CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1443	**Date: FEBRUARY 7, 2008**
	Change Request 5879

Subject: Home Health Prospective Payment System (HH PPS) Refinement and Rate Update for Calendar Year (CY) 2008

I. SUMMARY OF CHANGES: This CR updates the 60 day national episode rates and the national per-visit amounts under the HH PPS for CY 2008. CMS is also refining the case mix methodology. CMS is also rebasing and revising the home health market basket for CY 2008. The attached Recurring Update Notification applies to chapter 10, section 10.1.7 of the Medicare Claims Processing Manual (Pub. 100-04).

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: March 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.1.7/Basis of Medicare Prospective Payment Systems and Case-Mix

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1443	Date: February 7, 2008	Change Request: 5879

SUBJECT: Home Health Prospective Payment System (HH PPS) Refinement and Rate Update for Calendar Year (CY) 2008

Effective Date: **January 1, 2008**
Implementation Date: March 7, 2008

I. GENERAL INFORMATION

A. Background: Section 5201 of the Deficit Reduction Act (DRA) provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2008. The home health market basket percentage increase for CY 2008 is 3.0 percent. Section 5201 of the DRA also requires that home health agencies (HHAs) report such quality data as determined by the Secretary. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health market basket percentage increase of 1.0 percent for CY 2007.

B. Policy: Section 5201 of the DRA requires that HHAs report quality data or be subject to a 2 percent reduction to the home health market basket percentage increase applicable to HH PPS payments for CY 2008. The home health market basket update for CY 2008 is 3.0 percent. CMS is also revising the fixed dollar loss ratio, which is used in the calculation of outlier payments, from 0.67 in CY 2007 to 0.89 for CY 2008. The loss-sharing ratio of 0.80 remains unchanged.

In addition to the new case-mix adjustment that will be applied to 60-day episode payments, the labor and non-labor percentages applied in the wage-index adjustment are being revised. The labor portion applied will be .77082. The non-labor portion applied will be .22918. The labor adjustment to the PPS rates will continue to be based on the site of service of the beneficiary as set forth in 42 CFR 484.220 and 484.230. The labor adjustment is applied to both 60-day episode and per-visit payments. The CY 2008 payment rates apply to episodes that end on or after January 1, 2008, and before January 1, 2009.

The following three tables show the payments to HHAs that **do** report the required quality data:

For episodes that begin in CY 2007 and end in CY 2008, the new 153 HHRG case-mix model (and associated Grouper) would not yet be in effect. For that reason, episodes that begin in CY 2007 and end in CY 2008 will be paid at the rate of $2,337.06, and be further adjusted for wage differences and for case-mix, based on the current 80 HHRG case-mix model. CMS recognizes that the annual update for CY 2008 is for all episodes that end on or after January 1, 2008, and before January 1, 2009. By paying this rate ($2,337.06) for episodes that begin in CY 2007 and end in CY 2008, CMS will have appropriately recognized that these episodes are entitled to receive the CY 2008 home health market, even though the new case-mix model will not yet be in effect.

Total CY 2007 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (3.0 Percent)	Reduce by 2.75 Percent for Nominal Change in Case-Mix	Adjusted to Account for the 5 Percent Outlier Policy	National Standardized 60-Day Episode Payment Rate for Episodes Beginning in CY 2007 and Ending in CY 2008
$2,339.00	X 1.030	X 0.9725	X 1.05 X 0.95	$2,337.06

Next, in order to establish new rates based on a new case-mix system, CMS again starts with the CY 2007 national standardized 60-day episode payment rate and increase that rate by the rebased and revised home health market basket update (3.0 percent) ($2,339.00 * 1.030 = $2,409.17). CMS has to put dollars associated with the outlier targeted estimates back into the base rate. In the July 3, 2000, HH PPS final rule (65 FR 41184), CMS divided the base rate by 1.05 to account for the outlier target policy. Therefore, CMS proposed to multiply the $2,409.17 by 1.05, resulting in $2,529.63. Next, CMS needed to reduce this amount to pay for each of the final policies. As noted previously, based upon the change to the LUPA payment, the NRS redistribution, and the elimination of the SCIC policy, the amounts needed to account for outlier payments, and the reduction to account for the 2.75 percent case-mix change adjustment, CMS reduced the national standardized 60-day episode payment rate by $5.51, $44.38, $10.61, $123.09, and $75.72, respectively. Therefore, the CY 2008 updated national standardized 60-day episode payment rate, for episodes beginning and ending in CY 2008, is $2,270.32. These episodes would be further adjusted for case-mix based on the 153 HHRG case-mix model for episodes beginning and ending in CY 2008. As noted in the August 29, 2007, final rule with comment, the case-mix weights were increased by a budget neutrality factor of 1.238848031.

Total CY 2007 National Standardized 60-Day Episode Payment Rate	**Multiply by the Home Health Market Basket Update 3.00 Percent)**	**Adjusted to Return the Outlier Funds to the National Standardized 60-Day Episode Payment Rate**	**Updated and Outlier Adjusted National Standardized 60-Day Episode Payment**	**Changes to Account for LUPA Adjustment ($5.51), NRS Payment ($44.38), Elimination of SCIC Policy ($10.61), Outlier Policy ($123.09), and 2.75 Percent Reduction for Nominal Change in Case-Mix ($75.72) for Episodes Beginning and Ending in CY 2008**	**CY 2008 National Standardized 60-Day Episode Payment Rate for Episodes Beginning and Ending in CY 2008**
$2,339.00	X 1.030	X 1.05	$2,529.63	- $259.31	$2,270.32

The national standardized per-visit amounts are used to calculate low utilization payment adjustments (LUPAs) and outlier payments. The national per-visit amounts are as follows:

Home Health Discipline Type	**Final CY 2007 Per-Visit Amounts Per 60-Day Episode for LUPAs**	**Multiply by the Home Health Market Basket (3.0 Percent)**	**Adjusted to Account for the 5 Percent Outlier Policy**	**CY 2008 Per-Visit Payment Amount Per Discipline**
Home Health Aide	$46.24	X1.030	X 1.05 X 0.95	$47.51
Medical Social Services	$163.68	X1.030	X 1.05 X 0.95	$168.17
Occupational Therapy	$112.40	X1.030	X 1.05 X 0.95	$115.48
Physical Therapy	$111.65	X1.030	X 1.05 X 0.95	$114.71
Skilled Nursing	$102.11	X1.030	X 1.05 X 0.95	$104.91
Speech-Language Pathology	$121.32	X1.030	X 1.05 X 0.95	$124.65

The following three tables show the payments to HHAs that **do not** report the required quality data:

The DRA provides that if the required quality data is not submitted by an HHA, then the home health market basket percentage increase applicable to that provider's payments will be reduced by 2 percent. Therefore, the increase that is applied to CY 2008 payments to HHAs that do not report the required quality data is 1.0 percent (CY 2008 market basket update of 3.0 percent minus 2 percent).

The 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin in CY 2007 and end in CY 2008 is as follows:

Total CY 2007 National Standardized 60-Day Episode Payment Rate	**Multiply by the Home Health Market Basket Update (3.0 Percent) Minus 2 Percent**	**Reduce by 2.75 Percent for Nominal Change in Case-Mix**	**Adjusted to Account for the 5 Percent Outlier Policy**	**National Standardized 60-Day Episode Payment Rate for Episodes Beginning in CY 2007 and Ending in CY 2008 for HHAs That Do Not Submit Required Quality Data**
$2,339.00	X 1.010	X 0.9725	X 1.05 X 0.95	$2,291.68

The 60-day national episode payment made to HHAs that do not report the required quality data for episodes that begin and end in CY 2008 is as follows:

Total CY 2007 National Standardized 60-Day Episode Payment Rate	**Multiply by the Home Health Market Basket Update (3.0 Percent) minus 2.0 percent**	**Adjusted to Return the Outlier Funds to the National Standardized 60-Day Episode Payment Rate**	**Updated and Outlier Adjusted National Standardized 60-Day Episode Payment**	**Changes to Account for LUPA Adjustment ($5.51), NRS Payment ($44.38), Elimination of SCIC Policy ($10.61),Outlier Policy ($123.09), and 2.75 Percent Reduction for Nominal Change in Case-Mix ($75.72) = $259.31 ; Minus 2 Percentage Points off of the Home Health Market Basket Update (3.0 Percent)[1] for Episodes Beginning and Ending in CY 2008**	**CY 2008 National Standardized 60-Day Episode Payment Rate for Episodes Beginning and Ending in CY 2008 that do not submit required quality data**
$2,339.00	X 1.010	X 1.05	$2,480.51	- $254.27	$2,226.24

The per-visit amounts applied to LUPA and outlier payments to HHAs that do not report the quality data are as follows:

Home Health Discipline Type	**Final CY 2007 Per-Visit Amounts Per 60-Day Episode for LUPAs**	**Multiply by the Home Health Market Basket (3.0 Percent)[1] minus 2.0 percent**	**Adjusted to Account for the 5 Percent Outlier Policy**	**CY 2008 Per-Visit Payment Amount Per Discipline for A Beneficiary Who Resides In A Non-MSA For HHAs That Do Not Submit Required Quality Data**
Home Health Aide	$46.24	X1.010	X 1.05 X 0.95	$ 46.59
Medical Social Services	$163.68	X1.010	X 1.05 X 0.95	$ 164.90
Occupational Therapy	$112.40	X1.010	X 1.05 X 0.95	$ 113.24
Physical Therapy	$111.65	X1.010	X 1.05 X 0.95	$ 112.48
Skilled Nursing	$102.11	X1.010	X 1.05 X 0.95	$ 102.87
Speech-Language Pathology	$121.32	X1.010	X 1.05 X 0.95	$ 122.23

These changes are to be implemented through the Home Health Pricer software found in the intermediary standard systems.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5879.1	Medicare systems shall install a new HH PPS Pricer software module effective January 1, 2008.											HH Pricer
5879.2	Medicare systems shall apply the CY 2008 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2008, and on or before December 31, 2008.											HH Pricer
5879.3	Medicare systems shall apply the new case mix systems for episodes with claim statement "From" dates on or after January 1, 2008.											HH Pricer
5879.4	Medicare systems shall apply a fixed dollar loss amount of 89% of the standard episode payment when calculating outlier payments.											HH Pricer
5879.5	Medicare contractors shall update HHA provider files to reflect whether the HHA has submitted the required quality data.						X					
5879.5.1	If an HHA is identified as having submitted claims but not submitted quality data, Medicare contractors shall set an indicator of "2" in the "Federal PPS Blend Indicator" field of the provider file.						X					
5879.5.2	If an HHA is identified as having submitted claims but not submitted quality data and also is not eligible to receive RAP payments, Medicare contractors shall set an indicator of "3" in the "Federal PPS Blend Indicator" field of the provider file. **NOTE**: These HHAs will have an indicator of "1" in this field for the preceding year.						X					
5879.6	Medicare contractors shall contact any HHAs that will receive reduced payments to alert them to their base payment rate for CY 2008.						X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5879.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X			X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5879.1	The table of HIPPS code weights in the HH Pricer will be updated. FISS hours for installing this HH Pricer were allotted under Change Request 5663, Transmittal 1310.
5879.2	CMS will provide the RHHIs with a list of providers who have not submitted the required quality data. The list will be distributed via a Joint Signature Memorandum (JSM)/Technical Direction Letter (TDL).

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Sharon Ventura (policy) at 410-786-1985, or
Wil Gehne (claims processing) at 410-786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For TITLE XVIII Contractors,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix

(Rev. 1443; Issued: 02-07-08; Effective: 01-01-08; Implementation: 03-07-08)

There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types:

- Skilled nursing facilities;
- Outpatient hospital services;
- Home health agencies;
- Rehabilitation hospitals; and
- Others.

While there are commonalities among these systems, there are also variations in how each system operates and in the payment units for these systems. HH PPS is the only system with the 60-day episode as the payment unit.

The new payment rates will be issued annually in a Recurring Update Notification instruction.

The term prospective payment for Medicare does not imply a system where payment is made before services are delivered, or where payment levels are determined prior to the providing of care. With HH PPS, at least one service must be delivered before billing can occur. For HH PPS, a significant portion for the 60-day episode unit of payment will be made at the beginning of the episode with as little as one visit delivered. HH PPS also means a shift of the basis of payment from payment tied to a claim or distinct revenue or procedural code, to an episode.

Case-mix is an underlying concept in prospective payment. With the creation of inpatient hospital PPS, the first Medicare PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. Other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care, use this concept of case-mix complexity, meaning that patient characteristics affect the complexity, and therefore, cost of care. HH PPS considers a patient's clinical and functional condition, as well as service demands, in determining case-mix for home health care.

For individual Medicare inpatient acute care hospital bills, DRGs are produced by an electronic stream of claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the Medicare claims processing contractor. Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In

HH PPS, 60-day episode payments are case-mix adjusted using elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and re-assess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted episode payment is based on elements of the OASIS data set including the therapy visits provided over the course of the episode. The number of therapy visits projected at the start of the episode, entered in OASIS, will be confirmed by the visit information submitted on the claim for the episode. Though therapy visits are adjusted only with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mix adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the Medicare contractor processing home health claims performs pricing including wage index adjustment on both episode split percentage payments.