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42 CFR Part 431

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; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 431

[CMS–1450–P]

RIN 0938–AR52

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

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, the low-utilization payment adjustment (LUPA) add-on, the nonroutine medical supplies (NRS) conversion factor, and outlier payments under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2014. As required by the Affordable Care Act, this rule also proposes rebasing adjustments, with a 4-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. Finally, the proposed rule would also establish home health quality reporting requirements for CY 2014 payment and subsequent years and would clarify that a state Medicaid program must provide that, in certifying home health agencies, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid, the standard method that CMS and states use in the allocation of expenses related to surveys of SNF/NF nursing homes.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 26, 2013.

ADDRESSES: In commenting, please refer to file code CMS–1450–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 ''Submit a comment'' instructions.

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–1450–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–1450–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: Kristine Chu, (410) 786–8953, for information about rebasing and the HH payment reform study and report. Jenny Filipovits, (410) 786–8141, for information about cost allocation of survey expenses. Mollie Knight, (410) 786–7948, for information about the HH market basket. Hillary Loeffler, (410) 786–0456, for general information about the HH PPS. Joan Proctor, (410) 786–0949, for information about the HH PPS Grouper and ICD–10 Conversion. Kim Roche, (410) 786–3524, for information about the HH quality reporting program. Lori Teichman, (410) 786–6684, for information about HH CAHPS®.

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.

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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:

ACA The Affordable Care Act.
ACH LOS Acute care hospital length of stay.
ADL Activities of daily living.
AHRQ Agency for Healthcare Research and Quality.
APU Annual payment update.
BBA Balanced Budget Act of 1997 (Pub. L. 105–33, enacted August 5, 1997).
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, enacted November 29, 1999).
CAD Coronary artery disease.
CAH Critical access hospital.
CAHPS® Consumer assessment of healthcare providers and systems.
CBSA Core-based statistical area.
CASPER Certification and survey provider enhanced reports.
CHF Congestive heart failure.
CMI Case-mix index.
CMP Civil monetary penalties.
CMS Centers for Medicare & Medicaid Services.
CoPs Conditions of participation.
COPD Chronic obstructive pulmonary disease.
CVD Cardiovascular disease.
CY Calendar year.
DG Diagnostic group.
DHHS Department of Health and Human Services.
DM Diabetes mellitus.
DME Durable medical equipment.
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171, enacted February 8, 2006).
FDL Fixed dollar loss.
FFP Federal financial participation.
FI Fiscal intermediaries.
FR Federal Register
FY Fiscal year.
GEM General equivalency mapping.
HAVEN Home assessment validation and entry system.
HCC Hierarchical condition categories.
HCIS Health care information system.
HH Home health.
HHABN Home health advance beneficiary notice.
HHAs Home health agencies.
HHCAHPS® Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey.
HH PPS Home health prospective payment system.
HHQRP Home Health Quality Reporting Program.
HHRG Home health resource group.
HIPAA Health Insurance Portability Accountability Act of 1996 (Pub. L. 104–191, enacted August 21, 1996).
HIPPS Health insurance prospective payment system.
ICD–9 International Classification of Diseases, 9th Edition.
ICD–9–CM International Classification of Diseases, 9th Edition, Clinical Modification.
ICD–10 International Classification of Diseases, 10th Edition.
ICD–10–CM International Classification of Diseases, 10th Edition, Clinical Modification.
ICF–IID Intermediate care facilities for individuals with intellectual disabilities.
IH Inpatient hospitalization.
IPPS Acute Inpatient Prospective Payment System.
IRF Inpatient rehabilitation facility.
LTCH Long-term care hospital.
LUPA Low-utilization payment adjustment.
MAC Medicare Administrative Contractor.
MAP Measure applications partnership.
MedPAC Medicare Payment Advisory Commission.
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 areas.
MSS Medical Social Services.
NF Nursing facility.
NQF National Quality Forum.
NRS Non-routine supplies.
OASIS Outcome & 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.
P4R Pay-for-reporting.
PAC–PRD Post-Acute Care Payment Reform Demonstration.
PEP Partial episode payment [Adjustment].
POC Plan of care.
PRRB Provider Reimbursement Review Board.
PT Physical therapy.
QAP Quality assurance plan.
QIES CMS Health Care Quality Improvement System.
PRRB Provider Reimbursement Review Board.
RAP Request for anticipated payment.
RF Renal failure.
RFA Regulatory Flexibility Act (Pub. L. 96–354, enacted on September 19, 1980).
RHHIs Regional home health intermediaries.
RIA Regulatory impact analysis.
SCHIP State Children's Health Insurance Program.
SLP Speech-language pathology.
SN Skilled nursing.
SNF Skilled nursing facility.
TEP Technical Expert Panel.
UMRA Unfunded Mandates Reform Act of 1995 (Pub. L. 104–04, enacted on March 22, 1995).

I. Executive Summary

A. Purpose

This rule proposes updates to the payment rates for home health agencies (HHAs) for calendar year (CY) 2014, as required under section 1895(b) of the Social Security Act (the Act), including the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, the non-routine supplies (NRS) conversion factor, 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''). This proposed rule would also address: International Classification of Diseases, 9th Edition (ICD–9) grouper refinements; implementation of the International Classification of Diseases, 10th Edition (ICD–10); an adjustment to the case-mix weights; updates to the payment rates by the HH payment update percentage (market basket); adjustments for geographic differences in wage levels; outlier payments; the submission of quality data; and additional payments for services

provided in rural areas. This proposed rule would also clarify state Medicaid program requirements related to the cost of HHA surveys.

B. Summary of the Major Provisions

We recently completed a thorough review of the ICD–9–CM codes included in our home health prospective payment system (HH PPS) Grouper as part of our work transitioning from the ICD–9–CM to ICD–10–CM code set. As a result of that review, we identified two categories of codes, made up of 170 ICD–9–CM diagnosis codes, which we are proposing to remove from the HH PPS Grouper, effective January 1, 2014. In addition, we are proposing to implement, on October 1, 2014, the use of ICD–10–CM codes within our HH PPS Grouper.

Section 3131(a) of the Affordable Care Act requires that, starting in CY 2014, we apply an adjustment to the national, standardized 60-day episode payment rate and other applicable payment amounts 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, we must phase-in any adjustment over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year, and be fully implemented by CY 2017. As such, we are proposing rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, the NRS conversion factor, and an update to the LUPA add-on amount.

Section 3131(d) of the Affordable Care Act also requires us to report on whether a home health care access problem exists for patients with high severity of illness, low income patients, and/or patients in medically underserved areas and assess the costs associated with providing access to care for these populations. It also gives us the authority to analyze other areas of concern in the HH PPS and allows for demonstration authority to test the PPS changes. Finally, it requires us to recommend HH PPS improvements, if needed, based on the study findings and/or necessary additional analysis, in a Report to Congress due in March 2014. Our contractor held a Technical Expert Panel (TEP) meeting and a special Open Door Forum to gather input from the industry on the three vulnerable populations. We are currently conducting surveys of HHAs and physicians on access to care, and performing analyses of cost report and claims data to determine whether patient characteristics/types may be under-reimbursed. We will continue to collaborate with stakeholders, soliciting them for their thoughts, and provide updates on our progress.

We also propose to continue to use Outcome & Assessment Information Set (OASIS) data, claims data, and patient experience of care data, as forms of quality data to meet the requirement that HHAs submit data appropriate for the measurement of HH care quality for annual payment update (APU) 2014 and each subsequent year thereafter until further notice. Additionally, we propose two claims-based measures of HH patients who were recently hospitalized, as these patients are at an increased risk of additional acute care hospital use. We also propose to reduce the number of HH quality measures currently reported to HHAs. Lastly, we propose to review each state's allocation of costs for HHA surveys for compliance with OMB Circular A–87 principles and the statutes in 2014 with the goal of ensuring full compliance no later than July 2014. This proposed rule would clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid. This is the standard method that CMS and states use in the allocation of expenses related to surveys of skilled nursing facility (SNF)/NF nursing homes.

C. Summary of Costs and Benefits

Provision description	Total costs	Total benefits	Transfers
CY 2014 HH PPS Payment Rate Update.	N/A	The benefits of this proposed rule include paying more accurately for the delivery of home health services.	The overall economic impact of this proposed rule is an estimated $290 million in decreased payments to HHAs.
Cost Allocation of HHA Survey Expenses.	N/A	The benefits of this rule include clarifying that state Medicaid programs must share in the cost of HHA surveys. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid.	If implemented in the beginning of FY 2014 we project that aggregate Medicare and Medicaid home health survey costs in FY 2014 would be approximately $37.2 million. As these costs would be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated national state Medicaid share would amount to $18.6 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. At this rate the maximum net state costs for Medicaid matching funds incurred in FY 2014 would be approximately $4.65 million, spread out across all states and 2 territories. However, the proposed adherence date of July FY 2014 would reduce the Medicaid aggregate share to $4.65 million and the state Medicaid share to approximately $1.16 million. Some state Medicaid programs may currently pay for HHA surveys to some extent, but the amount is unknown.

II. Background

A. Statutory Background

Home Health PPS

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 a 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 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 that includes all costs for HH services that would have been covered and paid for on a reasonable cost basis had the HH PPS not been in effect 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 Affordable Care Act 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 2 percentage points. In the CY 2007 HH PPS final rule (71 FR 65884, 65935), we implemented the pay-for-reporting requirement of the DRA, which was codified at § 484.225(h) and (i). 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(c) 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) for 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.

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 this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year applicable under section 1895(b)(3)(A)(i)(III) of the Act and be fully implemented in CY 2017.

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 (PT), speech-language pathology (SLP), occupational therapy (OT), and medical social services (MSS)). Payment for 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. of this proposed rule). Payment for durable medical equipment (DME) 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. Specifically, the 60-day episode base rate is multiplied by the case-mix weight when determining 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 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 Medicare prospective payment system for HHAs for CY 2008. The CY 2008 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 in 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. To fully account for the 19.03 percent nominal case-mix growth which was identified from 2000 to 2009, we finalized a 3.79 percent payment reduction in CY 2012.

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 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. We considered proposing a 2.18 percent reduction to account for the remaining increase in measured nominal case-mix; however, we moved forward with 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).

III. Provisions of the Proposed Rule

A. Proposed ICD–9–CM Grouper Refinements, Effective January 1, 2014

CMS clinical staff (along with clinical and coding staff from Abt Associates (our support contractor) and 3M (our HH PPS grouper maintenance contractor), recently completed a thorough review of the ICD–9–CM codes included in our HH PPS Grouper. The HH PPS Grouper, which is used by the CMS OASIS submission system, is the official grouping software of the HH PPS. As a result of that review, we identified two categories of codes, made up of 170 ICD–9–CM diagnosis codes, which we are proposing to remove from the HH PPS Grouper, effective January 1, 2014. The first category (Category 1 in Table 2) includes codes that we propose to remove from the HH PPS grouper based upon clinical judgment that the ICD–9–CM code is ''too acute'', meaning that this condition could not be appropriately cared for in a HH setting. These codes likely reflect conditions the patient had prior to the HH admission (for example, while being treated in a hospital setting). It is anticipated that the condition progressed to a less acute state, or is completely resolved for the patient to be cared for in the home setting (and that often times another diagnosis code would have been a more accurate reflection of the patient's condition in the home). The second category (Category 2 in Table 2) includes codes that we propose to remove from the HH PPS Grouper based upon clinical judgment that the condition would not require HH intervention, would not impact the HH plan of care (POC), or would not result in additional resource use when providing HH services to the patient. Table 2 comprises ICD–9–CM codes that we propose to remove from the HH PPS grouper, effective January 1, 2014, along with the category classification.

TABLE 2—ICD–9–CM CODES REMOVED FROM THE HH PPS GROUPER AS OF JANUARY 1, 2014

ICD–9–CM Code	ICD–9–CM Long description	Category
003.1	Salmonella septicemia	1
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	1
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	1
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	1
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	1
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	1

TABLE 2—ICD–9–CM CODES REMOVED FROM THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long description	Category
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	1
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	1
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	1
282.42	Sickle-cell thalassemia with crisis	1
282.5	Sickle-cell trait	2
282.62	Hb-SS disease with crisis	1
282.64	Sickle-cell/Hb-C disease with crisis	1
282.69	Other sickle-cell disease with crisis	1
285.1	Acute posthemorrhagic anemia	1
289.52	Splenic sequestration	1
333.81	Blepharospasm	2
333.84	Organic writers' cramp	2
333.93	Benign shuddering attacks	2
333.94	Restless legs syndrome	2
348.5	Cerebral edema	1
401.0	Malignant essential hypertension	1
414.12	Dissection of coronary artery	1
447.2	Rupture of artery	1
493.21	Chronic obstructive asthma with status asthmaticus	1
530.21	Ulcer of esophagus with bleeding	1
530.4	Perforation of esophagus	1
530.7	Gastroesophageal laceration-hemorrhage syndrome	1
530.81	Esophageal reflux	2
530.82	Esophageal hemorrhage	1
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction	1
531.01	Acute gastric ulcer with hemorrhage, with obstruction	1
531.10	Acute gastric ulcer with perforation, without mention of obstruction	1
531.11	Acute gastric ulcer with perforation, with obstruction	1
531.20	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction	1
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction	1
531.31	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction	1
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction	1
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction	1
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction	1
531.51	Chronic or unspecified gastric ulcer with perforation, with obstruction	1
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction	1
531.61	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction	1
531.71	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction	1
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction	1
532.01	Acute duodenal ulcer with hemorrhage, with obstruction	1
532.10	Acute duodenal ulcer with perforation, without mention of obstruction	1
532.11	Acute duodenal ulcer with perforation, with obstruction	1
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction	1
532.21	Acute duodenal ulcer with hemorrhage and perforation, with obstruction	1
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction	1
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction	1
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction	1
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction	1
532.51	Chronic or unspecified duodenal ulcer with perforation, with obstruction	1
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.	1
532.61	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction	1
532.71	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction	1
532.91	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction	1
533.01	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction	1
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction	1
533.11	Acute peptic ulcer of unspecified site with perforation, with obstruction	1
533.20	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	1
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction	1
533.31	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, with obstruction.	1
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.	1
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction	1
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.	1

TABLE 2—ICD–9–CM CODES REMOVED FROM THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long description	Category
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction	1
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	1
533.61	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.	1
533.71	Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction.	1
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	1
534.01	Acute gastrojejunal ulcer, with hemorrhage, with obstruction	1
534.10	Acute gastrojejunal ulcer with perforation, without mention of obstruction	1
534.11	Acute gastrojejunal ulcer with perforation, with obstruction	1
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	1
534.21	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction	1
534.31	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	1
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	1
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction	1
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction	1
534.51	Chronic or unspecified gastrojejunal ulcer with perforation, with obstruction	1
534.60	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction.	1
534.61	Chronic or unspecified gastrojejunal ulcer with hemorrhage and perforation, with obstruction	1
534.71	Chronic gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	1
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	1
535.01	Acute gastritis, with hemorrhage	1
535.11	Atrophic gastritis, with hemorrhage	1
535.21	Gastric mucosal hypertrophy, with hemorrhage	1
535.31	Alcoholic gastritis, with hemorrhage	1
535.41	Other specified gastritis, with hemorrhage	1
535.51	Unspecified gastritis and gastroduodenitis, with hemorrhage	1
535.61	Duodenitis, with hemorrhage	1
535.71	Eosinophilic gastritis, with hemorrhage	1
536.1	Acute dilatation of stomach	1
537.3	Other obstruction of duodenum	1
537.4	Fistula of stomach or duodenum	1
537.6	Hourglass stricture or stenosis of stomach	1
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	1
537.84	Dielulafoy lesion (hemorrhagic) of stomach and duodenum	1
540.0	Acute appendicitis with generalized peritonitis	1
540.1	Acute appendicitis with peritoneal abscess	1
540.9	Acute appendicitis without mention of peritonitis	1
541	Appendicitis, unqualified	1
542	Other appendicitis	1
543.0	Hyperplasia of appendix (lymphoid)	1
557.0	Acute vascular insufficiency of intestine	1
560.0	Intussusception	1
560.1	Paralytic ileus	1
560.2	Volvulus	1
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)	1
560.89	Other specified intestinal obstruction	1
560.9	Unspecified intestinal obstruction	1
562.02	Diverticulosis of small intestine with hemorrhage	1
562.03	Diverticulitis of small intestine with hemorrhage	1
562.12	Diverticulosis of colon with hemorrhage	1
562.13	Diverticulitis of colon with hemorrhage	1
567.0	Peritonitis in infectious diseases classified elsewhere	1
567.1	Pneumococcal peritonitis	1
567.21	Peritonitis (acute) generalized	1
567.22	Peritoneal abscess	1
567.23	Spontaneous bacterial peritonitis	1
567.29	Other suppurative peritonitis	1
567.31	Psoas muscle abscess	1
567.38	Other retroperitoneal abscess	1
567.81	Choleperitonitis	1
567.82	Sclerosing mesenteritis	1
567.89	Other specified peritonitis	1
567.9	Unspecified peritonitis	1
568.81	Hemoperitoneum (nontraumatic)	1
569.3	Hemorrhage of rectum and anus	1

TABLE 2—ICD–9–CM CODES REMOVED FROM THE HH PPS GROUPER AS OF JANUARY 1, 2014—Continued

ICD–9–CM Code	ICD–9–CM Long description	Category
569.43	Anal sphincter tear-old	2
569.83	Perforation of intestine	1
569.85	Angiodysplasia of intestine with hemorrhage	1
569.86	Dieulafoy lesion (hemorrhagic) of intestine	1
572.0	Abscess of liver	1
572.1	Portal pyemia	1
574.00	Calculus of gallbladder with acute cholecystitis, without mention of obstruction	1
574.01	Calculus of gallbladder with acute cholecystitis, with obstruction	1
574.10	Calculus of gallbladder with other cholecystitis, without mention of obstruction	1
574.11	Calculus of gallbladder with other cholecystitis, with obstruction	1
574.21	Calculus of gallbladder without mention of cholecystitis, with obstruction	1
574.30	Calculus of bile duct with acute cholecystitis, without mention of obstruction	1
574.31	Calculus of bile duct with acute cholecystitis, with obstruction	1
574.41	Calculus of bile duct with other cholecystitis, with obstruction	1
574.51	Calculus of bile duct without mention of cholecystitis, with obstruction	1
574.60	Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction	1
574.61	Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction	1
574.71	Calculus of gallbladder and bile duct with other cholecystitis, with obstruction	1
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction.	1
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction	1
574.91	Calculus of gallbladder and bile duct without cholecystitis, with obstruction	1
575.0	Acute cholecystitis	1
575.2	Obstruction of gallbladder	1
575.3	Hydrops of gallbladder	1
575.4	Perforation of gallbladder	1
576.1	Cholangitis	1
576.2	Obstruction of bile duct	1
576.3	Perforation of bile duct	1
577.0	Acute pancreatitis	1
578.0	Hematemesis	1
578.9	Hemorrhage of gastrointestinal tract, unspecified	1
873.63	Broken tooth-uncomplic	2
998.11	Hemorrhage complicating a procedure	1
998.12	Hematoma complicating a procedure	1
998.2	Accidental puncture or laceration during a procedure, not elsewhere classified	1

Analysis of CY 2012 claims data shows that the average case-mix weight before the removal of the codes in Table 2 was 1.3517. It is estimated that the proposed removal of the 170 codes in Table 2 results in an average case-mix weight for CY 2012 of 1.3417. As described above, clinical judgment is that these codes are ''too acute,'' meaning that this condition could not be appropriately cared for in a HH setting (Category 1) or would not impact the HH POC or result in additional resource use (Category 2). Therefore, the inclusion of these diagnosis codes in the grouper was producing inaccurate overpayments.

B. International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion and Diagnosis Reporting on Home Health Claims

1. International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion

The Compliance date for adoption of the ICD–10–CM and ICD–10–PCS Medical Data Code Set is October 1, 2014, as announced in September 5, 2012 final rule, ''Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets'' (77 FR 54664). Under that final rule, the transition to ICD–10–CM is required for entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104–191, enacted on August 21, 1996). CMS, along with our support contractors, Abt Associates and 3M, spent the last 2 years implementing a process for the transition from the use of ICD–9–CM diagnosis codes to ICD–10–CM diagnosis codes within the HH PPS Grouper. As we outlined in the section above, we began this process with a review of the ICD–9–CM codes included in our HH PPS Grouper and identified certain codes that should be removed, and thus will not be included in our translation list of ICD–9–CM to ICD–10–CM codes.

3M produced a translation list using the General Equivalency Mappings (GEMs) tool. That translation list, produced by the GEMs tool, was then reviewed and revised to ensure the included codes are appropriate for use in the HH setting, based upon ICD–10–CM coding guidance. Modifications included:

• *Elimination of codes with ''initial encounter'' extensions listed in the GEMs translation.* ICD–10–CM codes that begin with S and T are used for reporting traumatic injuries, such as fractures and burns. These codes have a 7th character that indicates whether the treatment is for an initial encounter, subsequent encounter or a sequela (a residual effect (condition produced) after the acute phase of an illness or injury has terminated). The GEMs translation mapped ICD–9–CM traumatic injury codes to ICD–10–CM codes with the 7th character for an initial encounter. This extension is intended to be used when the patient is receiving active treatment such as

surgical treatment, an emergency department encounter, or evaluation and treatment by a new physician. These initial encounter extension codes are not appropriate for care in the HH setting and were deleted. Code extensions D, E, F, G, H, J, K, M, N, P, Q and R indicate the patient is being treated for a subsequent encounter (care for the injury during the healing or recovery phase) were included in the translation list in place of the initial encounter extensions. For example, S72.024A ''Nondisplaced fracture of epiphysis (separation) (upper) of right femur, initial encounter for closed fracture'' was deleted and S72.024D, S72.024E, S72.024F, S72.024G, S72.024H, S72.024J, S72.024K, S72.024M, S72.024N, S72.024P, S27.024Q, and S72.024R were retained for the reporting of aftercare provided by the HHA.

• *Elimination of codes for non-specific conditions when the clinician should be able to identify a more specific diagnosis based on clinical assessment.* The initial GEMs translation included non-specific codes, for example, ICD–10–CM code L02.519 ''cutaneous abscess of unspecified hand''. These have been deleted from the translation list whenever a more specific diagnosis could be identified by the clinician performing the initial assessment. The example code above (L02.519) was deleted because the clinician should be able to identify which hand had the abscess, and therefore, would report the injury using the code that specifies the right or left hand.

• *The diagnostic group (DG) assignment of ICD–10–CM codes in the translation replicates the ICD–9–CM assignment whenever possible.* Since ICD–9–CM to ICD–10–CM translation is not a 1-to-1 mapping process, there were cases where the DG assignment was ambiguous. When there was a conflict (such as 2 ICD–9–CM codes being translated to a single ICD–10–CM code that covered both conditions), DG assignment was based on clinical appropriateness and comparisons of relative resource use data (when available), such that the code was assigned to single DG that included other codes with similar resource use.

A draft list of ICD–10–CM codes to be included in the HH PPS Grouper has been developed based upon the process outlined above and 3M, our HH PPS Grouper maintenance contractor, has begun building and testing a Grouper version for use starting October 1, 2014, when OASIS–C1, the new version of the OASIS assessment which will use ICD–10–CM diagnosis codes, will be implemented. The draft translation list is available on the CMS HHA Center Web site at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html.* We plan to participate in any ICD–10–CM provider outreach sessions that are scheduled and to provide updates, such as notifying HHAs of the draft translation list's availability during the HH, Hospice, and DME Open Door Forums and through list-serve announcements.

We plan to post a draft ICD–10–CM HH PPS Grouper via the CMS Web site on or before July 1, 2014. We also plan to share the draft ICD–10–CM HH PPS Grouper with those vendors that have registered as beta-testers in advance of posting the draft ICD–10 HH PPS Grouper on the CMS Web site. The purpose of early release to the beta testers is to identify any significant issues early in the process. Providers who are interested in enrolling as a beta site can obtain more information on the HH PPS Grouper Web site at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.*

2. Diagnosis Reporting on Home Health Claims

Adherence to coding guidelines when assigning diagnosis codes is required under HIPAA. 3M conducted analysis of OASIS records and claims from CY 2011 and found that some HHAs were not complying with coding guidelines. Section 1.A.6 in the 2012 ICD–9–CM Coding Guidelines require that the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a ''use additional code'' note at the etiology code, and a ''code first'' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases, the title of these manifestation codes will include ''in diseases classified elsewhere'' or ''in conditions classified elsewhere.'' Codes with these phrases in the title are generally manifestation codes. ''In diseases classified elsewhere'' or ''in conditions classified elsewhere'' codes are never permitted to be used as first listed or principal diagnosis codes and they must be listed following the underlying condition. In ICD–10–CM, the same coding convention applies and can be found in section 1.A.13 of the ICD–10–CM guidance. Note, however, that there are also other manifestation codes that do not have ''in diseases classified elsewhere'' or ''in conditions classified elsewhere'' in their title. For such codes a ''use additional code'' note would still be present, and the rules for coding sequencing still apply. It should be noted that several dementia codes, which are not allowable as principal diagnoses per ICD–9–CM coding guidelines, are under the classification of ''Mental, Behavioral and Neurodevelopmental Disorders''. According to section 1.A6 of the ICD–9–CM coding guidelines for ''Mental, Behavioral and Neurodevelopmental Disorders'', dementias that fall under this category are ''most commonly a secondary manifestation of an underlying causal condition.'' To ensure additional compliance with ICD–10–CM Coding Guidelines, we will be adopting additional claims processing edits for all HH claims effective October 1, 2014. HH claims containing inappropriate principal or secondary diagnosis codes will be returned to the provider and will have to be corrected and resubmitted to be processed and paid. Additional details describing the specific edits that will be applied will be announced through a change request, an accompanying Medicare Learning Network article, and other CMS communication channels, such as the HH, Hospice, and DME Open Door Forum.

Finally, effective October 1, 2014, with the implementation of ICD–10–CM diagnosis code reporting, we anticipate that HHAs will be able to report all of the conditions included in the HH PPS Grouper as a primary or secondary diagnosis. There will no longer be a need for any conditions to be reported in the payment diagnosis field because all of the ICD–10–CM codes included in our HH PPS Grouper will be appropriate for reporting as a primary or secondary condition. As such, we are retiring Appendix D of OASIS (also referred to as Attachment D), effective October 1, 2014. All necessary guidance for providers is provided in the ICD–10–CM Coding Guidelines.

C. Proposed Adjustment to the HH PPS Case-Mix Weights

In the November 4, 2011 CY 2012 HH PPS final rule (76 FR 68543), we recalibrated the HH PPS case-mix weights to address incentives that existed in the HH PPS to provide unnecessary therapy services. In that final rule, we described that our review of HH PPS utilization data showed an increase in the share of episodes with very high numbers of therapy visits. This shift was first observed in 2008 and it continued in 2009. As described in the CY 2012 HH PPS final rule, we observed an increase of 25 percent in the share of episodes with 14 or more therapy visits from 2007 to 2008. In the

2009 sample, the share with 14 or more therapy visits continued to increase while the share of episodes with no therapy visits continued to decrease. The frequencies also indicated that the share of episodes with 20 or more therapy visits was 6 percent in 2009. This was a 50 percent increase from the share of episodes in 2007, when episodes with at least 20 therapy visits accounted for only 4 percent of episodes (76 FR 41003). Furthermore, in the CY 2012 HH PPS final rule, we described that in their 2010 and 2011 Reports to Congress, the Medicare Payment Advisory Commission (MedPAC) suggested that the HH PPS contains incentives which likely result in agencies providing more therapy than is needed. Moreover, in its 2011 Report to Congress, MedPAC suggested that the HH PPS may ''overvalue therapy services and undervalue nontherapy services.'' Our analysis of cost report data showed that in 2009, the average amount that payment exceeded cost for a normal (non-LUPA, non-PEP, non-outlier) episode with 14–19 therapy visits was more than $1,100 and the average amount that payment exceeded costs for a normal episode with 20 or more therapy visits was more than $1,500. In contrast, we noted that the average amount that payment exceeded costs for a normal episode with 1 to 5 therapy visits was around $300 (76 FR 68556). Therefore, we lowered the case-mix weights for high therapy episodes and increased the weights for episodes with little or no therapy. We then increased the average case-mix weights to 1.3440 to achieve budget neutrality to the most current, complete data available at the time, which was 2009. We stated that we believed the revision to the payment weights would result in more accurate HH PPS payments for targeted case-mix groups while addressing MedPAC's concerns that our reimbursement for therapy episodes was too high and our reimbursement for non-therapy episodes was too low. Also, we stated that we believed our revision of the payment weights will discourage the provision of unnecessary therapy services and will slow the growth of nominal case-mix (76 FR 68545).

As described in section III.D. of this proposed rule, we are proposing to rebase the national, standardized 60-day episode payment rate. One view of the goal for rebasing is to reset the payments under the HH PPS. When the HH PPS was created, we expected that the average case-mix weight would be around 1.00, but analysis has shown that it has consistently been above 1.00 since the start of the HH PPS. Therefore, as part of rebasing, for CY 2014, we propose to reset the average case-mix weight to 1.00. Specifically, we propose to use the 2012 revised case-mix weights, but lower them to an average case-mix weight of 1.00. We plan to implement the weight reduction by applying the same reduction factor to each weight, thereby maintaining the relative values in the weight set. Preliminary CY 2012 claims data shows that the average case-mix weight for non-LUPA episodes in 2012 is 1.3517. For CY 2014, we propose to reduce the average case-mix weight for 2012 from 1.3517 to 1.0000. We obtain the CY 2014 proposed weights shown in Table 3 by dividing the CY 2013 weights (which are the same weights as those finalized in CY 2012 rulemaking) by 1.3517. To offset the effect of resetting the case-mix weights such that the average is 1.00, we inflate the national, standardized 60-day episode payment rate by the same factor (1.3517) used to decrease the weights. The result will be the starting point from which rebasing adjustments are implemented. We note that the average case-mix weight for 2012 of 1.3517 is based on non-LUPA episodes starting from January 1, 2012 to May 31, 2012. As more 2012 data become available, we plan to update the estimated average case-mix weight for CY 2012 and adjust the case-mix weights and budget neutrality factor accordingly. Therefore, the weight reduction factor in the CY 2014 HH PPS final rule may be different from the one used to produce the proposed weights in this proposed rule. Please see the proposed weights in the Table 3.

TABLE 3—PROPOSED CY 2014 CASE-MIX WEIGHTS

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 Proposed HH PPS case-mix weights
10111	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F1S1	0.8186	0.6056
10112	1st and 2nd Episodes, 6 Therapy Visits	C1F1S2	0.9793	0.7245
10113	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F1S3	1.1401	0.8435
10114	1st and 2nd Episodes, 10 Therapy Visits	C1F1S4	1.3008	0.9623
10115	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4616	1.0813
10121	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F2S1	1.0275	0.7602
10122	1st and 2nd Episodes, 6 Therapy Visits	C1F2S2	1.1657	0.8624
10123	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F2S3	1.3039	0.9646
10124	1st and 2nd Episodes, 10 Therapy Visits	C1F2S4	1.4421	1.0669
10125	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5804	1.1692
10131	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F3S1	1.1233	0.8310
10132	1st and 2nd Episodes, 6 Therapy Visits	C1F3S2	1.2520	0.9262
10133	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3807	1.0215
10134	1st and 2nd Episodes, 10 Therapy Visits	C1F3S4	1.5094	1.1167
10135	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F3S5	1.6381	1.2119
10211	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F1S1	0.8340	0.6170
10212	1st and 2nd Episodes, 6 Therapy Visits	C2F1S2	1.0302	0.7622
10213	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F1S3	1.2265	0.9074
10214	1st and 2nd Episodes, 10 Therapy Visits	C2F1S4	1.4228	1.0526
10215	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6190	1.1978
10221	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F2S1	1.0429	0.7715
10222	1st and 2nd Episodes, 6 Therapy Visits	C2F2S2	1.2166	0.9001
10223	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3903	1.0286
10224	1st and 2nd Episodes, 10 Therapy Visits	C2F2S4	1.5641	1.1571
10225	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7378	1.2856
10231	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F3S1	1.1387	0.8424
10232	1st and 2nd Episodes, 6 Therapy Visits	C2F3S2	1.3029	0.9639

TABLE 3—PROPOSED CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 Proposed HH PPS case-mix weights
10233	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4671	1.0854
10234	1st and 2nd Episodes, 10 Therapy Visits	C2F3S4	1.6313	1.2069
10235	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F3S5	1.7956	1.3284
10311	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9071	0.6711
10312	1st and 2nd Episodes, 6 Therapy Visits	C3F1S2	1.1348	0.8395
10313	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3624	1.0079
10314	1st and 2nd Episodes, 10 Therapy Visits	C3F1S4	1.5900	1.1763
10315	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8177	1.3448
10321	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1160	0.8256
10322	1st and 2nd Episodes, 6 Therapy Visits	C3F2S2	1.3211	0.9774
10323	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5262	1.1291
10324	1st and 2nd Episodes, 10 Therapy Visits	C3F2S4	1.7313	1.2808
10325	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9364	1.4326
10331	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F3S1	1.2118	0.8965
10332	1st and 2nd Episodes, 6 Therapy Visits	C3F3S2	1.4074	1.0412
10333	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6030	1.1859
10334	1st and 2nd Episodes, 10 Therapy Visits	C3F3S4	1.7986	1.3306
10335	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F3S5	1.9942	1.4753
21111	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6223	1.2002
21112	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8331	1.3561
21113	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0438	1.5120
21121	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7186	1.2714
21122	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9496	1.4423
21123	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1807	1.6133
21131	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F3S1	1.7668	1.3071
21132	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F3S2	2.0252	1.4983
21133	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F3S3	2.2836	1.6894
21211	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8153	1.3430
21212	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0224	1.4962
21213	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2294	1.6493
21221	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9116	1.4142
21222	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1389	1.5824
21223	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3663	1.7506
21231	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F3S1	1.9598	1.4499
21232	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F3S2	2.2145	1.6383
21233	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F3S3	2.4691	1.8267
21311	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0453	1.5131
21312	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2682	1.6780
21313	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F1S3	2.4911	1.8429
21321	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1415	1.5843
21322	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3848	1.7643
21323	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6280	1.9442
21331	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F3S1	2.1897	1.6200
21332	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F3S2	2.4603	1.8202
21333	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7309	2.0203
22111	3rd+ Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6822	1.2445
22112	3rd+ Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8730	1.3857
22113	3rd+ Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0638	1.5268
22121	3rd+ Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7628	1.3041
22122	3rd+ Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9791	1.4642
22123	3rd+ Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1954	1.6242
22131	3rd+ Episodes, 14 to 15 Therapy Visits	C1F3S1	1.9247	1.4239
22132	3rd+ Episodes, 16 to 17 Therapy Visits	C1F3S2	2.1305	1.5762
22133	3rd+ Episodes, 18 to 19 Therapy Visits	C1F3S3	2.3362	1.7283
22211	3rd+ Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8508	1.3692
22212	3rd+ Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0460	1.5136
22213	3rd+ Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2412	1.6581
22221	3rd+ Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9314	1.4289
22222	3rd+ Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1521	1.5921
22223	3rd+ Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3729	1.7555
22231	3rd+ Episodes, 14 to 15 Therapy Visits	C2F3S1	2.0933	1.5486
22232	3rd+ Episodes, 16 to 17 Therapy Visits	C2F3S2	2.3035	1.7042
22233	3rd+ Episodes, 18 to 19 Therapy Visits	C2F3S3	2.5136	1.8596
22311	3rd+ Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0747	1.5349
22312	3rd+ Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2878	1.6925
22313	3rd+ Episodes, 18 to 19 Therapy Visits	C3F1S3	2.5009	1.8502
22321	3rd+ Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1553	1.5945
22322	3rd+ Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3940	1.7711

TABLE 3—PROPOSED CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 Proposed HH PPS case-mix weights
22323	3rd+ Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6326	1.9476
22331	3rd+ Episodes, 14 to 15 Therapy Visits	C3F3S1	2.3172	1.7143
22332	3rd+ Episodes, 16 to 17 Therapy Visits	C3F3S2	2.5453	1.8830
22333	3rd+ Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7734	2.0518
30111	3rd+ Episodes, 0 to 5 Therapy Visits	C1F1S1	0.6692	0.4951
30112	3rd+ Episodes, 6 Therapy Visits	C1F1S2	0.8718	0.6450
30113	3rd+ Episodes, 7 to 9 Therapy Visits	C1F1S3	1.0744	0.7949
30114	3rd+ Episodes, 10 Therapy Visits	C1F1S4	1.2770	0.9447
30115	3rd+ Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4796	1.0946
30121	3rd+ Episodes, 0 to 5 Therapy Visits	C1F2S1	0.8421	0.6230
30122	3rd+ Episodes, 6 Therapy Visits	C1F2S2	1.0263	0.7593
30123	3rd+ Episodes, 7 to 9 Therapy Visits	C1F2S3	1.2104	0.8955
30124	3rd+ Episodes, 10 Therapy Visits	C1F2S4	1.3945	1.0317
30125	3rd+ Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5787	1.1679
30131	3rd+ Episodes, 0 to 5 Therapy Visits	C1F3S1	0.9352	0.6919
30132	3rd+ Episodes, 6 Therapy Visits	C1F3S2	1.1331	0.8383
30133	3rd+ Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3310	0.9847
30134	3rd+ Episodes, 10 Therapy Visits	C1F3S4	1.5289	1.1311
30135	3rd+ Episodes, 11 to 13 Therapy Visits	C1F3S5	1.7268	1.2775
30211	3rd+ Episodes, 0 to 5 Therapy Visits	C2F1S1	0.7361	0.5446
30212	3rd+ Episodes, 6 Therapy Visits	C2F1S2	0.9591	0.7096
30213	3rd+ Episodes, 7 to 9 Therapy Visits	C2F1S3	1.1820	0.8745
30214	3rd+ Episodes, 10 Therapy Visits	C2F1S4	1.4049	1.0394
30215	3rd+ Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6278	1.2043
30221	3rd+ Episodes, 0 to 5 Therapy Visits	C2F2S1	0.9091	0.6726
30222	3rd+ Episodes, 6 Therapy Visits	C2F2S2	1.1136	0.8239
30223	3rd+ Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3180	0.9751
30224	3rd+ Episodes, 10 Therapy Visits	C2F2S4	1.5225	1.1264
30225	3rd+ Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7269	1.2776
30231	3rd+ Episodes, 0 to 5 Therapy Visits	C2F3S1	1.0022	0.7414
30232	3rd+ Episodes, 6 Therapy Visits	C2F3S2	1.2204	0.9029
30233	3rd+ Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4386	1.0643
30234	3rd+ Episodes, 10 Therapy Visits	C2F3S4	1.6568	1.2257
30235	3rd+ Episodes, 11 to 13 Therapy Visits	C2F3S5	1.8751	1.3872
30311	3rd+ Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9324	0.6898
30312	3rd+ Episodes, 6 Therapy Visits	C3F1S2	1.1609	0.8588
30313	3rd+ Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3893	1.0278
30314	3rd+ Episodes, 10 Therapy Visits	C3F1S4	1.6178	1.1969
30315	3rd+ Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8463	1.3659
30321	3rd+ Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1054	0.8178
30322	3rd+ Episodes, 6 Therapy Visits	C3F2S2	1.3154	0.9731
30323	3rd+ Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5254	1.1285
30324	3rd+ Episodes, 10 Therapy Visits	C3F2S4	1.7353	1.2838
30325	3rd+ Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9453	1.4392
30331	3rd+ Episodes, 0 to 5 Therapy Visits	C3F3S1	1.1985	0.8867
30332	3rd+ Episodes, 6 Therapy Visits	C3F3S2	1.4222	1.0522
30333	3rd+ Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6460	1.2177
30334	3rd+ Episodes, 10 Therapy Visits	C3F3S4	1.8697	1.3832
30335	3rd+ Episodes, 11 to 13 Therapy Visits	C3F3S5	2.0935	1.5488
40111	All Episodes, 20+ Therapy Visits	C1F1S1	2.2546	1.6680
40121	All Episodes, 20+ Therapy Visits	C1F2S1	2.4117	1.7842
40131	All Episodes, 20+ Therapy Visits	C1F3S1	2.5419	1.8805
40211	All Episodes, 20+ Therapy Visits	C2F1S1	2.4364	1.8025
40221	All Episodes, 20+ Therapy Visits	C2F2S1	2.5936	1.9188
40231	All Episodes, 20+ Therapy Visits	C2F3S1	2.7238	2.0151
40311	All Episodes, 20+ Therapy Visits	C3F1S1	2.7140	2.0078
40321	All Episodes, 20+ Therapy Visits	C3F2S1	2.8712	2.1241
40331	All Episodes, 20+ Therapy Visits	C3F3S1	3.0014	2.2205

We also note that we plan to continue to evaluate and potentially revise the case-mix weights relative to one another as more recent utilization and cost report data become available. Fully addressing MedPAC's concerns with the way the HH PPS factors therapy visits into the case-mix system is a complex process which will require more comprehensive analysis and potentially additional structural changes to the HH PPS. While we plan to address MedPAC's concerns in a more comprehensive way in future years, we propose that for the short term, we use the CY 2012 case-mix weights reset to an average case-mix of 1.0. We plan to continue to monitor case-mix growth

(both real and nominal case-mix growth), and address it accordingly in the future.

D. Rebasing the National, Standardized 60-day Episode Payment Rate, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor

1. Rebasing the National, Standardized 60-Day Episode Payment Rate

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 this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the amount (or amounts) in any given year applicable under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by CY 2017. To fulfill this mandate, we have performed extensive analysis of cost report and claims data. We used FY 2011 cost report data as of December 31, 2012; which was the latest, complete cost report data available at the time of the analysis.

a. Trimming Methodology

When examining data from all 10,327 Medicare cost reports from FY 2011, we found that a number of the cost reports had missing or questionable data and extreme values. These cost reports were often missing necessary information for calculating episode costs, reported significantly different data than data from prior cost reports for the same provider, or were markedly different than cost reports from the majority of HHAs during the same time period. Since these extreme values can significantly affect average estimated costs and are more indicative of misreporting rather than actual costs, we developed a trimming methodology to obtain a more robust estimate of costs.

The trimming methodology applied to the cost reports consisted of a two-tier process. First, providers' cost reports were compared longitudinally to identify large year-to-year discrepancies. Second, cost reports were compared cross-sectionally to cost reports from the same fiscal year. It should be noted that the trimming methodology was developed using FY 2000 through FY 2010 cost reports and then applied to the FY 2011 cost reports. The first step in the trimming methodology excluded all cost reports with missing provider numbers. In FY 2011, zero providers were excluded by this exclusion criterion. Next, cost reports that did not report the number of episodes were excluded from the FY 2011 sample. This restriction eliminated 2,348 of the FY 2011 cost reports. Of these 2,348 cost reports, 1,629 were also missing data on total costs or payments. The next step in the trimming methodology excluded cost reports that were significantly different from prior cost reports from the same provider. Specifically, we sorted the FY 2000 to FY 2011 cost reports by fiscal year for each provider and excluded a cost report if the number of episodes reported increased from the provider's previous cost report to the current cost report by: (1) More than a factor of ten and the new report of episodes is greater than 1,000; or (2) more than a factor of five and the new report of episodes is greater than or equal to 5,000. After dropping cost reports which met these exclusion criteria, the process was repeated for two additional iterations. This exclusion criterion resulted in the exclusion of 171 cost reports from the FY 2011 sample. The goal of this longitudinal exclusion criterion was to systematically eliminate misreporting of episodes.

Initially, we did not apply longitudinal trims; however, when looking at the cost reports from FY 2000 through FY 2011, we identified large drops in the average number of visits per episode across the years, which then resulted in a lower average cost per episode. Further examination of the cause of the drops in average visits per episode led to the identification of a number of providers who seemingly misreported the number of episodes on the cost report. The data showed that the number of episodes on the cost reports often outnumbered the number of episodes from the claims by factors of 10 or 20. Therefore, we developed the longitudinal trim to increase the accuracy of the data from the cost reports. After the longitudinal restriction was applied, there were 7,808 cost reports in the FY 2011 cost report sample.

After the longitudinal trims, we applied cross sectional trims to the sample, consisting of basic exclusions, some of which are similar to MedPAC's exclusion criteria. Specifically, cost reports were excluded if they met any of the following criteria:

- Cost report was not settled or tentatively settled (for freestanding facilities only).
- Time covered by the cost report was less than 10 months or greater than 14 months.
- The cost report was missing total payment or total cost information.
- Costs per episode were in the highest and lowest 1 percent across providers in the given year.
- The cost report had a negative value for the number of visits per episode for any discipline, as reported directly in the visit information.[1]
- The cost report showed an unreasonably high visit count (greater than 500,000,000) in any discipline. (*Note:* There were no cost reports with unreasonable high visit counts in FY 2011.)
- The cost report had negative average costs per visit in any discipline, derived from reported costs and visits on the cost report.
- The cost report had negative total costs.
- The provider reported fewer than 10 Medicare non-LUPA episodes on the FY cost report.
- The cost report was missing discipline-specific cost information where there was information on visits or vice versa.

In Table 4, we list information on the number of cost reports trimmed for each criterion. After applying the cross sectional trims, 6,252 cost reports were left in the 2011 sample. These cost reports were then used to estimate the average cost per visit and average cost per episode for 2011. We note that using the trimmed sample results in an estimated average cost per episode that was $1,000 more than the estimated cost per episode using the untrimmed, complete cost report sample.

[1] Visit information was taken from worksheet S3, column 5, rows 1–6 for freestanding providers and worksheet H6, column 4, rows 1–6 for hospital-based providers.

TABLE 4—COUNTS FOR EXCLUSION CRITERIA USED TO DEVELOP THE TRIMMED COST REPORT SAMPLE

Restrictions in cost report sample	Number of cost reports
Untrimmed sample size	10,327
Longitudinal restrictions:	
Missing Provider Number	0
Missing Episode Count	2348
Significant Episode Change from year to year	92
2nd iteration	54
3rd iteration	25
Sample Size after Longitudinal Restrictions	7808
Cross Sectional Restrictions:	
Not Settled (freestanding only)	874
<10 or >14 months in report	210
Missing Payments or Costs	11
Top and Bottom 1% of costs/episode	163
Greater than 500,000,000 visits	0
Negative costs per visit	5
Negative visits per episode	0
Negative total costs	0
Less than ten episodes	60
Missing visits when costs are reported or vice versa	375
Number of Cost Reports excluded by Cross Sectional Restrictions	1,556
Trimmed Cost Report sample	6,252

Note(s): The cross sectional restrictions are implemented simultaneously so cost reports may be counted in a number of the cross sectional restrictions (the numbers describing the cost reports for each of the cross sectional restrictions are not mutually exclusive). There were 1,556 cost reports excluded from the sample as a result of the cross sectional restrictions.

b. Cost Report Audits

To verify the integrity of the cost report data and to assess the validity of the trimming methodology, one of our Medicare Administrative Contractors (MAC) was tasked with performing audits of 100 HH cost reports. The cost reports were selected from a trimmed sample of FY 2010 cost reports, which was the latest data available at the time, and the audit sample was stratified across provider characteristics (such as agency size and ownership status) to ensure representation across provider types. Cost reports with 95 or fewer episodes were excluded from the audit sample so that we could focus the audits on providers that have a significant weight in the sample and that may have a substantial influence on the average costs per visit and the cost per episode estimates. In addition, we note that the audit sample was selected from a trimmed sample that had additionally been cross-referenced with claims data for accuracy.

The MAC conducted 98 audits. Two providers did not provide the information needed to complete the audit. The audit results showed that the majority of providers in the audit sample overstated their costs on the cost report by an average of about 8 percent. Commonly, providers reported non-allowable costs or lacked sufficient documentation to justify the allowable costs, which led to a decrease in the costs per visit. There were a small number of cases where the costs per visit either increased or were unchanged as a result of the audit. Of the 98 providers audited, eight providers were referred to the Zone Program Integrity Contractors for further fraud investigation as a result of the findings in their audits.

After obtaining the audit results, we applied weights to the data in the audit sample so that it would be representative of the trimmed sample and we could compare the costs per visit per discipline in the trimmed sample to the pre-audit sample and the post audit sample. The trimmed sample resulted in a slightly higher average cost per episode when compared to data in the pre-audit sample. When comparing the pre-audit sample data to the post-audit sample data, we observed an average reduction of 8 to 9 percent in the costs per visit across all disciplines, except medical social services which averaged a 5 percent reduction in the allowable costs per visit. These audited costs per visit across the disciplines reduced the average cost per episode by 7.8 percent when comparing the pre-audit data to the post-audit adjusted data. The results of the audits indicate that the trimmed sample used for this proposed rule likely over-estimates the average cost per visit and average cost per episode for providers.

c. Weighting the 2011 Trimmed Medicare Cost Report Sample and Computation of the 2011 Estimated Cost per Episode

After applying the trimming methodology to the 2011 Medicare cost reports, we computed the estimated mean cost per visit per discipline by dividing the total costs for a discipline by the total number of visits in our sample. We then applied weights to the sample to ensure that the costs per visit, per discipline used to calculate the average costs per episode were nationally representative. We calculated and applied weights based on three characteristics: provider type, provider size, and the providers' urban/rural status. We determined provider size by examining the number of episodes by provider on the 2011 claim. We determined provider type and urban/rural status by matching the trimmed cost report sample to the Provider of Services file. The Provider of Service file is data collected through the survey and certification process conducted for any institutional provider seeking inclusion in the Medicare and Medicaid programs. It contains information such as provider name, address, staffing, number of beds, ownership, and is used internally and by researchers to obtain certification information about the provider.

To weight the costs per visit per discipline in our sample to be nationally representative, we compared the number of visits in our sample in each

provider type-size-urban/rural combination to the number of visits in the provider type-size-urban/rural combination as taken from the national 2011 claims. The visits for a particular provider were weighted by the ratio of the number of visits in the type-size-urban/rural combination in the national claims over the number of visits in the type-size-urban/rural combination in our sample. That is, the total number of visits in the sample were weighted such that the total weights (weighted visits) in each of the type-size-urban/rural combination equaled the number of visits in the type-size-urban/rural combination as recorded on the claims, and the sum of weighted visits across all type-size-urban/rural combinations equals the total number of visits recorded on the claims. After reweighting the visits, the average costs per visit for each discipline for a provider was recalculated. We note that the weight each provider contributes to the average costs per visit is equal to the number of visits the provider reported on the cost report times the total number of visits for the provider's type-size-urban/rural combination in the national claims divided by the number of visits in the provider's type-size-urban/rural combination in our sample. As such, providers with a higher number of visits still receive more weight in calculating the mean, aside from the type-size-urban/rural representativeness adjustment. The estimated costs per visit per episode before and after weighting are shown in Table 5. The weighting results in higher average costs per visit for all disciplines as compared to the un-weighted average costs per visit. The CMS Home Health Agency (HHA) Center Web site (*http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*) provides a file with the resulting weights, the provider number, provider type, provider size, and urban/rural status and average costs per visit by discipline that can be used to produce the weighted average costs per visit for all disciplines as presented in Table 5. Documentation describing the fields on the cost report we used in our calculations is also available at *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp*.

TABLE 5—2011 ESTIMATED COSTS PER VISIT, UN-WEIGHTED AND WEIGHTED

Discipline	2011 Per-visit costs, unweighted	2011 Per-visit costs, weighted
Skilled Nursing	$129.56	$131.51
Home Health Aide	65.07	65.22
Physical Therapy	159.99	160.69
Occupational Therapy	158.96	159.55
Speech-Language Pathology	169.28	170.80
Medical Social Services	217.63	218.91

Source: CY 2011 Medicare claims data and FY 2011 Medicare cost report data as of December 31, 2012.
Notes(s): The costs per visit, per discipline for providers were weighted by provider type, provider size and urban/rural status to be nationally representative.

Using the nationally-weighted average costs per visit from the trimmed FY 2011 HH Medicare cost report sample and the visits per episode estimates for each discipline from 2011 national claims data, we estimated the 2011 average cost per episode. As shown in Table 6, we multiplied the average cost per visit by the average number of visits for each of the six disciplines and summed the results to generate an estimated 60-day episode cost for 2011 of $2,453.71. This methodology used to calculate the episode cost is consistent with the methodology used in setting the 60-day episode base rate for the HH PPS in 2000. We note that the 2011 estimated cost per episode includes normal, PEP, and outlier episodes.

TABLE 6—2011 AVERAGE COSTS PER VISIT AND AVERAGE NUMBER OF VISITS FOR A 60-DAY EPISODE

Discipline	2011 Average costs per visit	2011 Average number of visits	2011 60-Day episode costs
Skilled Nursing	$131.51	9.43	$1,240.14
Home Health Aide	65.22	2.80	182.62
Physical Therapy	160.69	4.86	780.95
Occupational Therapy	159.55	1.15	183.48
Speech- Language Pathology	170.80	0.21	35.87
Medical Social Services	218.91	0.14	30.65
Total	.....	.....	$2,453.71

Source: CY 2011 Medicare claims data and 2011 Medicare cost report data as of December 31, 2012.

d. Calculating the Estimated Average Cost per Episode

To determine the rebasing adjustment to the 60-day national, standardized episode payment rate, we compared the 2013 estimated average payment per episode to the 2013 estimated average cost per episode. To calculate the 2013 estimated average cost per episode, we first applied an adjustment to account for the visit distribution change observed in claims data from 2011 to 2012 (Table 7). We compared the 2011 estimated cost per episode using the 2011 visit distribution to the 2011 estimated cost per episode using the 2012 visit distribution. The 2011 estimated cost per episode is $2,453.71 when using the 2011 visit profile and the 2011 estimated cost per episode is $2,443.34 when using the 2012 visit profile. Using the two 2011 estimated costs per episode, we calculated an adjustment factor to account for the visit

difference between 2011 and 2012 claims (1 + (2443.34–2453.71)/2453.71 = 0.9958). We plan to update the 2012 visit distribution as more data become available, and therefore, the estimated cost per episode may change slightly for the final rule.

TABLE 7—COMPARISON OF THE 2011 AND 2012 VISIT DISTRIBUTION FROM CLAIMS DATA

Discipline	2011 Average number of visits per episode	2012 Average number of visits per episode
Skilled Nursing	9.43	9.39
Home Health Aide	2.80	2.62
Physical Therapy	4.86	4.88
Occupational Therapy	1.15	1.15
Speech- Language Pathology	0.21	0.23
Medical Social Services	0.14	0.14
Total Number of Visits per Episode	18.59	18.41

Source: CY 2011 Medicare claims data and CY 2012 Medicare claims data for episodes starting between January 1, 2012, and May 31, 2012.

After applying the adjustment to account for the visit distribution change between 2011 and 2012, we multiplied the estimated, average cost per episode by the HH market basket update for 2012 and by the HH market basket update for 2013. We note that when setting the 60-day episode base rate for the HH PPS in 2000, we also updated costs from cost reports by the market basket updates to reflect expected cost increases. This gives us an estimated, average cost per episode for CY 2013.

TABLE 8—2013 ESTIMATED COST PER EPISODE

2011 Estimated cost per episode	Factor for 2011–2012 visit distribution difference	2012 Market basket update	2013 Market basket update	2013 Estimated cost per episode
$2,453.71	× 0.9958	× 1.024	× 1.023	= $2,559.59

e. Calculating the Estimated Average Payment per Episode

To develop the 2013 estimated average payment per episode, we started with the CY 2012 national, standardized 60-day episode payment rate and applied a number of factors. Since we are proposing to reset the average case-mix weight from 1.3517 to 1.0000 (see section III.C. of this proposed rule), we first increased the CY 2012 60-day episode payment rate by 1.3517. The 60-day episode payment rate in CY 2012 was $2,138.52. By inflating the CY 2012 60-day episode payment rate by the budget neutrality factor to account for the downward adjustment of the weights to an average case-mix of 1.0000, we obtain the average CY 2012 payment per episode. Then by applying the CY 2013 payment policy updates (1.3 percent HH payment update percentage and the 1.32 percent payment reduction for nominal case-mix growth), we obtain the estimated average CY 2013 payment per episode. We note that the Medicare cost reports do not differentiate between normal, PEP, and outlier episodes in the reporting of costs per discipline. Therefore, the CY 2013 estimated average cost per episode includes costs for normal, PEP, and outlier episodes. To compare the episode payment to the average cost of an episode, we add the dollars from the 2.5 percent outlier pool back into the payment per episode (Table 9). In our calculation of the proposed CY 2014 national, standardized 60-day episode payment rate, we remove the outlier dollars (see Tables 16 and 17 in section III.E.4.b. of this proposed rule).

TABLE 9—2013 ESTIMATED AVERAGE PAYMENT PER EPISODE

2012 National, standardized 60-day episode payment rate	Budget neutrality factor to account for case-mix weight adjustment to 1.00	2013 Payment reduction for nominal case-mix growth	2013 HH Payment update percentage	Outlier adjustment	2013 Estimated average payment per episode
$2,138.52	× 1.3517	× 0.9868	× 1.013	÷ 0.975	= $2,963.65

f. Calculating the Rebasing Adjustment to the National, Standardized 60-day Episode Payment Rate

Comparing the 2013 estimated average payment per episode to the 2013 estimated average cost per episode; we obtain a difference of −13.63 percent (($2,559.59–$2,963.65)/$2,963.65) (see Table 10).

TABLE 10—COMPARISON OF THE AVERAGE PAYMENT PER EPISODE TO THE AVERAGE COST PER EPISODE

2013 Payment per episode	2013 Estimated cost per episode	Percent difference
$2,963.65	$2,559.59	−13.63

Phasing-in the −13.63 percent reduction over 4 years in equal increments would result in an annual reduction of 3.60 percent. Since the Affordable Care Act states that the reduction may be no more than 3.5 percent, we propose to reduce payments in each year from CY 2014 to CY 2017 by 3.5 percent.

2. Rebasing the Low Utilization Payment Adjustment (LUPA) Per-Visit Payment Amounts

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA.

a. Calculating the Rebasing Adjustment to the LUPA Per-Visit Amounts

To determine the rebasing adjustment for the per-visit payment rates, we compare the current per-visit, per-discipline payment rates to the estimated cost per visit, per discipline. The 2013 estimated per-visit costs per discipline are shown in Table 11. The 2011 per-visit costs per discipline are the same as those derived for the rebasing of the national, standardized 60-day episode payment rate (see Table 6). The average cost per-visit for NRS from the cost report sample is added to the 2011 estimated per-visit costs per discipline (see section III.D.3. of this proposed rule for more information on the calculation of the average NRS cost per visit). The per-visit costs are then increased by the HH market basket in 2012 and 2013 to obtain an estimate of the 2013 costs per visit, per discipline.

TABLE 11—2013 ESTIMATED AVERAGE COST PER-VISIT, PER-DISCIPLINE

Discipline	2011 Estimated average costs per visit	Average NRS cost per visit	2012 Market basket update	2013 Market basket update	2013 Estimated average cost per visit
Skilled Nursing	$131.51	+ $2.26	× 1.024	× 1.023	= $140.13
Home Health Aide	65.22	+ 2.26	×1.024	× 1.023	= 70.69
Physical Therapy	160.69	+ 2.26	×1.024	× 1.023	= 170.70
Occupational Therapy	159.55	+ 2.26	× 1.024	× 1.023	= 169.50
Speech-Language Pathology	170.80	+ 2.26	× 1.024	× 1.023	= 181.29
Medical Social Services	218.91	+ 2.26	× 1.024	× 1.023	= 231.69

Similar to the methodology used to determine the rebasing adjustment to the national, standardized 60-day episode payment rate, we took the current 2013 per-visit payment rates and, for comparison purposes only, put the dollars from the 2.5 percent outlier pool back into the payment rates (see Table 12). This allows us to compare the CY 2013 cost per-visit, per-discipline on the Medicare cost reports (which includes normal and outlier episodes) to the CY 2013 payment per-visit, per discipline.

TABLE 12—2013 PER-VISIT PAYMENT RATES

Discipline	2013 Per-visit payment rates (excluding outliers)	Outlier adjustment	2013 Per-visit payment rates (including outliers)
Skilled Nursing	$114.35	÷ 0.975	= 117.28
Home Health Aide	51.79	÷ 0.975	= 53.12
Physical Therapy	125.03	÷ 0.975	= 128.24
Occupational Therapy	125.88	÷ 0.975	= 129.11
Speech-Language Pathology	135.86	÷ 0.975	= 139.34
Medical Social Services	183.31	÷ 0.975	= 188.01

When comparing the payment per-visit, per discipline for LUPA episodes to the estimated average cost per-visit, per-discipline, we observe that costs per visit are higher than the 2013 per-visit payment rates (see Table 13) in the range of 19.5 percent to 33.1 percent. However, section 3131(a) of the Affordable Care Act mandates that we can only adjust the per-visit payment rates by 3.5 percent each year. Therefore, in this CY 2014 HH PPS propose rule, we propose to increase the per-visit payment rates by 3.5 percent every year from 2014 to 2017.

TABLE 13—DIFFERENCES BETWEEN THE CY 2013 PER VISIT PAYMENT RATES AND THE CY 2013 ESTIMATED AVERAGE COST PER VISIT

Discipline	2013 Per-visit payment rates	2013 Estimated average cost per visit	Difference
Skilled Nursing	$117.28	$140.13	+19.48%
Home Health Aide	53.12	70.69	+33.08%
Physical Therapy	128.24	170.70	+33.11%
Occupational Therapy	129.11	169.50	+31.28%
Speech- Language Pathology	139.34	181.29	+30.11%
Medical Social Services	188.01	231.69	+23.23%

3. Rebasing the Nonroutine Medical Supply (NRS) Conversion Factor

Payments for NRS are currently paid for by multiplying one of six severity levels by the NRS conversion factor. When the HH PPS was implemented on October 1, 2000, the national, standardized 60-day episode payment rate included an amount for NRS that was calculated based on costs from audited FY 1997 cost reports and the average cost of NRS unbundled and billed through Medicare part B (65 FR 41180). The NRS costs for all the providers in the audited cost report sample were weighted to represent the national population. That weighted total was divided by the number episodes for the providers in the audited cost report sample, to obtain an average cost per episode for NRS of $43.54. Added to this amount was $6.08 to account for the average cost of unbundled NRS billed through Medicare Part B, resulting in a total of $49.62 included in the national, standardized 60-day episode payment rate to account for NRS.

As stated in our CY 2008 HH PPS proposed rule, after the HH PPS went into effect, we received comments and correspondence expressing concern about the cost of supplies for certain patients with ''high'' supply costs (72 FR 25427, May 4, 2007). We acknowledged that, in general, NRS use is unevenly distributed across episodes of care. Therefore, we created an NRS conversion factor of $52.35 (the amount CMS originally included in the national, standardized 60-day episode payment rate of $49.62, updated by the market basket, and after an adjustment to account for nominal change in case-mix) that is further adjusted by one of six severity levels to ensure that the variation in NRS usage is more appropriately reflected in the HH PPS (72 FR 49852, August 29, 2007). Using additional variables from OASIS items and targeting certain conditions expected to be predictors of NRS use based on clinical considerations, a classification algorithm puts cases into one of the six severity levels and a regression model was used to develop the payment weights associated with each severity level. For more detail on how the final six NRS severity levels and associated payment weights were developed please see the CY 2008 HH PPS final rule (72 FR 49850, August 29, 2007). The 2008 NRS conversion factor has been updated by HH payment update percentages in years 2009 through 2013. The CY 2013 NRS conversion factor is $53.97 and CY 2013 NRS payments range from $14.56 for severity level 1 to $568.06 for severity level 6 (77 FR 67102).

a. Calculating the Rebasing Adjustment to the NRS Conversion Factor

In rebasing the NRS conversion factor, we used the trimmed sample of 6,252 cost reports from FY 2011, as described in section III.D.1. of this proposed rule, to calculate a visit-weighted estimate of NRS costs per visit. We additionally weight these estimates to be nationally representative based on the same factors described in section III.D.1. of this proposed rule (that is, facility type, urban/rural status, and facility size). The 2011 average NRS cost per visit was calculated to be $2.26.

To calculate, a 2011 estimated average NRS cost per episode we multiplied the average NRS costs per visit of $2.26 by the average number of visits per episode of 18.59 from 2011 claims data for a 2011 estimated average NRS cost per episode of $42.01. This amount was then adjusted to reflect the change in the average number of visits from 18.59, using 2011 claims data, to 18.41, using preliminary 2012 claims data ((1+((18.41–18.59)/18.59))= 0.9903). We inflated the result by the 2012 and 2013 HH market basket updates for a 2013 estimated average NRS cost per episode of $43.59 as shown in Table 14.

TABLE 14—2013 ESTIMATED AVERAGE NRS COST PER EPISODE

2011 Estimated average NRS cost per episode	Adjustment for change in average episode visits (2011 to 2012)	2012 Market basket update (2.4%)	2013 Market basket update (2.3%)	2013 Estimated average NRS cost per episode
$42.01	× 0.9903	×1.024	× 1.023	$43.58

To compare the 2013 estimated average NRS cost per episode to 2013 estimated average NRS payment per episode; we used preliminary 2012 claims data for non-LUPA episodes and the CY 2013 NRS conversion factor of $53.97 to determine the estimated 2013 average NRS payment per episode. The preliminary 2012 claims data shows that the distribution of episodes amongst the six severity levels differs from the distribution used when the NRS conversion factor and relative weights were established in CY 2008 as shown in Table 15.

TABLE 15—PERCENTAGE OF EPISODES BY NRS SEVERITY LEVEL

Severity level	Relative weight	Percent of episodes, CY 2008	Percent of episodes, CY 2012 (percent)
1	0.2698	63.7	69.5
2	0.9742	20.6	16.8
3	2.6712	6.7	6.2
4	3.9686	5.4	4.3
5	6.1198	3.2	2.9
6	10.5254	0.3	0.3

Source: The CY 2008 HH PPS Final Rule (72 FR 49852, August 29, 2007) and CY 2012 Medicare claims data for non-LUPA HH episodes beginning on or before May, 31, 2012, as of December 31, 2012.

Note(s): The distribution of episodes used to establish the CY 2008 relative weights was based on CY 2004 and CY 2005 claims data and a sample consisting of all agencies whose total charges reported on their 2001 claims matched their total charges reported in their 2001 cost reports (72 FR 49852).

Using the distribution of 2012 claims by severity level (Table 15), the relative weights, and the CY 2013 conversion factor of $53.97, the CY 2013 estimated average NRS payment per episode is $48.38. Comparing the 2013 estimated average NRS cost per episode to the 2013 estimated average NRS payment per episode, we obtain a difference of −9.92 percent (($43.58 − $48.38)/$48.38). Phasing-in the −9.92 percent reduction over 4 years in equal increments would result in an annual reduction of 2.58 percent. Therefore, we propose to reduce the NRS conversion factor in each year from 2014 to 2017 by 2.58 percent. We note that during our analysis of NRS costs and payments, we found that a significant number of providers listed charges for NRS on the home health claim, but those same providers did not list any NRS costs on their cost reports. Specifically, out of the 6,252 cost reports from FY 2011, as described in section III.D.1. of this proposed rule, 1,756 cost reports (28.1 percent) reported NRS charges in their claims, but listed $0 NRS costs on their cost reports. Given the need for extensive trimming of the cost reports as well as the findings from the audits and our analysis of NRS payments and costs, we are exploring possible additional edits to the cost report and quality checks at the time of submission to improve future cost reporting accuracy. We plan to update the 2012 distribution of episodes amongst the six severity levels as more data become available, and therefore, the estimated NRS cost per episode may change slightly for the final rule. For more information on the rebasing analyses performed, refer to the technical report titled ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates'' available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp.*

E. Proposed CY 2014 Rate Update

1. Proposed CY 2014 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. For CY 2014, there is no such percentage reduction. Therefore, the CY 2014 payment rates will be increased by the full HH market basket update.

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for CY 2014 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 2014 is 2.4 percent. This is based on Global Insight Inc.'s second quarter 2013 forecast, utilizing historical data through the first quarter of 2013. The HH 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 Quality Reporting Program (HHQRP)

a. General Considerations Used for Selection of Quality Measures for the HHQRP

The successful development of the HH Quality Reporting Program (HHQRP) that promotes the delivery of high quality healthcare services is our paramount concern. We seek to adopt measures for the HHQRP that promote efficient and safer care. Our measure selection activities for the HHQRP 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 by the NQF 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. Input from the MAP is located at *http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.* For more details about the pre-rulemaking process, see the FY 2013 IPPS/LTCH PPS final rule at 77 FR 53376 (August 31, 2012).

We also take into account national priorities, such as those established by the National Priorities Partnership at *http://www.qualityforum.org/npp/,* the HHS Strategic Plan *http://www.hhs.gov/secretary/about/priorities/priorities.html,* and the National Strategy for Quality Improvement in Healthcare located at *http://www.healthcare.gov/news/reports/nationalqualitystrategy032011.pdf.*

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 providers, purchasers/payers, and other stakeholders.

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 HHA that does not submit data to the Secretary in accordance with subclause (II) with respect to such a year, the HH 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 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 sub clause (II) available to the public. Such procedures shall ensure that a HHA 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.''

As codified at § 484.250(a), we established that the quality reporting requirements could be met by the submission of OASIS assessments and HH Care Consumer Assessment of Healthcare Providers and Systems Survey (HHCAHPS®). CMS has provided quality measures to HHAs via the Certification and Survey Provider Enhanced Reports (CASPER) reports available on the CMS Health Care Quality Improvement System (QIES) since 2002. A subset of the HH quality measures has been publicly reported on the 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 CY 2013 HH PPS final rules (76 FR68575 and 77 FR67093, respectively), we finalized that we would also use measures derived from Medicare claims data to measure HH quality.

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

The HH 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 under the HH CoPs § 484.1 through § 484.265. 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 nonskilled 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).

d. Home Health Care Quality Reporting Program Requirements for CY 2014 Payment and Subsequent Years

(1) Submission of OASIS Data

For CY 2014, we propose 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. This time period would allow for 12 full months of data collection and would provide us with the time necessary to analyze and make any necessary payment adjustments to the payment rates for CY 2014. We propose to continue this pattern for each subsequent year beyond CY 2014, considering OASIS assessments submitted in the time frame between July 1 of the calendar year 2 years prior to the calendar year of the Annual Payment Update (APU) effective date and July 1 of the calendar year 1 year prior to the calendar year of the APU effective date as fulfilling the OASIS portion of the quality reporting requirement for the subsequent APU.

(2) Home Health Rehospitalization and Emergency Department Use Without Readmission Claims-Based Measures

We propose to adopt two claims-based measures: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. These measures were included on the Measures Under Consideration list reviewed by the MAP in December 2012 and the MAP supported the direction of both measures. The Rehospitalization during the first 30 days of HH measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases in which patients who had an acute inpatient hospitalization in the 5 days before the start of their HH stay were admitted to an acute care hospital during the 30 days following the start of the HH stay.

The Emergency Department Use without Readmission measure estimates the risk-standardized rate of unplanned, all-cause hospital readmissions for cases in which patients who had an acute inpatient hospitalization in the 5 days before the start of a HH stay used an emergency department but were not admitted to an acute care hospital during the 30 days following the start of a HH stay.

We seek to develop a set of quality measures to report on HH patients who are recently hospitalized as these patients are at an increased risk of acute care hospital use, either through inpatient admission or emergency department use without inpatient admission. Addressing unplanned hospital readmissions is a high priority for HHS as our focus continues on promoting patient safety, eliminating healthcare associated infections, improving care transitions, and reducing the cost of healthcare. Readmissions are costly to the Medicare program and have been cited as sensitive to improvements in coordination of care and discharge planning for patients. Rates of rehospitalization remain substantial with 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of care. Currently, HHAs focus on measures of acute care hospitalization (applied to all HH patients) as a measure of their effectiveness. We will continue to publicly report the Acute Care Hospitalization and Emergency Department Use without Hospitalization measures, as these measures apply to all home health patients and will continue to be useful in selecting a home health agency. The proposed rehospitalization measures will allow HHAs to further target patients who entered HH after a hospitalization.

The proposed measures of acute care utilization by previously hospitalized patients are developed out of the NQF endorsed claims-based measures: (1) Acute Care Hospitalization (NQF #0171); and (2) Emergency Department Use without Hospitalization (NQF #0173) to better capture acute care hospitalizations and use of an emergency department for patients who are recently discharged from the hospital. These rehospitalization measures are harmonized with NQF-endorsed Hospital-Wide Risk-Adjusted All-Cause Unplanned Readmission Measure (NQF #1789) (see *http://www.qualityforum.org/Publications/2012/07/Patient_Outcomes_All-Cause_Readmissions_Expedited_Review_2011.aspx)* finalized for the Hospital IQR Program in the FY 2013 IPPS/LTCH PPS Final Rule (77 FR 53521 through 53528). Further, to the extent appropriate, the proposed HH rehospitalization measures are being harmonized with this measure and other measures of readmission rates developed for post-acute care (PAC) settings.

We intend to seek NQF endorsement of the: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Readmission during the first 30 days of HH measures. We are proposing to begin reporting feedback to HHAs on performance on these measures in CY 2014. These measures will be added to Home Health Compare for public reporting in CY2015. Additional details pertaining to these measures, including technical specifications, can be found at the HH Quality Initiative Web page located at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.*

We seek public comment on our proposed quality measures: (1) Rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH.

(3) Elimination of Stratification by Episode Length Process Measures

We are exploring ways to reduce the number of HH quality measures reported to HHAs on confidential CASPER reports. We propose to reduce the total number of measures on the CASPER reports by beginning to report only all-episodes measures for 9 process measures currently also stratified by episode length. We seek comments on this proposal to simplify reporting of process measures, which is based on the recommendation from the MAP to seek greater parsimony in these measures. Currently there are 97 quality measures included on the CASPER reports, of which 45 are process measures. This proposed reduction would decrease the total number of HH quality measures to 79 and reduce the number of process measures from 45 to 27. This change will enable HHAs to obtain the information they require for quality improvement activities related to the process measures in a less burdensome manner. Reducing the number of measures also facilitates the future development and implementation of other superior HH measures.

Nine measures currently stratified by episode length on CASPER reports include:

- Depression Interventions Implemented.
- Diabetic Foot Care and Patient/Caregiver Education Implemented.
- Heart Failure Symptoms Addressed.
- Pain Interventions Implemented.
- Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented.
- Pressure Ulcer Prevention Implemented.
- Drug Education on All Medications Provided to Patient/Caregiver.
- Potential Medication Issues Identified and Timely Physician Contact.
- Falls Prevention Steps Implemented.

For each of these nine measures, three versions of each measure are currently included on CASPER reports. The three versions are: (1) Short term episodes of care; (2) long term episodes of care; and (3) all episodes of care. We propose to eliminate the stratification by episode length, so that these measures are reported only for ''all episodes of care''. Thus, we propose to eliminate the ''short term'' and ''long term episodes of care'' measures from CASPER reports. This would remove 18 process measures from the current CASPER reports. Of note, only the ''short term episodes of care'' measures are currently reported on HH Compare. These would be replaced with the analogous ''all episodes of care'' measures.

No data will be lost in the elimination of the ''short and long term episodes of care'' measures as the ''all episodes of care'' measures capture all care interventions, regardless of episode length. Using only the ''all episodes of care'' measures would substantially increase the number of HHAs eligible for public reporting of these measures.

To summarize, for the CY 2014 payment update and for subsequent annual payment updates, we propose to continue to use a HHA's submission of OASIS assessments between July 1, and June 30 as fulfilling one portion of the quality reporting requirement for each payment year. Medicare claims data and HHCAHPS® data will also be used to measure HH care quality. We propose to adopt two claims-based measures: (1) rehospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. We propose to reduce the number of process measures by eliminating the stratification by episode length, only reporting on the ''all episodes of care'' measures. By eliminating the stratification of the short and long term episodes of care measures, there will be a reduction in the number of HH quality measures reported to HHAs on confidential CASPER reports.

e. Home Health Care CAHPS® Survey (HHCAHPS) ®

In the CY 2013 HH PPS final rule (77 FR 67094), we stated that the HH quality measures reporting requirements for Medicare-certified agencies includes the CAHPS® HH Care (HHCAHPS®) Survey for the CY 2013 APU. In CY 2012, we moved forward with the HHCAHPS® linkage to the pay-for-reporting (P4R) requirements affecting the HH PPS rate update for CY 2012. We maintained the stated HHCAHPS data requirements for CY 2013 that were set out in the CY 2012 HH PPS final rule, and in the CY 2013 HH PPS final rule, 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 have implemented a process to measure and publicly report patient experiences with HH 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 HH Care CAHPS® (HHCAHPS®) survey presents HH patients with a set of standardized questions about their HH care providers and about the quality of their HH care.

Prior to this survey, there was no national standard for collecting information about patient experiences that would enable valid comparisons across all HHAs. The history and development process for HHCAHPS® has been described in previous rules and it 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 required HHAs to report five measures—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 HH 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 focuses on areas where the HH patient is the best or only source for the information. The developmental work for the HHCAHPS® survey began in mid-2006, and the first HHCAHPS® survey was field-tested (to validate the length and content of the survey) in 2008 by the AHRQ and the CAHPS® grantees, and the final HHCAHPS® survey was used in a national randomized mode experiment in 2009 through 2010.

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 HH patient population.

All of the requirements about HH patient eligibility for the HHCAHPS® survey and conversely, which HH 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.* HH patients are eligible for HHCAHPS® if they received at least two skilled HH visits in the past 2 months, which are paid for by Medicare or Medicaid.

HH 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. 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.

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 now 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 CY 2010, CY 2011, CY 2012, and CY 2013 final rules, all 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
- 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 HH Care CAHPS® 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), 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) HHCAHPS® Requirements for the CY 2014 APU

In the CY 2013 HH PPS final rule (77 FR 67094), we stated that we would require continued monthly HHCAHPS® data collection and reporting for 4 quarters for the HHCAHPS® requirements for CY 2014 APU. The data collection period for the CY 2014 APU includes the second quarter 2012 through first quarter 2013 (the months of April 2012 through March 2013). HHAs were required to submit their HHCAHPS® data files to the HH CAHPS® Data Center for the second quarter 2012 by 11:59 p.m., Eastern daylight time (e.d.t.) on October 18, 2012; for the third quarter 2012 by 11:59 p.m., Eastern standard time (e.s.t.) on January 17, 2013; for the fourth quarter 2012 by 11:59 p.m., e.d.t. on April 18, 2013; and for the first quarter 2013 by 11:59 p.m., e.d.t. on July 18, 2013. These deadlines are firm; no exceptions are permitted.

We stated that we exempt HHAs receiving Medicare certification on or after April 1, 2012, from the full HHCAHPS® reporting requirement for the CY 2014 APU, because these HHAs were not Medicare-certified in the period of April 1, 2011, through March 31, 2012. These HHAs would not need to complete a HHCAHPS® Participation Exemption Request form for the CY 2014 APU. The Participation Exemption Form is discussed in the Collection of Information section of this rule. The form was used since CY 2012, and it was cited in the PRA package in 2010, but it did not have its own OMB number. We have submitted a revised PRA package about the HHCAHPS® survey (the package expires in March 2014) that also includes more information regarding the Participation Exemption Form.

As noted in the CY 2013 HH PPS final rule (77 FR 67094), HHAs that had fewer than 60 HHCAHPS®-eligible unduplicated or unique patients in the period of April 1, 2011, through March 31, 2012, are exempt from the HHCAHPS® data collection and submission requirements for the CY 2014 APU. Such HHAs were required to submit their patient counts for the period of April 1, 2011, through March 31, 2012, on the HHCAHPS® Participation Exemption Request form for the CY 2014 APU posted on *https://homehealthcahps.org* beginning April 1, 2012, by 11:59 p.m., e.d.t. on January 17, 2013. This deadline is firm, as are all of the quarterly data submission deadlines.

(4) HHCAHPS® Requirements for the CY 2015 APU

In the CY 2013 HH PPS final rule (77 FR 67094), we stated that for the CY 2015 APU, we would 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). HHAs are required to submit their HHCAHPS® data files to the HH CAHPS® Data Center for the second quarter 2013 by 11:59 p.m., e.d.t. on October 17, 2013; for the third quarter 2013 by 11:59 p.m., e.s.t. on January 16, 2014; for the fourth quarter 2013 by 11:59 p.m., e.d.t. on April 17, 2014; and for the first quarter 2014 by 11:59 p.m., e.d.t. on July 17, 2014. These deadlines are firm; no exceptions are permitted.

We will continue to exempt HHAs receiving Medicare certification on or after April 1, 2013, from the full HHCAHPS® reporting requirement for the CY 2015 APU because these HHAs would not have been Medicare-certified throughout the period of April 1, 2012 through March 31, 2013. These HHAs do not need to complete a HHCAHPS® Participation Exemption Request form for the CY 2015 APU.

We require that all HHAs that had fewer than 60 HHCAHPS®-eligible unduplicated or unique patients in the period of April 1, 2012, through March 31, 2013 are exempt from the HHCAHPS® data collection and submission requirements for the CY 2015 APU. Agencies with fewer than 60 HHCAHPS®-eligible, unduplicated or unique patients in the period of April 1, 2012, through March 31, 2013 are required to submit their patient counts on the HHCAHPS® Participation Exemption Request form for the CY 2015 APU, posted on *https://homehealthcahps.org* on April 1, 2013, by 11:59 p.m., e.d.t. on January 16, 2014. This deadline is firm, as is true of all quarterly data submission deadlines.

(5) HHCAHPS® Requirements for the CY 2016 APU

For the CY 2016 APU, we propose to require continued monthly HHCAHPS® data collection and reporting for 4 quarters. The data collection period for the CY 2016 APU is proposed to include the second quarter 2014 through the first quarter 2015 (the months of April 2014 through March 2015). We propose that HHAs would be required to submit their HHCAHPS® data files to the HH CAHPS® 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. We propose that these deadlines be firm; no exceptions would be permitted.

We propose to continue to 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 would not have been Medicare-certified throughout the period of April 1, 2013, through March 31, 2014. These HHAs would not need to complete a HHCAHPS® Participation Exemption Request form for the CY 2016 APU.

We propose to state 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 would be exempt from the HHCAHPS® data collection and submission requirements for the CY 2016 APU. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients in the period of April 1, 2013, through March 31, 2014, would 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. on January 15, 2015. This deadline would be firm, as would 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 propose to continue the HHCAHPS® reconsiderations and appeals process that we have finalized and that we have used for the CY 2012 APU and for the CY 2013 APU. We have described the HHCAHPS® reconsiderations process requirements in the notification memorandum that the Regional Home Health Intermediaries (RHHI)/MACs send to the affected HHAs, on behalf of CMS. HHAs have 30 days to send their documentation to support their request for reconsideration to CMS. It is important that the affected HHAs send in comprehensive information in their reconsideration letter/package because CMS 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.

f. Summary of Proposed Changes in CY 2014

We are not proposing any changes to the HHCAHPS® Survey in CY 2014.

g. For Further Information on the HHCAHPS® Survey

We 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®.

3. Home Health Wage Index

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. For CY 2014, as in previous years, we are proposing to base the wage index adjustment to the labor portion of the HH PPS rates on the most recent pre-floor and pre-reclassified hospital wage index. 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. We have consistently used the pre-floor, pre-reclassified hospital wage index data to adjust the labor portion of the HH PPS rates. We believe the use of the pre-floor, pre-reclassified hospital wage index data results in an appropriate adjustment to the labor portion of the costs, as required by statute.

In the CY 2006 HH PPS final rule for (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 addition, OMB published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. The OMB bulletins are available at *http://www.whitehouse.gov/omb/bulletins/index.html.*

For CY 2014, as in previous years, we are proposing to use the most recent pre-floor, pre-reclassified hospital wage index as the base for the wage index adjustment to the labor portion of the HH PPS rates. However, the FY 2014 pre-floor, pre-reclassified hospital wage index does not reflect OMB's new area delineations, based on the 2010 Census (outlined in OMB Bulletin 13–01, released on February 28, 2013), as those changes were not published until the Hospital Inpatient Prospective Payment System (IPPS) proposed rule (78 FR 27553) was in advanced stages of development. We intend to propose changes to the FY 2015 hospital wage index based on the newest CBSA changes in the FY 2015 IPPS proposed rule. Therefore, if CMS incorporates OMB's new area delineations, based on the 2010 Census, in the FY 2015 hospital wage index, those changes would also be reflected in the FY 2015 HH wage index.

Finally, we would continue to use the methodology discussed in the CY 2007 HH PPS final rule (71 FR 65884) to address those geographic areas in which there were no IPPS hospitals, and thus, no hospital wage data on which to base the calculation of the HH PPS wage index. For rural areas that do not have IPPS hospitals, and therefore, lack hospital wage data on which to base a wage index, we would use the average wage index from all contiguous CBSAs as a reasonable proxy. For rural Puerto Rico, we do not apply this methodology due to the distinct economic circumstances that exist there, but instead continue using the most recent wage index previously available for that area (from CY 2005).

For urban areas without IPPS hospitals, we use the average wage index of all urban areas within the State as a reasonable proxy for the wage index for that CBSA. For CY 2012, the only urban area without IPPS hospital wage data is Hinesville-Fort Stewart, Georgia (CBSA 25980).

The wage index values are 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.*

4. Proposed CY 2014 Payment Update

a. National, Standardized 60-Day Episode Payment Rate

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 § 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 difference, 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 would continue to be 78.535 percent and the

non-labor-related share would continue to be 21.465 percent as set out in the CY 2013 HH PPS final rule (77 FR 67068). The proposed CY 2014 HH PPS rates 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 proposed 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 would use to pay the claim.

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

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

b. Proposed CY 2014 National, Standardized 60-Day Episode Payment Rate

The proposed CY 2014 national, standardized 60-day episode payment rate would be $2,862.99 as calculated in Table 16. To determine the CY 2014 proposed national, standardized 60-day episode payment rate, we start with the 2013 average payment per episode ($2,963.65) calculated in section III.D.1. of this proposed rule. We then apply the 3.50 percent rebasing reduction (1 − 0.0350 = 0.9650) and remove the 2.5 percent for outlier payments that we put back in the rates as described in section III.D.1. of this proposed rule. We subsequently apply a standardization factor (1.0017) to ensure budget neutrality in episode payments using the 2014 wage index. The application of a standardization factor was also done when setting the original national, standardized 60-day episode payment rate for the HH PPS in 2000 per section 1895(3)(A)(i) of the Act. 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 calculate the standardization factor, we simulated total payments for non-LUPA episodes using the 2014 wage index and compared it to our simulation of total payments for non-LUPA episodes using the 2013 wage index. By dividing the total payments using the 2014 wage index by the total payments using the 2013 wage index, we obtain a standardization factor of 1.0017. We note that since we are implementing the adjustment to the case-mix weights in a budget neutral manner, there is no standardization factor needed to ensure budget neutrality in episode payments using the 2014 case-mix relative values. Lastly, we update payments by the CY 2014 market basket update (2.4 percent).

TABLE 16—CY 2014 PROPOSED 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

2013 Estimated average payment per episode	2014rebasing adjustment	Outlier adjustment factor	Standardization factor	2014 HH market basket	CY 2014 proposed national, standardized 60-day episode payment
$2,963.65	× 0.9650	× 0.975	× 1.0017	× 1.024	= $2,860.20

The proposed CY 2014 national, standardized 60-day episode payment rate for an HHA that does not submit the required quality data is updated by the proposed CY 2014 HH market basket update (2.4 percent) minus 2 percentage points and is shown in Table 17.

TABLE 17—FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA—PROPOSED CY 2014 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

2013 estimated average payment per episode	2014 rebasing adjustment	Outlier adjustment factor	Standardization factor	2014 HH market basket minus 2 percentage points	CY 2014 proposed national, standardized 60-day episode payment
$2,963.65	× 0.9650	× 0.975	× 1.0017	× 1.004	= $2,804.34

c. National Per-Visit Rates

The national per-visit rates are used to pay LUPAs 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 2014 national per-visit rates, we used the 2013 national per-visit rates adjusted to include the dollars from the 2.5 percent outlier pool as described in section III.D.2. of this proposed rule. We then apply the 3.5 percent rebasing increase to the 2013 outlier adjusted per-visit rates (1 + 0.035 = 1.035), remove the outlier payment adjustment that we used to inflate the rates for comparison purposes (to compare the rates to the estimated per visit costs) in section III.D.2. of this proposed rule, and apply a wage index budget neutrality factor of 1.0003 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index. We calculated the wage index budget neutrality factor by simulating total payments for LUPA episodes using the 2014 wage index and comparing it to simulated total payments for LUPA episodes using the 2013 wage index. We note that the LUPA per-visit payments are not calculated using case-mix weights and therefore, there is no case-mix standardization factor needed to ensure budget neutrality in LUPA payments. The per-visit rates for each discipline are then updated by the proposed CY 2014 HH market basket update of 2.4 percent. The national per-visit rates are adjusted by the wage index based on the site of service of the beneficiary. The per-visit payment amounts 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 2014 national per-visit rates are shown in Tables 18 and 19.

TABLE 18—PROPOSED CY 2014 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH discipline type	CY 2013 per-visit rates including outliers	CY 2014 rebasing adjustment	Outlier adjustment	Wage index budget neutrality factor	2014 HH market basket	Proposed CY 2014 per-visit rates
Home Health Aide	$53.12	× 1.035	× 0.975	× 1.0003	× 1.024	$54.91
Medical Social Services	188.01	× 1.035	× 0.975	× 1.0003	× 1.024	194.34
Occupational Therapy	129.11	× 1.035	× 0.975	× 1.0003	× 1.024	133.46
Physical Therapy	128.24	× 1.035	× 0.975	× 1.0003	× 1.024	132.56
Skilled Nursing	117.28	× 1.035	× 0.975	× 1.0003	× 1.024	121.23
Speech-Language Pathology	139.34	× 1.035	× 0.975	× 1.0003	× 1.024	144.03

The proposed CY 2014 per-visit payment rates for an HHA that does not submit the required quality data is updated by the proposed CY 2014 HH market basket update (2.4 percent) minus 2 percentage points and is shown in Table 19.

TABLE 19—PROPOSED CY 2014 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH discipline type	CY 2013 per-visit rates including outliers	CY 2014 rebasing adjustment	Outlier adjustment	Wage index budget neutrality factor	2014 HH market basket minus 2 percentage points	Proposed CY 2014 per-visit rates
Home Health Aide	$53.12	× 1.035	× 0.975	× 1.0003	× 1.004	$53.84
Medical Social Services	188.01	× 1.035	× 0.975	× 1.0003	× 1.004	190.54
Occupational Therapy	129.11	× 1.035	× 0.975	× 1.0003	× 1.004	130.85
Physical Therapy	128.24	× 1.035	× 0.975	× 1.0003	× 1.004	129.97
Skilled Nursing	117.28	× 1.035	× 0.975	× 1.0003	× 1.004	118.86
Speech-Language Pathology	139.34	× 1.035	× 0.975	× 1.0003	× 1.004	141.22

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

For episodes with four or fewer visits, Medicare pays on the basis of a national per-visit amount by discipline, referred to as a LUPA. As stated in our CY 2008 HH PPS proposed rule, after the HH PPS went into effect we received comments and correspondence suggesting that the LUPA payment rates do not adequately account for the front-loading of costs in an episode. Commenters suggested that because of the small number of visits in a LUPA episode, HHAs have little opportunity to spread the costs of lengthy initial visits over a full episode (72 FR 25424). In response to comments received, we conducted an initial descriptive analysis of visit log data from prior to the establishment of the HH PPS, showing that initial visits were 25 to 50 percent longer than subsequent visits in LUPA episodes that occur as the only or initial episode. These results indicated that payment for LUPA episodes may not offset the full cost of initial visits. Therefore, as specified in the CY 2008 HH PPS final rule, LUPA episodes that occur as the only episode or 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 (72 FR 49849).

The CY 2008 LUPA add-on amount was calculated using a large representative sample of claims from 2005 (72 FR 49848). The analysis examined minute data for skilled nursing, physical therapy, and speech-language pathology (SLP) as, per the Medicare CoPs at § 484.55(a)(1) and (a)(2), only these three disciplines are allowed to conduct the initial assessment visit. The analysis showed that the average excess of minutes for the first visit in LUPA episodes that were the only episode or an initial LUPA in a sequence of adjacent episodes was 38.5 minutes for the first visit if SN, 25.1 minutes for the first visit if PT, and 22.6 minutes for the first visit if SLP. Those excess minutes were then expressed as a proportion of the average number of minutes for all non-first visits in non-LUPA episodes (42.5 minutes, 45.6 minutes, and 48.6 minutes for SN, PT, and SLP, respectively). These proportions (90.6 percent, 55.0 percent, and 46.5 percent for SN, PT, and SLP, respectively) were used to inflate the LUPA per-visit payment rates. Finally, using an appropriate set of weights representing the share of LUPA first visits for SN (77.8 percent), PT (21.7 percent) and SLP (0.5 percent), we calculated a LUPA add-on payment amount of $87.93 for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes (Table 20). When the LUPA add-on payment amount was implemented in CY 2008, to account for the additional payment to LUPA episodes and maintain budget neutrality, a reduction was made to the national, standardized 60-day episode payment rate (72 FR 49849).

TABLE 20—CALCULATION OF THE LUPA ADD-ON AMOUNT, CY 2008

	Skilled nursing	Physical therapy	Speech-language pathology
(1) Proportional increase in minutes for an initial visit over non-initial visits	90.59%	55.04%	46.50%
(2) CY 2008 Per-Visit Amounts	$104.91	$114.71	$124.54
(3) Excess cost for initial visits (1*2)	$95.04	$63.14	$57.91
(4) Percent of initial assessment visits provided by this discipline	77.8%	21.7%	0.5%
(5) Add-on amount per discipline (3*4)	$73.94	$13.70	$0.29
(6) Total LUPA add-on Amount (Sum of row 5)	**$87.93**		

For this proposed rule we are using the same methodology used to establish the LUPA add-on amount for CY 2008. Specifically, we updated the analysis using 100 percent of LUPA episodes and a 20 percent sample of non-LUPA first episodes from preliminary CY 2012 claims data for episodes starting on or before May 31, 2012. The analysis showed that the average excess of minutes for the first visit in LUPA episodes that were the only episode or an initial LUPA in a sequence of adjacent episodes was 38.88 minutes for the first visit if SN, 32.75 minutes for the first visit if PT, and 32.28 minutes for the first visit if SLP. The average minutes for all non-first visits in non-LUPA episodes was 44.62 minutes for SN, 47.88 minutes for PT, and 51.31 minutes for SLP. Those excess minutes expressed as a proportion of the average minutes for all non-first visits in non-LUPA episodes are 87.14 percent for SN, 68.40 percent for PT, and 62.91 percent for SLP. We used these proportions to inflate the proposed LUPA per-visit payment rates in Table 18 of $121.23 for SN, $132.56 for PT, and $144.03 for SLP. We then calculated a set of weights representing the share of LUPA first visits for SN (81.74 percent), PT (17.87 percent) and SLP (0.39 percent) and using these weights, we calculated a LUPA add-on payment amount of $102.91 for LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes.

In lieu of a single LUPA add-on payment amount of $102.91, to ensure that the LUPA add-on amount equitably reflects the excess cost for an initial visit for each of the three disciplines (SN, PT, and SLP), we propose to 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 1 + the proportional increase in minutes for an initial visit over non-initial visits. The proposed LUPA add-on factors are: 1.8714 for SN; 1.6841 for PT; and 1.6293 for SLP. 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 would be $ $226.87 (1.8714 multiplied by $121.23). For more information on the analyses performed to update the LUPA add-on amount, please refer to the technical report titled ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates'' available on the CMS Home Health Agency (HHA) Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html?redirect=/center/hha.asp.*

e. Nonroutine Medical Supply 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 2014 proposed NRS conversion factor, we start with the 2013 NRS conversion factor ($53.97) and apply the 2.58

percent rebasing adjustment calculated in section II.D.3. of this proposed rule (1–0.0258 = 0.9742). We then update the conversion factor by the proposed CY 2014 HH market basket update (2.4 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 2014 is $53.84, as shown in Table 21.

TABLE 21—PROPOSED CY 2014 NRS CONVERSION FACTOR

CY 2013 NRS conversion factor	2014 rebasing adjustment	2014 HH market basket	Proposed CY 2014 NRS conversion factor
$53.97	× 0.9742	× 1.024	= $53.84

Using the proposed CY 2014 NRS conversion factor ($53.84), the payment amounts for the six severity levels are shown in Table 22.

TABLE 22—PROPOSED CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	Proposed NRS payment amount
1	0	0.2698	$14.53
2	1 to 14	0.9742	52.45
3	15 to 27	2.6712	143.82
4	28 to 48	3.9686	213.67
5	49 to 98	6.1198	329.49
6	99+	10.5254	566.69

For HHAs that do not submit the required quality data, we again begin with the CY 2013 NRS conversion factor ($53.97) and apply the 2.58 percent rebasing adjustment calculated in section II.D.3. of this proposed rule (1 − 0.0258 = 0.9742). We then update the NRS conversion factor by the proposed CY 2014 HH market basket update of 2.4 percent, minus 2 percentage points. The CY 2014 NRS conversion factor for HHAs that do not submit quality data is shown in Table 23.

TABLE 23—PROPOSED CY 2014 NRS CONVERSION FACTOR FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

CY 2013 NRS conversion factor	2014 rebasing adjustment	CY 2014 HH market basket minus 2 percentage points	Proposed CY 2014 NRS conversion factor
$53.97	× 0.9742	× 1.004	$52.79

The 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 24.

TABLE 24—PROPOSED CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	Proposed NRS payment amount
1	0	0.2698	$14.24
2	1 to 14	0.9742	51.43
3	15 to 27	2.6712	141.01
4	28 to 48	3.9686	209.50
5	49 to 98	6.1198	323.06
6	99+	10.5254	555.64

5. 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 would 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.

The 3 percent rural add-on is applied to the national, standardized 60-day episode payment rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when HH services are provided in rural (non-CBSA) areas. Refer to Tables 25 through 28 for these payment rates.

TABLE 25—PROPOSED CY 2014 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		
Proposed national standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Proposed rural national standardized 60-day episode payment rate	Proposed national standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	Proposed rural national standardized 60-day episode payment Rate
$2,860.20	× 1.03	$2,946.01	$2,804.34	× 1.03	$2,888.47

TABLE 26—PROPOSED CY 2014 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

HH discipline type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	Proposed per-visit rate	Multiply by the 3 percent rural add-on	Proposed rural per-visit rate	Proposed per-visit rate	Multiply by the 3 percent rural add-on	Proposed rural per-visit rate
HH Aide	$54.91	× 1.03	$56.56	$53.84	× 1.03	$55.46
MSS	194.34	× 1.03	200.17	190.54	× 1.03	196.26
OT	133.46	× 1.03	137.46	130.85	× 1.03	134.78
PT	132.56	× 1.03	136.54	129.97	× 1.03	133.87
SN	121.23	× 1.03	124.87	118.86	× 1.03	122.43
SLP	144.03	× 1.03	148.35	141.22	× 1.03	145.46

TABLE 27—PROPOSED CY 2014 NRS CONVERSION FACTOR FOR SERVICES PROVIDED IN RURAL AREAS

For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Proposed conversion factor	Multiply by the 3 percent rural add-on	Proposed rural conversion factor	Proposed conversion factor	Multiply by the 3 percent rural add-on	Proposed rural conversion factor
$53.84	× 1.03	$55.46	$52.79	× 1.03	$54.37

TABLE 28—PROPOSED CY 2014 NRS PAYMENT AMOUNTS FOR SERVICES PROVIDED IN RURAL AREAS

Severity level	Points (scoring)	For HHAs that DO submit quality data (NRS conversion factor = $55.46)		For HHAs that DO NOT submit quality data (NRS conversion factor = $54.37)	
		Relative weight	Total NRS payment amount for rural areas	Relative weight	Total NRS payment amount for rural areas
1	0	0.2698	$14.96	0.2698	$14.67
2	1 to 14	0.9742	54.03	0.9742	52.97
3	15 to 27	2.6712	148.14	2.6712	145.23
4	28 to 48	3.9686	220.10	3.9686	215.77
5	49 to 98	6.1198	339.40	6.1198	332.73
6	99+	10.5254	583.74	10.5254	572.27

F. Outlier Policy

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.

2. Regulatory Update

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 expenditures.)

For CY 2010, we first returned 5 percent of these dollars back into the national, standardized 60-day episode payment rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor. 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.

3. Statutory Update

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 with respect to 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 payment 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.

4. Loss-Sharing Ratio and Fixed Dollar Loss (FDL) 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 2012 claims data, the proposed CY 2014 payments rates in section III.E. in this proposed rule, and the FDL ratio of 0.45; we estimate that outlier payments would comprise

approximately 1.82 percent of total HH PPS payments in CY 2014. Simulating payments using preliminary CY 2012 claims data and the CY 2013 payment rates (77 FR 67100 through 67105); we estimate that outlier payments would comprise 1.78 percent of total payments. Given the proposed increases to the CY 2014 national per-visit payment rates, our analysis estimates a 0.04 percentage point increase in estimated outlier payments as a percent of total HH PPS payment. We further estimate that by the end of the 4-year phase-in period required by the Affordable Care Act, estimated outlier payments as a percent of total HH PPS payments would be approximately 1.94 percent. We note, however, that these estimates do not take in to account any changes in utilization that may have occurred in CY 2013, and would continue to occur in CY 2014, due to decreasing the FDL ratio from 0.67 percent to 0.45 percent. Therefore, we not proposing a change to the FDL ratio for CY 2014 as the claims data showing any utilization changes that may have resulted from an FDL of 0.45 will not be available for analysis until next year. In the final rule, we will update our estimate of outlier payments as a percent of total HH PPS payments using the best analysis the most current and complete year of HH PPS data and will continue to monitor the percent of total HH PPS payments paid as outlier payments.

5. Outlier Relationship to the HH Payment Study

As we discuss in section III.G. of this proposed rule, section 3131(d) of the Affordable Care Act requires CMS to conduct a study and report on developing HH PPS payment revisions that will ensure access to care and payment for patients with high severity of illness. Our Report to Congress containing this study's recommendations is due no later than March 1, 2014. Section 3131(d)(1)(A)(iii) of the Affordable Care Act, in particular, states that this study may include analysis of potential revisions to outlier payments to better reflect costs of treating Medicare beneficiaries with high levels of severity of illness.

G. Payment Reform: Home Health Study and Report

To address concerns that some beneficiaries are at risk of not having access to Medicare HH services, and that the current HH PPS may encourage providers to adopt selective admission patterns, section 3131(d) of the Affordable Care Act requires the Secretary to conduct a study on HHA costs involved with providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness (specifically, beneficiaries with ''high levels of severity of illness''). Section 3131(d) of the Affordable Care Act also gives the Secretary the authority to explore methods to revise the HH PPS to account for costs related to patient severity of illness or to improving beneficiary access to care and examine the potential impacts of any potential revisions to the payment system.

As we stated in the CY 2013 HH PPS proposed rule (77 FR 41572), we awarded a contract to L&M Policy Research in the fall of 2010 to perform exploratory work for the study on the vulnerable patient populations (that is, low-income Medicare beneficiaries, beneficiaries in medically underserved areas, and beneficiaries with high levels of severity of illness). The contractor performed a literature review of potential HH PPS payment vulnerabilities and access issues, established and convened technical expert panel (TEP) meetings and open door forums to help define the vulnerable patient populations and to gain insight on access issues these populations may face, and performed preliminary analysis looking at resource costs versus Medicare reimbursement.

In September 2011, we awarded a study contract to L&M Policy Research, along with subcontractors Avalere Health, Mathematica Policy Research, and Social & Scientific Systems, to develop an analytic plan, perform detailed analysis, and if necessary, develop recommendations for changes to the HH PPS. In 2012, we completed preliminary analyses on HHA costs associated with providing care for vulnerable patient populations. We presented our findings at a TEP meeting in December 2012 and received extensive feedback on our analyses. We refined our analytic approach based on feedback from the TEP meeting and we are in the process of performing the refined analyses. In addition to examining the costs of providing care to vulnerable patient populations, we are assessing whether the vulnerable patient populations experience access issues and potential factors that may prevent access to care. To do so, we mailed out HHA and physician surveys on access to care for vulnerable populations in February 2013. We are in the process of collecting and analyzing the data from the surveys.

The findings from our analysis of HHA costs and the survey on access to care for vulnerable patient populations may be used to develop recommendations on how to revise the current HH PPS to better account for costs and ensure access to care for these beneficiaries. Methods to revise the current HH PPS could include payment adjustments for services that involve either more or fewer resources, changes to reflect resources involved with providing HH services to low-income Medicare beneficiaries or Medicare beneficiaries residing in medically underserved area, and ways outlier payments could be revised to reflect costs of treating Medicare beneficiaries with high severity of illness. In addition, as part of the study, we may analyze operational issues involved with potential implementation of potential revisions to the HH payment system.

The Affordable Care Act requires that the Secretary submit a Report to Congress regarding the study no later than March 1, 2014. The report may contain recommendations for revisions to the HH PPS, recommendations for legislation and administrative action, and recommendations for whether further research is needed. The Congress also provided CMS with the authority to conduct a separate demonstration project to perform additional research and further explore recommendations from the study. We plan to provide updates regarding our progress on the HH study in future rulemaking and open door forums.

H. Cost Allocation of Survey Expenses

In the CY 2013 HH PPS proposed rule (77 FR 41548), we proposed to amend § 431.610(g), Relations with standard-setting and survey agencies, to require that Medicaid state plans explicitly include Medicaid's appropriate contribution to the cost of HH surveys. We proposed to add a reference to HHAs, along with NFs and ICFs/IIDs at § 431.610(g).

Surveys are required for determining a provider's or supplier's compliance with program participation requirements and the HHA surveys benefit both Medicare and Medicaid programs where the HHAs seek such dual certification. Thus, in accordance with OMB Circular A–87, the costs for surveys of HHAs that are certified for both Medicare and Medicaid should be shared between Medicare, Medicaid and state-only programs in proportion to the benefits received. However, to provide more time for dialogue with states and for any necessary adjustments to state Medicaid Plans, we removed the proposed provision at § 431.610(g) in the for CY 2013 HH PPS final rule (77 FR 67068). We are now proposing to

proceed to amend § 431.610(g) with additional explanation of our proposal, updated cost information, and request for comment on our proposed methodologies.

This proposed rule would clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency must carry out certain other responsibilities that already apply to surveys of nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF–IID), including sharing in the cost of HHA surveys. Section 431.610(g) provides for the availability of federal financial participation (FFP) in the cost of such surveys, except for expenditures that the survey agency makes that are attributable to the state's overall responsibilities under state law and regulations. We believe that the principles articulated in OMB Circular A–87 require that HHA survey costs be allocated to Medicaid, Medicare and state-only programs in proportion to the benefits received. However, we also believe that the proposed amendment to § 431.610(g) would add clarity, and that a proposed rule will offer states and the public additional opportunity to comment or pose questions that will further aid adherence to the appropriate cost allocation principles. We further invite public comment on our proposed methods to ensure compliance with these requirements. Specifically, we propose to review each state's allocation of costs for HHA surveys for adherence to OMB Circular A–87 principles and the statutes with the goal of ensuring full adherence by each state no later than July 2014. For that portion of costs attributable to Medicare and Medicaid, we would assign 50 percent to Medicare and 50 percent to Medicaid. This is the standard 50/50 method that CMS and states have used effectively for many years in the allocation of expenses related to surveys of SNF/NF nursing homes, an approach we consider to be more straight-forward and economical compared with calculation of unique percentages that vary state-to-state and year-by-year. Most importantly, a 50/50 method best reflects the reality that Medicare and Medicaid requirements for home health agencies are generally the same and each program benefits from the regulations.

An alternative to the proposed 50/50 method for allocating each state's Medicare/Medicaid HHS survey costs would be to fix each state's Medicaid share each year based on the proportion of Medicaid funding for HH services in the state compared to the combined Medicare and Medicaid total funding in the most recent years for which the data are reasonably complete. This is the method adopted for the disbursement of civil monetary penalties (CMPs) in the CY 2013 HH PPS proposed rule (77 FR 41548). However, the effective date of HHA CMPs is not until July 1, 2014. Our preparations for imposing such CMPs in 2014 indicate that the annual data collection and calculations necessary for that methodology are (a) More complicated and burdensome than necessary, (b) involve an inherent data lag that could create uncertainty for states and CMS in preparing state survey agency budgets, (c) sufficiently variable from year to year to create further uncertainty for states, (d) unable to anticipate the effects of substantial expansion of Medicaid under the Affordable Care Act (which could increasingly enlarge the state Medicaid share) and (e) would not recognize that both Medicare and Medicaid programs benefit from the regulations. Therefore, we believe that the more efficient and advantageous method, for both CMS and states, would be the 50/50 allocation method that has been used successfully for many years in the allocation of survey costs for SNF/NF nursing homes. We invite comment not only on the 50/50 allocation method for the costs of HHA survey expenses, but on whether the method of distribution for CMP receipts back to states and to the U.S. Treasury should be changed to the same 50/50 methodology. Based on such a 50/50 ratio for each state, and based upon the projected national HHA survey budget for FY 2014 of $37.2 million, if implemented in the beginning of FY 2014, the anticipated aggregate share for Medicaid would amount to $18.6 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. Therefore, the state Medicaid share will be approximately $4.65 million on an annualized basis. The $4.65 million cost is spread out over the 53 states/jurisdictions that currently conduct surveys under section 1864 of the Act. However, the proposed adherence date of July FY 2014 would reduce the Medicaid aggregate share to approximately $4.65 million (for 3 months of the annual $18.6 million aggregate cost) and the state Medicaid share to approximately $1.16 million (25 percent of expenses for the last quarter of FY 2014).

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. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

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

Unless otherwise noted, to derive average costs we used data from the U.S. Bureau of Labor Statistics for all salary estimates. The salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the March 2011 Employer Costs for Employee Compensation report by the Bureau.

We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs):

A. ICRs Regarding OASIS

The information collection requirements and burden estimates associated with OASIS have been approved by OMB under OCN 0938–0760. While OASIS is discussed in preamble section III E.2a, this proposed rule does not revise any of its information collection requirements or burden estimates and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.).

B. ICRs Regarding Cost Allocation of Home Health Agency (HHA) Survey Expenses (§ 431.610)

In § 431.610, HHAs would be added to the survey agency provision concerning Medicaid state plans. Since CMS already requires the state survey agencies to have qualified personnel perform onsite inspections as appropriate, we believe that the requirement to use qualified staff is met in the current state Medicaid plans. As explained in the preamble (section H, Cost Allocation of Survey Expenses), we also expect that the state Medicaid plans will provide for the appropriate Medicaid share of expenses for the conduct of HHA surveys. This is a budgeting task for which there may be

some incidental information collection burden. For some states we believe the information collection responsibility may be met within the context of their current state plan, while other states may need to make a simple amendment to their state Medicaid plan via use of the existing CMS–179 form (OCN 0938–0193). While CMS–179 would be the vehicle for transmitting the amendment to CMS, the amendment will be submitted to OMB for their review/approval under CMS–10489 (OCN 0938–NEW).

Consistent with time estimates for similar tasks, the time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If all states, DC, and 2 territories needed to make such a state plan amendment, the aggregate hours would be 13.25 non-recurring hours (15/60 * 53). Applying a national average professional surveyor cost per hour of approximately $50.23 (inclusive of salary and fringe benefits), we estimate that the maximum information collection cost would be approximately $667 ($50.23 * 13.25) if all states needed to file a state plan amendment.

Apart from the SPA-related requirements, this proposed rule would not revise any budget-related recordkeeping or reporting requirements or estimates and, therefore, does not require additional OMB review under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

C. ICRs Regarding Home Health Care CAHPS® (HHCAHPS®) Survey (§ 484.250)

As part of the DHHS Transparency Initiative on Quality Reporting, CMS implements the HHCAHPS® Survey to measure and to publicly report patients' experiences with home health care they receive from Medicare-certified agencies. Section 484.250, Patient Assessment Data, requires that HHAs submit to CMS, HHCAHPS® data in order to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235. The burden associated with this is the time and effort put forth by the HHAs to submit the HHCAHPS® data, the patients' burden to respond to the HHCAHPS® survey, and the cost to the HHAs to pay for the HHCAHPS® survey vendors to collect the data on their behalf. This burden is currently accounted for under OCN 0938–1066 (CMS–10275).

CMS allows Medicare-certified home health agencies that serve 59 or fewer HHCAHPS® eligible patients, to request an exemption from participating in the HHCAHPS® survey. Currently, we have posted the HHCAHPS® Participation Exemption Request (PER) Form for the CY 2015 Annual Payment Update on *https://homehealthcahps.org.* This form is in use without an OMB control number (OCN). The form is only to be used if home health agencies have 59 or fewer HHCAHPS® eligible patients in the count period that is referenced for a given calendar year. For the CY 2015 annual payment update, home health agencies with 59 or fewer HHCAHPS® patients in the period of April 2012 through March 2013 are exempt from participation in the HHCAHPS® Survey from April 2013 through March 2014, if they complete the HHCAHPS Participation Exemption Request Form for the CY 2015 Annual Payment Update, and the counts are verified in the CMS database for the same period. We are revising OCN 0938–1066 by adding the HHCAHPS® Participation Exemption Request Form for the CY Annual Payment Update and by adding our estimated burden that the form presents to Medicare-certified home health agencies.

The HHCAHPS® PER Form for the CY 2015 Annual Payment Update is a one-page form. We estimate that it would take 15 minutes to complete the form since it only has a few items to complete including one item concerning the count of HHCAHPS® eligible patients in an annual period. We believe that it would take an additional 20 minutes to count the patients and to verify the count. The annualized aggregated total burden to completion of the form would be 1,160 hr ((15 min + 20 min)/60 × 2,000 Medicare-certified home health agencies) at a total estimated cost of $36,400 for 2,000 home health agencies.

In deriving these figures, we used the following hourly labor rates and time to complete each task: $36.27/hr and 20 min (.33 hr) for a home health care agency director to check the work on the Participation Exemption Request Form and $24.92/hr and 15 min (.25 hr) for an executive assistant to perform the patient count and to complete the form. This amounts to $18.20 per respondent ($11.97 + $6.23) or $36,400 ($18.20 × 2,000) total.

D. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/,* or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

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

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–1450–P) Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov.*

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 notice has been designated as economically significant rule, under section 3(f)(1)of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis (RIA) that to the best of our ability presents the costs and benefits of the rulemaking. Also, the rule has been reviewed by OMB.

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) in any given year, applicable 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 proposed rule applies to Medicare payments under HH PPS in CY 2014. Accordingly, the following analysis describes the impact in CY 2014 only. We estimate that the net impact of the proposals in this rule is approximately $290 million in decreased payments to HHAs in CY 2014. The impact of the wage index would be a decrease of $40 million. However, we applied a standardization factor to the rates as discussed earlier. Therefore, the net effect of the wage index impact is zero dollars. The $290 million impact reflects the distributional effects of the 2.4 percent HH payment update percentage ($460 million increase), the effects of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the NRS conversion factor ($650 million decrease), and the effects of ICD–9 coding adjustments ($100 million decrease). The $290 million in savings is reflected in the last column of the first row in Table 29 as a 1.5 percent decrease in expenditures when comparing the CY 2013 HH PPS to the proposed CY 2014 HH PPS.

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 $34.5 million in any 1 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 Secretary has determined that this proposed rule would not have a significant economic impact on a substantial number of small entities.

A discussion on the alternatives considered is presented in section VI.E. of this proposed rule. The following analysis, with the rest of the preamble, constitutes our initial RFA analysis. We solicit comment on the RFA analysis provided.

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 proposed rule would 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 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2013, 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.

D. Detailed Economic Analysis

This proposed rule sets forth updates to the HH PPS rates contained in the CY 2013 HH PPS final rule. 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, based primarily on preliminary Medicare claims from 2012. 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 29 represents how HHA revenues are likely to be affected by the policy changes proposed in this rule. For this analysis, we used linked CY 2012 HH claims and OASIS assessments; the claims are for dates of service that started on or before May 31, 2012. The first column of Table 29 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 the wage index only. The fourth column shows the effects of the standardization factor only. 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 2014 wage index; and standardization. The sixth column displays the effects of ICD–9 coding changes and the seventh column shows the effects of the market basket increase. The last column shows the payment effects of all the proposed policies. For CY 2014, the average impact for all HHAs due to the effects of rebasing is a 3.4 percent decrease in payments. The overall impact for all HHAs, in estimated total payments from CY 2013 to CY 2014, is a decrease of approximately 1.5 percent.

TABLE 29—PROPOSED HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY

	Number of agencies	Proposed CY 2014 wage index (percent)	Standardization (percent)	Proposed rebasing, 2014 wage index, and standardization [1] (percent)	Proposed ICD–9 coding changes (percent)	CY 2014 HH market basket (percent)	Impact of all CY 2014 policies (percent)
All Agencies	11,152	−0.2	0.2	−3.4	−0.5	2.4	−1.5
Facility Type and Control:							
Free-Standing/Other Vol/NP	1,042	0.2	0.3	−2.9	−0.3	2.4	−0.8
Free-Standing/Other Proprietary	8,511	−0.3	0.2	−3.5	−0.6	2.4	−1.7
Free-Standing/Other Government	420	−0.3	0.1	−3.6	−0.4	2.4	−1.6
Facility-Based Vol/NP	810	0.0	0.2	−3.1	−0.3	2.4	−1.0
Facility-Based Proprietary	122	−0.1	0.1	−3.4	−0.4	2.4	−1.4
Facility-Based Government	247	−0.2	0.1	−3.5	−0.4	2.4	−1.5
Subtotal: Freestanding	9,973	−0.2	0.2	−3.4	−0.5	2.4	−1.5
Subtotal: Facility-based	1,179	0.0	0.2	−3.2	−0.3	2.4	−1.1
Subtotal: Vol/NP	1,852	0.1	0.2	−3.0	−0.3	2.4	−0.9
Subtotal: Proprietary	8,633	−0.3	0.2	−3.5	−0.6	2.4	−1.7
Subtotal: Government	667	−0.3	0.1	−3.5	−0.4	2.4	−1.5
Facility Type and Control: Rural:							
Free-Standing/Other Vol/NP	222	0.2	0.1	−3.0	−0.3	2.4	−0.9
Free-Standing/Other Proprietary	159	−0.3	0.1	−3.6	−0.4	2.4	−1.6
Free-Standing/Other Government	513	−0.3	0.1	−3.6	−0.5	2.4	−1.7
Facility-Based Vol/NP	279	0.1	0.1	−3.2	−0.3	2.4	−1.1
Facility-Based Proprietary	43	0.2	0.1	−3.1	−0.4	2.4	−1.1
Facility-Based Government	159	0.1	0.1	−3.2	−0.3	2.4	−1.1
Facility Type and Control: Urban:							
Free-Standing/Other Vol/NP	882	0.2	0.3	−2.9	−0.3	2.4	−0.8
Free-Standing/Other Proprietary	8,148	−0.3	0.2	−3.5	−0.6	2.4	−1.7
Free-Standing/Other Government	159	−0.4	0.1	−3.6	−0.4	2.4	−1.6
Facility-Based Vol/NP	531	0.0	0.2	−3.1	−0.3	2.4	−1.0
Facility-Based Proprietary	79	−0.2	0.1	−3.5	−0.4	2.4	−1.5
Facility-Based Government	88	−0.5	0.2	−3.6	−0.4	2.4	−1.6
Facility Location: Urban or Rural							0.0
Rural	1,265	−0.1	0.1	−3.4	−0.4	2.4	−1.4
Urban	9,887	−0.2	0.2	−3.4	−0.5	2.4	−1.5
Facility Location: Region of the Country:							
North	837	0.6	0.4	−2.4	−0.3	2.4	−0.3
Midwest	2,950	−0.5	0.1	−3.7	−0.4	2.4	−1.7
South	5,544	−0.5	0.1	−3.7	−0.6	2.4	−1.9
West	1,772	0.4	0.3	−2.7	−0.4	2.4	−0.7
Other	49	0.8	0.1	−2.4	−0.2	2.4	−0.2
Facility Location: Region of the Country (Census Region):							
New England	320	0.4	0.3	−2.7	−0.3	2.4	−0.6
Mid Atlantic	517	0.8	0.4	−2.3	−0.3	2.4	−0.2
East North Central	2,210	−0.6	0.1	−3.8	−0.4	2.4	−1.8
West North Central	740	−0.2	0.1	−3.4	−0.4	2.4	−1.4
South Atlantic	2,046	−0.6	0.1	−3.8	−0.5	2.4	−1.9
East South Central	436	−0.4	0.1	−3.7	−0.4	2.4	−1.7
West South Central	3,062	−0.3	0.1	−3.6	−0.9	2.4	−2.1
Mountain	638	0.0	0.2	−3.2	−0.4	2.4	−1.2
Pacific	1,134	0.6	0.3	−2.5	−0.4	2.4	−0.5
Facility Size (Number of 1st Episodes):							
< 100 episodes	3,385	−0.2	0.2	−3.5	−0.6	2.4	−1.7
100 to 249	2,971	−0.4	0.2	−3.6	−0.6	2.4	−1.8
250 to 499	2,237	−0.4	0.2	−3.6	−0.6	2.4	−1.8
500 to 999	1,477	−0.2	0.2	−3.4	−0.5	2.4	−1.5

TABLE 29—PROPOSED HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY—Continued

	Number of agencies	Proposed CY 2014 wage index (percent)	Standardization (percent)	Proposed rebasing, 2014 wage index, and standardization [1] (percent)	Proposed ICD–9 coding changes (percent)	CY 2014 HH market basket (percent)	Impact of all CY 2014 policies (percent)
1,000 or More	1,082	−0.1	0.2	−3.2	−0.4	2.4	−1.2

[1]The impact of rebasing includes the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit rates, and the NRS conversion factor and also includes the impact of the proposed LUPA add-on factors. The estimated impact of the NRS conversion factor rebasing adjustment, of −2.58 percent, is an overall −0.043 percent decrease in estimated payments to HHAs. The estimated impact of the proposed LUPA add-on factors is an overall 0.007 percent increase in payments to HHAs.

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

As described in section III.D. of this proposed rule, ''Rebasing the National, Standardized 60-day Episode Payment Rate, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor,'' the Affordable Care Act mandates that we rebase payments starting in CY 2014. In that section, we described our methodology for calculating the adjustments to the national, standardized 60-day episode payment rate and per-visit rates. We note that additional factors were considered but not incorporated into the methodology for calculating the rebasing adjustments. One such factor is a downward adjustment to the costs per-visit as a result of the findings from the audits of 98 Medicare HH cost reports. The results of the audits showed that agencies over-reported costs by an average of about 8 percent. Given this finding, we considered downward adjusting the costs on the cost report in order to better align payment with the agencies' true costs. We also considered updating costs by the HH payment update percentage (adjusted market basket) rather than the full HH market basket. In 2012 and 2013, HH payments were increased by the HH market basket minus one percentage point, as mandated by the Affordable Care Act. Furthermore, the Affordable Care Act mandates that CMS remove 5 percent of the national, standardized 60-day episode payment rate to fund the 2.5 percent outlier pool. Given this mandate, we considered setting our target national, standardized 60-day episode payment rate for rebasing at 5 percent below the estimated cost per episode that we derived from the 2011 cost reports. We plan to continue to evaluate these alternative factors for rebasing and may consider incorporating these factors into the CY 2014 HH PPS final rule.

In addition to the rebasing adjustments, we considered implementing a prospective reduction for nominal case-mix growth for CY 2014. In the past, various sources have suggested implementing a prospective nominal case-mix growth adjustment, which would attempt to predict the amount of nominal case-mix growth in future years and implement a reduction to prevent possible overpayments due to nominal case-mix growth. To date, we have implemented nominal case-mix growth adjustments retrospectively. That is, we use the most recent, complete data available—typically two to three years prior to the payment year—to identify nominal case-mix growth, and implement a payment reduction to account for the observed growth. The payment reductions for nominal case-mix growth do not attempt to re-coup overpayments made in previous years due to nominal case-mix growth. We plan to continue to monitor case-mix growth (both real and nominal case-mix growth) as more data become available and will consider implementing prospective reductions, as well as other possible approaches, to address nominal case-mix growth in future rulemaking.

F. Cost Allocation of Survey Expenses

We project that aggregate Medicare and Medicaid HH survey costs in FY 2014 will be approximately $37.2 million. As these costs would be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated national Medicaid share would amount to $18.6 million, if implemented at the beginning of FY 2014. However, the proposed adherence date of July FY 2014 would reduce the Medicaid aggregate share to approximately $4.65 million. The cost of surveys is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. State costs for Medicaid HH surveys incurred in FY 2014, with an adherence date of July FY 2014, would be approximately $1.16 million (25 percent of the aggregate $4.65 million Medicaid cost for the last quarter of the FY), spread out across all states and two territories. While we regard Medicaid fair share of costs to reflect an existing cost allocation principle, the methods for making the appropriate determinations have not been clear. Therefore, in this rule we delineate those methods and provide that the Medicaid responsibility be reflected in the state Medicaid Plan.

G. Accounting Statement and Table

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars_a004_a-4*), in Tables 30 and 31, we have prepared an accounting statement showing the classification of the transfers associated with the provisions of this proposed rule. Table 30 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 30—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE CY 2013 HH PPS TO THE CY 2014 HH PPS

Category	Transfers
Annualized Monetized Transfers	−$290 million.
From Whom to Whom?	Federal Government to HH providers.

Table 31 provides our best estimate of the proposed changes in the classification of the cost allocation of survey expenses.

TABLE 31—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS RELATING TO THE MEDICARE AND MEDICAID HOME HEALTH SURVEY AND CERTIFICATION COSTS, FYS 2013 TO 2014

Category	Transfers
Federal Medicaid HH survey & certification costs:	
Annualized Monetized Transfers	$17.44 Million.
From Whom to Whom?	Federal Government to Medicaid HH Survey Agencies.
State Medicaid HH survey & certification costs:	
Annualized Monetized Transfers	$1.16 Million.
From Whom to Whom?	State Governments to Medicaid HH Survey Agencies.
Medicare HH survey & certification costs:	
Annualized Monetized Transfers	−$18.6 Million.
From Whom to Whom?	Federal Government to Medicare HH Survey Agencies.

H. Conclusion

In conclusion, we estimate that the net impact of the proposals in this rule is approximately $290 million in CY 2014 savings. The $290 million reflects the distributional effects of an updated wage index ($40 million decrease), a standardization factor to ensure budget neutrality in episode payments using the 2014 wage index ($40 million increase), the 2.4 percent HH payment update percentage ($460 million increase), the ICD–9 grouper refinement ($100 million decrease), and the rebasing adjustments required by section 3131(a) of the Affordable Care Act ($650 million decrease). This analysis, together with the remainder of this preamble, provides a RIA.

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. This rule would have no substantial direct effect on state and local governments, preempt state law, or otherwise have Federalism implications.

List of Subjects in 42 CFR Part 431

Grant programs—health, Health facilities, Medicaid, Privacy, and Reporting and recordkeeping requirements.

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

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

■ 1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

■ 2. Section 431.610 is amended by revising paragraph (g) introductory text to read as follows:

§ 431.610 Relations with standard-setting and survey agencies.

* * * * *

(g) *Responsibilities of survey agency.* The plan must provide that, in certifying NFs, HHAs, and ICF–IIDs, the survey agency designated under paragraph (e) of this section will—

* * * * *

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

Dated: June 10, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 14, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–15766 Filed 6–27–13; 1:37 pm]

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