CHAPTER 12
SECTION 4

HOME HEALTH BENEFIT COVERAGE AND REIMBURSEMENT - PROSPECTIVE PAYMENT METHODOLOGY

ISSUE DATE:

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I. APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

To describe the payment methodology for services rendered to a TRICARE eligible beneficiary under a home health plan of care (POC) established by a physician.

III. POLICY

A. General Overview.

1. Under the new prospective payment system, TRICARE will reimburse HHAs a fixed case-mix and wage-adjusted 60-day episode payment amount for professional home health services, along with routine and non-routine medical supplies provided under the beneficiary's plan of care. Durable medical equipment (DME) orthotics, prosthetics, certain vaccines, injectable osteoporosis drugs, ambulance services operated by the HHA and other drugs and biologicals administered by other than oral method will be allowed outside the bundled episode-of-care payment rates.

2. The variation in reimbursement among beneficiaries receiving home health care under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care, with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. The resource consumption of these beneficiaries will be assessed using Outcome and Assessment Information Set (OASIS) selected data elements. The score values obtained from these selected data elements will be used to classify home health beneficiaries into one of 80 Home Health Resource Groups (HHRGs) groups, based on their average expected resource costs relative to other home health care patients.

3. The HHRG classification determines the cost weight; i.e., the appropriate case-mix weight adjustment factor that indicates the relative resources used and costliness of treating different patients. The cost weight for a particular HHRG is then multiplied by a standard average prospective payment amount for a 60-day episode of home health care. The case-mix adjusted standard prospective payment amount is then adjusted to reflect the geographic variation in wages to come up with the final HHA payment amount. Examples of the above calculations will be provided below in order to get a better understanding of the HHA prospective payment system being adopted in this rule, along with the home health benefit structure and applicable reporting requirements.

B. Episodes of Care.

1. The ordinary unit of payment is based on an authorized 60-day episode of care. This episode spans a 60-day period which begins with the start of care date (i.e., with the first billable service date) furnished to a beneficiary and ending 60 days later. Payment covers the entire episode of care regardless of the number of days of care actually provided during the 60-day period. The only exceptions to this standard payment period are when the following conditions exist: 1) partial episode payment (PEP) adjustment; 2) significant change in condition adjustment (SCIC); 3) low utilization payment adjustment (LUPA); 4) additional outlier payment; or 5) medical review determination. There is also downward adjustment in those situations in which the number of therapy services delivered during an episode does not meet the anticipated 10 therapy visits threshold. Reduced or additional amounts will be paid under the above situations.

2. If the beneficiary is still in treatment at the end of the initial 60-day episode of care, a decision has to be made regarding recertification for another 60-day episode of care; i.e., a physician must certify that the beneficiary is correctly assigned to one of the HHRGs. If the decision is to recertify, a new episode will begin on day 61 regardless of whether a billable visit is rendered on that day, and ends 60 days later. The HHA will be required to obtain an authorization for the new episode. This pattern would continue (the next episode would start on the 121st day, the next on the 181st day, etc.) as long as the beneficiary was receiving services under a HHA's plan of care. Extension of the home health agency benefit beyond the 60th day will require the HHA to fill out a new assessment (OASIS) in order to assign an appropriate HHRG (case mix category) for the next 60-day episode of care. A revised OASIS, along with the physician's plan of care and certification, is required before the HHA submits a bill for the next 60-day episode of care. The timely submission of this information is essential in determining whether the HHRG rate to be paid is appropriate and accurately reflects the beneficiary's clinical condition. There are currently no limits on the number of medically necessary consecutive 60-day episodes that beneficiaries may receive under the HHA prospective payment system. Allowing multiple episodes is intended to assure continuity of care and payment.

3. Consecutive authorized episodes will be paid at the full prospective rate as long as there are no intervening events or costs which would affect overall resource utilization under the initially designated case-mix assignment.

4. More than one episode for a single beneficiary may be authorized for the same or different dates of service. This will occur particularly in situations where there is a transfer to another HHA, or discharge and readmission to the same HHA.

5. Payment will be prorated when an episode ends before the 60th day in the case of a transfer to another HHA, or in the case of a discharge and readmission within the same 60-day period. Claims for episodes may also be submitted prior to the 60th day if the beneficiary has been discharged and treatment goals have been met, although payment will not be prorated unless more home health care is subsequently billed in the same 60-day period.

C. Case-Mix Adjustment.

1. Elements of the Case-Mix Model.

a. The variation in reimbursement among beneficiaries receiving home health care under this newly adopted prospective payment system will be dependent on the severity of the beneficiary's condition and expected resource consumption over a 60-day episode-of-care with special reimbursement provisions for major intervening events, significant changes in condition, and low or high resource utilization. A case mix system has been developed to measure the severity and projected resource utilization of beneficiaries receiving home health services using selected data elements off of the Outcome and Assessment Information Set (OASIS) assessment instrument (i.e., the assessment document submitted by HHAs for reimbursement) and an additional element measuring receipt of at least 10 visits for therapy services. These key data elements are organized and assigned a score value in order to measure the impact of clinical, functional and services utilization dimensions on total resource use. The resulting summed scores are used to assign a beneficiary to a particular severity level within each of the following domains:

(1) Clinical Severity Domain. The clinical severity domain captures significant indicators of clinical need for several OASIS items. These include patient history, sensory, integument, respiratory, elimination, and neuro/emotional/behavioral status. It includes OASIS items pertaining to the following clinical conditions and risk factors: diagnoses involving orthopedic, neurological, or diabetic conditions; therapies used at home (i.e., intravenous therapy or infusion therapy, parenteral and enteral nutrition); vision; pain frequency; pressure ulcers, stasis ulcers, burns, trauma and surgical wounds; dyspnea; urinary and bowel incontinence; bowel ostomy; and cognitive/behavioral problems, such as impaired decision making and hallucinations. The clinical severity domain has four severity levels (0-3) and takes into account the beneficiary's primary diagnosis and prevalent medical conditions.

(2) Functional Dimension. The functional status domain is comprised of six Activities of Daily Living (ADLs) from the ADL sections of the OASIS assessment instrument. These include upper and lower body dressing, bathing, toileting, transferring, and locomotion, and consists of 5 severity levels (0-4).

(3) Services Utilization Domain. The services utilization dimension has four severity levels (0-3) and includes two types of data elements. First is the patient's use of inpatient services (both inpatient and SNF/rehabilitation stays) in the 14 days preceding admission to home care. This information is obtained from the patient history section of the OASIS. The second data element in the service utilization dimension measures home health therapy hours (physical, occupational, or speech/language) totaling 8 hours (approximately 10 therapy visits) or more during the 60-day episode of care. The threshold of 8 hours targets additional payments for home health therapy to patients with a clear need for therapy.

(4) Other Variables Affecting Case-Mix Adjustment.

(a) Diagnosis. Since home health diagnosis is generally used informally to characterize home health patients and the types of services they require, it is an important variable in the case-mix adjustment process. Since OASIS completion rules require submission of only the first three digits of the ICD9-CM diagnosis code, the analysis used these categories. Since individual analysis of the 900+ codes was not practical, the diagnosis codes were grouped into Diagnostic Groups or DGs. These were based on the Quality Indicator Groups (QUIGs) that had been developed for use in monitoring home health care and outcomes with OASIS. Three of the DGS were found to be statistically significant predictors of home health resource use - Orthopedic, Neurologic, and Diabetic. A fourth category, Burn/Trauma, is not based on the QUIGs, but was subsequently added to the model to capture patients with high needs for wound care who are not otherwise captured by existing OASIS items. A listing of the ICD9-CM codes included in each DG as a primary or secondary diagnosis is presented in Chapter 12, Addendum H.

(b) Secondary Diagnoses. The first secondary diagnosis is considered in some cases when the diagnosis of interest for case-mix purposes is a code representing manifestation of an underlying condition which is entered as the primary diagnosis.

(c) Availability of Caregiver. The availability of a caregiver was excluded from the case-mix adjustment model since it was found to add little predictive insight given the variables that were already included.

(d) Service Utilization Variables. It was found that patients who had a rehab or SNF discharge, as well as a hospital discharge, in the 14 days before home health admission generally had lower resource use than patients who had been in a rehab or SNF only. It was felt that those who could move from a hospital to rehab/SNF to home care in 14 days were making good progress, while those who come to home care from a longer rehab or SNF stay likely had more chronic problems, or were progressing more slowly. Thus, lack of a recent hospital discharge (blank item M0175, line 1 on the OASIS) would be a definite predictor of resource utilization.

2. Response Values, Scores and Severity Levels.

a. OASIS Item Response Values. The Outcome and Assessment Information Set (OASIS) contains 90 data items. OASIS items responses involve unique statements that require an objective assessment, and the number of possible responses varies by item.

(1) Each of the possible responses have point values assigned to them that reflect their relationship to home health resource utilization.

(2) In most of the items, several responses are grouped and assigned one value. For example, for item M0670 (Bathing), response options 2, 3, 4, or 5 (ranging from "able to bathe in shower or tub with assistance of another person" to "totally bathed by another person") are all given a point value of 8. If the patient had been rated as independent in bathing, however, with response 0, no value is added to the score.

b. Point Scoring. The point values for the OASIS items within each of the three domains are summed to determine a patient's point score in each domain (clinical, functional and service utilization.) For example, if the response for each of the items listed in the Functional Domain is a 2, then the score for the domain would be calculated as follows in Figure 12-4-1.

FIGURE 12-4-1 CALCULATING DOMAIN SCORES FROM RESPONSE VALUES

M0650 / M0660	Dressing	Response 2 has a value of 4, so 4 is added to the score.
M0670	Bathing	Response 2 has a value of 8, so 8 is added to the sore.
M0680	Toileting	Response 2 has a value of 3, so 3 is added to the score.
M0690	Transferring	Response 2 has a value of 6, so 6 is added to the score.
M0700	Locomotion	Response 2 has a value of 6, so 6 is added to the score
Summing the values for the items produces a score of 27 for the function domain.		

c. Severity Levels. Within each domain, the total score is assigned to a severity level. For example, a summed score of 27 in the Functional Domain, as shown above, would place a patient in the "high" (F3) functional severity level. There are four clinical severity levels, five functional severity levels, and four service utilization severity levels. The range of scoring differs for each domain, so that a score of 25 in the Clinical Domain would correspond to a moderate (C2) clinical severity level, but a score of 25 in the Functional Domain would place the patient in the high functional severity level. A patient with a score of 43 for the Clinical Domain would be placed in the high clinical (C3) severity level, while a patient with a total score of 6 in the Service Domain would be placed in the moderate (S2) severity level for that domain.

d. Grid System of OASIS Items, Values and Scoring. The following figures (Figure 12-4-2 - Figure 12-4-4) list the OASIS items used in the case-mix model, along with corresponding descriptions, values and scoring:

FIGURE 12-4-2 CLINICAL SEVERITY DOMAIN

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0230 / M0240	Primary home care diagnosis (plus first secondary Dx ONLY for selected manifestation codes	**-credit only the single highest value:** If Orthopedic DG, add 11 to score If Diabetes DG, add 17 to score If Neurological DG, add 20 to score	Min (C)= 0-7 Low (C1)= 8-19 Mod (C2)= 20-40 High (C3)= 41+
M0250	IV/Infusion/Parenteral/ Enteral Therapies	**-credit only the single highest value:** If box 1, add 14 to score If box 2, add 20 to score If box 3, add 24 to score	
M0390	Vision	If box 1 or 2, add 6 to score	
M0420	Pain	If box 2 or 3, add 5 to score	

FIGURE 12-4-2 CLINICAL SEVERITY DOMAIN (CONTINUED)

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0440	Wound/Lesion	If box 1 and M0230 is Burn/Trauma DG, add 21 to score	Min (C)= 0-7 Low (C1)= 8-19 Mod (C2)= 20-40 High (C3)= 41+
M0450	Multiple pressure ulcers	If 2 or more stage 3 or 4 pressure ulcers, add 17 to score	
M0460	Most problematic pressure ulcer stage	If box 2, add 14 to score If box 3, add 22 to score	
M0488	Surgical wound status	If box 2, add 7 to score If box 3, add 15 to score	
M0490	Dyspnea	If box 2, 3 or 4, add 5 to score	
M0530	Urinary incontinence	If box 1 or 2, add 6 to score	
M0540	Bowel incontinence	If box 2-5, add 9 to score	
M0550	Bowel ostomy	If box 1 or 2, add 10 to score	
M0610	Behavioral problems	If box 1-6, add 3 to score	

FIGURE 12-4-3 FUNCTIONAL STATUS DOMAIN

OASIS+ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0650 (current) M0660 (current)	Dressing	If M0650 = box 1, 2 or 3 \ or M0660 = box 1, 2 or 3/} -> add 4 to score	Min (F0) = 0-2 Low (F1)= 3-15 Mod (F2)= 16-23 High (F3)= 24-29 Max (F4)= 30
M0670 (current)	Bathing	If box 2, 3, 4, or 5, add 8 to score	
M0680 (current)	Toileting	If box 2-4, add 3 to score	
M0690 (current)	Transferring	If box 1, add 3 to score If box 2-5, add 6 to score	
M0700 (current)	Locomotion	If box 1 or 2, add 6 to score If box 3-5, add 9 to score	

FIGURE 12-4-4 SERVICE UTILIZATION DOMAIN

OASIS+ ITEM	DESCRIPTION	VALUE	SEVERITY LEVELS
M0175 B line 1	NO Hospital discharge past 14 days	If box 1 is BLANK, add 1 to score	Min (S0)= 0-2 Low (S1)= 3 Mod (S2)= 4-6 High (S3)= 7
M0175 B line 2 or 3	Inpatient rehab/SNF discharge past 14 days	If box 2 or 3, add 2 to score	
M0825	Therapy threshold (10 or more therapy [PT, OT, SLP] visits during episode)	If box 1, add 4 to score	

3. Case-Mix Grouper. A case-mix grouper is used for assigning a severity level within each of the above dimensions and for classifying the beneficiary into one of 80 home health resource groups (HHRG). For example, the patient with high clinical severity (C3), high functional severity (F3), and moderate service utilization (S2) would be placed in the "C3F3S2" HHRG. The other HHRGs are derived in a similar manner. The HHRG indicates the extent and severity of the beneficiary's home health needs reflected in its relative case-mix weight (cost weight). The case-mix weight indicates the group's relative resource use and cost of treating different patients. The standardized prospective payment rate is multiplied by the beneficiary's assigned HHRG case-mix weight to come up with the 60-day episode payment.

4. Therapy Hours Verification. The total case-mix adjusted episode payment is based on elements of the OASIS data set, including the therapy hours or visits provided over the course of the episode. The number of therapy hours or visits projected at the start of the episode, entered in OASIS, will be confirmed by the hour or visit information submitted on the claim for the episode. Though therapy hours or visits are only adjusted with receipt of the claim at the end of the episode, both split percentage payments made for the episode are case-mixed adjusted based on Grouper software run by the HHAs, often incorporated in the HAVEN software supporting OASIS. Pricer software run by the contractors processing home health claims perform pricing, including wage index adjustments on both episode split percentage payments.

5. HHRG Updating. Since Outcome and Assessment Information Sets (OASIS) - B Supplemented - provides the core data elements necessary to classify a beneficiary into one of the 80 HHRGs, it must be updated upon: 1) start of care; 2) resumption of care after an inpatient stay; 3) follow-up or recertification for a new episode of care; or 3) transfer, discharge, or death of the beneficiary. Software programs are available for coding and validating OASIS data.

6. HHRG Reporting on Claim. Home health claims submitted for payment under PPS will be required to include a code that indicates the HHRG for the episode. However, the 6-character HHRG label will not be entered on the claim. Instead, a 5-character code called a "Health Insurance Prospective Payment System" or "HIPPS" code will be used. The HIPPS code indicates not only the HHRG to which the episode was assigned, but also which, if any, of the domains had OASIS items with missing or otherwise invalid data. Health Insurance Prospective Payment System (HIPPS) codes thus represent specific patient characteristics (or case-mix) on which TRICARE payment determinations are made. For HHAs, a specific set of these payment codes represents case-mix groups based on research into utilization and resource use patterns. They are used in association with special revenue codes used on CMS Form 1450 (UB-92) claim forms for institutional providers. Attached at Chapter 12, Addendum I is a worksheet that can be used in manually computing the HIPPS code from the original OASIS data.

a. Composition of HIPPS Codes for HHA PPS.

(1) The HIPPS Code is a distinct 5-position, alphanumeric code.

(a) The first position is a fixed letter "H" to designate home health, and does not correspond to any part of HHRG coding.

(b) The second, third and fourth positions of the code are a one-to-one crosswalk to the three domains of the HHRG coding system. The second through fourth positions of the HHA PPS HIPPS code will only allow alphabetical characters.

(c) The fifth position indicates which elements of the code were output from the Grouper based on complete OASIS data, or derived by the Grouper based on a system of defaults where OASIS data is incomplete. This position does not correspond to HHRGs since these codes do not differentiate payment groups depending on derived information. The fifth position will only allow numeric characters. Codes with a fifth position value other than "1" are produced from incomplete OASIS assessments not likely to be accepted by State OASIS repositories.

(d) The HHRG to HIPPS code crosswalk is summarized in Figure 12-4-5 below:

FIGURE 12-4-5 HHRG TO HIPPS CODE CROSSWALK

(CLINICAL) POSITION #2	(FUNCTIONAL) POSITION #3	(SERVICE) POSITION #4	POSITION #5	DOMAIN LEVEL
A (HHRG: C0)	E (HHRG: F0)	J (HHRG: S0)	1 = 2nd, 3rd & 4th positions computed	= min
B (HHRG: C1)	F (HHRG: F1)	K (HHRG: S1)	2 = 2nd position derived	= low
C (HHRG: C2)	G (HHRG: F2)	L (HHRG: S2)	3 = 3rd position derived	= mod
D (HHRG: C3)	H (HHRG: F3)	M (HHRG: S3)	4 = 4th position derived	= high
	I (HHRG: F4)		5 = 2nd & 3rd positions derived	= max
			6 = 3rd & 4th positions derived	
			7 = 2nd & 4th positions derived	
			8 = 2nd, 3rd & 4th positions derived	
		N thru Z	9, 0 (expansion values for future use)	

(2) The 80 HHRGs are represented in the claims system by 640 HIPPS codes - eight codes for each HHRG; but only one of the eight, with a final digit of "1", indicates a complete data set.

(3) The eight codes of a particular HHRG have the same case-mix weight associated with them. Therefore, all eight codes for that HHRG will be priced identically by the Pricer software.

(4) HIPPS codes created using this structure are only valid on claim lines with revenue code 023.

(5) Examples of HIPPS Codes:

(a) HAEJ1 would indicate a patient whose HHRG code is minimal clinical severity, minimal functional severity, and minimal service severity. All items in all domains had valid data, so all the codes were computed.

(b) HCFM5 would indicate a patient whose HHRG code is moderate clinical severity, low functional severity, and high service severity, and the codes for the functional and service domains were derived because some of the items in each of those domains had responses which were invalid.

(6) A complete list of HHRGs and corresponding HIPPS codes is presented at Chapter 12, Addendum J.

D. Grouper Linkage of Assessment with Payment.

1. HHAs are required to assess potential patients, and re-assess existing patients, using the OASIS (Outcome and Assessment Information Set) tool.

2. Grouper software determines the appropriate HHRG for payment of a HHA PPS 60-day episode from the results of an OASIS submission for a beneficiary as input, or "grouped" in this software. Grouper outputs HHRGs as HIPPS (Health Insurance Prospective Payment System) coding.

3. Grouper will also output a Claims-OASIS Matching Key, linking the HIPPS code to a particular OASIS submission, and a Grouper Version Number that is not used in billing.

4. Under HHA PPS, both the HIPPS code and the Claims-OASIS Matching Key will be entered on RAPs and claims.

E. Abbreviated Assessments for Establishment of Payments Under HHA PPS. Medicare-certified HHAs will be required to conduct abbreviated assessments for TRICARE beneficiaries who are under the age of eighteen or receiving maternity care for payment under the HHA PPS. This will require the manual completion and scoring of a Home Health Resource Group (HHRG) Worksheet (refer to Chapter 12, Addendum I for copy of worksheet). The HIPPS code generated from this scoring process will be submitted on the UB-92 for pricing and payment. This abbreviated 23 item assessment (as opposed to the full 79 item comprehensive assessment) will provide the minimal amount of data necessary for reimbursement under the HHA PPS. This is preferable, from an integrity standpoint, to dummying up the missing data elements on the comprehensive assessment. HHAs will also be responsible for collecting the OASIS data element links necessary in reporting the claims-OASIS matching key (i.e., the eighteen position code, containing the start of care date (eight positions, from OASIS item M0030), the date the assessment was completed (eight-positions, from OASIS item M0090), and the reason for assessment (two positions, from OASIS item M0100). The claims-OASIS matching key is reported in From Locator (FL) 44 of the UB-92.

1. The following hierarchy will be adhered to in the placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of eighteen or receiving maternity care. The MCSCs will adhere to this hierarchical placement through their role in establishing primary provider status under the HHA PPS (i.e., designating that HHA which may receive payment under the consolidated billing provisions for home health services provided under a plan of care.)

a. Authorization for care in and primary provider status designation for a Medicare certified HHA (i.e., in a HHA meeting all Medicare conditions of participation

[Sections 1861(o) and 1891 of the Social Security Act and part 484 of the Medicare regulation (42 CFR 484)] will result in payment of home health services under the PPS. The HHA will be reimbursed a fixed case-mix and wage-adjusted 60-day episode payment amount based on the HIPPS code generated from the required abbreviated assessment. For example, if there are two HHAs within a given treatment area that can provide care for a TRICARE beneficiary under the age of 18, and one is Medicare certified and the other is not due to its targeted patient population (HHA specializing solely in the home health needs of patients under the age of 18), the contractor will authorize care in, and designate primary provider status to, the Medicare HHA.

b. If a Medicare-certified HHA is not available within the service area, the MCSC may authorize care in a non-Medicare certified HHA (e.g., a HHA which has not sought Medicare certification/approval due to the specialized beneficiary categories it services - patients receiving maternity care and/or patients under the age 18) that qualifies for corporate services provider status under TRICARE (refer to the TRICARE Policy Manual, Chapter 11, Section 12.1, for the specific qualifying criteria for granting corporate services provider status under TRICARE.) The following payment provisions will apply to HHAs qualifying for coverage under the corporate services provider class:

(1) Otherwise covered professional services provided by TRICARE authorized individual providers employed by or under contract with a freestanding corporate entity will be paid under the TRICARE Maximum Allowable Charge (TMAC) reimbursement system, subject to any restrictions and limitations as may be prescribed under existing TRICARE Policy.

(2) Payment will also be allowed for supplies used by a TRICARE authorized individual provider employed by or contracted with a corporate services provider in the direct treatment of a TRICARE eligible beneficiary. Allowable supplies will be reimbursed in accordance with TRICARE allowable charge methodology as described in Chapter 5.

(3) Reimbursement of covered professional services and supplies will be made directly to the TRICARE authorized corporate services provider under its own tax identification number.

(4) There are also regulatory and contractual provisions currently in place that grant contractors the authority to establish alternative network reimbursement systems as long as they do not exceed what would have otherwise been allowed under Standard TRICARE payment methodologies.

F. Split Payments (Initial and Final Payments).

1. A split percentage approach has been taken in the payment of HHAs in order to minimize potential cash-flow problems.

a. A split percentage payment will be made for most episode periods. There will be two payments (initial and final) - the initial paid in response to a Request for Anticipated Payment (RAP), and the final in response to a claim. Added together, the initial and final payments equal 100 percent of the permissible reimbursement for the episode.

b. There will be a difference in the percentage split of initial and final payments for initial and subsequent episodes for patients in continuous care. For all initial episodes, the percentage split for the two payments will be 60 percent in response to the RAP, and 40 percent in response to the claim. For all subsequent episodes in periods of continuous care, each of the two percentage payments will equal 50 percent of the estimated case-mix adjusted episode payment. There is no set length required for a gap in services between episodes for a following episode to be considered initial rather than subsequent. If any gap occurs, the next episode will be considered initial for payment purposes.

c. The HHA may request and receive accelerated payment if the contractor fails to make timely payments. While a physician's signature is not required on the plan of care for initial payment, it is required prior to claim submission for final payment.

G. Calculation of Prospective Payment Amounts.

1. National 60-day Episode Payment Amounts.

a. Medicare, in establishment of its prospective payment amount, included all costs of home health services derived from audited Medicare cost reports for a nationally representative sample of home health agencies for FY 97. Base-year costs were adjusted using the latest available market basket increases between the cost reporting periods contained in the database and September 30, 2001. Total costs were divided by total visits in establishing an average cost per visit per discipline. The discipline specific cost per visit was then multiplied by the average number of visits per discipline provided within a 60-day episode of care in the establishment of a home health prospective payment rate per discipline. The 60-day utilization rates were derived from Medicare home health claims data for FY 97 and 98. The prospective payment rates for all 6 disciplines were summed to arrive at a total non-standardized prospective payment amount per 60-day episode of care.

b. Figure 12-4-6 provides the calculations involved in the establishment of the non-standardized prospective payment amount per 60-day episode in FY 2001, along with adjustments for non-routine medical supplies, Part B therapies and OASIS implementation and ongoing costs.

FIGURE 12-4-6 CALCULATION OF NATIONAL 60-DAY EPISODE PAYMENT AMOUNTS

DISCIPLINES	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	AVER. # VISITS PER 60-DAYS	HOME HEALTH PROSPECTIVE PAYMENT RATE
Home Health Aide Services	$ 5,915,395,602	141,682,907	$ 41.75	13.40	$ 559.45
Medical Social Services	458,571,353	2,985,588	153.59	0.32	49.15
Occupational Therapy	444,691,130	4,244,901	104.76	0.53	55.52
Physical Therapy	2,456,109,303	23,605,011	104.05	3.05	317.35
Skilled Nursing Services	12,108,884,714	127,515,950	94.96	14.08	1,337.04
Speech Pathology Service	223,173,331	1,970,399	113.26	0.18	20.39
Total Non-Standardized Prospective Payment Amount Per 60-day Episode for FY 2001: **$2,338.90**					

ADJUSTMENTS:	
1) Average cost per episode for non-routine medical supplies included in the home health benefit and reported as costs on the cost report	**$43.54**
2) Average payment per episode for non-routine medical supplies possibly unbundled and billed separately for Part B	**$6.08**
3) Average payment per episode for Part B therapies	**$17.76**
4) Average payment per episode for OASIS one time adjustment for form changes	**$5.50**
5) Average payment per episode for ongoing OASIS adjustment costs	**$4.32**
Total Non-Standardized Prospective Payment Amount for 60-day Episode for FY 2001 Plus Medical Supplies, Part B Therapies and OASIS	**$2,416.01**

C. The adjusted non-standardized prospective payment amount per 60-day episode for FY 2001 was adjusted as follows in Figure 12-4-7 for case-mix, budget neutrality and outliers in the establishment of a final standardized and budget neutral payment amount per 60-day episode for FY 2001.

FIGURE 12-4-7 STANDARDIZATION FOR CASE-MIX AND WAGE INDEX

NON-STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS	STANDARDIZATION FACTOR FOR WAGE INDEX AND CASE-MIX	BUDGET NEUTRALITY FACTOR	OUTLIER ADJUSTMENT FACTOR	STANDARDIZED PROSPECTIVE PAYMENT AMOUNT PER 60-DAYS
$2,416.01	0.96184	0.88423	1.05	**$2,115.30**

(1) The above 60-day episode payment calculations were derived using base-year costs and utilization rates and subsequently adjusted by annual inflationary update factors, the last three iterations of which can be found in Chapter 12, Addendum L (CY 2004), Addendum L (CY 2005), and Addendum L (CY 2006).

(2) The standardized prospective payment amount per 60-day episode of care is case-mix and wage-adjusted in determining payment to a specific HHA for a specific beneficiary. The wage adjustment is made to the labor portion (0.77668) of the standardized prospective payment amount after being multiplied by the beneficiary's designated HHRG case-mix weight. For example, a HHA serves a TRICARE beneficiary in Denver, CO. The HHA determines the patient is in HHRG C2F1S2 with a case-mix weight of 1.8496. The following steps are used in calculating the case-mix and wage-adjusted 60-day episode payment amount:

STEP 1: Multiply the standard 60-day prospective payment amount by the applicable case-mix weight.

(1.8496 x $2,115.30) = $3,912.46

STEP 2: Divide the case-mix adjustment episode payment into its labor and non-labor portions.

Labor Portion = (0.77668 x $3,912.46) = $3,038.73

Non-Labor Portion = (0.22332 x $3,912.46) = $873.73

STEP 3: Adjust the labor portion by multiplying by the wage index factor for Denver, CO.

(1.0190 x $3,038.73) = $3,096.47

STEP 4: Add the wage-adjusted labor portion to the non-labor portion to calculate the total case-mix and wage-adjusted episode payment.

($873.73 + $3,096.47) = $3,970.20

d. Since the initial methodology used in calculating the case-mix and wage adjusted 60-day episode payment amounts have not changed, the above example is still applicable using the updated wage indices and 60-day episode payment amounts (both the all-inclusive payment amount and per-discipline payment amount) contained in Chapter 12, Addendums L and M.

e. Annual Updating of HHA PPS Rates and Wage Indexes.

(1) In subsequent fiscal years, HHA PPS rates (i.e., both the national 60-day episode amount and per-visit rates) will be increased by the applicable home health market basket index change.

(2) Three iterations of these rates will be maintained in Chapter 12, Addendum L (CY 2004), Addendum L (CY 2005), and Addendum L (CY 2006). These rate adjustments are also integral data elements used in updating the Pricer.

(3) Three iterations of wage indexes will also be maintained in Chapter 12, Addendum M (FY 2004), Addendum M (CY 2005), and Addendum M (CY 2006) for computation of individual HHA payment amounts. These hospital wage indexes will lag behind by a full year in their application.

2. Calculation of Reduced Payments.

a. Under certain circumstances, payment will be less than the full 60-day episode rate to accommodate changes of events during the beneficiary's care. The start and end dates of each event will be used in the apportionment of the full-episode rate. These reduced payment amounts are referred to as: 1) partial-episode payment adjustments (PEP); 2) significant-change-in-condition payment adjustments (SCIC); 3) low utilization payment adjustments (LUPA); and 4) therapy threshold adjustments. Each of these payment reduction methodologies will be discussed in greater detail below.

NOTE: Since the basic methodology used in calculating HHA PPS adjustments (i.e., payment reductions for PEPs, SCICs, LUPAs and therapy thresholds) have not changed, the following examples are still applicable using the updated wage indices and 60-day episode payment amounts in Chapter 12, Addendums L and M.

(1) Partial-Episode Payment Adjustment (PEP). The PEP adjustment is used to accommodate payment for episodes of care less than 60 days resulting from one of the following intervening events: 1) beneficiary elected a transfer prior to the end of the 60-day

episode of care; or 2) beneficiary discharged after meeting all treatment goals in the original plan of care and subsequently readmitted to the same HHA before the end of the 60-day episode of care. The PEP adjustment is based on the span of days over which the beneficiary received treatment prior to the intervening event; i.e., the days, including the start-of-care date/first billable service date through and including the last billable service date, before the intervening event. The original plan of care must be terminated with no anticipated need for additional home health services. A new 60-day episode of care would have to be initiated upon return to a home health agency, requiring a physician's recertification of the plan of care, a new OASIS assessment, and authorization by the contractor. The PEP adjustment is calculated by multiplying the proportion of the 60-day episode during which the beneficiary was receiving care prior to the intervening event by the beneficiary's assigned 60-day episode payment. The PEP adjustment is only applicable for beneficiaries having more than four billable home health visits. Transfers of beneficiaries between HHAs of common ownership are only applicable when the agencies are located in different metropolitan statistical areas. Also, PEP adjustments do not apply in situations where a patient dies during a 60-day episode of care. Full episode payments are made in these particular cases. For example, a beneficiary assigned to HHRG C2F1S2 and receiving care in Denver, CO was discharged from a HHA on day 28 of a 60-day episode of care and subsequently returned to the same HHA on day 40. However, the first billable visit (i.e., a physician ordered visit under a new plan of care) did not occur until day 42. The beneficiary met the requirements for a PEP adjustment, in that the treatment goals of the original plan of care were accomplished and there was no anticipated need for home care during the balance of the 60-day episode. Since the last visit was furnished on day 28 of the initial 60-day episode, the PEP adjustment would be equal to the assigned 60-day episode payment times 28/60, representing the proportion of the 60 days that the patient was in treatment. Day 42 of the original episode becomes day 1 of the new certified 60-day episode. The following steps are used in calculating the partial-episode payment adjustment:

STEP 1: Calculate the proportion of the 60 days that the beneficiary was under treatment.

(28/60)= 0.4667

STEP 2: Multiply the beneficiary assigned 60-day episode payment amount by the proportion of days that the beneficiary was under treatment.

($3,970.20 x 0.4667) = $1,852.90

(2) Significant-Change-In-Condition (SCIC) Payment Adjustment. The full-episode payment amount is adjusted if the beneficiary experiences a significant change in condition during a 60-day episode that was not envisioned in the initial treatment plan. It reflects a proportional payment adjustment for both the time prior to and after the significant change in condition and results in the assignment of a new HHRG. The new HHRG is assigned based on the HHA's revised OASIS assessment, accompanied by appropriate changes in the physician's plan of care. The apportionment of payment is a two-part process. The first part involves determining the proportion of the 60-day episode prior to the significant change in condition and multiplying it by the original episode payment amount. The second part entails the multiplying of the remaining proportion of the 60-day episode

after the significant change in condition by the new episode payment level initiated through the certification and assessment process. For example, a Denver, CO HHA assigns a beneficiary to HHRG C2F1S2 that equals $3,970.20. The beneficiary's first billable day is day 1. The beneficiary experiences a significant change in condition on day 16. The last billable service day prior to the significant change in condition was day 18. The HHA completes a new OASIS assessment and obtains the necessary physician orders to change the case-mix assignment to HHRG C3F2S3, which equals $5,592.96. The HHA starts rendering services under the revised plan of care and at the new case-mix level on day 22. Days 1 through 18 are used in calculating the first part of the SCIC adjustment, while days 22 through 60 are used in calculating the second part of the SCIC adjustment. The following steps are used in calculating significant-change-in-condition payment adjustment:

STEP 1: Multiply the proportion of the 60-day episode before the SCIC by the original episode payment amount.

(Day 1 - Day 18) 18/60 x $3,970.20 = $1,191.06

STEP 2: Multiply the remaining proportion of the 60-day episode after the SCIC by the new episode payment amount.

(Day 22 - Day 60) 39/60 x $5,592.96 = $3,635.42

STEP 3: Add the episode payment amounts from Steps #1 & #2 above to obtain the total SCIC adjustment.

($1,191.06 + $3,635.42) = $4,826.48

(3) Low-Utilization Payment Adjustment (LUPA). The LUPA reduces the 60-day episode payments, or PEP amounts, for those beneficiaries receiving less than five home health visits during a 60-day episode of care. Payment for low-utilization episodes are made on a per-visit basis using the cost-per-visit rates by discipline calculated in Figure 12-4-1 plus additional amounts for: 1) nonroutine medical supplies paid under a home health plan of care; 2) nonroutine medical supplies possibly unbundled to Part B; 3) per-visit ongoing OASIS reporting adjustment; and 4) one-time OASIS scheduling implementation change. These cost-per-visit rates are standardized for wage index and adjusted for outliers to come up with final wage standardized and budget neutral per-visit payment amounts for 60-day episodes as reflected in Figure 12-4-8 below.

FIGURE 12-4-8 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for non-routine medical supplies*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Home Health Aide	$41.75	$1.94	$0.12	$0.21	0.96674	1.05	$43.37

*** Combined average cost per-visit amounts for non-routine medical supplies reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.**

FIGURE 12-4-8 PER VISIT PAYMENT AMOUNTS FOR LOW-UTILIZATION PAYMENT ADJUSTMENTS

Home health discipline type	Average cost per visit from the PPS audit sample	Average cost per visit for non-routine medical supplies*	Average cost per visit for ongoing OASIS adjustment costs	Average cost per visit for one-time OASIS scheduling change	Standardization factor for wage index	Outlier adjustment factor	Per-visit payment amounts per 60-day episode for FY 2001
Medical Social	153.59	1.94	0.12	0.21	0.96674	1.05	153.55
Physical Therapy	104.05	1.94	0.12	0.21	0.96674	1.05	104.74
Skilled Nursing	94.96	1.94	0.12	0.21	0.96674	1.05	95.79
Speech Pathology	113.26	1.94	0.12	0.21	0.96674	1.05	113.81
Occupational Therapy	104.76	1.94	0.12	0.21	0.96674	1.05	105.44

*** Combined average cost per-visit amounts for non-routine medical supplies reported as costs on the cost report and those which could have been unbundled and billed separately to Part B.**

The per-visit rates per discipline are wage-adjusted but not case-mix adjusted in determining the LUPA. For example, a beneficiary assigned to HHRG C2L1S2 and receiving care in a Denver, CO, HHA has one skilled nursing visit, one physical therapy visit and two home health visits. The per-visit payment amount (obtained from Figure 12-4-3 above) is multiplied by the number of visits for each discipline and summed to obtain an unadjusted low-utilization payment amount. This amount is then wage-adjusted to come up with the final low-utilization payment adjustment. The following steps are used in calculating the low-utilization payment adjustment:

NOTE: Since the basic methodology used in calculating HHA PPS outliers has not changed, the following example is still applicable using the updated wage indices, 60-day episode payment amounts and fixed dollar loss amounts in Chapter 12, Addendums L, M, and N.

STEP 1: Multiple the per-visit rate per discipline by the number of visits and add them together to get the total unadjusted low-utilization payment amount.

Skilled nursing visits (1 x $95.79)	=	$ 95.79
Physical therapy visits (1 x $104.74)	=	$104.74
Home health aide visits (2 x $43.37)	=	$ 86.74
Total unadjusted payment amount		$287.27

STEP 2: Multiply the unadjusted payment amount by its labor and non-labor related percentages to get the labor and non-labor portion of the payment amount.

Labor Portion	=	($287.27 x 0.77668)	=	$223.12
Non-labor Portion	=	($287.27 x 0.22332)	=	$64.15

STEP 3: Multiply the labor portion of the payment amount by the wage index for Denver, CO.

($223.12 x 1.0190) = $227.36

STEP 4: Add the labor and non-labor portions together to arrive at the low-utilization payment adjustment.

($227.36 + $64.15) = $291.51

(4) Therapy Threshold Adjustment. There is a downward adjustment in the 60-day episode payment amount if the number of therapy services delivered during an episode does not meet the threshold. The total case-mix adjusted episode payment is based on the OASIS assessment and the therapy hours provided over the course of the episode. The number of therapy hours projected on the OASIS assessment at the start of the episode, entered in OASIS, is confirmed by the visit information submitted in line-item detail on the claim for the episode. If therapy use is below the utilization threshold (i.e., the projected range of hours for physical, occupational or speech therapy combined), there is an automatic downward adjustment in the 60-day episode payment amount.

3. Calculation of Outlier Payments.

a. A methodology has been established under the HHA prospective payment system to allow for outlier payments in addition to regular 60-day episode payments for beneficiaries generating excessively large treatment costs. The outlier payments under this methodology are made for those episodes whose estimated imputed costs exceed the predetermined outlier thresholds established for each HHRG. Outlier payments are not restricted solely to standard 60-day episodes of care. They may also be extended for atypically costly beneficiaries who qualify for SCIC or PEP payment adjustments under the HHA prospective payment system. The outlier threshold amount for each HHRG is calculated by adding a fixed dollar loss amount, which is the same for all case-mix groups (HHRGs), to the HHRG's 60-day episode payment amount. A fixed dollar loss amount is also added to the PEP and SCIC adjustment payments in the establishment of PEP and SCIC outlier thresholds.

b. The outlier payment amount is a proportion of the wage-adjusted estimated imputed costs beyond the wage-adjusted threshold. The loss-sharing ratio is the proportion of additional costs paid as an outlier payment. The loss-sharing ratio, along with the fixed dollar loss amount, is used to constrain outlier costs to 5 percent of total episode payments. The estimated imputed costs are derived from those home health visits actually ordered and received during the 60-day episode. The total visits per discipline are multiplied by their national average per-visit amounts (refer to Figure 12-4-4 above for the calculation of national average per-visit amounts) and are wage-adjusted. The wage-adjusted imputed costs for each discipline are summed to get the total estimated wage-adjusted imputed costs for the 60-day episode of care. The outlier threshold is then subtracted from the total wage-adjusted imputed per visit costs for the 60-day episode to come up with the imputed costs in excess of the outlier threshold. The amount in excess of the outlier threshold is multiplied by 80 percent (i.e., the loss share ratio) to obtain the outlier payment. The HHA receives both the 60-day episode and outlier payment. For example, a beneficiary assigned to HHRG C2L2S2

[case-mix weight of 1.9532 and receiving HHA care in Missoula, MT (wage index of 0.9086)], has physician orders for and received 54 skilled nursing visits, 48 home health aide visits and 6 physical therapy visits. The following steps are used in calculating the outlier payment:

(1) Calculation of Case-Mix and Wage-Adjusted Episode Payment.

STEP 1: Multiply the case-mix weight for HHRG C2L2S2 by the standard 60-day prospective episode payment amount.

(1.9532 x $2,115.30) = $4,131.61

STEP 2: Divide the case-mix-adjusted episode payment amount into its labor and non-labor portions.

Labor Portion = (.77668 x $4,131.61) = $3,208.94
Non-labor Portion = (.22332 x $4,131.61) = $922.68

STEP 3: Multiply the labor portion of the case-mix adjusted episode payment by the wage index factor for Missoula, MT.

(0.9086 x $3,208.94) = $2,915.64

STEP 4: Add the wage-adjusted labor portion to the non-labor portion to get the total case-mix and wage-adjusted 60-day episode payment amount.

($2,915.64 + $922.68) = $3,838.32

(2) Calculation of the Wage-adjusted Outlier Threshold.

STEP 1: Multiply the 60-day episode payment amount by the fixed dollar loss ratio (1.13) to come up with the fixed dollar loss amount.

($2,115.30 x 1.13) = $2,390.29

STEP 2: Divide the fixed dollar loss amount into its labor and non-labor portions.

Labor Portion = (.77668 x $2,390.29) = $1,856.49
Non-labor Portion = (.22332 x $2,390.29) = $533.80

STEP 3: Multiply the labor portion of the fixed dollar loss amount by the wage index for Missoula, MT (0.9086).

(0.9086 x $1,856.49) = $1,686.80

STEP 4: Add back the non-labor portion to the wage-adjusted labor portion to get the total wage-adjusted fixed dollar loss amount.

($1,686.80 + $533.80) = $2,220.60

STEP 5: Add the case-mix and wage-adjusted 60-day episode payment amount to the wage-adjusted fixed dollar amount to obtain the wage-adjusted outlier threshold.

($3,838.32 + $2,220.60) = $6,058.92

(3) Calculation of Wage-Adjusted Imputed Cost of 60-day Episode.

STEP 1: Multiply the total number of visits by the national average cost per visit for each discipline to arrive at the imputed costs per discipline over the 60-day episode.

Skilled Nursing Visits	(54 x $95.79)	= $5,172.66
Home Health Aide Visits	(48 x $43.37)	= $2,081.76
Physical Therapy Visits	(6 x $104.74)	= $628.44

STEP 2: Calculate the wage-adjusted imputed costs by dividing the total imputed cost per discipline into their labor and non-labor portions and multiplying the labor portions by the wage index for Missoula, MT (0.9086) and adding back the non-labor portions to arrive at the total wage-adjusted imputed costs per discipline.

1 Skilled Nursing Visits

a Divide total imputed costs into their labor and non-labor portions.

Labor Portion	= (.77668 x $5,172.66)	=	$4,017.50
Non-labor Portion	= (.22332 x $5,172.66)	=	$1,155.16

b Wage-adjusted labor portion of imputed costs.

($4,017.50 x 0.9086) = $3,650.30

c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for skilled nursing visits.

($3,650.30 + $1,155.16) = $4,805.46

2 Home Health Aide Visits

a Divide total imputed costs into their labor and non-labor portions.

Labor Portion = (.77668 x $2,081.76) = $1,616.86
Non-labor Portion = (.22332 x $2,081.76) = $464.90

b Wage-adjusted labor portion of imputed costs.

($1,616.86 x 0.9086) = $1,469.08

c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

($1,469.08 + $464.90) = $1,933.98

3 Physical Therapy Visits

a Divide total imputed costs into their labor and non-labor portions.

Labor Portion = (.77668 x $628.44) = $488.10
Non-labor Portion = (.22332 x $628.44) = $140.34

b Wage-adjusted labor portion of imputed costs.

($488.10 x 0.9086) = $443.49

c Add back non-labor portion to wage-adjusted labor portion of imputed costs to come up with the total wage-adjusted imputed costs for home health aide visits.

($443.49+ $140.34) = $583.83

STEP 3: Add together the wage-adjusted imputed costs for the skilled nursing, home health aide and physical therapy visits to obtain the total wage-adjusted imputed costs of the 60-day episode.

($4,805.46 + $1,933.98 + $583.83) = $7,323.27

(4) Calculation of Outlier Payment.

STEP 1: Subtract the outlier threshold amount from the total wage-adjusted imputed costs to arrive at the costs in excess of the outlier threshold.

($7,323.27 - $6,058.92) =$1,264.35

STEP 2: Multiply the imputed cost amount in excess of the HHRG threshold amount by the loss sharing ratio (80 percent) to arrive at the outlier payment.

($1,264.35 x 0.80) = $1,018.68

(5) Calculation of Total Payment to HHA.

(a) Add the outlier payment amount to the case-mix and wage-adjusted 60-day episode payment amount to obtain the total payment to the HHA.

($3,838.32 + $1,018.68) = $4,857.00

H. Other Health Insurance (OHI) Under HHA PPS.

Payment under the HHA PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see Chapter 12, Section 6). However, if the beneficiary has other health insurance (OHI) which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing HHA claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

- END -