

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 409, 410, 411, 413, 424, and 484

[HCFA-1059-F]

RIN 0938-AJ24

**Medicare Program; Prospective Payment System for Home
Health Agencies**

AGENCY: Health Care Financing Administration (HCFA),
HHS.

ACTION: Final rule.

SUMMARY: This final rule establishes requirements for the new prospective payment system for home health agencies as required by section 4603 of the Balanced Budget Act of 1997, as amended by section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 and by sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. The requirements include the implementation of a prospective payment system for home health agencies, consolidated billing requirements, and a number of other related changes. The prospective payment system described in this rule

replaces the retrospective reasonable-cost-based system currently used by Medicare for the payment of home health services under Part A and Part B.

Effective Date: These regulations are effective October 1, 2000.

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In addition, because of the many terms to which we refer by abbreviation in this rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ADL Activities of Daily Living

BBA Balanced Budget Act of 1997

BBRA Medicare, Medicaid, and SCHIP Balanced Budget
Refinement Act of 1999

COPs Conditions of participation

DME Durable medical equipment

FIs Fiscal intermediaries

FFY	Federal fiscal year
FMR	Focused medical review
FY	Fiscal year
HHA	Home health agency
HIC	Health insurance claim
HHRGs	Home Health Resource Groups
IADL	Instrumental Activities of Daily Living
IPS	Interim payment system
LUPA	Low-utilization payment adjustment
MS	Medical social services
MSA	Metropolitan Statistical Area
NCSB	Neurological, cognitive, sensory, and behavioral variables
OASIS	Outcome and Assessment Information Set
OBQI	Outcome based quality improvement
OCESAA	Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999
OSCAR	On-line Survey and Certification System
OT	Occupational therapy
PEP	Partial episode payment
PPS	Prospective payment system
PT	Physical therapy
RHHI	Regional Home Health Intermediary

RUGs	Resource Utilization Groups
SCIC	Significant Change in Condition
SN	Skilled nursing service
SP	Speech-language pathology

I. Background

A. Current System for Payment of Home Health Agencies

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, enacted on August 5, 1997, significantly changed the way we pay for Medicare home health services. Until the implementation of a home health prospective payment system (PPS), home health agencies (HHAs) receive payment under a cost-based reimbursement system, referred to as the interim payment system and generally established by section 4602 of the BBA. The interim payment system imposes two sets of cost limits for HHAs. Section 4206(a) of the BBA reduced the home health per-visit cost limits from 112 percent of the mean labor-related and nonlabor-related, per-visit costs for freestanding agencies to 105 percent of the median. In addition, HHA costs are subjected to an aggregate per-beneficiary cost limitation. For those providers with a 12-month cost reporting period ending in Federal fiscal year (FFY) 1994, the per-beneficiary cost limitation is based on a

blend of costs (75 percent on 98 percent of the agency-specific costs and 25 percent on 98 percent of the standardized regional average of the costs for the agency's census region). For new providers and those providers without a 12-month cost-reporting period ending in FFY 1994, the per-beneficiary limitation is the national median of the per-beneficiary limits for HHAs. Under the interim payment system, HHAs are paid the lesser of (1) actual reasonable costs; (2) the per-visit limits; or (3) the per-beneficiary limits. Effective October 1, 1997, the interim payment system exists until prospective payment for HHAs is implemented.

On October 21, 1998, the Omnibus Consolidated and Emergency Supplemental Appropriations Act for FY 1999 (OCESAA), Public Law 105-277, was signed into law. Section 5101 of OCESAA amended section 1861(v)(1)(L) of the Social Security Act (the Act) by providing for adjustments to the per-beneficiary and per-visit limitations for cost-reporting periods beginning on or after October 1, 1998. We had published a notice with comment period establishing the cost limitations for cost reporting periods beginning on or after October 1, 1998 in the **Federal Register** that was entitled "Medicare

Program; Schedules of Per-Visit and Per-Beneficiary Limitations on Home Health Agency Costs for Cost Reporting Periods Beginning On or After October 1, 1998" on August 11, 1998 (63 FR 42912). OCESAA made the following adjustments to these limitations:

Providers with a 12-month cost reporting period ending during FY 1994, whose per-beneficiary limitations were less than the national median, which is to be set at 100 percent for comparison purposes, will get their current per-beneficiary limitation plus 1/3 of the difference between their rate and the adjusted national median per-beneficiary limitation. New providers and providers without a 12-month cost-reporting period ending in FFY 1994 whose first cost-reporting period begins before October 1, 1998 will receive 100 percent of the national median per-beneficiary limitation.

New providers whose first cost-reporting periods begin during FFY 1999 will receive 75 percent of the national median per-beneficiary limitation as published in the August 11, 1998 notice. In the case of a new provider or a provider that did not have a 12-month cost-reporting period beginning during FFY 1994 that filed an application for HHA provider status before October 15,

1998 or that was approved as a branch of its parent agency before that date and becomes a subunit of the parent agency or a separate freestanding agency on or after that date, the per-beneficiary limitation will be set at 100 percent of the median. The per-visit limitation effective for cost-reporting periods beginning on or after October 1, 1998 is set at 106 percent of the median instead of 105 percent of the median, as previously required in the BBA.

There was contingency language for the home health PPS provided in the BBA that was also amended by section 5101 of OCESAA. The language provided that if the Secretary, for any reason, does not establish and implement the PPS for home health services by October 1, 2000, the Secretary will provide for a reduction by 15 percent to the per-visit cost limits and per-beneficiary limits, as those limits would otherwise be in effect on September 30, 2000. Section 302 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106-113, enacted on November 29, 1999, however, subsequently removed the contingency language governing the 15 percent reduction to the IPS cost limits for FFY 2001. It also increased

the per-beneficiary limit for those providers with limits below the national median.

B. Requirements of the Balanced Budget Act of 1997, the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, and the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 for the Development of a Prospective Payment System for Home Health Agencies.

Section 4603(a) of the BBA provides the authority for the development of a PPS for all Medicare-covered home health services paid on a reasonable cost basis that will ultimately be based on units of payment by adding section 1895 to the Act entitled "Prospective Payment For Home Health Services."

Section 5101(c) of OCESAA amends section 1895(a) of the Act by removing the transition into the PPS by cost-reporting periods and requiring all HHAs to be paid under PPS effective upon the implementation date of the system. Section 1895(a) of the Act now states "Notwithstanding section 1861(v), the Secretary shall provide, for portions of cost reporting periods occurring on or after October 1, 2000, for payments for home health services in

accordance with a prospective payment system established by the Secretary under this section."

Section 1895(b)(1) of the Act requires the Secretary to establish a PPS for all costs of home health services. Under this system all services covered and paid for on a reasonable cost basis under the Medicare home health benefit as of the date of enactment of the BBA, including medical supplies, will be paid on the basis of a prospective payment amount. The Secretary may provide for a transition of not longer than 4 years during which a portion of the prospective payment may be agency-specific as long as the blend does not exceed budget-neutrality targets.

Section 1895(b)(2) of the Act requires the Secretary in defining a prospective payment amount to consider an appropriate unit of service and the number, type, and duration of visits furnished within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Section 1895(b)(3)(A)(i) of the Act requires that (1) the computation of a standard prospective payment amount include all costs of home health services covered

and paid for on a reasonable-cost basis and be initially based on the most recent audited cost report data available to the Secretary, and (2) the prospective payment amounts be standardized to eliminate the effects of case-mix and wage levels among HHAs.

Section 5101(c) of OCESAA modifies the effective date of the budget-neutrality targets for HHA PPS by amending section 1895(b)(3)(A)(ii) of the Act. Section 1895(b)(3)(A)(ii) of the Act, as amended, requires that the standard prospective payment limitation amounts be budget neutral to what would be expended under the current interim payment system with the limits reduced by 15 percent at the inception of the PPS on October 1, 2000. Section 302 of the BBRA, delayed the application of the 15 percent reduction in the budget neutrality target for PPS until one year after PPS implementation. The law further requires the Secretary to report within 6 months of implementation of PPS on the need for the 15 percent reduction.

Section 5101(d)(2) of OCESAA also modifies the statutory provisions dealing with the home health market basket percentage increase. For fiscal years 2002 or 2003, sections 1895(b)(3)(B)(i) and (b)(3)(B)(ii) of the

Act, as so modified, require that the standard prospective payment amounts be increased by a factor equal to the home health market basket minus 1.1 percentage points. In addition, for any subsequent fiscal years, the statute requires the rates to be increased by the applicable home health market basket index change. Section 306 of the BBRA amended the statute to provide a technical correction clarifying the applicable market basket increase for PPS in each of FYs 2002 and 2003. The technical correction clarifies that the update in home health PPS in FY 2002 and FY 2003 will be the home health market basket minus 1.1 percent.

Section 1895(b)(3)(C) of the Act requires the Secretary to reduce the prospective payment amounts if the Secretary accounts for an addition or adjustment to the payment amount made in the case of outlier payments. The reduction must be in a proportion such that the aggregate reduction in the prospective payment amounts for the given period equals the aggregate increase in payments resulting from the application of outlier payments.

Section 1895(b)(4) of the Act governs the payment computation. Sections 1895(b)(4)(A)(i) and (b)(4)(A)(ii)

of the Act require the standard prospective payment amount to be adjusted for case-mix and geographic differences in wage levels. Section 1895(b)(4)(B) of the Act requires the establishment of an appropriate case-mix adjustment factor that explains a significant amount of the variation in cost among different units of services. Similarly, section 1895(b)(4)(C) of the Act requires the establishment of wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. These wage-adjustment factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E) of the Act.

Section 1895(b)(5) of the Act gives the Secretary the option to grant additions or adjustments to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. Total outlier payments in a given fiscal year cannot exceed 5 percent of total payments projected or estimated.

Section 1895(b)(6) of the Act provides for the proration of prospective payment amounts between the HHAs

involved in the case of a patient electing to transfer or receive services from another HHA within the period covered by the prospective payment amount.

Section 1895(d) of the Act limits review of certain aspects of the HHA PPS. Specifically, there is no administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, of the following: the establishment of the transition period under 1895(b)(1) of the Act, the definition and application of payment units under section 1895(b)(2) of the Act, the computation of initial standard prospective amounts under 1895(b)(3)(A) of the Act (including the reduction described in section 1895(b)(3)(A)(ii) of the Act), the establishment of the adjustment for outliers under 1895(b)(3)(C) of the Act, the establishment of case-mix and area wage adjustments under 1895(b)(4) of the Act, and the establishment of any adjustments for outliers under 1895(b)(5) of the Act.

Section 4603(b) of the BBA amends section 1815(e)(2) of the Act by eliminating periodic interim payments for HHAs effective October 1, 2000.

Section 4603(c) of the BBA sets forth the following conforming amendments:

! Section 1814(b)(1) of the Act is amended to indicate that payments under Part A will also be made under section 1895 of the Act;

! Section 1833(a)(2)(A) of the Act is amended to require that home health services, other than a covered osteoporosis drug, are paid under HHA PPS;

! Section 1833(a)(2) is amended by adding a new subparagraph (G) regarding payment of Part B services at section 1861(s)(10)(A) of the Act; and

! Section 1842(b)(6)(F) is added to the Act and section 1832(a)(1) of the Act is amended to include a reference to section 1842(b)(6)(F), both governing the consolidated billing requirements.

Section 4603(d) of the BBA was amended by section 5101(c)(2) of OCESSA by changing the effective date language for the HHA PPS and the other changes made by section 4603 of the BBA. Section 4603(d) now provides that: "Except as otherwise provided, the amendments made by this section shall apply to portions of cost reporting periods occurring on or after October 1, 2000." This change requires all HHAs to be paid under HHA PPS effective October 1, 2000 regardless of the current cost-reporting period.

Section 4603(e) of the BBA sets forth the contingency language for HHA PPS noting that if the Secretary, for any reason, does not establish and implement HHA PPS on October 1, 2000, the per-visit cost limits and per-beneficiary limits under the interim payment system will be reduced by 15 percent. Section 302(a) of the BBRA of 1999 eliminated the interim payment system contingency language by striking this section from the statute.

Section 305 of the BBRA refined the consolidated billing requirements under PPS. The new law excludes durable medical equipment (DME) from the home health consolidated billing requirements.

C. Summary of the Proposed Rule

We published a proposed rule in the **Federal Register** on October 28, 1999 at (64 FR 58134) that set forth proposed requirements that would establish the new prospective payment system for home health agencies as required by the Balanced Budget Act (BBA) of 1997, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA), of 1999, and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The PPS would replace the

retrospective reasonable cost-based system currently used by Medicare for the payment of home health services under Part A and Part B.

1. Transition to PPS

The statute provides authority for a transition period of no longer than 4 years to PPS. We proposed a full transition to the PPS. The overwhelming majority of the industry seems eager to move to PPS. However, some individual home health agencies (HHAs) will object to PPS because they currently enjoy a competitive advantage with high cost limits under the interim payment system. Furthermore, the statute now requires that we pay all providers under PPS on October 1, 2000 rather than phasing in by cost reporting period.

2. Unit of Payment (60-Day Episode)

We proposed a 60-day episode as the basic unit of payment under the HHA PPS. Evidence from the Phase II per-episode HHA PPS demonstration illustrated that the length of a 60-day episode captured a majority of the patients. Moreover, the 60-day episode would coordinate with the 60-day physician recertification of the plan of care and with the 60-day reassessment of the patient using the Outcomes and Assessment Information Set

(OASIS). This would encourage physicians' involvement in the plan of care.

3. Split Percentage Payment Approach to the 60-Day Episode Payment (Periodic Interim Payments Statutorily Eliminated with PPS)

Because the PPS system must maintain a cash flow to agencies accustomed to billing on 30-day cycles or receiving periodic interim payments, we proposed a split percentage billing for each 60-day episode. Under this system, an agency would receive a partial episode payment (50 percent) as soon as it notifies us of an admission and a final percentage (50 percent) payment at the close of the 60-day episode.

4. Partial Episode Payment Adjustment (PEP Adjustment)

The partial episode payment adjustment (PEP adjustment) provides a simplified approach to the episode definition and accounts for key intervening events in a patient's care defined as:

- a beneficiary elected transfer, or
- a discharge and return to the same HHA that would warrant a new clock for purposes of payment, OASIS assessment, and physician certification of the new plan of care. When a new 60-day episode begins, the original

60-day episode payment is proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care before the intervening event. The proportional payment is the PEP adjustment.

The proposed PEP adjustment is based on the span of days including the start-of-care date/first billable service date through and including the last billable service date under the original plan of care before the intervening event. The PEP adjustment is calculated by using the span of days (first billable service date through and including the last billable service date) under the original plan of care as a proportion of 60. The proportion is multiplied by the original case-mix and wage-adjusted 60-day episode payment.

We also proposed to close out the initial episode payment with a PEP adjustment and restart the 60-day episode clock under an existing episode due to a beneficiary elected transfer. We are concerned that these transfer situations could be subject to manipulation. Therefore, we proposed that we will not apply the PEP adjustment if the transfer is between organizations of common ownership.

In addition, the discharge and return to the same HHA during the 60-day episode period is only recognized when a beneficiary reached the treatment goals in the original plan of care. The original plan of care must be terminated with no anticipated need for additional home health services for the balance of the 60-day period. The discharge cannot be a result of a significant change in condition. In order for the situation to be defined as a PEP adjustment due to discharge and return to the same HHA during the 60-day episode, the discharge must be a termination of the complete course of treatment in the original plan of care. We would not recognize any PEP adjustment in an attempt to circumvent the payment made under the significant change in condition payment adjustment discussed below.

5. Significant Change In Condition Adjustment (SCIC Adjustment)

We proposed that the third intervening event over a course of a 60-day episode of home health care that could trigger a change in payment level to be a significant change in the patient's condition. We proposed the significant change in condition payment adjustment (SCIC adjustment) as the proportional payment adjustment

reflecting the time both before and after the patient experienced a significant change in condition during the 60-day episode. The proposed SCIC adjustment occurs when a beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of SCIC payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in treatment approach in the patient's plan of care.

The SCIC adjustment is calculated in two parts. The first part of the SCIC adjustment reflects the adjustment to the level of payment before the significant change in the patient's condition during the 60-day episode. The second part of the SCIC adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day episode. The first part of the SCIC adjustment uses the span of days of the first billable service date through the last billable service date before the intervening event of the patient's significant change in condition that warrants a new case-mix assignment for

payment. The first part of the SCIC adjustment is determined by taking the span of days before the patient's significant change in condition as a proportion of 60 multiplied by the original episode payment amount. The original episode payment level is proportionally adjusted using the span of time the patient was under the care of the HHA before the significant change in condition that warranted an OASIS assessment, physician change orders indicating the need for a significant change in the course of the treatment plan, and the new case-mix assignment for payment at the end of the 60-day episode.

The second part of the SCIC adjustment reflects the time the patient is under the care of the HHA after the patient experienced the significant change in condition during the 60-day episode that warranted the new case-mix assignment for payment purposes. The second part of the SCIC adjustment is a proportional payment adjustment reflecting the time the patient will be under the care of the HHA after the significant change in condition and continuing until the end of the 60-day episode. Once the HHA completes the OASIS, obtains the necessary physician change orders reflecting the need for a new course of

treatment in the plan of care, and assigns a new case-mix level for payment, the second part of the SCIC adjustment begins. The second part of the SCIC adjustment is determined by taking the span of days (first billable service date through the last billable service date) after the patient experiences the significant change in condition through the balance of the 60-day episode as a proportion of 60 multiplied by the new episode payment level resulting from the significant change. The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second parts of the SCIC adjustment (or any applicable medical review or low utilization payment adjustment (LUPA) discussed below) determined at the final billing for the 60-day episode.

6. Low-utilization Payment Adjustment (LUPA)

We proposed payments for low-utilization episodes by paying those episodes at a standardized average per-visit amount. Episodes with four or fewer visits would be paid the per-visit amount times the number of visits actually provided during the episode. "Savings" from reduced episode payments would be redistributed to all episodes.

7. Case-Mix Methodology

In the proposed rule, we described a home health case-mix system developed under a research contract with Abt Associates, Inc., of Cambridge, Massachusetts. The case-mix system uses selected data elements from the OASIS assessment instrument and an additional data element measuring receipt of therapy services of at least 8 hours (the 8-hour threshold has been defined as 10 visits for purposes of case-mix adjustment of PPS reimbursements). The data elements are organized into three dimensions to capture clinical severity factors, functional severity factors, and services utilization factors influencing case-mix. The process of selecting data elements for each dimension was described in the proposed rule. In the clinical and functional dimensions, each data element is assigned a score value derived from multiple regression analysis of the Abt research data. The score value measures the impact of the data element on total resource use. Scores are also assigned to data elements in the services utilization dimension. To find a patient's case-mix group, the case-mix grouper sums the patient's scores within each of the three dimensions. The resulting sum is used to assign

the patient to a severity level on each dimension. There are four clinical severity levels, five functional severity levels, and four services utilization severity levels. Thus there are 80 possible combinations of severity levels across the three dimensions. Each combination defines one of the 80 groups in the case-mix system. For example, a patient with high clinical severity, moderate functional severity, and low services utilization severity is placed in the same group with all other patients whose summed scores place them in the same set of severity levels for the three dimensions.

8. Outlier Payments

Outlier payments are payments made in addition to the 60-day episode payments for episodes that incur unusually large costs. Outlier payments would be made for episodes whose estimated cost exceeds a threshold amount for each case-mix group. The outlier threshold for each case-mix group, PEP adjustment or total SCIC adjustment would be the episode payment amount, PEP adjustment, or total SCIC adjustment for that group plus a fixed dollar loss amount that is the same for all case-mix groups. The outlier payment would be a proportion of the amount of estimated costs beyond the threshold.

Costs would be estimated for each episode by applying standard per-visit amounts to the number of visits by discipline reported on claims. The fixed dollar loss amount and the loss-sharing proportion are chosen so that total outlier payments are estimated to be no more than 5 percent of estimated total payments. There is no need for a long-stay outlier payment because we would not be limiting the number of continuous episode payments in a fiscal year that may be made for Medicare covered home health care to eligible beneficiaries.

9. Consolidated Billing/Bundling

Under the consolidated billing requirement, we would require that the HHA submit all Medicare claims for the home health services included in 1861(m) of the Social Security Act while the beneficiary is under the home health plan of care established by a physician and is eligible for the home health benefit. The proposed rule included an approach that was superseded by changes to the law made by the BBRA.