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CMS PROPOSES 2012 MEDICARE HOME HEALTH PAYMENT CHANGES

Separate *Federal Register* filing for Medicaid home health services proposed to unify ACA provisions

The Centers for Medicare & Medicaid Services (CMS) today announced a number of proposed changes to Medicare home health payments for 2012 that if finalized will promote greater efficiency and payment accuracy.

A proposed rule was displayed at the *Federal Register* today proposing a 3.35 percent decrease in Medicare payments to home health agencies (HHAs) for calendar year (CY) 2012. This would be an estimated net decrease of \$640 million compared to HHA payments in CY 2011. It would include the combined effects of market basket and wage index updates (a \$310 million increase) and reductions to the home health prospective payment system (HH PPS) rates to account for increases in aggregate case-mix that are largely related to billing practices and not related to changes in the health status of patients (a \$950 million decrease).

Provisions of the Affordable Care Act (ACA) mandate that CMS apply a one (1) percentage point reduction to the CY 2012 home health market basket amount; this would equate to a proposed 1.5 percent update for HHAs next year. As part of the HH PPS rate update, CMS also proposes to reduce HH PPS rates by 5.06 percent in CY 2012 to account for the increase in the case-mix that is unrelated to changes in patient acuity.

The Medicare HHA proposed rule would also make structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

“CMS’s proposal reflects our commitment to ensure that we pay accurately for Medicare home health services as we improve the structure of our payment system and decrease incentives for upcoding,” said Jonathan Blum, Deputy Administrator and Director of the Center for Medicare.

Medicare pays home health agencies through a prospective payment system (PPS) which 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; such data are currently required from all Medicare-participating home health agencies (HHAs).

Home health payment rates have been updated annually by either the full home health market basket percentage increase, or by the home health market basket percentage increase as adjusted by Congress. CMS uses the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services. The Deficit Reduction Act of 2005 requires an adjustment to the home health market basket percentage update depending on HHAs submission of quality data. The proposed home health market basket increase for CY 2012 is 1.5 percent. HHAs that submit the required quality data would receive payments based on this full home health market basket update. If an HHA does not submit quality data, the home health market basket percentage increase would be reduced by 2 percentage points to -0.5 percent for CY 2012.

Under current Medicare policy a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. In today's proposed rule filing, Medicare has proposed to add flexibility to allow physicians who attended to a home health patient in an acute or post-acute setting to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

In a separate proposed rulemaking filed today (CMS-2348-P), CMS would require comparable face-to-face (F2F) encounters for people receiving Medicaid home health services to adhere to the unifying nature of these provisions made under the ACA.

To qualify for the Medicare home health benefits, a 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. Beneficiaries receiving Medicaid home health do not need to be homebound or require skilled care. Home health agencies participating in the Medicaid program must also adhere to Medicare conditions of participation.

Cindy Mann, director of CMS' Center for Medicaid, CHIP and Survey & Certification, said the alignment of F2F encounter requirements between the two CMS programs fulfills Section 6407 of the Affordable Care Act. "We established the Medicaid implementation of this requirement to align with Medicare's guidance to better facilitate home health services provided to individuals that are eligible for Medicare and Medicaid and to lessen the administrative burden on providers participating in both programs" Mann said.

This Medicaid regulation also clarifies long-standing CMS policy on locations and facilities in which home health services may be provided, in order for States to remain in compliance with the *Olmstead* Supreme Court decision.

The proposed rules went on display at 4:00 pm today (07/05/2011) at the *Federal Register*. The rule can be located at: <http://federalregister.gov/inspection.aspx>

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