and Medicaid Services (CMS) published in the Federal Register a “Notice of Proposed Rulemaking” (NPRM) regarding the calendar year (CY) 2013 home health prospective payment system (HHPPS) rates. The NPRM includes proposals to update the HHPPS rates, including the national standardized 60-day episode rates, the low-utilization payment amounts (LUPAs), the wage index and the home health outlier payments under Medicare effective January 1, 2013. CMS’s NPRM can be downloaded from the Federal Register at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-13/pdf/2012-16836.pdf

The proposed rule makes some adjustments to the face-to-face (F2F) and therapy assessment rules, and proposes requirements for the Hospice quality data reporting program. In addition, the proposed rule establishes requirements for unannounced, standard and extended surveys of home health agencies (HHAs) and provides a number of alternative (or intermediate) sanctions that could be imposed on HHAs that are found to be out of compliance with federal requirements.

The CY 2013 proposed rule represents a $20 million (0.1 percent) decrease in total expected Medicare payments to HHAs for CY 2013. Most agencies in Massachusetts will see modest increases to their rates for 2013.

CMS’s proposed rule for CY 2013 maintains most of the significant revisions CMS has made in recent years including the LUPA add-on payment amount, the non-routine medical supply conversion update factor, the establishment of OASIS requirements as conditions of payment, and the current home health resource groupings (HHRGs).

Finally, CMS’s proposed rule provides details on the market basket update, the continuation of the 3 percent rural add-on through 2015 (as mandated by the ACA), the “case-mix creep” adjustment, the ongoing home health outlier policy and the quality reporting requirements for the CY 2013 HHPPS, as they relate to the OASIS and the HH-CAHPS.

Market Basket Update

CMS’s proposed rule includes the rebasing and revision of the home health market basket, an exercise that has not happened since HHPPS was last rebased in 2008 using 2003 data. Rebasing the market basket is a statistical practice used to update factors and values to determine how much inflation has happened in the costs to operate a HHA each year. The home health market basket is simply an inflation update, but not the whole basis for the payment system. CMS is proposing to use 2010 data in the overall market basket calculation for the CY 2013 HHPPS. CMS’s 2013 market basket update is based on Global Insights, Inc.’s second quarter 2012
forecast, utilizing historical data through the first quarter of 2012. CMS’s proposed rule includes a 2.5 percent home health market basket increase for CY 2013. However, due to a provision within ACA, the market basket in CY 2011, 2012 and 2013 must be reduced by 1 percentage point, thus resulting in an actual CY 2013 market basket of 1.5 percent.

**2013 HHPPS Episodic Rate**

CMS’s proposed rule adjusts to $2,141.95 the national standardized episode payment rate effective for episodes ending January 1, 2013 through December 31, 2013. This new episode rate represents a slight increase of $3.43 (0.16%) per episode from the CY 2012 episode rate based on the application of the reduced market basket update (1.5 percent) and the revised 1.32 percent “case-mix creep” adjustment.

This new national standardized episode payment rate is adjusted by the applicable HHRG and wage index for the area in which the patient resides. Also, HHAs that failed to submit OASIS assessments for episodes beginning on or after July 1, 2011 and before July 1, 2012, would see their market basket update reduced by 2 percent, which results in an overall -0.5 percent update.

HHAs that provided Medicare services to beneficiaries residing in rural areas will receive a 3 percent add-on, bringing their proposed CY 2013 National Standardized Episode payment rate to $2,206.21 (or $2,141.95 multiplied by 1.03).

**Proposed CY 2013 LUPA Rates**

CMS’s proposed rule also revises payments associated with LUPA episodes. Because the LUPA rates are per-visit rates and not subject to changes in case-mix, CMS does not apply the “case-mix creep” reduction to them. However, HHAs which failed to submit OASIS assessment data for episodes beginning on or after July 1, 2011 and before July 1, 2012 would see their market basket update reduced by 2 percent, reducing their LUPA rate. HHAs that provided Medicare services to beneficiaries residing in rural areas will receive a 3 percent add-on to each CY 2013 LUPA discipline.

**Table 1: LUPA Rates**

<table>
<thead>
<tr>
<th>Discipline</th>
<th>National standard Per-visit rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN</td>
<td>$114.57</td>
</tr>
<tr>
<td>HH Aide</td>
<td>$ 51.90</td>
</tr>
<tr>
<td>PT</td>
<td>$125.28</td>
</tr>
<tr>
<td>OT</td>
<td>$126.12</td>
</tr>
<tr>
<td>SLP</td>
<td>$136.13</td>
</tr>
<tr>
<td>MSS</td>
<td>$183.67</td>
</tr>
<tr>
<td>First/Only LUPA</td>
<td>$96.04</td>
</tr>
</tbody>
</table>
Non-Routine Supplies Update

CMS’s 2013 NPRM continues the significant changes implemented in the 2008 HHPPS by separating payments for NRS from the HHPPS base rate and using a case-mix adjusted add-on payment for episodes where supplies are provided to patients meeting certain characteristics. Depending on the diagnosis of the patient (wounds, burns, post-operation complications, etc.) and the provider’s response to OASIS questions concerning ostomies, stasis ulcers and therapies at home, the provider will receive extra reimbursement from Medicare based on the patient’s severity group. CMS has calculated the proposed CY 2013 NRS conversion factor to be **$54.08**. The conversion factor is adjusted up or down using six severity group weightings. These amounts are **not** subject to adjustment through application of the area wage index. The NRS add-on is also not applied to LUPA episodes.

**Table 2: Proposed CY 2013 Non-Routine Medical Supply Weights**

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Percent of Episodes</th>
<th>Points</th>
<th>Relative Weight</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>63.70</td>
<td>0</td>
<td>0.2698</td>
<td>$14.59</td>
</tr>
<tr>
<td>2</td>
<td>20.60</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.68</td>
</tr>
<tr>
<td>3</td>
<td>6.70</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$144.46</td>
</tr>
<tr>
<td>4</td>
<td>5.40</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$214.62</td>
</tr>
<tr>
<td>5</td>
<td>3.20</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$330.96</td>
</tr>
<tr>
<td>6</td>
<td>0.30</td>
<td>99+</td>
<td>10.5254</td>
<td>$569.21</td>
</tr>
</tbody>
</table>

**“Case-Mix Creep” Adjustment**

CMS continues to address its perception of up-coding in Medicare home health services claims. In last year’s proposed rule, CMS suggested a 5.06 percent payment reduction in CY 2012 to fully account for unexplained changes that have resulted in a 19.03 percent increase in overall case-mix since the inception of PPS in 2000. However, CMS’s final rule in 2012 included a revised phase-in “case-mix creep” payment reduction of 3.79 in CY 2012 and 1.32 percent in CY 2013. This year’s proposed rule provides detailed analysis of CMS’s updated study of case-mix and coding changes between 2000 and 2010, specifically looking for reasons why the average case-mix weight increased from 1.3435 in 2009 1.3578 in 2010 (an approximately 1 percent increase). CMS noted that this average case-mix weight increase was caused by an increase in the reporting of secondary diagnoses as well as an increase in the percentage of episodes with therapy at all levels. CMS re-estimated the split between nominal and real case-mix growth and considered either taking the already scheduled case-mix creep cut of 1.32 percent or eliminating the complete growth in nominal case-mix growth by including the new growth in 2010 to increase the cut to 2.18 percent. However, CMS decided on keeping with the already scheduled 1.32 percent case-mix reduction and analyzing whether there is a change in the 2011 data.

(Note: HCA and other members of the home care industry have regularly submitted comments to CMS on the inequities of the “case-mix creep” adjustment since it was first implemented in 2007. Congressman James McGovern has again this year sponsored the “The Home Health Care Access Protection Act” which would amend Title XVIII of the Social Security Act by
instituting a rational, more transparent process for evaluating perceived increases in the average case-mix weight of Medicare home health services. The “Home Health Care Access Protection” directs the U.S. Health and Human Services (HHS) Secretary and CMS to convene a Technical Advisory Group to advise HHS and CMS about real changes in case-mix and changes in coding or classification of different units of services that do not reflect real changes in case-mix. Moreover, the Technical Advisory Group would consist of individuals and organizations representing the interest of Medicare beneficiaries and providers, such as the National Association for Home Care and Hospice (NAHC), the Visiting Nurse Associations of America (VNAA) and other health care academics and professionals.)

### Outlier Policy

CMS calculates that the 2010 data so far reflects that 2.12% of the permitted 2.5% of total PPS revenues is being expended on outlier payments. The rule proposes leaving the outlier policy unchanged pending further data reflecting the impact of the outlier cap and changes in therapy weights on total outlier cost. Two separate claims systems errors have allowed both over and underpayments of certain claims in the outlier cap editing system. These are being corrected, but they affect the data on outlier usage.

### CMS Maintains Current Case-Mix Weights & Therapy Thresholds

The proposed rule maintains the current case-mix adjustment model of 153 HHRGs and the multiple tiered therapy threshold model – with payment increase trigger points of 6, 14, and 20 visits. The rule also maintains the changes to the HHPPS case-mix coding weights included in last year’s final rule which eliminated hypertension as a factor in the calculation, reduced the weights on therapy episodes, and increased the weights on non-therapy services.

### Wage Index Update

For CY 2013 HHPPS, CMS will continue to use the Core Based Statistical Area (CBSA) wage area designations for purposes of determining the HHPPS wage index adjustment. CMS also continues to determine wage index by using the most recent pre-floor and pre-reclassification hospital wage index data. However, CMS has proposed to increase the labor portion of the rate to 78.535 percent from the current labor portion of 77.082 percent. The labor-related share includes wages and employee benefits. Individual agency wage indices are only applied to the labor-related portion of the national standardized episode rate. Because of this proposed revision, the non-labor related share in CY 2013 will be reduced to 21.465 percent.

CMS’s use of the CBSA wage area designations and the most recent pre-floor and pre-reclassification hospital wage index data has resulted in the following changes in Massachusetts:

### Table 3: Wage Index Changes for MA CBSAs

<table>
<thead>
<tr>
<th>CBSA/County</th>
<th>Current</th>
<th>2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>1.2838</td>
<td>1.2872</td>
<td>0.72%</td>
</tr>
<tr>
<td>Boston</td>
<td>1.2283</td>
<td>1.2394</td>
<td>1.19%</td>
</tr>
</tbody>
</table>
Middlesex                            1.1210                    1.1285  0.86%
Essex                                      1.0698                    1.0575  (0.66%)
Berkshire                             1.0616                   1.0745  1.21%
Bristol                                    1.0639                    1.0718  0.84%
Springfield                  1.0247                   1.0390  1.30%
Worcester                            1.1076                    1.1230  1.42%
Dukes/Nantucket             1.3962                    1.3570  (1.76%)

The Alliance has prepared a [spreadsheet listing all 2013 PPS case mix rates](#) for all MA counties.

*Note: the Alliance has annually made comments to CMS and the Congressional delegation about inequities, particularly in Essex country between a decreasing home health wage index, and an increasing hospital wage index due to reclassification of hospitals to the (higher) rural floor.*

**OASIS Update — Pay for Reporting, & HCA’s Concerns**

CMS will continue to reduce home health payment rates for HHAs that did not report OASIS quality data for the period of July 1, 2011 through July 1, 2012. For these HHAs, the home health market basket percentage increase will be reduced by 2 percentage points, resulting in a negative-0.5 percent update for 2013.

CMS has also determined that claims data are a more robust source for accurately measuring acute care hospitalizations than other data sources. Because of this, CMS proposes that the claims-based Acute Care Hospitalization measure will replace the OASIS-based measure on *Home Health Compare*. The OASIS-based measure will continue to be reported on the agency-specific Certification and Survey Provider Enhanced Reporting system (CASPER) reports. 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.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Update**

The proposed rule maintains existing policy as promulgated in the 2011 and 2012 rules expanding the home health quality measures to include the CAHPS home health survey as part of CMS’s CY 2013 annual payment update. Medicare certified HHAs will need to continue to provide their survey vendor with information about their survey-eligible patients every month in accordance with existing guidelines, and CAHPS survey will be analyzed quarterly. CMS is also proposing to codify the current guideline that all approved CAHPS survey vendors fully comply with all CAHPS oversight activities and plans to include this survey requirement in the COPs in Section 484.250(c). CMS continues to expect HHAs to target at least 300 completed CAHPS surveys annually. Smaller agencies unable to reach the 300-survey threshold by sampling are expected to survey all CAHPS-eligible patients. HHAs with 60 or fewer Medicare and CAHPS-eligible patients annually can continue to file an annual application to become exempt from participation.
The following CAHPS reported measures will be continued for 2013 and consist of four or more questions listed in parenthesis below:

- Patient Care (Q: 9, 16, 19, 24);
- Communication between providers and patients (Q: 2, 15, 17, 18, 22, 23); and
- Specific Care Issues on medications, home safety and pain (Q: 3, 4, 5, 10, 12, 13, 14).

Additionally, the two global ratings are the overall rating of care given by the HHA’s care providers (Q20) and the patient’s willingness to recommend the HHA to family and friends (Q25).

**Home Health Physician Face-to-Face Encounter for Medicare**

CMS’s final rule retains the existing physician face-to-face encounter (F2F) requirement mandated in the ACA that requires that prior to certifying a home health plan of care for a Medicare beneficiary – the physician or a specified nonphysician practitioner (NPP) must document that he or she has had a F2F encounter with the patient no more than 90 days prior to the home health start of care (SOC) date or 30 days after the SOC. Last year’s final rule revised an aspect of the F2F rule for patients discharged from a hospital or post-acute setting by allowing the attending hospitalist or post-acute physician (or non-physician practitioner) to report or communicate his or her clinical findings of the F2F encounter to the physician in the community for documentation as part of the signed certification.

This year, CMS is proposing to allow patients admitted to a HHA from an acute or post-acute facility to have the F2F requirement met by a NPP in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the facility. The supervising physician must inform the certifying physician in the community of the patient’s homebound status and need for skilled services. Documentation must still be signed by the certifying physician. CMS is also revising its regulatory language so as to not be prescriptive as to what entity must title the documentation. The F2F documentation must still be signed by the certifying physician, and the content requirements are not changing.

The proposed rule did not include any information as to when CMS may issue a separate final rule that calls for extending the physician face-to-face (F2F) rule to Medicaid, in accordance with requirements under the existing Medicare rule.

**Coverage of Therapy Services**

CMS’s proposed rule includes the following revisions intended to provide some additional flexibility to HHAs when meeting the new therapy assessment requirements:

- CMS proposes to revise the regulation 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 stop 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.

- With respect to the therapy assessments timing, CMS proposes to revise the regulations 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.
- Finally, CMS proposes to revise the therapy assessment regulations 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 the late reassessment.

(Note: HCA is interested in member comments as to whether these changes meet the intent of adding flexibility.)

New Survey & Enforcement Requirements Background

On August 2, 1991, CMS published the Survey Requirements and Alternative Sanctions for HHAs proposed rule that established survey and enforcement requirements, as well as alternative sanctions for HHAs. CMS never published a final rule. Due to the considerable length of time that has passed since publication of the August 2, 1991 proposed rule, CMS is now publishing a new proposed rule, which would implement those survey and enforcement requirements, as well as establish alternative for HHAs. Proposed are the following changes: (Note: HCA recommends that members review Pages 41575-41587 of the Federal Register for a complete summary.)

Definitions of Survey Types

The following definitions of the different surveys have been a part of longstanding CMS policy, but have not yet been categorized in the regulations for HHAs. The following is a summary of CMS’s survey definitions.

Standard Surveys – Are conducted not less than every 36 months, reviewing a random sample of individuals for which the HHA furnishes services including actual visits to homes to survey the quality of services provided as measured by indicators of medical, nursing, and rehabilitative care. The purpose of the home visit is to evaluate the extent to which the quality and scope of services attained and maintained the highest practicable functional capacity of the patient as reflected in the patient’s written plan of care and clinical records.

Partial Extended Surveys – Are conducted to determine if deficiencies and/or deficient practices exist that were not fully examined during the standard survey. At a minimum, the surveyor would review additional standards under the same COPs in which the deficient practice was identified under the standard survey. A COP may be considered out of compliance (and thus condition-level) for one or more standard level deficiency if, in a surveyor’s judgment, the standard level deficiency constitutes a significant or serious finding that adversely affects or has the potential to affect patient outcomes.
Extended Surveys – Would review the compliance with all COPs and standards applicable to the HHA and be conducted at any time but would be conducted when any condition-level deficiency was found. It would also review the HHA’s policies, procedures and practices that produced substandard care. It would be conducted no later than 14 days after a standard survey that found the HHA had furnished substandard care.

**Informal Dispute Resolution (IDR)**

CMS proposes adding an IDR process that would provide HHAs an informal opportunity to resolve disputes in the survey findings for those HHAs that are seeking certification from the state authority for continued participation in Medicare and for those HHAs that are currently under monitoring either through a complaint or through a validation survey. CMS states that whenever possible, it wants to provide every opportunity to settle disagreements at the earliest stage, prior to a formal hearing, conserving time and money potentially spent by the HHA, the state and CMS.

**Immediate Jeopardy Situations**

If an HHA’s deficiencies pose immediate jeopardy to the health or safety of its patients, CMS must take immediate action to notify the HHA. If deficiencies are not addressed and resolved within 23 days because the agency was unable or unwilling, CMS would terminate the provider agreement. It could also impose one or more of the other sanctions.

Notice of termination would be made within two days of its effective date. The agency would know of immediate jeopardy during the survey and at the exit conference.

The HHA would be required to transfer its patients to another local HHA within 30 days of termination and provide information, assistance and arrangements necessary for a safe and orderly transfer of its patients. The state would be required to assist the HHA.

**Process for Intermediate Sanctions**

Appeals will not delay sanctions and civil monetary penalties will continue to accrue but will not be collected until a final determination.

A condition-level deficiency that does not constitute immediate jeopardy to the health and safety of the individuals may result in termination or alternative sanctions or both.

Any deficiencies found at the branch level are counted against the HHA total business entity but not if the deficiency is found at a non-branch, sub-unit.

Agencies with deficiencies and any sanction must submit a Plan of Correction acceptable to CMS that details how the HHA will correct or has corrected each deficiency, how the agency would act to protect patients in similar situations, how it would assure the deficiency would not
recur, how the agency would monitor performance to sustain solutions, and in what timeframe corrective actions would be taken.

CMS will provide written notification of intent to impose any sanction and appeal rights, including IDR. At CMS’s discretion, alternative sanctions can be imposed for up to six months. The choice of alternative sanction or termination will be based on the impact on patient care and the seriousness of noncompliance.

**Proposed Alternative (Immediate) Sanctions**

1. **Civil Monetary Penalties**
   Monies collected will be disbursed 63 percent to the federal government and 37 percent to state governments. Costs of home health surveys charged to HHAs will be split according the same percentages between Medicare and Medicaid. These penalties will be imposed for failure to comply with one or more COPs regardless of immediate jeopardy.

2. **Suspension of Payment for New Admissions & New PPS Episodes**
   Payment would be suspended for all new admissions and episodes of care for a period not to exceed 6 months and end when substantial compliance is achieved or the agency is terminated. The agency would be required to notify all new patients or new episode patients, verbally and in writing, that Medicare might not be available. Suspended payments would not be subsequently restored.

3. **Imposition of Temporary Management**
   Temporary Management would be appointed by CMS or its authorized agent of a substitute manager or administrator who would be under the direction of the HHA’s governing body. The Temporary Manager has authority to hire, terminate, reassign staff, obligate HHA funds, alter HHA procedures, and manage the HHA to correct deficiencies. CMS would consider HHA or state agency recommendations for the Temporary Manager who would be required to have work experience and education that would qualify the individual to oversee the correction of the deficiencies.

4. **Directed Plan of Corrections**
   HHAs would be required to take specific actions to correct the deficient practices if the HHA failed to submit an acceptable plan of correction.

5. **Directed In-Service Training**
   CMS would specify directed in-service training for compliance problems resulting from a lack of knowledge relative to advances in health care technology and expectations for favorable patient outcomes in situations where staff performance resulted in deficient practices. The HHA would be required to use an in-service program conducted by instructors with in-depth knowledge of the areas that require specific training.
Finally, CMS requests comments on whether and when there should be public notices when there is suspension of payments for new admissions, or when civil monetary penalties are imposed.

**Hospice Quality Reporting**

The proposed rule contains a section pertaining to the Hospice Quality Reporting Program (HQRP on pages 41573-41575. CMS indicates it does not intend to expand collection requirements for CY 2013 (which will affect payments for FY2015) beyond those items being collected during the final calendar quarter of CY 2012 (which will affect payments for FY 2014). CMS also provides additional information about the pilot it currently has under way to test a hospice patient data set. CMS has indicated that it does not intend to move to public reporting of hospice quality indicators until it has developed a standardized data set for hospices.

**Provisions Related to ICD Coding, Grouper Coding**

CMS proposes to add coding edits to prevent a common misuse of code M1024 in the PPS Grouper and will reinforce compliance by restricting Code M1024 to only permit fracture (V-Code) diagnoses. CMS also proposes to pair the fracture (V-code) with appropriate diagnostic codes and the HHPPS grouper award points only when these pairings appear in the primary or secondary diagnosis fields. The grouper will also be changed to allow equivalent scoring when the Diabetes, Skin 1, or Neurological 1 codes are submitted immediately after the V-code in the M1020 position without requiring utilization of the payment diagnosis field. A minor technical correction to the G-Code description for G0158 has been made to use the title “occupational therapy assistant” versus “occupational therapist assistant” to accommodate the professional terminology preferred by the American Physical Therapy Association.

**Comment Period & Final Rule**

CMS’s proposed rule will be open for public comment until 5 p.m. on September 4, 2012. HCA plans to submit comments on behalf of the membership. Members are encouraged to share with HCA their concerns on CMS’s proposed rule by e-mailing Tim Burgers at tburgers@thinkhomecare.org.

CMS and HCA are particularly interested in hearing your comments on CMS’s therapy policy as well as the establishment of requirements for unannounced standard and extended surveys of HHAs, in addition to any other areas of concern. Providers interested in submitting their own comments can do so either electronically, by regular mail, by express or overnight mail, by hand, or by courier. CMS requests that those who comment refer to File Code CMS-1358-P. Electronic comments on the proposed rule can be sent to: http://www.regulations.gov (follow the instructions under the “More Search Options” tab). Providers preferring to submit comments by regular mail should send them to: CMS, Department of Health and Human Services, Attention: CMS-1358-P, P.O. Box 8016, Baltimore, MD 21244-8016. CMS requests that one original and two copies be included for those choosing to submit by regular mail.