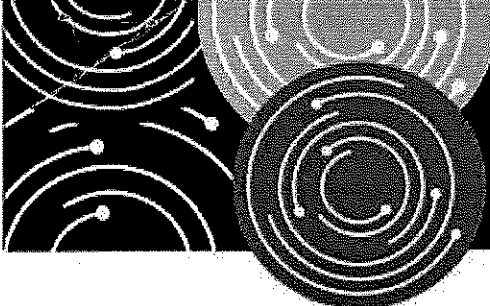

Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation

MLN Matters Number: MM11855	Related Change Request (CR) Number: 11855
Related CR Release Date: July 31, 2020	Effective Date: January 1, 2021
Related CR Transmittal Number: R10254CP	Implementation Date: January 4, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Home Health Agencies (HHAs) who wish to bill Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article informs you about the implementation of the Calendar Year (CY) 2021 Home Health (HH) Request for Anticipated Payment (RAP) payment policies. Please be sure your billing staffs are aware of these changes.

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), requires Medicare to change the unit of payment under the Home Health Prospective Payment System (HH PPS) from 60 days to 30 days.

- Under the HH PPS, Medicare makes a split-percentage payment for most 60-day episodes/30-day periods of care.
- The first payment is made in response to a RAP submitted at the beginning of the episode/period of care and a second payment is made in response to a final claim submitted at the end of the 60-day episode/30-day period of care.
- Added together, the first and second payment equal 100 percent of the permissible payment for the episode/30-day period.

The RAP also serves a greater operational role for the Medicare program by establishing the beneficiary's primary HHA in the Common Working File (CWF), so that the claims processing system can reject claims from providers or suppliers, other than the primary HHA, for the services and items subject to consolidated billing.

In the CY 2019 HH PPS final rule with comment period, the Centers for Medicare & Medicaid Services (CMS) finalized that HHAs certified for participation in Medicare effective on or after January 1, 2019 (newly enrolled), 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 HH period of care, as well as every 30 days thereafter, but no payment will be associated with the RAP submission.

In the CY 2020 HH PPS final rule with comment period, CMS finalized that HHAs that were certified for participation in Medicare with effective dates prior to January 1, 2019 (existing HHAs), would continue to receive split-percentage payments upon implementation of the Patient-Driven Groupings Model (PDGM) and the change to a 30-day unit of payment in CY 2020, but the up-front payment would be decreased from 60/50 percent to 20 percent (84 FR 60548).

Starting in CY 2021, the split-percentage payment would be lowered to 0 percent for all HHAs (newly enrolled and existing). However, all HHAs would still be required to submit a RAP at the beginning of each 30-day period of care (84 FR 60548). Since no payment will be associated with the submission of the RAP in CY 2021, HHAs are to submit the RAP when:

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 at 42 Code of Federal Regulations (CFR) Sections 484.60(b) and 409.43(d); and
2. The initial visit within the 60-day certification period has been made and the individual is admitted to HH care (84 FR 60548)

The information needed for submission of the RAP in CY 2021 will mirror the one-time Notice of Admission (NOA) process, also finalized in the CY 2020 HH PPS final rule with comment period, starting in CY 2022 (84 FR 60549).

In instances where the plan of care dictates multiple 30-day periods of care will be required to effectively treat the beneficiary, HHAs will be allowed to submit RAPs for both the first and second 30-day periods of care (for a 60-day certification) at the same time to help further reduce provider administrative burden (84 FR 60549).

Also 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 HH start of care date/admission date, or "from date" for subsequent 30-day periods, until the date the HHA submits the RAP. 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 Adjustment (LUPA) 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 regulations at 42 CFR 484.205(i)(3).

MACs will accept the KX modifier when reported with the Health Insurance Prospective Payment System (HIPPS) code on the revenue code 0023 line of Type of Bill (TOB) 032x (other than 0322 and 0320) as an indicator that an HHA requests an exception to the late RAP penalty. The HHA should provide sufficient information in the Remarks section of its claim to allow the MAC to research the exception request. If the remarks are not sufficient, the MAC will request documentation from the HHA.

The four circumstances that may qualify the HHA for an exception to the consequences of filing the RAP more than 5 calendar days after the HH period of care From date 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 MAC 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 MAC
4. Other circumstances determined by the MAC or CMS to be beyond the control of the HHA.

Other items of note for HHAs are:

- Value codes 61 and 85 are optional for RAPs with "From" dates on and after January 1, 2021
- Other Diagnosis Codes are optional for RAPs with "From" dates on and after January 1, 2021

ADDITIONAL INFORMATION

The official instruction, CR 11855, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/r10254CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

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DOCUMENT HISTORY

Date of Change	Description
July 31, 2020	Initial article released.

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