

## § 484.240

(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, or 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-15 minute unit amount of each discipline by the number of 15 minute units 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 2.5 percent of total payment under home health PPS.

(f) The total amount of outlier payments to a specific home health agency for a year may not exceed an amount equal to 10 percent of the total payments to the specific agency under home health PPS for the year.

[65 FR 41212, July 3, 2000, as amended at 72 FR 69879, Aug. 29, 2007; 80 FR 68717, Nov. 5, 2015; 81 FR 76796, Nov. 3, 2016]

## § 484.245 [Reserved]

### § 484.250 Patient assessment data.

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

(1) 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.

(2) The Home Health Care CAHPS survey data for CMS to administer the payment rate methodologies described in § 484.225(c), and to meet the quality

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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; 79 FR 66118, Nov. 6, 2014; 80 FR 68718, Nov. 5, 2015]

### § 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 application of the unit of payments,