HOME HEALTH CARE SERVICES PAYMENT SYSTEM

*payment***basics**

Revised: October 2018

Beneficiaries who are generally restricted to their homes and need skilled care (from a nurse, 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 services:

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

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 2016. Medicare pays for home health care with both Part A and Part B funds; in 2016, total payments were $18.1 billion. Over 12,200 agencies participated in the program in 2016.

In October 2000, CMS adopted a prospective payment system (PPS) that pays HHAs a predetermined rate for each 60-day episode of home health care. The payment rates are based on patients' conditions and service use, and they are adjusted to reflect the level of market input prices in the geographical area where services are delivered. If fewer than 5 visits are delivered during a 60-day episode, the HHA is paid per visit by visit type, rather than by the episode payment method. Adjustments for several other special circumstances, such as high-cost outliers, can also modify the payment.

Setting rates for Medicare home health services has always been complicated by the lack of a clear definition of the benefit. The benefit was originally intended for short-term, post-hospital recovery care for beneficiaries who could not leave their homes, but changes to eligibility criteria have expanded the benefit. Originally the benefit had more restrictive coverage standards, such as requiring a prior hospital stay or limiting the number of visits allowed. These limitations were eliminated, and a beneficiary can receive an unlimited number of episodes as long as they meet the other coverage criteria.

The care Medicare buys

Medicare purchases home health services in units of 60-day episodes. To capture differences in expected resource use, patients receiving 5 or more visits are assigned to 1 of 153 home health resource groups (HHRGs) based on clinical and functional status and service use as measured by the Outcome and Assessment Information Set (OASIS) (Figure 1). The information presented in this document applies to the 2018 home health payment year.

The 153 HHRGs are divided into 5 categories based on the amount of therapy provided and the episode's timing in a sequence of episodes. Four of the categories are based on a combination of whether the episode is an early episode (first or second episode) or late episode (third and subsequent episode) and whether the episode has zero to 13 therapy visits or 14 to 19 visits. A fifth separate category exists for episodes that have 20 or more therapy visits, and it is not affected by episode timing. These separate categories permit the case-mix system to differentiate between the resource use of different levels of therapy utilization and multiple episodes. The system is calibrated to provide higher payments for later episodes in a sequence of consecutive episodes (third and subsequent episodes), and raises payment as therapy visits increase.

This document does not reflect proposed legislation or regulatory actions.

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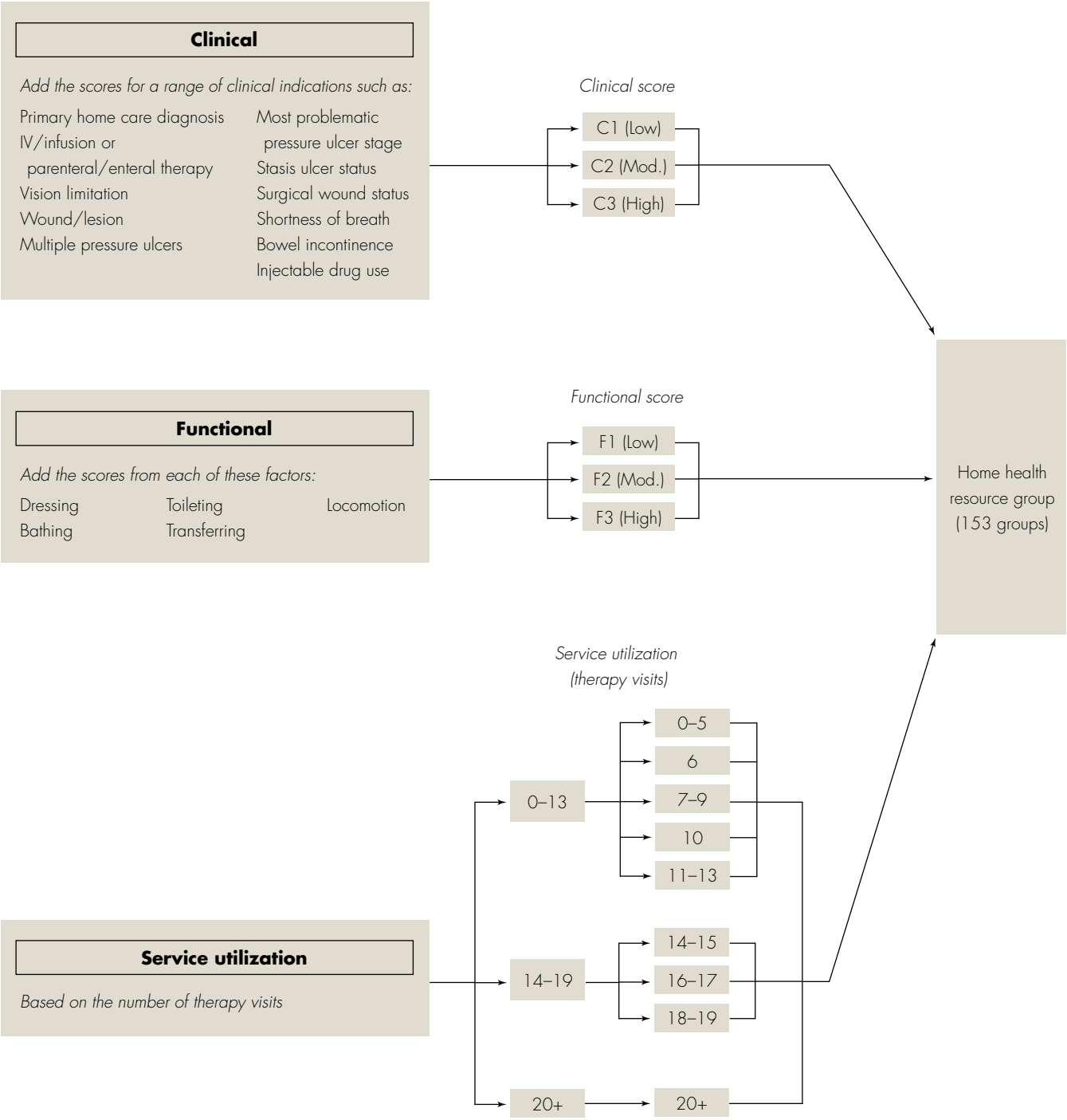
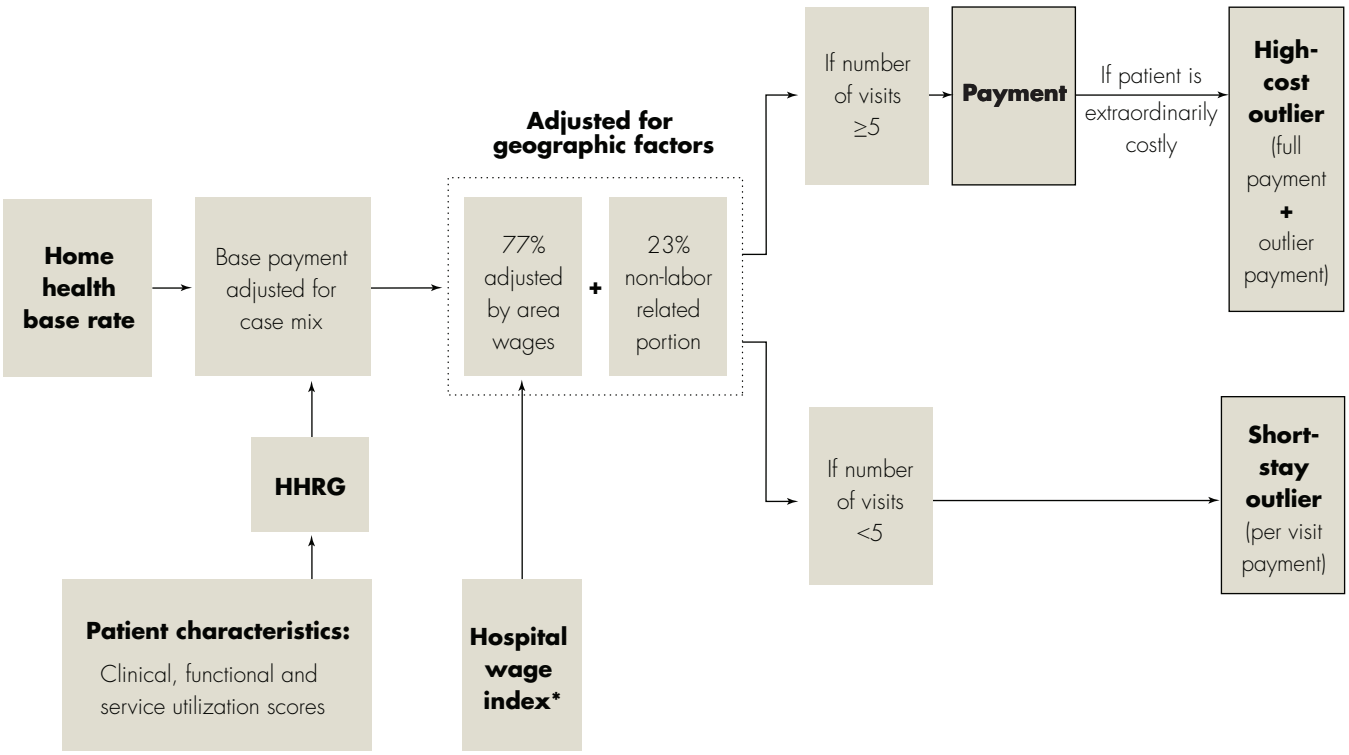
Figure 1 Clinical, functional, and service information from OASIS determines patients' home health resource group



Note: OASIS (Outcome and Assessment Information Set), IV (intravenous).

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2008. Medicare program; Home health prospective payment system rate update for calendar year 2009. Final rule. *Federal Register* 73, no. 213 (November 3): 65351–65384.

Figure 2 Home health care services prospective payment system



Note: HHRG (home health resource group).
*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.'

Setting the payment rates

The HHRGs range from groups of relatively uncomplicated patients to those of patients who have severe medical conditions, severe functional limitations, and need extensive therapy. 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. The payment rates for episodes in each local market are determined by adjusting a national average base amount—the amount that would be paid for a typical home health patient residing in an average market—for geographic factors and case mix (Figure 2). The base payment amount for 2018 is $3,039.64.

To adjust for geographic factors, the per episode payment rate is divided into labor and non-labor portions; the labor portion—77 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.

To adjust for case mix, the base rate is multiplied by the relative weight for each HHRG.

When a patient's episode 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 episode costs must exceed the payment rate by a certain amount set annually

by CMS.[1] To determine eligibility for an outlier payment, episode costs are imputed by multiplying the estimated national average per visit costs by type of visit—adjusted to reflect local input prices—by the numbers of visits by type during the episode. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference between the episode payment with the threshold and the episode's estimated costs.

The PPS also adjusts payments for nonroutine medical supplies (e.g., wound-related products). The payment is based on the beneficiary's estimated use of nonroutine supplies, based on the clinical and functional characteristics on the OASIS.

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 2019 was 2.1 percent.

Pay 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 for standardized measures (e.g., Outcome and Assessment Information Set (OASIS)) to avoid a 2 percentage point reduction in their annual basket update.

Medicare implemented a home health value-based purchasing program in 2018 in nine states. The program adjusts HHAs' Medicare payments (upward or downward) based on their performance on a set of quality measures relative to their peers.[2] Agencies received bonuses or penalties based on their performance on a set of 24 quality measures. The size of any bonus or penalty varied according to performance, but the program's design capped any increases or decreases at 3 percent of Medicare payments. Quality bonus payments were funded through a payment withhold of 5 percent in 2018, increasing to 8 percent by 2021. Performance will be evaluated on outcomes measures collected in the OASIS, patient experience survey measures from the Home Health Consumer Assessment of Health Providers and Systems (HH CAHPS), and claims-based quality measures. ■

1 The amount equaled 0.55 times the standard base payment amount in 2018 adjusted by the wage index.

2 The nine states include Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.