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CMS PROPOSES PAYMENT CHANGES TO MEDICARE HOME HEALTH SERVICES FOR 2011

The Centers for Medicare & Medicaid Services (CMS) today announced a number of changes to Medicare home health payments for 2011 that will promote efficiency in payments, implement provisions of the Affordable Care Act (ACA), and enhance program integrity.

The proposed rule, on display in the *Federal Register* today, represents a 4.75 percent decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2011. This is an estimated net decrease of \$900 million compared to payments HHAs received in CY 2010. It includes the combined effects of a market basket update, a wage index update, reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are unrelated to underlying changes in patients' health status, and other provisions mandated by the Affordable Care Act (ACA) of 2010.

The ACA mandates that CMS apply a 1 percentage point reduction to the CY 2011 home health market basket amount, which equates to a proposed 1.4 percent update for HHAs in CY 2011. CMS also proposes to further reduce HH PPS rates in CY 2011 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. Based on updated data analysis, instead of the planned 2.71 percent reduction for CY 2011, CMS proposes to reduce HH PPS rates by 3.79 percent in CY 2011 and an additional 3.79 percent in CY 2012.

The ACA also changes the existing home health outlier policy through a 5 percent reduction to HH PPS rates, with total outlier payments not to exceed 2.5 percent of the total payments estimated for a given year. HHAs are also permanently subject to a 10 percent agency-level cap on outlier payments.

“The new HH PPS provisions will help ensure more accurate payments under Medicare and reflect prudent financial stewardship of the Medicare Trust Fund,” said Jonathan Blum, director of the Center for Medicare and deputy administrator for CMS.

The proposed rule also offers an approach to implement an ACA provision, which mandates that, prior to certifying a patient's eligibility for the Medicare home health benefit, the physician must document that the physician or a non-physician practitioner has had a face-to-face encounter with the patient. "Patient care and access are ultimately what CMS is looking to protect, while working aggressively to prevent fraud. The proposed rule establishes timeframes for these encounters and documentation requirements associated with the provision," Blum said.

In CY 2010, CMS finalized a policy, which requires HHAs that change ownership within three years of initial enrollment to obtain a new State survey or accreditation. CMS now proposes exceptions to the 36-month provision for certain types of ownership transactions. CMS also proposes other changes to the 36-month rule and provides further clarification on its capitalization provisions. In addition, CMS proposes to clarify policies regarding the coverage of therapy services in the home health setting. Further, CMS provides clarification in this proposed rule regarding the quality reporting requirements for the CY 2012 HH PPS rate update, as it relates to the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAPHS) Survey.

Finally, the rule proposes an approach to implement an ACA hospice provision, which requires a hospice physician or nurse practitioner to see a patient prior to recertifying the patient's eligibility for hospice services.

Background

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical or speech therapy, or continue to need occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency.

Medicare pays HHAs through a system of prospective payments that pays at higher rates to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating HHAs.

Home health payment rates are updated annually by the home health market basket percentage increase. CMS uses the home health market basket index, which measures (and tracks) inflation in the prices of an appropriate mix of goods and services included in home health services.

Section 5201(c) of the Deficit Reduction Act (DRA) of 2005 provides for an adjustment to the home health market basket percentage update for CY 2007 and subsequent years depending on HHAs submission of quality data. HHAs that submit the required quality data would receive payments based on the home health market basket update of 1.4 percent for CY 2011. If an HHA does not submit quality data, the home health market basket percentage increase would be reduced by 2 percentage points to -0.6 percent for CY 2011.

More information is available at www.healthcare.gov, a new web portal made available by the U.S. Department of Health and Human Services.

The proposed rule will be published on July 23, 2010 at the *Federal Register*. The rule can be located at: http://www.ofr.gov/OFRUpload/OFRData/2010-17753_PI.pdf

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