

**§ 484.210**

when a beneficiary reached the goals in the original plan of care. The original plan of care must have been terminated with no anticipated need for additional home health services for the balance of the 60-day episode. If the intervening event warrants a new 60-day episode payment and the new physician certification of a new plan of care, the initial HHA receives a partial episode payment adjustment reflecting the length of time the patient remained under its care. A partial episode payment adjustment is determined in accordance with § 484.235.

(e) *Significant change in condition adjustment.* The 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 CMS 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 occurred. 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 total significant change in condition payment adjustment is a proportional payment adjustment reflecting the time both prior and after the patient experienced a significant change in condition during the 60-day episode. A SCIC adjustment is determined in accordance with § 484.237.

(f) *Outlier payment.* An HHA receives a national 60-day episode payment of a predetermined rate for a home health service paid on a reasonable cost basis as of August 5, 1997, unless the imputed cost of the 60-day episode exceeds a threshold amount. The outlier payment is defined to be a proportion of the imputed 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 is determined in accordance with § 484.240.

**42 CFR Ch. IV (10-1-03 Edition)**

**§ 484.210 Data used for the calculation of the national prospective 60-day episode payment.**

To calculate the national prospective 60-day episode payment, CMS uses the following:

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

**§ 484.215 Initial establishment of the calculation of the national 60-day episode payment.**

(a) *Determining an HHA's costs.* 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, CMS determines each HHA's costs by summing its allowable costs for the period. CMS determines the national mean cost per visit.

(b) *Determining HHA utilization.* In calculating the initial unadjusted national 60-day episode payment, CMS determines the national mean utilization for each of the six disciplines using home health claims data.

(c) *Use of the market basket index.* CMS uses the HHA market basket index to adjust the HHA cost data to reflect cost increases occurring between October 1, 1996 through September 30, 2001.

(d) *Calculation of the unadjusted national average prospective payment amount for the 60-day episode.* CMS calculates the unadjusted national 60-day episode payment in the following manner:

- (1) By computing the mean national cost per visit.
- (2) By computing the national mean utilization for each discipline.
- (3) By multiplying the mean national cost per visit by the national mean utilization summed in the aggregate for the six disciplines.

(4) By adding to the amount derived in paragraph (d)(3) of this section, amounts for nonroutine medical supplies, an OASIS adjustment for estimated ongoing reporting costs, an OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to October 1, 2000. The resulting amount is the unadjusted national 60-day episode rate.

(e) *Standardization of the data for variation in area wage levels and case-mix.* CMS standardizes—

(1) 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;

(2) The cost data for geographic variation in wage levels using the hospital wage index; and

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

**§ 484.220 Calculation of the adjusted national prospective 60-day episode payment rate for case-mix and area wage levels.**

CMS adjusts the national prospective 60-day episode payment rate to account for—

(a) HHA case-mix using a case-mix index to explain the relative resource utilization of different patients; and

(b) Geographic differences in wage levels using an appropriate wage index based on the site of service of the beneficiary.

**§ 484.225 Annual update of the unadjusted national prospective 60-day episode payment rate.**

(a) CMS updates the unadjusted national 60-day episode payment rate on a fiscal year basis.

(b) For fiscal year 2001, the unadjusted national 60-day episode payment rate is adjusted using the latest available home health market basket index factors.

(c) For fiscal years 2002 and 2003, the unadjusted national prospective 60-day episode payment rate is updated by a factor equal to the applicable home health market basket minus 1.1 percentage points.

(d) For subsequent fiscal years, the unadjusted national rate is equal to the rate for the previous fiscal year increased by the applicable home health market basket index amount.

**§ 484.230 Methodology used for the calculation of the low-utilization payment adjustment.**

An episode with four or fewer visits is paid the national per-visit amount by discipline updated annually by the applicable market basket for each visit type. The national per-visit amount is determined by using cost data set forth in § 484.210(a) and adjusting by the appropriate wage index based on the site of service for the beneficiary.

**§ 484.235 Methodology used for the calculation of the partial episode payment adjustment.**

(a) CMS makes a PEP adjustment to the original 60-day episode payment that is interrupted by an intervening event described in § 484.205(d).

(b) The original 60-day episode payment is adjusted to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date.

(c) The partial episode payment is calculated by determining the actual days served by the original HHA as a proportion of 60 multiplied by the initial 60-day episode payment.

**§ 484.237 Methodology used for the calculation of the significant change in condition payment adjustment.**

(a) CMS makes a SCIC payment adjustment to the original 60-day episode payment that is interrupted by the intervening event defined in § 484.205(e).

(b) The SCIC payment adjustment is calculated in two parts.

(1) The first part of the SCIC payment 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 first part of the SCIC adjustment is determined by taking the span of days (the first billable visit date through and including the last billable visit date) prior to the patient's significant change in condition as a proportion of 60 multiplied by the original episode amount.