



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE CY 2009
MEDICARE HOME HEALTH
PROSPECTIVE PAYMENT SYSTEM
UPDATE**

November 2008

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I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) released its update to the Home Health Prospective Payment System (HH PPS) for CY 2009 in the November 3, 2008 *Federal Register*.

The update includes a net payment increase of 0.15 percent, or \$30 million, reflecting a full marketbasket update of 2.9 percent and a 2.75 percent Behavioral Offset reduction.

Changes are effective January 1, 2009 unless otherwise noted.

II. HH PAYMENT RATES

Marketbasket Update

Federal Register page 65354

Background: The home health payment 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. Last year, CMS rebased and revised the HH marketbasket using federal fiscal year (FFY) 2003 Medicare cost report data.

For CY 2009, the full marketbasket update of 2.9 percent will be applied to HH PPS rates for Home Health Agencies (HHAs) that submit the required quality data. HHAs that fail to meet this requirement will have their marketbasket update reduced by 2.0 percent, resulting in a marketbasket update of 0.9 percent.

Behavioral Offset

Federal Register page 65353 - 65354

Background: A provision in the Benefits Improvement and Protection Act (BIPA) of 2000 gives CMS the authority to adjust HH payment rates 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 that analysis, CMS determined that 8.7 percent of the case mix change that occurred was due to coding practice changes, not “real” changes in case mix.

CMS has adopted a 4-year phase-in of the Behavioral Offset; applying a 2.75 percent reduction of the national standardized 60-day episode payment rate in CYs 2008 through 2010 and a 2.71 percent reduction for CY 2011.

For CY 2009, CMS is applying the 2.75 percent reduction. CMS is also seeking comments on the proposed 2.71 percent reduction for CY 2011.

National Standardized 60-Day Episode Payment Rate

Federal Register pages 65353 - 65354

The national 60-day episode payment rate for CY 2009 will be 0.15 percent higher than the CY 2008 rate of \$2,270.32. The change is due to the difference between the market basket update of 2.9 percent and the 2.75 percent behavioral offset reduction. There is no adjustment for budget neutrality in the CY 2009 HH PPS rates

because most of the payment components are unchanged from CY 2008.

Below is a calculation of the CY 2009 National 60-Day Episode Payment Rate:

CY 2008 National Standardized 60-Day Episode Payment Rate	\$2,270.32
Marketbasket Update	2.9%
CY 2008 Rate Before Outlier Carve-Out & Budget Neutrality Adjustments	\$2,336.16
Behavioral Offset	(\$64.24)
Total Adjustments for Outliers and Budget Neutrality	(\$64.24)
CY 2008 National Standardized 60-Day Episode Payment Rate	\$2,271.91

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 “**Reporting Requirements to Receive a Full Marketbasket Update**” section.

National Per-Visit Amounts

Federal Register page 65355

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.

The per-visit amounts for CYs 2007, 2008 and 2009 for HHAs that submit the required quality data are shown in the table below.

Per-Visit Payment Amounts:	CY 2007	CY 2008	CY 2009
Home Health Aide	\$46.24	\$47.51	\$48.89
Medical Social Services	\$163.68	\$168.17	\$173.05
Occupational Therapy	\$112.40	\$115.48	\$118.83
Physical Therapy	\$111.65	\$114.71	\$118.04
Skilled Nursing	\$102.11	\$104.91	\$107.95
Speech-Language Pathology	\$121.22	\$124.54	\$128.26

LUPA rates are not reduced for the Behavioral Offset because they are per-visit rates and not subject to case mix changes.

Non-Routine Medical Supplies

Federal Register pages 65355

Background: Since the inception of the HH PPS, payment for non-routine medical supplies (NRS) has been included in the national 60-day episode payment rate. The amount related to NRS was calculated using costs from facilities audited cost reports that were bundled into the 60-day episode payment rate. In the CY 2008 final rule, CMS carved the NRS component out of the 60-day rate and established a national NRS conversion factor with six severity group weights to provide more adequate reimbursement for episodes with a high utilization of NRS.

For CY 2009, the NRS conversion factor is \$52.39

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

Severity Level	Points (Scoring)	Relative Weight	Payment Amount
1	0	0.2698	\$14.13
2	1-14	0.9742	\$51.04
3	15-27	2.6712	\$139.94
4	28-48	3.9686	\$207.91
5	49-98	6.1198	\$320.62
6	99+	10.5254	\$551.43

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

III. REPORTING HOSPITAL QUALITY DATA

Reporting Requirements to Receive the Full Marketbasket

Federal Register page 65356

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 percent 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 2009), from the DRA quality-reporting requirement because data submission and analysis will not be possible.

For CY 2008, CMS required 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 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

For CY 2009, HHAs will continue to be required to submit the 12 OASIS quality measures to receive a full market basket update.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care

Federal Register pages 65356 – 6535

Background: The CAHPS surveys ask patients to report on and rate their experiences with health care. The CAHPS Home Health survey, first discussed in the May 4, 2007 proposed rule, asks home health patients several questions about their home health care providers and the quality of their home health care. The survey collects data on patients’ interactions with home health staff, provider care, and communication and patient characteristics.

Currently CMS is working with a contractor to develop protocols and guidelines for implementation of a CAHPS Home Health Care Survey. In addition, vendor training materials are currently being developed and recruitment and training will begin in 2009 for vendors who wish to be approved to collect data.

More information about the CAHPS can be found by calling 1-866-354-0985 or e-mailing HHCAHPS@rti.org.

Information about national implementation will be published in the CY 2010 Home Health Rule.

IV. FACILITY-LEVEL ADJUSTMENTS

Wage Index

Federal Register pages 65357- 65359

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 will continue to use the labor-related share of 77.082 percent for CY 2009.

CMS will continue to use the pre-rural floor, pre-reclassification hospital Wage Indexes to adjust the labor portions of the Home Health PPS rates.

V. CASE-LEVEL ADJUSTMENTS

Home Health Resource Groups

Background: Last year (CY 2008) CMS adopted a change to the HHRGs, increasing the number of groups from

80 to 153. CMS will maintain the current HHRGs and weights for CY 2009.

Cost Outliers

Federal Register page 65357

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 0.89 fixed-dollar loss (FDL) ratio times the national standardized 60-day episode payment rate), the agency receives an outlier payment that equates to 80 percent 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 notes that, based upon its analysis of CY 2007 data, outlier payments in CY 2009 would exceed 10 percent of total Home Health PPS payments. However, CMS believes that the excessive outlier payments are concentrated in only a few specific areas of the country. Therefore, in this Update Notice, CMS is maintaining the FDL ratio at 0.89 for CY 2009 (unchanged from CY 2008) and will be targeting inappropriate outlier payments.

Low-Utilization Payment Adjustment

Federal Register page 65355

Background: For episodes with four or fewer visits, HHAs 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. 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.

For CY 2009, "...the additional amount paid to LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode is \$90.48..."