CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1662	**Date: JANUARY 7, 2009**
	Change Request 6341

SUBJECT: Home Health Prospective Payment System Rate Update for Calendar Year 2009

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 2009. The attached Recurring Update Notification applies to Pub. 100-04, Medicare Claims Processing manual, chapter 10, section 10.1.6.

New / Revised Material
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

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:
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:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	**Transmittal: 1662**	**Date: January 7, 2009**	**Change Request: 6341**

SUBJECT: Home Health Prospective Payment System (HH PPS) Update for Calendar Year (CY) 2009

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Section 1895 (b)(3)(B)(v) of the Social Security Act provides that Medicare home health payments be updated by the applicable market basket percentage increase for CY 2009. The home health market basket percentage increase for CY 2009 is 2.9 percent. Section 1895 (b)(3)(B)(v) of the Act 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 0.9 percent for CY 2009.

B. Policy: Section 1895 (b)(3)(B)(v) of the Act 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 2009. The home health market basket update for CY 2009 is 2.9 percent. CMS is also holding the fixed dollar loss ratio used to calculate outlier payments to 0.89 for CY 2009. The loss-sharing ratio of 0.80 remains unchanged.

<u>The following two tables show the rates for HHAs that **DO** report the required quality data:</u>

In order to establish new payments for CY 2009, CMS starts with the CY 2008 national standardized 60-day episode payment of $2,270.32 and increases that by the home health market basket update for CY 2009 (2.9 percent). This figure is then reduced by the 2.75 percent case-mix adjustment. Refer to Table 1 for the calculations which yield a CY 2009 updated national standardized 60-day episode payment rate of $2,271.92. These payments will be further adjusted by the individual episode's case-mix weight and wage index.

Table 1				
National 60-Day Episode Amounts Updated by the Home Health Market Basket Update for CY 2009, Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary				
Total CY 2008 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (2.9 Percent)	Updated National Standardized 60-Day Episode Payment Rate	Reduce by 2.75 Percent for Nominal Change in Case-Mix	CY 2009 National Standardized 60-Day Episode Payment Rate
$2,270.32	X 1.029	$2,336.16	X 0.9725	$2,271.92

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:

Table 2			
National Per-Visit Amounts for LUPAs (Not including the Increase in Payment for a Beneficiary's Only Episode or the Initial Episode in a Sequence of Adjacent Episodes) and Outlier Calculations Updated by the Home Health Market Basket Update for CY 2009, Before Wage Index Adjustment Based on the Site of Service for the Beneficiary			
Home Health Discipline	CY 2008 Per-Visit Rate	Multiply by the CY 2009 Home Health Market Basket (2.9 percent)	CY 2009 Per-Visit Rate
Home Health Aide	$47.51	X 1.029	$48.89
Medical Social Services	$168.17	X 1.029	$173.05
Occupational Therapy	$115.48	X 1.029	$118.83
Physical Therapy	$114.71	X 1.029	$118.04
Skilled Nursing	$104.91	X 1.029	$107.95
Speech-Language Pathology	$124.65	X 1.029	$128.26

The following two tables show the rates for HHAs that **DO NOT** report the required quality data:

Section 1895 (b)(3)(B)(v) of the Act requires that if 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 2009 payments to HHAs that do not report the required quality data is 0.9 percent (CY 2009 market basket update of 2.9 percent minus 2 percent).

Table 3				
For HHAs that Do Not Submit the Required Quality Data -- National 60-Day Episode Amounts Updated by the Home Health Market Basket Update for CY 2009 Minus 2 Percent, Before Case-Mix Adjustment, Wage Index Adjustment Based on the Site of Service for the Beneficiary				
Total CY 2008 National Standardized 60-Day Episode Payment Rate	Multiply by the Home Health Market Basket Update (2.9 Percent) minus 2 percent	Updated National Standardized 60-Day Episode Payment for HHAs that do not submit required quality data	Reduce by 2.75 Percent for Nominal Change in Case-Mix	CY 2009 National Standardized 60-Day Episode Payment for HHAs that do not submit required quality data
$2,270.32	X 1.009	$2,290.75	X 0.9725	$2,227.75

Table 4			
For HHAs that Do Not Submit the Required Quality Data -- National Per-Visit Amounts for LUPAs (Not including the Increase in Payment for a Beneficiary's Only Episode or the Initial Episode in a Sequence of Adjacent Episodes) and Outlier Calculations Updated by the Home Health Market Basket Update for CY 2009 Minus 2 Percent, Before Wage Index Adjustment Based on the Site of Service for the Beneficiary			
Home Health Discipline	CY 2008 Per-Visit Rate	Multiply by the Home Health Market Basket Update (2.9 Percent) minus 2 percent	CY 2009 Per-Visit Rate
Home Health Aide	$47.51	X 1.009	$47.94
Medical Social Services	$168.17	X 1.009	$169.68
Occupational Therapy	$115.48	X 1.009	$116.52
Physical Therapy	$114.71	X 1.009	$115.74
Skilled Nursing	$104.91	X 1.009	$105.85
Speech-Language Pathology	$124.65	X 1.009	$125.77

LUPA episodes that occur as initial episodes in a sequence of adjacent episodes or as the only episode receive an additional payment. The Table 2 and Table 4 per-visit rates noted above are before that additional payment is added to the LUPA amount. For CY 2008, that amount was $87.93. This additional LUPA amount is updated by the home health market basket percentage update. Consequently, for CY 2009, the additional amount paid for LUPAs that occur as initial episodes in a sequence of adjacent episodes or as the only episode is $90.48 ($87.93 x 1.029).

As CMS did in the CY 2008 HH PPS final rule with comment, payments for non-routine supplies (NRS) are updated by the home health market basket and reduced by the 2.75 percent reduction to the rates through the updating of NRS conversion factor. NRS payments are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. For CY 2009 payments, the NRS conversion factor is increased by the CY 2009 home health market basket update of 2.9 percent and reduced by the 2.75 percent reduction to the rates. The NRS conversion factor for CY 2008 was $52.35. Consequently, for CY 2009, the NRS conversion factor is $52.39 ($52.35 x 1.029 x (1 – 0.0275)).

The payment amounts for the various severity levels based on the updated conversion factor are calculated in Table 5.

Table 5			
Relative Weights for the 6-Severity NRS System			
Severity Level	Points (Scoring)	Relative Weight	NRS Payment Amount
1	0	0.2698	$14.13
2	1 to 14	0.9742	$51.04
3	15 to 27	2.6712	$139.94
4	28 to 48	3.9686	$207.91
5	49 to 98	6.1198	$320.62
6	99+	10.5254	$551.43

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	
6341.1	Medicare systems shall install a new HH PPS Pricer software module effective January 1, 2009.											HH Pricer
6341.2	Medicare systems shall apply the CY 2009 HH PPS payment rates for episodes with claim statement "Through" dates on or after January 1, 2009 and on or before December 31, 2009.											HH Pricer
6341.3	Medicare systems shall apply a fixed dollar loss amount of 89% of the standard episode payment when calculating outlier payments.											HH Pricer
6341.4	Medicare contractors shall update HHA provider files to reflect whether the HHA has submitted the required quality data.						X					
6341.4.1	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					
6341.4.2	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" 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	
6341.5	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 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:

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

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.