II. Provisions of Proposed Rule

In the proposed rule that was published on October 28, 1999 (64 FR 54134), we proposed a number of revisions to the regulations in order to implement the prospective payment system, the HHA consolidated billing provision, and conforming statutory changes. We proposed to make conforming changes in 42 CFR parts 409, 424, and 484 to synchronize all timeframes for the plan of care certification, OASIS Recertification (follow-up) assessment, and episode payments to reflect a 60-day period. In addition, we proposed to add a new subpart in part 484 to set forth our new payment system for HHAs. These revisions and others are discussed in detail below.

First, we proposed to revise part 409, subpart E, and discussed the requirements that must be met for Medicare to make payment for home health services. We proposed to make a conforming change in §409.43 regarding the plan of care requirements. Specifically, we proposed to revise the frequency for review in paragraph (e) of this section by replacing the phrase "62 days" with "60 days unless there is--

- an intervening beneficiary elected transfer;
- a significant change in condition resulting in a new case-mix assignment; or
- a discharge and return to the same HHA during the 60-

day episode that warrants a new 60-day episode payment and a new physician certification of the new plan of care.

In addition, we proposed to revise subpart H of this part regarding payments of hospital insurance benefits. We proposed to revise paragraph (a) in §409.100, which discusses payment for services, to specify the conditions under which Medicare may pay hospital insurance benefits for home health services. We proposed to provide introductory text to paragraph (a) and to redesignate the current paragraph (a) as paragraph (a)(1). Proposed paragraph (a)(2) of this section would require that Medicare may pay hospital insurance benefits for the home health services specified at section 1861(m) of the Act, when furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA, to the HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

We proposed to make similar changes in part 410, subpart I, which deals with payment of benefits under Part B. We proposed to add a new paragraph (b)(19) to §410.150 to specify the conditions under which Medicare Part B pays for home health services. Specifically, proposed paragraph (b)(19)

specified that Medicare Part B pay a participating HHA, for home health services furnished to an individual who at the time the item or service is furnished is under a plan of care of an HHA (without regard to whether the item or service is furnished by the HHA directly, under arrangement with the HHA, or under any other contracting or consulting arrangement).

We also proposed to revise part 411 subpart A, which discusses excluded services. We proposed to add a new paragraph (q) to §411.15 to specify the conditions under which HHA services are excluded from coverage. Proposed paragraph (q) specified that a home health service as defined in section 1861(m) of the Act furnished to an individual who is under a plan of care of an HHA is excluded from coverage unless that HHA has submitted a claim for payment for such services.

We also proposed to simplify the authority citation for part 413. In §413.1 in the introduction to the section on principles of reasonable cost reimbursement, we proposed to add a new paragraph (h) to include the timeframe under which home health services will be paid prospectively. Paragraph (h) under this section specified that the amount paid for home health services as defined in section 1861(m) of the Act that are furnished beginning on or after October 1, 2000 to an eligible beneficiary under a home health plan of care is

determined according to the prospectively determined payment rates for HHAs set forth in part 484, subpart E of this chapter. In addition, we proposed to amend §413.64 concerning payments to providers. Specifically, we proposed to amend paragraph (h)(1) of this section by removing Part A and Part B HHA services from the periodic interim payment method.

We also proposed to revise part 424, which explains the conditions for Medicare payment. We proposed to revise §424.22 regarding the certification requirements as a condition for payment. We proposed to add a new paragraph (a)(1)(v) that would specify that as a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify that the individual is correctly assigned to one of the HHRGs. We proposed to make a conforming change at paragraph (b)(1) of this section regarding the timing of the recertification. Specifically, we proposed to amend §424.22(b) by replacing the phrase "at least every 2 months" with "at least every 60 days," and adding the following sentence: "Recertification is required at least every 60 days preferably unless there is a beneficiary elected transfer, a significant change in condition resulting in a new case-mix assignment, or a discharge and return to the same HHA during the 60-day episode that warrants a new 60-day episode

payment and a new physician certification of the new plan of care."

We proposed to add a new statutory authority, section 1895 of the Act, to paragraph(a) of §484.200, "Basis and scope." Section 1895(a) provides for the implementation of a prospective payment system for HHAs for portions of cost-reporting periods occurring on or after October 1, 2000.

We proposed to revise the regulations in 42 CFR part 484, which set forth the conditions that an HHA must meet in order to participate in Medicare. First, we proposed to revise the part heading from "Conditions Of Participation: Home Health Agencies" to the more generic heading "Home Health Services." We proposed to make a conforming change in §484.18(b) by replacing the phrase "62 days" with "60 days" unless there is--

- a beneficiary elected transfer;
- a significant change in condition resulting in a change in the case-mix assignment; or
- a discharge and return to the same HHA during the 60-day episode.

Also, we proposed to revise §484.55(d)(1) by replacing "every second calendar month" with language that reflects the 60-day episode and possible PEP Adjustment or SCIC Adjustment. We proposed to require that the

comprehensive assessment be updated and revised as frequently as the patient's condition warrants but not less frequently than every 60 days beginning with the start-of-care date unless there is--

- a beneficiary elected transfer;
- a significant change in condition resulting in a change in the case-mix assignment; or
- a discharge and return to the same HHA during the 60-day episode.

In addition, we proposed to add and reserve a new subpart D, then add a new subpart E, "Prospective Payment System for Home Health Agencies." This proposed subpart sets forth the regulatory framework of the new prospective payment system. It specifically discussed the development of the payment rates, associated adjustments, and related rules. In §484.202, "Definitions," we proposed the following definitions for purposes of this new subpart:

As used in this subpart--

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the clinical model.

Clinical model means a system for classifying Medicare-eligible patients under a home health plan of care into

mutually exclusive groups based on clinical, functional, and intensity-of-service criteria. The mutually exclusive groups are defined as Home Health Resource Groups (HHRGs).

Discipline means one of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

In proposed §484.205 "Basis of payment," we discussed the Medicare payment to providers of services. Proposed §484.205(a) described the method by which the provider would receive payment. Specifically, §484.205(a)(1) provided that an HHA receives a national 60-day episode payment of a predetermined rate for a home health service paid on a reasonable cost basis. We determine this national 60-day episode payment under the methodology set forth in §484.215. Paragraph (a)(2) specified that an HHA may receive a low-utilization payment adjustment (LUPA) of a predetermined per-visit rate. We proposed to determine the LUPA under the methodology set forth in § 484.230. Paragraph (a)(3) of this

section provided that an HHA may receive a partial episode payment (PEP) adjustment due to an intervening event during an existing 60-day episode that initiates the start of a new 60-day episode payment and a new patient plan of care. We proposed to determine the PEP Adjustment under the methodology set forth in §484.235. Paragraph (a)(4) of this section specified that a HHA may receive a significant change in condition (SCIC) Adjustment due to the intervening event defined as a significant change in the patient's condition during an existing 60-day episode. We proposed to determine the SCIC adjustment under a methodology set forth in 484.237.

Proposed paragraph (b) discussed the 60-day episode payment and circumstances surrounding adjustments to the payment method. This paragraph proposed that the national 60-day episode payment represents payment in full for all costs associated with furnishing a home health service paid on a reasonable cost basis as of August 5, 1997 (the date of the enactment of the BBA) unless the national 60-day episode payment is subject to a low-utilization payment adjustment as set forth in §484.230, a partial episode payment adjustment as set forth in §484.235, a significant change in condition payment adjustment as set forth in 484.237, or an additional outlier payment as set forth in §484.240. All payments under

this system may be subject to a medical review adjustment. We noted that DME provided as a home health service as defined in section 1861(m) of the Act would continue to be paid the fee schedule amount.

In paragraph (c) of this section, we proposed the low-utilization payment adjustment to the 60-day episode payment. We would require that an HHA receive a national 60-day episode payment of a predetermined rate for home health services paid on a reasonable cost basis as of August 5, 1997, unless we determine at the end of the 60-day episode that the HHA furnished minimal services to a patient during the 60-day episode. The low-utilization payment adjustment would be determined under the methodology set forth in §484.230.

In paragraph (d), we discussed the partial episode payment adjustment. We describe that an HHA receives a national payment of a predetermined rate for home health services paid on a reasonable cost basis as of August 5, 1997, unless there is an intervening event that warrants the initiation of a new 60-day episode payment and a new physician certification of the new plan of care. The initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care. A partial episode payment adjustment would be determined under the

methodology set forth in §484.235.

In paragraph (e), we discussed the significant change in condition adjustment. We discussed that the HHA receives a national 60-day episode payment of a pre-determined rate for home health services paid on a reasonable cost basis as of August 5, 1997, unless HCFA determines an intervening event defined as a beneficiary experiencing a significant change in condition during a 60-day episode that was not envisioned in the original plan of care. In order to receive a new case-mix assignment for purposes of payment during the 60-day episode, the HHA must complete an OASIS assessment and obtain the necessary physician change orders reflecting the significant change in the treatment approach in the patient's plan of care. The significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both before and after the patient experienced a significant change in condition during the 60-day episode.

In paragraph (f), we discussed how we treat payment for outliers. In this paragraph we would provide that an HHA receives a national 60-day episode payment of a predetermined rate for home health services paid on a reasonable-cost basis as of August 5, 1997, unless the estimated cost of the 60-day episode exceeds a threshold amount. The outlier payment is

defined to be a proportion of the estimated costs beyond the threshold. An outlier payment is a payment in addition to the national 60-day episode payment. The total of all outlier payments is limited to 5 percent of total outlays under the HHA PPS. An outlier payment would be determined under the methodology set forth in §484.240.

In proposed §484.210, we specified the data used for the calculation of the national prospective 60-day episode payment. These data include the following:

- Medicare cost data on the most recent audited cost report data available.
- Utilization data based on Medicare claims.
- An appropriate wage index to adjust for area wage differences.
- The most recent projections of increases in costs from the HHA market basket index.
- OASIS assessment data and other data that account for the relative resource utilization for different HHA Medicare patient case-mix.

Proposed §484.215, paragraphs (a) through (e) specified the methodology used for the calculation of the national 60-day episode payment. Proposed paragraph (a) specified that in calculating the initial unadjusted national 60-day episode

payment applicable for a service furnished by an HHA using data on the most recent available audited cost reports, we determined each HHA's costs by summing its allowable costs for the period. We then determined the national mean cost per visit.

Proposed paragraph (b) of this section specified that in calculating the initial unadjusted national 60-day episode payment, we determined the national mean utilization for each of the six disciplines using home health claims data.

Proposed paragraph (c) of this section specified that we used the HHA market basket index to adjust the HHA cost data to reflect cost increases occurring between October 1, 1996 through September 30, 2001. For each fiscal year from 2002 or 2003, we would update the cost data by a factor equivalent to the annual market basket index percentage minus 1.1 percentage points.

Proposed paragraph (d) regarding standardization of the data for variation in area wage levels and case-mix specified that we would standardize the cost data described in paragraph (a) of this section to remove the effects of geographic variation in wage levels and variation in case- mix. We would then standardize the cost data for geographic variation in wage levels using the hospital wage index. We standardized

the cost data for HHA variation in case-mix using the case-mix indices and other data that indicate HHA case-mix.

Proposed paragraph (e) of this section described how we calculated the unadjusted national average prospective payment amount for the 60-day episode. Specifically, we calculated this payment amount by--

- Computing the mean standardized national cost per visit;
- Computing the national mean utilization for each discipline; then
- Multiplying the mean standardized national cost per visit by the national mean utilization summed in the aggregate for each discipline.

Proposed §484.220 described how we calculated the national adjusted prospective 60-day episode payment rate for case-mix and area wage levels. This section specified that we adjusted the national prospective 60-day episode payment rate to account for HHA case-mix using a case-mix index to explain the relative resource utilization of different patients. We also adjusted the national prospective 60-day episode payment rate to account for geographic differences in wage levels using an appropriate wage index.

In proposed §484.225, we explained our methods for

annually updating the national adjusted prospective payment rates for inflation. We proposed to handle it in the following manner:

- We update the unadjusted national 60-day episode payment rate on a fiscal year basis.
- For FY 2001, the unadjusted national 60-day episode payment rate is adjusted using the latest available market basket factors.
- For fiscal year 2002 or 2003, the unadjusted national 60-day episode payment rate is equal to the rate for the previous period or fiscal year increased by a factor equal to the HHA market basket minus 1.1 percentage point.
- For any subsequent fiscal years, the unadjusted national rate is equal to the rate for the previous fiscal year increased by the applicable HHA market basket index amount.

In proposed §484.230, we explained the methodology we use for the calculation of the low-utilization payment adjustment. In this section, we specified that in calculating the low-utilization payment adjustment, an episode with four or fewer visits is paid the national average standardized per-visit amount by discipline for each visit type. We also specified that the national average standardized per-visit amount is

determined by using cost data set forth in §484.210(a) and adjusting by the appropriate wage index.

Proposed §484.235 illustrated the methodology we used to calculate the partial episode payment adjustment. The intervening event of either a beneficiary elected transfer or discharge and return to the same HHA during the 60-day episode warrants a new 60-day episode payment and a new physician certification of a new plan of care. The original 60-day episode payment is adjusted with a partial episode payment that reflects the length of time the beneficiary remained under the care of the original HHA. The partial episode payment is calculated using the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

Proposed 484.237 illustrated the methodology we used to calculate the significant change in condition payment adjustment. The intervening event, here, a beneficiary experiencing a significant change in condition during a 60-day episode that was not envisioned in the original plan of care, initiates the significant change in condition payment adjustment. The significant change in condition is calculated in two parts. The first part of the SCIC adjustment reflects the adjustment to the level of payment prior to the

significant change in the patient's condition during the 60-day episode. The second part of the SCIC adjustment reflects the adjustment to the level of payment after the significant change in the patient's condition occurs during the 60-day episode. The first part of the SCIC adjustment is determined by taking the span of days prior to the patient's significant change in condition as a proportion of 60 multiplied by the original episode amount. The original episode payment level is proportionally adjusted using the span of time the patient was under the care of the HHA prior to the significant change in condition that warranted an OASIS assessment, physician change orders indicating the need for the a significant change in the course of the treatment plan, and the new case-mix assignment for payment at the end of the 60-day episode. The second part of the SCIC adjustment is a proportional payment adjustment reflecting the time the patient will be under the care of the HHA after the significant change in condition and continuing until the end of the 60-day episode. The second part of the SCIC adjustment is determined by taking the span of days (first billable visit date through the last billable visit date) after the patient experiences the significant change in condition through the balance of the 60-day episode as a proportion of 60 multiplied by the new episode payment level

resulting from the significant change. The initial percentage payment provided at the start of the 60-day episode will be adjusted at the end of the episode to reflect the first and second part of the SCIC adjustment.

Proposed §484.240 described the methodology we used to calculate the outlier payment. The methodology for the calculation of the outlier payment would involve the following:

! We make an outlier payment for an episode whose estimated cost exceeds a threshold amount for each case-mix group.

! The outlier threshold for each case-mix group is the episode payment amount for that group plus a fixed dollar loss amount that is the same for all case-mix groups.

! The outlier payment is a proportion of the amount of estimated cost beyond the threshold.

! We estimate the cost for each episode by applying the standard per-visit amount to the number of visits by discipline reported on claims.

! The fixed dollar loss amount and the loss-sharing proportion are chosen so that the estimated total outlier payment is no more than 5 percent of total episode payment.

Proposed §484.250 related to data that must be submitted

for the development of a reliable case-mix. Specifically, we would require an HHA to submit the OASIS data described at the current §484.55(b)(1) and (d)(1) (that we proposed to revise in the proposed rule) to administer the payment rate methodologies described in §484.215 (methodology used for the calculation of the national 60-day episode payment), §484.230 (methodology used for the calculation of the LUPA) and 484.237 (methodology used for the calculation of the SCIC adjustment).

Proposed §484.260 discussed the limitation for review with regard to our new payment system. In this section, we specified that judicial or administrative review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of a payment unit including the national 60-day episode payment rate and the LUPA. This prohibition includes the establishment of the transition period, definition and application of the unit of payments, the computation of initial standard prospective payment amounts, the establishment of the adjustment for outliers, and the establishment of case-mix and area wage adjustment factors.