



HOME HEALTH PROSPECTIVE PAYMENT SYSTEM



Target Audience: Medicare Fee-For-Service Providers

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Learn about these Home Health Prospective Payment System (HH PPS) topics:

- Background
- Consolidated billing (CB) requirements
- Criteria that must be met to qualify for home health services
- Therapy services
- Elements of the HH PPS
- Updates to the HH PPS
- Physician billing and payment for home health services
- Market basket for calendar year (CY) 2018
- Home Health Quality Reporting Program (HH QRP)
- Resources



When we use “you” in this publication, we are referring to home health agencies (HHAs).

BACKGROUND

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

Since inception of the HH PPS in October 2000, the Centers for Medicare & Medicaid Services (CMS) implemented refinements in CYs 2008 and 2012. These changes to the case-mix model reflect:

- 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 (pulmonary, cardiac, gastrointestinal, blood disorders, affective and other psychoses, and cancer diagnosis groups)
- Certain secondary diagnoses and
- Changes to the therapy thresholds from a single 10-visit threshold to multiple thresholds

These changes improved the HH PPS by allowing more accurate case-mix adjustment without providing incentives for providers to distort appropriate patterns of care.

CB REQUIREMENTS

With the exception of certain covered osteoporosis drugs where the patient meets specific criteria, durable medical equipment (DME), and furnishing negative pressure wound therapy (NPWT) using a disposable device, payment for all services and supplies is included in the HH PPS episodic rate for individuals under a home health POC. You must provide the covered home health services (except DME) either directly or under arrangement (an outside supplier furnishes services under arrangement and looks to the HHA for payment). You must bill for such covered home health services, and payment must be made to you.

Home Health Services Subject to CB Requirements

These home health services are subject to the CB governing HH PPS:

- Part-time or intermittent skilled nursing (SN) and home health aide services – These services can be furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-language pathology (SLP) services
- Medical social services
- Routine and non-routine medical supplies
- Furnishing NPWT using a disposable device
- Covered osteoporosis drugs as defined in [Section 1861\(kk\) of the Act](#) (but excluding other drugs and biologicals)
- Medical services provided by an intern or resident-in-training of the program of the hospital (if you are affiliated or under common control with a hospital with an approved teaching program) and
- Home health services defined in [Section 1861\(m\) of the Act](#) provided under arrangement at hospitals, Skilled Nursing Facilities (SNFs), 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 (other than a physician) 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 for a patient who is in an open home health episode of care, except when provided incident to physician services, are subject to CB. Once a patient is discharged from home health and not under a home health POC, you are no longer responsible for medical supplies.

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

Osteoporosis Drugs

Osteoporosis drugs are included in CB under the home health benefit. However, payment is not bundled into the episodic payment rate. The HHA must bill for osteoporosis drugs according to billing instructions. Payment is in addition to the episodic payment rate.

NPWT Using a Disposable Device

As required under the Consolidated Appropriations Act of 2016, for services furnished on or after January 1, 2017, a separate payment is made to HHAs for NPWT using a disposable device for a patient under the home health benefit. NPWT using a disposable device is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy (in lieu of a conventional NPWT DME system). It also includes initially applying an entirely new disposable NPWT device or removing a disposable NPWT device and replacing it with an entirely new one. NPWT using a disposable device is excluded from the 60-day episode rate, but must be billed by the HHA while a patient is under a home health POC since the law requires CB of NPWT using a disposable device. For more information about NPWT using a disposable device, refer to [Clarification of Payment and Billing Policies for Negative Pressure Wound Therapy \(NPWT\) Using a Disposable Device](#).

CRITERIA THAT MUST BE MET TO QUALIFY FOR HOME HEALTH SERVICES

Medicare covers home health services when all of these criteria are met:

- The beneficiary to whom services are furnished is eligible and enrolled in Part A and/or Part B of the Medicare Program
- The beneficiary is eligible 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

For a patient to be eligible for Medicare home health services, he or she must meet all of these criteria:

1. Be confined to the home (that is, homebound)
2. Need skilled services
3. Be under the care of a physician
4. Receive services under a home health POC established and periodically reviewed by a physician and
5. Have a face-to-face encounter related to the primary reason the patient requires home health services with a physician or an allowed non-physician practitioner no more than 90 days prior to the home health start-of-care date or within 30 days of the start of the home health care

An individual is considered confined to the home (that is, homebound) if the following two criteria are met:

1. Criterion One:

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated

If the patient meets one of the Criterion One conditions, then the patient must ALSO meet two additional requirements defined in Criterion Two below.

2. Criterion Two:

- There must exist a normal inability to leave home AND
- Leaving home must require a considerable and taxing effort

The patient may be considered confined to the home (that is, homebound) if absences from the home are:

- Infrequent
- For periods of relatively short duration
- For the need to receive health care treatment
- For religious services



- To attend adult daycare programs or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber)

Some examples of persons confined to the home (that is, homebound) are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain, and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day and
- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations

For more information about certifying patient eligibility for Medicare home health services, refer to [Certifying Patients for the Medicare Home Health Benefit](#).

THErapy SERVICES

Skilled therapy services must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on his or her need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's 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
- 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
- Considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice



At defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (not an assistant) must perform the ordered therapy service and:

- Assess the patient using a method that allows for objective measurement of function and successive comparison of measurements
- Document the measurement results in the clinical record and
- Reassess the patient at least every 30 days in conjunction with an ordered therapy service for each therapy discipline for which services are provided

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

One of these 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 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 likely be insignificant in relation to the extent and duration of therapy services required to reach such potential.
 - Therapy is not required to effect improvement or restoration of function when a patient experienced a transient, temporary, or easily reversible loss of function (for example, 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" 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 that meets all of these requirements:
 - 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 to ensure the effectiveness of the treatment goals and ensure medical safety.
 - 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 (such as home health aides) are not billable as visits since you are responsible for ensuring that your staff are properly trained to perform any service you furnish. The cost of a skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.
3. The skills of a qualified therapist are needed to perform maintenance therapy that are:
- Reasonable and necessary services that should be covered when the clinical condition of the patient is such that the complexity of the therapy services are required to maintain function and:
 - 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 provide an effective maintenance program

ELEMENTS OF THE HH PPS

The elements of the HH PPS include:

- 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.

- A case-mix methodology adjusts payment rates based on characteristics of the patient and his or her corresponding resource needs (such as 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, you must provide a patient-specific comprehensive assessment that accurately reflects the patient's current health status. Your comprehensive assessment of each patient must also incorporate 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. These 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 (HHRGs) 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 where 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 where 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-unit of visit (1 unit = 15 minutes) amounts to the number of visits by discipline (SN 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 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 you as the outlier payment.

- Under the Affordable Care Act, beginning in CY 2011, an agency-level aggregate outlier cap was made permanent so that no more than 10 percent of a HHA's total payments are paid as outlier payments. 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.
- 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 home health POC. The original home health 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 home health POC and assessment is established. You initially receive 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.
- Per Section 50208 of the Bipartisan Budget Act of 2018, for home health services provided in rural areas with episodes ending on or after January 1, 2018, and before December 31, 2018, a 3 percent add-on will be applied to:
 - The national standardized 60-day episode rate
 - National per-visit rates
 - The LUPA payment amount and
 - The non-routine supply conversion factor



UPDATES TO THE HH PPS

As required by [Section 1895\(b\)\(3\)\(B\) of the Act](#), CMS historically updates the HH PPS rates annually in the Federal Register. The rates are effective on January 1 of each CY.

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 home health services furnished in a geographic area compared to the applicable national average level.

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.

For more information about HH PPS payment updates, visit the [CMS Home Health Agency Center](#) webpage and refer to the [CMS Announces Payment Changes for Medicare Home Health Agencies for 2018](#) fact sheet and [FY 2018 Home Health PPS Final Rule](#).

PHYSICIAN BILLING AND PAYMENT FOR HOME HEALTH SERVICES

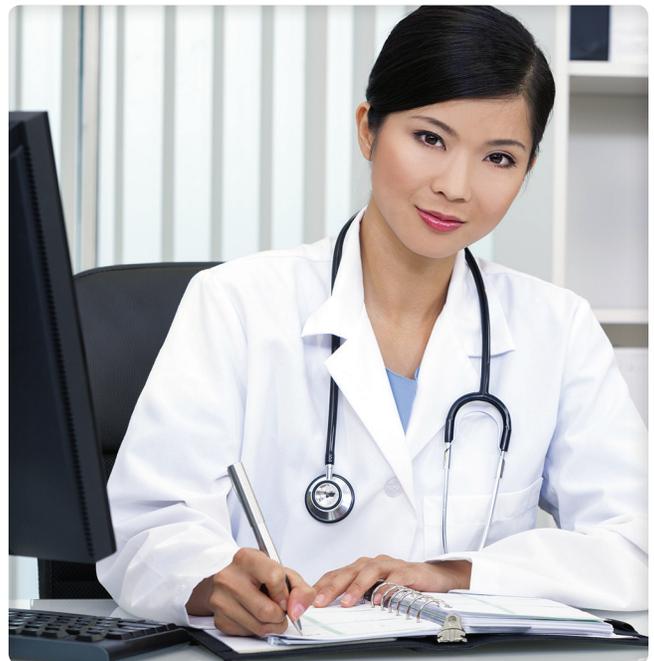
Codes for Certifying/Recertifying Eligibility for Home Health Services

Physicians use these HCPCS codes for claims when certifying/recertifying eligibility for home health services:

- HCPCS code G0180 – Physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present)
- HCPCS code G0179 – Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

When a physician certifies/recertifies patient eligibility and affirms implementation of a home health POC that meets the patient's needs, it can include contacting the HHA and reviewing patient status reports.

If a HHA claim is not covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support the patient's eligibility for the Medicare home health benefit, a physician's claim for certification/recertification of eligibility for home health services (HCPCS codes G0180 and G0179, respectively) is also not considered a Medicare-covered home health service.



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MARKET BASKET FOR CY 2018

The home health market basket percentage increase for CY 2018 is 1.0 percent.

HH QRP

[Section 1895\(b\)\(3\)\(B\)\(v\)\(II\) of the Act](#) established the HH QRP. Beginning in CY 2007, HHAs that do not report quality data to CMS will receive a reduction of 2 percentage points to the market basket update. Section 2(a) of the Improving Medicare Post-Acute Care Transformation Act of 2014 requires the public reporting of data on HHAs', SNFs', Inpatient Rehabilitation Facilities', and Long-Term Care Hospitals' quality measures and data on resource use and other measures. The Act also requires the Secretary of the U.S. Department of Health & Human Services to modify post-acute care assessment instruments to provide for the submission and comparison of standardized and interoperable patient assessment data on quality measures, which enable interoperability and improve quality and discharge planning, among other purposes.

Beginning July 1, 2015, HHAs must submit both admission and discharge OASIS assessments for a minimum of 70 percent of all patients with episodes of care occurring during the reporting period. The compliance threshold will be increased over the next 2 years to reach a maximum threshold of 90 percent.

Beginning in CY 2017, HHAs must report this quality measure:

- Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Short Stay) (National Quality Forum (NQF) #0678)

Beginning in CY 2018, HHAs must report these quality measures:

- Potentially Preventable 30-Day Post-Discharge Readmission Measure for Post-Acute Care Home Health Quality Reporting Program
- Total Medicare Spending per Beneficiary – Post-Acute Care Home Health Quality Reporting Program
- Discharge to Community – Post-Acute Care Home Health Quality Reporting Program
- Drug Regimen Review Conducted with Follow-Up for Identified Issues – Post-Acute Care Home Health Quality Reporting Program

Beginning in CY 2020, HHAs must report these quality measures:

- Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)

RESOURCES

HH PPS Resources

For More Information About...	Resource
HH PPS	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS Chapter 10 of the Medicare Claims Processing Manual (Publication 100-04)
Home Health Quality Initiatives	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits
Compilation of Social Security Laws	SSA.gov/OP_Home/ssact/title18/1800.htm
All Available Medicare Learning Network® (MLN) Products	MLN Catalog
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Section 1895 of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1895.htm
Section 1861(kk) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-kk
Section 1861(m) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-m
Clarification of Payment and Billing Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE17027.pdf
Certifying Patients for the Medicare Home Health Benefit	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1436.pdf
Outcome and Assessment Information Set (OASIS)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS
Section 1895(b)(3)(B) of the Act Section 1895(b)(4)(C) of the Act Section 1895(b)(3)(B)(v)(II) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1895.htm#act-1895-b

Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
CMS Home Health Agency Center	https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html
CMS Announces Payment Changes for Medicare Home Health Agencies for 2018	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-01-2.html
FY 2018 Home Health PPS Final Rule	https://www.federalregister.gov/d/2017-23935
Chapter 10 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf

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