



Well, the wait is finally over! The Health Care Financing Administration (HCFA) has published the long-awaited PROPOSED rules for the Prospective Payment System (PPS) reimbursement for Home Health agencies. There will be a 60-day comment period with Final rules to be released by July, 2000. The proposed regulation is subject to significant modification, and the proposed rates of payment may be adjusted. In this letter, we present a preliminary analysis of the proposed regulation.

The PPS for home health services is based upon an episodic reimbursement system that is case-mix adjusted to reflect the severity of the patient's condition, with a national payment rate adjusted by the area wage index. In addition to the national, case mix adjusted, episodic payment rate, additional adjustments are made for patients who receive a low level of utilization of services within the episode and for patients that are outliers, experiencing a high cost in the delivery of service within the episode. Payments are also prorated in certain circumstances.

National Payment Rate

The proposed national payment rate encompasses all disciplines of service, an OASIS adjustment, non-routine medical supplies, a standardization factor for wage index and case mix of .95502, a budget neutrality factor of .78578, and an outlier adjustment factor of 1.05 which allows the funding of the outlier payments, and further adjusted to reflect a 15 percent reduction as mandated by the Balanced Budget Act of 1997. The final calculation of the standardized prospective payment amount per 60-day episode for FY2001 is \$2,037.04. The standardized amount of \$2,037.04 must be specifically adjusted for each agency based upon the MSA and the specific case mix category for the patients served, based on where the patient resides.

The proposed regulation offers four examples for the computation of the case mix, wage adjusted prospective payment amount. Example #1 is set forth below.

Example 1. An HHA is providing services to a Medicare beneficiary in State College, PA. The HHA determines the beneficiary is in HHRG C2F2S2.

COMPUTATION OF CASE MIX AND WAGE ADJUSTED PROSPECTIVE PAYMENT AMOUNT

Case mix index from Table 9 for case mix group 1.8275

Standardized Prospective Payment Rate for FY 2001
 \$2,037.04

Calculate the Case Mix adjusted Prospective Payment Rate for FY 2001 (1.8275 * \$2,037.04)
 \$3,722.69

Calculate the Labor portion of the Prospective Payment Rate for FY 2001

Wage Component X
77.668%

Labor Portion of PPS Rate (.77668 X \$3,722.69)
..... \$2,891.34

Wage Index X
.9449

Apply wage index factor from Table 4B for patient in State College,
PA \$2,732.03

Calculate the Non-Labor portion of the Prospective Payment Rate for FY 2001

(.22332 X
\$3,722.69) \$831.35

Calculate Total Prospective Payment Rate for FY 2001 by adding the labor and non labor

portion of the case mix and wage index amounts (\$2,732.03 + \$831.35)
..... \$3,563.38

These rates will vary by agency, depending the on applicable wage index for the MSA where the patient resides. We have prepared a table of the actual PPS amount by MSA.

Case Mix Adjustment

The case mix adjustment is a classification system which assigns a patient to one of 80 patient groups, driven by OASIS data based on:

- Clinical dimensions,
- Functional Status dimensions
- Services Utilization dimensions, such as therapy and prior hospitalization.

The case mix adjustment provides a weighting or multiplier to the standard PPS rate designed to reflect varying patient care costs. HCFA expects to provide software to agencies which will automatically assign a patient to a group.

The case mix episodes range from .5276 to 2.5702 times the Wage-Adjusted Standardized PPS Amount. For Rural Louisiana agencies, we have calculated the reimbursement amount to range from a low of \$862.22 to a high of \$4,200.30 per 60-day episode. Langlinais & Broussard has compiled a table reflecting the various Wage-Adjusted

PPS Amounts for various MSA's for the 80 episodes. We have also enclosed a copy of the Decision Tree Logic (Table 7 of the Proposed PPS Rule) used to establish the episodic category.

Determination of Home Health Resource Group (HHRG)

In the HHRG case-mix classification system, patient characteristics and health status information from the OASIS-B such as "primary home care diagnosis", "ability to perform ADLs" as supplemented by projected therapy use during a 60-day episode, will be used to assign the patient to an HHRG for payment, which will ultimately determine the weight applied to the Wage Adjusted PPS Rate. The HHRG system measures three dimensions of case mix. Table 7 in the Federal Register provides the HHRG system three-level **DECISION TREE** logic. We have enclosed a copy of this Decision Tree with this letter. A patient will be classified in one of 80 possible HHRG categories based on this Decision Tree.

The first level of the decision tree is the **Clinical Dimension**, which is divided into four severity groups: minimum, low, moderate, or high clinical severity. To determine the severity group, a numeric score is applied to each answer provided to the following 12 clinical OASIS-B items: MO230 primary home health diagnosis, MO250 IV/Infusion/Parenteral/Enteral Therapies, MO390 Vision, MO420 Pain, MO460 Current Pressure Ulcer Stage, MO476 Stasis Ulcer, MO488 Surgical Wound, MO490 Dyspnea, MO530 Urinary Incontinence, MO540 Bowel Incontinence, MO550 Bowel Ostomy, MO610 Behavioral Problems. Table 7 provides the corresponding numeric scores for the responses provided to the items in the four severity groups within the Clinical Dimension. The scores are then summed. The severity level is determined by the value of the summed score.

The next level of the subdivision of the decision tree logic is based on patient **Functional Status Dimension** which is divided into five severity levels: minimum, low, moderate, high, or maximum functional severity. To determine the severity group, a numeric score is applied to each answer provided for the following six OASIS-B items: MO650 and MO660 Dressing Upper and Lower Body, MO670 Bathing, MO680 Toileting, MO690 Transferring, and MO700 Locomotion. Table 7 provides the corresponding numeric scores to the responses provided to the functional status items. The scores are then summed. The severity level for the Functional Dimension is determined by the value of the summed score.

The final level of the subdivision of the decision tree logic is the **Services Utilization Dimension**, in which a patient is assigned to one of the four severity levels: minimum, low, moderate, or high. To determine the severity group, a numeric score is applied to each answer provided to the following OASIS-B item which is divided into two questions, and one supplemental item regarding projected receipt of therapy use: MO170 hospital discharge in past 14 days, MO170 inpatient rehabilitation/SNF discharge in past 14 days, and receipt of therapy of 8 or more hours. Table 7 provides the corresponding scores to the responses provided to the items in the Services Utilization Dimension. The scores are then summed. The severity level for the Services Utilization Dimension is determined by the value of the summed scores. The case-mix treatment variable regarding the need for 8 or more hours of therapy in a 60-day episode will be defined as 10 visits of physical therapy, occupational therapy, or speech- language pathology services in any combination furnished during the 60-day episode. HHAs will project the therapy need for the patient at the start of the 60-day episode.

Once the Standardized Payment rate is calculated, there are other elements that need to be understood within this prospective payment regulation.

Episode Definition

HCFA has chosen to set the episodes at 60-day intervals (not two-month intervals).

An episode begins with the first billable visit and ends with the 60th day from the start of care. Subsequent episodes will begin as follows, day 61 through day 120; day 121 through day 180, etc.

The payment covers one individual for 60 days of care regardless of the number of days of care provided during an episode, except when one of the following three intervening events occur:

- the beneficiary voluntarily elects to transfer to another home health agency;
- the patient is discharged with all goals established in the plan of care having been met, and is later readmitted to the same HHA; or
- a significant change in patient's condition occurs which was not anticipated at the start of care and a new OASIS assessment is required of the patient.

Where one of the above events occur, a proportionate PPS payment amount will be paid instead of the full PPS amount. The adjustment will either be a **Partial Episode Payment (PEP)** or a **Significant Change in Condition Adjustment (SCIC)**.

The **PEP** applies when:

- the patient is transferred to another home health agency or
- is discharged with goals met, and readmitted to the same home health agency.

There will be no PEP where the transfer occurs between home health agencies with common ownership; a single payment will be made in those circumstances. The PEP will be the proportionate number of days from the start of care through the last billable visit. For example, if a patient is discharged with goals met on day 30 and readmitted to the same home health agency on day 38, the case mix adjusted payment amount will be 30/60 of the otherwise full PPS amount. A new episode will begin on day 38.

When there is **Significant Change in Condition (SCIC)**, the payment made to the home health agency will be:

- based upon the number of days of care between the start of care through the last date of service before the SCIC, plus
- a proportion of the case mix adjusted amount beginning with the SCIC to the end of the balance of the 60 day period.

For example, if a patient experiences an SCIC on the 35th day of the episode the agency will be reimbursed

- 35/60 of the original amount, PLUS
- 25/60 of the new amount based upon the SCIC

A patient can be furnished an unlimited number of 60-day episodes in a year, based upon each OASIS assessment. This will ensure that patients who require care over the long-term bring appropriate reimbursement to the provider.

Low Utilization Payment Adjustment

HCFA proposes a **Low Utilization Payment Adjustment (LUPA)** where the utilization consist of four or fewer visits in the episode. At this time , HCFA is also considering a six visit threshold and this could be modified pending comments received during the 60-day comment period. In the event of a LUPA patient, the HHA would be paid a national, standardized per visit amount by discipline adjusted by the area wage index.

The “unadjusted” standardized reimbursement per visit for the services are:

Skilled Nursing	\$ 76.32
Home Health Aide	34.44
Physical Therapy	83.39
Medical Social Services	123.31
Occupational Therapy	83.57
Speech Pathology	90.79

The actual amount may be more or less than the above amounts, depending on the Wage Index applicable to the Metropolitan Statistical Area in which the service is rendered. I have enclosed a table of the “Adjusted Standardized Reimbursement per visit for various MSA’s.

Outlier Payments

There will also be an outlier payment system to account for unusual patients that are not adequately accounted for in a national payment rate. HCFA proposes an outlier payment that utilizes a threshold for each case mix adjustment category that is based upon the 60-day episodic payment amount for that group plus a fixed dollar loss amount that is the same for all case mix groups. The proposed outlier option is a fixed dollar loss of 1.07 times the standard episode payment amount and a loss-sharing ratio of .60. The Federal Register furnishes the following example to illustrate how an outlier payment would be computed:

Example: An HHA serves a beneficiary who resides in Harrisburg, PA. The HHA determines the beneficiary is in HHRG C3F4S0. The episode contained 88 skilled nursing visits and 60 home health aide visits. It qualifies for outlier payments. To simplify matters and demonstrate the determination of outlier payments, the example begins after the case- mix-adjusted episode payment has been calculated. Further, Harrisburg was chosen because its wage-index value is very close to 1.0060, and again for simplicity, the wage-index adjustment has also been omitted.

1. Determine the outlier threshold for C3F4S0 with the fixed dollar loss option of 1.07:

Outlier threshold = Fixed Dollar Loss + Case-mix adj. payment

Standardized Amount (unadjusted for Wage Index)..... \$2,037.04

Fixed Dollar Loss	<u>1.07</u>
Fixed Dollar Loss (1.07 times \$2,037.04)	<u>\$2,179.63</u>
Standardized Amount, (unadjusted for Wage Index)	\$2,037.04
Case-mix Weight	<u>1.4357</u>
Case-mix adjusted episode payment = (\$2,037.04 * 1.4357)	<u>\$2,924.58</u>
Outlier threshold	<u>\$5,104.21</u>

2. Calculate the standard cost of the episode:

88 skilled nursing visits @ \$76.32	\$6,716.16
60 hh aide visits @ \$34.44	<u>\$2,066.40</u>
Total cost	<u>\$8,782.56</u>

3. Calculate the cost in excess of the threshold: \$8,782.56-\$5,104.21
 \$3,678.35

Loss Sharing Ratio X 60%

4. Calculate the outlier payment: \$3,678.35 times .6
\$2,207.01

5. Calculate total payment for the episode: \$2,924.58 + \$2,207.01
\$5,131.59

Split Payment

HCFA proposes an *initial payment of 50 percent* of the estimated case mix adjusted episode payment. The second, *final payment will equal 50 percent* of the actual case mix adjusted payment determined through a final claim of the residual payment following the expiration of the 60-day episode. Adjustments will be made at this time to reflect:

- level of therapy received
- low utilization patient adjustment (LUPA)
- partial episode payment adjustment (PEP)
- significant change in condition adjustment (SCIC) or
- medical review determination as applicable.

HCFA has requested comments from agencies on the impact to financially and operationally comply with the split percentage payment approach. In my view, the 50% initial payment will be insufficient based on the fact that the PPS demonstration project showed that 60 percent of all home health patient episodes are completed within 60 days, and 73 percent of patients complete care within 120 days, not to mention that the more expensive services (Skilled versus Aides) are provided in the earlier stages of an episode. HCFA is advancing 50% on the initial filing of the claim when it is known that the majority of resources are consumed in the first few days of admitting a patient.

Consolidated Billing

An agency must submit all Medicare claims for the home health services while a beneficiary is under the home health plan of care established by the physician. The consolidated billing requirement includes all disciplines of service, supplies, osteoporosis drugs, DME, and certain unusual services like medical services provided by interns or residents in training at the hospital and services provided at facilities that could not be provided in the home setting. Two options are being explored as to how this would be accomplished.

Under Option 1:

- all services that are included in the PPS amount payable with one billing and
- DME subject to the 20 percent co-insurance billed by the agency to the **intermediary**. Additional Reimbursement would be made to the HHA based on the DME fee schedule payment amount.

Under Option 2:

- all services that are included in the PPS amount payable with one billing and
- the DME billed to the DME **Part B Regional Carrier**. Reimbursement would be made to the HHA based on the DME fee schedule payment amount.

Transitioning From IPS to PPS

All home health agencies will transition to the PPS on October 1, 2000 regardless of cost-reporting year. This affects cost reporting responsibilities, OASIS assessments, and billings.

If a beneficiary is under an established home health plan of care before October 1, 2000 and the HHA has completed a start of care or follow up **OASIS earlier than September 1, 2000**, the HHA will need to complete a one time additional follow up OASIS within five days before October 1, 2000 for purposes of case mix classification. The agency will also need a recertification of the plan of care before the inception of PPS on October 1, 2000.

If a beneficiary is under an established home health care plan before October 1, 2000 and the HHA completed a start of care or follow up **OASIS on or after September 1, 2000** and does not wish to do a one-time OASIS at the inception of PPS, the HHA may use that earlier version of the OASIS. The agency HHA may use the recertification date from the earlier version of the plan of care.

In addition, all open bills for services provided September 30, 2000 or earlier will need to be closed as of September 30, 2000.

In order to avoid filing of a cutoff cost report as of 9/30/2000, HCFA is exploring the use of a supplemental schedule in the cost report to apportion costs prior to 10/1/2000 and subsequent to 9/30/2000.

Summation

The HHA PPS proposal seems to follow similar methodologies as was used for Hospitals in the establishment of DRG's. The system allows for changes in patient classification due to intervening events (PEP, SCIC) and provides for payment adjustments for high cost (Outlier) and low utilization (LUPA) patients.

One of the greatest concerns is: Will the 50 percent initial payment be sufficient, considering most of the care costs occur in the early stages of an episode? It is felt by many the mere 50% partial payment could cause severe cash flow problems. My initial view is that agencies should furnish comments during the 60-day comment period requesting at least a 60% initial payment since the PPS demonstration project showed that 60 percent of all home health patient episodes are completed within 60 days.

We strongly urge you to study the Proposed Rule and contact our firm concerning any questions or comments you may have. Keep in mind that this rule is subject to change before the final rule is issued. Any suggestions you may have to offer should be communicated to HCFA.

Immediate Recommendations

We recommend that agencies immediately begin assessing the impact PPS will have on their particular agency.

- Start by selecting a representative sample of patients (ideally, all patients for the year would be preferable to a sample). At the very least, focus on your top 20 most frequent diagnosis, also targeting the highest utilization diagnoses.
- Using OASIS along with the Decisions Tree, score each 60-day period for Clinical, Functional, and Service Utilization dimensions, and then assign a case mix category for each 60-day episode to each patient in the sample.

- Be sure to include all episodes for a patient starting with the initial start of care through the date of discharge.

- Compare Actual Cost Reimbursement using cost reporting information with PPS Reimbursement.

PPS will completely change the way agencies operate. The success of your agency will hinge on the ability to adapt to these new changes. It will become extremely important to undertake whatever steps are necessary to bring your agency technologically and operationally in line with the anticipated changes. We believe that one of the keys to success (and perhaps survival) will be the ability to gather the information in a timely fashion to properly bring clinical, billing, and financial aspects up to speed. If your computer hardware is more than two years old, it will be imperative to upgrade. Also, keep in close touch with your software vendor to monitor the progress being made to update the software to accommodate the new billing requirements. We have one year left under this fully cost reimbursed environment. If you must invest in new computers, software, training, etc. now is the time.

If we can be of assistance in this matter, please do not hesitate to give us a call.

Sincerely,

LANGLINAIS & BROUSSARD

Certified Public Accountants