

§ 484.220

§ 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.

(c) Beginning on January 1, 2023, CMS applies a cap on decreases to the home health wage index such that the wage index applied to a geographic area is not less than 95 percent of the wage index applied to that geographic area in the prior calendar year. The 5-percent cap on negative wage index changes is implemented in a budget neutral manner through the use of wage index budget neutrality factors.

[72 FR 49879, Aug. 29, 2007, as amended at 80 FR 68717, Nov. 5, 2015; 83 FR 56629, Nov. 13, 2018; 87 FR 66886, Nov. 4, 2022]

§ 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

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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 the previous calendar year increased by the applicable home health market basket index amount minus 2 percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be taken into account in computing the prospective payment amount for a subsequent calendar year.

(c) For CY 2020, the national, standardized prospective 30-day payment amount is an amount determined by the Secretary. CMS annually updates this amount on a calendar year basis in accordance with paragraphs (a) and (b) of this section.

[80 FR 68717, Nov. 5, 2015, as amended at 83 FR 56629, Nov. 13, 2018; 84 FR 60645, Nov. 8, 2019]

§ 484.230 Low-utilization payment adjustments.

(a) For episodes beginning on or before December 31, 2019, an episode with four or fewer visits is paid the national per-visit amount by discipline determined in accordance with § 484.215(a) and updated annually by the applicable market basket for each visit type, in accordance with § 484.225.

(1) The national per-visit amount is adjusted by the appropriate wage index based on the site of service of the beneficiary.

(2) An amount is added to the low-utilization payment adjustments for low-utilization episodes that occur as the beneficiary's only episode or initial episode in a sequence of adjacent episodes.

(3) For purposes of the home health PPS, a sequence of adjacent episodes for a beneficiary is a series of claims with no more than 60 days without home care between the end of one episode, which is the 60th day (except for episodes that have been PEP-adjusted), and the beginning of the next episode.

(b) For periods beginning on or after January 1, 2020, an HHA receives a national 30-day payment of a predetermined rate for home health services, unless CMS determines at the end of

the 30-day period that the HHA furnished minimal services to a patient during the 30-day period.

(1) For each payment group used to case-mix adjust the 30-day payment rate, the 10th percentile value of total visits during a 30-day period of care is used to create payment group specific thresholds with a minimum threshold of at least 2 visits for each case-mix group.

(2) A 30-day period with a total number of visits less than the threshold is paid the national per-visit amount by discipline determined in accordance with § 484.215(a) and updated annually by the applicable market basket for each visit type, in accordance with § 484.225.

(3) The national per-visit amount is adjusted by the appropriate wage index based on the site of service for the beneficiary.

(c) An amount is added to low-utilization payment adjustments for low-utilization periods that occur as the beneficiary's only 30-day period or initial 30-day period in a sequence of adjacent periods of care. For purposes of the home health PPS, a sequence of adjacent periods of care for a beneficiary is a series of claims with no more than 60 days without home care between the end of one period, which is the 30th day (except for episodes that have been partial payment adjusted), and the beginning of the next episode.

[83 FR 56629, Nov. 13, 2018]

§ 484.235 Partial payment adjustments.

(a) *Partial episode payments (PEPs) for episodes beginning on or before December 31, 2019.* (1) An HHA receives a national, standardized 60-day payment of a pre-determined rate for home health services unless CMS determines an intervening event, defined as a beneficiary elected transfer or discharge with goals met or no expectation of return to home health and the beneficiary returned to home health during the 60-day episode, warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician or allowed practitioner certification of the new plan of care are required.

(2) The PEP adjustment does not apply in situations of transfers among HHAs of common ownership.

(i) Those situations are considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode.

(ii) The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA.

(iii) The transferring HHA in situations of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided under arrangements to be paid.

(3) If the intervening event warrants a new 60-day payment and a new physician or allowed practitioner certification and a new plan of care, the initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care based on the first billable visit date through and including the last billable visit date. The PEP is calculated by determining the actual days served as a proportion of 60 multiplied by the initial 60-day payment amount.

(b) *Partial payment adjustments for periods beginning on or after January 1, 2020.* (1) An HHA receives a national, standardized 30-day payment of a pre-determined rate for home health services unless CMS determines an intervening event, defined as a beneficiary elected transfer or discharge with goals met or no expectation of return to home health and the beneficiary returned to home health during the 30-day period, warrants a new 30-day period for purposes of payment. A start of care OASIS assessment and certification of the new plan of care are required.

(2) The partial payment adjustment does not apply in situations of transfers among HHAs of common ownership.

(i) Those situations are considered services provided under arrangement on behalf of the originating HHA by