CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 253	**Date: DECEMBER 15, 2006**
	Change Request 5423

Subject: Home Health Prospective Payment System (HH PPS) Update for Calendar Year (CY) 2007

I. SUMMARY OF CHANGES: Section 5201 of the Deficit Reduction Act (DRA) requires that Home Health Agencies (HHAs) report quality data. HHAs that report the quality data receive a 3.3 percent increase in payments for CY 2007. HHAs that do not report the quality data receive a 2 percent reduction to the 3.3 percent increase in payments for CY 2007.

New / Revised Material
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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
N/A	

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

One Time Notification

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

Attachment – One Time Notification

Pub. 100-20	Transmittal: 253	Date: December 15, 2006	Change Request: 5423

SUBJECT: Home Health Prospective Payment System (HH PPS) Update for Calendar Year (CY) 2007

Effective Date: **January 1, 2007**

Implementation Date: January 2, 2007

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 2007. The home health market basket percentage increase for CY 2007 is 3.3 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 3.3 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 2007. The home health market basket update for CY 2007 is 3.3 percent. Section 5201 of the DRA also provides for a 5 percent payment increase for home health services furnished in a rural area with respect to episodes and visits beginning on or after January 1, 2006 and before January 1, 2007. The 1-year transition policy of using 50 percent of the Metropolitan Statistical Area-based and 50 percent of the Core Based Statistical Area (CBSA)-based wage index expires at the end of CY 2006. For CY 2007, CMS is using the CBSA-based wage index only. CMS is also revising the fixed dollar loss ratio, which is used in the calculation of outlier payments, from 0.65 in CY 2006 to 0.67 for CY 2007.

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 case mix adjustment is applied to 60-day episode payments. The labor adjustment is applied to both 60-day episode and per-visit payments. The CY 2007 payment rates apply to episodes that end on or after January 1, 2007, and before January 1, 2008.

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

CY 2006 national 60-day episode payment	3.3 percent update	CY 2007 national 60-day episode payment
$ 2,264.28	x 1.033	$2,339.00

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	CY 2006 per-visit payments	3.3 percent update	CY 2007 per-visit payments
Home Health Aide	$ 44.76	x 1.033	$ 46.24
Medical Social Services	$158.45	x 1.033	$163.68
Occupational Therapy	$108.81	x 1.033	$112.40

Physical Therapy	$108.08	x 1.033	$111.65
Skilled Nursing	$ 98.85	x 1.033	$102.11
Speech-Pathology	$117.44	x 1.033	$121.32

Section 5201 of the DRA also provides for a 5 percent payment increase for home health services furnished in a rural (non-CBSA) area for episodes and visits that **begin** on or after January 1, 2006 and before January 1, 2007. While the rural add-on primarily affects those episodes paid based on CY 2006 rates, it also affects a number of CY 2007 episodes.

CY 2007 national 60-day episode payment	**Rural add-on**	**CY 2007 60-day episode payment for rural areas**
$ 2,339.00	x 1.05	$2,455.95

The per-visit amounts applied to LUPA and outlier payments for services furnished in rural areas are as follows:

Home Health Discipline	**CY 2007 per-visit amounts**	**Rural add-on**	**CY 2007 per-visit amounts for rural areas**
Home Health Aide	$ 46.24	X 1.05	$ 48.55
Medical Social Services	$163.68	X 1.05	$171.86
Occupational Therapy	$112.40	X 1.05	$118.02
Physical Therapy	$111.65	X 1.05	$117.23
Skilled Nursing	$102.11	X 1.05	$107.22
Speech-Pathology	$121.32	X 1.05	$127.39

<u>The following tables show the payments to HHAs that **do not** report the required quality data:</u>

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 2007 payments to HHAs that do not report the required quality data is 1.3 percent (CY 2007 market basket update of 3.3 percent minus 2 percent). The rural add-on also applies to payments for services furnished in rural (non-CBSA) areas to HHAs that do not report the quality data. Again, the rural add-on applies to episodes that **begin** on or after January 1, 2006 and before January 1, 2007.

CY 2006 national 60-day episode payment	**1.3 percent update**	**CY 2007 60-day episode payment**	**Rural add-on**	**CY 2007 60-day episode payment for rural areas**
$ 2,264.28	X 1.013	$2,293.72	x 1.05	$2,408.41

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	CY 2006 per-visit amounts	Updated by 1.3 percent	CY 2007 per-visit amounts	Rural add-on	CY 2007 per-visit amounts for rural areas
Home Health Aide	$ 44.76	x 1.013	$ 45.34	x 1.05	$ 47.61
Medical Social Services	$158.45	x 1.013	$160.51	x 1.05	$168.54
Occupational Therapy	$108.81	x 1.013	$110.22	x 1.05	$115.73
Physical Therapy	$108.08	x 1.013	$109.49	x 1.05	$114.96
Skilled Nursing	$ 98.85	x 1.013	$100.14	x 1.05	$105.15
Speech-Pathology	$117.44	x 1.013	$118.97	x 1.05	$124.92

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

II. BUSINESS REQUIREMENTS

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	
5423.1	Medicare systems shall install a new HH PPS Pricer software module effective January 1, 2007.							X				
5423.2	Medicare systems shall apply the CY 2007 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2007, and on or before December 31, 2007.											HH Pricer
5423.3	Medicare systems shall apply the 5 percent rural add-on to HH PPS payment rates for episodes with claim statement "From" dates on or after January 1, 2006, and on or before December 31, 2006.											HH Pricer
5423.4	Medicare systems shall identify episodes that qualify for the 5 percent rural add-on using CBSA codes that begin with '999.'											HH Pricer
5423.5	Medicare systems shall apply a fixed dollar loss amount of 67% of the standard episode payment when calculating outlier payments.											HH Pricer
5423.6	Medicare contractors shall update HHA provider files to reflect whether the HHA has						X					

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	
	submitted the required quality data.											
5423.6.1	Medicare contractors shall compare the HHAs identified by CMS as not submitting the required quality data with their claims history to determine whether any of these HHAs have submitted claims to Medicare during the reporting period (July 1, 2005 – June 30, 2006).						X					
5423.6.2	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					
5423.6.3	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					
5423.7	Medicare systems shall apply the applicable non-rural or rural rates reflecting a 2% decrease if a value of "2" or "3" is reported in the "Federal PPS Blend Indicator" field of the provider file.											HH Pricer
5423.8	Medicare systems shall pay RAPs at 0% if a value of "3" is reported in the "Federal PPS Blend Indicator" field of the provider file.											HH Pricer
5423.9	Medicare contractors shall contact any HHAs that will receive reduced payments to alert them to their base payment rate for FY 2007.						X					

III. PROVIDER EDUCATION

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	
5423.10	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:
5423.1	The table of HIPPS code weights in the HH Pricer will not be updated.
5423.2 and 5423.3	Claim statement "From" and "Through" dates are reported in FL6 of the UB-92 claim form (or its electronic equivalent).
5423.6	CMS will provide the RHHIs with a list of providers who have not submitted the required quality data.
5423.6.2 and 5423.6.3.	The data in this field is currently transmitted to the HH Pricer by FISS in the "Init-Pay-Indicator" field of the Pricer input record.

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, Yvonne Young (claims processing) at 410-786-1886

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 FY 2007 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.