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MEMORANDUM

TO: HCBS Providers

FROM: Anne Hill, Community Services Policy Analyst
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DATE: November 8, 2010

SUBJECT: **Home Health PPS Rule for 2011**

ROUTE TO: Director, CFO

ABSTRACT: CMS releases HH PPS final rule for calendar year 2011.

Introduction

The Centers for Medicare & Medicaid Services (CMS) released its final rule to update the Medicare home health fee schedule for 2011, which incorporates a number of provisions included in the Patient Protection and Affordable Care Act (ACA). CMS estimates the final rule will generate \$960 million in savings for CY2011, amounting to a 4.89% decrease in home health expenditures when compared to CY2010.

The final rule will be formally published in the Federal Register on November 17, 2010. Attached is the CMS press release. The final rule can be found [here](#). Several provisions of the final rule are summarized below.

Code Creep

HH PPS rates will be reduced by 3.79% in CY2011 to account for “unwarranted higher-paying reimbursement codes that lead to an increase in case-mix severity” (code creep). CMS did not finalize an additional cut of 3.79% in CY2012, a change from the proposed rule. For CY2012, CMS plans to monitor the case-mix increase to see if any further coding-related cuts are warranted.

Market Basket Update

The home health market basket will be increased by 1.1%. This reflects a market basket update (of 2.1%) minus 1 percentage point, as required by the ACA.

Face-to-Face Encounter

As mandated by the ACA, a face-to-face encounter between a physician and Medicare beneficiary will be required before he or she may certify home health services. The face-to-face encounter may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant. According to the final rule, this encounter may occur up to 90 days prior to a home health episode if the reason for the encounter is related to the patient's need for home health. If no such encounter occurred, CMS will allow this face-to-face meeting to occur up to 30 days after the start of home health.

Outlier Policy

The home health outlier policy will be changed by a 5% reduction to the HH PPS rates. Total outlier payments will be capped at 2.5% of the total payments estimated for a given year. Home health agencies will also be permanently subject to a 10% agency-level cap on outlier payments. This outlier policy was also required by ACA.

36-Month Rule

In CY2010, CMS finalized a policy that requires home health agencies that change ownership within three years of initial enrollment to obtain a new state survey or accreditation. The final rule makes changes and clarifications to this 36-month rule. Exemptions to the 36-month provision will be made for certain types of bona fide ownership transactions. The final rule also clarifies that "indirect ownership changes are not subject to the 36-month rule."

Multiple Therapy-Visit Threshold Payments

The final rule will tighten the documentation needed to support the number of visits a patient needs for physical, occupational, speech language and rehabilitation therapy. Beginning April 1, 2011, the rule will also require that a qualified therapist personally reassess a patient needing 13 or 19 visits at least every 30 days. Reassessments must also be made on the 13th and 19th therapy visit, since the next visit would trigger an extra reimbursement amount. For beneficiaries living in rural areas, reassessments may be performed at any time after the 10th therapy visit but no later than the 13th visit and after the 16th therapy visit but no later than the 19th visit. Also, CMS would allow this schedule when there are circumstances that would preclude an assessment at the 13th and 19th visit.

Please contact us with any questions at ahill@nyahsa.org or call 518-449-2707 ext. 141 or pcucinelli@nyahsa.org or call ext. 145.