| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-02 Medicare Benefit Policy | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 10738** | **Date: May 7, 2021** |
| | **Change Request 12218** |

**SUBJECT: Home Health Manual Update to Implement Calendar Year 2021 Request for Anticipated Payment Policies and Corrections to Certification and Recertification for Home Health Beneficiaries**

**I. SUMMARY OF CHANGES:** This Change Request (CR) updates the Medicare Benefit Policy Manual, Publication 100-02, chapter 7 with Request for Anticipated (RAP) payment policy updates and corrections regarding who may sign the certification and recertification for home health beneficiaries.

**EFFECTIVE DATE: January 1, 2021**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 9, 2021**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 7/Table of Contents |
| R | 7/10.4/Split Percentage Payment Approach to the 30-Day Period Unit of Payment |
| R | 7/10.5/Requirements for Submission of "No-Pay" RAPs |
| R | 7/30.5.3/Who May Sign the Certification or Recertification |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-02 | Transmittal: 10738 | Date: May 7, 2021 | Change Request: 12218 |
|---|---|---|---|

**SUBJECT: Home Health Manual Update to Implement Calendar Year 2021 Request for Anticipated Payment Policies and Corrections to Certification and Recertification for Home Health Beneficiaries**

**EFFECTIVE DATE: January 1, 2021**
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## I. GENERAL INFORMATION

**A. Background:** Section 1895(b)(2) of the Social Security Act ("the Act"), as amended by section 51001(a) of the Bipartisan Budget Act of 2018 (BBA of 2018), required Medicare to change the unit of payment under the Home Health Prospective Payment System (HH PPS) from 60 days to 30 days. The statutorily required provisions in the BBA of 2018 resulted in the Patient-Driven Groupings Model, or (PDGM). Beginning on January 1 2020, home health agencies (HHAs) are paid a national, standardized 30-day period payment rate if a period of care meets a certain threshold of home health visits. This payment rate is adjusted for case-mix and geographic differences in wages. 30-day periods of care that do not meet the visit threshold are paid a per-visit payment rate for the discipline providing care. Under the HH PPS, Medicare makes a split-percentage payment for most 30-day periods of care. The first payment is made in response to a RAP submitted at the beginning of the period of care and a second payment is made in response to a final claim submitted at the end of the 30-day period of care. Added together, the first and second payment equal 100 percent of the permissible payment for the 30-day period.

Given a change in the unit of payment to a 30-day period, CMS finalized a phased-out approach of the split-percentage payment. In the Calendar Year (CY) 2019 HH PPS final rule with comment period, CMS finalized that newly-enrolled HHAs, that is HHAs certified for participation in Medicare effective on or after January 1, 2019, will not receive split percentage payments beginning in CY 2020 (83 FR 56463). Those HHAs are still required to submit a RAP at the beginning of a period of care in order to establish the home health period of care, as well as every 30 days thereafter; however, but no payment will be associated with the RAP submission.

In the CY 2020 HH PPS final rule with comment period (84 FR 60478), CMS finalized additional changes to the split-percentage payment approach. Specifically, CMS finalized:

(1) A reduction in the upfront amount paid in response to a RAP to 20 percent of the estimated final payment amount for both initial and subsequent 30-day periods of care for CY 2020;

(2) A reduction to the up-front amount paid in response to a RAP to zero percent of the estimated final payment amount for both initial and subsequent 30-day periods of care with a late submission penalty for failure to submit the RAP within 5 calendar days of the start of care for the first 30-day period within a 60-day certification period and within 5 calendar days of day 31 for the second, subsequent 30- day period in a 60-day certification period for CY 2021.

Payment for the 30-day period of care will be paid with the submission of a final claim.

**Certification or Recertification**

Section 3708 amended Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) to allow clinical nurse specialists, physician's assistants, and nurse practitioners (allowed practitioners) to certify eligibility and order services under the Medicare home health benefit. In the January 1, 2021 benefit policy manual update, CMS incorporated "allowed practitioners" into the home health policy manual language allowing

them to certify and order home health services. We erroneously included language limiting who may sign the plan of care to physicians and allowed practitioners in the same group practice, when a certifying physician or allowed practitioner is unavailable. We are correcting this language to indicate that such physician or non-physician practitioner must be authorized to care for the certifying physician's or allowed practitioner's patients in his/her absence; however, do not have to be in the same group practice as the certifying physician or allowed practitioner.

**B. Policy:** The split-percentage payment was reduced to zero percent for all HHAs and for all 30-day periods of care beginning on or after January 1, 2021. In instances where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549).

Submission of the zero pay RAP can be done when the following criteria have been met:

1. The appropriate physician's written or verbal order that sets out the services required for the initial visit has been received and documented, as required in regulation at 42 CFR 484.60(b) and 42 CFR 409.43(d);
2. The initial visit within the 60-day certification period must have been made and the individual admitted to home health care.

Additionally, for CY 2021, there will be a non-timely submission payment reduction when the HHA does not submit the RAP within 5 calendar days from the start of care date ("admission date" and "from date" on the claim will match the start of care date) for the first 30-day period of care in a 60-day certification period and within 5 calendar days of the "from date" for the second 30-day period of care in the 60-day certification period. This reduction in payment will be equal to a 1⁄30th reduction to the wage and case-mix adjusted 30-day period payment amount for each day from the home health start of care date/admission date, or "from date" for subsequent 30-day periods, until the date the HHA submits the RAP. In other words, the 1/30th reduction would be to the 30-day period payment amount, including any outlier payment, that the HHA otherwise would have received absent any reduction.

For Low Utilization Payment Adjustments (LUPAs) 30-day periods of care in which an HHA fails to submit a timely RAP, no LUPA per-visit payments would be made for visits that occurred on days that fall within the period of care prior to the submission of the RAP. The payment reduction cannot exceed the total payment of the claim. The payment reduction for the late submission of a RAP can be waived for exceptional circumstances as outlined in regulation at 42 CFR 484.205(i)(3).

For more information on claims processing for RAPs, view CR 11855- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation.

**Certification or Recertification**

The home health conditions of participation (CoPs) do not prohibit HHAs from accepting orders from multiple physicians, and with the recent statutory change, nurse practitioners, physician assistants, and clinical nurse specialists (i.e., allowed practitioners). The HHA is ultimately responsible for the plan of care, which includes assuring communication with all physicians and allowed practitioners involved in the plan of care and integrating orders from all physicians/allowed non-physician practitioners involved in the plan to assure the coordination of all services and interventions provided to the patient. This responsibility extends to a physician or other allowed non-physician practitioner, other than the certifying physician or allowed non-physician practitioner who established the home health plan of care, who signs the plan of care or the recertification statement in the absence of the certifying physician or allowed non-physician practitioner. This is only permitted when such physician or non-physician practitioner has been authorized to care for his/her patients in his/her absence. The HHA is responsible for ensuring that the physician or allowed non-physician practitioner who signs the plan of care and recertification statement was authorized

by the physician or allowed non-physician practitioner who established the plan of care and completed the certification for his/her patient in his/her absence.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 12218.1 | The contractors shall be aware of the manual changes to publication 100-02, chapter 7, Home Health Services. | | | X | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information: N/A**

## V. CONTACTS

**Pre-Implementation Contact(s):** Amanda Barnes, 443-651-1207 or amanda.barnes@cms.hhs.gov.
**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

# Medicare Benefit Policy Manual
## Chapter 7 - Home Health Services

**Table of Contents**
***(Rev.10738, Issued: 05-07-21)***

## 10.4 - Split Percentage Payment Approach to the 30-Day *Period* Unit of Payment

***(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)***

The HH PPS has set forth a split percentage payment approach to the 30-day unit of payment in calendar year (CY) 2020 only. For each 30-day period in CY 2020, there will be a 20/80 split percentage payment. That is, there will be a split percentage payment of 20 percent at the beginning of each 30-day period and a final percentage payment of 80 percent at the end of each 30-day period, unless there is an applicable adjustment, such as a low-utilization payment adjustment (LUPA).

For CY 2020, HHAs initially certified for participation in Medicare on or after January 1, 2019, do not receive split-percentage payments but will submit "no-pay" RAPs at the beginning of every 30-day period and will receive a final payment with a claim submission at the end of each 30-day period, unless there is an applicable adjustment.

*For CY 2021, all HHAs will submit a ''no pay'' RAP at the beginning of each 30-day period to allow the beneficiary to be claimed in the CWF and also to trigger the consolidated billing edits. This means that existing HHAs (those certified for participation in Medicare on or before December 31, 2018) will have their initial split-percentage payment reduced from 20 percent in CY 2020 to zero percent in CY 2021 for all 30-day periods of care and will submit a ''no-pay'' RAP for all 30-day periods of care in CY 2021. Newly enrolled HHAs (those certified for participation in Medicare on or after January 1, 2019) will continue to submit ''no-pay'' RAPs at the beginning of a 30-day period of care in order to establish the home health period of care, as well as every 30 days thereafter in CY 2021.*

*Where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the beneficiary, the HHA may submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification or a 60-day recertification) at the same time to help further reduce provider administrative burden.*
*Additionally, for CY 2021, there will be a non-timely submission reduction in payment amount tied to late submission of any ''no-pay'' RAPs when the HHA does not submit the RAP within 5 calendar days from the start of care date for the first 30-day period of care in a 60-day certification period and within 5 calendar days of day 31 for the second 30-day period of care in the 60-day certification period.*

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing" for requirements regarding split-percentage payments and RAP submissions.

## 10.5 – *Requirements for Submission of "No-Pay" RAPs*

***(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)***

*For CY 2021, submission of ''no-pay'' RAPs can be made when the following criteria have been met:*

*(1) The appropriate physician's or allowed practitioner's written or verbal order that sets out the services required for the initial visit has been received and documented as required at §§ 484.60(b) and 409.43(d);*

*(2) The initial visit within the 60-day certification period must have been made and the individual admitted to home health care.*

## 30.5.3 - Who May Sign the Certification or Recertification

***(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)***

The physician or allowed practitioner who signs the certification or recertification must be permitted to do so by 42 CFR 424.22. A physician or other allowed non-physician practitioner, *other than the certifying physician or certifying allowed practitioner who established the home health plan of care, may sign the plan*

*of care or the recertification statement in the absence of the certifying physician or certifying allowed practitioner. This is only permitted when such physician or allowed non-physician practitioner has been authorized to care for the certifying physician's or allowed practitioner's patients in his/her absence. The HHA is responsible for ensuring that the physician or allowed non-physician practitioner who signs the plan of care and recertification statement was authorized by the physician or allowed practitioner who established the plan of care and completed the certification for his/her patient in his/her absence.* The physician or allowed practitioner that performed the required face-to-face encounter must sign the certification of eligibility, unless the patient is directly admitted to home health care from an acute or post-acute care facility and the encounter was performed by a physician or allowed practitioner in such setting.