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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: July 15, 2014

SUBJECT: **Home Health Agency Proposed Medicare Rule for 2015**

ROUTE TO: Administrator/Director, CFO

ABSTRACT: CMS releases HHA PPS proposed rule for CY 2015.

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) 2015. The complete rule is published in the *Federal Register*. The final rule will likely be issued sometime in the last quarter of 2014.

Public comments on the proposed changes must be received by CMS by 5 p.m., Sept. 2, 2014. Comments should reference file code *CMS-1611-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.

CMS estimates that approximately 3.5 million beneficiaries receive home health services from nearly 12,000 home health agencies, costing Medicare approximately $18 billion in 2013.

Overall Impact

CMS is proposing measures that equal a **0.30 percent decrease** in total Medicare payments to HHAs for CY 2015. Nationally, total Medicare revenue would be reduced by approximately $58 million.

The proposed decrease in payments reflects the impact of the 2.2 percent home health payment update percentage ($427 million increase) and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor ($485 million decrease). Of course, this decrease does not take into account the additional 2 percent decrease due to sequestration.

The Affordable Care Act (ACA) requires that the market basket update for HHAs be adjusted by changes in economy-wide productivity factor for CY 2015 (and each subsequent calendar year). The CY 2015 home health market basket increase of 2.6 percent is decreased by the multifactor productivity adjustment of a negative 0.4 percentage points resulting in the net 2.2 percent payment update. CY 2015 will be the second year of the controversial four year phase-in for rebasing adjustments to the HH PPS payment rates.

The proposed rule implements increases to the national per-visit payment rates, a 2.82 percent reduction to the NRS conversion factor, and a reduction to the national, standardized 60-day episode rate of $80.95 for CY 2015. The proposed national, standardized 60-day episode payment for CY 2015 is $2,922.76.

Face-to-Face (F2F)

Effective January 1, 2011, section 6407 of the ACA requires as a condition of payment, that the certifying physician or allowed non-physician provider (NPP) must have a face-to-face (F2F) encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit. Current regulations require the encounter occur within 90 days before care begins or up to 30 days after care began. Documentation of the encounter must include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services.

According to the proposed rule, in an effort to simplify the F2F encounter regulations, reduce the burden to home health agencies (HHAs) and physicians, and to mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements, CMS proposes the following changes to the face-to-face encounter requirements:

- First, eliminate the narrative requirement currently in regulation, 424.22(a) (1) (v). The certifying physician would still be required to certify that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility.

    - However, in the next paragraph of the proposed rule it states,
      "For instances where the physician is ordering skilled nursing visits for management and evaluation of the patient's care plan, the physician will still be required to include a brief narrative that describes the clinical justification of this

need as part of the certification/recertification of eligibility as outlined in §424.22(a)(1)(i) and §424.22(b)(2). This requirement was implemented in the CY 2010 HH PPS final rule (74 FR 58111) and is not changing." LeadingAge NY will be commenting on this confusion.

- Second, for medical review purposes, CMS is proposing to only consider medical records from the patient's certifying physician or discharging facility in determining initial eligibility for the Medicare home health benefit. If the patient's medical record, used by the physician in certifying eligibility, was not sufficient to demonstrate that the patient was eligible to receive services under the Medicare home health benefit, payment would not be rendered for the home health services provided.

- Third, CMS is proposing that the physician claim for certification/re-certification of eligibility for home health services (not the face-to-face encounter visit) be considered a non-covered service if the HHA claim was non-covered because the patient was ineligible for the home health benefit.

CMS states that these proposed changes are responsive to the home health industries concerns. They request comments on these proposals and the associated changes in regulations 424.22.

Clarification on when documentation of a F2F encounter is required

The face-to-face encounter requirement applies to the physician's certification only, not the re-certification of eligibility for subsequent episodes. CMS previously clarified that the face-to-face encounter requirement applies to "initial episodes," the first in a series of episodes separated by no more than a 60-day gap.

CMS is proposing to clarify that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care OASIS is completed to initiate care. CMS will be revising Q & A # 11 on the CMS website to reflect this proposed clarification.

Rebasing

The ACA requires that beginning in CY 2014, CMS apply an adjustment to the national standardized 60-day episode rate and other applicable amounts 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 other relevant factors. Additionally, CMS must phase-in any adjustment over a four year period, in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year, and be fully implemented by CY 2017. CY 2015 will be the second year of the four year phase-in for rebasing adjustments to the HH PPS payment rates.

CMS continues to monitor potential impacts of rebasing. They have analyzed the 2012 home health agency cost report data to determine whether the average cost per episode was higher using 2012 cost report data compared to the 2011 cost report data used in calculating the

rebasing adjustments. CMS estimated the cost of a 60-day episode to be $2,413.82 using 2012 cost report data, see Table 1.

Table 1: Average Costs per Visit and Average Number of Visits for a 60-day Episode

Discipline	2012 Average costs per visit	2012 Average number of visits	2012 60-day episode costs
Skilled Nursing	$ 130.49	9.55	$ 1,246.18
Home Health Aide	$ 61.62	2.60	$ 160.21
Physical Therapy	$ 160.03	4.80	$ 768.14
Occupational Therapy	$ 157.78	1.09	$ 171.98
Speech-Language Pathology	$ 172.08	0.22	$ 37.86
Medical Social Services	$ 210.36	0.14	$ 29.45
Total			$ 2,413.82

Source: FY 2012 Medicare cost report data and 2012 Medicare claims data from the standard analytic file (as of June 2013) for episodes ending on or before December 31, 2012 for which CMS could link an OASIS assessment.

CMS estimated the 2013 60- day episode to be $2,477.01, see Table 2.

Table 2: 2013 Estimated Costs per Episode

Discipline	2012 Average costs per visit	2013 Average number of visits	2013 HH Market Basket	2013 Estimated Cost per Episode
Skilled Nursing	$ 130.49	9.30	1.023	$ 1,241.47
Home Health Aide	$ 61.62	2.42	1.023	$ 152.55
Physical Therapy	$ 160.03	4.99	1.023	$ 816.92
Occupational Therapy	$ 157.78	1.20	1.023	$ 193.69
Speech-Language Pathology	$ 172.08	0.24	1.023	$ 42.25
Medical Social Services	$ 210.36	0.14	1.023	$ 30.13
Total				$ 2,477.01

Source: FY 2012 Medicare cost report data and 2012 Medicare claims data from the standard analytic file (as of June 2013) for episodes ending on or before December 31, 2012 for which CMS could link an OASIS assessment.

The 2015 proposed rule implements increases to the national per-visit payment rates, a 2.82 percent reduction to the NRS conversion factor, and a reduction to the national, standardized 60-day episode rate of $80.95 for CY 2015.

The proposed national, standardized 60-day episode payment for CY 2015 is $2,922.76.

Recalibration of the HH PPS case-mix weights

In CY 2012, CMS removed two hypertension codes from the case-mix system and recalibrated the case-mix weights in a budget neutral manner. For CY 2015, CMS is proposing to recalibrate the HH PPS case-mix weights by adjusting the weights relative to one another, using CY 2013

home health claims data, to ensure that the case-mix weights reflect the most current utilization and resource data available.

CMS is proposing to apply the full 1.0237 case-mix budget neutrality factor to the national, standardized 60-day episode payment rate and will continue to monitor case-mix growth.

Proposed CY 2015 Rate Update
CY 2015 Home Health Market Basket Update

As noted above, the ACA requires that the market basket update for HHAs be adjusted by changes in economy-wide productivity for CY 2015 (and each subsequent calendar year). The CY 2015 home health market basket (2.6 percent) adjusted for multifactor productivity or MFP (0.4 percentage points) would result in a 2.2 percent payment update.

As a reminder, the ACA Section 1895(b)(3)(B) requires that the home health market basket percentage increase be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. In other words, for HHAs that do not submit the required quality data for CY 2015, the home health market basket update will be 0.2 percent (2.2 percent minus 2 percent).

Home Health Care Quality Reporting Program (HH QRP)

The Home Health Conditions of Participations (CoPs) require HHAs to submit OASIS assessments as a condition of payment and also for quality measurement purposes. HHAs that do not submit quality measure data to CMS will see a two percent reduction in their annual payment update (APU).

In February 2012, the Department of Health and Human Services Office of the Inspector General (OIG) performed a study and issued a report, "Limited Oversight of Home Health Agency OASIS Data", which found that CMS did not ensure accuracy or completeness of OASIS data. As a result of the study OIG recommended that HHAs that failed to submit OASIS data have a 2 percent payment reduction. In response CMS directed one of their contractors to design a pay-for-reporting performance system that could accurately measure the level of an HHA's submission of OASIS quality data. The proposed rule identifies seven types of assessments submitted by a HHA that fit the definition of a quality assessment.

To this end, CMS is proposing to establish a minimum submission threshold for the number of OASIS assessments that each HHA must submit. Beginning in CY 2015, the initial compliance threshold would be 70 percent. This means that HHAs would be required to submit both admission and discharge OASIS assessments for a minimum of 70 percent of all patients with episodes of care occurring during the reporting period. CMS is proposing to increase the threshold in 10 percent increments over the next two years to reach a maximum threshold of 90 percent. This proposal applies to the reporting period July 1, 2015 to June 30, 2016 to affect the APU in CY 2017.

To summarize, CMS is proposing to implement the pay-for- reporting performance requirement

beginning with all episodes of care that occur on or after July 1, 2015, in accordance with the following schedule:

- For episodes beginning on or after July 1, 2015 and before June 30, 2016, HHAs must score at least 70 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2017.

CMS is requesting comments on the proposal to implement the Pay-for-Reporting performance requirement.

Home Health Wage Index

CMS proposes changes to the wage index based on the newest Core Based Statistical Area (CBSA) changes for the HH PPS wage index and Office of Management and Budget (OMB) delineations, as described in OMB Bulletin No. 13-01. CMS believes that using the most recent OMB delineations will create a more accurate representation of geographic variation in wage levels.

The proposed changes will be made to the wage index using a blended wage index for a 1-year transition. CMS is referring to the blended wage index as the CY 2015 HH PPS transition wage index.

For each county, a blended wage index would be calculated as 50% of the CY 2015 wage index using the old OMB delineations, and 50% of the CY 2015 wage index using the revised OMB delineations.

CMS states if they used the new OMB delineations, a total of 105 counties that are currently considered part of a rural CBSA would be considered part of an urban CBSA effective CY 2015. In New York two counties that were considered rural are now seen as urban, they are Yates and Jefferson counties.

For a complete run down county by county, click here.

Proposed Home Health PPS CY 2015 Episodic Rate

CMS is proposing to use the same case-mix methodology as in CY 2008 adjusted as noted above.

Table 3: CY 2015 60-day National, Standardized 60-day Episode Payment Amount

CY 2014 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	Proposed CY 2015 National, Standardized 60-Day Episode Payment
$2,869.27	X 1.0012	X 1.0237	-$80.95	X 1.022	=$2,922.76

Source: CMS

The -$80.95 for the CY 2015 rebasing adjustment is clearly of serious concern for purposes of commenting on the proposed rule.

For HHAs that don't submit the required quality data the proposed CY 2015 HH payment update percentage of (2.2 percent) would then be reduced by 2 percentage points. See Table 4.

Table 4: HHAs that Do Not Submit the Quality Data – Proposed CY 2015 National, Standardized 60-Day Episode Payment Amount

CY 2014 National, Standardized 60-Day Episode Payment	Wage Index Budget Neutrality Factor	Case-Mix Weights Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage Minus 2 Percentage Points	Proposed CY 2015 National, Standardized 60-Day Episode Payment
$2,869.27	X 1.0012	X 1.0237	-$80.95	X 1.002	=$2,865.57

Source: CMS

Proposed National Per-Visits Rates/LUPAs

CMS calculated the national per-visit rate by starting with the CY 2014 national per-visit rates and then applying the wage index budget neutrality factor and then increasing each of the per-visits by the maximum rebasing adjustment. CMS obtained a wage budget neutrality factor of 1.0000. The last calculation for the per-visits rates for each discipline is updated by the CY 2015 HH payment update percentage of 2.2 percent. See Table 5.

Table 5: Proposed CY National Per-Visit Payment Amounts for HHAs that DO Submit the Required Quality Data

HH Discipline Type	CY 2014 Per-Visit Payment	Wage Index Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	Proposed CY 2015 Per-Visit Payment
Home Health Aide	$54.84	X 1.0000	+ $1.79	X 1.022	$57.88
Medical Social Services	$194.12	X 1.0000	+ $6.34	X 1.022	$204.87
Occupational Therapy	$133.30	X 1.0000	+ $4.35	X 1.022	$140.68
Physical Therapy	$132.40	X 1.0000	+ $4.32	X 1.022	$139.73
Skilled Nursing	$121.10	X 1.0000	+ $3.96	X 1.022	$127.81
Speech-Language Pathology	$143.88	X 1.0000	+ 4.70	X 1.022	$151.85

Source: CMS

Table 6: Proposed CY 2015 National Per-Visit Payment Amounts for HHAs that DO NOT Submit the Required Quality Data

HH Discipline Type	CY 2014 Per-Visit Rates	Wage Index Budget Neutrality Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage Minus 2 Percentage Points	Proposed CY 2015 Per-Visit Rates
Home Health Aide	$54.84	X 1.0000	+ $1.79	X 1.002	$56.74
Medical Social Services	$194.12	X 1.0000	+ $6.34	X 1.002	$200.86
Occupational Therapy	$133.30	X 1.0000	+ $4.35	X 1.002	$137.93
Physical Therapy	$132.40	X 1.0000	+ $4.32	X 1.002	$136.99
Skilled Nursing	$121.10	X 1.0000	+ $3.96	X 1.002	$125.31
Speech-Language Pathology	$143.88	X 1.0000	+ 4.70	X 1.002	$148.88

Source: CMS

The Low-Utilization Payment Adjustment (LUPA) in the proposed CY 2015 HH PPS is the same as the LUPA "add-on-factor in the 2014 final HH PPS rule. As you may recall in the CY 2014 HH PPS, CMS changed the methodology for calculating the LUPA add-on amount by finalizing the use of three LUPA add-on factors:

- 1.8451 for SN;
- 1.6700 for PT; and
- 1.6266 for SLP.

CMS then multiplied the per-visit amount for the first SN, PT or SLP visit in a LUPA episode that occur as the only episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount. For instance, for a LUPA episode that occurs as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit would be $235.82 (1.8451 multiplied by $127.81)

Proposed Non-Routine Medical Supply (NRS) Conversion Factor Update

CMS determined the proposed CY 2015 NRS conversion factor by starting with the 2014 NRS conversion factor of $53.65 and applying the -2.82 percent rebasing adjustments and then updating the conversion factor by the CY 2015 HH payment update of 2.2 percent. The proposed NRS conversion factor is shown in Table 5 for those HHAs who submit the required quality data and in Table 7 for those HHAs that do NOT submit the required data.

Table 7: Proposed CY 2015 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

CY 2014 NRS Conversion Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage	Proposed CY 2015 NRS Conversion Factor
$53.65	X 0.9718	X 1.022	=$53.28

Source: CMS

Table 8: Proposed CY 2015 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data

CY 2014 NRS Conversion Factor	CY 2015 Rebasing Adjustment	CY 2015 HH Payment Update Percentage Minus 2 Percentage Points	Proposed CY 2015 NRS Conversion Factor
$53.65	X 0.9718	X 1.002	$52.24

Source: CMS

Using the proposed CY 2015 NRS conversion factor, the proposed payment amounts for the six severity levels are shown in Table 9.

Table 9: Proposed CY 2015 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

Severity Level	Points (Scoring)	Relative Weight	Proposed CY 2015 NRS Payment Amounts
1	0	0.2698	$ 14.37
2	1 to 14	0.9742	$ 51.91
3	15 to 27	2.6712	$ 142.32
4	28 to 48	3.9686	$ 211.45
5	49 to 98	6.1198	$ 326.06
6	99+	10.5254	$ 560.79

Source: CMS

Rural-Add-on

According to Section 3131 (c) of the ACA amended section 421 (a) of the Medicare Modernization Act to provide an increase of 3 percent of payment amount for HH services furnished in a rural area for episodes and visits ending on or after April 1, 2010 and before January 1, 2016. The following Tables 10-11 show the proposed payment amount in rural areas.

Table 10: Proposed CY 2015 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 2015 National, Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Proposed CY 2015 Rural National, Standardized 60-Day Episode Payment Rate	CY 2015 National, Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Proposed CY 2015 Rural National, Standardized 60-Day Episode Payment Rate
$2,922.76	X 1.03	$3,010.44	$2,865.57	X 1.03	$2,951.54

Source: CMS

Table 11: Proposed CY 2015 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		
HH Discipline Type	CY 2015 Per-visit rate	Multiply by the 3 Percent Rural Add-On	Proposed CY 2015 Rural Per-Visit Rates	CY 2015 Per-visit rate	Multiply by the 3 Percent Rural Add-On	Proposed CY 2015 Rural Per-Visit Rates
HH Aide	$57.88	X 1.03	$59.62	$56.74	X 1.03	$58.44
MSS	$204.87	X 1.03	$211.02	$200.86	X 1.03	$206.89
OT	$140.68	X 1.03	$144.90	$137.93	X 1.03	$142.07
PT	$139.73	X 1.03	$143.92	$136.99	X 1.03	$141.10
SN	$127.81	X 1.03	$131.64	$125.31	X 1.03	$129.07
SLP	$151.85	X 1.03	$156.41	$148.88	X 1.03	$153.35

Source: CMS

Payments for High-Cost Outliers under the HH PPS/ Fixed Dollar Loss (FDL) Ratio and Loss Sharing Ratio

CMS continues the policy of CY 2011 by targeting up to 2.5 percent of estimated total payments to be paid as outlier payments and then apply a 10 percent agency-level outlier cap. CMS estimates using the proposed payment rate and a Fixed Dollar Loss (FDL) ratio of 0.45 the outlier payments would compromise approximately 2.26 percent of total HH PPS payments in 2015. They also forecast that in 2016 the estimated outlier payments as a percent of the total HH PPS payments will increase to 2.51 percent. To this end CMS is proposing not to change the FDL in 2015.

Medicare Coverage of Insulin Injections

In the proposed rule it states, "Home health policy regarding coverage of home health visits for the sole purpose of insulin injection is limited to patients that are physically or mentally unable to self-inject and there is no other person who is able or willing to inject the patient." The rule also cites an OIG audit in August 2013 where it was found that some previously covered home health visits for the sole purpose of insulin injections were unnecessary. CMS conducted a literature review and an analysis of CY 2012 claims data and found 81 percent of outlier payments would be made to proprietary HHAs and that approximately two-thirds of outlier payments would be paid to HHAs located in Florida, Texas, California, Oklahoma and New

York. CMS then conducted further analysis on more recent home health claims and OASIS data to further understand the role of HHAs in caring for the diabetic patient.

CMS is not proposing any policy changes at this time but they are *inviting public comment* on whether the conditions outlined in the following table represent a comprehensive list of codes that appropriately indicate whether a patient may not be able to self-inject and use an insulin pen.

ICD-9-CM Code	Description
Amputation	
V49.61	Thumb Amputation Status
V49.63	Hand Amputation Status
V49.64	Wrist Amputation Status
V49.65	Below elbow amputation status
V49.66	Above elbow amputation status
V49.67	Shoulder amputation status
885.0	Traumatic amputation of thumb w/o mention of complication
885.1	Traumatic amputation of thumb w/ mention of complication
886.0	Traumatic amputation of other fingers w/o mention of complication
886.1	Traumatic amputation of other fingers w/ mention of complication
887.0	Traumatic amputation of arm and hand, unilateral, below elbow w/o mention of complication
887.1	Traumatic amputation of arm and hand, unilateral, below elbow, complicated
887.2	Traumatic amputation of arm and hand, unilateral, at or above elbow w/o mention of complication
887.3	Traumatic amputation of arm and hand, unilateral, at or above elbow, complicated
887.4	Traumatic amputation of arm and hand, unilateral, level not specified, w/o mention of complication
887.5	Traumatic amputation of arm and hand, unilateral, level not specified, complicated
887.6	Traumatic amputation of arm and hand, bilateral, any level, w/o mention of complication
887.7	Traumatic amputation of arm and hand, bilateral, any level, complicated
Vision	
362.01	Background diabetic retinopathy
362.50	Macular degeneration (senile) of retina unspecified
362.51	Nonexudative senile macular degeneration of retina
362.52	Exudative senile macular degeneration of retina
362.53	Cystoid macular degeneration of retina
362.54	Macular cyst hole or pseudohole of retina
362.55	Toxic maculopathy of retina
362.56	Macular puckering of retina
362.57	Drusen (degenerative) of retina
366.00	Nonsenile cataract unspecified
366.01	Anterior subcapsular polar nonsenile cataract
366.02	Posterior subcapsular polar nonsenile cataract

ICD-9-CM Code	Description
366.03	Cortical lamellar or zonular nonsenile cataract
366.04	Nuclear nonsenile cataract
366.09	Other and combined forms of nonsenile cataract
366.10	Senile cataract unspecified
366.11	Pseudoexfoliation of lens capsule
366.12	Incipient senile cataract
366.13	Anterior subcapsular polar senile cataract
366.14	Posterior subcapsular polar senile cataract
366.15	Cortical senile cataract
366.16	Senile nuclear sclerosis
366.17	Total or mature cataract
366.18	Hypermature cataract
366.19	Other and combined forms of senile cataract
366.20	Traumatic cataract unspecified
366.21	Localized traumatic opacities
366.22	Total traumatic cataract
366.23	Partially resolved traumatic cataract
366.8	Other cataract
366.9	Unspecified cataract
366.41	Diabetic cataract
366.42	Tetanic cataract
366.43	Myotonic cataract
366.44	Cataract associated with other syndromes
366.45	Toxic cataract
366.46	Cataract associated with radiation and other physical influences
366.50	After-cataract unspecified
369.00	Impairment level not further specified
369.01	Better eye: total vision impairment; lesser eye: total vision impairment
369.10	Moderate or severe impairment, better eye, impairment level not further specified
369.11	Better eye: severe vision impairment; lesser eye: blind not further specified
369.13	Better eye: severe vision impairment; lesser eye: near-total vision impairment
369.14	Better eye: severe vision impairment; lesser eye: profound vision impairment
369.15	Better eye: moderate vision impairment; lesser eye: blind not further specified
369.16	Better eye: moderate vision impairment; lesser eye: total vision impairment
369.17	Better eye: moderate vision impairment; lesser eye: near-total vision impairment
369.18	Better eye: moderate vision impairment; lesser eye: profound vision impairment
369.20	Moderate to severe impairment; Low vision both eyes not otherwise specified
369.21	Better eye: severe vision impairment; lesser eye; impairment not further specified
369.22	Better eye: severe vision impairment; lesser eye: severe vision impairment
369.23	Better eye: moderate vision impairment; lesser eye: impairment not further specified
369.24	Better eye: moderate vision impairment; lesser eye: severe vision impairment
369.25	Better eye: moderate vision impairment; lesser eye: moderate vision impairment
369.3	Unqualified visual loss both eyes
369.4	Legal blindness as defined in U.S.A.
377.75	Cortical blindness
379.21	Vitreous degeneration
379.23	Vitreous hemorrhage
Cognitive/Behavioral	
290.0	Senile dementia uncomplicated
290.3	Senile dementia with delirium
290.40	Vascular dementia, uncomplicated
290.41	Vascular dementia, with delirium
290.42	Vascular dementia, with delusions
290.43	Vascular dementia, with depressed mood

ICD-9-CM Code	Description
294.11	Dementia in conditions classified elsewhere with behavioral disturbance
294.21	Dementia, unspecified, with behavioral disturbance
300.29	Other isolated or specific phobias
331.0	Alzheimer's disease
331.11	Pick's disease
331.19	Other frontotemporal dementia
331.2	Senile degeneration of brain
331.82	Dementia with lewy bodies
Arthritis	
715.11	Osteoarthrosis localized primary involving shoulder region
715.21	Osteoarthrosis localized secondary involving shoulder region
715.31	Osteoarthrosis localized not specified whether primary or secondary involving shoulder region
715.91	Osteoarthrosis unspecified whether generalized or localized involving shoulder region
715.12	Osteoarthrosis localized primary involving upper arm
715.22	Osteoarthrosis localized secondary involving upper arm
715.32	Osteoarthrosis localized not specified whether primary or secondary involving upper arm
715.92	Osteoarthrosis unspecified whether generalized or localized involving upper arm
715.13	Osteoarthrosis localized primary involving forearm
715.23	Osteoarthrosis localized secondary involving forearm
715.33	Osteoarthrosis localized not specified whether primary or secondary involving forearm
715.93	Osteoarthrosis unspecified whether generalized or localized involving forearm
715.04	Osteoarthrosis generalized involving hand
715.14	Osteoarthrosis localized primary involving hand
715.24	Osteoarthrosis localized secondary involving hand
715.34	Osteoarthrosis localized not specified whether primary or secondary involving hand
715.94	Osteoarthrosis unspecified whether generalized or localized involving hand
716.51	Unspecified polyarthropathy or polyarthritis involving shoulder region
716.52	Unspecified polyarthropathy or polyarthritis involving upper arm
716.53	Unspecified polyarthropathy or polyarthritis involving forearm
716.54	Unspecified polyarthropathy or polyarthritis involving hand
716.61	Unspecified monoarthritis involving shoulder region
716.62	Unspecified monoarthritis involving upper arm
716.63	Unspecified monoarthritis involving forearm
716.64	Unspecified monoarthritis involving hand
716.81	Other specified arthropathy involving shoulder region
716.82	Other specified arthropathy involving upper arm
716.83	Other specified arthropathy involving forearm
716.84	Other specified arthropathy involving hand
716.91	Unspecified arthropathy involving shoulder region
716.92	Unspecified arthropathy involving upper arm
716.93	Unspecified arthropathy involving forearm
716.94	Unspecified arthropathy involving hand
716.01	Kaschin-Beck disease shoulder region
716.02	Kaschin-Beck disease upper arm
716.04	Kaschin-Beck disease forarm
716.04	Kaschin-beck disease involving hand
719.81	Other specified disorders of joint of shoulder region
719.82	Other specified disorders of upper arm joint
719.83	Other specified disorders of joint, forearm
719.84	Other specified disorders of joint, hand
718.41	Contracture of joint of shoulder region
718.42	Contracture of joint, upper arm
718.43	Contracture of joint, forearm
718.44	Contracture of hand joint

ICD-9-CM Code	Description
714.0	Rheumatoid arthritis
Movement Disorders	
332.0	Paralysis agitans (Parkinson's)
332.1	Secondary parkinsonism
333.1	Essential and other specified forms of tremor
736.05	Wrist drop (acquired)
After Effects from Stroke/ Other Disorders of the Central Nervous System/Intellectual Disabilities	
438.21	Hemiplegia affecting dominant side
438.22	Hemiplegia affecting nondominant side
342.01	Flaccid hemiplegia and hemiparesis affecting dominant side
342.02	Flaccid hemiplegia and hemiparesis affecting nondominant side
342.11	Spastic hemiplegia and hemiparesis affecting dominant side
342.12	Spastic hemiplegia and hemiparesis affecting nondominant side
438.31	Monoplegia of upper limb affecting dominant side
438.32	Monoplegia of upper limb affecting nondominant side
343.3	Congenital monoplegia
344.41	Monoplegia of upper limb affecting dominant side
344.42	Monoplegia of upper limb affecting nondominant side
344.81	Locked-in state
344.00	Quadriplegia unspecified
344.01	Quadriplegia c1-c4 complete
344.02	Quadriplegia c1-c4 incomplete
344.03	Quadriplegia c5-c7 complete
344.04	Quadriplegia c5-c7 incomplete
343.0	Congenital diplegia
343.2	Congenital quadriplegia
344.2	Diplegia of upper limbs
318.0	Moderate intellectual disabilities
318.1	Severe intellectual disabilities
318.2	Profound intellectual disabilities

Source: CMS

HHA Value-Based Purchasing Model

CMS is proposing to implement a value-based purchasing (VBP) model for HHAs similar to what was implemented for Skilled Nursing Facilities (SNF). The intent of the HHA VBP is to tie a provider's payment to its performance in such a way as to reduce inappropriate or poorly furnished care and to reward those providers who provide quality care. Section 3006(b) (1) of the ACA directs the Secretary to develop a plan to implement such a program.

The proposed rule mentions the hospital-based VBP where 1.25 percent of hospital payments in 2014 are tied to the quality of care that hospitals provide. In the President's 2015 Budget he proposes VBP should be extended to additional providers including SNFs, HHAs, ambulatory surgical centers, and hospital outpatient departments.

If the HHA VBP is implemented it would begin in CY 2016. CMS will ask for additional comments on a more detailed model proposal in future rulemaking. CMS has put forth the following limited information:

- HHA VBP model would reduce or increase Medicare payments, in a 5-8% percent range, depending on the degree of quality performance;

- The model would apply to **ALL** HHAs in each of the projected five to eight states;
- The distribution of payments would be based on quality performance; and
- CMS believes the payment adjustment at risk will provide incentives to HHAs for improved planning, coordination, and management of care.

CMS is looking for feedback on the elements of the HHA VBP model, size of the payment incentives and percentage of payments that would need to be placed at risk in order to encourage HHAs to make the investments to improve the quality of care and the best approach for selecting states for this pilot.

Proposed Revisions to Speech-Language Pathologist (SLP) Personnel Qualifications

CMS is proposing to revise the personnel qualifications for SLPs to more closely align with regulatory requirements. They are suggesting that a qualified SLP is an individual who meets one of the following requirements:

- has a masters' or doctoral degree in speech-language pathology, **and**;
- is licensed as a speech-language pathologist by the state where they furnish services, **or**;
- has successfully completed 350 clock hours of supervised clinical practicum (or be in the process of completing these hours), at least nine months of supervised full-time speech-language pathology experience after completing a master's or doctoral degree in SLP or a related field **and**;
- has successfully completed a national examination approved by the Secretary.

CMS is soliciting comments on the SLP changes.

Proposed Therapy Reassessment Timeframes

CMS is proposing to lessen the burden on HHAs by simplifying 409.44(c) to require that therapy reassessments must be performed at least once every 14 calendar days. This requirement would apply to all episodes regardless of the number of therapy visits provided. This will eliminate the required 13th visit and 19th reassessment.

CMS is soliciting comments on this proposed change and the associated change in regulation 409.44.

Technical Regulation Text Changes

CMS is proposing technical corrections in 424.22(b) (1) to better align the recertification requirements with the Medicare Conditions of Participation (CoPs) for home health services. They are proposing to specify that recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode to coincide with the CoPs in 484.55(d)(1), which require the HHA to update the comprehensive assessment in the last 5 days of every 60-day episode of care.

Additionally, CMS is proposing to specify that the recertification is required at least every 60 days unless there is a beneficiary elected transfer or discharge with goals met and return to the same HHA during the 60-day episode.

Conclusion

The proposed rule focuses on many of the same areas of HH PPS case-mix weights, non-routine medical supplies (NRS), home health market basket, per-visit payment rates and we remain concern about rebasing and the impact it has on our HHAs. We support the revisions to the F2F requirements and we are carefully evaluating the proposed changes to the therapy reassessments. We are also carefully evaluating the new proposals on Speech Pathology participation conditions, insulin injections, and Value-Based Purchasing.

Please contact LeadingAge national at congress@leadingage.org and me at cudell@leadingageny.org to share your recommendations on the proposed rule and, especially, let us know what the impact of rebasing means to your agency. Other critical areas we need to hear from members on include the changes to the F2F requirements, therapy reassessments, Speech Pathology participation conditions, insulin injections, and Value-Based Purchasing.

For comments or questions regarding the HHA PPS proposed rule, please contact Cheryl Udell at cudell@leadingageny.org or at 518-867-8871.