the 30-day period that the HHA furnished minimal services to a patient during the 30-day period.

(1) For each payment group used to case-mix adjust the 30-day payment rate, the 10th percentile value of total visits during a 30-day period of care is used to create payment group specific thresholds with a minimum threshold of at least 2 visits for each case-mix group.

(2) A 30-day period with a total number of visits less than the threshold is paid the national per-visit amount by discipline determined in accordance with § 484.215(a) and updated annually by the applicable market basket for each visit type, in accordance with § 484.225.

(3) The national per-visit amount is adjusted by the appropriate wage index based on the site of service for the beneficiary.

(c) An amount is added to low-utilization payment adjustments for low-utilization periods that occur as the beneficiary's only 30-day period or initial 30-day period in a sequence of adjacent periods of care. For purposes of the home health PPS, a sequence of adjacent periods of care for a beneficiary is a series of claims with no more than 60 days without home care between the end of one period, which is the 30th day (except for episodes that have been partial payment adjusted), and the beginning of the next episode.

[83 FR 56629, Nov. 13, 2018]

§ 484.235 Partial payment adjustments.

(a) *Partial episode payments (PEPs) for episodes beginning on or before December 31, 2019.* (1) An HHA receives a national, standardized 60-day payment of a predetermined rate for home health services unless CMS determines an intervening event, defined as a beneficiary elected transfer or discharge with goals met or no expectation of return to home health and the beneficiary returned to home health during the 60-day episode, warrants a new 60-day episode for purposes of payment. A start of care OASIS assessment and physician or allowed practitioner certification of the new plan of care are required.

(2) The PEP adjustment does not apply in situations of transfers among HHAs of common ownership.

(i) Those situations are considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode.

(ii) The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA.

(iii) The transferring HHA in situations of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided under arrangements to be paid.

(3) If the intervening event warrants a new 60-day payment and a new physician or allowed practitioner certification and a new plan of care, the initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care based on the first billable visit date through and including the last billable visit date. The PEP is calculated by determining the actual days served as a proportion of 60 multiplied by the initial 60-day payment amount.

(b) *Partial payment adjustments for periods beginning on or after January 1, 2020.* (1) An HHA receives a national, standardized 30-day payment of a predetermined rate for home health services unless CMS determines an intervening event, defined as a beneficiary elected transfer or discharge with goals met or no expectation of return to home health and the beneficiary returned to home health during the 30-day period, warrants a new 30-day period for purposes of payment. A start of care OASIS assessment and certification of the new plan of care are required.

(2) The partial payment adjustment does not apply in situations of transfers among HHAs of common ownership.

(i) Those situations are considered services provided under arrangement on behalf of the originating HHA by

the receiving HHA with the common ownership interest for the balance of the 30-day period.

(ii) The common ownership exception to the transfer partial payment adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 30-day period before the transfer to the receiving HHA.

(iii) The transferring HHA in situations of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-for services in order for services provided under arrangements to be paid.

(3) If the intervening event warrants a new 30-day payment and a new physician or allowed practitioner certification and a new plan of care, the initial HHA receives a partial payment adjustment reflecting the length of time the patient remained under its care based on the first billable visit date through and including the last billable visit date. The partial payment is calculated by determining the actual days served as a proportion of 30 multiplied by the initial 30-day payment amount.

[83 FR 56629, Nov. 13, 2018, as amended at 85 FR 27628, May 8, 2020]

§ 484.240 Outlier payments.

(a) For episodes beginning on or before December 31, 2019, an HHA receives an outlier payment for an episode whose estimated costs exceeds a threshold amount for each case-mix group. The outlier threshold for each case-mix group is the episode payment amount for that group, or the PEP adjustment amount for the episode, plus a fixed dollar loss amount that is the same for all case-mix groups.

(b) For periods beginning on or after January 1, 2020, an HHA receives an outlier payment for a 30-day period whose estimated cost exceeds a threshold amount for each case-mix group. The outlier threshold for each case-mix group is the 30-day payment amount for that group, or the partial payment adjustment amount for the 30-day period, plus a fixed dollar loss amount that is the same for all case-mix groups.

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

(d) CMS imputes the cost for each claim by multiplying the national per-15 minute unit amount of each discipline by the number of 15 minute units in the discipline and computing the total imputed cost for all disciplines.

[83 FR 56630, Nov. 13, 2018]

§ 484.245 Requirements under the Home Health Quality Reporting Program (HH QRP).

(a) *Participation.* Beginning January 1, 2007, an HHA must report Home Health Quality Reporting Program (HH QRP) data in accordance with the requirements of this section.

(b) *Data submission.* (1) Except as provided in paragraph (d) of this section, and for a program year, an HHA must submit all of the following to CMS:

(i) Data—

(A) Required under section 1895(b)(3)(B)(v)(II) of the Act, including HHCAHPS survey data; and

(B) On measures specified under sections 1899B(c)(1) and 1899B(d)(1) of the Act.

(ii) Standardized patient assessment data required under section 1899B(b)(1) of the Act.

(iii) For purposes of HHCAHPS survey data submission, the following additional requirements apply:

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

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

(C) *CMS approval.* CMS approves an HHCAHPS survey vendor if the applicant has been in business for a minimum of 3 years and has conducted surveys of individuals and samples for at least 2 years.

(*1*) For HHCAHPS, a ''survey of individuals'' is defined as the collection of data from at least 600 individuals selected by statistical sampling methods