



**WISCONSIN HOSPITAL
ASSOCIATION**

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

August 2009

SUBMISSION OF COMMENTS

This document provides an overview of the Medicare proposed rule for the Home Health Prospective Payment System (PPS) for calendar year (CY) 2010. 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/HomeHealthPPS>

CMS must receive comments on the proposal by September 28 at 5 p.m. CMS requests that comments reference the file code CMS-1560-P.

Comments on the proposed rule can be submitted electronically at <http://www.regulations.gov>.

-OR-

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TABLE OF CONTENTS

I.	Overview.....	3
	- Major Provisions in the Proposed Rule	3
II.	Legislative Mandates.....	3
III.	HH Payment Rates	3
	- Marketbasket Update	3
	- Coding Adjustment	3
	- National Standardized 60-Day Episode Payment Rate	4
	- National Per-Visit Amounts	4
	- Non-Routine Medical Supplies—Payment	5
IV.	Reporting Home Health Quality Data	5
	- Outcome and Assessment Information Set (OASIS)	5
	- Health Insurance Prospective Payment System (HIPPS) Code Verification	5
	- CY 2010 Reporting HH Quality Measures for Annual Payment Update	5
	- CY 2011 HH Quality Measures.....	6
	-Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care.....	6
V.	Facility-Level Adjustments.....	6
	- Wage Index.....	6
VI.	Case-Level Adjustments.....	7
	- Cost Outliers.....	7
	- Low-Utilization Payment Adjustment	7
VII.	Other Provisions	7
	- Prohibition of Sharing Practice Location	7
	- Sale or Transfer of Ownership	7
	- Physician Certification and Recertification of the Home Health Plan of Care (POC).....	7

I. OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) released its proposed Home Health Prospective Payment System (HH PPS) rule for CY 2010 in the August 13, 2009 *Federal Register*.

Changes are effective January 1, 2010 unless otherwise noted.

Major Provisions in the Proposed Rule Include

-National Standardized 60-Day Episode Rate: CMS is proposing to increase the national 60-day episode rate from \$2,271.92 in CY 2009 to \$2,317.47 in CY 2010. This two percent increase includes a full marketbasket update offset by a reduction for coding changes. In addition, there is a 2.5 percent increase to the rate for the transfer of funds from the outlier carve-out (as explained below).

-Outlier Payments: CMS is proposing to reduce the estimated outlier pool payments as a percent of total HH PPS payments from 5 percent in CY 2009 to 2.5 percent in CY 2010 and return 2.5 percent of the outlier carve-out to the national standardized 60-day episode rate. In addition, CMS is also proposing to cap outlier payments at 10 percent of total HH payments for each agency in CY 2010.

-Quality Measures: CMS is proposing no changes to the current 12 home health quality measures reported for CY 2010. However, for CY 2011 CMS is proposing to expand the measures to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for home health care.

-Outcome and Assessment Information Set (OASIS) data: CMS is proposing to use a new version of the OASIS data called OASIS-C to collect data on all episodes of care beginning on or after January 1, 2010.

-Low Utilization Payment Adjustment (LUPA): CMS is proposing to increase the LUPA add-on payment amount from \$90.48 in CY 2009 to \$94.90 in CY 2010.

-Non-routine medical supplies (NRS): CMS is proposing to increase the NRS conversion factor from \$52.39 in CY 2009 to \$53.44 in CY 2010.

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 of 2005 (DRA) 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 page 40959

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' Proposal: For CY 2010, CMS is proposing a“. . . market basket update . . . of 2.2 percent.”

Coding Adjustment

Federal Register pages 40957 - 40959

Background: A provision in the 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 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 of 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 is proposing 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 states that: “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.”

National Standardized 60-Day Episode Payment Rate

Federal Register pages 40964 - 40965

CMS' Proposal: For CY 2010, CMS is proposing a“. . . national standardized 60-day episode payment rate of \$2,317.47.”

Below is a calculation of the proposed 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% proposed outlier pool	0.9750	
Subtotal		\$2,331.71
Marketbasket Update	1.022	
Subtotal		\$2,383.00
Reduction of 2.75% to account for coding changes	0.9725	
Proposed CY 2010 National Standardized 60-Day Episode Payment Rate		\$2,317.47

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 “CY 2010 Reporting HH Quality Measures for Annual Payment Update” section below.)

National Per-Visit Amounts

Federal Register page 40965

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

Per-Visit Payment Amounts:	CY 2009	CY 2010
Home Health Aide	\$48.89	\$51.28
Medical Social Services	\$173.05	\$181.51
Occupational Therapy	\$118.83	\$124.64
Physical Therapy	\$118.04	\$123.81
Skilled Nursing	\$107.95	\$113.23
Speech-Language Pathology	\$128.26	\$134.53

Non-Routine Medical Supplies—Payment

Federal Register pages 40966 - 40967

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. 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 is proposing that the “... *NRS conversion factor would be \$53.44*” Below are the proposed 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	\$14.42
2	1-14	0.9742	\$52.06
3	15-27	2.6712	\$142.75
4	28-48	3.9686	\$212.08
5	49-98	6.1198	\$327.04
6	99+	10.5254	\$562.48

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 40959 - 40963

The DRA required HHAs to collect and submit quality data in order 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.

HHAs are not 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 (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 below). CMS is requesting that the OMB modify the OASIS data set with the revised version being titled OASIS-C. The OASIS-C has undergone testing and was distributed earlier by CMS for public comment and received other technical expert reviews and recommendations. The OASIS-C is in the final stages of OMB clearance.

CMS’ Proposal: Upon approval from OMB, “. . . CMS intends to implement the use of the OASIS-C...on January 1, 2010.” CMS is proposing “...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. . .”

More information regarding OASIS-C can be found at the CMS website:

<http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1217682&intNumPerPage=10>.

Health Insurance Prospective Payment System (HIPPS) Code Verification

Federal Register pages 40967 - 40968

Background: Home Health agencies 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 and corresponding HIPPS code to CMS, the CMS OASIS submission system then validates the transmitted OASIS items, including the HIPPS code.

CMS has experienced a proliferation of incidents where the agency-submitted HIPPS code 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 code 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.

Moreover, 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 is clarifying "...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 is requiring "... the electronic reporting of OASIS to CMS as a condition of payment..."

CY 2010 Reporting HH Quality Measures for Annual Payment Update

In CY 2009, CMS required HHAs to submit data on 12 OASIS quality measures in order 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 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' Proposal: For CY 2010, CMS is proposing "...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 is proposing "... 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."

CY 2011 HH Quality Measures

CMS is requesting that the Office of Management and Budget (OMB) modify the OASIS data set (see Outcome and Assessment Information Set (OASIS) section above). The new version of OASIS data will be called OASIS-C. If approved CMS plans "...to 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. *“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*
- *Physician medication issues identified and timely physician contact during episode”*

“The implementation of OASIS-C will impact the quality data reporting requirement for the CY 2011 HH PPS. However, we expect the conversion from OASIS-B1 to OASIS-C to have little to no impact on HHAs’ ability to meet the quality data reporting requirements. . .”

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

The Home Health CAHPS (HHCAHPS) survey presents home health patients with a set of standardized questions that collects data on patients’ interactions with home health staff, provider care and communication and patient characteristics. CMS believes HHCAHPS is a tool that can be used to collect quality of care data and one that 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 the National Quality Forum (NQF) endorsement of March 31, 2009.

CMS plans to update the 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 is proposing “. . . 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 states 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 5 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 is proposing “...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 proposes “. . . 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 is setting a target minimum of 300 or more completed HHCAHPS surveys for each home health agency.

“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.”

V. FACILITY-LEVEL ADJUSTMENTS

Wage Index

Federal Register page 40963

Background: CMS is required by law 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 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' Proposal: For CY 2010, CMS is proposing to continue “. . . use of the pre-rural floor, pre-reclassification hospital wage index data. . . “

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

VI. CASE-LEVEL ADJUSTMENTS

Cost Outliers

Federal Register pages 40954 - 40957

Background: Outlier payments provide additional payment for extremely high cost cases. Currently, if a 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 percent of total HH PPS payments.

CMS' review of the data for CY 2009 yielded an estimate of outlier payments greater than 10 percent of the total, which is twice the statutory limit of 5 percent. 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 percent of total payments without risking access to care for high needs patients.

CMS' Proposal: For 2010, CMS is proposing “...to change our target percentage of outlier payments from 5 percent to approximately 2.5 percent of total estimated HH PPS payments.” As a result, “...will 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 is proposing “...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.”

Low-Utilization Payment Adjustment

Federal Register page 40966

Background: For HH 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.

CMS' Proposal: For CY 2010, CMS is proposing “. . . that the add-on to the LUPA payment to HHAs that submit the required quality data would be updated by the...market basket update.” and result in an add-on payment of \$94.90.

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

VII. OTHER PROVISIONS

Prohibition of Sharing Practice Location

Federal Register page 40971

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 is “...proposing 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 is soliciting comments on this proposal and would like to know if there are legitimate business reasons for a Medicare-enrolled HHA to share space with another Medicare-enrolled HHA or supplier when there is common ownership.

Sale or Transfer of Ownership

Federal Register pages 40971 - 40972

Background: CMS' current policy recommends surveys when there is a change of ownership, but doesn't 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 is proposing “...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....”

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

Federal Register pages 40972 - 40973

Background: There are several statutory and regulatory requirements that 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 states, “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 recertifications), as a means to promote that physician-patient contact and to help ensure the delivery of high quality HH services to our beneficiaries.”

CMS is specifically soliciting comments on this topic.