*Furnishing Negative Pressure Wound Therapy (NPWT) using a disposable device* means the application of a new applicable disposable device, as that term is defined in section 1834(s)(2) of the Act, which includes the professional services (specified by the assigned CPT® code) that are provided.

*HHCAHPS* stands for Home Health Care Consumer Assessment of Healthcare Providers and Systems.

*HH QRP* stands for Home Health Quality Reporting Program.

*Home health market basket index* means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

*Rural area* means an area defined in § 412.64(b)(1)(ii)(C) of this chapter.

*Urban area* means an area defined in § 412.64(b)(1)(ii)(A) and (B) of this chapter.

[70 FR 68142, Nov. 9, 2005, as amended at 81 FR 76796, Nov. 3, 2016; 83 FR 56628, Nov. 13, 2018; 84 FR 60644, Nov. 8, 2019]

### § 484.205 Basis of payment.

(a) *Method of payment.* An HHA receives a national, standardized prospective payment amount for home health services previously paid on a reasonable cost basis (except the osteoporosis drug defined in section 1861(kk) of the Act) as of August 5, 1997. The national, standardized prospective payment is determined in accordance with § 484.215.

(b) *Unit of payment*—(1) *Episodes before December 31, 2019.* For episodes beginning on or before December 31, 2019, an HHA receives a unit of payment equal to a national, standardized prospective 60-day episode payment amount.

(2) *Periods on or after January 1, 2020.* For periods beginning on or after January 1, 2020, a HHA receives a unit of payment equal to a national, standardized prospective 30-day payment amount.

(c) *OASIS data.* A HHA must submit to CMS the OASIS data described at § 484.55(b) and (d) in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.220, 484. 230, 484.235, and 484.240.

(d) *Payment adjustments.* The national, standardized prospective payment amount represents payment in full for all costs associated with furnishing home health services and is subject to the following adjustments and additional payments:

(1) A low-utilization payment adjustment (LUPA) of a predetermined per-visit rate as specified in § 484.230.

(2) A partial payment adjustment as specified in § 484.235.

(3) An outlier payment as specified in § 484.240.

(e) *Medical review.* All payments under this system may be subject to a medical review adjustment reflecting the following:

(1) Beneficiary eligibility.

(2) Medical necessity determinations.

(3) Case-mix group assignment.

(f) *Durable medical equipment (DME) and disposable devices.* DME provided as a home health service as defined in section 1861(m) of the Act is paid the fee schedule amount. Separate payment is made for ''furnishing NPWT using a disposable device,'' as that term is defined in § 484.202, and is not included in the national, standardized prospective payment.

(g) *Split percentage payments.* Normally, there are two payments (initial and final) paid for an HH PPS unit of payment. The initial payment is made in response to a request for anticipated payment (RAP) as described in paragraph (h) of this section, and the residual final payment is made in response to the submission of a final claim. Split percentage payments are made in accordance with requirements at § 409.43(c) of this chapter.

(1) *Split percentage payments for episodes beginning on or before December 31, 2019*—(i) *Initial and residual final payments for initial episodes on or before December 31, 2019.* (A) The initial payment for initial episodes is paid to an HHA at 60 percent of the case-mix and wage-adjusted 60-day episode rate.

(B) The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage-adjusted 60-day episode rate.

(ii) *Initial and residual final payments for subsequent episodes before December 31, 2019.* (A) The initial payment for subsequent episodes is paid to an HHA at 50 percent of the case-mix and wage-adjusted 60-day episode rate.

(B) The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage-adjusted 60-day episode rate.

(2) *Split percentage payments for periods beginning on or after January 1, 2020 through December 31, 2020*—(i) *HHAs certified for participation on or before December 31, 2018.* (A) The initial payment for all 30-day periods is paid to an HHA at 20 percent of the case-mix and wage-adjusted 30-day payment rate.

(B) The residual final payment for all 30-day periods is paid at 80 percent of the case-mix and wage-adjusted 30-day payment rate.

(ii) *HHAs certified for participation in Medicare on or after January 1, 2019.* Split percentage payments are not made to HHAs that are certified for participation in Medicare effective on or after January 1, 2019. Newly enrolled HHAs must submit a request for anticipated payment, which is set at 0 percent, at the beginning of every 30-day period. An HHA that is certified for participation in Medicare effective on or after January 1, 2019 receives a single payment for a 30-day period of care after the final claim is submitted.

(3) *Split percentage payments for periods beginning on or after January 1, 2021 through December 31, 2021.* All HHAs must submit a request for anticipated payment within 5 calendar days after the start of care date for initial 30-day periods and within 5 calendar days after the ''from date'' for each subsequent 30-day period of care, which is set at 0 percent at the beginning of every 30-day period. HHAs receive a single payment for a 30-day period of care after the final claim is submitted.

(4) *Payments for periods beginning on or after January 1, 2022.* All HHAs must submit a Notice of Admission (NOA) at the beginning of the initial 30-day period of care as described in paragraph (j) of this section. HHAs receive a single payment for a 30-day period of care after the final claim is submitted.

(h) *Requests for anticipated payment (RAP) for 30-day periods of care starting on January 1, 2020 through December 31, 2020.* (1) HHAs that are certified for participation in Medicare effective by December 31, 2018 submit requests for anticipated payment (RAPs) to request the initial split percentage payment as specified in paragraph (g) of this section. HHAs that are certified for participation in Medicare effective on or after January 1, 2019 are still required to submit RAPs although no split percentage payments are made in response to these RAP submissions. The HHA can submit a RAP when all of the following conditions are met:

(i) After the OASIS assessment required at § 484.55(b)(1) and (d) is complete, locked or export ready, or there is an agency-wide internal policy establishing the OASIS data is finalized for transmission to the national assessment system.

(ii) Once a physician or allowed practitioner's verbal orders for home care have been received and documented as required at §§ 484.60(b) and 409.43(d) of this chapter.

(iii) A plan of care has been established and sent to the physician or allowed practitioner as required at § 409.43(c) of this chapter.

(iv) The first service visit under that plan has been delivered.

(2) A RAP is based on the physician or allowed practitioner signature requirements in § 409.43(c) of this chapter and is not a Medicare claim for purposes of the Act (although it is a ''claim'' for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the following:

(i) Civil Monetary Penalties Law (as defined in 42 U.S.C. 1320a–7a(i)(2)).

(ii) The Civil False Claims Act (as defined in 31 U.S.C. 3729(c)).

(iii) The Criminal False Claims Act (18 U.S.C. 287)).

(iv) The RAP is canceled and recovered unless the claim is submitted within the greater of 60 days from the end date of the appropriate unit of payment, as defined in paragraph (b) of this section, or 60 days from the issuance of the RAP.

(3) CMS has the authority to reduce, disprove, or cancel a RAP in situations when protecting Medicare program integrity warrants this action.

(i) *Submission of RAPs for CY 2021*—(1) *General.* All HHAs must submit a RAP, which is to be paid at 0 percent, within 5 calendar days after the start of care and within 5 calendar days after the

''from date'' for each subsequent 30-day period of care.

(2) *Criteria for RAP submission for CY 2021.* The HHA shall submit RAPs only when all of the following conditions are met:

(i) Once physician or allowed practitioner's written or verbal orders that contain 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 within the 60-day certification period must have been made and the individual admitted to home health care.

(3) *Consequences of failure to submit a timely RAP.* When a home health agency does not file the required RAP for its Medicare patients within 5 calendar days after the start of each 30-day period of care—

(i) Medicare does not pay for those days of home health services based on the ''from date'' on the claim to the date of filing of the RAP;

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

(iii) No LUPA payments are made that fall within the late 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 RAP late.* (i) CMS may waive the consequences of failure to submit a timely-filed RAP specified in paragraph (i)(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 (i)(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.

(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]