in a sequence of adjacent episodes. For purposes of the home health PPS, a sequence of adjacent episodes for a beneficiary is a series of claims with no more than 60 days without home care between the end of one episode, which is the 60th day (except for episodes that have been PEP-adjusted), and the beginning of the next episode. This additional amount will be updated annually after 2008 by a factor equal to the applicable home health market basket percentage.

[65 FR 41212, July 3, 2000, as amended at 72 FR 69879, Aug. 29, 2007]

§ 484.235 Methodology used for the calculation of the partial episode payment adjustment.

(a) CMS makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event described in §484.205(d).

(b) The original 60-day episode payment is adjusted to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

(c) The partial episode payment is calculated by determining the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

§ 484.240 Methodology used for the calculation of the outlier payment.

(a) CMS makes an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

(b) The outlier threshold for each case-mix group is the episode payment amount for that group, the PEP adjustment amount for the episode plus a fixed dollar loss amount that is the same for all case-mix groups.

(c) The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

(d) CMS imputes the cost for each episode by multiplying the national per-visit amount of each discipline by the number of visits in the discipline and computing the total imputed cost for all disciplines.

(e) The fixed dollar loss amount and the loss sharing proportion are chosen so that the estimated total outlier payment is no more than 5 percent of total payment under home health PPS.

[65 FR 41212, July 3, 2000, as amended at 72 FR 69879, Aug. 29, 2007]

§ 484.245 Accelerated payments for home health agencies.

(a) General rule. Upon request, an accelerated payment may be made to an HHA that is receiving payment under the home health prospective payment system if the HHA is experiencing financial difficulties because there is a delay by the intermediary in making payment to the HHA.

(b) Approval of payment. An HHA’s request for an accelerated payment must be approved by the intermediary and CMS.

(c) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(d) Recovery of payment. Recovery of the accelerated payment is made by recoupment as HHA bills are processed or by direct payment by the HHA.

§ 484.250 Patient assessment data.

(a) Data submission. An HHA must submit the following data to CMS:

(1) The OASIS–C data described at §484.55(b)(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.

(2) The Home Health Care CAHPS survey data for CMS to administer the payment rate methodologies described in §484.225(i) of this subpart, and to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

(b) Patient count. An HHA that has less than 60 eligible unique HHCAHPS patients annually must annually submit to CMS their total HHCAHPS patient count to CMS to be exempt from the HHCAHPS reporting requirements for a calendar year period.

(c) Survey requirements. An HHA must contract with an approved, independent HHCAHPS survey vendor to administer the HHCAHPS Survey on its behalf.

(1) CMS approves an HHCAHPS survey vendor if such applicant has been