Small Entity Compliance Guide

Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2011; Changes in Certification Requirements for Home Health Agencies and Hospices

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The Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA, P.L. 104-121, March 29, 1996, as amended by P.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-1510-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, 2011. 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 95 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 2010 to CY 2011, is a decrease of approximately 4.89 percent. There is very little difference in the estimated impact on HHAs when looking at the type of facility.

Freestanding HHAs are estimated to see a 4.88 percent decrease in payments while facility based HHAs are estimated to see a 4.92 percent decrease. Similarly, voluntary not-for-profit HHAs are estimated to see a 4.97 percent decrease in payments, while for-profit HHAs are estimated to see a 4.84 percent decrease in payments. Rural agencies are estimated to see a 4.67 percent decrease in payment in CY 2011, while urban agencies are estimated to see a 4.93 percent decrease in payments.

Breaking this down even further, agencies in New England (-5.39 percent) and in the South (-5.19 percent) are estimated to experience the largest decreases, while HHAs in the Pacific (-4.49 percent) and the West (-4.66 percent) are estimated to have less of a decrease in payments in CY 2011.

For the purposes of impact analysis, the agency size categories for the proposed rule, and again for this final rule, were based on the number of first episodes in a random 20 percent beneficiary sample of CY 2008 claims data. Initial episodes, under the HH PPS, are defined as the first episode in a series of adjacent episodes (contiguous episodes that are separated by no more than a 60-day period between episodes) for a given beneficiary. Initial, or first, episodes are a good estimate of agency size, because this method approximates the number of admissions experienced by the agency based on approximately one-fifth of the total annual data.

As such, the size categories for these impact analyses are: less than 19 first episodes, 20 to 49 first episodes, 50 to 99 first episodes, 100 to 199 first episodes, and 200 or more first episodes. In general, smaller agencies are estimated to see less of a decrease in payments in CY 2011, than are larger agencies. Larger HHAs (those with 200 or more Medicare home health initial episodes per year) are estimated to experience a decrease in payments from CY 2010 to CY 2011 of approximately 4.93 percent. Mid-size to small agencies are expected to see a decrease in their payments in CY 2011, ranging from 4.73 percent to 4.88 percent.

We supplemented our impact analysis from the proposed rule by linking to Medicare cost report data which has total revenues for HHAs. Using total revenues 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 small HHAs fare slightly better, a 4.84 percent decrease in payments, than do large HHAs, which are estimated to experience a 5.01 percent decrease in payments in CY 2011.

In a separate, supplemental analysis, as merely an indicator of possible access to care issues, we looked at estimated margins of HHAs, by county, and the estimated effect that the provisions of this rule might have on HHA margins. We note that predicting the size of the increase in negative-margin agencies as a result of this rule is difficult to do because many agencies may find ways to cut costs or increase revenues so that margins do not deteriorate. We also note that margin analysis alone is not an accurate access to care indicator. Many factors affect whether agencies with low or negative margin would close or not, such as the organization's mission, the availability of alternate sources of funding, and whether or not the organization is embedded in a larger one.

As stated above, we estimate that this final rule would have a significant economic impact on a substantial number of small entities. In the proposed rule, our analysis on the impact on small HHAs was from an episodic perspective. As a result of the public comments received on the proposed rule, we supplemented our impact from the proposed rule by linking to Medicare cost report data, which has reported total revenues for HHAs. The results of that supplemental analysis reveal that in using Medicare cost report data and a $13.5 million threshold to determine small versus large HHAs, the effect on small HHAs is virtually unchanged from that which was described in the proposed rule.

In CY 2008 rulemaking, we promulgated case-mix reductions of 2.75 percent for CY 2008, CY 2009, CY 2010, and 2.71 percent for CY 2011. Since that rulemaking, our analysis still shows that case-mix continues to grow. More specifically, nominal case-mix has grown from the 11.75 percent growth identified in our analysis for the CY 2008 rulemaking to 17.45 percent for this rule. While the 2.71 percent case-mix reduction was promulgated in CY 2008 rulemaking, because nominal case-mix

continues to grow and thus to date we have not accounted for all of the increase in nominal case-mix growth, we believe it appropriate to reduce HH PPS rates now, so as to move towards more accurate payment for the delivery of HH services under the Medicare HH benefit.

Furthermore, we have amended our proposal from the proposed rule, which would have implemented 2 successive years of case-mix reductions at 3.79 percent, and are instead finalizing only one 3.79 percent reduction for CY 2011. We will study additional case-mix data, and methods to incorporate such data, into our methodology for measuring real versus nominal case-mix change in future rulemaking. The other reductions to the HH PPS payments discussed in this rule and included in the final provisions of this rule are not discretionary as they are required by the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010).

In addition, this rule implements Affordable Care Act provisions that change the HH PPS outlier policy and reduce the home health market basket update percentage. This rule also revises the home health agency (HHA) capitalization requirements and adds clarifying language to the "skilled services" section of the Medicare benefit Policy Manual. The rule finalizes a 3.79 percent reduction to rates for CY 2011 to account for changes in case-mix, which are unrelated to real changes in patient acuity. Additionally, this rule incorporates new legislative requirements regarding face-to-face encounters with providers related to home health and hospice care. Finally, this rule clarifies requirements for a Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care Survey (HHCAHPS) affecting payment to HHAs beginning in CY 2012.

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/.