

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Home Health Prospective Payment System

PAYMENT SYSTEM FACT SHEET SERIES





This publication provides the following information about the Home Health Prospective Payment System (HH PPS):

- ❖ Background;
- ❖ Consolidated billing requirements;
- ❖ Criteria that must be met to qualify for Home Health services;
- ❖ Coverage of Home Health services;
- ❖ Elements of the HH PPS;
- ❖ Updates to the HH PPS;
- ❖ Health care quality; and
- ❖ Resources.

Background

The HH PPS was implemented on October 1, 2000, as mandated by the Balanced Budget Act (BBA) of 1997 and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999. In calendar year (CY) 2008, the Centers for Medicare & Medicaid Services (CMS) implemented the first refinements to the HH PPS since its inception in October 2000. For 2008, CMS discontinued the use of a single 10-therapy threshold for the purpose of payment and implemented three therapy thresholds at 6, 14, and 20 visits. Additionally, the case-mix model was refined in CY 2008 to reflect the following:

- ❖ Different resource costs for early Home Health episodes versus later Home Health episodes;
- ❖ Expansion of the HH PPS case-mix variables to include scores for certain wound and skin conditions in the payment model;
- ❖ Inclusion of more diagnosis groups (e.g., pulmonary, cardiac, gastrointestinal, blood

disorders, affective and other psychoses, and cancer diagnosis groups); and

- ❖ Certain secondary diagnoses.

For CY 2012, CMS removed two hypertension codes from the case-mix system, lowered payments for high therapy episodes, and recalibrated the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments. These changes were intended to increase payment accuracy and reduce the growth in aggregate case-mix that is unrelated to changes in patients' health status.

Consolidated Billing Requirements

For individuals under a Home Health plan of care (POC), payment for all services and supplies is included in the HH PPS episodic rate, with the exception of certain covered osteoporosis drugs where the patient meets specific criteria and durable medical equipment (DME). The Home Health Agency (HHA) must provide the covered Home Health services (except DME) either directly or under arrangement. The HHA must bill for such covered Home Health services, and payment must be made to the HHA.

Home Health Services Subject to Consolidated Billing Requirements

The Home Health services included in the consolidated billing governing HH PPS are:

- ❖ Part-time or intermittent skilled nursing services;
- ❖ Part-time or intermittent Home Health aide services;
- ❖ Physical therapy (PT);
- ❖ Occupational therapy (OT);
- ❖ Speech-language pathology (SLP) services;
- ❖ Medical social services;
- ❖ Routine and non-routine medical supplies;
- ❖ Covered osteoporosis drugs as defined in Section 1861(kk) of the Social Security Act (the Act), but excluding other drugs and biologicals;
- ❖ For an HHA that is affiliated or under common control with a hospital with an approved teaching program, medical services provided by an intern or resident-in-training of the program of the hospital; and

- ❖ Home Health services defined in Section 1861(m) of the Act provided under arrangement at hospitals, Skilled Nursing Facilities (SNF), or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

Medical Supplies

The law requires all medical supplies (routine and non-routine) to be bundled while the patient is under a Home Health POC. The agency that establishes the episode is the only entity that can bill and receive payment for medical supplies during an episode for a patient under a Home Health POC. Reimbursement for routine and non-routine medical supplies is included in the payment rates for every Medicare Home Health patient.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled to the HHA episodic payment rate. Once a patient is discharged from Home Health and not under a Home Health POC, the HHA is no longer responsible for medical supplies.

DME, including supplies covered as DME, are paid separately from the PPS rates and are excluded from the consolidated billing requirements governing the PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient.



Osteoporosis Drugs

Osteoporosis drugs are included in consolidated billing under the Home Health benefit. However, payment is not bundled into the episodic payment rate. The HHA must bill for osteoporosis drugs in accordance with billing instructions. Payment is in addition to the episodic payment rate.

Criteria That Must Be Met to Qualify for Home Health Services

Medicare covers Home Health services when the following criteria are met:

- ❖ The patient to whom services are furnished is eligible and enrolled in the Medicare Program and is not enrolled in a Medicare Advantage Plan;
- ❖ The patient qualifies for coverage of Home Health services;
- ❖ The HHA furnishing the services has a valid agreement in effect to participate in the Medicare Program;
- ❖ The services for which payment is claimed are covered under the Medicare Home Health benefit;
- ❖ Medicare is the appropriate payer; and
- ❖ The services are not otherwise excluded from payment.

To qualify for Medicare Home Health services, a patient must:

- ❖ Be confined to the home;
- ❖ Be under the care of a physician who is a doctor of medicine, a doctor of osteopathy, or a doctor of podiatric medicine;
- ❖ Be receiving services under a POC established and periodically reviewed by a physician; and
- ❖ Be in need of:
 - Skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable); or

- PT or SLP services; or
- Continuing OT services.

Note: Effective January 1, 2012, CMS clarified the status of OT to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first OT service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, PT service, or SLP service as required by law. Once that requirement for covered OT has been met, however, all subsequent OT services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes).

Coverage of Home Health Services

A patient's residence is wherever he or she makes his or her home (e.g., own dwelling, apartment, relative's home, home for the aged, or other type of institution). However, an institution may not be considered a patient's residence if the institution meets the requirements of Section 1861(e)(1) or Section 1819(a)(1) of the Act. Included in this group are hospitals and SNFs as well as most nursing facilities under Medicaid.

For a patient to be considered confined to the home, the condition of the patient is such that:

- ❖ There exists a normal inability to leave the home; and
- ❖ Leaving the home would require a considerable and taxing effort.



The patient may be considered homebound if absences from the home are infrequent, for periods of relatively short duration, or for the need to receive health care treatment. In general, a patient is considered homebound if leaving the home is medically contraindicated or he or she has a condition due to an illness or injury that restricts the ability to leave the place of residence except with the aid or assistance of:

- ❖ A supportive device (e.g., crutches, cane, wheelchair, or walker);
- ❖ Special transportation; or
- ❖ Another person.

Required Face-to-Face Encounter

As a condition for payment, the Affordable Care Act requires that, prior to certifying a patient's eligibility for Medicare Home Health services, one of the following providers must have a face-to-face encounter with the patient that occurs no more than 90 days prior to the Home Health start of care date or within 30 days after the start of care:

- ❖ The certifying physician;
- ❖ The physician who cared for the patient in an acute or post-acute setting and has admitting privileges; or
- ❖ An allowed non-physician practitioner (NPP).

The following NPPs may perform the face-to-face encounter:

- ❖ A nurse practitioner or clinical nurse specialist who is working in collaboration with the certifying physician in accordance with State law;
- ❖ A certified nurse-midwife as authorized by State law; and
- ❖ A physician assistant under the supervision of the certifying physician.

In the CY 2011 HH PPS final rule located at <http://www.gpo.gov/fdsys/pkg/FR-2010-11-17/pdf/2010-27778.pdf> on the U.S. Government Printing Office (GPO) website and in Chapter 7, Section 30.5.1.1, of the "Medicare Benefit Policy Manual" (Publication 100-02) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf> on the CMS website, CMS allowed for the following when the patient is admitted to an HHA following an acute or post-acute stay:

- ❖ The physician who cared for the patient during the acute or post-acute stay may certify the

patient's eligibility for the Medicare Home Health benefit, document the encounter based on his or her experience with the patient in the acute or post-acute setting, and initiate and sign the patient's POC. The community physician who assumes responsibility for the patient's care after admission to the HHA will then oversee and update the POC as needed.

In the CY 2012 HH PPS final rule located at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-04/pdf/2011-28416.pdf> on the GPO website, CMS finalized the following policy:

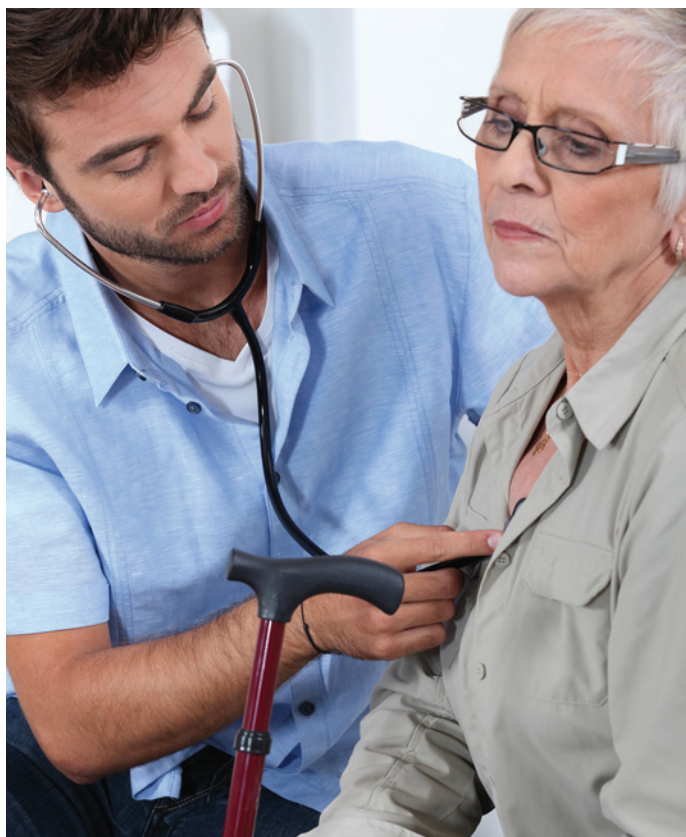
- ❖ For patients admitted to Home Health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility can perform the face-to-face encounter and inform the certifying physician, just as an allowed NPP can; and
- ❖ When the physician or allowed NPP who cared for the patient in an acute or post-acute facility performs the face-to-face encounter, he or she must communicate the clinical findings of the encounter to the certifying physician, unless he or she is also the certifying physician. The certifying physician must document that he or she, a physician who cared for the patient in an acute or post-acute facility, or an allowed NPP had a face-to-face encounter with the patient.

In the CY 2013 HH PPS final rule located at <http://www.gpo.gov/fdsys/pkg/FR-2012-11-08/pdf/2012-26904.pdf> on the GPO website, CMS finalized the following policy:

- ❖ For patients admitted to Home Health immediately after an acute or post-acute stay, an allowed NPP, in collaboration with or under the supervision of the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility, can perform the face-to-face encounter and communicate the clinical findings to the acute or post-acute physician. The acute or post-acute physician then communicates the NPP's clinical findings of the encounter to the certifying physician.

Face-To-Face Encounter Documentation Requirements

Face-to-face encounter documentation must be clearly titled, dated, and signed by the certifying



physician. Face-to-face encounter documentation must include:

- ❖ The date the certifying physician, allowed NPP, or the physician that cared for the patient in the acute or post-acute care setting saw the patient; and
- ❖ A brief narrative that describes how the patient's clinical condition, as seen during that encounter, supports the patient's homebound status and need for skilled services.

Below are two example narratives that describe a patient's clinical condition:

- ❖ The patient is homebound secondary to severe coronary artery disease which precludes the patient from physical activity. Short term skilled nursing services are needed to assess the patient's oral intake, output, and hydration status to assess if the patient needs a feeding tube; and
- ❖ Total knee replacement, needs PT, can't walk.

The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. The documentation may be written or typed.

The certifying physician's support staff may assist him or her in drafting the documentation for the physician to sign. For example, it is acceptable:

- ❖ For the certifying physician to dictate the documentation content to his or her support personnel to type;
- ❖ For the documentation to be generated from the physician's electronic health record; and
- ❖ For the physician's staff to extract the documentation content from the physician's records.

It is acceptable for the certifying physician to use the documentation content from the patient's discharge summary when the face-to-face encounter was performed by the physician who cared for the patient in an acute or post-acute facility.

It is unacceptable for the physician to verbally communicate the encounter to the HHA, with the HHA then documenting the encounter as part of the certification for the physician to sign.

Therapy Services

Skilled therapy services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of his or her unique medical condition. This means that the therapy services must:

- ❖ Be inherently complex, which means that they can be performed safely and/or effectively only by or under the general supervision of a skilled therapist;
- ❖ Be consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and
- ❖ Be considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

To be considered effective treatment for the patient's condition, the standards discussed below must be met.

At defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an

assistant) must perform the ordered therapy service. During these visits, the therapist must:

- ❖ Assess the patient using a method that allows for objective measurement of function and successive comparison of measurements; and
- ❖ Document the measurement results in the clinical record, as described below:

A. Initial therapy assessment:

- ◆ For each therapy discipline for which services are provided, the qualified therapist (instead of an assistant) must assess the patient's function using a method that objectively measures activities of daily living. Activities of daily living include, but are not limited to, the following:
 - Eating;
 - Swallowing;
 - Bathing;
 - Dressing;
 - Toileting;
 - Walking;
 - Climbing stairs;
 - Using assistive devices; and
 - Mental and cognitive factors; and
- ◆ If more than one discipline of therapy is provided, the qualified therapist from each of the disciplines must functionally assess the patient and comprehensively document the measurement results that correspond to his or her discipline and care plan goals in the clinical record;

B. Reassessment performed at least every 30 days in conjunction with an ordered therapy service:

- ◆ At least once every 30 days, for each therapy discipline for which services are provided, the qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with his or



her determination of the effectiveness of therapy or lack thereof. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline). This requirement does not mean that the therapist must perform a reassessment every 30th day after a patient begins receiving therapy services; rather, it is intended to ensure that a therapist, instead of a therapy assistant, will assess a Home Health patient at least once during a given 30-day period; and

- ◆ When more than one discipline of therapy is being provided, at least once every 30 days, the qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess the patient, compare the resultant measurement to prior assessment measurements, and document in the clinical record the measurement results along with his or her determination of the effectiveness of therapy or lack thereof. In multi-discipline therapy cases, the qualified therapist reassesses functional items, measures, and documents those items that correspond to his or her discipline and care plan goals. The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each

therapist's visit/assessment/measurement/documentation (of that discipline). For example, if a therapist conducted and documented the assessment of a patient during a visit on April 1, to meet the requirement of providing such a visit (for a particular discipline) at least once every 30 days the therapist, rather than an assistant, would need to provide that visit by May 1 to reassess the patient. On the therapist's May 1 visit, the clock would reset and the next 30-day count would begin on May 2; and

C. Reassessment performed prior to the 14th and 20th therapy visits:

- ◆ If a patient's course of therapy treatment reaches 13 Medicare-covered therapy visits, for each therapy discipline for which services are provided, the qualified therapist (instead of an assistant) must provide the 13th Medicare-covered therapy service and functionally reassess the patient, compare the resultant measurement to prior measurements, and document in the clinical record the measurement results along with his or her determination of the effectiveness of therapy or lack thereof;
- ◆ When the patient resides in a rural area or when documented circumstances outside the control of the therapist prevent the qualified therapist's visit at exactly the 13th Medicare-covered visit, the visit can occur after the 10th Medicare-covered therapy visit, but no later than the 13th Medicare-covered visit;
- ◆ If a patient's course of therapy treatment reaches 19 Medicare-covered therapy visits, the qualified therapist (instead of an assistant) must provide the 19th Medicare-covered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof;
- ◆ When the patient resides in a rural area or when documented exceptional circumstances exist, the qualified therapist's visit can occur after the 16th Medicare-covered therapy visit, but no later than the 19th Medicare-covered therapy visit;

- ◆ When more than one discipline of therapy is provided, the qualified therapist from each of the disciplines must provide the ordered therapy service and functionally reassess, measure, and document the effectiveness of therapy or lack thereof as follows:

- After the 10th Medicare-covered therapy visit, but no later than the 13th Medicare-covered therapy visit for the required 13th visit reassessment; and
- After the 16th Medicare-covered therapy visit, but no later than the 19th Medicare-covered therapy visit for the required 16th visit reassessment.

These Medicare-covered therapy visit timepoints relate to the sum total of therapy visits from all therapy disciplines. The qualified therapist reassesses functional items and measures those that correspond to his or her discipline and care plan goals; and

- ◆ For therapy services provided after the 13th and 19th Medicare-covered visit (sum total of therapy visits from all therapy disciplines), the qualified therapist(s) must:
 - Complete the assessment/measurement/documentation requirements;
 - Determine if the goals of the POC have been achieved or the POC requires updating. Changes to therapy goals or updated POCs are sent to the physician for signature or discharge; and
 - Document why the physician and therapist have determined that therapy should continue if the measurement results do not reveal progress toward therapy goals and/or do not indicate that the therapy is effective.

Services that involve activities for the general welfare of a patient (e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation) do not constitute skilled therapy since nonskilled individuals without the supervision of a therapist can perform these services.

One of the following three conditions must be met for therapy services to be covered:

- 1) The skills of a qualified therapist are needed to restore patient function as described below:
 - ❖ Therapy services must be provided with the expectation that, based on the assessment made by the physician of the patient's restorative potential, the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements;
 - ❖ Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential; and
 - ❖ Therapy is not required to effect improvement or restoration of function when a patient suffers a transient or easily reversible loss of function (e.g., temporary weakness following surgery) that could reasonably be expected to improve spontaneously as he or she gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury under this condition. However, if the criteria for maintenance therapy described in 3) The Skills of a Qualified Therapist Are Needed to Perform Maintenance Therapy below are met, therapy could be covered under that condition;
- 2) The patient's condition requires a qualified therapist to design or establish a maintenance program as described below:
 - ❖ If the patient's clinical condition requires the specialized skill, knowledge, and judgment of a qualified therapist to design or establish a maintenance program related to the illness or injury to ensure his or her safety and the effectiveness of the program, such services are covered;
 - ❖ During the last visit(s) for restorative treatment, the qualified therapist may develop a maintenance program. The goal of a maintenance program may be, for example, to maintain functional status or prevent decline in function;

- ❖ Periodic re-evaluations of the patient and adjustments to a maintenance program may be covered if such re-evaluations and adjustments require the specialized skills of a qualified therapist;
 - ❖ If a maintenance program is not established until after the rehabilitative therapy program has been completed or if there was no rehabilitative therapy program, a qualified therapist's development of a maintenance program is considered reasonable and necessary for the treatment of the patient's condition only when an identified danger to the patient exists; and
 - ❖ When designing or establishing a maintenance program, the qualified therapist must teach the patient, the patient's family, or caregivers necessary techniques, exercises, or precautions as necessary to treat the illness or injury. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., Home Health aides) are not billable as visits since the HHA is responsible for ensuring that its staff are properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency; or
- 3) The skills of a qualified therapist are needed to perform maintenance therapy as described below:
- ❖ Reasonable and necessary services should be covered when the clinical condition of the patient is such that the complexity of the therapy services required to maintain function:
 - ◆ Involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself or herself (not an assistant); or

- ◆ Must be delivered by the therapist himself or herself (not an assistant) to ensure the patient's safety and to provide an effective maintenance program.

Elements of the Home Health Prospective Payment System (HH PPS)

The elements of the HH PPS include the following:

- ❖ The unit of payment under the HH PPS is a 60-day episode of care. A split percentage payment is made for most HH PPS episode periods. There are two payments – initial and final. The first payment is made in response to a Request for Anticipated Payment (RAP), and the last payment is paid in response to a claim. Added together, the first and last payments equal 100 percent of the permissible payment for the episode;
- ❖ There is a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments is 60 percent in response to the RAP and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments is 50 percent of the estimated case-mix adjusted episode payment. The case-mix and wage-adjusted national 60-day episode payment is adjusted for case-mix based on the patient's condition and care needs or case-mix assignment. The payment is also adjusted to account for area wage differences;
- ❖ The HH PPS permits continuous episode recertifications for patients who continue to be eligible for the Home Health benefit. Medicare does not limit the number of continuous episode recertifications for patients who continue to be eligible for the Home Health benefit. For CY 2013, the 60-day base episode payment rate is \$2,137.73;
- ❖ A case-mix methodology adjusts payment rates based on characteristics of the patient and his or her corresponding resource needs (e.g., diagnosis, clinical factors, functional factors, and service needs). The 60-day episode rates are adjusted by case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS);



- ❖ After a physician prescribes a home care assessment, the HHA must provide a patient-specific comprehensive assessment that accurately reflects the patient's current health status. The HHA's comprehensive assessment of each patient must also incorporate use of the current version of the OASIS;
- ❖ The comprehensive assessment of each patient must identify the patient's continuing need for home care and meet his or her medical, nursing, rehabilitative, social, and discharge planning needs. The following factors determine the case-mix adjustment to the national standardized 60-day episode payment rate:
 - OASIS items that describe the patient's condition;
 - OASIS items that describe the patient's PT, OT, and SLP service needs; and
 - Whether a particular episode is early (first or second) or later (third or later) in the sequence of Home Health episodes for a patient.

Currently, 153 case-mix groups called Home Health Resource Groups (HHRG) as measured by the OASIS are available for classification. The assessment must also be completed for each subsequent episode of care a patient receives;

- ❖ The HH PPS uses wage adjustment factors that reflect the relevant level of wages and wage-related costs applicable to the furnishing of Home Health services and to provide appropriate adjustment to the episode payment to account for area wage differences. CMS applies the appropriate wage index to the labor portion of the HH PPS rate based on the geographic area in which the patient receives the Home Health services. Each HHA's labor market area is based on definitions of Core-Based Statistical Areas issued by the Office of Management and Budget. For the HH PPS, we use the pre-floor and pre-reclassified hospital wage index to adjust the labor portion of the HH PPS rates based on the geographic area in which the patient receives the Home Health services;
- ❖ The HH PPS allows for outlier payments to be made to providers, in addition to regular 60-day case-mix and wage-adjusted episode payments, for episodes with unusually large costs due to patient Home Health care needs. Outlier payments are made for episodes when the estimated costs exceed a threshold amount.

The wage-adjusted outlier costs are imputed for each episode by applying the national standardized per-visit amounts to the number of visits by discipline (skilled nursing visits; PT, OT, and SLP services; medical social work; or Home Health aide services) reported on the claim. The wage-adjusted outlier threshold amount is computed by summing the case-mix and wage-adjusted episode payment amount and the wage-adjusted fixed dollar loss (FDL) amount (the national standardized 60-day episode payment amount multiplied by the FDL ratio, adjusted to account for area wage differences). The FDL ratio for CY 2013 is 0.45. The outlier payment is determined by subtracting the wage-adjusted outlier threshold amount from the wage-adjusted outlier costs, of which 80 percent (the loss-sharing ratio) is paid to the HHA as the outlier payment;

- ❖ Per the BBA of 1997, at the onset of the HH PPS, the law required that if the Secretary of the Department of Health and Human Services chooses to have an outlier policy, the estimated total outlier payments could not exceed 5 percent of estimated total HH PPS payments in any given year. From the inception of the HH PPS through CY 2009, CMS managed the FDL ratio and the loss-sharing ratio to target an outlier payment outlay of up to, but no more than, 5 percent of total estimated HH PPS payments. CMS reduced the HH PPS base rates by 5 percent to fund these outlier payments. In later years, excessive growth in outlier payments had occurred under the HH PPS, primarily the



result of suspiciously high outlier payments in targeted areas of the country, resulting in outlier payments above the 5 percent target. Although program integrity efforts associated with excessive outlier payments continue in targeted areas of the country, CMS continued to be at risk of exceeding the 5 percent statutory limit on estimated outlier expenditures. For CY 2010, CMS changed its outlier policy to:

- Ensure appropriate payments for outlier episodes;
- Address some of the questionable growth in outlier expenditures in targeted areas such as Miami-Dade, Florida;
- Impose an agency aggregate outlier cap so that no more than 10 percent of an HHA's total payments are paid as outlier payments; and
- Target 2.5 percent for outlier payments, as a percentage of total estimated HH PPS payments, and return 2.5 percent to the HH PPS rates such that the rates would be reduced by 2.5 percent to fund an outlier pool of 2.5 percent of total estimated HH PPS payments.

Under the Affordable Care Act, beginning in CY 2011, the 10 percent outlier cap is permanent and the HH PPS base rates are reduced by 5 percent to fund outlier payments up to but no more than 2.5 percent of estimated total HH PPS payments in outlier payments;

- ❖ A Low-Utilization Payment Adjustment (LUPA) is made for patients who require four or fewer visits during the 60-day episode. These episodes are paid the wage-adjusted, service-specific per-visit amount multiplied by the number of discipline-specific visits actually furnished during the episode. For LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes for a given patient, an increased payment is made to account for the front-loading of assessment costs and administrative costs. That amount was established at \$87.93 for CY 2008 and has been updated by Home Health market basket increases for CYs 2009 – 2013. The LUPA add-on amount for CY 2013 is \$93.96;

- ❖ A partial episode payment (PEP) adjustment is made when a patient elects to transfer to another HHA or is discharged and readmitted to the same HHA during the 60-day episode. The discharge and return to the same HHA during the 60-day episode period is recognized only when a patient reaches the treatment goals in the original POC. The original POC must be terminated with no anticipated need for additional Home Health services for the balance of the 60-day period. The PEP adjustment is determined by proportionally adjusting the original 60-day episode payment to reflect the number of days the patient remained under the HHA's care before the intervening event. The 60-day episode clock is restarted for the subsequent episode and a new POC and assessment is established. The HHA initially receives approximately one-half of the new HHRG payment (based on the RAP) and the final residual payment based on the final claim for that 60-day episode; and
- ❖ Per Section 3131(c) of the Affordable Care Act, for Home Health services provided in rural areas with episodes ending on or after April 1, 2010, and before January 1, 2016, a 3 percent add-on will be applied to the following:
 - The national standardized 60-day episode rate;
 - National per-visit rates;
 - The LUPA payment amount; and
 - The non-routine supply (NRS) conversion factor.



Updates to the Home Health Prospective Payment System (HH PPS)

As required by Section 1895(b)(3)(B) of the Act, CMS has historically updated the HH PPS rates annually in the “Federal Register.” The rates are effective on January 1 of each CY.

The CY 2008 rule included an analysis indicating an increase in the case-mix since 2000. The 11.75 percent increase was unrelated to underlying changes in patients’ health status. To account for these changes, CMS implemented a four-year reduction to the episode rates and the NRS conversion factor. The reduction was 2.75 percent for three years beginning in CY 2008 with plans for a 2.71 percent reduction for the fourth year in CY 2011. However, updated analysis showed continued increases in case-mix that were unrelated to underlying changes in patient acuity. Therefore, for CY 2011, CMS reduced the episode rates and the NRS conversion factor by 3.79 percent and implemented a 3.79 percent case-mix reduction for CY 2012 as well. For

CY 2013, a 1.32 percent case-mix reduction has been implemented.

The Deficit Reduction Act added Section 1895(b)(3)(B)(v)(II) of the Act, which requires each HHA to submit quality data. For CY 2007 and subsequent years, HHAs that do not submit the required quality data will receive an episode rate that is equal to the previous year’s rate increased by the market basket update minus 2 percentage points.

Health Care Quality

The Home Health market basket percentage increase for CY 2013 is 2.3 percent. After reducing it by 1 percentage point as required by the Affordable Care Act, the market basket update becomes 1.3 percent. HHAs that do not report the required quality data receive a 2 percentage point reduction to the Home Health market basket of 1.3 percent, resulting in a market basket update of -0.7 percent for CY 2013.



Resources

For More Information About...	Resource
Home Health Prospective Payment System	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS on the CMS website Chapter 10 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf on the CMS website
Home Health Face-to-Face Encounters	MLN Matters® Article titled “A Physician’s Guide to Medicare’s Home Health Certification, Including the Face-to-Face Encounter” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1219.pdf on the CMS website Home Health Face-to-Face Encounter Questions & Answers located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/QandAsFull-revised-062712.pdf on the CMS website
Home Health Quality Initiatives	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits on the CMS website
Compilation of Social Security Laws	http://www.ssa.gov/OP_Home/ssact/title18/1800.htm on the U.S. Social Security Administration website
The “Federal Register”	http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR on the U.S. Government Printing Office website
All Available Medicare Learning Network® (MLN) Products	“Medicare Learning Network® Catalog of Products” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right 
Provider-Specific Medicare Information	MLN publication titled “MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers” booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website



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