

MEDICARE NEWS

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CMS finalizes 2012 Medicare home health payment changes

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule to update the Home Health Prospective Payment System (HH PPS) rates for Calendar Year (CY) 2012. Payments to home health agencies (HHAs) are estimated to decrease by approximately 2.31 percent or \$430 million in CY 2012, the net effect of a 1.4 percent payment update, the wage index update, and the case-mix coding adjustment.

This final rule reflects the ongoing efforts of CMS to support Medicare beneficiary access to home health services while continuing to improve payment accuracy.

The Affordable Care Act applies a 1 percentage point reduction to the CY 2012 home health market basket amount. As the CY 2012 market basket is equal to 2.4 percent, the payment update for HHAs in CY 2012 will be 1.4 percent.

CMS also reduced HH PPS rates in CY 2012 to account for additional growth in aggregate case-mix that is unrelated to changes in patients' health status. CMS has finalized a 3.79 percent reduction to the home health PPS rates for CY 2012 and an additional 1.32 percent reduction for CY 2013.

This rule also finalizes 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. These changes are intended to increase payment accuracy and reduce the growth in aggregate case-mix that is unrelated to changes in patients' health status.

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. The rule also finalizes added flexibility to allow physicians who cared for the patient in an acute or post-acute facility to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

Finally, this rule describes planned improvements to the home health publicly reported quality measures.

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 a payment update of 1.4 percent for CY 2012. If an HHA does not submit quality data, the home health market basket percentage increase is to be reduced by 2 percentage points, resulting in a payment update of -0.6 percent for CY 2012.

The final rule went on display at 4:15 pm today (10/31/2011) at the *Federal Register*. The rule can be located at: http://www.ofr.gov/OFRUpload/OFRData/2011-28416_PI.pdf.

More information about the Home Health Prospective Payment System can be located at: <http://www.cms.gov/HomeHealthPPS/>.

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