CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11296	**Date: March 25, 2022**
	Change Request 12615

SUBJECT: Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02)

I. SUMMARY OF CHANGES: This Change Request (CR) updates the Medicare Benefit Policy Manual, Publication 100-02, Chapter 7 to incorporate Calendar Year 2022's Policy Implementation of the Notice of Admission (NOA), eliminates the Request for Anticipated Payment (RAP) policy, and provides corrections and clarifications regarding who may sign the certification and recertification for home health beneficiaries.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 26, 2022
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/Submission of the Notice of Admission (NOA)
R	7/10.5/Requirements for Submission of NOA
R	7/30.2.1/Definition of an Allowed Practitioner

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: 11296	Date: March 25, 2022	Change Request: 12615

SUBJECT: Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02)

EFFECTIVE DATE: January 1, 2022
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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.

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 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 that HHAs shall no longer submit Requests for Anticipated Payment (RAPs) for any home health period of care with a from date on or after January 1, 2022. Instead, for each admission to home health, the HHA notifies Medicare systems via submission of a one-time Notice of Admission (NOA). There is no upfront payment with submission of the NOA. Payment for each 30-day period of care will be paid with the submission of a final claim.

Section 3708 of the CARES Act 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. We are adding clarifying language to the definition of "allowed practitioners" in order to make clear that nurse practitioners and clinical nurse specialists acting as "allowed practitioners" under the Medicare home health benefit must work in collaboration with a physician, as well as in accordance with state practice laws.

B. Policy: <u>NOA</u>

Beginning on or after January 1, 2022, RAPs will be replaced with the one-time NOA. NOAs must be submitted timely. That is, the NOA must be submitted within 5 calendar days from the start of care date, to establish that the beneficiary is under a Medicare home health period of care and also to trigger home health consolidated billing edits required under section 1842(b)(6)(F) of the Act.

Only one NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims for that beneficiary.

Submission of the NOA can be done when the following criteria have been met:

1. The appropriate physician 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 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.

In instances where an NOA is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payment, by the number of days from the home health admission date to the date the NOA is submitted to, and accepted by, the A/B MAC (home health and hospice (HHH)), divided by 30. No Low Utilization Payment Adjustment per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

If an HHA fails to file a timely NOA, it may request an exception, which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;

2. an event that produces a data filing problem due to a CMS or A/B MAC HHH systems issue that is beyond the control of the HHA;

3. a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC HHH; or,

4. other circumstances determined by the A/B MAC HHH or CMS to be beyond the control of the HHA.

For more information on claims processing for NOA, view CR 12256- Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) – Manual Instructions- https://www.cms.gov/files/document/mm12256.pdf.

Definition of Allowed Practitioners

Allowed practitioners are defined at § 484.2 as a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined at this part. NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs such services. PA means an individual as defined at §410.74(a) and (c). Clinical nurse specialist means an individual as defined at §410.76(a) and (b), and who is working in collaboration with the physician as defined at §410.76(c)(3). NP means an individual as defined at §410.75(a) and (b), and who is working in collaboration with the physician as defined at §410.75(c)(3). Individual states have varying requirements for conditions of practice, which determine whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required; however, a CNS and NP must work in collaboration with a physician in accordance with sections 410.76(c) and 410.75(c) even if state laws governing collaboration do not exist.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility			
		A/B MAC	DME	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12615.1	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		
12615.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			X		

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. 11296, Issued: 03-25-22)

10.4 – *Submission of the Notice of Admission (NOA)*

(Rev.11296, Issued: 03-25-22, Effective: 01-01-22, Implementation: 05-26-22)

Beginning January 1, 2022, HHAs will no longer submit Requests for Anticipated Payment (RAPs). Instead, for each admission to home health, the HHA notifies Medicare systems via submission of an NOA. The NOA is a one-time submission to establish that the beneficiary is under a home health period of care and trigger home health consolidated billing edits. The NOA covers contiguous 30-day periods of care until the individual is discharged from Medicare home health services. There is no upfront payment with the submission of the NOA.

The NOA must be submitted timely. All HHAs must submit an NOA to their Medicare contractor within 5 calendar days from the start of care date to establish that the beneficiary is under a Medicare home health period of care and also to trigger home health consolidated billing edits required under section 1842(b)(6)(F) of the Act. For example, if the start of care date is January 1, 2022, the NOA would be considered timely-filed if it is submitted on or before January 6, 2022.

Example:

1/1/2022 = Day 0 (start of the first 30- day period of care)

1/6/2022 = Day 5 (An NOA submitted on or before this date would be considered ‘‘timely-filed’’.)

1/7/2022 and after = Day 6 and beyond (An NOA submitted on and after this date would be considered untimely and would trigger the penalty.)

In instances where an NOA is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payments, by the number of days from the home health admission date until the date the NOA is submitted to, and accepted by, the A/B MAC (HHH), divided by 30. No LUPA per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

CMS may waive the consequences of failure to submit a timely-filed NOA if it is determined that a circumstance encountered by a home health agency is exceptional and qualifies for waiver of the consequence. An exceptional circumstance may be due to, but is not limited to the following:

• Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the home health agency’s ability to operate.

• A CMS or Medicare contractor systems issue that is beyond the control of the home health agency.

• A newly Medicare-certified home health agency that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.

• Other situations determined by CMS to be beyond the control of the home health agency.

If an HHA believes that there is a circumstance that may qualify for an exception, the HHA must fully document and furnish any requested documentation to their MAC for a determination of exception.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, “Home Health Agency Billing” for requirements regarding the notice of admission process.

10.5 - *Requirements for Submission of the NOA*

(Rev.11296, Issued: 03-25-22, Effective: 01-01-22, Implementation: 05-26-22)

For CY 2022, submission of the NOA 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.

30.2.1 – Definition of an Allowed Practitioner

(Rev.11296, Issued: 03-25-22, Effective: 01-01-22, Implementation: 05-26-22)

Allowed practitioners in addition to physicians, can certify and recertify beneficiaries for eligibility, order home health services, and establish and review the care plan. Allowed practitioners are defined at § 484.2 as a physician assistant *(PA)*, nurse practitioner *(NP)*, or clinical nurse specialist *(CNS) as* defined at this part. NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs such services. *Physician assistant means an individual as defined at § 410.74(a) and (c). Clinical nurse specialist means an individual as defined at § 410.76(a) and (b), and who is working in collaboration with the physician as defined at § 410.76(c)(3). Nurse practitioner means an individual as defined at § 410.75(a) and (b), and who is working in collaboration with the physician as defined at § 410.75(c)(3).* Individual states have varying requirements for conditions of practice, which determine whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required*; however, a CNS and NP must work in collaboration with a physician in accordance with §§ 410.76(c) and 410.75(c) even if state laws governing collaboration do not exist*.