



**WISCONSIN HOSPITAL  
ASSOCIATION**

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**SUMMARY OF THE CY 2008  
MEDICARE HOME HEALTH  
PROSPECTIVE PAYMENT SYSTEM  
PROPOSED RULE**

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**May 2007**

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## 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) 2008. 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 July 3. CMS requests that comments refer to the file code CMS-1541-P. All comments should reference “PROVISIONS OF THE PROPOSED REGULATIONS” as the issue identifier.

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-1541-P  
P.O. Box 8012  
Baltimore, MD 21244-8012

Express/Overnight Mail (an original and two copies):

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1541-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  
(call first to schedule delivery -  
(410) 786-7195)

## I. OVERVIEW

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

The proposed changes include refinements to the HH case-mix classification system that would increase the number of case-mix groups from 80 in CY 2007 to 153 in CY 2008, three-years of 2.75% reductions 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 proposed Medicare HH PPS rule for CY 2008 in the May 4, 2007 *Federal Register*. Changes are effective January 1, 2008 unless otherwise noted.

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

Note: Since publication of the HH proposed rule, CMS has issued a correction notice for Tables 4, 5, and 12A. This notice, along with links to corrected versions of the tables, is available on the CMS Web site at <http://www.cms.hhs.gov/center/hha.asp>.

## II. HH PAYMENT RATES

### Marketbasket Update for CY 2008

*Federal Register* pages 25435 – 25442 and 25449 – 25452

**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.”*

The proposed full marketbasket update of 2.9% 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 and receive a marketbasket update of 0.9%.

In addition to providing a full marketbasket update, CMS is proposing to rebase and revise the HH marketbasket. The HH marketbasket was last rebased in the CY 2005 update, using Federal Fiscal Year (FFY) 2000 data. CMS is proposing to rebase the HH marketbasket using FFY 2003 Medicare cost report data, the latest and most complete data available on HHA costs. In revising the marketbasket, CMS has proposed modification to the wages and salaries, and benefits cost categories in order to reflect a new data source on the occupational mix of HHAs. CMS is not proposing any changes to the price proxies used in the HH marketbasket or the HH blended wage and benefit proxies.

The rebasing and revision of the HH marketbasket does not change the marketbasket projection for CY 2008 when compared to the current update methodology and data (2.9% in both cases).

Based on the rebasing and revision to the HH marketbasket, CMS has proposed an increase to the labor-related share from 76.775% in CY 2007 to 77.082% in CY 2008.

## **Behavioral Offset**

*Federal Register* pages 25392 – 25420

**Background:** A provision in the Benefits Improvement and Protection Act (BIPA) of 2000 provides CMS the authority to adjust HH payment rates to eliminate the effect of changes in coding 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 and increases driven by payment incentives. Based on the analysis, CMS has 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.”*

A complete discussion of this topic area, including the methods and the data used to develop the behavioral offset to be applied to the HH payment rates (2.75% for CYs 2008, 2009, and 2010), is available in the *Federal Register* pages referenced in the heading above.

## **National Standardized 60-Day Episode Payment Rate**

*Federal Register* pages 25442 – 25445 and 25449 – 25452

For episodes that both begin and end in CY 2008, the proposed National 60-Day Episode Payment Rate effective January 1, 2008 is \$2,300.60. The proposed National 60-Day Episode Payment Rate for CY 2008 is 1.6% lower than the CY 2007 rate of \$2,339.00. This is due to the 2.75% behavioral offset reduction, a change to how the outlier policy affects the calculation of the rate, and downward adjustments to maintain budget neutrality for the proposed policy changes to payment for Non-Routine Medical Supplies (NRS), the Significant Change in Condition (SCIC) Adjustment, and the Low-Utilization Payment Adjustment (LUPA).

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

<b>CY 2007 National Standardized 60-Day Episode Payment Rate</b>	<b>\$2,339.00</b>
Outlier Funds (return CY 2007 outlier target to base rate)	5.0%
Marketbasket Update	2.9%
Behavioral Offset	-2.75%
<b>CY 2008 Rate Before Budget Neutrality &amp; Outlier Carve Out</b>	<b>\$2,457.67</b>
Outlier Carve Out	(\$94.02)
NRS Policy Change	(\$40.88)
SCIC Policy Change	(\$15.71)
LUPA Policy Change	(\$6.46)
<b>Total Adjustments for Outliers and Budget Neutrality</b>	<b>(\$157.07)</b>
<b>CY 2008 National Standardized 60-Day Episode Payment Rate</b>	<b>\$2,300.60</b>

For episodes that begin in CY 2007 and end in CY 2008, the National 60-Day Episode Payment Rate is \$2,355.96. This rate includes the CY 2008 update, the proposed behavioral offset (see “Behavioral Offset” section above), and adjustment for the outlier policy. These episodes will use the case-mix based on the CY 2007 80 HHRG case-mix system.

The amounts shown above (for both episodes that occur entirely in CY 2008 and episodes that overlap CYs 2007 and 2008) assume 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 complete 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 25444 – 25445. This example includes the case-mix weights from the refined case-mix system, the proposed policy change to payment for NRS, and the revised labor-share. Please see the appropriate sections below for a complete discussion of the proposed changes. It should be noted that the wage index shown in the sample is actually for CY 2007; 2008 data are not yet available, and will be incorporated in the final rule.

It should be noted that the text provided for the sample, *Federal Register* text (page 25444) conflicts with step-by-step calculation provided on the following page (page 25445). Per CMS, the step-by-step calculation provided on *Federal Register* page 25445 is correct.

## National Per-Visit Amounts

*Federal Register* pages 25446 – 25447

**Background:** National Per-Visit Amounts are used for the low-utilization payment adjustment (see “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.”

The National Per-Visit Amounts are not subject to the proposed 2.75% behavioral offset reduction. The proposed amounts by discipline are as follows:

<b>Per-Visit Payment Amounts:</b>	<b>CY 2007</b>	<b>CY 2008</b>
Home Health Aide	\$46.24	\$47.91
Medical Social Services	\$163.68	\$169.53
Occupational Therapy	\$112.40	\$116.42
Physical Therapy	\$111.65	\$115.63
Skilled Nursing	\$102.11	\$105.76
Speech-Language Pathology	\$121.22	\$125.55

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 section “Submission of Quality Data to Receive a Full Marketbasket Update” below.

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

*Federal Register* pages 25426 – 25434

**Background:** Since the inception of the HH PPS, payment for NRS has been included in the National 60-Day Episode Payment Rate. The amount bundled into the National 60-Day Episode Payment Rate to account for NRS was calculated using NRS costs from audited cost report data.

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. Currently, most patients do not use any NRS, many use a small amount, and a small number of patients use a large amount of NRS.

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

Assignment of the NRS severity level will be made on the basis of a scoring system similar to that in use for HHRGs, wherein certain Outcome and Assessment Information Set (OASIS) items will have point values. The sum of these point values will indicate the appropriate NRS severity level for a given episode. Table 12A\*, on *Federal Register* pages 25430 – 25431, shows the OASIS items and diagnoses to be used as scored variables. CMS is proposing to exclude enteral nutrition from the scoring system, despite some evidence that these patients incur higher than average NRS costs. CMS is seeking comment on this issue. A complete discussion of the proposed scoring system is available in the *Federal Register* pages referenced in the heading above.

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

Severity Level	Points (Scoring)	Relative Weight	Payment Amount
0	0	0.2456	\$12.96
1	1–16	1.0356	\$54.65
2	17–34	2.0746	\$109.48
3	35–59	4.0776	\$215.17
4	60+	6.9612	\$367.34

Like the National 60-Day Episode Payment Rate, the proposed national NRS conversion factor includes the CY 2008 update, the proposed behavioral offset (see “Behavioral Offset” section above), and adjustment for the outlier policy.

CMS considered, but is not proposing, an outlier policy for NRS costs. In addition, LUPA episodes will not be eligible for the NRS add-on. CMS is specifically soliciting comment on alternative approaches for NRS payments for LUPAs.

The proposed change in payment for NRS will be implemented in a budget neutral manner, reducing the National Standardized 60-Day Episode Payment Rate by \$40.88.

\* Note: Since publication of the HH proposed rule, CMS has issued a correction notice for tables 4, 5, and 12A. This notice, along with links to corrected versions of the tables, is available on the CMS Web site at <http://www.cms.hhs.gov/center/hha.asp>.

### III. PATIENT CLASSIFICATION SYSTEM

#### Home Health Resource Groups (HHRGs) – Refinement

*Federal Register* pages 25358 – 25395

**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 form 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.”

*“The final set of proposed clinical conditions resulting from our exploratory series of analyses covers more types of conditions than were used in the original case-mix model. . .”*

*“. . . heart and mental conditions are now assigned case-mix scores. More wound conditions are assigned scores . . .”*

*“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.”*

*“The proposed four equation model, with multiple therapy thresholds and payment graduation between those thresholds, adds a certain amount of complexity to the HH PPS. Consequently, in order to group beneficiaries into case-mix groups in this proposed four equation model, we propose to make changes to the OASIS to capture the projected number of total therapy visits for a given 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.

The proposed case-mix adjustment variables and scores as well as the proposed diagnosis categories for case-mix adjustment variables is available on Tables 2a and 2b, *Federal Register* pages 25367 – 25386.

**CMS Proposal – Revision 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 . . .”*

In revising the existing 10-visit therapy threshold for the service utilization portion of the classification system, CMS has created three thresholds for therapy visits to capture the projected number of total therapy visits: 0 to 13 visits, 14 to 19 visits, and 20 or more visits.

**CMS Proposal – Score for Episode Timing:** *“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 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 considered, but is not proposing, adjustments pertaining to clinical issues and social characteristics such as caregiver availability.

The proposed changes to the HH patient classification system will result in an expansion of the current 80 case-mix groups in CY 2007 to 153 case-mix groups in CY 2008. As noted above, the OASIS dataset will be expanded to include the proposed refinements.

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* page 25389. To maintain budget neutrality, each of the relative weights has been adjusted by a factor of 1.194227193.

\* Note: Since publication of the HH proposed rule, CMS has issued a correction notice for Tables 4, 5, and 12A. This notice, along with links to corrected versions of the tables, is available on the CMS Web site at <http://www.cms.hhs.gov/center/hha.asp>.

## IV. REPORTING OF HOSPITAL QUALITY DATA

### Reporting Requirements to Receive the Full Marketbasket Update

*Federal Register* pages 25449 – 25452

**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 CY 2007, CMS required HHAs to submit data for ten 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 ten measures currently 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

**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.”*

*“We specifically propose to add the following two additional quality measures . . .*

- *Emergent Care for Wound Infections, Deteriorating Wound Status; and*
- *Improvement in Status of Surgical Wound.”*

*“These additional NQF endorsed measures that will provide a more complete picture of the level of quality care delivered by HHAs. . .”*

Like the ten currently reported measures, the data elements used to calculate the two proposed new measures are already included in the OASIS instrument, therefore there will be no additional reporting requirement for HHAs.

CMS will consider OASIS data submitted by HHAs for episodes beginning on or after July 1, 2006 and before July 1, 2007 as meeting the reporting requirement. This will provide a full 12 months of data and allow CMS the opportunity to analyze and make any necessary payment adjustments to the CY 2008 payment rates.

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.

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 and will post the two newly proposed measures once they are finalized.

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 quality of care being provided by HHAs. CMS is also in the process of developing an instrument to measure patient satisfaction, the Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS expects to begin field-testing it in summer or fall of 2007, for implementation in late 2008 and potential application to the CY 2010 pay for reporting requirements.

The reduced payment rates for HHAs that are non-compliant with the quality-reporting program are available in the *Federal Register* pages referenced in the heading above.

## V. FACILITY-LEVEL ADJUSTMENTS

### Wage Index

*Federal Register* pages 25447 – 25449

**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.*”

It should be noted that Addenda A and B on *Federal Register* pages 25459 – 254481 of the proposed rule contain 2007 pre-floor and pre-reclassified hospital wage indexes (2008 pre-floor and pre-reclassified hospital wage index data are not yet available).

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. This issue is applicable to the following areas:

- Hinesville, Georgia (CBSA 25980) (Urban);

- Certain counties in Massachusetts (Rural); and
- Certain areas of Puerto Rico (Rural).

CMS adopted policies beginning in CY 2006 that are intended to apply generally to any areas for which there is no hospital wage data.

- For urban areas: All of the urban CBSAs within the state are used to calculate a statewide urban average wage index. CMS proposes to continue this practice for CY 2008.
- For rural areas: CMS initially used the CY 2005 pre-floor, pre-reclassified hospital wage index value. For CY 2007, CMS imputed a wage index by averaging the wage index values from contiguous CBSAs. CMS is proposing to continue to apply this methodology for CY 2008.

In determining an imputed rural wage index, CMS interprets the term “contiguous” to mean sharing a border. Therefore, if a body of water forms the boundary between two CBSAs, those CBSAs are considered to be contiguous. CMS has found this to be inappropriate in relation to Puerto Rico. Therefore, Puerto Rico is specifically excepted from this policy. CMS is proposing to continue the practice begun in CY 2007 of using the most recent wage index previously available for Puerto Rico, which is 0.4047.

## VI. CASE-LEVEL ADJUSTMENTS

### Cost Outliers

*Federal Register* pages 25434 – 25435

**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 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 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 . . .”

*“Some preliminary analysis shows the FDL ratio could be as low as 0.42 in a refined HH PPS. We believe that analysis of more recent data could indicate that a change in the FDL ratio is appropriate. Consequently for the final rule, we will rely on the latest data and best analysis available at the time to estimate outlier payments and update the FDL ratio if appropriate.”*

For CY 2008, CMS has proposed to separate payment for NRS from the National Standardized 60-Day Episode Payment Rate and treat payment for NRS as an add-on (see “Non-Routine Medical Supplies (NRS) – Payment” section above). Because payment for NRS was included in the base rate of the National Standardized 60-Day Episode Payment Rate, both the proposed National Standardized 60-Day Episode Payment Rate and the proposed computed NRS add-on amount will contribute towards reaching the outlier threshold in the outlier payment calculation.

### Low-Utilization Payment Adjustment (LUPA)

**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.”

*“. . . the additional payment for such LUPA episodes will be updated annually by the home health market basket percentage increase. As with the other components of the LUPA methodology, this increase for situations where a LUPA is the only episode or the initial episode in a sequence of adjacent episodes will be wage-adjusted.”*

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

CMS is specifically soliciting comments on this and alternative methodologies for fairly compensating HHAs for the cost of lengthier start of care visits associated with LUPA episodes. For a complete discussion of the methodology used to develop this proposal, please see the *Federal Register* pages referenced in the heading above.

The proposed change to the LUPA policy will be implemented in a budget neutral manner, reducing the National Standardized 60-Day Episode Payment Rate by \$6.46.

## **Significant Change In Condition (SCIC) Adjustment**

*Federal Register* pages 25425 – 25426

**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.”

*“Episodes that are currently SCIC adjusted would be treated as normal episodes and will receive payment for the entire 60-day period based on the initial, and only, HHRG code. The national standardized 60-day episode payment rate . . . of the proposed rule takes into account this proposed change in SCIC policy and is, therefore, slightly lower than it would have been without proposing this change.”*

CMS cites a number of reasons for proposing to eliminate the SCIC adjustment for CY 2008. These include negative margins for SCIC episodes, HHA difficulty in interpreting when to apply the SCIC adjustment policy, the administrative burden to HHAs of adhering to the policy, and the impact of eliminating the SCIC adjustment (an increase of 0.5% of total payments). A complete discussion of the rationale behind the elimination of the SCIC adjustment is available in the *Federal Register* pages referenced in the heading above.

As noted in the proposal above, the elimination of the SCIC adjustment will be implemented in a budget neutral manner, reducing the National Standardized 60-Day Episode Payment Rate by \$15.71.

## **Partial Episode Payment (PEP) Adjustment**

*Federal Register* pages 25422 – 25423

**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. These 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 Proposal:** In the proposed rule, CMS reviewed, but did not propose any changes to PEP adjustment policy for CY 2008.