documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to the following:

(A) Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the home health agency's ability to operate.

(B) A CMS or Medicare contractor systems issue that is beyond the control of the home health agency.

(C) A newly Medicare-certified home health agency that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.

(D) Other situations determined by CMS to be beyond the control of the home health agency.

(j) *Submission of Notice of Admission (NOA)*—(1) *For periods of care that begin on and after January 1, 2022.* For all 30-day periods of care after January 1, 2022, all HHAs must submit a Notice of Admission (NOA) to their Medicare contractor within 5 calendar days after the start of care date. The NOA is a one-time submission to establish the home health period of care and covers contiguous 30-day periods of care until the individual is discharged from Medicare home health services.

(2) *Criteria for NOA submission.* In order to submit the NOA, the following criteria must be met:

(i) Once a physician or allowed practitioner's written or verbal orders that contains the services required for the initial visit have been received and documented as required at §§ 484.60(b) and 409.43(d) of this chapter.

(ii) The initial visit must have been made and the individual admitted to home health care.

(3) *Consequences of failure to submit a timely Notice of Admission.* When a home health agency does not file the required NOA for its Medicare patients within 5 calendar days after the start of care—

(i) Medicare does not pay for those days of home health services from the start date to the date of filing of the notice of admission;

(ii) The wage and case-mix adjusted 30-day period payment amount is reduced by 1/30th for each day from the home health start of care date until the date of filing of the NOA;

(iii) No LUPA payments are made that fall within the late NOA period;

(iv) The payment reduction cannot exceed the total payment of the claim; and

(v)(A) The non-covered days are a provider liability; and

(B) The provider must not bill the beneficiary for the non-covered days.

(4) *Exception to the consequences for filing the NOA late.* (i) CMS may waive the consequences of failure to submit a timely-filed NOA specified in paragraph (j)(3) of this section.

(ii) CMS determines if a circumstance encountered by a home health agency is exceptional and qualifies for waiver of the consequence specified in paragraph (j)(3) of this section.

(iii) A home health agency must fully document and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to the following:

(A) Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the home health agency's ability to operate.

(B) A CMS or Medicare contractor systems issue that is beyond the control of the home health agency.

(C) A newly Medicare-certified home health agency that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.

(D) Other situations determined by CMS to be beyond the control of the home health agency.

[83 FR 56628, Nov. 13, 2018, as amended at 84 FR 60644, Nov. 8, 2019; 85 FR 27628, May 8, 2020]

§ 484.215 Initial establishment of the calculation of the national, standardized prospective payment rates.

(a) *Determining an HHA's costs.* In calculating the initial unadjusted national 60-day episode payment applicable for a service furnished by an HHA using data on the most recent available audited cost reports, CMS determines each HHA's costs by summing its allowable costs for the period. CMS determines the national mean cost per visit.

(b) *Determining HHA utilization.* In calculating the initial unadjusted national 60-day episode payment, CMS determines the national mean utilization for each of the six disciplines using home health claims data.

(c) *Use of the market basket index.* CMS uses the HHA market basket index to adjust the HHA cost data to reflect cost increases occurring between October 1, 1996 through September 30, 2001.

(d) *Calculation of the unadjusted national average prospective payment amount for the 60-day episode.* For episodes beginning on or before December 31, 2019, CMS calculates the unadjusted national 60-day episode payment in the following manner:

(1) By computing the mean national cost per visit.

(2) By computing the national mean utilization for each discipline.

(3) By multiplying the mean national cost per visit by the national mean utilization summed in the aggregate for the six disciplines.

(4) By adding to the amount derived in paragraph (d)(3) of this section, amounts for nonroutine medical supplies, an OASIS adjustment for estimated ongoing reporting costs, an OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to October 1, 2000. The resulting amount is the unadjusted national 60-day episode rate.

(e) *Standardization of the data for variation in area wage levels and case-mix.* CMS standardizes—

(1) The cost data described in paragraph (a) of this section to remove the effects of geographic variation in wage levels and variation in case-mix;

(2) The cost data for geographic variation in wage levels using the hospital wage index; and

(3) The cost data for HHA variation in case-mix using the case-mix indices and other data that indicate HHA case-mix.

(f) For periods beginning on or after January 1, 2020, a national, standardized prospective 30-day payment rate applies. The national, standardized prospective 30-day payment rate is an amount determined by the Secretary, as subsequently adjusted in accordance with § 484.225.

[65 FR 41212, July 3, 2000, as amended at 83 FR 56629, Nov. 13, 2018]

§ 484.220 Calculation of the case-mix and wage area adjusted prospective payment rates.

CMS adjusts the national, standardized prospective payment rates as referenced in § 484.215 to account for the following:

(a) HHA case-mix using a case-mix index to explain the relative resource utilization of different patients. To address changes to the case-mix that are a result of changes in the coding or classification of different units of service that do not reflect real changes in case-mix, the national, standardized prospective payment rate will be adjusted downward as follows:

(1) For CY 2008, the adjustment is 2.75 percent.

(2) For CY 2009 and CY 2010, the adjustment is 2.75 percent in each year.

(3) For CY 2011, the adjustment is 3.79 percent.

(4) For CY 2012, the adjustment is 3.79 percent.

(5) For CY 2013, the adjustment is 1.32 percent.

(6) For CY 2016, CY 2017, and CY 2018, the adjustment is 0.97 percent in each year.

(b) Geographic differences in wage levels using an appropriate wage index based on the site of service of the beneficiary.

[72 FR 49879, Aug. 29, 2007, as amended at 80 FR 68717, Nov. 5, 2015; 83 FR 56629, Nov. 13, 2018]

§ 484.225 Annual update of the unadjusted national, standardized prospective payment rates.

(a) CMS annually updates the unadjusted national, standardized prospective payment rate on a calendar year basis (in accordance with section 1895(b)(1)(B) of the Act).

(b) For 2007 and subsequent calendar years, in accordance with section 1895(b)(3)(B)(v) of the Act, in the case of a home health agency that does not submit home health quality data, as specified by the Secretary, the unadjusted national, standardized prospective rate is equal to the rate for