

PPS Final Rule 2011: What will it mean for you?

Presented by:
Cheri Whalen

Vice President of EDI and
Regulatory Compliance



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The industry's leading provider of Web-based management software, outsource services and consultation exclusively for Home Health Care and Hospice Care agencies.

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Introduction

Cheri Whalen
VP of EDI & Compliance



Cheri joined HCF in 2004, bringing over 10 years of prior experience focused exclusively within the Home Health and Hospice software industry to our team. Her Home Health and Hospice experience includes customer service, quality assurance, documentation, development of billing and regulatory software design requirements, HIPAA Compliance Champion and overseeing regulatory compliance for business units, employees, and software products.

Cheri currently assists Home Health and Hospice agencies with setting up and maintaining regulatory compliance with Medicare, state auditors and accrediting bodies as well as providing software design for billing, electronic data interchange and regulatory compliance.

Cheri also oversees the company's interests in compliance with the many federal regulations (including HIPAA and HITECH) and provides educational opportunities for our customers and our employees.

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Effective Dates

Changes apply to episodes ending
January 1, 2011

Episodes you currently have in
process will fall under these rules.



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Case Mix Changes

- Case mix reduction of 3.79% for CY 2011
- CMS has indicated another 3.79% reduction for 2012
 - Continuing to evaluate



CY 2011 Payment Rates

2011 Base Rate
\$2,192.07

2011 RURAL Base
Rate **\$2,257.83**

Discipline	Non – Rural	Rural
HHA	\$ 50.42	\$ 51.93
MSS	\$ 178.46	\$ 183.81
OT	\$ 122.54	\$ 126.22
PT	\$ 121.73	\$ 125.38
SN	\$ 111.32	\$ 114.66
SLP	\$ 132.27	\$ 136.24

*note a 2% reduction to these rates when not submitting quality data

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CY 2011 Payment Rates

Non-Routine Supply Rates (NRS)

*note a 2% reduction to these rates when not submitting quality data

Severity Level	Non – Rural	Rural
1	\$ 14.18	\$ 14.61
2	\$ 51.18	\$ 52.72
3	\$ 140.34	\$ 144.55
4	\$ 208.51	\$ 214.77
5	\$ 321.53	\$ 331.18
6	\$ 553.00	\$ 569.59

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CY 2011 Payment Rates

LUPA Add-On Rates

Non – Rural	Rural
\$ 93.31	\$ 96.11

*note a 2% reduction to these rates when not submitting quality data



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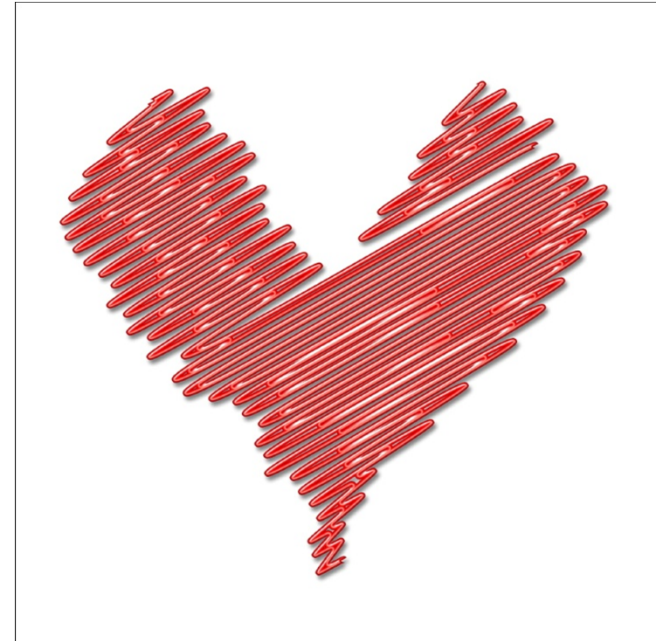
Other CY 2011 Payment Adjustments

- Outlier
 - The 10% agency-level cap was made permanent
- Fixed Dollar Loss
 - Remains the same at .67
- Quality Data Submission
 - Remains the same at a 2% base-rate reduction for providers who do not submit their OASIS data.

Hypertension

CMS had originally proposed a change to drop Hypertension scoring from the case-mix

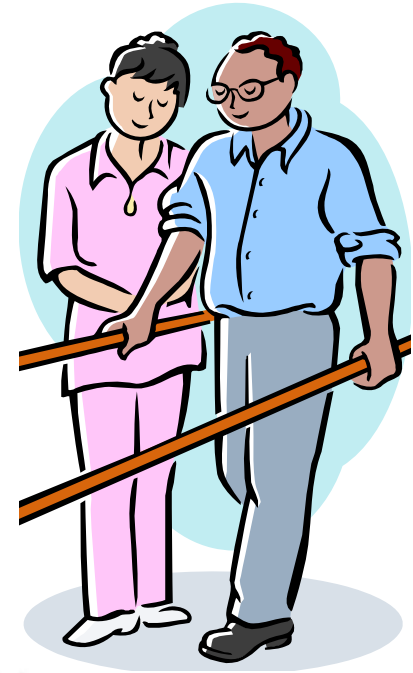
Due to comments during the proposal period, CMS has left the hypertension scoring as it is but expect additional review in this area.



Therapy Coverage Requirements

Changes to therapy coverage requirements:

- Assessments must be completed by a qualified therapist for the service
- Measureable treatment goals in the plan of care & clinical record
- Assessments must be an objective measurement with a succession of comparable measurements to show progress toward the goal or the effectiveness of the therapy.
- Assessments must measure and document the progress toward the goal at least once every 30 days during the course of treatment.



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Therapy Qualifications

- Patients needing 13 or 19 therapy visits will require the qualified therapist to perform a visit and assessment to measure and document the effectiveness of the therapy.
 - If progress toward the plan of care goal cannot be measured or documentation does not support the expectation of reasonable progress, CMS can discontinue coverage.
 - Each therapy discipline required for the patient must be assessed by the 13th and 19th visits
 - Exceptions provided for rural areas or when outside the control of the therapist (documented)



Therapy Qualifications: Maintenance

Maintenance Therapy will be covered when:

- Specific to illness or injury
- Requires the skills of a therapist
- Identifies program design (by qualified therapist), instruction & re-evaluation



Therapy Assessment Implementation

Therapy Assessment changes are effective 1/1/2011; however, CMS has delayed the implementation to allow for a transition period.

You will have until April 2011 to implement, and additional guidance will be provided by CMS in the future.



Home Health Compare

Process measures were publically reported Oct 2010.

- Timely initiation of care
- Influenza immunization received for current flu season
- Pneumococcal polysaccharide vaccine ever received
- Heart failure symptoms address during short term episodes
- Diabetic foot care and patient education implemented during short-term episodes of care
- Pain assessment conducted
- Pain interventions implemented during short-term episodes
- Depression assessment conducted
- Drug education on all medications provided to patient/caregiver during short-term episodes
- Falls risk assessment for patients 65 and older
- Pressure ulcer prevention plans implemented
- Pressure ulcer risk assessment conducted
- Pressure ulcer prevention included in the plan of care

New OASIS-C Outcome measures will publically reported July 2011

- Improvement in ambulation/locomotion
- Improvement in bathing
- Improvement in *bed* transferring
- Improvement in management of oral meds
- Improvement in pain interfering with activity
- Acute care hospitalizations
- Emergent care Use *without hospitalization*
- Improvement in dyspnea
- Improvement in surgical wounds

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HH CAHPS Reporting

CMS expects a dry run of 1 full month of data in the third quarter of 2010 reported by your HHCAPHS vendor

Continuous reporting must start 4th quarter 2010 and 1st quarter 2011

Agencies with less than 60 eligible patients (per year) and new agencies can request an exemption

Dry Run & exemption deadline is January 21, 2011

Non-participation will result in a 2% reduction in the market basket



Additional Billing Codes

CMS is implementing the addition of new G-code changes for billing to further define services provided.

G – Code	Description
G0151	<i>Qualified</i> PT
G0152	<i>Qualified</i> OT
G0153	<i>Qualified</i> SLP
G0157	PTA
G0158	OTA
G0159	Maintenance Therapy by qualified PT
G0160	Maintenance Therapy by qualified OT
G0161	Maintenance Therapy by qualified SLP
G0154	Skilled licensed Nurse (direct patient care)
G0162	Management & Eval of POC RN
G0163	Observation & Assessment of Patient Condition LPN or RN
G0164	Skilled licensed Nurse Training/Education of patient/family

HHA Capitalization Requirements

CMS has implemented requirements for new HHA's to not only have their "initial operating reserve funds" be available at certification, but have this reserve fund available through the application process as well as 3 months after billing privileges are instated.

The contractor will provide the exact IROF amount to prospective HHA's.

- The IROF is a requirement for enrollment
- Medicare billing privileges will be denied or revoked if the HHA could not provide proof of IROF within 30 days of request
- HHA must have IROF at the time of application, all times during the enrollment process, and for 3 months after billing privileges have been established.

Change of Ownership 36-Month Rule

CMS implemented the “36-month” rule for changes in ownership of HHA’s which precluded any HHA to change hands (100% ownership change) within 36-months of Medicare enrollment without having to recertify the agency

During this implementation period CMS has determined there are certain instances where a change in ownership should be allowed without having to recertify.

- Medicare Billing privileges and certification do not transfer
- Must reapply to Medicare and pass certification
- Applies when >50% ownership changes
 - Total for the entire 36-months
 - Includes asset sales, stock transfers, consolidations and mergers

36-month rule Exceptions

- 2 consecutive years of full cost reports submitted by the HHA
- Internal restructuring of the parent company
- Change of business structure, but owners remain the same (LLC to Corporation)
- Owner Dies



Change of Ownership 36-Month Rule Implementation

- Applies only to direct ownership changes
- Applies to nonprofit agencies as well
- New rules apply to ownership changes after Jan 1, 2011
- Existing rules apply through December 31, 2010



Home Health Face-to-Face Encounters

- Physician must have a face-to-face encounter within 90 days of the HH SOC or within 30 days after the HH SOC
- Physician must document on the certification how the clinical findings of the encounter support the eligibility requirements for the patient to be homebound and need intermittent skilled nurse or therapy.
- Documentation of the encounter must be a separate and distinct section or an addendum to the certification
 - Must include why the clinical findings of the encounter support HH Eligibility
- Documentation must be dated



Hospice Face-to-Face Encounters

- Hospice physicians or NPs must make a face-to-face encounter with the patient no later than 30 days prior to the 3rd benefit period recertification and each subsequent recertification (60-day periods)
- Encounter must justify why the physician believes the patient has a life expectancy of 6 months or less
- Effective January 1, 2011 for qualifying benefit periods
 - Patients in 3rd benefit period or later in 2011 will have to have the F2F encounter and the F2F documentation

Hospice Face-to-Face Encounters

- Certifications and recertifications must show the dates of the benefit period to which they apply
- F2F encounters are non-billable on Hospice claims
- Hospice physician **MUST** be employed or working under arrangement with a hospice.
- Hospice physician who has the F2F encounter must be the same physician who is composing the narrative and signing the certification.

THANK YOU!

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