HCFA Publishes Final Home Health PPS Rule

by Donald D. Asmonga

The Health Care Financing Administration (HCFA) published the final rule for the prospective payment system (PPS) for home health agencies in July. This rule, which takes effect October 1, 2000, replaces the retrospective reasonable-cost-based system used to pay for home health services under Medicare parts A and B.

According to HCFA, the following is required under the home health PPS:

- Medicare will pay home health agencies for each covered 60-day episode of care. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. Payments cover skilled nursing and home-health aide visits, covered therapy, medical social services, and supplies.
- Medicare will pay home health agencies at a higher rate to care for those beneficiaries with greater needs. Payment rates are based on relevant data from patient assessments conducted by clinicians as already required for all Medicare-participating home health agencies.
- For each 60-day episode, the payment system will use national payment rates (ranging from approximately $1,100 to $5,900, depending on the intensity of care required by each beneficiary) with adjustments to reflect area wage differences.
- Agencies will receive additional payments for an individual beneficiary if the cost of care was significantly higher than the specified payment rate. Such "outlier" payments should account for the unusual resource needs of specific beneficiaries.
- To ensure agencies receive adequate up-front payment, HCFA will pay 60 percent of the initial episode payment when the agency first accepts a new Medicare patient as part of a streamlined approval process. Agencies will receive the remaining 40 percent at the end of the first 60-day episode. For subsequent episodes, payments will be divided equally between the beginning and end of the episode.
- Payment rates will be adjusted to reflect significant changes in a patient's condition during each Medicare-covered episode of care.
- Home health agencies will receive less than the full 60-day episode rate if they provide only a minimal number of visits to beneficiaries.
- Medicare will pay home health agencies and other suppliers separately for medically necessary durable medical equipment provided under the home health plan. In the Balanced Budget Refinement Act of 1999, Congress eliminated an earlier law that would have required agencies to bill for this equipment even if outside suppliers provided it.
- To ensure agencies provide adequate services to beneficiaries, HCFA will conduct extensive medical review to obtain early feedback on common errors, vulnerabilities, and trends. HCFA also will monitor the quality of patient care using information from the comprehensive patient assessments already used by agencies.

AHIMA's Comments Influence Final Rule

In response to the original proposed rule, one of AHIMA's comments addressed the OASIS diagnosis-reporting requirement that only permits three-digit ICD-9-CM category codes to be reported. AHIMA contended that allowing only the three-digit ICD-9-CM category code violates official coding guidelines. Further, AHIMA argued that this adversely affects clinical severity data and hinders the design of the home health classification system.

In the final rule, HCFA agreed that "a lack of specificity in code assignment somewhat diminishes accurate case-mix development and ascertainment. To help rectify the situation, we urge agencies to voluntarily code to the complete the four-digit or five-digit code level."

For more information about the final rule, visit www.access.gpo.gov. Future issues of the *Journal of AHIMA* will provide further analysis of the home health PPS final rule.

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