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Health care legislative and regulatory update



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CMS Issues Proposed CY 2011 Home Health Update with Overall Negative 4.75 Percent Increase

The Centers for Medicare & Medicaid Services (CMS) have released a proposed calendar year (CY) 2011 update to the home health prospective payment system (HH PPS). The proposal would increase the HH PPS market basket by 2.4 percent, reduce that amount by 1.0 percent as mandated by the *Affordable Care Act* (ACA), and reduce payments by a 3.79 percent factor to account for increases unrelated to changes in “real” case-mix.

A [copy](#) of the proposed rule is on display at the *Federal Register* Office with publications scheduled for July 23rd. A 60-day comment period ending September 14th is provided.

CMS says that the proposal would set forth an update to the HH PPS rates, including: the national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply (NRS) conversion factors, and the low utilization payment amount (LUPA) add-on. The rule also proposes to update the wage index, and in accordance with the ACA, to update the outlier policy. In addition, the rule proposes changes to the home health agency (HHA) capitalization requirements. And, the rule would incorporate new legislative requirements regarding face-to-face encounters with providers related to home health and hospice care.

Comment

This year’s proposed update factors are estimated by CMS to reduce overall HHA payments by \$900 million from current CY 2010 amounts. The CY 2010 changes and payments were estimated to be \$140 million less than the CY 2009 amounts.

While the update factors appear straightforward and reflect current law, the significant change to adjust payments for “increases in aggregate case-mix that are unrelated to underlying changes in patients’ health status” is a major issue from both a conceptual and fiscal perspective.

The agency appears to focus on making adjustments for prior years when such adjustments accrue to its benefit. However, other elements, including errors in market basket forecasts and outlier payment estimates of the prospective payment systems that could increase provider payments, seem to go unanswered.

CMS acknowledges that the ACA recognizes a provider’s PPS rates can be less than the prior year. The national standardized 60-day rate would be \$157.73 less than the current amount (\$2,312.94 less \$2,155.21).

This rule is well written and has limited the amount of history regarding prior rulemaking changes, making it easy to follow.

Case Mix

In CY 2008, CMS finalized a reduction over 4 years to the national standardized 60-day episode payments rates to account for an 11.75 percent increase in case-mix which CMS said was not related to treatment of more resource intense patients.

The 11.75 percent increase was based on an analysis of data through 2005. CMS finalized a 2.75 percent reduction each year for 2008, 2009 and 2010, and 2.71 reduction for CY 2011 to account for this growth in case-mix.

CMS says that using newer data, the 11.75 percent amount has increased to 17.45 percent. CMS says that “If we were to account for the remainder of the 17.45 percent residual increase in nominal case-mix over CY 2011 and CY 2012, we estimate that the percentage reduction to the national standardized 60-day episode rates and the NRS conversion factor for nominal case-mix change for each of the two calendar years (2011 and 2012) of the case-mix change adjustment would be 3.79 percent per year.”

CMS is proposing to reduce the national standardized 60-day episode rates by 3.79 percent for CYs 2011 and 2012.

CY 2011 Rate Changes

The proposed HH PPS market basket update for CY 2011 is 2.4 percent. The ACA reduces the 2.4 percent update by 1.0 percent to 1.4 percent for those HHAs submitting quality data and -0.6 for those that do not.

CMS notes that it is proposing a policy of targeting outlier payments to be approximately 2.5 percent of total HH PPS payments in CY 2011. Also, CMS is proposing to return 2.5 percent back into the HH PPS rates, to include the national standardized 60-day episode payment rate. Therefore, to calculate the proposed CY 2011 national standardized 60-day episode payment rate, CMS first increases the CY 2010 national standardized 60-day episode payment rate (\$2,312.94) to adjust for the 2.5 percent set aside in CY 2010 for outlier payments and then reduces that adjusted payment amount by 5 percent, for outlier payments as a percentage of total HH PPS payment as mandated by ACA Section 3131. Next, CMS updates the payment amount by the current proposed CY 2011 home health market basket update of 1.4 percent.

As noted above, CMS proposes to reduce rates by 3.79 percent in CY 2011 for case-mix changes, resulting in a proposed updated CY 2011 national standardized 60-day episode payment rate of **\$2,198.58**. The following tables reflect these calculations:

National Standardized 60-Day Episode Payment Rate Updated by the Home Health Market Basket Update for CY 2011					
Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary					
CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the Outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiplied by the proposed home health market basket update (1.4 percent)	Reduced by 3.79 percent for nominal change in case-mix	CY 2011 National Standardized 60-Day Episode Payment Rate for HHAs that submit required quality data.
\$2,312.94	/0.975	X 0.95	X 1.014	X 0.9621	\$2,198.58

For HHAs that <i>DO NOT</i> Submit the Required Quality Data; National Standardized 60-Day Episode Payment Rate Updated by the Home Health Market Basket Update for CY 2010, Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary					
CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the Outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiplied by the proposed home health market basket update (0.994 percent)	Reduced by 3.79 percent for nominal change in case-mix	CY 2011 National Standardized 60-Day Episode Payment Rate for HHAs that submit required quality data.
\$2,312.94	/0.975	X 0.95	X 0.994	X 0.9621	\$2,155.21

National Per-Visit Rates Used to Pay Low Utilization Payment Adjustment (LUPA) and Compute Imputed Costs Used in Outlier Calculations

The CY 2011 national per-visit rates per discipline are shown in the table below. The six home health disciplines are Home Health Aide (HH aide), Medical Social Services (MSS), Occupational Therapy (OT), Physical Therapy (PT), Skilled Nursing (SN), and Speech Language Therapy (SLP).

Proposed National Per-Visit Rates for LUPAs (Not including the LUPA Add-On Payment Amount for a Beneficiary's Only Episode or the Initial Episode in a Sequence of Adjacent Episodes) and Outlier Calculations Updated by the Proposed CY 2011 Home Health Market Basket Update, Before Wage Index Adjustment							
				For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
Home Health Discipline Type	CY 2010 Per-Visit Amounts Per 60-Day Episode for LUPAs	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by 5 percent due to the outlier adjustment mandated by the ACA	Multiplied by the proposed home health market basket update of 1.4 percent	CY 2011 per-visit payment amount for HHAs that DO submit the required quality data	Multiplied by the proposed home health market basket update of 1.4 percent minus 2.0 percent (-0.6)	CY 2011 per-visit payment amount for HHAs that DO NOT submit the required quality data
Home Health Aide	\$51.18	/0.975	X 0.95	X 1.014	\$50.57	X 0.994	\$49.57
Medical Social Services	\$181.16	/0.975	X 0.95	X 1.014	\$178.99	X 0.994	\$175.46
Occupational Therapy	\$124.40	/0.975	X 0.95	X 1.014	\$122.91	X 0.994	\$120.48
Physical Therapy	\$123.57	/0.975	X 0.95	X 1.014	\$122.09	X 0.994	\$119.68
Skilled Nursing	\$113.01	/0.975	X 0.95	X 1.014	\$111.65	X 0.994	\$109.45
Speech-Language Pathology	\$134.27	/0.975	X 0.95	X 1.014	\$132.66	X 0.994	\$130.04

LUPA Add-on Payment Amount

Beginning in CY 2008, LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for area wage differences. The proposed CY 2011 is **\$93.58** for HHAs that report quality data and **\$91.74** for those that do not.

Non-Routine Medical Supply Conversion Factor

Payments for non-routine medical supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2011, the proposed NRS conversion factor is **\$50.70** for HHAs providing quality data, and **\$49.70** for those that do not.

For HHAs Reporting Quality			
Relative Weights for the 6-Severity NRS System			
Severity		Relative	NRS Payment
Level	Points (Scoring)	Weight	Amount
1	0	0.2698	\$13.68
2	1 to 14	0.9742	\$49.39
3	15 to 27	2.6712	\$135.43
4	28 to 48	3.9686	\$201.21
5	49 to 98	6.1198	\$310.27
6	99+	10.5254	\$533.64

For HHAs NOT Reporting Quality			
Relative Weights for the 6-Severity NRS System			
Severity		Relative	NRS
Level	Points (Scoring)	Weight	Payment Amount
1	0	0.2698	\$13.41
2	1 to 14	0.9742	\$48.42
3	15 to 27	2.6712	\$132.76
4	28 to 48	3.9686	\$197.24
5	49 to 98	6.1198	\$304.15
6	99+	10.5254	\$523.11

Rural Add-On

ACA Section 3131(c) provides an increase of 3.0 percent to the payment amounts for HH services furnished in a rural area ending after April 1, 2010 and before January 1, 2016. There is no budget neutrality associated with is mandate.

The 3.0 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-CBSA) area. CMS notes it implemented this provision for CY 2010, for episodes and visits ending on or after April 1, 2010 and ending before January 1, 2011 through Program Memorandum “Temporary 3 Percent Rural Add-On for the Home Health Prospective Payment System (HH PPS)” (Transmittal #674/Change Request #6955, issued April 23, 2010).

The CY 2011 payment amounts for 60-day episodes for services provided in a rural area before case-mix and wage index adjustments for HHAs that **Do** submit quality data is **\$2,264.54**, and for HHAs that **Do Not** is **\$2,219.87**.

The proposed CY 2011 **national per-visit rates** per discipline provided in a **rural** area are shown below.

Home Health Discipline Type	For HHAs that DO submit quality data	For HHAs that DO NOT submit quality data
	Proposed Total CY 2011 per-visit rate for Rural Areas	Proposed Total CY 2011 per-visit rate for Rural Areas
Home Health Aide	\$52.09	\$51.06
Medical Social Services	\$184.36	\$180.72
Occupational Therapy	\$126.60	\$124.09
Physical Therapy	\$125.75	\$123.27
Skilled Nursing	\$115.00	\$112.73
Speech-Language Pathology	\$136.64	\$133.94

The **Non-Routine Medical Supply Conversion Factor Update** for services provided in a **rural** area are as follows.

Severity Level	Points (Scoring)	For HHAs that DO submit quality data	For HHAs that DO NOT submit quality data
		Total Proposed NRS Payment Amount for Rural Areas	Total Proposed NRS Payment Amount for Rural Areas
1	0	\$14.09	\$13.81
2	1 to 14	\$50.87	\$49.87
3	15 to 27	\$139.49	\$136.74
4	28 to 48	\$207.25	\$203.16
5	49 to 98	\$319.58	\$313.27
6	99+	\$549.65	\$538.80

Outlier Policy

CMS notes that the ACA requires the agency to implement a HH PPS outlier policy whereby CMS reduces the standard episode payment by 5.0 percent, and targets up to 2.5 percent of total projected estimated HH PPS payments to be paid as outlier payments.

CMS has updated its analysis from the CY 2010 HH PPS final rule and has estimated that by maintaining a fixed dollar loss (FDL) ratio of 0.67, in conjunction with a 10 percent cap on outlier payments at the HHA level, CMS would pay no more than the 2.5 percent target of outlier payments as a percentage of total HH PPS payments

Home Health Wage Index

The Core-Based Statistical Areas (CBSAs) and their associated wage index values are shown in the proposed rule's Addendum B. The wage index values for rural areas are shown in Addendum A.

Enrollment Provisions for HHAs

1. HHA Capitalization

CMS is proposing that a prospective HHA be required to submit verification of compliance with having sufficient capitalization requirements at §489.28: (1) at the time of application submission, (2) during the period in which a State Agency or CMS-approved accreditation organization is making a determination as to whether the provider is in compliance with the Conditions of Participation; and (3) within the three months immediately following the issuance of a Medicare billing privileges.

2. Change of Ownership

CMS is proposing exemptions to the 36-month provision for certain legitimate transactions related to HHAs. In particular, CMS would add subparagraph (2) as exemptions to 42 CFR §424.550(b)(1) for:

- A publicly-traded company is acquiring another HHA and both entities have submitted cost reports to Medicare for the previous five (5) years.
- An HHA parent company is undergoing an internal corporate restructuring, such as a merger or consolidation, and the HHA has submitted a cost report to Medicare for the previous five (5) years.
- The owners of an existing HHA decide to change the existing business structure (e.g., partnership to a limited liability corporation or sole proprietorship to subchapter S corporation), the individual owners remain the same, and there is no change in majority ownership (i.e., 50 percent or more ownership in the HHA.)
- The death of an owner who owns 49 percent or less (where several individuals and/or organizations are co-owners of an HHA and one of the owners dies) interest in an HHA.

Home Health Face-To-Face Encounter

CMS proposes revising §424.22(a)(1)(v) such that for initial certifications, prior to a physician signing that certification and thus certifying a patient's eligibility for the Medicare home health benefit, the physician responsible for certifying the patient for home health services must document that a face-to-face patient encounter (including through the use of telehealth if appropriate) has occurred no more than 30 days prior to the home health start-of-care date by himself or herself, or by an authorized non-physician practitioner.

Hospice Face-to-Face

ACA section 3132 requires hospices to adopt MedPAC's hospice program eligibility recertification recommendations. Specifically, the bill amends section 1814(a)(7) of the Act to require that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the 180-day recertification, and prior to each subsequent recertification.

At §418.22(a)(4) CMS proposes that hospice physicians or NPs make these required visits no more than 15 calendar days prior to the 180-day recertifications and subsequent recertifications, and that the visit findings be used by the certifying physician to determine continued eligibility for hospice care.

Hypertension Diagnosis Coding Under the HH PPS

CMS is proposing to remove ICD-9-CM code 401.9, Unspecified Essential Hypertension, and ICD-9-CM code 401.1, Benign Hypertension, from the HH PPS case mix model's hypertension group.

Therapy Coverage Requirements

CMS is proposing to revise

(1) §409.44(c)(1) so that, with respect to physical therapy, occupational therapy, and speech language pathology, and clarify that:

- The patient's plan of care would include a course of therapy and therapy goals which would be consistent with the patient's functional assessment, both of which are included in the patient's clinical record. The patient's clinical record would document the necessity for the course of therapy described in the plan of care. Specifically, the clinical record would document how the course of therapy for the beneficiary's illness or injury is in accordance with accepted standards of clinical practice.
- Therapy treatment goals would be described in the plan of care, and they would be measurable. Specifically, therapy treatment goals would be such that progress toward those goals could be objectively measured. The goals would also pertain directly to the patient's illness or injury and the patient's resultant functional impairments.
- The patient's clinical record would demonstrate that the method used to assess a patient's function included the objective measurement of function in accordance with accepted standards of clinical practice. As such, successive functional assessments would enable comparison of successive measurements, thus enabling objective measurement of therapy progress.

(2) §409.44(c)(2)(i) as follows:

- For those patients requiring 13 or 19 therapy visits, the patient would be functionally re-assessed by a qualified therapist, minimally, on the 13th and the 19th therapy visit (thus requiring reassessment prior to the HH PPS therapy thresholds of 14 and 20 therapy visits), and at least every 30 days.
- No subsequent therapy visits would be covered until the qualified therapist has completed the reassessment, objectively measured progress (or lack of progress) toward goals, determined if goals have been achieved or require updating, and documented the therapy progress in the clinical record. If the objective measurements of the reassessment do not reveal progress toward goals, the qualified therapist, together with the physician, would determine whether the therapy is still effective or should be discontinued. If therapy is continued, the clinical record would be documented with a clinically supportable statement of why there is an expectation that anticipated improvement is attainable in a reasonable and generally predictable period of time.

Comment

The proposal contains an extensive narrative on documentation requirements. This material should be reviewed by those involved in this process to insure compliance with CMS' record keeping.

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