# PUBLICATION

## Highlights of the 2015 Home Health Prospective Payment Rule [Ober|Kaler]

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**On November 6, 2014, CMS published its final Medicare home health prospective payment system (HH PPS) rule for calendar year (CY) 2015. As highlighted below, notable changes in the HH PPS final rule include: (1) a payment reduction of $60 million; (2) elimination of the existing face-to-face narrative requirements; (3) a "pay for reporting" performance program; and (4) revised therapy reassessment requirements.**

- ***Rate changes:*** In total, Medicare payments to home health agencies for CY 2015 will be reduced by .30 percent, or $60 million. While CMS is providing for a 2.1 percent increase to the payment rates via the home health payment update percentage (an increase of $390 million), the overall decrease in Medicare payments is the result of the second year of the four-year phase-in of the rebasing adjustments to the national standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies conversion factor (a $450 million decrease).
- ***Face-to-face encounter requirements:*** The HH PPS final rule makes a number of significant changes to existing face-to-face encounter requirements, effective for all episodes beginning on or after January 1, 2015. First, the current face-to-face narrative requirement, i.e., explanation as to why the clinical findings of an encounter support a patient's homebound status, is no longer required on the *certification*. Therefore, the narrative requirement will no longer be a condition of payment. Although, note that certifying physicians or allowed non-physician practitioners must still have (a) a face-to-face encounter with a beneficiary before certifying the beneficiary's eligibility for the home health benefit; and (b) sufficient documentation *in their own files* to support the certification of a patient's homebound status and the need for skilled nursing or therapy services. Second, in the event a home health agency (HHA) claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services will likewise be denied. Per CMS, the physician's claim will be considered non-covered because there is "no corresponding claim for Medicare-covered home health services." Lastly, CMS clarified that a face-to-face encounter is required for certifications, rather than initial episodes, and that certifications will be considered any time a new start of care assessment is completed to initiate care.
- ***Home Health Quality Reporting Program Update (HHQRP):*** While HHAs have been statutorily required to report OASIS for a number of years, and OASIS reporting is a condition of payment, CMS is now instituting a "pay for reporting" performance requirement. For episodes beginning on or after July 1st, 2015 and before June 30th, 2015, HHAs must meet a minimum submission threshold of 70 percent for certain OASIS assessments, or be subject to a 2 percentage point reduction to their market basket update for CY 2017. Prior to increasing the minimum submission threshold in later years, CMS has pledged to monitor provider performance from July 1, 2014 through June 30, 2015, in order to evaluate appropriate pay-for-reporting performance standards in subsequent years.
- ***Therapy reassessments:*** CMS is eliminating the requirement that home health therapy reassessments be performed at the 13th and 19th visits, effective for episodes beginning on or after January 1, 2015. Rather, a qualified therapist must perform a reassessment every 30 calendar days. Notably, therapists are provided some flexibility with respect to the timing of the reassessment. In the final rule, CMS noted, "the reassessment could be done on the 21st day or the 28th day as clinically appropriate and deemed necessary by the therapist."

While in its proposed HH PPS rule, CMS invited comments on a potential HHA value-based purchasing (VBP) model (in which a percentage of HHA payments would be tied to certain quality of care measures), CMS ultimately decided not to move forward with such a model. The HHA VBP under consideration would have included a five to eight percent adjustment in payment made after each planned performance period, in a projected five to eight states. CMS noted that if it intends to move forward with the implementation of a HHA VBP model in CY 2016, it will seek additional comments.