

HOME HEALTH CARE SERVICES PAYMENT SYSTEM

paymentbasics

Revised:
October 2020

Beneficiaries who are generally restricted to their homes and need skilled care (from a nurse or a physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency (HHA) personnel visit beneficiaries' homes to provide:

- skilled nursing care;
- physical, occupational, and speech therapy;
- medical social work; and
- home health aide services.

Medicare's home health benefit originally had restrictive coverage standards, such as requiring a prior hospital stay or limiting the number of visits allowed. These limitations were later eliminated, so that a beneficiary can receive covered home health services for an unlimited period of time as long as they meet the other coverage criteria. Beneficiaries are not required to make any copayments or other cost sharing for these services.

About 3.4 million beneficiaries used home health care in 2018. Medicare pays for home health care with both Part A and Part B funds; in 2018, total payments were \$17.9 billion. Over 11,500 agencies participated in the program in 2018.

Defining the care Medicare buys

Beginning in 2020, as required by the Bipartisan Budget Act of 2018 (BBA of 2018), Medicare pays a predetermined payment rate for a 30-day period of home health care. (Previously, Medicare paid for home health care in 60-day units.) The payment is intended to cover all operating and capital costs that efficient providers are expected to incur in furnishing skilled nursing care; physical, occupational,

and speech therapy; medical social work services; and aide services in a beneficiary's home during a 30-day period.

Setting the payment rates

Payments to home health agencies are determined by adjusting a base payment amount (the amount that would be paid for a typical home health patient residing in an average market area) to reflect differences in patient characteristics (case mix) and in the level of market input prices in the geographical area where services are delivered (Figure 1). The base payment amount for 2020 is \$ 1,864.

Beginning in 2020, CMS uses a new home health case-mix system, the Patient Driven Groupings Model (PDGM), to adjust payment for differences in patient characteristics (Figure 2). The PDGM categorizes each period into 432 home health resource groups (HHRGs) based on:

Period timing—A newly initiated home health period (with no home health services in the preceding 60 days) is classified as “early,” while periods that are immediately preceded by a 30-day period are classified as “late.”

Referral source—Early periods that are preceded by a stay at an inpatient hospital, long-term care hospital, inpatient rehabilitation facility, or skilled nursing facility are classified as institutional periods. Early periods that are not preceded by these services are classified as community-admitted periods. Later periods are classified as institutional if they are preceded by a hospital stay; otherwise they are classified as community-admitted periods.

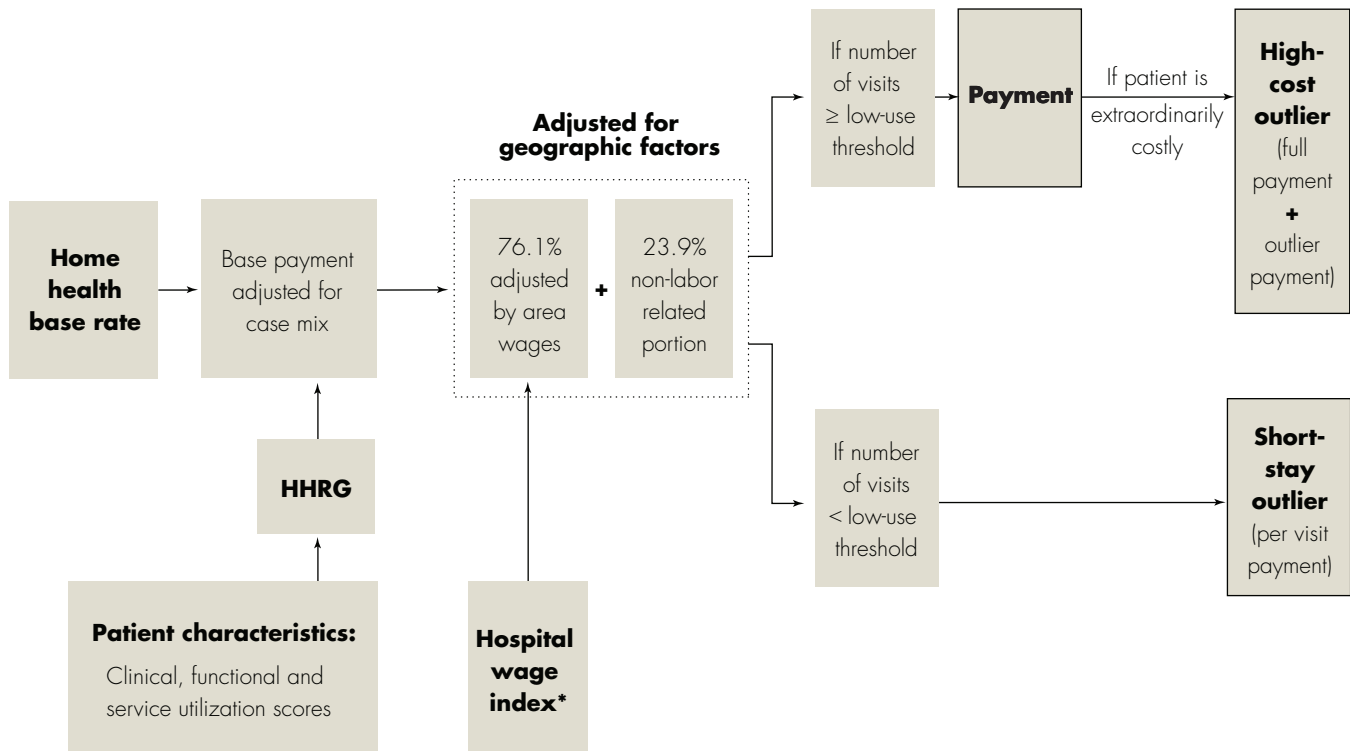
Clinical category—Patients are assigned to one of 12 clinical categories based on their reported conditions or treatments.

The policies discussed in this document were current as of September 15, 2020, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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Figure 1 Home health care services prospective payment system, 2020



Note: HHRG (home health resource group). The low-use threshold varies by payment group and ranges from two to six visits.

*The home health care services prospective payment system uses a version of the hospital wage index called the pre-floor, pre-classification hospital wage index.

Functional impairment—Patients are assigned to one of three functional impairment levels based on reported cognitive and physical functioning information.

Presence of comorbidities—The case-mix system also includes a three-tiered adjustment for selected comorbidities.

Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient.

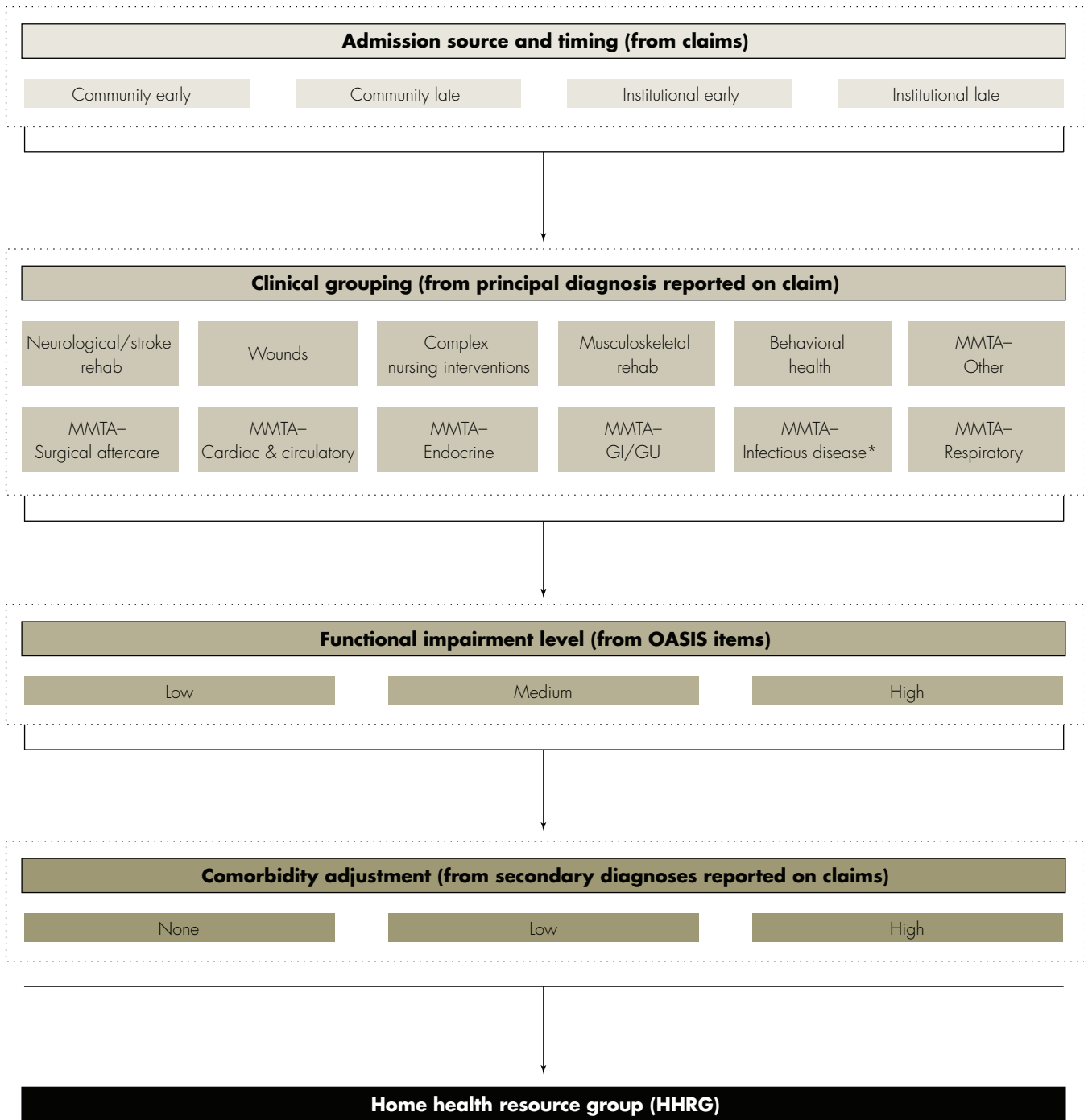
To adjust for geographic factors, the per period payment rate is divided into labor and non-labor portions; the labor portion—76.1 percent—is adjusted by a version of the hospital wage index to account for geographic differences in

the input-price level in the local market for labor-related inputs to home health services. Unlike most other Medicare payment systems, the local area adjustment for home health services is determined by the beneficiary’s residence rather than the provider’s location. The total payment is the sum of the adjusted labor portion and the nonlabor portion.

Low-use periods

Low-use periods (periods with relatively few visits) are paid on a per visit basis. The threshold for the low-use payment adjustment (LUPA) varies from two to six visits, depending on the payment group to which a period has been assigned. Periods above the threshold receive the full case-mix-adjusted 30-day payment under the PDGM.

Figure 2 The home health Patient-Driven Groupings Model, 2020



Note: MMTA (medication management, teaching, and assessment), (GI/GU (gastrointestinal tract/genitourinary system), OASIS (Outcome and Assessment Information Set).
 *Includes neoplasms and blood-forming diseases.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. CY 2019 Medicare home health prospective payment system (HH PPS) rates and wage index for calendar year (CY) 2019. Final rule. *Federal Register* 83, no. 219 (November 13): 56406–56638.

High-cost outliers

When a patient's period of care involves an unusually large number or a costly mix of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed period costs must exceed the payment rate by a certain amount set annually by CMS.¹ The total cost of a period is determined by multiplying the minutes of patient care for each covered service by a standardized per minute cost factor. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference between the period payment with the threshold and the period's estimated costs.

Payment for quality reporting and performance

The home health PPS has two programs intended to improve quality. The first is a pay-for-reporting program under which HHAs must report quality-of-care data to avoid a 2 percentage point reduction in their annual market basket update.

Second, Medicare implemented a home health value-based purchasing program in 2018 in nine states.² The program adjusts

HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures relative to their peers. Agencies receive bonuses or penalties based on their performance on a set of 16 quality, outcome, and patient experience measures. The size of any bonus or penalty varies according to performance, but the program's design caps any increases or decreases at 3 percent of Medicare payments. Quality bonus payments are funded through a payment withhold of 6 percent in 2020, increasing to 8 percent by 2022.

Payment updates

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies. The update for 2021 is 2.7 percent. ■

- 1 The amount equals 0.63 times the standard base payment amount in 2020 adjusted by the wage index.
- 2 The nine states are Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.