

(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 in business for a minimum of 3 years and has conducted surveys of individuals and samples for at least 2 years.

(i) For HHCAHPS, a "survey of individuals" is defined as the collection of data from at least 600 individuals selected by statistical sampling methods and the data collected are used for statistical purposes.

(ii) All applicants that meet these requirements will be approved by CMS.

(2) No organization, firm, or business that owns, operates, or provides staffing for a HHA is permitted to administer its own Home Health Care CAHPS (HHCAHPS) Survey or administer the survey on behalf of any other HHA in the capacity as an HHCAHPS survey vendor. Such organizations will not be approved by CMS as HHCAHPS survey vendors.

(3) Approved HHCAHPS survey vendors must fully comply with all HHCAHPS oversight activities, including allowing CMS and its HHCAHPS program team to perform site visits at the vendors' company locations.

[76 FR 68606, Nov. 4, 2011, as amended at 77 FR 67164, Nov. 8, 2012]

#### § 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and