



Home Health Prospective Payment System



What's Changed?

- Medicare will pay all HHAs a 0% split-percentage payment (page 4)
- Beginning in CY 2022, HHAs will no longer submit a no-pay RAP (page 4)
- The LUPA threshold changed to a variable threshold (page 8)
- HHAs may use telecommunications technologies to care for patients (page 8)
- Home infusion therapy services excluded from the definition of home health services (page 8)
- HHAs must report data using OASIS and HHCAHPS (page 9)

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Introduction

This booklet educates home health providers about:

- Consolidated billing (CB) requirements
- Elements of the Home Health Prospective Payment System (HH PPS)
- Case-mix and other payment adjustments
- Updates to the HH PPS
- Physician and allowed practitioner billing and payment for home health services

Background

The Balanced Budget Act of 1997 (BBA) (Public Law 105–33), enacted on August 5, 1997, significantly changed the way Medicare pays for home health services. Before the start of the HH PPS on October 1, 2000, Medicare paid home health agencies (HHAs) under a retrospective payment system. BBA Section 4603(a) mandated the development of a HH PPS for all Medicare-covered home health services provided under a plan of care (POC) paid on a reasonable cost basis by adding [Section 1895 of the Social Security Act](#) (the Act).

Beginning in October 2000, Medicare paid HHAs under a HH PPS for 60-day episodes of care that included all covered home health services. Medicare adjusted the 60-day payment amount for case-mix and area wage differences. The case-mix adjustment under this system included a clinical dimension, a functional dimension, and a service dimension (payment increases if the HHA meets a certain threshold of therapy visits).

The Bipartisan Budget Act of 2018 (BBA of 2018) included several requirements for home health payment reform, effective January 1, 2020. These requirements included the elimination of therapy thresholds for case-mix adjustment and a change in the unit of home health payment from a 60-day episode to a 30-day period. The mandated home health payment reform resulted in the development of an alternate case-mix adjustment method called the Patient-Driven Groupings Model (PDGM). The PDGM is effective for 30-day periods of care that begin on or after January 1, 2020, and relies on clinical characteristics and other information to place patients into meaningful payment categories.

CB Requirements

Medicare pays HHAs one standardized payment for all the covered home health services and supplies provided to a patient within a 30-day period of care, as long as the patient is under a home health POC. The payment is adjusted for case-mix and area wage differences. A patient can have more than one 30-day period of care.

Most home health services must meet CB requirements. Under CB, the primary HHA is responsible for submitting all Medicare claims for the services and supplies provided to a patient. If the primary HHA has an arrangement with an outside supplier or provider, that outside supplier or provider must ask the HHA for payment. They can't bill Medicare.

Medicare pays for some services and supplies outside of the 30-day period payment rate even though these services must meet CB requirements. This means the HHA receives payment for these services and supplies in addition to the 30-day period bundled payment. To receive payment, the HHA must bill for these services and supplies while a patient is under a home health POC.

Some services and supplies are excluded from CB requirements, including durable medical equipment (DME). Medicare can be billed separately for these services and supplies.

Home Health Services & Medical Supplies Subject to CB Requirements

The following services and supplies must meet CB requirements, and are included in the 30-day period payment:

- Part-time or intermittent skilled nursing (SN) and home health aide services
- **Note:** HHAs may provide part-time or intermittent SN and home health aide services any number of days per week. The HHA must provide them (combined) less than 8 hours each day and less than 28 hours each week. On a case-by-case basis, HHAs may be allowed to provide up to 35 hours each week.
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-language pathology (SLP) services
- Medical social services
- Routine and non-routine medical supplies
- An intern or resident-in-training of the program of the hospital (if the HHA is affiliated or under common control with a hospital with an approved teaching program) providing medical services
- Home health services defined in [Section 1861\(m\) of the Act](#) under arrangement at hospitals, Skilled Nursing Facilities, or rehabilitation centers when the services involve equipment too cumbersome to bring to the home, or providers supply the services while the patient is at the facility
- Routine and non-routine medical supplies, except when they are provided incident to physician services

The following services and supplies must meet CB requirements, but are billed in addition to the 30-day period payment:

- NPWT using a disposable device (for further billing instructions, refer to [Medicare Claims Processing Manual, Chapter 10, Section 90.3](#))
- Certain covered injectable osteoporosis drugs (for further billing instructions, refer to [Medicare Claims Processing Manual, Chapter 10, Section 90.1](#))

Elements of the Home Health Prospective Payment System

RAP and NOA

Effective CY 2021, Medicare will pay all HHAs a 0% split-percentage payment. All HHAs must submit a no-pay request for anticipated payment (RAP) at the beginning of each 30-day period of care ([84 FR 60548](#)). Since there's no payment associated with the submission of the RAP in CY 2021, HHAs submit the RAP when:

- The HHA gets and documents the physician or allowed practitioner's written or verbal order that sets out the services required for the initial visit as required at 42 Code of Federal Regulations (CFR) Sections [484.60\(b\)](#) and [409.43\(d\)](#)
- The physician or allowed practitioner makes the initial visit within the 60-day certification period and the patient is admitted to home health care ([84 FR 60548](#))

Beginning in CY 2022, HHAs will no longer submit a no-pay RAP. Instead, Medicare requires all HHAs to submit a Notice of Admission (NOA) within 5 days of the patient's start-of-care date. This establishes the primary HHA and alerts the claims processing system that a 30-day home health period of care has begun.

The HHA submits the NOA under any of the following conditions:

- The certifying physician or allowed practitioner signs the POC
- If the signed POC isn't available at the time of the NOA submission, then the HHA must base the submission on either of the following:
 - A physician or allowed practitioner's verbal order that:
 - Is recorded in the POC
 - Includes a description of the patient's condition and the services the home health agency will provide
 - Includes the signed and dated attestation of the registered nurse or qualified therapist (as defined in §484.115) responsible for providing or supervising the ordered service in the POC
 - Is copied into the POC and the POC is immediately submitted to the physician or allowed practitioner
 - A referral with detailed orders for the services to be provided; this must be signed and dated by the physician or allowed practitioner

Medicare adjusts the national, standardized 30-day period payment for case-mix based on the patient's condition and care needs. Medicare also adjusts the payment for area wage differences.

PDGM & HHRGs

The PDGM case-mix method adjusts the 30-day period payment rates based on clinical characteristics of the patient and their resource needs. It places 30-day periods of care into different subgroups for each of the following broad categories:

Admission Source: This category includes 2 subgroups. Periods of care are grouped based on whether the patient was admitted to home health from a community or institutional admission source. Medicare gets this information from Medicare claims.

Timing of the 30-day Period: This category includes 2 subgroups. Periods of care are grouped based on whether the home health period of care is early (the first 30-day period) or late (subsequent 30-day periods in a sequence of periods). Medicare gets this information from Medicare claims.

Clinical Grouping: This category includes 12 subgroups. Periods of care are grouped based on the principal diagnosis reported; the subgroups include:

- Musculoskeletal rehabilitation
- Neuro/stroke rehabilitation
- Wounds
- Complex nursing interventions
- Behavioral health
- Medication management teaching and assessment for a variety of surgical or medical conditions

Functional Impairment Level: This category includes 3 subgroups. Periods of care are grouped based on whether the patient has a low, medium, or high functional impairment level. Medicare assigns this level based on responses to certain items from the home health Outcome and Assessment Information Set (OASIS).

Comorbidity Adjustment: This category includes 3 subgroups. Periods of care are grouped based on secondary diagnoses reported on claims. Medicare assigns a no, low, or high payment adjustment. Medicare gets this information from home health claims.

In total, there are $2 \times 2 \times 12 \times 3 \times 3 = 432$ possible case-mix groups called home health resource groups (HHRGs) based on the variables in the case-mix method.

The unit of home health payment is a 30-day period of care, but recertifications, completion of the OASIS, and updates to the POC remain on a 60-day basis. The HH PPS permits continuous recertifications for eligible home health benefit patients. Medicare doesn't limit the number of continuous recertifications for eligible home health benefit patients.

Wage Adjustment Factors

The HH PPS adjusts each 30-day period payment based on wage levels and the wage-related costs associated with giving home health care to patients in different geographical areas. CMS applies the appropriate wage index to the labor portion of the HH PPS rate based on the geographic area where the patient gets home health services. The Office of Management and Budget (OMB) defines Core-Based Statistical Areas (CBSAs) that are the basis of each labor market area. For the HH PPS, CMS uses the pre-floor and pre-reclassified hospital wage index to adjust the labor portion of the HH PPS rates.

You can find more information about the CY HH PPS Wage Index at the [Home Health Agency Center](#) webpage.

Outlier Payments, PEPs, & Rural Add-On Payments

Calculating Outlier Payments

When a 30-day period has unusually large costs because of patient home health care needs, Medicare allows outlier payments. These outlier payments are in addition to regular 30-day case-mix and wage-adjusted period payments and are made when the estimated costs exceed a threshold amount for each HHRG.

To calculate the imputed cost for a 30-day period, CMS:

- Calculates the per-unit payment amounts (1 unit = 15 minutes), using the national per-visit payment amounts for each discipline
- Multiplies the per-unit amounts by the number of units per discipline
- Totals the imputed cost for all disciplines (summed across the 6 disciplines of care)

Medicare computes the wage-adjusted outlier threshold amount by:

- Summing the case-mix and wage-adjusted 30-day period payment amount and the wage-adjusted fixed dollar loss (FDL) amount (the national standardized 30-day period payment amount multiplied by the FDL ratio, adjusted to account for area wage differences)
- Subtracting the wage-adjusted outlier threshold amount from the wage-adjusted outlier costs

Medicare pays 80% (the loss-sharing ratio) of that to the HHA as the outlier payment

- Medicare caps outlier payments as a percent of total annual payments for each HHA at 10%.
- The law requires that total outlier payments in a given year can't exceed 2.5% of total payments, projected or estimated

PEPs

Medicare makes a partial episode payment (PEP) adjustment if:

- A patient transfers from one HHA to another

Or

- A patient discharges and readmits to the same agency within 30 days of the original 30-day period start date

Medicare prorates the case-mix adjusted payment for 30-day periods of that type based on the length of the 30-day period ending in transfer or discharge and readmission. This results in a partial payment adjustment.

Rural Add-On Payments

Medicare also offers rural add-on payments for episodes or periods ending during CYs 2019 through 2022.

The rural add-on percentages vary depending on the rural county's (or equivalent area's) classification into 1 of 3 distinct categories:

- High use
- Low-population density
- All others

LUPA

Medicare makes a Low Utilization Payment Adjustment (LUPA) payment for 30-day periods where the number of visits is below the case-mix group's threshold.

- Each of the 432 case-mix groups has a threshold that determines if the 30-day period gets a LUPA
- For each case-mix group, the 10th percentile value of visits is used to create a case-mix, group-specific LUPA threshold with a minimum threshold of at least 2 for each group
- Medicare pays for a 30-day period with a total number of visits below the LUPA threshold per-visit rather than paying the case-mix adjusted 30-day payment amount

For LUPA periods that occur as the only period or the first period in a sequence of adjacent periods for a patient, Medicare makes an increased payment for the front-loading of assessment costs and administrative costs.

In CY 2020, the LUPA threshold changed from a fixed threshold of 4 visits to a variable threshold that ranges from 2-6 visits based on the Health Insurance Prospective Payment System (HIPPS) payment code billed.

Providers must submit appropriate claims and supporting documentation for the LUPA threshold applied. Documentation includes the:

- Patient's condition
- Care needs or case-mix assignment

Note: Medicare may adjust a home health claim based on other claims, which may or may not yet be billed or processed. Those claims could affect the common working file (CWF) and the HIPPS already billed or paid.

For more information about HH PPS payment updates, including the yearly market basket update, refer to the [CMS Home Health Agency Center](#) and the [Home Health PPS Regulations and Notices](#) webpages.

Updates to the HH PPS

The [CY 2021 Home Health PPS final rule](#) implemented changes to the home health regulations about the use of telecommunications technology to provide services under the Medicare home health benefit. Effective January 1, 2021, HHAs can use telecommunications technologies to provide care to patients under the Medicare home health benefit. As a condition for payment:

- The physician or allowed practitioner must include any provision of remote patient monitoring or other services provided via a telecommunications system or audio-only technology in the POC.
- HHAs can't substitute use of telecommunications or audio-only technology for a home visit ordered as part of the POC or for the purposes of patient eligibility or payment. Using telecommunications technology or audio-only technology must relate to the patient-specific needs as identified in the comprehensive assessment.

Section 5012 of the [21st Century Cures Act](#) amended [section 1861\(m\) of the Act](#) to exclude home infusion therapy services from the definition of home health services. Effective January 1, 2021:

- o Medicare only pays for home infusion therapy services needed to administer home infusion drugs
- o An HHA must be accredited and enrolled in Medicare as a qualified home infusion therapy supplier to provide and bill for home infusion therapy services under the home infusion therapy services benefit
- o If an HHA doesn't become accredited and enrolled as a qualified home infusion therapy supplier and treats a patient receiving a home infusion drug, the HHA must sub-contract with a qualified home infusion therapy supplier to provide the services related to the home infusion drug

For more information, visit the [Home Infusion Therapy Services](#) webpage.

Physician and Allowed Practitioner Billing & Payment

Codes for Certifying & Recertifying Eligibility

Physicians and allowed practitioners use these HCPCS codes for claims when certifying and recertifying eligibility for home health services:

- HCPCS code G0180 – Physician or allowed practitioner certification for Medicare-covered home health services under a home health POC (patient not present) including contacts with the HHA

This includes the review of patient status reports. Medicare requires physicians and allowed practitioners to review these reports to affirm the beginning of the POC.

- HCPCS code G0179 – Physician or allowed practitioner recertification for Medicare-covered home health services under a home health POC (patient not present)

This includes physicians and allowed practitioners contacting the HHA and reviewing patient status reports. Medicare requires physicians and allowed practitioners to review these reports to verify the beginning of the POC.

Medicare won't cover a physician or allowed practitioner's HHA claim for certification or recertification of eligibility for home health services (HCPCS codes G0180 and G0179, respectively) if the physician or allowed practitioner didn't complete the certification or recertification of eligibility or if there's insufficient documentation to support the patient's eligibility for Medicare home health benefit.

For more information about certifying patient eligibility for Medicare home health services, refer to the [Medicare Benefit Policy Manual Chapter 7 - Home Health Services, Section 30.5.1 - Physician or Allowed Practitioner Certification](#).

Home Health Quality Reporting Program (HH QRP)

Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 ([The IMPACT Act](#)) requires HHAs, Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, and Long-Term Care Hospitals to submit quality measures and data on resource use and other measures. HHAs submit this data through the Outcome and Assessment Information Set (OASIS). HHAs that don't report quality data to CMS will get a reduction of 2 percentage points to the market basket update. Beginning July 1, 2017, HHAs must submit both admission and discharge OASIS assessments for at least 90% of patients with episodes of care occurring during the reporting period.

Beginning CY 2020, HHAs must report data using OASIS and Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS). HHAs use additional measures on each claim:

- Improvement in Ambulation/Location (NQF #0167)
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
- Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)
- Improvement in Bathing (NQF #0174)

- Improvement in Bed Transferring (NQF #0175)
- Drug Regimen Review Conducted With Follow-Up For Identified Issues – Post-Acute Care (PAC) HH QRP
- Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care
- Improvement in Dyspnea
- Influenza Vaccination Received for Current Flu Season
- Improvement in Management of Oral Medications (NQF #0176)
- Improvement in Pain Interfering With Activity (NQF #0177)
- Changes in Skin-Integrity Post-Acute Care
- Timely Initiation of Care (NQF #0526)
- Acute Care Hospitalization During the First 60 Days of HH (NQF #0171)
- Discharge to Community-Post Acute Care Home Health (HH) Quality Reporting Program (QRP) (NQF #3477)
- Emergency Department Use without Hospitalization During the First 60 Days (NQF #0173)
- Total Estimated Medicare Spending Per Beneficiary (MSPB) Post-Acute Care (PAC) HH QRP
- Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program
- CAHPS Home Health Care Survey Experience with Care (NQF #0517)

Resources

- [Chapter 4 of the Medicare General Information, Eligibility, and Entitlement Manual \(Publication 100-01\)](#)
- [Compilation of Social Security Laws](#)
- [HH PPS webpage](#)
- [Home Health Quality Reporting Program](#)
- [Medicare.gov](#)
- [The Medicare Learning Network® \(MLN\)](#)

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