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

and the data collected are used for statistical purposes.

(*2*) All applicants that meet the requirements in this paragraph (b)(1)(iii)(C) are approved by CMS.

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

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

(2) The data submitted under paragraph (b) of this section must be submitted in the form and manner, and at a time, specified by CMS.

(3) *Measure removal factors.* CMS may remove a quality measure from the HH QRP based on one or more of the following factors:

(i) Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made.

(ii) Performance or improvement on a measure does not result in better patient outcomes.

(iii) A measure does not align with current clinical guidelines or practice.

(iv) The availability of a more broadly applicable (across settings, populations, or conditions) measure for the particular topic.

(v) The availability of a measure that is more proximal in time to desired patient outcomes for the particular topic.

(vi) The availability of a measure that is more strongly associated with desired patient outcomes for the particular topic.

(vii) Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.

(viii) The costs associated with a measure outweigh the benefit of its continued use in the program.

(c) *Exceptions and extension requirements.* (1) An HHA may request and CMS may grant exceptions or extensions to the reporting requirements under paragraph (b) of this section for one or more quarters, when there are certain extraordinary circumstances beyond the control of the HHA.

(2) An HHA may request an exception or extension within 90 days of the date that the extraordinary circumstances occurred by sending an email to CMS HHAPU reconsiderations at *HHAPUReconsiderations@cms.hhs.gov* that contains all of the following information:

(i) HHA CMS Certification Number (CCN).

(ii) HHA Business Name.

(iii) HHA Business Address.

(iv) CEO or CEO-designated personnel contact information including name, title, telephone number, email address, and mailing address (the address must be a physical address, not a post office box).

(v) HHA's reason for requesting the exception or extension.

(vi) Evidence of the impact of extraordinary circumstances, including, but not limited to, photographs, newspaper, and other media articles.

(vii) Date when the HHA believes it will be able to again submit data under paragraph (b) of this section and a justification for the proposed date.

(3) Except as provided in paragraph (c)(4) of this section, CMS does not consider an exception or extension request unless the HHA requesting such exception or extension has complied fully with the requirements in this paragraph (c).

(4) CMS may grant exceptions or extensions to HHAs without a request if it determines that one or more of the following has occurred:

(i) An extraordinary circumstance, such as an act of nature, affects an entire region or locale.

(ii) A systemic problem with one of CMS's data collection systems directly affects the ability of an HHA to submit data under paragraph (b) of this section.

(d) *Reconsiderations.* (1)(i) HHAs that do not meet the quality reporting requirements under this section for a program year will receive a letter of noncompliance via the United States

Postal Service and the CMS-designated data submission system.

(ii) An HHA may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance.

(2) Reconsideration requests may be submitted to CMS by sending an email to CMS HHAPU reconsiderations at *HHAPureConsiderations@cms.hhs.gov* containing all of the following information:

(i) HHA CCN.

(ii) HHA Business Name.

(iii) HHA Business Address.

(iv) CEO or CEO-designated personnel contact information including name, title, telephone number, email address, and mailing address (the address must be a physical address, not a post office box).

(v) CMS identified reason(s) for non-compliance as stated in the non-compliance letter.

(vi) Reason(s) for requesting reconsideration, including all supporting documentation.

(3) CMS does not consider a reconsideration request unless the HHA has complied fully with the submission requirements in paragraphs (d)(1) and (2) of this section.

(4) CMS makes a decision on the request for reconsideration and provide notice of the decision to the HHA via letter sent via the United States Postal Service.

(e) *Appeals.* An HHA that is dissatisfied with CMS' decision on a request for reconsideration submitted under paragraph (d) of this section may file an appeal with the Provider Reimbursement Review Board (PRRB) under 42 CFR part 405, subpart R.

[84 FR 60645, Nov. 8, 2019, as amended at 87 FR 66886, Nov. 4, 2022]

§ 484.250 OASIS data.

An HHA must submit to CMS the OASIS data described at § 484.55(b) and (d) as is necessary for CMS to administer the payment rate methodologies described in §§ 484.215, 484.220, 484.230, 484.235, and 484.240.

[84 FR 60646, Nov. 8, 2019]

§ 484.260 Limitation on review.

An HHA is not entitled to judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, with regard to the establishment of the payment unit, including the national 60-day prospective episode payment rate, adjustments and outlier payments. An HHA is not entitled to the review regarding the establishment of the transition period, definition and application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.

§ 484.265 Additional payment.

An additional payment is made to a home health agency in accordance with § 476.78 of this chapter for the costs of sending requested patient records to the QIO in electronic format, by facsimile, or by photocopying and mailing.

[85 FR 59026, Sept. 18, 2020]

Subpart F—Home Health Value-Based Purchasing (HHVBP) Models

SOURCE: 80 FR 68718, Nov. 5, 2015, unless otherwise noted.

HHVBP MODEL COMPONENTS FOR COMPETING HOME HEALTH AGENCIES WITHIN STATE BOUNDARIES FOR THE ORIGINAL HHVBP MODEL

§ 484.300 Basis and scope of subpart.

This subpart is established under sections 1102, 1115A, and 1871 of the Act (42 U.S.C. 1315a), which authorizes the Secretary to issue regulations to operate the Medicare program and test innovative payment and service delivery models to improve coordination, quality, and efficiency of health care services furnished under Title XVIII.

§ 484.305 Definitions.

As used in this subpart—

Applicable measure means a measure for which a competing HHA has provided a minimum of—

(1) Twenty home health episodes of care per year for the OASIS-based measures;