DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 431

[CMS–1450–F]

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: Final rule.

SUMMARY: This final rule will 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, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective January 1, 2014. As required by the Affordable Care Act, this rule establishes 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. In addition, this final rule will remove 170 diagnosis codes from assignment to diagnosis groups within the HH PPS Grouper, effective January 1, 2014. Finally, this rule will establish home health quality reporting requirements for CY 2014 payment and subsequent years and will clarify that a state Medicaid program must provide that, in certifying HHAs, the state's designated survey agency 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 will 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 nursing homes.

DATES: These regulations are effective on January 1, 2014.

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SUPPLEMENTARY INFORMATION:

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Acronyms

In addition, because of the many terms to which we refer by abbreviation in this final 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.
CAGR Compound Annual Growth Rate.
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.
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 supply.
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 updates 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, and the 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 rule will also address: International Classification of Diseases, 9th Edition (ICD–9) Grouper refinements; implementation of the International Classification of Diseases, 10th Edition (ICD–10); a budget neutral adjustment to the case-mix weights; updates to the payment rates by the HH payment update percentage (for this final rule, the HH 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 rule also clarifies state Medicaid program requirements related to the cost of HHA surveys.

B. Summary of the Major Provisions

In this final rule, we will remove 170 diagnosis codes from assignment to diagnosis groups within the HH PPS Grouper, effective January 1, 2014. In addition, on October 1, 2014, we will begin the use of ICD–10–CM codes within the HH PPS Grouper.

For CY 2014, we are adjusting the case-mix weights in order to reduce the average case-mix weight for CY 2012 from 1.3464 to 1.0000, in a budget neutral manner. As required by section 3131(a) of the Affordable Care Act, we are rebasing the national, standardized 60-day episode payment amount, the national per-visit rates and the NRS conversion factor. The rebasing adjustments will occur over the next four years. The rebasing adjustments will reduce the national, standardized 60-day episode payment amount in each year from CY 2014 to CY 2017 by $80.95, which is 3.5 percent of the national, standardized 60-day episode payment amount as of the date of enactment of the Affordable Care Act ($2,312.94 in CY 2010). In each year from CY 2014 to CY 2017, the rebasing adjustments will increase the national per-visit payment amounts by 3.5 percent of the national per-visit payment amounts in CY 2010 as described in section IV.D.2. The rebasing adjustments will reduce the NRS conversion factor in each year from CY 2014 to CY 2017 by 2.82 percent. We will use three LUPA add-on factors in calculating the LUPA add-on payment amount for LUPA episodes that are the only episode or the first episode in a sequence of adjacent episodes. We will update the home health wage index and increase payment rates for CY 2014 by 2.3 percent as described in section IV.E.4.

We will continue work on the home health study required by section 3131(d) of the Affordable Care Act, which will assess the costs associated with providing access to care to patients with high severity of illness, low income patients, and/or patients in medically underserved areas. Additionally, we will 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 the annual payment update (APU) for

2014. We will implement two claims-based measures of quality for HH patients who were recently hospitalized, as these patients are at an increased risk of additional acute care hospital use. We are also reducing the number of HH quality measures currently reported to HHAs.

Lastly, we will 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 rule will 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 will assign 50 percent to Medicare and 50 percent to Medicaid.

C. Summary of Costs and Benefits

TABLE 1—SUMMARY OF COSTS, BENEFITS AND TRANSFERS

Provision description	Total costs	Total benefits	Transfers
CY 2014 HH PPS Payment Rate Update.	N/A	The benefits of this final rule include paying more accurately for the delivery of home health services.	The overall economic impact of this final rule is an estimated $200 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 aggregate 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. The federal Medicaid share will reflect the remaining $3.49 million, with an adherence date of July FY 2014. Some state Medicaid programs may currently pay for HHA surveys to some extent, but the amount is unknown.

II. Background

A. Statutory Background of the 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, added section 1895 of the Act, which 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 1895 of the Act entitled ''Prospective Payment For Home Health Services'' mandated the development of a HH PPS for all Medicare-covered HH services that were paid on a reasonable cost basis. 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) adjustment of the standardized prospective payment amount 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, amended section 1895(b)(5) of the Act, so that if the Secretary provides for an outlier policy, total outlier payments in a given year would not exceed 2.5 percent of total payments projected or estimated and that the standard prospective payment (or amounts) are reduced by 5 percent. The provision also made permanent a 10 percent agency-level outlier payment cap.

In accordance with the statute, we published a final rule in the July 3, 2000 **Federal Register** (65 FR 41128) to implement the HH PPS. 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 covered services, consolidated billing requirements, and a number of other related policies. 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 a 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 payment update percentage increase is reduced by 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 HH quality reporting requirement was implemented on January 1, 2007.

The Affordable Care Act made additional changes to the HH PPS. Section 3131(c) of the Affordable Care Act amended 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 amount 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 adjustment must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010) 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 non-routine medical supplies is no longer part of the national, standardized 60-day episode rate and is computed by multiplying the relative weight for a particular non-routine supply (NRS) severity level by the NRS conversion factor (See section IV.D.4.e. of this final rule). Payment for durable medical equipment (DME) covered under the HH benefit is made outside the HH PPS. 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 low-utilization payment adjustment (LUPA) episode. 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 HH PPS for CY 2008. The CY 2008 HH PPS final 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, to 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 and a 1.32 percent payment reduction for CY 2013.

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 from 2000 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. Summary of the Provisions of the Proposed Rule

The CY 2014 HH PPS proposed rule (78 FR 40272) included the following proposals and updates:

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

- We proposed to remove 170 ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014.

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

- We notified the home health industry that on October 1, 2014, we are implementing the use of ICD–10–CM codes within our HH PPS Grouper. We provided the industry with a link to the CMS Web site that contains the draft HH PPS Grouper ICD–10–CM translation list along with a proposed schedule for releasing the draft and final ICD–10–CM HH PPS Groupers.

- We notified HHAs that 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. The 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.

C. Adjustment to the HH PPS Case-Mix Weights

- We analyzed preliminary 2012 claims data, which showed an average case-mix weight for 2012 of 1.3517. We proposed to reduce the average case-mix weight for 2014 from 1.3517 to 1.0000. We proposed that the decrease in the weights from 1.3517 to 1.0000 would be added back into the national, standardized 60-day episode payment amount and serve as the starting point for the rebasing adjustment calculation.

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 Amount

In the proposed rule, we estimated that the 2013 average cost per episode was $2,559.59. The 2013 estimated average payment per episode was $2,963.65. When comparing the 2013 costs to 2013 payments, we obtained a difference of −13.63 percent, or a reduction of 3.60 percent over four years in equal increments using a compound annual growth rate (CAGR) formula (($2,559.59/$2,963.65)$^{1/4}$ − 1). Since the Affordable Care Act states that the adjustment(s) may be no more than 3.5 percent in a given year, we proposed a reduction to the national, standardized 60-day episode rate of 3.50 percent in each year from CY 2014 through CY 2017.

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

In the proposed rule, when comparing 2013 estimated average costs per-visit to 2013 payments per-visit for each of six disciplines, we obtained differences ranging from +19.48 percent for skilled nursing up to +33.11 percent for physical therapy. If the increases were phased-in over four years in equal increments using a CAGR formula, the annual increases would range from +4.55 percent for skilled nursing to +7.41 percent for physical therapy. Since the Affordable Care Act states that the adjustment(s) may be no more than 3.5 percent in a given year, we proposed an increase to each of the six per-visit payment rates of 3.50 percent in each year from CY 2014 through CY 2017.

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

In the proposed rule, when comparing the 2013 estimated average NRS payment per episode of $48.38 to the 2013 estimated average NRS cost per episode of $43.58; we obtained 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 using a CAGR formula would result in an annual reduction of 2.58 percent. Therefore, we proposed to reduce payments each year, from CY 2014 through CY 2017, by 2.58 percent.

E. CY 2014 Home Health Payment Rate Update

We proposed to continue to use OASIS data, claims data, and patient experience of care data as forms of quality data to meet the reporting requirement that HHAs submit data appropriate for the measurement of home health care quality for CY 2014 and each subsequent year thereafter until further notice. We proposed that the measures reported on Home Health Compare continue to meet the requirement to make data available to the public until further notice; we proposed to add two new claims-based measures: (1) Re-hospitalization During the First 30 Days of a Home Health Stay, and (2) Home Health Emergency Department Use Without Readmission; and to reduce the number of home health quality measures currently reported to HHAs individually. We stated that we plan to include information regarding the requirements of the HH Conditions of Participation (CoPs) related to submission of OASIS assessments and the necessity of submitting both start of episode and end of episode assessments in order to calculate quality measures. We did not propose changes to HH CAHPS and we stated that we plan to continue this requirement and data collection activities.

In the proposed rule, we stated that we would update the HH PPS payment rates by the HH PPS payment update percentage of 2.4 percent and we proposed, consistent with long-standing policy, to update the home health wage index using the pre-floor, pre-reclassified hospital wage index for 2014. We also proposed to offset the overall impact from the use of the updated wage index on the national, standardized 60-day episode payment rate and the national per-visit rates using a standardization factor. Finally, we proposed to create three LUPA add-on factors, rather than a single LUPA add-on amount.

F. Outlier Policy

We did not propose changes to our outlier policy.

G. Payment Reform: Home Health Study and Report

Section 3131(d) of the Affordable Care Act requires the Secretary to assess costs associated with providing access to care for patients with high severity of illness, low income patients, and/or patients in medically underserved areas. It also gives the Secretary the authority to analyze other factors in the HH PPS and allows for demonstration authority to test the PPS changes. Finally, it requires the Secretary to make recommendations for legislation or administrative action, if needed, in a Report to Congress due no later than March 1, 2014. We provided an update on the status of the Report to Congress in the proposed rule.

H. Cost Allocation of Survey Expenses

We proposed that Medicaid responsibilities for home health surveys be explicitly recognized in the state Medicaid program and that CMS will review each state's allocation of costs for HHA surveys for adherence to OMB Circular A–87 principles in 2014, with the goal of ensuring full adherence no later than July 2014. For that portion of costs attributable to Medicare and Medicaid, CMS will 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 nursing homes.

IV. Provisions of the Proposed Rule and Response to Comments

We received approximately 84 timely responses, many of which contained multiple comments on the CY 2014 HH PPS proposed rule (78 FR 40272) from the public. We received comments from various trade associations, HHAs, individual registered nurses, physicians, clinicians, health care industry organizations, and health care consulting firms. The following sections, arranged by subject area, include a summary of the public comments received, and out responses.

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

As stated in the CY 2014 HH PPS proposed rule, CMS clinical staff (along with clinical and coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor), 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 proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014. The first category (Category 1 in Table 2) included ICD–9–CM codes that, based upon clinical judgment, were ''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 will have been a more accurate reflection of the patient's condition in the home). The second category (Category 2 in Table 2) included codes that, based upon clinical judgment, reflect a condition that does 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 includes all 170 ICD–9–CM diagnosis codes that we proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper, effective January 1, 2014, along with the category classification.

TABLE 2—ICD–9–CM CODES REMOVED FROM DIAGNOSIS GROUP ASSIGNMENT IN 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
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

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

ICD–9–CM Code	ICD–9–CM Long Description	Category
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
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

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

ICD–9–CM Code	ICD–9–CM Long Description	Category
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
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

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

ICD–9–CM Code	ICD–9–CM Long Description	Category
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 the most current, complete CY 2012 claims data (a full year of CY 2012 claims data versus the preliminary data from the first half of CY 2012 used for the CY 2014 HH PPS proposed rule) shows that the average case-mix weight before the removal of the codes in Table 2 was 1.3555. It is estimated that the removal of the 170 codes in Table 2 results in an average case-mix weight for CY 2012 of 1.3464. 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.

The following is a summary of the comments we received regarding the proposed ICD–9–CM Grouper Refinements.

Comment: A few commenters agreed with our assessment that many of the conditions that we proposed to remove are too acute to be treated in a home health setting (category 1 codes from Table 2).

Response: We thank the commenters for their support in our efforts to remove conditions that are ''too acute'' to be treated the HH setting from assignment to one of our diagnosis groups within the HH PPS Grouper.

Comment: There were several commenters who believed that the removal of the category 1 ICD–9–CM codes (''too acute'') from our diagnosis groups would limit the scope of physician/medical practice in the home. Other commenters stated that removal of category 1 codes from assignment to one of our diagnosis groups could lead to increased hospital length of stay and could limit access to home health care, especially for patients living in rural areas. Other commenters believed that removal of category 1 diagnoses would mean a reduction of the accuracy of the information reported for payment and that physicians would be compelled to change the diagnosis codes upon hospital discharge for the post-acute management of the patient.

Response: We recognize the valuable services being provided to Medicare beneficiaries in the home health environment and understand the goal of home health services is to help reduce hospitalizations, empower patients to be active participants in their health care, and to practice patient-centered care. The intent of the removal of category 1 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper is neither to limit access to home health care nor to limit the practice of appropriate health care in the home.

We proposed to remove category 1 ICD–9–CM diagnosis codes from our diagnosis groups to ensure greater compliance with ICD–9–CM Coding Guidelines and to assure home health providers are accurately describing the patient characteristics that impact the home health plan of care. Per the ICD–9–CM Coding Guidelines, ''list first the ICD–9–CM code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided.'' For home health services, the diagnosis coding should reflect the reason the patient requires home health services and interventions.

In the CY 2014 HH PPS proposed rule, the category 1 codes proposed to be removed from assignment to one of our diagnosis groups within the HH PPS Grouper are not conditions that would be treated in an individual's home. For example, ICD–9–CM code, 447.2, Rupture of Artery, would be an emergency situation and treatment for such a condition could not be safely treated in the home environment. One commenter provided the following scenario: ''your average COPDer has chronic obstructive asthma, they catch an infection and go into status asthmaticus and go to the hospital for treatment. After a couple of days, they are sent home with a home care referral. Wouldn't the diagnosis be 493.21 (chronic obstructive asthma with status asthmaticus)?'' We agree that the staticus asthmaticus is a condition a hospital would treat during the hospital stay because it refers to a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. However, once the patient is discharged from the hospital, the staticus asthmaticus is no longer active and the patient could be safely discharged back into the community. Clinically, a patient with active staticus asthmaticus could not be safely treated in the home environment, as is the case with all of the category 1 conditions. However, this is not to say that patients who have had these conditions, were treated for the acute presentation, exacerbation or complication, and have been discharged with a home health referral, are not eligible for home health services. In referring to the commenter's clinical scenario above, an appropriate diagnostic code for a home care intervention could be reported as: COPD (496.0) or chronic obstructive asthma (493.2). In fact, patients who have had these conditions and have been treated in the inpatient or outpatient setting may benefit from home health services in treating the sequelae or aftercare that is needed for these conditions.

It is our expectation that home health agencies, who receive referrals for patients who have been treated for these acute conditions, will continue to provide the aftercare services required. The home health care that is required by these patients is the aftercare services and interventions to help reduce any post-acute complications and readmissions. Home health providers are in the ideal position to help in the recovery of the individuals who have

suffered from these acute conditions. Therefore, we do not expect that the removal of these proposed ICD–9–CM codes from one of our diagnosis groups will limit access to needed home health care services for those living in either urban or rural areas. We also do not believe that the scope of physician/medical practice in the home environment will be limited by this proposal. We believe that a physician, using his or her best clinical judgment, would not make a home health care referral for the initial treatment of the listed conditions as these conditions would usually warrant more intensive interventions at presentation. We do believe that a physician would make a home health referral for the aftercare treatment that would be required as a result of these conditions or as a result of the initial treatment of these conditions. Many of the clinical scenarios provided by commenters addressed the home health interventions that were being provided for patients who had been treated in an inpatient or outpatient setting for these conditions. The referral for the home health services and interventions were actually for the aftercare services needed for these conditions.

We do not support physicians changing diagnoses at hospital discharge but we do expect that they will continue to use their clinical expertise and judgment when making home health care referrals to meet the medically necessary aftercare needs of their patients. Additionally, it is the responsibility of the home health providers to contact, as necessary, any referring physician for clarification of all conditions that the prompted the home health referral and the services being requested for the post-acute management of these patients.

Comment: We received a few comments expressing the concern for the increased administrative costs associated with the ICD–9–CM coding requirements. Other commenters were concerned that the removal of these codes would affect Part B claims and believed that denial rates would increase as a result. A few commenters believed that the only reason to remove these codes from assignment to one of our diagnosis groups within the HH PPS Grouper is to further reduce reimbursement.

Response: We disagree that there are increased administrative costs or that this policy would impact Part B claims and result in claims denials. The basis for removal of these codes is to encourage compliance with ICD–9–CM coding guidelines and ensures that conditions that are either too acute to be treated in a home health setting or do not represent the resources assigned to a diagnosis group are removed to ensure appropriate reimbursement for home health services and not to simply reduce reimbursement. We recognize that by removing these ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper some home health providers may have to change coding practices. However, compliance with the ICD–9–CM Coding Guidelines has been a longstanding policy. In our regulations at 45 CFR 162.1002, the Secretary adopted the ICD–9–CM code set, including The Official ICD–9–CM Guidelines for Coding and Reporting. We believe there are ample, available resources in regards to the ICD–9–CM Coding Guidelines to support home health providers to determine the appropriate ICD–9–CM diagnosis codes for all healthcare documentation requirements. These free resources are available at the following links: *http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html?redirect=/ICD9ProviderDiagnosticCodes/*, *http://www.cms.gov/medicare-coverage-database/staticpages/icd-9-code-lookup.aspx*, or on the CDC's Web site at: *http://www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf*.

While physicians use their clinical judgment to determine the principal diagnosis (or diagnoses) of their patients, we do not require them to determine the actual codes associated with those diagnoses for inclusion on the OASIS assessment of home health claims. Our intent in removing category 1 conditions is to ensure that all healthcare providers, including home health care providers, are following the ICD–9–CM Coding Guidelines to paint the most accurate picture of their patient population, as well as the services they are providing in the home health environment. We do not expect that there will be an increase in any denial of claims for appropriate, medically necessary, home care services.

Comment: Several commenters stated that there is ''no clinical evidence'' to support the removal of some of the 170 diagnosis codes. Most notably, some commenters believed that post-hemorrhagic anemia, acute pancreatitis, abscess of the liver, and gastrointestinal disorders were appropriate diagnoses to treat in the home environment. These commenters stated patients with these diagnoses require ongoing home care for services such as home infusion of antibiotics and total parenteral nutrition, wound care, drain care, lab work, and symptom management. Other commenters stated the esophageal reflux and restless leg syndrome should remain in the HH PPS Grouper as these two conditions require increased nursing interventions for evaluation and monitoring, such as nutritional status and side effects from medications.

Response: In the CY 2014 HH PPS proposed rule, we did state that the review of these ICD–9–CM diagnosis codes (those under Category 1 on Table 2,) included CMS clinical staff (including doctors and nurses) as well as with the clinicians and certified coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor). This review received input from a variety of clinicians to ensure that the proposed removal of any diagnosis codes would be done in a thoughtful, clinically responsible manner. Additionally, data analysis by Abt Associates reveals that most home health providers are appropriately coding the aftercare codes for the home care services required for these conditions after they have been stabilized from their acute state. The analysis reveals that most of the 162 category 1 codes that we proposed to remove from assignment to one of our diagnosis groups within the HH PPS Grouper are not commonly reported codes on the OASIS assessment (see Table 3). As a result, we do not believe that these codes will have a significant impact on the current coding patterns of a majority of home health care providers.

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
003.1	Salmonella septicemia	24
250.20	Diabetes with hyperosmolarity, type II or unspecified type, not stated as uncontrolled	1,056
250.21	Diabetes with hyperosmolarity, type I [juvenile type], not stated as uncontrolled	34

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
250.22	Diabetes with hyperosmolarity, type II or unspecified type, uncontrolled	466
250.23	Diabetes with hyperosmolarity, type I [juvenile type], uncontrolled	29
250.30	Diabetes with other coma, type II or unspecified type, not stated as uncontrolled	332
250.31	Diabetes with other coma, type I [juvenile type], not stated as uncontrolled	65
250.32	Diabetes with other coma, type II or unspecified type, uncontrolled	60
250.33	Diabetes with other coma, type I [juvenile type], uncontrolled	13
282.42	Sickle-cell thalassemia with crisis	29
282.62	Hb-SS disease with crisis	382
282.64	Sickle-cell/Hb-C disease with crisis	49
282.69	Other sickle-cell disease with crisis	110
285.1	Acute posthemorrhagic anemia	26,547
289.52	Splenic sequestration	9
348.5	Cerebral edema	237
401.0	Malignant essential hypertension	34,207
414.12	Dissection of coronary artery	49
447.2	Rupture of artery	145
493.21	Chronic obstructive asthma with status asthmaticus	7,765
530.21	Ulcer of esophagus with bleeding	442
530.4	Perforation of esophagus	252
530.7	Gastroesophageal laceration-hemorrhage syndrome	407
530.82	Esophageal hemorrhage	183
531.00	Acute gastric ulcer with hemorrhage, without mention of obstruction	1,334
531.01	Acute gastric ulcer with hemorrhage, with obstruction	62
531.10	Acute gastric ulcer with perforation, without mention of obstruction	249
531.11	Acute gastric ulcer with perforation, with obstruction	20
531.20	Acute gastric ulcer with hemorrhage and perforation, without mention of obstruction	109
531.21	Acute gastric ulcer with hemorrhage and perforation, with obstruction	25
531.31	Acute gastric ulcer without mention of hemorrhage or perforation, with obstruction	49
531.40	Chronic or unspecified gastric ulcer with hemorrhage, without mention of obstruction	1,105
531.41	Chronic or unspecified gastric ulcer with hemorrhage, with obstruction	24
531.50	Chronic or unspecified gastric ulcer with perforation, without mention of obstruction	128
531.51	Chronic or unspecified gastric ulcer with perforation, with obstruction	4
531.61	Chronic or unspecified gastric ulcer with hemorrhage and perforation, with obstruction	119
531.60	Chronic or unspecified gastric ulcer with hemorrhage and perforation, without mention of obstruction	13
531.71	Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction	41
531.91	Gastric ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	249
532.00	Acute duodenal ulcer with hemorrhage, without mention of obstruction	835
532.01	Acute duodenal ulcer with hemorrhage, with obstruction	40
532.10	Acute duodenal ulcer with perforation, without mention of obstruction	257
532.11	Acute duodenal ulcer with perforation, with obstruction	38
532.20	Acute duodenal ulcer with hemorrhage and perforation, without mention of obstruction	92
532.21	Acute duodenal ulcer with hemorrhage and perforation, with obstruction	5
532.31	Acute duodenal ulcer without mention of hemorrhage or perforation, with obstruction	27
532.40	Chronic or unspecified duodenal ulcer with hemorrhage, without mention of obstruction	562
532.41	Chronic or unspecified duodenal ulcer with hemorrhage, with obstruction	3
532.50	Chronic or unspecified duodenal ulcer with perforation, without mention of obstruction	132
532.51	Chronic or unspecified duodenal ulcer with perforation, with obstruction	12
532.60	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, without mention of obstruction.	57
532.61	Chronic or unspecified duodenal ulcer with hemorrhage and perforation, with obstruction	7
532.71	Chronic duodenal ulcer without mention of hemorrhage or perforation, with obstruction	15
532.91	Duodenal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	73
533.00	Acute peptic ulcer of unspecified site with hemorrhage, without mention of obstruction	663
533.01	Acute peptic ulcer of unspecified site with hemorrhage, with obstruction	23
533.10	Acute peptic ulcer of unspecified site with perforation, without mention of obstruction	96
533.11	Acute peptic ulcer of unspecified site with perforation, with obstruction	4
533.20	Acute peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	65
533.21	Acute peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction	27
533.31	Acute peptic ulcer of unspecified site without mention of hemorrhage and perforation, with obstruction.	67
533.40	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, without mention of obstruction.	693
533.41	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage, with obstruction	17
533.50	Chronic or unspecified peptic ulcer of unspecified site with perforation, without mention of obstruction.	128
533.51	Chronic or unspecified peptic ulcer of unspecified site with perforation, with obstruction	8
533.60	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, without mention of obstruction.	53

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
533.61	Chronic or unspecified peptic ulcer of unspecified site with hemorrhage and perforation, with obstruction.	9
533.71	Chronic peptic ulcer of unspecified site without mention of hemorrhage or perforation, with obstruction.	72
533.91	Peptic ulcer of unspecified site, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	266
534.00	Acute gastrojejunal ulcer with hemorrhage, without mention of obstruction	116
534.01	Acute gastrojejunal ulcer, with hemorrhage, with obstruction	7
534.10	Acute gastrojejunal ulcer with perforation, without mention of obstruction	20
534.11	Acute gastrojejunal ulcer with perforation, with obstruction	6
534.20	Acute gastrojejunal ulcer with hemorrhage and perforation, without mention of obstruction	15
534.21	Acute gastrojejunal ulcer with hemorrhage and perforation, with obstruction	2
534.31	Acute gastrojejunal ulcer without mention of hemorrhage or perforation, with obstruction	6
534.40	Chronic or unspecified gastrojejunal ulcer with hemorrhage, without mention of obstruction	103
534.41	Chronic or unspecified gastrojejunal ulcer, with hemorrhage, with obstruction	8
534.50	Chronic or unspecified gastrojejunal ulcer with perforation, without mention of obstruction	26
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.	6
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	3
534.91	Gastrojejunal ulcer, unspecified as acute or chronic, without mention of hemorrhage or perforation, with obstruction.	32
535.01	Acute gastritis, with hemorrhage	652
535.11	Atrophic gastritis, with hemorrhage	108
535.21	Gastric mucosal hypertrophy, with hemorrhage	13
535.31	Alcoholic gastritis, with hemorrhage	61
535.41	Other specified gastritis, with hemorrhage	332
535.51	Unspecified gastritis and gastroduodenitis, with hemorrhage	659
535.61	Duodenitis, with hemorrhage	91
535.71	Eosinophilic gastritis, with hemorrhage	3
536.1	Acute dilatation of stomach	23
537.3	Other obstruction of duodenum	280
537.4	Fistula of stomach or duodenum	343
537.6	Hourglass stricture or stenosis of stomach	14
537.83	Angiodysplasia of stomach and duodenum with hemorrhage	304
537.84	Dielulafoy lesion (hemorrhagic) of stomach and duodenum	50
540.0	Acute appendicitis with generalized peritonitis	764
540.1	Acute appendicitis with peritoneal abscess	458
540.9	Acute appendicitis without mention of peritonitis	656
541.	Appendicitis, unqualified	385
542.	Other appendicitis	43
543.0	Hyperplasia of appendix (lymphoid)	4
557.0	Acute vascular insufficiency of intestine	1,453
560.0	Intussusception	145
560.1	Paralytic ileus	2,050
560.2	Volvulus	1,057
560.81	Intestinal or peritoneal adhesions with obstruction (postoperative) (postinfection)	1,355
560.89	Other specified intestinal obstruction	1,310
560.9	Unspecified intestinal obstruction	12,860
562.02	Diverticulosis of small intestine with hemorrhage	230
562.03	Diverticulitis of small intestine with hemorrhage	189
562.12	Diverticulosis of colon with hemorrhage	2,699
562.13	Diverticulitis of colon with hemorrhage	2,193
567.0	Peritonitis in infectious diseases classified elsewhere	30
567.1	Pneumococcal peritonitis	8
567.21	Peritonitis (acute) generalized	213
567.22	Peritoneal abscess	2,715
567.23	Spontaneous bacterial peritonitis	219
567.29	Other suppurative peritonitis	210
567.31	Psoas muscle abscess	318
567.38	Other retroperitoneal abscess	230
567.81	Choleperitonitis	33
567.82	Sclerosing mesenteritis	116
567.89	Other specified peritonitis	107
567.9	Unspecified peritonitis	910
568.81	Hemoperitoneum (nontraumatic)	265
569.3	Hemorrhage of rectum and anus	2,161
569.83	Perforation of intestine	2,610
569.85	Angiodysplasia of intestine with hemorrhage	196

TABLE 3—TOTAL NUMBER OF EPISODES FOR SELECTED ICD–9–CM DIAGNOSIS CODES, CY 2012—Continued

ICD-9-CM code	ICD-9-CM long description	Number of episodes, CY 2012
569.86	Dieulafoy lesion (hemorrhagic) of intestine	15
572.0	Abscess of liver	1,134
572.1	Portal pyemia	25
574.00	Calculus of gallbladder with acute cholecystitis, without mention of obstruction	1,850
574.01	Calculus of gallbladder with acute cholecystitis, with obstruction	435
574.10	Calculus of gallbladder with other cholecystitis, without mention of obstruction	1,205
574.11	Calculus of gallbladder with other cholecystitis, with obstruction	184
574.21	Calculus of gallbladder without mention of cholecystitis, with obstruction	425
574.30	Calculus of bile duct with acute cholecystitis, without mention of obstruction	308
574.31	Calculus of bile duct with acute cholecystitis, with obstruction	190
574.41	Calculus of bile duct with other cholecystitis, with obstruction	81
574.51	Calculus of bile duct without mention of cholecystitis, with obstruction	371
574.60	Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction	187
574.61	Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction	125
574.71	Calculus of gallbladder and bile duct with other cholecystitis, with obstruction	41
574.80	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction.	86
574.81	Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction	36
574.91	Calculus of gallbladder and bile duct without cholecystitis, with obstruction	58
575.0	Acute cholecystitis	4,728
575.2	Obstruction of gallbladder	131
575.3	Hydrops of gallbladder	20
575.4	Perforation of gallbladder	90
576.1	Cholangitis	1,556
576.2	Obstruction of bile duct	1,417
576.3	Perforation of bile duct	21
577.0	Acute pancreatitis	8,033
578.0	Hematemesis	287
578.9	Hemorrhage of gastrointestinal tract, unspecified	23,650
998.11	Hemorrhage complicating a procedure	369
998.12	Hematoma complicating a procedure	2,337
998.2	Accidental puncture or laceration during a procedure, not elsewhere classified	635

Source: Medicare claims data for episodes ending in CY 2012 (as of June 30, 2013) for a 100 percent sample of beneficiaries for which we had a linked OASIS assessment.

Furthermore, the National Guideline Clearinghouse, a public resource for evidence-based clinical practice guidelines, was also consulted to determine the most current standards of practice regarding these conditions. The evidence-based practice guidelines further lend support that the proposed category 1 diagnosis codes, including those mentioned by the commenters, are conditions that typically warrant initial acute care interventions either in the inpatient, outpatient or emergency department setting. Clinical practice guidelines for a variety of conditions can be found at the National Clearinghouse Guidelines Web site at the following: *http://www.guideline.gov/browse/by-topic-detail.aspx?id=11560&ct=1*.

We are in agreement with the commenters who stated that patients with these acute diagnoses require ongoing home care for services such as home infusion of antibiotics and total parenteral nutrition, wound care, drain care, lab work, and symptom management. These are aftercare services that are required by patients who have been diagnosed and initially treated for the listed diseases or diagnoses. These aftercare services are ideally provided by home health providers and these services can be safely administered in the home environment as long as Medicare beneficiaries meet home health care eligibility requirements. As discussed earlier, there are appropriate ICD–9–CM aftercare codes that can be listed on the OASIS assessment to more fully explain the home health care interventions being provided. We are stating that those codes should be listed on the OASIS assessment form to best explain the reasons for the home health encounter. The disease states precipitating these services can still be listed on the OASIS assessment, but they are not the primary reason for the home health interventions. Therefore, these ICD–9–CM diagnosis codes would not be part of the HH PPS Grouper as there are other aftercare diagnosis codes which are more appropriate to be listed as the reason for home health needs per ICD–9–CM Coding Guidelines.

As for the ICD–9–CM diagnosis codes mentioned by the commenters, ''esophageal reflux'' and ''restless leg syndrome'', that are classified as Category 2 in Table 2 (meaning these codes that would not require HH intervention, would not impact the HH plan of care, or would not result in additional resource use when providing HH services to the patient), these two codes listed as the primary diagnosis alone do not necessarily warrant home health interventions. The fact that an individual has been diagnosed with either of these chronic conditions does not provide sufficient cause for an increase in home health resource use. They can be listed on the OASIS assessment to more fully describe the home health patient, but the expectation is that a stable, chronic condition would not be listed as the primary reason for the home health referral or the need for home health interventions. However, for acute exacerbations or complications from these two conditions, there are other ICD–9–CM diagnosis codes within the HH PPS Grouper that more specifically identify the need for home health services and the interventions that would be required for their management. We are stating that providers should first list those

appropriate ICD–9–CM diagnosis codes if they are the primary reason for home health services, have an impact on the home health plan of care or would result in additional home health resources.

Comment: Some commenters made the recommendation that CMS should form a workgroup with other home health stakeholders to further determine whether these ICD–9–CM diagnosis codes should be removed from the HH PPS Grouper. A few commenters believed that we should delay removing these diagnosis codes until the implementation of ICD–10–CM on October 1, 2014. Several commenters acknowledged that most of these codes are inappropriate for use in the home health setting because of the high acuity level associated with the initial treatment of these conditions.

Response: We believe that sufficient analysis and discussion has been conducted regarding the removal of these 170 ICD–9–CM diagnosis codes. In the CY 2014 HH PPS proposed rule, we noted that the review of these ICD–9–CM diagnosis codes included CMS clinical staff (including doctors and nurses) as well as with the clinicians and certified coding staff from Abt Associates (our support contractor) and 3M (our HH PPS Grouper maintenance contractor). This review received input from a variety of clinicians to ensure that the proposed removal of any diagnosis codes would be done in a thoughtful, clinically responsible manner. We do not believe that delaying the effective date of this proposal to correspond to the implementation of ICD–10–CM is necessary because these codes are infrequently used diagnosis codes on the OASIS assessment and only a small number of home health providers will be impacted by their removal from the HH PPS Grouper.

Comment: A few commenters believed that removal of these 170 ICD–9–CM diagnosis codes would have a detrimental impact on Accountable Care Organization (ACO) and Independence at Home (IAH) demonstration programs.

Response: We disagree that the removal of these diagnosis codes would have a detrimental impact on current demonstration programs. For participation in IAH demonstration programs eligibility requirements are as stated: ''Eligibility criteria are designed to target the most costly beneficiaries with advanced chronic illnesses and substantial disabilities. Beneficiaries must be entitled to Part A and enrolled in Part B, not enrolled in a Medicare Advantage plan or a Program for All-Inclusive Care for the Elderly, and cannot be enrolled in a practice that is part of the Medicare Shared Savings Program or other shared savings demonstrations. Applicable beneficiaries are defined as Medicare FFS patients who have at least two chronic illnesses, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease, ischemic heart disease, stroke, dementias such as Alzheimer's disease, neurodegenerative diseases, and other diseases and conditions designated by the Secretary that result in high costs. Rather than specifying a list of chronic conditions, CMS, for purposes of this demonstration, is defining chronic disease or condition to mean a disease or medical condition that is expected to last for more than 1 year, limits what a person can do, and requires ongoing medical monitoring. Beneficiaries must also need human assistance with two or more activities of daily living (ADLs), have had a non-elective hospital admission within the last 12 months, and have used acute or sub-acute rehabilitation services within the last 12 months. Although practices will report chronic conditions and ADL limitations, chronic conditions and ADLs are subject to medical record audit.[1]'' The goal of ACOs is to provide coordinated care across various health care providers and care transitions. With this type of care model, the expectation is collaborative, coordinated care will result in high quality, cost-effective care. We expect that with each care transition, the appropriate ICD–9–CM codes, per ICD–9–CM Coding Guidelines, would be listed on comprehensive assessment and claims forms. Hospital at home programs typically focus on chronic conditions that typically have exacerbation risks such as congestive heart failure, chronic obstructive pulmonary disease and cellulitis. As such, removal of the ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper should not have an impact on programs such as ACO and IAH demonstrations.

Comment: A few commenters stated that the removal of these 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper goes against the technological advancements of telemedicine and telehealth. Other commenters believed that this change could create a potential professional liability risk issue.

Response: We do not believe the removal of these seldom used diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper would impede any advances in technology or innovations in the delivery of care. Home health delivers care to those Medicare beneficiaries who are homebound but require ongoing health care services. We believe that the primary method for this care in the home health environment is hands-on care, meaning healthcare providers come to the individual's home to provide the care and services needed based on the comprehensive assessment and home health plan of care in collaboration with the patient and the referring physician. Telehealth and telemedicine should be considered an adjunct to, not a replacement of, the variety of comprehensive home health care services available for eligible Medicare beneficiaries. We do encourage all healthcare providers, across all healthcare settings to be innovative in their delivery of services and to incorporate models of care to fully utilize technology to best meet the needs of their patient populations. Section 1895(e) of the Act governs the HH PPS and provides that telehealth services are outside the scope of the Medicare home health benefit and HH PPS. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the HH PPS. As stated in our regulations at § 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.

In addition, we do not believe that by removing the proposed ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper that there will be any increased liability risks on providers. We do believe that referring physicians will continue to use their best clinical judgment to diagnose, to make treatment recommendations, and to determine the appropriate services and resources needed for the delivery of quality, safe care for their patients. Collaboration and communication between referring physicians and home health providers are two factors to help minimize risk

[1] *https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/IAH_Solicitation.pdf*

when caring for Medicare beneficiaries who are receiving home health services.

Comment: A couple of commenters stated that our removal of the 170 codes from assignment to one of our diagnosis groups within the HH PPS Grouper serves only to reduce overall payments by 0.5 percent, reducing overall payments by $100 million in 2014 alone.

Response: As outlined in the CY 2014 HH PPS proposed rule, the removal of the 170 codes encourages compliance with ICD–9–CM coding guidelines and ensures that conditions that are either too acute to be treated in a home health setting or do not represent the resources assigned to a diagnosis group are removed from assignment to one of our diagnosis groups within the HH PPS Grouper. We contend that the removal of these codes is appropriate, either because these conditions cannot be appropriately treated in a home health setting, or because these conditions do not impact the home health plan of care and result in overpayments to HHAs.

Comment: A few commenters stated that the removal of these diagnosis codes may impact the accuracy of the HH PPS case-mix model.

Response: We proposed to remove the 170 codes from assignment to one of our diagnosis groups within the HH PPS Grouper because we concluded that the codes were not reflecting actual conditions being treated or that the condition had no impact on resource use. We note that the HH PPS case-mix model was originally designed with general code categories. Since the basis for proposing to remove the 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper was that either (a) they were not reflecting the actual condition being treated in home health, or (b) the condition would not impact resource use, eliminating them should have minimal impact on the accuracy of the HH PPS case-mix model. The impact of any single diagnosis on a case mix assignment depends on the accumulation of points from other conditions. It is often the case that the clinical component in the case-mix model does not change because of the removal of one source of points. Those agencies that are treating patients with conditions in category 2, will no longer receive additional reimbursement for conditions that do not require the same level of resources as other conditions within that diagnosis group (see Table 4).

TABLE 4—AVERAGE RESOURCES FOR SELECTED ICD–9–CM DIAGNOSIS CODES COMPARED TO AVERAGE RESOURCES FOR THE DIAGNOSIS GROUP, CY 2012

ICD–9–CM Code	ICD–9–CM long description	Mean resources	Mean resources for diagnosis group	Number of episodes, CY 2012
282.5	Sickle-cell trait	521.62	493.49	340
333.81	Blepharospasm	565.55	598.95	110
333.84	Organic writers' cramp	111.76	598.95	1
333.93	Benign shuddering attacks	595.90	598.95	4
333.94	Restless legs syndrome (RLS)	507.32	598.95	25,655
530.81	Esophageal reflux	499.01	510.45	726,692
569.43	Anal sphincter tear (healed) (old)	352.26	510.45	7
873.63	Open wound of tooth (broken) (fractured) (due to trauma), without mention of complication.	447.74	635.52	21

Source: Medicare claims data for episodes ending in CY 2012 (as of June 30, 2013) for a 100 percent sample of beneficiaries for which we had a linked OASIS assessment.

Comment: A commenter stated that CMS should delay the removal of codes until after ICD–10–CM implementation similar to the delay granted to Inpatient Rehabilitation Facilities because the full cost ramifications cannot be predicted without a crosswalk of codes and values from ICD–9–CM to ICD–10–CM. Commenters also requested that the removal of the 170 diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper be done in a budget neutral manner.

Response: To prevent additional inaccurate overpayments and because the payment impact has been analyzed, we do not agree that a delay in removing these codes until after ICD–10–CM implementation is warranted. As we stated above, we contend that the removal of these codes from assignment to one of our diagnosis groups within the HH PPS Grouper is appropriate either because these conditions cannot be appropriately treated in a home health setting, or because these conditions would not impact the home health plan of care and result in overpayments to HHAs. We will provide the ICD–10–CM codes and the diagnostic group to which the codes are assigned in the ICD–10–CM Grouper, which will be posted to our Web site in July 2014.

Comment: A couple of commenters stated that their analysis of the impact showed a greater impact and contended that this demonstrates common use of these codes.

Response: We based our payment impact analysis upon 2012 claims data and assumptions were included in our analysis whereby for certain conditions we believe that coding behavior adjustments would result in the assignment of another diagnosis code within the same diagnosis group leading to the same case-mix weight as what is currently awarded.

Comment: A commenter stated that in 2000, when the HH PPS was created, costs and revenues were based on appropriately identified ICD–9–CM codes, including the 170 proposed for deletion.

Response: In 2000, the HH PPS identified ICD–9–CM codes and awarded points specific to orthopedic, neurologic and diabetes. A majority of these 170 codes were not included in the 2000 HH PPS. In addition, most of the diagnosis codes included in the 2000 HH PPS were assigned at the code category level with the exception of certain orthopedic, neurologic and diabetic conditions within a particular code category which based upon clinical judgment and coding practices were inappropriate for home care. In the 2008 refinement, we added additional diagnosis groups and specified the appropriate four and five digit diagnosis codes. In our review of the current diagnosis codes in preparation for transition to ICD–10–CM reporting, we found that these 170 codes were mistakenly included.

Comment: A commenter agreed with our assessment that many of the conditions were too acute or did not

impact the plan of care but requested additional guidance from CMS in reducing coding errors by educating home health agencies on common coding errors, publish frequently asked questions and open door forums on this issue.

Response: It is our intent to provide ongoing communication, collaboration and education with home health providers to ensure that adequate guidance is provided. This communication will not be limited to the release of Change Requests, which can be found on our home health Web site at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html.* Additionally, we encourage all interested stakeholders to participate in the CMS Home Health and Hospice Open Door Forums where questions, concerns and issues can be addressed with specialists within CMS. Information regarding Open Door Forums can be found on our Web site at *http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html.*

Final Decision: We are finalizing the removal of 170 ICD–9–CM diagnosis codes from assignment to one of our diagnosis groups within the HH PPS Grouper as proposed, effective January 1, 2014.

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 the 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, have 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 section IV.A in this final rule and also in the CY 2014 HH PPS proposed rule (78 FR 40276), 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 from assignment to one of our diagnosis groups within the HH PPS Grouper, 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) and 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 two 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 was developed based upon the process outlined above, and 3M, our HH PPS Grouper maintenance contractor, is in the process of 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 was made 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 post the 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.*

The following is a summary of the comments we received regarding the adoption of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) Conversion.

Comment: One commenter suggested that CMS consider providing additional

lead time for software vendors and agencies to test and make the systems changes necessary to submit ICD–10–CM claims on October 1, 2014. The commenter suggested that the draft Grouper be made available by May 1, 2014 versus July 1, 2014.

Response: In consultation with our support contractor a timeline was built for implementation of an ICD–10–CM Grouper. The timeline requires a translation list and final decisions on logic to be completed prior to the release of a draft Grouper. The translation list and final decisions on logic will not be completed early enough for us to commit to an earlier delivery date than July 1, 2014.

Comment: One commenter stated that they are not able to fully assess the cost impact of the transition from ICD–9–CM to ICD–10–CM reporting without a crosswalk of codes and code values.

Response: The diagnostic group assignment of ICD–10–CM codes in our draft list of codes replicates the ICD–9–CM assignment where possible. Because there is not a 1-to-1 mapping process, we cannot always directly and succinctly crosswalk ICD–9–CM codes to ICD–10–CM codes. However, we have provided the ICD–10–CM codes and the diagnostic group to which the codes were assigned. We plan to have the ICD–10–CM Grouper posted to our Web site in July 2014 for use by home health agencies.

Comment: One commenter expressed concern that the elimination of certain non-specific ICD–10–CM codes would increase the administrative burden on home health agencies by requiring a higher level of expertise in coding and one commenter expressed concern about the administrative costs associated with the implementation of the ICD–10–CM reporting.

Response: The only non-specific ICD–10–CM codes that were not included in our translation were those where the clinician could identify a more specific diagnosis during the initial assessment. We believe that requiring more specific coding does not increase administrative burden but rather encourages the reporting of a specific, more accurate, diagnosis based upon the assessment performed in compliance with ICD–10–CM coding guidelines that requires coding to the highest level of specificity. We note that transition to ICD–10–CM is required for entities covered by the Health Insurance Portability and Accountability Act of 1996 and 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 the **Federal Register**, September 5, 2012 final rule (77 FR 54664), ''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. The Secretary has announced that all entities, including HHAs, must be in compliance with adoption of ICD–10–CM and ICD–10–PCS Medical Data Code Set October 1, 2014.

2. Diagnosis Reporting on Home Health Claims

Adherence to ICD–9–CM and ICD–10–CM 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 ICD–9–CM 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 will 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 noted in the CY 2014 HH PPS proposed rule that 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.

No comments were received regarding the clarification on Diagnosis Reporting on Home Health Claims.

C. Adjustment to the HH PPS Case-Mix Weights

As described in section IV.D. of this rule, we are rebasing the national, standardized 60-day episode payment rate. In the CY 2014 proposed rule, we stated that a goal of rebasing is to reset the base payments under the HH PPS. When the HH PPS was created, we expected that the average case-mix weight would be around 1.0000, but analysis has shown that it has consistently been above 1.0000 since the start of the HH PPS. Therefore, as part of rebasing, for CY 2014, we proposed to use the 2012 case-mix weights, but lower them to an average case-mix weight of 1.0000. We also proposed to increase the national, standardized 60-day episode payment rate by the same factor used to lower the rates to 1.0000, making the downward adjustment to the weights budget neutral. As we noted in the proposed rule, in applying the same reduction factor to each weight we are still maintaining the relative values in the weight set. Preliminary CY 2012 claims data on non-LUPA episodes

starting from January 1, 2012 to May 31, 2012 showed that the average case-mix weight for non-LUPA episodes in 2012 was 1.3517. In the CY 2014 proposed rule, we stated that as more 2012 data become available, we planned to update the estimated average case-mix weight for CY 2012 and adjust the case-mix weights and budget neutrality factor accordingly.

The following is a summary of the comments we received regarding the proposed adjustment to the HH PPS case-mix weights.

Comment: One commenter supported the case-mix update reset, particularly given the proposed changes to rebase the HH payments

Response: We thank the commenter for the comment.

Comment: Commenters stated that CMS did not account for the removal of the ICD–9–CM codes from the case-mix system, which is estimated to drop the average case-mix weight from 1.3517 to 1.3417, in either the adjustment to the case-mix weights or the payment rates.

Response: We find these comments compelling and we plan to change the adjustment to the weights so that it reflects the estimated average case-mix after the removal of the ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper. See also section IV.D. where we discuss how using the average case-mix in CY 2012, after the removal of the ICD–9–CM codes from assignment to one of our diagnosis groups within the HH PPS Grouper, is used in the national, standardized 60-day episode payment rate rebasing adjustment calculation.

Comment: One commenter stated that the approach does not account for genuine increases in case-mix due to real increases in the severity of need since the inception of the HH PPS which are caused by earlier and sicker hospital discharges, technology improvements which allow for complex cases to be cared for at the home, improvements in accuracy of OASIS, and increased therapy needs which indicate a higher level of patient acuity. Other commenters stated that the 1.0000 level set at the beginning of the HH PPS should have been higher and that patients' severity, as well as their resource needs have changed since the HH PPS.

Response: As we stated in the proposed rule, we are lowering the weights to an average of 1.0000 (by dividing each weight using the same divisor) so that the national, standardized 60-day episode payment rate is the average payment per episode. The lowering of the weights to 1.0000 is a way to reset the system. We note that in lowering the weights to average 1.0000, we correspondingly inflate the national, standardized 60-day episode payment rate, of which the inflation includes both real and nominal case-mix. The adjustment to the case-mix weights is therefore budget neutral. In other words, we are completely offsetting the reduction in the weights (to average value of 1.0000) by increasing the national, standardized 60-day episode payment rate. Increases in the costs of patient care since the inception of the HH PPS, which would reflect treating patients with a higher average level of severity, are reflected in the FY 2011 cost data used in the rebasing calculation and accounted for in the rebasing adjustments. The data and methodology for calculating the rebasing adjustments are described in section IV.D. of this final rule.

Comment: One commenter stated that while the proposed case-mix weight adjustments might be budget neutral in the aggregate, it would not be so on a weight-by-weight basis, and the impact on many agencies would be additional reductions in reimbursements, beyond the rebasing reductions. In addition, one commenter stated that the proposal to reduce each of the 153 Home Health Resource Groups (HHRGs) was arbitrary in its attempt to achieve an aggregate case-mix benchmark without regard for the impact of rebasing on specific clinical scenarios. Another commenter stated that CMS should either abandon or delay the case-mix weight adjustments and rebasing approach and spend the next year performing a realistic analysis of true HHA costs and beneficiary needs for home health services. Similarly, a commenter stated that CMS has not assessed whether the number of HHRGs is appropriate or whether the payment for each is adequate. Several commenters stated that CMS should complete an analysis of the adequacy of the case-mix weights this year and encouraged CMS to undertake a comprehensive review of the case-mix weights during the coming year for the CY 2015 rule.

Response: The adjustment to the case-mix weights was performed in a budget neutral way. We increased the national, standardized 60-day episode payment rate by the same factor used to lower the case-mix weights to 1.0000 to determine the starting point for rebasing, so the average payment for agencies is the same with the case-mix weights decreased as the average payment for agencies if the weights were not decreased to 1.0000 and the national, standardized 60-day episode payment was not increased. In the CY 2012 HH PPS final rule (76 FR 68526), we recalibrated the case-mix weights. We plan to examine the effects of the CY 2012 recalibration as cost report data become available. In addition, we are currently in the process of reassessing the entire case-mix system. We recently awarded a new research and technical assistance contract to Abt Associates to examine the findings of the home health study, monitor potential impacts of rebasing and other recent policy changes, and develop payment reform options to ensure access to care for vulnerable populations and address payment vulnerabilities in the current payment system.

Final Decision: Since the CY 2014 proposed rule, we analyzed a full year of CY 2012 claims data (the most current, complete data available), rather than claims data from the first six months of CY 2012, and the results indicate that the average case-mix weight for non-LUPA episodes in 2012 was 1.3547. However, since we are finalizing the removal of 170 ICD–9–CM diagnosis codes from the HH PPS grouper, effective January 1, 2014, we estimate the average case-mix weight for non-LUPA episodes in 2012 would decrease to 1.3464 with those codes removed. Therefore, for CY 2014, we will reduce the average case-mix weight for 2012 from 1.3464 to 1.0000. The CY 2014 weights shown in Table 5 were obtained by dividing the CY 2013 weights (which are the same weights as those finalized in CY 2012 rulemaking) by 1.3464. To offset the effect of resetting the case-mix weights such that the average is 1.0000, we inflate the national, standardized 60-day episode payment rate by the same factor (1.3464) used to decrease the weights. The result will be the starting point from which rebasing adjustments are implemented.

As noted in the CY 2014 proposed rule, 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. We also plan to continue to monitor case-mix growth (both real and nominal case-mix growth), and address it accordingly in the future.

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
10111	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F1S1	0.8186	0.6080
10112	1st and 2nd Episodes, 6 Therapy Visits	C1F1S2	0.9793	0.7273
10113	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F1S3	1.1401	0.8468
10114	1st and 2nd Episodes, 10 Therapy Visits	C1F1S4	1.3008	0.9661
10115	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4616	1.0856
10121	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F2S1	1.0275	0.7631
10122	1st and 2nd Episodes, 6 Therapy Visits	C1F2S2	1.1657	0.8658
10123	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F2S3	1.3039	0.9684
10124	1st and 2nd Episodes, 10 Therapy Visits	C1F2S4	1.4421	1.0711
10125	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5804	1.1738
10131	1st and 2nd Episodes, 0 to 5 Therapy Visits	C1F3S1	1.1233	0.8343
10132	1st and 2nd Episodes, 6 Therapy Visits	C1F3S2	1.2520	0.9299
10133	1st and 2nd Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3807	1.0255
10134	1st and 2nd Episodes, 10 Therapy Visits	C1F3S4	1.5094	1.1211
10135	1st and 2nd Episodes, 11 to 13 Therapy Visits	C1F3S5	1.6381	1.2167
10211	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F1S1	0.8340	0.6194
10212	1st and 2nd Episodes, 6 Therapy Visits	C2F1S2	1.0302	0.7652
10213	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F1S3	1.2265	0.9109
10214	1st and 2nd Episodes, 10 Therapy Visits	C2F1S4	1.4228	1.0567
10215	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6190	1.2025
10221	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F2S1	1.0429	0.7746
10222	1st and 2nd Episodes, 6 Therapy Visits	C2F2S2	1.2166	0.9036
10223	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3903	1.0326
10224	1st and 2nd Episodes, 10 Therapy Visits	C2F2S4	1.5641	1.1617
10225	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7378	1.2907
10231	1st and 2nd Episodes, 0 to 5 Therapy Visits	C2F3S1	1.1387	0.8457
10232	1st and 2nd Episodes, 6 Therapy Visits	C2F3S2	1.3029	0.9677
10233	1st and 2nd Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4671	1.0896
10234	1st and 2nd Episodes, 10 Therapy Visits	C2F3S4	1.6313	1.2116
10235	1st and 2nd Episodes, 11 to 13 Therapy Visits	C2F3S5	1.7956	1.3336
10311	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9071	0.6737
10312	1st and 2nd Episodes, 6 Therapy Visits	C3F1S2	1.1348	0.8428
10313	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3624	1.0119
10314	1st and 2nd Episodes, 10 Therapy Visits	C3F1S4	1.5900	1.1809
10315	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8177	1.3500
10321	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1160	0.8289
10322	1st and 2nd Episodes, 6 Therapy Visits	C3F2S2	1.3211	0.9812
10323	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5262	1.1335
10324	1st and 2nd Episodes, 10 Therapy Visits	C3F2S4	1.7313	1.2859
10325	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9364	1.4382
10331	1st and 2nd Episodes, 0 to 5 Therapy Visits	C3F3S1	1.2118	0.9000
10332	1st and 2nd Episodes, 6 Therapy Visits	C3F3S2	1.4074	1.0453
10333	1st and 2nd Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6030	1.1906
10334	1st and 2nd Episodes, 10 Therapy Visits	C3F3S4	1.7986	1.3359
10335	1st and 2nd Episodes, 11 to 13 Therapy Visits	C3F3S5	1.9942	1.4811
21111	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6223	1.2049
21112	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8331	1.3615
21113	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0438	1.5180
21121	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7186	1.2764
21122	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9496	1.4480
21123	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1807	1.6197
21131	1st and 2nd Episodes, 14 to 15 Therapy Visits	C1F3S1	1.7668	1.3122
21132	1st and 2nd Episodes, 16 to 17 Therapy Visits	C1F3S2	2.0252	1.5042
21133	1st and 2nd Episodes, 18 to 19 Therapy Visits	C1F3S3	2.2836	1.6961
21211	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8153	1.3483
21212	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0224	1.5021
21213	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2294	1.6558
21221	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9116	1.4198
21222	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1389	1.5886
21223	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3663	1.7575
21231	1st and 2nd Episodes, 14 to 15 Therapy Visits	C2F3S1	1.9598	1.4556
21232	1st and 2nd Episodes, 16 to 17 Therapy Visits	C2F3S2	2.2145	1.6448
21233	1st and 2nd Episodes, 18 to 19 Therapy Visits	C2F3S3	2.4691	1.8339
21311	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0453	1.5191
21312	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2682	1.6846
21313	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F1S3	2.4911	1.8502
21321	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1415	1.5905
21322	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3848	1.7712
21323	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6280	1.9519
21331	1st and 2nd Episodes, 14 to 15 Therapy Visits	C3F3S1	2.1897	1.6263

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
21332	1st and 2nd Episodes, 16 to 17 Therapy Visits	C3F3S2	2.4603	1.8273
21333	1st and 2nd Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7309	2.0283
22111	3rd+ Episodes, 14 to 15 Therapy Visits	C1F1S1	1.6822	1.2494
22112	3rd+ Episodes, 16 to 17 Therapy Visits	C1F1S2	1.8730	1.3911
22113	3rd+ Episodes, 18 to 19 Therapy Visits	C1F1S3	2.0638	1.5328
22121	3rd+ Episodes, 14 to 15 Therapy Visits	C1F2S1	1.7628	1.3093
22122	3rd+ Episodes, 16 to 17 Therapy Visits	C1F2S2	1.9791	1.4699
22123	3rd+ Episodes, 18 to 19 Therapy Visits	C1F2S3	2.1954	1.6306
22131	3rd+ Episodes, 14 to 15 Therapy Visits	C1F3S1	1.9247	1.4295
22132	3rd+ Episodes, 16 to 17 Therapy Visits	C1F3S2	2.1305	1.5824
22133	3rd+ Episodes, 18 to 19 Therapy Visits	C1F3S3	2.3362	1.7351
22211	3rd+ Episodes, 14 to 15 Therapy Visits	C2F1S1	1.8508	1.3746
22212	3rd+ Episodes, 16 to 17 Therapy Visits	C2F1S2	2.0460	1.5196
22213	3rd+ Episodes, 18 to 19 Therapy Visits	C2F1S3	2.2412	1.6646
22221	3rd+ Episodes, 14 to 15 Therapy Visits	C2F2S1	1.9314	1.4345
22222	3rd+ Episodes, 16 to 17 Therapy Visits	C2F2S2	2.1521	1.5984
22223	3rd+ Episodes, 18 to 19 Therapy Visits	C2F2S3	2.3729	1.7624
22231	3rd+ Episodes, 14 to 15 Therapy Visits	C2F3S1	2.0933	1.5547
22232	3rd+ Episodes, 16 to 17 Therapy Visits	C2F3S2	2.3035	1.7109
22233	3rd+ Episodes, 18 to 19 Therapy Visits	C2F3S3	2.5136	1.8669
22311	3rd+ Episodes, 14 to 15 Therapy Visits	C3F1S1	2.0747	1.5409
22312	3rd+ Episodes, 16 to 17 Therapy Visits	C3F1S2	2.2878	1.6992
22313	3rd+ Episodes, 18 to 19 Therapy Visits	C3F1S3	2.5009	1.8575
22321	3rd+ Episodes, 14 to 15 Therapy Visits	C3F2S1	2.1553	1.6008
22322	3rd+ Episodes, 16 to 17 Therapy Visits	C3F2S2	2.3940	1.7781
22323	3rd+ Episodes, 18 to 19 Therapy Visits	C3F2S3	2.6326	1.9553
22331	3rd+ Episodes, 14 to 15 Therapy Visits	C3F3S1	2.3172	1.7210
22332	3rd+ Episodes, 16 to 17 Therapy Visits	C3F3S2	2.5453	1.8904
22333	3rd+ Episodes, 18 to 19 Therapy Visits	C3F3S3	2.7734	2.0599
30111	3rd+ Episodes, 0 to 5 Therapy Visits	C1F1S1	0.6692	0.4970
30112	3rd+ Episodes, 6 Therapy Visits	C1F1S2	0.8718	0.6475
30113	3rd+ Episodes, 7 to 9 Therapy Visits	C1F1S3	1.0744	0.7980
30114	3rd+ Episodes, 10 Therapy Visits	C1F1S4	1.2770	0.9485
30115	3rd+ Episodes, 11 to 13 Therapy Visits	C1F1S5	1.4796	1.0989
30121	3rd+ Episodes, 0 to 5 Therapy Visits	C1F2S1	0.8421	0.6254
30122	3rd+ Episodes, 6 Therapy Visits	C1F2S2	1.0263	0.7623
30123	3rd+ Episodes, 7 to 9 Therapy Visits	C1F2S3	1.2104	0.8990
30124	3rd+ Episodes, 10 Therapy Visits	C1F2S4	1.3945	1.0357
30125	3rd+ Episodes, 11 to 13 Therapy Visits	C1F2S5	1.5787	1.1725
30131	3rd+ Episodes, 0 to 5 Therapy Visits	C1F3S1	0.9352	0.6946
30132	3rd+ Episodes, 6 Therapy Visits	C1F3S2	1.1331	0.8416
30133	3rd+ Episodes, 7 to 9 Therapy Visits	C1F3S3	1.3310	0.9886
30134	3rd+ Episodes, 10 Therapy Visits	C1F3S4	1.5289	1.1355
30135	3rd+ Episodes, 11 to 13 Therapy Visits	C1F3S5	1.7268	1.2825
30211	3rd+ Episodes, 0 to 5 Therapy Visits	C2F1S1	0.7361	0.5467
30212	3rd+ Episodes, 6 Therapy Visits	C2F1S2	0.9591	0.7123
30213	3rd+ Episodes, 7 to 9 Therapy Visits	C2F1S3	1.1820	0.8779
30214	3rd+ Episodes, 10 Therapy Visits	C2F1S4	1.4049	1.0434
30215	3rd+ Episodes, 11 to 13 Therapy Visits	C2F1S5	1.6278	1.2090
30221	3rd+ Episodes, 0 to 5 Therapy Visits	C2F2S1	0.9091	0.6752
30222	3rd+ Episodes, 6 Therapy Visits	C2F2S2	1.1136	0.8271
30223	3rd+ Episodes, 7 to 9 Therapy Visits	C2F2S3	1.3180	0.9789
30224	3rd+ Episodes, 10 Therapy Visits	C2F2S4	1.5225	1.1308
30225	3rd+ Episodes, 11 to 13 Therapy Visits	C2F2S5	1.7269	1.2826
30231	3rd+ Episodes, 0 to 5 Therapy Visits	C2F3S1	1.0022	0.7444
30232	3rd+ Episodes, 6 Therapy Visits	C2F3S2	1.2204	0.9064
30233	3rd+ Episodes, 7 to 9 Therapy Visits	C2F3S3	1.4386	1.0685
30234	3rd+ Episodes, 10 Therapy Visits	C2F3S4	1.6568	1.2305
30235	3rd+ Episodes, 11 to 13 Therapy Visits	C2F3S5	1.8751	1.3927
30311	3rd+ Episodes, 0 to 5 Therapy Visits	C3F1S1	0.9324	0.6925
30312	3rd+ Episodes, 6 Therapy Visits	C3F1S2	1.1609	0.8622
30313	3rd+ Episodes, 7 to 9 Therapy Visits	C3F1S3	1.3893	1.0319
30314	3rd+ Episodes, 10 Therapy Visits	C3F1S4	1.6178	1.2016
30315	3rd+ Episodes, 11 to 13 Therapy Visits	C3F1S5	1.8463	1.3713
30321	3rd+ Episodes, 0 to 5 Therapy Visits	C3F2S1	1.1054	0.8210
30322	3rd+ Episodes, 6 Therapy Visits	C3F2S2	1.3154	0.9770
30323	3rd+ Episodes, 7 to 9 Therapy Visits	C3F2S3	1.5254	1.1329
30324	3rd+ Episodes, 10 Therapy Visits	C3F2S4	1.7353	1.2888
30325	3rd+ Episodes, 11 to 13 Therapy Visits	C3F2S5	1.9453	1.4448
30331	3rd+ Episodes, 0 to 5 Therapy Visits	C3F3S1	1.1985	0.8902

TABLE 5—FINAL CY 2014 CASE-MIX WEIGHTS—Continued

Payment group	Description	Clinical, functional, and service levels	2013 HH PPS case-mix weights	2014 HH PPS case-mix weights
30332	3rd+ Episodes, 6 Therapy Visits	C3F3S2	1.4222	1.0563
30333	3rd+ Episodes, 7 to 9 Therapy Visits	C3F3S3	1.6460	1.2225
30334	3rd+ Episodes, 10 Therapy Visits	C3F3S4	1.8697	1.3887
30335	3rd+ Episodes, 11 to 13 Therapy Visits	C3F3S5	2.0935	1.5549
40111	All Episodes, 20+ Therapy Visits	C1F1S1	2.2546	1.6745
40121	All Episodes, 20+ Therapy Visits	C1F2S1	2.4117	1.7912
40131	All Episodes, 20+ Therapy Visits	C1F3S1	2.5419	1.8879
40211	All Episodes, 20+ Therapy Visits	C2F1S1	2.4364	1.8096
40221	All Episodes, 20+ Therapy Visits	C2F2S1	2.5936	1.9263
40231	All Episodes, 20+ Therapy Visits	C2F3S1	2.7238	2.0230
40311	All Episodes, 20+ Therapy Visits	C3F1S1	2.7140	2.0157
40321	All Episodes, 20+ Therapy Visits	C3F2S1	2.8712	2.1325
40331	All Episodes, 20+ Therapy Visits	C3F3S1	3.0014	2.2292

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

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

Section 3131(a) of the Affordable Care Act requires that starting in CY 2014, the Secretary must apply an adjustment to the national, standardized 60-day episode payment amount 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 requires that this rebasing must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010) under section 1895(b)(3)(A)(i)(III) of the Act, and be fully implemented by CY 2017.

In the CY 2014 HH PPS proposed rule, we described our extensive analysis of cost report and claims data and proposed rebasing adjustments to the national, standardized 60-day episode payment amount, the LUPA per-visit payment amounts, and the NRS conversion factor. 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, Audit Results and Weighting

In the CY 2014 HH PPS proposed rule, we described the trimming methodology used to obtain a more robust estimate of costs, which consisted of longitudinal and cross-sectional trims. After applying the trimming methodology, 6,252 cost reports were left in the 2011 sample, out of 10,327 cost reports. These cost reports were then used to estimate the average cost per visit and average cost per episode for 2011.

In addition, we described the results of the audits of 100 FY 2010 HHA Medicare cost reports. We stated that 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 rule likely over-estimates the average cost per visit and average cost per episode for providers.

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. Using the nationally-weighted average costs per visit from the trimmed FY 2011 HHA 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

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

Discipline	2011 Average costs per visit	2011 Average number of visits	2011 60-Day episode costs
Total	.....	18.59	2,453.71

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

b. Calculating the Estimated Average Cost per Episode

In the CY 2014 HH PPS proposed rule, to determine the rebasing adjustment to the 60-day national, standardized episode payment amount, 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. 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. In the CY 2014 HH PPS proposed rule, we stated that the 2011 estimated cost per episode is $2,453.71 when using the 2011 visit profile and is $2,443.34 when using the 2012 visit profile. We calculated an adjustment factor to account for the visit differences between 2011 and 2012 (1 + (2,443.34–2,453.71)/2,453.71 = 0.9958). The 2012 visit profile in the CY 2014 HH PPS proposed rule was calculated using preliminary CY 2012 claims data for episodes starting on or before May 31, 2012. We also stated in the CY 2014 HH PPS proposed rule that we planned to update the 2012 visit distribution as more data become available, and therefore, the estimated cost per episode may change slightly. Using the most current, complete CY 2012 data for this final rule (a full year of claims data), we re-examined the 2012 visit distribution and re-calculated the 2011 estimated cost per episode using the updated 2012 visit profile ($2,448.95). The adjustment factor was also re-calculated to account for the change in the number of visits between 2011 and 2012 (1 + (2,448.95–2,453.71)/2,453.71 = 0.9981). The CY 2011 visit distribution, the CY 2012 visit distribution using partial CY 2012 data as described in the CY 2014 HH PPS proposed rule, and the CY 2012 visit distribution using complete CY 2012 data are shown in Table 7. We note that since complete CY 2013 claims data was not available at the time of this final rule, we did not make any adjustments for changes in the visit distribution from CY 2012 to CY 2013 as part of developing the estimated CY 2013 average cost per episode.

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 (published in CY 2014 HH PPS proposed rule)	2012 Average number of visits per episode (using full CY 2012 data)
Skilled Nursing	9.43	9.39	9.44
Home Health Aide	2.80	2.62	2.63
Physical Therapy	4.86	4.88	4.86
Occupational Therapy	1.15	1.15	1.16
Speech-Language Pathology	0.21	0.23	0.23
Medical Social Services	0.14	0.14	0.14
Total Number of Visits per Episode	18.59	18.41	18.46

Source: CY 2011 Medicare claims data, CY 2012 Medicare claims data as of December 31, 2012 for episodes starting between January 1, 2012 and May 31, 2012, and CY 2012 Medicare claims data (as of June 2013) for episodes ending on or before December 31, 2012 for which we had a linked OASIS assessment.

After applying the adjustment to account for the visit distribution change between 2011 and 2012, we calculate the estimated average cost per episode for CY 2013 by multiplying the estimated, average cost per episode by the HH market basket for 2012 and by the HH market basket for 2013 (Table 8). When setting the 60-day episode base rate for the HH PPS in 2000, we also updated costs from cost reports by the HH market basket to reflect expected inflation. We note that the 2013 estimated cost per episode shown in Table 8 reflects the updated 2012 visit profile, and therefore numbers have changed slightly from the CY 2014 HH PPS proposed rule.

TABLE 8—2013 ESTIMATED COST PER EPISODE

2011 Estimated cost per episode	Factor for 2011–2012 visit distribution difference	2012 HH market basket	2013 HH market basket	2013 Estimated cost per episode
$2,453.71	× 0.9981	× 1.024	× 1.023	= $2,565.51

c. Calculating the Estimated Average Payment per Episode

To develop the 2013 estimated average payment per episode, in our updated analyses for this final rule, we start with the CY 2012 national, standardized 60-day episode payment rate and apply a number of factors. In the CY 2014 HH PPS proposed rule, we proposed to reset the average case-mix weight from 1.3517 to 1.0000 and increased the CY 2012 60-day episode payment rate by 1.3517. Since we are resetting the average case-mix weight from 1.3464 to 1.0000 (see section IV.C. of this rule), we increase the CY 2012 60-day episode payment rate by 1.3464. As such, the numbers in Table 9 are different from the numbers in the CY 2014 HH PPS proposed rule. 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 (the 1.32 percent payment reduction for nominal case-mix growth and the 1.3 percent HH payment update percentage), 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. Later, in our calculation of the CY 2014 national, standardized 60-day episode payment rate, we remove the outlier dollars (see Tables 20 and 21 in section IV.E.4.b. of this rule).

TABLE 8—2013 ESTIMATED COST PER EPISODE

2012 National, standardized 60-day episode payment rate	Budget neutrality factor to account for case-mix weight adjustment to 1.0000	2013 Payment reduction for nominal case-mix growth	2013 HH Payment update percentage	Outlier adjustment	2013 Estimated average payment per episode
$2,138.52	× 1.3464	× 0.9868	× 1.013	÷ 0.975	=$2,952.03

d. Calculating the Rebasing Adjustment to the National, Standardized 60-day Episode Payment Amount

In the CY 2014 HH PPS proposed rule, we compared the 2013 estimated average payment per episode to the 2013 estimated average cost per episode and obtained a difference of −13.63 percent (($2,559.59 − $2,963.65)/$2,963.65). We stated that phasing-in the −13.63 percent adjustment over 4 years in equal increments would result in an annual reduction to the national, standardized 60-day payment rate of 3.60 percent, determined using a compound annual growth rate (CAGR) formula (($2,559.59/$2,963.65) $^{1/4}$ −1 = −0.0360). Given the 3.5 percent limit set in statute, we proposed to reduce the national, standardized 60-day episode payment amount by 3.5 percent in each year, 2014 through 2017. For this final rule, when comparing the updated 2013 estimated average cost per episode and 2013 estimated average payment per episode we obtained a difference of −13.09 percent (($2,565.51—$2,952.03)/$2,952.03), as shown in Table 10. Phasing-in the −13.09 percent over 4 years in equal increments would result in an annual reduction of 3.45 percent, determined using a CAGR formula.

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

2013 Payment per episode	2013 Estimated cost per episode	Percentage change
$2,952.03	$2,565.51	−13.09

In order to align episode payments with costs, we would implement a −3.45 percent rebasing adjustment to the national, standardized 60-day episode payment rate each year from 2014 through 2017. Our initial interpretation of section 3131(a) of the Affordable Care Act for the CY 2014 HH PPS proposed rule reflects how one would ideally rebase a payment system and supports a −3.45 percent rebasing adjustment to the national, standardized 60-day episode payment rate. However, commenters stated that since the statute specifies that the rebasing adjustments ''may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act'', the maximum adjustment of 3.5 percent should be calculated using the CY 2010 payment rates. Upon further review of the specific language in the statute, we agree with the commenters. Therefore, as specified by statute, the rebasing adjustment is limited to 3.5 percent of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94 (74 FR 58106), or $80.95.

The −3.45 percent rebasing adjustment to the 2013 national, standardized 60-day payment rate described above exceeds the maximum adjustment specified by statute of $80.95. A −3.45 percent rebasing adjustment would result in a decrease of $99.56 for CY 2014 ($2,952.03 * 0.975 (remove the outlier dollars that we put back in the rates for comparison purposes as described above) * 1.0026 (wage index standardization factor as described in section IV.E.4.b of this final rule) * 0.0345 = $99.56). In addition, a −3.45 percent rebasing adjustment for CY 2015 through 2017 would also exceed the maximum adjustment allowed under statute of $80.95. Given that a −3.45 percent adjustment for CY 2014 through CY 2017 would result in larger dollar amount reductions than the maximum dollar amount allowed under section 3131(a) of $80.95, we are limited to implementing a reduction of $80.95 to the national, standardized 60-day episode payment amount each year for CY 2014 through CY 2017.

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

As stated in the CY 2014 HH PPS proposed rule, to determine the rebasing adjustment for the national per-visit payment rates, we compared the current national per-visit 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 IV.D.3. of this 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 cost per visit	Average NRS cost per visit	2012 HH market basket	2013 HH market basket	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 national 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 NATIONAL PER-VISIT PAYMENT RATES

Discipline	2013 Per-visit payment rates (excluding outlier pool)	Outlier adjustment	2013 Per-visit payment rates (including outlier pool)
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 national per-visit payment rate, per discipline for LUPA episodes to the 2013 estimated average cost per-visit, per-discipline, we observe that costs per visit are higher than the 2013 national per-visit payment rates (see Table 13), ranging from +19.5 percent to +33.1 percent.

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	Percentage change
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

We stated that phasing-in the adjustments, ranging from + 19.48 percent to + 33.11 percent in Table 13 above, over 4 years in equal increments, would result in annual increases ranging from 4.55 to 7.41 percent, determined using a compound annual growth rate (CAGR) formula. Given the 3.5 percent limit set in statute, we proposed to increase the per-visit payment rates by 3.5 percent every year from 2014 to 2017 in order to better

align the national per-visit payment amounts with costs. However, the statute limits the rebasing adjustment that can be applied. As explained in more detail below, several commenters stated that since the statute specifies that the rebasing adjustments ''may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act'', the maximum adjustment of 3.5 percent should be calculated using the CY 2010 payment rates. Upon further review of the specific language in the statute, we agree with the commenters. Therefore, because of the language in the statute, we are limited to increasing the national per-visit payment amounts by no more than the amounts outlined in Table 14 below.

TABLE 14—MAXIMUM ADJUSTMENTS TO THE NATIONAL PER-VISIT PAYMENT RATES, NOT TO EXCEED 3.5 PERCENT OF THE AMOUNT(S) IN CY 2010

Discipline	2010 National per-visit payment rates	Maximum 3.5% adjustment to per-visit rates
Skilled Nursing	$113.01	$3.96
Home Health Aide	51.18	1.79
Physical Therapy	123.57	4.32
Occupational Therapy	124.40	4.35
Speech-Language Pathology	134.27	4.70
Medical Social Services	181.16	6.34

Source: (74 FR 58107).

The annual increases ranging from 4.55 to 7.41 percent determined using a CAGR formula and the percentage changes in Table 13 above would exceed the maximum adjustments allowed under statute for CY 2014 through 2017 (see Table 15 below). In addition, increasing the national per-visit payment rates by 3.5 percent each year, as proposed, would also exceed the maximum adjustments allowed under statute given that the rebasing adjustments cannot be more than 3.5 percent of the CY 2010 national per-visit rates in any given year (see Table 15 below). Therefore, we are limited to implementing the dollar amount increases to the national per-visit payment rates outlined in Table 14 above each year, CY 2014 through CY 2017.

TABLE 15—CAGR AND PROPOSED 3.5 PERCENT DOLLAR INCREASES AND THE MAXIMUM ADJUSTMENTS TO THE NATIONAL PER-VISIT PAYMENT RATES, NOT TO EXCEED 3.5 PERCENT OF THE AMOUNT(S) IN CY 2010

Discipline	2013 National per-visit payment rates	Wage Index standardization [1]	CAGR percent increase	CAGR dollar amount increase	Proposed 3.5 percent dollar amount increase	Maximum 3.5% adjustment to per-visit rates
Skilled Nursing	$114.35	$114.42	4.55	$5.21	$4.00	$3.96
Home Health Aide	51.79	51.82	7.41	3.84	1.81	1.79
Physical Therapy	125.03	125.11	7.41	9.27	4.38	4.32
Occupational Therapy	125.88	125.96	7.04	8.87	4.41	4.35
Speech-Language Pathology	135.86	135.94	6.80	9.24	4.76	4.70
Medical Social Services	183.31	183.42	5.36	9.83	6.42	6.34

[1] Column 2 is multiplied by the wage index standardization factor for the national per-visit payment rates of 1.0006 as described in section IV.E.4.b.

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 as described in the CY 2014 HH PPS proposed rule, we used the trimmed sample of 6,252 cost reports from FY 2011, as described in section IV.D.1. of this 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 IV.D.1. of this 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 for the CY 2014 HH PPS proposed rule, 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 then inflated the result by the 2012 and 2013 HH market basket for a 2013 estimated average NRS cost per episode of $43.58. For this final rule, using the more current, complete CY 2012 claims data, the average number of visits in 2012 decreases to 18.46. Therefore, the adjustment for the change in the average number of visits per episode between CY 2011 and CY 2012 will be ((1+ 18.46 – 18.59)/18.59)) = 0. 9930). We then inflate the result by the 2012 and 2013 HH market basket for a 2013 estimated average NRS cost per episode of $43.53 as shown in Table 16.

TABLE 16—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	× 0.9930	× 1.024	× 1.023	$43.70

To compare the 2013 estimated average NRS cost per episode to 2013 estimated average NRS payment per episode, for the CY 2014 HH PPS proposed rule we used preliminary 2012 claims data for non-LUPA episodes and the CY 2013 NRS conversion factor of $53.97 to calculate the estimated 2013 average NRS payment per episode of $48.38. For this final rule, using the more current, complete CY 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 17.

TABLE 17—PERCENTAGE OF EPISODES BY NRS SEVERITY LEVEL

Severity level	Relative weight	Percent of episodes, CY 2008 final rule	Percent of episodes, CY 2012
1	0.2698	63.7	69.3
2	0.9742	20.6	16.7
3	2.6712	6.7	6.4
4	3.9686	5.4	4.3
5	6.1198	3.2	3.0
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 (as of June 30, 2013) for non-LUPA HH episodes ending on or before December 31, 2012 for which we had a linked OASIS assessment.

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).

In the proposed rule, when comparing the 2013 estimated average NRS payment per episode of $48.38 to the 2013 estimated average NRS cost per episode of $43.58; we obtained 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, using a CAGR formula, would result in an annual reduction of 2.58 percent. Using the updated distribution of CY 2012 claims by severity level and the relative weights in Table 17 with the CY 2013 conversion factor of $53.97, the CY 2013 estimated average NRS payment per episode is $49.00. Comparing the 2013 estimated average NRS cost per episode to the 2013 estimated average NRS payment per episode, we obtain a difference of −10.82 percent (($43.70–$49.00)/$49.00). Phasing-in the −10.82 percent adjustment over 4 years in equal increments, using a CAGR formula, will result in an annual reduction of 2.82 percent, or $1.52 in CY 2014 ($53.97 x 0.0282 = $1.52). This $1.52 does not exceed 3.5 percent of the CY 2010 NRS conversion factor, which is calculated to be $1.87 ($53.34 x 0.035). We noted in the CY 2014 HH PPS proposed rule 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 IV.D.1.of this 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 (78 FR 40290). For more information on the rebasing analyses performed, refer to the technical reports for both the proposed and final rules 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*.

The following is a summary of the comments we received regarding the proposed rebasing adjustments to the National, Standardized 60-day Episode Payment Amount, LUPA Per-Visit Payment Amounts, and the (NRS) Conversion Factor.

Comment: Commenters stated that the maximum allowable rebasing reduction should be calculated from the CY 2010 standardized base amount, not the CY 2013 average payment. The commenters stated that the Affordable Care Act refers to ''the date of enactment'' and since the Affordable Care Act was enacted on March 23, 2010, CY 2010 payment amounts should be used when calculating the maximum allowable reduction for rebasing. In addition, commenters argued that the limit should be calculated using the national standardized episode payment rate, rather than the episode payment rate multiplied by the average case-mix.

Response: While we interpreted the statutory language differently for the CY 2014 HH PPS proposed rule and believe that the proposed rule reflects the how one would ideally rebase a payment system, upon further review, we agree with the commenters regarding the date of enactment and will use the CY 2010 payment rates to determine whether any of the rebasing adjustments exceed 3.5 percent.

Comment: MedPAC was supportive of the proposed adjustments to the payment amounts, but expressed concerns that the proposed rebasing adjustment to the national, standardized 60 day episode amount of −3.5 percent will be too modest and leave agencies with substantial profit opportunities. MedPAC stated that much of the annual rebasing reductions will be offset by the payment update for each year in 2014 to 2017 and estimates that the cumulative net payment reduction to the national, standardized 60-day episode payment amount after four years will equal approximately 4 percent. MedPAC noted that the rebasing reductions are smaller than the net reductions implemented in 2010 through 2013, a period when the base rate was reduced by 7.6 percent, and noted that the four-year cumulative net effect of the rebasing reductions is smaller than the 4.89 percent estimated one-year payment reduction for CY 2011. MedPAC stated that they recommended to the Congress that the statute should be changed so that rebasing could be implemented in a shorter period and also recommended that the market basket updates be eliminated to bring costs closer to payments than the current approach.

Response: We thank MedPAC for their comments. As MedPAC noted, we proposed a 3.5 percent reduction to the CY 2013 national, standardized 60-day episode payment rate for CY 2014 and an additional 3.5 percent in each year 2015 through CY 2017. However, we do not have the statutory authority to either shorten the 4-year phase-in period or eliminate the annual payment updates. As brought to our attention by commenters, the maximum rebasing adjustment amounts are now calculated using 3.5 percent of the CY 2010 payment rates. Consequently, for this final rule that requirement results in a $80.95 dollar reduction to the national, standardized 60-day episode payment amount in each year from CY 2014 through CY 2017 as described in section IV.D.1.d above. This is equivalent to a 2.81 percent reduction to the national, standardized 60-day episode payment rate for 2014 rather than a 3.45 percent reduction.[2]

Comment: Several commenters stated that CMS should not implement the proposed payment reductions. Commenters stated that the proposed payment reductions may impact quality of care and diminish health care system efficiency, as well as limit provider's ability to participate in broader delivery system reform efforts. Specifically, commenters stated that home health care prevents hospital readmissions and is less costly than other post-acute settings, and that the rebasing adjustments may increase the use of more costly institutional care, like hospitals, which is against the goal of health care reform to improve outcomes and care coordination, prevent hospitalizations and re-hospitalizations, and reduce costs. A commenter stated that patient outcomes have improved and that spending in FY 2011 is similar to FY 1996, indicating that reductions are not needed. Another commenter stated that CMS should ensure that the final rebasing policy reflects the goals to improve patient care and outcomes, encourage coordination among providers, and appropriately manage the cost of care without harming patient affordability, quality, or access.

Response: Section 3131(a) of the Affordable Care Act requires that the HH PPS payment amount(s) ''shall be adjusted by a percentage determined appropriate by the Secretary to reflect factors such as the 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 factors that the Secretary considers to be relevant.'' In their 2013 Report to Congress, MedPAC stated that ''the number and types of visits in a home health episode changed significantly after the HH PPS was introduced, although the payments were based on the older, higher level of use and costs''.[3] Furthermore, based on analysis of FY 2011 cost report data, the 60-day episode costs, the per-visit rate costs, and NRS costs have changed since the start of the HH PPS (65 FR 41184) and CMS is implementing adjustments to the HH PPS payment amounts to reflect those changes. The goal of the adjustments is to align payment with costs, similar to what was done when setting the original base rate and per-visit amounts, and the methodology to determine the rebasing adjustment is very similar to the methodology used to set the original base rate and per-visit amounts. CMS plans to monitor the effects of the rebasing adjustments on access and quality of care for any unintended effects.

Comment: One commenter stated that the differences between cost and payment may be related to fraud and abuse and that targeted efforts to address fraud or examination of Medicare eligibility policies rather than across the board cuts should be implemented. One commenter stated that instead of finalizing the rebasing proposal, CMS should start the development of a new payment methodology for the therapy component of the HH PPS that accurately bases payment on the severity of the patient and the necessary resources to treat the condition, rather than basing payment on thresholds. Other commenters stated

[2] $2,952.03 * 0.975 (remove the outlier dollars that we put back in the rates for comparison purposes) * 1.0026 (wage index standardization factor as describe in section IV.E.4.b of this final rule) = $2,885.71. $2885.71 − $80.95 = $2,804.76. ($2,804.76 − $2,885.71)/$2,885.71 = 2.81%)

[3] MedPAC. ''Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare.'' Report to the Congress—Medicare Payment Policy. March 2013, p. 34.

that CMS should either abandon or delay the case-mix weight adjustments and rebasing approach and spend the next year performing a realistic analysis of true home health agency costs and beneficiary needs for home health services.

Response: Section 3131(a) of the Affordable Care Act requires a four year phase-in of rebasing, in equal increments, to start in CY 2014 and be fully implemented in CY 2017. Therefore, based on statutory requirements, rebasing cannot be delayed or eliminated once we have determined that rebasing is necessary. Differences between estimated episode costs and payments indicate a need to better align payment with costs and therefore, rebasing of the HH PPS payment amounts is needed. We intend to explore these commenters' concerns in ongoing research. We recently awarded a contract to Abt Associates to explore the findings and any recommendations from the home health study mandated by section 3131(d) of the Affordable Care Act, reassess the case-mix system, monitor potential impacts of rebasing and other recent payment policy changes, and develop reform options to ensure continued access and quality of care as well as address potential vulnerabilities in the current payment system.

Comment: Commenters stated that the proposed reductions puts the nation's economic recovery at risk since it targets the home health sector and the home health care community has been a primary driver of job growth.

Response: The impact of the rebasing adjustments for CY 2014 is estimated to be approximately −2.7 percent as described in section VII. However, the net impact for CY 2014, given all the payment changes for CY 2014, including the payment update percentage, is estimated at −1.05 percent. This net reduction over the four years is much smaller than some previous net reductions implemented in single payment years, such as the net reduction finalized in CY 2011. In CY 2011, CMS estimated that the net impact of the payment policies for that year to be −4.89 percent. Yet, according to MedPAC, the home health industry did not seem to be adversely impacted as the number of home health agencies from 2010 to 2011 grew from 11,654 to 12,199 and the number of home health episodes from 2010 to 2011 grew similarly, with 6.8 million episodes in 2010 and 6.9 million episodes in 2011.[4] Therefore, we do not expect that the rebasing adjustments for CY 2014 will have a significant impact but we will be monitoring the impact of rebasing on access to home health care.

Comment: One commenter argued that language in section 3143 of the Affordable Care Act prohibits CMS from implementing rate rebasing as proposed because it will result in the reduction of guaranteed home health benefits, and that the guaranteed home health benefits include reasonable access to a provider that accepts Medicare payment.

Response: Section 3143 of the Affordable Care Act reads that ''Nothing in the provisions of, or amendments made by, this Act shall result in the reduction of guaranteed home health benefits under title XVIII of the Social Security Act.'' We interpret this to mean that with regards to the statutory language at 1814(a)(2)(C), 1835(a)(2)(A), 1861(m) and 1861(kk), there are to be no changes to the scope of coverage under the Medicare home health benefit. The Congress inserted the rebasing provision into section 1895 of the Act (Prospective Payment System of Home Health Services), which calls for the rebasing of the amount(s) applicable under that section of the Act. We fully intend to monitor the effects of any adjustment made to the payment amounts in this final rule for any unintended results, including any substantial impact on access to care. We also note that, as mandated in section 3131(a) of the Affordable Care Act, MedPAC will conduct a study on the rebasing implementation, which will include impact analysis on access to care, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations, if necessary.

Comment: Commenters stated that the rebasing reductions will drive payments below costs in almost every state by 2017, causing access issues and impacting quality of care. Commenters stated that by setting the payment at costs, it guarantees that 50 percent of the HHAs will be paid less than cost by CY 2017 and that a margin is needed to meet normal business operational needs, such as the need for capital funding, keeping staff and attracting new staff, and investment in new technologies and care delivery models. One commenter stated that there is no precedent in payment adjustments that call for the estimation of profit margins regardless of type of entity and the ''elimination of entire average, estimated margins'' for the industry. The commenter recommended that CMS engage in an in-depth analysis and study of the economics at play in the home health marketplace in determining the level of profit/margin that is reasonable to offer and stated that home health agencies have little other revenue, such as commercial insurance revenue, to help counter reductions in Medicare payment and that agencies have little opportunity for margin outside of Medicare.

Response: The rebasing methodology used to develop the proposed rebasing adjustments is very similar to the methodology used in 2000 where the episode rate and per-visit amounts were equated to the estimated costs per episode or per visit. Notably, in 2000, even though the episode and per-visit amounts were aligned with the expected cost for HH PPS episodes, there were high margins in the first year of the HH PPS, in large part due to HHAs providing fewer visits than anticipated. In addition, MedPAC stated in their March 2013 Report to the Congress, ''Margins have stayed high since 2001 because annual increases in payment have exceeded growth in costs. The Commission's review of the annual change in cost per episode suggests that cost growth has been minimal, typically less than 1 percent. In some years, a decline has been observed. Average payments per episode have generally increased from year to year, driven by market basket increases and increases in the average case-mix index.''

While we calculated the proposed adjustments for rebasing by aligning payment to costs, we did not factor in potential opportunities for HHAs to increase efficiencies into the calculation of the rebasing adjustments. We also note that the rebasing adjustments to the national, standardized 60-day episode payment rate for CY 2014 through 2017 will be lower than the proposed adjustments given that we cannot implement a reduction that exceeds 3.5 percent of the CY 2010 national, standardized 60-day episode payment rate of $2,312.94 or a reduction greater than $80.95 in a given year. Similar to 2000, we expect that in the upcoming years HHAs will increase efficiencies in some operating areas and institute mechanisms to better control costs. In their 2013 Report to Congress, MedPAC stated ''low cost growth or no cost growth has been typical for home health care, and in some years we have observed a decline in cost per episode. The ability of HHAs to keep costs low has contributed to the high margins under the Medicare PPS.''

In addition, the rebasing adjustments over the next four years will be partly offset by the HH PPS payment update percentage and, therefore, the net

[4] MedPAC. ''Chapter 9: Home Health Care Services.'' Report to the Congress—Medicare Payment Policy. March 2013, p. 194–195.

impact on HHAs will be smaller than payment reductions absorbed by the industry in previous years. We plan to monitor the impact of the rebasing adjustments for any unintended consequences. As noted above, as mandated in section 3131(a) of the Affordable Care Act, MedPAC will conduct a study on the rebasing implementation, which will include impact analysis on access to care, quality outcomes, the number of home health agencies, and rural, urban, for-profit, and non-profit agencies, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations.

Comment: Commenters stated that the rural add-on only applies to episodes through December 2016 and therefore, the rural communities and frontier areas may be hit hard in 2017 by the combination of the rebasing adjustments and the expiration of the rural add-on policy. Commenters asked CMS to do a more thorough investigation of health care costs in rural areas. Commenters stated rural area HHAs experience higher costs in part due to longer drive times to reach rural residents.

Response: Thank you for the comment. We plan to continue to explore the costs associated with rural areas. We are currently in the process of implementing a ''Frontier Community Health Integration Project'' demonstration that may be useful in providing information on whether there are substantial cost differences between urban and rural areas, driven primarily by increased transportation costs. However, we note that in their 2013 Report to Congress, MedPAC stated that the use of the ''broad targeted add-on, providing the same payment for all rural areas regardless of access, results in rural areas with the highest utilization drawing a disproportionate share of the add-on payments.'' MedPAC stated that ''70 percent of the episodes that received the add-on payments in 2011 were in rural counties with utilization significantly higher than the national average'' and recommended that Medicare target payment adjustments for rural areas to those areas that have access challenges. We will take MedPAC's recommendation into account when assessing cost differences between urban and rural areas.

Comment: Commenters stated that the proposed rebasing policy will have unintended impacts for vulnerable patients, such as those with higher costs or more complex care needs. Commenters stated that CMS should not implement rebasing until the study required under section 3131(d) of the Affordable Care Act is completed and the report is delivered to the Congress. Commenters stated that the study directs CMS to look at the cost of treating certain subgroups and that the study was intended to be coupled with rebasing, stating that the CY 2014 policies will be implemented just months before the statutory deadline for the Report to Congress on the study. The commenters asked CMS to consider the findings of the study and the risks associated with the rebasing adjustments for vulnerable populations and re-assess the proposed reductions. Some commenters stated that CMS should consider incorporating findings from the Visiting Nurse Associations of America (VNAA) Vulnerable Patient study into the rebasing methodology. Commenters stated that the VNAA Vulnerable Patient study found that Medicare home health episodes for patients with certain characteristics, such as those with poorly controlled chronic conditions, lower median household incomes or serious or frail status, have significantly lower reimbursement compared to cost than other patients. Commenters also cited types of beneficiaries which may be vulnerable, including but not limited to African and Hispanic home health beneficiaries and mentally-ill patients. Commenters stated that the CY 2014 HH PPS proposed rule needs to consider and adopt protective measures to ensure access to care for vulnerable patients.

A commenter also asked if CMS considered the aging of the American and Medicare population, the increase in the awareness and acceptance of home health as a viable health care option, and the increase in incentives for hospitals to discharge patients earlier resulting in a higher patient acuity for home health patients in the rebasing analysis. The commenter recommended that CMS implement a study of the 1999 consultant's report by the National Science Foundation to assess the comparability of patient needs presented in 1999 versus patient needs being present in 2013 and implement a research effort to look at the changes in home health care since 2000.

Response: We agree with the commenters that the case-mix system and home health study findings should be examined and addressed. However, the findings and recommendations of the study will not be final until spring of next year and section 3131(a) of the Affordable Care Act mandates that CMS implement rebasing starting in CY 2014. The home health study did take into account the findings from the VNAA Vulnerable Patient study and as noted, we recently awarded a contract to Abt Associates to perform follow-on work to the home health study. The contractor will further explore findings and recommendations from the home health study, reassess the case-mix system, monitor potential impacts of rebasing and other recent payment policy changes, and develop reform options to ensure continued access and quality of care for any vulnerable beneficiaries as well as address potential vulnerabilities in the current payment system.

Comment: One commenter stated that there are negative margins associated with the provision of services to Medicaid, uninsured, and managed care patients and that positive Medicare margins are needed to subsidize the cost of providing services to these patients. Another commenter stated that the rule needs to consider the impact of expansion of Medicare Advantage plans and Fully Integrated Dual Advantage plans that will likely decrease Medicare revenues and profit margins.

Response: While industry representatives contend that Medicare payments should subsidize payments from other payers (in large part Medicaid), we disagree. Medicare has never set payments so as to cross-subsidize other payers. Section 1861(v)(1)(A) of the Act states ''under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.'' As MedPAC stated in its March 2011 Report to Congress, cross-subsidization is not advisable for two significant reasons: ''Raising Medicare rates to supplement low Medicaid payments would result in poorly targeted subsidies. Facilities with high shares of Medicare payments—presumably the facilities that need revenues the least—would receive the most in subsidies from the higher Medicare payments, while facilities with low Medicare shares— presumably the facilities with the greatest need—would receive the smallest subsidies. Finally, increased Medicare payment rates could encourage states to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates.[5]''

In addition, we examined the proportion of Medicare-paid visits on the cost reports in our sample and found that the majority of visits recorded on

[5] MedPAC. ''Chapter 7: Skilled Nursing Facility Services.'' Report to the Congress—Medicare Payment Policy. March 2011, p. 159.

the cost report are Medicare-paid visits. As such, the average cost per visit is more representative of Medicare visit costs. We examined whether the average costs per visit may be different for Medicare versus other payers by examining the relationship between the providers' average costs per visit and the provider's proportion of visits that were paid by Medicare. Specifically, we grouped providers with similar proportions of Medicare visits (for example, those with 60–70 percent of visits as Medicare-paid visits and other 10 percentage point groupings) and examined the average costs per visit across the groups. We did not see a consistent relationship between costs and the Medicare share of visits, either across disciplines or across the provider groups.

Comment: Several commenters opposed the use of 6,252 out of 10,327 cost reports for rebasing. One commenter stated that there were about 10 percent of home health agencies that participate in the Medicare program that did not submit cost reports and therefore, did not have their cost data included in the rebasing analysis and one commenter stated that the majority of the agencies trimmed were small agencies, which will be severely impacted by rebasing. Commenters stated that this level of trimming was not necessary to gain reliable data and stated that over 9,000 cost reports were reliable and useable. Commenters noted that for the Hospital Outpatient Prospective Payment System (OPPS), CMS only removed 25 percent of cost reports. Commenters recommended CMS revisit the trim methodology to include as many cost reports as possible.

Response: We appreciate the commenter's concern on the number of providers used in (or excluded from) the HHA rebasing analysis. As stated in the CY 2014 HH PPS proposed rule, 1,629 of the 10,327 cost reports were missing data on total Medicare costs or Medicare payments and 375 cost reports either had missing visits when costs were reported or missing costs when visits were reported. Otherwise stated, approximately 20 percent of the 10,327 Medicare cost reports were incomplete. Of the remaining 8,323 completed Medicare cost reports, approximately 75 percent were included in the rebasing analysis. In the CY 2014 HH PPS proposed rule (78 FR 40285), we provided a complete description of the methods used to trim the cost reports.

We performed analysis on both the trimmed and untrimmed sample. We found that using the trimmed sample resulted in an estimated average cost per episode that was much higher than the estimated cost per episode using the untrimmed cost report sample. The estimated average cost per episode using the untrimmed cost report sample was $1,883.63 compared to $2,453.71 using the trimmed cost report sample. If CMS were to use the untrimmed cost report sample, the percentage for the rebasing reduction, if there was no statutory limit, would likely have been much larger than with the trimmed sample. With regards to the comment about the exclusions of agencies that didn't submit cost report data or the disproportionate exclusion of agencies that were small, as described in section IV.D.1. of this rule, the per-visit costs obtained from the cost reports in our sample were weighted to be nationally representative by facility type, urban/rural status, and facility size. Therefore, the costs per visit used to calculate the estimated episode cost should be nationally representative and appropriately reflect small agencies.

Many of the edits applied are similar to those edits applied in other PPS systems and by MedPAC (including but not limited to, the exclusion of providers with missing Medicare Payments, missing Medicare costs, missing Medicare episodes, and reports that are less than 10 months or greater than 14 months). We continue to believe that our trimming methodology and our weighting methodology is technically appropriate and produces a nationally-representative costs per visit and costs per episode.

Comment: Some commenters stated that the data used for rebasing are outdated and that 2012 cost report data should be used, arguing that the CY 2012 cost reports portray a more accurate picture of providers' financial state. A number of commenters cited that 2012 cost reports would better capture agency costs, such as but not limited to, those associated with the full implementation of face-to-face and therapy requirements and the CY 2012 recalibration. Commenters stated that the 2012 cost reports reflect declining average revenue, increased costs, and lower average margins, particularly among small home health agencies, and that Medicare margins have been declining over the years.

Response: We disagree with the commenter's claim that the cost reports used are not the most current, complete data available for rebasing. As of June 30, 2013, there were over 10,000 FY 2011 freestanding and hospital-based HHA cost reports of which over 90 percent are settled. Also, as of June 30, 2013, there are only about 6,800 FY 2012 freestanding and hospital-based cost reports of which roughly only 60 percent are settled. Therefore, the FY 2011 cost report data is the most complete data available at the time of the rebasing analysis.

In response to the commenter's claims that the CY 2012 cost reports portray a more accurate picture of providers' financial state, we calculated the average costs per visit for a matched sample of 2011 and 2012 providers using our rebasing sample of cost reports described in section IV.D.1 and in the CY 2014 HH PPS proposed rule (78 FR 40284) and preliminary 2012 home health agency Medicare cost report data (approximately 5,700 2012 cost reports). We found that the average costs per visit for all disciplines (home health aide, medical social services, occupational therapy, physical therapy, skilled nursing, and speech-language therapy) remained virtually unchanged (see Table 18), while the total number of visits per episode from 2011 to 2012 dropped from 18.59 to 18.39, as shown in Table 7. This drop in total visits from 2011 to 2012 with virtually no changes in the costs per visit suggest that the 2012 estimated cost per episode may be less than the cost per episode estimated using FY 2011 cost report data.

TABLE 18—AVERAGE COST PER VISIT, 2011 AND 2012

	2011	2012
Skilled Nursing	$ 133.65	$ 133.71
Physical Therapy	161.05	162.81
Occupational Therapy	158.80	159.22
Speech-Language Pathology	170.20	173.06
Medical Social Services	220.91	219.74

TABLE 18—AVERAGE COST PER VISIT, 2011 AND 2012—Continued

	2011	2012
Home Health Aide	69.79	65.63

Source: FY 2011 Medicare cost report data as of December 31, 2012 and FY 2012 Medicare cost report data as of June 30, 2013 for providers who were included in the rebasing sample described in section IV.D.1.a. and for which a FY 2012 cost report was on file. We weighted the average costs per visit in 2012 by size, ownership type, and urban-rural status to mimic the distribution of providers in the 2011 claims used for weighing the 2011 average costs per visit used for rebasing.

In addition, the calculations of the proposed CY 2014 rebasing adjustments include a 2.4 percent and a 2.3 percent increase to account for the market basket CY 2012 and CY 2013 updates, respectively. These updates reflect the latest forecast of the HHA market basket available at the time of rate setting. However, the actual (reflecting historical data rather than a forecast) HHA market basket increase for 2012 is now measured to be 1.7 percent (0.7 percentage points lower than the forecasted increase for CY 2012 of 2.4 percent). Preliminary data also suggests the CY 2013 market basket update of 2.3 percent was overstated by roughly 0.5 percentage points. The home health market basket percentage increases can be found here: *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-summary.pdf*. We would note that the CY 2012 market basket update was based on the 2003-based HHA market basket while the Web site reference above includes the 2010-based HHA market basket increase, which is used for CY 2013 and subsequent years.

Comment: Several commenters stated that CMS should include all home health service costs in its calculation of the cost of care. Commenters stated that the overhead costs of hospital-based home health agencies were not factored into the cost calculations and also listed several costs that they stated are not reflected in the 2011 cost reports, such as new resources needed for the growth of Accountable Care Organizations (ACOs), bundled payment initiatives, Independence at Home program, hospital readmissions reduction program, wage and employee health benefit changes, mandatory employer costs/penalties, HIPAA compliance, work with physicians related to PECOS, and implementation and administration of OASIS–C. Numerous commenters also stated that the CY 2011 cost reports did not reflect new regulatory obligations, such as the costs associated with therapy and face-to-face requirements, HH CAHPS survey requirements and the upcoming implementation of ICD–10–CM.

Several commenters disagreed with CMS' exclusion of non-allowable costs which they state are part of operating a business, such as bad debt, taxes, franchise fees, fundraising costs in a non-profit, marketing costs and business development costs, full administrative and general costs including those that are non-reimbursable under Medicare cost reimbursement principles, and formal and informal home office costs, respiratory therapy, nutritionist, dietician services, health information technology, telehealth, computerized information technology, and documentation time.

Response: Overhead costs of hospital-based home health agencies were factored into the cost calculations as we used cost measures where both direct service and indirect (such as, administrative and general) costs have been allocated to the appropriate cost centers. Please see page 17 of the technical report titled ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Proposed Rule'' 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.*

The 2011 HHA Medicare cost reports used in the rebasing analysis reflect the costs of complying with longstanding regulatory requirements, such as HIPAA, and the implementation of OASIS–C on January 1, 2010, and HH CAHPS survey requirements in the fourth quarter of CY 2010. In addition, the face-to-face encounter requirement mandated by the Affordable Care Act was implemented on January 1, 2011 (with a compliance deadline of April 1, 2011) and therefore, the costs of the face-to-face encounter requirement are likewise accounted for in the 2011 cost reports used for rebasing. The therapy reassessment requirements were implemented on April 1, 2011. We believe that the 2011 cost reports would reflect the costs of complying with the new therapy reassessment requirements as agencies should have begun altering their documentation practices and therapist oversight activities early in 2011 to comply with the reassessment requirements. Nevertheless, we did perform analysis of preliminary 2012 cost report data and found virtually no changes in the costs-per-visit. This in conjunction with the drop in visits from 2011 to 2012 suggests that the 2012 estimated cost-per-episode may be less than the estimated 2011 cost per episode. While we acknowledge that the costs of implementing ICD–10–CM code set, effective October 1, 2014, and of educating physicians on enrollment in PECOS are not reflected in the cost reports we used, we did use the most current, complete cost report data available at the time of issuing this rule to calculate the rebasing adjustments. Section 3131(a) of the Affordable Care Act requires us to rebase payments starting in CY 2014 to be fully phased-in by CY 2017. As stated earlier, as of June 30, 2013, there are only about 6,800 FY 2012 freestanding and hospital-based cost reports of which roughly only 60 percent are settled. Therefore, the FY 2011 cost report data is most complete data currently available and was the data used for the rebasing analysis. We note that while participation in ACOs, bundled payment initiatives and the ''Independence at Home'' program are encouraged, participation is likely to occur among agencies that believe they can ''work smarter'' to achieve the aims of those programs. As with other voluntary programs, agencies self-select into them for a variety of reasons, and not only reasons related to possible costs of participation. Further, the hospital readmission reduction program is aimed at keeping patients with certain conditions from being re-hospitalized within 30 days of discharge and reduces payments to hospitals with excess readmissions. HHAs do not receive reduced payment when excess readmissions occur at a particular hospital. However, we would expect that HHAs would continue to provide quality care so that readmissions are minimized. In addition, we note that the hospital readmissions reduction program could create an incentive for hospitals to make more use of home care as a way to help prevent hospital readmissions.

With regards to the costs included in the rebasing methodology, section 1861(v)(1)(A) states that ''The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.'' We also note that section 1895(e) of the Act governs the HH PPS and states that telehealth services are outside the scope of the Medicare home health benefit and home health PPS. This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As set forth in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit.

Although commenters took issue with certain non-reimbursable costs not being included in the cost calculations, we note that the home health agency Medicare cost report form has undergone little to no revision since 1985. Prior to the interim payment system (1997–2000), providers were paid at cost for the direct and indirect costs associated with providing skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services along with routine and non-routine medical supplies. While HHAs were receiving cost-based reimbursement, the number of agencies, users and services expanded rapidly in the early 1990s, indicating that non-reimbursable costs were not substantial enough to discourage new agencies from entering the market. When the HH PPS was implemented in 2000, non-reimbursable costs were not considered, nor did the industry comment on the FY 2000 HH PPS proposed rule that they were concerned about non-reimbursable costs being excluded from the cost calculations. After HH PPS implementation, the number of agencies grew once again from approximately 7,500 agencies in 2000 to over 12,000 in 2011. We continue to believe that the cost calculations performed for determining the rebasing adjustments mandated by the Affordable Care Act are appropriate and reflect the direct and indirect costs of home health services rendered to Medicare beneficiaries.

Comment: One commenter stated that there was an ''order of operations'' issue in the methodology used for rebasing. The commenter stated that when CMS first increased the estimated payment rate to account for the weight reductions (that is, the resetting of the average weight to 1.0000), it significantly increased the base to which the 3.5 percent cut was applied. If the same percentage cut were made to the lower pre-neutralized standardized rate, the 3.5 percent cut would have been about 1 percent lower, or $28.92 an episode. The commenter thought that CMS should restore this amount to the base rate.

Response: The starting point to which the rebasing adjustments are applied is the CY 2013 estimated average payment per episode, which we compare to the CY 2013 estimated average costs per episode. The increase in the CY 2012 national, standardized 60-day episode payment rate by the budget neutrality factor is used to estimate CY 2012 average payment. The CY 2012 average payment is then adjusted by the CY 2013 adjustments (nominal case-mix reduction and HH payment update percentage). The increase in the base rate must occur before the rebasing adjustments are applied, not afterwards, as the rebasing adjustment is calculated by comparing average payments to average costs. We also note that the rebasing adjustments cannot exceed 3.5 percent of the CY 2010 payment amounts in absolute terms.

Comment: One commenter stated that CMS' approach ignores regional differences in home health operating margins. Another commenter stated that the methodology ignores the diversity in the home care industry and the populations they serve and that the populations served varies by geography, patient characteristics, case-mix, size, and payer makeup. The commenter stated that under the current rebasing methodology, CMS is making a false assumption that all home care agencies are operating under similar conditions with similar populations, and agencies with smaller margins will not be able to accommodate the lower payment rates. A commenter encouraged CMS to make distinctions between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies, and that CMS should consider setting rates based upon averages among each of the primary groups of HH providers.

Response: We disagree with the commenters claims that our rebasing adjustment methodology ignores the diversity in the home care industry and the populations they serve. First, our approach reflects case-mix which takes into consideration the characteristics of the patients. As always, we welcome suggestions for additional measures that could potentially improve the case-mix adjustment as we continue in our case mix research. Second, as described in section IV.D.1. of this rule, we used urban/rural classification, size class, and agency type (nonprofit, for-profit, government, and facility-based) weights to estimate the national average cost per visit. In addition, the payment system reflects geographic variation in cost by adjusting payments using the wage index and by rural agency payment adjustments. CMS does not design payment rates for different sizes of agencies for several reasons, including that this would weaken incentives for efficient organization of the home health industry by agency size and could impair the program's ability to benefit from economies of scale that affect agency costs.

In addition, we note that in their 2013 Report to Congress, MedPAC stated, ''The need to reset the base rate in Medicare is particularly acute because high margins exist across the range of agency types. Urban, rural, for-profit, and nonprofit agencies have margins in excess of 12 percent. While some agencies have margins significantly lower than average, the Commission's review of agencies in 2007 found that these differences are primarily due to their higher costs. These higher costs do not appear to be related to patient severity, as low-margin agencies, for most measures, did not serve more severely ill patients.''

Comment: One commenter stated that the total Medicare cost and the number of episodes should have been used to calculate the average cost per episode instead of the methodology used by CMS and that the actual payment should have been obtained from cost report data, not simulated. The commenter also stated that the wage index adjustment was not taken into account.

Response: The methodology used the average costs per visit (obtained from the Medicare cost reports) multiplied by the number of Medicare visits per episode (obtained from the Medicare claims) by discipline to calculate the average cost per episode. We believe

that Medicare claims are a more reliable data source; although we note that visit per episode counts on Medicare claims and on Medicare cost reports were similar. The methodology in this rule is the same methodology used for the implementation of the HH PPS base payment rate in FY 2001. In addition, we note that the regulations at 42 CFR 484.215(b) state: ''CMS determines the national mean utilization for each of the six disciplines using home health claims data'' in calculating the national, standardized 60-day episode payment amount. We continue to believe that our methodology was, and continues to be, technically appropriate and best reflects national costs per episode. Lastly, we disagree with the commenter's claim that we did not take into account the wage index adjustment. As stated in the CY 2014 HH PPS proposed rule (78 FR 40296), we apply a standardization factor (1.0017) to eliminate the effects of variation in area wage adjustments among different home health agencies in a budget neutral manner.

Comment: Commenters stated that the CY 2014 HH PPS proposed rule doesn't offer the mathematical calculation CMS used to divide the 13.63 percent difference between payments and costs into four reductions of 3.6 percent, stating that 13.63 divided by 4 is 3.4075. Commenters asked for an explanation of the calculation, indicating that a correction may be needed.

Response: We calculated the 3.6 percent reduction in the CY 2014 HH PPS proposed rule using a CAGR formula. The CAGR formula used to get the 3.6 percent annual reduction for each of the four years was ($2,559.59/$2,963.65) $^{1/4}$–1. The initial target aggregate reduction was determined to be 13.63 percent, which the statute requires to be phased-in over a four year period (2014–2017) in equal increments. The annual reduction necessary to yield 13.63 percent after 4 years is 3.6 percent, because $(1–0.036)^4 = 1–0.1363$.[6]

This method reflects compounding growth rates over time. We note that while we calculated a 3.6 percent reduction for the CY 2014 HH PPS proposed rule, as we discussed earlier in this section, the Affordable Care Act mandates that the rebasing adjustment to the amount (or amounts) be no more than 3.5 percent of the 2010 payment amounts. As noted previously, the maximum adjustment for rebasing the national, standardized 60-day payment rate has been determined to be $80.95.

Comment: One commenter stated that when developing the rebasing adjustment, CMS double counted factors that have already been accounted for in other reimbursement reductions since the enactment of the Affordable Care Act while excluding other factors that should have been considered. The commenter stated that CMS adjusted reimbursement rates multiple times based on the same factors. The commenter stated that the number of visits in a home health episode was already addressed. The commenter stated that between 1998 and 2001, the average number of home health visits per episode dropped from 31.6 to 21.4 and remained at this level through 2009 and that market forces have already corrected imbalances in the number of visits in a home health episode. The commenter also stated that in the CY 2013 HH PPS rule, CMS already considered case-mix data and determined that no further adjustment was necessary. The commenter stated that adjusting reimbursement rates based on case-mix or the mix of services again would be ''double counting.'' In addition, the commenter stated that CMS already accounted for the level of intensity of services in a home health episode through the case-mix payment reductions and further reducing it would be double counting.

Response: As we stated above, in their 2013 Report to Congress, MedPAC stated that ''the number and types of visits in a home health episode changed significantly after the home health PPS was introduced, although the payments were based on the older, higher level of use and costs'' (p. 34). The episode payment amount has not been updated to reflect the change in the number of visits since the start of the HH PPS and therefore, CMS is not double counting the change in the number of visits. CMS is also not double counting the mix of services or level of intensity of services in the episode. The average number of visits per discipline per episode used when setting the base rate in 2000 is different from the average number of visits per discipline using 2011 claims data (Table 19). In addition, as indicated by the cost per visit per discipline differences between the per visit rates used to develop the 2000 base rate and the per visit rates calculated from FY 2011 data, the intensity of the services in the episode likely have also changed. CMS has not previously updated the national, standardized episode payment rate to reflect the total visit changes per episode, the change in the mix of services, and the change in the intensity of services. The case-mix reductions which the commenter mentions were implemented to align the payment with patient severity and to account for the nominal increases in the reported case-mix, changes not related to real increases in patient severity, by home health agencies. The goal of rebasing is to align the national, standardized payment rate and other applicable amounts with episode costs, similar to what was done when developing the episode payment rate in 2000. Given the differences in episode payment and costs and the differences in the assumed composition of visits and intensity when developing the base rate versus the composition of visits and intensity reflected in the 2011 cost report and claims data, CMS proposed that a rebasing adjustment be applied to the national, standardized episode payment amount for rebasing.

TABLE 19—AVERAGE NUMBER OF VISITS, CY 1998 AND CY 2011

	Average number of visits used to develop 2000 base rate (CY 1998 claims data)	Average number of visits from CY 2011 claims data
Home Health Aide	13.4	2.80
Medical Social Services	0.32	0.14
Occupational Therapy	0.53	1.15
Physical Therapy	3.05	4.86

[6] Due to rounding, there is a 0.01 percentage point difference between the calculated and reported numbers.

TABLE 19—AVERAGE NUMBER OF VISITS, CY 1998 AND CY 2011—Continued

	Average number of visits used to develop 2000 base rate (CY 1998 claims data)	Average number of visits from CY 2011 claims data
Skilled Nursing	14.08	9.43
Speech-Language Pathology	0.18	0.21

Source: 65 FR 41171 and CY 2011 Medicare claims data.

Comment: A commenter stated that the methodology relies on proxies for payment and cost determinations when the information is readily available from cost report data. The commenter stated that the proxies CMS used are different than the actual episode costs and payments on the cost report and the combined difference between the actual and proxy calculation should lead to a lower rebasing adjustment than the adjustment proposed. The commenter recommended that CMS use direct data rather than the proxies used in the CY 2014 HH PPS proposed rule. The commenter also stated that the methodology fails to account for and address the wide range in revenue/cost per episode experienced by HHAs and that a single payment rate adjusted with the current ''weak'' adjusters leads to payment inaccuracies that require a rate ''cushion'' to maintain access to care. The commenter stated that CMS should look at all ways of calculating average costs of home health services, such as look into the median instead of the mean, and look into the multiple options for forecasting cost and payment trends. The commenter stated that all calculation options should be explored and evaluated and the option that would result in the ''the greatest degree of financial stability'' should be implemented. Another commenter urged CMS to ensure the methodology used to determine the rebasing adjustments is accurate.

Response: We believe that Medicare home health care providers overall have benefited from a substantial rate ''cushion'' under the HH PPS, as margin estimates over the years demonstrate. Because the margin has been so large, while we have seen little change in patient characteristics and relatively little change in aggregate resources used to care for the patients, we infer that access to care does not appear to be a problem. Furthermore, we have had no direct indications of access problems. Although it is possible that reducing the large rate ''cushion'' could create financial pressures, we believe many circumstances and considerations other than patient clinical status enter into the decision of the amount of resources per episode; the multiplicity of such factors is suggested by the large portion of variability in resources or margins unexplained by statistical models in recent studies of potential case mix variables. Our statistical analysis of margins suggests that many of these factors are agency-related, and therefore they may need examination by agencies to ensure efficient service delivery. Outlier payments are also available to agencies for those episodes whose imputed cost exceeds a threshold amount for each case-mix group HHRG due to unusual variations in the type or amount of medically necessary care. We anticipate that continuing studies of improvements to the case mix adjustment methodology will lead to a stronger case mix adjustment before the rebasing phase-in is complete. We welcome suggestions for new measures that are suitable for incorporation into the case mix adjuster.

With regards to the comment about using the median rather than the mean, the median is typically used in order to avoid having extreme values unduly influence the measure of the typical value. We have already trimmed the cost report sample to avoid having extreme values influence the average value to some degree. We also do not believe the upper and lower values, after the trimming, are skewing the mean but rather that the upper and lower values reflect legitimate payments obtained from cleaned up data and therefore, the mean should be used. Also, using an average accounts precisely for the costs incurred by the industry because the mean times the number of units equals the total costs. With a median, one may be accounting for more or less than the industry's total costs. In addition, the median calculated by the commenter was likely done at the agency level rather than the episode level, giving smaller agencies with higher costs more weight than the episode level average. In the rebasing methodology for this final rule, CMS makes use of the fact that much of the utilization is in lower-cost, large agencies, which would not be reflected if the median was used.

We disagree with the commenter's suggestion that the Medicare claims data is a proxy and should not be used to calculate the average costs per episode. We believe that Medicare claims are a more reliable data source and its use is consistent with the methodology used in setting the 60-day episode base rate for the HH PPS in 2000. In addition, we note that in at 42 CFR 484.215(b), ''CMS determines the national mean utilization for each of the six disciplines using home health claims data'' in calculating the national, standardized 60-day episode payment amount and we believe that the use of claims data to calculate the average estimated payment more accurately reflects the actual payment agencies received.

Comment: A commenter stated that fraudulent payment should be excluded from the payment history statistics and recommended that CMS ''restart'' the rebasing efforts, consulting with specific working groups comprised of industry and patient advocacy groups.

Response: Section 3131(a) of the ACA mandates that rebasing be implemented starting in CY 2014 so the rebasing adjustments must be implemented beginning on January 1, 2014. We note that claims in CY 2011 and CY 2012 that were subsequently denied before the creation of the Standard Analytical Files (SAF) used for this analysis were excluded.

Comment: One commenter stated that in the CY 2014 HH PPS proposed rule, there was no indication whether the audited HHAs were provided appeals rights and that the limited audit is unreliable for use in calculating payment rates. The commenter recommended that CMS continue to reject a downward adjustment to the average costs per visit calculation as a result of the audit findings since the HHAs audited do not represent the universe of HHAs, the auditors' findings were not subject to review, and cost report auditing is ''an ancient process which hasn't been done for years''. In

addition, a commenter stated that the 8 percent of costs were disallowed for unspecified reasons. Another commenter stated that home health agencies have no incentives for ensuring the accuracy of their cost reports and the data is inaccurate and not representative of the costs that agencies actually incur and that there is no way to determine the accuracy of the reports that CMS included in the sample. Commenters stated that the cost report does not separate costs between payers and the costs solely attributed to Medicare cannot be isolated and are higher than the costs for other payers.

Response: We contracted with a Medicare Administrative Contractor (MAC) to conduct audits on 2010 Medicare cost reports of 100 home health agencies. Since two providers did not provide the information needed to complete the audit, the MAC audited 98 HHA cost reports. As stated in the CY 2014 HH PPS proposed rule, the audited providers overstated their costs by about 8 percent. The overstatement of their costs was due to the inappropriate inclusion of costs, including but not limited to, excess salary expense and/or excess owner's compensation, private duty nursing costs, luxury auto expenses, non-allowable costs for marketing/advertising/public relations, Federal Tax returns for an HHA owner, landscaping fees for an HHA owner's home, and lobbying expenses. We note that any HHA that received an adjustment based on the audit of their cost report was sent a revised Notice of Program Reimbursement (NPR) letter. With each NPR, there was an attachment explaining the appeal rights to the provider. To date, none of the freestanding HHAs or the hospital-based HHAs filed an appeal.

We disagree with the commenters' claim that home health agencies have no incentives for ensuring the accuracy of their cost reports and that the CR data are inaccurate and not representative of the costs that agencies actually incur. Each HH cost report is required to be certified by the Officer or Director of the home health agency. Specifically, the HHA Medicare Cost Report (MCR) Form (CMS–1728–94) states the following:

''I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Home Health Agency Cost Report and the Balance Sheet and Statement of Revenue and Expenses prepared by ____ (provider name(s) and number(s) for the cost report beginning ____ and ending ____, and that to the best of my knowledge and belief, it is a true, correct and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.''

We also note that the HHA MCR referenced statement above includes the following:

''Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or were otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.''

As always, we encourage providers to fill out the Medicare cost reports as accurately as possible.

Comment: Another commenter stated that CMS should look at the impact of the rebasing reductions on agencies that already have either negative or low margins. A commenter stated that MedPAC projected a smaller margin for freestanding HHAs than CMS calculated and that while the CMS projection is not an overall Medicare margin, the comparison shows the risks of CMS' approach to rebasing. The commenter stated that they projected a smaller margin in 2013 than CMS projected and suggested that the rebasing adjustment be no more than 1.75 percent in the aggregate in each of the years of rebasing phase-in. In addition, commenters performed their own impact analysis and provided the results of their analysis in the comment. Commenters stated that their analysis showed that 47 of the 50 States as well as District of Columbia will experience negative margins by 2017 if the rebasing adjustments are implemented, thereby causing access issues. Commenters stated that some states have negative margins currently or may have negative margins as early as CY 2014 if the rebasing adjustments are implemented. Providers from various states, such as but not limited to New Hampshire, North Carolina, South Carolina, Indiana, New Jersey, New York, Kansas, Michigan, Washington, Massachusetts, Pennsylvania, Virginia, Rhode Island, Connecticut, Texas, Hawaii, and California, stated that many if not all of the agencies in their state will have negative margins by 2017 if the rebasing adjustments are implemented. Commenters stated that they project that nearly three quarters of all home health agencies nationwide will experience net operating losses and that the national average Medicare margin will drop to −9.77 percent in 2017. A number of commenters stated that the rebasing cut is reminiscent of the actual impact of the interim payment system, which ''wiped out 31 percent of home health agencies between 1997 and 2000.'' Commenters stated that small to medium sized businesses would be disproportionately affected by the rebasing adjustments, including those operating in medically-underserved areas, and that this impact should have been assessed and quantified by CMS. Commenters also stated that hospital-based home health providers will be disproportionately affected by the rebasing cuts and that they treat patients with higher acuity or who are more complex. Commenters stated that hospital-based agencies already have negative margins and HHAs should be given an opportunity to generate a margin needed for ongoing investments to improve care. Other commenters stated that non-profit agencies would be adversely affected by the rebasing adjustments.

Response: It is important to note that the commenters' views on the impact of the rebasing reductions on margin are starkly different from MedPAC's predictions of HHA Medicare margins. As stated in their comment, MedPAC estimates that the cumulative net payment reduction to the national, standardized 60-day episode payment amount after four years will equal approximately 4 percent. MedPAC expressed concerns that the rebasing reductions were too modest and will do little to reduce home health agencies' unusually high profitability under Medicare, stating that payments are at an inappropriately high level for all agencies. In addition, in their 2013 Report to Congress, MedPAC recommended that rebasing should be implemented in two years and that the payment updates be eliminated. MedPAC stated in their 2013 Report to Congress, ''The Patient Protection and Affordable Care Act of 2010 includes reductions in payments for home health care, but these policies will leave home health agencies with margins well in excess of cost. Overpaying for home health services has negative financial consequences for the federal government and raises the Medicare premiums beneficiaries pay.''

We conducted analysis similar to that of the National Association for Home Care and Hospice (NAHC) on Medicare margins for 2011 as result of comments received (8,623 usable 2011 cost reports). We found that approximately 30 percent of HHAs reported having a negative margin in 2011. In addition, 10 percent of HHAs had negative margins for at least two of the past five years

(from 2007–2011), while 5 percent of HHAs, half of which were hospital-based HHAs, were operating with negative margins for all of the past five years (from 2007–2011). We question how an HHA can still be operating after at least 5 years with negative margins and whether these HHAs have incentives to report negative margins (such as cost shifting/allocation by hospitals amongst their various units). If we assume no behavior change, similar to analysis completed by NAHC, the data suggest that approximately 70 percent of HHAs would be operating with negative margins by 2017 when we take into account the proposed 3.5 percent reduction to the national, standardized 60-day payment rate and other proposed payment changes in the proposed rule. However, we also performed an analysis examining the accuracy of margin predictions. For our analysis, we developed margin predictions using prior year cost report data and predicted margins for future years given the policy changes finalized for the future years. We then compared the predicted margin to the actual margin calculated. Specifically, we used 2007, 2008, 2009, and 2010 cost report data and predicted margins one, two, and three years later. We then used cost report data to calculate the actual margins for those years. Our analysis showed that the actual margin is approximately three percentage points higher than the predicted median margin for each additional year of prediction. For example, using 2008 cost report data and predicting margins for 2009, 2010, and 2011, applying the payment policies implemented in each year and increasing costs by the full market basket update each year, the actual median margins were three, six, and nine percentage points higher than the predicted median margin, respectively. Similarly, the percentage of providers estimated to have negative margins is overestimated by five percentage points per year of prediction, on average. As such, we estimate that if the proposed payment changes were finalized, approximately 43 percent—not 70 percent— of providers would have negative margins in CY 2017 and that of the 43 percent of providers predicted to have negative margins, 77 percent of these providers already reported negative margins in 2011.

We note that the final rebasing adjustment to the national, standardized 60-day episode payment rate after incorporating complete 2012 claims data and comments received is an approximate reduction of 2.8 percent for 2014–2017 and the overall impact of all of the rebasing adjustments is about −2.7 percent. Re-running the margins analysis using the finalized payment changes and adjusting our predicted margins to account for differences we observed between previous predicted margins and actual margins, we estimated that approximately 40 percent of providers will have negative margins in CY 2017 and that of the 40 percent of providers predicted to have negative margins, 83 percent of these providers already reported negative margins in 2011.

With regards to comments about the interim payment system, we note that in their 2013 Report to Congress, MedPAC stated that during the interim payment system (1997–2000), when payments dropped by about 50 percent in two years, many agencies exited the program. However, new agencies entered the program (about 200 new agencies a year) and existing agencies expanded their service areas to enter markets left by exiting agencies. This is due in part to the low capital requirements for home health care services that allow the industry to react rapidly when the supply of agencies changes or contracts. Reviews of access found that access to care remained adequate during this period despite a substantial decline in the number of agencies (Liu *et al.* 2003).

Comment: Commenters stated that CMS should look at the impact of rebasing on LUPA episodes. A commenter stated that patients receiving LUPAs may be vulnerable beneficiaries and that agencies with higher LUPA numbers may have lower or negative overall margins. In addition, the commenter stated that if the normal episodes are rebased to estimated cost, but the LUPA episodes are paid at less than cost, the overall effect on agencies with any LUPA episodes will be negative margins. One commenter stated that CMS should study LUPA services and payment and adjust overall payment to at least cover the costs incurred by agencies serving the patients. Specifically, commenters stated that the rebasing adjustments for LUPA per visit payments should be higher than 3.5 percent a year and that the 3.5 percent limit in the Affordable Care Act refers to the overall impact of the rebasing changes, not the individual rebasing adjustment amounts. Another commenter stated that CMS should closely review the statutory provision to determine whether there is flexibility to further raise the LUPA payments and if not, to seek legislative authority that would permit payments to be raised to the estimated level of cost, stating that LUPA episodes guard against the incentive to get a full 60-day episode payment for episodes with low visit counts. In contrast, one commenter stated that they were concerned the proposed increases to LUPA episodes may encourage HHAs to stint therapy services to Medicare beneficiaries receiving care and further exacerbate the issue of cherry-picking in post-acute care settings. Commenters stated that CMS should make changes to LUPA payments separately from other policies in the rule and commenter cited the LUPA add-on payment as an example. A commenter suggested that CMS could eliminate the outlier adjustment in calculating the per-visit rates since outlier payments have been significantly below the 2.5 percent target for the last several years. Other commenters suggested that CMS rebase the system or fix the LUPA system by adding LUPA floor or non-LUPA episode percentage caps at the agency level instead of implementing reductions.

Response: We believe that the better reading of the statute requires us to apply rebasing adjustments to the individual payment amounts, not aggregate amounts. Therefore, we are applying the rebasing adjustments to the individual payment amounts. In addition, given the interpretation of the 3.5 percent limit as of the date of enactment of the Affordable Care Act, as mentioned by a commenter, the LUPA per-visit amounts will be increased by the maximum dollar limit calculated using CY 2010 payment amounts, as shown in Table 14. This results in slightly lower increases to the LUPA rates than originally proposed in the CY 2014 HH PPS proposed rule. We share commenters' concerns about the incentive issues surrounding LUPA payments. We re-examined our LUPA add-on methodology but did not find a basis for revising our proposal for rebasing the add-on. We note that we plan to monitor LUPA episodes and further examine LUPA-related payment policies in the new contract awarded to Abt Associates to perform follow-on work for the home health study and monitor impacts of rebasing and other recent payment changes.

Comment: Several commenters stated that they were concerned that the costs of NRS for hospital-based home health agencies were not captured since Form CMS–2552–10 doesn't allow the reporting of these Medicare costs.

Response: NRS costs for hospital-based HHAs were included in calculation of the 2011 average NRS cost per visit. These costs are to be reported on CMS form 2552–10, worksheet H, line 12.

Comment: A commenter stated that in the CY 2014 HH PPS proposed rule, CMS states that there are a significant number of agencies that did not properly report NRS cost on their cost report, yet CMS seemed to use their data in rebasing the NRS Conversion Factor. The commenter urged CMS to either recalculate the NRS rebasing using validated, accurate data, or hold off on rebasing the NRS Conversion Factor until better data becomes available.

Response: In the CY 2014 HH PPS proposed rule, we noted that a significant number of HHAs (1,756) listed charges for NRS on the home health claim, but did not list any NRS costs on the cost report (78 FR 40290). As we stated in the CY 2014 HH PPS proposed rule, we calculated the average NRS cost per visit using the same cost report sample used to calculate the other adjustments to the national, standardized 60-day episode payment amount and the national per-visit rates, thus maintaining a consistent approach (78 FR 40289). We remind the industry again that each home health cost report is required to be certified by the Officer or Director the home health agency. We also welcome suggestions for improving compliance and accuracy on cost reports within the current cost reporting forms.

Comment: Commenters stated that the CY 2014 HH PPS proposed rule did not include a detailed and cumulative quantitative analysis of the impact and economic effects of the proposed provisions nor a cumulative cost analysis or quantification of the rule's projected future costs that is required for any economically significant regulation under Executive Orders 13563 and 12866. Commenters also stated that CMS should take into account the other Affordable Care Act mandated reductions (adjustments to the home health market basket updates, productivity adjustments, and outlier payment reduction), case-mix reductions, and sequestration, when developing the rebasing adjustments. A commenter stated that the impact analysis should look at access to care and should describe the locales where care is provided rather than gross aggregate impacts. The commenter stated that the impact analysis should look at the overall impact on the financial viability of HHAs rather than on the reduction in revenue and should look at the overall impact on Medicare spending in all relevant sectors, such as the inpatient hospitalization and skilled nursing facility care. Another commenter stated that CMS should consider the role that HHAs play in reducing the overall costs of health care by treating patients in a lower cost setting than institutional care. Many commenters stated that a multi-year analysis of the impact of the payment cuts should be performed, instead of a one-year impact analysis.

Response: Executive Orders 13563 and 12866 require us to assess the costs, benefits, and transfer effects of rulemaking. Because the most quantifiable impact of the rule is the transfer effect associated with Medicare payments (revenues), we focus our analysis on the impact of various policy proposals on payments from one year to the next. While we acknowledge that many factors and statutory requirements affect home health agencies, given the lack of data on local market conditions and individual provider's operations, we cannot provide the detailed analysis suggested by the commenters. We note that the net reduction in payments to HHAs in this final rule of 1.05 percent for CY 2014 is less than the net reduction in the proposed rule of 1.5 percent and less than the net reductions in prior years, notably the −4.89 percent net reduction in payments to HHAs in CY 2011.

Executive Order 13563 specifies, to the extent practicable, agencies should assess the costs of cumulative regulations. However, given potential utilization pattern changes, wage index changes, changes to the market basket forecasts, and unknowns regarding future policy changes, we believe it is neither practicable nor appropriate to forecast the cumulative impact of the rebasing adjustments on Medicare payments to HHAs for future years at this time. 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 would make it difficult to predict accurately the full scope of the impact upon HHAs for future years beyond CY 2014.

Comment: Commenters stated that contrary to the Regulatory Flexibility Act (RFA), the CY 2014 HH PPS proposed rule doesn't include a detailed analysis of its impact on small businesses. A commenter also cited the Data Quality Act, stating there are detailed analytic requirements on federal agencies prior to issuing economically significant regulations. Commenters noted that the CY 2014 HH PPS proposed rule was of sufficient concern to the U.S. Small Business Administration that it felt compelled to issue a Regulatory Alert to HHAs and other small businesses to submit comments on the CY 2014 HH PPS proposed rule. Another commenter stated that most home health agencies meet the U.S. Small Business Administration's definition of a small business and that the smallest home health agencies already have net negative Medicare margins and serve a disproportionate share of vulnerable patient populations. A commenter submitted a report on the impact of home health rebasing on small business as well as a state level impact analysis of rebasing performed by two contractors.

Response: 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. The economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. However, the estimated impact for CY 2014 in the CY 2014 HH PPS proposed rule was −1.5 percent, under the threshold of 3–5 percent to be considered significant. Included in table 33 in section VII is an estimate of the impacts according to HHA type, area, and number of first episodes. According to the impact table for this final rule, the overall estimated impact is −1.05 percent, with HHAs that have less than 100 first episodes experiencing estimated decreases in Medicare revenues of −1.27 percent and HHAs with 1,000 or more first episodes experiencing estimated decreases in Medicare revenues of −0.90 percent.

While commenters mentioned the Data Quality Act (section 515(a) of the Treasury and General Government Appropriations Act for Fiscal Year 2001 (Pub. L. 106–554)) in public comments, they did not state that CMS was not in compliance. The Data Quality Act directed the OMB to issue government-wide guidelines that provide policy and procedural guidance to federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information, including statistical

information, disseminated by federal agencies. We believe that we have complied with section 3131(a) of the Affordable Care Act in a straightforward and transparent manner and that we adhered to the principles of the Data Quality Act by ensuring that the information provided to the industry was of sufficient quality, objectivity, utility, and integrity. We provided the industry with detailed information on our calculations in the preamble of the CY 2014 HH PPS proposed rule as well supporting documentation in the form of a public use file and a technical rebasing report posted on the HHA Center Web site at: *http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html*.

Comment: Another commenter recommended that CMS develop a detailed plan for monitoring the impact of any HH PPS payment reductions (such as by examining measures relating to beneficiary access, quality of care and beneficiary experience of care) and that CMS commit to reporting to Congressional Committees of jurisdiction, the Medicare Payment Advisory Commission, and the public the results of this ongoing monitoring effort. The commenter stated that CMS should use authority available to the agency to ensure Medicare beneficiaries have appropriate access to home health.

Response: As we noted above, we recently awarded a contract to Abt Associates that will, among other things, develop and implement a system for monitoring access to care. We will make every effort to ensure that beneficiaries, and in particular vulnerable patient populations, continue to have access to quality home health care. We believe the four year phase-in of the rebasing adjustment will lessen any impact on access as HHAs develop ways to increase efficiencies while maintaining quality of care. As mandated in section 3131(a) of the Affordable Care Act and also noted above, MedPAC will conduct a study on the rebasing implementation, which will include an impact analysis on access to care, and submit a Report to Congress no later than January 1, 2015, along with any potential recommendations, if necessary.

Final Decisions:

Based on comments received, and section 3131(a) statutory language describing the maximum adjustment amounts for rebasing, we are finalizing a $80.95 reduction to the national, standardized 60-day episode payment rate in each year, CY 2014 through CY 2017. Section 3131(a) of the Affordable Care Act requires that the rebasing adjustment must be phased-in over a 4-year period in equal increments, not to exceed 3.5 percent of the payment amount (or amounts) as of the date of enactment (March 23, 2010). As described earlier, the maximum adjustment for the national, standardized 60-day payment rate is calculated to be $80.95 ($2,312.94 * 0.035). When determining the CY 2014 base payment amount, we will apply the $80.95 reduction to the CY 2013 base payment amount (which has been increased due to the resetting of the case-mix weights to 1.0000). Please see Section E for more details on the finalized CY 2014 payment rates. For CY 2015 through CY 2017, we will apply a $80.95 reduction to the previous year's base payment amount prior to the annual HH PPS payment update percentage.

Similar to the rebasing adjustment for the national, standardized 60-day payment rate, we are finalizing equal dollar adjustments to the per-visit payment amounts for CY 2014 through CY 2017, as shown in Tables 14 and 15. The adjustments to the national per-visit payment rates are capped at 3.5 percent of the national per-visit payment amounts in CY 2010, which are lower than the CY 2013 per-visit amounts. Therefore, the maximum adjustments to the national per-visit payment rates allowed by statute, and finalized in this final rule, are lower than the adjustments we proposed.

We are finalizing a reduction to the NRS conversion factor in each year from 2014 through 2017 of 2.82 percent, or $1.52 in CY 2014. Taking into account the statutory language stating that the amount of any adjustment for the year may not exceed 3.5 percent of the amount as of the date of enactment of the Affordable Care Act, we determined, as described in the preamble language above, that the final reduction to the NRS conversion factor of 2.82 percent in CY 2014 would not exceed 3.5 percent of the CY 2010 NRS conversion factor of $53.34 (53.34 * 0.035 = $1.87). In addition, we believe there is a very low likelihood that future adjustments of −2.82 percent in CY 2015 through 2017 would ever exceed the statutory limit. As such, we are finalizing a reduction to the NRS conversion factor of 2.82 percent each year from CY 2014 through CY 2017.

Section IV.E.4 contains the finalized payment rates for CY 2014 for the National, Standardized 60-day Episode Payment Amount, LUPA Per-Visit Payment Amounts, and Nonroutine Medical Supply (NRS) Conversion Factor, accounting for the rebasing adjustments.

E. CY 2014 Home Health Payment Rate Update

1. CY 2014 HH 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 HH PPS payment update percentage increase to the CY 2014 payment rates will be 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 HH PPS market basket update for CY 2014 is 2.3 percent. This is based on Global Insight Inc.'s third quarter 2013 forecast, utilizing historical data through the second 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).

The following is a summary of the comments we received regarding the home health market basket update.

Comment: A commenter supports CMS's proposal to provide a full market basket increase. The commenter further requests that CMS support future market basket increases, which are important to HHAs feeling the impact of several years of market basket reductions. The commenter also states that providers are preparing for a productivity adjustment cut effective in 2015.

Response: We appreciate the comment in support of using the full market basket update. The reductions to the market basket updates in previous years had been required by various statutes. Likewise, the productivity adjustment that would begin in CY 2015 is a statutory requirement and as such, we do not have the authority to waive

the application of the productivity adjustment.

Final Decision: For CY 2014, as required by section 1895(b)(3)(B) of the Act, the HH PPS payment update percentage will be 2.3 percent.

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. 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 home health 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 Home Health Care CAHPS® (HHCAHPS®) survey presents home health patients with a set of standardized questions about their home health care providers and about the quality of their home health care.

Prior to this survey, there was no national standard for collecting information about patient experiences that will 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 report five measures from the HHCAHPS® Survey—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 Home Health 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 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 home health patient population.

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

Home health 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 HHCAHPS® 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, 67164), 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).

(3) 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 will 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 HHCAHPS® 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 will 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.

(4) HHCAHPS® Requirements for the CY 2016 APU

For the CY 2016 APU, we require continued monthly HHCAHPS® data collection and reporting for 4 quarters. The data collection period for the CY 2016 APU includes the second quarter 2014 through the first quarter 2015 (the months of April 2014 through March 2015). HHAs will be required to submit their HHCAHPS® data files to the HHCAHPS® 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. These deadlines will be firm; no exceptions will be permitted.

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

We require 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 are exempt from the HHCAHPS® data collection and submission requirements for the CY 2016 APU, upon completion of the Participation Exemption Request form. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients in the period of April 1, 2013, through March 31, 2014, will 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 will be firm, as will be all of the quarterly data submission deadlines.

(5) 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 will 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 Technical Direction Letter that CMS sends to the affected HHAs, on or about the first Friday in September. HHAs have 30 days from their receipt of the Technical Direction Letter informing them that they did not meet the HHCAHPS requirements for the CY period, to send all documentation that supports their requests 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.

The following is a summary of the comments we received regarding HHCAHPS®:

Comment: We received a comment that supported HHCAHPS® as a useful tool for quality improvement and for empowering patients as equal partners in their plans of health care. This commenter said that member providers have used the HHCAHPS® survey to identify high-risk patients and to provide additional care support to them in managing their illnesses.

Response: We are very happy to hear these statements of support for HHCAHPS® and to learn about how providers are using the survey for quality improvement.

Comment: We received a comment that HHCAHPS® is an unfunded administrative burden on HHAs as a mandate that requires significant time to work with CMS's approved vendor selected by the provider.

Response: The collection of the patient's perspectives of care data for similar CAHPS® surveys, such as Hospital CAHPS®, follow the same model where providers pay the approved survey vendors for the HHCAHPS® data collection, and CMS pays for the HHCAHPS® survey vendor approval process, survey vendor training, technical support and assistance for home health agencies and for the vendors, monitoring and oversight of the vendors, and data analysis and public reporting of the HHCAHPS® survey data. HHAs are strongly encouraged to report their respective HHCAHPS® costs on their cost reports but should note that the HHCAHPS® costs are not reimbursable under the HH PPS. CMS strongly encourages HHAs to shop around for the best cost value for them before choosing and contracting with an approved HHCAHPS® vendor to conduct the HHCAHPS® survey on their behalf.

Comment: We received comments that CMS requires the use of external CMS-approved vendors but holds the home health agencies responsible for assuring that these vendors perform properly. These commenters emphasized that CMS should change this policy and monitor the performance of the outside vendors and penalize the vendors, not the home health agencies, if the vendors fail to perform.

Response: We believe that HHAs must monitor their vendors to ensure that vendors submit data on time, by using the information that is available to them on the HHCAHPS® Data Submission Reports. This will also ensure that data is submitted in the proper format, and will subsequently be successfully submitted to the HHCAHPS® Data Center.

If CMS or the CMS Data Warehouse contractor become aware that an HHCAHPS vendor has significant issues that would put HHAs at risk for not meeting the APU requirements, CMS and the CMS Contractor will immediately alert the affected HHAs. The intent of this alert is to provide these agencies with sufficient time to switch vendors and to ensure that the HHAs will not be penalized if their data collection activities are interrupted because of circumstances outside of their control. HHAs are strongly encouraged to call email *hhcahps@rti.org* or telephone RTI, the federal contractor, at (866) 354–0954, to change vendors and to ensure that their HHCAHPS® data collection will continue. HHAs are always advised to check the official HHCAHPS® Web site, *https://homehealthcahps.org* for all information about HHCAHPS®. In the event that CMS has found problems with a vendor, we would also note this next to the vendor name on the vendor list that is posted on *https://homehealthcahps.org*. If we find that a vendor does not comply with HHCAHPS® protocols and guidelines for the implementation of the HHCAHPS® survey, or correct their deficiencies in a timely manner, then we will remove that vendor from the approved list.

Final Decision: We are not recommending any changes as a result of comments received.

f. Summary of Changes in CY 2014 for the HHCAHPS® Survey

For the CY 2014 HH PPS Final Rule, we are finalizing the proposed requirements for HHCAHPS® as proposed in the CY 2014 HH PPS Proposed Rule.

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®.

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). The MAP is a public-private partnership comprised of multi-stakeholder groups convened 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 Social Security Act (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.ahrq.gov/workingforquality/nqs/nqsplans.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 home health agency (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 CY2013 HH PPS final rules (76 FR 68575 and 77 FR 67093, respectively), we finalized that we will 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 proposed 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 will allow for 12 full months of data collection and will provide us with the time necessary to analyze and make any necessary payment adjustments to the payment rates for CY 2014. We proposed 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.

The following is a summary of the comments we received regarding the submission of OASIS assessments to fulfill one portion of the quality reporting requirement for CY 2014 Payment and Subsequent Years.

Comment: Several commenters supported the proposals regarding considering OASIS assessments as fulfilling one portion of the quality reporting requirement for CY2014 and each subsequent year. We received no comments in opposition.

Response: We appreciate the commenters' support for the proposals.

Final Decision: After considering all of the comments we received, we are finalizing the proposals as proposed. CMS will consider OASIS assessments submitted by HHAs to CMS in compliance with the HH CoPs and Conditions for Payment for episodes beginning on or after July 1, 2012, and before July 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. We will also continue this pattern for each subsequent year beyond CY 2014, considering OASIS assessments submitted for episodes beginning on July 1st of the calendar year 2 years prior to the calendar year of the APU effective date and ending June 30th of the calendar year 1 year prior to the calendar year of the APU effective date as fulfilling the OASIS portion of the HH quality reporting requirement. HHA OASIS assessments will be considered complete if they comply with the HH CoPs and Conditions for Payment that apply to the applicable year.

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

We proposed 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 patients who had an acute inpatient hospitalization in the 5 days before the start of their HH stay and 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 use of an emergency department for patients who

had an acute inpatient hospitalization in the 5 days before the start of a HH stay and used an emergency department, yet were not admitted to an acute care hospital during the 30 days following the start of a HH stay.

We worked 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 rehospitalization measures will allow HHAs to further target patients who entered HH after a hospitalization.

The 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 HH rehospitalization measures are 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 proposed 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 CY 2015. 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 solicited 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. We also proposed to provide feedback to HHAs on performance of these measures in CY 2014. The following is a summary of the comments we received regarding these two quality measures:

Comment: Several commenters stated that they support the addition of the proposed quality measures to the HHQRP. One commenter specifically supported the proposal for reporting feedback to HHAs on performance of these measures in CY 2014. We also received a number of comments stating that, according to the Measures Application Partnership (MAP) report from January of 2013, the proposed quality measures required further development and encouraging CMS to submit them for NQF endorsement prior to full implementation and public reporting.

Response: We appreciate the commenters' support for the addition of the proposed quality measures to the HHQRP. We are finalizing the proposal to provide feedback to HHAs on performance of these measures in CY 2014. In December 2012, the MAP supported the direction of both measures because they address the PAC/LTC core concept of avoidable admissions. The MAP did acknowledge that the measures should be appropriately risk adjusted to accommodate variations in population. The risk model was developed and then minimally changed as a result of comment to this rule. The final list of risk factors will be posted on cms.gov by December 6, 2013. We plan to submit the two quality measures for NQF endorsement by the submission deadline of December 6, 2013. These measures will be added to Home Health Compare for public reporting in CY2015.

Comment: One commenter requested that CMS clarify what course of action it would take if NQF fails to endorse the proposed quality measures. The commenter also stated that their understanding of section 1890 of the Act is that CMS is required to use endorsed measures in its quality reporting programs.

Response: As noted in the response to the previous comment, we plan to submit the measures for NQF endorsement in the fourth quarter of CY 2013. However, based on our interpretation of section 1895(b)(3)(B)(v) of the Act, we may adopt measures for the HHQRP that are not NQF-endorsed. If NQF does not endorse the proposed quality measures, CMS will consider NQF's rationale for not endorsing the measures and decide how to proceed.

Comment: Several commenters stated that the proposed quality measures are too similar to the existing Acute Care Hospitalization and Emergency Department Use without Hospitalization measures. Several additional commenters were uncertain about how the proposed measures differ from the measures of Acute Care Hospitalization and ED Use currently published on Home Health Compare or were unaware that the Acute Care Hospitalization and ED Use without Hospitalization are currently part of the HHQRP measure set. These commenters recommended that CMS modify the proposed measures so that they are more similar to the existing measures. We also received a number of comments stating that if we finalize the proposed quality measures we should consider removing the existing Acute Care Hospitalization and Emergency Department Use without Hospitalization measures from the HHQRP because publicly reporting all four measures might be confusing for HHAs and the public.

Response: The two quality measures we proposed are different from the existing NQF-endorsed Acute Care Hospitalization and ED Use without Hospitalization measures. The proposed quality measures specifically target the previously hospitalized home health population, whereas the existing, NQF-endorsed Acute Care Hospitalization and Emergency Department Use without Hospitalization measures evaluate home health agencies on their care for all of their Medicare patients. While the proposed quality measures apply only to patients who were hospitalized in the five days prior to starting home health, which includes only about 35 percent of

HH patients, the Acute Care Hospitalization and Emergency Department Use without Hospitalization measures apply to the entire home health population covered by original Medicare. In addition, the Acute Care Hospitalization measure includes hospitalizations that occur during the first 60 days of home care, and the proposed Rehospitalization measure only applies to the first 30 days of home care. We believe that the two quality measure sets can be used in conjunction to evaluate home health care quality, and that, by comparing home health agencies on both sets of claims-based measures, consumers can gain a more complete and accurate picture of how much acute care is used by patients of the agencies.

Comment: One commenter requested that CMS clarify the source of a statistic cited in the proposed rule, namely the 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of HH care and also requested that CMS clarify the reason for the difference between the national average rate of unplanned rehospitalization in the first 30 days of HH care (14.4 percent) and the national average rate for the Acute Care Hospitalization rate published on Home Health Compare (17 percent).

Response: We appreciate the comments. The statistic that 14.4 percent of HH patients experience an unplanned rehospitalization in the first 30 days of HH care is calculated by applying the specifications for the Rehospitalization during the first 30 days of HH measure to 12 months of fee-for-service Medicare claims (July 2011 through June 2012). The Rehospitalization during the first 30 days of HH measure is only calculated for Medicare fee-for-service patients because encounter data is available through fee-for-service claims. The 17 percent national average hospitalization rate represents hospitalizations during the first 60 days of home health for all Medicare fee-for-service patients, calculated according to the specifications for the Acute Care Hospitalization measure.

Comment: One commenter stated that CMS appears to take the position that 14.4 percent of HH patients experiencing an unplanned rehospitalization in the first 30 days of HH care is an unacceptable number. The commenter noted that a portion of those readmissions may be unavoidable.

Response: We thank the commenter for the comment. We agree with the commenter that some readmissions to the hospital and emergency department visits may not be preventable. We believe that HHAs can provide the highest quality care and coordination of care for their patients so that the rate of preventable readmissions is reduced.

Comment: With regards to the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure, one commenter stated that CMS should take into account the increase in the number of urgent care centers in certain areas of the country, which could skew the performance rates for the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure across different HHAs across the country.

Response: We appreciate the comment. We are investigating the impact of urgent care centers on these measures. While we expect that urgent care sometimes substitutes for Emergency Department use, the availability of urgent care centers should similarly impact all agencies in an area similarly, and thus performance on the ED Use without Hospital Readmission measure should still be meaningfully compared among agencies in the same area.

Comment: One commenter expressed concern that the proposed quality measures do not consider the length of time that the patient has been receiving HH care before requiring rehospitalization or treatment in the emergency department.

Response: We appreciate the commenter's concern. We examined the relationship between time in home health and hospitalizations and found that home health patients experience a nearly constant hazard of hospitalization per day. By measuring rehospitalizations over a fixed 30 day window (rather than over the entire home health episode) the relationship between length of stay and rehospitalization is mitigated. While we acknowledge that other approaches could also be appropriate, we chose the fixed measurement window approach for simplicity and to be consistent with the existing NQF endorsed measures of Acute Care Hospitalization and ED Use.

Comment: One commenter stated that they do not support the five-day timeframe used to specify the eligible patient population and encouraged further analysis of how the time interval between hospital discharge and home health admission impacts subsequent patient outcomes. The commenter expressed particular concern that some hospitals may delay home health admission until 3 days after hospital discharge in an attempt to maximize DRG reimbursement.

Response: We appreciate the commenter's feedback. We believe that the five-day timeframe used to specify the eligible patient population for the measures is appropriate. Shortening the 5 day window is undesirable for several reasons. First, it would exclude some patients from the measures who are not cared for in any other post-acute setting. Additionally, a shorter window (such as a two-day window to be consistent with the CoPs) may encourage agencies to delay the start of care for particularly unstable patients so that they are not held accountable for the rehospitalization of such patients.

Comment: One commenter asked how short Skilled Nursing Facility (SNF) stays occurring between hospital discharge and start of HH care are accounted for in the measures.

Response: The measure specifications exclude patients who receive care from another post-acute setting, such as a SNF or an IRF between hospital discharge and start of home health are excluded from both measures.

Comment: One commenter stated that HHAs may not be entirely responsible for a patient's return to an emergency room or inpatient acute care facility, since HHAs follow orders prescribed by the physician. The commenter stated that an HHA does not have the authority to override the physician's decision to admit the HH patient to an inpatient acute care facility.

Response: We appreciate the commenter's concern. We understand that Emergency Department use or Hospitalization is sometimes necessary. We do believe, however, that the care that a patient receives from a HHA can reduce the need for that patient to be readmitted to the hospital.

Comment: We received a number of comments stating that agencies should not be held responsible for patients who are readmitted to an acute-care setting within 30 days of entering HH, if these patients have been discharged from home health for appropriate reasons (for example, the patient is no longer homebound or is no longer in need of skilled services) within the 30-day period. One commenter requested that CMS clarify whether patients discharged from HH care within the 30-day measurement period would be included or excluded from the proposed quality measures.

Response: We appreciate the comments. We believe that the care and education provided by HHAs can have a positive impact on the health status and self-care processes of many of the these patients, even if they were discharged due to appropriate reasons such as no longer being homebound

and/or no longer in need of skilled care. Therefore home health care can reduce the likelihood of hospital readmission even after the patient is discharged from the HHA. Thus, as documented in the measure specifications, patients who are discharged from home health within the 30-day observation period are counted in the denominators of the quality measures.

Comment: Two commenters stated that they are concerned about the impact of the increasing use of ''observation stays'' in lieu of inpatient admission on the rates of the proposed quality measures, since there may be significant variation in the use of observation stays versus inpatient admission within a state, region, or the United States.

Response: We appreciate the commenters' concern. Observation stays that begin in a hospital emergency department will be captured on the Emergency Department Use without Hospital Readmission during the first 30 days of HH measure rather than in the Rehospitalization measure, as these events are billed to Medicare as outpatient services rather than inpatient services.

Comment: Two commenters expressed support for the proposed exclusions for both measures. We also received a number of comments stating that it is unclear whether and how CMS excludes planned hospitalizations from the proposed quality measures.

Response: We appreciate the commenters' support for the exclusions. Additionally, we would like to point out that the specifications for the measures clarify that the measures exclude planned hospitalizations using the same algorithm as the NQF-endorsed Hospital-Wide All-Cause Unplanned Readmission (HWR) measure. This algorithm identifies planned hospitalizations based on diagnostic and procedural information available on claims data. Those specifications can be found at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html*.

Comment: One commenter requested that CMS clarify the term ''risk-standardized'' as it is used in the proposed rule to describe the proposed quality measures.

Response: We would like to clarify that the term ''risk-standardized,'' which appears in the section of the proposed rule that describes the proposed quality measures, is interchangeable with ''risk-adjusted,'' that is, the quality measures are risk-adjusted to account for beneficiary factors that may affect rates of hospitalization but are outside of the HHA's control.

Comment: Several commenters expressed concerns that the proposed quality measures do not appropriately take into account other settings where the patient may have received care.

Response: We appreciate the commenters' concern. The specifications for the measures exclude home health stays in which the patient received treatment in another setting between hospital discharge and the start of home health as these patients' outcomes may be affected by this intervening care. In addition, the risk adjustment model takes into account settings in which the beneficiary received care prior to hospitalization by examining Medicare fee-for-service claims in the 30 days prior to the start of the HH stay. We believe that the measures appropriately take into account other settings.

Comment: Several commenters stated that they support the proposed approach to risk adjustment. Additionally, we received a number of comments stating that CMS should include other risk factors in the risk adjustment model. One commenter stated that it is unclear why certain OASIS items have been included and others have been excluded.

Response: We appreciate the commenters' support for the risk adjustment approach. We also appreciate the comment that additional data derived from OASIS may be useful as risk adjustment factors for the measures. Currently, CMS has chosen to include all the Activities of Daily Living (ADLs) information that is readily available on Medicare claims as risk adjustment factors, including composite measures of Dressing Upper or Lower Body, Bathing, Toileting, Transferring, and Ambulation. However, incorporating additional OASIS data elements into the risk adjustment model would require the ability to match OASIS assessments to claims accurately, which is currently infeasible.

Comment: One commenter stated that CMS should take into account additional patient characteristics such as race, ethnicity, and religion, which may influence a patient's preference to be hospitalized, in the risk adjustment model.

Response: While risk-adjustment is used to ensure that measured rates are comparable across agencies with different patient populations, CMS believes that adjusting for race, ethnicity, or religion would obscure disparities in outcomes between more advantaged and less advantaged groups. We note, however, that we have examined disparities between subpopulations defined by race, age, and gender for the measures; this information was included in the technical brief posted for public comment through the Measures Management Blueprint process on the CMS Quality Measures Public Comment from June 25, 2013 to August 26, 2013.

Comment: One commenter stated that CMS should make public a clear list of the risk adjustment factors used to calculate the proposed measures.

Response: The technical specifications that were available for these measures at the time we issued the proposed rule included a list of types of risk factors that were included in a preliminary risk-adjustment model. We subsequently minimally refined the risk adjustment model in response to the public comments received during the Measures Management Blueprint process. The refinements involved statistical categorization and were not substantive; the types of risk factors are unchanged from those noted in the technical specifications. By December 6, 2013, we will post the final technical specifications on the Home Health Quality Initiative page, which will include a list of all risk adjustment factors and model coefficients for each factor.

Comment: Several commenters stated that they support alignment of the proposed quality measures with the readmission measures of hospitals and other post-acute care providers. We also received several comments stating that CMS should adopt disease-specific readmission measures to align disease specific quality improvement efforts in HHAs with hospitals and across care settings. Several commenters stated that the proposed quality measures do not align with the Hospital 30-day Readmission measure, which only includes three causes—Myocardial Infarction (MI), Heart Failure (HF), and Pneumonia.

Response: We appreciate the support for the alignment of the quality measures with the readmission measures of hospitals and other post-acute care providers. Currently, the measures align with the NQF-endorsed Hospital-Wide All Cause Unplanned Readmission measure. We also appreciate the recommendation to develop disease-specific readmission measures across care settings. We will take into account the recommendation to develop disease-specific readmission measures across care settings as part of future measure development work.

Comment: Several commenters stated that they support the use administrative

claims data to calculate the proposed quality measures.

Response: We thank the commenters for their support.

Comment: We received a number of comments stating that CMS should seek broader input from the home health care community and public when developing the proposed quality measures and home health quality measures in general.

Response: We thank the commenters for the comment. We do seek input from the home health community and the general public through the CMS Quality Measures Public Comment Page on cms.gov. Development of all four home health claims-based measures, including the two proposed measures, was also informed by outreach conducted for the 2011 Home Health Value-based Purchasing Report to Congress, including expert interviews and a listening session. Additionally, the home health measures technical expert panel (initially convened in late 2010) reviewed and discussed the measures. To maintain transparency in future measure development work, CMS will continue to seek input from the public.

Final Decision: After consideration of the comments received, we are finalizing the adoption of the two claims-based measures: (1) Re-hospitalization during the first 30 days of HH; and (2) Emergency Department Use without Hospital Readmission during the first 30 days of HH. We will provide feedback to HHAs on their measure rates in CY 2014.

(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 proposed 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 solicited comments on this proposal to simplify the reporting of process measures, which is based on the recommendation from the MAP to achieve greater parsimony in these measures. Currently there are 97 quality measures included on the CASPER reports, of which 45 are process measures. This reduction will 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 proposed to eliminate the stratification by episode length, so that these measures are reported only for ''all episodes of care''. Thus, we proposed to eliminate the ''short term'' and ''long term episodes of care'' measures from CASPER reports. This will 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 will 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 will substantially increase the number of HHAs eligible for public reporting of these measures.

The following is a summary of the comments we received regarding the proposal to eliminate stratification by episode length process measures.

Comment: Several commenters stated that they support this proposal. We received no comments in opposition. We also received a few comments requesting that CMS give HHAs continued access to HHQRP data files to allow them to calculate their own short-term and long-term rates and to benchmark their performance on those rates against other HHAs.

Response: We appreciate the commenters' feedback. We understand that the HHAs need access to detailed data to inform their quality improvement efforts. However, the CASPER system currently does not support access to patient-level data for process measures so agencies will not be able to calculate separate rates for short-term versus long-term patients. We will examine adding such functionality to future revisions of CASPER reports.

Final Response: After consideration of the comments received, we are finalizing policies related to the reduction of the number of process measures as proposed. We will reduce the total number of measures on the CASPER reports by reporting only all-episode measures for 9 process measures currently also stratified by episode length. We will eliminate the stratification by episode length by removing the ''short term'' and ''long term episodes of care'' measures from the CASPER reports so that the measures are only reported for all episodes of care. The ''short term episodes of care'' measures currently publicly reported on Home Health Compare will be replaced with the analogous ''all episodes of care'' measures.

To summarize, we are finalizing the proposals to continue to use a HHA's submission of OASIS assessments for episodes between July 1 of the calendar year two years prior to the calendar year of the APU effective date and June 30 of the calendar year one year prior to the calendar year of the APU effective date as fulfilling one portion of the quality reporting requirement for each payment year; 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, to begin reporting feedback to HHAs on performance on these measures in CY 2014; and to reduce the number of process measures reported on the CASPER reports by eliminating the stratification by episode length for 9 process measures.

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 will 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 will 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 make 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 will also be reflected in the CY 2015 HH wage index.

Finally, we will 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 will 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 2014, 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*.

The following is a summary of the comments we received regarding the home health wage index.

Comment: Several commenters expressed concern that HHAs compete with hospitals and hospices for skilled clinicians, yet the wage indices for home health, hospice, and hospitals vary widely within a specific geographic region. While hospitals can reclassify to neighboring CBSAs or take advantage of the rural floor, HHAs do not have this ability. Commenters believed that this results in inadequate home health cost adjustments that negatively impact HHAs ability to recruit and retain nurses and therapists in a highly competitive health care labor market. Commenters suggested that CMS develop regulatory and legislative remedies to the continuing problem of wage index disparity. Commenters urge CMS to implement a policy to limit the wage index variations between provider types within CBSAs and adjacent markets. Commenters requested that CMS allow HHAs the same reclassification as hospitals if they provide services in the same service area. Commenters suggest that rural floors be set for HHAs.

Response: As previously stated in the CY 2009 HH PPS final rule, (74 FR 58105), the regulations that govern the HH PPS do not provide a mechanism for allowing HHAs to seek geographic reclassification or to utilize the rural floor provisions that exist for IPPS hospitals. The rural floor provision in section 4410 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) is specific to hospitals. The reclassification provision found in section 1886(d)(10) of the Act is also specific to hospitals.

Comment: A commenter believed that using the pre-floor, pre-reclassified hospital wage index is inadequate for adjusting home health costs. The commenter cites the unpredictable year-to-year swings in wage index values. The commenter stated that CMS's decision to switch from MSAs to CBSAs seven years ago has had serious financial ramifications for HHAs in various parts of the country. The commenter questioned the accuracy and completeness of hospital cost reports.

Response: We believe that adjusting payments based on the CBSA areas is the best available method of compensating for differences in labor markets. The HH PPS used a 50/50 blend of the MSA-based and the CBSA-based wage indexes in CY 2006. Since CY 2007, the HH PPS has utilized the CBSA-based wage index in its entirety. In regard to the accuracy and completeness of hospital cost reports, we utilize efficient mechanisms to ensure the accuracy of the hospital cost report data and resulting wage index. The HH PPS uses the pre-floor, pre-reclassified hospital wage index. This wage index is calculated based on cost report data from hospitals paid under the IPPS. All IPPS hospitals are required to complete the wage index survey (Worksheet S–3, Parts II and III) of their Medicare cost reports. Our intermediaries perform desk reviews on all hospitals' Worksheet S–3 wage data, and we run edits on the wage data to further ensure the accuracy and validity of the wage data. In addition, HHAs may submit comments on the hospital wage index during the annual IPPS rulemaking. We believe that our review processes result in an accurate collection of wage data.

Comment: A commenter requested that CMS publish the methodology for arriving at the wage index used by the HH PPS.

Response: The HH PPS uses the pre-floor, pre-reclassified hospital wage index. The methodology for calculating the pre-floor, pre-reclassified hospital wage index is published annually in the IPPS final rule. The FY 2014 IPPS final rule is available at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2014-IPPS-Final-Rule-Home-Page.html*.

Comment: A commenter urged CMS to expedite its review of the wage index and implement a system that not only recognizes variations between localities, but also treats all provider types within a local market equitably. Until such a system is in place, the commenter urged CMS to implement and adjust the 2014 wage index in such a way as to limit the wage index disparity between provider types within a given CBSA to no more than 10 percent. A commenter recommended that until the wage index

can be adjusted, that HHAs be given interim wage index parity adjustments similar to that which hospitals in the same geographic area receive.

Response: The hospital wage index is updated in a budget neutral manner. Establishing limits on how much a wage index may increase or decrease from year-to-year is not consistent with budget neutrality. As noted above, the geographic reclassifications and adjustments that hospitals may apply for are not available to providers other than hospitals.

Comment: A commenter stated that differences in the occupational personnel pool and costs between hospitals and HHAs make use of the hospital wage index inappropriate in the home health setting. The commenter further stated that using the hospital wage index is inappropriate because hospitals benefit from institutional efficiencies which HHAs are not afforded. The commenter asked CMS to develop a home health specific wage index. The commenter stated that until CMS develops a home health specific wage index, he will support CMS' proposal to incorporate OMB's new area delineations in the CY 2015 HH wage index as the improved specificity should provide some relief. In addition, several other commenters recommended that CMS reform or implement a new HH wage index system.

Response: Our previous attempts at either proposing or developing a home health specific wage index were not well received by the home health industry. Generally, the volatility of the home health wage data, and the resources needed to audit and verify those data, make it difficult to ensure that such a wage index accurately reflects the wages and wage-related costs applicable providing home health services. We believe that a HH specific wage index should be more reflective of the wages and salaries in a specific area, be based upon stable data sources, and significantly improve our ability to determine HH payments without being overly burdensome.

Comment: A commenter noted that dropping critical access hospitals (CAHs) from the calculation of the wage index, beginning in 2004, compromises the accuracy and appropriateness of using a hospital wage index to determine the labor costs of HHAs providing services in rural areas.

Response: Although the pre-floor, pre-reclassified hospital wage index does not include data from CAHs, we believe it reflects the relative level of wages and wage-related costs applicable to providing home health services.

Final Decision: For CY 2014, we will use the FY 2014 pre-floor, pre-reclassified hospital wage index as the wage index adjustment to the labor portion of the HH PPS rates.

4. 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 42 CFR 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 differences, 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 will continue to be 78.535 percent and the non-labor-related share will continue to be 21.465 percent as set out in the CY 2013 HH PPS final rule (77 FR 67068). The 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 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 will 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. CY 2014 National, Standardized 60-Day Episode Payment Rate

The CY 2014 national, standardized 60-day episode payment rate will be $2,869.27 as calculated in Table 20. To determine the CY 2014 national, standardized 60-day episode payment rate, we start with the CY 2013 average payment per episode ($2,952.03) calculated in section IV.D.1. of this rule. We remove the 2.5 percent for outlier payments that we put back in the rates as described in section IV.D.1. of this rule, and subsequently apply a standardization factor of 1.0026 to the national, standardized 60-day episode rate to ensure budget neutrality in episode payments using the 2014 wage index. The application of a standardization factor was also done when setting the initial 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 1.0026. 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. We then apply the $80.95 reduction (which is 3.5 percent of the CY 2010 national, standardized 60-day episode rate of $2,312.94) and, lastly, we update payments by the CY 2014 HH payment update percentage of 2.3 percent.

TABLE 20—CY 2014 60-DAY NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2013 Estimated average payment per episode	Outlier adjustment factor	Standardization factor	CY 2014 Rebasing adjustment	CY 2014 HH market basket update	CY 2014 National, standardized 60-day episode payment
$2,952.03	× 0.975	× 1.0026	−$80.95	× 1.023	= $2,869.27

The CY 2014 national, standardized 60-day episode payment rate for an HHA that does not submit the required quality data is updated by the CY 2014 HH market basket update (2.3 percent) minus 2 percentage points and is shown in Table 21.

TABLE 21—FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA—CY 2014 NATIONAL, STANDARDIZED 60-DAY EPISODE PAYMENT AMOUNT

CY 2013 Estimated average payment per episode	Outlier adjustment factor	Standardization factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update minus 2 percentage points	CY 2014 National, standardized 60-day episode payment
$2,952.03	× 0.975	× 1.0026	−$80.95	× 1.003	= $2,813.18

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 start with the CY 2013 national per-visit rates. We then apply a wage index budget neutrality factor of 1.0006 to ensure budget neutrality for LUPA per-visit payments after applying the 2014 wage index, and increase each of the six per-visit rates by the maximum rebasing adjustments described in section IV.D of this rule. We calculate 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. Finally, the per-visit rates for each discipline are then updated by the CY 2014 HH payment update percentage of 2.3 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 CY 2014 national per-visit rates are shown in Tables 22 and 23.

TABLE 22—CY 2014 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

HH Discipline type	CY 2013 Per-visit payment	Wage index budget neutrality factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update	CY 2014 Per-visit payment
Home Health Aide	$51.79	× 1.0006	+ $1.79	× 1.023	$54.84
Medical Social Services	183.31	× 1.0006	+ 6.34	× 1.023	194.12
Occupational Therapy	125.88	× 1.0006	+ 4.35	× 1.023	133.30
Physical Therapy	125.03	× 1.0006	+ 4.32	× 1.023	132.40
Skilled Nursing	114.35	× 1.0006	+ 3.96	× 1.023	121.10
Speech-Language Pathology	135.86	× 1.0006	+ 4.70	× 1.023	143.88

The CY 2014 per-visit payment rates for an HHA that does not submit the required quality data are updated by the CY 2014 HH payment update percentage (2.3 percent) minus 2 percentage points and is shown in Table 23.

TABLE 23—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	Wage index budget neutrality factor	CY 2014 Rebasing adjustment	CY 2014 HH Market basket update minus 2 percentage points	CY 2014 Per-visit rates
Home Health Aide	$51.79	× 1.0006	+ $1.79	× 1.003	$53.77
Medical Social Services	183.31	× 1.0006	+ 6.34	× 1.003	190.33
Occupational Therapy	125.88	× 1.0006	+ 4.35	× 1.003	130.70
Physical Therapy	125.03	× 1.0006	+ 4.32	× 1.003	129.81
Skilled Nursing	114.35	× 1.0006	+ 3.96	× 1.003	118.73
Speech-Language Pathology	135.86	× 1.0006	+ 4.70	× 1.003	141.06

d. 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 24). 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 24—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 final rule we used 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 CY 2012 claims data. The analysis shows 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 are 37.27 minutes for the first visit if SN, 31.69 minutes for the first visit if PT, and 31.56 minutes for the first visit if SLP. The average minutes for all non-first visits in non-LUPA episodes are 44.10 minutes for SN, 47.30 minutes for PT, and 50.37 minutes for SLP. Those excess minutes expressed as a proportion of the average minutes for all non-first visits in non-LUPA episodes are 84.51 percent for SN, 67.00 percent for PT, and 62.66 percent for SLP. We used these proportions to inflate the LUPA per-visit payment rates in Table 22 of $121.10 for SN, $132.40 for PT, and $143.88 for

SLP. We then calculated a set of weights representing the share of LUPA first visits for SN (81.97 percent), PT (17.61 percent) and SLP (0.42 percent) and using these weights, we calculated a LUPA add-on payment amount of $99.89 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 $99.89, 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 proposed 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. Using complete CY 2012 claims data, the LUPA add-on factors are calculated to be: 1.8451 for SN; 1.6700 for PT; and 1.6266 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 will be $223.44 (1.8451 multiplied by $121.10). 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—CY 2014 Home Health Prospective Payment System Final Rule'' 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.*

The following is a summary of the comments we received regarding the LUPA add-on factors.

Comment: We received one comment that was supportive of the proposed LUPA add-on factors and no comments in opposition.

Response: We appreciate the commenter's support and we believe that proposed creation of three LUPA add-on factors will result in more accurate LUPA add-on payments reflecting the discipline that performed the initial assessment visit.

Final Decision: We are finalizing three LUPA add-on factors to be used in calculating the LUPA add-on payment amount. Those three factors are 1.8451 for skilled nursing, 1.6700 for physical therapy and 1.6266 for speech-language pathology when that discipline is the first skilled visit in a LUPA episode that occurs as the only episode or an initial episode in a sequence of adjacent episodes.

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 NRS conversion factor, we start with the 2013 NRS conversion factor ($53.97) and apply the 2.82 percent rebasing adjustment calculated in section IV.D.3. of this rule (1–0.0282 = 0.9718). We then update the conversion factor by the CY 2014 HH market basket update (2.3 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 NRS conversion factor for CY 2014 is $53.65 as shown in Table 25.

TABLE 25—CY 2014 NRS CONVERSION FACTOR FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

CY 2013 NRS conversion factor	2014 Rebasing adjustment	2014 HH market basket update	CY 2014 NRS conversion factor
$53.97	× 0.9718	× 1.023	= $53.65

Using the CY 2014 NRS conversion factor ($53.65), the payment amounts for the six severity levels are shown in Table 26.

TABLE 26—CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	NRS Payment amount
1	0	0.2698	$14.47
2	1 to 14	0.9742	52.27
3	15 to 27	2.6712	143.31
4	28 to 48	3.9686	212.92
5	49 to 98	6.1198	328.33
6	99+	10.5254	564.69

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 −2.82 percent rebasing adjustment calculated in section IV.D.3. of this rule (1 − 0.0282= 0.9718). We then update the NRS conversion factor by the CY 2014 HH market basket update of 2.3 percent, minus 2 percentage points. The CY 2014 NRS conversion factor for HHAs that do not submit quality data is shown in Table 27.

TABLE 27—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 update minus 2 percentage points	CY 2014 NRS Conversion factor
$53.97	× 0.9718	× 1.003	$52.61

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 28.

TABLE 28—CY 2014 NRS PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

Severity level	Points (scoring)	Relative weight	NRS Payment amount
1	0	0.2698	$14.19
2	1 to 14	0.9742	51.25
3	15 to 27	2.6712	140.53
4	28 to 48	3.9686	208.79
5	49 to 98	6.1198	321.96
6	99+	10.5254	553.74

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 will 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 following is a summary of the comments we received regarding HH services provided in rural areas.

Comment: A commenter noted that heavy mileage, travel time, poor roads and other factors increase the expense of serving rural patients and stated that decreasing Medicare payments will impact HHA's ability to serve rural beneficiaries.

Response: We believe that Medicare home health services are integral to the healthcare of many beneficiaries, including those who reside in rural areas. For episodes and visits ending on or after April 1, 2010, and before January 1, 2016, payments for services provided to patients in rural areas are increased by 3 percent as required by section 3131(c) of the Affordable Care Act.

Comment: A commenter recommends that CMS implement a population density factor by zip code during the calculation of the labor portion of the payment amount to account for increased costs of providing services in less densely populated (primarily rural) areas. The commenter states that the population density adjustment would reduce excess reimbursement for services provided in densely populated urban areas and congregate living facilities. The commenter recommends that the adjustment be budget neutral or perhaps result in a cost savings.

Response: We do not have evidence that a population density adjustment is appropriate. While rural HHAs cite the added cost of long distance travel to provide care for their patients, urban/non-rural HHAs cite added costs associated with needed security measures and traffic volume.

Final Decision: For CY 2014, HH payment rates for services provided to beneficiaries in rural areas will be increased by 3 percent as mandated by section 3131(c) of the Affordable Care Act. The 3 percent rural add-on is applied to the national, standardized 60-day episode payment rate, national per-visit rates, and NRS conversion factor when HH services are provided in rural (non-CBSA) areas. Refer to Tables 29 through 32 for these payment rates.

TABLE 29—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		
CY 2014 National, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	CY 2014 Rural national, standardized 60-day episode payment rate	CY 2014 National, standardized 60-day episode payment rate	Multiply by the 3 percent rural add-on	CY 2014 Rural national, standardized 60-day episode payment rate
$2,869.27	× 1.03	$2,955.35	$2,813.18	× 1.03	$2,897.58

TABLE 30—CY 2014 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA

	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
HH Discipline type	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate
HH Aide	$54.84	× 1.03	$56.49	$53.77	× 1.03	$55.38
MSS	194.12	× 1.03	199.94	190.33	× 1.03	196.04

TABLE 30—CY 2014 PER-VISIT AMOUNTS FOR SERVICES PROVIDED IN A RURAL AREA—Continued

HH Discipline type	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate	CY 2014 Per-visit rate	Multiply by the 3 percent rural add-on	CY 2014 Rural per-visit rate
OT	133.30	× 1.03	137.30	130.70	× 1.03	134.62
PT	132.40	× 1.03	136.37	129.81	× 1.03	133.70
SN	121.10	× 1.03	124.73	118.73	× 1.03	122.29
SLP	143.88	× 1.03	148.20	141.06	× 1.03	145.29

TABLE 31—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		
CY 2014 Conversion factor	Multiply by the 3 percent rural add-on	CY 2014 Rural conversion factor	CY 2014 Conversion factor	Multiply by the 3 percent rural add-on	CY 2014 Rural conversion factor
$53.65	× 1.03	$55.26	$52.61	× 1.03	$54.19

TABLE 32—CY 2014 NRS PAYMENT AMOUNTS FOR SERVICES PROVIDED IN RURAL AREAS

Severity level	Points (Scoring)	For HHAs that DO submit quality data (CY 2014 NRS conversion factor=$55.26)		For HHAs that DO NOT submit quality data (CY 2014 NRS conversion factor=$54.19)	
		Relative weight	Total NRS payment amount for rural areas	Relative weight	Total NRS payment amount for rural areas
1	0	0.2698	$14.91	0.2698	$14.62
2	1 to 14	0.9742	53.83	0.9742	52.79
3	15 to 27	2.6712	147.61	2.6712	144.75
4	28 to 48	3.9686	219.30	3.9686	215.06
5	49 to 98	6.1198	338.18	6.1198	331.63
6	99+	10.5254	581.63	10.5254	570.37

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 published on July 3, 2000 (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 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, payment amount for NRS, and the 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, the provision,

''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. Then, we 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 did not propose a change to the loss-sharing ratio in the HH PPS proposed rule (78 FR 40301). 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, achieved 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.

For this final rule, simulating payments using more complete CY 2012 claims data (a full year of data rather than preliminary data from the first half of 2012) and the CY 2013 payment rates (77 FR 67100 through 67105); we estimate that outlier payments in CY 2013 would comprise 1.79 percent of total payments. Based on simulations using CY 2012 claims data, the CY 2014 payments rates in section IV.E., and an FDL ratio of 0.45; we estimate that outlier payments in CY 2014 would comprise approximately 1.86 percent of total HH PPS payments in CY 2014. Given the increases to the CY 2014 national per-visit payment rates and the national, standardized 60-day episode payment rate as a result of making the case-mix adjustment in section IV.C budget neutral and the starting point for the rebasing calculations in section IV.D, our analysis estimates a 0.07 percentage point increase in 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 will be approximately 2.07 percent. We did not propose a change to the FDL ratio or loss-sharing ratio for CY 2014 as we believed that maintaining an FDL of 0.45 and a loss-sharing ratio of 0.80 are appropriate given the percentage of outlier payments is estimated to increase as a result of the increasing the national per-visit amounts through the rebasing adjustments and the claims data showing any utilization changes that may have resulted from decreasing the FDL of 0.45 in CY 2013 would not be available for analysis until next year.

5. Outlier Relationship to the HH Payment Study

As we discuss in section IV.G. of this final 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.

Although we did not propose any changes to the outlier policy, the following is a summary of the comments we received regarding outlier payments.

Comment: Several commenters stated that estimated outlier payments as a percent of total payments for CY 2014 is below the budgeted amount of 2.5 percent and that the FDL ratio and/or loss-sharing ratio should be set so that estimated outlier payments as a percent of total payments would reach 2.5 percent. One commenter stated that because the national, standardized 60-day episode payment rate is increased as a result of the adjustment to the case-mix weights in section IV.C., fewer episodes qualify for outlier payments, contributing to estimated outlier payments falling short of 2.5 percent of total payments.

Response: We did not propose 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 would not be available for analysis until next year. In addition, we

note that the percentage of outlier payments is estimated to increase as a result of both increasing the national per-visit amounts over the next four years (which will increase an episode's imputed costs) and as a result of decreasing the national, standardized 60-day episode payment rate over the next four years (which will decrease the fixed-dollar loss threshold amount). We are also concerned that if we decreased the FDL ratio or increased the loss-sharing ratio we could potentially pay more than 2.5 percent of estimated total payments as outlier payments and that episodes without unusual variations in the type or amount of medically necessary care would qualify for outlier payments, which is contrary to the intent of the policy. Consequently, for the above stated reasons, we believe that we should not make any changes/revisions to our outlier payment methodology at this time.

Comment: One commenter recommended that CMS eliminate outlier payments in their entirety and return the 2.5 percent withhold to the base payment rates.

Response: We are required in section 1895(b)(5)(A) of the Act, to include an outlier pool of an amount that is 2.5 percent. We do believe that the statute allows the Secretary the discretion as to whether or not to have an outlier policy under the HH PPS. To date, analysis on the outlier policy has not been conducted. We plan to look into whether or not an outlier policy remains to be appropriate as well as ways to maintain an outlier policy for episodes that incur unusually high costs due to patient care needs without qualifying episodes of care that do not meet that criteria or are potentially fraudulent. We recently awarded a new contract to address any findings from the home health study required by section 3131(d) of the Affordable Care Act, monitor the potential impact of the rebasing adjustments and other recent payment changes, and develop payment options to ensure ongoing access to care for vulnerable populations, which may include potential revisions to the outlier payment methodology to better reflect costs of treating Medicare beneficiaries with high levels of severity of illness.

Comment: A few commenters stated that they do not believe that the 10 percent agency-level cap on outlier payments is an effective fraud fighting policy and recommended that CMS exempt certain HHAs that serve high-cost patients with multiple clinical issues from the10 percent agency-level cap.

Response: The 10 percent agency-level cap on outlier payments is a statutory requirement in section 1895(b)(5)(B) of the Act and thus we do not have the authority to rescind this policy or exempt HHAs from this provision.

Final Decision: We are finalizing no change to the FDL ratio or loss sharing ratio for CY 2014. However, we will continue to monitor outlier payments and continue to explore ways to maintain an outlier policy for episodes that incur unusually high costs due to patient care needs without qualifying episodes of care that do not meet that criteria.

The Office of Inspector General (OIG) released a Management Implications Report in August of 2013 that concluded there is a ''systemic weakness that results in Medicare coverage of unnecessary home health care for diabetic patients''. The OIG report noted that investigations show that the majority of beneficiaries involved in fraudulent schemes have a primary diagnosis of diabetes that OIG Special Agents found falsified medical records documenting patients having hand tremors and poor vision that preventing them from drawing insulin in a syringe, visually verifying the correct dosage, and injecting the insulin themselves, when the patients did not in fact suffer those symptoms.

In light of the OIG report, we conducted analysis and simulations performed on CY 2012 claims data. We found that nearly 44 percent of the episodes that would qualify for outlier payments had a primary diagnosis of diabetes and 16 percent of episodes that would quality for outlier payments had a primary diagnosis of ''Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled.'' Our simulations also estimated that approximately 81 percent of outlier payments would be paid to proprietary agencies and that approximately two-thirds of outlier payments would be paid to HHAs located in Florida (27 percent), Texas (24 percent) and California (15 percent).

We conducted additional analyses on episodes in our simulations that would have resulted in outlier payments over $10,000. Of note, 95 percent of episodes that would have resulted in outlier payments over $10,000 were for patients with a primary diagnosis of diabetes or long-term use of insulin, most were concentrated in Florida, Texas, New York and California and Oklahoma, and on average, these outlier episodes had 160 skilled nursing visits in a 60-day episode of care.[7] Given that nearly half of all outlier cases in our simulation that would qualify for outlier payments have a primary diagnosis of diabetes and the OIG's assertion that there is a ''systemic weakness that results in Medicare coverage of unnecessary home health care for diabetic patients'' and investigations show that the majority of beneficiaries involved in fraudulent schemes have a primary diagnosis of diabetes, we believe that our current outlier payment methodology needs to be re-examined and potentially revised. With nearly 16 percent of episodes simulated to qualify for outlier payments having a primary diagnosis of ''Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled'' we believe that episodes that do not have unusual variations in the type or amount of medically necessary care are qualifying for outlier payments, potentially through suspect fraudulent billing practices, which is contrary to the intent of the policy. As we have noted in the past (74 FR 580085), we are committed to addressing potentially fraudulent activities, especially those in areas where we see suspicious outlier payments. As we noted above, we plan to examine potential revisions to the outlier payment methodology through a new contract awarded to Abt Associates to address these findings and also any findings from the home health study required by section 3131(d) of the Affordable Care Act.

G. Payment Reform: Home Health Study and Report

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.

[7] This analysis simulated payments using CY 2012 claims data and CY 2012 payment rates. The simulations did not take into account the 10-percent outlier cap. Some episodes may have qualified for outlier payments in the simulations, but were not paid accordingly if the HHA was at or over its 10 percent cap on outlier payments as a percent of total payments.

As we stated in the CY 2013 HH PPS proposed rule (77 FR 41572), we awarded an initial 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 subsequent 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 appropriate, develop recommendations for changes to the HH PPS. In 2012, L&M completed preliminary analyses on HHA costs associated with providing care for vulnerable patient populations. L&M presented their findings at a TEP meeting in December 2012 and received extensive feedback on our analyses. L&M refined their analytic approach based on feedback from the TEP meeting and is in the process of completing the refined analyses. In addition to examining the costs of providing care to vulnerable patient populations, survey data was collected and analyzed to assess whether the vulnerable patient populations experience access issues and identify potential factors that may prevent access to care. Since the CY 2014 HH PPS proposed rule, L&M presented the survey findings and the analyses of HHA costs to the technical expert panel during a webinar and received their feedback. The survey findings and the analyses of HHA costs are currently being reviewed and have not yet been finalized.

The findings from the 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, L&M 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.

The following is a summary of the comments we received regarding the Payment Reform: Home Health Study and Report.

Comment: One commenter stated that physical therapists and other home health clinicians should be active participants in the collection of analysis of data gathering in the study and that CMS should provide updates to the stakeholder community on the plan and design of the study.

Response: We are currently in the process of reviewing the study findings but thank the commenter for their interest in being part of the study. We plan to provide updates to the industry and stakeholder community once findings are finalized.

Comment: Several commenters encouraged CMS to review the study results and address any clear access or cost concerns identified in the study in the 2014 rule through the grouper, the case-mix weights, and/or the outlier calculations. Some commenters encouraged CMS to incorporate the findings from the VNAA Vulnerable Patient Study into the case-mix system for CY 2014. Multiple commenters stated that the findings of CMS' home health study and the VNAA Vulnerable Patient Study should be taken into account when finalizing the rebasing provisions.

Many commenters supported CMS' research on costs for vulnerable populations and stated that it is mainly the not-for-profit HHAs that treat the most vulnerable patients and that Medicare does not fully cover the cost of these patients. One commenter recommended that CMS expedite the study research and incorporate suitable adjustments to the HH PPS to ensure that beneficiaries with high levels of severity of illness or other vulnerable populations have appropriate access to home health services.

Response: In September 2013, we awarded a contract to perform follow-on work for the home health study. The new contract with Abt Associates will examine the findings of the home health study, monitor potential impacts of rebasing and other recent policy changes, and develop payment reform options to ensure access to care for vulnerable populations and address payment vulnerabilities in the current payment system. Given the statutory mandate that the rebasing adjustments must be implemented starting at the beginning of CY 2014, we are required to implement the reductions before the study findings will be finalized. However, we will continue to assess the case-mix system and improve the case-mix system as necessary.

Final Decision: We appreciate the comments on the home health study and will take the comments into consideration for the follow-on work under the new contract.

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 programs, we removed the proposed provision at § 431.610(g) in the CY 2013 HH PPS final rule (77 FR 67068). In the CY 2014 HH PPS proposed rule we again proposed to amend § 431.610(g) with additional explanation of our proposal and with updated cost information.

We noted 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 explained that the proposed amendment to § 431.610(g) would add clarity, and that the proposed rule would 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 invited public comment on our proposed methods to ensure compliance with these requirements. Specifically, we proposed 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 proposed to 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, we explained that 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 HHA 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 final rule (77 FR 67078). 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) will not recognize that both Medicare and Medicaid programs benefit from the regulations. Therefore, we expressed our belief 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 and NF. We invited 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 would be approximately $4.65 million on an annualized basis. The $4.65 million cost would be spread out over the 53 states/jurisdictions that currently conduct surveys under section 1864 of the Act. However, the 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).

We received a total of 7 pertinent comments from 5 organizations regarding the Cost Allocation of Survey Expenses proposal. The following is a summary of the comments we received.

Comment: Two organizations supported the proposed cost allocation and the proposed 50/50 split between Medicare and Medicaid for that proportion of the overall expense attributed to those programs. The commenters noted that the 50/50 split has been in long-standing use for the allocation of survey costs for skilled nursing facilities that are dually certified for Medicare and Medicaid.

Response: These comments reflect the allocation methodology proposed in the notice of proposed rule-making. We concur with the comments.

Comment: Another commenter agreed with the preamble statement that costs should be allocated in proportion to benefits received, but disputed that the costs should be split 50/50 between Medicare and Medicaid. The commenter expressed the belief that Medicaid receives less than 50 percent of the benefit on the grounds that (a) OASIS (Outcome and Assessment Information Set) drives much of S&C activity, and no State uses OASIS in rate setting; (b) Medicare requires that beneficiaries be homebound, in contrast to Medicaid home health policy mandates; (c) Medicare and its survey activities are focused on a medical model in contrast to Medicaid's focus on support for activities of daily living and heavy reliance on home health aides rather than skilled nurses; and (d) about 77 percent of the commenter's state Medicaid home health beneficiaries are under age 65, with children representing 34 percent of those beneficiaries receiving Medicaid home health services.

Response: We appreciate the distinctions between Medicare and Medicaid that the commenter makes, but do not agree that these distinctions are particularly relevant to the issue of survey expenses. Medicare and Medicaid pay for survey expenses to assess a provider's compliance with Conditions of Participation (CoPs). HHAs providing services under Medicaid's home health benefit must meet the CoPs for Medicare, as specified at § 440.70(d). As articulated in the State Operations Manual at 2202.3E, if home care is provided by an entity required to meet the Medicare CoPs for any reason, then the entity must apply all the requirements of the CoPs, including the comprehensive assessment and OASIS data reporting requirements, to all patients of the agency, including patients treated under a Medicaid waiver or state plan, as applicable, with certain minor exceptions.

In short, the CoPs expressed in 42 CFR part 484 benefit both Medicare and Medicaid patients. For example, the regulations begin with a focus on proper organization of the HHA and qualifications of personnel. The first full CoP delineates patient rights that apply equally to Medicare and Medicaid patients, such as informing patients of their rights in advance, the right to file

a grievance and to have a grievance investigated, the right to be informed and participate in planning care and treatment, the right to have medical records held confidentially, and the right to have his or her property treated with respect. An entire CoP (§ 484.36) is dedicated to home health aides, an area that the commenter observes is particularly important for Medicaid. Similarly, § 484.55 obliges HHAs to conduct a timely and comprehensive assessment of the care and support needs of each individual. This is a basic expectation regardless of whether it is viewed through the lens of a medical model or daily living and support model.

With regard to OASIS, some states do indeed use OASIS in their HHA rate-setting methodology, but such use is immaterial to the question at hand, since the survey process is concerned with application of the CoPs and quality of care, not enforcement of payment policy or the calculation of payment rates. Further, OASIS is an integral part of the comprehensive assessment process required at § 484.55. The comprehensive assessment regulation requires that HHAs use a standard core data set, that is, OASIS, when evaluating adult, non-maternity Medicare and Medicaid patients (except those receiving exclusively homemaker or chore services). OASIS data must be collected and reported for Medicaid as well as Medicare beneficiaries in accordance with § 484.20.

Because the focus of the survey process is on compliance with the CoPs, and the CoPs apply to all patients served by the HHA, it is largely immaterial whether the majority of the work for either Medicare or Medicaid is done by registered nurses or home health aides, whether a medical model or daily living and support model predominates, or whether the majority of the clientele is under or over the age of 65.

It is arguably the case that certain specific standards tend to apply to some groups more than to others. For example, § 484.55(c) requiring drug regimen review may most benefit those patients taking many medications, while § 484.34 governing medical social work may most benefit individuals who face challenging social and emotional factors related to health problems. However, the preponderance of standards benefits almost all patients regardless of payment source. This is particularly true of the most common area identified for deficiency citations by surveyors as a result of the onsite survey process. In FY 2012, for example, the most frequently-cited deficiencies were for failure to ensure that a written plan of care was established and periodically reviewed (8.6 percent of all agencies surveyed), the assessment included a review of all medications (6.1 percent), the plan of care covered applicable diagnoses and required services and visits (6.0 percent), a record of past and current findings was maintained (5.2 percent), and that care was provided in accordance with commonly-accepted professional standards (3.9 percent). Therefore, while there are differences between Medicare and Medicaid coverage, we do not agree that such differences materially affect the extent to which the CoPs benefit Medicare compared to Medicaid beneficiaries when the regulations are taken as a whole.

Comment: Another commenter stated that the proposed rule would result in a loss of federal funds for the state and comes at a very inconvenient time, since the state survey agency's state funding in the past 3 years has been level-funded in the state budget while the survey agency's responsibilities have grown, the Medicare portion of survey agency funding has been reduced considerably, and the proposed rule would require changes in the state accounting system, which would add costs that should be recognized by CMS.

Response: We very much appreciate the extraordinary fiscal constraints under which most states have recently labored. We also acknowledge that federal budget sequestration resulted in a decrease in federal funding for the Medicare portion of state survey agency responsibilities. Neither observation, however, directly affects the question of whether Medicare and Medicaid should both contribute to the cost of surveys, in accordance with the accounting principles articulated in OMB Circular A–87. We appreciate that there is some fiscal impact for states, but note that the Medicaid impact is mitigated by two major factors. First, Medicaid's share is treated as a Medicaid administrative cost, reimbursable at the professional staff rate of 75 percent. This means that the state Medicaid cost is limited to 25 percent of the Medicaid share. Second, we sought to provide states with considerable preparatory time. As discussed in the preamble, we first published a notice of proposed rule-making on this topic in 2012 (CY 2013 HH PPS proposed rule (77 FR 41548)), but postponed action on a final rule in order to provide more time for states. Further, in our latest proposal we delayed the proposed enforcement date until July 1, 2014 to offer even more preparatory time for states. In various national calls and meetings with state survey agencies over the past two years, we also communicated our intent to issue and finalize the proposal to ensure that Medicaid contributes its fair share of the cost of HHA surveys. The combined effect has been to provide states with almost 2 years advance notice of CMS enforcement. We believe that the FY 2013 reduction in Medicare funding for state survey work reinforces the need to ensure that all appropriate payment sources are contributing their fair share of survey expenses, rather than expecting Medicare to shoulder a disproportionate share.

We appreciate that some states may need to make minor accounting system changes and will work with such states to accomplish the changes expeditiously. We expect that arrangements for Medicaid fair share contributions to the cost of the HHA surveys can easily be built on the procedures and requirements that are already in place for states to receive Medicaid federal financial participation for certain existing activities, such as the cost of surveys in nursing facilities. States already track the survey hours and costs associated with home health surveys. The 50/50 methodology specified in this rule for allocating expenses between Medicare and Medicaid simplifies the cost accounting. Further, states are already required under § 431.610(h)(2) to remove from federal reimbursement claims the costs of surveying for HHA compliance with state-only laws and regulations. We therefore expect that there already exists the appropriate infrastructure for proper cost accounting, but that some states may need to establish additional, internal cost accounting codes. We plan to work with states to make any accounting system changes in state cost accounting systems that are necessary to ensure there are proper audit trails and data to support claims for federal reimbursement.

Comment: Another commenter observed that there was a number of different methods that CMS could use to arrive at an appropriate split between Medicare and Medicaid contributions, such as the proportion of aggregate Medicare or Medicaid spending to the combined total spending of the two programs. The commenter also stated that the volume of survey activity in a state should inform the cost-share assigned to a state.

Response: We discussed the aggregate spending method in our notice of proposed rule-making, and explained that we were proposing the 50/50 split as an administratively simpler and appropriate alternative that has been in long-standing use with respect to

surveys of SNF and NF. The commenter did not recommend the aggregate method, nor did any other commenter, but simply expressed the aggregate method as an acceptable alternative. We are therefore retaining the proposed 50/50 cost-allocation methodology. With regard to the comment that survey activity in a state should inform the cost-share assigned to a state, our methodology would incorporate that principle. The amount of Medicaid funding for HHA surveys in each state would be based on 50 percent of the total cost of surveys in the particular state in question that is attributable to the Medicare and Medicaid share of total cost (exclusive of any state-only cost attributable to state licensure requirements).

Response Based on No Comments: CMS received no comments on whether the method of distribution for CMP receipts back to the states and to the U.S. Treasury should be changed to the same
50/50 methodology. If CMS does propose a change in the CMP receipt distribution methodology, we will propose the change in the CY 2015 HH PPS proposed rule.

Final Decision: After careful consideration of the comments, we conclude that it is appropriate and warranted to publish in this final rule the regulatory changes we proposed to ensure that state Medicaid programs include explicit provision to contribute to the cost of HHA surveys in accordance with OMB Circular A–87, with the costs that are attributable to Medicare and Medicaid shared on a 50/50 basis between the two programs.

V. 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.

In the July 3, 2013, proposed rule we solicited public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs). A summary of the public comments we received, and our responses, can be found in sections IV.E.2 and IV.H of this preamble. This final rule does not revise any of the proposed rule's PRA-related requirements or burden estimates, except to clarify that existing state plan provisions already address Medicaid coverage for state survey costs and states will not have the burden of submitting a State Plan Amendment (SPA) when they ensure that Medicaid contributes its fair share to the cost of HHA surveys (described below in V.B).

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 IV.E.2.a, this 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. Cost Allocation of Home Health Agency (HHA) Survey Expenses (§ 431.610)

In § 431.610(g), HHAs have been added to the survey agency provision concerning state Medicaid programs. Since CMS already requires that state survey agencies 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 (*see* section IV.H, Cost Allocation of Survey Expenses, of this final rule) and in the CY 2014 HH PPS proposed rule (78 FR 40302), we also expect that state Medicaid programs will provide for the appropriate Medicaid share of expenses for the conduct of HHA surveys. This is a budgeting and accounting task. Since state Medicaid plans already provide for the necessary relations with state survey agencies, we do not believe it will be necessary for states to submit a state plan amendment. We believe the responsibilities for Medicaid home health survey costs may be met through appropriate budgeting and accounting adjustments within the context of each state's current Medicaid plan. This rule will not revise any budget-related recordkeeping or reporting requirements or estimates for state Medicaid agencies 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

In the proposed rule, CMS proposed to add the OMB number to the HHCAHPS Participation Exemption Request Form. CMS did not receive any comments about the proposed change, and CMS is moving forward with adding the OMB number to the Participation Exemption Request Form. This is discussed in the preamble in the section about the Home Health CAHPS (HHCAHPS) survey in the Quality Reporting Requirement section at IV.E.2.e. 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.* 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. While the HHCAHPS® Participation Exemption Request Form is in use without an OMB control number, we are revising OCN 0938–1066 by adding the form and our estimated burden to that the control number.

The HHCAHPS® PER Form for the CY 2015 Annual Payment Update is a one-page form. We estimate that it will 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 will take an additional 20 minutes to count the patients and to verify the count. The annualized aggregated total burden to completion of the form is 1,170 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 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 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 information collection requirements. If you comment on these information collection and recordkeeping requirements, please submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–1450–F) Fax: (202) 395–6974; or Email: *OIRA_submission@omb.eop.gov*.

PRA-specific comments must be received on/by January 2, 2014.

VI. Waiver of Delay in Effective Date

In the absence of an appropriation for FY 2014 or a Continuing Resolution, the federal government shut down on October 1, 2013. During the funding lapse, which lasted from October 1, 2013 through October 16, 2013, only excepted operations continued, which largely excluded work on this final rule. Accordingly, most of the work on this final rule was not completed in accordance with our usual schedule for final calendar-year-based payment rules, which aims for an issuance date of November 1 followed by an effective date of January 1 to ensure that the policies are effective at the start of the calendar year to which they apply. We ordinarily provide a 60-day delay in the effective date of final rules after the date they are issued. The 60-day delay in effective date can be waived, however, if the agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued. We believe it would be contrary to the public interest to delay the effective date of the HH PPS, HH PPS Grouper refinements, rebasing, and quality reporting portions of this final rule. The HH PPS is a calendar-year payment system, and we typically issue the final rule by November 1 of each year to ensure that the payment policies for the system, associated HH PPS Grouper, and quality reporting requirements are effective on January 1, the first day of the calendar year to which the policies are intended to apply. Likewise, the HH PPS rebasing is required by section 3131(a) of the Affordable Care Act to be effective for the entirety of calendar year 2014. If the effective date of this final rule were to be delayed by 60 days, the policies adopted in this final rule would not be effective until January 21, 2014. This would be contrary to the public's interest in ensuring that home health agencies and state survey agencies receive appropriate payments in a timely manner. For these reasons we find that the delayed effective date is both impracticable and contrary to the public interest, and we are waiving such delay in the effective date of this final rule.

VII. 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 final rule has been designated as economically significant, under section 3(f)(1) of Executive Order 12866, and thus is a major rule under the Congressional Review Act. 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) as of the date of enactment (2010) 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 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 $200 million in decreased payments to HHAs in CY 2014. The impact of the 2014 wage index would be a decrease of $50 million. However, we applied a standardization factor to the rates as discussed earlier. Therefore, the net effect of the 2014 wage index is zero dollars. The −$200 million impact reflects the distributional effects of the 2.3 percent HH payment update percentage ($440 million increase), the effects of the rebasing adjustments to the national, standardized 60-day episode payment amount, the national per-visit payment rates, and the NRS conversion factor for an impact of −2.73 percent ($520 million decrease), and the effects of the ICD–9–CM HH PPS Grouper refinements of −0.62 percent ($120 million decrease). The $200 million in decreased payments is reflected in the last column of the first row in Table 33 as a 1.05 percent decrease in expenditures when comparing CY 2013 payments to estimated CY 2014 payments.

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 economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. As we discussed in the preamble of this final rule in response to comments (section IV.D), the majority of HHAs' visits are Medicare-paid visits and therefore the majority of HHAs' revenue consists of Medicare payments. Based on our analysis, we conclude that the policies finalized in this rule will not result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of HHAs. Therefore, the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities. Further detail is presented in Table 33 below, by HHA type and area.

Executive Order 13563 specifies, to the extent practicable, agencies should assess the costs of cumulative regulations. However, given potential utilization pattern changes, wage index changes, changes to the market basket forecasts, and unknowns regarding future policy changes, we believe it is neither practicable nor appropriate to forecast the cumulative impact of the rebasing adjustments on Medicare payments to HHAs for future years at this time. 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 would make it difficult to predict accurately the full scope of the impact upon HHAs for future years beyond CY 2014. We note that the rebasing adjustments to the national, standardized 60-day episode payment rate and the national per-visit rates are capped at the statutory limit of 3.5 percent of the CY 2010 amounts (as described in the preamble in section IV.D) for each year, 2014 through 2017. The NRS rebasing adjustment will be −2.82 percent in each year, 2014 through 2017. As described in section IV.D of the preamble, the −2.82 percent rebasing adjustment will not exceed the statutory limit in CY 2014 and there is a very low likelihood that future adjustments of −2.82 percent in CY 2015 through 2017 would exceed the statutory limit.

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 604 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 final rule applies to HHAs. Therefore, the Secretary has determined that this rule will 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 final 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 in CY 2014.

D. Detailed Economic Analysis

This final rule sets forth updates to the HH PPS rates contained in the CY 2013 HH PPS final rule. The impact analysis of this rule presents the estimated expenditure effects of policy changes 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 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 33 represents how HHA Medicare revenues are likely to be affected by the policy changes in this rule. For this analysis, we used linked CY 2012 HH claims and OASIS assessments; the claims are for dates of service that ended in CY 2012. The first column of Table 33 classifies HHAs according to a number of characteristics including provider type, geographic region, and urban and rural locations. The second column shows the payment effects of the wage index. The third column shows the effects of the standardization factor. The forth column shows the effects of the ICD–9–CM Grouper scoring changes. The fifth column displays 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 as well as the effects of the LUPA add-on factors. The sixth column shows the effects of the market basket increase. The seventh column shows the payment effects of all the finalized policies.

Overall, HHAs are anticipated to experience a 1.05 percent decrease in payment in CY 2014, with freestanding HHAs anticipated to experience a 1.10 percent decrease in payments while facility-based HHAs and non-profit HHAs are anticipated to experience a 0.58 percent and a 0.49 percent decrease in payments, respectively. Government-owned HHAs are anticipated to experience a 0.92 percent decrease in payments and proprietary HHAs are anticipated to experience a 1.27 percent decrease in payments. Rural HHAs are anticipated to experience a decrease in estimated payments ranging from 0.45 percent for facility-based non-profit HHAs to 1.08 for freestanding government-owned HHAs. Urban HHAs are anticipated to experience a decrease in estimated payments, ranging from 0.47 percent for freestanding non-profit HHAs to 1.29 percent for freestanding proprietary HHAs. The overall impact in the South is estimated to be a 1.56 percent decrease in payments whereas the overall impact to the ''Other'' category (for example, Puerto Rico, Guam, U.S. Virgin Islands), is estimated at 0.14 percent increase in payments. The Pacific census region is estimated to receive a 0.34 percent increase in payments for CY 2014; however, in contrast, the West South Central census region is estimated to receive a 1.74 percent decrease in payments for CY 2014. Finally, HHAs with less than 100 first episodes are anticipated to experience a 1.27 percent decrease in payments compared to a 0.90 percent decrease in payments in CY 2014 for HHAs with 1,000 or more first episodes. A substantial amount of the variation in the estimated impacts of the proposals in this final rule in different areas of the country can be attributed to variations in the CY 2014 wage index used to adjust payments under the HH PPS. Instances where the impact, due to the rebasing adjustments, is less than others can be attributed to differences in the incidence of outlier payments and LUPA episodes, which are paid using the national per-visit payment rates that are subject to payment increases due to the rebasing adjustments. We note that some individual HHAs within the same group may experience different impacts on payments than others due to the distributional impact of the CY 2014 wage index, the extent to which HHAs utilized the 170 ICD–9–CM codes that will be removed from scoring points in the HH PPS Grouper as of January 1, 2014, and the degree of Medicare utilization.

TABLE 33—HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY

	Number of agencies	CY 2014 Wage index (%)	Standardization (%)	ICD–9–CM Grouper scoring changes (%)	Rebasing [1] (%)	CY 2014 HH Payment update percentage (%)	Impact of all CY 2014 policies (%)
All Agencies	11,620	−0.25	0.25	−0.62	−2.73	2.30	−1.05
Facility Type and Control							
Free-Standing/Other Vol/NP	1,057	0.10	0.22	−0.40	−2.71	2.30	−0.49
Free-Standing/Other Proprietary	8,967	−0.37	0.25	−0.71	−2.74	2.30	−1.27
Free-Standing/Other Government	421	−0.24	0.25	−0.50	−2.73	2.30	−0.92
Facility-Based Vol/NP	813	0.01	0.24	−0.33	−2.72	2.30	−0.50
Facility-Based Proprietary	117	−0.17	0.25	−0.52	−2.77	2.30	−0.91
Facility-Based Government	245	−0.34	0.25	−0.39	−2.75	2.30	−0.93
Subtotal: Freestanding	10,445	−0.27	0.25	−0.65	−2.73	2.30	−1.10
Subtotal: Facility-based	1,175	−0.04	0.24	−0.35	−2.73	2.30	−0.58
Subtotal: Vol/NP	1,870	0.07	0.23	−0.38	−2.71	2.30	−0.49
Subtotal: Proprietary	9,084	−0.37	0.25	−0.71	−2.74	2.30	−1.27

TABLE 33—HOME HEALTH AGENCY POLICY IMPACTS FOR CY 2014, BY FACILITY TYPE AND AREA OF THE COUNTRY—Continued

	Number of agencies	CY 2014 Wage index (%)	Standardization (%)	ICD–9–CM Grouper scoring changes (%)	Rebasing [1] (%)	CY 2014 HH Payment update percentage (%)	Impact of all CY 2014 policies (%)
Subtotal: Government	666	−0.28	0.25	−0.45	−2.74	2.30	−-0.92
Facility Type and Control: Rural							
Free-Standing/Other Vol/NP	205	−0.01	0.25	−0.31	−2.75	2.30	−0.52
Free-Standing/Other Proprietary	142	−0.12	0.25	−0.43	−2.77	2.30	−0.77
Free-Standing/Other Government	468	−0.29	0.26	−0.58	−2.77	2.30	−1.08
Facility-Based Vol/NP	262	0.10	0.24	−0.34	−2.75	2.30	−0.45
Facility-Based Proprietary	35	0.18	0.24	−0.53	−2.77	2.30	−0.58
Facility-Based Government	153	−0.21	0.26	−0.34	−2.77	2.30	−0.76
Facility Type and Control: Urban							
Free-Standing/Other Vol/NP	915	0.11	0.22	−0.40	−2.70	2.30	−0.47
Free-Standing/Other Proprietary	8,652	−0.38	0.25	−0.72	−2.74	2.30	−1.29
Free-Standing/Other Government	170	−0.32	0.26	−0.54	−2.74	2.30	−1.04
Facility-Based Vol/NP	551	−0.01	0.24	−0.33	−2.72	2.30	−0.52
Facility-Based Proprietary	82	−0.25	0.26	−0.51	−2.77	2.30	−0.97
Facility-Based Government	92	−0.40	0.25	−0.42	−2.73	2.30	−1.00
Facility Location: Urban or Rural							
Rural	1,158	−0.11	0.25	−0.46	−2.76	2.30	−0.78
Urban	10,462	−0.26	0.25	−0.62	−2.73	2.30	−1.06
Facility Location: Region of the Country							
North	874	0.47	0.20	−0.36	−2.70	2.30	−0.09
Midwest	3,107	−0.52	0.25	−0.53	−2.76	2.30	−1.26
South	5,727	−0.61	0.26	−0.77	−2.74	2.30	−1.56
West	1,862	0.62	0.23	−0.46	−2.69	2.30	0.00
Other	50	0.64	0.23	−0.22	−2.81	2.30	0.14
Facility Location: Region of the Country (Census Region)							
New England	334	0.12	0.23	−0.41	−2.72	2.30	−0.48
Mid Atlantic	540	0.68	0.18	−0.33	−2.69	2.30	0.14
East North Central	2,343	−0.54	0.25	−0.56	−2.76	2.30	−1.31
West North Central	764	−0.44	0.25	−0.43	−2.75	2.30	−1.07
South Atlantic	2,122	−0.71	0.27	−0.63	−2.73	2.30	−1.50
East South Central	440	−0.41	0.26	−0.57	−2.78	2.30	−1.20
West South Central	3,165	−0.58	0.26	−0.99	−2.73	2.30	−1.74
Mountain	672	−0.30	0.26	−0.45	−2.71	2.30	−0.90
Pacific	1,190	0.98	0.21	−0.47	−2.68	2.30	0.34
Facility Size (Number of 1st Episodes)							
<100 episodes	2,881	−0.33	0.25	−0.72	−2.77	2.30	−1.27
100 to 249	2,617	−0.41	0.26	−0.78	−2.75	2.30	−1.38
250 to 499	2,577	−0.42	0.26	−0.77	−2.74	2.30	−1.37
500 to 999	1,878	−0.28	0.25	−0.65	−2.73	2.30	−1.11
1,000 or More	1,667	−0.18	0.24	−0.54	−2.72	2.30	−0.90

Source: CY 2012 Medicare claims data for episodes ending on or before December 31, 2012 (as of June 2013) for which we had a linked OASIS assessment.

[1] The impact of rebasing includes the rebasing adjustments to the national, standardized 60-day episode payment rate (−2.81 percent), the national per-visit rates (+3.45 percent), and the NRS conversion factor (−2.82%). It also includes the impact of the LUPA add-on factors. The estimated impact of the NRS conversion factor rebasing adjustment is an overall −0.05 percent decrease in estimated payments to HHAs. The estimated impact of the LUPA add-on factors is an overall 0.01 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 the proposed rule (78 FR 40307), we noted that additional factors were considered, but not incorporated into the methodology for calculating the rebasing adjustments. One such factor was 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. More information on the analysis of the audit results can be found in the report titled: ''Analyses in Support of Rebasing & Updating the Medicare Home Health Payment Rates—CY 2014 Home Health Prospective Payment System Proposed Rule'' 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*. 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. 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 did not incorporate any of the options discussed above as those changes would not impact the final rebasing adjustments to the national, standardized 60-day episode payment rate or national per-visit payment rates as those adjustments are at the statutory limit (no more than 3.5 percent of the CY 2010 payment rates). We note that if we implemented the rebasing adjustments using the methodology described in the CY 2014 HH PPS proposed rule, the effects from the rebasing adjustments would have been a 3.4 percent reduction in payments to HHAs in CY 2014 compared to CY 2013 rather than a 2.7 percent reduction described above. We estimate that a 2.7 percent reduction versus a 3.4 percent reduction in payments results in an increase in payments to HHAs of $140 million for CY 2014 and $1.1 billion through 2017.

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 to date 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.

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 will be assigned 50 percent to Medicare and 50 percent to Medicaid for each state, the anticipated aggregate Medicaid share would amount to $18.6 million, if implemented at the beginning of FY2014. However, the enforcement date of July FY 2014 will 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. Therefore, the states' portion of the Medicaid HH survey costs incurred in FY 2014, with an adherence date of July FY 2014, will 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. Furthermore, the Federal Medicaid share will reflect the remaining $3.49 million, with an adherence date of July FY 2014. 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 Program.

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 34 and 35, we have prepared an accounting statement showing the classification of the transfers associated with the provisions of this final rule. Table 34 provides our best estimate of the decrease in Medicare payments under the HH PPS as a result of the changes presented in this final rule.

TABLE 34—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE CY 2013 HH PPS TO THE CY 2014 HH PPS

Category	Transfers
Annualized Monetized Transfers	−$200 million

TABLE 34—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED TRANSFERS, FROM THE CY 2013 HH PPS TO THE CY 2014 HH PPS—Continued

Category	Transfers
From Whom to Whom?	Federal Government to HH providers

Table 35 provides our best estimate of the changes in the classification of the cost allocation of survey expenses.

TABLE 35—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	$3.49 Million*
From Whom to Whom?	Federal Government (Medicaid) to Federal Government (Medicare)
State Medicaid HH Survey & Certification Costs	
Annualized Monetized Transfers	$1.16 Million*
From Whom to Whom?	State Governments (Medicaid) to Federal Government (Medicare)

*HH survey and certification costs reflect an adherence date of July FY 2014.

H. Conclusion

In conclusion, we estimate that the net impact of this rule is approximately $200 million in CY 2014 savings. The −$200 million reflects the distributional effects of an updated wage index ($50 million decrease), a standardization factor to ensure budget neutrality in episode payments using the 2014 wage index ($50 million increase), the 2.3 percent HH payment update percentage ($440 million increase), the rebasing adjustments required by section 3131(a) of the Affordable Care Act of −2.73 percent ($520 million decrease), and the ICD–9–CM HH PPS Grouper refinements of −0.62 percent ($120 million decrease).

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. We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it will not have substantial direct effects on the rights, roles, and responsibilities of states, local or tribal governments.

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 amends 42 CFR part 431 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: November 12, 2013.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: November 18, 2013.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

[FR Doc. 2013–28457 Filed 11–22–13; 4:15 pm]

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