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Centers for Medicare & Medicaid Services

42 CFR Parts 409, 424, 484, and 489
Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2010; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

42 CFR Parts 409, 424, 484, and 489

[CMS–1560–P]

RIN 0938–AP20

Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2010

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth an update to the Home Health Prospective Payment System (HH PPS) rates; the national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply (NRS) conversion factor, and the low utilization payment amount (LUPA) add-on payment amount, under the Medicare prospective payment system for home health agencies effective January 1, 2010. In addition, this rule proposes a change to the HH PPS outlier policy and proposes to require the submission of OASIS data as a condition for payment under the HH PPS. Also, this rule proposes payment safeguards that would improve our enrollment process, improve the quality of care that Medicare beneficiaries receive from HHAs, and reduce the Medicare program's vulnerability to fraud. This rule also proposes clarifying language to the ''skilled services'' section and Condition of Participation (CoP) section of our regulations. This proposed rule also clarifies the coverage of routine medical supplies under the HH PPS. We are also soliciting comments on: Physician/patient interaction associated with the home health plan of care (POC); a Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health Care Survey; the Outcome and Assessment Information Set (OASIS), Version C, effective January 1, 2010; proposed pay for reporting measures for use in CY 2011; and a number of minor payment-related issues. We are also responding to comments received as a result of our solicitation in the CY 2008 HH PPS final rule with comment period.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 28, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1560–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1560–P, P.O. Box 8016, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1560–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

FOR FURTHER INFORMATION CONTACT:

Randy Throndset, (410) 786–0131 (overall HH PPS).

Sharon Ventura, (410) 786–1985 (for information related to payment rates and wage indexes).

James Bossenmeyer, (410) 786–9317 (for information related to payment safeguards).

Doug Brown, (410) 786–0028 (for quality issues).

Kathleen Walch, (410) 786–7970 (for skilled services requirements and clinical issues).

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I. Background

A. Requirements of the Balanced Budget Act of 1997 for Establishing the Prospective Payment System for Home Health Services

The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) enacted on August 5, 1997, significantly changed the way Medicare pays for Medicare home health services. Section 4603 of the BBA mandated the development of the home health prospective payment system (HH PPS). Until the implementation of a HH PPS on October 1, 2000, home health agencies (HHAs) received payment under a cost-based reimbursement system.

Section 4603(a) of the BBA mandated the development of a HH PPS for all Medicare-covered home health services provided under a plan of care (POC) that were paid on a reasonable cost basis by adding section 1895 of the Social Security Act (the Act), entitled ''Prospective Payment For Home Health Services''. Section 1895(b)(1) of the Act requires the Secretary to establish a HH PPS for all costs of home health services paid under Medicare.

Section 1895(b)(3)(A) of the Act requires that: (1) The computation of a standard prospective payment amount include all costs for home health services covered and paid for on a reasonable cost basis and be initially based on the most recent audited cost report data available to the Secretary, and (2) the prospective payment amounts be standardized to eliminate the effects of case-mix and wage levels among HHAs.

Section 1895(b)(3)(B) of the Act addresses the annual update to the standard prospective payment amounts by the home health applicable percentage increase.

Section 1895(b)(4) of the Act governs the payment computation. Sections 1895(b)(4)(A)(i) and (b)(4)(A)(ii) of the Act require the standard prospective payment amount to be adjusted for case-mix and geographic differences in wage levels.

Section 1895(b)(4)(B) of the Act requires the establishment of an appropriate case-mix change adjustment factor that adjusts for significant variation in costs among different units of services.

Similarly, section 1895(b)(4)(C) of the Act requires the establishment of wage adjustment factors that reflect the relative level of wages, and wage-related costs applicable to home health services furnished in a geographic area compared to the applicable national average level. Pursuant to 1895(b)(4)(c), the wage-adjustment factors used by the Secretary may be the factors used under section 1886(d)(3)(E) of the Act.

Section 1895(b)(5) of the Act gives the Secretary the option to make additions or adjustments to the payment amount otherwise paid in the case of outliers because of unusual variations in the type or amount of medically necessary care. Total outlier payments in a given fiscal year (FY) or year may not exceed 5 percent of total payments projected or estimated.

In accordance with the statute, we published a final rule (65 FR 41128) in the **Federal Register** on July 3, 2000, to implement the HH PPS legislation. The July 2000 final rule established requirements for the new HH PPS for home health services as required by section 4603 of the BBA, as subsequently amended by section 5101 of the Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA) for Fiscal Year 1999, (Pub. L. 105–277), enacted on October 21, 1998; and by sections 302, 305, and 306 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, (Pub. L. 106–113), enacted on November 29, 1999. The requirements include the implementation of a HH PPS for home health services, consolidated billing requirements, and a number of other related changes. The HH PPS described in that rule replaced the retrospective reasonable cost-based system that was used by Medicare for the payment of home health services under Part A and Part B. For a complete and full description of the HH PPS as required by the BBA, see the July 2000 HH PPS final rule (65 FR 41128 through 41214).

B. Deficit Reduction Act of 2005

On February 8, 2006, the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) was enacted. Section 5201 of the DRA requires HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to payment. This requirement is applicable for CY 2007 and each subsequent year. If an HHA does not submit quality data, the home health market basket percentage increase will be reduced 2 percentage points. In accordance with the statute, we published a final rule (71 FR 65884, 65935) in the **Federal Register** on November 9, 2006 to implement the pay-for-reporting requirement of the DRA, codified at 42 CFR 484.225(h) and (i).

C. System for Payment of Home Health Services

Generally, Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for the applicable case-mix and wage index. The national standardized 60-day episode rate includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine medical supplies (NRS), is no longer part of the national standardized 60-day episode rate and is computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor (See section III.C.4.e). Durable medical equipment covered under the home health benefit is paid for outside the HH PPS payment. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification to assign patients to a home health resource group (HHRG). Clinical needs, functional status, and service utilization are computed from responses to selected data elements in the OASIS assessment instrument.

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit rate by discipline; an episode consisting of four or fewer visits within a 60-day period receives what is referred to as a low utilization payment adjustment (LUPA). Medicare also adjusts the national standardized 60-day episode payment rate for certain intervening events that are subject to a

partial episode payment adjustment (PEP adjustment). For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.

D. Corrections

We published a final rule with comment period in the **Federal Register** on August 29, 2007 (72 FR 49762) that set forth a refinement and rate update to the 60-day national episode rates and the national per-visit rates under the Medicare prospective payment system for home health services for CY 2008. In this final rule with comment period, in Table 10B (72 FR 49854), the short description for ICD–9–CM code 250.8x & 707.10–707.9 should read ''PRIMARY DIAGNOSIS = 250.8x AND FIRST OTHER DIAGNOSIS = 707.10–707.9''. Instead of a formal correction notice, we are notifying the public of this correction in this proposed rule, and subsequent final rule.

E. Updates to the HH PPS

As required by section 1895(b)(3)(B) of the Act, we have historically updated the HH PPS rates annually in the **Federal Register.**

We published a notice in the **Federal Register** on November 3, 2008 (73 FR 65351) that set forth the update to the 60-day national episode rates and the national per-visit rates under the Medicare prospective payment system for home health services for CY 2009.

II. Analysis of and Responses to Comments on the HH PPS Refinement and Rate Update for CY 2008

Our August 29, 2007 final rule with comment period set forth an update to the 60-day national episode rates and the national per-visit rates under the Medicare prospective payment system for HHAs for CY 2008. For that final rule, analysis performed on home health claims data, from CY 2005, indicated a 12.78 percent increase in the observed case-mix since 2000. The case-mix represented the variations in conditions of the patient population served by the HHAs. We then performed a more detailed analysis on the 12.78 percent increase in case-mix to see if any portion of that increase was associated with a real change in the actual clinical condition of home health patients. CMS examined data on demographics, family support, pre-admission location, clinical severity, and non-home health Part A Medicare expenditure data to predict the average case mix weight for 2005. As a result of that analysis, CMS recognized that an 11.75 percent increase in case-mix was due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients.

To account for the changes in case-mix that were not related to an underlying change in patient health status, CMS implemented a reduction over 4 years in the national standardized 60-day episode payment rates and the NRS conversion factor. That reduction was to be taken at 2.75 percent per year for three years beginning in CY 2008 and at 2.71 percent for the fourth year in CY 2011. CMS indicated that it would continue to monitor for any further increase in case-mix that was not related to a change in patient status, and would adjust the percentage reductions and/or implement further case-mix change adjustments in the future.

The CY 2008 HH PPS final rule with comment period specifically solicited comments on the 2.71 percent reduction that is scheduled to occur in 2011. In response, we received approximately 44 items of correspondence from the public. Comments originated from trade associations, HHAs, hospitals, and health care professionals such as physicians, nurses, social workers, and physical and occupational therapists. In the HH PPS Rate Update for CY 2009, we stated that we would delay our responses to these comments until future rulemaking, enabling us to respond more comprehensively as more current data became available. The following discussion, arranged by subject area, includes our responses to the comments.

A. Payment Reductions in the 4th Year (2011)

Comment: Commenters requested that CMS release the Abt technical report so that the industry could review the data and information within it. Without the Abt report, the commenters stated the industry would be unable to offer meaningful comments on the case mix-reductions.

Response: The Abt Technical Report was posted online and made available to the public on April 30, 2008 at: *http://www.cms.hhs.gov/Reports/downloads/Coleman_Final_April_2008.pdf.* Although we posted the report later than anticipated, we believe that the CY 2008 HH PPS final rule with comment period adequately presented information, documentation and evidence describing the Abt case-mix study and CMS' rationale for the reductions. Accordingly, we believe we have provided sufficient time and information to the public to fully review and comment upon the rate reductions that will take effect in CY 2011.

Comment: A commenter suggested that the 4th year cut of 2.71 percent be eliminated or indefinitely deferred until better data are available. Some commenters stated that an additional year of rate cuts will place a financial burden on HHAs, and will result in limited access to home care, especially in rural areas. These commenters further state that limited access may result in more hospitalizations and/or care being provided in more costly settings. Commenters also stated that imposing a 4th year reduction on HHAs would be detrimental and unduly harsh, as many HHAs are already struggling to meet the rising costs of providing care, and that the reductions will cause HHAs to operate at negative margins and likely close.

Several commenters suggested alternatives to CMS' approach to adjusting for nominal case-mix. For example, one commenter suggested spreading the total cuts across a 6-year period rather than a 4-year period, enabling CMS to better monitor the impact of the CY 2008 HH PPS refinements and CY 2008 and 2009 reductions prior to imposing additional reductions.

Another commenter suggested that CMS withdraw its decision to reduce the payment rates until CMS could design and implement a better method to analyze changes in the case-mix, based on adjusted final claims data that would utilize patient characteristics in the model, as well as changes in per-patient annual expenditures, patient clinical, functional, and service utilization data, and dynamic factors in the Medicare system that impact on the nature of patients served with home health care.

Response: Our continued analysis shows that Medicare nominal case-mix continues to increase. Therefore, we continue to believe it necessary to reduce rates through 2011 to counterbalance the Medicare expenditure effects of this nominal increase. We also continue to believe that phasing in the reductions over a four-year period provides fair and ample time for HHAs to prepare for the reductions.

As more current data become available, we will continue to update our case-mix analysis. As discussed in Section III.B. of this proposed rule, based on analysis of data through 2007, nominal case-mix has further increased. We now estimate that the nominal case-mix has grown by an estimated 13.56 percent between FY 1999 (the Interim Payment System (IPS) baseline period) and 2007, an additional 1.81 percentage points above the previously recognized

increase. If we were to account for the entire 13.56 percent increase in nominal case-mix in one year (taking into account that we have already imposed 2.75 percentage reductions in CY 2008 and CY 2009), we estimate that the percentage reduction in the national standardized 60-day episode payment rates and the NRS conversion factor would be 6.89 percent in CY 2010. If we were to account for the entire 13.56 percent increase in nominal case-mix over two years (taking into account that we have already imposed 2.75 percentage reductions in CY 2008 and CY 2009), we estimate that the percentage reduction in the national standardized 60-day episode payment rates and the NRS conversion factor for each of the remaining two years (2010 and 2011) would be 3.51 percent per year. As discussed in Section II.C. of this proposed rule, we currently plan to move forward with the CY 2010 reduction of 2.75 percent, as set forth in the CY 2008 final rule. However, we note that, in light of, among other things, new policy developments, more recent information, or changed circumstances from the time the CY 2008 rule was published, the Secretary is also considering making additional changes in the final rule to account for the residual increase in nominal case-mix discussed above. In such an instance, we would consider accounting for the residual increase in nominal case-mix in one year in the final rule, which we estimate would result in a 6.89 percent reduction to the national standardized 60-day episode payment rates and the NRS conversion factor for CY 2010. We are seeking comments on the full range of potential nominal case-mix reduction percentages.

With high projected HH margins and continued growth in the number of new HH agencies, we do not believe that the 2.71 percent reduction for 2011 will result in decreased access to home health care for Medicare beneficiaries. The Medicare Payment Advisory Commission's (MedPAC) March 2009 Annual Report states that the home health industry margin for 2007 was 16.6 percent and projects that average margins for 2009, which considers the 2.75 reduction, will be 12.2 percent. MedPAC also analyzed the average rate of HH cost growth and found that in most years, the rate of actual cost growth in HHAs has been lower than the rate of inflation indicated by the home health market basket. MedPAC reports that payments for HHAs have exceeded costs for all of the period under PPS by a wide margin.

Also, in their March 2009 report, MedPAC reports a 32 percent growth in the number of HH agencies since 2003, stating that the supply of agencies continues to increase faster than the growth in the overall number of Medicare beneficiaries. We believe that new home health providers continue to enter the home health industry because Medicare payment levels give them adequate incentive to do so.

In response to commenters who suggested that we consider alternative methods to identify nominal case-mix before we impose the CY 2011 reductions, we continue to believe that the Abt model adequately identifies nominal case-mix. As we described in our August 2007 final rule, our enhanced model included variables such as changes in the age structure of the home health user population, changes in the types of patients being admitted to home health, utilization of Medicare Part A services in the 120 days leading up to home health, the type of preadmission acute care stays when the patient last had such a stay and variables describing living situations. Many of these model enhancements addressed suggestions made by the industry in their proposed rule comments.

B. General Case-mix Comments

Our August 29, 2007 final rule with comment period solicited comments only on the 2.71 percent fourth year reduction (72 FR 49762). Nevertheless, we received several comments unrelated to the fourth year reduction. Because such comments (including comments on outliers, LUPAs (Low Utilization Payment Adjustments), OASIS, wage index, operational issues, diagnosis coding, HHRGs, and wound care payment) are out of the scope of this rulemaking, we are not responding to these comments in this proposed rule. However, we are responding to comments on case-mix measurement methodology, as we believe such comments are tangentially related to the reduction for CY 2011, and because we wish to fully address this issue.

Comment: A commenter stated that the August 27, 2007 final rule with comment period was not a ''logical outgrowth'' of the May 4, 2007 proposed rule. The commenter stated that CMS used a different methodology for evaluating case-mix weight scores and changes in patient characteristics than had been used in the proposed rule. The commenter recommended that CMS engage in another cycle of rulemaking in order to provide further opportunity to comment.

Response: The policy adopted in the August 2007 final rule was a policy that adjusted payments in order to account for increases in nominal case-mix. This policy was both proposed and finalized. The commenter is addressing not the policy of adjusting payments for nominal case-mix increases, but rather, how CMS implements this policy; that is, the methodology CMS uses for determining the level of nominal case-mix increase. While we do not believe we are required to subject our exact, final calculations regarding the increase to public comment, it is also important to note that our final methodology clearly was an outgrowth of the proposed rule. The proposed rule included a detailed analysis of various kinds of data, such as an extensive review of the content of changes in OASIS instructions, a review of changes in the frequencies of severity levels of the case-mix system, and a detailed presentation of how OASIS items other than those used for case-mix frequently changed little, if at all. We also discussed the pattern of change in functional items, showing that for a number of items, some changes occurred at the high-functioning end, while the worst-functioning levels didn't increase in the population. There was a similar analysis of wound item changes. Our interpretation of the totality of the data was that real case-mix did not materially change since the IPS baseline. We also identified a large increase in post-surgical patients with their traditionally lower case-mix index. However, we made an adjustment to our estimate of case-mix change to account for the change in the composition of the home health industry on account of the exit of some hospital-owned agencies. These details enabled the home health industry to analyze our proposed methodology and provide comments suggesting specific types of changes in patient acuity that could help to explain identified changes in home health case-mix. For the final rule, we enhanced our formal estimate of case-mix change, which we had statistically adjusted to account for change in the presence of hospital-owned agencies in the industry, with a methodology that statistically adjusted for multiple factors, including the types of factors mentioned by commenters. Application of this model allowed us to simultaneously ''subtract'' from the growth in the national case-mix index the effects of a multitude of factors besides the change in hospital-owned agencies. Additionally, in the May 4, 2007 proposed rule (72 FR 25395) we indicated that our analysis for the final rule would be updated to include 2005 data.

Specifically, for the final rule, we updated the case-mix index and some of the statistical data (*e.g.,* average resources per episode) to include 2005 data. We also added analyses focusing on certain types of patients, including those mentioned in public comments on the proposal (*e.g.,* knee replacement patients). Further, as just discussed in the paragraph above, we added results from a multivariate model of case-mix that isolated real case-mix change between the HH IPS baseline and 2005. The newly added data and the model responded to comments that cited circumstances of particular types of patients and/or sought additional types of evidence. These added data and analyses were made in response to the proposed rule comments. The data and information added for the final rule, along with the entire array of evidence we presented in the proposed and the final rule are the bases for the identification of nominal case-mix change.

Comment: Some commenters focused on the finding that only 8 percent of the case-mix change from 2000 to 2005 was real. These commenters recommended that CMS start with the assumption that all case-mix change is real, and only consider the amount that could be estimated as nominal to be unjustified.

Another commenter pointed to CMS' assertion that ''real'' case-mix increased prior to implementation of the HH PPS (prior to September 2000) and argued that this fact demonstrates that it was unreasonable for CMS to assume that none of the change after that point was real.

Commenters suggested that case-mix has increased due to several factors, including earlier discharges from general acute hospitals, PPS changes that provided incentives to treat higher-acuity patients, and other post-acute care regulations issued by CMS (such as the inpatient rehabilitation ''75% Rule''), which diverts more medically complex patients to homecare. One commenter urged CMS to defer any adjustment for case-mix change and to perform an analysis that accounted for these factors.

Response: The predictive model isolated 8.03 percent of the overall 12.78 percent increase in case-mix as real, resulting in an 11.75 percent nominal increase in case-mix. We relied on those results to arrive at the nominal case-mix reductions −2.75 percent for 3 years and −2.71 percent for the fourth year of the phase-in. (Refer to Section III.B. of this proposed rule for an update based on analysis of data through 2007.) Thus, our model allowed and presumed some real case-mix change. The model data relied on claims data instead of OASIS data (with the exception of one variable, which described the patient's living situation), to avoid reliance on data which we knew were subject to coding changes such as those resulting from educational improvements, changes in OASIS instructions, and financial incentives. The model takes into account the total change between the baseline and the follow-up year (2005) in the sources of patients (hospital, inpatient rehabilitation facility, and skilled nursing facility). It also takes into account total change in the types of acute hospital problems and hospital-recorded comorbidities experienced by patients before they entered home health care, total change in living situation, and total change in patients' Part A expenditures incurred in the 120 days leading up to the beginning of each episode (expenditures were adjusted for price increases). Length of stay is also accounted for by summing the number of inpatient days of various types. Additionally, we added analyses focusing on certain types of patients, including those mentioned in public comments on the proposal (*e.g.,* knee replacement patients).

Every predictive model has its limitations; however, we believe the model and data we used were the best available for the purposes of measuring case-mix in an unbiased manner. For example, we relied on hospital claims data instead of OASIS data (with the exception of one OASIS variable), and enhanced our calculation method to include a multivariate approach to case-mix measurement. For those patients who were hospitalized before home care, the model included whether the hospitalization was surgical or medical, and in many cases the model identified the particular, detailed conditions that were responsible for that hospital stay. These additions to the model were suggested by the industry in comments on the proposed rule.

Moreover, we again note that the Abt model was not the sole basis for the final regulation provision on nominal case-mix change. The basis for the final provision was the entire array of evidence we presented in the proposed and the final rules. In addition, in the May 4, 2007, proposed rule (72 FR 25362–25366) we noted data as well as commentary from observers indicating that therapy treatment plans were sometimes ''padded'' to reach the ten-visit therapy threshold; we consider this behavior a component of nominal case-mix change, because therapy visits help to determine the case-mix group.

In response to the comment that CMS should have started with the assumption that all case-mix growth was real, and then calculate what portion, if any, was nominal, the model did assess real case-mix using a variety of Part A claims. We then compared the model's prediction of real case-mix with the actual billed case-mix, determining the calculated difference to be nominal. The May 4, 2007, proposed rule put the case-mix of the Medicare home health population in historical perspective. It described the changes affecting the home health benefit since the Balanced Budget Act of 1997 and cited MedPAC, GAO and other literature findings that the HH IPS had a strong impact on the types of patients served. We compared the case-mix index from the Abt Associates study sample with the case-mix index of the HH IPS baseline (1999–2000), a comparison that suggested that changes in real case-mix did occur as a result of the HH IPS. Literature findings (GAO, ''Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services,'' September 1998, GAO/HEHS–98–238) describe an HH IPS incentive to admit many different patients with short-term or rehabilitation needs instead of lengthy low skilled care needs. We did not rule out that some of the change during that period was nominal, in part because the HH PPS proposed rule of 1999 probably affected provider behavior.

Moreover, our analysis of changes in resource use showed that resource use stayed below the resource use level of the HH IPS period for much of the succeeding five years, casting doubt on the commenters' assertion that patient acuity increased. Specifically, after the IPS was implemented, we saw a decline in visit use from 73 visits per person in 1997 to 42 visits per person in 1999. The number of visits further decreased under the HH PPS, decreasing to 37 in 2000, and 31 for each year 2001 through 2004.

Comment: A commenter believes that CMS's decision to implement these payment reductions is unjustified and flawed for two basic reasons: (1) There have been actual changes in the home health population; and (2) providers have improved the accuracy of OASIS coding. The commenter refers to recently released data by Outcome Concept Systems citing the average 2005 adjusted case-mix weight nationally and in New York was approximately 1.15, not 1.2361, as CMS asserts.

The commenter believes that the average case-mix weight has changed because CMS fails to consider therapy as a patient characteristic and because patients' clinical severity has increased. Furthermore, the commenter believes

that the increase in patients' clinical needs is largely due to an inpatient hospital payment system that has created incentives for early discharge of patients who require more care. The result is a home health population with higher acuity and more intense resource needs. The commenter also states that growth in Medicare Advantage plans has shifted lower acuity patients out of traditional Medicare, leaving higher need and higher cost beneficiaries within the traditional Medicare program.

A commenter stated that current OASIS data show that HHAs are admitting increased numbers of beneficiaries with: (1) Comorbidities such as diabetes and obesity; (2) abnormalities of gait; (3) wound infections; (4) urinary incontinence; and (5) increased cognitive function deficits. The accumulative effect of these admissions has necessitated increased therapy services which have resulted in higher clinical and functional scores in case-mix weights. In addition, the commenter believes that physical therapy services were underutilized during the HH IPS and at the onset of the HH PPS because of lack of clinical knowledge and understanding of best practice standards. The delivery of medical services in the home has improved over recent years. This is evident by implementation of quality measures and outcomes data. Several commenters believe that the increase in average case-mix can be attributed fully to an improvement in each agency's ability to correctly answer OASIS items and increased emphasis on OASIS validity by Quality Improvement Organizations (QIO). Another commenter stated that their agency has experienced a change in the percentage of orthopedic patients due to changes in regulations for rehabilitation hospitals.

Response: In the May 4, 2007 HH PPS proposed rule, we indicated that the analysis of national case-mix would be updated using 2005 data in that year's HH PPS final rule, and that the annual adjustments for nominal case-mix change would be modified accordingly.

As we have noted elsewhere, improvements in coding do not represent real case-mix changes, which means that the Medicare program arguably may have overpaid for some of the services which were provided after improvements in OASIS coding were implemented. CMS subsequently adjusted the standardized payment amount to compensate for the nominal change in case-mix used to pay claims in the years following the introduction of the PPS.

We acknowledge that therapy treatment services were used as a case-mix characteristic in the case-mix model, in the absence of sufficient explanatory power from OASIS data items to model resource use by themselves. However, we found a dramatic change in the distribution of episodes according to the number of therapy visits between the HH IPS baseline period and the early years of the HH PPS period, and the new distribution has persisted. We continue to believe that the change in this short period is an indication of behavioral change on the part of home health agencies, and is not necessarily related to real case-mix change. Moreover, the distributional shift occurred in the absence of convincing evidence from various OASIS items that patients were actually more impaired and sickly. Furthermore, when we took account of patient characteristics in the model of real case-mix change, the results did not support a large difference in patient acuity.

We also note that the reporting of more comorbidities by HHAs is not clear evidence of change in patient status, as it could be a result of improvements in coding training alone. In addition, changes in regulations affecting rehabilitation hospitals are represented in the case-mix change model by the variables that measure the source of admission.

To the extent that the home health industry has accomplished improvements in patient function without adding significant resources to the provision of care in home health episodes, we understand this is likely attributable to shifts in the service mix provided within the episode, as well as improved care practices. Again, however, the situation does not necessarily indicate a real change in case-mix.

Without more detailed information about their analysis, we are unable to comment on the implication in the statistic from Outcome Concept Systems in New York State (as reported by the commenter) that the average case-mix rose only 1.15 as compared to 1.2361 in CMS's analysis. The average case-mix is computed from an extremely large representative sample of national home health claims data. The commenter does not provide information about the method of adjustment, the conditions of data-gathering, or the quality or source of the data sources used by Outcome Concept Systems.

Comment: A commenter stated that CMS' review of 20 percent of claims (OASIS for 2004–2005) does not reflect the patient characteristics in 2007, and it certainly does not reflect those receiving services in 2010 and 2011.

Response: We based our proposals on the latest statistically representative data available, and those data were from 2005 at the time of the preparation of the final regulation. We will continue to update the data as they become available.

Comment: A commenter stated that CMS should look more closely at specific agencies it suspects may be upcoding and then seek financial restitution from those that are ultimately deemed to be following this practice. Across-the-board cuts of this magnitude are unwarranted at a time when the home health industry should be receiving additional support to serve an expanding older population.

Response: As we stated in the CY 2008 HH PPS final rule (72 FR at 49837), we believe that it is more appropriate to implement a nationwide approach to the issue of a case-mix change adjustment. An individual agency approach would be administratively burdensome and difficult to implement. Policies to address the identity of agencies in light of changes to organizational structures and configurations would need to be developed. Furthermore, smaller agencies might have difficulty in providing accurate measures of real case-mix changes because of their small caseloads. Because the nominal increase in case-mix grew significantly from 2003 to 2005 (8.7 percent to 11.75 percent), we spread out the schedule of adjustments from 3 years to 4 years in order to ameliorate the impact that would have been felt by HHAs had we decided to account for the entire 11.75 percent increase in case-mix over 3 years.

Comment: A commenter is concerned that CMS has not correctly addressed factors measuring the apparent ''creep''. Additionally, the commenter states that it was useful to have CMS clarify that they had excluded LUPAs from the two measurement bases utilized and that fact raises an issue that CMS did not address in the rule. When the original HH PPS was proposed (October 1999) and finalized (July 2000), CMS asserted that it expected LUPA incidence, as estimated by its actuaries, would be five percent. Actual incidence has, since implementation, averaged sixteen percent of total reimbursements. Using just a five percent rate of occurrence resulted in every original HHRG assigned a lower value than if CMS had used, say, a fifteen percent rate of incidence. Accordingly, the commenter argues that home health agencies were

under-compensated by approximately 11 percent for LUPA savings.

Response: While this comment is outside the scope of the topic (the 4th year reductions) which we solicited comments on, we will briefly respond. In the July 2000 final rule (65 FR 41162), we stated that the estimate of the percentage of LUPA episodes was an actuarial estimate, as were the estimates of incidence of SCICs, PEPs, and outliers. Our base episode payment rates are derived using the best data available at that time. The commenter is correct that the actual number of LUPA episodes is higher than our original estimate. However, while it is true that 16 percent of episodes from the 1998 pre-PPS data analysis were shown to be LUPA-type episodes (65 FR 41186), we also provided reasoning in that discussion as to why we believed actual LUPA incidence under the HH PPS would be lower. Granted, the incidence of LUPAs did not drop to the level of 5 percent of the total number of episodes as was originally estimated, however the average actual incidence of LUPAs is, and has always been considerably lower than the 16 percent suggested by the commenter. In fact, data analysis shows us that the incidence of LUPA episodes was first measured at approximately 15.2 percent of the total number of episodes and has continued to decrease under the HH PPS. Specifically, recent analysis of home health claims shows that LUPA episodes made up approximately 10.6 percent of the total number HH PPS episodes in CY 2007.

Another important fact that should not be lost, as part of this discussion, is that while the incidence of LUPAs is less than originally estimated, we note that the average number of home health visits provided per episode for non-LUPAs episodes is also lower than what we originally estimated (65 FR 41171) when we built the base payment rates (21.16 vs 25.5 home health visits). Hence, the national standardized 60-day episode payment is currently based on the delivery of significantly more home health visits per episode (25.5) than is currently being delivered (21.16).

It is also worth noting that the manner in which the commenter appears to arrive at their under-compensation of payment percentage is by subtracting the original estimate for LUPA episodes of 5 percent from their inaccurate estimate of 16 percent incidence of LUPA episodes. In addition to the commenters 16 percent being inaccurate (as mentioned above), it is important to point out that even in doing the math, an inaccurate 16 percent minus 5 percent actually reflects that there is an 11 percentage point difference between the two, not an 11 percent under-compensation in payment as the commenter suggests. Because the incidence of LUPAs is considerably lower than the 16 percent that the commenter suggests, and the average number of home health visits per episode is far less than originally estimated, HHAs have not been under-compensated by 11 percent, as the commenter suggests.

Since the inception of the HH PPS, we have monitored home health utilization in preparing the refinements to the HH PPS. We have always contended that it would not be appropriate to address single aspects of the system, as the many pieces/aspects of the system interact and there are causes and effects that each has on one another. Consequently, we have addressed those issues for which we believed we had adequate information, as a result of our analysis in the CY 2008 HH PPS proposed and final rules. In doing so, as is generally done in a prospective payment system, we decided not to make retroactive adjustments for actual utilization that differed from estimates.

III. Provisions of the Proposed Rule

A. Outlier Policy

1. Background

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the regular 60-day case-mix and wage-adjusted episode payment amount in the case of episodes that incur unusually high costs due to patient home health care needs. This section further stipulates that total outlier payments in a given year may not exceed 5 percent of total projected or estimated HH PPS payments. Section 1895(b)(3)(C) of the Act stipulates that the standard episode payment be reduced by such a proportion to account for the aggregate increase in payments resulting from outlier payments.

In the July 2000 final rule (65 FR 41189), we described and subsequently implemented an HH PPS outlier policy under which we reduce the standard episode payment by 5 percent, and target up to 5 percent of total projected estimated HH PPS payments to be paid as outlier payments. The July 2000 final rule described a methodology for determining outlier payments. Under this system, outlier payments are made for episodes whose estimated cost exceeds a threshold amount. The episode's estimated cost is the sum of the national wage-adjusted per-visit rate amounts for all visits delivered during the episode. The outlier threshold is defined as the national standardized 60-day episode payment rate for that case-mix group plus a fixed dollar loss (FDL) amount. Both components of the outlier threshold are wage-adjusted. The wage-adjusted FDL amount represents the amount of loss that an agency must experience before an episode becomes eligible for outlier payments. The wage-adjusted FDL amount is computed by multiplying the national standardized 60-day episode payment amount by the FDL ratio, and wage-adjusting that amount. That wage-adjusted FDL amount is added to the HH PPS payment amount to arrive at the wage-adjusted outlier threshold amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated costs beyond the wage-adjusted outlier threshold amount. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. The FDL ratio and the loss-sharing ratio were selected so that the estimated total outlier payments would not exceed the 5 percent level. We chose a value of 0.80 for the loss-sharing ratio, which is relatively high, but preserves incentives for agencies to attempt to provide care efficiently for outlier cases. A loss-sharing ratio of 0.80 means that Medicare pays 80 percent of the additional costs above the wage-adjusted outlier threshold amount. A loss-sharing ratio of 0.80 is also consistent with the loss-sharing ratios used in other Medicare PPS outlier policies, such as inpatient hospital, inpatient rehabilitation, long-term hospital, and inpatient psychiatric payment systems. In CY 2000, we estimated that a FDL ratio of 1.13 would yield estimated total outlier payments that were projected to be no more than 5 percent of total HH PPS payments. As discussed in the October 1999 proposed rule (64 FR 58169) and the July 2000 final rule (65 FR 41189), the percentage constraint on total outlier payments creates a tradeoff between the values selected for the FDL amount and the loss-sharing ratio. For a given level of outlier payments, a higher fixed dollar loss amount reduces the number of cases that receive outlier payments, but makes it possible to select a higher loss-sharing ratio and therefore increase outlier payments per episode. Alternatively, a lower fixed dollar loss amount means that more episodes qualify for outlier payments but outlier payments per episode must be lower. Therefore, setting these two parameters involves policy choices about the number of outlier cases and their rate of payment.

When the data became available, we performed an analysis of CY 2001 home

health claims data. This analysis revealed that outlier episodes represented approximately 3 percent of total episodes and 3 percent of total HH PPS payments. Additionally, we performed the same analysis on CY 2002 and CY 2003 home health claims data and found the number of outlier episodes and payments held at approximately 3 percent of total episodes and total HH PPS payments, respectively. Based on these analyses and comments we received, we decided that an update to the FDL ratio would be appropriate.

To that end, for the October 22, 2004 HH PPS rate update for the CY 2005 final rule, we performed data analysis on CY 2003 HH PPS claims data. The results of that analysis indicated that a FDL ratio of 0.70 was consistent with the existing loss-sharing ratio of 0.80 and a projected target percentage of estimated outlier payments of no more than 5 percent. Consequently, we updated the FDL ratio from the initial ratio of 1.13 to an FDL ratio of 0.70. Our analysis showed that reducing the FDL ratio from 1.13 to 0.70 would increase the percentage of episodes that qualified for outlier episodes from 3.0 percent to approximately 5.9 percent. A FDL ratio of 0.70 also better met the estimated 5 percent target of outlier payments to total HH PPS payments. We believed that this updated FDL ratio of 0.70 preserved a reasonable degree of cost sharing, while allowing a greater number of episodes to qualify for outlier payments.

Our CY 2006 update to the HH PPS rates (70 FR 68132) updated the FDL ratio from 0.70 to 0.65 to allow even more home health episodes to qualify for outlier payments and to better meet the estimated 5 percent target of outlier payments to total HH PPS payments. For the CY 2006 update, we used CY 2004 home health claims data.

In our CY 2007 update to the HH PPS rates (71 FR 65884) we again updated the FDL ratio from 0.65 to 0.67 to better meet the estimated 5 percent target of outlier payments to total HH PPS payments. For the CY 2007 update, we used CY 2005 home health claims data.

In the CY 2008 final rule with comment period, in the interest of using the latest data and best analysis available, we performed supplemental analysis on the most recent data available in order to best estimate the FDL ratio. That analysis derived a final FDL ratio of 0.89 for CY 2008.

In order to determine the appropriate value for the FDL ratio for the CY 2009 rate update, in the November 3, 2008 HH PPS Rate Update for CY 2009 notice (73 FR 65351), we performed an analysis using the most recent, complete available data at the time (CY 2006), applying a methodology similar to that which we used to update the FDL ratio in the CY 2008 HH PPS final rule. That updated analysis projected that in CY 2009 we would expend an estimated 10.26 percent of total estimated HH PPS payments in outlier payments, more than twice our 5 percent statutory limit. Our analysis also revealed that this growth in outlier payments was primarily the result of excessive growth in outlier payments in a few discrete areas of the country. We noticed statistical anomalies in outlier payments in terms of both high outlier dollars and as a percentage of total HH PPS payments, in areas such as Miami-Dade Florida, where outlier payments to providers far exceed the national average and the 5 percent target for outlier payments. Using similar analysis to what was performed for the CY 2008 final rule with comment, we estimated that we would need to raise our FDL ratio from 0.89 to 2.71 for CY 2009 in order for estimated outlier payments to be no more than 5 percent of total HH PPS payments. In addition, the size of these statistical anomalies raised concerns about the medical necessity of the outlier episodes in some areas. However, in our CY 2009 payment update, we did not raise the FDL ratio to 2.71, given the statistical outlier data anomalies that we identified in certain targeted areas, because program integrity efforts, such as payment suspensions for suspect HHAs, were underway to address excessive, suspect outlier payments that were occurring in these areas. Instead, we maintained the then-current (CY 2008) FDL ratio of 0.89 in CY 2009 while actions to remedy any inappropriate outlier payments in these target areas of the country were effectuated.

2. Proposed Change to Target Outlier Payment Percentage

For CY 2010 rulemaking, we have expanded our outlier analysis. In addition to assessing what FDL ratio would most accurately achieve the 5 percent target of outlier payments as a percentage of total HH PPS payments, we also performed analyses to assess the appropriateness of adopting a lower target percentage of outlier payments to total HH PPS payments. Some commenters to our CY 2008 proposed rule suggested that CMS should consider targeting a lower percentage in outlier payments to total estimated HH PPS payments.

Commenters suggested that by lowering the target outlier percentage to total estimated HH payments, CMS could then return to the national standardized 60-day episode payment rate, a portion of that 5 percent which was originally withheld from the rates to fund the 5 percent of total estimated HH PPS outlier payments. In our response to the CY 2008 comments, we described our concern that reducing the target outlier percentage could risk access to home care for high needs patients. However, recent analysis of more current data, specifically CY 2007 and CY 2008 data, suggests that a target around that of 2.5 percent in outlier payments to total estimated HH PPS payments may be a more appropriate target than 5 percent, while not risking access to care for high needs patients. Section 1895(b)(5) of the Act states that the Secretary ''may'' provide for an addition or adjustment to the payment amount otherwise made in the case of outliers. It goes on to say that if the Secretary decides to provide such a payment, that the total amount of the additional payments or payment adjustments may not exceed 5 percent of the total payment projected or estimated to be made under the payment system. Consequently, providing an addition or adjustment to the payment amount for outliers is optional and not statutorily required. We performed an analysis of all providers who receive outlier payments, focusing our analysis on total HH PPS payments, total outlier payments, number of episodes, number of outlier episodes, and location of provider. As discussed below under ''Proposed Outlier Cap Policy'', our analysis incorporates a proposed 10 percent cap on outliers and looks at outlier payments as a percentage of total HH PPS payments with that 10 percent cap in place. In our analysis of 2007 data, after implementing the 10 percent cap, outlier dollars accounted for approximately 2.1 percent of total HH PPS payments.

Additionally, we performed a separate analysis on a major association of home health agencies who claim to be safety-net providers, serving sicker, more costly patients. The average outlier payment to these agencies is also under 2 percent. Therefore, we believe a target of less than 5 percent for outlier dollars as a percentage of total estimated HH PPS payments is appropriate. However, past years' data trends show us that outlier payments will likely continue to grow. Consequently, we propose to change our target percentage of outlier payments from 5 percent to approximately 2.5 percent of total estimated HH PPS payments.

Currently, we reduce the national standardized 60-day episode payment

rates, the national per-visit rates, the LUPA add-on amount, and the NRS conversion factor by 5 percent in order to create an outlier pool that accommodates estimated outlier payments of 5 percent of total HH PPS payments. Targeting the percentage of outlier payments at approximately 2.5 percent will allow us to create a smaller outlier pool and return the remaining 2.5 percent to the HH PPS rates. We would retain a 2.5 percent reduction to the national standardized 60-day episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor to fund the proposed target of approximately 2.5 percent of total estimated HH PPS payments in outlier payments, adhering to the statutory requirement in Section 1895(b)(3) of the Act.

3. Proposed Outlier Cap Policy

Although program integrity efforts associated with excessive outlier payments continue in targeted areas of the country, we continue to be at risk of exceeding the 5 percent statutory limit on estimated outlier expenditures. Therefore, our recent analysis also focused on whether a broader policy change to our outlier payment policy might also be warranted, to mitigate possible billing vulnerabilities associated with excessive outlier payments, and to adhere to our statutory limit on outlier payments.

We also considered eliminating outlier payments altogether and restoring the 5 percent, originally taken out of the national standardized 60-day episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor to pay for the existing outlier policy, back into the HH PPS rates. Eliminating outlier payments would simplify payments to HHAs and remove the vulnerability associated with inappropriate outlier payments. However, we are concerned that eliminating outlier payments to HHAs could result in denying added protection to HHAs that historically treat sicker, more costly patients.

In attempts to better estimate outlier payments as a percentage of total HH PPS payments and to mitigate vulnerabilities associated with inappropriate outlier payments, we also looked into options that would impose an outlier cap, at the agency level, such that in any given year, an individual HHA would receive no more than a set percentage of its total HH PPS payments in outlier payments. We performed extensive analyses to model the impact to HHAs of a variety of percent caps in outlier payments. A primary focus of this analysis was to identify HHAs which would be representative of the types of agencies we are most concerned about disadvantaging with an outlier policy that included an outlier cap at the agency level. Our analysis revealed that a 10 percent agency cap in outlier payments would mitigate potential inappropriate outlier billing vulnerabilities while minimizing the access to care risk for high needs patients.

We used CY 2007 claims data to perform a detailed impact analysis. We identified 1137 HH agencies whose outlier payments exceeded 10 percent of their total HH PPS payments in CY 2007. However, we excluded 700 of these agencies from the impact analysis, because these agencies received sizeable outlier payments (totaling at least around $100,000), had high percentages (at least around 30 percent) of outlier payments to total HH PPS payments, and were located in the counties in FL, TX and CA where we believe possible program integrity issues had been identified.

We targeted our in-depth impact analysis to the remaining 437 agencies, about 5 percent of all Medicare home health agencies. We analyzed these agencies as a group and individually. Our analysis focused on total HH PPS payments, total outlier payments, number of episodes, number of outlier episodes, percentage reductions in payments if a 10 percent outlier cap were imposed, and location. Analyzing CY 2007 data, these 437 agencies would have experienced about a 10 percent decrease in their total HH payments if an outlier cap of 10 percent, at the agency level, were imposed. As we looked closely at the individual 437 agencies, we excluded additional agencies for a number of reasons. Specifically, we excluded 70 agencies that had fewer than 20 Medicare HH episodes, believing that Medicare beneficiaries account for such a small part of their business that they are not representative of the types of agencies we are most concerned about disadvantaging with an outlier cap policy.

We excluded an additional 197 agencies because they are also located in the counties identified as experiencing program integrity problems. While these 197 agencies did not receive exorbitant outlier payments, their relatively high outlier payment percentages to total agency HH PPS payments led us to suspect inappropriate payments. We believe that the remaining 170 agencies, representing less than 2 percent of all Medicare home health agencies, are representative of the types of agencies we are most concerned about disadvantaging with an outlier policy that included a 10 percent cap at the agency level.

This analysis showed that almost all of the 170 agencies are in urban areas, with only 16 agencies in rural areas. The total number of episodes that resulted in outlier payments is 4,497, about 15 percent of their total episodes. The total HH PPS payments for these agencies equaled about $85 million in CY 2007. The total outlier payments for these agencies equaled $14.4 million, representing an average of about 17 percent of their total HH PPS payments. The total amount of payments that would be lost by these providers due to a 10 percent cap would be $6.6 million, representing an average of approximately 7.9 percent of their total HH PPS payments. However, because most affected agencies are in urban areas, and there is not an access problem with regard to receiving home health services in urban areas, we do not expect that an outlier cap of 10 percent at the agency level would result in any access to care issues.

Additionally, we also performed a separate analysis of the major home health agency association which claims to service a sicker, more costly population. In 2007, only one of these agencies exceeded 10 percent of its total episode payments in outlier payments, receiving approximately 15 percent of its total HH PPS payments in outlier payments.

Finally, we performed an analysis of the impact that imposing an outlier cap of 10 percent at the agency level would have on total outlier payments as a percentage of total HH PPS payments. The FDL ratio for CY 2007 was 0.67. In simulating for 2010 using 2007 data, imposing an outlier cap of 10 percent at the agency level, we estimate that we would pay approximately 2.32 percent of total HH PPS payments in outlier payments.

Therefore, to mitigate possible billing vulnerabilities associated with excessive outlier payments, and to adhere to our statutory limit on outlier payments, we propose to implement an agency level outlier cap such that in any given calendar year, an individual HHA would receive no more than 10 percent of its total HH PPS payments in outlier payments. Additionally, we propose to reduce the FDL ratio to 0.67 for CY 2010. This combination of a 10 percent agency level outlier cap, and reduced FDL ratio of 0.67, and allowing for future growth in outlier payments, results in a projected target outlier payment outlay of approximately 2.5

percent of total HH PPS payments in outlier payments.

Our analysis demonstrates that approximately 2 percent of HH agencies may experience an average 7.9 percent decrease in payments. This decrease will be mitigated by a 2.5 percent increase in the HH PPS rates, as a result of lowering the outlier pool from 5 percent to 2.5 percent. However, these impacts are averages. Some agencies that legitimately serve a sicker population may experience a larger decrease. Because MedPAC reported in their January 2009 public meeting (*http://www.medpac.gov/transcripts/0108-0109MedPAC.final.pdf*) that Medicare beneficiaries have access to an adequate number of HHAs, we do not believe this policy will result in access to home care issues for high needs patients.

As discussed in the CY 2009 HH PPS Update notice (73 FR 65357), past experience has shown that outlier payments have been increasing as a percentage of total payments from 4.1 percent in CY 2005, to 5.0 percent in CY 2006, to 6.4 percent in CY 2007. Analysis at the time of the above notice indicated that we could expect outlier payments as a percentage of total HH PPS payments to be approximately 8.1 percent of total payments in CY 2008, and increase to approximately 10.26 percent in CY 2009. Given that predicted trend in outlier payments, we estimated that we would have had to raise our FDL ratio from 0.89 to 2.71 for CY2009 in order to ensure that estimated outlier payments would be no more than 5 percent of total HH PPS payments. We believe that it is the high suspect outlier payments in suspect areas of the country that cause existing data analysis to seemingly require such a high FDL ratio in order to meet the target 5 percent of total HH PPS payments.

Because outlier payments continues to grow, and those outlier payments as a percentage of total HH PPS payments already exceed the statutory limit, absent our proposed outlier cap of 10 percent at the agency level, we would be required to raise the FDL ratio to a level much higher than either the current 0.89 or the proposed 0.67, and doing so would deleteriously affect agencies providing legitimate care to home health beneficiaries. We do not believe that raising the FDL ratio to such a high level, making it even harder for legitimate episodes to qualify for outlier payments, is the appropriate policy, especially given the fact that we believe it is these high suspect outlier payments in suspect areas of the country that are causing outlier payments as a percentage of total HH PPS payments to continue to increase to levels beyond the existing 5 percent target. Conversely, we believe that our proposed outlier policy that includes a 10 percent cap on outlier payments at the agency level, in concert with a new 2.5 percent outlier pool (as opposed to the existing 5 percent outlier pool), and returning 2.5 percent back into the national standardized 60-day episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor, with a 0.67 FDL ratio, would be the appropriate policy at this time. We expect the new outlier policy to curtail approximately $340 million, in CY 2010, in what we believe to be inappropriate outlier payments.

Finally, CMS will continue to monitor the trends in outlier payments and these policy effects. Specifically, CMS plans to analyze overall national spending on outlier payments relative to the new 2.5 percent outlier pool by geographic area and provider type. CMS also plans on looking at outlier payments, per HHA, relative to the proposed 10 percent cap on outlier payments at the agency level by geographic area and provider type. So far as activities related to high suspect outlier payments, CMS is continuing with program integrity efforts including possible payment suspensions for suspect agencies. If we are unable to see measurable improvements with respect to suspected fraudulent billing practices as they relate to HHA outlier payments, CMS may consider eliminating the outlier policy entirely in future rulemaking.

Proposed implementation approach to a 10 percent agency level outlier cap.

CMS envisions the proposed 10 percent cap on outlier payments at the agency level would be managed by the claims processing system. For each HH provider, for a given calendar year, the claims processing system would maintain a running tally of YTD total HH PPS payments and YTD actual outlier payments. The claims processing system would ensure that each time a claim for a provider was processed; YTD outlier payments for that calendar year could never exceed 10 percent of YTD total HH PPS payments for that provider for that calendar year. As a provider's claims (RAPs and final claims) were processed and YTD HH PPS payments for that calendar year increased throughout the course of the year, the claims processing system would be triggered to pay outlier payments, adjusting prior final claims by paying previously unpaid outlier payments, as the YTD total HH PPS payments for that calendar year allowed, never exceeding 10 percent of total YTD HH payments for that calendar year. In cases where a provider submitted a claim with an outlier payment early in the year when YTD total HH PPS payments for that calendar year were low, outlier payments would be delayed until YTD total HH PPS payments for that calendar year reached a level to pay the outlier payment.

More specifically, instead of a given claim being readjusted several times as total HH PPS payments increase, but not enough to pay an entire outlier payment on a given claim, we are considering a process by which an outlier payment on a previous claim would not be adjusted until total HH PPS payments for that calendar year were such that the entire outlier payment could be made without exceeding 10 percent of total HH PPS payments for a particular HHA for that calendar year. Doing so would avoid not only the cost of possible multiple adjustments to a given claim, but would also simplify the process making adjustments easier to track and understand. We solicit comments on these proposed outlier policy changes.

B. Case-Mix Measurement Analysis

In the CY 2008 HH PPS final rule with comment period, we stated that we would continue to monitor case-mix changes in the HH PPS and to update our analysis to measure change in case-mix, both nominal and real. We have continued to monitor case-mix changes and our latest analysis supports the payment adjustments which we implemented in the CY 2008 HH PPS.

We have updated our examination of five conditions that commenters on our case mix change adjustment suggested indicate a real case mix change. This analysis was originally summarized as Table 8 in the August 29, 2007, final rule. The updated results (see Table 1 below) show that the shares of episodes preceded by a hospital discharge for hip fracture, congestive heart failure, and cerebrovascular accident have continued to decline since the IPS baseline. The percent share for hip and knee replacements rose and then began to decline slightly around the middle of the time series shown. (**Note:** data since 2005 for joint replacements differ slightly from the original Table regarding the five conditions published in the August 29, 2007, Final Rule because we changed our methodology to recognize several ICD–9 procedure code changes that affected joint replacements). The increase in joint replacements as a proportion of all episodes was not sustained at the 2004–2005 level by the end of the period, perhaps because whatever mechanism operated to cause the growth lost some

of its strength, or perhaps because even faster growth occurred in other types of episodes (such as outlier episodes and/or later episodes).

Our interpretation of these trends in the Aug. 29, 2007, Final Rule was that, with the possible exception of knee replacements, the trends observed at that time were not clearly indicative of a more-severe case mix. If anything, the sustained downward trend for hip fracture, CHF, and CVA suggest that the burden of these diseases on home health providers is lighter now than it used to be. For hip replacement, the share appears to have ended up (thus far) below the share of such patients during the IPS period. For knee replacements, it appears that shares may have ceased climbing. Our interpretation of the knee replacement trend in the August 29, 2007, final rule was that this category constituted a small share, that the Abt case mix change model took account of it, and that based on the model results the knee replacement change apparently was not enough to move the estimate of real case mix change very much. The updated data now suggest that knee replacements leveled off as a share of total episodes since around 2005. As a result, we have not changed our interpretation of the trends in episode shares for these five conditions.

Our estimates of average number of days from hospital discharge to entrance into home health were an attempt to examine the hypothesis that patients were entering home health in a more sickly condition. We did not see any evidence of that for the three medical conditions; the number of days prior to entering home health exhibits no clear trend. For joint replacements, as in the earlier analysis, we saw a continuing decline in the average number of days prior to entering home health. These patients may present in a more sickly condition than was the case under IPS, but they are no longer a growing share of the HH caseload and represent slightly less than 4% of the episodes. Combined with the downward or stabilizing trends in the shares for all five conditions, the shortening of the time period to admission for the two joint replacement conditions does not suggest an overall more-acute case mix, at least as indicated by these five conditions. As we noted in the CY 2008 final rule, the Abt Associates model simultaneously takes account of all of the kinds of patients incurring home health episodes, including the five conditions detailed here.

TABLE 1

		FY 2000	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008*
Hip fracture	pct share	0.82	0.83	0.75	0.73	0.70	0.62	0.56	0.50	0.48
	days prior to entering	7.19	7.12	7.17	7.21	7.30	7.10	7.08	7.20	7.00
Congestive heart failure	pct share	3.31	3.06	2.96	2.89	2.72	2.45	2.23	1.95	2.06
	days prior to entering	3.38	3.28	3.35	3.33	3.36	3.40	3.40	3.53	3.55
Cerebrovascular accident	pct share	1.52	1.45	1.40	1.29	1.15	1.03	0.92	0.85	0.82
	days prior to entering	4.32	4.23	4.21	4.29	4.20	4.32	4.31	4.42	4.59
Hip replacement	pct share	1.47	1.65	1.64	1.59	1.63	1.49	1.38	1.33	1.27
	days prior to entering	6.45	6.32	6.26	6.29	5.92	5.56	5.30	5.01	4.78
Knee replacement	pct share	1.89	2.20	2.31	2.44	2.59	2.74	2.62	2.49	2.64
	days prior to entering	5.40	5.30	5.42	5.19	4.93	4.60	4.25	3.99	3.71

Note: Based on a 10% beneficiary HH user sample.
*CY 2008 data for first quarter of the year only.

In the course of updating the estimate of real case-mix change, our analysis contractor, Abt Associates, discovered a number of errors in data handling for the case-mix change model. The analysis files included relatively small numbers of records that should have been excluded, and relatively small numbers that were dropped but that should have been included. Another error was in the handling of missing data for one of the key variables in the regression model (patient's living situation); data were not recognized as missing and were therefore miscoded. Methodologically, an improvement was implemented to ensure that the observation period for the IPS baseline sample was consistent with the observation period for the PPS sample (2005).

Abt Associates made corrections in response to each problem identified. The only significant change in results came from correcting the handling of missing data. Correcting this error (by imputing values for cases with missing data) caused an increase in the estimated real change in case-mix. Our original estimate, published in the CY 2008 HH PPS final rule (72 FR 49842), was that about 8.03 percent of the increase in case-mix between the IPS baseline (1999–2000) and 2005 was due to actual changes in patient characteristics (*i.e.,* ''real''). After this correction, the real case-mix change estimate for the same period increased by several percentage points. Had the data corrections and improvements been implemented in the CY 2008 HH PPS final rule, our estimate of real case-mix change, as a percentage of total case-mix change, would have been approximately 14.15 percent as opposed to 8.03 percent (73 FR 49833, 49842). Updating that analysis, using PPS data from 2006, our best estimate of real case-mix change, as a percentage of total case-mix change, is slightly lower (11.45 percent). This is due to the combination of continued strong annual growth between 2005 and 2006 in the average case-mix weight, along with little change between 2005 and 2006 in patient characteristics.

We have further updated our case-mix analysis, for this rule, using PPS data from 2007. That analysis indicated a 15.03 percent increase in the overall observed case-mix since 2000. We next determined what portion of that increase was associated with a real change in the actual clinical condition of home health patients. As was done for the CY 2008 final rule, using Abt Associates' 6-phase model, we examined data on demographics, family support, pre-admission location, clinical severity, and non-home health Part A Medicare expenditure data to predict the average case mix weight for 2007. As such, our best estimate is that approximately 9.77 percent of the 15.03 percent increase in the overall observed case-mix between the IPS baseline and 2007 is real, that is, due to actual changes in patient characteristics.

The estimate of real case-mix change continues to decrease for a number of reasons: First, because the nominal change in case mix continues to grow, real case-mix as a percentage of the total change/increase in case-mix becomes

less. With each successive sample, beginning with 2005 data (in the CY 2008 final rule), the predicted average national case-mix weight is moving very little because the variables in the model used to predict case-mix are not changing much. At the same time, the actual average case-mix continues to grow steadily. Thus, the gap between the predicted case-mix value, which is based on information external to the OASIS, and the actual case-mix value, grows with each successive sample. Consequently, as a result of this analysis, CMS recognizes that a 13.56 percent nominal increase ($15.03 - (15.03 \times 0.0977)$) in case-mix is due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients.

To compensate for this growth over four years, an increase of this magnitude (13.56 percent), had it existed when the CY 2008 final rule was published, would have implied reductions in the rates of 3.13 percent per year for 4 years (CY 2008–CY 2011). We stated in our CY 2008 HH PPS proposed and final rules that we might find it necessary to adjust the offsets as new data became available. Given that we have adjusted the rates for two consecutive years by -2.75 percent in each year, based on 2007 data available for this proposed rule, if we were to account for the residual increase in nominal case-mix over the next two years, maintain our existing policy of a -2.75 percent case-mix change in 2010, and account for the residual increase in nominal case-mix in 2011, we estimate that the percentage reduction in the rates for nominal case-mix change in 2011 would be 4.26 percent. If we were to account (in the final rule) for the full residual increase in nominal case-mix in CY 2010, we estimate that the percentage reduction to the national standardized 60-day episode rates and the NRS conversion factor would be 6.89 percent. Similarly, if we were to account (in the final rule) for the full residual increase in nominal case-mix in two years, we estimate that the percentage reduction to the national standardized 60-day episode payment rates and the NRS conversion factor would be 3.51 percent, per year, in CY 2010 and CY 2011. We are planning to move forward with our existing policy, as implemented in the August 22, 2007 HH PPS Refinement and Rate Update for CY 2008 final rule with comment, of imposing a 2.75 percent reduction to the national standardized 60-day episode rates and the NRS conversion factor for CY 2010. We are accepting comments on the reduction percentages. We will continue to monitor any future changes in case-mix as more current data become available. Given the continued growth in nominal case-mix, we expect to revise, upward, the 2.71 percent reduction to the national standardized 60-day episode rates and the NRS conversion factor for CY 2011 in next year's rule. Analysis in next year's rule will update the measure of the nominal increase in case-mix and compute the appropriate percent reduction to the national standardized 60-day episode rates and the NRS conversion factor to account for that increase.

We may update the above-mentioned analysis for the final rule in a number of ways. We have been assembling data to enhance the Abt model to take into account factors that might have been unmeasured in the original model. We plan to introduce diagnostic summaries created from a broader sweep of the patient's claims history, including Part B claims. Specifically, we may add information from the Medicare Hierarchical Coexisting Condition (HCC) data file to identify diagnoses for home health users and their impact on the predicted real case-mix weight. The HCC system is used for risk adjustment in Part C of the Medicare program. CMS annually produces an HCC record containing diagnosis flags and an HCC ''score'' for every beneficiary. The diagnoses used for HCC risk adjustment come from hospital inpatient claims (primary and secondary diagnoses) (including rehabilitation, long-term, and psychiatric hospitals), hospital outpatient department claims, physician claims, and claims from clinically trained nonphysicians such as podiatrists, psychologists, and physical therapists. Until now, diagnostic information for the Abt model came from Part A inpatient claims only.

Commenters have suggested that we take into account changes in the role of managed care in the Medicare program. These commenters stated that growth in managed care enrollment implies a generally sicker population remaining in the fee-for-service program; a change in home health users' general health status might be reflected in OASIS items that determine the episode's HHRG. Medicare managed care began to grow modestly in 2004, but growth accelerated in 2006. Therefore, another enhancement that we may test is a variable measuring managed care penetration in the beneficiary's area; this variable is intended to capture any possible effects of attrition from FFS Medicare due to growing enrollment in Medicare Advantage plans. Attrition might result in the exit of relatively healthy beneficiaries from the FFS program, leaving a population in FFS whose average health status worsens over time. It is only the FFS population that is at risk for home health benefit use in the HH PPS.

C. Proposed CY 2010 Rate Update

1. The Home Health Market Basket Update

Section 1895(b)(3)(B) of the Act requires for CY 2010 that the standard prospective payment amounts be increased by a factor equal to the applicable home health market basket update for those HHAs that submit quality data as required by the Secretary.

The proposed HH PPS market basket update for CY 2010 is 2.2 percent. This is based on Global Insight Inc.'s first quarter 2009 forecast, utilizing historical data through the fourth quarter 2008. A detailed description of how we derive the HHA market basket is available in the CY 2008 Home Health PPS proposed rule (72 FR 25356, 25435).

2. Home Health Care Quality Improvement

Section 1895(b)(3)(B)(v)(II) of the Act requires that ''each home health agency shall submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.'' In addition, section 1895(b)(3)(B)(v)(I) of the Act dictates that ''for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points.'' This requirement has been codified in regulations at § 484.225.

CMS published information about the quality measures in the **Federal Register** as a proposed rule on May 4, 2007 (72 FR 25449, 25452) and as a final rule with comment period on August 29, 2007 (72 FR 49861, 49864). We proposed and made final, the decision to use a subset of OASIS data that is publicly reported on Home Health Compare as the appropriate measure of home health quality.

Reporting these quality data has also required the development of several supporting mechanisms such as the HAVEN software, used to encode and transmit data using a CMS standard electronic record layout, edit specifications, and data dictionary. The HAVEN software includes the required

OASIS data set that has become a standard part of HHA operations. These early investments in data infrastructure and supporting software that CMS and HHAs have made over the past several years in order to create this quality reporting structure have been successful in making quality reporting and measurement an integral component of the HHA industry.

Development and selection of home health quality measures is a constant and dynamic process based on the characteristics and needs of the population served. A total of 54 quality measures are currently reported to home health agencies for use in their Outcomes Based Quality Improvement (OBQI) activities. Every three years a selection of Home Health quality measures are submitted to the National Quality Forum (NQF) for consideration and endorsement through their consensus process. A subset of measures are chosen by CMS for public reporting on the Home Health Compare Web site. The following twelve measures are currently publicly reported:

- Improvement in ambulation/locomotion,
- Improvement in bathing,
- Improvement in transferring,
- Improvement in management of oral medications,
- Improvement in pain interfering with activity,
- Acute care hospitalization,
- Emergent care,
- Discharge to community,
- Improvement in Dyspnea,
- Improvement in urinary incontinence,
- Improvement in status of surgical wounds, and
- Emergent care for wound infections, deteriorating wound status.

Accordingly, for CY 2010, we propose to continue to use submission of OASIS data and the quality measures that are publicly reported on Home Health Compare to meet the requirement that the HHA submit data appropriate for the measurement of health care quality. Continuing to use the specified measures from the OASIS instrument for purposes of measuring health care quality ensures that providers will not have an additional burden of reporting through a separate mechanism, and that the costs associated with the development and testing of a new reporting mechanism can be avoided.

We are proposing for CY 2010 to consider OASIS assessments submitted by HHAs to CMS in compliance with HHA conditions of participation for episodes beginning on or after July 1, 2008 and before July 1, 2009 as fulfilling the quality reporting requirement for CY 2010. This time period would allow 12 full months of data collection and would provide us the time necessary to analyze and make any necessary payment adjustments to the payment rates in CY 2010 and each year thereafter. We propose to reconcile the OASIS submissions with claims data in order to verify full compliance with the quality reporting requirements in CY 2010 and each year thereafter on an annual cycle July 1 through June 30 as described above.

As set forth in the CY 2008 final rule with comment period (72 FR 49863), agencies do not need to submit quality measures for reporting purposes for those patients who are excluded from the OASIS submission requirements under the Home Health Conditions of Participation (CoP). The conditions of participation (42 CFR 484.200–484.265) that require submission also provide for exclusions from this requirement if:

- Those patients are receiving only non-skilled services,
- Neither Medicare nor Medicaid is paying for home health care (patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement),
- Those patients are receiving pre- or post-partum services, or
- Those patients are under the age of 18 years.

As set forth in the CY 2008 final rule with comment period (72 FR 49863), agencies that certify on or after May 31 of the preceding year involved are excluded from any payment penalty for quality reporting purposes for the following CY. Therefore, HHAs that are certified on or after May 1, 2009 are excluded from the quality reporting requirement for CY 2010 payments since data submission and analysis will not be possible for an agency certified this late in the reporting time period. At the earliest time possible after obtaining the CMS Certification Number (CCN), reporting would be mandatory. These exclusions only affect quality reporting requirements and do not affect the HHA's reporting responsibilities under the CoP.

HHAs that meet the reporting requirements would be eligible for the full home health market basket percentage increase. HHAs that do not meet the reporting requirements would be subject to a 2 percent reduction to the home health market basket increase. We provide the proposed payment rates in Tables 1, 2, and 3.

Section 1895(b)(3)(B)(v)(III) of the Act further requires that ''[t]he Secretary shall establish procedures for making data submitted under subclause (II) available to the public. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.'' To meet the requirement for making such data public, we propose to continue using the *Home Health Compare* Web site, which lists HHAs geographically. Currently, the Home Health Compare Web site lists 12 quality measures from the OASIS set as described above. The Home Health Compare Web site is located at the following Web address: *http://www.medicare.gov/HHCompare/Home.asp.* Each HHA currently has pre-publication access (through the CMS contractor) to its own quality data (which the contractor updates periodically). We plan to continue this process, to enable each agency to view its quality measures before public posting of data on *Home Health Compare.*

CMS is requesting OMB approval to modify the OASIS data set. This process is in the final stages of OMB clearance. Pending OMB approval, CMS intends to implement the use of the OASIS–C (Form Number CMS–R–245 (OMB# 0938–0760)) on January 1, 2010. This revision to the current OASIS version B–1 has undergone additional testing as part of the information collection request approved under OMB control number 0938–1040. As part of the OMB approval process, the revision to the current OASIS version was also distributed for public comment and other technical expert recommendations over the past few years. We propose that this new version of OASIS be collected on episodes of care with a corresponding OASIS item (M0090) date of January 1, 2010 or later. The OASIS–C can be found using the following link: *http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=descending&itemID=CMS1217682&intNumPerPage=10*

We are also planning to update *Home Health Compare* to reflect the addition of the following 13 new process of care measures:

- Timely initiation of care,
- Influenza immunization received for current flu season,
- Pneumococcal polysaccharide vaccine ever received,
- Heart failure symptoms addressed during short-term episodes,
- Diabetic foot care and patient education implemented during short-term episodes of care,
- Pain assessment conducted,
- Pain interventions implemented during short-term episodes,

• Depression assessment conducted,
• Drug education on all medications provided to patient/caregiver during short-term episodes.
• Falls risk assessment for patients 65 and older,
• Pressure ulcer prevention plans implemented,
• Pressure ulcer risk assessment conducted, and
• Pressure ulcer prevention included in the plan of care.

Also under consideration are three additional process of care measures that may be added to Home Health Compare based on results of consumer testing. Those additional process measures are:

• Drug education on high risk medications provided to patient/caregiver at start of episode;
• Potential medication issues identified and timely physician contact at start of episode;
• Potential medication issues identified and timely physician contact during episode.

The implementation of OASIS–C will impact the quality data reporting requirement for the CY 2011 HH PPS. However, we expect the conversion from OASIS–B1 to OASIS–C to have little to no impact on HHAs' ability to meet the quality data reporting requirements under Section 1895(b)(3)(B)(v).

For CY 2011, CMS proposes to expand the home health quality measures reporting requirements to include the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey (pending OMB approval). The CAHPS® Home Health Care Survey (hereafter ''HHCAHPS'') is a quality tool that we believe that we can use to collect quality of care data, as required by section 1895(b)(3)(B)(v)(II) of the Act, and as permitted under section 1861(o)(8) of the Act, which requires any Medicare participating HHA to ''meet [] such additional requirements * * * as the Secretary finds necessary for the effective and efficient operation of the program''. The HHCAHPS data collection will support the effective and efficient operation of the program because patients' feedback on their perspectives of the home health quality of care from the agency cannot be obtained from any other quality measure in the program. The Home Health Care Survey is part of a family of CAHPS® surveys that ask patients to report on and rate their experiences with health care. The HHCAHPS survey developed by the Agency for Healthcare Research and Quality (AHRQ) which is part of the Department of Health and Human Services, presents home health patients with a set of standardized questions about their home health care providers and the quality of their home health care. Prior to this survey, there was no national standard for collecting information about patient experiences that would enable valid comparisons across all HHAs.

AHRQ developed the HHCAHPS survey with the assistance of many entities (for example, government agencies, professional stakeholders, consumer groups and other key individuals and organizations involved in home health care). The HHCAHPS survey was designed to measure and assess the experiences of those persons receiving home health care with the following three goals in mind:

• To produce comparable data on patients' perspectives of care that allow objective and meaningful comparisons between home health agencies on domains that are important to consumers;
• To create incentives for agencies to improve their quality of care through public reporting of survey results; and
• To hold health care providers accountable by informing the public about the providers' quality of care (*http://www.homehealthcahps.org*).

These three goals support Section 1861(o)(8) of the Act, which requires any Medicare participating HHA to ''meet [] such additional requirements * * * as the Secretary finds necessary for the effective and efficient operation of the program.''

The development process for the survey began in 2006 and included a public call for measures, review of the existing literature, consumer input, stakeholder input, public response to **Federal Register** notices, and a field test conducted by AHRQ. AHRQ conducted this field test to validate the length and content of the HHCAHPS survey. CMS submitted the survey to the National Quality Forum (NQF) for consideration and endorsement via their consensus process. NQF endorsement represents the consensus opinion of many healthcare providers, consumer groups, professional organizations, health care purchasers, Federal agencies and research and quality organizations. The survey received NQF endorsement on March 31, 2009.

The HHCAHPS survey includes 34 questions that cover topics such as specific types of care provided by home health providers, communication with providers, interactions with the HHA, and global ratings of the agency. For public reporting purposes, CMS will utilize composite measures and global ratings of care. Each composite measure consists of four or more questions that ask about one of the following related topics:

• Patient care;
• Communications between providers and patients;
• Specific care issues (medications, home safety and pain).

There are also two global ratings; the first rating asks the patient to assess the care given by the HHA's care providers, and the second asks the patient about his/her willingness to recommend the HHA to family and friends.

We are proposing two options for administering the HHCAHPS survey. The agency can choose to administer the existing HHCAHPS survey, or the HHA can integrate additional questions within the HHCAHPS survey. If an agency chooses to implement an integrated survey, the core questions from the HHCAHPS survey (questions 1 through 25) must be placed before any specific/supplemental questions that the HHA wishes to add to the survey. Questions 26 through 34 (the ''About You'' survey questions) must be administered as a unit—although they may be placed either before or after any supplemental questions that the HHA wishes to add to the HHCAHPS survey. If no HHA-specific questions are to be added to the HHCAHPS survey, the ''About You'' questions should follow the core questions (numbered 1 through 25) on the HHCAHPS survey.

The survey is currently available in both English and Spanish. HHAs and their survey vendors will *not* be permitted to translate the HHCAHPS survey into any other languages on their own. However, CMS will provide additional translations of the survey over time. The Web site *https://www.homehealthcahps.org* will provide information about the subsequent availability of additional translations. CMS also solicits user suggestions for any additional language translations. Such suggestions should be submitted online to the HHCAHPS Survey Coordination Team, at *HHCAHPS@rti.org.* HHAs interested in learning about the survey are encouraged to view the HHCAHPS survey Web site, at *https://www.homehealthcahps.org.* Agencies can also call toll-free, 1–866–354–0985, or send an e-mail to the HHCAHPS Survey Coordination Team at *HHCAHPS@rti.org* for more information.

The following types of home health care patients will be considered eligible to participate in the HHCAHPS survey:

• Current or discharged patients who had at least one home health visit at any time during the sample month;

• Patients who were at least 18 years of age at any time during the sample period, and are believed to be alive;

• Patients who received *at least two visits* from HHA personnel during a 60-day look-back period (Note that the 60-day look-back period is defined as the 60-day period prior to and including the last day in the sample month.);

• Patients who have not been selected for the monthly sample during any month in the current quarter or during the 5 months immediately prior to the sample month;

• Patients who are not currently receiving hospice care;

• Patients who do not have routine ''maternity'' care as the primary reason for receiving home health care; and

• Patients who have *not* requested ''no publicity status.''

CMS has modeled HHCAHPS after the Hospital CAHPS survey where both the CAHPS and clinical data are collected for both Medicare and non-Medicare patients to get a complete picture of hospital quality. Since HHCAHPS data are not used to develop case-mix collection of data for HHCAHPS are not carried out under the auspices of section 4602(e) of the BBA, such collections are not subject to the OASIS limitation to Medicare and Medicaid patients only, set out under section 704(a) of the MMA. To collect and submit HHCAHPS data to CMS, Medicare-certified agencies will need to contract with an approved HHCAHPS survey vendor. Interested vendors can now apply to become approved HHCAHPS vendors. The application process is delineated online at *https://www.homehealthcahps.org.* Vendors will also be required to attend training conducted by CMS and the HHCAHPS Survey Coordination Team. HHAs that are interested in participating in the HHCAHPS survey may do so on a voluntary basis for the remaining months of 2009. Such agencies must select a vendor from the list of HHCAHPS approved survey vendors. This listing will be available on the Web site *https://www.homehealthcahps.org* during the summer of 2009.

CMS proposes that beginning in the first quarter of CY 2010, all Medicare-certified HHAs shall begin to collect the CAHPS® Home Health Care (HHCAHPS) survey data in accordance with the Protocols and Guidelines Manual located on the HHCAHPS Web site *https://www.homehealthcahps.org.* HHAs shall contract with approved HHCAHPS survey vendors that are posted on *https://www.homehealthcahps.org* to conduct the survey on behalf of HHAs. CMS proposes that participating home health agencies conduct a dry run of the survey for at least one month in the first quarter of 2010 (January, and/or February, and/or March 2010), and submit the dry run data to the Home Health CAHPS® Data Center by 11:59 p.m. EST on June 23, 2010. The dry run data would not be publicly reported on the *Home Health Compare.* This dry run would provide an opportunity for vendors and HHAs to acquire first-hand experience with data collection, including sampling and data submission to the Home Health CAHPS® Data Center, with no public reporting of the results. CMS proposes that all Medicare-certified HHAs continuously collect HHCAHPS survey data every quarter beginning in the second quarter (April, May and June) of 2010, and submit these data for the second quarter of 2010 to the Home Health CAHPS® Data Center by 11:59 p.m. EST on September 22, 2010. CMS proposes that these data submission deadlines are firm; that is, there will be no late submissions allowed.

The Medicare-certified HHAs will need to provide their respective survey vendors with information about their survey-eligible patients (either current or discharged) every month in accordance with the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org.* The details about selecting the HHA sample are delineated in the Protocols and Guidelines manual on the Web site *https://www.homehealthcahps.org.* It is proposed that the HHCAHPS survey data be submitted and analyzed quarterly, and that the sample selection and data collection occur on a monthly basis. HHAs should target 300 HHCAHPS survey completes annually. Smaller agencies that are unable to reach 300 survey completes by sampling should survey all HHCAHPS eligible patients. For reasons of statistical precision, a target minimum of 300 or more completed Home Health CAHPS surveys has been set for each home health agency. 300 completes is based on a reliability target of 0.8 or higher. We propose that survey vendors initiate the survey for each monthly sample within three weeks after the end of the sample month. All data collection for each monthly sample would have to be completed within six weeks (42 days) after data collection began. CMS has approved three modes of the survey to be used: Mail only, telephone only, and mail with telephone follow-up (the ''mixed mode''). We are proposing that for mail-only and mixed-mode surveys, data collection for a monthly sample would have to end six weeks after the first questionnaire was mailed. For telephone-only surveys, data collection would have to end six weeks following the first telephone attempt.

CMS is aware that there is a wide variation in the size of Medicare-certified HHAs. CMS proposes that the requirement to collect HHCAHPS survey data be waived for agencies that serve fewer than 60 HHCAHPS eligible patients annually. We are proposing this threshold amount in order to exempt agencies that serve a very small home health eligible population. These agencies serve, on average, 5 or fewer patients per month. The HHCAHPS eligible, unduplicated patient counts for the period of October 1 through September 30 for a given year would be used to determine if the HHA would have to participate in the HHCAHPS survey in the next calendar year. If a Medicare-certified HHA had fewer than 60 eligible, unduplicated HHCAHPS eligible patients for the period October 1 through September 30, then they would be excluded from the HHCAHPS requirement for the next calendar year. For example, if a small HHA had 85 patients in the period October 1, 2008 through September 30, 2009, and 45 of the patients were routine maternity patients, then there would only be 40 HHCAHPS eligible patients. This agency would therefore not be required to participate in the HHCAHPS survey. Alternatively, if a small HHA had 85 patients for the period October 1, 2008 through September 30, 2009, and 70 of these patients were eligible to participate in the HHCAHPS survey (*i.e.,* because they: (1) Were 65 years or older; (2) were recently discharged from the hospital to their homes; (3) were not receiving hospice care; (4) were not designated as ''no publicity'' patients; and (5) had received at least two home health visits) this agency would be required to participate in the HHCAHPS survey. Only Medicare-certified HHAs with fewer than 60 eligible, unduplicated patients for the period October 1, 2008 through September 30, 2009 would submit their patient counts to the HHCAHPS Data Center by Wednesday, January 13, 2010.

We also propose that newly Medicare-certified HHAs (that is, those certified on or after January 1, 2010 for payments to be made in CY 2011) be excluded from the HHCAHPS survey reporting requirement, as data submission and analysis would not be possible for an agency so late in the reporting period. In future years, agencies that first certify on or after January 1 of the preceding year would be excluded from any payment penalty for reporting purposes in the following CY. We note that this exclusion for new HHAs pertains only

to the HHCAHPS survey reporting requirement.

CMS strongly recommends that HHAs participating in HHCAHPS survey promptly review the required Data Submission Summary Reports that are delineated in the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org.* These reports will enable the HHA to ensure that its survey vendor has submitted their data on time, and that the data has been accepted/received by the Home Health CAHPS® Data Center.

CMS anticipates first reporting HHCAHPS survey data in early 2011 on *Home Health Compare.* The HHCAHPS survey data would be updated quarterly. HHAs would be provided a preview of the data each quarter before it was reported on *Home Health Compare.*

CMS proposes that vendors and HHAs be required to participate in HHCAHPS survey oversight activities to ensure compliance with HHCAHPS survey protocols, guidelines and survey requirements. The purpose of the oversight activities is to ensure that HHAs and approved survey vendors follow the Protocols and Guidelines Manual. It is proposed that all approved survey vendors develop a Quality Assurance Plan (QAP) for survey administration in accordance with the Protocols and Guidelines Manual. The QAP should include the following:

- Organizational chart;
- Work plan for survey implementation;
- Description of survey procedures and quality controls;
- Quality assurance oversight of on-site work and of all subcontractors work; and
- Confidentiality/Privacy and Security procedures in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

As part of the oversight activities the HHCAHPS Survey Coordination Team would conduct on-site visits or conference calls. The HHCAHPS Survey Coordination Team would review the survey vendor's survey systems, and will assess administration protocols based on the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org.* All materials relevant to survey administration would be subject to review. The proposed systems and program review would include, but not be limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) data receipt, entry and storage facilities; and (d) written documentation of survey processes. Organizations would be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. Survey vendors will be subject to follow-up site visits as needed.

CMS strongly recommends that all HHAs participating in the HHCAHPS survey regularly check the Web site, *https://www.homehealthcahps.org* for program updates and information.

As mandated in current law, all HHAs, unless covered by specific exclusions, will continue to be required to meet the quality reporting requirements or be subject to a 2 percent reduction in the home health market basket percentage increase in accordance with section 1895(b)(3)(B)(v)(I) of the Act. A reconsideration and appeals process is being developed for HHAs who fail to meet the HHCAHPS reporting requirements. These procedures would be outlined in the HH PPS proposed rule for CY 2011 in which we are proposing that the HHCAHPS survey would be linked to home health payment, as a requirement under the regulation requiring the reporting of quality data.

3. Home Health Wage Index

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services and to provide appropriate adjustments to the episode payment amounts under the HH PPS to account for area wage differences. As discussed previously, we apply the appropriate wage index value to the labor portion (77.082 percent) of the HH PPS rates based on the site of service for the beneficiary (defined by section 1861(m) of the Act as the beneficiary's place of residence). Generally, we determine each HHA's labor market area based on definitions of Metropolitan Statistical Areas (MSAs) issued by the Office of Management and Budget (OMB). We have consistently used the pre-floor, pre-reclassified hospital wage index data to adjust the labor portion of the HH PPS rates. We believe the use of the pre-floor, pre-reclassified hospital wage index data results in the appropriate adjustment to the labor portion of the costs as required by statute.

In the November 9, 2005 final rule for CY 2006 (70 FR 68132), we adopted revised labor market area definitions based on Core-Based Statistical Areas (CBSAs). At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS). In adopting the CBSA designations, we identified some geographic areas where there are no hospitals and, thus, no hospital wage data on which to base the calculation of the home health wage index. We continue to use the methodology discussed in the November 9, 2006 final rule for CY 2007 (71 FR 65884) to address the geographic areas that lack hospital wage data on which to base the calculation of their home health wage index. For rural areas that do not have IPPS hospitals, we use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to calculate the wage index for rural Massachusetts. However, we could not apply this methodology to rural Puerto Rico due to the distinct economic circumstances that exist there, but instead continue using the most recent wage index previously available for that area (from CY 2005). For urban areas without IPPS hospitals, we use the average wage index of all urban areas within the State as a reasonable proxy for the wage index for that CBSA. The only urban area without IPPS hospital wage data is Hinesville-Fort Stewart, Georgia (CBSA 25980).

On November 20, 2008, OMB issued Bulletin No. 09–01 located at Web address *http://www.whitehouse.gov/omb/bulletins/fy2009/09–01.pdf.* This bulletin highlights three geographic areas that were previously classified as Micropolitan Statistical Areas but now qualify as Metropolitan Statistical Areas. The three areas are (1) CBSA 16020, Cape Girardeau-Jackson, MO–IL (this includes Alexander County in Illinois and Bollinger and Cape Girardeau Counties in Missouri); (2) CBSA 31740, Manhattan, KS (this includes Geary, Pottawatomie, and Riley Counties in Kansas); and (3) CBSA 31860, Mankato-North Mankato, MN (this includes Blue Earth and Nicollet Counties in Minnesota). These three new CBSAs and their associated wage index values are shown in Addendum B.

4. Proposed CY 2010 Payment Update

a. National Standardized 60-Day Episode Rate

The Medicare HH PPS has been in effect since October 1, 2000. As set forth in the final rule published July 3, 2000 in the **Federal Register** (65 FR 41128), the unit of payment under the Medicare HH PPS is a national standardized 60-day episode rate. As set forth in § 484.220, we adjust the national standardized 60-day episode rate by a case-mix relative weight and a wage

index value based on the site of service for the beneficiary.

In the CY 2008 HH PPS final rule with comment period, we refined the case-mix methodology and also rebased and revised the home health market basket. The labor-related share of the case-mix adjusted 60-day episode rate is 77.082 percent and the non-labor-related share is 22.918 percent. The proposed CY 2010 HH PPS rates use the same case-mix methodology and application of the wage index adjustment to the labor portion of the HH PPS rates as set forth in the CY 2008 HH PPS final rule with comment period. We multiply the national 60-day episode rate by the patient's applicable case-mix weight. We divide the case-mix adjusted amount into a labor and non-labor portion. We multiply the labor portion by the applicable wage index based on the site of service of the beneficiary. We add the wage-adjusted portion to the non-labor portion yielding the case-mix and wage adjusted 60-day episode rate subject to any additional applicable adjustments.

In accordance with section 1895(b)(3)(B) of the Act, we update the HH PPS rates annually in a separate **Federal Register** document. The HH PPS regulations at 42 CFR 484.225 set forth the specific annual percentage update. In accordance with § 484.225(i), in the case of a HHA that does not submit home health quality data, as specified by the Secretary, the unadjusted national prospective 60-day episode rate is equal to the rate for the previous calendar year increased by the applicable home health market basket index amount minus two percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be taken into account in computing the prospective payment amount for a subsequent calendar year.

For CY 2010, we will base the wage index adjustment to the labor portion of the HH PPS rates on the most recent pre-floor and pre-reclassified hospital wage index. As discussed in the July 3, 2000 HH PPS final rule, for episodes with four or fewer visits, Medicare pays the national per-visit amount by discipline, referred to as a LUPA. We update the national per-visit rates by discipline annually by the applicable home health market basket percentage. We adjust the national per-visit rate by the appropriate wage index based on the site of service for the beneficiary, as set forth in § 484.230. We will adjust the labor portion of the updated national per-visit rates used to calculate LUPAs by the most recent pre-floor and pre-reclassified hospital wage index, as discussed in the CY 2008 HH PPS final rule with comment period. We are also updating the LUPA add-on payment amount and the NRS conversion factor by the applicable home health market basket update of 2.2 percent for CY 2010.

Medicare pays the 60-day case-mix and wage-adjusted episode payment on a split percentage payment approach. The split percentage payment approach includes an initial percentage payment and a final percentage payment as set forth in § 484.205(b)(1) and § 484.205(b)(2). We may base the initial percentage payment on the submission of a request for anticipated payment (RAP) and the final percentage payment on the submission of the claim for the episode, as discussed in § 409.43. The claim for the episode that the HHA submits for the final percentage payment determines the total payment amount for the episode and whether we make an applicable adjustment to the 60-day case-mix and wage-adjusted episode payment. The end date of the 60-day episode as reported on the claim determines which calendar year rates Medicare would use to pay the claim.

We may also adjust the 60-day case-mix and wage-adjusted episode payment based on the information submitted on the claim to reflect the following:

- A low utilization payment provided on a per-visit basis as set forth in § 484.205(c) and § 484.230.
- A partial episode payment adjustment as set forth in § 484.205(d) and § 484.235.
- An outlier payment as set forth in § 484.205(e) and § 484.240.

b. Proposed Updated CY 2010 National Standardized 60-Day Episode Payment Rate

In calculating the annual update for the CY 2010 national standardized 60-day episode payment rates, we first look at the CY 2009 rates as a starting point. The CY 2009 national standardized 60-day episode payment rate is $2,271.92.

As previously discussed in section II.B., ''Outlier Policy'', of this proposed rule, in our proposed policy of targeting outlier payments to be approximately 2.5 percent of total HH PPS payments in CY 2010, we are proposing to return 2.5 percent back into the HH PPS rates, to include the national standardized 60-day episode payment rate. As such, to calculate the proposed CY 2010 national standardized 60-day episode payment rate, we first increase the CY 2009 national standardized 60-day episode payment rate ($2,271.92) to adjust for the 5 percent originally set aside for outlier payments. We then reduce that adjusted payment amount by 2.5 percent, the proposed target percentage of outlier payments as a percentage of total HH PPS payment. Next, we update by the current proposed CY 2010 home health market basket update percentage of 2.2 percent.

As previously discussed in Section II.C., ''Case-Mix Measurement Analysis'', of this proposed rule, our updated analysis of the change in case-mix not due to an underlying change in patient health status reveals additional increase in nominal change in case-mix. However, we are maintaining our existing policy to reduce rates by 2.75 percent in CY 2010. Consequently, to calculate the proposed CY 2010 national standardized 60-day episode payment rate, we then reduce the rate by 2.75 percent, for a proposed updated CY 2010 national standardized 60-day episode payment rate of $2,325.79. The proposed updated CY 2010 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 2. The proposed updated CY 2010 national standardized 60-day episode payment rate for an HHA that does not submit the required quality data (home health market basket update of 2.2 percent is reduced by 2 percent) is shown in Table 3.

TABLE 2—PROPOSED NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT RATE UPDATED BY THE PROPOSED HOME HEALTH MARKET BASKET UPDATE FOR CY 2010, BEFORE CASE-MIX ADJUSTMENT AND WAGE ADJUSTMENT BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY

CY 2009 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds, that paid for the original 5% target for outlier payments	Adjusted to account for the proposed 2.5% outlier policy	Multiply by the proposed home health market basket update (2.2 percent) [1]	Reduce by 2.75 percent for nominal change in case-mix	Proposed CY 2010 National Standardized 60-Day Episode Payment Rate
$2,271.92	/ 0.95	× 0.975	× 1.022	× 0.9725	$2,317.47

[1] The proposed estimated home health market basket update of 2.2 percent for CY 2010 is based on Global Insight Inc., 1st Qtr 2009 forecast with historical data through 4th Qtr 2008.

TABLE 3—FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA; PROPOSED NATIONAL STANDARDIZED 60-DAY EPISODE PAYMENT RATE UPDATED BY THE PROPOSED HOME HEALTH MARKET BASKET UPDATE FOR CY 2010, BEFORE CASE-MIX ADJUSTMENT AND WAGE ADJUSTMENT BASED ON THE SITE OF SERVICE FOR THE BENEFICIARY

Total CY 2009 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds, that paid for the original 5% target for outliers	Adjusted to account for the proposed 2.5% outlier policy	Multiply by the proposed home health market basket update (2.2 percent) [1] minus 2 percent for a 0.2 percent update	Reduce by 2.75 percent for nominal change in case-mix	Proposed CY 2010 National Standardized 60-Day Episode Payment Rate for HHAs that do not submit required quality data
$2,271.92	/ 0.95	× 0.975	× 1.002	× 0.9725	$2,272.12

[1] The proposed estimated home health market basket update of 2.2 percent for CY 2010 is based on Global Insight Inc., 1st Qtr 2009 forecast with historical data through 4th Qtr 2008.

c. Proposed National Per-Visit Rates Used To Pay LUPAs and Compute Imputed Costs Used in Outlier Calculations

In calculating the proposed CY 2010 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, we start with the CY 2009 national per-visit rates. We first adjust the CY 2009 national per-visit rates to adjust for the 5 percent originally set aside for outlier payments. We then reduce those national per-visit rates by 2.5 percent, the proposed target percentage of outlier payments as a percentage of total HH PPS payment. Next we update by the current proposed CY 2010 home health market basket update percentage of 2.2 percent. National per-visit rates are not subject to the 2.75 percent reduction related to the nominal increase in case-mix because they are per-visit rates and hence not case-mix adjusted. The proposed CY 2010 national per-visit rates per discipline are shown in Table 4. The six home health disciplines are Home Health Aide (HH aide), Medical Social Services (MSS), Occupational Therapy (OT), Physical Therapy (PT), Skilled Nursing (SN), and Speech Language Therapy (SLP).

TABLE 4—PROPOSED NATIONAL PER-VISIT RATES FOR LUPAS (NOT INCLUDING THE LUPA ADD-ON PAYMENT AMOUNT FOR A BENEFICIARY'S ONLY EPISODE OR THE INITIAL EPISODE IN A SEQUENCE OF ADJACENT EPISODES) AND OUTLIER CALCULATIONS UPDATED BY THE PROPOSED CY 2010 HOME HEALTH MARKET BASKET UPDATE, BEFORE WAGE INDEX ADJUSTMENT

Home Health Discipline Type	CY 2009 Per-Visit Amounts Per 60-Day Episode for LUPAs	Adjusted to return the outlier funds that paid for the original 5% target for outlier payments	Adjusted to account for the proposed 2.5% outlier policy	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
				Multiply by the proposed home health market basket update (2.2 percent) [1]	CY 2010 per-visit payment amount for HHAs that DO submit the required quality data	Multiply by the proposed home health market basket update (2.2 percent) [1] minus 2 percent, for a 0.2 percent update	CY 2010 per-visit payment amount for HHAs that DO NOT submit the required quality data
Home Health Aide	$48.89	/ 0.95	× 0.975	× 1.022	$51.28	× 1.002	$50.28
Medical Social Services	173.05	/ 0.95	× 0.975	× 1.022	181.51	× 1.002	177.96
Occupational Therapy	118.83	/ 0.95	× 0.975	× 1.022	124.64	× 1.002	122.20
Physical Therapy	118.04	/ 0.95	× 0.975	× 1.022	123.81	× 1.002	121.39
Skilled Nursing	107.95	/ 0.95	× 0.975	× 1.022	113.23	× 1.002	111.01
Speech-Language Pathology	128.26	/ 0.95	× 0.975	× 1.022	134.53	× 1.002	131.90

[1] The proposed estimated home health market basket update of 2.2 percent for CY 2010 is based on Global Insight Inc., 1st Qtr 2009 forecast with historical data through 4th Qtr 2008.

d. Proposed LUPA Add-On Payment Amount Update

Beginning in CY 2008, LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for area wage differences. As previously discussed, we are proposing to return 2.5 percent back into the HH PPS rates, to include the LUPA add-on payment amount, as a result of our proposed policy to target outlier payments to be approximately 2.5 percent of total HH PPS payments in CY 2010. As such, we first adjust the CY 2009 LUPA add-on payment amount to adjust for the 5 percent originally set aside for outlier payments. We then reduce that amount by 2.5 percent, the proposed target percentage of outlier payments as a percentage of total HH PPS payment. Next we update by the current proposed CY 2010 home health market basket update percentage of 2.2 percent. The LUPA add-on payment amount is not subject to the 2.75 percent reduction related to the nominal increase in case-mix because it is an add-on to the per-visit rates which are not case-mix adjusted. The proposed CY 2010 LUPA add-on payment amount is shown in Table 5 below. Just as the standardized 60-day episode rate and the per-visit rates paid to HHAs that do not submit the required quality are reduced by 2 percent, the additional LUPA payment should be reduced by 2 percent also. In neither the CY 2008 nor the CY 2009 HH PPS rulemaking did we include such an adjustment to the LUPA add-on payment amount. For CY 2010, we propose that the add-on to the LUPA payment to HHAs that submit the required quality data would be updated by the home health market basket update. We propose that the add-on to the LUPA payment to HHAs that do not submit the required quality data would be updated by the home health market basket update minus two percent.

TABLE 5—PROPOSED CY 2010 LUPA ADD-ON PAYMENT AMOUNTS

CY 2009 LUPA add-on payment amount adjusted to return the outlier funds, that paid for the original 5% target for outliers	Adjusted to return the outlier funds, that paid for the original 5% target for outliers	Adjusted to account for the proposed 2.5% outlier policy	For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
			Multiply by the proposed home health market basket update (2.2 percent)[1]	Proposed CY 2010 LUPA add-on payment amount for HHAs that DO submit required quality data	Multiply by the proposed home health market basket update (2.2 percent)[1] minus 2 percent, for a 0.2 percent update	Proposed CY 2010 LUPA add-on payment amount for HHAs that DO NOT submit required quality data
$90.48	/ 0.95	× 0.975	× 1.022	$94.90	× 1.002	$93.05

[1] The proposed estimated home health market basket update of 2.2 percent for CY 2010 is based on Global Insight Inc., 1st Qtr 2009 forecast with historical data through 4th Qtr 2008.

e. Proposed Non-Routine Medical Supply Conversion Factor Update

Payments for non-routine medical supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. We first adjust the CY 2009 NRS conversion factor ($52.39) to adjust for the 5 percent originally set aside for outlier payments. We then reduce that amount by 2.5 percent, the proposed target percentage of outlier payments as a percentage of total HH PPS payment. Next we update by the current proposed CY 2010 home health market basket update percentage of 2.2 percent. Finally, we then reduce that adjusted payment amount by 2.75, to account for the increase in nominal case-mix. The proposed CY 2010 NRS conversion factor is shown in Table 6a below. The NRS conversion factor for CY 2009 was $52.39. Consequently, for CY 2010, the proposed NRS conversion factor would be $53.44.

TABLE 6a—PROPOSED CY 2010 NRS CONVERSION FACTOR FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

CY2009 NRS Conversion Factor	Adjusted to return the outlier funds, that paid for the original 5% target for outlier payments	Adjusted to account for the proposed 2.5% outlier policy	Multiply by the proposed home health market basket update (2.2 percent)	Reduce by 2.75 percent for nominal change in case-mix	Proposed CY 2010 NRS Conversion Factor for HHAs that Do submit the required quality data
$52.39	/ 0.95	× 0.975	× 1.022	× 0.9725	$53.44

The proposed payment amounts, using the above computed proposed CY 2010 NRS conversion factor ($53.44), for the various severity levels based on the proposed updated conversion factor are calculated in Table 6b.

TABLE 6b—RELATIVE WEIGHTS FOR THE 6-SEVERITY NRS SYSTEM

Severity level	Points (scoring)	Relative weight	Proposed NRS payment amount
1	0	0.2698	$14.42
2	1 to 14	0.9742	52.06
3	15 to 27	2.6712	142.75
4	28 to 48	3.9686	212.08
5	49 to 98	6.1198	327.04
6	99 +	10.5254	562.48

For HHAs that do not submit the required quality data, we again begin with the CY 2009 NRs conversion factor. We first adjust the CY 2009 NRS conversion factor ($52.39) to adjust for the 5 percent originally set aside for outlier payments. We then reduce that amount by 2.5 percent, the proposed target percentage of outlier payments as a percentage of total HH PPS payment. Next we update by the current proposed CY 2010 home health market basket update percentage of 2.2 percent minus 2 percent for a 0.002 percent update. Finally, we then reduce that adjusted payment amount by 2.75, to account for the increase in nominal case-mix. The proposed CY 2010 NRS conversion factor is shown in Table 7a below.5

TABLE 7a—PROPOSED CY 2010 NRS CONVERSION FACTOR FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

CY 2009 NRS Conversion Factor	Adjusted to return the outlier funds, that paid for the original 5% target for outlier payments	Adjusted to account for the proposed 2.5% outlier policy	Multiply by the proposed home health market basket update (2.2 percent) minus 2 percent for a 0.25 update	Reduce by 2.75 percent for nominal change in case-mix	Proposed CY 2010 NRS Conversion Factor for HHAs that Do submit the required quality data
$52.39	/ 0.95	× 0.975	× 1.002	× 0.9725	$52.39

The proposed payment amounts for the various severity levels based on the proposed updated conversions factor, for HHAs that do not submit quality data, are calculated in Table 7b, below.

TABLE 7b—RELATIVE WEIGHTS FOR THE 6-SEVERITY FOR HHAS THAT DO NOT SUBMIT QUALITY DATA

Severity level	Points (scoring)	Relative weight	Proposed NRS payment amount
1	0	0.2698	$14.13
2	1 to 14	0.9742	51.04
3	15 to 27	2.6712	139.94
4	28 to 48	3.9686	207.91
5	49 to 98	6.1198	320.62
6	99 +	10.5254	551.43

D. OASIS Issues

1. HIPPS Code Reporting

We would first like to clarify our policy regarding the submission of the Health Insurance Prospective Payment System (HIPPS) code to CMS via the OASIS. § 484.250 requires HHAs to submit to CMS the OASIS data described in § 484.55(b)(1) and § 484.55(d)(1) in order for CMS to administer the payment rate methodologies. Also, as described in § 484.20, HHAs must electronically report all OASIS data collected in accordance with § 484.55 as a condition of participation, and HHAs must encode and electronically transmit the completed OASIS assessment to CMS in the standard data format as described in § 484.20(d). For those OASIS assessments required for payment, the standard format which is electronically transmitted by the HHA to CMS includes a HIPPS code, generated by grouper software at the HHA. When an HHA electronically transmits OASIS assessments to CMS (via the State agency), the CMS OASIS submission system performs a validation check of the transmitted OASIS items, including the submitted HIPPS code. If the CMS OASIS submission system validation determines that the submitted HIPPS code is in error, it informs HHAs of that error via the Final Validation Report which is returned to HHA. The Final Validation Report will include the valid, CMS OASIS submission system calculated HIPPS code. We have become aware of a proliferation of incidents where the HIPPS code submitted to CMS on the OASIS does not match the HIPPS code which is calculated by the CMS OASIS submission system. The HH PPS Grouper Software, which is used by the CMS OASIS submission system in its validation, is the official grouping software of the HH PPS, and thus the HIPPS code produced by the CMS OASIS submission system is the HIPPS code that should ultimately be billed on the claim. Consequently, in the interest of accurate coding and billing, we propose that the HHA be required to ensure that the HIPPS code billed on the claim is consistent with that which CMS' OASIS submission system calculated. In the case where the Final Validation Report returns to the HHA a HIPPS code which is different than the HIPPS code submitted to CMS by the HHA on the OASIS, the HHA must ensure that the HIPPS code from the Final Validation report is the HIPPS code reported on the bill.

2. OASIS Submission as a ''Condition of Payment''

Section 484.20 requires that HHAs must electronically report to CMS (via the State agency or OASIS contractor) all OASIS data collected in accordance with § 484.55 as a condition of participation. Additionally, § 484.250 requires that HHAs must submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies. Building on the above clarification for HHAs to ensure the HIPPS code reported on the bill is consistent with that which CMS' OASIS submission system calculated, and in order to be consistent with § 484.250, we are proposing to require the electronic reporting of OASIS to CMS as a condition of payment in § 484.210. Currently, as a requirement for pay for reporting, HHAs are required to submit quality data (that being OASIS data) in order to receive the full home health market basket update to the rates. The

burden associated with the requirement for the HHA to submit the OASIS is currently accounted for under OMB# 0938–0761. Making OASIS submission a condition for payment is consistent with both OASIS submissions being a condition of participation and a requirement to receive full market basket updates under pay for reporting. As such, we are proposing to revise § 484.210 ''Data used for the calculation of the national prospective 60-day episode payment'' to reflect this requirement.

E. Qualifications for Coverage as They Relate to Skilled Services Requirements

To qualify for Medicare coverage of home health services a Medicare beneficiary must meet each of the following requirements as stipulated in § 409.42: Be confined to the home or an institution that is not a hospital, SNF, or nursing facility as defined in sections 1861(e)(1), 1819(a)(1) or 1919 of Act; be under the care of a physician as described in § 409.42(b); be under a plan of care that meets the requirements specified in § 409.43; the care must be furnished by or under arrangements made by a participating HHA, and the beneficiary must be in need of skilled services as described in § 409.42(c). Subsection 409.42(c) of our regulations requires that the beneficiary need at least one of the following services as certified by a physician in accordance with § 424.22: Intermittent skilled nursing services and the need for skilled services which meet the criteria in § 409.32; Physical therapy which meets the requirements of § 409.44(c), Speech-language pathology which meets the requirements of § 409.44(c); or have a continuing need for occupational therapy that meets the requirements of § 409.44(c), subject to the limitations described in § 409.42(c)(4).

Basis for Revisions to § 409.42(c)(1), 409.44(b), and § 424.22

In recent years, MedPAC, the HHS Office of the Inspector General (OIG), and Medicaid State agencies suggested the need for CMS to clarify the Medicare home health coverage criteria regarding the skilled services specified at *§ 409.42.* In their March 2004 report (*http://www.medpac.gov/documents/Mar04_Entire_reportv3.pdf*), MedPAC reported that the Medicare eligibility criteria for the home health benefits leaves a great deal open to interpretation, describing a particular concern with the lack of clarity regarding the Medicare home health skilled nursing services requirement. In their Memorandum Report dated February 5, 2009 titled ''Medicaid and Medicare Home Health Payments for Skilled Nursing and Home Health Aide Services'' (*http://oig.hhs.gov/oei/reports/oei-07–06–00641.pdf*), the OIG also stated that Medicare coverage policy regarding skilled nursing services lacked clarity. The OIG indicated that our payment methodology might be prone to error. HHAs were unclear about which skilled nursing services were covered by Medicare's home health benefit. Further, Medicaid State agencies have also communicated to CMS their concerns that HHAs find it difficult to accurately determine when services provided to dually Medicare and Medicaid eligible individuals (''dual eligibles'') meet the Medicare coverage criteria, especially the requirements for needing skilled nursing care on an intermittent basis. State Medicaid agencies have communicated to CMS that this ambiguity is resulting in some HHAs routinely submitting all claims for dual-eligible persons with chronic care needs to their State Medicaid agencies for payment. State Medicaid agencies and CMS are concerned about this practice, referencing the requirement under the Social Security Act that Medicaid must be the payer of last resort. State agencies have told CMS that some of these claims would have been covered and paid by Medicare if they were submitted for payment. Other State agencies have used Medicaid post payment reviews to identify claims they believe should have been paid by another payer (*e.g.,* Medicare).

In 2006, CMS and certain Medicaid State Agencies embarked on an educational initiative to improve the ability of HHAs, State Agencies, and CMS contractors to make appropriate coverage decisions, resulting in an improved ability by HHAs to identify the appropriate payer for services provided, ultimately improving HHA billing accuracy.

As part of its provider education program, CMS focused on clarifying § 409.42 ''Beneficiary qualifications for coverage of services''. During the course of the training, it became apparent that confusion existed among certain Medicaid State Agencies and HHAs regarding under what circumstances the overall management and evaluation of a care plan would constitute a skilled service. HHAs asked what underlying conditions, complications, or circumstances would require a patient otherwise receiving unskilled services to need care plan management and evaluation by a registered nurse, thus rendering such care skilled. CMS therefore ensured that the training provided a particular focus on the requirement that a beneficiary be in need of skilled services. CMS provided comprehensive guidance to clarify that in the home health setting, management and evaluation of a patient care plan is considered a reasonable and necessary skilled service only when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. Another area of confusion that surfaced during the training was when the need for patient education services constitutes skilled services in the home health setting. HHAs questioned which specific sorts of educational services would render the education a skilled service in the home health setting.

To address the concerns identified by OIG, MedPAC, State Medicaid agencies and the clarity concerns home health agencies communicated to CMS during the 2006 training, we propose to revise § 409.42(c)(1) to further clarify that in order for services to be considered skilled in the home health setting, certain limitations (discussed below) would apply. We believe these revisions would assist HHAs in their determination of home health eligibility and will enable HHAs to more accurately bill for their dual eligible population.

Proposed Revisions to § 409.42(c)(1)

To clarify what constitutes skilled services in the home health setting, we are proposing the following revision to § 409.42. We propose to add a qualifying instruction to § 409.42(c)(1) to explain that intermittent skilled nursing services meeting the criteria for skilled services and the need for skilled services found in § 409.32 (with examples in § 409.33 (a) and (b)) are subject to certain limitations in the home health setting. We propose to describe the limitations in two new paragraphs, § 409.42(c)(1)(i) and § 409.42(c)(1)(ii).

Proposed New Paragraph § 409.42(c)(1)(i)

Our policy at § 409.33(a)(1) describes that the development, management, and evaluation of a patient's care plan based on physician's orders constitute skilled services when, because of the patient's physical or medical condition, oversight by technical or professional personnel is needed to promote recovery and ensure medical safety. The examples described in § 409.33(a)(1)(ii) further describe that when the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel,

it is appropriate to infer that skilled services are being provided.

We propose in § 409.42(c)(1)(i) that in the home health setting, management and evaluation of a patient care plan is considered a reasonable and necessary skilled service only when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose.

Further, in § 409.42(c)(1)(i) we also propose to clarify that to be considered a skilled service, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurses to promote the patient's recovery and medical safety in view of the overall condition. Where nursing visits are not needed to observe and assess the effects of the nonskilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service.

Additionally, we propose to further clarify in § 409.42(c)(1)(i) that in some cases, the condition of the patient may require that a service that would normally be considered unskilled be classified as a skilled nursing service given a patient's unique circumstances. This would occur when the patient's underlying condition or complication required that only a registered nurse could ensure that essential non-skilled care was achieving its purpose. The registered nurse would ensure that services were safely and effectively performed. However, any individual service would not be deemed a skilled nursing service merely because it was performed by or under the supervision of a licensed nurse. Where a service can be safely and effectively performed (or self administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled service although a nurse actually provided the service.

Proposed New Paragraph § 409.42(c)(1)(ii)

Additionally, we also propose a new § 409.42(c)(1)(ii), which would clarify when patient education services as described in § 409.33(a)(3) constituted skilled services in the home health setting. Current § 409.32(a)(3) states that patient education services are skilled services if the use of technical or professional personnel is necessary to teach patient self-maintenance. However, to address the concerns and lack of clarity surrounding when educations services are skilled services as described above, we are proposing to add a new paragraph, § 409.42(c)(1)(ii). In the home health setting, skilled education services would be deemed to no longer be needed when it became apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained. Further teaching and training would cease to be reasonable and necessary in this case, and would cease to be considered a skilled service. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

Proposed Change to § 409.44(b)

We are proposing to revise the introductory material at § 409.44(b)(1), to refer to the newly proposed limitations of skilled services in the home health benefit at § 409.42(c)(1)(i) and 409.42(c)(1)(ii). The clauses under the revised paragraphs (i) through (iv) would remain unchanged.

Proposed Revision to § 424.22(a)(1)(i) and § 424.22(b)(2)

We also propose to revise § 424.22(a)(1)(i) and § 424.22(b)(2) to require a written narrative of clinical justification on the physician certification and recertification for the targeted condition where the patient's overall condition supports a finding that recovery and safety could be ensured only if the care was planned, managed, and evaluated by a registered nurse. We believe that this revision would address HHAs' questions regarding the specific circumstances which would necessitate the need for skilled management and evaluation of the care plan. Additionally, we believe this requirement would be an important step in enhancing the physician accountability and involvement in the patient's plan of care.

As we described above, many Medicaid State Agencies and HHAs contend that there is confusion as to when overall management and evaluation of a care plan constitute a skilled service. They questioned what specific beneficiary underlying conditions, or complications or circumstances would warrant a patient who was receiving unskilled services to need care plan management and evaluation by a registered nurse, thus rendering the care skilled. To clarify for home health agencies what specific circumstances would necessitate the involvement of a registered nurse in the development, management, and evaluation of a patient's care plan when only unskilled services are being provided, we propose additions to the home health certification content requirements as described at § 424.22(a)(i) and recertification content requirements at § 424.22(b)(2). Specifically, when a patient's underlying condition or complication requires exclusively that a registered nurse ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, we propose to require the physician include a written narrative on the certification and recertification describing the physician's clinical justification of this need.

In the Physician Fee Schedule proposed rule published in the July 7, 2008 **Federal Register** (73 FR 38578), we solicited comments asking the industry to suggest options to enhance contact between the physician and the patient. In that solicitation of comments, we described policy options that we had been considering such as a review of the RVUs associated with the certification and recertification of the HH plan of care (POC), and that we were considering proposing new requirements, for example, a requirement for ''direct'' patient contact with the physician, to ensure more active physician involvement in the certification and recertification of the HH POC.

As a result of this solicitation, some commenters suggested that CMS establish documentation expectations associated with the certification and recertification of the need for Medicare home health services. We are continuing to consider policy options to enhance the physician-patient interaction in the home health setting. We believe that the commenters' suggestion that CMS establish documentation expectations associated with the certification and recertification, such as our proposed clinical justification narrative requirement, may be a first step in achieving this goal.

Finally, we believe that this new requirement would increase physician accountability and oversight of the certification and recertification of home health services and plan of care by focusing attention on the physician's responsibility to set out the clinical basis for this skilled need as indicated in the patient's medical record.

This brief narrative could be written or typed on the certification form itself. We do not believe that this brief narrative should be allowed as an attachment to the certification form because an attachment could easily be prepared by someone other than the physician, and what we are seeking is more direct involvement on part of the physician. We seek comments on whether this proposed requirement would increase physician engagement in the certification and recertification process, and clarify industry confusion associated with when a patient's condition would require the need for a registered nurse to oversee the patient's care plan, thus rendering such ''skilled care'' under our payment system.

F. OASIS for Significant Change in Condition: No Longer Associated With Payment

We propose to remove an obsolete reference to ''new case-mix assignments'' as a result of significant changes in a patient's condition that appears in 42 CFR 484 subpart E at § 484.55(d)(1)(ii). The significant change in condition (SCIC), as it relates to new case-mix assignments affecting payment, was an element of the HH PPS at the time of its first implementation in fiscal year 2000. However, as part of the HH PPS payment refinements implemented in CY 2008, we eliminated the SCIC policy, and the assignment of subsequent case-mix assignments under the HH PPS. However, it should be noted that it was not the SCIC payment policy that required the HHA to perform the assessment, but rather the significant change in the patient's condition. We are not proposing to change that requirement. A HHA would still be required to perform an assessment in the event that a patient experienced a significant change in condition. The proposed modification is only that a new case-mix assignment is no longer associated with this assessment.

In addition, we propose to revise § 484.250 to delete an obsolete reference to § 484.237. § 484.237 referred to the SCIC payment policy and was removed in the CY 2008 HH PPS final rule (72 FR 49879).

G. Proposed Payment Safeguards for Home Health Agencies

The provisions contained in this section are designed to: (1) Improve our ability to verify that home health agencies (HHAs) meet minimum enrollment criteria; (2) ensure that HHAs that are changing ownership meet and continue to meet the Conditions of Participation for HHAs found in 42 CFR Part 484; and (3) improve the quality of care that Medicare beneficiaries receive from HHAs.

1. Program Integrity Concerns Involving Home Health Agencies (HHAs)

The fraudulent business practices of certain HHAs continue to cost the Medicare program millions of dollars nationwide. This issue was discussed in a recent report issued by the Government Accountability Office (GAO) entitled ''Improvements Needed to Address Improper Payments in Home Health'' (GAO–09–185). This report, discussed in more detail below, concluded, in part, that ''In the absence of greater prevention, detection, and enforcement efforts, the Medicare home health benefit will continue to be a ready target for fraud and abuse.''

The problem has been especially acute in, though by no means limited to, the States of Texas and California. In Los Angeles County in California, for instance, the amount of money for which HHAs in that county billed Medicare between Fiscal Years 2003 and 2006 rose from $569 million to $921 million–an increase of 62 percent, and one that was not accompanied by a similar increase in the county's Medicare beneficiary population. There has also been an abnormal proliferation of HHAs in California as a whole. Between October 2002 and May 2007, the number of HHAs in the State rose by 25 percent—again, without a concomitant upswing in the number of Medicare beneficiaries in California. This suggests that there may also be an increase in improper billing. HHA proliferation has been an even bigger problem in Texas. Between October 2002 and October 2006, the number of HHAs in the State doubled, while—during this same period—the number of HHAs in Harris County, Texas (which includes the city of Houston) increased by almost 150 percent. As with California, these figures are out of all proportion with any increase in the beneficiary population or demand for HHA services in Texas or Harris County.

The aforementioned GAO report expressed similar concerns. It noted that, nationwide, ''spending on the Medicare home health benefit grew about 44 percent from 2002 through 2006, despite an increase of just less than 17 percent in the number of beneficiaries using the benefit during that 5-year period.'' The report also noted discrepancies in States other than Texas and California. To illustrate, between 2002 and 2006, the number of HHAs that billed Medicare rose in Florida by 100 percent, in Michigan by 62 percent, in Illinois by 59 percent, in Ohio by 42 percent, in Arizona by 32 percent, and in the District of Columbia by 67 percent. However, the increases in the number of Part A beneficiaries who used HHA services in these six jurisdictions were as follows: Florida—28 percent; Michigan—19 percent; Illinois—23 percent; Ohio—14 percent; Arizona—4 percent; and the District of Columbia—2 percent.

The disparity in many jurisdictions between the increase in the number of HHAs and the rise in the number of beneficiaries is so overwhelming that it cannot be attributed solely to an aging populace. The fact that, as shown above, between 2002 and 2006, the number of HHAs in Arizona rose at a rate 8 times greater than the number of Part A beneficiaries that use HHA services—and that the rate was an astounding 33 times greater in Washington, DC—must raise serious questions as to the legitimacy of some of these entities.

The GAO report also outlined a number of instances of allegedly fraudulent activities on the part of HHAs. In a particularly glaring example in Houston, Texas, the GAO noted the following: ''One PSC (Program Safeguard Contractor) interviewed 670 Houston beneficiaries who had the most severe clinical rating and who were patients of HHAs identified by the PSC as having aberrant billing patterns. The PSC found 91 percent of claims for these beneficiaries to be in error. Nearly 50 percent of the beneficiaries were not homebound and therefore were not eligible to receive any Medicare home health services. The investigators also found that while 39 percent of the beneficiaries they interviewed were eligible for the benefit, their clinical severity had been exaggerated. The PSC concluded that only 9 percent of claims for the 670 beneficiaries were properly coded. In addition, the PSC found that other home health beneficiaries it interviewed were not homebound; for instance, some were mowing their lawns when investigators came to interview them.''

Of particular concern to CMS is that the problems discussed above have been seen with HHAs on a far greater scale than with any other type of certified provider. The dramatic rise in the number of HHAs in relation to the increase in Medicare beneficiaries has not been even remotely duplicated with other Part A entities. In sum, the relative level of potentially fraudulent behavior among HHAs exceeds that of other certified provider types, and it is for this reason that CMS needs to take additional steps to ensure that only legitimate, bona fide HHAs remain enrolled in the Medicare program.

2. Prohibition on Sharing of Practice Location

In 2008, we determined that a number of HHAs had enrolled or attempted to enroll into the Medicare program using the same practice location or base of operations listed in Section 4 of their respective Medicare provider enrollment applications. In one case, a business attempted to enroll more than twenty different HHAs with the same Section 4 practice location as the base of operations.

We believe that allowing HHAs to share practice locations, operations, and other aspects of the provider's operations (for example, patient and financial records) in this manner constitutes a significant risk to the Medicare program. To allow an HHA to share its Section 4 practice location or base of operations with another Medicare-enrolled HHA or supplier limits the ability of CMS, a State survey agency, or an accreditation organization to ensure that each HHA meets the Conditions of Participation specified at 42 CFR part 484. Indeed, pursuant to Section 1866(j)(1)(A) of the Act, the Secretary is required to establish by regulation a process for the enrollment of providers and suppliers into the Medicare program. However, the sharing of HHA practice locations or bases of operations listed in Section 4 of the Medicare provider enrollment application hinders CMS's ability to properly enroll HHAs into Medicare because of the extreme difficulty in determining which site is in operation at a particular time, and which provider has control over the space, staff, equipment, *etc.* We do not believe that legitimate HHA providers share Section 4 practice locations or bases of operations with another Medicare-enrolled HHA or supplier.

At § 489.19, we are proposing a provision that would prohibit an HHA from sharing, leasing, or subleasing its practice location or base of operations listed in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier. We believe that this provision is consistent with existing provisions found in § 410.33(g)(15), which established limitations on the sharing of space (that is, a practice location) by independent diagnostic testing facilities (IDTF).

At § 489.12(a)(5), we are proposing to allow CMS to refuse to enter into a provider agreement with a prospective HHA if we determined, under proposed 42 CFR 489.19, that the HHA was sharing, leasing, or subleasing its practice location or base of operations listed in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.

At § 424.530(a)(8), we are proposing to allow a Medicare contractor, including a Regional Home Health Intermediary or A/B MAC, to deny Medicare billing privileges to an HHA if it determined, under proposed 42 CFR 489.19, that the HHA was sharing, leasing, or subleasing its practice location or base of operations listed in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.

At § 424.535(a)(11), we are proposing to allow a Medicare contractor, including a Regional Home Health Intermediary or A/B MAC, to revoke the Medicare billing privileges of an HHA that it determined, under proposed 42 CFR 489.19, was sharing, leasing, or subleasing its practice location or base of operations listed in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.

We are, nevertheless, soliciting comments on whether there are legitimate business reasons for a Medicare-enrolled HHA to share space with another Medicare-enrolled HHA or supplier when there is common ownership. We are also soliciting comments on whether there are legitimate business reasons for a Medicare-enrolled HHA to be co-located with another Medicare-enrolled HHA or supplier when there is no common ownership. In addition, we are soliciting comments on whether there are legitimate business reasons for a Medicare-enrolled HHA to engage in leasing or subleasing arrangements with a Medicare-enrolled supplier when there is common ownership.

3. Sale or Transfer of Ownership Within 3 Years of Enrollment

We have recently found instances where owners of a HHA, some of which were working in concert with brokers or organizations operating ''turn-key'' businesses, have enrolled or have attempted to enroll in the Medicare program for the specific purpose of selling the Medicare billing privileges and the Medicare provider agreement of their HHA to a third-party. In this scenario, the buyer or seller of the HHA typically would notify Medicare of the sale or change of ownership via the Medicare enrollment application (CMS–855A) after the billing privileges have been transferred when the HHA is sold.

Current CMS policy recommends surveys when there is a change of ownership. However, surveys in cases of a change of ownership do not occur with the frequency that they do when providers initially enroll in Medicare. Consequently, there are instances in which a change of ownership takes place yet the new owner does not undergo a survey, in which case Medicare cannot conclusively ascertain whether the business, under new ownership, meets the Conditions of Participation under 42 CFR part 484. This serves as an incentive for certain prospective providers to enroll in the Medicare program with the sole purpose of transferring Medicare billing privileges and the associated provider agreement when the business is sold.

This is problematic for two reasons. First, the prospective provider has minimal incentive for ensuring quality care for its patients after it is enrolled because its exclusive objective for participating in Medicare in the first place is to sell the business shortly after receiving Medicare billing privileges. In other words, the provider, aware that it may be able to sell the business without the HHA having to undergo a survey, may have little motivation to ensure that it is in compliance with the Conditions of Participation under 42 CFR part 484, since it intends on selling the business in any event. Medicare beneficiaries, therefore, may receive inadequate services as a result of this activity. Second, without the protection that a survey provides, the HHA may attempt to bill Medicare for these insufficient services. These circumstances increase the risk for an HHA to submit inappropriate and potentially fraudulent claims to Medicare, which places the Medicare Trust Funds at risk.

We further note that 42 CFR 424.550(a) states that a provider or supplier ''is prohibited from selling its Medicare billing number or privileges to any individual or entity, or allowing another individual or entity to use its Medicare billing number.'' We believe that the ''turn-key'' scenarios described in this subsection 2 fall within the general intent and purview of this provision, in that the broker may focus more on the selling of the HHA's billing privileges, rather than of the HHA itself. Nevertheless, while the provisions of 42 CFR § 424.550(a) and (b) were designed to prohibit this type of practice, we cannot realistically enforce the prohibitions on the sale, including an asset sale or stock transfer, or transfer of billing privileges, unless we can confirm the nature of the financial arrangements involved therein.

We recognize that the issue of a potential lack of a survey in HHA ownership changes exists with respect

to other types of providers and certified suppliers. Yet there are several reasons as to why this concern is more acute with HHAs than with other provider types. First, and as already outlined in subsection 1, the level of fraud in the HHA sector appears to be more prevalent than with other provider categories. Second, CMS has not seen the types of turn-key arrangements described above with any type of provider or certified supplier other than HHAs. It is the combination of these two factors that, in our view, make it necessary for us to focus the proposed provisions below on HHAs, rather than on provider types with whom our concerns are not nearly as acute. We stress that CMS in the past has undertaken a number of enrollment initiatives to ensure that only eligible and qualified providers and suppliers obtain and maintain Medicare billing privileges; specifically, CMS promulgated rules to address fraud and abuse and quality of care concerns for IDTFs (in 42 CFR 410.33(g)) as well as suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) (42 CFR 424.57(c)). We therefore believe, for the reasons just stated, that a similar approach is warranted here with respect to HHAs. With that said, and in view of the aforementioned schemes that appear to be designed to subvert Medicare's existing statutory and regulatory authorities related to enrollment and State survey procedures, we maintain that additional tools are needed to address this program vulnerability.

At 42 CFR 424.550(b)(1), we are proposing that an HHA undergoing an ownership change (including asset sales and stock transfers) must obtain an initial State survey or accreditation by an approved accreditation organization if the change takes place within 36 months after the effective date of the HHA's enrollment in Medicare. This means that any change of ownership that occurs during the 36 months following an initial enrollment would not result in the transfer of the HHA's provider agreement and Medicare billing privileges to the new owner. The new owner of the existing HHA would instead be required to enroll in the Medicare program as a new provider under the provisions of § 424.510 and obtain an initial State survey or accreditation by an approved accreditation organization. This is to ensure that the HHA under new ownership remains in compliance with the Conditions of Participation in 42 CFR part 484. We believe that this will help deter turn-key entities from purchasing HHAs for the sole purpose of selling them, in that the facility will be unable to undergo a change of ownership within the above-referenced 36-month period without the HHA being subject to a State survey.

We further believe that 36 months is an appropriate period of time for which to apply this requirement. It is long enough to ensure that a newly-enrolled HHA is serious about furnishing quality services to Medicare beneficiaries and is not merely looking to sell the HHA's Medicare billing privileges at the earliest possible moment. Conversely, a 36-month timeframe is, in our view, not so extensive as to greatly hinder the ability of a bonafide HHA to sell its business after the HHA has been operational and providing legitimate Medicare services for a reasonable period of time. While we do recognize that some legitimate, newly-enrolling HHAs may be inconvenienced by their inability to utilize, for a certain amount of time, the change of ownership provisions in 42 CFR 489.18, we also stress that the aforementioned survey requirement will, to a substantial extent, benefit legitimate members of the HHA provider community, in that it will help ensure that unqualified HHAs are no longer in the Medicare program. This will, for bonafide HHAs, reduce competition from less than legitimate HHAs and, on a larger level; help protect the Medicare Trust Funds.

Finally, if adopted, we believe that any change of ownership (including asset sales or stock transfers) that is pending a Medicare contractor's review and approval at the time this rule becomes effective, would be subject to this provision.

4. Home Health Agency Reactivations of Medicare Billing Privileges

In order to help address CMS' concerns about potentially inappropriate activity by HHAs, an additional tool that we therefore believe is necessary to help stem this behavior involves enhanced safeguards for use as part of the reactivation process identified in § 424.540(a).

To ensure that HHAs whose Medicare billing privileges have been deactivated for 12 months of non-billing and who seek to reactivate these privileges are still in compliance with the Conditions of Participation in 42 CFR part 484, we propose to revise § 424.540(b)(3) from its current form, ''Reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement'' to ''With the exception of home health agencies, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement.'' We are also proposing to add § 424.540(b)(3)(i), which states that any HHA whose Medicare billing privileges are deactivated under the provisions found in § 424.540(a) are also required to obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated.

As already explained, CMS remains concerned about the excessive level of potentially inappropriate activity in the HHA arena. To this end, CMS believes that the proposed provisions outlined in this subsection will, for reasons already identified, help address the concerns outlined in the aforementioned GAO report by ensuring that HHAs are in constant and verifiable compliance with the HHA Conditions of Participation found in 42 CFR part 484, and that only qualified and legitimate home health providers are enrolled in Medicare.

H. Physician Certification and Recertification of the Home Health Plan of Care

a. Background

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act require that a plan for furnishing home health services be established and periodically reviewed by a physician in order for Medicare payments for those services to be made. Our regulations at § 409.43(e) specifically states that a home health plan of care (HH POC) must be reviewed, signed, and dated by the physician who reviews the POC (as specified in § 409.42(b)) in consultation with agency clinical staff at least every 60 days (or more frequently as specified in § 409.43(e)(1)). Additionally, § 424.22(b) states that a recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the home health POC. These schedules, for the review of the POC and the recertification, coordinate well with the 60-day episode payment unit under the HH PPS. In implementing the statutory requirement as well as these regulations, we believed that these requirements would encourage enhanced physician involvement in the HH POC and patient management, and would include more direct ''in-person'' patient encounters (as logistically feasible).

Currently, physicians are paid for both the certification and recertification

of the HH POC under HCPCS codes G0180 and G0179, respectively. The basis for the payment amounts of these physician services is the relative resources in RVUs required to furnish these services. We believe physician involvement is very important in maintaining quality of care under the HH PPS.

In the HH PPS proposed rule published in the October 28, 1999 **Federal Register** (64 FR 58196), we had proposed to require the physician to certify the case-mix weight/home health resource group (HHRG) as part of the required physician certification of the POC. This reflected our belief that the physician should be more involved in the decentralized delivery of home health services. However, in the final rule published in the July 3, 2000 **Federal Register** (65 FR 41163), we did not finalize that proposal and decided to focus our attention on physician certification and education in order to better involve the physician in the delivery of home health services.

b. Solicitation of Comments

It has come to our attention that physician involvement in the certification and recertification of HH POC varies greatly. While some physicians have direct contact with their patients in the delivery of home health services, we believe that a significant number of physicians provide only a brief, albeit thorough, review of the HH POC, without any direct contact with the patient. We continue to believe that active involvement of the physician, including ''in-person'' contact with the patient, during the certification and recertification of the HH POC is essential for the delivery of high quality HH services.

In the Physician Fee Schedule proposed rule published in the July 7, 2008 **Federal Register** (73 FR 38578), we mentioned several options to enhance direct contact between the physician and the patient. First, we considered a review of the RVUs associated with the certification and recertification of the HH POC. As a result of that review, the payment amounts to physicians could be reduced based on a more accurate determination of the actual RVUs required to provide these services. We also considered proposing new requirements; for example, a requirement for ''direct'' patient contact with the physician, to ensure more active physician involvement in the certification and recertification of the HH POC. We specifically solicited comments on these policy options. The following is a summary of the comments and our responses as published in the Physician Fee Schedule final rule published in the November 19, 2008 **Federal Register** (73 FR 69855).

Most commenters suggested that we leave our current policies and payment to physicians unchanged, at least until further analysis is completed. To that end, it was suggested that we continue to study the role of the physician in home care and determine which factors enhance a physician's ability to conduct oversight activities, ensure appropriateness of care, and work collaboratively with HHAs without further burdening Medicare beneficiaries. Commenters urged CMS to engage with industry organizations that represent the physicians that furnish these services, to determine goals and assess options. Commenters further suggested that goals and options could include revising the procedure codes used for billing, assessing the current RVUs, and establishing documentation expectations.

Some commenters suggested that payments to physicians for certifying and recertifying HH POCs should be restructured to provide incentives for greater physician involvement, to include personally seeing the patients. Specifically, some commenters suggested adding different payments for the varying levels of physician involvement in the certification and recertification of HH POCs. Other commenters urged CMS to consider how home telehealth can be employed to a greater degree to increase input of clinical information directly to physicians in lieu of face-to-face contact.

Other commenters suggested that we actively support amending the Medicare statute to allow nurse practitioners (NPs) to certify and recertify HH POCs. Some commenters suggested that we actively support demonstrations and legislative proposals to build on the concept of merging home care with primary care under a single care management entity for persons in the advanced stages of chronic illnesses. Other commenters suggested that payment to medical directors should be restored to HHAs, along with requirements for their education and a definition of their role, and that we consider reimbursement for a planning teleconference between the physician and home health personnel.

In the November 19, 2008 final rule, we expressed our appreciation for the comments and responded that we would continue to analyze and consider the comments and suggestions in future rulemaking. Additionally, as a result of comments received on the above physician rule, as it relates to physician-patient contact, we are considering the possibility of requiring physicians to make phone calls to patients at various times over the course of home health treatment (prior to recertifications), as a means to promote that physician-patient contact and to help ensure the delivery of high quality HH services to our beneficiaries.

In this HH PPS proposed rule for CY 2010, we are specifically soliciting additional comments on this topic.

I. Routine Medical Supplies

HHAs have expressed to the HHS Office of the Inspector General (OIG) some confusion regarding routine medical supplies and how we account for the cost of those supplies. Therefore, we would like to reiterate our policy regarding routine medical supplies and how they are reimbursed under the HH PPS.

Section 1895(b)(1) states that ''all services covered and paid on a reasonable cost basis under the Medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount * * *.'' The cost of routine medical supplies was included in the average cost-per-visit amounts derived from the audit sample. These average cost-per-visit amounts were used to calculate the initial HH PPS rates published in the July 3, 2000 HH PPS final rule (FR 65 41184). Because reimbursement for routine medical supplies is bundled into the HH PPS 60-day episode rate and the per-visit rates, HHAs may not bill separately for routine supplies.

As noted in Chapter 7—Home Health Services of the Medicare Benefit Policy Manual (Pub. 100–02), sections 50.4.1.2 and 50.4.1.3, routine supplies are supplies that are customarily used in small quantities during the course of most home care visits. They are usually included in the staff's supplies and not designated for a specific patient. Routine supplies would not include those supplies that are specifically ordered by the physician or are essential to HHA personnel in order to effectuate the plan of care. Examples of supplies which are usually considered routine include, but are not limited to:

A. Dressings and Skin Care

- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Nonsterile applicators; and
- 4 X 4's.

B. Infection Control Protection

- Nonsterile gloves;
- Aprons;
- Masks; and
- Gowns.

C. Blood Drawing Supplies

- Specimen containers.

D. Incontinence Supplies

- Incontinence briefs and Chux covered in the normal course of a visit. For example, if a home health aide in the course of a bathing visit to a patient determines the patient requires an incontinence brief change, the incontinence brief in this example would be covered as a routine medical supply.

E. Other

- Thermometers; and
- Tongue depressors.

There are occasions when the supplies listed in the above examples would be considered non-routine and thus would be considered a billable supply, *i.e.,* if they are required in quantity, for recurring need, and are included in the plan of care. Examples include, but are not limited to, tape, and 4 X 4s for major dressings.

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-Day notice in the **Federal Register** and solicit public comment before a collection of information (COI) requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding the Requirements for Home Health Services

Section 424.22 proposes that if a patient's underlying condition or complication required a registered nurse to ensure that essential non-skilled care was achieving its purpose, and necessitated a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician would include a written narrative describing the clinical justification of this need.

The burden associated with this requirement would be the time and effort put forth by the physician to include the written narrative. We estimate it would take one physician approximately 5 minutes to meet this requirement. We estimate the frequency of such a situation to occur in about 5 percent of episodes (or about 345,600 episodes a year); therefore, the total annual burden associated with this requirement would be 28,800 hours for CY 2010.

B. ICRs Regarding Deactivation of Medicare Billing Privileges

In the proposed § 424.540(b)(3)(i), an HHA whose Medicare billing privileges are deactivated under the provisions found in 424.540(a) must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privilege can be reactivated. The burden associated with this requirement would be the time and effort put forth by the HHA to obtain a State survey or accreditation. We estimate it would take the prospective provider/owner 60 hours to obtain a State survey or accreditation. We estimate that there would be 2,000 such occurrences annually; therefore, the total annual burden associated with this requirement would be 120,000 hours.

C. ICRs Regarding Prohibition Against Sale or Transfer of Billing Privileges

At § 424.550(b)(1) we propose that an HHA undergoing an ownership change would have to obtain an initial State survey or accreditation by an approved accreditation organization if the change takes place within 36 months after the effective date of the HHA's participation in Medicare. Between April 2008 and April 2009, approximately 2,000 Medicare-enrolled HHAs—or 22.5 percent of the 9,000 total number of HHAs enrolled in Medicare—underwent a change of ownership. Naturally, the magnitude of the ownership changes varied by HHA, but the fact that almost one-quarter of all Medicare-enrolled HHAs changed ownership in some form within the past year is, for the reasons outlined in the preamble to this proposed rule, significant.

It is also important to note that of the 2,000 ownership changes, approximately 20 percent occurred in Texas, another 20 percent in Florida, and 14 percent in California, meaning that over one-half of all changes in ownership occurred in three States. Though it is possible that, if this provision was implemented, the number of total annual ownership changes would decrease, we will assume that the figure of 2,000 would remain constant. The burden associated with the proposed requirement in § 424.550(b)(1) would be twofold. First, the HHA would need to complete and submit a Medicare enrollment application (paper or electronic) as an initial applicant. This can be done electronically via the Internet-Based Provider Enrollment, Chain and Ownership System (PECOS) or by using the paper CMS–855 enrollment application. The estimated burden of completing the entire application as a new enrollee is 3 hours. Thus, the estimated annual burden for the approximately 2,000 HHAs that will change ownership would be 6,000 hours. Second, the provider would need to undergo a survey (or obtain accreditation in lieu of a survey) and perform administrative activities associated therewith. We estimate that the total hourly burden to the HHA for said activities would be 60 hours, for an annual burden of 120,000 hours (2,000 HHAs × 60 hours). Therefore, we estimate that the total annual burden of compliance with § 424.550(b)(1) would be 126,000 hours (120,000 hours + 6,000 hours).

D. ICRs Regarding Patient Assessment Data

Section 484.210 would require an HHA to submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230 and 484.235.

The burden associated with this is the time and effort put forth by the HHA to submit the OASIS data. This burden is currently accounted for under OMB# 0938–0761.

OMB No.	Number of Requirements	Number of respondents	Burden hours	Total annual burden hours
None	424.22	345,600	1/12	28,800

OMB No.	Number of Requirements	Number of respondents	Burden hours	Total annual burden hours
None	424.540(a)(3)(i)	2,000	60	120,000
None	424.550(b)(1)	2,000	63	126,000
0938–0761	484.210	(1)	(1)	(1)

[1] Not applicable.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, CMS–1560–P.

Fax: (202) 395–6974; or

E-mail: *OIRA_submission@omb.eop.gov*

E. ICRs Regarding Annual Update of the Unadjusted National Prospective 60-day Episode Payment Rate

Section 484.225(i) requires the submission of quality measures as specified by the Secretary. As part of this requirement, each HHA sponsoring a Home Health Care CAHPS (HHCAHPS) Survey must prepare and submit to its survey vendor a file containing patient data on patients served the preceding month that will be used by the survey vendor to select the sample and field the survey. This file (essentially the sampling frame) for most home health agencies can be generated from existing databases with minimal effort. For some small HHAs, preparation of a monthly sample frame may require more time. However, data elements needed on the sample frame will be kept at a minimum to reduce the burden on all HHAs.

The burden associated with this requirement is the time and effort put forth by the HHA to prepare and submit the file containing patient data on patients. The survey instrument and procedures for completing the instrument are designed to minimize burden on all respondents. No significant burden is expected for small agencies beyond providing their contracted vendor with a monthly file of patients served.

Initially, we estimate it would take one HHA 5 hours for the first month to meet this requirement. The subsequent monthly burden is estimated to be 30 minutes per HHA. We estimate approximately 7,000 HHAs would be submitting this data annually. Based on that number, the burden associated with the first month is estimated at 35,000 hours. The burden would decrease to 2,100 for subsequent months. Therefore, the total annual burden for the first year would total 58,100.

The burden associated with the home health patient's submission of the HHCAHPS survey is currently pending OMB approval (CMS–10275/OMB# 0938–NEW). Once OMB approval has been obtained, CMS will revise the package to include the burden on the HHAs as discussed above.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993 as further amended) the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis, that to the best of our ability, presents the costs and benefits of the rulemaking.

1. HHA Provisions Regarding Co-Mingling, Ownership Changes, and Reactivation of Billing Privileges

We believe that our proposals regarding: (1) The prohibition against co-mingling, (2) HHA changes of ownership, and (3) the reactivation of HHA billing privileges would have minimal budgetary impact, as the total number of entities that will be effected each year would be small. Moreover, we believe that these changes are necessary to ensure that currently enrolled and prospective HHAs are billing for the services provided and are in compliance with the conditions of participation in 42 CFR part 484, and all other Medicare requirements.

As for the issue of beneficiary access, the number of affected HHAs is such that we do not believe that beneficiaries would be adversely impacted by the proposed provisions. To the contrary, any reduction in the number of enrolled HHAs that would result from the implementation of these proposed provisions would be more than offset by the assurance that those HHAs that cannot meet Medicare requirements and quality standards are no longer in the program.

We are unable to determine the exact extent to which currently enrolled and prospective HHAs would be able to meet the requirements outlined in the proposed provisions. In addition, as a result of a dearth of quantifiable data, we cannot effectively derive an estimate of the monetary impacts of these provisions. Accordingly, we are seeking public comment so that the public may provide any data available that provides a calculable impact or any alternative to the proposed provisions.

1. CY 2010 Update

The update set forth in this proposed rule applies to Medicare payments under HH PPS in CY 2010. Accordingly, the following analysis describes the impact in CY 2010 only. We estimate that the net impact of the proposals in this rule, including a 2.75 percent reduction to the national standardized

60-day episode payment rates and the NRS conversion factor to account for the case-mix change adjustment, is approximately $100 million in CY 2010 savings. The estimated $100 million impact reflects the distributional effects of an updated wage index (−$10 million) as well as the 2.2 percent home health market basket increase (an additional $390 million in CY 2010 expenditures attributable only to the CY 2010 home health market basket), and the 2.75 percent decrease (−$480 million for the third year of a 4-year phase-in) to the HH PPS national standardized 60-day episode rate to account for the case-mix change adjustment under the HH PPS. The $100 million is reflected in column 5 of Table 8 as a 0.86 percent decrease in expenditures when comparing the current CY 2009 system to the CY 2010 system. If the Secretary were to impose a 6.89 percent decrease to the national standardized 60-day episode rates and the NRS conversion factor in CY 2010, to account for the increase in nominal case-mix, the impact would be an estimated decrease in payments to HHAs of 4.9 percent (column 3 of Table 8) or $1,220 million. Similarly, if the Secretary were to impose a 3.51 percent decrease to the national standardized 60-day episode rates and the NRS conversion factor in CY 2010, to account for the increase in nominal case-mix, the impact would be an estimated decrease in payments to HHAs of 1.6 percent (column 4 of table 8) or $590 million. For comparison purposes, estimated impacts that take these alternative percentage reductions (6.89 percent and 3.51 percent) into account can be found in columns 3 and 4 of Table 8 in Section VI.B. of this rule.

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $7 million to $34.5 million in any 1 year. For the purposes of the RFA, approximately 75 percent of HHAs are considered to small businesses according to the Small Business Administration's size standards with total revenues of $13.5 million or less in any 1 year. Individuals and States are not included in the definition of a small entity. Excluding HHAs in areas of the country where high and suspect outlier payments exist, this proposed rule is estimated to have an overall positive effect upon small entities (see section IB.B ''Anticipated Effects'', of this proposed rule, for supporting analysis).

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 100 beds. This proposed rule applies to home health agencies. Therefore, the Secretary has determined that this proposed rule will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of about $100 million or more in 1995 dollars, updated for inflation. That threshold is currently approximately $133 million in 2009. This proposed rule is not anticipated to have an effect on State, local, or tribal governments, in the aggregate, or by the private sector, of $133 million or more.

Executive Order 13132 established certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it would not have substantial direct effects on the rights, roles, and responsibilities of States, local, or tribal governments.

B. Anticipated Effects

This proposed rule sets forth updates to the HH PPS rates contained in the CY 2009 notice (73 FR 65351, November 3, 2008). The impact analysis of this proposed rule presents the estimated expenditure effects of policy changes proposed in this rule. We use the latest data and best analysis available, but we do not make adjustments for future changes in such variables as number of visits or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare home health benefit, based on Medicare claims from 2007. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to errors resulting from other changes in the impact time period assessed. Some examples of such possible events are newly-legislated general Medicare program funding changes made by the Congress, or changes specifically related to HHAs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, the BBRA, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the MMA, the DRA, or new statutory provisions. Although these changes may not be specific to the HH PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon HHAs.

Table 8 represents how home health agency revenues are likely to be affected by the policy changes described in this rule. For this analysis, we used linked home health claims and OASIS assessments; the claims represented a 20-percent sample of 60-day episodes occurring in CY 2007. Column one of this table classifies HHAs according to a number of characteristics including provider type, geographic region, and urban versus rural location.

For the purposes of analyzing impacts on payments, we performed three simulations and compared them to each other. Based on our assumption that outliers, as a percentage of total HH PPS payments, will be no more than 5 percent in CY 2009, the 2009 baseline, for the purposes of these simulations, we assumed that the full 5 percent outlay for outliers will be paid under our policy in 2009 of a 0.89 FDL ratio. As described in section III.A. of this proposed rule, given our proposed policies of a 0.67 FDL ratio and a 10 percent cap on outlier payments, we would return 2.5 percent back into the national standardized 60-day episode payment rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor, and then estimate outlier payments to be approximately 2.5 percent of total HH PPS payments in CY 2010. All three simulations use a CBSA-based wage index reported on the 2007 claims to determine the appropriate wage index.

The first simulation estimates CY 2009 payments under the current system (to include the 2009 wage index). The second simulation estimates CY 2009 payments under the current system, but with the 2010 wage index. The second simulation produces an estimate of what total payments using

the sample data would have been in CY 2009 without any of the proposed provisions in this rule, except for that of the 2010 wage index. The third simulation estimates CY 2010 payments with the 2010 wage index, incorporating our maintaining of the 2.75 percent reduction to the HH PPS rates, as well as all the proposed provisions of this rule.

These simulations demonstrate the effects of: A new 2010 wage index, a 2.75 percent reduction to account for the increase in nominal case-mix, a 2.2 percent market basket update, a 2.5 percent increase to account for a new outlier target of 2.5 percent, a 0.67 FDL ratio, and a 10 percent cap on outlier payments. Specifically, the second column of Table 8 shows the percent change due to the effects of the 2010 wage index. The third and fourth columns are for comparison purposes, and show the percent change due to the combined effects of the 2010 wage index, an alternative 6.89 percent reduction (column 3) or an alternative 3.51 percent reduction (column 4) to the rates to account for the increase in nominal case-mix, the 2.2 percent home health market basket update, the 2.5 percent increase to the HH PPS rates to account for an approximate 2.5 percent target for outliers as a percentage of total HH PPS payments, a 0.67 FDL ratio, and a 10 percent outlier cap. The fifth column of Table 8 shows the percent change due to the combined effects of the 2010 wage index, our maintaining of a 2.75 percent reductions to the rates to account for the increase in nominal case-mix, the 2.2 percent home health market basket update, the 2.5 percent increase to the HH PPS rates to account for an approximate 2.5 percent target for outliers as a percentage of total HH PPS payments, a 0.67 FDL ratio, and a 10 percent outlier cap.

The overall percentage change, for all HHAs, in estimated total payments from CY 2009 to CY 2010 is a decrease of approximately 0.86 percent. Rural HHAs, however, are estimated to see an increase in payments from CY 2009 to CY 2010 of about 3.45 percent. On the other hand, urban HHAs are expected to see a decrease of approximately 1.64 percent in payments from CY 2009 to CY 2010.

Voluntary non-profit HHAs (3.52 percent), facility-based HHAs (3.90 percent), and government owned HHAs (3.11 percent) are estimated to see an increase in the percentage change in estimated total payments from CY 2009 to CY 2010. Proprietary and freestanding HHAs, on the other hand, are estimated to see decreases of 3.14 percent and 1.73 percent, respectively, in estimated total payments from CY 2009 to CY 2010. Freestanding HHAs, broken out, show that voluntary non-profit and governmental HHAs are estimated to see increases of 3.22 percent and 2.63 percent, respectively, in estimated total payments from CY 2009 to CY 2010.

HHAs in the North and Midwest regions are expected to experience a percentage change increase in the estimated total payments from CY 2009 to CY 2010 of 3.79 percent and 3.67 percent, respectively. HHAs in the South and West regions of the country are estimated to experience decreases in the percentage change in estimated total payments from CY 2009 to CY 2010 of 4.01 percent and 1.52 percent. We believe that the major contributors to the estimated decreases in payments in these areas of the country are those with high and suspect outlier payments.

Breaking this down even further, it is estimated that New England, Mid Atlantic, East South Central, East North Central, and West North Central area HHAs are all expected to experience increases in their payments in CY 2010 ranging from just over 2 percent to almost 5 percent. Conversely, South Atlantic and Pacific HHAs are expected to experience decreases, 11.68 percent and 2.90 percent respectively, in the percentage change in estimated total payments from CY 2009 to CY 2010. Again, we believe that the major contributors to the estimated decreases in payments in these areas of the country are those with high and suspect outlier payments.

Larger HHAs (those with 200 or more Medicare home health initial episodes per year) are estimated to experience an increase in payments from CY 2009 to CY 2010 of approximately 2.44 percent. Mid-size to small agencies are expected to see a decrease in their payments in CY 2010, ranging from 1.77 percent to 15.93 percent. However, we believe that the major contributors to the estimated decreases in payments for mid-size to small agencies are those agencies in areas of the country with high and suspect outlier payments. Consequently, we have provided a more detailed discussion, and analysis in Table 9 below, that demonstrates where, in the country, these estimated large decreases for mid-size to small agencies are occurring.

TABLE 8—IMPACT BY AGENCY TYPE

Group	Comparisons			
	Percent change due to the effects of the updated wage index only (percent)	(For comparison purposes) Impact of CY 2010 proposed policies [1] (w/alternative 6.89 percent reduction in place of the proposed 2.75 percent reduction) (percent)	(For comparison purposes) Impact of CY 2010 proposed policies [1] (w/alternative 3.51 percent reduction in place of the proposed 2.75 percent reduction) (percent)	Impact of CY 2010 proposed policies [1] (percent)
Type of Facility:				
Free-Standing/Other Vol/NP	−0.01	−0.89	2.47	3.22
Free-Standing/Other Proprietary	−0.05	−7.25	−4.00	−3.27
Free-Standing/Other Government	−0.32	−1.49	1.88	2.63
Facility-Based Vol/NP	−0.12	−0.22	3.19	3.96
Facility-Based Proprietary	−0.22	−0.57	2.89	3.66
Facility-Based Government	−0.27	−0.56	2.88	3.65
Subtotal: Freestanding	−0.05	−5.74	−2.46	−1.73
Subtotal: Facility-based	−0.15	−0.29	3.13	3.90
Subtotal: Vol/PNP	−0.06	−0.62	2.76	3.52
Subtotal: Proprietary	−0.05	−7.12	−3.87	−3.14

TABLE 8—IMPACT BY AGENCY TYPE—Continued

Group	Comparisons			
	Percent change due to the effects of the updated wage index only (percent)	(For comparison purposes) Impact of CY 2010 proposed policies [1] (w/alternative 6.89 percent reduction in place of the proposed 2.75 percent reduction) (percent)	(For comparison purposes) Impact of CY 2010 proposed policies [1] (w/alternative 3.51 percent reduction in place of the proposed 2.75 percent reduction) (percent)	Impact of CY 2010 proposed policies [1] (percent)
Subtotal: Government	−0.30	−1.05	2.35	3.11
Total	−0.06	−4.90	−1.60	−0.86
Type of Facility (Rural * Only):				
Free-Standing/Other Vol/NP	−0.50	−0.61	2.83	3.60
Free-Standing/Other Proprietary	−0.14	−0.98	2.51	3.29
Free-Standing/Other Government	−0.58	−0.52	2.88	3.63
Facility-Based Vol/NP	−0.44	−0.52	2.91	3.68
Facility-Based Proprietary	−0.62	−1.30	2.16	2.93
Facility-Based Government	−0.42	−0.47	2.97	3.74
Type of Facility (Urban * Only):				
Free-Standing/Other Vol/NP	0.06	−0.93	2.41	3.16
Free-Standing/Other Proprietary	−0.03	−8.11	−4.89	−4.17
Free-Standing/Other Government	−0.04	−2.58	0.76	1.51
Facility-Based Vol/NP	−0.04	−0.14	3.27	4.03
Facility-Based Proprietary	0.03	−0.10	3.35	4.13
Facility-Based Government	−0.03	−0.71	2.75	3.52
Type of Facility (Urban* or Rural*):				
Rural	−0.31	−0.79	2.67	3.45
Urban	−0.02	−5.64	−2.37	−1.64
Total	−0.06	−4.90	−1.60	−0.86
Facility Location: Region*:				
North	0.05	−0.30	3.04	3.79
South	−0.05	−7.95	−4.73	−4.01
Midwest	−0.23	−0.57	2.89	3.67
West	−0.08	−5.55	−2.26	−1.52
Outlying	0.37	0.21	3.68	4.46
Total	−0.06	−4.90	−1.60	−0.86
Facility Location: Area of the Country:				
New England	0.53	0.75	4.13	4.88
Mid Atlantic	−0.21	−0.87	2.44	3.19
South Atlantic	0.27	−15.29	−12.34	−11.68
East South Central	−0.23	−0.57	2.94	3.72
West South Central	−0.29	−3.71	−0.34	0.41
East North Central	−0.27	−0.62	2.85	3.62
West North Central	−0.07	−0.37	3.08	3.85
Mountain	0.33	−2.05	1.33	2.09
Pacific	−0.23	−6.88	−3.63	−2.90
Outlying	0.37	0.21	3.68	4.46
Total	−0.06	−4.90	−1.60	−0.86
Facility Size: (Number of First Episodes):				
< 19	0.12	−19.43	−16.57	−15.93
20 to 49	0.03	−15.28	−12.29	−11.62
50 to 99	−0.04	−12.79	−9.72	−9.04
100 to 199	−0.13	−5.79	−2.51	−1.77
200 or More	−0.07	−1.70	1.69	2.44
Total	−0.06	−4.90	−1.60	−0.86

Note: Based on a 20% sample of CY 2007 claims linked to OASIS assessments.

*Urban/rural status, for the purposes of these simulations, is based on the wage index on which episode payment is based. The wage index is based on the site of service of the beneficiary.

REGION KEY:

New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; **Middle Atlantic** = Pennsylvania, New Jersey, New York; **South Atlantic** = Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; **East North Central** = Illinois, Indiana, Michigan, Ohio, Wisconsin; **East South Central** = Alabama, Kentucky, Mississippi, Tennessee; **West North Central** = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; **West South Central** = Arkansas, Louisiana, Oklahoma, Texas; **Mountain** = Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; **Pacific** = Alaska, California, Hawaii, Oregon, Washington; **Outlying** = Guam, Puerto Rico, Virgin Islands

[1] **Percent change due to the effects of the update wage index, the 2.2% home health market basket update, the 2.75% reduction to the national standardized episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor for nominal increase in case-mix, the 2.5% increase in the rates due to the new approximate 2.5% target for outliers as a percentage of total HH PPS payments, a 0.67 FDL ratio, and a 10% outlier cap**

Given the overall large negative impact observed by smaller agencies, we performed more detailed analysis targeted at identifying where the large negative impacts were occurring. Table 9 below presents the results of the regional analysis for small agencies. Column 1, of Table 9, shows the regional and agency size classifications similar to those in Table 8. In column 2 we repeat the overall impacts (from Table 8) for those classifications. In columns 3 through 7, we drill down in our analysis, looking at those classifications by the size of the agency (as defined by the number of first episodes). It is clear from this analysis that, for smaller agencies, the vast majority of the negative impact is occurring in areas of the country (such as the South and South Atlantic) where there exist high and suspect outlier payments. Specifically, in columns 3, 4, and 5 of Table 9, for the South Atlantic area of the country (which includes Miami-Dade, Florida), the negative percentage impacts in payment ranging from around 40 percent to just over 53 percent are evidence that it is the high and suspect outlier payments in areas such as this, that are skewing the results of the overall impact analysis. Estimated impacts for small agencies in the South (negative impacts ranging around 15 percent to 22 percent) and the Pacific (negative impacts ranging from around 11 percent to 17%) areas of the country, reflect similar results. Conversely, small HHAs in most other parts of the country are estimated to see increases in payments in CY 2010, ranging from 0.20 percent to almost 4.5 percent. Consequently, we believe that small HHAs without high and suspect outlier payments, on average, will see a positive impact on their payments in CY 2010. We do not believe there would be any significant impact on beneficiaries, as a result of the provisions of this rule. Areas where negative impacts have been estimated for HHAs, are primarily urban, and thus we believe that beneficiaries have a reasonable pool of HHAs from which to receive home health services.

TABLE 9—SMALL AGENCY IMPACTS

Group	Comparison of 2009–2010 Changes					
	Overall (percent)	< 20 episodes (percent)	20–49 episodes (percent)	50–99 episodes (percent)	100–199 episodes (percent)	200 or more episodes (percent)
Facility Location: Region of the Country						
North	3.79	0.20	3.05	3.06	3.70	3.83
South	−4.01	−21.93	−17.44	−14.71	−3.67	1.29
Midwest	3.67	2.63	3.45	3.52	3.79	3.75
West	−1.52	−5.67	−10.21	−9.16	−3.78	1.98
Outlying	4.46	4.48	4.41	4.86	4.40	4.44
TOTAL	−0.86	−15.93	−11.62	−9.04	−1.77	2.44
Facility Location: Region of the Country (Census Region)						
New England	4.88	−3.21	3.53	4.79	4.05	5.04
Mid Atlantic	3.19	3.94	2.59	1.42	3.30	3.21
South Atlantic	−11.68	−53.28	−45.86	−40.50	−16.47	−0.59
East South Central	3.72	4.11	2.30	3.90	3.24	3.79
West South Central	0.41	−5.64	−2.55	−1.26	1.67	2.27
East North Central	3.62	2.45	3.21	3.61	3.88	3.69
West North Central	3.85	4.05	4.69	3.17	3.46	3.99
Mountain	2.09	1.59	−1.38	1.52	1.80	2.99
Pacific	−2.90	−11.37	−16.68	−13.11	−6.55	1.65
Outlying	4.46	4.48	4.41	4.86	4.40	4.44
TOTAL	−0.86	−15.93	−11.62	−9.04	−1.77	2.44
Facility Size (Number of First Episodes)						
< 19 episodes	−15.93	−15.93	.....	.....	.....	.....
20 to 49	−11.62	.....	−11.62	.....	.....	.....
50 to 99	−9.04	.....	.....	−9.04	.....	.....
100 to 199	−1.77	.....	.....	.....	−1.77	.....
200 or More	2.44	.....	.....	.....	.....	2.44

TABLE 9—SMALL AGENCY IMPACTS—Continued

Group	Comparison of 2009–2010 Changes					
	Overall (percent)	< 20 episodes (percent)	20–49 episodes (percent)	50–99 episodes (percent)	100–199 episodes (percent)	200 or more episodes (percent)
TOTAL	−0.86	−15.93	−11.62	−9.04	−1.77	2.44

REGION KEY:
New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont;
Middle Atlantic = Pennsylvania, New Jersey, New York; **South Atlantic** = Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia; **East North Central** = Illinois, Indiana, Michigan, Ohio, Wisconsin; **East South Central** = Alabama, Kentucky, Mississippi, Tennessee; **West North Central** = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota; **West South Central** = Arkansas, Louisiana, Oklahoma, Texas; **Mountain** = Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming; **Pacific** = Alaska, California, Hawaii, Oregon, Washington; **Outlying** = Guam, Puerto Rico, Virgin Islands.

C. Accounting Statement and Table

Whenever a rule is considered a significant rule under Executive Order 12866, we are required to develop an Accounting Statement showing the classification of the expenditures associated with the provisions of this proposed rule.

Table 10, below provides our best estimate of the decrease in Medicare payments under the HH PPS as a result of the changes presented in this proposed rule based on the best available data. The expenditures are classified as a transfer to the Federal Government of $100 million dollars.

TABLE 10—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM THE 2009 HH PPS CALENDAR YEAR TO THE 2010 HH PPS CALENDAR YEAR

Category	Transfers
Annualized Monetized Transfers.	Negative transfer—Estimated decrease in expenditures: $100 million.
From Whom To Whom.	Federal Government to HH Providers.

D. Conclusion

In conclusion, we estimate that the net impact of the proposals in this rule, including a 2.75 percent reduction to the national standardized 60-day episode rates and the NRS conversion factor to account for the case-mix change adjustment, is approximately $100 million in CY 2010 savings. The $100 million impact reflects the distributional effects of an updated wage index (−$10 million) as well as the 2.2 percent home health market basket increase (an additional $390 million in CY 2010 expenditures attributable only to the CY 2010 home health market basket), and the 2.75 percent decrease (−$480 million for the third year of a 4-year phase-in) to the national standardized 60-day episode rates and the NRS conversion factor to account for the case-mix change adjustment under the HH PPS. This analysis above, together with the remainder of this preamble, provides a Regulatory Impact Analysis.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and budget.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 409.42 is amended as follows:

A. Revising paragraph (c)(1).

B. Adding paragraph (c)(1)(i) and (c)(1)(ii)

The revisions and additions read as follows:

§ 409.42 Beneficiary qualifications for coverage of services.

* * * * *

(c) * * *

(1) Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in § 409.32. (Also see § 409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services.) These criteria are subject to the following limitations in the home health setting:

(i) In the home health setting, management and evaluation of a patient care plan is considered a reasonable and necessary skilled service only when underlying conditions or complications are such that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. To be considered a skilled service, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurses to promote the patient's recovery and medical safety in view of the overall condition. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service. In some cases, the condition of the patient may cause a service that would originally be considered unskilled to be considered a skilled nursing service. This would occur when the patient's underlying condition or complication requires that only a registered nurse can ensure that essential non-skilled care is achieving its purpose. The registered nurse is ensuring that service is safely and effectively performed. However, a service is not considered a skilled nursing service merely because it is performed by or under the supervision of a licensed nurse. Where a service can be safely and effectively performed (or

self administered) by non-licensed staff without the direct supervision of a nurse, the service cannot be regarded as a skilled service even if a nurse actually provides the service.

(ii) In the home health setting, skilled education services are no longer needed if it becomes apparent, after a reasonable period of time, that the patient, family, or caregiver could not or would not be trained. Further teaching and training would cease to be reasonable and necessary in this case, and would cease to be considered a skilled service. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

* * * * *

3. Section 409.43 is amended by revising paragraph (e)(1)(ii) to read as follows:

§ 409.43 Plan of care requirements.

* * * * *

(e) * * *

(1) * * *

(ii) Significant change in condition; or

* * * * *

4. Section 409.44 is amended by revising the introductory paragraph of (b)(1) to read as follows:

§ 409.44 Skilled services requirements.

* * * * *

(b) * * *

(1) Skilled nursing care consists of those services that must, under State law, be performed by a registered nurse, or practical (vocational) nurse, as defined in § 484.4 of this chapter, meet the criteria for skilled nursing services specified in § 409.32, and meet the qualifications for coverage of skilled services specified in § 409.42(c). See § 409.33(a) and (b) for a description of skilled nursing services and examples of them.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

5. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

6. Section 424.22 is amended as follows:

A. Revising paragraph (a)(1)(i);

B. Revising paragraph (b)(2).

§ 424.22 Requirements for home health services.

(a) * * *

(1) * * *

(i) The individual needs or needed intermittent skilled nursing care, or physical or speech therapy, or (for the period from July through November 30, 1981) occupational therapy. If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a written narrative describing the clinical justification of this need.

* * * * *

(b) * * *

(2) *Content and basis of recertification.* The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical therapy or speech therapy. If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a written narrative describing the clinical justification of this need.

* * * * *

7. Section 424.530 is amended by adding paragraph (a)(8) to read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(8) A prospective HHA is determined, under 42 CFR § 489.19, to be sharing, leasing, or subleasing its practice location or base of operations identified in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.

* * * * *

8. Section 424.535 is amended by adding paragraph (a)(11) to read as follows:

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) * * *

(11) An HHA is determined, under 42 CFR § 489.19, to be sharing, leasing, or subleasing its practice location or base of operations identified in Section 4 of its Medicare provider enrollment application with or to another Medicare-enrolled HHA or supplier.

* * * * *

9. Section 424.540 is amended by revising paragraph (b)(3) to read as follows:

§ 424.540 Deactivation of Medicare billing privileges.

* * * * *

(b) * * *

(3) With the exception of home health agencies, reactivation of Medicare billing privileges does not require a new certification of the provider or supplier by the State survey agency or the establishment of a new provider agreement.

(i) An HHA whose Medicare billing privileges are deactivated under the provisions found at 42 CFR 424.540(a) must obtain an initial State survey or accreditation by an approved accreditation organization before its Medicare billing privileges can be reactivated.

(ii) [Reserved]

* * * * *

10. Section 424.550 is amended by adding paragraphs (b)(1) and (2) to read as follows:

§ 424.550 Prohibitions on the sale or transfer of billing privileges.

* * * * *

(b) * * *

(1) If an owner of a home health agency sells (including asset sales or stock transfers), transfers or relinquishes ownership of the HHA within 36 months after the effective date of the HHA's enrollment in Medicare, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

(i) Enroll in the Medicare program as a new HHA under the provisions of § 424.510, and

(ii) Obtain a State survey or an accreditation from an approved accreditation organization.

(2) [Reserved]

* * * * *

PART 484—HOME HEALTH SERVICES

11. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C.1302 and 1395(hh)).

Subpart C—Furnishing of Services

12. Section 484.55 is amended by revising paragraph (d)(1)(ii) to read as follows:

§ 484.55 Condition of participation: Comprehensive assessment of patients.

* * * * *

(d) * * *

(1) * * *

(ii) Significant change in condition; or

* * * * *

Subpart E—Prospective Payment System for Home Health Agencies

13. Section 484.210 is amended by revising paragraph (e) to read as follows:

§ 484.210 Data used for the calculation of the national prospective 60-day episode payment.

* * * * *

(e) OASIS assessment data and other data that account for the relative resource utilization for different HHA Medicare patient case-mix. An HHA must submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230 and 484.235.

14. Revising § 484.250 to read as follows:

§ 484.250 Patient assessment data.

An HHA must submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

15. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

16. Section 489.12 is amended by adding paragraph (a)(5) to read as follows:

§ 489.12 Decision to deny an agreement.

(a) * * *

(5) A prospective HHA is determined to be sharing, leasing, or subleasing its practice location or base of operations identified in Section 4 of its Medicare provider enrollment application with or to another Medicare enrolled HHA or supplier in violation of the HHA space sharing prohibition set forth in § 489.19.

* * * * *

17. Adding a new § 489.19 to read as follows:

§ 489.19 Prohibition on space sharing.

An HHA is prohibited from engaging in the following space sharing and/or leasing arrangements:

(a) Sharing its practice location or base of operations identified in Section 4 of its Medicare provider enrollment application with another Medicare-enrolled HHA or supplier; or

(b) Leasing or subleasing its practice location or base of operations identified in Section 4 of its Medicare provider enrollment application to another Medicare-enrolled HHA or supplier.

Authority: (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 28, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: July 17, 2009.

Kathleen Sebelius,

Secretary.

Note: The following addenda will not be published in the Code of Federal Regulations.

BILLING CODE 4120–01–P

TABLE 1 - INPATIENT REHABILITATION FACILITY WAGE INDEX FOR URBAN AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8097
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3399
10420	Akron, OH Portage County, OH Summit County, OH	0.8917
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.8703
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8707
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9210
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8130
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9499
11020	Altoona, PA Blair County, PA	0.8521
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8927
11180	Ames, IA Story County, IA	0.9487
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1931
11300	Anderson, IN Madison County, IN	0.8760
11340	Anderson, SC Anderson County, SC	0.9570
11460	Ann Arbor, MI Washtenaw County, MI	1.0445
11500	Anniston-Oxford, AL Calhoun County, AL	0.7927
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9440

CBSA Code	Urban Area (Constituent Counties)	Wage Index
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9142
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9591
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9754
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1973
12220	Auburn-Opelika, AL Lee County, AL	0.7544

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9615
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9536
12540	Bakersfield, CA Kern County, CA	1.1189
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0055
12620	Bangor, ME Penobscot County, ME	1.0174
12700	Barnstable Town, MA Barnstable County, MA	1.2643
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8163
12980	Battle Creek, MI Calhoun County, MI	1.0120
13020	Bay City, MI Bay County, MI	0.9248
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8479
13380	Bellingham, WA Whatcom County, WA	1.1640
13460	Bend, OR Deschutes County, OR	1.1375
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0548
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8805
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8574

CBSA Code	Urban Area (Constituent Counties)	Wage Index
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8792
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7148
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8155
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8979
14060	Bloomington-Normal, IL McLean County, IL	0.9323
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9268
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.1897
14500	Boulder, CO Boulder County, CO	1.0302
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8388
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	0.9900
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0770
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2868
15180	Brownsville-Harlingen, TX Cameron County, TX	0.8916
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9567
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9537
15500	Burlington, NC Alamance County, NC	0.8736
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9254
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1086
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0346
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8841

CBSA Code	Urban Area (Constituent Counties)	Wage Index
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9396
16180	Carson City, NV Carson City, NV	1.0128
16220	Casper, WY Natrona County, WY	0.9579
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8919
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9461
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8275
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9209
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9595
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9816
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8878
16940	Cheyenne, WY Laramie County, WY	0.9276
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0399
17020	Chico, CA Butte County, CA	1.0897

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9687
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8298
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8010
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9241
17660	Coeur d'Alene, ID Kootenai County, ID	0.9322
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9346
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9977
17860	Columbia, MO Boone County, MO Howard County, MO	0.8540
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8933
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.8739
18020	Columbus, IN Bartholomew County, IN	0.9739
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	0.9943

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8598
18700	Corvallis, OR Benton County, OR	1.1304
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.7816
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9945
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8705
19180	Danville, IL Vermilion County, IL	0.9374
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8395
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8435
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9203
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7803
19500	Decatur, IL Macon County, IL	0.8145
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8890
19740	Denver-Aurora, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0818
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9535
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9958
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7613

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20100	Dover, DE Kent County, DE	1.0325
20220	Dubuque, IA Dubuque County, IA	0.8380
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0363
20500	Durham, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9732
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9668
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1283
20940	El Centro, CA Imperial County, CA	0.8746
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8525
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9568
21300	Elmira, NY Chemung County, NY	0.8247
21340	El Paso, TX El Paso County, TX	0.8694
21500	Erie, PA Erie County, PA	0.8713

CBSA Code	Urban Area (Constituent Counties)	Wage Index
21660	Eugene-Springfield, OR Lane County, OR	1.1061
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8690
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1297
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.4061
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8166
22140	Farmington, NM San Juan County, NM	0.8051
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9340
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8970
22380	Flagstaff, AZ Coconino County, AZ	1.1743
22420	Flint, MI Genesee County, MI	1.1425
22500	Florence, SC Darlington County, SC Florence County, SC	0.8130

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.7871
22540	Fond du Lac, WI Fond du Lac County, WI	0.9293
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9867
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	0.9946
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7697
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.8769
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9176
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9709
23420	Fresno, CA Fresno County, CA	1.1009
23460	Gadsden, AL Etowah County, AL	0.7983
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9312
23580	Gainesville, GA Hall County, GA	0.9109

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9250
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8473
24140	Goldsboro, NC Wayne County, NC	0.9143
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7565
24300	Grand Junction, CO Mesa County, CO	0.9812
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9184
24500	Great Falls, MT Cascade County, MT	0.8784
24540	Greeley, CO Weld County, CO	0.9684
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9709
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9011
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9448

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9961
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3249
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9029
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.8997
25260	Hanford-Corcoran, CA Kings County, CA	1.0870
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9153
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.8894
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1069
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7337
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8976
25980	Hinesville-Fort Stewart, GA[1] Liberty County, GA Long County, GA	0.9110
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9008
26180	Honolulu, HI Honolulu County, HI	1.1811
26300	Hot Springs, AR Garland County, AR	0.9113
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7758
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9838
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9254
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9082

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9080
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9908
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9483
27060	Ithaca, NY Tompkins County, NY	0.9614
27100	Jackson, MI Jackson County, MI	0.9309
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8067
27180	Jackson, TN Chester County, TN Madison County, TN	0.8523
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8999
27340	Jacksonville, NC Onslow County, NC	0.8177
27500	Janesville, WI Rock County, WI	0.9662
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8775
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7971
27780	Johnstown, PA Cambria County, PA	0.7920
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7916
27900	Joplin, MO Jasper County, MO Newton County, MO	0.9406
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0801
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0485

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9610
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9911
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8765
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7743
28740	Kingston, NY Ulster County, NY	0.9375
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7881
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9349
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9758
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9221
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8374
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.7556
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0389
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	0.9797
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8530
29540	Lancaster, PA Lancaster County, PA	0.9363
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	0.9931

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29700	Laredo, TX Webb County, TX	0.8366
29740	Las Cruces, NM Dona Ana County, NM	0.8929
29820	Las Vegas-Paradise, NV Clark County, NV	1.1971
29940	Lawrence, KS Douglas County, KS	0.8343
30020	Lawton, OK Comanche County, OK	0.8211
30140	Lebanon, PA Lebanon County, PA	0.8954
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9465
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9200
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9110
30620	Lima, OH Allen County, OH	0.9427
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9759
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8672
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8765
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8370
31020	Longview, WA Cowlitz County, WA	1.1207
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2208
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9249
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8731

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8774
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9570
31460	Madera, CA Madera County, CA	0.7939
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.0967
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0359
31900	Mansfield, OH Richland County, OH	0.9330
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3940
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9009
32780	Medford, OR Jackson County, OR	1.0244

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32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9232
32900	Merced, CA Merced County, CA	1.2243
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	0.9830
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9159
33260	Midland, TX Midland County, TX	0.9827
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0080

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33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1150
33540	Missoula, MT Missoula County, MT	0.8973
33660	Mobile, AL Mobile County, AL	0.7908
33700	Modesto, CA Stanislaus County, CA	1.2194
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.7900
33780	Monroe, MI Monroe County, MI	0.8941
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8283
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8528
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7254
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0292
34620	Muncie, IN Delaware County, IN	0.8489
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0055
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8652
34900	Napa, CA Napa County, CA	1.4520
34940	Naples-Marco Island, FL Collier County, FL	0.9672
34980	Nashville-Davidson--Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9504
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2453

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35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1731
35300	New Haven-Milford, CT New Haven County, CT	1.1742
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9103
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2885
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9066
35980	Norwich-New London, CT New London County, CT	1.1398
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6092
36100	Ocala, FL Marion County, FL	0.8512
36140	Ocean City, NJ Cape May County, NJ	1.1496
36220	Odessa, TX Ector County, TX	0.9475
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9153
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8724
36500	Olympia, WA Thurston County, WA	1.1537
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9441

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36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9111
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9474
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8685
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.1951
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9332
37380	Palm Coast, FL Flagler County, FL	0.8963
37460	Panama City-Lynn Haven, FL Bay County, FL	0.8360
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7867
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8102
37764	Peabody, MA Essex County, MA	1.0747
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8242

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37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9038
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0979
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.0379
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7926
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8678
38340	Pittsfield, MA Berkshire County, MA	1.0445
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9343

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4289
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9942
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1456
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	0.9870
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.0920
39140	Prescott, AZ Yavapai County, AZ	1.0221
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0696
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9381
39380	Pueblo, CO Pueblo County, CO	0.8713
39460	Punta Gorda, FL Charlotte County, FL	0.8976
39540	Racine, WI Racine County, WI	0.9054
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9817
39660	Rapid City, SD Meade County, SD Pennington County, SD	0.9598
39740	Reading, PA Berks County, PA	0.9242
39820	Redding, CA Shasta County, CA	1.3731
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0317

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40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9363
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1468
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8660
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1214
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8811
40420	Rockford, IL Boone County, IL Winnebago County, IL	0.9835
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	0.9926
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9031
40660	Rome, GA Floyd County, GA	0.9134
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3572
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8702
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.0976
41100	St. George, UT Washington County, UT	0.9021
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0380

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9006
41420	Salem, OR Marion County, OR Polk County, OR	1.0884
41500	Salinas, CA Monterey County, CA	1.4987
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9246
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9158
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8424
41700	San Antonio, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.8856
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1538
41780	Sandusky, OH Erie County, OH	0.8870
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5529
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4756
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6141

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	0.4393

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2441
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1993
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1909
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6429
42140	Santa Fe, NM Santa Fe County, NM	1.0610
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.5528
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9152
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8333
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1755
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9217
43100	Sheboygan, WI Sheboygan County, WI	0.8920
43300	Sherman-Denison, TX Grayson County, TX	0.9024
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8442

CBSA Code	Urban Area (Constituent Counties)	Wage Index
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.8915
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9354
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9761
43900	Spartanburg, SC Spartanburg County, SC	0.9025
44060	Spokane, WA Spokane County, WA	1.0559
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9102
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0405
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8424
44220	Springfield, OH Clark County, OH	0.8876
44300	State College, PA Centre County, PA	0.8937
44700	Stockton, CA San Joaquin County, CA	1.2015
44940	Sumter, SC Sumter County, SC	0.8257
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9787
45104	Tacoma, WA Pierce County, WA	1.1241
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8964
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.8852
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9085
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8144
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9407

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8756
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0604
46060	Tucson, AZ Pima County, AZ	0.9229
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8445
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8496
46340	Tyler, TX Smith County, TX	0.8804
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8404
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8027
46700	Vallejo-Fairfield, CA Solano County, CA	1.4359

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47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8124
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0366
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8884
47300	Visalia-Porterville, CA Tulare County, CA	1.0144
47380	Waco, TX McLennan County, TX	0.8596
47580	Warner Robins, GA Houston County, GA	0.8989
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9904

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0827
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8490
48140	Wausau, WI Marathon County, WI	0.9615
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.8079
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	0.9544
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9757
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6955
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9069
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8832
48700	Williamsport, PA Lycoming County, PA	0.8096
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0696
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9089
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	0.9801
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9016

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49340	Worcester, MA Worcester County, MA	1.0836
49420	Yakima, WA Yakima County, WA	0.9948
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3432
49620	York-Hanover, PA York County, PA	0.9518
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8915
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1137
49740	Yuma, AZ Yuma County, AZ	0.9281

[1] At this time, there are no hospitals located in this urban area on which to base a wage index. We use the average wage index of all of the urban areas within the State to serve as a reasonable proxy.

Table 2 - INPATIENT REHABILITATION FACILITY WAGE INDEX FOR RURAL AREAS FOR DISCHARGES OCCURRING FROM OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2010

State Code	Nonurban Area	Wage Index
1	Alabama	0.7587
2	Alaska	1.1898
3	Arizona	0.8453
4	Arkansas	0.7473
5	California	1.2275
6	Colorado	0.9570
7	Connecticut	1.1016
8	Delaware	0.9962
10	Florida	0.8504
11	Georgia	0.7612
12	Hawaii	1.0999
13	Idaho	0.7651
14	Illinois	0.8386
15	Indiana	0.8473
16	Iowa	0.8804
17	Kansas	0.8052
18	Kentucky	0.7803
19	Louisiana	0.7447
20	Maine	0.8644
21	Maryland	0.8883
22	Massachusetts[1]	1.1670
23	Michigan	0.8887
24	Minnesota	0.9059
25	Mississippi	0.7584
26	Missouri	0.7982
27	Montana	0.8658
28	Nebraska	0.8730
29	Nevada	0.9382

State Code	Nonurban Area	Wage Index
30	New Hampshire	1.0219
31	New Jersey[1]	-----
32	New Mexico	0.8812
33	New York	0.8145
34	North Carolina	0.8576
35	North Dakota	0.7205
36	Ohio	0.8588
37	Oklahoma	0.7732
38	Oregon	1.0218
39	Pennsylvania	0.8365
40	Puerto Rico1	0.4047
41	Rhode Island[1]	-----
42	South Carolina	0.8538
43	South Dakota	0.8603
44	Tennessee	0.7789
45	Texas	0.7894
46	Utah	0.8267
47	Vermont	1.0079
48	Virgin Islands	0.6971
49	Virginia	0.7861
50	Washington	1.0181
51	West Virginia	0.7503
52	Wisconsin	0.9373
53	Wyoming	0.9315
65	Guam	0.9611

[1] All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural; however, no short-term, acute care hospitals are located in the area(s) for FY 2010. The rural Massachusetts wage index is calculated as the average of all contiguous CBSAs. The Puerto Rico wage index is the same as FY 2009.

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