Summary of Policy Changes from Proposed Rule Published on October 28, 1999 Compared to Final Regulation

PROPOSED RULE	**FINAL RULE**
Statutory Effective Date for all Medicare participating HHAs: 10/1/00	Unchanged
For eligible beneficiaries under a home health plan of care: 60 Day Episode Payment-National Rate without any Blend 60 Day Episode Rate Includes Home Health Services Paid on a Reasonable Cost Basis: 6 Disciplines of Home Health Care (Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Speech Language Pathology & Medical Social Services) and Medical Supplies (Routine & Non-Routine Medical Supplies) Separate Payment Amount from the PPS Rate for the covered injectable osteoporosis drug and DME.	Unchanged
Standardized National 60 Day Episode Rate= $2,037.04 Set Amount for Each Episode	Standardized National 60 Day Episode Rate= **$2,115.30** Set Amount for Each Episode
Included in National 60 Day Episode Rate: Amount included for Average Cost per Episode for Non-Routine Medical Supplies Included under Home Health Benefit Reported on Cost Report in the 60 Day National Episode Rate = $52.78	Included in National 60 Day Episode Rate: Amount included for Average Cost per Episode for Non-Routine Medical Supplies Included under Home Health Benefit Reported on Cost Report in the 60 Day National Episode Rate = **$43.54**
Included in National 60 Day Episode Rate: Average Cost per Episode for Non-Routine Medical Supplies Possibly Unbundled and Billed to Part B while under a home health episode in CY 1997 (199 Codes) = $10.35	Included in National 60 Day Episode Rate: Average Cost per Episode for Non-Routine Medical Supplies Possibly Unbundled and Billed to Part B while under a home health episode in CY 1998 (178 Codes based on analysis in response to public comments) = **$6.08**
	Included in National 60 Day Episode Rate: In response to comments, provided similar analysis on Part B therapies that could have been unbundled to Part B while under a home health plan of episode in CY 1998= **$17.67**
Included in National 60 Day Episode Rate: AveragePayment per Episode for Ongoing Oasis Adjustment Costs = $4.32	Included in National 60 Day Episode Rate: AveragePayment per Episode for Ongoing Oasis Adjustment Costs = **$4.32**
	Included in National 60 Day Episode Rate: In response to comments, provided a one time first year implementation cost for OASIS form changes = **$5.50**

National 60 Day Episode Standardization Factor for Wage Index & Case Mix (Abt Data Only) .95502	National 60 Day Episode Standardization Factor for Wage Index & Case Mix (Abt Data & National OASIS Data) **.96184**
Budget Neutrality Factor-PPS Budget Neutral to IPS in FY 2001 w/Limits Reduced by 15% .78578 ($17,599 million projected IPS in FY 2001 w/limits reduced by 15%/$22,346 million projected PPS in FY 2001) Estimated Episodes =8.985 million Projected Outlays for PPS FY 2001 = $22,346 million Projected Outlays for IPS in FY 2001 w/limits reduced by 15% = $17,559 million ($17,466 million + $93 million for non-routine medical supplies that could have been unbundled to Part B prior to PPS)	**Budget Neutrality Factor-PPS Budget Neutral to IPS in FY 2001(BBRA of 1999 postponed 15% reduction in the budget neutrality target for one year)** **.88423 ($11,382 million projected IPS in FY2001-$57.25 million projected LUPA episodes in FY 2001 before budget neutrality/$12,807 million projected PPS in FY 2001)** **Estimated Episodes = 5.580 million** **Projected Outlays for PPS FY 2001 = $12,807 million** **Projected Outlays for IPS in FY 2001=$11,382 million ($11,273 million FY2001 President=s Budget Assumptions + $109 million for Part B Therapies that could have been unbundled to Part B prior to PPS)**
Outlier Adjustment Factor for 60 day episode rate calculation = 1.05	Unchanged
CY 1997 Average Utilization Data from Episode File-Episodes w/5 or more visits Average number of visits for episodes w/5 or more visits from CY 1997 Episode File Home Health Aide= 17.59 Medical Social Services = .36 Occupational Therapy = .48 Physical Therapy = 2.74 Skilled Nursing = 14.69 Speech Pathology = .18 Total = 36.04	**CY 1998 Average Utilization Data from Episode File-Episodes w/ 5 or more visits** **Average number of visits for episodes w/5 or more visits from CY 1998 Episode File** **Home Health Aide=13.4** **Medical Social Services = .32** **Occupational Therapy = .53** **Physical Therapy = 3.05** **Skilled Nursing = 14.08** **Speech Pathology = .18** **Total = 31.56**
Representative Sample Audited Cost Report Data - CR Years Ending in FY 1997 Average Cost Per Visit from the PPS Audit Sample Home Health Aide=$41.66 Medical Social Services = $154.03 Occupational Therapy = $103.79 Physical Therapy = $103.56 Skilled Nursing = $94.62 Speech Pathology = $112.91	**Representative Sample Audited Cost Report Data - CR Years Ending in FY 1997- Updated** **Average Cost Per Visit from the PPS Audit Sample-Updated** **Home Health Aide=$41.75** **Medical Social Services = $153.59** **Occupational Therapy = $104.76** **Physical Therapy = $104.05** **Skilled Nursing = $94.96** **Speech Pathology = $113.26**
Continuous Certifications for Eligible Beneficiaries	Unchanged
Split Percentage Payment Approach Initial 50% of the 60 day case mix and wage adjusted	Split Percentage Payment Approach **For first episodes, initial 60% of the 60 day case mix**

episode paid at the onset of the episode and the residual 50% paid at the end.	**and wage adjusted episode paid at the onset of the episode and the residual 40% paid at the end. Subsequent episodes for eligible beneficiaries who require continuous home care are paid at the 50/50 percentage split.**
Rules Governing Split Percentage Payments New Notice of Admission Identifies the HHA as primary for the 60 Day Episode. Initial Claim submitted for initial percentage payment based on signed plan of care.	Rules Governing Split Percentage Payments No need for proposed notice of admission due to the new RAP approach based on physician verbal orders and documentation. RAPs not initial claims available before physician signed plan of care, not subject to payment floor. If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a request for anticipated payment or ARAP@ for the initial percentage payment based on physician verbal orders. The request for anticipated payment of the initial percentage payment must be based on: a physician's verbal order that is recorded in the plan of care; includes a description of the patient's condition and the services to be provided by the home health agency; includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care; and the plan of care is copied and is immediately submitted to the physician OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician. HCFA has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal orders 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 Civil Monetary Penalties law, Civil False Claims Act and the Criminal False Claims Act), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment. The plan of care must be signed and dated by a physician as described who meets the certification and recertification requirements of section 424.22 and before the claim for each episode for services is submitted for the final percentage payment (40% for new patients and 50% for subsequent episodes). Any changes in the plan of care must be signed and dated by a physician.

Final Claim submitted for residual percentage payment based on signed plan of care.	No Change-Final Claim submitted for residual percentage payment based on signed plan of care.
Law Eliminates Periodic Interim Payments with PPS	Unchanged
Low Utilization Payment Adjustment (LUPA) Proposing Four or Fewer Visit Threshold Episodes with four or fewer visits are paid the national average per visit amounts for FY 2001. These per visit amounts will be further divided into a wage adjusted labor portion and a non-labor portion: Home Health Aide = $34.44 Medical Social Services = $123.31 Occupational Therapy Services = $83.57 Physical Therapy Services = $83.39 Skilled Nursing Services = $76.32 Speech Pathology Services = $90.79 LUPA Rate Components Reflected in Proposed Amounts Listed Above: Average per visit cost for non-routine medical supplies reported on the cost report = $1.41 Average cost per visit for non-routine medical supplies that could have been unbundled to Part B prior to PPS = $0.35 Average cost per visit for ongoing OASIS reporting = $.12 Standardization factor for wage index = .94622 Budget Neutrality Factor= .78578 Outlier Adjustment = 1.05	Low Utilization Payment Adjustment (LUPA) Retained Four or Fewer Visit Threshold **Episodes with four or fewer visits are paid the recomputed national average per visit amounts FY 2001 (Included additional OASIS and therapy adjustments). These per visit amounts will be further divided into a wage adjusted labor portion and a non-labor portion:** **Home Health Aide = $43.37** **Medical Social Services = $153.55** **Occupational Therapy Services = $105.44** **Physical Therapy Services = $104.74** **Skilled Nursing Services = $95.79** **Speech Pathology Services = $113.81** **LUPA Rate Components Reflected in Final Amounts Listed Above:** **Average per visit cost for non-routine medical supplies reported on the cost report = $1.71** **Average cost per visit for non-routine medical supplies that could have been unbundled to Part B prior to PPS = $0.23** **Average cost per visit for ongoing OASIS reporting =$.12** **Average Cost per visit for one-time OASIS scheduling Implementation Change = $.21** **Standardization factor for wage index = .96674** **Budget Neutrality Factor = Not Applicable** **Outlier Adjustment = 1.05**
Significant Change In Condition (SCIC) Payment Adjustment If a patient experiences a significant change in condition that was not envisioned in the original plan of care, the HHA may adjust the payment level to reflect the resources needed to treat the significant change in condition. The SCIC adjustment is a proportional payment adjustment reflecting the time both before and after the patient experienced the	Significant Change In Condition (SCIC) Payment Adjustment Unchanged

significant change in condition during the episode. The SCIC adjustment does not restart the 60 day episode clock. The SCIC adjustment occurs within an episode. In order to receive a new case mix assignment for the purposes of a SCIC adjustment during the 60 day episode, the HHA must complete an OASIS assessment and obtain necessary physician change orders reflecting the significant change in treatment approach in the patient=s plan of care. The first part of the SCIC adjustment is calculated by taking the span of days (first billable visit date through the last billable visit date) before the patient experienced the significant change as a proportion of 60 multiplied by the original case mix and wage adjusted 60 day episode. The second part of the SCIC adjustment is calculated by taking the span of days (first billable visit date through the last billable visit date) after the patient experienced the significant change as a proportion of 60 multiplied by the new case mix and wage adjusted 60 day episode for the balance of the episode. The therapy threshold for case mix purposes applies to the total 60 day episode. In the case of a SCIC adjusted episode, the therapy threshold applies cumulatively to the total episode.	
Partial Episode Payment Adjustment (PEP Adjustment) In case of beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode, the original episode is closed out with a proportional payment. A new 60 day episode clock for payment, OASIS assessment & plan of care certification begins as a result of the beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode. Proportional payment is calculated using span of days (first billable visit through last billable visit) as a proportion of 60 multiplied by the original case mix and wage adjusted 60 day episode payment. PEP Adjustment does not apply under circumstances of HHAs under common ownership as defined in PRM 1004. Those situations are under arrangement.	Partial Episode Payment Adjustment (PEP Adjustment) In case of beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode, the original episode is closed out with a proportional payment. A new 60 day episode clock for payment, OASIS assessment & plan of care certification begins as a result of the beneficiary elected transfer or discharge and return to the same HHA during a 60 day episode. Retained billable visit dates: Proportional payment is calculated using span of days (first billable visit through last billable visit) as a proportion of 60 multiplied by the original case mix and wage adjusted 60 day episode payment PEP adjustment does not apply in circumstances of HHAs under common ownership as defined in 42 CFR 424 for the balance of the 60 day episode, unless the beneficiary moves out of the MSA or non-MSA during the episode. Situations that meet the definition of common ownership are considered to be under arrangement.

The therapy threshold for case mix purposes applies separately to the proportional adjustment and the resulting new episode.	The therapy threshold for case mix purposes applies separately to the proportional adjustment and the resulting new episode.
Cost Outlier Payments-holding estimated outlays at 5% Fixed Dollar Loss of 107% of the 60 day national standardized episode amount Loss Sharing Ratio=60% Imputed Amounts for Episode=Per Visit Amounts from NPRM Table 6 Wage Adjusted for Beneficiary Site of Service Wage Adjusted (outlier threshold & imputed amounts)	**Cost Outlier Payments-holding estimated outlays at 5%** **Fixed Dollar Loss of 113% of the 60 day national standardized episode amount** **Loss Sharing Ratio=80%** **Imputed Amounts for Episode=Per Visit Amounts from Final Regulation Table 6 Wage Adjusted for Beneficiary Site of Service** **Wage Adjusted (outlier threshold & imputed amounts)**
Case Mix 80 Groups 19 OASIS Items & Therapy Variable Clinical,Functional,Intensity of Service Domain	**Case Mix** **80 Groups** **23 OASIS Items (Including new Therapy Variable)** **Changes Designed to give more weight to serious conditions, particularly wounds and wound related conditions.** **Clinical Domain** **MO240-Added Secondary Diagnosis due to manifestation of underlying medical condition. Only codes from original list in NPRM that must be coded secondary.** **MO440-Added Wound/Lesion distinction for Burns & Trauma Diagnoses in MO230** **MO450 -Added Multiple Pressure Ulcers-split stages of ulcers-added points for 2 or more stage 3 or 4 pressure ulcers** **Functional Domain-Retained** **Intensity of Service Domain** **MO175-Distinction between previous stay in SNF versus Nursing Home** **MO825-New Therapy Threshold Variable**
Wage Index-Adjusts Labor Portion of Rates Based on Site of Service of Beneficiary Episode Rates,Adjustments, LUPA Rates, Outlier Calculations use the latest pre-floor and pre-reclassified hospital wage index	Unchanged-latest version of pre-floor & pre-reclassified hospital wage index
Proposed Requirement Physician must certify the HHRG as part of the plan of care certification requirements.	Eliminated Proposed Requirement Physician must certify the HHRG as part of the plan of care certification requirements
Consolidated Billing Requirements Govern all Covered Home Health Services listed in 1861(m) of the Social Security Act. 6 Disciplines of Home Health Routine & Non-Routine Medical Supplies	Balanced Budget Refinement Act of 1999 Removed Durable Medical Equipment from the Consolidated Billing Requirements Governing HHA PPS Consolidated Billing Requirements Govern all Covered

Durable Medical Equipment Covered Injectable Osteoporosis Drug HHA must bill Medicare for the services governed by the Consolidated Billing Requirements. As long as the HHA bills Medicare directly for payment for these items or services, HHA may provide these services either directly or under arrangement.	Home Health Services listed in 1861(m) (except durable medical equipment) of the Social Security Act. 6 Disciplines of Home Health Routine & Non-Routine Medical Supplies Covered Injectable Osteoporosis Drug HHA must bill Medicare for the services governed by the Consolidated Billing Requirements. As long as the HHA bills Medicare directly for payment for these items or services, HHA may provide these services either directly or under arrangement.
IMPACT of PPS Rates on HHAs by Type and Location Based on Audited Cost Report Sample HHAs Proposed Rule PPS Rates must be Budget Neutral to the IPS Limits Reduced by 15% in FY2001 **Type of HHA — % Change from IPS to PPS Proposed Rule** All Agencies — 0.0 By Urban/Rural and Provider Type: Rural Freestanding: For Profit -17.0 Govt=l 46.4 Non-Profit 13.7 Provider Based 10.1 Urban Freestanding: For Profit -18.4 Govt=l 50.9 Non-Profit 20.5 Provider Based 2.1 By Provider Type: Freestanding: For Profit -18.1 Govt=l 47.9 Non-Profit 19.4 Provider Based 3.8 By Urban/Rural: Rural Agencies 4.2 Urban Agencies -0.4 By Region: Midwest States 21.8 Northeast States 21.4 Southern States -15.5 Western States -1.3	**IMPACT of PPS Rates on HHAs by Type and Location Based on Audited Cost Report Sample HHAs Final Rule Rates must be Budget Neutral to the IPS Limits in FY2001 (BBRA Change)** **Type of HHA — % Change from IPS to PPS Proposed Rule** **All Agencies — 0.0** **By Urban/Rural and Provider Type:** **Rural** **Freestanding: For Profit -7.50** **Govt=l 29.98** **Non-Profit 13.28** **Provider Based 5.31** **Urban** **Freestanding: For Profit -14.25** **Govt=l 20.58** **Non-Profit 18.89** **Provider Based -2.50** **By Provider Type:** **Freestanding: For Profit -12.77** **Govt=l 26.50** **Non-Profit 17.88** **Provider Based -1.03** **By Urban/Rural:** **Rural Agencies 5.94** **Urban Agencies -0.08** **By Region:** **Midwest States 14.77** **Northeast States 15.37** **Southern States -16.75** **Western States 17.84**

Grace Periods for OASIS Assessments and Plan of Care Certifications Associated with Transition of all HHAs to PPS Effective October 1, 2000 Proposed a one-month grace period for both OASIS assessments and plan of care certification requirements	Grace Periods for OASIS Assessments and Plan of Care Certifications Associated with Transition of all HHAs to PPS Effective October 1, 2000 HCFA is providing a one-time implementation grace period for OASIS assessments and plan of care certifications to alleviate transition concerns associated with all HHAs starting PPS with the same effective date of 10/1/00. Plan of Care Certifications: For established home health beneficiaries as of September 1, 2000, we are providing a one time grace period that provides a certification period up to a maximum of 90 days (September 1, 2000 through and including November 29, 2000). HHAs in conjunction with a certifying physician and HHA may have a one-time maximum 90 day plan of care certification. The regulatory requirements governing the Medicare home health benefit before PPS would apply to the certification period up to and including September 30, 2000. The plan of care must reflect a statistical break between the pre-PPS physician ordered services September 1,2000-September 30, 2000) and the post-physician ordered services (October 1, 2000-November 29, 2000). Included in the statistical break is the notation of the start of care date/first billable visit date for this patient under PPS OASIS Assessment Schedules Grace Periods for patients under an established plan of care: -On or after September 1, 2000 - September 30, 2000, HHAs may use the most recent OASIS start of care or follow-up to group for case mix. -On or after August 1, 2000-August 31, 2000, HHAs discretion to complete the next schedule in September 2000 for case mix -On or after October 1, 2000 resume OASIS requirements governing last five days of episode certification period. * In order to take advantage of grace periods, HHAs need to use grouper software during September 2000.

Home Health Prospective Payment System (PPS)

These are some basic questions and answers regarding home health PPS policy based on the final regulation.

The Law requires us to develop a unit of payment. The unit of payment under HHA PPS is a national 60 day episode rate with applicable adjustments (discussed below).

What is included in the 60 day episode rate? The Law requires us to include all covered home health services paid on a reasonable cost basis. The law requires the 60 day episode to include all covered home health services, including medical supplies, previously payable on a reasonable cost basis. That means the 60-Day Episode Rate includes costs for the six home health disciplines and the costs for non-routine medical supplies. The six home health disciplines included in the 60 Day Episode Rate are: skilled nursing services, home health aide services, physical therapy, speech-language pathology services, occupational therapy services, and medical social services.

The 60 day episode rate also includes amounts for: non-routine medical supplies and therapies that could have been unbundled to part B prior to PPS ,ongoing reporting costs associated with OASIS, and a one time first year of PPS cost adjustment reflecting implementation costs associated with the revised OASIS assessment schedules needed to classify patients into appropriate case mix categories.

The law specifically excludes durable medical equipment and the injectable osteoporosis drug from the 60 day episode rate. Durable Medical Equipment (DME) continues to be paid on the fee schedule outside of the PPS rate. DME are items such as wheelchairs and walkers.

A Conforming Amendment in the law provides a separate payment amount from the PPS rate for the injectable osteoporosis drug covered under the home health benefit. The new law, the balanced budget refinement act of 1999 passed in November 1999 removed durable medical equipment from the consolidated billing requirements governing PPS. However, the covered injectable osteoporosis drug is still subject to the consolidated billing requirements governing home health PPS.

What if a beneficiary continues to need Medicare home health services beyond 60 Days?

HHA PPS allows Continuous Episode Recertifications for patients who continue to be eligible for the home health benefit. We are not limiting the number of continuous episode recertifications for beneficiaries who continue to be eligible for the home health benefit.

Will I have cash flow under PPS?

Yes. In order to ensure adequate cash flow to HHAs, HCFA has set forth a split percentage payment approach to the 60 day episode. For initial episodes, there will be a 60/40 split percentage payment. Sixty percent of the episode will be paid at the beginning of the episode and forty percent will be paid at the end of the episode. For all subsequent episodes for beneficiaries who receive continuous home health care, the episodes will be paid at a 50/50 percentage split.

For example, an initial case mix and wage adjusted 60 day episode of $2000 will be paid at the 60/40 split. The HHA would receive an initial percentage payment of $1200 and a final

percentage payment of $800, unless there is an applicable adjustment (low utilization payment adjustment, significant change in condition payment adjustment, partial episode payment adjustment, cost outlier payment or medical review determination). Further, the initial percentage payment will be based on a request for anticipated payment discussed below.

What are the physician signature requirements for the split percentage payments?
If a physician signed plan of care is not available at the beginning of the episode, the HHA may submit a request for anticipated payment or ARAP@ for the initial percentage payment based on physician verbal orders. The request for anticipated payment of the initial percentage payment must be based on: a physician=s verbal order that is recorded in the plan of care; includes a description of the patient=s condition and the services to be provided by the home health agency; includes an attestation (relating to the physician=s orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care; and the plan of care is copied and is immediately submitted to the physician OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician.

HCFA has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal orders 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 Civil Monetary Penalties law, Civil False Claims Act and the Criminal False Claims Act, the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.

The plan of care must be signed and dated by a physician as described who meets the certification and recertification requirements of section 424.22 and before the claim for each episode for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician.

Will I continue to receive periodic interim payments (PIP) under home health PPS?
No. The law eliminates PIP with PPS. However, PIP providers will continue to receive their last PIP payments in October 2000 for cost based services rendered in September 2000 under the interim payment system. In addition, the higher upfront percentage payment coupled with the RAP based on physician verbal orders will provide cash flow to all providers.

How do I calculate the case mix & wage adjusted 60-day episode payment?
The **STANDARDIZED 60 DAY EPISODE PAYMENT** which is set amount for each episode **$2,115.30**--(See Table 5 in the Final Regulation) is **multiplied** by the patient=s assigned **CASE MIX WEIGHT**. There are 80 possible case mix weights based on the OASIS assessment of the patient. Our case mix adjustment methodology uses the combination of scores from the 23 OASIS items (including the new projected therapy variable: See Tables 7, 8A, 8B & 9 in the final regulation for complete explanation of the case mix methodology approach and scoring) that result in one of 80 case mix assignments for each patient.

The standardized episode amount multiplied by the patient=s case mix weight equals the CASE MIX ADJUSTED 60 DAY EPISODE PAYMENT

The CASE MIX ADJUSTED 60-DAY EPISODE PAYMENT IS DIVIDED INTO THE LABOR PORTION, which is 77.668% of the amount, AND THE NON-LABOR PORTION which is 22.332% of the amount.

The LABOR PORTION IS MULTIPLIED BY THE WAGE INDEX BASED ON THE SITE OF SERVICE OF THE BENEFICIARY. That equals the WAGE ADJUSTED PORTION of the Rate.

The WAGE ADJUSTED PORTION IS ADDED TO THE NON-LABOR PORTION. That equals the Total Case Mix & Wage Adjusted 60-Day Episode Rate.

As discussed above, new patients are paid on a 60/40 percentage split. Subsequent episodes for patients who require continuous care are paid on a 50/50 percentage split.

Example: An HHA is providing services to a new eligible patient in State College, PA. The HHA determines the beneficiary is in HHRG C2F2S2.

COMPUTATION OF CASE MIX AND WAGE ADJUSTED PROSPECTIVE PAYMENT AMOUNT	
Case mix index from Table 9 for case mix group	1.9532
Standardized Prospective Payment Rate for FY 2001	$2,115.30
Calculate the Case Mix adjusted Prospective Payment Rate for FY 2001 1.9532 * $2,115.30	$4,131.60
Calculate the Labor portion of the Prospective Payment Rate for FY 2001 .77668 * $4,131.60	$3,208.93
Apply wage index factor from Table 4B for patient in State College, PA 0.9139 * $3,208.93	$2,932.64
Calculate the Non- Labor portion of the Prospective Payment Rate for FY 2001 .22332 * $4,131.60	$922.67
Calculate Total Prospective Payment Rate for FY 2001 by adding the labor and non labor portion of the case mix and wage index amounts $2,932.64+ $922.67	$3,855.31
RAP is submitted for the initial 60% payment for the new patient	

(.60 *$3,855.31)	$2,313.19
If no applicable adjustment, the residual 40% is paid at the end of the episode (.40 *$3,855.31)	$1,542.12

Episode Examples

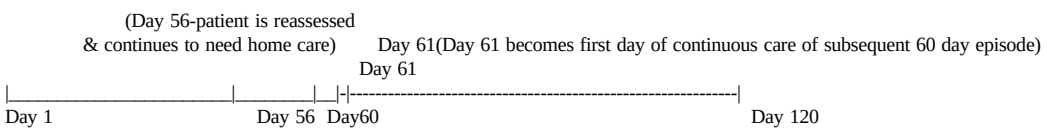
1) 60-Day Episode-No Adjustments & No Recertification

A new patient is assessed and assigned to a case mix and wage adjusted 60 day episode that equals $3,000. The HHA in this example submits a RAP with all applicable documentation and receives an initial percentage payment of $1,800 (60% of $3,000). The patient meets the treatment goals and is discharged on Day 30. The patient does not experience any other event that results in an applicable adjustment. The HHA submits the claim for the residual final percentage payment of $1,200 (40% of $3,000). Even though the HHA only served the patient from Day 1-30, it receives the total case mix and wage adjusted 60 day episode payment of $3,000 for the patient.

2) Continuous Home Care

In the first 60 day episode, a new patient is assessed and assigned to a $3,000 case mix and wage adjusted 60 day episode. The HHA submits a RAP for the initial percentage payment of $1,800 (.60 * $3,000).The patient does not experience an intervening discharge and return to the same HHA, transfer, significant change in condition during the 60 day episode or LUPA.The HHA submits the claim for the residual 40% split payment

During the last 5 days of the episode, the OASIS assessment indicates the need for continuous home health care and a subsequent 60 day episode. The patient is assigned to a subsequent case mix and wage adjusted episode of $3,200. The HHA submits a RAP for the 50% initial percentage payment for the subsequent episode (50% of $3,200 = $1,600). If there is no applicable adjustment, the HHA will receive the residual 50% ($1,600) upon submission of the claim.



3) Significant Change in Condition

A patient=s significant change in condition is an intervening event over the course of a 60 day episode of home health care that could trigger a change in payment level. The significant change in condition (SCIC) payment adjustment is the proportional payment adjustment that reflects the time both before and after the patient experiences a significant change in condition. The SCIC payment adjustment occurs within a 60 day episode and does not restart the 60 day episode clock. The SCIC payment adjustment occurs when a beneficiary experiences a significant change in condition during a 60 day episode that was not envisioned in the original plan of care. In order to receive a new case assignment for purposes of payment during the 60 day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in treatment approach in the patient=s plan of care.

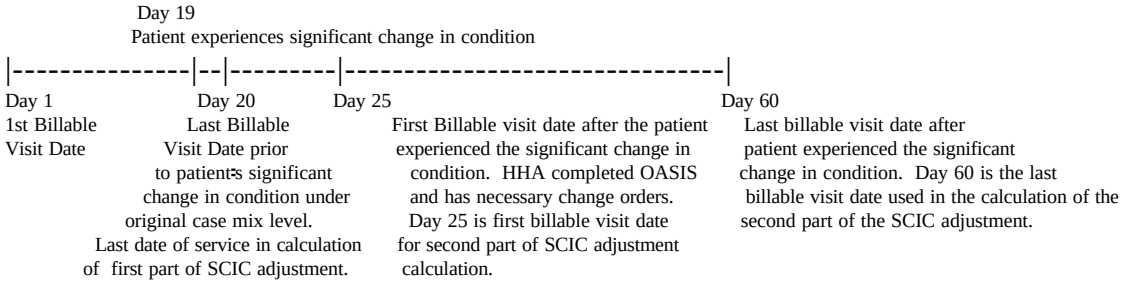
The SCIC payment adjustment occurs in two parts. The first part of the SCIC adjustment uses the span of days of the first billable visit date through the last billable visit date prior the patient=s significant change in condition that warrants a new case mix assignment for payment and physician change orders. That span of billable visit dates as a proportion of 60 is multiplied by the original case mix and wage adjusted 60 day episode payment. The second part of the SCIC adjustment is determined by taking the span of days of the first billable visit date through the last billable visit date after the patient experiences the significant change in condition for the balance of the 60 day episode as a proportion of 60 multiplied by the new case mix and wage adjusted 60 day episode payment amount. The total SCIC adjusted episode amount is the sum of the proportional parts.

For example: An HHA assigns a new patient to a case mix and wage adjusted episode that equals $2,000. Since the patient is new, the episode would be paid at the 60/40 percentage split. The HHA submits the RAP with the appropriate documentation for the initial 60% payment of $1,200.The patient=s first billable visit date is Day 1. The patient experiences a significant change in condition on Day 19. The last billable visit date prior to the significant change in condition is Day 20. The HHA completes the appropriate OASIS assessment, obtains the necessary change orders to alter the course of treatment in the plan of care, and changes the case mix assignment for payment reflecting the patient=s change in condition. The HHA has all of the necessary information to begin rendering services under the revised plan of care and at the new case mix and wage adjusted episode level of $4,000. The first billable visit date under the revised plan of care at the new case mix level is Day 25. Day 25 is the first billable visit date under the second part of the SCIC adjustment. Day 60 is the last billable visit date at the new case mix level.

The first part of the SCIC adjustment:
(Day 1- Day 20) 20/60 *$2,000 = $666.67

The second part of the SCIC adjustment:
(Day 25- Day 60) 36/60 * $4,000 = $2,400

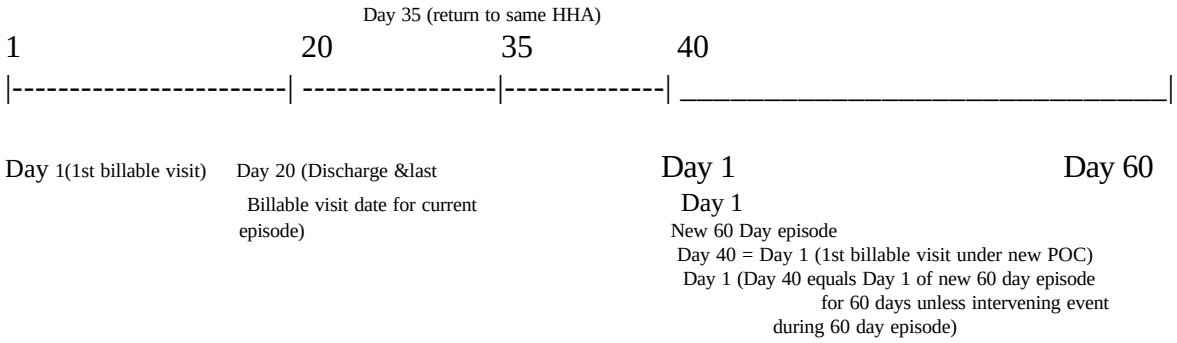
Total SCIC Adjusted Episode payment = $3,066.67
The original 60% payment of $1,200 (60% of $2,000) would be adjusted with $1,866.67 to pay the balance of the total SCIC adjustment of $3,066.67 unless there is an applicable adjustment.



4) Discharge and Return to Same HHA during the 60 Day Episode
In a 60 day episode, a new patient is discharged on Day 20 and returns to the same HHA on Day 35. The patient met the treatment goals in the original plan of care and is subsequently readmitted needing a new treatment plan. The original plan of care was terminated with no anticipated need for home care during the balance of the 60 day episode. The initial percentage payment (60% for the new patient) would be adjusted to recognize the 20 days served by the HHA under the initial case mix category. The last ordered visit was coincidentally rendered on Day 20 of the initial 60 day episode. For example, the new patient is assigned to a case mix and wage adjusted episode that equals $3,000 episode payment, is discharged on Day 20 and returns to the same HHA on Day 35. The HHA would reassess the patient on or about Day 35 and start a new 60 day clock for physician recertification, OASIS, and case mix assignment for payment. The start of the new payment clock corresponds to the first physician ordered service/billable visit date in the new plan of care. For purposes of this example the first physician ordered service in the new plan of care for the new 60 day episode payment is Day 40. Day 40 of the old episode becomes the first day of the new certified period. The new certified period covers Day 1 plus 59 days unless there is an applicable adjustment.

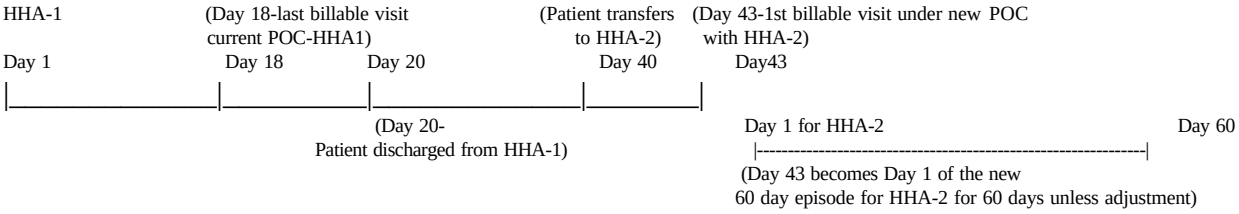
The adjusted payment for the partial episode spans the start of care date (Day 1-first physician ordered service) thru and including the last day of the 60 day episode that includes the last physician ordered billable visit as a proportion of 60 days. The adjusted payment for the partial episode in this example spans Day 1 thru and including Day 20. Day 20 is the last day of the original episode that includes a

physician ordered/billable service. The adjusted payment for the partial episode would equal $3000 * 20/60.The triggering event for end of the partial episode is the last date of service with a physician ordered/billable service. The triggering date for the new episode is the first physician ordered service/billable visit date in the new plan of care corresponding to the new 60 day episode due to discharge and return to HHA in same episode.



5)Transfer

In a 60 day episode, a continuous home care patient is assigned to a case mix and wage adjusted episode that equals $3000 by HHA-1 and is discharged on Day 20. The HHA-1 has already submitted a RAP and received the initial 50% payment of $1,500 (50% of $3,000). Day 18 is the last day of the current 60-day episode with a physician ordered/billable visit. The patient transfers to HHA-2 on Day 40. HHA-2 assesses the patient and obtains physician orders for a new plan of care. The first ordered service/billable service is Day 43. Day 43 becomes Day 1 of the new 60 day episode for HHA-2. The adjusted payment for the partial episode for HHA-1 equals $3000 * 18/60 = $900. The initial percentage payment of $1,500 will be adjusted to reflect the PEP adjustment of $900. The triggering event for the new 60 day episode is the first ordered service in the new plan of care corresponding to the new episode 60 day episode due to the beneficiary elected transfer.



What is a Low Utilization Payment Adjustment ?

Episodes with four or fewer visits will be paid the national average per visit amounts by discipline adjusted for wages based on the site of service of the beneficiary instead of the full episode payment. Episodes with four or fewer visits will be adjusted with a low utilization payment adjustment (LUPA).

Low Utilization Payment Amounts from Table 6 of the Final Home Health PPS Regulation

Home Health Aide	$43.37
Medical Social Services	$153.55
Occupational Therapy Services	$105.44
Physical Therapy Services	$104.74
Skilled Nursing Services	$95.79
Speech Pathology Services	$113.81

LUPA EXAMPLE. An HHA in Baltimore, MD assigns a new patient to an HHRG at the start of a 60-day episode. The claim for the patient indicates that only two visits (one skilled nursing and one home

health aide) were furnished during the 60-day episode. The HHA would be paid the low-utilization payment adjustment. Any necessary adjustment to the initial 60 percent initial payment for the episode would be made.

COMPUTATION OF WAGE INDEX ADJUSTED LOW UTILIZATION PAYMENT

Number and Visit Discipline Type	**Final Wage Standardized Per-Visit Payment Amounts Per 60-Day Episode for FY2001**
1 Skilled Nursing Visit	**$95.79**
1 Home Health Aide Visit	**$43.37**

Calculate the labor portion of the Standardized Per-Visit Payment Amount for 1 Skilled Nursing Visit .77668 * $95.79	**$74.40**
Apply wage index factor from Table 4B for Baltimore, MD .9892 * $74.40	**$73.60**
Calculate the non-labor portion of the Standardized Per-Visit Payment Amount for 1 Skilled Nursing Visit .22332* $95.79	**$21.39**
SUBTOTAL-Low Utilization Payment for 1 Wage Adjusted Skilled Nursing Visit rendered in a 60-day episode $73.60+ $21.39	**$94.99**
Calculate the labor portion of the Standardized Per-Visit Payment Amount for 1 home health aide visit .77668* $43.37	**$33.69**
Apply wage index factor from Table 4B for Baltimore, MD .9892*$33.69	**$33.33**
Calculate the non-labor portion of the Standardized Per-Visit Payment Amount for 1 home health aide visit .22332 * $43.37	**$9.69**

SUBTOTAL--Low Utilization Payment for 1 wage adjusted home health aide visit rendered in a 60-day episode $33.33+ $9.69	**$43.02**
Calculate Total Low Utilization Payment Adjustment for 2 visits provided during the 60- day episode by adding the wage adjusted skilled nursing visit and the wage adjusted home health aide visit $94.99+ $43.02	**$138.01**

Cost Outlier Payments

How does my patient qualify for an cost outlier payment?

To Qualify for an outlier payment--the episode must exceed the outlier threshold

You Have to ask--does the AMOUNT of the episode exceed the outlier threshold and by how much?

The HHA must incur amounts that exceed the outlier threshold

Outlier Threshold = Case Mix & Wage Adjusted Episode Amount + Wage Adjusted Fixed Dollar Loss Amount (Fixed dollar loss amount = 113% of the 60 day national standardized amount $2,115.30)

Once the HHA exceeds the outlier threshold,

The HHA has to ABSORB A PERCENTAGE OF THE AMOUNT BEYOND THE THRESHOLD BEFORE RECEIVING AN OUTLIER PAYMENT

THE PERCENTAGE OF THE AMOUNT ABSORBED BEYOND THE OUTLIER THRESHOLD is the LOSS SHARING RATIO (Loss Sharing Ratio = 80%).

This is a case for illustrative purposes only. An HHA serves a patient to a Medicare beneficiary in State College PA. The HHA determines the patient is in HHRG C2F2S2. The patient had physician orders for and received 55 skilled nursing visits and 40 home health aide visits during the 60 day episode.

NOTE: THESE CALCULATIONS ARE MADE AUTOMATICALLY BY PRICER SOFTWARE IN HCFA SYSTEMS AND NEED NOT BE COMPUTED BY THE PROVIDER

Calculate the Wage Adjusted Outlier Threshold. The Wage Adjusted Outlier Threshold Amount is the sum of the Wage and Case Mix Adjusted 60 Day Episode Amount and the Wage Adjusted Fixed Dollar Loss Amount.

Calculate Case Mix and Wage Adjusted Episode

Case Mix Weight = 1.9532

Standard 60 Day Prospective Episode Payment Amount= $2,115.30

Calculate the Case Mix Adjusted Episode Payment by Multiplying the Standard 60 Day Prospective Episode Payment Amount by the Applicable Case Mix Weight = (1.9532 * $2,115.30) = $4,131.60

Divide the Case Mix Adjusted Episode Payment into the Labor and Non-Labor Portions

Labor Portion = (.77668 * $4131.60) = $3,208.93
Wage Adjust the Labor Portion by Multiplying the Labor Portion by the Wage Index Factor (.9139 * $3,208.93) = $2,932.64
Calculate Non-Labor Portion = (.22332 * $4,131.60) = $922.67
Add Wage Adjusted Labor Portion to Non-Labor Portion to Calculate the Total Case Mix and Wage Adjusted Episode Payment = (2,932.64 + $922.67) = $3,855.31

Calculate Wage Adjusted Fixed Dollar Loss Amount
Fixed Dollar Loss Amount = Standard 60 Day Episode Payment Multiplied by 1.13 ($2115.30 * 1.13) = $2,390.29
Divide Fixed Dollar Loss Amount into Labor and Non Labor Portions:
Calculate Labor Portion of Fixed Dollar Loss Amount = (.77668 * $2,390.29) = $1,856.49
Wage Adjust the Labor Portion by Multiplying the Labor Portion of the Fixed Dollar Loss by Multiplying the Labor Portion of the Fixed Dollar Loss Amount by the Wage Index (.9139 * $1,856.49) = $1,696.65
Calculate Non-Labor Portion of Fixed Dollar Loss Amount = (.22332 * $2,390.29) = $533.80
Calculate Total Wage Adjusted Fixed Dollar Loss Amount by adding the wage adjusted portion of the fixed dollar loss amount to the non labor portion of the fixed dollar loss amount ($1,696.65 + $533.80) = $2,230.45
Wage adjusted outlier threshold = Case-mix and wage adjusted episode amount + wage adjusted fixed dollar loss amount = ($3,855.31 + 2230.45) = $6,085.76

Calculate the Wage Adjusted Imputed Cost of the Episode
Multiply the total number of visits by the national average per visit amounts listed in Table 6.
55 skilled nursing visits * $ 95.79 (national average per skilled nursing visit cost) = $5,268.45
40 home health aide visits * $43.37 (national average per home health aide visit cost) = $1,734.80
Calculate the wage adjusted labor and non-labor portions for the imputed skilled nursing visit costs
Labor Portion= ($5,268.45* .77668) = $4,091.90
Adjust the labor portion by the wage index
Wage Adjusted Skilled Nursing Labor Portion = ($4,091.90 * .9139) = $3,739.59
Wage Adjusted Skilled Nursing Labor Portion = $3,739.59
Calculate the Skilled Nursing Non-Labor Portion
Non-Labor Portion = ($5,268.45 * .22332) = $1,176.55
Non-Labor Skilled Nursing Portion = $1,176.55

Total Wage Adjusted Imputed Costs for Skilled Nursing Visits = $4,916.14
(Wage Adjusted Skilled Nursing Labor Portion of $3,739.59 + **Non-Labor Skilled Nursing Portion of $1,176.55) =** $**4,916.14**

Calculate the wage adjusted labor and non-labor portions for the imputed home health aide visit costs
Labor Portion= ($1,734.80* .77668) = $1,347.38
Adjust the labor portion by the wage index
Wage Adjusted Home Health Aide Labor Portion = ($1,347.38 * .9139) = $1,231.37
Wage Adjusted Home Health Aide Labor Portion = $1,231.37
Calculate the Home Health Aide Non-Labor Portion

Non-Labor Portion = ($1,734.80 * .22332) = $387.42
Non-Labor Home Health Aide Portion = $387.42

Total Wage Adjusted Imputed Costs for Home Health Aide Visits = $1,618.79 (Wage Adjusted Home Health Aide Labor Portion of $1,231.37 + **Non-Labor Home Health Aide Portion of $387.42) =** $ **1,618.79**

Total Wage Adjusted Imputed Costs for Skilled Nursing and Home Health Visits During the 60 Day Episode = ($4,916.14 + $1,618.79) = $ 6,534.93

Calculate the Amount in Absorbed by the HHA in Excess of the Outlier Threshold
Subtract the Outlier Threshold from the Total Wage Adjusted Imputed Per Visit Costs for the Episode
$**6,534.93** (Total Imputed Wage Adjusted Per Visit Costs) - (Outlier Threshold) = **$6,085.76**
$ **449.17**
Imputed Amount in Excess of the Outlier Threshold Absorbed by the HHA = $449.17

Calculate Outlier Payment by Multiplying the Imputed Amount in Excess of the Outlier Threshold Absorbed by the HHA By the Loss Sharing Ratio (80%)
$449.17 (Imputed Amount in Excess of the Outlier Threshold Absorbed by the HHA * .80 (Risk Sharing Ratio) = $ 359.34

Outlier Payment = $359.34
The HHA in this illustrative example would receive the total case mix and wage adjusted 60 day episode payment of $3,855.31 plus the additional outlier payment of $359.34
Total Payment (Episode & Outlier Payment) = ($3,855.31 + $359.34) = $4,214.65

What are the implementation grace periods for OASIS assessments and plan of care certifications governing the effective date of PPS?
HCFA is providing a one-time implementation grace period for OASIS assessments and plan of care certifications to alleviate transition concerns associated with all HHAs starting PPS with the same effective date of 10/1/00.

Plan of Care Certifications: For established home health beneficiaries as of September 1, 2000, we are providing a one time grace period that provides a certification period up to a maximum of 90 days (September 1, 2000 through and including November 29, 2000). HHAs in conjunction with a certifying physician and HHA may have a one-time maximum 90 day plan of care certification. The regulatory requirements governing the Medicare home health benefit before PPS would apply

to the certification period up to and including September 30, 2000. The plan of care must reflect a statistical break between the pre-PPS physician ordered services September 1,2000-September 30, 2000) and the post-physician ordered services (October 1, 2000-November 29, 2000). Included in the statistical break is the notation of the start of care date/first billable visit date for this patient under PPS

OASIS Assessment Schedules Grace Periods for patients under an established plan of care:
On or after September 1, 2000 - September 30, 2000, HHAs may use the most recent OASIS start of care or follow-up to group for case mix.

On or after August 1, 2000-August 31, 2000, HHA=s discretion to complete the next schedule in September 2000 for case mix

On or after October 1, 2000 resume OASIS requirements governing last five days of episode certification period.

What are the OASIS Assessment Schedules Used for Corresponding Payment Adjustments ?

Type of Episode or Adjustment	**Elements of OASIS Assessment: M0100 & M0825 Response Selection**
1. Initial, whether first or new 60-day episode resulting from PEP Adjustment	Start of Care: (M0100) RFA 1 and (M0825) select 0-No or 1-Yes
2. SCIC with intervening Hospital Stay during current episode	Resumption of Care: (M0100) RFA 3 and (M0825) is 0-No or 1-Yes If a patient was transferred to the hospital without agency discharge during the current episode, the required assessment upon return to home is the Resumption of Care assessment (RFA 3). The Resumption of Care assessment is required within 48 hours of the patient=s return from the inpatient facility. ***The Resumption of Care assessment (RFA 3) also serves to determine the appropriate new case mix assignment for the***

	SCIC adjustment.
3. SCIC <u>with</u> intervening Hospital Stay at the end of an episode	Resumption of Care: (M0100) RFA 3 and (M0825) is 0-No or 1-Yes ***and Followup (M0100) RFA4 and (M0825) is 0-No or 1-Yes*** If a patient was transferred to the hospital without agency discharge, the required assessment upon return to home is the Resumption of Care assessment (RFA 3). The Resumption of Care assessment is required within 48 hours of the patient's return from the inpatient facility. The recertification (Follow-up, RFA 4) comprehensive assessment is required in the last five days of the certification period; for payment purposes, this assessment is used to determine the case mix assignment for the subsequent 60-day period. ***If the second part of the SCIC adjustment occurs in the last five days of the certification period, two comprehensive assessments are required.*** One assessment will be done for the resumption of care (RFA 3) and (M0825) select 0-No or 1-Yes; the other will ***be done*** for the recertification (Follow-up) assessment (***RFA4***) and (M0825) select 0-No or 1-Yes. ***The reason two assessments are required is that therapy need must be predicted and reported on the OASIS record*** for each discrete 60 day episode.
4. SCIC <u>without</u> intervening Hospital Stay	Other Follow-Up Assessment: (M0100) RFA 5 and (M0825) select 0-No or 1-Yes
5. Subsequent 60-day episode due to the need for continuous home health care after an initial 60 day episode	Recertification (Follow-up): (M0100) ***RFA 4*** and (M0825) select 0-No or 1-Yes