CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2116	**Date: DECEMBER 10, 2010**
	Change Request 7253

NOTE: This Transmittal is no longer sensitive and is being re-communicated December 28, 2010. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Home Health Prospective Payment System Rate (HH PPS) Update for Calendar Year (CY) 2011

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 2011. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 10.1.6.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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:
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: 2116	Date: December 10, 2010	Change Request: 7253

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SUBJECT: Home Health Prospective Payment System (HH PPS) Update for Calendar Year (CY) 2011

Effective Date: January 1, 2011
Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: The Affordable Care Act of 2010 legislated several changes to Section 1895(b) of the Social Security Act (the Act) and hence the HH PPS Update for CY 2011.

Section 1895 (b)(3)(B)(v) of the Act provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2011. 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 application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year." The home health market basket percentage increase for CY 2011 is 2.1 percent. However, after reducing it by 1 percentage point as required by the Affordable Care Act, the home health market basket update for CY 2011 becomes 1.1 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 -0.9 percent for CY 2011.

Section 3131(b)(1) of the Affordable Care Act amended section 1895(b)(3)(C) of the Act, "Adjustment for outliers," to state, "The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period." In addition, section 3131(b)(2) of the Affordable Care Act amended section 1895(b)(5) of the Act by re-designating the existing language as section 1895(b)(5)(A) of the Act, and revising it to state that the Secretary, "may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year." As such, CMS' HH PPS outlier policy must reduce payment rates by 5 percent, and target up to 2.5 percent of total estimated HH PPS payments to be paid as outlier payments.

For CY 2010, CMS implemented a 1-year agency-level cap by limiting home health outlier payments to be no more than 10 percent of an agency's total payments. Section 3131(b)(2)(C) of the Affordable Care Act makes this 10 percent agency-level cap a statutory requirement, by adding a paragraph, (B) "Program Specific Outlier Cap", to section 1895(b)(5) of the Act. The new paragraph states, "The estimated total amount of additional payments or payment adjustments made … with respect to a home health agency for a year (beginning with

2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year". Therefore, the 10 percent agency-level outlier cap will continue in CY 2011 and subsequent calendar years.

In addition, Section 3131(c) of the Affordable Care Act amended section 421(a) of the 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 2011 is 2.1 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the home health market basket update for CY 2011 becomes 1.1 percent. HHAs that do not report the required quality data will receive a 2 percent reduction to the home health market basket update of 1.1 percent resulting in a home health market basket update of -0.9 percent for CY 2011.

2) Outlier payments

Section 3131(b) of the Affordable Care Act requires the following outlier policy: (1) reduce the standard payment amount (or amounts) by 5 percent; (2) target to pay no more than 2.5 percent of estimated total payments for outliers; and (3) apply a 10 percent agency-level cap on outlier payments as a percentage of total HH PPS payments.

CMS will first return the 2.5 percent held for the target CY 2010 outlier pool to the CY 2011 payment rates. CMS will then reduce these rates by 5 percent as required by section 1895(b)(3)(C) of the Act, as amended by section 3131(b)(1) of the Affordable Care Act. For CY 2011 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 2010, remain unchanged for CY 2011.

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 2011 national standardized 60-day episode payment rate, CMS will first increase the CY 2010 national standardized 60-day episode payment rate to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010. CMS will then reduce that adjusted payment amount by 5 percent, to account for the new outlier policy as established per section 3131(b)(1) of the Affordable Care Act. Next, CMS will update the payment amount by the CY 2011 home health market basket update of 1.1 percent (the 2.1 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 2011 national standardized 60-day episode payment rate. The updated CY 2011 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 2011 Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary

Total CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the home health market basket update of 1.1%	Reduce by 3.79% for nominal change in case-mix	CY 2011 National Standardized 60-Day Episode Payment Rate
$2,312.94	÷ 0.975	X 0.95	X 1.011	X 0.9621	$2,192.07

The updated CY 2011 national standardized 60-day episode payment rate for an HHA that does **not** submit the required quality data is subject to a HH market basket update of 1.1 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 2011 Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary

CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by 5 percent due to the outlier adjustment mandated by the Affordable Care Act	Multiply by the home health market basket update of 1.1 percent minus 2 percentage points (-0.9 percent)	Reduce by 3.79 percent for nominal change in case-mix	CY 2011 National Standardized 60-Day Episode Payment Rate.
$2,312.94	÷ 0.975	X 0.95	X 0.991	X 0.9621	$2,148.71

In calculating the CY 2011 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, the CY 2010 national per-visit rates for each discipline are

first adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010. These national per-visit rates are then reduced by 5 percent as mandated by section 1895(b)(3)(C) of the Act, as amended by section 3131(b)(1) of the Affordable Care Act. Finally, the national per-visit rates are updated by the CY 2011 HH market basket update of 1.1 percent for HHAs that submit quality data, and by 1.1 percent minus 2 percentage points (-0.9 percent) for HHAs that do not submit quality data.

The CY 2011 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 CY 2011 Home Health Market Basket Update, Before Wage Index Adjustment

				For HHAs that **DO** submit quality data		For HHAs that DO **NOT** submit quality data	
Home Health Discipline Type	CY 2010 Per-Visit Amounts Per 60-Day Episode	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by 5 percent due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the home health market basket update of 1.1 percent	CY 2011 per-visit payment amount for HHAs that DO submit the required quality data	Multiply by the home health market basket update of 1.1 percent minus 2 percentage points (-0.9 percent)	CY 2011 per-visit payment amount for HHAs that DO NOT submit the required quality data
HH Aide	$51.18	÷ 0.975	X 0.95	X 1.011	$50.42	X 0.991	$49.42
MSS	$181.16	÷ 0.975	X 0.95	X 1.011	$178.46	X 0.991	$174.93
OT	$124.40	÷ 0.975	X 0.95	X 1.011	$122.54	X 0.991	$120.12
PT	$123.57	÷ 0.975	X 0.95	X 1.011	$121.73	X 0.991	$119.32
SN	$113.01	÷ 0.975	X 0.95	X 1.011	$111.32	X 0.991	$109.12
SLP	$134.27	÷ 0.975	X 0.95	X 1.011	$132.27	X 0.991	$129.65

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 2011 LUPA add-on payment is updated in Table 4.

Table 4

CY 2011 LUPA Add-On Amounts

	For HHAs that **DO** submit quality data	For HHAs that DO **NOT** submit quality data

CY 2010 LUPA Add-On Amount Adjusted to return the outlier funds, that paid for the original 5 percent target for outliers	Adjusted to return the outlier funds that paid for the 2.5 percent target for outlier payments in CY 2010	Reduced by 5 percent due to the outlier adjustment mandated by the Affordable Care Act		Multiply by the home health market basket update of 1.1 percent	CY 2011 LUPA Add-On Amount for HHAs that DO submit required quality data		Multiply by the home health market basket update of 1.1 percent minus 2 percentage points (-0.9 percent)	CY 2011 LUPA Add-On Amount for HHAs that DO NOT submit required quality data
$94.72	÷ 0.975	X 0.95		X 1.011	$93.31		X 0.991	$91.46

Payments for 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 2011 payments is updated in Table 5a.

Table 5a				
CY 2011 NRS Conversion Factor for HHAs that **DO** Submit Quality Data				
CY 2010 NRS Conversion Factor	Adjusted to return the outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the Home Health Market Basket Update (1.1%)	CY 2011 NRS Conversion Factor
53.34	÷ 0.975	X 0.95	X 1.011	$52.54

The payment amounts for the various NRS severity levels based on the updated conversion factor 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	$14.18
2	1 to 14	0.9742	$51.18
3	15 to 27	2.6712	$140.34
4	28 to 48	3.9686	$208.51
5	49 to 98	6.1198	$321.53
6	99+	10.5254	$553.00

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

Table 6a				
CY 2011 NRS Conversion Factor for HHAs that DO **NOT** Submit Quality Data				
CY 2010 NRS Conversion Factor	Adjusted to return the outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the Home Health Market Basket Update (1.1%) minus 2 percentage points (-0.9 percent)	CY 2011 NRS Conversion Factor
53.34	÷ 0.975	X 0.95	X 0.991	$51.50

The payment amounts for the various NRS severity levels based on the updated conversion factor 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	$13.89
2	1 to 14	0.9742	$50.17
3	15 to 27	2.6712	$137.57
4	28 to 48	3.9686	$204.38
5	49 to 98	6.1198	$315.17
6	99+	10.5254	$542.06

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-CBSA) areas. Refer to Tables 7 thru 10b for these payment rates.

Table 7					
CY 2011 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 2011 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Total CY 2011 National Standardized 60-Day Episode Payment Rate	CY 2011 National Standardized 60-Day Episode Payment Rate	Multiply by the 3 Percent Rural Add-On	Total CY 2011 National Standardized 60-Day Episode Payment Rate
$2,192.07	X 1.03	$2,257.83	$2,148.71	X 1.03	$2,213.17

Table 8						
Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment						
	For HHAs that **DO** submit quality data			For HHAs that DO **NOT** submit quality data		
Home Health Discipline Type	CY 2011 per-visit rate For HHAs that **DO** submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 per-visit rate for Rural Areas	CY 2011 per-visit rate For HHAs that DO **NOT** submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 per-visit rate for Rural Areas
HH Aide	$50.42	X 1.03	$51.93	$49.42	X 1.03	$50.90
MSS	$178.46	X 1.03	$183.81	$174.93	X 1.03	$180.18
OT	$122.54	X 1.03	$126.22	$120.12	X 1.03	$123.72
PT	$121.73	X 1.03	$125.38	$119.32	X 1.03	$122.90
SN	$111.32	X 1.03	$114.66	$109.12	X 1.03	$112.39
SLP	$132.27	X 1.03	$136.24	$129.65	X 1.03	$133.54

Table 9						
Total CY 2011 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 2011 LUPA Add-On Amount For HHAs that **DO** submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 LUPA Add-On Amount for Rural Areas		CY 2011 LUPA Add-On Amount For HHAs that DO **NOT** submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 LUPA Add-On Amount for Rural Areas
$93.31	X 1.03	$96.11		$91.46	X 1.03	$94.20

Table 10a					
Total CY 2011 Conversion Factor for Services Provided in Rural Areas					
For HHAs that **DO** submit quality data			For HHAs that DO **NOT** submit quality data		
CY 2011 Conversion Factor For HHAs that DO submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 Conversion Factor for Rural Areas	CY 2011 Conversion Factor For HHAs that DO NOT submit quality data	Multiply by the 3 Percent Rural Add-On	Total CY 2011 Conversion Factor for Rural Areas
$52.54	X 1.03	$54.12	$51.50	X 1.03	$53.05

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=$54.12)		For HHAs that DO **NOT** submit quality data (NRS Conversion Factor=$53.05)	
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	$14.60	0.2698	$14.31
2	1 to 14	0.9742	$52.72	0.9742	$51.68
3	15 to 27	2.6712	$144.57	2.6712	$141.71
4	28 to 48	3.9686	$214.78	3.9686	$210.53
5	49 to 98	6.1198	$331.20	6.1198	$324.66
6	99+	10.5254	$569.63	10.5254	$558.37

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	
7253.1	Medicare systems shall install a new HH PPS Pricer software module effective January 1, 2011.							X				HH Pricer
7253.2	Medicare systems shall apply the CY 2011 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2011, and on or before December 31, 2011.											HH Pricer
7253.3	Medicare systems shall apply a fixed dollar loss amount of 67% of the standard episode payment when calculating outlier payments.											HH Pricer
7253.4	Medicare contractors shall update HHA provider files to reflect whether the HHA has submitted the required quality data.						X					
7253.4.1	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	X				
7253.4.2	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" 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 MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
7253.5	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 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:
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): Appropriate Regional Office

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 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.