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Home Health Providers Face Additional Cuts and Scrutiny for Therapy Services, but Gain Some Flexibility in Face-to-Face Encounter Requirements

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In a final rule published in the *Federal Register* on November 4, 2011,[1] the Centers for Medicare & Medicaid Services ("CMS") announced it will decrease payments to home health agencies ("HHAs") by $430 million in 2012. The home health prospective payment system ("HH PPS") final rule also revises case-mix weights in response to concerns that HHAs are overcompensated for therapy services and incentivized to provide unnecessary therapy services, and adds flexibility to the face-to-face encounter requirement for patients discharged to home health from hospitals or post-acute facilities.

Payment Reductions

The calendar year ("CY") 2012 HH PPS update set forth in the final rule will result in an overall decrease of $430 million in payments to HHAs, a 2.31 percent decrease from CY 2011 payments. The payment reductions are the combined result of an updated wage index ($10 million increase), a 1.4 percent market basket payment update ($280 million increase), and a 3.79 percent case-mix adjustment to the national standardized 60-day episode rates ($720 million decrease).

Market Basket Update

Section 3401(e) of the Affordable Care Act ("ACA")[2] mandates a one percentage point reduction in the market basket increase for CY 2011 and CY 2012. The final rule adopts a 2.4 percent market basket update for CY 2012, a minute change from the 2.5 percent update announced in the proposed rule due to a revised forecast based upon more recent historical data. As adjusted by the ACA reduction, the final HH PPS market

[1] Centers for Medicare & Medicaid Services, *Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012, Final Rule*, 76 FED. REG. 68526 - 68607 (Nov. 4, 2011).

[2] Patient Protection and Affordable Care Act (Pub. L 11-148), *as amended by* the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) [hereinafter "ACA"].

basket increase to be applied to the CY 2012 standard prospective payment rates is 1.4 percent.

Case-Mix Adjustment

In the CY 2011 HH PPS rulemaking, CMS identified a 17.45 percent "nominal" increase in case-mix (growth in aggregate case-mix unrelated to changes in patient acuity) from 2000 to 2008. In order to fully account for this nominal case-mix growth, CMS proposed 3.79 payment reductions in both CY 2011 and CY 2012, but ultimately deferred finalizing the payment reduction for CY 2012, pending further study of the case-mix data.

In the interim, CMS had an independent review of its methodology for identifying real case-mix growth performed that, as the final rule notes, found that overall CMS's models are robust. CMS also re-analyzed real and nominal case-mix growth from 2000 to 2009, incorporating variables derived from Hierarchical Conditions Categories ("HCC") data. CMS determined that its latest analysis continues to support the need to make payment adjustments to account for nominal case-mix growth. Furthermore, in its updated analysis, CMS identified a nominal case-mix increase of 19.03 percent from 2000 to 2009 and determined that an additional payment reduction of 5.06 percent to the national standardized 60-day episode rates is needed to account for the outstanding amount of nominal case-mix change from 2000 through 2009.

CMS initially proposed to implement the entire 5.06 percent reduction in CY 2012, but, in the final rule, decided upon a phased-in implantation, imposing the 5.06 percent reduction across two years. CMS believes that, as a result of the CY 2011 rulemaking, providers expected and planned for CMS to impose a 3.79 percent payment reduction in CY 2012, and therefore, in the final rule, CMS finalized a 3.79 percent reduction for CY 2012 and a 1.32 percent reduction for CY 2013. CMS stated that the 2012 and 2013 payment reductions will enable it to account for the nominal case-mix identified through CY 2009, to follow through with the planned 3.79 percent payment reduction for CY 2012, and to allow for HHAs to adopt process efficiencies associated with the CY 2011 legislative and regulatory requirements during CY 2012.

Revisions to Case-Mix Weights to Address Therapy Services Concerns

CMS is revising the case-mix weights for CY 2012 not only as a result of removing two hypertension codes from the case-mix system, but also to address incentives to provide unnecessary therapy services resulting from the 2008 revisions to the HH PPS.

CMS gave significant attention in its 2012 rulemaking to the 2010 and 2011 MedPAC Reports to Congress and concurred with MedPAC's findings that:

(1) The amount of therapy utilization changed significantly in response to the 2008 HH PPS revisions, and the sudden shift in 2008 to episodes with therapy services at new therapy thresholds suggests inappropriate therapy utilization. Moreover, MedPAC reported in 2011 that the volume data for 2009 indicates that the shifts that occurred in 2008 are continuing, with more than a 20-percent

increase in episodes with 14 or more therapy visits and a 30-percent increase in episodes with 20 or more therapy visits.[3]

(2) HHAs with high margins had high case-mix values that were attributable to the agencies providing more therapy episodes. MedPAC found this correlation between high agency margins and high volumes of therapy episodes to strongly suggest that the costs that the HH PPS assigns to therapy services when deriving the relative payment weights are too high in comparison to actual costs incurred by agencies for therapy services. Thus, the current HH PPS likely overpays for episodes with high case-mix values and underpays for episodes with low case-mix values.

CMS also noted that the growing use of therapy assistants (instead of qualified therapists) has contributed to the overpayment for therapy services because 2005 data was used for the percentage of therapy assistants that is reflected in the therapy-wage weighted minutes used in the calculations of HH PPS relative resources costs, and the percentage of physical and occupational therapy provided by therapy assistants increased 5 percent between 2005 and 2009.

Therefore, for CY 2012, CMS will revise the case-mix weights by lowering the relative weights for episodes with high therapy and by increasing the weights for episodes with little or no therapy. In the final rule, CMS noted that it had conducted further analysis after publication of the CY 2012 HH PPS proposed rule, and, as a result, refined the final rule revisions to the case-mix weights. CMS also noted that, because it is required to revise the case-mix weights in a budget neutral manner, HH PPS dollars will be redistributed from high therapy payment groups to other HH PPS case-mix groups, such as groups with little or no therapy.

CMS believes that the revisions to the payment weights will result in more accurate HH PPS payments for targeted case-mix groups while addressing MedPAC's concerns that the current case-mix system creates significant incentives to favor therapy patients, avoid high-cost nontherapy patients, and base the number of therapy visits on payment incentives instead of patient characteristics. CMS acknowledged that the CY 2012 changes to case-mix weights are an interim fix while it undertakes a more comprehensive analysis to fully address MedPAC's concerns with the way the HH PPS factors therapy visits into the case-mix system. As such, providers should expect to see further structural changes to the HH PPS.

Face-to-Face Encounters

ACA amended the requirements for physician certification of home health services to require that, as a condition of payment, prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that the physician himself or herself, or an allowed nonphysician practitioner ("NPP") working with the physician,

[3] The threshold system adopted under the 2008 revisions sets therapy thresholds at 6, 14, and 20 visits.

has had a face-to-face encounter with the patient.[4] HHAs have been required to comply with the face-to-face encounter requirements since April 1, 2011.

Importantly, CMS addressed what it called an "unintentional gap" in ACA by not explicitly including language that allows the acute or post-acute attending physician to inform the certifying physician regarding his or her face-to-face encounters with the patient to satisfy the requirement. CMS stated that ACA does not preclude a patient's acute or post-acute physician from informing the certifying physician regarding his or her experience with the patient for the purpose of the face-to-face encounter requirement, much like a NPP currently can.

The final rule revises applicable regulations[5] to incorporate CMS's position: effective with starts of care beginning January 1, 2012, and later, for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in the acute or post-acute facility may perform the face-to-face encounter and communicate the clinical findings of that encounter to the certifying physician. CMS commented that the HHA may facilitate communications between the physicians, including sending the discharge plan to the certifying physician. The patient's discharge summary or discharge plan can serve as the face-to-face documentation if it includes the signature of the certifying physician and the required content.

What the CY 2012 HH PPS Signals for Home Health Providers and Stakeholders

The perception that HHAs are overcompensated under the HH PPS has resulted in increased scrutiny by CMS and others, such that the payment reductions of recent years may be only the start of more widespread changes to home health reimbursement levels and methodology.

Under the recently enacted Budget Control Act ("BCA"), federal spending will be reduced over 10 years while the debt ceiling is raised. The BCA establishes a two-step process to extend the debt limit. The first phase of the new law reduces discretionary spending by almost $1 trillion and establishes 10-year caps on non-security spending. The second phase establishes a 12-member bipartisan, bicameral Joint Select Committee on Deficit Reduction (the so-called "Super Committee") charged with identifying up to $1.5 trillion more in deficit reduction. If legislation that achieves at least $1.2 trillion in deficit reduction is not enacted by January 15, 2012, automatic across-the-board budget cuts of 2 percent (known as "sequestration") will be applied to all but a few exempt programs.

The Super Committee has authority to issue subpoenas and to hold hearings and public meetings, and may consider all proposals regarding deficit reduction, including, defense and non-defense discretionary spending, tax revenue, and cuts to entitlement programs. A simple majority vote within the Super Committee is required for approval of a deficit reduction proposal. There is a general consensus that if the Super Committee is to reach its deficit reduction goal, reductions in federal health care spending will be part of

[4] ACA § 6407(a).
[5] 42 C.F.R. § 424.22(a)(1)(v).

the package. Cuts to home health services are likely to be part of the Super Committee's deliberations. Among the proposals to cut home health services that may be considered by the Super Committee are the following:

- **President's Plan for Economic Growth and Deficit Reduction—September 2011:** A proposal to create a home health copayment of $100 per home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay. This would apply to new beneficiaries beginning in 2017. This proposal is expected to save $400 million over 10 years.

- **Medicare Payment Commission Report to Congress—March 2011:** Several proposals regarding home health services, including: (1) eliminating the market basket update for 2012; (2) directing the Department of Health and Human Services ("HHS") to implement a two-year rebasing of home health rates beginning in 2013; (3) directing HHS to establish a per episode co-pay for home health episodes not preceded by hospitalization or post-acute care use; and (4) revising the home health case-mix system to rely on patient characteristics and not the number of therapy visits as a payment factor.

- **The National Commission on Fiscal Responsibility and Reform's Report—December 2010:** A proposal to accelerate changes regarding reimbursements for home health providers included in ACA to incorporate a productivity adjustment beginning in 2013 and directing HHS to phase in rebasing the HH PPS by 2015, as opposed to 2017.

In addition, in September 2011, the Senate Finance Committee ("Committee") released a report[6] examining provider treatment patterns following the 2008 changes to the HH PPS therapy thresholds. The Committee noted that "[u]nder the home health PPS, providers have broad discretion over the number of therapy visits to provide patients and therefore have control of the single-largest variable in determining reimbursement and overall changes,"[7] and then called for CMS to move toward taking therapy out of the home health payment model. The Committee referenced MedPAC's work with the Urban Institute to develop an alternative payment model that does not rely on therapy utilization to determine reimbursement levels, and urged CMS to closely examine any approach that focuses on patient well-being and health characteristics rather than numerical utilization measure. Reflecting on the steps taken by CMS over the last two years to address the overutilization of home therapy services, the Committee was encouraged and believes that CMS is "moving in the right direction."

Home health providers and stakeholders in the home health industry should brace for additional changes to the HH PPS. In the short term, providers and stakeholders should carefully monitor the work of the Super Committee in order to best plan for any additional payment reductions. It is also important to keep an eye on initiatives

[6] STAFF OF SEN. COMM. ON FINANCE, 112TH CONG., REP. ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD, S. Prt. 112-24 (Comm. Print 2011).
[7] *Id*. at 28.

stemming from ACA to develop alternative payment models, particularly models developed under the Center for Medicare and Medicaid Innovation.

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