# SUMMARY OF THE CY 2008 MEDICARE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM FINAL RULE

**September 2007**

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# I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) has adopted changes to the Home Health (HH) Prospective Payment System (PPS) which provide the first major refinement to the system since its implementation in October 2000.

The adopted changes include refinements to the HH case-mix classification system that increase the number of case-mix groups from 80 in calendar year (CY) 2007 to 153 in CY 2008, applies reductions of 2.75% for the first 3 years beginning in 2008 and 2.71% in 2011 to the National Standardized 60-Day episode payment rate to address what CMS is considering coding changes, and changes to the current case-level payment adjustments.

CMS published the final Medicare HH PPS rule for CY 2008 in the August 29, 2007 *Federal Register*. Changes are effective January 1, 2008 unless otherwise noted.

**Please note that text in italics is extracted from either the May 4, 2007 or August 29, 2007*Federal Register.***

# II. HH PAYMENT RATES

## Marketbasket Update for CY 2008

*Federal Register* pages 49857 - 49858

**Background**: 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 Proposal**: *". . . we are proposing to first increase the CY 2007 national standardized 60-day episode payment rate ($2,339.00) by the proposed estimated rebased and revised home health market basket update of 2.9 percent for CY 2008." "The estimated home health market basket update of 2.9 percent for CY 2008 is based on Global Insight, Inc, 4th Qtr, 2006 forecast with historical data through 3rd Qtr, 2006."*

**CMS Final Rule:** *"The final HH market basket update for CY 2008 is 3.0 percent, which is based on Global Insight Inc.'s (GII) 2007 2nd quarter forecast, the most current forecast available at the time of publication of the final rule."*

The CY 2008 full marketbasket update of 3.0% applies to Home Health Agencies (HHAs) that submit quality data in accordance with the rules discussed in the "**Submission of Quality Data to Receive the Full Marketbasket Update**" section below. HHAs that fail to meet this requirement will have their marketbasket update reduced by 2.0 percentage points, resulting in a marketbasket update of 1.0%.

However, the Children's Health and Medicare Protection (CHAMP) Act of 2007, which has been passed by the U.S House of Representatives, would eliminate the HH marketbasket update in CY 2008. It is uncertain whether this proposal will be included in any final legislative package that passes both chambers and is signed by the President.

In addition, CMS in the final rule adopted their proposal to rebase and revise the HH marketbasket using FFY 2003 Medicare cost report data, the latest and most complete data available for HHA costs. The HH marketbasket was last rebased in the CY 2005 update, using Federal Fiscal Year (FFY) 2000 data. Furthermore, CMS made modifications to the wages, salaries, and benefits cost categories in order to reflect a new data source on the occupational mix of HHAs. CMS did not make any changes to the price proxies used in the HH marketbasket or the HH blended wage and benefit proxies. Based on the rebasing and revision of the HH

marketbasket, CMS will increase the labor-related share from 76.775% in CY 2007 to 77.082% on CY 2008.

## Behavioral Offset

*Federal Register* pages 49832 – 49844

**Background**: A provision in the Benefits Improvement and Protection Act (BIPA) of 2000 provides CMS the authority to adjust HH payment rates in order to eliminate the effect of changes due to coding improvements or classification of discharges that do not reflect real changes in case-mix.

Using HH data samples from two time periods (pre-and post-HH PPS implementation), CMS conducted an analysis to distinguish between case-mix increases attributable to real changes in clinical condition versus increases driven by payment incentives. Based on the analysis, CMS determined that 8.7% of the case-mix change that occurred was due to coding practice changes based on financial incentives, not "real" change in case-mix.

**CMS Proposal**: *"We propose to implement a 3-year phase-in of the total downward adjustment for nominal changes in case-mix by reducing the national standardized 60-day episode payment rate by 2.75 percent each year up to and including CY 2010."*

**CMS Final Rule:** *"Since publication of the proposed rule, we updated our analysis to use 100 percent of the HH IPS file for our baseline and a 20-percent sample of 2005 claims data"*. Therefore, for CY 2008, ". . . *we are finalizing the proposed 2.75 percent reduction of the national standardized 60-day episode payment rate for 3 years beginning in 2008 and extending that adjustment period to a fourth year via a 2.71 percent reduction for 2011"*.

CMS did not include the fourth year adjustment of 2.71 in their proposed rule. **Therefore, CMS will accept comments on the 2.71 percent case-mix change adjustment for 2011 no later than 5 p.m. on October 29, 2007.**

A complete discussion of this topic area, including the methods and the data used to develop the HH behavioral offset, is available in the *Federal Register* pages referenced in the heading above.

## National Standardized 60-Day Episode Payment Rate

*Federal Register* pages 49864 - 49873

**CMS Final Rule:** Beginning January 1, 2008**,** episodes that both begin and end in CY 2008 will receive a national 60-day episode payment rate of $2,270.32. These episodes will use the CY 2008 case-mix based on the new 153 HHRG case-mix system.

The national 60-day episode payment rate for CY 2008 will be 2.9% lower than the CY 2007 rate of $2,339.00. The reduction is due to following: the 2.75% behavioral offset reduction; a change to how the outlier policy affects the calculation of the rate; the downward adjustments to maintain budget neutrality for the proposed policy changes to payment for Non-Routine Medical Supplies (NRS) and the Low-Utilization Payment Adjustment (LUPA), and the removal of the Significant Change in Condition (SCIC) Adjustment.

Below is a calculation of the CY 2008 National 60-Day Episode Payment Rate:

| **CY 2007 National Standardized 60-Day Episode Payment Rate** | **$2,339.00** |
|---|---|
| Outlier Funds (return CY 2008 outlier target to base rate) | 5.0% |
| Marketbasket Update | 3.0% |
| **CY 2008 Rate Before Outlier Carve-Out & Budget Neutrality Adjustments** | **$2,529.63** |
| Behavioral Offset | ($69.56) |
| Outlier Carve-Out | ($127.22) |
| NRS Budget Neutrality | ($45.87) |
| SCIC Elimination | ($10.96) |
| LUPA Budget Neutrality | ($5.70) |
| **Total Adjustments for Outliers and Budget Neutrality** | ($259.31) |
| **CY 2008 National Standardized 60-Day Episode Payment Rate** | **$2,270.32** |

For episodes that begin in CY 2007 and end in CY 2008, the national 60-day episode payment rate is $2,337.06. This rate includes the CY 2008 update, a reduction for a change in case-mix **(see "Behavioral Offset" section above)**, and an adjustment for the outlier policy. The case-mix for these episodes will be based on the CY 2007, 80 HHRG case-mix system.

The amounts shown above (for episodes that occur entirely in CY 2008 and episodes that overlap CYs 2007 and 2008) represent a HHAs full compliance with the 2008 quality-reporting program. HHAs that do not submit quality data will receive a 2.0 percentage point reduction to the national 60-day episode payment rate. For a completed discussion of the quality-reporting program, see the **"Submission of Quality Data to Receive a Full Marketbasket Update"** section below.

A detailed sample calculation for a HH episode that occurs entirely within CY 2008 is available on *Federal Register* pages 49866 - 49871.

## National Per-Visit Amounts

*Federal Register* page 49868

**Background**: National per-visit amounts are used for the low-utilization payment adjustment **(see the "Low-Utilization Payment Adjustment (LUPA)" section below)** and to compute imputed costs used in outlier calculations.

**CMS Proposal**: *"We propose to increase the CY 2007 per-visit amounts for each home health discipline for CY 2008 by the proposed estimated rebased and revised home health market basket update (2.9 percent), then multiply by 1.05 and 0.958614805 to account for the estimated percentage of outlier payments as a result of the current FDL ratio of 0.67"*

**CMS Final Rule**: *"In calculating the CY 2008 national per-visit amount. . . we increase the CY 2007 per-visit amounts for each home health discipline for CY 2008 by the rebased and revised home health market basket update (3.0 percent), then multiply by 1.05 and 0.95 to account for the estimated percentage of outlier payments."*

The national per-visit amounts are not subject to the 2.75% behavioral offset reduction. The amounts by

discipline are as follows:

| Per-Visit Payment Amounts: | CY 2007 | CY 2008 |
|---|---|---|
| Home Health Aide | $46.24 | $47.51 |
| Medical Social Services | $163.68 | $168.17 |
| Occupational Therapy | $112.40 | $115.48 |
| Physical Therapy | $111.65 | $114.71 |
| Skilled Nursing | $102.11 | $104.91 |
| Speech-Language Pathology | $121.22 | $124.54 |

The amounts shown above assume a HHA's full compliance with the 2008 quality-reporting program. HHAs that do not submit quality data will receive a 2.0 percentage point reduction to the national per-visit amounts. For a complete discussion of the quality-reporting program, see the **"Submission of Quality Data to Receive a Full Marketbasket Update"** section below.

## Non-Routine Medical Supplies (NRS) – Payment

*Federal Register* pages 49850 – 49855

**Background**: Since the inception of the HH PPS, payment for NRS has been included in the national 60-day episode payment rate. The amount related to the NRS was calculated using NRS costs from audited cost report data and than bundled into the 60-day episode payment rate.

CMS stated "*While most patients do not use NRS, many use a small amount, and a small number of patients use a large amount of NRS*." Therefore, CMS conducted an analysis for the proposed rule to address NRS, concerned that the current policy to include payment for NRS in the national 60-day episode payment rate does not reflect the uneven distribution of NRS across HH episodes of care.

**CMS Proposal**: *"We propose to account for NRS costs based on five severity groups and a national . . . NRS conversion factor of $52.77."*

**CMS Final Rule**: For CY 2008, ". . . *as a result of further analysis, we are implementing a system that pays for non-routine supplies based on 6 severity groups. The 6th group is a subset of the previously proposed 5th group*". *"We note we are revising our NRS policy to require HHAs to specifically note on submitted claims NRS in any episode in which a NRS is provided"*.

Below are the final payment amounts for NRS based on severity level:

| Severity Level | Points (Scoring) | Relative Weight | Payment Amount |
|---|---|---|---|
| 1 | 0 | 0.2698 | $14.12 |
| 2 | 1-14 | 0.9742 | $51.00 |
| 3 | 15-27 | 2.6712 | $139.84 |
| 4 | 28-48 | 3.9686 | $207.76 |
| 5 | 49-98 | 6.1198 | $320.37 |
| 6 | 99+ | 10.5254 | $551.00 |

Like the national 60-day episode payment rate, the national NRS conversion factor includes adjustments for the marketbasket update, the behavioral offset reduction, and the outlier policy. LUPA episodes will not be eligible for the NRS add-on.

*"To ensure that NRS costs are being reported, claims that do not report NRS costs, unless explicitly noted by the HHA that NRS was not provided, will be returned to the provider (RTP). For episodes in which NRS was provided, the provider will need to resubmit the claim with NRS reported. For episodes in which NRS was not provided, the HHA will need to explicitly note that fact on the claim. We will allow a grace period, which will be determined and communicated in instructions from CMS."*

# III. PATIENT CLASSIFICATION SYSTEM

## Home Health Resource Groups (HHRGs) – Refinement

*Federal Register* pages 49770- 49832

**Background**: Under the HH PPS, payment for a given episode of care is determined by assignment to a HHRG based on similar levels of resource use in three dimensions:

- clinical severity;
- functional status; and
- service utilization.

The assignment of cases to each of the different levels is determined primarily by using selected data elements from the OASIS tool including the measurement of predicted therapy services based on a 10-visit threshold. There are four levels of clinical severity, five levels of functional status, and four levels of service utilization, combining to create 80 HHRGs. Each episode is assigned a case-mix weight that is then used to adjust the payment amount.

This original case-mix model was developed using data from first episodes only and a relatively small set of clinical, functional, and service utilization variables.

**CMS Proposal –HH Patient Classification System Refinement**: *". . . we propose that the case-mix adjustment be refined to incorporate an expanded set of case-mix variables to capture the additional clinical conditions and comorbidities; four separate regression models that recognize four different types of episodes; and a graduated, three-threshold approach to accounting for therapy utilization."*

*"We also propose to assign scores to certain secondary diagnoses, used to account for cost-increasing effects of comorbidities."*

*". . . we also propose that a small number of interactions – combinations of conditions in the same episode – be assigned scores, to capture the synergistic effect on resource use of certain conditions that coexist in the episode."*

CMS refers to the revised case-mix model in the proposed rule as the "four-equation model." This model creates a scoring system that attempts to account for the episode number within a sequence of adjacent episodes along with the projected number of total therapy visits for the given episode. According to CMS, this structure recognizes cost differences between earlier and later episodes, and between therapy treatment plans.

**CMS Final Rule:** For CY 2008, *"We concluded that the proposed four equation model in the proposed rule was reliable notwithstanding reporting changes expected from the introduction of V-codes on OASIS. We made a number of refinements based on the validation model we estimated using the FY 2005 analytic file."*

**CMS Proposal – Addition of Therapy Visit Thresholds**: *". . . we propose to make changes to the OASIS to capture the projected number of total therapy visits for a given episode . . . as opposed to indicating if there is a projected need for ten or more therapy visits (current OASIS item M0825)."*

*"We are proposing no change in the current way in which we measure therapy thresholds, which is based on counting therapy visits . . ."*

Currently, scoring for therapy visits is based on an expectation of at least 10 visits for therapy services.

**CMS Final Rule:** For CY 2008, CMS has adopted their proposal to use multiple therapy visit thresholds as opposed to a single 10-therapy threshold. "*We are implementing the three therapy thresholds of 6, 14, and 20".*

**CMS Proposal – Later Episodes**: *"For the purposes of payment, we propose to make changes to the OASIS . . . by adding a new OASIS item to capture whether an episode is an early or later episode. If an HHA is uncertain as to whether the episode is an early or later episode, we propose to base payment as though the episode were an early episode."*

**CMS Final Rule:** For CY 2008, *". . . we are implementing the proposed aspect of the case-mix model that recognizes and differentiates payment for episodes of care based on whether a patient is in what is considered to be an early or later episode of care as we believe that it better accounts for the higher resource use per episode and the different relationship between clinical conditions and resource use that exists in later episodes."*

**CMS Proposal – Excluded OASIS Variable**: *"We propose to exclude OASIS item M0175, which the case-mix system uses to identify the patient's pre-admission location, from the case-mix models. Under this proposal, there would be no case-mix score for M0175. . . . the . . . impact of including information from M0175 was small, both in terms of case-mix scores and the overall payment accuracy of the case-mix model."*

**CMS Final Rule:** For CY 2008, *"We are not eliminating M0175 from the OASIS . . . but only removing it from the case-mix model." ". . . we dropped M0175 from the case-mix algorithm, in part due to the challenges faced by agencies in accurately ascertaining the information needed for M1075."*

As a result of the adopted changes to the HH patient classification system, the case-mix groups will increase from 80 in CY 2007 to 153 in CY 2008.

The CY 2008 case-mix adjustment variables and scores as well as the diagnosis categories for case-mix adjustment variables are available on Tables 2a and 2b, *Federal Register* pages 49782 – 49817.

The refinement to the HH patient classification system includes revisions to the case-mix weights. The case-mix groups and weights are available on Table 5, *Federal Register* pages 49828 - 49832. To maintain budget neutrality, each of the relative weights has been adjusted by a factor of 1.238848031.

# IV. REPORTING OF HOSPITAL QUALITY DATA

## Reporting Requirements to Receive the Full Marketbasket

*Federal Register* pages 49861 – 49864

**Background**: Section 5201(c) of the Deficit Reduction Act (DRA) required HHAs to submit quality data to receive a full Medicare marketbasket update for CY 2007 and thereafter. HHAs that do not submit quality data are subject to a 2.0 percentage point reduction to the marketbasket update.

For purposes of receiving the full update, HHAs will not be required to submit quality measures for those patients who are excluded from the requirement for OASIS submission as a condition 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 will exclude newly certified HHAs (certified on or after May 31, 2007 for payments to be made in CY 2008), from the DRA quality-reporting requirement because data submission and analysis will not be possible.

**CMS Proposal**: *"We are proposing to continue to use OASIS data and the current 10 quality measures, and to add two additional quality measures based on those data for the CY 2008 HH PPS quality data reporting requirement."*

**CMS Final Rule:** For CY 2008, "*We are adopting, as final, the two quality measures and note that a total of 12 quality measures are necessary to meet the statutory submission of quality data to maintain the full home health market basket percentage increase"*

*"We proposed, for CY 2008, to consider OASIS data submitted by HHAs to CMS for episodes beginning on or after July 1, 2006 and before July 1, 2007 as meeting the reporting requirement for calendar year 2008. This reporting time period will allow 12 full months of data and will provide CMS the time necessary to analyze and make any necessary payment adjustments to the CY 2008 payment rates. HHAs that meet the reporting requirement shall be eligible for the full home health market basket percentage increase. We received no comments and are adopting this proposal as final"*

For CY 2008, CMS will require HHAs to submit data for 12 OASIS quality measures to receive a full marketbasket update. The reporting of these measures, endorsed by the National Quality Forum (NQF), is required as a condition of participation in the Medicare program. The 12 measures to be reported by HHAs to receive a full marketbasket update 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 |
| · Emergent Care for Wound Infections, Deteriorating Wound Status | · Improvement in the status of surgical wounds |

CMS notes that in the coming years it will continue to 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.

# V. FACILITY-LEVEL ADJUSTMENTS

## Wage Index

*Federal Register* pages 49858 – 49861

**Background**: CMS is required to adjust HH payment rates to account for geographic area wage differences. CMS defines the HH PPS labor market areas according to the Core-Based Statistical Areas (CBSAs) used in the Inpatient PPS. The wage index used to adjust the HH payment rates is based on the geographic area in which the beneficiary received the HH services.

**CMS Proposal**: *"We propose to use the 2008 pre-floor and pre-reclassified hospital wage index (not including any reclassification . . . to adjust rates for CY 2008 and will publish those wage index values in the final rule."*

**CMS Final Rule**: "*For the CY 2008 update to home health payment rates, we are finalizing the wage index and associated policies in that we will continue to use the most recent pre-floor and pre-reclassified hospital wage index. In addition, we note that we plan to evaluate any policies adopted in the FY 2008 IPPS final rule that affect the wage index . . .*"

# VI. CASE-LEVEL ADJUSTMENTS

## Cost Outliers

*Federal Register* pages 49855 – 49857

**Background**: Outlier payments 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 national per-visit amount) exceeds the fixed-loss threshold (as measured by the case-mix and wage-adjusted payment for the episode plus the 0.67 fixed-dollar loss (FDL) ratio times the national standardized 60-day episode payment rate), the agency receives an outlier payment that equates to 80% of the amount over the fixed-loss threshold. By law, CMS must project outlier payments to be no more than 5 percent of total home health payments.

**CMS Proposal**: *". . . we are proposing to maintain the FDL ratio of 0.67. By maintaining the FDL ratio of 0.67, we believe we will continue to meet the statutory requirement of having an outlier payment outlay that does not exceed 5 percent of total HH PPS payments . . ."*

**CMS Final Rule: ". . .** *in this final rule we are implementing a FDL ratio of 0.89 for FY 2008."* **". . .** *we further believe that a FDL ratio of 0.89 will continue to meet the statutory requirement of having an estimated outlier payment outlay that does not exceed the 5 percent of total estimated HH PPS payments, while still providing for an adequate number of episodes to qualify for outlier payments Therefore, to account for an outlier policy that estimates outlier payments to be no more than 5 percent of total HH PPS payments, and to maintain budget neutrality, we reduce the national standardized 60-day episode payment rate".*

*"We will continue to monitor the trends in outlier payments and the effects of the refinements, and will adjust the FDL ratio as needed."*

## Low-Utilization Payment Adjustment (LUPA)

*Federal Register* pages 49848 – 49849

**Background**: For episodes with four or fewer visits, HHAs receive a LUPA. Under these circumstances, the HHA is paid a wage-adjusted national average payment per visit according to the type of visit provided. Currently, all LUPA episodes receive the same per-visit payment amount regardless of the costs associated with lengthier start of care visits, a common characteristic of LUPA episodes.

**CMS Proposal**: *". . . we propose an increase of $92.63 for LUPA episodes that occur as the only episode or the initial episode during a sequence of adjacent episodes."*

Episodes are considered to be ''adjacent'' if they are separated by no more than a 60-day period between claims.

**CMS Final Rule:** For CY 2008, "*After updating the payment model using 2005 data and re-analyzing the characteristics of all LUPAs, the results continue to support providing a revised payment for LUPA episodes, but only for those that occur as the first episode in a sequence of adjacent episodes or the only episode"*

*". . . for this final rule, we are implementing the proposed provision of paying a revised payment amount to LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes. That additional amount has been calculated to be $87.93, for CY 2008. To account for the additional payment to LUPA episodes that occur as the first episode in a sequence of adjacent episodes or as the only episode, and maintain budget neutrality, we reduce the national standardized 60-day episode payment rate."*

## Significant Change In Condition (SCIC) Adjustment

*Federal Register* pages 49849 – 49850

**Background**: The SCIC adjustment is a proportional payment to HHAs that occurs when a beneficiary experiences a significant change in condition during the 60-day episode that was not envisioned in the original plan of care. Currently, the SCIC adjustment is calculated in two parts, proportionally adjusting the level of payment to account for the period before and after the significant change in condition occurs. "*In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS and obtain the necessary physician orders reflecting the significant change in treatment in the patient's plan of care."*

**CMS Proposal**: *". . . we are proposing to eliminate the SCIC adjustment from the HH PPS."*

**CMS Final Rule:** For CY 2008, "*In summary, based in part, upon comments received, as well as our continued analysis of this issue, we are finalizing our proposal to eliminate the SCIC adjustment policy. To account for the elimination of the SCIC adjustment, and to maintain budget neutrality, we reduce the national standardized 60-day episode payment rate."*

## Partial Episode Payment (PEP) Adjustment

*Federal Register* pages 49846 – 49848

**Background**: The PEP adjustment is a proportional payment to HHAs that accounts for "key intervening events" in a patient's care. An episode of care is considered to be partial if a new episode begins less than 60 days from the start of the first. When a new 60-day episode begins, the original national standardized 60-day episode payment rate is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care before the intervening event. The intervening events are defined as a beneficiary elected transfer or a discharge and return to the same HHA that warrants the start of new episode of care.

**CMS Final Rule:** *"In summary, there are several methods that could be used to refine the PEP adjustment, as recommended by commenters. Another possible approach could involve weighting the payment to reflect the front-loading of visits, but it is not clear at this time what an appropriate approach to refinement of the PEP policy would be. We intend to study the comments provided, continue public discussion on this issue, and look towards the possible refinement of this adjustment in future rulemaking."*