

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2356	Date: November 23, 2011
	Change Request 7657

SUBJECT: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2012

I. SUMMARY OF CHANGES: This Change Request updates the 60-day national episode rates, the national per-visit amounts, LUPA add-on amount, and non-routine medical supply payment amounts under the HH PPS for CY 2012. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 10.1.6.

EFFECTIVE DATE: January 1, 2012

IMPLEMENTATION DATE: January 3, 2012

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	n/a

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

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

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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2356	Date: November 23, 2011	Change Request: 7657
-------------	-------------------	-------------------------	----------------------

SUBJECT: Home Health Prospective Payment System (HH PPS) Update for Calendar Year (CY) 2012

EFFECTIVE DATE: January 1, 2012

IMPLEMENTATION DATE: January 3, 2012

I. GENERAL INFORMATION

A. Background: The Affordable Care Act of 2010 mandated several changes to Section 1895(b) of the Social Security Act and hence the HH PPS Update for CY 2012.

Section 1895 (b)(3)(B)(v) of the Social Security Act (the Act) provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2012. Section 3401(e) of the Affordable Care Act amended section 1895(b)(3)(B) of the Act by adding a new clause (vi) which states, “After determining the home health market basket percentage increase ... the Secretary shall reduce such percentage ... for each of 2011, 2012, and 2013, by 1 percentage point.” The home health market basket percentage increase for CY 2012 is 2.4 percent. However, after reducing it by 1 percentage point as required by the Affordable Care Act, the CY 2012 HH PPS payment update percentage becomes 1.4 percent. In addition, section 1895 (b)(3)(B)(v) of the Act 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 2.4 percent. That percentage (0.4 percent) is further reduced by 1 percentage point as required by the Affordable Care Act, for a final HH PPS payment update of -0.6 percent for CY 2012 for HHAs that do not report the required quality data.

In addition, Section 3131(c) of the Affordable Care Act amended section 421(a) of the Medicare Modernization Act (MMA), which was amended by section 5201(b) of the DRA. The amended section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016. The statute waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

B. Policy:

1) Market Basket Update

The home health market basket percentage increase for CY 2012 is 2.4 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the CY 2012 HH PPS payment update percentage becomes 1.4 percent. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health market basket update of 2.4 percent, further reduced by 1 percentage point per the Affordable Care Act, for a final HH PPS payment update of -0.6 percent for CY 2012.

2) Outlier payments

Section 3131(b) of the Affordable Care Act requires the following outlier policy: (1) target to pay no more than 2.5 percent of estimated total payments for outliers and (2) apply a 10 percent agency-level cap on outlier payments as a percentage of total HH PPS payments.

For CY 2012 and subsequent calendar years, the total amount of the additional payments or payment adjustments made may not exceed 2.5 percent of the total payments projected or estimated to be made based on the PPS in that year as required by section 1895(b)(5)(A) of the Act as amended by section 3131(b)(2)(B) of the Affordable Care Act. Per section 3131(b)(2)(C) of the Affordable Care Act, outlier payments to HHAs will be capped at 10 percent of that HHA’s total HH PPS payments.

The fixed dollar loss ratio of 0.67 and the loss-sharing ratio of 0.80, used to calculate outlier payments for CY 2011, remain unchanged for CY 2012.

3) Rural Add-on

As stipulated in section 3131(c) of the Affordable Care Act, the 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, low utilization payment adjustment (LUPA) add-on payment, and non-routine medical supply (NRS) conversion factor when home health services are provided in rural (non-CBSA) areas.

4) Payment Calculations & Rate Tables

In order to calculate the CY 2012 national standardized 60-day episode payment rate, CMS will update the payment amount by the CY 2012 HH PPS payment update percentage of 1.4 percent (the 2.4 percent home health market basket update percentage minus 1 percentage point, per section 3401(e)(2) of the Affordable Care Act).

CMS’ updated analysis of the change in case-mix that is not due to an underlying change in patient health status reveals additional increase in nominal change in case-mix. Therefore, CMS will next reduce rates by 3.79 percent resulting in an updated CY 2012 national standardized 60-day episode payment rate. The updated CY 2012 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 1. These payments are further adjusted by the individual episode’s case-mix weight and wage index.

Table 1

For HHAs that Do Submit Quality Data -- National 60-Day Episode Amounts Updated by the Home Health Market Basket Update for CY 2012 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary			
Total CY 2011 National Standardized 60-Day Episode Payment Rate	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	Reduce by 3.79% for nominal change in case-mix	CY 2012 National Standardized 60-Day Episode Payment Rate
\$2,192.07	X 1.014	X 0.9621	\$2,138.52

The updated CY 2012 national standardized 60-day episode payment rate for an HHA that does **not** submit the required quality data is subject to a HH PPS payment update percentage of 1.4 percent reduced by 2 percentage points as shown in Table 2. These payments are further adjusted by the individual episode’s case-mix weight and wage index.

Table 2

For HHAs that Do **Not** Submit Quality Data -- National 60-Day Episode Payment Amount Updated by the Home Health Market Basket Update (minus 2 percentage points) for CY 2012 Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary

CY 2011 National Standardized 60-Day Episode Payment Rate	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	Reduce by 3.79 percent for nominal change in case-mix	CY 2012 National Standardized 60-Day Episode Payment Rate.
\$2,192.07	x 0.994	X 0.9621	\$2,096.34

In calculating the CY 2012 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, the CY 2011 national per-visit rates are updated by the CY 2012 HH PPS payment update percentage of 1.4 percent for HHAs that submit quality data, and by 1.4 percent minus 2 percentage points (-0.6 percent) for HHAs that do not submit quality data.

The CY 2012 national per-visit rates per discipline are shown in Table 3. The six HH disciplines are as follows:

- Home Health Aide (HH aide);
- Medical Social Services (MSS);
- Occupational Therapy (OT);
- Physical Therapy (PT);
- Skilled Nursing (SN); and
- Speech Language Pathology Therapy (SLP).

Table 3

National Per-Visit Amounts for LUPAs (Not including the LUPA Add-On Amount for a Beneficiary's Only Episode or the Initial Episode in a Sequence of Adjacent Episodes) and Outlier Calculations Updated by the HH PPS Payment Update Percentage, Before Wage Index Adjustment

		For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
Home Health Discipline Type	CY 2011 Per-Visit Amounts Per 60-Day Episode	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 per-visit payment	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 per-visit payment
HH Aide	\$50.42	X 1.014	\$51.13	X 0.994	\$50.12
MSS	\$178.46	X 1.014	\$180.96	X 0.994	\$177.39
OT	\$122.54	X 1.014	\$124.26	X 0.994	\$121.80
PT	\$121.73	X 1.014	\$123.43	X 0.994	\$121.00
SN	\$111.32	X 1.014	\$112.88	X 0.994	\$110.65
SLP	\$132.27	X 1.014	\$134.12	X 0.994	\$131.48

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The per-visit rates noted above are before that additional payment is added to the LUPA amount. The CY 2012 LUPA add-on payment is updated in Table 4.

Table 4				
CY 2012 LUPA Add-On Amounts				
	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
CY 2011 LUPA Add-On Amount	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 LUPA Add-On Amount	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 LUPA Add-On Amount
\$93.31	X 1.014	\$94.62	X 0.994	\$92.75

Payments for non-routine supplies (NRS) are computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor. The NRS conversion factor for CY 2012 payments is updated in Table 5a.

Table 5a		
CY 2012 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data		
CY 2011 NRS Conversion Factor	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent	CY 2012 NRS Conversion Factor
\$52.54	X 1.014	\$53.28

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 5a, above, are shown in Table 5b.

Table 5b			
Relative Weights for the 6-Severity NRS System for HHAs that DO Submit Quality Data			
Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	\$14.37
2	1 to 14	0.9742	\$51.91
3	15 to 27	2.6712	\$142.32

4	28 to 48	3.9686	\$211.45
5	49 to 98	6.1198	\$326.06
6	99+	10.5254	\$560.79

The NRS conversion factor for HHAs that do not submit quality data is shown in Table 6a.

Table 6a		
CY 2012 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data		
CY 2011 NRS Conversion Factor	Multiply by the CY 2012 HH PPS payment update percentage of 1.4 percent minus 2 percentage points (-0.6 percent)	CY 2012 NRS Conversion Factor
\$52.54	X 0.994	\$52.22

The payment amounts for the various NRS severity levels based on the updated conversion factor from Table 6a, above, are shown in Table 6b.

Table 6b			
Relative Weights for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data			
Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	\$14.09
2	1 to 14	0.9742	\$50.87
3	15 to 27	2.6712	\$139.49
4	28 to 48	3.9686	\$207.24
5	49 to 98	6.1198	\$319.58
6	99+	10.5254	\$549.64

The 3 percent rural add-on, per section 3131(c) of the Affordable Care Act, is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-Core Based Statistical Areas (CBSAs)). Refer to Tables 7 thru 10b for these payment rates.

Table 7					
CY 2012 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment					
For HHAs that DO Submit Quality Data			For HHAs that DO NOT Submit Quality Data		
CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Total CY 2012 National Standardized 60-Day Episode Payment Rate	CY 2012 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Total CY 2012 National Standardized 60-Day Episode Payment Rate
\$2,138.52	X 1.03	\$2,202.68	\$2,096.34	X 1.03	\$2,159.23

Table 8						
CY 2012 Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment						
Home Health Discipline Type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2012 per-visit rate For HHAs that DO submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 per-visit rate for Rural Areas	CY 2012 per-visit rate For HHAs that DO NOT submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 per-visit rate for Rural Areas
HH Aide	\$51.13	X 1.03	\$52.66	\$50.12	X 1.03	\$51.62
MSS	\$180.96	X 1.03	\$186.39	\$177.39	X 1.03	\$182.71
OT	\$124.26	X 1.03	\$127.99	\$121.80	X 1.03	\$125.45
PT	\$123.43	X 1.03	\$127.13	\$121.00	X 1.03	\$124.63
SN	\$112.88	X 1.03	\$116.27	\$110.65	X 1.03	\$113.97
SLP	\$134.12	X 1.03	\$138.14	\$131.48	X 1.03	\$135.42

Table 9					
Total CY 2012 LUPA Add-On Amounts for Services Provided in Rural Areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2012 LUPA Add-On Amount For HHAs that DO submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 LUPA Add-On Amount for Rural Areas	CY 2012 LUPA Add-On Amount For HHAs that DO NOT submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 LUPA Add-On Amount for Rural Areas
\$94.62	X 1.03	\$97.46	\$92.75	X 1.03	\$95.53

Table 10a					
Total CY 2012 Conversion Factor for Services Provided in Rural Areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2012 Conversion Factor For HHAs that DO submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 Conversion Factor for Rural Areas	CY 2012 Conversion Factor For HHAs that DO NOT submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2012 Conversion Factor for Rural Areas
\$53.28	X 1.03	\$54.88	\$52.22	X 1.03	\$53.79

Table 10b					
Relative Weights for the 6-Severity NRS System for Services Provided in Rural Areas					
		For HHAs that DO submit quality data (NRS Conversion Factor=\$54.88)		For HHAs that DO NOT submit quality data (NRS Conversion Factor=\$53.79)	
Severity Level	Points (Scoring)	Relative Weight	Total NRS Payment Amount for Rural Areas	Relative Weight	Total NRS Payment Amount for Rural Areas
1	0	0.2698	\$14.81	0.2698	\$14.51
2	1 to 14	0.9742	\$53.46	0.9742	\$52.40
3	15 to 27	2.6712	\$146.60	2.6712	\$143.68
4	28 to 48	3.9686	\$217.80	3.9686	\$213.47
5	49 to 98	6.1198	\$335.85	6.1198	\$329.18
6	99+	10.5254	\$577.63	10.5254	\$566.16

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	D M E	F I	C A R R I E R	D M R C	R E H R I	Shared-System Maintainers				OTHER
		M A C	M A C					F I S S	M C S	V M S	C W F	
7657.1	Medicare systems shall install a new HH PPS Pricer software module effective January 1, 2012.							X				HH Pricer
7657.2	Medicare systems shall apply the CY 2012 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2012 and on or before December 31, 2012.											HH Pricer
7657.3	Medicare contractors shall update HHA provider files to reflect whether the HHA has submitted the required quality data.						X					
7657.3.1	If an HHA is identified as having submitted claims but not submitted quality data, Medicare contractors shall set an indicator of						X	X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R R E R	D M R C	R H R I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
	"2" in the "Federal PPS Blend Indicator" field of the provider file.										
7657.3.2	If an HHA is identified as having submitted claims but not submitted quality data and also is not eligible to receive a Request for Anticipated Payment (RAP), 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" or "3" in this field for the preceding year.					X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M M A C	F I I E R	C A R R E R	D M R C	R H R I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
7657.4	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 one 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	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I I E R	C A R R E R	D M R R I	R H H I	Shared-System Maintainers			
							F I S S	M C S	V M S	C W F	
	community in billing and administering the Medicare program correctly.										

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:
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): Sharon Ventura (policy) at 410-786-1985

Post-Implementation Contact(s): Contact your Contracting Officer’s Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

A. For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

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):

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.