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CMS ANNOUNCES PAYMENT CHANGES FOR MEDICARE HOME HEALTH SERVICES AND CERTAIN DURABLE MEDICAL EQUIPMENT

The Centers for Medicare & Medicaid Services (CMS) today announced a 3.3 percent market basket increase for Medicare payment rates for home health services for calendar year 2007. The home health prospective payment system (HH PPS) annual update will bring an estimated additional \$410 million in wage adjusted payments to home health agencies next year.

“CMS is dedicated to ensuring high quality home health care for our Medicare beneficiaries,” said Leslie V. Norwalk, Esq., Acting Administrator of the Centers for Medicare & Medicaid Services, which oversees the Medicare home health payment system. “This rule rewards home health agencies who continue to report quality data and also provides beneficiaries with access to more affordable oxygen equipment.”

Medicare pays home health agencies through a prospective payment system (PPS), which pays at higher rates for care furnished to beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as currently required for all Medicare-participating home health agencies (HHAs).

Home health payment rates have been updated annually by either the full home health market basket percentage increase, or by the home health market basket percentage increase as mandated by Congress. CMS uses the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in providing home health services. Section 5201(c) of the Deficit Reduction Act (DRA) of 2005 provides for an adjustment to the home health market basket percentage update for CY 2007 and subsequent years depending on the submission of quality data by HHAs.

HHAs collect and report Outcome and Assessment Information Set (OASIS) data. For CY 2007, CMS will evaluate home health care quality by continuing to rely on the submission of OASIS assessments and publicly report the 10 nationally accepted and approved quality measures through the CMS Home Health Compare website. Continuing to use the OASIS instrument mitigates the burden and cost of reporting through a separate mechanism.

HHAs that submit the required quality data using OASIS will receive payments based on the full home health market basket update of 3.3 percent for CY 2007. If a HHA does not submit quality data, the home health market basket update will be reduced by 2 percentage points to 1.3 percent for CY 2007. Rural home health agencies that participate in the ongoing quality reporting effort will

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receive an average estimated 3.6 percent increase in payment, while urban agencies who continue to provide quality data will experience an estimated 3.1 percent increase in payments.

To qualify for the Medicare home health benefit, a Medicare beneficiary must be under the care of a physician, have an intermittent need for skilled nursing care, or need physical, speech or occupational therapy. The beneficiary must be homebound and receive home health services from a Medicare approved home health agency.

The final rule also changes how Medicare will pay for oxygen and oxygen equipment, as well as capped rental items, such as wheelchairs and hospital beds, and establishes new protections for beneficiaries who require these items. Oxygen and oxygen equipment and capped rental items are paid under the Medicare Part B durable medical equipment (DME) benefit. These changes will save beneficiaries and taxpayers money, while ensuring that beneficiaries get the items and services they need.

The final rule implements Section 5101 of the DRA that requires suppliers to transfer title of oxygen equipment to the beneficiary after 36 months of rental payments and capped rental items after 13 months. After the transfer of title, Medicare rental payments and beneficiary coinsurance on the rental payments will no longer be made.

After a beneficiary owns the equipment, Medicare will also make the following payments:

- ❑ Medicare will continue to make monthly payments for oxygen contents for beneficiary-owned tanks and cylinders for as long as the beneficiary medically needs oxygen.
- ❑ Medicare will pay for reasonable and necessary maintenance and servicing of beneficiary-owned oxygen equipment and capped rental DME not covered by a supplier's or manufacturer's warranty. Specifically, CMS will allow payments for general maintenance and servicing visits every six months beginning six months after ownership for those beneficiaries using certain oxygen equipment, in addition to allowing payment for any reasonable and necessary repairs. Payment for maintenance and servicing will be based, as it is currently for other beneficiary owned DME equipment, on the carrier's or the DME Medicare Administrative Contractor's rates for parts and labor.
- ❑ For those beneficiaries who own liquid and gaseous tanks and cylinders and for whom they are no longer medically necessary, CMS will allow one payment for suppliers to pick-up and store or dispose the equipment.
- ❑ Medicare will continue to make separate payment for necessary supplies and accessories such as replacement of cannulas and tubing.

Previously, beneficiaries and Medicare made monthly payments for oxygen and oxygen equipment for as long as the beneficiary needs them. As a result, the beneficiary's coinsurance payments alone eventually exceed the total cost of the equipment. Also previously, Medicare and the beneficiary generally made rental payments for capped rental items for fifteen months, after which time payment

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stopped and Medicare paid an automatic servicing and maintenance fee regardless of whether any service and maintenance was actually furnished. Title to the equipment remained with the supplier. In the case of beneficiaries using oxygen equipment on December 31, 2005, the 36-month rental period begins on January 1, 2006. For new beneficiaries using oxygen equipment or capped rental items on or after January 1, 2006, the rental period will began the first day of their rental.

“There has been a great deal of misinformation about whether Medicare will continue to cover supplies and services for oxygen equipment,” said Ms. Norwalk. “Be assured that beneficiaries will get the personalized support that they need.”

CMS used its authority provided in the Medicare statute to establish separate classes and payment amounts for oxygen generating portable equipment (OGPE), and for gaseous and liquid oxygen contents that must be delivered for beneficiary-owned stationary and portable oxygen equipment. OGPE are new technologies that eliminate the need for refilling and delivery of oxygen contents. For the final rule, the OGPE add-on rate for 2007 will be \$51.63 per month. CMS also used the authority to increase the payment amount from \$20.77 to \$77.45 per month for delivery of portable oxygen contents for beneficiary-owned tanks and cylinders. The goals of these policies are to ensure that payments for oxygen and oxygen equipment are accurate, that beneficiaries who use portable oxygen systems have sufficient access to oxygen contents, and that Medicare payments do not create inappropriate incentives to provide particular types of oxygen technology. Since the law requires that these changes be budget-neutral, CMS will redistribute the current payment amounts each year to insure annual budget neutrality of the new classes. The new classes and revised payment amounts for oxygen and oxygen equipment will be effective on January 1, 2007 for new and existing users.

The final rule also contains new supplier requirements to safeguard beneficiaries now that they will own their oxygen equipment and capped rental items. These include requiring a supplier who furnishes rented oxygen equipment or a capped rental item in the first month to continue furnishing the item throughout the entire rental period and if suppliers switch out equipment that the replacement equipment be of same or greater value. Also in the final rule, suppliers may be responsible to replace equipment that does not last for the reasonable useful lifetime established for the equipment under the Medicare program. Additionally, CMS is also requiring a supplier to disclose its intentions regarding assignment for the entire rental period and this information will be posted on the CMS website.

The final rule went on display at 4:00 pm today (11/1/06) and will be published in the *Federal Register* at a future date. The rule can be located at:

www.cms.hhs.gov/HomeHealthPPS/downloads/CMS1304Fdisplay.pdf.

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