Home Care Alliance of Massachusetts
Analysis of the Proposed Medicare Home Health PPS Rate Rule

Overview
On July 3, the U.S. Centers for Medicare and Medicaid Services (CMS) published in the Federal Register a “Notice of Proposed Rulemaking” (NPRM) for the calendar year (CY) 2014 home health prospective payment system (HHPPS) rates. The proposed rule updates to the payment rates for home health agencies (HHAs) for calendar year (CY) 2014, including a long-awaited rebasing adjustments to the national, standardized 60-day episodic payment rate, the national per-visit rates, and the non-routine supplies (NRS) conversion factor, as required by the Affordable Care Act (ACA). CMS’s proposed rebasing methodology calls for significant reductions in Medicare home health rates, leading to a continued deterioration in provider operating margins if implemented as proposed.

This proposed rule also includes: refinements to the International Classification of Diseases (ICD) 9th Edition grouper; implementation of the ICD 10th Edition; a significant decrease to the case-mix weights as a result of the rebasing process; a proposed market basket update to the payment rates; adjustments to the geographic wage index; continuation of the 3% rural add-on; and continuation of the existing home health outlier policy. The proposed rule also maintains all of the new survey and enforcement requirements promulgated in last year’s final HHPPS rule but clarifies state Medicaid program requirements related to the cost of these HHA surveys.

In its proposal, CMS projects that Medicare payments to HHAs in CY 2014 will be reduced by 1.5%, or $290 million nationally, based on the net impact of its proposed policies, which include a series of positive and negative rate adjustments. Specifically, this aggregate proposed decrease reflects the cumulative impact of the following:
- Rebasings adjustments to the national standardized 60-day episodic payment rate, the national per visit payment rates, and the NRS conversion factor (an overall $650 million decrease);
- A 2.4% home health market-basket payment update (an overall $460 million increase); and
- Effects of ICD-9-CM coding adjustments (an overall $100 million decrease).

CMS’s proposed rebasing changes are perhaps the most complex factor of the new rule. As required by the ACA, rebasing will be phased-in over a four-year period in equal increments. Thus, starting with 2014, CMS plans to impose a 3.5% rebasing adjustment in 2014, 2015, 2016, and 2017. This 3.5% reduction is based on CMS’s projection of an average home health margin of 13.63% in 2013 (calculated as the difference between the average national episode revenue in home health and the average national episode cost) using 2011 cost report data.

Based on this assumption of a 13.63% margin, CMS asserts that a 3.6% reduction in each of the next four years is needed in order to achieve rebasing; however, the ACA limits the rate of rebasing to a maximum of 3.5% annually. Irrespective of the 3.5% maximum under ACA, it is unclear how CMS arrived at its assumption of a 3.6% reduction needed to achieve rebasing since this figure, if multiplied by four (for a cumulative 14.4% reduction), is a higher impact than the 13.63% margin assumed by CMS’s projections of Medicare margins.

For CYs 2011, 2012 and 2013, ACA mandated that the home health market basket update be reduced by 1 percentage point. Since there is no such mandate for CY 2014, the proposed rule includes the full market basket update of 2.4%.

Finally, CMS’s proposed rule does not discuss or make any changes to the face-to-face (F2F) and therapy assessment rules that were recently revised in the 2013 final rule and keeps in place the quality reporting requirements for the CY 2014 HHPPS, as they relate to the Outcome and Assessment Information Set (OASIS) and the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey. The following is a detailed summary of CMS’s NPRM for the CY 2014 HHPPS.
Rebasing Methodology

Rebasing the National Base Episodic Rate
As per ACA, beginning in CY 2014, CMS will apply an adjustment to the national standardized 60-day episodic rate and other applicable calculations 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 any other relevant factors.

The rebasing proposal and calculations are based on CMS’s review of data in 6,225 Medicare cost reports from 2011. (CMS disqualified 4,102 Medicare cost reports due to many factors such as missing episode data or information not being officially settled.) CMS also had one of its Medicare Administrative Contractors (MACs) conduct a sample audit of 98 Medicare cost reports. Based on this analysis, CMS calculated the proposed 4-year 3.5% rebasing adjustment.

However, CMS’s analysis is significantly at odds with 2011 cost report data examined by the National Association for Home Care and Hospice (NAHC) that shows a national home health margin of 11.25% based on NAHC’s analysis of over 9,000 Medicare cost reports from 2011. NAHC is currently conducting additional analysis of this cost report data. The Home Care Alliance will be working with NAHC to incorporate these concerns into our comments on the proposed rule.

Rebasing to the Case-Mix Weights & Case-Mix Creep Adjustment
CMS’s proposal states that when HHPPS was created, CMS expected that the average case-mix weight (CMW) would be approximately 1.00 but that CMS’s analysis has shown that this CMW has consistently been above 1.00 since the start of HHPPS. Based on this assertion, CMS proposes in the 2014 HHPPS to use the 2012 revised CMWs for each of the 153 home health resource groups (HHRGs) but lower them so that the average CMW weight in CY 2014 is 1.00. Consequently, all case mix weights are reduced by 26%.

To offset the effect of re-setting the CMWs such that the average is 1.00, CMS increased the proposed CY 2014 national, standardized 60-day episodic payment rate by the same factor used to decrease the weights (1.3517) from $2,137.73 to $2860.20.

To read the full report on how CMS conducted rebasing visit the CMS Website here:

ICD-9-CM Code Changes and ICD-10-CM Implementation
The 2014 proposed rule describes how CMS’s clinical staff and the coding staff from Abt Associates, a CMS contractor, recently completed a thorough review of the ICD-9-CM codes included in CMS’s HHPPS Grouper. The HHPPS Grouper, which is used by the CMS OASIS submission system, is the official grouping software of the HHPPS.

As a result of that review, CMS and Abt Associates identified 170 ICD-9-CM diagnosis codes that CMS is proposing to remove from the HHPPS Grouper, effective January 1, 2014. Based on clinical analysis, CMS proposes to eliminate the use of 170 ICD-9 Codes that currently affect payment in the HHPPS grouper program. CMS provides two justifications for elimination of the codes: Some of the codes are deemed inappropriate as a home health diagnoses because they are “too acute” meaning that they are not appropriate for use in the home health setting; other codes proposed for elimination are codes that CMS deemed do not require home health intervention, would not impact a home health plan of care or would not require additional home health resources. (Tables listing these specific codes are on pages 40276 – 40279 of the Federal Register notice of the proposed rule.)

CMS indicates that eliminating these inappropriate codes will reduce the average case mix weight by 0.74%, which they consider a justified reduction to eliminate overpayments resulting from inappropriate use of these codes.
Finally, CMS’s proposed rule confirms that ICD-10-CM diagnosis codes are set to be adopted by **October 1, 2014** for use by entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including home health agencies.

**Market Basket Update**
CMS’s proposed rule implements a full market basket update of **2.4%** for CY 2014 payment rates. The market basket update is based on Global Insights, Inc.’s second quarter 2013 forecast, utilizing historical data through the first quarter of 2013.

**Rural Add-On**
Section 3131(c) of ACA reinstated the Medicare home health rural add-on for home health episodes and visits furnished in a rural area beginning on or after April 1, 2010 and before January 1, 2016. The 3% rural add-on is applied to the national standardized 60-day episodic rate, national per-visit rates, Low Utilization Payment Adjustment (LUPA) add-on payment, and NRS conversion factor when home health services are provided in rural areas. The only areas in Massachusetts designated as rural are Nantucket and Martha’s Vineyard.

**Calculating the HHPPS Episodic Rate**
CMS’s proposed CY 2014 national, standardized 60-day episode payment rate is **$2,860.20**. To determine this rate, CMS started with the 2013 average payment per episode ($2,963.65) and applied its -3.5% rebasing adjustment, a -2.5% outlier adjustment, a +0.17% budget neutrality adjustment, and the +2.4% market basket increase. The Alliance has prepared an [Excel spreadsheet showing all episodic rates](#) (adjusted by case mix and regional wage index).

**Proposed CY 2014 National Per-Visit/LUPA Rates**
To calculate the CY 2014 national per-visit (aka LUPA) rates, CMS first compared the current per-visit, discipline payment rates to the estimated 2013 cost per-visit by discipline. This analysis revealed that costs per visit would be 19.5 to 33.1% higher than the current 2013 per-visit payment rates. However, ACA mandates that CMS can only adjust the per-visit payment rates by 3.5% each year. Therefore, in the CY 2014 HHPPS proposed rule, CMS proposes to **increase** the per-visit payment rates by 3.5% every year from 2014 to 2017.

CMS then removed the 2.5% factor for outlier payments (multiplying by 0.975) and then applied a wage index budget neutrality factor of 1.0003 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index. The per-visit rates for each discipline are then updated by the proposed CY 2014 market basket update of 2.4%.

CMS will continue paying a “LUPA add-on” for episodes with four or fewer visits. However, for 2014 CMS proposes to vary the add-on depending on which discipline makes the first visit in the affected episode. CMS proposes the following multiplication factors to the regular per-visit amount by discipline:  
- SN - 1.8714;  
- PT - 1.6841;  
- OT - 1.6293.

**Proposed CY 2014 Non-Routine Supplies Calculation**
CMS’s proposed rule 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 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.

To determine the CY 2014 proposed NRS conversion factor, CMS started with the 2013 NRS conversion factor ($53.97) and then applied a 2.58% rebasing reduction. CMS then updated the NRS conversion factor by the proposed CY 2014 market basket update (2.4%). The proposed NRS conversion factor for CY 2014 is **$53.84**. Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor, as follows:
### Proposed CY 2014 NRS Weights

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>% of Episodes</th>
<th>Points</th>
<th>Relative Weights</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>63.70%</td>
<td>0</td>
<td>0.2698</td>
<td>$14.53</td>
</tr>
<tr>
<td>2</td>
<td>20.60%</td>
<td>1 to 14</td>
<td>0.9742</td>
<td>$52.45</td>
</tr>
<tr>
<td>3</td>
<td>6.70%</td>
<td>15 to 27</td>
<td>2.6712</td>
<td>$143.82</td>
</tr>
<tr>
<td>4</td>
<td>5.40%</td>
<td>28 to 48</td>
<td>3.9686</td>
<td>$213.67</td>
</tr>
<tr>
<td>5</td>
<td>3.20%</td>
<td>49 to 98</td>
<td>6.1198</td>
<td>$329.49</td>
</tr>
<tr>
<td>6</td>
<td>0.30%</td>
<td>99+</td>
<td>10.5254</td>
<td>$566.69</td>
</tr>
</tbody>
</table>

### Outlier Policy Update

CMS’s proposed rule retains all of the outlier payment policy revisions associated with previous final rules including the reduction of the total outlier fund from 5% to 2.5% of the total home health services estimated expenditures. CMS made this change because its analysis of 2010 data showed that providers were expending just 85 percent of the total amount permitted for outlier payments. This total allowance is 2.5% of all PPS revenues nationally. CMS’s proposed rule also continues to impose a per provider outlier cap of no more than 10% of total Medicare revenues.

CMS’s proposed rule also retains the fixed dollar loss (FDL) ratio, which is the eligibility standard by which home health episodes qualify for an outlier payment of 0.45%. The current FDL was lowered to 0.45% in CMS’s CY 2013 PPS final rule from 0.67% in 2010-2012. CMS is also maintaining the current outlier loss sharing ratio of 0.80%. In the proposed rule, CMS estimates that outlier payments would comprise approximately 1.82% of total HHPPS payments in CY 2014, based on simulations using preliminary CY 2012 claims data, the proposed CY 2014 payment rates and the continuation of the FDL ratio of 0.45. CMS approximates further that estimated outlier payments as a % of total HHPPS payments would be approximately 1.94% by the end of the four-year phase-in period required by ACA. CMS notes, however, that these estimates do not take into account any changes in utilization that may have occurred in CY 2013 and would continue to occur in CY 2014, due to decreasing the FDL ratio from 0.67% to 0.45%. Hence, CMS is not proposing a change to the FDL ratio for CY 2014, as the claims data showing any utilization changes that may have resulted from an FDL of 0.45 will not be available for analysis until next year.

### Wage Index Update

For CY 2014 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 each HHA’s wage index by using the most recent pre-floor and pre-reclassification hospital wage index data available to adjust the labor portion of the HHPPS rates based on the geographic area in which beneficiaries receive their Medicare home health services.

CMS’s proposed rule maintains the labor portion of the rate (78.535%) which was revised in last year’s final rule. The labor-related share includes wages and employee benefits. Individual agency wage indices are only applied to the labor-related share. The non-labor-related share in CY 2014 is proposed to be maintained at 21.465%.

### Summary of Wage Index Changes

The Home Health Wage Index Tables are on the [CMS Home Health PPS Website](http://www.cms.gov) and not included in the actual rule. For Massachusetts:

<table>
<thead>
<tr>
<th>CBSA</th>
<th>2013 Index</th>
<th>2014 Index</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnstable</td>
<td>1.2843</td>
<td>1.3062</td>
<td>1.7%</td>
</tr>
<tr>
<td>Norfolk/Plymouth/Suffolk</td>
<td>1.2378</td>
<td>1.2505</td>
<td>1.0%</td>
</tr>
<tr>
<td>Middlesex</td>
<td>1.1262</td>
<td>1.1201</td>
<td>(0.5%)</td>
</tr>
<tr>
<td>Essex</td>
<td>1.0551</td>
<td>1.0571</td>
<td>0.2%</td>
</tr>
<tr>
<td>Berkshire</td>
<td>1.0721</td>
<td>1.0966</td>
<td>2.3%</td>
</tr>
<tr>
<td>Bristol &amp; RI</td>
<td>1.0699</td>
<td>1.0579</td>
<td>(1.1%)</td>
</tr>
</tbody>
</table>
OASIS & Home Health Quality Reporting Update & HCA’s Concerns

CMS’s proposed rule will continue to reduce home health payment rates for HHAs that did not report OASIS quality data for episodes beginning on or after July 1, 2012 and before July 1, 2013. For agencies that did not submit the OASIS data, the home health market basket percentage increase will be reduced by 2% for 2014.

Because CMS believes that claims data are a more robust source of information for accurately measuring acute care hospitalizations than other data sources, the proposed rule adds two claims-based quality measures: 1) rehospitalization during the first 30 days of a home health stay, and 2) emergency department use without hospital readmission during the first 30 days of home health. CMS believes these proposed re-hospitalization measures will allow HHAs to further target patients who entered home health after a hospitalization. In addition, CMS states that this rule would reduce the number of home health quality measures currently reported to home health agencies to simplify their use for quality improvement activities.

CMS intends to seek National Quality Forum (NQF) endorsement of these two re-hospitalization measures and proposes to begin reporting feedback to HHAs on their performance of these measures in CY 2014. These measures will be added to the Home Health Compare website for public reporting in CY 2015. Additional details pertaining to these measures, including technical specifications, can be found on the CMS Home Health Quality Initiative website.

Proposed CASPER Report Changes

CMS’s proposed rule states that CMS is exploring ways to reduce the number of home health quality measures reported to HHAs on confidential CASPER reports. CMS proposes to reduce the total number of measures on the CASPER reports by beginning to report only “all-episodes” measures for nine process measures currently also stratified by episode length. (Stratification is the process of dividing members of the population into homogeneous subgroups before sampling).

CMS is asking for comments on this proposal to simplify reporting of process measures, which is based on the recommendation from the Measure Applications Partnership (MAP) to seek greater simplicity in these measures. Currently, there are 97 quality measures included on the CASPER reports, of which 45 are process measures. This proposed reduction would decrease the total number of home health quality measures to 79 and reduce the number of process measures from 45 to 27. This change will enable HHAs to obtain the information they require for quality improvement activities related to the process measures in a less burdensome manner. Reducing the number of measures also facilitates the future development and implementation of other home health measures.

The nine measures currently stratified by episode length on CASPER reports include:
- Depression interventions implemented;
- Diabetic foot care and patient/caregiver education implemented;
- Heart failure symptoms addressed;
- Pain interventions implemented;
- Treatment of pressure ulcers based on principles of moist wound healing implemented;
- Pressure ulcer prevention implemented;
- Drug education on all medications provided to patient/caregiver;
- Potential medication issues identified and timely physician contact; and
- Falls prevention steps implemented.

For each of these nine measures, three versions of each measure are currently included on CASPER reports. The three versions are: 1) short term episodes of care; 2) long term episodes of care; and 3) all episodes of care. CMS is
proposing to eliminate the stratification by episode length, so that these measures are reported only for “all episodes of care.” Thus, CMS proposes to eliminate the “short term” and “long term episodes of care” measures from CASPER reports. This would remove 18 process measures from the current CASPER reports. Of note, only the “short term episodes of care” measures are currently reported on Home Health Compare. These would be replaced with the analogous “all episodes of care” measures.


CMS’s proposed rule maintains its existing policy as promulgated in the 2011, 2012, and 2013 HHPPS Final Rules to expand the home health quality measures to include the HHCAHPS home health survey as part of CMS’s CY 2014 annual payment update.

All 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 HHCAHPS survey data is required to be submitted and analyzed quarterly. CMS encourages HHAs to monitor their respective HHCAHPS vendors to assure they are submitting HHCAHPS data on time using the HHCAHPS Data Submission Reports.

The proposed rule also maintains the current guideline that all approved HHCAHPS survey vendors fully comply with all HHCAHPS oversight activities, and CMS plans to include this survey requirement in the COPs in Section 484.250(c). HHCAHPS survey vendors are required to attend introductory trainings and all update trainings conducted by CMS and the HHCAHPS Survey Coordination Team, as well as pass a post-training certification test. There are now 30 approved HHCAHPS survey vendors. The list of approved HHCAHPS survey vendors is available at [https://homehealthcahps.org](https://homehealthcahps.org).

The HHCAHPS survey is currently available in English, Spanish, Chinese, Russian, and Vietnamese. CMS will continue to consider additional language translations.

**Other Updates**

**Home Health Physician Face-to-Face (F2F) Encounter for Medicare**

CMS’s proposed rule retains the existing physician face-to-face encounter (F2F) requirement which is mandated under Section 6407(a) of ACA.

**Upcoming Survey & Enforcement Requirements & Proposed Cost Allocation of Survey Expenses**

CMS’s proposed rule maintains all of the survey requirements and alternative sanctions for HHAs that were outlined in last year’s final rule. Highlights include:

- Definitions of survey types (standard, partial extended, extended and unannounced) and actions;
- Survey frequency and surveyor qualifications;
- Information on CMS’s new Informal Dispute Resolution (IDR) process that is scheduled to be implemented July 1, 2014;
- Information on immediate jeopardy situations and the process for intermediate sanctions; and
- The following alternative sanctions for HHAs with deficiencies:
  - Civil Monetary Penalties (CMPs)
  - Suspension of Payment for New Patients
  - Imposition of Temporary Management
  - Directed Plan of Corrections (POC)
  - Directed In-Service Training

CMS’s proposed rule reiterates that the CMPs and Suspension of Payment for New Admission are still scheduled for July 1, 2014 and that CMS will provide further guidance on the alternative sanctions implementation process via Interpretative Guidelines.
The proposed rule would ensure that Medicaid responsibilities for home health surveys are explicitly recognized in the State Medicaid Plan. For that portion of costs attributable to Medicare and Medicaid, CMS would assign 50 percent to Medicare and 50% to Medicaid, the same methodology that is used to allocate costs for dually-certified nursing homes.

**In Conclusion: HCA’s Analysis & Concerns**

The Alliance has serious concerns with CMS’s approach to rebasing rates in the CY 2014 proposed PPS rule. CMS’s proposal threatens access to Medicare home health services by recommending millions of dollars in new home care payment cuts due to the rebasing of PPS, piled on top of past Medicare reductions, including sequestration cuts and other unfunded burdensome regulations. Like these previous cuts and regulations, the execution and underlying assumptions behind the rate changes proposed in the CY 2014 PPS appear to be arbitrary, at odds with the nature of providing care to vulnerable patients, and contrary to the objective of serving these patients in the least costly and least restrictive setting.

In addition to the complicated new methodologies used to calculate CMS’s rebasing policy, the 2014 proposed rule retains, unchanged, virtually all of the regulatory requirements (i.e., the face-to-face mandate, the physician ordering and referral requirements, HHCAHPS reporting, and others) that have created enormous cost burdens for home care providers struggling in the face of cuts already imposed under ACA, the sequestration process, and at the state level.

**Comment Period & Issuance of the CY 2014 Final Rule**

CMS’s proposed rule will be open for public comment until 5 p.m. on August 26, 2013. The Alliance will be submitting comments on behalf of the membership. Members are encouraged to submit comments as well. Providers interested in submitting their own comments should reference **File Code CMS-1450-P**. Electronic comments on the proposed rule can be sent to [http://www.regulations.gov](http://www.regulations.gov) (follow the instructions under the “More Search Options” tab). Providers preferring to submit comments by mail should send them to: CMS, Department of Health and Human Services, Attention: CMS-1450-P, P.O. Box 8016, Baltimore, MD 21244-8016.

The Alliance will share with the membership our comments to CMS shortly after they are submitted. We anticipate that CMS will post the final rule for the CY 2014 HHPPS in the *Federal Register* towards the end of October.

**Open Member Briefing**

The Alliance will host an open conference call to brief members on the proposed rule and to gather member input on Tuesday, July 23, 10:30 a.m. – 12:00 noon. To sign up for the conference call, please email tburgers@thinkhomecare.org.