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Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 424, 484, 488, 498

[CMS–1611–P]

RIN 0938–AS14

Medicare and Medicaid Programs; CY 2015 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Survey and Enforcement Requirements for Home Health Agencies

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2015. As required by the Affordable Care Act, this rule implements the second year of the four-year phase-in of the rebasing adjustments to the HH PPS payment rates. This rule provides information on our efforts to monitor the potential impacts of the rebasing adjustments and the Affordable Care Act mandated face-to-face encounter requirement. This rule also proposes: Changes to simplify the face-to-face encounter regulatory requirements; changes to the HH PPS case-mix weights; changes to the home health quality reporting program requirements; changes to simplify the therapy reassessment timeframes; a revision to the Speech-Language Pathology (SLP) personnel qualifications; minor technical regulations text changes; and limitations on the reviewability of the civil monetary penalty provisions. Finally, this proposed rule also discusses Medicare coverage of insulin injections under the HH PPS, the delay in the implementation of ICD–10–CM, and solicits comments on a HH value-based purchasing (HH VBP) model.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 2, 2014.

ADDRESSES: In commenting, please refer to file code CMS–1611–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–1611–P, P.O. Box 8016, Baltimore, MD 21244–8016.

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–1611–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.

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

FOR FURTHER INFORMATION CONTACT:
Hillary Loeffler, (410) 786–0456, for general information about the HH PPS.

Joan Proctor, (410) 786–0949, for information about the HH PPS Grouper, ICD–9–CM coding, and ICD–10–CM Conversion.

Kristine Chu, (410) 786–8953, for information about rebasing and the HH PPS case-mix weights.

Hudson Osgood, (410) 786–7897, for information about the HH market basket.

Caroline Gallaher, (410) 786–8705, for information about the HH quality reporting program.

Lori Teichman, (410) 786–6684, for information about HHCAHPS.

Peggye Wilkerson, (410) 786–4857, for information about survey and enforcement requirements for HHAs.

Robert Flemming, (410) 786–4830, for information about the HH VBP model.

Danielle Shearer, (410) 786–6617, for information about SLP personnel qualifications.

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.

Table of Contents

I. Executive Summary
A. Purpose
B. Summary of the Major Provisions
C. Summary of Costs and Benefits
II. Background
A. Statutory Background
B. System for Payment of Home Health Services
C. Updates to the HH PPS
III. Provisions of the Proposed Rule
A. Monitoring for Potential Impacts—Affordable Care Act Rebasing Adjustments and the Face-to-Face Encounter Requirement
1. Affordable Care Act Rebasing Adjustments

2. Affordable Care Act Face-to-Face Encounter Requirement
B. Proposed Changes to the Face-to-Face Encounter Documentation Requirements
1. Statutory and Regulatory Requirements
2. Proposed Changes to the Face-to-Face Encounter Narrative Requirement and Non-Coverage of Associated Physician Certification/Re-Certification Claims
3. Proposed Clarification on When Documentation of a Face-to-Face Encounter is Required
C. Proposed Recalibration of the HH PPS Case-Mix Weights
D. CY 2015 Rate Update
1. Proposed CY 2015 Home Health Market Basket Update
2. Home Health Care Quality Reporting Program (HHQRP)
a. General Considerations Used for Selection of Quality Measures for the HHQRP
b. Background and Quality Reporting Requirements
c. OASIS Data Submission and OASIS Data for Annual Payment Update
d. Updates to HH QRP Measures Which Are Made as a Result of Review by the NQF Process
e. Home Health Care CAHPS Survey (HHCAHPS)
3. Proposed CY 2015 Home Health Wage Index
4. Home Health Wage Index
a. Background
b. Update
c. Proposed Implementation of New Labor Market Delineations
5. Proposed CY 2015 Annual Payment Update
a. Background
b. Proposed CY 2015 National, Standardized 60-Day Episode Payment Rate
c. Proposed CY 2015 National Per-Visit Rates
d. Low-Utilization Payment Adjustment (LUPA) Add-On Factors
e. Proposed CY 2015 Nonroutine Medical Supply Conversion Factor and Relative Weights
f. Rural Add-On
E. Payments for High-Cost Outliers under the HH PPS
1. Background
2. Fixed Dollar Loss (FDL) Ratio and Loss-Sharing Ratio
F. Medicare Coverage of Insulin Injections under the HH PPS
G. Implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM)
H. Proposed Change to the Therapy Reassessment Timeframes
I. HHA Value-Based Purchasing Model
J. Advancing Health Information Exchange
K. Proposed Revisions to the Speech-Language Pathologist Personnel Qualifications
L. Proposed Technical Regulations Text Changes
M. Survey and Enforcement Requirements for Home Health Agencies
1. Statutory Background and Authority
2. Reviewability Pursuant to Appeals
3. Technical Adjustment
IV. Collection of Information Requirements
V. Response to Comments
VI. Regulatory Impact Analysis
VII. Federalism Analysis
Regulations Text

Acronyms

In addition, because of the many terms to which we refer by abbreviation in this proposed rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ACH LOS Acute Care Hospital Length of Stay
ADL Activities of Daily Living
APU Annual Payment Update
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
CAD Coronary Artery Disease
CAH Critical Access Hospital
CBSA Core-Based Statistical Area
CASPER Certification and Survey Provider Enhanced Reports
CHF Congestive Heart Failure
CMI Case-Mix Index
CMP Civil Money Penalty
CMS Centers for Medicare & Medicaid Services
CoPs Conditions of Participation
COPD Chronic Obstructive Pulmonary Disease
CVD Cardiovascular Disease
CY Calendar Year
DM Diabetes Mellitus
DRA Deficit Reduction Act of 2005, Pub. L. 109–171, enacted February 8, 2006
FDL Fixed Dollar Loss
FI Fiscal Intermediaries
FR Federal Register
FY Fiscal Year
HAVEN Home Assessment Validation and Entry System
HCC Hierarchical Condition Categories
HCIS Health Care Information System
HH Home Health
HHA Home Health Agency
HHCAHPS Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey
HH PPS Home Health Prospective Payment System
HHRG Home Health Resource Group
HIPPS Health Insurance Prospective Payment System
ICD–9–CM International Classification of Diseases, Ninth Revision, Clinical Modification
ICD–10–CM International Classification of Diseases, Tenth Revision, Clinical Modification
IH Inpatient Hospitalization
IRF Inpatient Rehabilitation Facility
LTCH Long-Term Care Hospital
LUPA Low-Utilization Payment Adjustment
MEPS Medical Expenditures Panel Survey
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173, enacted December 8, 2003
MSA Metropolitan Statistical Area
MSS Medical Social Services
NQF National Quality Forum
NRS Non-Routine Supplies
OASIS Outcome and Assessment Information Set
OBRA Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–2–3, enacted December 22, 1987
OCESAA Omnibus Consolidated and Emergency Supplemental Appropriations Act, Pub. L. 105–277, enacted October 21, 1998
OES Occupational Employment Statistics
OIG Office of Inspector General
OT Occupational Therapy
OMB Office of Management and Budget
MFP Multifactor productivity
PAMA Protecting Access to Medicare Act of 2014
PAC–PRD Post-Acute Care Payment Reform Demonstration
PEP Partial Episode Payment Adjustment
PT Physical Therapy
QAP Quality Assurance Plan
PRRB Provider Reimbursement Review Board
RAP Request for Anticipated Payment
RF Renal Failure
RFA Regulatory Flexibility Act, Pub. L. 96–354
RHHIs Regional Home Health Intermediaries
RIA Regulatory Impact Analysis
SAF Standard Analytic File
SLP Speech-Language Pathology
SN Skilled Nursing
SNF Skilled Nursing Facility
UMRA Unfunded Mandates Reform Act of 1995.

I. Executive Summary

A. Purpose

This proposed rule would update the payment rates for HHAs for calendar year (CY) 2015, as required under section 1895(b) of the Social Security Act (the Act). This would reflect the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, and the NRS conversion factor finalized in the CY 2014 HH PPS final rule (78 FR 72256), required under section 3131(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively referred to as the ''Affordable Care Act''). Updates to payment rates under the HH PPS would also include a proposal to change the home health wage index to incorporate the new Office of Management and Budget (OMB) core-based statistical area (CBSA) definitions and updates to the payment rates by the home health payment update percentage, which would reflect the productivity adjustment mandated by 3401(e) of the Affordable Care Act.

This proposed rule also discusses: Our efforts to monitor the potential

impacts of the Affordable Care Act mandated rebasing adjustments and the face-to-face encounter requirement (sections 3131(a) and 6407, respectively, of the Affordable Care Act); coverage of insulin injections under the HH PPS; and the delay in the implementation of the International Classification of Diseases, 10th Edition, Clinical Modification (ICD–10–CM) as a result of recent Congressional action (section 212 of the Protecting Access to Medicare Act, Public Law 113–93 (''PAMA'')). This proposed rule also proposes changes to simplify the regulations at § 424.22(a)(1)(v) that govern the face-to-face encounter requirement mandated by section 6407 of the Affordable Care Act; changes to the HH PPS case-mix weights under section 1895(b)(4)(A)(i) and (b)(4)(B) of the Act; changes to the home health quality reporting program requirements under section 1895(b)(3)(B)(v)(II) of the Act; changes to simplify the therapy reassessment timeframes specified in regulation at § 409.44(c)(2)(C) and (D); a revision to the personnel qualifications for SLP at § 484.4; and minor technical regulations text changes at § 424.22(b)(1) and § 484.250(a)(1). This proposed rule would also place limitations on the reviewability of CMS's decision to impose a civil monetary penalty for noncompliance with federal participation requirements. Finally, the proposed rule discusses and solicits comments on a HH VBP model.

B. Summary of the Major Provisions

As required by section 3131(a) of the Affordable Care Act and finalized in the CY 2014 HH final rule, ''Medicare and Medicaid Programs; Home Health Prospective Payment System Rate Update for CY 2014, Home Health Quality Reporting Requirements, and Cost Allocation of Home Health Survey Expenses'' (78 FR 77256, December 2, 2013), we are implementing the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit rates and the NRS conversion factor in section III.D.4. The rebasing adjustments for CY 2015 would reduce the national, standardized 60-day episode payment amount by $80.95, increase the national per-visit payment amounts by 3.5 percent of the national per-visit payment amounts in CY 2010 with the increases ranging from $6.34 for medical social services to $1.79 for home health aide services as described in section III.A, and reduce the NRS conversion factor by 2.82 percent.

This proposed rule also discusses our efforts to monitor the potential impacts of the rebasing adjustments and the Affordable Care Act mandated face-to-face encounter requirement in section III.A and, in section III.B. We would propose changes to the face-to-face encounter narrative requirement. In addition, we are proposing that associated physician claims for certification/re-certification of eligibility (patient not present) not be eligible to be paid when a patient does not meet home health eligibility criteria. We would also clarify in sub-regulatory guidance when the face-to-face encounter requirement would be applicable. In section III.C, we are proposing to recalibrate the HH PPS case-mix weights, using the most current cost and utilization data available, in a budget neutral manner. In section III.D.1, we propose to update the payment rates under the HH PPS by the home health payment update percentage of 2.2 percent (using the 2010-based Home Health Agency (HHA) market basket update of 2.6 percent, minus a 0.4 percentage point reduction for productivity as required by 1895(b)(3)(B)(vi)(I) of the Act. In section III.D.3, we propose to update the home health wage index using a 50/50 blend of the existing core-based statistical area (CBSA) designations and the new CBSA designations outlined in a February 28, 2013, Office of Management and Budget (OMB) bulletin, respectively. In section III.E, we propose no changes to the fixed-dollar loss (FDL) and loss-sharing ratios used in calculating high-cost outlier payments under the HH PPS.

This proposed rule also proposes changes to the home health quality reporting program in section III.D.2, including the establishment of a minimum threshold for submission of OASIS assessments for purposes of quality reporting compliance, the establishment of a policy for the adoption of changes to measures that occur in-between rulemaking cycles as a result of the NQF process, and submission dates for the HHCAHPS Survey moving forward through CY 2017. In section III.F, we discuss recent analysis of home health claims identified with skilled nursing visits likely done for the sole purpose of insulin injection assistance, and the lack of any secondary diagnoses on the home health claim to support that the patient was physically or mentally unable to self-inject. We discuss, in section III.G, the delay in the implementation of ICD–10–CM as a result of section 212 of PAMA. In section III.H we seek to simplify the therapy reassessment regulations by proposing that therapy reassessments are to occur every 14 calendar days rather than before the 14th and 20th visits and once every 30 calendar days. Finally, in section III.I, we plan to discuss and solicit comments on an HH VBP model; in section III.J, we propose to revise the personnel qualifications for SLP; in section III.K we are proposing minor technical regulations text changes; and in section III.L we are proposing to place limitations on the reviewability of the civil monetary penalty that is imposed on a HHA for noncompliance with federal participation requirements.

C. Summary of Costs and Transfers

TABLE 1—SUMMARY OF COSTS AND TRANSFERS

Provision Description	Costs	Transfers
CY 2015 HH PPS Payment Rate Update.	A net reduction in burden of $21.55 million associated with certifying patient eligibility for home health services & certification form revisions.	The overall economic impact of this proposed rule is an estimated $58 million in decreased payments to HHAs.

II. Background

A. Statutory Background

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

Section 4603(a) of the BBA mandated the development of a HH PPS for all Medicare-covered HH 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 HH services paid under Medicare.

Section 1895(b)(3)(A) of the Act requires the following: (1) The computation of a standard prospective payment amount include all costs for HH services covered and paid for on a reasonable cost basis and that such amounts be initially based on the most recent audited cost report data available to the Secretary; and (2) the standardized prospective payment amount be adjusted to account for 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 HH 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 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 HH services furnished in a geographic area compared to the applicable national average level. Under section 1895(b)(4)(C) of the Act, 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 due to unusual variations in the type or amount of medically necessary care. Section 3131(b)(2) of the Patient Protection and Affordable Care Act of 2010 (the Affordable Care Act) (Pub. L. 111–148, enacted March 23, 2010) revised section 1895(b)(5) of the Act so that total outlier payments in a given year would not exceed 2.5 percent of total payments projected or estimated. The provision also made permanent a 10 percent agency-level outlier payment cap.

In accordance with the statute, as amended by the BBA, we published a final rule in the July 3, 2000 **Federal Register** (65 FR 41128) to implement the HH PPS legislation. The July 2000 final rule established requirements for the new HH PPS for HH 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 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 November 29, 1999). The requirements include the implementation of a HH PPS for HH 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 HH 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).

Section 5201(c) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted February 8, 2006) added new section 1895(b)(3)(B)(v) to the Act, requiring HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to the annual applicable percentage increase. This data submission requirement is applicable for CY 2007 and each subsequent year. If an HHA does not submit quality data, the HH market basket percentage increase is reduced by 2 percentage points. In the November 9, 2006 **Federal Register** (71 FR 65884, 65935), we published a final rule to implement the pay-for-reporting requirement of the DRA, which was codified at § 484.225(h) and (i) in accordance with the statute. The pay-for-reporting requirement was implemented on January 1, 2007.

The Affordable Care Act made additional changes to the HH PPS. One of the changes in section 3131 of the Affordable Care Act is the amendment to section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted on December 8, 2003) as amended by section 5201(b) of the DRA. The amended section 421(a) of the MMA now requires, for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) with respect to episodes and visits ending on or after April 1, 2010, and before January 1, 2016, that the Secretary increase, by 3 percent, the payment amount otherwise made under section 1895 of the Act.

B. 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 HH disciplines (skilled nursing, HH aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine 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 II.D.4.e). Payment for durable medical equipment covered under the HH benefit is made outside the HH PPS payment system. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification system to assign patients to a home health resource group (HHRG). The clinical severity level, functional severity level, and service utilization are computed from responses to selected data elements in the OASIS assessment instrument and are used to place the patient in a particular HHRG. Each HHRG has an associated case-mix weight which is used in calculating the payment for an episode.

For episodes with four or fewer visits, Medicare pays national per-visit rates based on the discipline(s) providing the services. 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.

C. 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**. The 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 HH PPS for CY 2008. The CY 2008 HH PPS final rule included an analysis performed on CY 2005 HH claims data, which indicated a 12.78 percent increase in the observed case-mix since 2000. Case-mix represents the variations in conditions of the patient population served by the HHAs. Subsequently, a more detailed analysis was performed on the 2005 case-mix data to evaluate if any portion of the 12.78 percent increase was associated with a change in the actual clinical condition of HH patients. We

examined data on demographics, family severity, and non-HH Part A Medicare expenditures to predict the average case-mix weight for 2005. We identified 8.03 percent of the total case-mix change as real, and therefore, decreased the 12.78 percent of total case-mix change by 8.03 percent to get a final nominal case-mix increase measure of 11.75 percent (0.1278 * (1 − 0.0803) = 0.1175).

To account for the changes in case-mix that were not related to an underlying change in patient health status, we implemented a reduction, over 4 years, to the national, standardized 60-day episode payment rates. That reduction was to be 2.75 percent per year for 3 years beginning in CY 2008 and 2.71 percent for the fourth year in CY 2011. In the CY 2011 HH PPS final rule (76 FR 68532), we updated our analyses of case-mix change and finalized a reduction of 3.79 percent, instead of 2.71 percent, for CY 2011 and deferred finalizing a payment reduction for CY 2012 until further study of the case-mix change data and methodology was completed.

In the CY 2012 HH PPS final rule (76 FR 68526), we updated the 60-day national episode rates and the national per-visit rates. In addition, as discussed in the CY 2012 HH PPS final rule (76 FR 68528), our analysis indicated that there was a 22.59 percent increase in overall case-mix from 2000 to 2009 and that only 15.76 percent of that overall observed case-mix percentage increase was due to real case-mix change. As a result of our analysis, we identified a 19.03 percent nominal increase in case-mix. At that time, to fully account for the 19.03 percent nominal case-mix growth identified from 2000 to 2009, we finalized a 3.79 percent payment reduction in CY 2012 and a 1.32 percent payment reduction for CY 2013.

In the CY 2013 HH PPS final rule (77 FR 67078), we implemented a 1.32 percent reduction to the payment rates for CY 2013 to account for nominal case-mix growth from 2000 through 2010. When taking into account the total measure of case-mix change (23.90 percent) and the 15.97 percent of total case-mix change estimated as real from 2000 to 2010, we obtained a final nominal case-mix change measure of 20.08 percent from 2000 to 2010 (0.2390 * (1 − 0.1597) = 0.2008). To fully account for the remainder of the 20.08 percent increase in nominal case-mix beyond that which was accounted for in previous payment reductions, we estimated that the percentage reduction to the national, standardized 60-day episode rates for nominal case-mix change would be 2.18 percent. Although we considered proposing a 2.18 percent reduction to account for the remaining increase in measured nominal case-mix, we finalized the 1.32 percent payment reduction to the national, standardized 60-day episode rates in the CY 2012 HH PPS final rule (76 FR 68532).

Section 3131(a) of the Affordable Care Act requires that, beginning in CY 2014, CMS apply an adjustment to the national, standardized 60-day episode rate and other amounts that reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. Additionally, CMS must phase in any adjustment over a four-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of enactment of the Affordable Care Act, and fully implement the rebasing adjustments by CY 2017. The statute specifies that the maximum rebasing adjustment is to be no more than 3.5 percent per year of the CY 2010 rates. Therefore, in the CY 2014 HH PPS final rule (78 FR 72256) for each year, CY 2014 through CY 2017, we finalized a fixed-dollar reduction to the national, standardized 60-day episode payment rate of $80.95 per year, increases to the national per-visit payment rates per year as reflected in Table 2, and a decrease to the NRS conversion factor of 2.82 percent per year. We also finalized three separate LUPA add-on factors for skilled nursing, physical therapy, and speech-language pathology and removed 170 diagnosis codes from assignment to diagnosis groups in the HH PPS Grouper.

TABLE 2—MAXIMUM ADJUSTMENTS TO THE NATIONAL PER-VISIT PAYMENT RATES

[Not to exceed 3.5 percent of the amount(s) in CY 2010]

	2010 National per-visit payment rates	Maximum adjustments per year (CY 2014 through CY 2017)
Skilled Nursing	$113.01	$3.96
Home Health Aide	51.18	1.79
Physical Therapy	123.57	4.32
Occupational Therapy	124.40	4.35
Speech-Language Pathology	134.27	4.70
Medical Social Services	181.16	6.34

III. Provisions of the Proposed Rule

A. Monitoring for Potential Impacts—Affordable Care Act Rebasing Adjustments and the Face-to-Face Encounter Requirement

1. Affordable Care Act Rebasing Adjustments

As stated in the CY 2014 HH PPS final rule, we plan to monitor potential impacts of rebasing. Although we do not have enough CY 2014 home health claims data to analyze as part of our effort in monitoring the potential impacts of the rebasing adjustments finalized in the CY 2014 HH PPS final rule (78 FR 72293), we have analyzed 2012 home health agency cost report data to determine whether the average cost per episode was higher using 2012 cost report data compared to the 2011 cost report data used in calculating the rebasing adjustments. Specifically, we re-estimated the cost of a 60-day episode using 2012 cost report and 2012 claims data, rather than using 2011 cost report and 2012 claims data. To determine the 2012 average cost per visit per discipline, we applied the same trimming methodology outlined in the CY 2014 HH PPS proposed rule (78 FR 40284) and weighted the costs per visit from the 2012 cost reports by size,

facility type, and urban/rural location so the costs per visit were nationally representative. The 2012 average number of visits was taken from 2012 claims data. We estimate the cost of a 60-day episode to be $2,413.82 using 2012 cost report data (Table 3).

TABLE 3—AVERAGE COSTS PER VISIT AND AVERAGE NUMBER OF VISITS FOR A 60-DAY EPISODE

Discipline	2012 Average costs per visit	2012 Average number of visits	2012 60-day episode costs
Skilled Nursing	$130.49	9.55	$1,246.18
Home Health Aide	61.62	2.60	160.21
Physical Therapy	160.03	4.80	768.14
Occupational Therapy	157.78	1.09	171.98
Speech-Language Pathology	172.08	0.22	37.86
Medical Social Services	210.36	0.14	29.45
Total			2,413.82

Source: FY 2012 Medicare cost report data and 2012 Medicare claims data from the standard analytic file (as of June 2013) for episodes ending on or before December 31, 2012 for which we could link an OASIS assessment.

Using the most current claims data—CY 2013 data (as of December 31, 2013), we re-examined the 2012 visit distribution and re-calculated the 2013 estimated cost per episode using the updated 2013 visit profile. We estimate the 2013 60-day episode cost to be $2,477.01(Table 4).

TABLE 4—2013 ESTIMATED COST PER EPISODE

Discipline	2012 Average costs per visit	2013 Average number of visits	2013 HH market basket	2013 Estimated cost per episode
Skilled Nursing	$130.49	9.30	1.023	$1,241.47
Home Health Aide	61.62	2.42	1.023	152.55
Physical Therapy	160.03	4.99	1.023	816.92
Occupational Therapy	157.78	1.20	1.023	193.69
Speech-Language Pathology	172.08	0.24	1.023	42.25
Medical Social Services	210.36	0.14	1.023	30.13
Total				2,477.01

Source: FY 2012 Medicare cost report data and 2013 Medicare claims data from the standard analytic file (as of December 2013) for episodes ending on or before December 31, 2013 for which we could link an OASIS assessment.

In the CY 2014 HH PPS final rule (78 FR 72277), using 2011 cost report data, we estimated the 2012 60-day episode cost to be about $2,507.83 ($2,453.71 * 0.9981 * 1.024) and the 2013 60-day episode cost to be $2,565.51 ($2,453.71 * 0.9981 * 1.024 * 1.023). Using 2012 cost report data, the 2012 and 2013 estimated cost per episode ($2,413.82 and $2,477.01, respectively) are lower than the episode costs we estimated using 2011 cost report data for the CY 2014 HH PPS final rule. We note that the proposed CY 2015 national, standardized 60-day episode payment rate is $2,922.76 as described in section III.D.4. of this proposed rule.

In the CY 2014 HH PPS final rule, we stated that our analysis of 2011 cost report data and 2012 claims data indicated a need for a −3.45 percent rebasing adjustment to the national, standardized 60-day episode payment rate each year for four years. However, as specified by statute, the rebasing adjustment is limited to 3.5 percent of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94 (74 FR 58106), or $80.95. We stated that given that a −3.45 percent adjustment for CY 2014 through CY 2017 would result in larger dollar amount reductions than the maximum dollar amount allowed under section 3131(a) of the Affordable Care Act of $80.95, we are limited to implementing a reduction of $80.95 (approximately 2.8 percent) to the national, standardized 60-day episode payment amount each year for CY 2014 through CY 2017. Our latest analysis of 2012 cost report data suggests that an even larger reduction (4.29 percent) than the reduction described in the CY 2014 final rule (3.45 percent) would be needed in order to align payments to costs. We will continue to monitor potential impacts of rebasing.

2. Affordable Care Act Face-to-Face Encounter Requirement

Effective January 1, 2011, section 6407 the Affordable Care Act requires that as a condition for payment, prior to certifying a patient's eligibility for the Medicare home health benefit, the physician must document that the physician himself or herself, or an allowed nonphysician practitioner (NPP), as described below, had a face-to-face encounter with the patient. The regulations at 424.22(a)(1)(v) currently require that that the face-to-face encounter be related to the primary reason the patient requires home health services and occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. In addition, as part of the certification of eligibility, the certifying physician must document the date of the encounter and include an explanation (narrative) of why the clinical findings of such encounter support that the patient is homebound, as defined in subsections 1814(a) and 1835(a) of the Act, and in need of either intermittent skilled nursing services or therapy services, as defined in § 409.42(c). The face-to-face encounter requirement was enacted, in part, to discourage physicians certifying patient eligibility for the Medicare home health benefit from relying solely on

information provided by the HHAs when making eligibility determinations and other decisions about patient care.

In the CY 2011 HH PPS final rule, in which we implemented the face-to-face encounter provision of the Affordable Care Act, some commenters expressed concern that this requirement would diminish access to home health services (75 FR 70427). We examined home health claims data from before implementation of the face-to-face encounter requirement (CY 2010), the year of implementation (CY 2011), and the years following implementation (CY 2012 and CY 2013), to determine whether there were indications of access issues as a result of this requirement. Nationally, utilization held relatively constant between CY 2010 and CY 2011 and decreased slightly in CY 2012 (see Table 5). While Table 5 contains preliminary CY 2013 data, the discussion in this section will focus mostly on CY 2010 through CY 2012 data. We will update our analysis with complete CY 2013 data in the final rule. Between CY 2010 and CY 2011, there was a 0.81 percent decrease in number of episodes, and a 1.37 percent decrease in the number of episodes between CY 2011 and CY 2012. However, there was a 0.51 percent increase in the number of beneficiaries with at least one home health episode between CY 2010 and CY 2011 and between CY 2011 and CY 2012 the number of beneficiaries with at least one episode held relatively constant. Home health users (beneficiaries with at least one home health episode) as a percentage of Part A and/or Part B fee-for-service (FFS) beneficiaries decreased slightly from 9.3 percent in CY 2010 to 9.2 percent in CY 2011to 9.0 percent in CY 2012 and the number of episodes per Part A and/or Part B FFS beneficiaries decreased slightly between CY 2010 and CY 2011, but remained relatively constant 0.18 or 18 episodes per 100 Medicare Part A FFS beneficiaries for CY 2012). We note these observed decreases between CY 2010 and CY 2012, for the most part, are likely the result of increases in FFS enrollment between CY 2010 and CY 2012. Newly eligibly Medicare beneficiaries are typically not of the age where home health services are needed and therefore, without any changes in utilization, we would expect home health users and the number of episodes per Part A and/or B FFS beneficiaries to decrease with an increase in the number of newly enrolled FFS beneficiaries. The number of HHAs providing at least one home health episode increased steadily from CY 2010 through CY 2013 (see Table 5).

TABLE 5—HOME HEALTH STATISTICS, CY 2010 THROUGH CY 2013

	2010	2011	2012	2013 (Preliminary)
Number of episodes	6,833,669	6,821,459	6,727,875	6,600,631
Beneficiaries receiving at least 1 episode (Home Health Users)	3,431,696	3,449,231	3,446,122	3,432,571
Part A and/or B FFS beneficiaries	36,818,078	37,686,526	38,224,640	38,501,512
Episodes per Part A and/or B FFS beneficiaries	0.19	0.18	0.18	0.17
Home health users as a percentage of Part A and/or B FFS beneficiaries	9.3%	9.2%	9.0%	8.9%
HHAs providing at least 1 episode	10,916	11,446	11,746	11,820

Source: National claims history (NCH) data obtained from Chronic Condition Warehouse (CCW)—Accessed on May 14, 2014. Medicare enrollment information obtained from the CCW Master Beneficiary Summary File. Beneficiaries are the total number of beneficiaries in a given year with at least 1 month of Part A or Part B Fee For Service Coverage without having any months of Medicare Advantage Coverage.

Note(s): These results include all episode types (Normal, PEP, Outlier, LUPA) and also include episodes from outlying areas (outside of 50 States and District of Columbia). Only episodes with a through date in the year specified are included. Episodes with a claim frequency code equal to "0" ("Non-payment/zero claims") and "2" ("Interim—first claim") are excluded. If a beneficiary is treated by providers from multiple states within a year the beneficiary is counted within each state's unique number of beneficiaries served.

Although home health utilization at the national level appears to have held relatively constant between CY 2010 and CY 2011 with a slight decrease in utilization in CY 2012, the decrease in utilization in CY 2012 did not occur in all states. For example, the number of episodes increased between CY 2010 and CY 2011 and again, in some instances, between CY 2011 and CY 2012 in Alabama, California, and Virginia, to name a few. The number of episodes per Part A and/or Part B FFS beneficiaries for these states also remained roughly the same between CY 2010 through CY 2012 (see Table 6).

TABLE 6—HOME HEALTH STATISTICS FOR SELECT STATES WITH INCREASING NUMBERS OF HOME HEALTH EPISODES, CY 2010 THROUGH CY 2012

	Year	AL	CA	MA	NJ	VA
Number of Episodes	2010	149,242	428,491	183,271	142,328	142,660
	2011	151,131	451,749	186,849	143,127	149,154
	2012	151,812	477,732	183,625	142,129	154,677
Beneficiaries Receiving at Least 1 Episode (Home Health Users)	2010	68,949	259,013	103,954	95,804	83,933
	2011	70,539	270,259	107,520	97,190	86,796
	2012	71,186	281,023	106,910	96,534	89,879
Part A and/or Part B FFS Beneficiaries	2010	689,302	3,199,845	890,472	1,205,049	1,014,248
	2011	717,413	3,294,574	934,312	1,228,239	1,055,516
	2012	732,952	3,397,936	959,015	1,232,950	1,086,474
Episodes per Part A and/or Part B FFS beneficiaries	2010	0.22	0.13	0.21	0.12	0.14
	2011	0.21	0.14	0.20	0.12	0.14
	2012	0.21	0.14	0.19	0.12	14
Home Health Users as a Percentage of Part A and/or B FFS beneficiaries	2010	10.00%	8.09%	11.67%	7.95%	8.28%

TABLE 6—HOME HEALTH STATISTICS FOR SELECT STATES WITH INCREASING NUMBERS OF HOME HEALTH EPISODES, CY 2010 THROUGH CY 2012—Continued

	Year	AL	CA	MA	NJ	VA
	2011	9.83%	8.20%	11.51%	7.91%	8.22%
	2012	9.71%	8.27%	11.15%	7.83%	8.27%
Providers Providing at Least 1 Episode	2010	148	925	138	49	196
	2011	150	1,013	150	48	209
	2012	148	1,073	160	47	219

Source: National claims history (NCH) data obtained from Chronic Condition Warehouse (CCW)—Accessed on May 14, 2014. Medicare enrollment information obtained from the CCW Master Beneficiary Summary File. Beneficiaries are the total number of beneficiaries in a given year with at least 1 month of Part A or Part B Fee For Service Coverage without having any months of Medicare Advantage Coverage.

Note(s): These results include all episode types (Normal, PEP, Outlier, LUPA) and also include episodes from outlying areas (outside of 50 States and District of Columbia). Only episodes with a through date in the year specified are included. Episodes with a claim frequency code equal to ''0'' (''Non-payment/zero claims'') and ''2'' (''Interim—first claim'') are excluded. If a beneficiary is treated by providers from multiple states within a year the beneficiary is counted within each state's unique number of beneficiaries served.

In general, between CY 2010 and CY 2012 the number of episodes for states with the highest utilization of Medicare home health (as measured by the number of episodes per Part A and/or Part B FFS beneficiary) decreased; however, even with this decrease between CY 2010 and CY 2012, the five states listed in Table 7 continue to be among the states with the highest utilization of Medicare home health nationally (see Figure 1). If we were to exclude the five states listed in Table 7 from the national figures in Table 5, home health users (beneficiaries with at least one home health episode) as a percentage of Part A and/or Part B fee-for-service (FFS) beneficiaries would decrease from to 9.0 percent to 8.1 percent for CY 2012 and the number of episodes per Part A and/or Part B FFS beneficiaries would decrease from 0.18 (or 18 episodes per 100 Medicare Part A and/or Part B FFS beneficiaries) to 0.14 (or 14 episodes per 100 Medicare Part A and/or Part B FFS beneficiaries) for CY 2012. We also note that two of the states with the greatest number of home health episodes per Part A and/or Part B FFS beneficiaries (Table 7 and Figure 1) have areas with suspect billing practices. Moratoria on enrollment of new HHAs, effective January 30, 2014, were put in place for: Miami, FL; Chicago, IL; Fort Lauderdale, FL; Detroit, MI; Dallas, TX; and Houston, TX.

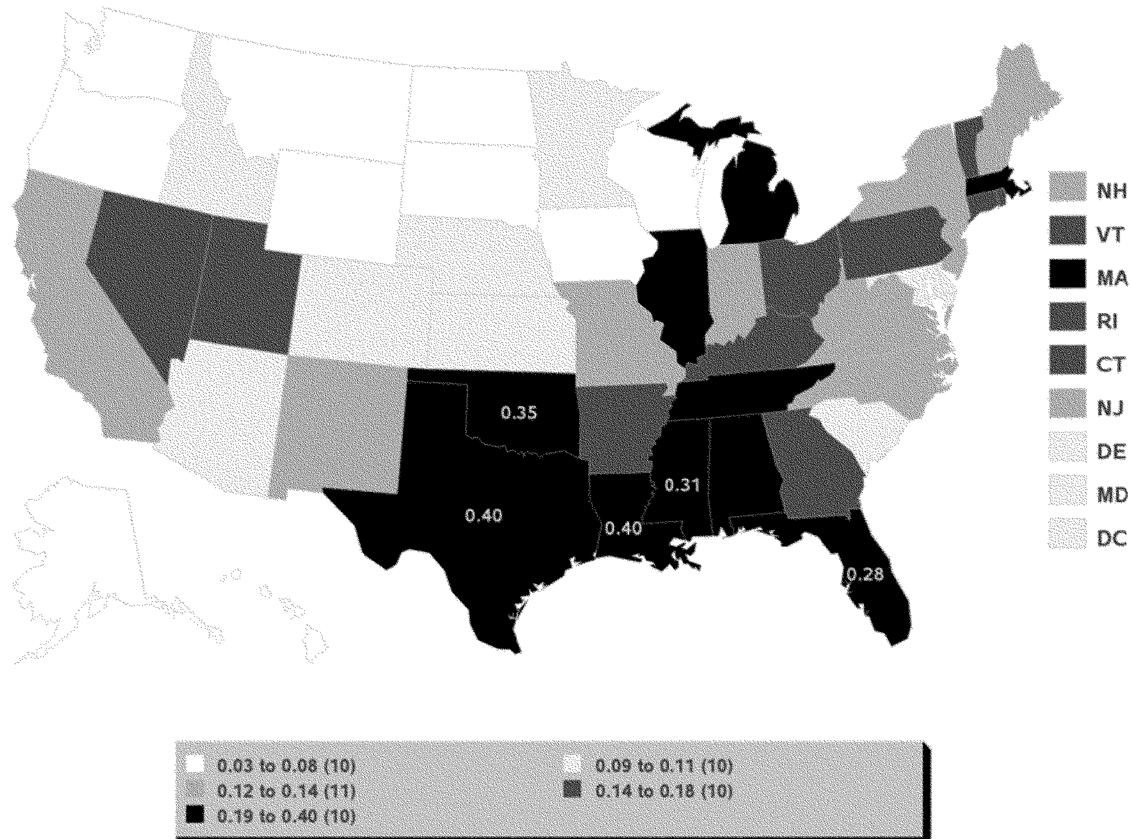
TABLE 7—HOME HEALTH STATISTICS FOR THE STATES WITH THE HIGHEST NUMBER OF HOME HEALTH EPISODES PER PART A AND/OR PART B FFS BENEFICIARIES, CY 2010 THROUGH CY 2012

	Year	TX	FL	OK	MS	LA
Number of Episodes	2010	1,127,852	689,183	208,555	153,169	256,014
	2011	1,107,605	701,426	203,112	153,983	249,479
	2012	1,054,244	691,255	196,887	148,516	230,115
Beneficiaries Receiving at Least 1 Episode (Home Health Users)	2010	366,844	355,181	68,440	55,132	77,976
	2011	363,474	355,900	67,218	55,818	77,677
	2012	350,803	354,838	65,948	55,438	74,755
Part A and/or Part B FFS Beneficiaries	2010	2,500,237	2,422,141	533,792	465,129	544,555
	2011	2,597,406	2,454,124	549,687	476,497	561,531
	2012	2,604,458	2,451,790	558,500	480,218	568,483
Episodes per Part A and/or Part B FFS beneficiaries	2010	0.45	0.28	0.39	0.33	0.47
	2011	0.43	0.29	0.37	0.32	0.44
	2012	0.40	0.28	0.35	0.31	0.40
Home Health Users as a Percentage of Part A and/or Part B FFS Beneficiaries	2010	14.67%	14.66%	12.82%	11.85%	14.32%
	2011	13.99%	14.50%	12.23%	11.71%	13.83%
	2012	13.47%	14.47%	11.81%	11.54%	13.15%
Providers Providing at Least 1 Episode	2010	2,352	1,348	240	53	213
	2011	2,472	1,426	252	51	216
	2012	2,549	1,430	254	48	213

Source: National claims history (NCH) data obtained from Chronic Condition Warehouse (CCW)—Accessed on May 14, 2014. Medicare enrollment information obtained from the CCW Master Beneficiary Summary File. Beneficiaries are the total number of beneficiaries in a given year with at least 1 month of Part A or Part B Fee For Service Coverage without having any months of Medicare Advantage Coverage.

Note(s): These results include all episode types (Normal, PEP, Outlier, LUPA) and also include episodes from outlying areas (outside of 50 States and District of Columbia). Only episodes with a through date in the year specified are included. Episodes with a claim frequency code equal to ''0'' (''Non-payment/zero claims'') and ''2'' (''Interim—first claim'') are excluded. If a beneficiary is treated by providers from multiple states within a year the beneficiary is counted within each state's unique number of beneficiaries served.

Figure 1: Home Health Episodes per Part A and/or Part B FFS Beneficiaries - CY 2012



For CY 2011, in addition to the implementation of the Affordable Care Act face-to-face encounter requirement, HHAs were also subject to new therapy reassessment requirements, payments were reduced to account for increases in nominal case-mix, and the Affordable Care Act mandated that the HH PPS payment rates be reduced by 5 percent to pay up to, but no more than 2.5 percent of total HH PPS payments as outlier payments. The estimated net impact to HHAs for CY 2011 was a decrease in total HH PPS payments of 4.78 percent. Therefore, any changes in utilization between CY 2010 and CY 2011 cannot be solely attributable to the implementation of the face-to-face encounter requirement. For CY 2012 we recalibrated the case-mix weights, including the removal of two hypertension codes from scoring points in the HH PPS Grouper and lowering the case-mix weights for high therapy cases estimated net impact to HHAs, and reduced HH PPS rates in CY 2012 by 3.79 percent to account for additional growth in aggregate case-mix that was unrelated to changes in patients' health status. The estimated net impact to HHAs for CY 2012 was a decrease in total HH PPS payments of 2.31 percent. Again, any changes in utilization between CY 2011 and CY 2012 cannot be solely attributable to the implementation of the face-to-face encounter requirement. Given that a decrease in the number of episodes between CY 2010 and CY 2012 occurred in states that have the highest home health utilization (number of episodes per Part A and/or Part B FFS beneficiaries) and not all states experienced declines in episode volume during that time period, we believe that the implementation of the face-to-face encounter requirement could be considered a contributing factor. We will continue to monitor for potential impacts due to the implementation of the face-to-face encounter requirements and other policy changes in the future. Independent effects of any one policy may be difficult to discern in years where multiple policy changes occur in any given year.

B. Proposed Changes to the Face-to-Face Encounter Requirements

1. Statutory and Regulatory Requirements

As a condition for payment, section 6407 of the Affordable Care Act requires that, prior to certifying a patient's eligibility for the Medicare home health benefit, the physician must document that the physician himself or herself or an allowed nonphysician practitioner (NPP) had a face-to-face encounter with the patient. Specifically, sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, as amended by the Affordable Care Act, state that a nurse practitioner or clinical nurse specialist, as those terms are defined in section 1861(aa)(5) of the Act, working in collaboration with the physician in accordance with state law, or a certified nurse-midwife (as defined in section 1861(gg) of the Act) as authorized by state law, or a physician assistant (as defined in section 1861(aa)(5) of the Act) under the supervision of the physician may perform the face-to-face encounter.

The goal of the Affordable Care Act provision was to achieve greater physician accountability in certifying a

patient's eligibility and in establishing a patient's plan of care. We believed this goal could be better achieved if the face-to-face encounter occurred closer to the start of home health care, increasing the likelihood that the clinical conditions exhibited by the patient during the encounter are related to the primary reason the patient comes to need home health care. The certifying physician is responsible for determining whether the patient meets the eligibility criteria (that is, homebound and skilled need) and for understanding the current clinical needs of the patient such that he or she can establish an effective plan of care. As such, CMS regulations at § 424.22(a)(1)(v) require that that the face-to-face encounter be related to the primary reason the patient requires home health services and occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. In addition, as part of the certification of eligibility, the certifying physician must document the date of the encounter and include an explanation (narrative) of why the clinical findings of such encounter support that the patient is homebound, as defined in sections 1835(a) and 1814(a) of the Act, and in need of either intermittent skilled nursing services or therapy services, as defined in § 409.42(c).

The ''Requirements for Home Health Services'' describes certifying a patient's eligibility for the Medicare home health benefit, and as stated in the ''Content of the Certification'' under § 424.22 (a)(1), a physician must certify that:

- The individual needs or needed intermittent skilled nursing care, physical therapy, and/or speech-language pathology services as defined in § 409.42(c).
- Home health services are or were required because the individual was confined to the home (as defined in sections 1835(a) and 1814(a) of the Act), except when receiving outpatient services.
- A plan for furnishing the services has been established and is or will be periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law).[1]
- Home health services will be or were furnished while the individual is or was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
- A face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was related to the primary reason the patient requires home health services. This also includes documenting the date of the encounter and including an explanation of why the clinical findings of such encounter support that the patient is homebound (as defined in § 1835(a) and § 1814(a) of the Act) and in need of either intermittent skilled nursing services or therapy services as defined in § 409.42(c). The documentation must be clearly titled and dated and the documentation must be signed by the certifying physician.

For instances where the physician orders skilled nursing visits for management and evaluation of the patient's care plan,[2] the physician must include a brief narrative that describes the clinical justification of this need and the narrative must be located immediately before the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately after the narrative in the addendum.

When there is a continuous need for home health care after an initial 60-day episode of care, a physician is also required to recertify the patient's eligibility for the home health benefit. In accordance with § 424.22 (b), a recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed and dated by the physician who reviews the plan of care. In recertifying the patient's eligibility for the home health benefit, the recertification must indicate the continuing need for skilled services and estimate how much longer the skilled services will be required. The 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–language pathology services. Again, for instances where the physician ordering skilled nursing visits for management and evaluation of the patient's care plan, the physician must include a brief narrative that describes the clinical justification of this need and the narrative must be located immediately before the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately after the narrative in the addendum.

In the CY 2012 HH PPS final rule (76 FR 68597), we stated that, in addition to the certifying physician and allowed NPPs (as defined by the Act and outlined above), the physician who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health care, and who had privileges in such facility, could also perform the face-to-face encounter. In the CY 2013 HH PPS final rule (77 FR 67068) we revised our regulations so that an allowed NPP, collaborating with or under the supervision of the physician who cared for the patient in the acute/post-acute care facility, can communicate the clinical findings that support the patient's needs for skilled care and homebound status to the acute/post-acute care physician. In turn, the acute/post-acute care physician would communicate the clinical findings that support the patient's needs for skilled care and homebound status from the encounter performed by the NPP to the certifying physician to document. Policy always permitted allowed NPPs in the acute/post-acute care setting from which the patient is directly admitted to home health care to perform the face-to-face encounter and communicate directly with the certifying physician the clinical findings from the encounter and how such findings support that the patient is homebound and needs skilled services (77 FR 67106).

2. Proposed Changes to the Face-to-Face Encounter Narrative Requirement and Non-Coverage of Associated Physician Certification/Re-Certification Claims

Each year, the CMS' Office of Financial Management (OFM), under the Comprehensive Error Rate Testing (CERT) program, calculates the Medicare Fee-for-Service (FFS) improper payment rate. For the FY 2013

[1] The physician cannot have a financial relationship as defined in § 411.354 of this chapter, with that HHA, unless the physician's relationship meets one of the exceptions in section 1877 of the Act, which sets forth general exceptions to the referral prohibition related to both ownership/investment and compensation; exceptions to the referral prohibition related to ownership or investment interests; and exceptions to the referral prohibition related to compensation arrangements.

[2] Skilled nursing visits for management and evaluation of the patient's care plan are reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential *unskilled* care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition (reference § 409.33 and section 40.1.2.2 in Chapter 7 of the Medicare Benefits Policy Manual (Pub. 100–02)).

report period (reflecting claims processed between July 2011 and June 2012), the national Medicare FFS improper payment rate was calculated to be 10.1 percent.[3] For that same report period, the improper payment rate for home health services was 17.3 percent, representing a projected improper payment amount of approximately $3 billion.[4] The improper payments identified by the CERT program represent instances in which a health care provider fails to comply with the Medicare coverage and billing requirements and are not necessarily a result of fraudulent activity.[5]

The majority of home health improper payments were due to ''insufficient documentation'' errors. ''Insufficient documentation'' errors occur when the medical documentation submitted is inadequate to support payment for the services billed or when a specific documentation element that is required (as described above) is missing. Most ''insufficient documentation'' errors for home health occurred when the narrative portion of the face-to-face encounter documentation did not sufficiently describe how the clinical findings from the encounter supported the beneficiary's homebound status and need for skilled services, as required by § 424.22(a)(1)(v).

The home health industry continues to voice concerns regarding the implementation of the Affordable Care Act face-to-face encounter documentation requirement. The home health industry cites challenges that HHAs face in meeting the face-to-face encounter documentation requirements regarding the required narrative, including a perceived lack of established standards for compliance that can be adequately understood and applied by the physicians and HHAs. In addition, the home health industry conveys frustration with having to rely on the physician to satisfy the face-to-face encounter documentation requirements without incentives to encourage physician compliance. Correspondence received to date has expressed concern over the ''extensive and redundant'' narrative required by regulation for face-to-face encounter documentation purposes when detailed evidence to support the physician certification of homebound status and medical necessity is available in clinical records. In addition, correspondence stated that the narrative requirement was not explicit in the Affordable Care Act provision requiring a face-to-face encounter as part of the certification of eligibility and that a narrative requirement goes beyond Congressional intent.

We agree that there should be sufficient evidence in the patient's medical record to demonstrate that the patient meets the Medicare home health eligibility criteria. Therefore, in an effort to simplify the face-to-face encounter regulations, reduce burden for HHAs and physicians, and to mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements, we propose that:

(1) The narrative requirement in regulation at § 424.22(a)(1)(v) would be eliminated. The certifying physician would still be required to certify that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in § 424.22(a)(1)(v)(A), and to document the date of the encounter as part of the certification of eligibility.

For instances where the physician is ordering skilled nursing visits for management and evaluation of the patient's care plan, the physician will still be required to include a brief narrative that describes the clinical justification of this need as part of the certification/re-certification of eligibility as outlined in § 424.22(a)(1)(i) and § 424.22(b)(2). This requirement was implemented in the CY 2010 HH PPS final rule (74 FR 58111) and is not changing.

(2) In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, we would review only the medical record for the patient from the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home health) used to support the physician's certification of patient eligibility, as described in paragraphs (a)(1) and (b) of this section. If the patient's medical record, used by the physician in certifying eligibility, was not sufficient to demonstrate that the patient was eligible to receive services under the Medicare home health benefit, payment would not be rendered for home health services provided.

(3) Physician claims for certification/re-certification of eligibility for home health services (G0180 and G0179, respectively) would not be covered if the HHA claim itself was non-covered because the certification/re-certification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit. However, rather than specify this in our regulations, this proposal would be implemented through future sub-regulatory guidance.

We believe that these proposals are responsive to home health industry concerns regarding the face-to-face encounter requirements articulated above. We invite comment on these proposals and the associated change in the regulation at § 424.22 in section VI.

3. Proposed Clarification on When Documentation of a Face-to-Face Encounter Is Required

In the CY 2011 HH PPS final rule (75 FR 70372), in response to a commenter who asked whether the face-to-face encounter is required only for the first episode, we stated that the Congress enacted the face-to-face encounter requirement to apply to the physician's certification, not recertifications. In sub-regulatory guidance (face-to-face encounter Q&As on the CMS Web site at: *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Home-Health-Questions-Answers.pdf*), response to Q&A #11 states that the face-to-face encounter requirement applies to ''initial episodes'' (the first in a series of episodes separated by no more than a 60-day gap). The distinction between what is considered a certification (versus a recertification) and what is considered an initial episode is important in determining whether the face-to-face encounter requirement is applicable.

Recent inquiries question whether the face-to-face encounter requirement applies to situations where the beneficiary was discharged from home health with goals met/no expectation of return to home health care and readmitted to home health less than 60 days later. In this situation, the second episode would be considered a certification, not a recertification, because the HHA would be required to complete a new start of care OASIS to initiate care. However, for payment

[3] U.S. Department of Health and Human Services, ''*FY 2013 Agency Financial Report''*, accessed on April 23, 2014 at: *http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf.*

[4] U.S. Department of Health and Human Services, ''*The Supplementary Appendices for the Medicare Fee-for-Service 2013 Improper Payment Rate Report''*, accessed on April 23, 2014 at: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/November2013ReportPeriodAppendixFinal12-13-2013_508Compliance_Approved12-27-13.pdf.*

[5] The CERT improper payment rate is not a ''fraud rate,'' but is a measurement of payments made that did not meet Medicare requirements. The CERT program cannot label a claim fraudulent.

purposes, the second episode would be considered a subsequent episode, because there was no gap of 60 days or more between the first and second episodes of care. Therefore, in order to determine when documentation of a patient's face-to-face encounter is required under sections 1814(a)(2)(C) and 1835 (a)(2)(A) of the Act, we are proposing to clarify that the face-to-face encounter requirement is applicable for certifications (not recertifications), rather than initial episodes. A certification (versus recertification) is considered to be any time that a new start of care OASIS is completed to initiate care. Because we are proposing to clarify that a certification is considered to be any time a that a new start of care OASIS is completed to initiate care, we would also revise Q&A #11 on the CMS Web site (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Home-Health-Questions-Answers.pdf*) to reflect this proposed clarification. If a patient was transferred to the hospital and remained in the hospital after day 61 (or after the first day of the next certification period), once the patient returns home, a new start of care OASIS must be completed. Therefore, this new episode would not be considered continuous and a face-to-face encounter needs to be documented as part of the certification of patient eligibility.[6]

C. Proposed Recalibration of the HH PPS Case-Mix Weights

For CY 2012, we removed two hypertension codes from our case-mix system and recalibrated the case-mix weights in a budget neutral manner. When recalibrating the case-mix weights for the CY 2012 HH PPS final rule, we used CY 2005 data in the four-equation model used to determine the clinical and functional points for a home health episode and CY 2007 data in the payment regression model used to determine the case-mix weights. We estimated the coefficients for the variables in the four-equation model using CY 2005 data to maintain the same variables we used for CY 2008 when we implemented the four-equation model, thus minimizing substantial changes. Due to a noticeable shift in the number of therapy visits provided as a result of the 2008 refinements, at the time, we decided to use CY 2007 data in the payment regression. As part of the CY 2012 recalibration, we lowered the high therapy weights and raised the low or no therapy weights to address MedPAC's concerns that the HH PPS overvalues therapy episodes and undervalues non-therapy episodes (March 2011 MedPAC Report to the Congress: Medicare Payment Policy, p. 176). These adjustments better aligned the case-mix weights with episode costs estimated from cost report data. The CY 2012 recalibration, itself, was implemented in a budget neutral manner. However, we note that in the CY 2012 HH PPS final rule, we also finalized a 3.79 percent reduction to payments in CY 2012 and a 1.32 percent reduction for CY 2013 to account for the nominal case-mix growth identified through CY 2009.

For CY 2014, as part of the Affordable Care Act mandated rebasing effort, we reset the case-mix weights, lowering the average case-mix weight to 1.0000. To lower the case-mix weights to 1.0000, each case-mix weight was decreased by the same factor (1.3464), thereby maintaining the same relative values between the weights. This resetting of the case-mix weights was done in a budget neutral manner, inflating the starting point for rebasing by the same factor that was used to decrease the weights. In the CY 2014 HH PPS final rule, we also finalized a reduction ($80.95) to the national, standardized 60-day episode payment amount each year from CY 2014 through CY 2017 to better align payments with costs (78 FR 72293).

For CY 2015, we propose to recalibrate the case-mix weights, adjusting the weights relative to one another using more current data and aligning payments with current utilization data in a budget neutral manner. We are also proposing to recalibrate the case-mix weights in subsequent payment updates based on the methodology finalized in the CY 2012 HH PPS final rule (76 FR 68526) and the 2008 refinements (72 FR 25359–25392), with the proposed minor changes outlined below. We used preliminary CY 2013 home health claims data (as of December 31, 2013) to generate the proposed CY 2015 case-mix weights using the same methodology finalized in the CY 2012 HH PPS final rule, except where noted below. Similar to the CY 2012 recalibration, some exclusion criteria were applied to the CY 2013 home health claims data used to generate the proposed CY 2015 case-mix weights. Specifically, we excluded Request for Anticipated Payment (RAP) claims, claims without a matched OASIS, claims where total minutes equal 0, claims where the payment amount equals 0, claims where paid days equal 0, claims where covered visits equal 0, and claims without a HIPPS code. In addition, the episodes used in the recalibration were normal episodes. PEP, LUPA, outlier, and capped outlier (that is, episodes that are paid as normal episodes, but would have been outliers had the HHA not reached the outlier cap) episodes were dropped from the data file.[7]

Similar to the CY 2012 recalibration, the first step in the proposed CY 2015 recalibration was to re-estimate the four-equation model used to determine the clinical and functional points for an episode. The dependent variable for the CY 2015 recalibration is the same as the CY 2012 recalibration, wage-weighted minutes of care. The wage-weighted minutes of care are determined using the CY 2012 Bureau of Labor Statistics national hourly wage plus fringe rates for the six home health disciplines and the minutes per visit from the claim.

The CY 2012 four-equation model contained the same variables and restrictions as the four-equation model used in the CY 2008 refinements (*http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/Coleman_Final_April_2008.pdf*). The model was estimated using CY 2005 data, same data used in the CY 2008 refinements, thereby minimizing changes in the points for the CY 2012 four-equation model. For the CY 2015 four-equation model, we re-examined all of the four-equation or ''leg'' variables for each of the 51 grouper variables in the CY 2008 model. Therefore, a grouper variable that may have dropped out of the model in one of the four equations in CY 2008 may be in the CY 2015 four-equation model and vice versa. Furthermore, the specific therapy indicator variables that were in the CY 2012 four-equation model were dropped in the CY 2015 four-equation model so that the number of therapy visits provided had less of an impact on the process used to create the case-mix weights.

The steps used to estimate the four-equation model are similar to the steps used in the CY 2008 refinements. They are as follows: [8]

(1) We estimated a regression model where the dependent variable is wage-

[6] *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISConsiderationsforPPS.pdf.*

[7] At a later point, when normalizing the weights, PEP episodes are included in the analysis.

[8] All the regressions mentioned in steps 1–4 are estimated with robust standard errors clustered at the beneficiary ID level. This is to account for beneficiaries appearing in the data multiple times. When that occurs, the standard errors can be correlated causing the p-value to be biased downward. Clustered standard errors account for that bias.

weighted minutes of care. Independent variables were indicators for which equation or ''leg'' the episode is in. The four legs of the model are leg 1: Early episodes 0–13 therapy visits, leg 2: Early episodes 14+ therapy visits, leg 3: Later episodes 0–13 therapy visits, and leg 4: Later episodes 14+ therapy visits.[9] Also, independent variables for each of the 51 grouper variables for each leg of the model are included in the model.

(2) Once the four-equation model is estimated, we drop all grouper variables with a coefficient less than 5 from the model. We re-estimate the model and continue to drop variables and re-estimate until there are no grouper variables with a coefficient of 5 or less.

(3) Taking the final iteration of the model in the previous step, we drop all grouper variables with a p-value greater than 0.10. We then re-estimate the model.

(4) Taking the model in the previous step, we begin to apply restrictions to certain coefficients. Within a grouper variable we first look across the coefficients for leg1 and leg3. We perform an equality test on those coefficients. If the coefficients are not significantly different from one another (using a p-value of 0.05), we set a restriction for that grouper variable such that the coefficients are equal across leg1 and leg3. We run these tests for all grouper variables for leg1 and leg3. We also run these tests for all grouper variables for leg2 and leg4.[10] After all restrictions are set, we re-run the regression again taking those restrictions into account.

(5) Taking in the model from step 4, we drop variables that have a coefficient less than 5 and re-estimate the model a final time. Using preliminary 2013 claims data, there was only 1 grouper variable with a negative coefficient that was dropped from the model.

The results from the final four-equation model are used to determine the clinical and functional points for an episode and place episodes in the different clinical and functional levels used to estimate the payment regression model. We take the coefficients from the four equation model, divide them by 10, and round to the nearest integer to determine the points associated with each variable. The points for each of the grouper variables for each leg of the model are shown in Table 8. The points for the clinical variables are added together to determine an episode's clinical score. The points for the functional variables are added together to determine an episode's functional score.

TABLE 8—CASE-MIX ADJUSTMENT VARIABLES AND SCORES

	Episode number within sequence of adjacent episodes Therapy visits *EQUATION:*	1 or 2 0–13 *1*	1 or 2 14+ *2*	3+ 0–13 *3*	3+ 14+ *4*
	CLINICAL DIMENSION				
1	Primary or Other Diagnosis = Blindness/Low Vision				
2	Primary or Other Diagnosis = Blood disorders		6		3
3	Primary or Other Diagnosis = Cancer, selected benign neoplasms		8		8
4	Primary Diagnosis = Diabetes		8		8
5	Other Diagnosis = Diabetes	1			
6	Primary or Other Diagnosis = Dysphagia *AND* Primary or Other Diagnosis = Neuro 3—Stroke	2	16	1	9
7	Primary or Other Diagnosis = Dysphagia *AND* M1030 (Therapy at home) = 3 (Enteral)	2	7		7
8	Primary or Other Diagnosis = Gastrointestinal disorders				
9	Primary or Other Diagnosis = Gastrointestinal disorders *AND* M1630 (ostomy) = 1 or 2		5		
10	Primary or Other Diagnosis = Gastrointestinal disorders *AND* Primary or Other Diagnosis = Neuro 1—Brain disorders and paralysis, *OR* Neuro 2—Peripheral neurological disorders, *OR* Neuro 3—Stroke, *OR* Neuro 4—Multiple Sclerosis				
11	Primary or Other Diagnosis = Heart Disease OR Hypertension	1			
12	Primary Diagnosis = Neuro 1—Brain disorders and paralysis	3	11	6	11
13	Primary or Other Diagnosis = Neuro 1—Brain disorders and paralysis. *AND* M1840 (Toilet transfer) = 2 or more				
14	Primary or Other Diagnosis = Neuro 1—Brain disorders and paralysis *OR* Neuro 2—Peripheral neurological disorders. *AND* M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	2	7	1	7
15	Primary or Other Diagnosis = Neuro 3—Stroke	3	10	2	
16	Primary or Other Diagnosis = Neuro 3—Stroke *AND* M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3		4		9
17	Primary or Other Diagnosis = Neuro 3—Stroke *AND* M1860 (Ambulation) = 4 or more				

[9] Early episodes are defined as the 1st or 2nd episode in a sequence of adjacent covered episodes. Later episodes are defined as the 3rd episode and beyond in a sequence of adjacent covered episodes. Episodes are considered to be adjacent if they are separated by no more than a 60-day period between claims.

[10] In the CY 2008 rule, there was a further step taken to determine if the coefficients of a grouper variable are equal across all 4 legs. This step was not taken at this time.

TABLE 8—CASE-MIX ADJUSTMENT VARIABLES AND SCORES—Continued

18	Primary or Other Diagnosis = Neuro 4—Multiple Sclerosis *AND AT LEAST ONE OF THE FOLLOWING:*. M1830 (Bathing) = 2 or more *OR* M1840 (Toilet transfer) = 2 or more *OR* M1850 (Transferring) = 2 or more *OR* M1860 (Ambulation) = 4 or more	3	8	6	14
19	Primary or Other Diagnosis = Ortho 1—Leg Disorders or Gait Disorders. *AND* M1324 (most problematic pressure ulcer stage) = 1, 2, 3 or 4	8	1	8	4
20	Primary or Other Diagnosis = Ortho 1—Leg OR Ortho 2—Other orthopedic disorders. *AND* M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	3	4	3	
21	Primary or Other Diagnosis = Psych 1—Affective and other psychoses, depression.				
22	Primary or Other Diagnosis = Psych 2—Degenerative and other organic psychiatric disorders.				
23	Primary or Other Diagnosis = Pulmonary disorders				
24	Primary or Other Diagnosis = Pulmonary disorders *AND* M1860 (Ambulation) = 1 or more				
25	Primary Diagnosis = Skin 1—Traumatic wounds, burns, and post-operative complications.	4	20	8	20
26	Other Diagnosis = Skin 1—Traumatic wounds, burns, post-operative complications.	5	14	7	14
27	Primary or Other Diagnosis = Skin 1—Traumatic wounds, burns, and post-operative complications *OR* Skin 2—Ulcers and other skin conditions. *AND* M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)	4		1	
28	Primary or Other Diagnosis = Skin 2—Ulcers and other skin conditions.	2	17	8	17
29	Primary or Other Diagnosis = Tracheostomy	4	16	4	16
30	Primary or Other Diagnosis = Urostomy/Cystostomy		18		14
31	M1030 (Therapy at home) = 1 (IV/Infusion) or 2 (Parenteral)		17	5	17
32	M1030 (Therapy at home) = 3 (Enteral)		16		7
33	M1200 (Vision) = 1 or more				
34	M1242 (Pain) = 3 or 4	2		1	
35	M1308 = Two or more pressure ulcers at stage 3 or 4	4	7	4	7
36	M1324 (Most problematic pressure ulcer stage) = 1 or 2	3	18	7	15
37	M1324 (Most problematic pressure ulcer stage) = 3 or 4	8	31	11	26
38	M1334 (Stasis ulcer status) = 2	4	12	7	22
39	M1334 (Stasis ulcer status) = 3	7	17	10	17
40	M1342 (Surgical wound status) = 2	1	7	6	14
41	M1342 (Surgical wound status) = 3		6	5	10
42	M1400 (Dyspnea) = 2, 3, or 4		2		3
43	M1620 (Bowel Incontinence) = 2 to 5		3		3
44	M1630 (Ostomy) = 1 or 2	4	11	3	11
45	M2030 (Injectable Drug Use) = 0, 1, 2, or 3				
	FUNCTIONAL DIMENSION				
46	M1810 or M1820 (Dressing upper or lower body) = 1, 2, or 3	2		1	
47	M1830 (Bathing) = 2 or more	6	3	5	
48	M1840 (Toilet transferring) = 2 or more	1	3		3
49	M1850 (Transferring) = 2 or more	3	4	2	
50	M1860 (Ambulation) = 1, 2 or 3	7		3	
51	M1860 (Ambulation) = 4 or more	7	8	6	8

Source: CY 2013 home health claims data as of December 31, 2013 from the home health Standard Analytic File (SAF). We excluded LUPA episodes, outlier episodes, and episodes with PEP adjustments.

Note(s): Points are additive, however points may not be given for the same line item in the table more than once. Please see Medicare Home Health Diagnosis Coding guidance at: *http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp* for definitions of primary and secondary diagnoses.

In updating the four-equation model with 2013 data (the last update to the four-equation model used 2005 data), there were significant changes to the point values for the variables in the four-equation model. These reflect changes in the relationship between the grouper variables and resource use since 2005. The CY 2015 four-equation model resulted in 121 point-giving variables being used in the model (as compared to the 164 variables for the 2012 recalibration). There were 19 variables that were added to the model and 62 variables that were dropped from the

model due to the lack of additional resources associated with the variable. The points for 56 variables increased in the CY 2015 four-equation model and the points for 28 variables in decreased in the CY 2015 four-equation model.

Since there were a number of significant changes to the point values associated with the four-equation model, we are proposing to redefine the clinical and functional thresholds so that they would be reflective of the new points associated with the CY 2015 four-equation model. Specifically, after estimating the points for each of the variables and summing the clinical and functional points for each episode, we looked at the distribution of the clinical score and functional score, breaking the episodes into different steps. The categorizations for the steps are as follows:

- Step 1: First and second episodes, 0–13 therapy visits.
- Step 2.1: First and second episodes, 14–19 therapy visits.
- Step 2.2: Third episodes and beyond, 14–19 therapy visits.
- Step 3: Third episodes and beyond, 0–13 therapy visits.
- Step 4: Episodes with 20+ therapy visits.

Similar to the methodology used in the CY 2008 refinements, we then divide the distribution of the clinical score for episodes within a step such that a third of episodes are classified as low clinical score, a third of episodes are classified as medium clinical score, and a third of episodes are classified as high clinical score. The same approach is then done looking at the functional score. It was not always possible to evenly divide the episodes within each level, by step, into thirds due to many episodes being clustered around one particular score.[11] Also, we looked at the average resource use associated with each clinical and functional score and used that to guide where we placed our thresholds. We tried to group scores with similar average resource use within the same level (even if it means that more or less than a third of episodes are placed within a level by step). The new thresholds based off of the CY 2015 four-equation model points are shown in Table 9.

TABLE 9—CY 2015 CLINICAL AND FUNCTIONAL THRESHOLDS

		1st and 2nd episodes		3rd+ episodes		All episodes
		0 to 13 therapy visits	14 to 19 therapy visits	0 to 13 therapy visits	14 to 19 therapy visits	20+ therapy visits
Grouping Step:		1	2	3	4	5
Equation(s) used to calculate points: (see Table 8)		1	2	3	4	(2&4)
Dimension	Severity Level.					
Clinical	C1	0 to 1	0	0	0 to 3	0 to 3.
	C2	2 to 3	1 to 7	1	4 to 12	4 to 16.
	C3	4+	8+	2+	13+	17+.
Functional	F1	0 to 14	0 to 3	0 to 8	0	0 to 2.
	F2	15	4 to 12	9	1 to 7	3 to 4.
	F3	16+	13+	10+	8+	5+.

Once the thresholds were determined and each episode was assigned a clinical and functional level, the payment regression was estimated with an episode's wage-weighted minutes of care as the dependent variable. Independent variables in the model were indicators for the step of the episode as well for the clinical and functional levels within each step of the episode. Like the four-equation model, the payment regression model is also estimated with robust standard errors that are clustered at the beneficiary level. Table 10 shows the regression coefficients for the variables in the proposed payment regression model. The R-squared value for the payment regression model is 0.4691 (an increase from 0.3769 for the CY 2012 recalibration).

TABLE 10—PROPOSED PAYMENT REGRESSION MODEL

Variable description	Proposed CY 2015 payment regression coefficients
Step 1, Clinical Score Medium	$24.43
Step 1, Clinical Score High	59.46
Step 1, Functional Score Medium	81.03
Step 1, Functional Score High	120.87
Step 2.1, Clinical Score Medium	56.61
Step 2.1, Clinical Score High	175.83
Step 2.1, Functional Score Medium	25.84
Step 2.1, Functional Score High	90.77
Step 2.2, Clinical Score Medium	90.83
Step 2.2, Clinical Score High	201.06
Step 2.2, Functional Score Medium	18.50

[11] For Step 1, 55% of episodes were in the medium functional level (All with score 15).

For Step 2.1, 60.9% of episodes were in the low functional level (Most with score 3, some with score 0).

For Step 2.2, 70.3% of episodes were in the low functional level (All with score 0).

For Step 3, 52.3% of episodes were in the medium functional level (all with score 9).

For Step 4, 41.6% of episodes were in the medium functional level (almost all with score 3).

TABLE 10—PROPOSED PAYMENT REGRESSION MODEL—Continued

Variable description	Proposed CY 2015 payment regression coefficients
Step 2.2, Functional Score High	91.18
Step 3, Clinical Score Medium	10.42
Step 3, Clinical Score High	85.74
Step 3, Functional Score Medium	49.62
Step 3, Functional Score High	84.57
Step 4, Clinical Score Medium	77.85
Step 4, Clinical Score High	237.87
Step 4, Functional Score Medium	38.26
Step 4, Functional Score High	93.84
Step 2.1, 1st and 2nd Episodes, 14 to 19 Therapy Visits	438.76
Step 2.2, 3rd+ Episodes, 14 to 19 Therapy Visits	448.05
Step 3, 3rd+ Episodes, 0–13 Therapy Visits	−65.84
Step 4, All Episodes, 20+ Therapy Visits	857.63
Intercept	368.93

Source: CY 2013 home health claims data as of December 31, 2013 from the home health standard analytic file (SAF).

The method used to derive the proposed CY 2015 case-mix weights from the payment regression model coefficients is the same as the method used to derive the CY 2012 case-mix weights. This method is described below.

(1) We used the coefficients from the payment regression model to predict each episode's wage-weighted minutes of care (resource use). We then divided these predicted values by the mean of the dependent variable (that is, the average wage-weighted minutes of care across all episodes used in the payment regression). This division constructs the weight for each episode, which is simply the ratio of the episode's predicted wage-weighted minutes of care divided by the average wage-weighted minutes of care in the sample. Each episode was then aggregated into one of the 153 home health resource groups (HHRGs) and the ''raw'' weight for each HHRG was calculated as the average of the episode weights within the HHRG.

(2) In the next step of weight revision, the weights associated with 0 to 5 therapy visits were increased by 3.75 percent. Also, the weights associated with 14–15 therapy visits were decreased by 2.5 percent and the weights associated with 20+ therapy visits were decreased by 5 percent. These adjustments were made to discourage inappropriate use of therapy while addressing concerns that non-therapy services are undervalued. These adjustments to the case-mix weights are the same as the ones used in the CY 2012 recalibration (76 FR 68557).

(3) After the adjustments in step (2) were applied to the raw weights, the weights were further adjusted to create an increase in the payment weights for the therapy visit steps between the therapy thresholds. Weights with the same clinical severity level, functional severity level, and early/later episode status were grouped together. Then within those groups, the weights for each therapy step between thresholds were gradually increased. We did this by interpolating between the main thresholds on the model (from 0–5 to 14–15 therapy visits, and from 14–15 to 20+ therapy visits). We used a linear model to implement the interpolation so the payment weight increase for each step between the thresholds (such as the increase between 0–5 therapy visits and 6 therapy visits and the increase between 6 therapy visits and 7–9 therapy visits) was constant. This interpolation is the identical to the process finalized in the CY 2012 final rule (76 FR 68555).

(4) The interpolated weights were then adjusted so that the average case-mix for the weights was equal to 1.[12] This last step creates the proposed CY 2015 case-mix weights shown in Table 11.

TABLE 11—PROPOSED CY 2015 CASE-MIX PAYMENT WEIGHTS

Payment group	Step (episode and/or therapy visit ranges)	Clinical and functional levels (1 = Low; 2 = Medium; 3= High)	CY 2015 proposed case-mix weights
10111	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F1S1	0.5984
10112	1st and 2nd Episodes, 6 Therapy Visits	C1F1S2	0.7250
10113	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F1S3	0.8515
10114	1st and 2nd Episodes, 10 Therapy Visits	C1F1S4	0.9781
10115	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F1S5	1.1046
10121	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F2S1	0.7299
10122	1st and 2nd Episodes, 6 Therapy Visits	C1F2S2	0.8380
10123	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F2S3	0.9461
10124	1st and 2nd Episodes, 10 Therapy Visits	C1F2S4	1.0543
10125	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F2S5	1.1624
10131	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F3S1	0.7945
10132	1st and 2nd Episodes, 6 Therapy Visits	C1F3S2	0.9095

[12] When computing the average, we compute a weighted average, assigning a value of one to each normal episode and a value equal to the episode length divided by 60 for PEPs.

TABLE 11—PROPOSED CY 2015 CASE-MIX PAYMENT WEIGHTS—Continued

Payment group	Step (episode and/or therapy visit ranges)	Clinical and functional levels (1 = Low; 2 = Medium; 3= High)	CY 2015 proposed case-mix weights
10133	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F3S3	1.0245
10134	1st and 2nd Episodes, 10 Therapy Visits	C1F3S4	1.1395
10135	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F3S5	1.2545
10211	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F1S1	0.6381
10212	1st and 2nd Episodes, 6 Therapy Visits	C2F1S2	0.7739
10213	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F1S3	0.9098
10214	1st and 2nd Episodes, 10 Therapy Visits	C2F1S4	1.0457
10215	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F1S5	1.1816
10221	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F2S1	0.7695
10222	1st and 2nd Episodes, 6 Therapy Visits	C2F2S2	0.8870
10223	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F2S3	1.0044
10224	1st and 2nd Episodes, 10 Therapy Visits	C2F2S4	1.1219
10225	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F2S5	1.2394
10231	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F3S1	0.8341
10232	1st and 2nd Episodes, 6 Therapy Visits	C2F3S2	0.9585
10233	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F3S3	1.0828
10234	1st and 2nd Episodes, 10 Therapy Visits	C2F3S4	1.2071
10235	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F3S5	1.3315
10311	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F1S1	0.6949
10312	1st and 2nd Episodes, 6 Therapy Visits	C3F1S2	0.8557
10313	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F1S3	1.0166
10314	1st and 2nd Episodes, 10 Therapy Visits	C3F1S4	1.1775
10315	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F1S5	1.3383
10321	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F2S1	0.8263
10322	1st and 2nd Episodes, 6 Therapy Visits	C3F2S2	0.9688
10323	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F2S3	1.1112
10324	1st and 2nd Episodes, 10 Therapy Visits	C3F2S4	1.2537
10325	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F2S5	1.3961
10331	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F3S1	0.8909
10332	1st and 2nd Episodes, 6 Therapy Visits	C3F3S2	1.0403
10333	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F3S3	1.1896
10334	1st and 2nd Episodes, 10 Therapy Visits	C3F3S4	1.3389
10335	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F3S5	1.4882
21111	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F1S1	1.2312
21112	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F1S2	1.4280
21113	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F1S3	1.6249
21121	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F2S1	1.2706
21122	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F2S2	1.4732
21123	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F2S3	1.6759
21131	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F3S1	1.3695
21132	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F3S2	1.5667
21133	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F3S3	1.7639
21211	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F1S1	1.3175
21212	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F1S2	1.5241
21213	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F1S3	1.7307
21221	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F2S1	1.3569
21222	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F2S2	1.5693
21223	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F2S3	1.7817
21231	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F3S1	1.4558
21232	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F3S2	1.6628
21233	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F3S3	1.8698
21311	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F1S1	1.4992
21312	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F1S2	1.7245
21313	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F1S3	1.9498
21321	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F2S1	1.5386
21322	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F2S2	1.7697
21323	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F2S3	2.0008
21331	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F3S1	1.6376
21332	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F3S2	1.8632
21333	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F3S3	2.0888
22111	3rd+ Episodes, 14 to 15 Therapy Visits	C1F1S1	1.2454
22112	3rd+ Episodes, 16 to 17 Therapy Visits	C1F1S2	1.4375
22113	3rd+ Episodes, 18 to 19 Therapy Visits	C1F1S3	1.6296
22121	3rd+ Episodes, 14 to 15 Therapy Visits	C1F2S1	1.2736
22122	3rd+ Episodes, 16 to 17 Therapy Visits	C1F2S2	1.4752
22123	3rd+ Episodes, 18 to 19 Therapy Visits	C1F2S3	1.6769
22131	3rd+ Episodes, 14 to 15 Therapy Visits	C1F3S1	1.3843
22132	3rd+ Episodes, 16 to 17 Therapy Visits	C1F3S2	1.5766

TABLE 11—PROPOSED CY 2015 CASE-MIX PAYMENT WEIGHTS—Continued

Payment group	Step (episode and/or therapy visit ranges)	Clinical and functional levels (1 = Low; 2 = Medium; 3= High)	CY 2015 proposed case-mix weights
22133	3rd+ Episodes, 18 to 19 Therapy Visits	C1F3S3	1.7689
22211	3rd+ Episodes, 14 to 15 Therapy Visits	C2F1S1	1.3838
22212	3rd+ Episodes, 16 to 17 Therapy Visits	C2F1S2	1.5683
22213	3rd+ Episodes, 18 to 19 Therapy Visits	C2F1S3	1.7529
22221	3rd+ Episodes, 14 to 15 Therapy Visits	C2F2S1	1.4120
22222	3rd+ Episodes, 16 to 17 Therapy Visits	C2F2S2	1.6061
22223	3rd+ Episodes, 18 to 19 Therapy Visits	C2F2S3	1.8001
22231	3rd+ Episodes, 14 to 15 Therapy Visits	C2F3S1	1.5228
22232	3rd+ Episodes, 16 to 17 Therapy Visits	C2F3S2	1.7074
22233	3rd+ Episodes, 18 to 19 Therapy Visits	C2F3S3	1.8921
22311	3rd+ Episodes, 14 to 15 Therapy Visits	C3F1S1	1.5518
22312	3rd+ Episodes, 16 to 17 Therapy Visits	C3F1S2	1.7596
22313	3rd+ Episodes, 18 to 19 Therapy Visits	C3F1S3	1.9673
22321	3rd+ Episodes, 14 to 15 Therapy Visits	C3F2S1	1.5800
22322	3rd+ Episodes, 16 to 17 Therapy Visits	C3F2S2	1.7973
22323	3rd+ Episodes, 18 to 19 Therapy Visits	C3F2S3	2.0146
22331	3rd+ Episodes, 14 to 15 Therapy Visits	C3F3S1	1.6908
22332	3rd+ Episodes, 16 to 17 Therapy Visits	C3F3S2	1.8987
22333	3rd+ Episodes, 18 to 19 Therapy Visits	C3F3S3	2.1065
30111	3rd+ Episodes, 0 to 5 Therapy Visits	C1F1S1	0.4916
30112	3rd+ Episodes, 6 Therapy Visits	C1F1S2	0.6424
30113	3rd+ Episodes, 7 to 9 Therapy Visits	C1F1S3	0.7931
30114	3rd+ Episodes, 10 Therapy Visits	C1F1S4	0.9439
30115	3rd+ Episodes, 11 to 13 Therapy Visits	C1F1S5	1.0946
30121	3rd+ Episodes, 0 to 5 Therapy Visits	C1F2S1	0.5721
30122	3rd+ Episodes, 6 Therapy Visits	C1F2S2	0.7124
30123	3rd+ Episodes, 7 to 9 Therapy Visits	C1F2S3	0.8527
30124	3rd+ Episodes, 10 Therapy Visits	C1F2S4	0.9930
30125	3rd+ Episodes, 11 to 13 Therapy Visits	C1F2S5	1.1333
30131	3rd+ Episodes, 0 to 5 Therapy Visits	C1F3S1	0.6288
30132	3rd+ Episodes, 6 Therapy Visits	C1F3S2	0.7799
30133	3rd+ Episodes, 7 to 9 Therapy Visits	C1F3S3	0.9310
30134	3rd+ Episodes, 10 Therapy Visits	C1F3S4	1.0821
30135	3rd+ Episodes, 11 to 13 Therapy Visits	C1F3S5	1.2332
30211	3rd+ Episodes, 0 to 5 Therapy Visits	C2F1S1	0.5085
30212	3rd+ Episodes, 6 Therapy Visits	C2F1S2	0.6836
30213	3rd+ Episodes, 7 to 9 Therapy Visits	C2F1S3	0.8586
30214	3rd+ Episodes, 10 Therapy Visits	C2F1S4	1.0337
30215	3rd+ Episodes, 11 to 13 Therapy Visits	C2F1S5	1.2088
30221	3rd+ Episodes, 0 to 5 Therapy Visits	C2F2S1	0.5890
30222	3rd+ Episodes, 6 Therapy Visits	C2F2S2	0.7536
30223	3rd+ Episodes, 7 to 9 Therapy Visits	C2F2S3	0.9182
30224	3rd+ Episodes, 10 Therapy Visits	C2F2S4	1.0828
30225	3rd+ Episodes, 11 to 13 Therapy Visits	C2F2S5	1.2474
30231	3rd+ Episodes, 0 to 5 Therapy Visits	C2F3S1	0.6457
30232	3rd+ Episodes, 6 Therapy Visits	C2F3S2	0.8211
30233	3rd+ Episodes, 7 to 9 Therapy Visits	C2F3S3	0.9965
30234	3rd+ Episodes, 10 Therapy Visits	C2F3S4	1.1720
30235	3rd+ Episodes, 11 to 13 Therapy Visits	C2F3S5	1.3474
30311	3rd+ Episodes, 0 to 5 Therapy Visits	C3F1S1	0.6307
30312	3rd+ Episodes, 6 Therapy Visits	C3F1S2	0.8149
30313	3rd+ Episodes, 7 to 9 Therapy Visits	C3F1S3	0.9992
30314	3rd+ Episodes, 10 Therapy Visits	C3F1S4	1.1834
30315	3rd+ Episodes, 11 to 13 Therapy Visits	C3F1S5	1.3676
30321	3rd+ Episodes, 0 to 5 Therapy Visits	C3F2S1	0.7112
30322	3rd+ Episodes, 6 Therapy Visits	C3F2S2	0.8850
30323	3rd+ Episodes, 7 to 9 Therapy Visits	C3F2S3	1.0587
30324	3rd+ Episodes, 10 Therapy Visits	C3F2S4	1.2325
30325	3rd+ Episodes, 11 to 13 Therapy Visits	C3F2S5	1.4063
30331	3rd+ Episodes, 0 to 5 Therapy Visits	C3F3S1	0.7679
30332	3rd+ Episodes, 6 Therapy Visits	C3F3S2	0.9525
30333	3rd+ Episodes, 7 to 9 Therapy Visits	C3F3S3	1.1370
30334	3rd+ Episodes, 10 Therapy Visits	C3F3S4	1.3216
30335	3rd+ Episodes, 11 to 13 Therapy Visits	C3F3S5	1.5062
40111	All Episodes, 20+ Therapy Visits	C1F1S1	1.8217
40121	All Episodes, 20+ Therapy Visits	C1F2S1	1.8786
40131	All Episodes, 20+ Therapy Visits	C1F3S1	1.9611
40211	All Episodes, 20+ Therapy Visits	C2F1S1	1.9374

TABLE 11—PROPOSED CY 2015 CASE-MIX PAYMENT WEIGHTS—Continued

Payment group	Step (episode and/or therapy visit ranges)	Clinical and functional levels (1 = Low; 2 = Medium; 3= High)	CY 2015 proposed case-mix weights
40221	All Episodes, 20+ Therapy Visits	C2F2S1	1.9942
40231	All Episodes, 20+ Therapy Visits	C2F3S1	2.0767
40311	All Episodes, 20+ Therapy Visits	C3F1S1	2.1750
40321	All Episodes, 20+ Therapy Visits	C3F2S1	2.2319
40331	All Episodes, 20+ Therapy Visits	C3F3S1	2.3144

To ensure the changes to the case-mix weights are implemented in a budget neutral manner, we propose to apply a case-mix budget neutrality factor to the CY 2015 national, standardized 60-day episode payment rate (see section III.D.4. of this proposed rule). The case-mix budget neutrality factor is calculated as the ratio of total payments when CY 2015 case-mix weights are applied to CY 2013 utilization (claims) data to total payments when CY 2014 case-mix weights are applied to CY 2013 utilization data. This produces the proposed case-mix budget neutrality factor for CY 2015 of 1.0237. We note that the CY 2013 data used to develop the proposed case-mix weights is preliminary (CY 2013 claims data as of December 31, 2013) and we propose to update the case-mix weights with more complete CY 2013 data (as of June 30, 2014) in the final rule. Therefore, the points associated with each of the grouper variables, the new clinical and functional thresholds, and the CY 2015 case-mix weights may change between the CY 2015 HH PPS proposed and final rules.

Section 1895(b)(3)(B)(iv) of the Act gives CMS the authority to implement payment reductions for nominal case-mix growth (that is, changes in case-mix that are not related to actual changes in patient characteristics over time). Previously, we accounted for nominal case-mix growth from 2000 to 2009 through case-mix reductions implemented from 2008 through 2013 (76 FR 68528–68543). In the CY 2013 HH PPS proposed rule, we stated that we found that 15.97 percent of the total case-mix change was real from 2000 to 2010 (77 FR 41553). In the CY 2014 HH PPS final rule, we used 2012 claims data to rebase payments (78 FR 72277). Since we were resetting the payment amounts with 2012 data, we did not take into account nominal case-mix growth from 2009 through 2012.

For this proposed rule, we examined case-mix growth from CY 2012 to CY 2013 using CY 2012 and preliminary CY 2013 claims data. In applying the 15.97 percent estimate of real case-mix growth to the total estimated case-mix growth from CY 2012 to CY 2013 (2.37 percent), we estimate that a case-mix reduction of 2.00 percent, to account for nominal case-mix growth, would be warranted. We considered adjusting the case-mix budget neutrality factor to take into account the 2.00 percent growth in nominal case-mix, which would result in a case-mix budget neutrality adjustment of 1.0037 rather than 1.0237. However, we are proposing to apply the full 1.0237 case-mix budget neutrality factor to the national, standardized 60-day episode payment rate. We will continue to monitor case-mix growth and may consider whether to propose nominal case-mix reductions in future rulemaking.

D. Proposed CY 2015 Rate Update

1. Proposed CY 2015 Home Health Market Basket Update

Section 1895(b)(3)(B) of the Act, as amended by section 3401(e) of the Affordable Care Act, adds new clause (vi) which states, ''After determining the home health market basket percentage increase . . . the Secretary shall reduce such percentage . . . for each of 2011, 2012, and 2013, by 1 percentage point. The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.'' Therefore, as mandated by the Affordable Care Act, for CYs 2011, 2012, and 2013, the HH market basket update was reduced by 1 percentage point.

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for CY 2015 be increased by a factor equal to the applicable HH market basket update for those HHAs that submit quality data as required by the Secretary. The proposed HH PPS market basket update for CY 2015 is 2.6 percent. This is based on Global Insight Inc.'s first quarter 2014 forecast of the 2010-based HH market basket, with historical data through the fourth quarter of 2013. A detailed description of how we derive the HHA market basket is available in the CY 2013 HH PPS final rule (77 FR 67080–67090).

For CY 2015, section 3401(e) of the Affordable Care Act, requires that, in CY 2015 (and in subsequent calendar years), the market basket percentage under the HHA prospective payment system as described in section 1895(b)(3)(B) of the Act be annually adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment, described in section 1886(b)(3)(B)(xi)(II) of the Act, to be equal to the 10-year moving average of change in annual economy-wide private nonfarm business multifactor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, calendar year, cost reporting period, or other annual period) (the ''MFP adjustment''). The Bureau of Labor Statistics (BLS) is the agency that publishes the official measure of private nonfarm business MFP. Please see *http://www.bls.gov/mfp* to obtain the BLS historical published MFP data. We note that the proposed methodology for calculating and applying the MFP adjustment to the HHA payment update is similar to the methodology used in other Medicare provider payment systems as required by section 3401 of the Affordable Care Act.

The projection of MFP is currently produced by IHS Global Insight, Inc.'s (IGI), an economic forecasting firm. To generate a forecast of MFP, IGI replicated the MFP measure calculated by the BLS using a series of proxy variables derived from IGI's U.S. macroeconomic models. These models take into account a very broad range of factors that influence the total U.S. economy. IGI forecasts the underlying proxy components such as gross domestic product (GDP), capital, and labor inputs required to estimate MFP and then combines those projections according to the BLS methodology. In Table 12, we identify each of the major

MFP component series employed by the BLS to measure MFP. We also provide the corresponding concepts forecasted by IGI and determined to be the best available proxies for the BLS series.

TABLE 12—MULTIFACTOR PRODUCTIVITY COMPONENT SERIES EMPLOYED BY THE BUREAU OF LABOR STATISTICS AND IHS GLOBAL INSIGHT

BLS series	IGI series
Real value-added output.	Non-housing non-government non-farm real GDP.
Private non-farm business sector labor input.	Hours of all persons in private non-farm establishments adjusted for labor composition.
Aggregate capital inputs.	Real effective capital stock used for full employment GDP.

IGI found that the historical growth rates of the BLS components used to calculate MFP and the IGI components identified are consistent across all series and therefore suitable proxies for calculating MFP. For more information regarding the BLS method for estimating productivity, please see the following link: *http://www.bls.gov/mfp/mprtech.pdf.*

During the development of this proposed rule, the BLS published a historical time series of private nonfarm business MFP for 1987 through 2012. Using this historical MFP series and the IGI forecasted series, IGI has developed a forecast of MFP for 2013 through 2024, as described below.

To create a forecast of the BLS' MFP index, the forecasted annual growth rates of the ''non-housing, nongovernment, non-farm, real GDP,'' ''hours of all persons in private nonfarm establishments adjusted for labor composition,'' and ''real effective capital stock'' series (ranging from 2013 to 2024) are used to ''grow'' the levels of the ''real value-added output,'' ''private non-farm business sector labor input,'' and ''aggregate capital input'' series published by the BLS. Projections of the ''hours of all persons'' measure are calculated using the difference between the projected growth rates of real output per hour and real GDP. This difference is then adjusted to account for changes in labor composition in the forecast interval. Using these three key concepts, MFP is derived by subtracting the contribution of labor and capital inputs from output growth. However, to estimate MFP, we need to understand the relative contributions of labor and capital to total output growth. Therefore, two additional measures are needed to operationalize the estimation of the IGI MFP projection: Labor compensation and capital income. The sum of labor compensation and capital income represents total income. The BLS calculates labor compensation and capital income (in current dollar terms) to derive the nominal values of labor and capital inputs. IGI uses the ''nongovernment total compensation'' and ''flow of capital services from the total private non-residential capital stock'' series as proxies for the BLS' income measures. These two proxy measures for income are divided by total income to obtain the shares of labor compensation and capital income to total income. To estimate labor's contribution and capital's contribution to the growth in total output, the growth rates of the proxy variables for labor and capital inputs are multiplied by their respective shares of total income. These contributions of labor and capital to output growth is subtracted from total output growth to calculate the ''change in the growth rates of multifactor productivity:''

MFP = Total output growth − ((labor input growth * labor compensation share) + (capital input growth * capital income share))

The change in the growth rates (also referred to as the compound growth rates) of the IGI MFP are multiplied by 100 to calculate the percent change in growth rates (the percent change in growth rates are published by the BLS for its historical MFP measure). Finally, the growth rates of the IGI MFP are converted to index levels to be consistent with the BLS' methodology. For benchmarking purposes, the historical growth rates of IGI's proxy variables were used to estimate a historical measure of MFP, which was compared to the historical MFP estimate published by the BLS. The comparison revealed that the growth rates of the components were consistent across all series, and therefore validated the use of the proxy variables in generating the IGI MFP projections. The resulting MFP index was then interpolated to a quarterly frequency using the Bassie method for temporal disaggregation. The Bassie technique utilizes an indicator (pattern) series for its calculations. IGI uses the index of output per hour (published by the BLS) as an indicator when interpolating the MFP index.

As described previously, the proposed CY 2015 HHA market basket percentage update would be 2.6 percent. Section 3401(e) of the Affordable Care Act amends section 1895(b)(3)(B) of the Act by adding a new clause, which requires that after establishing the percentage update for calendar year 2015 (and each subsequent year), ''the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II)'' (which we refer to as the multifactor productivity adjustment or MFP adjustment).

To calculate the MFP-adjusted update for the HHA market basket, we propose that the MFP percentage adjustment be subtracted from the CY 2015 market basket update calculated using the CY 2010-based HHA market basket. We propose that the end of the 10-year moving average of changes in the MFP should coincide with the end of the appropriate CY update period. Since the market basket update is reduced by the MFP adjustment to determine the annual update for the HH PPS, we believe it is appropriate for the data and time period associated with both components of the calculation (the market basket and the productivity adjustment) to end on December 15, 2015, so that changes in market conditions are aligned.

Therefore, for the CY 2015 update, we propose that the MFP adjustment be calculated as the 10-year moving average of changes in MFP for the period ending December 31, 2015. We propose to round the final annual adjustment to the one-tenth of one percentage point level up or down as applicable according to conventional rounding rules (that is, if the number we are rounding is followed by 5, 6, 7, 8, or 9, we will round the number up; if the number we are rounding is followed by 1, 2, 3, or 4, we will round the number down).

The market basket percentage we are proposing for CY 2015 for the HHA market basket is based on the 1st quarter 2014 forecast of the CY 2010-based HHA market basket update, which is estimated to be 2.6 percent. This market basket percentage would then be reduced by the MFP adjustment (the 10-year moving average of MFP for the period ending December 31, 2015) of 0.4 percent, which is calculated as described above and based on IGI's 1st quarter 2014 forecast. The resulting MFP-adjusted HHA market basket update is equal to 2.2 percent, or 2.6 percent less 0.4 percent. We propose that if more recent data are subsequently available (for example, a more recent estimate of the market basket and MFP adjustment), we would use such data, if appropriate, to determine the CY 2015 market basket update and MFP adjustment in the CY 2015 HHA PPS final rule.

Section 1895(b)(3)(B) of the Act requires that the home health market basket percentage increase be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2015, the home health market basket update will be 0.2 percent (2.2 percent minus 2 percent). As noted previously, the home health market basket was rebased and revised in CY 2013. A detailed description of how we derive the HHA market basket is available in the CY 2013 HH PPS final rule (77 FR 67080, 67090).

2. Home Health Care Quality Reporting Program (HH QRP)

a. General Considerations Used for Selection of Quality Measures for the HH QRP

The successful development of the Home Health Quality Reporting Program (HH QRP) that promotes the delivery of high quality healthcare services is our paramount concern. We seek to adopt measures for the HH QRP that promote more efficient and safer care. Our measure selection activities for the HH QRP takes into consideration input we receive from the Measure Applications Partnership (MAP), convened by the National Quality Forum (NQF) as part of a pre-rulemaking process that we have established and are required to follow under section 1890A of the Act. The MAP is a public-private partnership comprised of multi-stakeholder groups convened for the primary purpose of providing input to CMS on the selection of certain categories of quality and efficiency measures, as required by section 1890A(a)(3) of the Act. By February 1st of each year, the NQF must provide that input to CMS.

More details about the pre-rulemaking process can be found at *http://www.qualityforum.org/map.*

MAP reports to view and download are available at *http://www.qualityforum.org/Setting_Priorities/Partnership/MAP_Final_Reports.aspx.*

Our measure development and selection activities for the HH QRP take into account national priorities, such as those established by the National Priorities Partnership (*http://www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx*), the Department of Health & Human Services (HHS) Strategic Plan (*http://www.hhs.gov/secretary/about/priorities/priorities.html,* the National Quality Strategy (NQS) (*http://www.ahrq.gov/workingforquality/reports.htm*), and the CMS Quality Strategy (*http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.html*).

To the extent practicable, we have sought to adopt measures that have been endorsed by the national consensus organization under contract to endorse standardized healthcare quality measures pursuant to section 1890 of the Act, recommended by multi-stakeholder organizations, and developed with the input of patients, providers, purchasers/payers, and other stakeholders. At this time, the National Quality Forum (NQF) is the national consensus organization that is under contract with HHS to provide review and endorsement of quality measures.

b. Background and Quality Reporting Requirements

Section 1895(b)(3)(B)(v)(II) of the Act states 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 states 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(i). HHAs that meet the quality data reporting requirements are eligible for the full home health (HH) market basket percentage increase. HHAs that do not meet the reporting requirements are subject to a 2 percentage point reduction to the HH market basket increase.

Section 1895(b)(3)(B)(v)(III) of the Act further states 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.''

Medicare home health regulations, as codified at § 484.250(a), require HHAs to submit OASIS assessments and Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HH CAHPS®) data to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act. We provide quality measure data to HHAs via the Certification and Survey Provider Enhanced Reports (CASPER reports) which are available on the CMS Health Care Quality Improvement System (QIES). A subset of the HH quality measures has been publicly reported on the Home Health Compare (HH Compare) Web site since 2003. The CY 2012 HH PPS final rule (76 FR 68576), identifies the current HH QRP measures. The selected measures that are made available to the public can be viewed on the HH Compare Web site located at *http://www.medicare.gov/HHCompare/Home.asp.* As stated in the CY 2012 and CY2013 HH PPS final rules (76 FR 68575 and 77 FR 67093, respectively), we finalized that we will also use measures derived from Medicare claims data to measure HH quality.

In the CY 2014 HH PPS final rule, we finalized a proposal to add two claims-based measures to the HH QRP, and also stated that we would begin reporting the data from these measures to HHAs beginning in CY 2014. These claims based measures are: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. Also, in this rule, we finalized our proposal to reduce the number of process measures reported on the CASPER reports by eliminating the stratification by episode length for 9 process measures. While no timeframe was given for the removal of these measures, we have scheduled them for removal from the CASPER folders in October 2014. In addition, five short stay measures which had previously been reported on Home Health Compare were recently removed from public reporting and replaced with non-stratified ''all episodes of care'' versions of these measures.

c. OASIS Data Submission and OASIS Data for Annual Payment Update

(1) Statutory Authority

The Home Health conditions of participation (CoPs) at § 484.55(d) require that the comprehensive assessment must be updated and revised (including the administration of the OASIS) no less frequently than: (1) The last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the 60-day episode; (2) within 48 hours of the patient's return to the home from a hospital admission of 24 hours

or more for any reason other than diagnostic tests; and (3) at discharge.

It is important to note that to calculate quality measures from OASIS data, there must be a complete quality episode, which requires both a Start of Care (initial assessment) or Resumption of Care OASIS assessment and a Transfer or Discharge OASIS assessment. Failure to submit sufficient OASIS assessments to allow calculation of quality measures, including transfer and discharge assessments, is failure to comply with the CoPs.

HHAs do not need to submit OASIS data for those patients who are excluded from the OASIS submission requirements. As described in the December 23, 2005 Medicare and Medicaid Programs: Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies final rule (70 FR 76202), we define the exclusion as those patients:

- Receiving only non-skilled services;
- For whom neither Medicare nor Medicaid is paying for HH care (patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement);
- Receiving pre- or post-partum services; or
- Under the age of 18 years.

As set forth in the CY 2008 HH PPS final rule (72 FR 49863), HHAs that become Medicare-certified on or after May 31 of the preceding year are not subject to the OASIS quality reporting requirement nor any payment penalty for quality reporting purposes for the following year. For example, HHAs certified on or after May 31, 2013 are not subject to the 2 percentage point reduction to their market basket update for CY 2014. These exclusions only affect quality reporting requirements and do not affect the HHA's reporting responsibilities as announced in the December 23, 2005 final rule, ''Medicare and Medicaid Programs; Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies'' (70 FR 76202).

(2) Home Health Quality Reporting Program Requirements for CY 2015 Payment and Subsequent Years

In the CY 2014 Home Health Final rule (78 FR 72297), we finalized a proposal to consider OASIS assessments submitted by HHAs to CMS in compliance with HH CoPs and Conditions for Payment for episodes beginning on or after July 1, 2012, and before July 1, 2013 as fulfilling one portion of the quality reporting requirement for CY 2014. In addition, we finalized a proposal to continue this pattern for each subsequent year beyond CY 2014, considering OASIS assessments submitted for episodes beginning on July 1st of the calendar year 2 years prior to the calendar year of the Annual Payment Update (APU) effective date and ending June 30th of the calendar year 1 year prior to the calendar year of the APU effective date as fulfilling the OASIS portion of the HH quality reporting requirement.

(3) Establishing a ''Pay-for-Reporting'' Performance Requirement for Submission of OASIS Quality Data

Section 1895(b)(3)(B)(v)(I) of the Act states 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 ''pay-for-reporting'' requirement was implemented on January 1, 2007. However, to date, the quantity of OASIS assessments each HHA must submit to meet this requirement has never been proposed and finalized through rulemaking or through the sub-regulatory process. We believe that this matter should be addressed for several reasons.

We believe that defining a more explicit performance requirement for the submission of OASIS data by HHAs would better meet section 5201(c)(2) of the Deficit Reduction Act of 2005 (DRA), which 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 February 2012, the Department of Health & Human Services Office of the Inspector General (OIG) performed a study to: (1) Determine the extent to which home health agencies (HHAs) meet Federal reporting requirements for the Outcome and Assessment Information Set (OASIS) data; (2) to determine the extent to which states meet federal reporting requirements for OASIS data; and (3) to determine the extent to which the Centers for Medicare & Medicaid Services (CMS) oversees the accuracy and completeness of OASIS data submitted by HHAs. In a report entitled, ''Limited Oversight of Home Health Agency OASIS Data,'' [13] the OIG stated their finding that ''CMS did not ensure the accuracy or completeness of OASIS data.'' The OIG recommended that we ''identify all HHAs that failed to submit OASIS data and apply the 2-percent payment reduction to them''. We believe that establishing a performance requirement for submission of OASIS quality data would be responsive to the recommendations of the OIG.

In response to these requirements and the OIG report, we directed one of our contractors (the University of Colorado, Anschutz Medical Campus) to design a pay-for-reporting performance system model that could accurately measure the level of an HHA's submission of OASIS quality data. After review and analysis of several years of OASIS data, the researchers at the University of Colorado were able to develop a performance system which is driven by the principle that each HHA would be expected to submit a minimum set of two ''matching'' assessments for each patient admitted to their agency. These matching assessments together create what is considered a ''quality episode of care'', which would ideally consist of a Start of Care (SOC) or Resumption of Care (ROC) assessment and a matching End of Care (EOC) assessment. However, the researchers at the University of Colorado determined that there are several scenarios that could meet this ''matching assessment requirement'' of the new pay-for-reporting performance requirement. These scenarios have been defined as ''quality assessments'', which are defined as assessments that create a quality episode of care during the reporting period or could create a quality episode if the reporting period were expanded to an earlier reporting period or into the next reporting period.

Seven types of assessments submitted by an HHA fit this definition of a quality assessment. These are:

- A Start of Care (SOC) or Resumption of Care (ROC) assessment that has a matching End of Care (EOC) assessment. EOC assessments are assessments that are conducted at transfer to an inpatient facility (with or without discharge), death, or discharge from home health care. These two assessments (the SOC or ROC assessment and the EOC assessment) create a regular quality episode of care and both count as quality assessments.
- An SOC/ROC assessment that could begin an episode of care, but occurs in the last 60 days of the performance

[13] *http://oig.hhs.gov/oei/reports/oei-01-10-00460.asp.*

period. This is labeled as a ''Late SOC/ROC'' quality assessment.

An EOC assessment that could end an episode of care that began in the previous reporting period, (that is, an EOC that occurs in the first 60 days of the performance period.) This is labeled as an ''Early EOC'' quality assessment.

- An SOC/ROC assessment that is followed by one or more follow-up assessments, the last of which occurs in the last 60 days of the performance period. This is labeled as an ''SOC/ROC Pseudo Episode'' quality assessment.
- An EOC assessment is preceded by one or more Follow-up assessments, the last of which occurs in the first 60 days of the performance period. This is labeled an ''EOC Pseudo Episode'' quality assessment.
- An SOC/ROC assessment that is part of a known one-visit episode. This is labeled as a ''One-visit episode'' quality assessment.
- SOC, ROC, and EOC assessments that do not meet any of these definitions are labeled as ''Non-Quality'' assessments.
- Follow-up assessments (that is, where the M0100 Reason for Assessment = '04' or '05') are considered ''Neutral'' assessments and do not count toward or against the pay for reporting performance requirement.

Compliance with this performance requirement can be measured through the use of an uncomplicated mathematical formula. This Pay for Reporting performance requirement metric has been titled as the ''Quality Assessments Only'' (QAO) formula because only those OASIS assessments that contribute, or could contribute, to creating a quality episode of care are included in the computation. The formula based on this definition is as follows:

$$QAO = \frac{(\text{\# of Quality Assessments})}{(\text{\# of Quality Assessments} + \text{\# of NonQuality Assessments})} * 100$$

Our ultimate goal is to require all HHAs to achieve a Pay-for-Reporting performance requirement compliance rate of 90 percent or more, as calculated using the QAO metric illustrated above. However, we propose to implement this performance requirement in an incremental fashion over a 3 year period. We propose to require each HHA to reach a compliance rate of 70 percent or better during the first reporting period [14] that the new Pay-for-Reporting performance requirement is implemented. We further propose to increase the Pay-for-Reporting performance requirement by 10 percent in the second reporting period, and then by an additional 10 percent in the third reporting period until a pay-for-reporting performance requirement of 90 percent is reached.

To summarize, we propose to implement the pay-for- reporting performance requirement beginning with all episodes of care that occur on or after July 1, 2015, in accordance with the following schedule:

- For episodes beginning on or after July 1st, 2015 and before June 30th, 2016, HHAs must score at least 70 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2017.
- For episodes beginning on or after July 1st, 2016 and before June 30th, 2017, HHAs must score at least 80 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2018.
- For episodes beginning on or after July 1st, 2017, and thereafter, and before June 30th, 2018 and thereafter, HHAs must score at least 90 percent on the QAO metric of pay-for-reporting performance or be subject to a 2 percentage point reduction to their market basket update for CY 2019, and each subsequent year thereafter.

We solicit public comment on our proposal to implement the Pay-for-Reporting performance requirement, as described previously, for the Home Health Quality Reporting Program.

d. Updates to HH QRP Measures Which Are Made as a Result of Review by the NQF Process

Section 1895(b)(3)(B)(v)(II) of the Act generally requires the Secretary to adopt measures that have been endorsed by the entity with a contract under section 1890(a) of the Act. This contract is currently held by the NQF. The NQF is a voluntary consensus standard-setting organization with a diverse representation of consumer, purchaser, provider, academic, clinical, and other health care stakeholder organizations. The NQF was established to standardize health care quality measurement and reporting through its consensus development process.[15]

The NQF undertakes to: (1) Review new quality measures and national consensus standards for measuring and publicly reporting on performance; (2) provide for annual measure maintenance updates to be submitted by the measure steward for endorsed quality measures; (3) provide for measure maintenance endorsement on a 3-year cycle; (4) conduct a required follow-up review of measures with time limited endorsement for consideration of full endorsement; and (5) conduct ad hoc reviews of endorsed quality measures, practices, consensus standards, or events when there is adequate justification for a review. In the normal course of measure maintenance, the NQF solicits information from measure stewards for annual reviews to review measures for continued endorsement in a specific 3-year cycle. In this measure maintenance process, the measure steward is responsible for updating and maintaining the currency and relevance of the measure and for confirming existing specifications to the NQF on an annual basis. As part of the ad hoc review process, the ad hoc review requester and the measure steward are responsible for submitting evidence for review by a NQF Technical Expert panel which, in turn, provides input to the Consensus Standards Approval Committee which then makes a decision on endorsement status and/or specification changes for the measure, practice, or event.

Through the NQF's measure maintenance process, the NQF endorsed measures are sometimes updated to incorporate changes that we believe do not substantially change the nature of the measure. With respect to what constitutes a substantive versus a non-substantive change, we expect to make this determination on a measure-by-measure basis. Examples of such non-substantive changes might include updated diagnosis or procedure codes, medication updates for categories of

[14] The term ''reporting period'' is defined as the submission of OASIS assessments for episodes between July 1 (of the calendar year two years prior to the calendar year of the APU effective date) through the following June 30th (of the calendar year one year prior to the calendar year of the APU effective date) each year.

[15] For more information about the NQF Consensus Development Process, please visit the NQF Web site using the following link: *http://www.qualityforum.org/Measuring_Performance/Consensus_Development_Process.aspx.*

medications, broadening of age ranges, and changes to exclusions for a measure. We believe that non-substantive changes may include updates to measures based upon changes to guidelines upon which the measures are based. These types of maintenance changes are distinct from more substantive changes to measures that result in what can be considered new or different measures, and that they do not trigger the same agency obligations under the Administrative Procedure Act.

We are proposing that, if the NQF updates an endorsed measure that we have adopted for the HH QRP in a manner that we consider to not substantially change the nature of the measure, we would use a sub-regulatory process to incorporate those updates to the measure specifications that apply to the program. Specifically, we would revise the information that is posted on the CMS Home Health Quality Initiatives Web site at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html* so that it clearly identifies the updates and provides links to where additional information on the updates can be found. In addition, we would refer HHAs to the NQF Web site for the most up-to date information about the quality measures (*http://www.qualityforum.org/*). We would provide sufficient lead time for HHAs to implement the changes where changes to the data collection systems would be necessary.

We would continue to use the rulemaking process to adopt changes to measures that we consider to substantially change the nature of the measure. Examples of changes that we might consider to be substantive would be those in which the changes are so significant that the measure is no longer the same measure, or when a standard of performance assessed by a measure becomes more stringent, such as changes in acceptable timing of medication, procedure/process, test administration, or expansion of the measure to a new setting. We believe that our proposal adequately balances our need to incorporate NQF updates to NQF endorsed measures used in the HH QRP in the most expeditious manner possible, while preserving the public's ability to comment on updates to measures that so fundamentally change an endorsed measure that it is no longer the same measure that we originally adopted.

We note that a similar policy was adopted for the Hospital IQR Program, the PPS-Exempt Cancer Hospital (PCH) Quality Reporting Program, the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) and the Inpatient Psychiatric Facility (IPF) Quality Reporting Program.

We invite public comment on our proposal to adopt a policy in which NQF changes to a measure that are non-substantive in nature will be adopted using a sub-regulatory process and NQF changes that are substantive in nature will be adopted through the rulemaking process.

e. Home Health Care CAHPS® Survey (HHCAHPS)

In the CY 2014 HH PPS final rule (78 FR 72294), we stated that the HH quality measures reporting requirements for Medicare-certified agencies includes the Home Health Care CAHPS® (HHCAHPS) Survey for the CY 2014 APU. We maintained the stated HHCAHPS data requirements for CY 2014 set out in previous rules, for the continuous monthly data collection and quarterly data submission of HHCAHPS data.

(1) Background and Description of HHCAHPS

As part of the HHS Transparency Initiative, we implemented a process to measure and publicly report patient experiences with home health care, using a survey developed by the Agency for Healthcare Research and Quality's (AHRQ's) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program and endorsed by the NQF in March 2009 (NQF Number 0517). The HHCAHPS survey is part of a family of CAHPS® surveys that asks patients to report on and rate their experiences with health care. The Home Health Care CAHPS® (HHCAHPS) survey presents home health patients with a set of standardized questions about their home health care providers and about the quality of their home health care.

Prior to this survey, there was no national standard for collecting information about patient experiences that will enable valid comparisons across all HHAs. The history and development process for HHCAHPS has been described in previous rules and is also available on the official HHCAHPS Web site at *https://homehealthcahps.org* and in the annually-updated *HHCAHPS Protocols and Guidelines Manual,* which is downloadable from *https://homehealthcahps.org.*

For public reporting purposes, we report five measures from the HHCAHPS Survey—three composite measures and two global ratings of care that are derived from the questions on the HHCAHPS survey. The publicly reported data are adjusted for differences in patient mix across HHAs. We update the HHCAHPS data on Home Health Compare on *www.medicare.gov* quarterly. Each HHCAHPS composite measure consists of four or more individual survey items regarding one of the following related topics:

• Patient care (Q9, Q16, Q19, and Q24);
• Communications between providers and patients (Q2, Q15, Q17, Q18, Q22, and Q23); and
• Specific care issues on medications, home safety, and pain (Q3, Q4, Q5, Q10, Q12, Q13, and Q14).

The two global ratings are the overall rating of care given by the HHA's care providers (Q20), and the patient's willingness to recommend the HHA to family and friends (Q25).

The HHCAHPS survey is currently available in English, Spanish, Chinese, Russian, and Vietnamese. The OMB number on these surveys is the same (0938–1066). All of these surveys are on the Home Health Care CAHPS® Web site, *https://homehealthcahps.org.* We will continue to consider additional language translations of the HHCAHPS in response to the needs of the home health patient population.

All of the requirements about home health patient eligibility for the HHCAHPS survey and conversely, which home health patients are ineligible for the HHCAHPS survey are delineated and detailed in the *HHCAHPS Protocols and Guidelines Manual,* which is downloadable at *https://homehealthcahps.org.* Home health patients are eligible for HHCAHPS if they received at least two skilled home health visits in the past 2 months, which are paid for by Medicare or Medicaid.

Home health patients are *ineligible* for inclusion in HHCAHPS surveys if one of these conditions pertains to them:

• Are under the age of 18;
• Are deceased prior to the date the sample is pulled;
• Receive hospice care;
• Receive routine maternity care only;
• Are not considered survey eligible because the state in which the patient lives restricts release of patient information for a specific condition or illness that the patient has; or
• No Publicity patients, defined as patients who on their own initiative at their first encounter with the HHAs make it very clear that no one outside of the agencies can be advised of their patient status, and no one outside of the HHAs can contact them for any reason.

We stated in previous rules that Medicare-certified HHAs are required to contract with an approved HHCAHPS survey vendor. This requirement continues, and Medicare-certified agencies also must provide on a monthly basis a list of their patients served to their respective HHCAHPS survey vendors. Agencies are not allowed to influence at all how their patients respond to the HHCAHPS survey.

As previously required, HHCAHPS survey vendors are required to attend introductory and all update trainings conducted by CMS and the HHCAHPS Survey Coordination Team, as well as to pass a post-training certification test. We have approximately 30 approved HHCAHPS survey vendors. The list of approved HHCAHPS survey vendors is available at *https://homehealthcahps.org.*

(2) HHCAHPS Oversight Activities

We stated in prior final rules that all approved HHCAHPS survey vendors are required to participate in HHCAHPS oversight activities to ensure compliance with HHCAHPS protocols, guidelines, and survey requirements. The purpose of the oversight activities is to ensure that approved HHCAHPS survey vendors follow the *HHCAHPS Protocols and Guidelines Manual.* As stated previously in the five prior final rules to this proposed rule, all HHCAHPS approved survey vendors must develop a Quality Assurance Plan (QAP) for survey administration in accordance with the *HHCAHPS Protocols and Guidelines Manual.* An HHCAHPS survey vendor's first QAP must be submitted within 6 weeks of the data submission deadline date after the vendor's first quarterly data submission. The QAP must be updated and submitted annually thereafter and at any time that changes occur in staff or vendor capabilities or systems. A model QAP is included in the *HHCAHPS Protocols and Guidelines Manual.* The QAP must include the following:

- Organizational Background and Staff Experience;
- Work Plan;
- Sampling Plan;
- Survey Implementation Plan;
- Data Security, Confidentiality and Privacy Plan; and
- Questionnaire Attachments

As part of the oversight activities, the HHCAHPS Survey Coordination Team conducts on-site visits to all approved HHCAHPS survey vendors. The purpose of the site visits is to allow the HHCAHPS Coordination Team to observe the entire HHCAHPS Survey implementation process, from the sampling stage through file preparation and submission, as well as to assess data security and storage. The HHCAHPS Survey Coordination Team reviews the HHCAHPS survey vendor's survey systems, and assesses administration protocols based on the *HHCAHPS Protocols and Guidelines Manual* posted at *https://homehealthcahps.org.* The systems and program site visit review includes, but is not limited to the following:

- Survey management and data systems;
- Printing and mailing materials and facilities;
- Telephone call center facilities;
- Data receipt, entry and storage facilities; and
- Written documentation of survey processes.

After the site visits, HHCAHPS survey vendors are given a defined time period in which to correct any identified issues and provide follow-up documentation of corrections for review. HHCAHPS survey vendors are subject to follow-up site visits on an as-needed basis.

In the CY 2013 HH PPS final rule (77 FR 67094, 67164), we codified the current guideline that all approved HHCAHPS survey vendors fully comply with all HHCAHPS oversight activities. We included this survey requirement at § 484.250(c)(3).

(3) HHCAHPS Requirements for the CY 2015 APU

In the CY 2014 HH PPS final rule (78 FR 72294), we stated that for the CY 2015 APU, we will require continued monthly HHCAHPS data collection and reporting for 4 quarters. The data collection period for CY 2015 APU includes the second quarter 2013 through the first quarter 2014 (the months of April 2013 through March 2014). Although these dates are past, we wished to state them in this proposed rule so that HHAs are again reminded of what months constituted the requirements for the CY 2015 APU. HHAs are required to submit their HHCAHPS data files to the HHCAHPS Data Center for the HHCAHPS data from the first quarter of 2014 data by 11:59 p.m., e.d.t. on July 17, 2014. This deadline is firm; no exceptions are permitted.

(4) HHCAHPS Requirements for the CY 2016 APU

For the CY 2016 APU, we require continued monthly HHCAHPS data collection and reporting for 4 quarters. The data collection period for the CY 2016 APU includes the second quarter 2014 through the first quarter 2015 (the months of April 2014 through March 2015). HHAs will be required to submit their HHCAHPS data files to the HHCAHPS Data Center for the second quarter 2014 by 11:59 p.m., e.d.t. on October 16, 2014; for the third quarter 2014 by 11:59 p.m., e.s.t. on January 15, 2015; for the fourth quarter 2014 by 11:59 p.m., e.d.t. on April 16, 2015; and for the first quarter 2015 by 11:59 p.m., e.d.t. on July 16, 2015. These deadlines will be firm; no exceptions will be permitted.

We will exempt HHAs receiving Medicare certification after the period in which HHAs do their patient count (April 1, 2013 through March 31, 2014) on or after April 1, 2014, from the full HHCAHPS reporting requirement for the CY 2016 APU, because these HHAs will not have been Medicare-certified throughout the period of April 1, 2013, through March 31, 2014. These HHAs will not need to complete a HHCAHPS Participation Exemption Request form for the CY 2016 APU.

We require that all HHAs that had fewer than 60 HHCAHPS-eligible unduplicated or unique patients in the period of April 1, 2013 through March 31, 2014 are exempt from the HHCAHPS data collection and submission requirements for the CY 2016 APU, upon completion of the CY 2016 HHCAHPS Participation Exemption Request form. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients in the period of April 1, 2013, through March 31, 2014, will be required to submit their patient counts on the HHCAHPS Participation Exemption Request form for the CY 2016 APU posted on *https://homehealthcahps.org* on April 1, 2014, by 11:59 p.m., e.s.t. by March 31, 2015. This deadline will be firm, as will be all of the quarterly data submission deadlines.

(5) HHCAHPS Requirements for the CY 2017 APU

For the CY 2017 APU, we require continued monthly HHCAHPS data collection and reporting for 4 quarters. The data collection period for the CY 2017 APU includes the second quarter 2015 through the first quarter 2016 (the months of April 2015 through March 2016). HHAs will be required to submit their HHCAHPS data files to the HHCAHPS Data Center for the second quarter 2015 by 11:59 p.m., e.d.t. on October 15, 2015; for the third quarter 2015 by 11:59 p.m., e.s.t. on January 12, 2016; for the fourth quarter 2015 by 11:59 p.m., e.d.t. on April 21, 2016; and for the first quarter 2016 by 11:59 p.m., e.d.t. on July 21, 2016. These deadlines will be firm; no exceptions will be permitted.

We will exempt HHAs receiving Medicare certification after the period in which HHAs do their patient count (April 1, 2014 through March 31, 2015) on or after April 1, 2015, from the full HHCAHPS reporting requirement for the CY 2016 APU, because these HHAs will not have been Medicare-certified throughout the period of April 1, 2014, through March 31, 2015. These HHAs will not need to complete a HHCAHPS Participation Exemption Request form for the CY 2017 APU.

We require that all HHAs that had fewer than 60 HHCAHPS-eligible unduplicated or unique patients in the period of April 1, 2014, through March 31, 2015 are exempt from the HHCAHPS data collection and submission requirements for the CY 2017 APU, upon completion of the CY 2017 HHCAHPS Participation Exemption Request form. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients in the period of April 1, 2014, through March 31, 2015, will be required to submit their patient counts on the HHCAHPS Participation Exemption Request form for the CY 2017 APU posted on *https://homehealthcahps.org* on April 1, 2015, by 11:59 p.m., e.s.t. by March 31, 2016. This deadline will be firm, as will be all of the quarterly data submission deadlines.

(6) HHCAHPS Reconsiderations and Appeals Process

HHAs should monitor their respective HHCAHPS survey vendors to ensure that vendors submit their HHCAHPS data on time, by accessing their HHCAHPS Data Submission Reports on *https://homehealthcahps.org.* This will help HHAs ensure that their data are submitted in the proper format for data processing to the HHCAHPS Data Center.

We will continue HHCAHPS oversight activities as finalized in the CY 2014 rule. In the CY 2013 HH PPS final rule (77 FR 6704, 67164), we codified the current guideline that all approved HHCAHPS survey vendors must fully comply with all HHCAHPS oversight activities. We included this survey requirement at § 484.250(c)(3).

We will continue the HHCAHPS reconsiderations and appeals process that we have finalized and that we have used for prior periods for the CY 2012, CY 2013, and CY 2014 APU determinations. We have described the HHCAHPS reconsiderations process requirements in the Technical Direction Letter that we send to the affected HHAs, on or about the first Friday in September. HHAs have 30 days from their receipt of the Technical Direction Letter informing them that they did not meet the HHCAHPS requirements for the CY period, to send all documentation that supports their requests for reconsideration to CMS. It is important that the affected HHAs send in comprehensive information in their reconsideration letter/package because we will not contact the affected HHAs to request additional information or to clarify incomplete or inconclusive information. If clear evidence to support a finding of compliance is not present, the 2 percent reduction in the APU will be upheld. If clear evidence of compliance is present, the 2 percent reduction for the APU will be reversed. We will notify affected HHAs by about mid-December. If we determine to uphold the 2 percent reduction, the HHA may further appeal the 2 percent reduction via the Provider Reimbursement Review Board (PRRB) appeals process.

(7) Summary

We are not proposing any changes to the participation requirements, or to the requirements pertaining to the implementation of the Home Health CAHPS® Survey (HHCAHPS). We again strongly encourage HHAs to learn about the survey and view the HHCAHPS Survey Web site at the official Web site for the HHCAHPS at *https://homehealthcahps.org.* HHAs can also send an email to the HHCAHPS Survey Coordination Team at *HHCAHPS@rti.org,* or telephone toll-free (1–866–354–0985) for more information about HHCAHPS.

4. Home Health Wage Index

a. Background

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to provide appropriate adjustments to the proportion of the payment amount under the HH PPS that account for area wage differences, using adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of HH services. Since the inception of the HH PPS, we have used inpatient hospital wage data in developing a wage index to be applied to HH payments. We propose to continue this practice for CY 2015, as we continue to believe that, in the absence of HH-specific wage data, using inpatient hospital wage data is appropriate and reasonable for the HH PPS. Specifically, we propose to continue to use the pre-floor, pre-reclassified hospital wage index as the wage adjustment to the labor portion of the HH PPS rates. For CY 2015, the updated wage data are for hospital cost reporting periods beginning on or after October 1, 2010 and before October 1, 2011 (FY 2011 cost report data).

We would apply the appropriate wage index value to the labor portion 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). Previously, we determined each HHA's labor market area based on definitions of metropolitan statistical areas (MSAs) issued by the OMB. In the CY 2006 HH PPS final rule (70 FR 68132), we began adopting revised labor market area definitions as discussed in the OMB Bulletin No. 03–04 (June 6, 2003). This bulletin announced revised definitions for MSAs and the creation of micropolitan statistical areas and core-based statistical areas (CBSAs). The bulletin is available online at *www.whitehouse.gov/omb/bulletins/b03-04.html.* In adopting the CBSA geographic designations, we provided a one-year transition in CY 2006 with a blended wage index for all sites of service. For CY 2006, the wage index for each geographic area consisted of a blend of 50 percent of the CY 2006 MSA-based wage index and 50 percent of the CY 2006 CBSA-based wage index. We referred to the blended wage index as the CY 2006 HH PPS transition wage index. As discussed in the CY 2006 HH PPS final rule (70 FR 68132), since the expiration of this one-year transition on December 31, 2006, we have used the full CBSA-based wage index values.

We propose to continue to use the same methodology discussed in the CY 2007 HH PPS final rule (71 FR 65884) to address those geographic areas in which there are no inpatient hospitals, and thus, no hospital wage data on which to base the calculation of the CY 2015 HH PPS wage index. For rural areas that do not have inpatient hospitals, we will use the average wage index from all contiguous CBSAs as a reasonable proxy. For CY 2015, there are no rural areas that do not have inpatient hospitals, and thus, this methodology would not be applied. For rural Puerto Rico, we do not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the close proximity to one another of almost all of Puerto Rico's various urban and non-urban areas, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas). Instead, we would continue to use the most recent wage index previously available for that area. For urban areas without inpatient 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. For CY 2015, the only urban area without inpatient hospital wage data is Hinesville, Georgia (CBSA 25980).

b. Update

On February 28, 2013, OMB issued Bulletin No. 13–01, announcing revisions to the delineations of MSAs, Micropolitan Statistical Areas, and CBSAs, and guidance on uses of the delineation of these areas. This bulletin is available online at *http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.* This bulletin states that it ''provides the delineations of all Metropolitan Statistical Areas, Metropolitan Divisions, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas in the United States and Puerto Rico based on the standards published on June 28, 2010, in the **Federal Register** (75 FR 37246–37252) and Census Bureau data.''

While the revisions OMB published on February 28, 2013 are not as sweeping as the changes made when we adopted the CBSA geographic designations for CY 2006, the February 28, 2013 bulletin does contain a number of significant changes. For example, there are new CBSAs, urban counties that have become rural, rural counties that have become urban, and existing CBSAs that have been split apart.

As discussed in the CY 2014 HH PPS final rule (78 FR 72302), the changes made by the bulletin and their ramifications required extensive review by CMS before using them for the HH PPS wage index. We have completed our assessment and in the FY 2015 IPPS proposed rule (79 FR 27978), we proposed to use the most recent labor market area delineations issued by OMB for payments for inpatient stays at general acute care and long-term care hospitals (LTCHs). In addition, in the FY 2015 Skilled Nursing Facility (SNF) PPS proposed rule (79 FR 25767), we proposed to use the new labor market delineations issued by OMB for payments for SNFs. We are proposing changes to the HH PPS wage index based on the newest OMB delineations, as described in OMB Bulletin No. 13–01.

c. Proposed Implementation of New Labor Market Delineations

We believe it is important for the HH PPS to use the latest OMB delineations available to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. While CMS and other stakeholders have explored potential alternatives to the current CBSA-based labor market system (we refer readers to the CMS Web site at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html*), no consensus has been achieved regarding how best to implement a replacement system. As discussed in the FY 2005 IPPS final rule (69 FR 49027), ''While we recognize that MSAs are not designed specifically to define labor market areas, we believe they do represent a useful proxy for this purpose.'' We further believe that using the most current OMB delineations would increase the integrity of the HH PPS wage index by creating a more accurate representation of geographic variation in wage levels. We have reviewed our findings and impacts relating to the new OMB delineations, and have concluded that there is no compelling reason to further delay implementation.

We propose incorporating the new CBSA delineations into the CY 2015 HH PPS wage index in the same manner in which the CBSAs were first incorporated into the HH PPS wage index in CY 2006 (70 FR 68138). We propose to use a one-year blended wage index for CY 2015. We refer to this blended wage index as the CY 2015 HH PPS transition wage index. The transition wage index would consist of a 50/50 blend of the wage index values using OMB's old area delineations and the wage index values using OMB's new area delineations. That is, for each county, a blended wage index would be calculated equal to fifty percent of the CY 2015 wage index using the old labor market area delineation and fifty percent of the CY 2015 wage index using the new labor market area delineation (both using FY 2011 hospital wage data). This ultimately results in an average of the two values.

If we adopt the new OMB delineations, a total of 37 counties (and county equivalents) that are currently considered part of an urban CBSA would be considered rural beginning in CY 2015. Table 13 below lists the 37 urban counties that would change to rural status.

TABLE 13—COUNTIES THAT WOULD CHANGE TO RURAL STATUS

County	State	CBSA No. under CY 2014 HH PPS	CBSA Name
Greene County	IN	14020	Bloomington, IN.
Anson County	NC	16740	Charlotte-Gastonia-Rock Hill, NC-SC.
Franklin County	IN	17140	Cincinnati-Middletown, OH-KY-IN.
Stewart County	TN	17300	Clarksville, TN-KY.
Howard County	MO	17860	Columbia, MO.
Delta County	TX	19124	Dallas-Fort Worth-Arlington, TX.
Pittsylvania County	VA	19260	Danville, VA.
Danville City	VA	19260	Danville, VA.
Preble County	OH	19380	Dayton, OH.
Gibson County	IN	21780	Evansville, IN-KY.
Webster County	KY	21780	Evansville, IN-KY.
Franklin County	AR	22900	Fort Smith, AR-OK.
Ionia County	MI	24340	Grand Rapids-Wyoming, MI.
Newaygo County	MI	24340	Grand Rapids-Wyoming, MI.
Greene County	NC	24780	Greenville, NC.
Stone County	MS	25060	Gulfport-Biloxi, MS.
Morgan County	WV	25180	Hagerstown-Martinsburg, MD-WV.
San Jacinto County	TX	26420	Houston-Sugar Land-Baytown, TX.
Franklin County	KS	28140	Kansas City, MO-KS.
Tipton County	IN	29020	Kokomo, IN.
Nelson County	KY	31140	Louisville/Jefferson County, KY-IN.
Geary County	KS	31740	Manhattan, KS.

TABLE 13—COUNTIES THAT WOULD CHANGE TO RURAL STATUS—Continued

County	State	CBSA No. under CY 2014 HH PPS	CBSA Name
Washington County	OH	37620	Parkersburg-Marietta-Vienna, WV-OH.
Pleasants County	WV	37620	Parkersburg-Marietta-Vienna, WV-OH.
George County	MS	37700	Pascagoula, MS.
Power County	ID	38540	Pocatello, ID.
Cumberland County	VA	40060	Richmond, VA.
King and Queen County	VA	40060	Richmond, VA.
Louisa County	VA	40060	Richmond, VA.
Washington County	MO	41180	St. Louis, MO-IL.
Summit County	UT	41620	Salt Lake City, UT.
Erie County	OH	41780	Sandusky, OH.
Franklin County	MA	44140	Springfield, MA.
Ottawa County	OH	45780	Toledo, OH.
Greene County	AL	46220	Tuscaloosa, AL.
Calhoun County	TX	47020	Victoria, TX.
Surry County	VA	47260	Virginia Beach-Norfolk-Newport News, VA-NC.

If we finalize our proposal to implement the new OMB delineations, a total of 105 counties (and county equivalents) that are currently located in rural areas would be considered part of an urban CBSA beginning in CY 2015. Table 14 lists the 105 rural counties that would change to urban status.

TABLE 14—COUNTIES THAT WOULD CHANGE TO URBAN STATUS

County	State	CBSA No.	CBSA Name
Utuado Municipio	PR	10380	Aguadilla-Isabela, PR.
Linn County	OR	10540	Albany, OR.
Oldham County	TX	11100	Amarillo, TX.
Morgan County	GA	12060	Atlanta-Sandy Springs-Roswell, GA.
Lincoln County	GA	12260	Augusta-Richmond County, GA-SC.
Newton County	TX	13140	Beaumont-Port Arthur, TX.
Fayette County	WV	13220	Beckley, WV.
Raleigh County	WV	13220	Beckley, WV.
Golden Valley County	MT	13740	Billings, MT.
Oliver County	ND	13900	Bismarck, ND.
Sioux County	ND	13900	Bismarck, ND.
Floyd County	VI	13980	Blacksburg-Christiansburg-Radford, VA.
De Witt County	IL	14010	Bloomington, IL.
Columbia County	PA	14100	Bloomsburg-Berwick, PA.
Montour County	PA	14100	Bloomsburg-Berwick, PA.
Allen County	KY	14540	Bowling Green, KY.
Butler County	KY	14540	Bowling Green, KY.
St. Mary's County	MD	15680	California-Lexington Park, MD.
Jackson County	IL	16060	Carbondale-Marion, IL.
Williamson County	IL	16060	Carbondale-Marion, IL.
Franklin County	PA	16540	Chambersburg-Waynesboro, PA.
Iredell County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lincoln County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Rowan County	NC	16740	Charlotte-Concord-Gastonia, NC-SC.
Chester County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Lancaster County	SC	16740	Charlotte-Concord-Gastonia, NC-SC.
Buckingham County	VA	16820	Charlottesville, VA.
Union County	IN	17140	Cincinnati, OH-KY-IN.
Hocking County	OH	18140	Columbus, OH.
Perry County	OH	18140	Columbus, OH.
Walton County	FL	18880	Crestview-Fort Walton Beach-Destin, FL.
Hood County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Somervell County	TX	23104	Dallas-Fort Worth-Arlington, TX.
Baldwin County	AL	19300	Daphne-Fairhope-Foley, AL.
Monroe County	PA	20700	East Stroudsburg, PA.
Hudspeth County	TX	21340	El Paso, TX.
Adams County	PA	23900	Gettysburg, PA.
Hall County	NE	24260	Grand Island, NE.
Hamilton County	NE	24260	Grand Island, NE.
Howard County	NE	24260	Grand Island, NE.
Merrick County	NE	24260	Grand Island, NE.
Montcalm County	MI	24340	Grand Rapids-Wyoming, MI.
Josephine County	OR	24420	Grants Pass, OR.
Tangipahoa Parish	LA	25220	Hammond, LA.

TABLE 14—COUNTIES THAT WOULD CHANGE TO URBAN STATUS—Continued

County	State	CBSA No.	CBSA Name
Beaufort County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Jasper County	SC	25940	Hilton Head Island-Bluffton-Beaufort, SC.
Citrus County	FL	26140	Homosassa Springs, FL.
Butte County	ID	26820	Idaho Falls, ID.
Yazoo County	MS	27140	Jackson, MS.
Crockett County	TN	27180	Jackson, TN.
Kalawao County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Maui County	HI	27980	Kahului-Wailuku-Lahaina, HI.
Campbell County	TN	28940	Knoxville, TN.
Morgan County	TN	28940	Knoxville, TN.
Roane County	TN	28940	Knoxville, TN.
Acadia Parish	LA	29180	Lafayette, LA.
Iberia Parish	LA	29180	Lafayette, LA.
Vermilion Parish	LA	29180	Lafayette, LA.
Cotton County	OK	30020	Lawton, OK.
Scott County	IN	31140	Louisville/Jefferson County, KY-IN.
Lynn County	TX	31180	Lubbock, TX.
Green County	WI	31540	Madison, WI.
Benton County	MS	32820	Memphis, TN-MS-AR.
Midland County	MI	33220	Midland, MI.
Martin County	TX	33260	Midland, TX.
Le Sueur County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Mille Lacs County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Sibley County	MN	33460	Minneapolis-St. Paul-Bloomington, MN-WI.
Maury County	TN	34980	Nashville-Davidson-Murfreesboro-Franklin, TN.
Craven County	NC	35100	New Bern, NC.
Jones County	NC	35100	New Bern, NC.
Pamlico County	NC	35100	New Bern, NC.
St. James Parish	LA	35380	New Orleans-Metairie, LA.
Box Elder County	UT	36260	Ogden-Clearfield, UT.
Gulf County	FL	37460	Panama City, FL.
Custer County	SD	39660	Rapid City, SD.
Fillmore County	MN	40340	Rochester, MN.
Yates County	NY	40380	Rochester, NY.
Sussex County	DE	41540	Salisbury, MD-DE.
Worcester County	MA	41540	Salisbury, MD-DE.
Highlands County	FL	42700	Sebring, FL.
Webster Parish	LA	43340	Shreveport-Bossier City, LA.
Cochise County	AZ	43420	Sierra Vista-Douglas, AZ.
Plymouth County	IA	43580	Sioux City, IA-NE-SD.
Union County	SC	43900	Spartanburg, SC.
Pend Oreille County	WA	44060	Spokane-Spokane Valley, WA.
Stevens County	WA	44060	Spokane-Spokane Valley, WA.
Augusta County	VA	44420	Staunton-Waynesboro, VA.
Staunton City	VA	44420	Staunton-Waynesboro, VA.
Waynesboro City	VA	44420	Staunton-Waynesboro, VA.
Little River County	AR	45500	Texarkana, TX-AR.
Sumter County	FL	45540	The Villages, FL.
Pickens County	AL	46220	Tuscaloosa, AL.
Gates County	NC	47260	Virginia Beach-Norfolk-Newport News, VA-NC.
Falls County	TX	47380	Waco, TX.
Columbia County	WA	47460	Walla Walla, WA.
Walla Walla County	WA	47460	Walla Walla, WA.
Peach County	GA	47580	Warner Robins, GA.
Pulaski County	GA	47580	Warner Robins, GA.
Culpeper County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Rappahannock County	VA	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV.
Jefferson County	NY	48060	Watertown-Fort Drum, NY.
Kingman County	KS	48620	Wichita, KS.
Davidson County	NC	49180	Winston-Salem, NC.
Windham County	CT	49340	Worcester, MA-CT.

In addition to rural counties becoming urban and urban counties becoming rural, several urban counties would shift from one urban CBSA to another urban CBSA under our proposal to adopt the new OMB delineations. In other cases, applying the new OMB delineations would involve a change only in CBSA name or number, while the CBSA continues to encompass the same constituent counties. For example, CBSA 29140 (Lafayette, IN), would experience both a change to its number and its name, and would become CBSA 29200 (Lafayette-West Lafayette, IN), while all of its three constituent counties would remain the same. We are not discussing these proposed changes in this section because they are inconsequential changes with respect to the HH PPS wage index. However, in

other cases, if we adopt the new OMB delineations, counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs.

In one type of change, an entire CBSA would be subsumed by another CBSA. For example, CBSA 37380 (Palm Coast, FL) currently is a single county (Flagler, FL) CBSA. Flagler County would be a part of CBSA 19660 (Deltona-Daytona Beach-Ormond Beach, FL) under the new OMB delineations.

In another type of change, some CBSAs have counties that would split off to become part of or to form entirely new labor market areas. For example, CBSA 37964 (Philadelphia Metropolitan Division of MSA 37980) currently is comprised of five Pennsylvania counties (Bucks, Chester, Delaware, Montgomery, and Philadelphia). If we adopt the new OMB delineations, Montgomery, Bucks, and Chester counties would split off and form the new CBSA 33874 (Montgomery County-Bucks County-Chester County, PA Metropolitan Division of MSA 37980), while Delaware and Philadelphia counties would remain in CBSA 37964.

Finally, in some cases, a CBSA would lose counties to another existing CBSA if we adopt the new OMB delineations. For example, Lincoln County and Putnam County, WV would move from CBSA 16620 (Charleston, WV) to CBSA 26580 (Huntington-Ashland, WV KY OH). CBSA 16620 would still exist in the new labor market delineations with fewer constituent counties. Table 15 lists the urban counties that would move from one urban CBSA to another urban CBSA if we adopt the new OMB delineations.

TABLE 15—COUNTIES THAT WOULD CHANGE TO A DIFFERENT CBSA

Previous CBSA	New CBSA	County	State
11300	26900	Madison County	IN
11340	24860	Anderson County	SC
14060	14010	McLean County	IL
37764	15764	Essex County	MA
16620	26580	Lincoln County	WV
16620	26580	Putnam County	WV
16974	20994	DeKalb County	IL
16974	20994	Kane County	IL
21940	41980	Ceiba Municipio	PR
21940	41980	Fajardo Municipio	PR
21940	41980	Luquillo Municipio	PR
26100	24340	Ottawa County	MI
31140	21060	Meade County	KY
34100	28940	Grainger County	TN
35644	35614	Bergen County	NJ
35644	35614	Hudson County	NJ
20764	35614	Middlesex County	NJ
20764	35614	Monmouth County	NJ
20764	35614	Ocean County	NJ
35644	35614	Passaic County	NJ
20764	35084	Somerset County	NJ
35644	35614	Bronx County	NY
35644	35614	Kings County	NY
35644	35614	New York County	NY
35644	20524	Putnam County	NY
35644	35614	Queens County	NY
35644	35614	Richmond County	NY
35644	35614	Rockland County	NY
35644	35614	Westchester County	NY
37380	19660	Flagler County	FL
37700	25060	Jackson County	MS
37964	33874	Bucks County	PA
37964	33874	Chester County	PA
37964	33874	Montgomery County	PA
39100	20524	Dutchess County	NY
39100	35614	Orange County	NY
41884	42034	Marin County	CA
41980	11640	Arecibo Municipio	PR
41980	11640	Camuy Municipio	PR
41980	11640	Hatillo Municipio	PR
41980	11640	Quebradillas Municipio	PR
48900	34820	Brunswick County	NC
49500	38660	Guánica Municipio	PR
49500	38660	Guayanilla Municipio	PR
49500	38660	Peñuelas Municipio	PR
49500	38660	Yauco Municipio	PR

As discussed in the FY 2015 SNF PPS proposed rule (79 FR 25767), we proposed to adopt OMB's new delineations in the SNF PPS in the same manner that we are proposing to adopt the new delineations in the HH PPS. The FY 2015 SNF PPS proposed rule includes extensive analysis of the application of OMB's new delineations as well as other alternatives considered.

For the reasons discussed above, and based on provider reaction during the CY 2006 rulemaking cycle to the proposed adoption of the new CBSA definitions, we are proposing to apply a

one-year blended wage index in CY 2015 for all geographic areas to assist providers in adapting to these proposed changes. This transition policy would be for a one-year period, going into effect January 1, 2015, and continuing through December 31, 2015. Thus, beginning January 1, 2016, the wage index for all HH PPS payments would be fully based on the new OMB delineations. We invite comments on our proposed transition methodology, as well as on the other transition options discussed above.

The wage index Addendum provides a crosswalk between the CY 2015 wage index using the current OMB delineations in effect in CY 2014 and the CY 2015 wage index using the revised OMB delineations. Addendum A shows each state and county and its corresponding proposed transition wage index along with the previous CBSA number, the new CBSA number and the new CBSA name. Due to the calculation of the blended transition wage index, some CBSAs may have more than one transition wage index value associated with that CBSA. However, each county will have only one transition wage index. Therefore, for counties located in CBSAs that correspond to more than one transition wage index, a number other than the CBSA number would be used for claims submission for CY 2015 only. These numbers are shown in the last column of Addendum A. The proposed CY 2015 transition wage index as set forth in Addendum A is available on the CMS Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.*

5. Proposed CY 2015 Annual Payment Update

a. Background

The Medicare HH PPS has been in effect since October 1, 2000. As set forth in the July 3, 2000 final rule (65 FR 41128), the base unit of payment under the Medicare HH PPS is a national, standardized 60-day episode payment rate. As set forth in 42 CFR 484.220, we adjust the national, standardized 60-day episode payment rate by a case-mix relative weight and a wage index value based on the site of service for the beneficiary.

To provide appropriate adjustments to the proportion of the payment amount under the HH PPS to account for area wage differences, we apply the appropriate wage index value to the labor portion of the HH PPS rates. The labor-related share of the case-mix adjusted 60-day episode rate will continue to be 78.535 percent and the non-labor-related share will continue to be 21.465 percent as set out in the CY 2013 HH PPS final rule (77 FR 67068). The CY 2015 HH PPS rates would use the same case-mix methodology as set forth in the CY 2008 HH PPS final rule with comment period (72 FR 49762) and adjusted as described in section III.C. of this rule. The following are the steps we take to compute the case-mix and wage-adjusted 60-day episode rate:

(1) Multiply the national 60-day episode rate by the patient's applicable case-mix weight.

(2) Divide the case-mix adjusted amount into a labor (78.535 percent) and a non-labor portion (21.465 percent).

(3) Multiply the labor portion by the applicable wage index based on the site of service of the beneficiary.

(4) 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, this document constitutes the annual update of the HH PPS rates. Section 484.225 sets forth the specific annual percentage update methodology. In accordance with § 484.225(i), for a HHA that does not submit HH 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 HH 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 considered in computing the prospective payment amount for a subsequent calendar year.

Medicare pays the national, standardized 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 will 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 adjustment (LUPA) is provided on a per-visit basis as set forth in § 484.205(c) and § 484.230.
- A partial episode payment (PEP) 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 CY 2015 National, Standardized 60-Day Episode Payment Rate

Section 1895(3)(A)(i) of the Act required that the 60-day episode base rate and other applicable amounts be standardized in a manner that eliminates the effects of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner. To determine the proposed CY 2015 national, standardized 60-day episode payment rate, we would apply a wage index standardization factor, a case-mix budget neutrality factor described in section III.C, the rebasing adjustment described in section II.C, and the MFP-adjusted home health market basket update discussed in section III.D.1 of this proposed rule.

To calculate the wage index standardization factor, henceforth referred to as the wage index budget neutrality factor, we simulated total payments for non-LUPA episodes using the 2015 wage index and compared it to our simulation of total payments for non-LUPA episodes using the 2014 wage index. By dividing the total payments for non-LUPA episodes using the 2015 wage index by the total payments for non-LUPA episodes using the 2014 wage index, we obtain a wage index budget neutrality factor of 1.0012. We would apply the wage index budget neutrality factor of 1.0012 to the CY 2015 national, standardized 60-day episode rate.

As discussed in section III.C of this proposed rule, to ensure the changes to the case-mix weights are implemented in a budget neutral manner, we would apply a case-mix weights budget neutrality factor to the CY 2015 national, standardized 60-day episode payment rate. The case-mix weights budget neutrality factor is calculated as the ratio of total payments when CY 2015 case-mix weights are applied to CY 2013 utilization (claims) data to total payments when CY 2014 case-mix

weights are applied to CY 2013 utilization data. The case-mix budget neutrality factor for CY 2015 would be 1.0237 as proposed in section III.C of this proposed rule.

Then, we would apply the −$80.95 rebasing adjustment finalized in the CY 2014 HH PPS final rule (78 FR 72256) and discussed in section II.C. Lastly, we would update the payment rates by the CY 2015 HH payment update percentage of 2.2 percent (MFP-adjusted home health market basket update) as described in section III.D.1 of this proposed rule. The proposed CY 2015 national, standardized 60-day episode payment rate would be $2,922.76 as calculated in Table 16.

TABLE 16—CY 2015 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2014 national, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	CY 2015 Rebasing adjustment	CY 2015 HH payment update percentage	Proposed CY 2015 national, standardized 60-day episode payment
$2,869.27	× 1.0012	× 1.0237	− $80.95	× 1.022	= $2,922.76

The proposed CY 2015 national, standardized 60-day episode payment rate for an HHA that does not submit the required quality data is updated by the CY 2015 HH payment update percentage (2.2 percent) minus 2 percentage points and is shown in Table 17.

TABLE 17—FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA—PROPOSED CY 2015 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2014 National, standardized 60-day episode payment	Wage index budget neutrality factor	Case-mix weights budget neutrality factor	CY 2015 Rebasing adjustment	CY 2015 HH Payment update percentage minus 2 percentage points	Proposed CY 2015 national, standardized 60-day episode payment
$2,869.27	× 1.0012	× 1.0237	− $80.95	× 1.002	= $2,865.57

c. Proposed National Per-Visit Rates

The national per-visit rates are used to pay LUPAs (episodes with four or fewer visits) and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by type of visit or HH discipline. The six HH disciplines are as follows:

- Home health aide (HH aide);
- Medical Social Services (MSS);
- Occupational therapy (OT);
- Physical therapy (PT);
- Skilled nursing (SN); and
- Speech-language pathology (SLP).

To calculate the CY 2015 national per-visit rates, we start with the CY 2014 national per-visit rates. We then apply a wage index budget neutrality factor to ensure budget neutrality for LUPA per-visit payments and increase each of the six per-visit rates by the maximum rebasing adjustments described in section II.C. of this rule. We calculate the wage index budget neutrality factor by simulating total payments for LUPA episodes using the 2015 wage index and comparing it to simulated total payments for LUPA episodes using the 2014 wage index. By dividing the total payments for LUPA episodes using the 2015 wage index by the total payments for LUPA episodes using the 2014 wage index, we obtain a wage index budget neutrality factor of 1.0000. We would apply the wage index budget neutrality factor of 1.0000 to the CY 2015 national per-visit rates.

The LUPA per-visit rates are not calculated using case-mix weights. Therefore, there is no case-mix weights budget neutrality factor is needed to ensure budget neutrality for LUPA payments. Finally, the per-visit rates for each discipline are updated by the CY 2015 HH payment update percentage of 2.2 percent. The national per-visit rates are adjusted by the wage index based on the site of service of the beneficiary. The per-visit payments for LUPAs are separate from the LUPA add-on payment amount, which is paid for episodes that occur as the only episode or initial episode in a sequence of adjacent episodes. The proposed CY 2015 national per-visit rates are shown in Tables 18 and 19.

TABLE 18—PROPOSED CY 2015 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

HH Discipline type	CY 2014 Per-visit payment	Wage index budget neutrality factor	CY 2015 Rebasing adjustment	CY 2015 HH Payment update percentage	Proposed CY 2015 per-visit payment
Home Health Aide	$54.84	× 1.0000	+ $1.79	× 1.022	$57.88
Medical Social Services	$194.12	× 1.0000	+ $6.34	× 1.022	$204.87
Occupational Therapy	$133.30	× 1.0000	+ $4.35	× 1.022	$140.68
Physical Therapy	$132.40	× 1.0000	+ $4.32	× 1.022	$139.73
Skilled Nursing	$121.10	× 1.0000	+ $3.96	× 1.022	$127.81
Speech-Language Pathology	$143.88	× 1.0000	+ 4.70	× 1.022	$151.85

The proposed CY 2015 per-visit payment rates for an HHA that does not submit the required quality data are updated by the CY 2015 HH payment update percentage (2.2 percent) minus 2

percentage points and is shown in Table 19.

TABLE 19—PROPOSED CY 2015 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline Type	CY 2014 Per-visit rates	Wage index budget neutrality factor	CY 2015 Rebasing adjustment	CY 2015 HH Payment update percentage minus 2 percentage points	Proposed CY 2015 per-visit rates
Home Health Aide	$54.84	× 1.0000	+ $1.79	× 1.002	$56.74
Medical Social Services	$194.12	× 1.0000	+ $6.34	× 1.002	$200.86
Occupational Therapy	$133.30	× 1.0000	+ $4.35	× 1.002	$137.93
Physical Therapy	$132.40	× 1.0000	+ $4.32	× 1.002	$136.99
Skilled Nursing	$121.10	× 1.0000	+ $3.96	× 1.002	$125.31
Speech-Language Pathology	$143.88	× 1.0000	+ 4.70	× 1.002	$148.88

d. Low-Utilization Payment Adjustment (LUPA) Add-On Factors

LUPA episodes that occur as the only episode or as an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences. In the CY 2014 HH PPS final rule, we changed the methodology for calculating the LUPA add-on amount by finalizing the use of three LUPA add-on factors: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP (78 FR 72306). We multiply the per-visit payment amount for the first SN, PT, or SLP visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by the appropriate factor to determine the LUPA add-on payment amount. For example, for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, if the first skilled visit is SN, the payment for that visit will be $235.82 (1.8451 multiplied by $127.81).

e. Proposed Non-Routine Medical Supply (NRS) Conversion Factor Update

Payments for NRS are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. To determine the CY 2015 NRS conversion factor, we start with the 2014 NRS conversion factor ($53.65) and apply the −2.82 percent rebasing adjustment calculated in section II.C. of this rule (1 − 0.0282 = 0.9718). We then update the conversion factor by the CY 2015 HH payment update percentage (2.2 percent). We do not apply a standardization factor as the NRS payment amount calculated from the conversion factor is not wage or case-mix adjusted when the final claim payment amount is computed. The proposed NRS conversion factor for CY 2015 is shown in Table 20.

TABLE 20—PROPOSED CY 2015 NRS CONVERSION FACTOR FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

CY 2014 NRS conversion factor	CY 2015 Rebasing adjustment	CY 2015 HH Payment update percentage	Proposed CY 2015 NRS conversion factor
$53.65	× 0.9718	× 1.022	= $53.28

Using the proposed CY 2015 NRS conversion factor, the proposed payment amounts for the six severity levels are shown in Table 21.

TABLE 21—PROPOSED CY 2015 NRS PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	Proposed CY 2015 NRS payment amounts
1	0	0.2698	$14.37
2	1 to 14	0.9742	51.91
3	15 to 27	2.6712	142.32
4	28 to 48	3.9686	211.45
5	49 to 98	6.1198	326.06
6	99+	10.5254	560.79

For HHAs that do not submit the required quality data, we again begin with the CY 2014 NRS conversion factor ($53.65) and apply the −2.82 percent rebasing adjustment discussed in section II.C of this proposed rule (1 − 0.0282 = 0.9718). We then update the NRS conversion factor by the CY 2015 HH payment update percentage (2.2 percent) minus 2 percentage points. The proposed CY 2015 NRS conversion factor for HHAs that do not submit quality data is shown in Table 22.

TABLE 22—PROPOSED CY 2015 NRS CONVERSION FACTOR FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

CY 2014 NRS conversion factor	CY 2015 Re-basing adjustment	CY 2015 HH Payment update percentage minus 2 percentage points	Proposed CY 2015 NRS conversion factor
$53.65	× 0.9718	× 1.002	$52.24

The proposed payment amounts for the various severity levels based on the updated conversion factor for HHAs that do not submit quality data are calculated in Table 23.

TABLE 23—PROPOSED CY 2015 NRS PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	Proposed CY 2015 NRS payment amounts
1	0	0.2698	$14.09
2	1 to 14	0.9742	50.89
3	15 to 27	2.6712	139.54
4	28 to 48	3.9686	207.32
5	49 to 98	6.1198	319.70
6	99+	10.5254	549.85

f. Rural Add-On

Section 421(a) of the MMA required, for HH services furnished in a rural areas (as defined in section 1886(d)(2)(D) of the Act), for episodes or visits ending on or after April 1, 2004, and before April 1, 2005, that the Secretary increase the payment amount that otherwise will have been made under section 1895 of the Act for the services by 5 percent.

Section 5201 of the DRA amended section 421(a) of the MMA. The amended section 421(a) of the MMA required, for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), on or after January 1, 2006 and before January 1, 2007, that the Secretary increase the payment amount otherwise made under section 1895 of the Act for those services by 5 percent.

Section 3131(c) of the Affordable Care Act amended section 421(a) of the MMA to provide an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for HH services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), for episodes and visits ending on or after April 1, 2010, and before January 1, 2016.

Section 421 of the MMA, as amended, waives budget neutrality related to this provision, as the statute specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to HH services furnished during a period to offset the increase in payments resulting in the application of this section of the statute.

Refer to Tables 24 through 27 for the proposed payment rates for home health services provided in rural areas.

TABLE 24—PROPOSED CY 2015 PAYMENT AMOUNTS FOR 60-DAY EPISODES FOR SERVICES PROVIDED IN A RURAL AREA

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2015 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural national, standardized 60-day episode payment rate	CY 2015 national, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural national, standardized 60-day episode payment rate
$2,922.76	× 1.03	$3,010.44	$2,865.57	× 1.03	$2,951.54

TABLE 25—PROPOSED CY 2015 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
HH discipline type	CY 2015 per-visit rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural per-visit rates	CY 2015 per-visit rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural per-visit rates
HH Aide	$57.88	× 1.03	$59.62	$56.74	× 1.03	$58.44
MSS	204.87	× 1.03	211.02	200.86	× 1.03	206.89
OT	140.68	× 1.03	144.90	137.93	× 1.03	142.07
PT	139.73	× 1.03	143.92	136.99	× 1.03	141.10
SN	127.81	× 1.03	131.64	125.31	× 1.03	129.07

TABLE 25—PROPOSED CY 2015 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA—Continued

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
HH discipline type	CY 2015 per-visit rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural per-visit rates	CY 2015 per-visit rate	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural per-visit rates
SLP	151.85	× 1.03	156.41	148.88	× 1.03	153.35

TABLE 26—PROPOSED CY 2015 NRS CONVERSION FACTOR FOR SERVICES PROVIDED IN RURAL AREAS

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
CY 2015 conversion factor	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural NRS conversion factor	CY 2015 conversion factor	Multiply by the 3 percent rural add-on	Proposed CY 2015 rural NRS conversion factor
$53.28	× 1.03	$54.88	$52.24	× 1.03	$53.81

TABLE 27—PROPOSED CY 2015 NRS PAYMENT AMOUNTS FOR SERVICES PROVIDED IN RURAL AREAS

Severity level	Points (scoring)	For HHAs that DO submit quality data (proposed CY 2015 NRS conversion factor = $54.88)		For HHAs that DO NOT submit quality data (proposed CY 2015 NRS conversion factor = $53.81)	
		Relative weight	Proposed CY 2015 NRS payment amounts for rural areas	Relative weight	Proposed CY 2015 NRS payment amounts for rural areas
1	0	0.2698	$14.81	0.2698	$14.52
2	1 to 14	0.9742	53.46	0.9742	52.42
3	15 to 27	2.6712	146.60	2.6712	143.74
4	28 to 48	3.9686	217.80	3.9686	213.55
5	49 to 98	6.1198	335.85	6.1198	329.31
6	99+	10.5254	577.63	10.5254	566.37

E. Payments for High-Cost Outliers Under the HH PPS

1. Background

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the national, standardized 60-day case-mix and wage-adjusted episode payment amounts in the case of episodes that incur unusually high costs due to patient care needs. Prior to the enactment of the Affordable Care Act, section 1895(b)(5) of the Act stipulated that projected total outlier payments could not exceed 5 percent of total projected or estimated HH payments in a given year. In the Medicare Program; Prospective Payment System for Home Health Agencies final rule (65 FR 41188 through 41190), we described the method for determining outlier payments. Under this system, outlier payments are made for episodes whose estimated costs exceed a threshold amount for each HH Resource Group (HHRG). The episode's estimated cost is the sum of the national wage-adjusted per-visit payment amounts for all visits delivered during the episode. The outlier threshold for each case-mix group or PEP adjustment is defined as the 60-day episode payment or PEP adjustment for that group plus a fixed-dollar loss (FDL) amount. The outlier payment is defined to be a proportion of the wage-adjusted estimated cost beyond the wage-adjusted threshold. The threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and wage-adjusted FDL amount. The proportion of additional costs over the outlier threshold amount paid as outlier payments is referred to as the loss-sharing ratio.

In the CY 2010 HH PPS final rule (74 FR 58080 through 58087), we discussed excessive growth in outlier payments, primarily the result of unusually high outlier payments in a few areas of the country. Despite program integrity efforts associated with excessive outlier payments in targeted areas of the country, we discovered that outlier expenditures still exceeded the 5 percent, target and, in the absence of corrective measures, would continue do to so. Consequently, we assessed the appropriateness of taking action to curb outlier abuse. To mitigate possible billing vulnerabilities associated with excessive outlier payments and adhere to our statutory limit on outlier payments, we adopted an outlier policy that included a 10 percent agency-level cap on outlier payments. This cap was implemented in concert with a reduced FDL ratio of 0.67. These policies resulted in a projected target outlier pool of approximately 2.5 percent. (The previous outlier pool was 5 percent of total HH expenditure). For CY 2010, we first returned 5 percent of these dollars 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. Then, we reduced the CY 2010 rates by 2.5 percent to account for the new outlier pool of 2.5 percent. This outlier policy was adopted for CY 2010 only.

As we noted in the CY 2011 HH PPS final rule (75 FR 70397 through 70399), section 3131(b)(1) of the Affordable Care Act amended section 1895(b)(3)(C) of the Act. As amended, ''Adjustment for outliers,'' states that ''The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to HH services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to 5 percent of the total payments estimated to be made based on the prospective payment system under this subsection for the period.'' In addition,

section 3131(b)(2) of the Affordable Care Act amended section 1895(b)(5) of the Act by re-designating the existing language as section 1895(b)(5)(A) of the Act, and revising it to state that the Secretary, ''subject to [a 10 percent program-specific outlier cap], may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph for a fiscal year or year may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.''

As such, beginning in CY 2011, our HH PPS outlier policy is that we reduce payment rates by 5 percent and target up to 2.5 percent of total estimated HH PPS payments to be paid as outliers. To do so, we first returned the 2.5 percent held for the target CY 2010 outlier pool to the national, standardized 60-day episode rates, the national per visit rates, the LUPA add-on payment amount, and the NRS conversion factor for CY 2010. We then reduced the rates by 5 percent as required by section 1895(b)(3)(C) of the Act, as amended by section 3131(b)(1) of the Affordable Care Act. For CY 2011 and subsequent calendar years we target up to 2.5 percent of estimated total payments to be paid as outlier payments, and apply a 10 percent agency-level outlier cap.

2. Fixed Dollar Loss (FDL) Ratio and Loss-Sharing Ratio

For a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of episodes that can receive outlier payments, but makes it possible to select a higher loss-sharing ratio, and therefore, increase outlier payments for outlier episodes. Alternatively, a lower FDL ratio means that more episodes can qualify for outlier payments, but outlier payments per episode must then be lower.

The FDL ratio and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). Historically, we have used a value of 0.80 for the loss-sharing ratio which, we believe, preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. We are not proposing a change to the loss-sharing ratio in this proposed rule.

In the CY 2011 HH PPS final rule (75 FR 70398), in targeting total outlier payments as 2.5 percent of total HH PPS payments, we implemented an FDL ratio of 0.67, and we maintained that ratio in CY 2012. Simulations based on CY 2010 claims data completed for the CY 2013 HH PPS final rule showed that outlier payments were estimated to comprise approximately 2.18 percent of total HH PPS payments in CY 2013, and as such, we lowered the FDL ratio from 0.67 to 0.45. We stated that lowering the FDL ratio to 0.45, while maintaining a loss-sharing ratio of 0.80, struck an effective balance of compensating for high-cost episodes while allowing more episodes to qualify as outlier payments (77 FR 67080). The national, standardized 60-day episode payment amount is multiplied by the FDL ratio. That amount is wage-adjusted to derive the wage-adjusted FDL amount, which is added to the case-mix and wage-adjusted 60-day episode payment amount to determine the outlier threshold amount that costs have to exceed before Medicare will pay 80 percent of the additional estimated costs.

Based on simulations using preliminary CY 2013 claims data, the proposed CY 2015 payments rates in section III.D.4 of this proposed rule, and the FDL ratio of 0.45; we estimate that outlier payments would comprise approximately 2.26 percent of total HH PPS payments in CY 2015. Simulating payments using preliminary CY 2013 claims data and the CY 2014 payment rates (78 FR 72304 through 72308), we estimate that outlier payments would comprise 2.01 percent of total payments. Given the proposed increases to the CY 2015 national per-visit payment rates, our analysis estimates an additional 0.25 percentage point increase in estimated outlier payments as a percent of total HH PPS payments each year that we phase-in the rebasing adjustments described in section II.C. We estimate that for CY 2016, estimated outlier payments as a percent of total HH PPS payments will increase to 2.51 percent. We note that these estimates do not take in to account any changes in utilization that may have occurred in CY 2014, and would continue to occur in CY 2015. Therefore, we are not proposing a change to the FDL ratio for CY 2015. In the final rule, we will update our estimate of outlier payments as a percent of total HH PPS payments using the most current and complete year of HH PPS data. We will continue to monitor the percent of total HH PPS payments paid as outlier payments to determine if future adjustments to either the FDL ratio or loss-sharing ratio are warranted.

F. Medicare Coverage of Insulin Injections Under the HH PPS

Home health policy regarding coverage of home health visits for the sole purpose of insulin injections is limited to patients that are physically or mentally unable to self-inject and there is no other person who is able and willing to inject the patient.[16] However, the Office of Inspector General concluded in August 2013 that some previously covered home health visits for the sole purpose of insulin injections were unnecessary because the patient was physically and mentally able to self-inject.[17] In addition, results from analysis in response to public comments on the CY 2014 HH PPS final rule found that episodes that qualify for outlier payments in excess of $10,000 had, on average, 160 skilled nursing visits in a 60-day episode of care with 95 percent of the episodes listing a primary diagnosis of diabetes or long-term use of insulin (78 FR 72310). Therefore, we conducted a literature review regarding generally accepted clinical management practices for diabetic patients and conducted further analysis of home health claims data to investigate the extent to which episodes with visits likely for the sole purpose of insulin injections are in fact limited to patients that are physically or mentally unable to self-inject.

As generally accepted by the medical community, older patients (age 65 and older) are more likely to have impairments in dexterity, cognition, vision, and hearing.[18] While studies have shown that most elderly patients starting or continuing on insulin can inject themselves, these conditions may affect the elderly individual's ability to self-inject insulin. It is clinically essential that there is careful assessment prior to the initiation of home care, and throughout the course of treatment, regarding the patient's capacity for self-injection. There are multiple reliable, and validated assessment tools that may be used to assess the elderly individual's ability to self-inject. These tools assess the individual's ability to perform activities of daily living (ADLs), as well as, cognitive, functional, and

[16] Medicare Coverage Benefit Policy Manual (Pub. 100–02), Section 40.1.2.4.B.2 ''Insulin Injections''.

[17] Levinson, Daniel R. Management Implication Report 12–0011, Unnecessary Home Health Care for Diabetic Patients.

[18] Strategies for Insulin Injection Therapy in Diabetes Self-Management. (2011). American Association of Diabetes Educators.

behavioral status.[19] These assessment tools have also proved valid for judging patients' ability to inject insulin independently and to recognize and deal with hypoglycemia.[20]

Another important consideration with regards to insulin administration in the elderly population is the possibility of dosing errors.[21] Correct administration and accurate dosing is important in order to prevent serious complications, such as hypoglycemia and hyperglycemia. The traditional vial and syringe method of insulin administration involves several steps, including injecting air into the vial, drawing an amount out of the vial into a syringe with small measuring increments, and verifying the correct dose visually.[22] In some cases, an insulin pen can be used as an alternative to the traditional vial and syringe method.

Insulin pens are designed to facilitate easy self-administration, the possession of which would suggest the ability to self-inject. Additionally, insulin pens often come pre-filled with insulin or must be used with a pre-filled cartridge thus potentially negating the need for skilled nursing for the purpose of calculating and filling appropriate doses. It is recognized that visual impairment, joint immobility and/or pain, peripheral neuropathy, and cognitive issues may affect the ability of elderly patients to determine correct insulin dosing and injection. Our literature review indicates that insulin pen devices may be beneficial in terms of safety for elderly patients due to these visual or physical disabilities.[23] To determine whether to use a traditional vial and syringe method of insulin administration versus an insulin pen, the physician must consider and understand the advantages these devices offer over traditional vials and syringes. These advantages include:

- Convenience, as the insulin pen eliminates the need to draw up a dose;
- Greater dose accuracy and reliability, especially for low doses which are often needed in the elderly;
- Sensory and auditory feedback associated with the dial mechanism on many pens may also benefit those with visual impairments;
- Pen devices are also more compact, portable and easier to grip, which may benefit those with impairments in manual dexterity; and
- Less painful injections and overall ease of use.[24]

Although pen devices are often perceived to be more costly than vialed insulin, study results indicate that elderly diabetic patients are more likely to accept pen devices and adhere to therapy, which leads to better glycemic control that decreases long-term complications and associated healthcare costs.[25] The significantly improved safety profiles of pen devices also avert costly episodes of hypoglycemia.[26] It also should be noted that most insurance plans, including Medicare Part D plans, charge the patient the same amount for a month supply of insulin in the pen device as insulin in the vial.[27] Furthermore, pharmacoeconomic data reveal cost benefits for using pens versus syringes due to improved treatment adherence and reduced health care utilization.[28] Additionally, in some cases the individual with coverage for insulin pens may have one co-pay, resulting in getting more insulin than if purchasing a vial. And, there is less waste with pens because insulin vials should be discarded after 28 days after opening. However, there may be clinical reasons for the use of the traditional vial and insulin syringe as opposed to the insulin pen, including the fact that not all insulin preparations are available via insulin pen. In such circumstances, there are multiple assistive aids and devices to facilitate self-injection of insulin for those with cognitive or functional limitations. These include: nonvisual insulin measurement devices; syringe magnifiers; needle guides; prefilled insulin syringes; and vial stabilizers to help ensure accuracy and aid in insulin delivery.[29] It is expected that providers will assess the needs, abilities, and preference of the patient requiring insulin to facilitate patient autonomy, efficiency, and safety in diabetes self-management, including the administration of insulin.

Further research regarding self-injection of insulin, whether via a vial and syringe method or insulin pen, shows that education for starting insulin and monitoring should be provided by a diabetes nurse specialist, and typically entails 5 to 10 face-to-face contacts either in the patient's home or at the diabetes clinic; these are in addition to telephone contacts to further reinforce teaching and to answer patient questions.[30] This type of assessment and education allows for patient autonomy and self-efficiency and is often a preferred mode for diabetes self-management.

In the CY 2014 HH PPS final rule (78 FR 72256), we noted "The Office of Inspector General (OIG) released a "Management Implications Report in August of 2013" that concluded there is a "systemic weakness that results in Medicare coverage of unnecessary home health care for diabetic patients". The OIG report noted that investigations show that the majority of beneficiaries involved in fraudulent schemes have a primary diagnosis of diabetes. The report noted that OIG Special Agents found falsified medical records documenting patients having hand tremors and poor vision preventing them from drawing insulin into a syringe, visually verifying the correct dosage, and injecting the insulin themselves, when the patients did not in fact suffer those symptoms.

In light of the OIG report, we conducted analysis and performed simulations using CY 2012 claims data and described our findings in the CY 2014 Home Health PPS Final Rule (78 FR 72310). We found that nearly 44 percent of the episodes that would qualify for outlier payments had a primary diagnosis of diabetes and 16 percent of episodes that would quality for outlier payments had a primary diagnosis of "Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled." Qualifying for outlier

[19] Hendra, T.J. Starting insulin therapy in elderly patients. (2012). Journal of the Royal Society of Medicine. 95(9), 453–455.

[20] Sinclair AJ, Turnbull CJ, Croxson SCM. Document of care for older people with diabetes. Postgrad Med J 1996;72: 334–8.

[21] Coscelli C, Lostia S, Lunetta M, Nosari I, Coronel GA. Safety, efficacy, acceptability of a pre-filled insulin pen in diabetic patients over 60 years old. Diabetes Research and Clinical Practice. 1995;38:173–7. [PubMed]

[22] Flemming DR. Mightier than the syringe. Am J Nurs. 2000;100:44–8. [PubMed]

[23] Wright, B., Bellone, J., McCoy, E. (2010). A review of insulin pen devices and use in elderly, diabetic population. Clinical Medicine Insights: Endocrinology and Diabetes. 3:53–63. Doi: 10.4137/CMED.S5534.

[24] Wright, B., Bellone, J., McCoy, E. (2010). A review of insulin pen devices and use in elderly, diabetic population. Clinical Medicine Insights: Endocrinology and Diabetes. 3:53–63. Doi: 10.4137/CMED.S5534.

[25] Strategies for Insulin Injection Therapy in Diabetes Self-Management. (2011). American Association of Diabetes Educators.

[26] Strategies for Insulin Injection Therapy in Diabetes Self-Management. (2011). American Association of Diabetes Educators.

[27] Wright, B., Bellone, J., McCoy, E. (2010). A review of insulin pen devices and use in elderly, diabetic population. Clinical Medicine Insights: Endocrinology and Diabetes. 3:53–63. Doi: 10.4137/CMED.S5534

[28] Strategies for Insulin Injection Therapy in Diabetes Self-Management. (2011). American Association of Diabetes Educators.

[29] Strategies for Insulin Injection Therapy in Diabetes Self-Management. (2011). American Association of Diabetes Educators.

[30] Hendra, T.J. Starting insulin therapy in elderly patients. (2012). Journal of the Royal Society of Medicine. 95(9), 453–455. *http://www.ncbi.nlm.nih.gov*.

payments should indicate an increased resource and service need. However, uncomplicated and controlled diabetes typically would be viewed as stable without clinical complications and would not warrant increased resource and service needs nor would it appear to warrant outlier payments. Our simulations estimated that approximately 81 percent of outlier payments would be paid to proprietary HHAs and that approximately two-thirds of outlier payments would be paid to HHAs located in Florida (27 percent), Texas (24 percent) and California (15 percent). We also conducted additional analyses on episodes in our simulations that would have resulted in outlier payments of over $10,000. Of note, 95 percent of episodes that would have resulted in outlier payments of over $10,000 were for patients with a primary diagnosis of diabetes or long-term use of insulin, and most were concentrated in Florida, Texas, New York, California, and Oklahoma. On average, these outlier episodes had 160 skilled nursing visits in a 60-day episode of care.[31]

Based upon the initial data analysis described above and the information found in the literature review, we conducted further data analysis with more recent home health claims and OASIS data (CY 2012 and CY 2013) to expand our understanding of the diabetic patient in the home health setting. Specifically, we investigated the extent to which beneficiaries with a diabetes-related principal diagnosis received home health services likely for the primary purpose of insulin injection assistance and whether such services were warranted by other documented medical conditions. We also analyzed the magnitude of Medicare payments associated with home health services provided to this population of interest. The analysis was conducted by Acumen, LLC because of their capacity to provide real-time claims data analysis across all parts of the Medicare program (that is, Part A, Part B, and Part D).

Our analysis began with identifying episodes for the home health diabetic population based on claims and OASIS assessments most likely to be associated with insulin injection assistance. We used the following criteria to identify the home health diabetic population of interest: (1) A diabetic condition listed as the principal/primary diagnosis on the home health claim; (2) Medicare Part A or Part B enrollment for at least three months prior to the episode and during the episode; and (3) episodes with at least 45 skilled visits. This threshold was determined based on the distribution in the average number and length of skilled nursing visits for episodes meeting criteria 1 and 2 above using CY 2013 home health claims data. The average number of skilled nursing visits for beneficiaries who receive at least one skilled nursing visit appeared to increase from 20 visits at the 90th percentile, to 50 visits at the 95th percentile. Additionally, the average length of a skilled nursing visit for episodes between the 90th and 95th percentiles was 37 minutes, less than half the length of visits for episode between the 75th and 90th percentiles.

Approximately 49,100 episodes met the study population criteria described above, accounting for approximately $298 million in Medicare home health payments in CY 2013. Of the 49,100 episodes of interest, 71 percent received outlier payments and, on average, there were 86 skilled nursing visits per episode. In addition, 12 percent of the episodes in the study population were for patients prescribed an insulin pen to self-inject and more than half of the episodes billed (27,439) were for claims that listed ICD–9–CM 2500x, ''Diabetes Mellitus without mention of complication'', as the principal diagnosis code. ICD–9–CM describes the code 250.0x as diabetes mellitus without mention of complications (complications can include hypo- or hyperglycemia, or manifestations classified as renal, ophthalmic, neurological, peripheral circulatory damage or neuropathy). Clinically, this code generally means that the diabetes is being well-controlled and there are no apparent complications or symptoms resulting from the diabetes. Diabetes that is controlled and without complications does not warrant intensive intervention or daily skilled nursing visits; rather, it warrants knowledge of the condition and routine monitoring.

As discussed above in this section, the traditional vial and syringe method of insulin administration is one of two methods of insulin administration (excluding the use of insulin pumps). The alternative to the traditional vial and syringe method is the use of insulin pens. We believe that insulin pens are usually prescribed for those beneficiaries that are able to self-administer the insulin via an insulin pen. Therefore, the possession of a prescribed insulin pen would suggest the ability to self-inject. Since insulin pens often come pre-filled with insulin or must be used with a pre-filled cartridge, we believe there would not be a need for skilled nursing for the purpose of insulin injection assistance. We expect providers to assess the needs, abilities, and preference of the patient requiring insulin to facilitate patient autonomy, efficiency, and safety in diabetes self-management, including the administration of insulin. As noted above, approximately 12 percent of the episodes in the study population with visits likely for the purpose of insulin injection assistance were for patients prescribed an insulin pen to self-inject, which does not conform to our current policy that home health visits for the sole purpose of insulin injection assistance is limited to patients that are physically or mentally unable to self-inject and there is no other person who is able and willing to inject the patient.

Furthermore, we recognize that our current sub-regulatory guidance may not adequately address the method of delivery. We are considering additional guidance that may be necessary surrounding insulin injection assistance provided via a pen based upon our analyses described above. We have found that literature supports that insulin pens may reduce expenses for the patient in the form of co-pays and may increase patient adherence to their treatment plan. Therefore, we encourage physicians to consider the potential benefits derived in prescribing insulin pens, when clinically appropriate, given the patient's condition.

We also investigated whether secondary diagnosis codes listed on home health claims support that the patient, either for physical or mental reasons, cannot self-inject. Our contractor, Abt Associates, with review and clinical input from CMS clinical staff and experts, created a list of ICD–9–CM codes that indicate a patient has impairments in dexterity, cognition, vision, and/or hearing that may cause the patient to be unable to self-inject insulin. We found that 49 percent of home health episodes in our study population did not have a secondary diagnosis from that ICD–9–CM code list on the home health claim that supported that the patient was physically or mentally unable to self-inject. When examining only the initial home health episodes of our study population, we found that 67 percent of initial home health episodes with skilled nursing visits likely for insulin injections did not have a secondary diagnosis on the home health claim that supported that the patient was physically or mentally unable to self-

[31] This analysis simulated payments using CY 2012 claims data and CY 2012 payment rates. The simulations did not take into account the 10-percent outlier cap. Some episodes may have qualified for outlier payments in the simulations, but were not paid accordingly if the HHA was at or over its 10 percent cap on outlier payments as a percent of total payments.

inject. Using the same list of ICD–9–CM diagnosis codes, we examined both the secondary diagnoses on the home health claim and diagnoses on non-home health claims in the three months prior to starting home health care for initial home health episodes. We found that for initial home health episodes in our study population that the percentage of episodes that did not have a secondary diagnosis to support that the patient cannot self-inject would decrease from 67 percent to 47 percent if the home health claim included diagnoses found in other claim types during the three months prior to entering home care. We do recognize that, in spite of all of the education, assistive devices and support, there may still be those who are unable to self-inject insulin and will require ongoing skilled nursing visits for insulin administration assistance. However, there is an expectation that the physician and the HHA would clearly document detailed clinical findings and rationale as to why an individual is unable to self-inject, including the reporting of an appropriate secondary condition that supports the inability of the patient to self-inject.

As described above, a group of CMS clinicians and contractor clinicians developed a list of conditions that would support the need for ongoing home health skilled nursing visits for insulin injection assistance for instances where the patient is physically or mentally unable to self-inject and there is no able or willing caregiver to provide assistance. We expect the conditions included in Table 28 to be listed on the claim and OASIS to support the need for skilled nursing visits for insulin injection assistance.

TABLE 28—ICD–9–CM DIAGNOSIS CODES THAT INDICATE A POTENTIAL INABILITY TO SELF-INJECT INSULIN

ICD–9–CM Code	Description
Amputation:	
V49.61	Thumb Amputation Status.
V49.63	Hand Amputation Status.
V49.64	Wrist Amputation Status.
V49.65	Below elbow amputation status.
V49.66	Above elbow amputation status.
V49.67	Shoulder amputation status.
885.0	Traumatic amputation of thumb w/o mention of complication.
885.1	Traumatic amputation of thumb w/mention of complication.
886.0	Traumatic amputation of other fingers w/o mention of complication.
886.1	Traumatic amputation of other fingers w/mention of complication.
887.0	Traumatic amputation of arm and hand, unilateral, below elbow w/o mention of complication.
887.1	Traumatic amputation of arm and hand, unilateral, below elbow, complicated.
887.2	Traumatic amputation of arm and hand, unilateral, at or above elbow w/o mention of complication.
887.3	Traumatic amputation of arm and hand, unilateral, at or above elbow, complicated.
887.4	Traumatic amputation of arm and hand, unilateral, level not specified, w/o mention of complication.
887.5	Traumatic amputation of arm and hand, unilateral, level not specified, complicated.
887.6	Traumatic amputation of arm and hand, bilateral, any level, w/o mention of complication.
887.7	Traumatic amputation of arm and hand, bilateral, any level, complicated.
Vision:	
362.01	Background diabetic retinopathy.
362.50	Macular degeneration (senile) of retina unspecified.
362.51	Nonexudative senile macular degeneration of retina.
362.52	Exudative senile macular degeneration of retina.
362.53	Cystoid macular degeneration of retina.
362.54	Macular cyst hole or pseudohole of retina.
362.55	Toxic maculopathy of retina.
362.56	Macular puckering of retina.
362.57	Drusen (degenerative) of retina.
366.00	Nonsenile cataract unspecified.
366.01	Anterior subcapsular polar nonsenile cataract.
366.02	Posterior subcapsular polar nonsenile cataract.
366.03	Cortical lamellar or zonular nonsenile cataract.
366.04	Nuclear nonsenile cataract.
366.09	Other and combined forms of nonsenile cataract.
366.10	Senile cataract unspecified.
366.11	Pseudoexfoliation of lens capsule.
366.12	Incipient senile cataract.
366.13	Anterior subcapsular polar senile cataract.
366.14	Posterior subcapsular polar senile cataract.
366.15	Cortical senile cataract.
366.16	Senile nuclear sclerosis.
366.17	Total or mature cataract.
366.18	Hypermature cataract.
366.19	Other and combined forms of senile cataract.
366.20	Traumatic cataract unspecified.
366.21	Localized traumatic opacities.
366.22	Total traumatic cataract.
366.23	Partially resolved traumatic cataract.
366.8	Other cataract.
366.9	Unspecified cataract.
366.41	Diabetic cataract.
366.42	Tetanic cataract.
366.43	Myotonic cataract.

TABLE 28—ICD–9–CM DIAGNOSIS CODES THAT INDICATE A POTENTIAL INABILITY TO SELF-INJECT INSULIN—Continued

ICD–9–CM Code	Description
366.44	Cataract associated with other syndromes.
366.45	Toxic cataract.
366.46	Cataract associated with radiation and other physical influences.
366.50	After-cataract unspecified.
369.00	Impairment level not further specified.
369.01	Better eye: total vision impairment; lesser eye: total vision impairment.
369.10	Moderate or severe impairment, better eye, impairment level not further specified.
369.11	Better eye: severe vision impairment; lesser eye: blind not further specified.
369.13	Better eye: severe vision impairment; lesser eye: near-total vision impairment.
369.14	Better eye: severe vision impairment; lesser eye: profound vision impairment.
369.15	Better eye: moderate vision impairment; lesser eye: blind not further specified.
369.16	Better eye: moderate vision impairment; lesser eye: total vision impairment.
369.17	Better eye: moderate vision impairment; lesser eye: near-total vision impairment.
369.18	Better eye: moderate vision impairment; lesser eye: profound vision impairment.
369.20	Moderate to severe impairment; Low vision both eyes not otherwise specified.
369.21	Better eye: severe vision impairment; lesser eye; impairment not further specified.
369.22	Better eye: severe vision impairment; lesser eye: severe vision impairment.
369.23	Better eye: moderate vision impairment; lesser eye: impairment not further specified.
369.24	Better eye: moderate vision impairment; lesser eye: severe vision impairment.
369.25	Better eye: moderate vision impairment; lesser eye: moderate vision impairment.
369.3	Unqualified visual loss both eyes.
369.4	Legal blindness as defined in U.S.A..
377.75	Cortical blindness.
379.21	Vitreous degeneration.
379.23	Vitreous hemorrhage.
Cognitive/Behavioral:	
290.0	Senile dementia uncomplicated.
290.3	Senile dementia with delirium.
290.40	Vascular dementia, uncomplicated.
290.41	Vascular dementia, with delirium.
290.42	Vascular dementia, with delusions.
290.43	Vascular dementia, with depressed mood.
294.11	Dementia in conditions classified elsewhere with behavioral disturbance.
294.21	Dementia, unspecified, with behavioral disturbance.
300.29	Other isolated or specific phobias.
331.0	Alzheimer's disease.
331.11	Pick's disease.
331.19	Other frontotemporal dementia.
331.2	Senile degeneration of brain.
331.82	Dementia with lewy bodies.
Arthritis:	
715.11	Osteoarthrosis localized primary involving shoulder region.
715.21	Osteoarthrosis localized secondary involving shoulder region.
715.31	Osteoarthrosis localized not specified whether primary or secondary involving shoulder region.
715.91	Osteoarthrosis unspecified whether generalized or localized involving shoulder region.
715.12	Osteoarthrosis localized primary involving upper arm.
715.22	Osteoarthrosis localized secondary involving upper arm.
715.32	Osteoarthrosis localized not specified whether primary or secondary involving upper arm.
715.92	Osteoarthrosis unspecified whether generalized or localized involving upper arm.
715.13	Osteoarthrosis localized primary involving forearm.
715.23	Osteoarthrosis localized secondary involving forearm.
715.33	Osteoarthrosis localized not specified whether primary or secondary involving forearm.
715.93	Osteoarthrosis unspecified whether generalized or localized involving forearm.
715.04	Osteoarthrosis generalized involving hand.
715.14	Osteoarthrosis localized primary involving hand.
715.24	Osteoarthrosis localized secondary involving hand.
715.34	Osteoarthrosis localized not specified whether primary or secondary involving hand.
715.94	Osteoarthrosis unspecified whether generalized or localized involving hand.
716.51	Unspecified polyarthropathy or polyarthritis involving shoulder region.
716.52	Unspecified polyarthropathy or polyarthritis involving upper arm.
716.53	Unspecified polyarthropathy or polyarthritis involving forearm.
716.54	Unspecified polyarthropathy or polyarthritis involving hand.
716.61	Unspecified monoarthritis involving shoulder region.
716.62	Unspecified monoarthritis involving upper arm.
716.63	Unspecified monoarthritis involving forearm.
716.64	Unspecified monoarthritis involving hand.
716.81	Other specified arthropathy involving shoulder region.
716.82	Other specified arthropathy involving upper arm.
716.83	Other specified arthropathy involving forearm.
716.84	Other specified arthropathy involving hand.
716.91	Unspecified arthropathy involving shoulder region.
716.92	Unspecified arthropathy involving upper arm.

TABLE 28—ICD–9–CM DIAGNOSIS CODES THAT INDICATE A POTENTIAL INABILITY TO SELF-INJECT INSULIN—Continued

ICD–9–CM Code	Description
716.93	Unspecified arthropathy involving forearm.
716.94	Unspecified arthropathy involving hand.
716.01	Kaschin-Beck disease shoulder region.
716.02	Kaschin-Beck disease upper arm.
716.04	Kaschin-Beck disease forearm.
716.04	Kaschin-beck disease involving hand.
719.81	Other specified disorders of joint of shoulder region.
719.82	Other specified disorders of upper arm joint.
719.83	Other specified disorders of joint, forearm.
719.84	Other specified disorders of joint, hand.
718.41	Contracture of joint of shoulder region.
718.42	Contracture of joint, upper arm.
718.43	Contracture of joint, forearm.
718.44	Contracture of hand joint.
714.0	Rheumatoid arthritis.
Movement Disorders:	
332.0	Paralysis agitans (Parkinson's).
332.1	Secondary parkinsonism.
333.1	Essential and other specified forms of tremor.
736.05	Wrist drop (acquired).
After Effects from Stroke/Other Disorders of the Central Nervous System/Intellectual Disabilities:	
438.21	Hemiplegia affecting dominant side.
438.22	Hemiplegia affecting nondominant side.
342.01	Flaccid hemiplegia and hemiparesis affecting dominant side.
342.02	Flaccid hemiplegia and hemiparesis affecting nondominant side.
342.11	Spastic hemiplegia and hemiparesis affecting dominant side.
342.12	Spastic hemiplegia and hemiparesis affecting nondominant side.
438.31	Monoplegia of upper limb affecting dominant side.
438.32	Monoplegia of upper limb affecting nondominant side.
343.3	Congenital monoplegia.
344.41	Monoplegia of upper limb affecting dominant side.
344.42	Monoplegia of upper limb affecting nondominant side.
344.81	Locked-in state.
344.00	Quadriplegia unspecified.
344.01	Quadriplegia c1-c4 complete.
344.02	Quadriplegia c1-c4 incomplete.
344.03	Quadriplegia c5-c7 complete.
344.04	Quadriplegia c5-c7 incomplete.
343.0	Congenital diplegia.
343.2	Congenital quadriplegia.
344.2	Diplegia of upper limbs.
318.0	Moderate intellectual disabilities.
318.1	Severe intellectual disabilities.
318.2	Profound intellectual disabilities.

Although we are not proposing any policy changes at this time, we are soliciting public comments on whether the conditions in Table 28 represent a comprehensive list of codes that appropriately indicate that a patient may not be able to self-inject and the use of insulin pens in home health. We plan to continue monitoring claims that are likely for the purpose of insulin injection assistance. Historical evidence in the medical record must support the clinical legitimacy of the secondary condition(s) and resulting disability that limit the beneficiary's ability to self-inject.

G. Implementation of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM)

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. 113–93) was enacted. Section 212 of the PAMA, titled ''Delay in Transition from ICD–9 to ICD–10 Code Sets,'' provides that ''[t]he Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and § 162.1002 of title 45, Code of Federal Regulations.''

On May 1, 2014, the Secretary announced that HHS expects to issue an interim final rule that will require use of ICD–10 beginning October 1, 2015 and continue to require use of ICD–9–CM through September 30, 2015. This announcement, which is available on the CMS Web site at *http://cms.gov/Medicare/Coding/ICD10/index.html,* means that ICD–9–CM diagnosis codes will continue to be used for home health claims reporting until October 1, 2015, when ICD–10–CM is required. Diagnosis reporting on home health claims must adhere to ICD–9–CM coding conventions and guidelines regarding the selection of principal diagnosis and the reporting of additional diagnoses until that time. The current ICD–9–CM Coding Guidelines refer to the use of the International Classification of Diseases,

9th Revision, Clinical Modification (ICD–9–CM) and are available through the CMS Web site at: *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html* or on the CDC's Web site at *http://www.cdc.gov/nchs/icd/icd9cm.htm*. We plan to disseminate this information through the HHA Center Web site, the Home Health, Hospice and DME Open Door Forum, and in the CY 2015 HH PPS final rule.

H. Proposed Change to the Therapy Reassessment Timeframes

As discussed in our CY 2011 HH PPS final rule (75 FR 70372), effective January 1, 2011, therapy reassessments must be performed on or ''close to'' the 13th and 19th therapy visits and at least once every 30 days. A qualified therapist, of the corresponding discipline for the type of therapy being provided, must functionally reassess the patient using a method which would include objective measurement. The measurement results and corresponding effectiveness of the therapy, or lack thereof, must be documented in the clinical record. We anticipated that policy regarding therapy coverage and therapy reassessments would address payment vulnerabilities that have led to high use and sometimes overuse of therapy services. We also discussed our expectation that this policy change would ensure more qualified therapist involvement for beneficiaries receiving high amounts of therapy. In our CY 2013 HH PPS final rule (77 FR 67068), effective January 1, 2013, we provided further clarifications regarding therapy coverage and therapy reassessments. Specifically, similar to the existing requirements for therapy reassessments when the patient resides in a rural area, we finalized changes to § 409.44(c)(2)(i)(C)(*2*) and (D)(*2*) specifying that when multiple types of therapy are provided, each therapist must assess the patient after the 10th therapy visit but no later than the 13th therapy visit and after the 16th therapy visit but no later than the 19th therapy visit for the plan of care. In § 409.44(c)(2)(i)(E)(1), we specified that when a therapy reassessment is missed, any visits for that discipline prior to the next reassessment are non-covered.

Our analysis of data from CYs 2010 through 2013 shows that the frequency of episodes with therapy visits reaching 14 and 20 therapy visits did not change substantially as a result of the therapy reassessment policy implemented in CY 2011 (see Table 29). The percentage of episodes with at least 14 covered therapy visits was 17.2 percent in CY 2010 and decreased to 16.0 percent in CY 2011. In CY 2013 the percentage of episodes with at least 14 covered therapy visits increased to 16.3 percent. Likewise, the percentage of episodes with at least 20 covered therapy visits was 6.0 percent in CY 2010 and decreased to 5.4 percent in CY 2011. In CY 2013, the percentage of episodes with at least 20 covered therapy visits was 5.3 percent. We analyzed data for specific types of providers (for example, non-profit, for profit, freestanding, facility-based), and we found the similar trends in the number of episodes with at least 14 and 20 covered therapy visits. For example, for non-profit HHAs, the percentage of episodes with at least 14 covered therapy visits decreased from 11.8 percent in CY 2010 to 11.1 in CY 2011 and episodes with at least 20 covered therapy visits decreased from 4.2 percent in CY 2010 to 3.9 percent in CY 2011. For proprietary HHAs, the percentage of episodes with at least 14 covered therapy visits decreased from 19.7 percent in CY 2010 to 18.2 percent in CY 2011 and episodes with at least 20 covered therapy visits decreased from 6.8 percent in CY 2010 to 6.1 percent in CY 2011.

As we stated in section III.A of this proposed rule, in addition to the implementation of the therapy reassessment requirements in CY 2011, HHAs were also subject to the Affordable Care Act face-to-face encounter requirement, payments were reduced to account for increases nominal case-mix, and the Affordable Care Act mandated that the HH PPS payment rates be reduced by 5 percent to pay up to, but no more than 2.5 percent of total HH PPS payments as outlier payments. The estimated net impact to HHAs for CY 2011 was a decrease in total HH PPS payments of 4.78 percent. The independent effects of any one policy may be difficult to discern in years where multiple policy changes occur in any given year. We note that in our CY 2012 HH PPS final rule (76 FR 68526), we recalibrated and reduced the HH PPS case-mix weights for episodes reaching 14 and 20 therapy visits, thereby greatly diminishing the payment incentive for episodes at those therapy thresholds.

TABLE 29—PERCENTAGE OF EPISODES WITH 14 AND 20 THERAPY VISITS, CY 2010 THROUGH 2013

Calendar year	Episodes with at least 1 covered therapy visit	Episodes with at least 14 covered therapy visits	Episodes with at least 20 covered therapy visits
2010	54.1%	17.2%	6.0%
2011	54.2%	16.0%	5.4%
2012	55.2%	15.6%	5.2%
2013	56.3%	16.3%	5.3%

Source: CY 2010 claims from the Datalink file and CY 2011 through CY 2013 claims from the standard analytic file (SAF).
Note(s): For CY 2010, we included all episodes that began on or after January 1, 2010 and ended on or before December 31, 2010 and we included a 20% sample of episodes that began in CY 2009 but ended in CY 2010. For CY 2011 and CY 2013, we included all episodes that ended on or before December 31 of that CY (including 100% of episodes that began in the previous CY, but ended in the current CY).

Since the therapy reassessment requirements were implemented in CY 2011, providers have expressed frustration regarding the timing of reassessments for multi-discipline therapy episodes. In multiple therapy episodes, therapists must communicate when a planned visit and/or reassessment is missed to accurately track and count visits. Otherwise, therapy reassessments may be in jeopardy of not being performed during the required timeframe increasing the risk of subsequent visits being non-covered. As stated above, our recent analysis of claims data from CY 2010 through CY 2013 shows no significant change in the percentage of cases reaching the 14 therapy visit and 20 therapy visit thresholds between CY 2010 and CY 2011. Moreover, payment increases at the 14 therapy visit and 20 therapy visit thresholds have been mitigated since the recalibration of the case-mix weights in CY 2012. Therefore, we propose to simplify § 409.44(c)(2) to require a qualified therapist (instead of an assistant) from each discipline to provide the needed therapy service and functionally reassess the patient in

accordance with § 409.44(c)(2)(i)(A) at least every 14 calendar days.

The requirement to perform a therapy reassessment at least once every 14 calendar days would apply to all episodes regardless of the number of therapy visits provided. All other requirements related to therapy reassessments would remain unchanged, such as a qualified therapist (instead of an assistant), from each therapy discipline provided, would still be required to provide the ordered therapy service and functionally reassess the patient using a method which would include objective measurements. The measurement results and corresponding effectiveness of the therapy, or lack thereof, would be documented in the clinical record. We believe that revising this requirement would make it easier and less burdensome for HHAs to track and to schedule therapy reassessments every 14 calendar days as opposed to tracking and counting therapy visits, especially for multiple-discipline therapy episodes. We also believe that this proposal would reduce the risk of non-covered visits so that therapists could focus more on providing quality care for their patients, while still promoting therapist involvement and quality treatment for all beneficiaries, regardless of the level of therapy provided.

We invite comment on this proposal and the associated change in the regulation at § 409.44 in section VI. of this proposed rule.

I. HHA Value-Based Purchasing Model

As we discussed previously in the FY 2009 proposed rule for Skilled Nursing Facilities (73 FR 25918, 25932, May 7, 2008), value-based purchasing (VBP) programs, in general, are intended to tie a provider's payment to its performance in such a way as to reduce inappropriate or poorly furnished care and identify and reward those who furnish quality patient care. Section 3006(b)(1) of the Affordable Care Act directed the Secretary to develop a plan to implement a VBP program for home health agencies (HHAs) and to issue an associated Report to Congress (Report). The Secretary issued that Report, which is available online at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/stage-2-NPRM.PDF*.

The Report included a roadmap for HHA VBP implementation. The Report outlined the need to develop a HHA VBP program that aligns with other Medicare programs and coordinates incentives to improve quality. The Report indicated that a HHA VBP program should build on and refine existing quality measurement tools and processes. In addition, the Report indicated that one of the ways that such a program could link payment to quality would be to tie payments to overall quality performance.

Section 402 of Public Law 92–603 provided authority for the CMS to conduct the Home Health Pay-for-Performance (HHPFP) Demonstration that ran from 2008 to 2010. The results of that Demonstration found limited quality improvement in certain measures after comparing the quality of care furnished by Demonstration participants to the quality of care furnished by the control group. One important lesson learned from the HHPFP Demonstration was the need to link the home health agency's quality improvement efforts and the incentives. HHAs in three of the four regions generated enough savings to have incentive payments in the first year of the Demonstration, but the size of payments were unknown until after the conclusion of the Demonstration. This time lag on paying incentive payments did not provide a sufficient incentive to HHAs to make investments necessary to improve quality. The Demonstration suggested that future models could benefit from ensuring that incentives are reliable enough, of sufficient magnitude, and paid in a timely fashion to encourage HHAs to be fully engaged in the quality of care initiative. The evaluation report is available online at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/Downloads/HHP4P_Demo_Eval_Final_Vol1.pdf*.

We have already successfully implemented the Hospital Value-Based Purchasing (HVBP) program where 1.25 percent of hospital payments in FY 2014 are tied to the quality of care that the hospitals provide. This percentage amount will gradually increase to 2.0 percent in FY 2017 and subsequent years. The President's 2015 Budget proposes that value-based purchasing should be extended to additional providers including skilled nursing facilities, home health agencies, ambulatory surgical centers, and hospital outpatient departments. Therefore, we are now considering testing a HHA VBP model that builds on what we have learned from the HVBP program. The model also presents an opportunity to test whether larger incentives than what have been previously tested will lead to even greater improvement in the quality of care furnished to beneficiaries. The HHA VBP model that is being considered would offer both a greater potential reward for high performing HHAs as well as a greater potential downside risk for low performing HHAs. If implemented, the model would begin at the outset of CY 2016, and include an array of measures that can capture the multiple dimensions of care that HHAs furnish. Building upon the successes of other related programs, we are seeking to implement a model with greater upside benefit and downside risk to motivate HHAs to make the substantive investments necessary to improve the quality of care furnished by HHAs.

As currently envisioned, the HHA VBP model would reduce or increase Medicare payments, in a 5–8 percent range, depending on the degree of quality performance in various measures to be selected. The model would apply to all HHAs in each of the projected five to eight states selected to participate in the model. The distribution of payments would be based on quality performance, as measured by both achievement and improvement across multiple quality measures. Some HHAs would receive higher payments than standard fee-for-service payments and some HHAs would receive lower payments, similar to the HVBP program. We believe the payment adjustment at risk would provide an incentive among all HHAs to provide significantly better quality through improved planning, coordination, and management of care. To be eligible for any incentive payments, HHAs would need to achieve a minimal threshold in quality performance with respect to the care that they furnish. The size of the award would be dependent on the level of quality furnished above the minimal threshold with the highest performance awards going to HHAs with the highest overall level of or improvement in quality.

HHAs that meet or exceed the performance standards based on quality and efficiency metrics would be eligible to earn performance payments. The size of the performance payment would be dependent upon the provider's performance relative to other HHAs within its participating state. HHAs that exceed the performance standards and demonstrate the greatest level of overall quality or quality improvement on the selected measures would have the opportunity to receive performance payment adjustments greater than the amount of the payment reduction, and would therefore see a net payment increase as a result of this model. Those HHAs that fail to meet the performance standard would receive lower payments than what would have been reimbursed

under the traditional FFS Medicare payment system, and would therefore see a net payment decrease to Medicare payments as a result of this model. We are proposing to use the waiver authority under section 1115A of the Act to waive the applicable Medicare payment provisions for HHAs in the selected states and apply a reduction or increase to current Medicare payments to these HHAs, which would be dependent on their performance.

We are considering an HHA VBP model in which participation by all HHAs in five to eight selected states is mandatory. We believe requiring all HHAs in selected states to participate in the model will ensure that: (1) There is no selection bias, (2) participating HHAs are representative of HHAs nationally, and (3) there is sufficient participation to generate meaningful results. In our experience, providers are generally reluctant to participate voluntarily in models in which their Medicare payments are subject to reduction. In this proposed rule, we invite comments on the HHA VBP model outlined above, including elements of the model, size of the payment incentives and percentage of payments that would need to be placed at risk in order to spur HHAs to make the necessary investments to improve the quality of care for Medicare beneficiaries, the timing of the incentive payments, and how performance payments should be distributed. We also invite comments on the best approach for selecting states for participation in this model. Approaches could include: (1) Selecting states randomly, (2) selecting states based on quality, utilization, health IT, or efficiency metrics or a combination, or (3) other considerations.

We note that if we decide to move forward with the implementation of this HHA VBP model in CY 2016, we intend to invite additional comments on a more detailed model proposal to be included in future rulemaking.

J. Advancing Health Information Exchange

HHS believes all patients, their families, and their healthcare providers should have consistent and timely access to their health information in a standardized format that can be securely exchanged between the patient, providers, and others involved in the patient's care. (HHS August 2013 Statement, ''Principles and Strategies for Accelerating Health Information Exchange.'') The Department is committed to accelerating health information exchange (HIE) through the use of electronic health records (EHRs) and other types of health information technology (HIT) across the broader care continuum through a number of initiatives including: (1) Alignment of incentives and payment adjustments to encourage provider adoption and optimization of HIT and HIE services through Medicare and Medicaid payment policies, (2) adoption of common standards and certification requirements for interoperable HIT, (3) support for privacy and security of patient information across all HIE-focused initiatives, and (4) governance of health information networks. These initiatives are designed to encourage HIE among all health care providers, including professionals and hospitals eligible for the Medicare and Medicaid EHR Incentive Programs and those who are not eligible for the EHR Incentive programs, and are designed to improve care delivery and coordination across the entire care continuum. To increase flexibility in the Office of the National Coordinator for Health Information Technology's (ONC) regulatory certification structure and expand HIT certification, ONC has proposed a voluntary 2015 Edition EHR Certification rule to more easily accommodate HIT certification for technology used by other types of health care settings where individual or institutional health care providers are not typically eligible for incentive payments under the EHR Incentive Programs, such as long-term and post-acute care and behavioral health settings (79 FR 10880).

We believe that HIE and the use of certified EHRs by HHAs (and other providers ineligible for the Medicare and Medicaid EHR Incentive programs) can effectively and efficiently help providers improve internal care delivery practices, support management of patient care across the continuum, and enable the reporting of electronically specified clinical quality measures (eCQMs). More information on the identification of EHR certification criteria and development of standards applicable to HH can be found at:

- *http://healthit.gov/policy-researchers-implementers/standards-and-certification-regulations*
- *http://www.healthit.gov/facas/FACAS/health-it-policy-committee/hitpc-workgroups/certificationadoption*
- *http://wiki.siframework.org/LCC+LTPAC+Care+Transition+SWG*
- *http://wiki.siframework.org/Longitudinal+Coordination+of+Care*

K. Proposed Revisions to the Speech-Language Pathologist Personnel Qualifications

We propose to revise the personnel qualifications for speech-language pathologists (SLP) to more closely align the regulatory requirements with those set forth in section 1861(ll) of the Act. We propose to require that a qualified SLP be an individual who has a master's or doctoral degree in speech-language pathology, and who is licensed as a speech-language pathologist by the State in which he or she furnishes such services. To the extent of our knowledge, all states license SLPs; therefore, all SLPs would be covered by this option. We believe that deferring to the states to establish specific SLP requirements would allow all appropriate SLPs to provide services to Medicare beneficiaries. Should a state choose to not offer licensure at some point in the future, we propose a second, more specific, option for qualification. In that circumstance, we would require that an SLP successfully complete 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience); perform not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field; and successfully complete a national examination in speech-language pathology approved by the Secretary. These specific requirements are set forth in the Act, and we believe that they are appropriate for inclusion in the regulations as well.

We invite comments on this technical correction and associated change in the regulations at § 484.4 in section VI.

L. Proposed Technical Regulations Text Changes

We propose to make technical corrections in § 424.22(b)(1) to better align the recertification requirements with the Medicare Conditions of Participation (CoPs) for home health services. Specifically, we propose that § 424.22(b)(1) would specify that recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode to coincide with the CoP requirements in § 484.55(d)(1), which require the HHA to update the comprehensive assessment in the last 5 days of every 60-day episode of care. As stated in § 484.55, the comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. We also propose to specify in § 424.22(b)(1) that recertification is required at least every 60 days *unless* there is a beneficiary elected transfer or a discharge with goals met and return to the same HHA

during the 60-day episode. The word ''unless'' was inadvertently left out of the payment regulations text. Inserting ''unless'' into § 424.22(b) (1) realigns the recertification requirements with the CoPs at § 484.55(d)(1).

As outlined in the ''Medicare Program; Prospective Payment System for Home Health Agencies'' final rule published on July 3, 2000 (65 FR 41188 through 41190), a partial episode payment (PEP) adjustment applies to two intervening events: (1) Where the beneficiary elects a transfer to another HHA during a 60-day episode or the patient; or (2) a discharge and return to the same HHA during the 60-day episode when a beneficiary reached the treatment goals in the plan of care. To discharge with goals met, the plan of care must be terminated with no anticipated need for additional home health services for the balance of the 60-day period. A PEP adjustment proportionally adjusts the national, standardized 60-day episode payment amount to reflect the length of time the beneficiary remained under the agency's care before the intervening event.

We propose to revise § 424.22(b)(1)(ii) to clarify that if a beneficiary is discharged with goals met and/or no expectation of a return to home health care and returns to the same HHA during the 60-day episode a new start of care would be initiated (rather than an update to the comprehensive assessment) and thus the second episode would be considered a certification, not a recertification,[32] and would be subject to § 424.22(a)(1).

We also propose to make a technical correction in § 484.250(a)(1) to remove the ''-C'' after ''OASIS'' in § 484.250(a)(1), so that the regulation refers generically to the version of OASIS currently approved by the Secretary, and to align this section with the payment regulations at § 484.210(e). Specifically, an HHA must submit to CMS the OASIS data described at § 484.55(b)(1) and (d)(1) for CMS to administer the payment rate methodologies described in § 484.215, § 484.230, and § 484.235 and to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

We invite comments on these technical corrections and associated changes in the regulations at § 424.22 and § 484.250 in section VI.

[32] *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISConsiderationsforPPS.pdf.*

M. Survey and Enforcement Requirements for Home Health Agencies

1. Statutory Background and Authority

Section 4023 of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L 100–203, enacted on December 22, 1987) added subsections 1891(e) and (f) to the Act, which expanded the Secretary's options to enforce federal requirements for home health agencies (HHAs or the agency). Sections 1861(e)(1) and (2) of the Act provide that if CMS determines that an HHA is not in compliance with the Medicare home health Conditions of Participation and the deficiencies involved either do or do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, then we may terminate the provider agreement, impose an alternative sanction(s), or both. Section 1891(f)(1)(B) of the Act authorizes the Secretary to develop and implement appropriate procedures for appealing determinations relating to the imposition of alternative sanctions.

In the November 8, 2012 **Federal Register** (77 FR 67068), we published in the ''Alternative Sanctions for Home Health Agencies With Deficiencies'' final rule (part 488, subpart J), as well as made corresponding revisions to sections § 489.53 and § 498.3. This subpart J added the rules for enforcement actions for HHAs including alternative sanctions. Section 488.810(g) provides that 42 CFR part 498 applies when an HHA requests a hearing on a determination of noncompliance that leads to the imposition of a sanction, including termination. Section 488.845(b) describes the ranges of CMPs that may be imposed for all condition-level findings: upper range ($8,500 to $10,000); middle range ($1,500 to $8,500); lower range ($500 to $4,000), as well as CMPs imposed per instance of noncompliance ($1,000 to $10,000).

Section 488.845(c)(2) addresses the appeals procedures when CMPs are imposed, including the need for any appeal request to meet the requirements of § 498.40 and the option for waiver of a hearing.

2. Reviewability Pursuant to Appeals

We propose to amend § 488.845 by adding a new paragraph (h) which would explain the reviewability of a CMP that is imposed on a HHA for noncompliance with federal participation requirements. The new language will provide that when administrative law judges, state hearing officers (or higher administrative review authorities) find that the basis for imposing a civil money penalty exists, as specified in § 488.485, he or she may not set a penalty of zero or reduce a penalty to zero; review the exercise of discretion by CMS or the state to impose a civil money penalty; or, in reviewing the amount of the penalty, consider any factors other than those specified in § 488.485(b)(1)(i) through (b)(1)(iv). That is, when the administrative law judge or state hearing officer (or higher administrative authority) finds noncompliance supporting the imposition of the CMP, he or she must retain some amount of penalty consistent with the ranges of penalty amounts established in § 488.845(b). The proposed language for HHA reviews is similar to the current § 488.438(e) governing the scope of review for civil money penalties imposed against skilled nursing facilities, and is also consistent with section 1128A(d) of the Act which requires that specific factors be considered in determining the amount of any penalty.

3. Technical Adjustment

We are also proposing to amend § 498.3, Scope and Applicability, by revising paragraph (b)(13) to include specific cross reference to proposed § 488.845(h) and to revise the reference to section § 488.740 which was a typographical error and replace it with section § 488.820 which is the actual section that lists the sanctions available to be imposed against an HHA. We are also amending § 498.3(b)(14)(i) to include cross reference to proposed § 488.845(h) which establishes the scope of CMP review for HHAs. Finally, we are proposing to amend § 498.60 to include specific references to HHAs and proposed § 488.845(h).

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 requirement is submitted to the Office of Management and Budget (OMB) for review and approval. 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 the information collection requirement (ICR) related to the proposed changes to the home health face-to-face encounter requirements in section III.B and the proposed change to the therapy reassessment timeframes in section III.H. These proposed changes are associated with ICR approved under OMB control number as 0938–1083.

A. Proposed Changes to the Face-to-Face Encounter Requirements

The following assumptions were used in estimating the burden for the proposed changes to the home health face-to-face requirements:

TABLE 30—HOME HEALTH FACE-TO-FACE ENCOUNTER BURDEN ESTIMATE ASSUMPTIONS

Number of Medicare-billing HHAs, from CY 2013 claims with matched OASIS assessments	11,521
Hourly rate of an office employee (Executive Secretaries and Executive Administrative Assistants, 43–6014)	$20.54 ($15.80 × 1.30)
Hourly rate of an administrator (General and Operations Managers, 11–1021)	$64.65 ($49.73 × 1.30)
Hourly rate of Family and General Practitioners (29–1062)	$112.91 ($86.85 × 1.30)

Note: CY = Calendar Year

All salary information is from the Bureau of Labor Statistics (BLS) Web site at *http://www.bls.gov/oes/current/naics4_621600.htm* and includes a fringe benefits package worth 30 percent of the base salary. The mean hourly wage rates are based on May 2013 BLS data for each discipline, for those providing ''home health care services.''

1. Proposed Changes to the Face-to-Face Encounter Narrative Requirement

Sections 1814(a)(2)(C) and 1835 (a)(2)(A) of the Act, as amended by section 6407 of the Affordable Care Act require that, as a condition for payment, prior to certifying a patient's eligibility for the Medicare home health benefit the physician must document that the physician himself or herself or an allowed nonphysician practitioner (NPP) had a face-to-face encounter with the patient. Section 424.22(a)(1)(v) currently requires that the face-to-face encounter be related to the primary reason the patient requires home health services and occur no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care. In addition, as part of the certification of eligibility, the certifying physician must document the date of the encounter and include an explanation (narrative) of why the clinical findings of such encounter support that the patient is homebound, as defined in section 1835(a) of the Act, and in need of either intermittent skilled nursing services or therapy services, as defined in § 409.42(c).

To simplify the face-to-face encounter regulations, reduce burden for HHAs and physicians, and to mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements, we propose to eliminate the narrative requirement at § 424.22(a)(1)(v). The certifying physician will still be required to certify that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in § 424.22(a)(1)(v)(A), and to document the date of the encounter as part of the certification of eligibility.

In eliminating the face-to-face encounter narrative requirement, we assume that there will be a one-time burden for the HHA to modify the certification form, which the HHA provides to the certifying physician. The revised certification form must allow the certifying physician to certify that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed NPP as defined in § 424.22(a)(1)(v)(A). In addition, the certification form must allow the certifying physician to document the date that the face-to-face encounter occurred.

We estimate that it would take a home health clerical staff person 15 minutes (15/60 = 0.25 hours) to modify the certification form, and the HHA administrator 15 minutes (15/60 = 0.25 hours) to review the revised form. The clerical time plus administrator time equals a one-time burden of 30 minutes or (30/60) = 0.50 hours per HHA. For all 11,521 HHAs, the total time required would be (0.50 × 11,521) = 5,761 hours. At $20.54 per hour for an office employee, the cost per HHA would be (0.25 × $20.54) = $5.14. At $64.65 per hour for the administrator's time, the cost per HHA would be (0.25 × $64.65) = $16.16. Therefore, the total one-time cost per HHA would be $21.30, and the total one-time cost for all HHAs would be ($21.30 × 11,521) = $245,397.

In the CY 2011 HH PPS final rule (75 FR 70455), we estimated that the certifying physician's burden for composing the face-to-face encounter narrative, which includes how the clinical findings of the encounter support eligibility (writing, typing, or dictating the face-to-face encounter narrative) signing, and dating the patient's face-to-face encounter, was 5 minutes for each certification (5/60 = 0.0833 hours). Because it has been our longstanding manual policy that physicians sign and date certifications and recertifications, there is no additional burden to physicians for signing and dating the face-to-face encounter documentation. We estimate that there would be 3,096,680 initial home health episodes in a year based on 2012 claims data from the home health Datalink file. As such, the estimated burden for the certifying physician to write the face-to-face encounter narrative would have been 0.0833 hours per certification (5/60 = 0.0833 hours) or 257,953 hours total (0.0833 hours × 3,096,680 initial home health episodes). The estimated cost for the certifying physician to write the face-to-face encounter narrative would have been $9.41 per certification (0.0833 × $112.91) or $29,139,759 total ($9.41 × 3,096,680) for CY 2015.

Although we are proposing to eliminate the narrative, the certifying physician will still be required to document the date of the face-to-face encounter as part of the certification of eligibility. We estimate that it would take no more than 1 minute for the certifying physician to document the date that the face-to-face encounter occurred (1/60 = 0.0166 hours). The estimated burden for the certifying physician to continue to document the date of the face-to-face encounter would be 0.0166 hours per certification or 51,405 hours total (0.0166 hours × 3,096,680 initial home health episodes). The estimated cost for the certifying physician to continue to document the date of the face-to-face encounter would be $1.87 per certification (0.0166 ×

$112.91) or $5,790,792 total ($1.87 × 3,096,680) for CY 2015. Therefore, in eliminating the face-to-face encounter narrative requirement, as proposed in section III.B. of this proposed rule, we estimate that burden and costs will be reduced for certifying physicians by 206,548 hours (257,953 − 51,405) and $23,348,967 ($29,139,759 − $5,790,792), respectively for CY 2015.

2. Proposed Clarification on When Documentation of a Face-to-Face Encounter is Required

To determine when documentation of a patient's face-to-face encounter is required under sections 1814(a)(2)(C) and 1835 (a)(2)(A) of the Act, we are proposing to clarify that the face-to-face encounter requirement is applicable for certifications (not recertifications), rather than initial episodes. A certification (versus recertification) is generally considered to be any time that a new start of care OASIS is completed to initiate care. We estimate that of the 6,562,856 episodes in the CY 2012 home health Datalink file, 3,096,680 start of care assessments were performed on initial home health episodes. If this proposal is implemented, an additional 830,287 episodes would require documentation of a face-to-face encounter for subsequent episodes that were initiated with a new start of care OASIS assessment. We estimate that it would take no more than 1 minute for the certifying physician to document the date that the face-to-face encounter occurred (1/60 = 0.0166 hours). The estimated burden for the certifying physician to document the date of the face-to-face encounter for each certification (any time a new start of care OASIS is completed to initiate care) would be 0.0166 hours or 13,783 total hours (0.0166 hours × 830,287 additional home health episodes). The estimated cost for the certifying physician to document the date of the face-to-face encounter for each additional home health episode would be $1.87 per certification (0.0166 × $112.91) or $1,552,637 total ($1.87 × 830,287) for CY 2015.

TABLE 31—ESTIMATED ONE-TIME FORM REVISION BURDEN FOR HHAS

OMB No.	Requirement	HHAs	Responses	Hr. burden	Total time	Total dollars
0938–1083	§ 424.22(a)(1)(v)	11,521	1	0.5 hour	5,761 hours	$245,397

TABLE 32—ESTIMATED BURDEN REDUCTION FOR CERTIFYING PHYSICIANS

[No Longer Drafting a Face-to-Face Encounter Narrative]

OMB No.	Requirement	Certifi-cations	Responses	Hr. burden	Total time	Total dollars
0938–1083	§ 424.22(a)(1)(v)	3,096,680	1	(0.0667) hour	(206,548) hours	($23,348,967)

TABLE 33—ESTIMATED BURDEN FOR CERTIFYING PHYSICIANS

[Documenting the Date of the Face-to-Face Encounter for Additional Certifications]

OMB No.	Requirement	Certifi-cations	Responses	Hr. burden	Total time	Total dollars
0938–1083	§ 424.22(a)(1)(v)	830,287	1	0.0166 hour	13,783 hours	$1,552,637

In summary, all of the proposed changes to the face-to-face encounter requirements in section III.B of this proposed rule, including changes to § 424.22(a)(1)(v), will result in an estimated net reduction in burden for certifying physicians of 192,765 hours or $21,796,330 (see Tables 32 and 33). The proposed changes to the face-to-face encounter requirements at § 424.22(a)(1)(v) will result in a one-time burden for HHAs to revise the certification form of 5,761 hours or $245,397 (Table 31).

B. Proposed Change to the Therapy Reassessment Timeframes

Currently, section 409.44(c) requires that patient's function must be initially assessed and periodically reassessed by a qualified therapist, of the corresponding discipline for the type of therapy being provided, using a method which would include objective measurement. If more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must perform the assessment and periodic reassessments. The measurement results and corresponding effectiveness of the therapy, or lack thereof, must be documented in the clinical record. At least every 30 days a qualified therapist (instead of an assistant) must provide the needed therapy service and functionally reassess the patient. If a patient is expected to require 13 and/or 19 therapy visits, a qualified therapist (instead of an assistant) must provide all of the therapy services on the 13th visit and/or 19th therapy visit and functionally reassess the patient in accordance with § 409.44(c)(2)(i)(A). When the patient resides in a rural area or if the patient is receiving multiple types of therapy, a therapist from each discipline (not an assistant) must assess the patient after the 10th therapy visit but no later than the 13th therapy visit and after the 16th therapy visit but no later than the 19th therapy visit for the plan of care. In instances where the frequency of a particular discipline, as ordered by a physician, does not make it feasible for the reassessment to occur during the specified timeframes without providing an extra unnecessary visit or delaying a visit, then it is acceptable for the qualified therapist from that discipline to provide all of the therapy and functionally reassess the patient during the visit associated with that discipline that is scheduled to occur closest to the 14th and/or 20th Medicare-covered therapy visit, but no later than the 13th and/or 19th Medicare-covered therapy visit. When a therapy reassessment is missed, any visits for that discipline prior to the next reassessment are non-covered.

To lessen the burden on HHAs of counting visits and to reduce the risk of noncovered visits so that therapists can focus more on providing quality care for their patients, we propose to simplify § 409.44(c) to require that therapy reassessments must be performed at least once every 14 calendar days. The requirement to perform a therapy reassessment at least once every 14 calendar days would apply to all episodes regardless of the number of therapy visits provided. All other requirements related to therapy reassessments would remain unchanged. A qualified therapist (instead of an assistant), from each therapy discipline provided, must provide the ordered therapy service and functionally reassess the patient using a method which would include objective measurement. The measurement results and corresponding effectiveness of the therapy, or lack thereof, must be documented in the clinical record.

In the CY 2011 HH PPS final rule we stated that the therapy reassessment requirements in § 409.44(c) are already part of the home health CoPs, as well as from accepted standards of clinical practice, and therefore, we believe that these requirements do not create any additional burden on HHAs (75 FR 70454). As stated in the CY 2011 HH PPS final rule, longstanding CoP policy at § 484.55 requires HHAs to document progress toward goals and the regulations at § 409.44(c)(2)(i) already mandate that for therapy services to be covered in the home health setting, the services must be considered under accepted practice to be a specific, safe, and effective treatment for the beneficiary's condition. The functional assessment does not require a special visit to the patient, but is conducted as part of a regularly scheduled therapy visit. Functional assessments are necessary to demonstrate progress (or the lack thereof) toward therapy goals, and are already part of accepted standards of clinical practice, which include assessing a patient's function on an ongoing basis as part of each visit. The CY 2011 HH PPS final rule goes on to state that both the functional assessment and its accompanying documentation are already part of existing HHA practices and accepted standards of clinical practice. Therefore, we continue to believe that changing the required reassessment timeframes from every 30 days and prior to the 14th and 20th visits to every 14 calendar days does not place any new documentation requirements on HHAs.

We are revising the currently approved PRA package (OMB# 0938–1083) to describe these changes to the regulatory text.

C. Submission of PRA-Related Comments

If you comment on these information collection and recordkeeping requirements, please submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule.

PRA-specific comments must be received on/by August 6, 2014.

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. Introduction

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA, March 22, 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 Orders 12866 and 13563 direct 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This proposed rule has been designated as economically significant under section 3(f)(1) of Executive Order 12866, since the aggregate transfer impacts in calendar year 2015 will exceed the $100 million threshold. The net transfer impacts are estimated to be −$58 million. Furthermore, we estimate a net reduction of $21.55 million in calendar year 2015 burden costs related to the certification requirements for home health agencies and associated physicians. Lastly, this proposed rule is a major rule under the Congressional Review Act and as a result, we have prepared a regulatory impact analysis (RIA) that, to the best of our ability, presents the costs and benefits of the rulemaking. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

B. Statement of Need

Section 1895(b)(1) of the Act requires the Secretary to establish a HH PPS for all costs of HH services paid under Medicare. In addition, section 1895(b)(3)(A) of the Act requires (1) the computation of a standard prospective payment amount include all costs for HH services covered and paid for on a reasonable cost basis and that such amounts be initially based on the most recent audited cost report data available to the Secretary, and (2) the standardized prospective payment amount be adjusted to account for 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 HH 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 appropriate case-mix adjustment factors for significant variation in costs among different units of services. Lastly, 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 HH services furnished in a geographic area compared to the applicable national average level.

Section 1895(b)(5) of the Act gives the Secretary the option to make changes to the payment amount otherwise paid in the case of outliers because of unusual variations in the type or amount of medically necessary care. Section 1895(b)(3)(B)(v) of the Act requires HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to the annual applicable percentage increase. Also, section 1886(d)(2)(D) of the Act requires that HH services furnished in a rural area for episodes and visits ending on or after April 1, 2010, and before January 1, 2016, receive an increase of 3 percent the payment amount

otherwise made under section 1895 of the Act.

Section 3131(a) of the Affordable Care Act mandates that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of enactment (2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented in CY 2017.

C. Overall Impact

The update set forth in this rule applies to Medicare payments under HH PPS in CY 2015. Accordingly, the following analysis describes the impact in CY 2015 only. We estimate that the net impact of the proposals in this rule is approximately $58 million in decreased payments to HHAs in CY 2015. We applied a wage index budget neutrality factor and a case-mix weights budget neutrality factor to the rates as discussed in section III.D.4. of this proposed rule; therefore, the estimated impact of the 2015 wage index proposed in section III.D.3. of this proposed rule and the recalibration of the case-mix weights for 2015 proposed in section III.C. of this proposed rule is zero. The −$58 million impact reflects the distributional effects of the 2.2 percent HH payment update percentage ($427 million increase) and the effects of the second year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit payment rates, and the NRS conversion factor for an impact of −2.5 percent ($485 million decrease). The $58 million in decreased payments is reflected in the last column of the first row in Table 34 as a 0.3 percent decrease in expenditures when comparing CY 2014 payments to estimated CY 2015 payments.

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 less than $7.0 million to $35.5 million in any one year. For the purposes of the RFA, we estimate that almost all HHAs are small entities as that term is used in the RFA. Individuals and states are not included in the definition of a small entity. The economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically "significant" only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of HHAs' visits are Medicare-paid visits and therefore the majority of HHAs' revenue consists of Medicare payments. Based on our analysis, we conclude that the policies proposed in this rule will not result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of HHAs. Therefore, the Secretary has determined that this proposed rule will not have a significant economic impact on a substantial number of small entities. Further detail is presented in Table 34, by HHA type and location.

Executive Order 13563 specifies, to the extent practicable, agencies should assess the costs of cumulative regulations. However, given potential utilization pattern changes, wage index changes, changes to the market basket forecasts, and unknowns regarding future policy changes, we believe it is neither practicable nor appropriate to forecast the cumulative impact of the rebasing adjustments on Medicare payments to HHAs for future years at this time. Changes to the Medicare program may continue to be made as a result of the Affordable Care Act, 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 would make it difficult to predict accurately the full scope of the impact upon HHAs for future years beyond CY 2015. We note that the rebasing adjustments to the national, standardized 60-day episode payment rate and the national per-visit rates are capped at the statutory limit of 3.5 percent of the CY 2010 amounts (as described in the preamble in section II.C. of this proposed rule) for each year, 2014 through 2017. The NRS rebasing adjustment will be −2.82 percent in each year, 2014 through 2017.

In addition, section 1102(b) of the Act requires us to prepare a RIA 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 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 HHAs. Therefore, the Secretary has determined that this rule will not have a significant economic impact on the operations of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately $141 million. 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 $141 million or more in CY 2015.

D. Detailed Economic Analysis

This proposed rule sets forth updates for CY 2015 to the HH PPS rates contained in the CY 2014 HH PPS final rule (78 FR 72304 through 72308). 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 HH benefit, primarily on preliminary Medicare claims from 2013. 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 Affordable Care Act, 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 34 represents how HHA revenues are likely to be affected by the policy changes proposed in this rule. For this analysis, we used an analytic file with linked CY 2013 HH claims data (as of December 31, 2013) for dates of service that ended on or before December 31, 2013, and OASIS assessments. The first column of Table 34 classifies HHAs according to a number of characteristics including provider type, geographic region, and urban and rural locations. The third column shows the payment effects of proposed CY 2015 wage index. The fourth column shows the payment effects of the proposed CY 2015 case-mix weights. The fifth column shows the effects of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and NRS conversion factor. The sixth column shows the effects of the CY 2015 home health payment update percentage (the home health market basket update adjusted for multifactor productivity as discussed in section III.D.1. of this proposed rule). The last column shows the payment effects of all the proposed policies.

Overall, HHAs are anticipated to experience a 0.3 percent decrease in payment in CY 2015, with freestanding HHAs anticipated to experience a 0.3 percent decrease in payments while facility-based HHAs and non-profit HHAs are anticipated to experience a 0.4 percent and a 0.6 percent increase in payments, respectively. Government-owned HHAs are anticipated to experience a 0.3 percent decrease in payments and proprietary HHAs are anticipated to experience a 0.6 percent decrease in payments. Rural HHAs are anticipated to experience a decrease in payments of 0.5 percent with rural freestanding government-owned HHAs and rural facility-based proprietary HHAs both estimated to experience a −1.1 percent decrease in payments. In contrast, rural facility-based non-profit HHAs are estimated to experience a 0.5 percent increase in payments. Urban HHAs are anticipated to experience a decrease in payments of 0.2 percent. Urban freestanding proprietary HHAs estimated to experience a 0.5 percent decrease in payments, whereas urban freestanding and facility-based non-profit HHAs are estimated to experience a 0.6 percent increase in payments for CY 2015. The overall impact in the South is estimated to be a 0.9 percent decrease in payments whereas the overall impact in the North is estimated to be a 1.1 percent increase in payments. The West South Central census region is estimated to receive a 2.4 percent decrease in payments for CY 2015; however, in contrast, the New England census region is estimated to receive a 1.5 percent increase in payments for CY 2015. Finally, HHAs with less than 100 first episodes are anticipated to experience a 0.6 percent decrease in payments compared to a 0.00 percent decrease in payments in CY 2015 for HHAs with 1,000 or more first episodes. A substantial amount of the variation in the estimated impacts of the proposals in this proposed rule in different areas of the country can be attributed to variations in the CY 2015 wage index used to adjust payments under the HH PPS and to the effects of the recalibration of the case-mix weights. Instances where the impact, due to the rebasing adjustments, is less than others can be attributed to differences in the incidence of outlier payments and LUPA episodes, which are paid using the national per-visit payment rates that are subject to payment increases due to the rebasing adjustments. We note that some individual HHAs within the same group may experience different impacts on payments than others due to the distributional impact of the CY 2015 wage index, the extent to which HHAs had episodes in case-mix groups where the case-mix weight decreased for CY 2015 relative to CY 2014, and the degree of Medicare utilization.

For CY 2015, the average impact for all HHAs due to the effects of rebasing is an estimated 2.5 percent decrease in payments. The overall impact for all HHAs as a result of this proposed rule is a decrease of approximately 0.3 percent in estimated total payments from CY 2014 to CY 2015.

TABLE 34—ESTIMATED HOME HEALTH AGENCY IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTRY, CY 2015

	Number of agencies	Proposed CY 2015 wage index [1] (percent)	CY 2015 case-mix weights [2] (percent)	Rebasing [3] (percent)	CY 2015 HH payment update percentage [4] (percent)	Impact of all CY 2015 policies (percent)
All Agencies	11,521	0.0	0.0	−2.5	2.2	−0.3
Facility Type and Control:						
Free-Standing/Other Vol/NP	1,031	0.4	0.3	−2.3	2.2	0.6
Free-Standing/Other Proprietary	8,957	−0.1	−0.1	−2.5	2.2	−0.6
Free-Standing/Other Government	398	0.1	−0.3	−2.4	2.2	−0.4
Facility-Based Vol/NP	788	0.2	0.6	−2.4	2.2	0.6
Facility-Based Proprietary	113	−0.4	0.5	−2.5	2.2	−0.2
Facility-Based Government	234	−0.1	0.2	−2.4	2.2	−0.2
Subtotal: Freestanding	10,386	0.0	−0.1	−2.5	2.2	−0.3
Subtotal: Facility-based	1,135	0.2	0.5	−2.4	2.2	0.4
Subtotal: Vol/NP	1,819	0.3	0.4	−2.4	2.2	0.6
Subtotal: Proprietary	9,070	−0.1	−0.1	−2.5	2.2	−0.6
Subtotal: Government	632	0.0	−0.1	−2.4	2.2	−0.3
Facility Type and Control: Rural:						
Free-Standing/Other Vol/NP	193	−0.3	0.1	−2.4	2.2	−0.4
Free-Standing/Other Proprietary	136	0.4	−0.1	−2.5	2.2	0.0
Free-Standing/Other Government	459	0.0	−0.9	−2.4	2.2	−1.1
Facility-Based Vol/NP	255	0.4	0.4	−2.5	2.2	0.5
Facility-Based Proprietary	31	0.0	−0.8	−2.5	2.2	−1.1
Facility-Based Government	138	0.1	−0.1	−2.4	2.2	−0.1
Facility Type and Control: Urban:						
Free-Standing/Other Vol/NP	891	0.4	0.4	−2.3	2.2	0.6
Free-Standing/Other Proprietary	8,644	−0.1	−0.1	−2.5	2.2	−0.5
Free-Standing/Other Government	158	0.3	−0.3	−2.5	2.2	−0.3
Facility-Based Vol/NP	533	0.2	0.6	−2.4	2.2	0.6

TABLE 34—ESTIMATED HOME HEALTH AGENCY IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTRY, CY 2015—Continued

	Number of agencies	Proposed CY 2015 wage index [1] (percent)	CY 2015 case-mix weights [2] (percent)	Rebasing [3] (percent)	CY 2015 HH payment update percentage [4] (percent)	Impact of all CY 2015 policies (percent)
Facility-Based Proprietary	82	−0.5	0.7	−2.4	2.2	0.0
Facility-Based Government	96	−0.2	0.3	−2.5	2.2	−0.2
Facility Location: Urban or Rural:						0.0
Rural	1,117	0.1	−0.3	−2.4	2.2	−0.5
Urban	10,404	−0.0	0.0	−2.5	2.2	−0.2
Facility Location: Region of the Country:						
North	857	0.7	0.4	−2.2	2.2	1.1
Midwest	3,095	−0.1	0.5	−2.5	2.2	0.1
South	5,613	−0.3	−0.4	−2.5	2.2	−0.9
West	1,916	0.3	0.2	−2.4	2.2	0.3
Other	40	0.2	−0.4	−2.5	2.2	−0.5
Facility Location: Region of the Country (Census Region):						
New England	336	1.1	0.5	−2.3	2.2	1.5
Mid Atlantic	521	0.4	0.4	−2.2	2.2	0.8
East North Central	2,358	−0.1	0.4	−2.5	2.2	−0.1
West North Central	737	0.2	0.9	−2.5	2.2	0.8
South Atlantic	2,028	−0.3	1.1	−2.5	2.2	0.5
East South Central	438	−0.7	−0.3	−2.6	2.2	−1.4
West South Central	3,147	−0.2	−2.0	−2.5	2.2	−2.4
Mountain	679	−0.1	0.9	−2.4	2.2	0.7
Pacific	1,237	0.5	−0.1	−2.4	2.2	0.1
Facility Size (Number of 1st Episodes):						
<100 episodes	3,126	−0.2	−0.2	−2.5	2.2	−0.6
100 to 249	2,879	−0.2	−0.2	−2.5	2.2	−0.7
250 to 499	2,453	−0.2	−0.2	−2.5	2.2	−0.6
500 to 999	1,725	−0.1	0.0	−2.5	2.2	−0.4
1,000 or More	1,338	0.1	0.1	−2.4	2.2	0.0

Source: CY 2013 Medicare claims data for episodes ending on or before December 31, 2013 (as of December 31, 2013) for which we had a linked OASIS assessment.

[1] The impact of the proposed CY 2015 home health wage index reflects the transition to new CBSA designations as outlined in section III.D.3 of this proposed rule offset by the wage index budget neutrality factor described in section III.D.4 of this proposed rule.

[2] The impact of the proposed CY 2015 home health case-mix weights reflects the recalibration of the case-mix weights as outlined in section III.C of this proposed rule offset by the case-mix weights budget neutrality factor described in section III.D.4 of this proposed rule.

[3] The impact of rebasing includes the rebasing adjustments to the national, standardized 60-day episode payment rate (−2.75 percent after the CY 2014 payment rate was adjusted for the wage index and case-mix weight budget neutrality factors), the national per-visit rates (+3.26 percent), and the NRS conversion factor (−2.82%). The estimated impact of the NRS conversion factor rebasing adjustment is an overall −0.01 percent decrease in estimated payments to HHAs. The overall impact of all the rebasing adjustments finalized in the CY 2014 HH PPS proposed rule and implemented for CY 2015 are lower than the overall impact in the CY 2014 due to an increase in estimated outlier payments. As the national per-visit rates increase and the national, standardized 60-day episode rate decreases more episodes qualify for outlier payments. In addition, we decreased the fixed-dollar loss (FDL) ratio from 0.67 to 0.45 effective CY 2013 in order to qualify more episodes as outliers and we use CY 2013 utilization in simulating impacts for the CY 2015 HH PPS proposed rule.

[4] The CY 2015 home health payment update percentage reflects the home health market basket update of 2.6 percent, reduced by a 0.4 percentage point multifactor productivity (MFP) adjustment as required under section 1895(b)(3)(B)(vi)(I) of the Act, as described in section III.D.1 of this proposed rule.

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.

E. Alternatives Considered

In recalibrating the HH PPS case-mix weights for CY 2015, as proposed in section III.C. of this proposed rule, we considered adjusting the payment rates in section III.D.4 to make the recalibration budget neutral only with regards to our estimate of real case-mix growth between CY 2012 and the CY 2013. Section 1895(b)(3)(B)(iv) of the Act gives CMS the authority to implement payment reductions for nominal case-mix growth—changes in case-mix that are unrelated to actual changes in patient health status. If we were to implement the recalibration of the case-mix weights outlined in section III.C in a budget neutral manner only with regards to our estimate of real case-mix growth between CY 2012 and CY 2013, we estimate that the aggregate impact would be a net decrease of $410 million in payments to HHAs, resulting from a $485 million decrease due to the second year of the Affordable Care Act mandated rebasing adjustments, a $427 million increase due to the home health payment update percentage, and a $350 million decrease (−1.8 percent) due to only making the case-mix weights recalibration budget neutral with regards to our estimate of real increases in patient severity. However, instead of implementing a case-mix budget neutrality factor that only reflects our estimate of real increases in patient severity; we plan to recalibrate the case-mix weights in a fully budget-neutral manner and continue to monitor case-

mix growth (both real and nominal case-mix growth) as more data become available.

With regard to the proposal discussed in section III.D.3 of this proposed rule related to our adoption of the revised OMB delineations for purposes of calculating the wage index, we believe implementing the new OMB delineations would result in wage index values being more representative of the actual costs of labor in a given area. We considered having no transition period and fully implementing the proposed new OMB delineations beginning in CY 2015. This would mean that we would adopt the revised OMB delineations on January 1, 2015. However, this would not provide any time for HHAs to adapt to the new OMB delineations. We believe that it would be appropriate to provide for a transition period to mitigate the potential for resulting short-term instability and negative impact on certain HHAs, and to provide time for HHAs to adjust to their new labor market area delineations. In determining an appropriate transition methodology, consistent with the objectives set forth in the FY 2006 SNF PPS final rule (70 FR 45041), we first considered transitioning the wage index to the revised OMB delineations over a number of years in order minimize the impact of the proposed wage index changes in a given year. However, we also believe this must be balanced against the need to ensure the most accurate payments possible, which argues for a faster transition to the revised OMB delineations. We believe that using the most current OMB delineations would increase the integrity of the HH PPS wage index by creating a more accurate representation of geographic variation in wage levels. As such, we believe that utilizing a one-year (rather than a multiple year) transition with a blended wage index in CY 2015 would strike the best balance. Second, we considered what type of blend would be appropriate for purposes of the transition wage index. We are proposing that HHAs would receive a one-year blended wage index using 50 percent of their CY 2015 wage index based on the proposed new OMB delineations and 50 percent of their CY 2015 wage index based on the FY 2014 OMB delineations. We believe that a 50/50 blend would best mitigate the negative payment impacts associated with the implementation of the proposed new OMB delineations. While we considered alternatives to the 50/50 blend, we believe this type of split balances the increases and decreases in wage index values associated with this proposal, as well as provides a readily understandable calculation for HHAs.

Next, we considered whether or not the blended wage index should be used for all HHAs or for only a subset of HHAs, such as those HHAs that would experience a decrease in their respective wage index values due to implementation of the revised OMB delineations. As required in section 1895(b)(3) of the Act, the wage index adjustment must be implemented in a budget-neutral manner. As such, if we were to apply the transition policy only to those HHAs that would experience a decrease in their respective wage index values due to implementation of the revised OMB delineations, the wage index budget neutrality factor, discussed in section III.D.4, would result in reduced base rates for all HHAs as compared to the budget neutrality factor that results from applying the blended wage index to all HHAs.

For the reasons discussed above, we believe that our proposal to use a one-year transition with a blended wage index in CY 2015 appropriately balances the interests of all HHAs and would best achieve our objective of providing relief to negatively impacted HHAs.

Section 3131(a) of the Affordable Care Act mandates that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment rate and other amounts applicable under section 1895(b)(3)(A)(i)(III) of the Act to reflect factors such as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other relevant factors. In addition, section 3131(a) of the Affordable Care Act mandates that rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) as of the date of enactment (2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented in CY 2017. Therefore, in the CY 2014 HH PPS final rule (78 FR 77256), we finalized rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit rates and the NRS conversion factor. As we noted in the CY 2014 HH PPS final rule, because section 3131(a) of the Affordable Care Act requires a four year phase-in of rebasing, in equal increments, to start in CY 2014 and be fully implemented in CY 2017, we do not have the discretion to delay, change, or eliminate the rebasing adjustments once we have determined that rebasing is necessary (78 FR 72283).

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for CY 2015 be increased by a factor equal to the applicable HH market basket update for those HHAs that submit quality data as required by the Secretary. For CY 2015, section 3401(e) of the Affordable Care Act, requires that, in CY 2015 (and in subsequent calendar years), the market basket update under the HHA prospective payment system, as described in section 1895(b)(3)(B) of the Act, be annually adjusted by changes in economy-wide productivity. Beginning in CY 2015, section 1895(b)(3)(B)(vi)(I) of the Act, as amended by section 3401(e) of the Affordable Care Act, requires the application of the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act to the HHA PPS for CY 2015 and each subsequent CY. The −0.4 percentage point productivity adjustment to the proposed CY 2015 home health market basket update (2.6 percent), is discussed in the preamble of this rule and is not discretionary as it is a requirement in section 1895(b)(3)(B)(vi)(I) of the Act (as amended by the Affordable Care Act).

We invite comments on the alternatives discussed in this analysis.

F. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), in Table 35, we have prepared an accounting statement showing the classification of the transfers and costs associated with the provisions of this proposed rule. Table 35 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. Table 35 also reflects the estimated change in costs and burden for certifying physicians and HHAs as a result of the proposed changes to the face-to-face encounter requirements in section III.B. We estimate a net reduction in burden for certifying physicians of 192,765 hours or $21,796,330 (see section IV of this proposed rule). In addition, Table 35 reflects our estimate of a one-time burden for HHAs to revise the certification form of 5,761 hours or $245,397 as described in section IV. of this proposed rule.

TABLE 35—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS AND COSTS, FROM THE CYS 2014 TO 2015 *

Category	Transfers
Annualized Monetized Transfers	−$58 million.
From Whom to Whom?	Federal Government to HHAs.
Category	**Costs**
Annualized Monetized Net Reduction in Burden for Physicians Certifying Patient Eligibility for Home Health Services & HHAs for Certification Form Revision.	−$21.55 million.

* The estimates reflect 2014 dollars.

G. Conclusion

In conclusion, we estimate that the net impact of the proposals in this rule is a decrease in Medicare payments to HHAs of $58 million for CY 2015. The $58 million decrease in estimated payments for CY 2015 reflects the distributional effects of the 2.2 percent CY 2015 HH payment update percentage ($427 million increase) and the second year of the 4-year phase-in of the rebasing adjustments required by section 3131(a) of the Affordable Care Act ($485 million decrease). Also, starting in CY 2015, certifying physicians are estimated to incur a net reduction in burden costs of $21,796,330 and HHAs are expected to incur a one-time increase in burden costs to revise the certification form of $245,397 as a result of the proposal to eliminate the face-to-face encounter narrative requirement. This analysis, together with the remainder of this preamble, provides an initial Regulatory Flexibility Analysis.

VII. Federalism Analysis

Executive Order 13132 on Federalism (August 4, 1999) establishes certain requirements that an agency must meet when it promulgates a 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 will not have substantial direct effects on the rights, roles, and responsibilities of states, local or tribal governments.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 424

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

42 CFR Part 484

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

42 CFR Part 488

Administrative practice and procedure, Health facilities, Medicare, and Reporting and recordkeeping requirements.

42 CFR Part 498

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 409.44 is amended by—
■ A. Removing ''intermediary's'' from paragraph (a) and adding ''Medicare Administrative Contractor's'' in its place.
■ B. Removing ''30'' from paragraph (c)(2)(i)(B) adding ''14 calendar'' in its place each time it appears.
■ C. Removing paragraphs (c)(2)(i)(C) and (D).
■ D. Redesignating paragraphs (c)(2)(i)(E) through (H) as paragraphs (c)(2)(i)(C) through (F).
■ E. Removing ''(c)(2)(i)(A), (B), (C), and (D) of this section,'' from newly redesignated paragraph (c)(2)(i)(C) introductory text and adding ''(c)(2)(i)(A) and (B) of this section,'' in its place.
■ F. Removing ''(c)(2)(i)(E)(*2*) and (c)(2)(i)(E)(*3*) of this section are met,'' from newly redesignated paragraph (c)(2)(i)(C)(*1*) and adding ''(c)(2)(i)(C)(*2*) and (c)(2)(i)(C)(*3*) of this section are met,'' in its place.
■ G. Removing ''§ 409.44(c)(2)(i)(H) of this section.'' from newly redesignated paragraph (c)(2)(i)(C)(*3*) and adding ''§ 409.44(c)(2)(i)(F) of this section.'' in its place.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 3. 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).

■ 4. Section 424.22 is amended by—
■ A. Revising paragraphs (a) and (b) and adding new paragraph (c).
■ B. Removing ''(d)(i)'' from paragraph (d)(2) and adding ''(d)(1)'' in its place.

The revisions read as follows:

§ 424.22 Requirements for home health services.

* * * * *

(a) *Certification*—(1) *Content of certification.* As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify the patient's eligibility for the home health benefit, as outlined in 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, as follows in paragraphs (a)(1)(i) through (v) of this section. The patient's medical record, as specified in paragraph (c) of this section, must support the certification of eligibility as outlined in paragraph (a)(1)(i) through (v) of this section.

(i) The individual needs or needed intermittent skilled nursing care, or physical therapy or speech-language pathology services as defined in § 409.42(c) of this chapter. 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 brief narrative describing the clinical justification of this need. If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form, in

addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

(ii) Home health services are or were required because the individual is or was confined to the home, as defined in sections 1835(a) and 1814(a) of the Act, except when receiving outpatient services.

(iii) A plan for furnishing the services has been established and will be or was periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)

(iv) The services will be or were furnished while the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

(v) A face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in paragraph (a)(1)(v)(A) of this section. The certifying physician must also document the date of the encounter as part of the certification.

(A) The face-to-face encounter must be performed by one of the following:

(*1*) The certifying physician himself or herself.

(*2*) A physician, with privileges, who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

(*3*) A nurse practitioner or a clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act) who is working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(*4*) A certified nurse midwife (as defined in section 1861(gg) of the Act) as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(*5*) A physician assistant (as defined in section 1861(aa)(5) of the Act) under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

(B) The face-to-face patient encounter may occur through telehealth, in compliance with Section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

(*1*) *Timing and signature.* The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.

(*2*) [Reserved]

(b) *Recertification*—(1) Timing and signature of recertification. Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode. Recertification should occur at the time the plan of care is reviewed, and must be signed and dated by the physician who reviews the plan of care. Recertification is required at least every 60 days unless there is a—

(i) Beneficiary elected transfer; or

(ii) Discharge with goals met and/or no expectation of a return to home health care.

(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 brief narrative describing the clinical justification of this need. If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the recertification form, in addition to the physician's signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

(c) *Determining patient eligibility for Medicare home health services.* In determining whether a patient is or was eligible to receive services under the Medicare home health benefit at the start of home health care, only the medical record for the patient from the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home health) used to support the physician's certification of patient eligibility, as described in paragraphs (a)(1) and (b) of this section, will be reviewed. If the patient's medical record used in certifying eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

* * * * *

PART 484—HOME HEALTH SERVICES

■ 5. 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)) unless otherwise indicated.

■ 6. Section 484.4 is amended by revising the definition of ''speech-language pathologist'' to read as follows:

§ 484.4 Personnel qualifications.

* * * * *

Speech-language pathologist. A person who has a master's or doctoral degree in speech-language pathology, and who meets either of the following requirements:

(a) Is licensed as a speech-language pathologist by the State in which the individual furnishes such services; or

(b) In the case of an individual who furnishes services in a State which does not license speech-language pathologists:

(1) Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience);

(2) Performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field; and

(3) Successfully completed a national examination in speech-language pathology approved by the Secretary.

■ 7. Section 484.250 is amended by revising paragraph (a)(1) to read as follows:

§ 484.250 Patient assessment data.

(a) * * *

(1) The OASIS data described at § 484.55(b)(1) and (d)(1) of this part for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235 of this subpart, and to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

* * * * *

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

■ 8. The authority citation for part 488 continues to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act, unless otherwise noted (42 U.S.C. 1302, 1320a–7j, and 1395hh); Pub. L. 110–149, 121 Stat. 1819.

■ 9. Section 488.845 is amended by adding paragraph (h) to read as follows:

§ 488.845 Civil money penalties.

* * * * *

(h) *Review of the penalty.* When an administrative law judge or state hearing officer (or higher administrative review authority) finds that the basis for imposing a civil monetary penalty exists, as specified in this part, the administrative law judge, State hearing officer (or higher administrative review authority) may not—

(1) Set a penalty of zero or reduce a penalty to zero;

(2) Review the exercise of discretion by CMS to impose a civil monetary penalty; and

(3) Consider any factors in reviewing the amount of the penalty other than those specified in paragraph (b) of this section.

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTCIPATION OF ICFS/IID AND CERTAIN NFS IN THE MEDICAID PROGRAM

■ 10. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102, 1128I and 1871 of the Social Security Act (42 U.S.C. 1302, 1320a–7j, and 1395hh).

■ 11. Section 498.3 is amended by revising paragraphs (b)(13) and (b)(14)(i) to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) * * *

(13) Except as provided at paragraph (d)(12) of this section for SNFs, NFs and HHAs, the finding of noncompliance leading to the imposition of enforcement actions specified in § 488.406 or § 488.820 of this chapter, but not the determination as to which sanction was imposed. The scope of review on the imposition if a civil money penalty is specified in § 488.438(e) and § 488.845(h) of this chapter.

(14) * * *

(i) The range of civil money penalty amounts that CMS could collect (for SNFs or NFs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in § 488.438(e) of this chapter and for HHAs, the scope of review during a hearing on the imposition of a civil money penalty is set forth in § 488.845(h) of this chapter); or

* * * * *

■ 12. Section 498.60 is amended by revising paragraphs (c)(1) and (c)(2) to read as follows:

§ 498.60 Conduct of hearing.

* * * * *

(c) * * *

(1) The scope of review is as specified in § 488.438(e) and § 488.845(h) of this chapter; and

(2) CMS' determination as to the level of noncompliance of a SNF, NF or HHA must be upheld unless it is clearly erroneous.

Dated: June 16, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 19, 2014.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

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