



WISCONSIN HOSPITAL
ASSOCIATION

**SUMMARY OF THE CY 2007
MEDICARE HOME HEALTH
PROSPECTIVE PAYMENT SYSTEM
FINAL RULE**

November 2006

TABLE OF CONTENTS

I.	Overview	1
II.	Provisions of the DRA	1
	- Submission of Quality Data to Receive the Full Marketbasket Update	1
	- Rural Add-on	2
	- Payment for Oxygen Equipment, Oxygen Contents, and Capped Rental DME	2
III.	Standard Rates	3
	- Marketbasket Update for CY 2007	3
	- National 60-day Episode Rate.....	3
	- National Per-Visit Amounts.....	3
IV.	Rate Adjustments	4
	- Patient Classification System.....	4
	- Wage Index–Labor-Market Areas.....	4
	- Wage Index–Wage Data	5
	- Wage Index–CBSAs with No Hospitals	5
	- Outliers	5
V.	Other	5
	- Health Care Information Transparency and Health Information Technology	5

I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the final rule for the Medicare Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2007 in the November 9 *Federal Register*. The final rule includes provisions to implement changes contained in the Deficit Reduction Act of 2005 (DRA). These provisions include the requirement for home health agencies (HHAs) to submit quality data to receive a full marketbasket update, the continuation of a 5% add-on for services provided in rural areas, and a revision of the payment methodology for oxygen equipment, oxygen contents, and capped rental durable medical equipment (DME).

II. PROVISIONS OF THE DRA

Submission of Quality Data to Receive the Full Marketbasket Update

(*Federal Register* pages 65888 - 65891)

Section 5201(c) of the DRA requires HHAs to submit quality data to receive a full Medicare marketbasket update for CY 2007 and thereafter. HHAs that do not submit quality data will be subject to a 2.0% reduction to the marketbasket update, and will therefore receive an update of 1.3%.

Current law requires the use of a standardized assessment instrument for quality oversight of HHAs. HHAs meet this requirement by collecting and reporting Outcome and Assessment Information Set (OASIS) data. The OASIS data provide consumers and HHAs with ten publicly reported home health quality measures. The National Quality Forum (NQF) has endorsed these measures. The ten measures are:

Improvement in ambulation/locomotion	Acute care hospitalization
Improvement in bathing	Emergent care
Improvement in transferring	Improvement in dyspnea
Improvement in management of oral medications	Improvement in urinary incontinence
Improvement in pain interfering with activity	Discharge to community

CMS will require that agencies submit data for the ten OASIS quality measures to receive a full update in CY 2007. CMS will review the OASIS data submitted by HHAs for episodes beginning on or after July 1, 2005 and before July 1, 2006 to determine compliance with the reporting requirement. This will provide CMS with a full 12 months of data and will allow CMS the time necessary to analyze and make any necessary payment adjustments to the CY 2007 payment rates.

HHAs are required as a Medicare condition of participation to submit OASIS data. However, under the conditions of participation clause, HHAs are excluded from the OASIS reporting requirement for individual patients if:

- those patients are receiving only non-skilled services;
- neither Medicare nor Medicaid is paying for home health care (patients receiving care under a Medicare or Medicaid managed care plan are not excluded from the OASIS reporting requirement);
- those patients are receiving pre- or post-partum services; or
- those patients are under 18 years old.

For purposes of receiving the full update, HHAs will not be required to submit quality measures for those patients who are excluded from OASIS submission as a condition of participation.

In addition, CMS will exclude newly certified HHAs (certified on or after May 31, 2006 for payments to be made in CY 2007), from the DRA reporting requirement because data submission and analysis will not be possible. For future years, HHAs that are certified on or after May 31 of the preceding year will be excluded from any payment penalty under the DRA for the following calendar year.

The DRA further requires that quality data submitted by HHAs be available to the public and available to HHAs for review prior to publication. To meet this requirement, CMS will continue to use the CMS Home Health Compare Web site at <http://www.medicare.gov/HHCompare/Home.asp>, which currently posts the ten OASIS quality measures for all Medicare-approved HHAs.

CMS notes that in the coming years it will pursue the development and refinement of patient level process measures and the OASIS tool to more accurately reflect the level of quality care being provided by HHAs.

Rural Add-On

(Federal Register pages 65887 - 65888)

Section 5201(b) of the DRA provides for a 5% add-on for episodes or visits performed in rural areas, effective January 1 through December 31, 2006. However, CMS is allowing this 5% rural add-on to continue for episodes that begin prior to January 1, 2007 but end in CY 2007. As a result, the 5% rural add-on for episodes beginning in CY 2006 but ending in CY 2007 will be based on CY 2007 rates.

Payment for Oxygen Equipment, Oxygen Contents, and Capped Rental DME

(Federal Register pages 65893 - 65901)

Sections 5101(a) and 5101(b) of the DRA legislate policy changes regarding beneficiary ownership of certain DME. These changes mainly affect suppliers of certain DME and beneficiaries. Below is a listing of the topic areas addressed in the final rule relating to beneficiary ownership of certain DME. A complete discussion of these payment revisions can be found on the *Federal Register* pages referenced in the heading above.

- payment for oxygen, oxygen equipment, and capped rental DME items;
- payment for oxygen contents for beneficiary-owned oxygen equipment;
- classes of oxygen and oxygen equipment;
- payment for maintenance and servicing of oxygen and oxygen equipment and capped rental items;
- payment for replacement of beneficiary-owned oxygen equipment, capped rental items, and associated supplies and accessories; and
- adjustment to the definition of periods of continuous use.

III. STANDARD RATES

Marketbasket Update for CY 2007

(Federal Register pages 65902 - 65903)

The home health update is based on a marketbasket factor that is intended to reflect changes over time in the prices of an appropriate mix of goods and services included in covered home health services. Due to the use of more recent data, CMS has revised the marketbasket update in the final rule from 3.1% as proposed to 3.3% in CY 2007. This represents the full marketbasket increase and will be effective January 1, 2007. However, this marketbasket update applies to HHAs that submit quality data in accordance with the rules discussed in the “Submission of Quality Data to Receive the Full Marketbasket Update” section above. HHAs that fail to meet this requirement will have their marketbasket update reduced by 2.0% and receive an update of 1.3%.

National 60-day Episode Rate

(Federal Register pages 65886 - 65887)

In CY 2007, home health providers will receive a 60-day episode rate based on the CY 2006 rate of \$2,264.28 updated by the CY 2007 marketbasket update of 3.3% for a final CY 2007 60-day episode rate of \$2,339.00.

CY 2006 60-Day Episode Rate	Final CY 2007 60-Day Episode Rate
\$2,264.28	\$2,339.00

National Per-Visit Amounts

(Federal Register page 65887)

For episodes with four or fewer visits, HHAs will receive a low utilization payment adjustment (LUPA). Under these circumstances, the HHA is paid a wage-adjusted national average payment per visit according to the type of visit provided.

Based on final CY 2007 marketbasket update, the final CY 2007 standard per-visit amounts by discipline are as follows:

Home Health Discipline Type	CY 2006 Per-Visit Payment Amount	Final CY 2007 Per-Visit Payment Amount
Home Health Aide	\$44.76	\$46.24
Medical Social Services	\$158.45	\$163.68
Occupational Therapy	\$108.81	\$112.40
Physical Therapy	\$108.08	\$111.65
Skilled Nursing	\$98.85	\$102.11
Speech-Language Pathology	\$117.44	\$121.32

Please note that the discipline per-visit amounts listed above are used not only for LUPA adjustments, but also to compute costs for outlier payment calculations.

IV. RATE ADJUSTMENTS

Patient Classification System

The payment for a given episode of care is determined by assignment to a Home Health Resource Group (HHRG) based on similar levels of resource use in three areas: clinical severity, functional status, and service utilization. The assignment of cases to each of the different levels is determined primarily by the answers to OASIS items. There are four levels of clinical severity, five levels of functional status, and four levels of service utilization combining to form 80 HHRGs. Each episode is assigned a case-mix weight that is then used to adjust the payment amount.

CMS will not recalibrate the HHRG weights for CY 2007.

Wage Index—Labor-Market Areas

(Federal Register pages 65892 - 65893)

CMS is required to adjust home health episode payment amounts to account for area wage differences. CMS determines the HH PPS labor market areas based on definitions used in the Inpatient PPS.

In federal fiscal year 2005, CMS implemented revised wage areas based on Core-based Statistical Areas (CBSAs) defined using data from the 2000 U.S. Census for the Inpatient PPS. These definitions replaced the Metropolitan Statistical Areas (MSAs). In CY 2006, these revised wage areas were adopted for the HH PPS. Because of the redistributive impact of this change, CMS provided a one-year transition from the old MSA wage index to the revised CBSA wage index areas. A blended wage index was calculated combining 50% of the wage index based on the new definitions and 50% based on the old definitions.

For CY 2007, CMS will implement 100% of the HHA wage index on the new CBSA labor market designations.

Wage Index—Wage Data

(Federal Register pages 65892 - 65893)

In the final rule, CMS will continue to use the most recent hospital wage index data available, and will adjust the HH PPS episode rate by the 2007 pre-reclassified, pre-rural floor inpatient hospital wage index. In addition, in CY 2007, CMS will continue to apply the labor-related share amount of 76.775% to the portion of the case-mix adjusted national episode rate that is to be adjusted by the wage index.

Wage Index—CBSAs with No Hospitals

(Federal Register pages 65892 - 65893)

In adopting the CBSA designations in CY 2006, CMS identified geographic areas where there were no hospitals, and thus no hospital wage data on which to base the calculation of the home health wage index. For CY 2007, CMS is changing the way it imputes a wage index for these special situations involving rural areas, but will keep its methodology the same as the current methodology for urban areas. The only urban area affected is Hinesville, Georgia.

For rural areas, CMS will use the average wage index from all CBSAs that are contiguous to that rural area if the rural area does not have rural hospital wage data. CMS defines contiguous as sharing a border. For CY 2007, this will only affect rural Massachusetts, resulting in an imputed rural wage index of 1.1661.

Outliers

(Federal Register pages 65891 - 65892)

Due to the procurement of more recent data since the issuance of the proposed rule, specifically CY 2005 HHA claims data; CMS has revised the fixed-dollar loss (FDL) ratio to 0.67 for CY 2007 from the proposed ratio of 0.65 in calculating an HHA's outlier payment adjustment.

Outlier payment adjustments provide additional payment for extremely high-cost cases. Currently, if the HHA's cost for an episode (as measured by the number of visits multiplied by the wage index-adjusted standard per-visit payment amount) exceeds the fixed-loss threshold (case-mix and wage-adjusted payment for the episode plus the 0.67 FDL times the standard payment amount), the agency receives an outlier payment of 80% of the amount over the fixed-loss threshold. By law, CMS must project outlier payments to be no more than 5% of total home health payments.

V. OTHER**Health Care Information Transparency and Health Information Technology**

(Federal Register pages 65901 - 65902)

The final rule addresses transparency initiatives and the use of health information technology as a means to help improve health care quality and efficiency. This topic was thoroughly addressed in the April 25, 2006 Inpatient PPS proposed rule.