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for Senior Living & Community Services
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MEMORANDUM

TO: Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst
Anne Hill, Community Services Policy Analyst

DATE: December 8, 2009

SUBJECT: **HH PPS for CY 2010**

ROUTE TO: Administrator, CFO

ABSTRACT: CMS issues CY 2010 final Medicare home health PPS rule.

Introduction

On August 13, 2009 the Centers for Medicare and Medicaid Services (CMS) released their revised version of the proposed rule updating the Medicare home health agency (HHA) prospective payment system (PPS) rates for calendar year (CY) 2010, effective 01/01/10. The proposed rule can be viewed in its entirety at: http://edocket.access.gpo.gov/2009/R9-18587.htm.

CMS subsequently issued its final rule for next year with only minor adjustments from the details found in NYAHSA Doc ID # n00003787, including a slight reduction in the Market Basket Index (MBI) from the originally proposed 2.2 percent to 2.0 percent. The final rule can be viewed at *Federal Register Volume 74 Number 216*.

CY 2010 MBI

The MBI increase for CY 2010 of 2.0 percent is lower than this year's 2.9 percent. As detailed below, however, this 2.0 percent will be offset by the ongoing phase-in of the case-mix "creep" adjustment and adjustments to the current outlier policy. With all of these adjustments in mind, the standardized episodic payment rate moves from $2,271.92 for CY 2009 to $2,312.94 for CY 2010. This represents an increase of $41.02 or approximately 1.8 percent (please refer to Table 3. below).

CMS is projecting savings of $140 million based on the combination of these changes to the HH PPS, or an overall reduction of 1.2 percent. However, most regions in the state will be seeing an increase in their regional wage indexes, thereby helping to mitigate some of the impact of these negative adjustments (Table 1.).

Legislative Considerations

Providers should keep in mind that the current health care reform debate in Washington could have a dramatic impact on PPS rates for both HHAs and skilled nursing facilities (SNFs).

Specifically, the Medicare Payment Advisory Commission (MedPAC) has been advocating for some time for a freeze on any increases in both SNF and HHA payments based upon their analysis showing an approximately 12 percent margin built into both sets of rates.

NYAHSA Doc. ID # n000003969 provides members with a comprehensive analysis of the current health care reform debate in Washington. In addition, the AAHSA maintains a federal Health Reform Hub on their Web site at: www.aahsa.org. The House has completed debate on their health care reform bill (*H.R. 3200, America's Affordable Health Choices Act of 2009*).

On Nov. 18, 2009, Majority Leader Harry Reid (D-Nev.) unveiled the *HR 3590 Patient Protection and Affordable Care Act*, legislation that combines S. 1679, the health bill approved by the Senate Committee on Health, Education, Labor and Pensions (HELP) and S. 1796, the Senate Finance Committee bill. On November 21, 2009 the Senate voted to bring its health care reform bill to the floor for debate.

A key provision of the Senate bill is the allowance for a full Medicare payment update for HHAs and SNFs in 2010. This is in contract to the House version which seeks to freeze any Medicare inflationary adjustments effective 1/1/10.

In addition, both the Senate and House measures contain the Community First Choice Option and spousal impoverishment reforms to expand the availability of Medicaid coverage of home and community-based services. Both versions also contain the Community Living Assistance Services and Supports (CLASS) Act, which would create an insurance program for adults who become functionally disabled. If passed, this program will essentially create a national long term care insurance product, funded similar to the manner in which Medicare is funded through voluntary payroll deductions.

2010 Wage Index Revisions

For New York, 11 out of the 14 regions are seeing an increase in their wage indexes or wage indexes that are remaining essentially unchanged, using the Core Based Statistical Area (CBSA) methodology and hospital wage data. This marks a positive shift from this year's final rule in which 12 out of 14 regions experienced a decrease from CY 2008. An increase in a region's wage index will augment the 2.0 percent MBI, while a decrease will partially offset the MBI. In the case of three regions, Glens Falls, Kingston and Rochester, their respective wage indexes are decreasing. CMS is applying a 77.082 percent factor to determine the labor portion of the rate, with a corresponding non-labor share of 22.918. Please see the following table:

Table 1. Comparison of 2009 and 2010 Medicare Wage Indexes

Year	Region						
	Albany	Binghamton	Buffalo	Elmira	Glens Falls	Ithaca	Kingston
2009	0.8708	0.8574	0.9537	0.8247	0.8473	0.9614	0.9375
2010	0.8777	0.8780	0.9740	0.8341	0.8456	1.0112	0.9367
	Nassau	NYC	Poughkeepsie	Rochester	Syracuse	Utica	Rural
2009	1.2453	1.2885	1.0920	0.8811	0.9787	0.8404	0.8145
2010	1.2477	1.3005	1.1216	0.8724	0.9785	0.8460	0.8269

Source: CMS HHA PPS Final Rule for FY 2009

The county level breakdown of regions is as follows:

Table 2. - Payment Localities

Payment Locality	Counties
Albany-Schenectady-Troy	Albany, Rensselaer, Saratoga, Schenectady, Schoharie
Binghamton	Broome, Tioga
Buffalo-Niagara Falls	Erie, Niagara
Elmira	Chemung
Glens Falls	Warren, Washington
Ithaca	Tompkins
Kingston	Ulster
Nassau-Suffolk	Nassau, Suffolk
New York City	Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, Westchester (NJ – Bergen, Hudson, and Passaic)
Poughkeepsie	Dutchess, Orange
Rochester	Livingston, Monroe, Ontario, Orleans, Wayne
Syracuse	Madison, Onondaga, Oswego
Utica-Rome	Herkimer, Oneida
Non-Urban (Rural)	All Other Counties

2010 PPS 60-Day Episodic Rate Formula

Table 3 shows the calculation of the 60-day episodic rate as discussed above:

Table 3. Calculation of CY 2010 Standard EPR.

Table 3--Proposed National Standardized 60-Day Episode Payment Rate Update Formula

	Adjusted to return the outlier funds that paid for the original 5% target for outlier payments	Adjusted to account for CMS' proposed 2.5% outlier policy	2.0 % MBI Adjustment	2.75% case-mix creep reduction	CY 2010 National Standardized Episodic Payment Rate
CY 2009 National Standardized 60-Day Episode Payment Rate	Divided by 0.95	x 0.975	x 1.02	x 0.9725	$2,312.94
$2,271.92					

Source: CMS HH PPS Final Rule for CY 2010

See below for additional details on the outlier policy and case-mix creep adjustments. The standardized rate is further adjusted by the appropriate case-mix and wage index (based upon the CBSA in which the patient resides).

Please be reminded that HHAs that failed to submit the required Outcome and Assessment Information Set (OASIS) assessments for episodes beginning on or after July 1, 2008 and before July1, 2009, will see their MBI reduced by 2.0 percent.

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit rate by discipline; an episode consisting of four or fewer visits within a 60-day period receives what is

referred to as a low utilization payment adjustment (LUPA). Medicare also adjusts the national standardized 60-day episode payment rate for certain intervening events that are subject to a partial episode payment (PEP) adjustment. For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.

Payment for non-routine medical supplies (NRS), is no longer part of the national standardized 60-day episode rate and is computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. Durable medical equipment covered under the home health benefit is paid for outside the HH PPS payment. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification to assign patients to a home health resource group (HHRG).

- **Calculation Tools**

Updates to the home health grouper software continue to be available from CMS at: http://www.cms.hhs.gov/HomeHealthPPS/05_CaseMIxGrouperSoftware.asp.

As of December 7, 2009, AAHSA has updated its Medicare home health rate calculator for 2010 that reflects the final rule. AAHSA's home health calculation tool takes all the separate components of the rate into account to automatically compute your agency's payment rate for each separate Home Health Resource Groups (HHRG). To access the password protected spreadsheet please go to: http://www.aahsa.org/pLogin.aspx?src=HHA_Calculation_Tool_CY_2010_%20FINAL_UNPROTECTED.xls.

Outlier Policy

The outlier threshold is defined as the national standardized 60-day episode payment rate for that case-mix group plus a fixed dollar loss (FDL) amount. Both components of the outlier threshold are wage-adjusted. The wage-adjusted FDL amount represents the amount of loss that an agency must experience before an episode becomes eligible for outlier payments.

CMS allows for the provision of an addition or adjustment to the regular 60-day case-mix and wage-adjusted episode payment amount in the case of episodes that incur unusually high costs due to patient home health care needs. These outlier payments in a given year may not exceed 5 percent of total projected or estimated HH PPS payments and the standard episode payment is reduced by such a proportion to account for the aggregate increase in payments resulting from outlier payments.

The CY 2010 rule includes a provision to reduce the amount from 5 percent of the total estimated home health expenditures to 2.5 percent and institute a per provider cap of 10 percent. One change from the proposed rule is to limit these outlier adjustments to one year only. CMS' stated reason for the change is to deal with perceived abuses of the policy in limited areas of the country (not New York). The fiscal intermediaries will be required to maintain a running tally of each HHA's outlier payments to ensure that the 10 percent cap is not exceeded, with an end-of-year reconciliation to total payments. CMS believes that this will impact only a small number of providers, since most HHAs already fall below the cap.

- **FDL**

The rule also changes to the Fixed Dollar Loss (FDL) ratio for determining outlier eligibility standards to a factor of 0.67 for CY 2010 reduced from 0.89 for CY 2009. CMS analysis demonstrates that approximately 2 percent of HHAs may experience an average 7.9 percent decrease in outlier payments. This decrease will be mitigated by a 2.5 percent increase in the HH PPS rates, as a result of lowering the outlier pool from 5 percent to 2.5 percent. The CY 2010 FDL amount is calculated by multiplying the standard episodic payment amount ($2,312.94) by the FDL (0.67) for an amount of $1,549.67, before any wage or case-mix adjustment. This means that on average providers will absorb approximately $1,549.67 of costs in addition to their loss-sharing portion in excess of the outlier threshold.

Case-Mix Creep Adjustment

The case-mix creep adjustment is an important carry over from the CY 2008 final rule. According to CMS, an analysis of home health claims data indicates a significant increase in the observed case-mix since 2000, which CMS believes is due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients. Of the average 23.3 percent change in case-mix, CMS believes that 8.7 percent is due to nominal changes rather than actual changes in the underlying condition of home care patients. To correct for what CMS views as case-mix "creep", CMS had proposed reducing the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in CY 2008. As noted below, this will reduce the impact of the 2.0 percent market basket increase for CY 2010, the third year of the 3 year phase-in, with a final 4th year adjustment of minus 2.71 percent in 2011.

The changes implemented with the CY 2008 rule assumed a case-mix creep of 8.7 percent based on CY 2005 data. In the proposed rule, CMS claimed that the impact of case-mix creep had increased based on CY 2006 and CY 2007 data, and that additional adjustments are warranted. The proposed rule contained proposals for additional adjustments over the next two years as follows:

1. 2.75 percent in 2010 and 4.26 percent in 2011;
2. 6.89 percent in 2010; or
3. 3.51 percent for both years

The language in the proposed rule seemed to favor option 1, and CMS cautioned that further analysis may result in additional negative adjustments.

However, the final rule rejects the additional adjustments and limits the adjustments to the original 2.75 percent in 2010 and 2.71 percent in 2011. CMS will continue to evaluate the situation and may re-visit further adjustments in the future.

CY 2010 LUPA Modifications

The CY 2008 rule modified the low utilization payment adjustment (LUPA) and eliminated the significant change in condition payment adjustment. The same rule increased payment for LUPA episodes that occur as the only episode or the first episode during a series of home health interventions to account for the initial greater costs in such episodes.

The current proposed rule increases payments for "Only Episode" LUPAs to $94.72 (increase from $90.48) for add-on payments for single episodes and/or initial episode in a sequence of

adjacent episodes to HHAs that do not submit required OASIS quality data. The following table presents the per visit LUPA add-on by discipline:

Table 4. CY 2010 LUPA Rates

Home Health Disciplines	CY 2009 LUPA Rates	Adjusted to return the outlier funds paid for the original 5% target Divided by 0.95	Adjusted per proposed 2.5 % outlier policy x 0.975	2.0 % MBI	CY 2010 LUPA Rates
Home Health Aide	$48.89	0.95	0.975	1.02	$51.18
Skilled Nursing	$107.95	0.95	0.975	1.02	$113.01
Physical Therapy	$118.04	0.95	0.975	1.02	$123.57
Occupation Therapy	$118.83	0.95	0.975	1.02	$124.40
Speech Therapy	$128.26	0.95	0.975	1.02	$134.27
Medical SW	$173.05	0.95	0.975	1.02	$181.16

Source: CMS CY 2010 HH PPS Final Rule

Here again, for those agencies that did not submit their OASIS data fro the period 7/1/08 through 7/1/09, the 2.0 percent MBI reduction is applied.

Non-routine Medical Supplies

Medicare now pays for NRS based on 6 severity groups, similar to the proposed clinical case-mix model, which according to CMS more accurately reflects home health agency costs for NRS. Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor.

CMS is implementing a slight increase in the CY 2010 conversion factor from $52.39 to $53.34. The NRS amounts listed below include the MBI, case-mix creep, and outlier policy adjustments (these amounts are not subject to wage index adjustment). Please see the following table for a breakdown by severity group:

Table 5. NRS Payments

Severity Level	Points	Relative Weights	Payment
1	0	0.2698	$14.39
2	1 to 14	0.9742	$51.96
3	15 to 27	2.6712	$142.48
4	28 to 48	3.9686	$211.69
5	49 to 98	6.1198	$326.43
6	99+	10.5254	$561.42

Source: CMS CY 2010 HH PPS Final Rule

HHRG

The final rule maintains the same case-mix changes implemented with the CY 2008 rule including:

- ***Changes to Therapy Threshold Visits*** **–** CY 2008 implemented changes to the case-mix model including replacing the current therapy threshold at 10 visits per episode with three new therapy thresholds at 6, 14, and 20 therapy visits. The new thresholds have graduated payment levels between the proposed therapy thresholds to reduce incentives to inappropriately target higher thresholds.

- ***Case-Mix Groups*** **–** The number of case-mix groups was almost doubled from the current 80 to 153.

Quality and Data Issues

For **CY 2012**, CMS proposes to expand the home health quality (originally proposed for 2011) measures reporting requirements to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care Survey. The CAHPS Home Health Care Survey is a quality tool that we believe CMS intends to use to collect quality of care data. The HH CAHPS data collection will solicit patients' feedback on their perspectives of the home health quality of care from the agency that cannot be obtained from any other quality measure in the program. The Home Health Care Survey is part of a family of CAHPS surveys that ask patients to report on and rate their experiences with health care.

The HH CAHPS survey developed by the Agency for Healthcare Research and Quality (AHRQ), which is part of the Department of Health and Human Services, presents home health patients with a set of standardized questions about their home health care providers and the quality of their home health care. Prior to this survey, there was no national standard for collecting information about patient experiences that would enable valid comparisons across all HHAs.

The HH CAHPS survey includes 34 questions covering areas such as specific types of care provided by home health providers, communication with providers, interactions with the HHA, and global ratings of the agency. For public reporting purposes, CMS will implement composite measures and global ratings of care. Each composite measure consists of four or more questions that ask about one of the following topics:

- Patient care;
- Communications between providers and patients; and
- Specific care issues (medications, home safety and pain).

There are also two global ratings; the first rating asks the patient to assess the care given by the HHA's care providers, and the second asks the patient about his/her willingness to recommend the HHA to family and friends.

CMS will waive the collection of HH CAHPS survey data for agencies that serve fewer than 60 HH CAHPS eligible patients annually.

Some changes from the proposed rule include:

1. The survey is required for only Medicare and Medicaid clients and is optional for those clients who also have additional payers;
2. CMS will accept V codes instead of ICD-9 codes;
3. Impacted agencies must conduct a trial of the survey in the third quarter of 2010 (July, August, September) and submit the trial data to the CAHPS data center by January 21, 2011;
4. Official data must be submitted for the fourth quarter of 2010 (October – December) by April 21, 2011 and then continuing submit from that point forward; and
5. Providers should monitor the CAHPS Web site at www.homehealthcahps.org for further details, including the designation of a CAHPS contractor.

- **OASIS**

CMS intends to implement the use of the OASIS-C (Form Number CMS-R-245(OMB 0938-0760)) on January 1, 2010. This revision to the current OASIS version B-1 has undergone additional testing as part of the information collection request approved under OMB control number 0938-1040. As part of the OMB approval process, the revision to the current OASIS version was also distributed for public comment and other technical expert recommendations over the past few years. CMS proposes 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. The OASIS-C is posted at: http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp.

Agencies that certify on or after May 31 of the preceding year involved are excluded 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. At the earliest time possible after obtaining the CMS Certification Number (CCN), reporting would be mandatory.

As noted in the payment rate discussion above, HHAs that meet the reporting requirements would be eligible for the full home health market basket percentage increase. HHAs that do not meet the reporting requirements would be subject to a 2 percent reduction to the home health MBI.

- **Home Health Compare**

CMS is also updating the Home Health Compare to reflect the addition of the following 13 new process of care measures:

1. Timely initiation of care;
2. Influenza immunization received for current flu season;
3. Pneumococcal polysaccharide vaccine ever received;
4. Heart failure symptoms addressed during short-term episodes;
5. Diabetic foot care and patient education implemented during short-term episodes of care;
6. Pain assessment conducted;
7. Pain interventions implemented during short-term episodes;
8. Depression assessment conducted;
9. Drug education on all medications provided to patient/ caregiver during short-term episodes;

10. Falls risk assessment for patients 65 and older;
11. Pressure ulcer prevention plans implemented;
12. Pressure ulcer risk assessment conducted; and
13. Pressure ulcer prevention included in the plan of care.

Still under consideration are three additional process of care measures that may be added to Home Health Compare based on results of consumer testing. Those additional process measures are:

1. Drug education on high risk medications provided to patient/caregiver at start of episode;
2. Potential medication issues identified and timely physician contact **at start** of episode; and
3. Potential medication issues identified and timely physician contact **during** episode.

CMS believes that the implementation of OASIS-C will impact the quality data reporting requirement for the **CY 2011** HH PPS. However, they 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.

- **Standards of Coverage**

The final rule modifies coverage standards involving the "Management and Evaluation of a Care Plan" and skilled "Teaching and Education." This change essentially puts into formal regulation what has generally been considered the standard of practice. Regarding the care plan, the change now requires skilled nursing evaluation and monitoring. With respect to the teaching component, providers are now required to determine when a reasonable period of time has passed without achieving a successful outcome.

Conclusion

Please direct your comments or questions to Patrick Cucinelli at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.