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MEMORANDUM

TO: Community Services Members

FROM: Patrick Cucinelli, Senior Financial Policy Analyst

DATE: December 29, 2009

SUBJECT: **Limitation on HH PPS Outlier Payments**

ROUTE TO: Administrator, CFO

ABSTRACT: CMS issues directions on 10 percent annual outlier payment limit.

Introduction

NYAHSA Doc. ID # n00004131 provides members with details on the final home health agency (HHA) prospective payment system (PPS) rule for calendar year (CY) 2010. This memo includes information on the provision to reduce the system-wide amount of outlier payments from 5 percent of the total estimated home health expenditures to 2.5 percent. In addition, the Centers for Medicare and Medicaid Services (CMS) is instituting a per provider cap of 10 percent for CY 2010 only. 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. CMS believes that this will impact only a small number of providers, since most HHAs already fall below the cap.

CR 6759

CMS has issued Change Request (CR) 6759, advising the Medicare Administrative Contractors (MACs) on the details of the change. CR 6759 spells out the basic policy limiting outlier payments to each HHA to less than 10 percent of the HHA's total HH PPS payments for the year.

HHA PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 60-day periods, Medicare claims processing systems will provide extra or "outlier" payments in addition to the case-mix adjusted episode payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations are calculated by comparing the total of the products of:

- The number of visits of each discipline on the claim and each wage-adjusted national standardized per visit rate for each discipline; with

- The sum of the episode payment and a wage-adjusted standard fixed loss threshold amount.

If the total product of the number of the visits and the national standardized visit rates is greater than the case-mix specific payment amount plus the fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the product exceeds the sum will be paid to the HHA as an outlier payment in addition to the episode.

Outlier payment amounts are wage index adjusted to reflect the region in which the beneficiary was served and are made for specific episode claims. The outlier payment is a payment for an entire episode, and therefore carried only at the claim level in paid claim history.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment is included in the total payment for the episode claim on a remittance, identified separately on the claim in history using **value code 17** with an associated dollar amount representing the outlier payment.

Outlier payments also appear on the electronic remittance advice in a separate segment. The term outlier has been used in the past by Medicare to address exceptional cases both in terms of cost and length of stay. While there is a cost outlier, there is no need for a long stay outlier payment for HHA PPS, because the number of continuous episodes of care for eligible beneficiaries is unlimited.

In order to implement the 10 percent limitation, the MACs are now required to track both the total amount of payments and the total amount of outlier payments that each HHA receives. Whenever a home care claim is processed, the MAC will compare these two amounts to determine if the 10 percent threshold is met.

If the threshold is not met then the outlier payments will be processes as normal. Partial outlier payments will not be made. Only if the entire outlier payment on the claim does not result in the limitation being met will the outlier payment for that claim be made. Hitting the 10 percent limitation only impacts the outlier payment and does not affect the other HHA PPS amounts to be paid on the claim. Providers will be alerted to the fact that they have reached the 10 percent limit by the addition of claim adjustment reason code **"45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement"** on the remittance advice.

The payment of subsequent claims can impact whether a provider still meets the 10 percent threshold. Therefore, the MACs will also perform a quarterly reconciliation (February, May, August, and November) and any outlier payments subsequently found to be payable will be automatically released with a **contractor-initiated adjustment type-of-bill 3XI**, with the normal outlier payment identifier code.

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

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