



WISCONSIN HOSPITAL
ASSOCIATION, INC.

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

August 2006

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Home Health Prospective Payment System (HH PPS) for calendar year (CY) 2007. Additional information regarding the Home Health PPS is available on the Centers for Medicare and Medicaid Services (CMS) Web site at <http://www.cms.hhs.gov/center/hha.asp>.

CMS must receive comments on the proposal by 5 p.m. on September 25. CMS requests that comments reference the file code CMS-1304-P.

Comments on the proposed rule can be:

Submitted electronically at:

<http://www.cms.hhs.gov/eRulemaking>.

Click on the "Submit electronic comments on CMS regulations with an open comment period" link.

(Attachments should be in Microsoft Word, WordPerfect, or Excel format.)

-OR-

Regular Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1304-P
P.O. Box 8014
Baltimore, MD 21244-8014

Express/Overnight Mail (an original and two copies):
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1304-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

-OR-

Hand-delivered to (an original and two copies):
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

OR 7500 Security Boulevard
Baltimore, MD 21244 -1850

I. OVERVIEW

CMS published the proposed HH PPS rule for CY 2007 in the August 3 *Federal Register*. The proposal 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).

- Note: text in italics is extracted from the *Federal Register*.

II. PROVISIONS OF THE DRA

Submission of Quality Data to Receive a Full Marketbasket Update (*Federal Register* page 44087 – 44090)

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% payment reduction.

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. These measures have been endorsed by the National Quality Forum (NQF). 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

For CY 2007, CMS is proposing to consider submission of the ten OASIS quality measures as meeting the quality data submission requirement of the DRA. CMS will review the OASIS data submitted by HHAs for episodes beginning on or after July 1, 2005 and before July 1, 2006 (CY 2005) as meeting 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, submission of these data is not mandatory for patients who are not Medicare beneficiaries or are not receiving Medicare-covered home health services. Therefore, the proposed rule does not require HHAs to submit quality measures for those patients who are excluded from OASIS submission as a condition of participation. Under the conditions of participation, 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.

CMS is proposing to 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, CMS is proposing that HHAs certified on or after May 31 of the preceding year 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 is proposing to continue to use the CMS Home Health Compare Web site at <http://www.medicare.gov/HHCompare/Home.asp>. This Web site 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. CMS is seeking comments on measures of home health care processes for which there is evidence of improved care to beneficiaries.

Rural Add-On

(Federal Register pages 44086 – 44087)

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. CMS is allowing this add-on for episodes beginning in CY 2006 even if they end after December 31, 2006. Episodes that begin prior to December 31, 2006 but end in CY 2007 will receive a 5% add-on to the CY 2007 rates.

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

(Federal Register pages 44092 - 44100)

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 proposed rule relating to beneficiary ownership of certain DME. A complete discussion of these payment revisions can be found in 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 page 44085 – 44086)

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. CMS is estimating that the CY 2007 update will be 3.1% for HHAs that submit quality data in accordance with the rules discussed in the “Submission of Quality Data to Receive a Full Marketbasket Update” section above.

National 60-day Episode Rate

(Federal Register page 44085)

In determining the CY 2007 standard prospective payment amount, CMS’ starting point was the published rate in Transmittal 211, issued February 10, 2006. The CY 2006 national 60-day episode rate, as modified by section 5201(a)(4) of the DRA is \$2,264.28. CMS is proposing to update this rate to CY 2007 by the applicable marketbasket percentage (3.1%). Therefore, the proposed national 60-day episode rate effective January 1, 2007 is \$2,334.47.

CY 2006 60-Day Episode Rate	Proposed CY 2007 60-Day Episode Rate
\$2,264.28	\$2,334.47

National Per-Visit Amounts

(Federal Register page 44085)

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

The proposed CY 2007 standard per-visit amounts by discipline are as follows:

Home Health Discipline Type	CY 2006 Per-Visit Payment Amount	Proposed CY 2007 Per-Visit Payment Amount
Home Health Aide	\$44.76	\$46.15
Medical Social Services	\$158.45	\$163.36
Occupational Therapy	\$108.81	\$112.18
Physical Therapy	\$108.08	\$111.43
Skilled Nursing	\$98.85	\$101.91
Speech-Language Pathology	\$117.44	\$121.08

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

(Federal Register page not available)

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 has not proposed to recalibrate the HHRG weights for CY 2007.

Wage Index—Labor-Market Areas

(Federal Register pages 44091 - 44092)

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 FFY 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, 100% of the HHA wage index will be based upon the CBSA configurations.

Wage Index—Wage Data

(Federal Register pages 44091 – 44092)

Currently, the HH PPS uses the most recent pre-floor and pre-reclassified hospital wage index data to adjust the labor portion of the rates based on the geographic area in which the beneficiary receives the home health services.

CMS is proposing to 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. The portion of the case-mix adjusted national episode rate to be adjusted by the wage index, the labor-related share, is proposed at 76.775% (no change from the CY 2006 labor-related share).

Wage Index—CBSAs with No Hospitals and Therefore No Data to Calculate a Home Health Wage Index

(Federal Register pages 44091 – 44092)

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 2006, CMS adopted a policy for both rural and urban areas where this occurred. For rural areas, CMS used the CY 2005 pre-floor, pre-reclassified hospital wage index value when no rural hospital wage data are available. For urban areas, all of the urban CBSAs within the state were used to calculate a statewide urban average wage index. For CY 2006, these policies applied to:

- Rural Massachusetts;
- Rural Puerto Rico; and
- Hinesville, Georgia.

CMS is proposing to apply this same policy for CY 2007 for urban areas. However, CMS is considering an alternative methodology for deriving a rural wage index. Under this alternative, CMS would impute a rural wage index value by using a simple average CBSA-based rural wage index value at the Census Division level. Census Divisions are defined by the U.S. Census Bureau and are available at http://www.census.gov/geo/www/us_regdiv.pdf.

Using this methodology, the proposed wage index for rural Massachusetts would increase from 1.0216 to 1.0227. CMS believes that this is a reasonable proxy as it uses current rural wage index values from states within the same Census Divisions, with similar economics. This alternative methodology would not be applied to rural Puerto Rico. CMS is requesting comments on this alternative methodology.

Cost Outliers

(Federal Register pages 44090 – 44091)

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 0.65 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.

CMS has not proposed changes to outlier policy for CY 2007. CMS stated that it would update the policy if necessary, depending on the availability of more recent data at the time of final rule's publication.

Other Rate Adjustments

(Federal Register page not available)

Medicare also proposes adjusting the 60-day episode payment for certain intervening events that give rise to a partial episode payment PEP adjustment or a significant change in condition SCIC adjustment.

CMS has not proposed changes to these payment rules for CY 2007. A complete description of these payment rules is available in the July 3, 2000 HH PPS final rule *Federal Register*, available at http://frwebgate.access.gpo.gov/hh_final_rule_7-3-00.

V. OTHER

Health Care Information Transparency and Health Information Technology

(Federal Register pages 44100 – 44101)

The proposed rule also addresses transparency initiatives and the use of health information technology (HIT) 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.