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## The New Home Health Prospective Payment System: Overview

Late on Wednesday, August 22, the Centers for Medicare and Medicaid Services (CMS) issued the Final Rule setting out reforms and refinements to the Medicare Home Health Prospective Payment System (HHPPS). This Final Rule adopts much of the structural and operational elements of the April 26 proposal, but departs from it in some significant areas that will have dramatic financial consequences to home health agencies. In the first year of implementation, the rule will bring an estimated increase of only \$30 million in home health expenditures with reductions of over \$6 billion by 2012. CMS itself estimates that all sectors of home health agencies, freestanding, hospital-based, non-profit and for profit will suffer payment reduction under this rule.

Over the coming days, the National Association for Home Care and Hospice, Inc. (NAHC) will offer detailed explanation and analysis of the rule. This article is intended to display the core elements of the rule in order for agencies to have a quick understanding of what can be expected in 2008. NAHC also will be holding two emergency teleconferences to address the new rule. On September 5, 2007, a teleconference is scheduled to provide participants with a detailed overview of the new HHPPS. On September 14, 2007, a second teleconference will focus on billing and IT issues involved in implementing the new system. At the NAHC Annual Meeting in Denver we will present a series of HHPPS focused workshops on the new system, clinical and operational implications, financial management impact, and billing/IT considerations. Finally, this edition of NAHC Report includes an outline of the NAHC Action Plan that sets out the strategy devised to respond to the rule and continuing problems with the CMS direction on HHPPS.

The following is an overview of the major provisions of the Final Rule, along with a comparison to the Proposed Rule.

### PAYMENT RATE COMPONENTS

The rule includes several elements that contribute to the actual payment rates. Included among these elements is the highly controversial "case mix creep" adjustment.

#### **Market Basket Index (Inflation rate update)**

**Proposed** : 2.9%

**Final** : 3.0%

However, this update remains at risk through Congressional action. The House of Representatives already has passed Medicare legislation that eliminates the inflation update for 2008. The Senate has not acted on Medicare legislation. Congress will reconvene after Labor Day to take up Medicare related matters.

#### **Base Episode Payment Rates**

**Proposed** : \$2355.96 for episodes beginning in 2007 and ending in 2008; \$2300.60 for episodes beginning and ending in 2008

**Final** : \$2337.06 for episodes beginning in 2007 and ending in 2008; \$2270.32 for episodes beginning and ending in 2008

**The difference between the proposed and final rates relates to changes in the adjustments to SCIC, LUPA and non-routine supply add-ons, and the outlier payment policy**

#### **Low Utilization Payment Adjustment (LUPA)**

CMS continues the application of a LUPA when the episode includes 4 or fewer visits. Per visit payments rates are set at discipline specific levels. As with the proposed changes, Medicare institutes a LUPA add-on for LUPA episodes that are start of care episodes or the sole episode of care.

**Proposed** : \$92.63 add-on for SOC or sole LUPA episodes

**Final** : **\$87.93 add-on for SOC or sole LUPA episodes**

## **Case Mix Creep Adjustment**

This is the most controversial element of the HHPPS reforms. NAHC has vigorously challenged this matter and will continue to do so (see Action Plan).

**Proposed** : 8.25% rate reduction over 3 years at 2.75% for each of 2008, 2009, and 2010

**Final** : **10.96% rate reduction over 4 years at 2.75% for 2008-2010 and 2.71% for 2011**

The change in the adjustment is explained by CMS as due to its ongoing review of data through 2005. The original CMS proposal limited its focus to 2003. NAHC holds to the position that this adjustment is arbitrary and capricious without a reliable basis in fact or assumption

## **Budget Neutrality Adjustment**

CMS must make final rate adjustments to insure that no more and no less is spent in the aggregate under the new HHPPS than would be spent under the existing system. The budget neutrality adjustment assumes the same inflation rate and case mix creep adjustment in both cases. With this reform, CMS chose to apply a budget neutrality adjustment to the case mix weights rather than the base payment rate. Nonetheless, it has a significant impact on the actual payment amounts that are made.

**Proposed** : 1.194227193

**Final** : 1.23884803 **Difference of 4.4%**

This is a major improvement from the proposed rule. It will result in higher payment rates for each of the 153 case mix categories by increasing the multiplier (case mix weight) that is applied to the base rate.

## **Wage Index**

The wage index adjusts payment rates based on the geographic location of the patient. This is a crucial component to the ultimate rate calculation. The index has been known to swing radically from one year to the next.

**Proposed** : Most recently available pre-rural floor, pre-reclassified hospital wage index

**Final**: Most recently available pre-rural floor, pre-reclassified hospital wage index

NAHC considers this index to be outdated and inappropriate for use and continues to advocate for an index that brings annual stability and parity with other health care providers such as hospitals. MedPAC has proposed an index reform to Congress that NAHC considers to be a significant improvement.

## **Outlier Payment**

Medicare law reserves 5% of projected home health expenditures to fund outlier cases. **Historically, the outlier spending has fallen short of the budgeted amount. A key component in the outlier payment determination is the Fixed Dollar Loss ratio (FDL). The FDL sets the point at which a case becomes eligible for outlier payment. The higher the FDL, the fewer the cases eligible for outlier payment.**

**Proposed** : FDL set at 0.67 (same as currently)

**Final** : FDL increased to 0.89

CMS determined that the current 0.67 FDL is likely to lead to spending in excess of the 5% outlier budget necessitating an increase in the FDL.

# **HHPPS STRUCTURAL CHANGES**

## **Case Mix Adjuster**

The most significant change in the HHPPS is the revised case mix adjustment model. The Final Rule makes minor modifications from the proposed model.

**Proposed** : 153 case mix categories with modifications of OASIS inputs, scoring weights, and recalibration of the Clinical, Functional, and Service "domains." A Four Equation model with differing payment for Early and Late episodes (third or later)

**Final** : The model is tweaked, but the proposed structure remains reasonably intact as set out above

## **Therapy Threshold**

The proposal eliminated the 10 visit threshold at which higher payment rates would occur and replaced it with a three step threshold and incremental payments for increased visits between the thresholds.

**Proposed** : 6, 14, and 20 visit thresholds, with incremental payment increases for 7-13 visits and 15-19 visits.

**Final** : Consistent with proposed structure

## **Significant Change in Condition (SCIC) adjustment**

The SCIC was intended to adjust payment to reflect increased needs that occur after the start of the episode. It never worked as intended. NAHC has long recommended its elimination.

**Proposed** : Eliminates SCIC

**Final** : Eliminates SCIC

## **MO175**

This OASIS element adjusts payment rates based on the patient's site of care during the 14 days prior to admission to home health services. It is confusing and difficult to administer because of the lack of timely data on pre-admission care.

**Proposed** : Eliminates MO175 from payment rate determinations

**Final** : Same as proposed

## **Medical Supplies**

CMS had proposed a radical change in the manner of providing reimbursement for medical supplies. Currently, the episodic base rate includes a component that accounts for supply cost without regard to a patient's actual usage. The proposed rule established a separate Non-Routine Medical Supplies add-on that is determined based on patient characteristics that indicate a likely need for certain levels of supplies. The proposal did not provide a supplies add-on for LUPA episodes or reflect changes in patients that occur after the start of the episode.

**Proposed** : Five severity levels (case mix categories) established with no add-on for LUPA episodes and no add-on to reflect changes after the start of the episode

**Final** : Six severity levels with payment ranging from \$14.12 to \$551.00 with no add-on for LUPA episodes and no add-on to reflect changes after the start of the episode

As this outline indicates, CMS made significant changes in the final rule while maintaining the basic structure of HHPPS reform set out in the proposed rule. Agencies will have their work cut out for them to implement the rule and initiate operational, financial and clinical changes by the end of the year. NAHC will be there to help throughout. To access the complete CMS Final Rule, click:

<http://www.cms.hhs.gov/homehealthPPS/downloads/CMS-1541-FCdisplay.pdf>