



**WISCONSIN HOSPITAL
ASSOCIATION**

**SUMMARY OF THE FINAL
CY 2010 MEDICARE
HOME HEALTH RULE**

November 2009

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I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) published the final Medicare Home Health Prospective Payment System (HH PPS) rule for calendar year (CY) 2010 in the November 10 *Federal Register*. Changes are effective January 1, 2010 unless otherwise noted. This document provides an overview of the final rule; additional information regarding the HH PPS is available on the CMS Web site at <http://www.cms.hhs.gov/HomeHealthPPS>.

Note: Text in italics is extracted from either the August 13 or November 10 *Federal Register*.

Major Provisions in the Final Rule

- **National Standardized 60-Day Episode Rate:** CMS is increasing the national 60-day episode rate from \$2,271.92 in CY 2009 to \$2,312.94 in CY 2010. This 1.8% increase reflects a full marketbasket update minus a reduction for coding improvement. In addition, there is a 2.5% increase to reflect the transfer of funds from the outlier carve-out (as explained below). Home health agencies that do not submit the required quality data will receive a 2.0 percentage point reduction to the national standardized 60-day episode rate.
- **Outlier Payments:** CMS is reducing the outlier pool percent from 5% of total HH PPS payments in CY 2009 to 2.5% in CY 2010, returning 2.5% of the outlier carve-out to the national standardized 60-day episode rate. In addition, CMS will cap outlier payments at 10% per agency for CY 2010.
- **Quality Measures:** CMS is not adopting any changes to the current 12 home health quality measures for CY 2010. However, CMS plans to move ahead with the expansion of measures to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for home health care for CY 2012 rather than CY 2011, which was proposed. In addition, CMS still intends to conduct a dry run of the survey for participating home health agencies for at least one month in the third quarter of 2010 and submit those results to the Home Health CAHPS Data Center by January 21, 2011.
- **Outcome and Assessment Information Set (OASIS) Data:** CMS is adopting a new version of OASIS called OASIS-C to collect data on all episodes of care beginning on or after January 1, 2010. In doing so, CMS will introduce 13 new National Quality Forum (NQF)-endorsed process of care measures that will be collected using the OASIS-C instrument beginning January 1, 2010 and reported on the Home Health Compare Web site by October 2010.
- **Low Utilization Payment Adjustment (LUPA):** CMS is increasing the LUPA add-on payment amount from \$90.48 in CY 2009 to \$94.72 in CY 2010. The LUPA add-on is not subject to the coding reduction of 2.75% because these are per-visit rates and not subject to case mix changes.
- **Non-Routine Medical Supplies (NRS):** CMS is increasing the NRS conversion factor from \$52.39 in CY 2009 to \$53.34 in CY 2010. Payments for NRS are reduced by the 2.75% adjustment for changes in coding and documentation.

II. LEGISLATIVE MANDATES

The Benefits Improvement and Protection Act (BIPA) of 2000; the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; and the Deficit Reduction Act (DRA) of 2005 each contain Medicare provisions that either currently affect program payment policy or will begin to affect payment policy in upcoming calendar years. Where appropriate, legislative references are provided in the text below.

III. HH PAYMENT RATES

Marketbasket Update

Federal Register pages 59095 - 58096

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.

In 2008, CMS rebased and revised the HH marketbasket using federal fiscal year (FFY) 2003 Medicare cost report data.

CMS' Final Rule: For CY 2010, CMS will provide a “. . . *marketbasket update of 2.0 percent.*”

Coding Adjustment

Federal Register pages 58087 - 58095

Background: A BIPA provision gives CMS 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 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 coding improvements. Based on that analysis, CMS determined that 13.56% of the case mix change was due to coding practice changes, and not “real” changes in case mix.

CMS adopted a four-year phase-in of the coding adjustment, applying a 2.75% reduction to the national standardized 60-day episode payment rate in CYs 2008 through 2010, and a 2.71% reduction for CY 2011.

CMS' Proposal: For CY 2010, CMS proposed to continue with the four-year phase-in and implement a 2.75% reduction to the national standardized 60-day episode payment rate for changes due to coding. CMS stated, “*Given the continued rise in nominal case-mix, we expect to revise, upward, the 2.71 percent reduction . . . for CY 2011 in next year's rule.*”

CMS' Final Rule: For CY 2010, CMS is adopting the above proposal as final.

National Standardized 60-Day Episode Payment Rate

Federal Register pages 58106 - 58107

CMS' Final Rule: For CY 2010, CMS will provide a “. . . *final updated . . . national standardized 60-day episode payment rate of \$2,312.94.*”

Below is a calculation of the final CY 2010 national 60-day episode payment rate:

CY 2009 National Standardized 60-Day Episode Payment Rate		\$2,271.92
Adjustment to return the outlier funds that were set at 5%	0.9500	
Subtotal		\$2,391.49
Adjustment to remove 2.5% final outlier pool	0.9750	
Subtotal		\$2,331.71
Marketbasket Update	1.020	
Subtotal		\$2,378.34
Reduction of 2.75% to account for coding changes	0.9725	
Final CY 2010 National Standardized 60-Day Episode Payment Rate		\$2,312.94

Home health agencies (HHAs) that do not adequately report 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 “CY 2010 Reporting HH Quality Measures for Annual Payment Update” section on page 7.

National Per-Visit Amounts

Federal Register page 58107

Background: National per-visit amounts are used for the low-utilization payment adjustment (see the “Low-Utilization Payment Adjustment [LUPA]” section on page 11) and to compute imputed costs used in outlier calculations.

The per-visit amounts for CYs 2009 and 2010 for HHAs that report the required quality data are shown in the table below. The national per-visit payment amounts are not reduced by the final 2.75% coding adjustment.

Per-Visit Payment Amounts:	CY 2009	CY 2010
Home Health Aide	\$48.89	\$51.18
Medical Social Services	\$173.05	\$181.16
Occupational Therapy	\$118.83	\$124.40
Physical Therapy	\$118.04	\$123.57
Skilled Nursing	\$107.95	\$113.01
Speech-Language Pathology	\$128.26	\$134.27

Non-Routine Medical Supplies—Payment

Federal Register pages 58108 - 58109

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 NRS was calculated using costs from facilities’ audited cost reports. In the CY 2008 final HH PPS rule, CMS carved out the NRS component from the 60-day rate and established a separate national NRS conversion factor with six severity group weights to provide more adequate reimbursement for episodes with a high utilization of NRS.

CMS’ Proposal: For CY 2010, CMS proposed that the “. . . NRS conversion factor would be \$53.44.”

CMS' Final Rule: “For CY 2010, the NRS conversion factor is \$53.34.”

Below are the final payment amounts for NRS for HHAs that submit quality data based on severity level:

Severity Level	Points (Scoring)	Relative Weight	Payment Amount
1	0	0.2698	\$14.39
2	1-14	0.9742	\$51.96
3	15-27	2.6712	\$142.48
4	28-48	3.9686	\$211.69
5	49-98	6.1198	\$326.43
6	99+	10.5254	\$561.42

Like the national 60-day episode payment rate, the national NRS conversion factor includes adjustments for outlier payments, the marketbasket update, and the coding adjustment.

IV. REPORTING HOME HEALTH QUALITY DATA

Federal Register pages 58096 - 58104

The DRA required HHAs to collect and report quality data to receive a full Medicare marketbasket update for CY 2007 and thereafter. HHAs that do not adequately report quality data are subject to a 2.0 percentage point reduction to the marketbasket update.

HHAs are not required to report 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 (those certified on or after May 31 of the preceding year) from any payment penalty for quality reporting purposes for the following CY. “Therefore, HHAs that are certified on or after May 1, 2009 are excluded from the quality reporting requirement for CY 2010 payments since data submission and analysis will not be possible for an agency certified this late in the reporting time period.”

Outcome and Assessment Information Set (OASIS)

Background: CMS uses a subset of the OASIS data, currently 12 home health quality measures, for public reporting of HH quality on its Home Health Compare Web site (see “CY 2010 Reporting HH Quality Measures for Annual Payment Update” section on page 10). After additional testing, collection of public comments, and other technical expert recommendations over the years, CMS has finally received Office of Management and Budget (OMB) approval to modify the OASIS data set with the revised version called OASIS-C.

OASIS-C will collect data on important aspects of a patient's health status including clinical condition, functional abilities, and service needs. As a result, a clinician will be able to capture a clear and accurate picture of the patient, which will assist in development of an appropriate plan of care.

CMS' Proposal: Upon approval from OMB, “. . . CMS intends to implement the use of the OASIS-C . . . on January 1, 2010.” CMS proposed “. . . that this new version of OASIS be collected on episodes of care with a corresponding OASIS item (M0090) date of January 1, 2010 or later.”

Once approved CMS plans “. . . to update Home Health Compare to reflect the addition of . . . 13 new process of care measures.”

CMS' Final Rule: OMB has approved OASIS-C; therefore, the data will be collected for “. . . episodes of care beginning on or after January 1, 2010.” “. . . as a result of implementing OASIS-C, we will update Home Health Compare to reflect the addition of the . . . 13 new process of care measures.

“We believe that software vendors who took timely advantage of the resources made available will be prepared for the OASIS-C transition. In addition, the state systems are being configured to accept OASIS-C as of January 1, 2010, as is the updated home health PPS grouper software. This information has been available since August.

“Agencies will not be introduced to new quality measures until September 2010 and additional resources related to these will be made available. We will shortly be posting the final OASIS-C user Guidance Manual, and we will be offering free training teleconferences through the Medicare Learning Network.”

Health Insurance Prospective Payment System (HIPPS) Code Verification

Federal Register pages 58109 - 58111

Background: HHAs are required to report all OASIS data as a condition of participation and they must encode and electronically transmit the completed OASIS assessment to CMS in a standard format. The standard format includes a HIPPS code, which is generated by grouper software. Once the agency transmits the OASIS assessment and corresponding HIPPS code to CMS, the CMS OASIS submission system validates the transmitted OASIS items, including the HIPPS code.

CMS has experienced a proliferation of incidents where the HIPPS code on the HHA claim does not match the CMS HIPPS code. CMS maintains that its HH PPS grouper software used to validate HIPPS codes is the official grouper software of HH PPS. This same software is available for free and can be downloaded from the CMS Web site. This grouper software should be used by vendors in their programs to process OASIS and generate a HIPPS codes for agencies. If the HH PPS grouper software is used and performs correctly in vendors' programs, there should be no difference between HIPPS codes generated by an agency or CMS.

When the CMS OASIS submission system finds HIPPS code errors, it informs agencies of those errors via the “final validation report,” a report generated and sent back to the agency. The final validation report includes the wrong HIPPS code submitted by the agency and the corrected HIPPS code validated by CMS. The corrected CMS HIPPS code is the code that should be billed on the claim.

CMS' Proposal: For 2010, CMS clarified “. . . that the HHA be required to ensure that the HIPPS code billed on the claim is consistent with that which CMS' OASIS submission system calculated.” In doing so CMS proposed “. . . the electronic reporting of OASIS to CMS as a condition of payment.”

CMS' Final Rule: For CY 2010, CMS has adopted the above proposal as final.

CY 2010 Reporting HH Quality Measures for Annual Payment Update

In CY 2009, CMS required HHAs to submit data on 12 OASIS quality measures to receive a full marketbasket update. The reporting of these measures, endorsed by NQF, is required as a condition of participation in Medicare. The 12 measures to be reported by HHAs are:

· Improvement in	· Acute care
· Improvement in	· 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

CMS’ Proposal: For CY 2010, CMS proposed “. . . to continue to use the submission of OASIS data and the quality measures that are publicly reported on Home Health Compare to meet the requirement that the HHA submit data appropriate for the measurement of health care quality.”

In addition, CMS proposed “. . . to consider OASIS assessments submitted by HHAs to CMS in compliance with HHA conditions of participation for episodes beginning on or after July 1, 2008 and before July 1, 2009 as fulfilling the quality reporting requirement for CY 2010.”

CMS’ Final Rule: For CY 2010, CMS is adopting the above proposal as final.

CY 2011 HH Quality Measures

CMS received approval by OMB to modify the OASIS data set (see “Outcome and Assessment Information Set” section on page 5). The new version of OASIS data will be called OASIS-C. “. . . as a result of implementing OASIS-C, we will update Home Health Compare to reflect the addition of the following 13 new process of care measures:

- *Timely initiation of care;*
- *Influenza immunization received for current flu season;*
- *Pneumococcal polysaccharide vaccine ever received;*
- *Heart failure symptoms addressed during short-term episodes;*
- *Diabetic foot care and patient education implemented during short-term episodes of care;*
- *Pain assessment conducted;*
- *Pain interventions implemented during short-term episodes;*
- *Depression assessment conducted;*
- *Drug education of all medications provided to patient/caregiver during short-term episodes;*
- *Falls risk assessment for patients 65 and older;*
- *Pressure ulcer prevention plans implemented;*
- *Pressure ulcer risk assessment conducted; and*
- *Pressure ulcer prevention included in the plan of care.”*

In addition, CMS is considering three additional process of care measures, based on results of consumer testing that may be added to Home Health Compare. CMS states, “Those additional process measures are:

- *Drug education on high risk medications provided to patient/caregiver at start of episode;*
- *Potential medication issue identification and timely physician contact at start of episode; and*

- *Physician medication issues identified and timely physician contact during episode.*

“Data related to the process measures will be collected in the OASIS-C instrument beginning January 1, 2010 and the first reports on process measures are projected to be available to agencies in September 2010. . . . CMS plans that the process measures will be reported on Home Health Compare no earlier than October 2010.”

Consumer Assessment of Healthcare Providers and Systems—Home Health Care

The Home Health CAHPS (HHCAHPS) survey presents home health patients with a set of standardized questions that collect data on patients’ interactions with home health staff, provider care and communication, and patient characteristics. HHCAHPS asks patients to rate their home care experience by assessing the care they received and their willingness to recommend the agency to others. The survey was developed by the Agency for Healthcare Research and Quality and received NQF endorsement.

CMS plans to update HHCAHPS survey data on a quarterly basis. HHAs would be provided a preview of the data each quarter before it is reported on Home Health Compare, beginning in early 2011.

CMS’ Proposal: For CY 2011, CMS proposed “. . . to expand the home health quality measures reporting requirements to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care Survey (pending OMB approval).” CMS stated that “. . . a reconsideration and appeals process is being developed for HHAs who fail to meet the HHCAHPS reporting requirements.

“The following types of home health care patients will be considered eligible to participate in the HHCAHPS survey:

- *Current or discharged patients who had at least one home health visit at any time during the sample month;*
- *Patients who were at least 18 years of age at any time during the sample period, and are believed to be alive;*
- *Patients who received at least two visits from HHA personnel during a 60-day look-back period (Note that the 60-day look-back period is defined as the 60-day period prior to and including the last day in the sample month.);*
- *Patients who have not been selected for the monthly sample during any month in the current quarter or during the five months immediately prior to the sample month;*
- *Patients who are not currently receiving hospice care;*
- *Patients who do not have routine ‘maternity’ care as the primary reason for receiving home health care; and*
- *Patients who have not requested ‘no publicity status.’”*

In addition, CMS proposed “. . . that beginning in the first quarter of CY 2010, all Medicare-certified HHAs shall begin to collect the CAHPS Home Health Care (HHCAHPS) survey data CMS proposes that participating home health agencies conduct a dry run of the survey for at least one month in the first quarter of 2010 . . . and submit the dry run data to the Home Health CAHPS Data Center by . . . June 23, 2010.”

CMS also proposed “. . . that all Medicare-certified HHAs continuously collect HHCAHPS survey data every quarter beginning in the second quarter (April, May and June) of 2010, and submit these data for the second quarter of 2010 to the Home Health CAHPS® Data Center by . . . September 22, 2010.” CMS indicates that “. . . to collect and submit HHCAHPS data to CMS, Medicare-certified agencies will need to contract with an approved HHCAHPS survey vendor.”

“CMS proposes that the requirement to collect HHCAHPS survey data be waived for agencies that serve fewer

than 60 HHCAHPS eligible patients annually.

“We also propose that newly Medicare-certified HHAs (that is, those certified on or after January 1, 2010 for payments to be made in CY 2011) be excluded from the HHCAHPS survey reporting requirement, as data submission and analysis would not be possible for an agency so late in the reporting period.

“CMS proposes that vendors and HHAs be required to participate in HHCAHPS survey oversight activities to ensure compliance with HHCAHPS survey protocols, guidelines, and survey requirements.”

CMS’ Final Rule: For CY 2010, CMS intends “. . . to move forward with the implementation of the HHCAHPS. However, we intend to link the survey to the CY 2012 payment update rather than to the CY 2011 payment update.”

CMS says it “. . . is delaying the linkage of HHCAHPS data to the quality reporting requirements for the annual payment update by 6 months. This will allow home health agencies to first fully implement OASIS-C before being required to implement the HHCAHPS survey for payment considerations. As such, agencies will be required to do a dry run for at least one month in third quarter CY 2010, and to begin data collection on an ongoing basis in October 2010. With this change, HHAs will be required to submit dry run data from the third quarter of CY 2010 to the Home Health CAHPS Data Center by . . . January 21, 2011. Similarly, HHAs will be required to submit data for the fourth quarter of CY 2010 to the Home Health CAHPS Data Center by . . . April 21, 2011.

“. . . we are recommending that the submission of HHCAHPS data be initially applied to Medicare and Medicaid patients only. Only Medicare and/or Medicaid patients are included in the HHCAHPS survey. All other eligibility criteria are being implemented as proposed.

“Agencies that have fewer than 60 eligible, unduplicated patients would be exempt from data collection from third quarter CY 2010 through second quarter CY 2011.

“. . . home health agencies certified on or after April 1, 2011 will be excluded from the HHCAHPS reporting requirement for CY 2012 as data submission and analysis will not be possible for an agency this late in the CY 2012 reporting period.”

CMS is setting a target minimum of 300 or more completed HHCAHPS surveys for each home health agency. However, *“We will accept less than 300 survey completes annually if an agency is unable to achieve that number. Compliance is based on whether the agency did the survey and followed the protocols.”*

V. FACILITY-LEVEL ADJUSTMENTS

Wage Index

Federal Register pages 58104 - 58105

Background: CMS is required by law to adjust HH PPS 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 pre-rural floor, pre-reclassified hospital wage index used to adjust the HH payment rates is based on the geographic area in which the beneficiary received the HH services.

CMS’ Final Rule: For CY 2010, CMS will to continue “. . . use of the pre-rural floor, pre-reclassification hospital wage index data”

In addition, “. . . the labor-related share . . . is 77.082 percent”

VI. CASE-LEVEL ADJUSTMENTS

Cost Outliers

Federal Register pages 58080 - 58087

Background: Outlier payments provide additional payment for extremely high-cost cases. Currently, if an HHA's costs for an episode of care (measured by the number of visits multiplied by the wage index-adjusted national per-visit amount) exceeds the fixed-loss threshold (measured by the case-mix and wage-adjusted payment for the episode plus a 0.89 fixed-dollar loss [FDL] ratio times the national standardized 60-day episode payment rate), the agency receives an outlier payment that equals 80% of the HHA's costs over the fixed-loss threshold.

Each year, CMS performs a review of the most recent data to estimate what outlier payments are expected to be, in order to appropriately adjust the outlier threshold and maintain outlier payments at no more than 5% of total HH PPS payments.

CMS' review of the data for CY 2009 yielded an estimate of outlier payments greater than 10% of the total, which is twice the statutory limit of 5%. CMS states that the primary reason for the increase in outlier payments is excessive cost growth in a few discrete areas of the country. In response, CMS suspended payments for suspect HHAs in those targeted areas.

CMS' recent analysis of the current data suggests that the outlier payments could be reduced to around 2.0% of total payments without risking access to care for high-needs patients.

CMS' Proposal: For 2010, CMS proposed “. . . to change our target percentage of outlier payments from 5 percent to approximately 2.5 percent of total estimated HH PPS payments.” This would, “. . . allow us to create a smaller outlier pool and return the remaining 2.5 percent to the HH PPS rates.”

In addition, to mitigate possible billing vulnerabilities associated with excessive outlier payments, CMS proposed “. . . to implement an agency level outlier cap such that in any given calendar year, an individual HHA would receive no more than 10 percent of its total HH PPS payments in outlier payments. Additionally, we propose to reduce the FDL ratio to 0.67 for CY 2010.”

“CMS envisions the proposed 10 percent cap on outlier payments at the agency level would be managed by the claims processing system. For each HH provider, for a given calendar year, the claims processing system would maintain a running tally of YTD total HH PPS payments and YTD actual outlier payments. The claims processing system would ensure that each time a claim for a provider was processed; YTD outlier payments for that calendar year could never exceed 10 percent of YTD total HH PPS payments for that provider for that calendar year.”

CMS' Final Rule: For CY 2010, CMS is adopting the above proposal as final.

“. . . an agency's outlier payments are to be capped at 10 percent of its total HH PPS payments (of which outlier payments are a part).” CMS will enforce the 10% outlier cap per each home health provider by using “. . . the claims processing system to maintain a running tally of the year-to-date (YTD) total home health payments. The claims processing system will ensure that each time an outlier claim for an agency is processed, actual outlier payments will never exceed 10 percent of the agency's YTD total payments.”

“ . . . if it is determined that paying the outlier portion of the total HH PPS payment for that claim would result in the HHA exceeding the 10 percent cap in outlier payments, the outlier portion of the claim would not be paid at that time.”

Low-Utilization Payment Adjustment (LUPA)

Federal Register pages 58107 - 58108

Background: For HH 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: For CY 2010, CMS proposed *“ . . . that the add-on to the LUPA payment to HHAs that submit the required quality data would be updated by the . . . marketbasket update,”* resulting in an add-on payment of \$94.90.

CMS' Final Rule: For CY 2010, CMS updated *“ . . . the add-on to the LUPA payment to HHAs that submit the required quality data . . . by the full home health market basket update . . . ”* resulting in an add-on payment of \$94.72.

“The LUPA add-on payment amount is not subject to the 2.75 percent reduction related to the nominal increase in case mix because it is an add-on to the per-visit rates”

VII. OTHER PROVISIONS

Prohibition of Sharing Practice Location

Federal Register pages 58117 - 58118

Background: In 2008, it was determined that several HHAs had enrolled or tried to enroll into the Medicare program using the same practice location listed in Section 4 of their Medicare provider enrollment applications.

CMS' Proposal: CMS proposed *“ . . . a provision that would prohibit an HHA from sharing, leasing, or subleasing its practice location or base of operations listed in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.”*

CMS' Final Rule: For CY 2010, CMS has *“ . . . decided not to finalize this provision in the final rule.”*

Sale or Transfer of Ownership

Federal Register pages 58118 - 58121

Background: CMS' current policy recommends surveys when there is a change of ownership, but does not set rules for when the survey should take place. This allows a change of ownership to occur without the new owner undergoing a survey.

CMS' Proposal: CMS proposed *“ . . . that an HHA undergoing ownership changes (including asset sales and stock transfers) must obtain an initial state survey or accreditation by an approved accreditation organization if the change takes place within 36 months after the effective date of the HHA's enrollment in Medicare The new owner of the existing HHA would instead be required to enroll in the Medicare program as a new provider.”*

CMS' Final Rule: For CY 2010, CMS is adopting the above proposal as final. CMS states, “. . . an HHA undergoing a change of ownership within the first 36 months after its enrollment remains Medicare-certified and that its provider agreement has not been revoked.”

Physician Certification and Recertification of the Home Health Plan of Care (POC)

Federal Register pages 58121 - 58122

Background: Several statutory and regulatory requirements promote the physician's active involvement in home health services and CMS continues to propose ways to encourage “more direct ‘in-person’ patient encounters” with physicians.

CMS' Proposal: CMS stated, “We continue to believe that active involvement of the physician, including “in-person” contact with the patient, during the certification and recertification of the HH POC is essential for the delivery of high quality HH services.” CMS outlines several past options to promote “more direct ‘in-person’ patient encounters” with physicians. This includes “. . . the possibility of requiring physicians to make phone calls to patients at various times over the course of home health treatment (prior to recertification), as a means to promote that physician-patient contact and to help ensure the delivery of high quality HH services to our beneficiaries.”

CMS' Final Rule: For CY 2010, CMS “. . . will continue to address our concerns surrounding this issue, and analyze and consider those comments and suggestions in future policymaking and future rulemaking.”