

## **VNAA Brief Summary Final Home Health Payment Rule for CY 2012**

CMS has released its public display copy of the Final Home Health Payment Rule for 2012. It makes several changes to the proposed rule based on updated data and public comment. The basic outlines of the rule remain largely unchanged but payment improves somewhat due to a phase-in of the creep cuts over 2 years. The net average payment impacts on nonprofit providers, both free-standing and provider-based improve to positive .30% and .87% respectively (from negative .49% & positive .17%). Due to the rural add-on the impacts on free-standing rural are higher. Impacts for proprietary agencies are still significant negatives with free-standing proprietaries at an average cut of minus 3.51%. The key provisions include:

- CMS implements a 1.4% (vs. 1.5% proposed) increase in the market basket adjustment for home health based on the actual final market basket number of 2.4% minus the 1% reduction dictated by Congress.
- CMS spreads the proposed 5.06% “creep cut” for nominal case mix change over two years rather than taking the entire amount in 2012. The 2012 reduction will be the same as that proposed in 2011, 3.79%. CMS postpones the additional 1.32% for 2013.
- The standardized HHPPS payment rate moves from to \$2138.52 (urban) and to \$2202.68 (rural).
- CMS finalizes the elimination of the unspecified hypertension codes and adjusts the scoring of HHPPS accordingly.
- CMS adjusts the case mix weights associated with therapy and redistributes the weights in a budget neutral manner but, based on more empirical data and modeling, changes the distribution somewhat. It increases payments 3.75% for 1-5 Therapy visits (vs. 7.5), for 14-15 visits it reduces payments 2.5% (vs. 5%), for 20+ therapy visits it reduces payments 5% (vs. 10%).
- CMS recognizes its obligation to pay out the full outlier pool of 2.5%. But, based on data showing an increase to 1.91% expended since the proposed rule, it freezes the outlier factors at the proposed level of .67 fixed dollar loss ratio and .80 loss-sharing ratio.
- CMS maintains its use of the existing wage index methodology pending the study mandated in the Affordable Care Act.
- CMS will continue to report 13 process measures and nine outcome measures, use claims data vs. OASIS to report ER use without hospitalization but eliminate

reporting the outcome indicator based on number of pressure sores as unrelated to risk adjusted outcomes.

- CMS' plans for incorporation of HHCAHPS (experience of care) measures as publically reported moves forward as proposed. There is a note reminding agencies that they are responsible for monitoring their vendors.
- CMS incorporates the changes and clarification in therapy and the liberalization of face to face with minor tweaks to language.
- CMS indicates that its work on the Vulnerable Patient Study continues and is still open to agency input.
- CMS announces a teleconference to roll out ICD-10 and anticipates the cross walk of HHRG diagnoses from ICD9 to ICD10 will be delayed until spring, 2012.
- CMS makes some language tweaks to clarify the definition of homebound.

A more comprehensive analysis will be forthcoming from VNAA or at [www.VNAA.org](http://www.VNAA.org).

The full text of the rule, including detailed rates and case mix weights can be viewed at: [http://www.ofr.gov/OFRUpload/OFRData/2011-28416\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-28416_PI.pdf).

2012 Wage Index Tables are under the 2012 Payment Rule at: [www.cms.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage](http://www.cms.gov/HomeHealthPPS/HHPPSRN/list.asp#TopOfPage).