Small Entity Compliance Guide

Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2012; Changes in Certification Requirements for Home Health Agencies and Hospices

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The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA, Pub.L. 104-121, March 29, 1996, as amended by Pub.L. 110-28, May 25, 2007) contains requirements for issuance of "small entity compliance guides." Guides are to explain what actions affected entities must take to comply with agency rules. Such guides must be prepared when agencies issue final rules for which agencies were required to prepare a Final Regulatory Flexibility Analysis under the Regulatory Flexibility Act (RFA). The overall impact of the CY 2010 HH PPS final regulation, as is detailed in the RFA of the regulation and discussed below, reflects an estimated decrease in payments to home health agencies. This final rule is estimated to have a significant economic impact on a substantial number of small entities. The complete text of this final rule can be found on the CMS Web site by clicking on the link to "CMS-1353-F" at http://www.cms.hhs.gov/center/hha.asp.

As required under section 1895(b)(3)(B) of the Social Security Act (the Act), this final rule updates the Home Health Prospective Payment System (HH PPS) rates; the national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply (NRS) conversion factors, and the low utilization payment amount (LUPA) add-on payment amounts, under the Medicare prospective payment system for home health agencies effective January 1, 2012. In accordance with section 1895(b)(4)(C) of the Act, this rule also updates the wage index used under the HH PPS.

For the purposes of the RFA, our updated data show that approximately 98 percent of HHAs are considered to be small businesses according to the Small Business Administration's size standards with total revenues of $13.5 million or less in any one year. Individuals and States are not included in the definition of a small entity. The Secretary has determined that this final rule would have a significant economic impact on a substantial number of small entities.

The overall impact, for all HHAs, in estimated total payments from CY 2011 to CY 2012, is a decrease of approximately 2.31 percent.

Rural and voluntary non-profit agencies fare considerably better than urban and proprietary agencies as a result of the provisions of this final rule. We believe this is due mainly to the distributional effects of the recalibration of the case-mix weights as described in section II.A of the final rule. Essentially, these impacts suggest that under the current case-mix system, rural and voluntary non-profit agencies bill less for high therapy episodes than do urban and proprietary agencies.

There is not much difference in the estimated impact (2.79 to 2.98 percent decreases) on HHAs when looking at the facility size based on the number of first episodes, with the lone exception being that the largest HHAs are estimated to see a 1.88 percent decrease in payments in CY 2012. In addition, using total revenues from linked Medicare cost reports, and the $13.5 million threshold of the RFA, we categorized an HHA as being either small or large. To perform this analysis, we were able to match approximately 72 percent of the cost report data to our model. For the remainder of the agencies in the model, we proxy for large agencies as those agencies with at least 750 first episodes (doing so results in approximately 95 percent of agencies being classified as small and 5 percent of agencies being large, which is reflective of what our cost report files show us). This analysis provides similar results to the one using first episodes as a measure of an agency's size in that larger agencies do better, a 0.92 percent decrease, than do small HHAs, which are estimated to experience a 2.62 percent decrease.

There is considerable variation in the estimated impacts depending on the region of the country in which the HHA is located. HHAs in the North are estimated to see a 1.31percent increase in payments while HHAs in other regions are estimated to receive between a 0.09 percent increase in payments (West) and a 3.83 percent decrease (South). HHAs in the New England, Mid Atlantic, and Pacific areas of the country are estimated to receive increases of 1.37 percent, 1.27 percent and 1.33 percent, respectively. However, HHAs in the South Atlantic, East South Central, West South Central, East North Central, West North Central, and Mountain areas of the country are estimated to receive decreases in payments ranging from 0.50 percent to 4.78 percent.

Freestanding HHAs are estimated to see a 2.73 percent decrease in payments while facility-based HHAs are estimated to see a 0.53 percent increase in payments. Voluntary not-for-profit HHAs are estimated to see a 0.52 percent increase in payments, while for-profit HHAs are estimated to see a 3.49 percent decrease in payments in CY 2012. Rural agencies are estimated to see a 1.52 percent decrease in payments in CY 2012, while urban agencies are estimated to see a 2.45 percent decrease in payments. Rural, freestanding, voluntary not-for-profit HHAs are estimated to see a 1.56 percent increase in payments. As described above, we believe the considerable variation in some of the estimated impacts is due mainly to the distributional effects of the recalibration of the case-mix weights.

In CY 2011 rulemaking, we proposed to apply a 3.79 percent reduction to payments in CY 2011 and an additional 3.79 percent reduction in CY 2012 to account for nominal case-mix growth we identified through CY 2008. However, we deferred finalizing the CY 2012 reduction pending an independent review of our method for identifying real case-mix growth. (That independent review has been completed, as we reported in the CY 2012 HH PPS proposed rule.) Because we believe that providers likely expected and planned for us to impose a 3.79 percent payment reduction in CY 2012, we are finalizing a 3.79 percent reduction in CY 2012 and a 1.32 percent reduction for CY 2013. These reductions enable us to account for the nominal case-mix which we have identified through CY 2009, to follow through with the planned 3.79 percent reduction for CY2012, and to allow for HHAs' adopting process efficiencies during CY 2012.

In addition, this rule implements Affordable Care Act provisions that reduce the home health market basket update percentage. The rule finalizes a 3.79 percent reduction to rates for CY 2012 to account for changes in case-mix, which are unrelated to real changes in patient acuity.

CMS provides the following on-line manuals that present compliance information regarding our home health regulations. The manuals are frequently updated to reflect the latest changes in Medicare home health policy. These manuals serve, in part, as a system of small entity compliance guides that meet the letter and spirit of the Small Business Regulatory Enforcement fairness Act (SBREFA).

Medicare Benefit Policy Manual; Chapter 7- Home Health Services:
http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf.

Medicare Claims Processing Manual; Chapter 10- Home Health Agency Billing:
http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf.

CMS also conducts Open Door Forums (ODFs) to improve transparency in CMS's policies. These forums provide small entities with an opportunity to obtain information, as questions, and express their views to senior CMS officials on nearly all major regulatory issues, especially those that might affect providers in a new or burdensome way. As such, information on Home Health, Hospice, and Durable Medical Equipment ODFs can be found at
http://www.cms.hhs.gov/OpenDoorForums/17_ODF_HHHDME.asp#TopOfPage.

CMS also communicates information to providers through the use of mailing lists, or listservs. HHAs can join the "HH-PPS-L" list by filling out and submitting the form at
https://list.nih.gov/cgi-bin/wa?SUBED1=hh-pps-l&A=1.

CMS also informs the public about the changes CMS is proposing or making in the programs that it administers. CMS posts the Quarterly Provider Update at the beginning of each quarter at
http://www.cms.hhs.gov/quarterlyproviderupdates/.