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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

DATE: September 9, 2009

SUBJECT: **HH PPS for CY 2010**

ROUTE TO: Administrator, CFO

ABSTRACT: CMS issues 2010 proposed 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 final rule can be viewed in its entirety at: http://edocket.access.gpo.gov/2009/R9-18587.htm.

Comment Period

As noted in NYAHSA Doc. ID # n00003726, the comment period on the proposed rule ends at 5:00 p.m. on September 28, 2009. The most convenient method for submitting comments is electronically via the CMS Web site at http://www.regulations.gov and following the instructions under "More Search Options." Your comments should reference file code CMS-1560-P. Please see the proposed rule for instructions on submitting via telefax or regular mail.

CY 2010 MBI

The Market Basket Index (MBI) increase for CY 2010 will be 2.2 percent, which is slightly lower than this year's 2.9 percent. As detailed below, however, this 2.2 percent will be offset by the ongoing phase-in of the case-mix "creep" adjustment. However, as also detailed below, most regions in the state will be seeing an increase in their regional wage indexes, thereby helping to mitigate some of the negative impact of this adjustment.

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.

In the House's main version of a health care reform bill (*H.R. 3200, America's Affordable Health Choices Act of 2009*) there is provision for a freeze on Market Basket Index (MBI) increases for both types of providers. The proposed freeze would be effective CY 2010 for HHAs. Overall, the House bill contains approximately $500 billion in provider cuts over a ten year period, with approximately 11.4 percent of the cuts hitting HHAs and 6.4 percent hitting SNFs. If you have not already done so, please visit the AAHSA Web site (www.aahsa.org) and support our advocacy to preserve the MBI.

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. 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 add to the 2.2 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. 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

CMS is proposing adjusting the base average 60-day episodic payment rate effective for episodes ending January 1, 2010 through December 31, 2010 to $2,317.47. This new episodic rate represents a slight increase of $45.55 per episode from the CY 2009 episodic rate and is based upon the following formula:

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

CY 2009 National Standardized 60-Day Episode Payment Rate	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	2.2 % MBI Adjustment	2.75% case-mix creep reduction	CY 2010 National Standardized Episodic Payment Rate
$2,271.92	Divided by 0.95	x 0.975	x 1.022	x 0.9725	$2,317.47

Source: CMS HH PPS Proposed 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 Core Based Statistical Area 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.

AAHSA also updated its Medicare home health rate calculator for CY 2010 on their Web site at: http://www.aahsa.org/article.aspx?id=5774. AAHSA's home health calculation tool takes all

these separate components into account to automatically compute an agency's payment rate for each separate HHRG.

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 proposed 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. CMS's 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 would 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 proposes 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.

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", this rule proposes to reduce 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 2.2 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. CMS is now claiming that the case-mix creep has increased based on CY 2006 and CY 2007 data, and that additional adjustments are warranted, less than one of three proposed options for the next two years:

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 seems to favor option 1, and providers are cautioned that CMS is indicating that further analysis may result in additional negative adjustments.

CY 2010 LUPA Modifications

The CY 2008 rule modified the low utilization payment adjustment (LUPA) and eliminated the significant change in condition payment adjustment (see below). The 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 $93.05 (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 Medicare LUPA Rates by Discipline per Visit (excluding the $93.05 only episode payment).

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	2.2 % MBI	CY 2010 LUPA Rates
Home Health Aide	$48.89	0.95	0.975	1.022	$50.28
Skilled Nursing	$107.95	0.95	0.975	1.022	$111.01
Physical Therapy	$118.04	0.95	0.975	1.022	$121.39
Occupation Therapy	$118.83	0.95	0.975	1.022	$122.20
Speech Therapy	$128.26	0.95	0.975	1.022	$131.90
Medical SW	$173.05	0.95	0.975	1.022	$177.96

Source: CMS CY 2010 HH PPS Proposed Rule

Here again, for those agencies that did not submit their OASIS data fro the period 7/1/08 through 7/1/09, the 2.2 percent MBI is reduced to 0.2 percent for LUPA rates.

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 proposing a slight increase in the CY 2010 conversion factor from $52.39 to $53.44. Please see the following table for a breakdown by severity group:

Table 5 CY 2010 Non-routine Medical Supply Weights and Payments

Severity Level	Points	Relative Weights	Payment
1	0	0.2698	$14.42
2	1 to 14	0.9742	$52.06
3	15 to 27	2.6712	$142.75
4	28 to 48	3.9686	$212.08
5	49 to 98	6.1198	$327.04
6	99+	10.5254	$562.48

Source: CMS CY 2010 HH PPS Proposed Rule

HHRG

The proposed 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 2011**, CMS proposes 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 Office of Management and Budget (OMB) approval). 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 that cover topics 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 utilize composite measures and global ratings of care. Each composite measure consists of four or more questions that ask about one of the following related 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 proposes that the requirement to collect HH CAHPS survey data be waived for agencies that serve fewer than 60 HH CAHPS eligible patients annually.

- **OASIS**

CMS is requesting OMB approval to modify the OASIS data set. This process is in the final stages of OMB clearance. Pending OMB approval, 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 can be found using the following link: http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp.

- **Home Health Compare**

As set forth in the CY 2008 final rule with comment period, 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.

CMS is also planning to update 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.

Also 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**

CMS is also proposing a series of clarifications on the basic standards of coverage, defining in more detail the basic requirements needed to meet the definition of skilled care. Providers should review the proposed rule for more details. Although none of the proposals appears to create any new requirements per se, the clarifications can be used by survey agencies, including state Medicaid agencies in enforcing compliance. This section also includes a requirement for greater documentation relative to physician intervention in the form of a written narrative described by CMS as: "this new requirement would increase physician accountability and oversight of the certification and recertification of home health services and plan of care by focusing attention on the physician's responsibility to set out the clinical basis for this skilled need as indicated in the patient's medical record."

Conclusion

CMS typically finalizes its HH PPS rule sometime in the Fall. NYAHSA is interested in any member input on the rule in its proposed form that we may share with CMS. Please share your comments or questions with me at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.