BLACKTREE
HEALTHCARE CONSULTING

Financial Impact of the Medicare Rate Changes for 2015

November 2014

Overview

- Financial Basics to the Final Rule
- Stats
- Face-to-Face Changes
- Wage Index Changes
- Recalibration
- Case Mix Analysis
- Therapy Assessments
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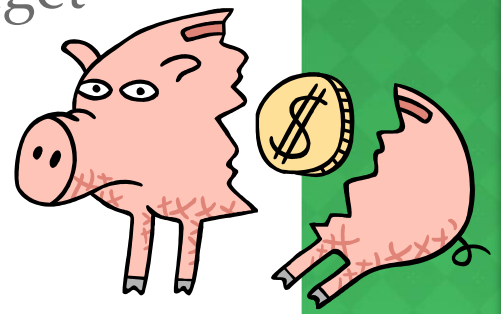
Financial Basics of the Final Rule

- CMS estimates a decrease of $60M in payments
- CY 2015 Base Rate = $2,961.38 (1.3% increase from the proposed rule)
  - Increase of $92.11 from 2014 base rate of $2,869.27
- Base rate includes
  - 0.24% increase due to wage index budget neutrality factor
  - 3.66% increase due to case-mix weights budget neutrality factor
  - Rebasing =3.5% decrease or -$80.95
  - 2.1% increase for market basket update



Financial Basics of the Final Rule

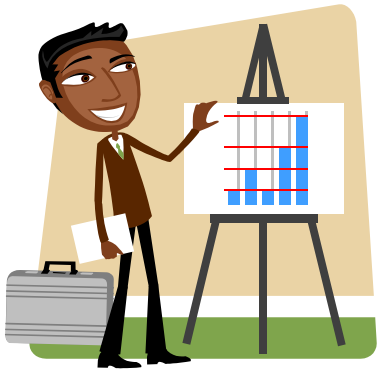
- Rural Add-on of 3% is set to expire on 1/1/16
- NRS base rate went down slightly from $53.65 to $53.23
- No change in outliers

LUPA Rates

TABLE 24—CY 2015 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	CY 2015 Per-visit payment
Home Health Aide	$54.84	×; 1.0012	+ $1.79	×; 1.021	$57.89
Medical Social Services	194.12	×; 1.0012	+ $6.34	×; 1.021	204.91
Occupational Therapy	133.30	×; 1.0012	+ $4.35	×; 1.021	140.70
Physical Therapy	132.40	×; 1.0012	+ $4.32	×; 1.021	139.75
Skilled Nursing	121.10	×; 1.0012	+ $3.96	×; 1.021	127.83
Speech-Language Pathology	143.88	×; 1.0012	+ 4.70	×; 1.021	151.88

Stats



Home Health Stats

TABLE 5—HOME HEALTH STATISTICS, CY 2010 THROUGH CY 2013

	2010	2011	2012	2013
Number of episodes	6,833,669	6,821,459	6,727,875	6,708,923
Beneficiaries receiving at least 1 episode (Home Health Users)	3,431,696	3,449,231	3,446,122	3,484,579
Part A and/or B FFS beneficiaries	36,818,078	37,686,526	38,224,640	38,505,609
Episodes per Part A and/or B FFS beneficiaries	0.19	0.18	0.18	0.17
Home health users as a percentage of Part A and/or B FFS beneficiaries	9.3%	9.2%	9.0%	9.0%
HHAs providing at least 1 episode	10,916	11,446	11,746	11,889

- Concerns with access to care due to previously established face-to-face requirement in 2011 along with rebasing
  - MEDPAC to complete a study on access to care by 1/1/15
- CMS does not believe it to be an issue as they attribute to more patients moving to FFS plans
- Massachusetts was one of five states that saw an increase in home health episodes (1.9% or 3,600 episodes)
- Texas had a 12% drop in episodes
  - If excluded from analysis, episodes would have increased 0.13% instead of dropping 1.8%

Home Health Stats

- Future Decreased Payments?
  - MEDPAC shows a 12% profit margin for for-profit and not-for-profit agencies based on 2012 cost reports
  - Analysis showed that case mix creep continues to be a problem
    - Increased 2.76% between CY 2012 and CY 2013 with 2.32% of growth being nominal
    - Did not perform any additional case mix creep adjustments than what was currently scheduled but may do nominal ones in future rule making

Face-to-Face Changes

Face-to-Face Changes

- Physician narrative eliminated
  - Still applies for episodes beginning prior to 1/1/15
  - CMS will not go back and retrospectively review accounts previously denied for lacking a physician narrative
- Narrative still needed for SN management and evaluation (G0162)
  - Accounts for 1.5% of all visits
- Face-to-Face needed for all SOC OASIS
  - Clarified PEP situations where they were considered subsequent episodes
  - Many agencies have been obtaining this information but worst case scenario is 830,287 new face-to-face documents would be required with this clarification

Face-to-Face Changes

- Physician Impact
  - Narrative is required to maintained in the physician's medical records
  - HHA's must request medical records from physician if claim audited for compliance
  - If physician billed for G0180 or G0179, their claims would be denied if home health claim denied for insufficient documentation
    - Small dollar physician claims and many do not bill for these services
  - Physician specific probes if patterns of non-compliance exist for not sending documents or inadequate documentation

Face to Face Changes

- Physician Impact
  - Can incorporate HHA information on the patient's homebound status in to their medical record
    - Physician must sign off on this info
    - Info must corroborate the physicians own documentation including diagnosis and patients condition on the assessment

Wage Index Changes

Wage Index Changes

- Continues to be based on pre-floor, pre-classified hospital IP data
- CBSA boundaries have changed
  - Urban to Urban = 46 (Ex-Essex County)
  - Urban to Rural = 37(Ex -Franklin County)
  - Rural to Urban = 105
- 50/50 blend of existing CBSA designations and the new CBSA designations

Massachusetts Wage Index Changes

County Name	CY 2014 Wage Index	CY 2015 Transition Wage Index	% Change 2014 to Transition	CY 2015 Wage Index under previous CBSA designation	CY 2015 Wage Index under new CBSA designation	% Change if Not 50/50 Blend
Barnstable	1.3007	1.3124	0.9%	1.3124	1.3124	0.9%
Berkshire	1.092	1.0807	-1.0%	1.0807	1.0807	-1.0%
Bristol	1.0539	1.0634	0.9%	1.0634	1.0634	0.9%
Dukes	1.3614	1.2737	**-6.4%**	1.3920	1.1553	**-15.1%**
Essex	1.0553	1.0964	**3.9%**	1.0769	1.1159	**5.7%**
Franklin	1.0383	1.0912	**5.1%**	1.0271	1.1553	**11.3%**
Hampden	1.0383	1.0249	-1.3%	1.0271	1.0226	-1.5%
Hampshire	1.0383	1.0249	-1.3%	1.0271	1.0226	-1.5%
Middlesex	1.1146	1.1245	0.9%	1.1330	1.1159	0.1%
Nantucket	1.3614	1.2737	**-6.4%**	1.3920	1.1553	**-15.1%**
Norfolk	1.2453	1.2679	1.8%	1.2679	1.2679	1.8%
Plymouth	1.2453	1.2679	1.8%	1.2679	1.2679	1.8%
Suffolk	1.2453	1.2679	1.8%	1.2679	1.2679	1.8%
Worcester	1.1584	1.1509	-0.6%	1.1525	1.1493	-0.8%

Recalibration

Recalibration

- What is it?
  - CMS updated the case mix weights and clinical/functional thresholds for all the HIPPS codes
- Why?
  - Previous amounts were determined based on 2005 data
  - CY 2015 update is based on 2013 claims data and more accurately reflects current utilization patterns and cost
  - Match payments with costs
- How?
  - CMS used the same logic for CY 2015 as CY 2012

Recalibration

- What does it mean for you?
  - Payment amounts are now different for each HIPPS code
  - Clinical/Functional scoring scenarios on the OASIS are changed
- Future Changes
  - Recalibration to occur every year based on new claims data

OASIS Scoring Changes

- Summary of changes to OASIS variables
  - 124 variables in CY2015 (was 162 in CY2014)
    - 21 variables added
    - 63 variables were dropped
      - Most of these had small point totals last year and were on the verge of being eliminated
    - 57 variables had an increase in points
    - 25 variables had a decrease in points
    - 17 remained the same
- Additions and deletion of variable to continue in future years

OASIS Scoring Changes

- Table 12 of the final rule lists all scenarios that receive points
  - M0 items no longer receiving clinical points in any of the 4 equations
    - M1200 (Vision) = 1 or more
    - M2030 (Injectable Drug Use) = 0,1,2, or 3
  - Eight diagnosis scenarios no longer receiving points
    - Listed as Clinical Dimension questions 1, 10, 13, 17, 21, 22, 23, and 24

CY2015 Clinical/Functional Domain Scoring

TABLE 13: CY 2015 Clinical and Functional Thresholds

		1st and 2nd Episodes		3rd+ Episodes		All Episodes
		0 to 13 therapy visits	14 to 19 therapy visits	0 to 13 therapy visits	14 to 19 therapy visits	20+ therapy visits
Grouping Step:		1	2	3	4	5
Equation(s) used to calculate points: (see Table 12)		1	2	3	4	(2&4)
Dimension	Severity Level					
Clinical	C1	0 to 1	0 to 1	0	0 to 5	0 to 3
	C2	2 to 3	2 to 7	1	6 to 12	4 to 16
	C3	4+	8+	2+	13+	17+
Functional	F1	0 to 14	0 to 3	0 to 9	0	0 to 2
	F2	15	4 to 13	10	1 to 7	3 to 5
	F3	16+	14+	11+	8+	6+

- Point ranges were used to distribute episodes equally across the clinical/functional domains (1/3 of episodes for each domain)

CY2014 Clinical/Functional Domain Scoring

	Equation 1	Equation 2	Equation 3	Equation 4	Equation 5	Value
C1	0 to 4	0 to 6	0 to 2	0 to 8	0 to 7	A
C2	5 to 8	7 to 14	3 to 5	9 to 16	8 to 14	B
C3	9+	15+	6+	17+	15+	C
F1	0 to 5	0 to 6	0 to 8	0 to 7	0 to 6	F
F2	6	7	9	8	7	G
F3	7+	8+	10+	9+	8+	H

Case Mix Analysis

Case Mix Weight

- What makes up a case mix weight?
  - Mix of services provided
  - Cost of services provided as determined by BLS hourly rates
  - Length of the visits
  - Number of visits provided

Therapy Grouping Case Mix Comparison (All Episodes)

Therapy Threshold	Case Mix Change 2014 to 2015
20+	4.14%
18 to 19	2.63%
16 to 17	0.74%
14 to 15	-1.70%
11 to 13	-2.12%
10	-2.65%
7 to 9	-3.36%
6	-4.36%
0-5	-5.84%
Grand Total	**-1.72%**

- Data above includes both early and late episodes

Therapy Grouping Case Mix Comparison (Early Episodes)

Therapy Threshold	Case Mix Change 2014 to 2015
18 to 19	2.79%
16 to 17	1.09%
14 to 15	-1.12%
11 to 13	-1.15%
10	-1.18%
7 to 9	-1.21%
0-5	-1.22%
6	-1.23%
Grand Total	**-0.40%**

- Data above includes only early episodes

Therapy Grouping Case Mix Comparison (Late Episodes)

Therapy Threshold	Case Mix Change 2014 to 2015
18 to 19	2.47%
16 to 17	0.38%
14 to 15	-2.29%
11 to 13	-3.09%
10	-4.12%
7 to 9	-5.52%
6	-7.48%
0-5	-10.47%
Grand Total	**-3.77%**

- Data above includes only late episodes

Reimbursement

- Why is Medicare continuing to reward episodes with high therapy by providing more reimbursement?
  - Visit utilization has changed from 2007 to 2013
    - Therapy which is a higher cost increased by 0.8 visits
    - SN visits decreased by 0.8 visits
    - HHA visits decreased by 1.4 visits
    - 0 to 5 therapy visit grouping saw a visit decrease of 1.9 visits with SN and HHA making up this drop
      - Constitutes over 50% of the episodes
  - Budget Neutrality
  - Many late episodes have a lower case mix score than early episodes with the same clinical, functional, and service domains
    - Late episodes saw a significant decrease in visit utilization from 2007 to 2013 when compared to early episodes

Therapy Utilization by Grouping

TABLE 16—SUMMARY STATISTICS—EPISODES FROM 2013

[Only normal episodes]

Therapy group	Number of episodes	Nursing	Aides	PT	OT	SLP	MSS	All therapy	All visits
0–5	2,951,379	8.9	2.1	0.6	0.1	0.0	0.1	0.7	11.8
6	224,325	6.0	1.3	5.2	0.6	0.1	0.1	6.0	13.3
7–9	664,911	6.5	1.5	6.9	0.9	0.2	0.2	7.9	16.0
10	184,871	6.8	1.7	8.5	1.3	0.2	0.2	10.0	18.6
11–13	532,875	7.1	2.0	10.0	1.7	0.3	0.2	12.0	21.2
14–15	249,627	7.3	2.4	11.6	2.4	0.4	0.2	14.5	24.3
16–17	267,500	6.5	2.5	13.5	2.5	0.4	0.2	16.4	25.6
18–19	173,769	7.0	2.6	13.8	4.0	0.6	0.2	18.4	28.2
20+	328,295	8.1	3.5	14.9	7.9	1.9	0.3	24.8	36.6
Total	5,577,552	7.9	2.1	5.1	1.2	0.2	0.1	6.5	16.7

Source: Data on episodes with a through date in 2013 using complete CY 2013 claims data as of June 30, 2014.

TABLE 17—SUMMARY STATISTICS—EPISODES FROM 2007 (FILE USED IN CY 2012 RECALIBRATION)

[Only normal episodes]

Therapy group	Number of episodes	Nursing	Aides	PT	OT	SLP	MSS	All therapy	All visits
Average number of visits for Normal episodes with a through date in 2007									
0–5	520,639	9.3	3.6	0.6	0.1	0.0	0.1	0.7	13.7
6	28,349	5.5	1.7	5.3	0.6	0.1	0.2	6.0	13.4
7–9	59,156	5.9	2.1	6.9	0.9	0.1	0.2	7.9	16.1
10	47,798	7.2	2.8	8.9	1.0	0.1	0.2	10.0	20.1
11–13	107,970	7.2	3.5	10.5	1.2	0.1	0.2	11.9	22.7
14–15	38,188	7.3	4.0	12.1	2.1	0.3	0.2	14.5	25.9
16–17	29,322	7.2	4.4	13.6	2.5	0.4	0.2	16.5	28.4
18–19	17,679	7.4	4.4	14.4	3.5	0.5	0.2	18.4	30.5
20+	39,395	7.4	5.2	16.3	7.1	1.5	0.3	24.9	37.9
Total	888,496	8.3	3.5	4.7	0.9	0.1	0.1	5.7	17.7

Therapy Assessments

Therapy Reassessments

- Previous Rule Assessment Schedule
  - 13th and 19th therapy visit (non rural) and once every 30 days per discipline
- Proposed Rule
  - Eliminate the 13th and 19th threshold and do assessment once every 14 days per discipline
- Final Rule
  - Eliminated the 13th and 19th threshold requirement and requires a reassessment every 30 days for each therapy discipline
    - The 30 day clock starts the day after your assessment
    - Episodes beginning on or after 1/1/15

Therapy Assistants

Table 36—Percentage of Visits Provided by a Physical Therapy and Occupational Therapy Assistants, CY 2011 Through 2013 Back to Top

Year	Percentage of PT visits provided by a PTA	Percentage of OT visits provided by an OTA
2011	23.8	14.4
2012	28.5	15.4
2013	29.2	15.4

Source: Analysis of CY 2011 through CY 2013 claims data from the Standard Analytic File (SAF).

- Continue to see a shift to cheaper cost options for providing therapy visits
- No change in therapy reimbursement if you use a therapist or an assistant
- Since 2012, use of assistants impacts overall industry case mix weights as CMS calculates an episode's resource use

Quality

Quality – Pay For Reporting

- Requirement since 2007 but no quantity of OASIS assessments each HHA must submit to meet this requirement was never established
  - Episodes on or before 7/1/15 to 6/30/16 must have 70% Quality Assessment Only (QAO) metric or will be penalized 2% of payments
  - Year 2 was originally proposed at 80% and year 3 at 90% but these are currently on hold to see how year 1 goes
    - Year 2 threshold may be increased to 90%

Insulin Injections

- CMS looking at patients inability to self inject compared to previously submitted claims data
  - These were a high percentage of the outlier payments which were typically over $10,000
  - CMS sampled patients and 12% of sample had an insulin pen which would suggest the ability to self inject
  - 16% of patients that would be an outlier had a dx of "Diabetes Mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled"
  - Many accounts had one dx with no secondary dx to support why patient can not self administer
- No policy changes at this time but CMS asked for comments on their rationale about the pen and the dx code that indicate a potential inability to self inject insulin

General Impact

General Impact*

- Table 41 in the Final Rule shows the estimated home health agency impacts by facility type and area of the country for CY2015
- New England shows a 1.6% increase in rates while all agencies show a -0.3 decrease
  - Note- each agency's impact is unique base on patients served, visits utilization patterns ,and coding techniques
- Link to the Final Rule
  - https://www.federalregister.gov/articles/2014/11/06/2014-26057/medicare-and-medicaid-programs-cy-2015-home-health-prospective-payment-system-rate-update-home#t-39

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