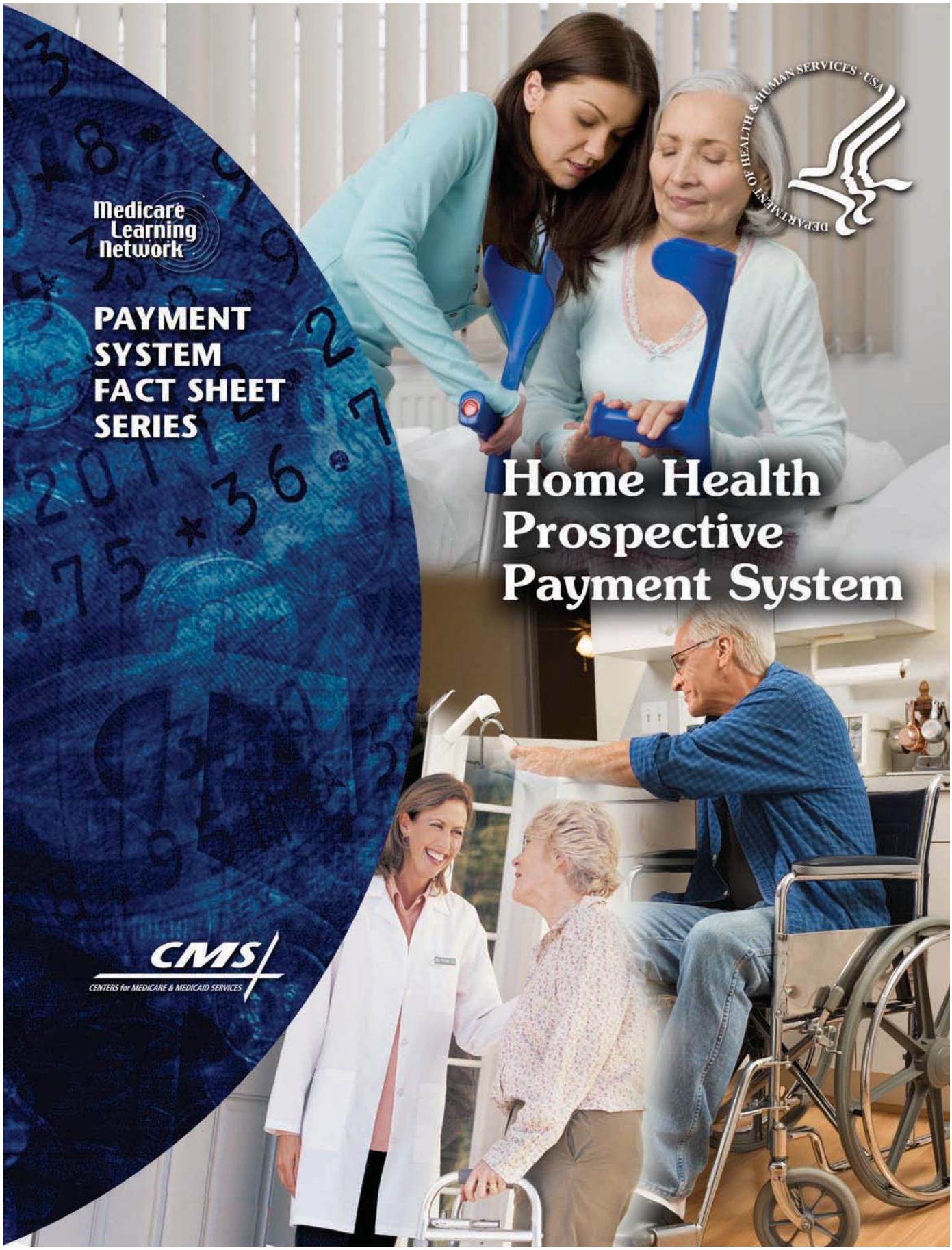
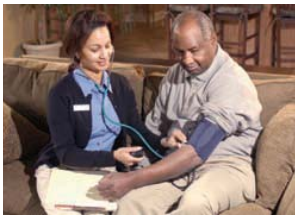

Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
Home Health Prospective Payment System
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

The **Home Health Prospective Payment System (HH PPS)** was implemented on October 1, 2000 as mandated by the Balanced Budget Act of 1997 and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999.

Under the HH PPS consolidated billing requirement, Home Health Agencies (HHA) must bill for all of the following:

- Skilled nursing services;
- Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services;
- Routine and non-routine medical supplies;
- HH aide services; and
- Medical social services.



Durable medical equipment (DME) is excluded from the consolidated billing requirement and is paid on the fee schedule outside the HH PPS rate. Effective April 1, 2008, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

- Be awarded a contract to furnish the items in this area; or
- Use a contract supplier in the community to furnish these items.

HHA claims for competitively bid DME should be submitted to DME Medicare Administrative Contractors. Claims that at are not subject to competitive bidding should be submitted to Regional Home Health Intermediaries (RHHI).

COVERAGE OF HOME HEALTH SERVICES

Medicare covers HH services when the following criteria are met:

- The patient to whom the services are furnished is an eligible Medicare beneficiary who is not enrolled in a Medicare Advantage Plan;
- The HHA that furnishes the services has in effect a valid agreement to participate in the Medicare Program;
- The patient qualifies for coverage of HH services;
- The services are a covered Medicare benefit;
- Medicare is the appropriate payer; and
- The services are not otherwise excluded from payment.

To qualify for the Medicare HH benefit, a patient must:

- Be confined to the home;
- Be under the care of a physician;
- Be receiving services under a plan of care 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), be in need of PT or SLP services, or have a continuing need for OT 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, other type of institution). Hospitals, Skilled Nursing Facilities, and most nursing facilities under the Medicaid Program are not considered a patient's residence under the HH benefit if they meet the requirements under §§1861(e)(1) or 1819 (a)(1) of the Social Security Act.

For a patient to be considered confined to the home, leaving home requires 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 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, walker);
- Special transportation; or
- Another person.

ELEMENTS OF THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

The elements of the HH PPS include the following:

- **Payment for the 60-day episode**—The unit of payment under the HH PPS is a 60-day episode of care. The HHA receives approximately half of the estimated base payment for the full 60 days when the RHHI receives the request for anticipated payment and the residual half at the close of the 60-day episode unless there is an applicable adjustment to that amount. The adjusted base payment is based on the patient's condition and care needs or case-mix assignment. Another 60-day episode can be initiated for longer-stay patients.
- **Case-mix adjustment**—After a physician prescribes a HH plan of care, the HHA uses the Outcome and Assessment Information Set (OASIS) to assess the patient's condition and the likely skilled nursing care, therapy, medical social services, and HH aide services that will be needed at the beginning of the episode of care. OASIS items that describe the patient's condition and his or her PT, OT, and SLP services needs are used to determine the case-mix adjustment to the standard payment rate. Currently eighty case-mix groups called Home Health Resource Groups (HHRG) as measured by the OASIS are available for patient classification. Beginning in calendar year (CY) 2008, one hundred and fifty-three HHRGs will be available. The assessment must be completed for each subsequent episode of care a patient receives.
- **Outlier payment**—An additional payment is made to the 60-day case-mix adjusted episode payment for patients who incur unusually large costs. The outlier cost is imputed for each episode by applying standard per-visit amounts to the number of visits by discipline (skilled nursing visits; PT, OT, and SLP services; or HH aide services) reported on claims. The outlier payment is determined by subtracting the sum of the case-mix and wage adjusted amount and the outlier threshold amount from the imputed cost, of which eighty percent (the loss-sharing ratio) is paid to the HHA as the outlier payment. Annual total national outlier payments for HH services

may not be more than five percent of the estimated total HH PPS payments.

- **Adjustment for four or fewer visits**—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 labor adjusted, standardized, service-specific per-visit amount multiplied by the number of visits actually furnished during the episode. Beginning in CY 2008, for LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes for a given beneficiary, there is an increase in payment of $87.93 to account for the front-loading of assessment costs and administrative costs.
- **Adjustment for change in condition**—Currently, when a patient experiences significant change in condition (SCIC) during the 60-day episode that was not envisioned in the original physician's plan of care and case-mix adjustment, a SCIC adjustment can occur, which requires the determination of a new payment amount. Beginning on January 1, 2008, the SCIC adjustment policy will be eliminated based on comments from the public and continued analysis of the policy.
- **Adjustment for transfer to another HHA**—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 PEP adjustment is determined by proportionally adjusting the original 60-day episode payment to reflect the length of time the patient remained under the HHA's care before the intervening event. The new episode is paid an initial episode payment of one half of the new HHRG. A new plan of care and assessment is required when a new 60-day episode begins.

During the period January 1, 2008 through December 31, 2008, the Centers for Medicare & Medicaid Services (CMS) will pay for the delivery of HH services based on whether or not HHAs have submitted the OASIS quality data required by the statute during the time period after July 1, 2006 and before July 1, 2007 (the reporting requirement for CY 2008). HHAs that submit quality data will be paid CY 2008 HH PPS rates based on the full HH market basket update of 3.0 percent. HHAs that do not submit quality data will be paid based on a 1.0 percent market basket update.

To find additional information about the HH PPS, visit **http://www.cms.hhs.gov/HomeHealthPPS** on the CMS website.

Medicare Contracting Reform (MCR) Update
In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at **http://www.cms.hhs.gov/MedicareContractingReform/** on the CMS website.

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