Federal Register

Friday,
July 23, 2010

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 418, 424, et al.

Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 409, 418, 424, 484, and 489

[CMS–1510–P]

RIN 0938–AP88

Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would set forth an update to the Home Health Prospective Payment System (HH PPS) rates, including: The national standardized 60-day episode rates, the national per-visit rates, the non-routine medical supply (NRS) conversion factors, and the low utilization payment amount (LUPA) add-on payment amounts, under the Medicare prospective payment system for HHAs effective January 1, 2011. This rule also proposes to update the wage index used under the HH PPS and, in accordance with The Affordable Care Act of 2010 (The Affordable Care Act), Public Law 111–148, to update the HH PPS outlier policy. In addition, this rule proposes changes to the home health agency (HHA) capitalization requirements. This rule further proposes to add clarifying language to the "skilled services" section. Finally, this rule incorporates new legislative requirements regarding face-to-face encounters with providers related to home health and hospice care.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 14, 2010.

ADDRESSES: In commenting, please refer to file code CMS–1510–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1510–P, P.O. Box 1850, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1510–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, *see* the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:
Randy Throndset, (410) 786–0131 (overall HH PPS).
James Bossenmeyer, (410) 786–9317 (for information related to payment safeguards).
Doug Brown, (410) 786–0028 (for quality issues).
Kathleen Walch, (410) 786–7970 (for skilled services requirements and clinical issues).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

I. Background
A. Statutory Background
B. System for Payment of Home Health Services
C. Updates to the HH PPS
II. Provisions of the Proposed Regulation
A. Case-Mix Measurement
B. Hypertension Diagnosis Coding Under the HH–PPS
C. Therapy Coverage Requirements
D. Collecting Additional Claims Data for Future HH PPS Enhancements and Soliciting Comments on HH PPS Improvements
E. Outlier Policy
1. Background
2. Regulatory Update
3. Statutory Update
4. Outlier Cap
5. Loss Sharing Ratio and Fixed Dollar Ratio
6. Solicitation of Comments Regarding Imputed Costs
F. Proposed CY 2011 Payment Update
1. Home Health Market Basket Update
2. Home Health Care Quality Improvement
a. OASIS
b. Home Health Care CAHPS Survey (HH CAHPS)
3. Home Health Wage Index
4. Proposed CY 2011 Payment Update
a. National Standardized 60-Day Episode Rate
b. Proposed Updated CY 2011 National Standardized 60-Day Episode Payment Rate
c. Proposed National Per-Visit Rates Used To Pay LUPA's and Compute Imputed Costs Used in Outlier Calculations

d. Proposed LUPA Add-On Payment Amount Update
e. Non-Routine Medical Supply Commission Factor Update
5. Rural Add-On
G. Enrollment Provisions for HHAs
1. HHA Capitalization
2. Change of Ownership
3. Change in Majority Ownership Within 36 Months of Initial Enrollment or Change in Ownership
H. Home Health Face-to-Face Encounter
I. Solicitation of Comments: Future Plans To Group HH PPS Claims Centrally During Claims Processing
J. Proposed New Requirements Affecting Hospice Certifications and Recertification
III. Collection of Information Requirements
IV. Regulatory Impact Analysis

I. Background

A. Statutory Background

The Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33) enacted on August 5, 1997, significantly changed the way Medicare pays for Medicare home health services. Section 4603 of the BBA mandated the development of the home health prospective payment system (HH PPS). Until the implementation of a HH PPS on October 1, 2000, home health agencies (HHAs) received payment under a retrospective reimbursement system.

Section 4603(a) of the BBA mandated the development of a HH PPS for all Medicare-covered home health services provided under a plan of care (POC) that were paid on a reasonable cost basis by adding section 1895 of the Social Security Act (the Act), entitled "Prospective Payment for Home Health Services". Section 1895(b)(1) of the Act requires the Secretary to establish a HH PPS for all costs of home health services paid under Medicare.

Section 1895(b)(3)(A) of the Act requires that: (1) The computation of a standard prospective payment amount include all costs for home health 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 level differences among HHAs.

Section 1895(b)(3)(B) of the Act addresses the annual update to the standard prospective payment amounts by the home health 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 that adjusts 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 home health services furnished in a geographic area compared to the applicable national average level. Pursuant to 1895(b)(4)(C), 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, as amended by Section 3131 of the Affordable Care Act signed by the President on March 23, 2010 (Pub. L. 111–148), gives the Secretary the option to make additions or adjustments 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 3131(b) revised Section 1895(b)(5) so that total outlier payments in a given fiscal year (FY) or year may not exceed 2.5 percent of total payments projected or estimated.

In accordance with the statute, as amended by the BBA, we published a final rule (65 FR 41128) in the **Federal Register** on July 3, 2000, to implement the 1997 HH PPS legislation. The July 2000 final rule established requirements for the new HH PPS for home health 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 on 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 on November 29, 1999. The requirements include the implementation of a HH PPS for home health services, consolidated billing requirements, and a number of other related changes. The HH PPS described in that rule replaced the retrospective reasonable cost-based system that was used by Medicare for the payment of home health 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).

On February 8, 2006, the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) was enacted. Section 5201 of the DRA added new Section 1895(b)(3)(B)(v) to the Act, which requires HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to payment. This requirement is applicable for CY 2007 and each subsequent year. If an HHA does not submit quality data, the home health market basket percentage increase is reduced 2 percentage points. In accordance with the statute, we published a final rule (71 FR 65884, 65935) in the **Federal Register** on November 9, 2006, to implement the pay-for-reporting requirement of the DRA, which was codified at 42 CFR 484.225(h) and (i).

The Affordable Care Act made additional changes to the HH PPS. One of the changes in section 3131 of the Affordable Care Act is the amendment to section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173) as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Pub. L. 109–171). The amended section 421(a) of the MMA requires, for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act) with respect to 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.

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 home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine medical supplies (NRS) is no longer part of the national standardized 60-day episode rate and is computed by multiplying the relative weight for a particular NRS severity level by the NRS conversion factor (*See* section III.C.4.e). Payment for durable medical equipment covered under the home health benefit is made outside the HH PPS payment. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification to assign patients to a home health resource group (HHRG). Clinical needs, functional status, and service utilization are computed from responses to selected data elements in the OASIS assessment instrument.

For episodes with four or fewer visits, Medicare pays on the basis of a national

per-visit rate by discipline; 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). 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**.

Our 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 Medicare prospective payment system for HHAs for CY 2008. For analysis performed on CY 2005 home health claims data indicated a 12.78 percent increase in the observed case-mix since 2000. The case-mix represented the variations in conditions of the patient population served by the HHAs. Then a more detailed analysis was performed on the 12.78 percent increase in case-mix to see if any portion of that increase was associated with a real change in the actual clinical condition of home health patients. CMS examined data on demographics, family severity, and non-home health Part A Medicare expenditure data to predict the average case-mix weight for 2005. As a result of that analysis, CMS recognized that an 11.75 percent increase in case-mix was due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients.

To account for the changes in case-mix that were not related to an underlying change in patient health status, CMS implemented a reduction over 4 years in the national standardized 60-day episode payment rates and the NRS conversion factor. That reduction was to be taken at 2.75 percent per year for three years beginning in CY 2008 and at 2.71 percent for the fourth year in CY 2011. CMS indicated that it would continue to monitor for any further increase in case-mix that was not related to a change in patient status, and would adjust the percentage reductions and/or implement further case-mix change adjustments in the future.

Most recently, we published a final rule in the **Federal Register** on November 10, 2009 (74 FR 58077) that set forth the update to the 60-day national episode rates and the national per-visit rates under the Medicare prospective payment system for home health services for CY 2010.

II. Provisions of the Proposed Regulation

A. Case-Mix Measurement

Since the HH PPS CY 2008 proposed rule, we have stated in HH PPS rulemaking that we would continue to monitor case-mix changes in the HH PPS and to update our analysis to measure change in case-mix, both nominal and real. We have continued to monitor case-mix changes, and our latest analysis continues to support the payment adjustments which we implemented in the CY 2008 HH PPS. As discussed in the CY 2010 rule, the analysis then indicated a 15.03 percent increase in the overall observed case-mix since 2000. We next determined what portion of that increase was associated with a real change in the actual clinical condition of home health patients.

As was done for the CY 2008 final rule, we used data from the pre-PPS period to estimate a regression-based, predictive model of individual case-mix weights based on measures of patients' demographic characteristics, clinical status, inpatient history, and Medicare costs in the time period leading up to their home health episodes. The regression coefficients from this model were applied to later episodes, allowing estimation of how much of the change in observed case-mix is attributable to changes in patient characteristics over time. We classify the sources of case-mix change into two major types: predicted and unpredicted. Predicted (or real) change is based on the relationship between patient characteristics and case-mix (that is coefficients from the regression model) and changes in the characteristics of patients over time (that is the change in mean values of the model covariates). Unpredicted (or nominal) change is the portion of case-mix change that cannot be explained by changes in patient characteristics. Nominal case-mix change is assumed to reflect differences over time in agency coding practices.

Our best estimate in the CY 2010 rule was that approximately 9.77 percent of the 15.03 percent increase in the overall observed case-mix between the IPS baseline and 2007 was real, that is, due to actual changes in patient characteristics. Our estimate was that a 13.56 percent nominal increase ($15.03 - (15.03 \times 0.0977)$) in case-mix was due to changes in coding procedures and documentation rather than to treatment of more resource-intensive patients.

We have since updated that analysis to include an additional year of data (CY 2008) for this CY 2011 proposed rule. This analysis was based on regression coefficients from CY 2008 episodes that reflect the relationship between model covariates and case-mix using the HHRG153 system. We used these regression coefficients combined with changes in patient characteristics to measure the amount of predicted case mix change for 2007 through 2008.

Our analyses indicate a 19.40 percent increase in the overall observed case-mix since 2000. Our estimate is that approximately 10.07 percent of the total increase in the overall observed case-mix between the IPS baseline and 2008 is real, that is, associated with actual changes in patient characteristics. Specifics regarding this analysis are described later in this section.

The estimate of real case-mix change is a small proportion of the total change in case mix since the IPS baseline. With each successive sample, beginning with 2005 data (in the CY 2008 final rule), the predicted average national case-mix weight has changed very little because the variables (such as preadmission location, non-home health Part A Medicare expenditures, and inpatient stay classification, as mentioned above) in the model used to predict case-mix are not changing much. At the same time, the actual average case-mix has continued to grow steadily. Thus, the gap between the predicted case-mix value, which is based on information external to the OASIS, and the actual case-mix value, has increased with each successive year of data. Consequently, as a result of this analysis, we recognize that a 17.45 percent nominal increase ($19.40 - (19.40 \times 0.1007)$) in case-mix is due to changes in coding practices and documentation rather than to treatment of more resource-intensive patients. This 17.45 percent increase in case mix reflects a much larger increase in nominal case-mix from the IPS baseline to 2008 than had been previously been occurring under the HH PPS. Specifically, from 2000 to 2007, we observed about a 1 percent per year increase in total average case-mix. However, that annual change increased to slightly more than 4 percent between 2007 and 2008.

We wanted to determine how this growth in case-mix weight from 2007 to 2008 was affected by the changes implemented with the 2008 refinements. We identified these average case-mix values by estimating the average case mix weight on the 2007 claims of a random 20 percent sample of HH beneficiaries. We used two groupers—the 80-group 2007 grouper

(average = 1.2606) and the 153-group 2008 grouper (average = 1.2552). The difference in averages was −0.0054, indicating that the changeover to the new 2008 grouper algorithm itself slightly reduced the average case mix weight.

Next, to assess behavioral changes which may have been incentivized by the 2008 refinements, we estimated the average case mix weights on both 2007 claims data and 2008 claims data for a random 20 percent sample of HH beneficiaries, using the 2008 grouper. (Only non-LUPA episodes are included in this analysis, as LUPA episodes are not paid using case mix weights.) We compared the resulting averages. The total change using the 2008 grouper was 0.0533: the 2007 average was 1.2552 and the 2008 average was 1.3085. It is important to note that this comparison of the 2007 and 2008 claims data uses the same grouper (the 153-group system, which includes co-morbid conditions), and that this estimate of national average case-mix on the 2007 sample differs very little (that is −.0054) from the estimate we derived from using the actual grouper in effect in 2007.

We decomposed the change in average case-mix weight, 0.0533, into an effect of the 2007–2008 shift in the distribution of the number of therapy visits per episode, and an effect of the 2007–2008 change in the average case-mix weight at each count of therapy visits in the distribution. The latter is assumed to result mostly from the incentives to report co-morbid conditions, stemming from the introduction of the 153 group system.

The former is assumed to result mostly from a behavioral response on the part of agencies to the new system of therapy thresholds introduced in 2008. Prior to 2008, case mix weights were generally highest for episodes that met the single, 10-visit therapy threshold. Under the system in place since 2008, multiple thresholds above and below 10 therapy visits were created. By creating multiple thresholds and severity steps between thresholds, we intended to move incentives away from payment-driven therapy treatment plans to clinically driven ones. However, creating a new set of high therapy thresholds above 13 therapy visits, to adequately compensate agencies for treating the relatively few patients needing such large amounts of therapy, also may have had unintended consequences. One such consequence may have been that agencies responded by padding treatment plans to reach the new, higher thresholds. Episodes which would require such high numbers of therapy visits generally would have very high case mix weights (mostly weights of 2 or higher).

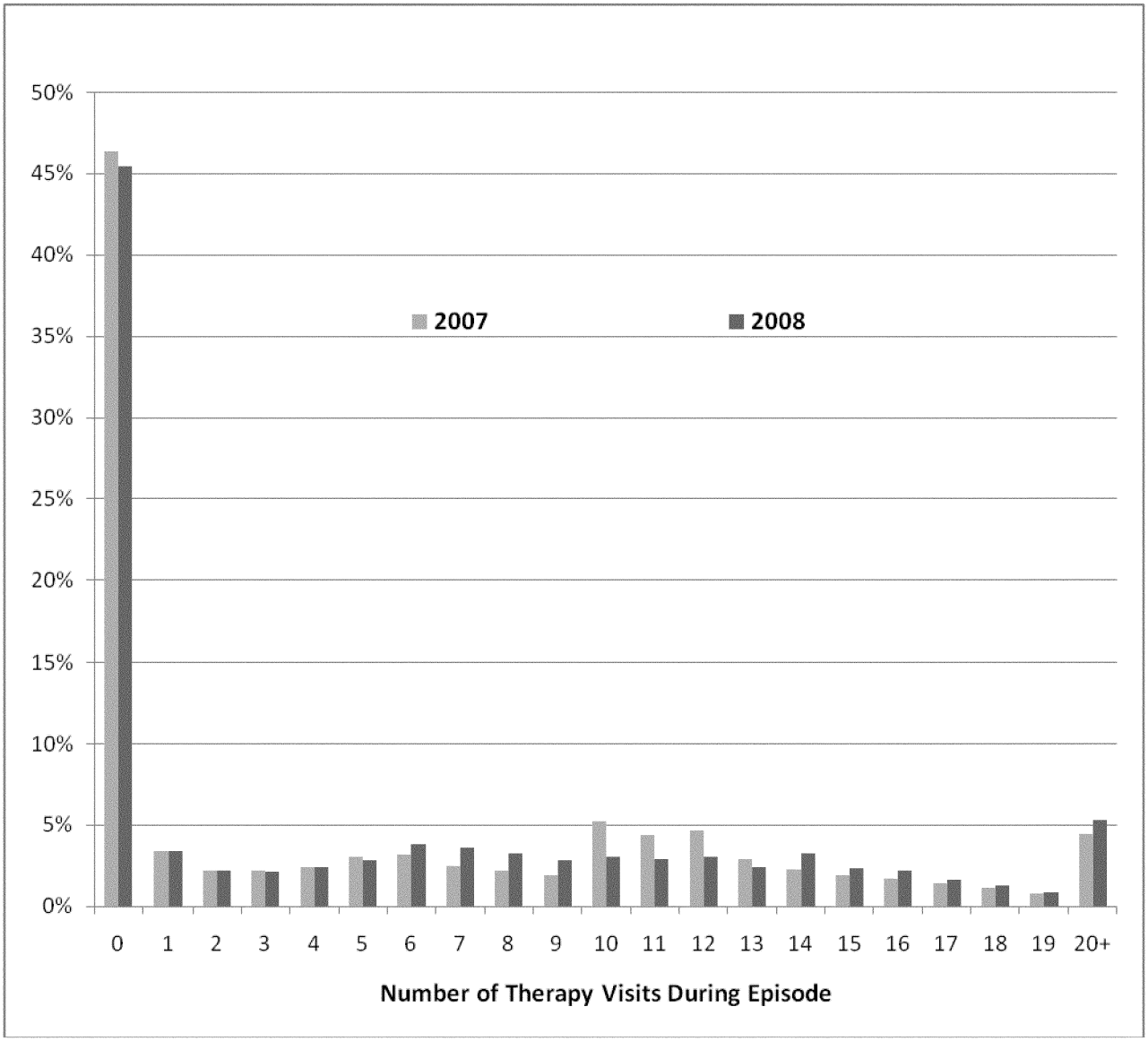
The decomposition method first holds the average case mix weight constant (at the 2007 values) at each level of therapy visits, and measures the effect of the shift to the new distribution of therapy visits. The method then holds the distribution of therapy visits constant (at the 2007 distribution) and measures the effect of the change in average case mix weight at each level of therapy visits. The results were that .0205, or 38 percent (.0205/.0533=.38), of the total change in average case-mix weights from 2007 to 2008 was due to the shift in distribution of therapy visits per episode.

Figure 1 illustrates the 2007 through 2008 change in the proportion of episodes delivering each individual number of therapy visits. Several changes are notable. First, the percentage of episodes increased at the new, higher therapy visit thresholds (14–19 and 20+). The share of episodes at 20 visits or more increased from 4.4 percent in 2007 to 5.3 percent in 2008, a substantial increase of about 20 percent. The large shift towards therapy visit levels of 14 and higher was unexpected.

Second, the percentage of episodes at the single therapy threshold (10 visits) that existed before 2008 decreased, as did the percentage of episodes between 11 and 13 therapy visits. In 2007, as a proportion of all episodes with at least one therapy visit, episodes with 10 to 13 therapy visits were 32 percent; by 2008, only 21 percent of all therapy episodes were in this range. (Note: Figure 1 displays percents of total non-LUPA episodes, not just episodes with at least one therapy visit.) Third, the proportion of episodes at the new threshold below 10 visits, which is 6 visits, increased, as did the proportion of episodes with 7, 8, or 9 visits. The system of therapy steps we defined for the 2008 refinements included a step for 7–9 visits (*see* Table 4 of The August 29, 2007 final rule [72 FR 49762]). Finally, the proportion of total episodes receiving any therapy visits increased slightly, from 54 percent to 55 percent. The average number of therapy visits per episode increased from 5.63 to 5.83 (data not shown).

BILLING CODE 4120–01–P

Figure 1: Percent of Non-LUPA Episodes According to Number of Therapy Visits: 2007 vs. 2008



Note: Based on a 20 percent beneficiary sample. Episodes with no therapy visits serve patients who have needs for intermittent skilled nursing care but not for rehabilitation services.

BILLING CODE 4120–01–C

The remaining .0328, or 62 percent of the total change (.0328/.0533=.62) in overall average case-mix weight from 2007 to 2008 was due to an increase in the average case-mix weight at each level of therapy visits per episode. Table 1 shows the increases.

Table 1 Average Case Mix Weight According to Number of Therapy Visits, 2007 and 2008

Number of therapy visits per episode	2007 average	2008 average	Change	Percent change
0	0.8673	0.9022	0.0348	4.01%
1	0.8608	0.8847	0.0239	2.77%
2	0.8582	0.8817	0.0235	2.74%
3	0.8471	0.8739	0.0268	3.16%
4	0.8353	0.8645	0.0292	3.50%
5	0.8036	0.8378	0.0342	4.26%
6	1.0773	1.1205	0.0432	4.01%
7	1.2885	1.3338	0.0453	3.52%
8	1.2955	1.3350	0.0395	3.05%
9	1.3009	1.3345	0.0336	2.58%
10	1.5348	1.5575	0.0227	1.48%
11	1.7105	1.7400	0.0295	1.73%
12	1.7175	1.7435	0.0260	1.51%
13	1.7147	1.7461	0.0314	1.83%
14	2.0788	2.1197	0.0409	1.97%
15	2.0777	2.1112	0.0335	1.61%
16	2.2247	2.2586	0.0339	1.52%
17	2.2235	2.2494	0.0259	1.16%
18	2.3672	2.3946	0.0274	1.16%
19	2.3732	2.3940	0.0208	0.88%
20+	3.1177	3.1425	0.0248	0.80%

Note: Based on a 20% beneficiary sample. The HHRG grouping system effective January 1, 2008, was used to classify non-LUPA episodes of both annual samples into the 153-group case mix system for calculating average case mix weight.

The averages increased for all levels of therapy visits per episode, with the change ranging from 0.02 to 0.05. The percentage changes appear to decline with more therapy visits, because the level of the average case mix value increases with each number of therapy visits; however, there was no rising trend in the absolute change as the number of therapy visits increased.

Looking directly into the reporting of comorbidities, we examined the proportion of episodes that had nonblank diagnoses reported in M0240 (Diagnoses and Severity Index). Our concern was that agencies were reporting more comorbidities, since the refined system allocates case mix points for secondary diagnoses, whereas the system prior to the refinements did not. Longstanding OASIS manual language instructs providers to encode diagnosis on the OASIS only when the condition is unresolved and only when the condition has an impact on the home health care. The data comparing the percentages are shown in Table 2.

The results were a substantial increase in the percentage of episodes with a reported diagnosis code in M0240: A 10.4 percentage point increase from 2007–2008 in M0240d; a 16.4 percentage point increase in M0240e; and a 19.9 percentage point increase in M0240f. Table 2 also indicates that these changes represented a significantly larger increase in completion rates in these diagnosis fields compared to annual increases of about 3.0 percentage points in 2005–2006, and about 7.0 percentage points in 2006–2007. We note that we published the proposed refinements in the May 2007 **Federal Register** (72 FR 25356). Release of the proposal around mid-year could have been a factor in the higher growth of these episodes during the period 2006 through 2007, relative to 2005 through 2006.

We believe it is unlikely that the actual disease burden of home health patients, as indicated by reported comorbidities, changed so dramatically in a single year; instead, we believe the incentives to report more comorbidities under the refined case mix system are the reason for the large increases in reported comorbidities.

Table 2: Percentage of Episodes in Each Year Which have Non-Blank Entries For the Diagnosis Variable Listed

Year	M0240b	M0240c	M0240d	M0240e	M0240f
	%	%	%	%	%
2005	97.0%	87.4%	71.2%	52.2%	33.8%
2006	97.8%	89.8%	74.7%	55.6%	36.6%
2007	98.6%	93.0%	80.4%	62.8%	43.4%
2008	99.5%	97.2%	90.8%	79.2%	63.1%

Note: Based on a 20% beneficiary sample, including LUPA and non-LUPA episodes.

An illustrative instance of diagnosis coding change under the HH PPS refinements is hypertension. Our analysis of 8 years of claims shows that reporting of this diagnosis grew exceedingly quickly in 2008. Table 3 shows the proportion of HH PPS claims reporting essential hypertension, according to ICD–9–CM hypertension code, for 2001 to 2008. The data indicate a sudden jump of approximately 12 percentage points in reporting of unspecified hypertension when the refined HH PPS added hypertension as a case mix code in 2008. Annual changes in use of this code were small up until 2005 (in the range of 0.1 to 2.4 percentage points), after which there were two years of 6-percentage point increases, followed by the 12-percentage point increase coincident with the 2008 refinements. Malignant hypertension is unusual; it has been falling as a percentage of episodes. Reporting of benign hypertension, which is somewhat more common than malignant hypertension, has been slowly rising since 2001.

Table 3: Percent of episodes reporting hypertension
ICD9 diagnosis codes: 2001-2008

	ICD-9 401.0 malignant	ICD-9 401.1 benign	ICD-9 401.9 unspecified
2001	0.7	0.9	24.8
2002	0.8	1.1	26.0
2003	0.8	1.3	26.1
2004	0.6	2.0	25.3
2005	0.6	2.9	27.7
2006	0.5	3.4	33.9
2007	0.5	3.4	39.9
2008	0.5	3.8	52.1

Note: Based on a 10% beneficiary sample, including LUPA and non-LUPA episodes and excluding outlier episodes.

At the same time, there are indications that the services utilization associated with the most commonly reported hypertension diagnosis code, hypertension, unspecified, no longer is responsible for added resource requirements in home care. Originally, hypertension was selected for inclusion in the refined HH PPS system because data suggested it elevated utilization. Table 4a illustrates the trends; it shows the average number of visits per episode, according to type of hypertension diagnosis code. (We exclude outlier cases because of the effect that growing numbers of outlier episodes may have had beginning around 2005 and 2006; extremely large numbers of visits in the distribution can distort the average.)

Generally episodes reporting malignant or benign hypertension exhibit a decline in number of visits per episode during the middle of the 8-year

period. The averages then rise slightly. The averages for episodes reporting unspecified hypertension declined until 2005, and then stabilized.

Comparing these data with averages for episodes not reporting hypertension, we see that hypertension is generally associated with more visits, especially if the hypertension was reported as malignant or benign. However, in 2007, the unspecified hypertension episodes had an average number of visits equivalent to that of the non-HBP episodes. By 2008, the average number of visits for episodes not reporting hypertension rose slightly, while the average for unspecified hypertension did not. As a result, by 2008, the average number of visits for claims reporting unspecified hypertension is slightly lower than the average for claims not reporting hypertension. Further, the benign hypertension episodes, with a slightly increased share of the sample between 2007 and 2008, exhibited a small reduction in the average number of visits.

Table 4a: Annual mean number of visits, for hypertension-coded episodes: 2001-2008

	ICD-9 401.0 malignant	ICD-9 401.1 Benign	ICD-9 401.9 Unspecified	No hypertension
2001	18.2	18.1	17.6	16.8
2002	17.4	18.0	17.6	16.7
2003	17.5	17.3	17.2	16.4
2004	17.2	16.8	16.7	16.4
2005	16.7	15.9	16.0	15.9
2006	16.1	15.9	16.0	15.9
2007	16.5	16.3	16.0	16.0
2008	16.8	16.1	16.0	16.1

Note: Based on a 10% beneficiary sample, including LUPA and non-LUPA episodes and excluding outlier episodes.

This pattern illustrates an expected effect of nominal coding change. We observe a 12-percentage point increase in use of unspecified hypertension, but no longer do these hypertension patients use more resources than others. These results appear possibly consistent with a phenomenon in which agencies increased their reporting of hypertension in situations where it did not meet the home health diagnosis reporting criteria. More generally, the results are suggestive of changed coding practice in which less-severe episodes are being reported with hypertension in 2008 than used to be the case.

These analyses of the change in the therapy visit distribution, change in average case mix weights at each level of therapy visits, increased use of secondary diagnosis fields, and the change in reporting of hypertension all suggest that the refinements which were implemented in 2008 affected case-mix weights, with greater therapy visits and reporting of co-morbidities each as contributing factors. However, as described below, the analyses do not indicate a significant increase in real case-mix. Experience with previous analyses reported in our past regulations shows that relatively small proportions of the total case mix change since the IPS baseline can be considered real case mix change.

Our estimate that 10.07 percent of the total percentage change in the national average case mix weight since the IPS baseline is due to real change in case mix, is consistent with past results. Most of the case mix change has been due to improved coding, coding practice changes, and other behavioral responses to the prospective payment system, such as more use of high therapy treatment plans. We are therefore proposing to exercise authority to compensate for nominal case mix change by making reductions to the PPS rates, as we have done since 2008.

For this year's analysis, we used the same approach, a model designed to measure real change in case mix, which we developed for the CY 2008 HH PPS final rule (72 FR 49841) and continue to use for HH PPS rulemaking. For this year's analyses, we utilized a fuller version of the 3M APR–DRG grouper that allowed us to expand the number of APR–DRG-related groups in the model. As previously, we included indicators for each APR–DRG group's different severity level if at least 25 episodes had the APR–DRG/severity combination in the IPS period file. This expanded APR–DRG model was used to re-estimate the IPS period model of case-mix weight.

We also rebased the expanded APR–DRG model on CY2008 data, using case-mix weights produced by the refined (153-group) HH PPS grouper. One slight difference in the rebased model is that because we are using 2008 data, the "living arrangement" variables are missing on follow-up OASIS assessments. Consequently, we were not able to use this variable in the re-based model.

We used the results of that rebasing to predict real case mix for 2007. The national average case mix weight in 2008 was 1.3085. The rebased model of real case mix predicts a quantity change in real case mix of −0.0025 when working backwards from 2008 (1.3085) to 2007 (1.3060). The predicted level of real case mix in 2007, which we derived from the IPS-based model is 1.1152. To compute a predicted real case mix level for 2008, we increased the predicted level of real case mix in 2007, 1.1152, by the percentage growth (1.3085/1.3060) in real case mix that we estimated from the rebased model. The result is a predicted level of real case

mix in 2008 of 1.1173 ((1.3085/1.3060) × 1.1152 = 1.1173).

To compute the predicted quantity change in real case mix from the IPS baseline to 2008, we subtracted from the IPS baseline average case mix weight from the predicted level the real case mix in IPS, for a quantity change of 0.0214 (1.1173 − 1.0959 = 0.0214). The total difference in case mix from baseline to 2008 is 0.2126 (1.3085 − 1.0959 = 0.2126). Therefore, the quantity change from baseline to 2008 in real case mix represents a 10.07 percent increase (0.0214/0.2126 = 0.1007 or 10.07 percent).

The percent change in overall case mix from the IPS baseline to 2008 is 19.40 percent ((1.3085/1.0959) − 1 = 0.1940 or 19.40 percent). To estimate the percent growth in case mix due to nominal change (that is, change in case mix not due to actual changes in patient acuity), we reduced the overall 19.40 percent change in case mix by the 10.07 percent increase due to real case mix change, which yielded a residual of 17.45 percent ((1 − 0.1007) * 0.1940 = 0.1745).

As we fully described earlier in this proposed rule, our August 29, 2007, final rule for CY 2008 finalized a reduction over 4 years in the national standardized 60-day episode payments rates to account for an 11.75 percent increase in case-mix which was not related to treatment of more resource intense patients. The 11.75 percent increase was based on an analysis of data through 2005. We finalized a 2.75 percent reduction each year for 2008, 2009 and 2010, and 2.71 percent reduction for CY 2011 to account for this growth in case-mix. We have stated in HH PPS rulemaking, since the CY 2008 HH PPS proposed rule, that we might find it necessary to adjust the annual offsets (case-mix reduction percentages) as new data became available. Because our current analysis reveals that nominal case-mix has continued to grow, we are faced with having to account for the additional increase in nominal case-mix beyond that which was identified for CY 2008 rulemaking. If we were to account for the remainder of the 17.45 percent residual increase in nominal case-mix over CY 2011 and CY 2012, we estimate that the percentage reduction to the national standardized 60-day episode rates and the NRS conversion factor for nominal case-mix change for each of the two calendar years (2011 and 2012) of the case-mix change adjustment would be 3.79 percent per year. If we were to fully account for the remaining residual increase in nominal case-mix in CY 2011, we estimate that the percentage reduction to the national standardized 60-day episode rates and the NRS conversion factor would be 7.43 percent. Because the Affordable Care Act contains other provisions which have an effect on HH PPS payments, we are not proposing to account for the entire residual increase in nominal case-mix in CY 2011, instead we propose to account for the identified increase over CY 2011 and CY 2012. We propose to impose a 3.79 percent reduction per year to the national standardized 60-day episode rates and the NRS conversion factor for CY 2011 and CY 2012. Should we identify further increases in nominal case-mix as more current data become available, it is our intent to account fully for those increases when they are identified, rather than continuing to phase-in the reductions over more than 1 year. We will continue to monitor any future changes in case-mix as more current data become available and make updates as appropriate.

B. Hypertension Diagnosis Coding Under the HH PPS

As part of this rule, we are proposing to remove ICD–9–CM code 401.9, Unspecified Essential Hypertension, and ICD–9–CM code 401.1, Benign Hypertension, from the HH PPS case mix model's hypertension group, originally reflected in Table 2B of the August 29, 2007, CY 2008 HH PPS final rule (72 FR 49762) (subsequent updates to Table 2B have been provided in HH PPS grouper software releases). In this section we explain the basis for this proposal.

As part of our refinements to the HH PPS, beginning in CY 2008, unspecified hypertension and benign hypertension were included as diagnoses in our HH PPS case mix system. Recent analysis of home health diagnosis coding shows a significant change in the frequency of assigning certain hypertension diagnoses during CY 2008. Specifically, our analysis of HH PPS claims from 2001 to 2008 shows a sudden increase in the reporting of unspecified hypertension and benign hypertension on home health claims in CY 2008 (*see* Table 3: Percent of episodes reporting hypertension ICD–9–CM diagnosis codes: 2001–2008, of this proposed rule).

Classification of blood pressure (BP) was revised in 2003 by the National Heart, Lung and Blood Institute (NHLBI) in their "Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure" (the JNC 7 report) and published in the May 21, 2003, Journal of the American Medical Association. These revisions provided specific clinical guidelines for prevention, detection, and treatment of high blood pressure. The guidelines, approved by the Coordinating Committee of the NHLBI's National High Blood Pressure Education Program (NHBPEP), also streamlined the steps by which doctors diagnose and treat patients. A key aspect of the guidelines includes the introduction of a "pre-hypertension" level for individuals with a systolic blood pressure of 120–139 mm Hg or a diastolic blood pressure of 80–89 mm Hg. This recognition represented a change from traditional medical views on the implications of blood pressures slightly above 120/80. Traditionally, such low levels were not considered a significant clinical finding. No diagnosis was reportable. There was no medical treatment ordered; nor was a change of lifestyle recommended.

Based upon our review of the revised clinical guidelines, and our review of the ICD–9–CM classification of essential hypertension, if the patient is considered "pre-hypertensive," some may conclude that a diagnosis of benign hypertension may be assigned. If an individual is designated as pre-hypertensive, the guidelines stipulate that this individual will generally require health promoting lifestyle modifications to prevent cardiovascular disease. Additional treatments may or may not be appropriate.

The impact of the new guidelines for hypertension is the reclassification of certain patients to a hypertension diagnosis, whereas prior to the guidelines, no hypertension diagnosis was indicated. Furthermore, under the guidelines, some of the patients deemed hypertensive may not need skilled services. Moreover, as we described above, we see a substantial increase in the reporting of unspecified hypertension, along with some evidence that home health patients with either unspecified or benign hypertension no longer require extra resources. Given the new guidelines for hypertension and their impact on coding, along with coding behavior changes in 2008, we believe including unspecified and benign hypertension in the HH PPS case mix model reduces the model's accuracy. As such we do not believe that we should be including these diagnoses in our case-mix system.

We also believe that the developments in clinical guidelines of recent years may have led to ambiguity in the definition of hypertension in the ICD–9–CM classification system. The "ICD–9–CM Official Guidelines for Coding and Reporting", and the alphabetic and tabular indexes of the ICD–9–CM published after May 2003 (effective date

of the "NHLBI Guidelines for Hypertension"), fail to include the NHLBI Blood Pressure (BP) guidelines and classification terminology. The NHLBI specific BP mmHg measurements and BP terms are not included in the ICD–9–CM classification system.

In the August 29, 2007, CY 2008 HH PPS final rule, we removed diagnosis codes proposed in the NPRM if the code was assigned to a minor condition or mild symptom that may be found in the elderly population; codes that are non-specific or ambiguous; and codes that lack consensus for clear diagnostic criteria within the medical community. Due to their unclear relationship with NHLIB guidelines, the unspecified and benign hypertension codes fail to meet the criteria we laid out in 2007.

In summary, continued inclusion of the unspecified and benign hypertension codes in the HH PPS case mix system threatens to move the HH PPS case-mix model away from a foundation of reliable and meaningful diagnosis codes that are appropriate for home care. Therefore, we are proposing to remove ICD–9–CM code 401.9, Unspecified Essential Hypertension, and ICD–9–CM code 401.1, Benign Essential Hypertension, from the HH PPS case mix model's hypertension group, in order to correlate with the goals of our HH PPS case-mix system.

C. Therapy Coverage Requirements

With the inception of the HH PPS, as set forth in the July 3, 2000 final rule (65 FR 41128), patients were grouped according to their therapy utilization status in order to ensure that patients who required therapy would maintain access to appropriate services. In the final rule, we described that we had performed research regarding how to use assessment information to predict how much therapy a patient would need over the course of a 60-day period. The research found that the assessment data could not predict the amount of required therapy with sufficient accuracy for use in the payment system. Knowing that under a PPS there is significant risk that providers might skimp on high-cost services such as therapy, we decided to establish a therapy threshold to ensure that therapy would not be under-provided. We used clinical judgment to determine what amount of therapy would need to be provided to ensure a meaningful amount of rehabilitation services to patients who could clearly benefit from it. We determined that this amount would be at least 8 hours of therapy services during the 60-day episode. Since the average therapy visit was 48 minutes long, it would take 10 visits to provide at least 8 hours worth of therapy. Therefore, we established a corresponding 10-visit therapy threshold to identify "high" therapy cases, and paid home health agencies significantly more for patients receiving high therapy.

In the years following the adoption of the HH PPS, we have continued to analyze the effectiveness of the 10-visit therapy threshold in ensuring that rehabilitation services were being provided to patients who could clearly benefit from them. Our analyses suggested that therapy was not being under-provided, but rather suggested that in many cases therapy was being over-provided. As described in the May 4, 2007 HH PPS proposed rule (72 FR 25356), our analysis of the evidence suggested that the single 10-visit threshold offered too strong a financial incentive to provide 10 therapy visits when a lower amount of therapy was more clinically appropriate. In other words, the data suggested that financial incentives to provide 10 therapy visits overpowered clinical considerations in therapy prescriptions. During this time we conducted further research to model therapy need, but it was again unsuccessful. We explained in our proposed rule in May 2007 that a return to per-visit payment for therapy visits did not meet our objectives for having a prospective payment system. Therefore, in the CY 2008 final rule, we established a system of three thresholds with graduated steps in between which met our objectives of retaining prospectivity in the payment system, reducing the strong incentive resulting from a single threshold, restoring clinical considerations in therapy provision, and paying more accurately for therapy utilization below the original 10-visit threshold. Those three thresholds are at 6 therapy visits, 14 therapy visits, and 20 therapy visits. As a disincentive for agencies to deliver more than the appropriate, clinically determined number of therapy visits, payment for additional therapy visits between the three thresholds increases gradually, incorporating a declining rather than a constant payment amount per added therapy visit. In our May 4, 2007 HH PPS proposed rule, at 72 FR 25363, we provided further details explaining the selection of these thresholds.

Analysis of CY 2008 data continues to suggest that some HHAs may be providing unnecessary therapy. The 2008 data show a 30 percent increase in episodes with between 6–9 therapy visits, which suggests that the 2008 changes may have been successful in improving clinical considerations in the volume of therapy provided. In their March 2010 report MedPAC states that 2008 data also reveal a 26 percent increase of episodes with 14 or more therapy visits (MedPAC, *Report to Congress: Medicare Payment Policy,* Section B, Chapter 3, March 2010, p. 203). The increase in episodes with 14 or more therapy visits is especially evident in areas of the country where home health fraud is suspected, such as Miami-Dade, Florida.

While this suggests that the therapy payment policies are vulnerable to fraud and abuse, the swift, across-the-board therapy utilization changes suggest another, more fundamental concern. MedPAC wrote that the magnitude of therapy utilization changes and their correlations with the payment threshold changes suggest that payment incentives continue to influence treatment patterns [MedPAC, 2010, p. 206]. The Commissioners believed that payment policy is such a significant factor in treatment patterns because the criteria for receipt of the home health benefit are ill-defined. They suggested that improved guidelines that more specifically identify patients who are most appropriate for HH care would facilitate more appropriate and uniform use of the benefit [MedPAC, 2010, p. 203]. To address the concerns of MedPAC, we are proposing to clarify our policies regarding coverage of therapy services at 409.44(c) in order to assist HHAs, and to curb misuse of the benefit.

We believe these clarifications also could slow the case-mix growth which is unrelated to real changes in patient acuity (nominal case-mix). As we described above in Section A ("Case Mix Measurement"), between 2007 and 2008 we observed a case-mix increase of more than 4 percent. An analysis of this growth revealed that approximately 38 percent of the total case mix change between 2007 and 2008 was due to the shift in distribution of therapy visits. By describing more clearly the therapy coverage criteria in the home health setting, thereby enabling providers to better understand when providing therapy to home health patients is appropriate, we believe that beginning in calendar year 2011, a slower rate of nominal case-mix growth may be achieved.

Proposed Clarifications to 42 CFR 409.44(c)(1)

Regulations at § 409.44(c)(1) mandate that for physical therapy, speech language pathology, or occupational therapy to be covered under the home health benefit, therapy services must

relate directly and specifically to a treatment regimen, be established by the physician (after any needed consultation with a qualified therapist), that is designed to treat the beneficiary's illness or injury. A qualified therapist is one who meets the personnel requirements in the CoPs at 42 CFR 484.4. To ensure that therapy services relate directly and specifically to a treatment regimen designed to treat the beneficiary's illness or injury, we are proposing to clarify our coverage requirements. Specifically, we are proposing to revise § 409.44(c)(1) so that, with respect to physical therapy, occupational therapy, and speech language pathology, we may clarify that:

- The patient's plan of care would include a course of therapy and therapy goals which would be consistent with the patient's functional assessment, both of which are included in the patient's clinical record. The patient's clinical record would document the necessity for the course of therapy described in the plan of care. Specifically, the clinical record would document how the course of therapy for the beneficiary's illness or injury is in accordance with accepted standards of clinical practice.
- Therapy treatment goals would be described in the plan of care, and they would be measurable. Specifically, therapy treatment goals would be such that progress toward those goals could be objectively measured. The goals would also pertain directly to the patient's illness or injury and the patient's resultant functional impairments.
- The patient's clinical record would demonstrate that the method used to assess a patient's function included the objective measurement of function in accordance with accepted standards of clinical practice. As such, successive functional assessments would enable comparison of successive measurements, thus enabling objective measurement of therapy progress.

One example of objective measures is functional assessment individual item and summary findings (and comparisons to prior assessment results/clinical findings) from OASIS functional items or other commercially available therapy outcomes instruments. Similarly, another example would be functional assessment findings (and comparisons to prior assessment results/clinical findings) from tests and measurements validated in the professional literature, or used as part of accepted standards of clinical practice that are appropriate for the condition/function being measured.

Proposed Clarifications to 42 CFR 409.44(c)(2)(i)

Current regulations at § 409.44(c)(2)(i) mandate that for physical therapy, speech language pathology, or occupational therapy services to be covered in the home health setting, the services must be considered under accepted practices to be a specific, safe, and effective treatment for the beneficiary's condition.

To clarify what we mean by "accepted practice" and "effective treatment", we are proposing to clarify home health therapy coverage criteria at § 409.44(c)(2)(i). These clarifications describe our expectations that HHAs would regularly reassess a therapy patient's physical function, and would objectively measure a patient's progress toward therapy goals to determine whether therapy services continued to be effective, or whether therapy ceased to be covered. These clarifications also describe clinical record documentation expectations associated with documenting effective therapy progress.

We are proposing to revise § 409.44(c)(2)(i) as follows:

Functional Reassessment Expectations

In order to ensure that a patient receiving home health therapy services appropriately remained eligible for the benefit in accordance with accepted practice, and that the services continued to be effective, the patient's function would be periodically reassessed by a qualified therapist. As we described above, for therapy to be covered in the home health setting, the method used to assess a patient's function would include objective measurement of function in accordance with accepted standards of clinical practice. As such, progress toward therapy goals would be objectively measurable by comparing measurements obtained at successive functional assessment time points. The objective measurements obtained from the periodic reassessment of function would reflect progress (or lack of progress) toward therapy goals, or achievement of therapy goals and the measurements would be documented in the clinical record.

While a qualified therapist could include, as part of the functional assessment or reassessment, objective measurements or observations made by a PTA or OTA within their scope of practice, the qualified therapist would have to actively and personally participate in the functional assessment, and measure the patient's progress.

- For those patients requiring 13 or 19 therapy visits, the patient would be functionally re-assessed by a qualified therapist, minimally, on the 13th and the 19th therapy visit (thus requiring reassessment prior to the HH PPS therapy thresholds of 14 and 20 therapy visits), and at least every 30 days.
- No subsequent therapy visits would be covered until the qualified therapist has completed the reassessment, objectively measured progress (or lack of progress) toward goals, determine if goals have been achieved or require updating, and documented the therapy progress in the clinical record. If the objective measurements of the reassessment do not reveal progress toward goals, the qualified therapist, together with the physician, would determined whether the therapy is still effective or should be discontinued. If therapy is continued, the clinical record would be documented, as described below, with a clinically supportable statement of why there is an expectation that anticipated improvement is attainable in a reasonable and generally predictable period of time.

These reassessments would ensure that the patient was receiving effective care while also ensuring that, except for covered maintenance therapy as described later in this section, patients were not remaining on the benefit and continuing to receive therapy services after the therapy goals were met, or after improvement could no longer be expected.

Documenting "Effective" Therapy Progress

Assistant's Participation in Documenting "Effective" Therapy Progress

We are proposing that physical therapist assistants or occupational therapy assistants could objectively document progress between the functional reassessments by a qualified therapist and/or physician. Clinical notes written by assistants are not complete functional assessments of progress.

Only a qualified therapist would be able to document a patient's progress towards goals as measured during a functional reassessment, regardless of whether the assistant wrote other clinical notes. However, notes written by assistants are part of the clinical record and need not be copied into the reassessment documentation. Clinical notes written by assistants would supplement the functional reassessment documentation of qualified therapist and would include:

- The date that the clinical note was written; the assistant's signature and job title, or for dictated documentation, the identification of the assistant who

composed the clinical note, and the date on which it was dictated;

• Objective measurements (preferred) or description of changes in status relative to each goal currently being addressed in treatment, if they occurred. Note that assistants would not make clinical judgments about why progress was or was not made, but could report the progress objectively.

Descriptions would make identifiable reference to the goals in the current plan of care.

Qualified Therapist's Responsibility in "Effective" Progress Documentation

In addition to the proposed requirements above for clinical documentation by assistants, we are also proposing in § 409.44(c)(2)(i) that the patient's progress documentation by a qualified therapist would also include:

• Documentation of objective measurement obtained during the functional assessment and extent of progress (or lack thereof) toward each therapy goal.

• Plans for continuing or discontinuing treatment, with reference to evaluation results, and/or treatment plan revisions.

• Changes to goals or an updated plan of care that is sent to the physician for signature or for discharge.

• Documentation of objective evidence or a clinically supportable statement of expectation that: (1) The patient's condition has the potential to improve or is improving in response to therapy; or (2) maximum improvement is yet to be attained, and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. Objective evidence would consist of standardized patient assessments, outcome measurement tools, or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, and during and/or after treatment would be required to quantify progress and support justifications for continued treatment.

Proposed Clarifications to 42 CFR 409.44(c)(2)(iii)

Regulations at § 409.44(c)(2)(iii) presently mandate that for therapy services to be covered in the home health setting, there must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific disease, or the skills of a therapist must be necessary to establish a safe and effective maintenance program in connection with a specific disease or the skills of a therapist must be necessary to perform a safe and effective maintenance program. We would clarify these requirements:

• The first sentence currently states, "There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition."

We propose clarifying the regulatory text to clarify that "material" improvement requires that the clinical record demonstrate that the patient is making functional improvements that are ongoing and of practical value, when measured against his or her condition at the start of treatment.

We are proposing to clarify that the concept of rehabilitative therapy includes recovery or improvement in function and, when possible, restoration to a previous level of health and well-being.

Covered therapy services under the home health benefit shall be rehabilitative therapy services unless they meet the criteria for maintenance therapy requiring the skills of a therapist as described below.

We are proposing to clarify the regulatory text so that if an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be considered reasonable and necessary, and therefore would not be covered as rehabilitative therapy services.

We are also proposing to clarify the regulatory text to describe that therapy is covered as rehabilitative therapy when the skills of a therapist are necessary to safely and effectively furnish or supervise a recognized therapy service whose goal is improvement of an impairment or functional limitation.

We are proposing to clarify in regulatory text that therapy would not be covered to effect improvement or restoration of function where a patient suffered a transient and easily reversible loss or reduction of function (*e.g.,* temporary weakness which may follow a brief period of bed rest following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury, and the services would not be covered.

If at any point in the treatment of an illness, it was determined that the treatment was not rehabilitative and did not legitimately require the services of a qualified therapist for management of a maintenance program as described below, the services would no longer be considered reasonable and necessary and therapy would cease to be covered.

• As currently stated, § 409.44(c)(2)(iii) also covers occupational therapy, physical therapy, or speech language pathology if the services are "necessary to establish a safe and effective maintenance program required in connection with a specific disease."

We are proposing to clarify the existing regulatory text by adding that the specialized skill, knowledge and judgment of a therapist would be required in developing a maintenance program, and services would be covered to design or establish the plan, to ensure patient safety, to train the patient, family members and/or unskilled personnel in carrying out the maintenance plan, and to make periodic reevaluations of the plan.

When indicated, during the last visit(s) for rehabilitative treatment, the clinician may develop a maintenance program for the patient. The goals of a maintenance program would be, for example, to maintain functional status or to prevent decline in function.

We are also proposing to clarify that if a maintenance program was initiated after the rehabilitative therapy program had been completed (rather than by a clinician at the last rehabilitative therapy session), development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient's condition, with one exception. We propose that when a patient qualifies for Medicare's home health benefit based on an intermittent skilled nursing need, a qualified therapist may develop a maintenance program to maintain functional status or to prevent decline in function, at any point in the episode.

The services of a qualified therapist would not be necessary to carry out a maintenance program, and would not be covered under ordinary circumstances. The patient could perform such a program independently or with the assistance of unskilled personnel or family members.

We also are proposing to clarify circumstances under which CMS would cover therapy services for carrying out

a maintenance program. If the clinical condition of the patient were such that the services required to maintain function involved the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) in order to provide both a safe and effective maintenance program and to ensure patient safety, those reasonable and necessary services would be covered, even if the skills of a therapist were not ordinarily needed to carry out the activities performed as part of the maintenance program.

Clarifications to § 409.44(c)(2)(iv)

In order to clarify § 409.44(c)(2)(iv), which mandates that for therapy to be covered in the home health setting, the amount, frequency, and duration of the services must be reasonable, we propose to revise § 409.44(c)(2)(iv) to require that:

- The amount, frequency and duration of therapy services must be reasonable and necessary, as determined by a qualified therapist and/or physician, using accepted standards of clinical practice.
- The plan of care or the functional assessment would include any variable factors that influence the patient's condition or affect the patient's response to treatment, especially those factors that influence the clinician's decision to provide more services than are typical for the patient's condition.
- The clinical record documentation would have to include objective measurements that demonstrated that the patient was making progress toward goals. If progress could not be measured, and continued improvement cannot be expected, therapy services would cease to be covered, with two exceptions. First, therapy could still be considered reasonable and necessary (and thus covered) if therapy progress regressed or plateaued, if the reason(s) for lack of progress were documented, and the justification supporting the expectation that progress would be regained and maintained with continued therapy was also documented. Second, therapy could be considered reasonable and necessary (and thus covered) under specific circumstances when maintenance therapy is established or provided, as explained previously in this section.

D. Collecting Additional Claims Data for Future HH PPS Enhancements and Soliciting Comments on HH PPS Improvements

The 2009 MedPAC report recommended that CMS improve the HH PPS to mitigate vulnerabilities such as payment incentives to provide unnecessary services. We believe that we need more specific resource use data to fully address these vulnerabilities. Therefore, we are planning to require HHAs to report additional data on the HH claim beginning in CY 2011. Data collection requirements are handled via a separate administrative process, and are not part of this rulemaking.

In their March 2010 report, MedPAC suggested that the HH PPS case-mix weights needed adjustment. Our current therapy weights are calibrated assuming that 79 percent of the time, HH therapy is provided by therapists. We believe that the current mix of therapy services may have changed. To ensure we accurately update the case-mix weights, we believe there is a need to collect additional data on the HH claim to differentiate between the therapy visits provided by therapy assistants versus therapists.

We typically consider skilled nursing services to involve direct skilled nursing care to a patient, and therapy services to be restorative therapy. However, in limited situations, regulations deem a set of nursing services which are not direct care skilled nursing as skilled services and also deem a set of therapy services which are not restorative therapy as skilled therapy. Therefore, we are planning to require HHAs to report additional data on the HH claim to differentiate between these deemed skilled services and direct care skilled nursing or restorative therapy. We believe that these data will help us better understand services provided, enabling us to more accurately address overutilization vulnerabilities.

Currently, we use the following G-codes to define therapy services in the home health setting:

- *G0151* Services of physical therapist in home health setting, each 15 minutes.
- *G0152* Services of an occupational therapist in home health setting, each 15 minutes.
- *G0153* Services of a speech-language pathologist in home health setting, each 15 minutes.

We are planning to revise the current definitions for existing G-codes for physical therapists (G0151), occupational therapists (G0152), and speech-language pathologists (G0153), to include in the descriptions that they are intended for the reporting of services provided by a qualified physical or occupational therapist or speech-language pathologist. A qualified therapist is one who meets the personnel requirements in the CoPs at 42 CFR 484.4. Additionally, we are planning to require the reporting of two additional G-codes to report the delivery of therapy services by assistants. The following are draft descriptions for those revised and new G-codes, for the reporting of restorative therapy visits by qualified therapists and qualified assistants. Since these new G-codes do not yet exist, we have entitled all the new G-codes as G-CodeX, with the 'X' being a number to indicate which new code.

- *G0151* Services performed by a qualified physical therapist in the home health setting, each 15 minutes.
- *G0152* Services performed by a qualified occupational therapist in the home health setting, each 15 minutes.
- *G0153* Services performed by a qualified speech-language pathologist in the home health setting, each 15 minutes.
- *G-Code1* Services performed by a qualified physical therapist assistant in the home health setting, each 15 minutes.
- *G-Code2* Services performed by a qualified occupational therapist assistant in the home health setting, each 15 minutes.

We are also planning to require new G-codes for the reporting of the establishment or delivery of therapy maintenance programs by qualified therapists. The following are draft descriptions for those new G-codes, for the reporting of the establishment or delivery of therapy maintenance programs by therapists:

- *G-Code3* Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, each 15 minutes.
- *G-Code4* Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, each 15 minutes.
- *G-Code5* Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or deliver of a safe and effective therapy maintenance program, each 15 minutes.

Currently we use the following G-code for the reporting of skilled nursing services in the home:

- *G0154* Skilled services of a nurse in the home health setting, each 15 minutes.

We are planning to revise the current definition for the existing G-code for skilled nursing services (G0154), and require HHAs to use G0154 only for the reporting of direct skilled nursing care to the patient by a licensed nurse. Additionally, we are planning to require two new G-codes: One for the reporting

of the skilled services of a licensed nurse in the management and evaluation of the care plan or the observation and assessment of a patient's conditions when only the specialized skills of a licensed nurse can determine the patient's status until the treatment regimen is essentially stabilized; and another for the reporting of the training or education of a patient, a patient's family, or caregiver:

- *G0154* Skilled services of a licensed nurse in the home health setting, each 15 minutes.
- *G-Code6* Skilled services by a licensed nurse, in the delivery of management & evaluation of the plan of care, or the observation and assessment of the patient's condition while a patient's treatment regime is stabilized, in the home health setting, each 15 minutes.
- *G-Code7* Skilled services of a licensed nurse, in the training and/or education of a patient or family member, in the home health setting, each 15 minutes.

In addition to our plans for collecting additional claims data for future HH PPS enhancements, we are considering other possible changes to the HH PPS. As such, we are also soliciting comments on options to restructure the HH PPS to mitigate the overutilization and up-coding risks that current data suggest. Specifically, we are soliciting comments on possible policy options such as using the new claims data to better account for therapy resource use and limiting the use of co-morbid conditions in payment algorithms.

E. Outlier Policy

1. Background

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the regular 60-day case-mix and wage-adjusted episode payment amounts in the case of episodes that incur unusually high costs due to patient home health care needs. Prior to the enactment of The Affordable Care Act, this section stipulated that total outlier payments could not exceed 5 percent of total projected or estimated HH payments in a given year. Under the HH PPS, outlier payments are made for episodes for which the estimated costs exceed a threshold amount. The wage adjusted fixed dollar loss (FDL) amount represents the amount of loss that an agency must absorb before an episode becomes eligible for outlier payments. As outlined in our FY 2000 HH PPS final rule (65 FR 41188–41190), we provided for outlier payments projected to not exceed 5 percent of total payments and we adjusted the payment rates accordingly.

2. Regulatory Update

In our November 10, 2009 HH PPS final rule for CY 2010 (74 FR 58080–58087), we explained that our analysis revealed excessive growth in outlier payments in a few discrete areas of the country. Despite program integrity efforts associated with excessive outlier payments in targeted areas of the country, we discovered that outlier expenditures exceeded the 5 percent statutory limit. Consequently, we assessed the appropriateness of taking action to curb outlier abuse.

In order to mitigate possible billing vulnerabilities associated with excessive outlier payments, and to adhere to our statutory limit on outlier payments, we adopted an outlier policy that included a 10 percent agency level cap on outlier payments in concert with a reduced FDL ratio of 0.67. This 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 back into the national standardized 60-day episode 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

Section 3131(b)(1) of the The Affordable Care Act amended Section 1895(b)(3)(C), "Adjustment for outliers"; that subparagraph now reads, "The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health 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 amends Section 1895(b)(5) of the Act by taking the existing language, re-designating it as 1895(b)(5)(A) of the Act, and revising it such that it states that the Secretary, "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, we are required to implement a HH PPS outlier policy whereby we reduce the standard episode payment by 5 percent, and target up to 2.5 percent of total projected estimated HH PPS payments to be paid as outlier payments. We would first return the 2.5 percent that we took out of the national standardized 60-day episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor for CY 2010 that paid for the CY 2010 outlier pool of 2.5 percent. We will then reduce those 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, the total amount of the additional payments or payment adjustments made may not exceed 2.5 percent of the total payments projected or estimated to be made based on the prospective payment system in that year as required by Section 1895(b)(5)(A) of the Act as amended by Section 3131(b)(2)(B) of The Affordable Care Act.

4. Outlier Cap

As stated earlier, for CY 2010 only, we capped home health outlier payments at a maximum of 10 percent per agency (74 FR 58080–58087). Section 3131(b)(2)(C) of The Affordable Care Act adds a paragraph, (B) "Program Specific Outlier Cap", to Section 1895(b)(5) of the Act. The new paragraph states, "The estimated total amount of additional payments or payment adjustments made * * * with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section * * * with respect to the home health agency for the year." Therefore, the 10 percent per agency outlier cap would continue in CY 2011 and subsequent calendar years as required by section 1895(b)(5)(B) of the Act as amended by section 3131(b)(2)(C) of The Affordable Care Act. Section 3131(b) requires that we (1) Reduce the standard payment rates by 5 percent, (2) pay no more than 2.5 percent of total estimated payments for outliers, and (3) apply a 10% agency aggregate outlier cap.

5. Loss-Sharing Ratio and Fixed Dollar Loss Ratio

The July 2000 final rule (65 FR 41189) described a methodology for determining outlier payments. Under this system, outlier payments are made

for episodes whose estimated cost exceeds a threshold amount. The episode's estimated cost is the sum of the national wage-adjusted per-visit rate amounts for all visits delivered during the episode. The outlier threshold is defined as the national standardized 60-day episode payment rate for that case-mix group plus a fixed dollar loss (FDL) amount. Both components of the outlier threshold are wage-adjusted. The wage adjusted FDL amount represents the amount of loss that an agency must experience before an episode becomes eligible for outlier payments. The wage adjusted FDL amount is computed by multiplying the national standardized 60-day episode payment amount by the FDL ratio, and wage-adjusting that amount. That wage-adjusted FDL amount is added to the HH PPS payment amount to arrive at the wage adjusted outlier threshold amount.

The outlier payment is defined to be a proportion of the wage-adjusted estimated costs beyond the wage-adjusted outlier threshold amount. The proportion of additional costs paid as outlier payments is referred to as the loss-sharing ratio. The FDL ratio and the loss-sharing ratio were selected so that the estimated total outlier payments would not exceed the 5 percent level. We chose a value of 0.80 for the loss-sharing ratio, which is relatively high, but 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 costs above the wage-adjusted outlier threshold amount. A loss-sharing ratio of 0.80 is also consistent with the loss-sharing ratios used in other Medicare PPS outlier policies, such as inpatient hospital, inpatient rehabilitation, long-term hospital, and inpatient psychiatric payment systems. As discussed in the October 1999 proposed rule (64 FR 58169) and the July 2000 final rule (65 FR 41189), the percentage constraint on total outlier payments creates a tradeoff between the values selected for the FDL amount and the loss-sharing ratio. For a given level of outlier payments, a higher FDL amount reduces the number of cases that receive outlier payments, but makes it possible to select a higher loss-sharing ratio and therefore increase outlier payments per episode. Alternatively, a lower FDL amount means that more episodes qualify for outlier payments but outlier payments per episode must be lower.

Therefore, setting these two parameters involves policy choices about the number of outlier cases and their rate of payment. In the CY 2010 HH PPS final rule (74 FR 58086), we implemented a FDL ratio of 0.67.

For this proposed rule, we have updated our analysis from the CY 2010 HH PPS final rule and we estimate that maintaining a FDL ratio of 0.67, in conjunction with a 10 percent cap on outlier payments at the agency level, would pay no more than the 2.5 percent target of outlier payments as a percentage of total HH PPS payments as required by Section 1895(b)(5)(A) of the Act, as amended by section 3131(b)(2)(B) of The Affordable Care Act.

6. Solicitation of Comments Regarding Imputed Costs

The Affordable Care Act requires CMS to conduct a study which includes analysis of ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries. CMS will produce a Report to Congress containing this study's recommendations no later than March 1, 2014.

To consider outlier policy improvements in the nearer term we are soliciting comments regarding alternate policy options and the methodologies to better account for high cost patients. In particular, we would like the industry's input on alternatives to how we impute costs in the calculation of the outlier payments.

We have discussed and are exploring the possible use of visit intensity data in the imputing of costs as part of the outlier payment calculation and would be interested in the industry's views on such an alternative. In addition, we would like to receive feedback concerning the use of diagnoses codes (for example, diabetes) as a factor to be used to calculate the imputed costs associated with outlier payments. We believe that to modifying the fixed dollar loss ratio or the loss sharing ratio, at this point in time, would not improve the current policy, but we solicit industry comments on this as well.

F. Proposed CY 2011 Rate Update

1. Home Health Market Basket Update

Section 1895(b)(3)(B) of the Act requires for CY 2011 that the standard prospective payment amounts be increased by a factor equal to the applicable home health market basket update for those HHAs that submit quality data as required by the Secretary. Section 3401(e) of The Affordable Care Act amended section 1895(b)(3)(B) of the Act by adding a 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."

The proposed HH PPS market basket update for CY 2011 is 2.4 percent. This is based on Global Insight Inc.'s first quarter 2010 forecast, utilizing historical data through the fourth quarter of 2009. A detailed description of how we derive the HHA market basket is available in the CY 2008 Home Health PPS proposed rule (72 FR 25356, 25435). Due to the new requirement at section 1895(b)(3)(B)(vi) of the Act, the proposed CY 2011 market basket update of 2.4 percent must be reduced by 1 percentage point to 1.4 percent. In effect, the proposed CY 2011 market basket update becomes 1.4 percent. The law does not permit us to exercise any discretion with respect to the application of this reduction.

2. Home Health Care Quality Improvement

a. OASIS

Section 1895(b)(3)(B)(v)(II) of the Act requires 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 dictates that "for 2007 and each subsequent year, in the case of a home health agency that does not submit data to the Secretary in accordance with sub clause (II) with respect to such a year, the home health 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).

Accordingly, for CY 2011, we propose to continue to use a HHA's submission of OASIS data to meet the requirement that the HHA submit data appropriate for the measurement of health care quality. We are proposing for CY 2011 to consider OASIS assessments submitted by HHAs to CMS in compliance with HHA Conditions of Participation for episodes beginning on or after July 1, 2009 and before July 1, 2010 as fulfilling the quality reporting requirement for CY 2011. This time period would allow 12 full months of

data collection and would provide us the time necessary to analyze and make any necessary payment adjustments to the payment rates in CY 2011. We propose to reconcile the OASIS submissions with claims data in order to verify full compliance with the quality reporting requirements in CY 2011 and each year thereafter on an annual cycle July 1 through June 30 as described above.

As set forth in the CY 2008 final rule, agencies do not need to submit quality data for those patients who are excluded from the OASIS submission requirements under the Home Health Conditions of Participation (CoP) (42 CFR 484.200 through 484.265) as well as those excluded, as described at 70 FR 76202:

- Those patients receiving only non-skilled services,
- Neither Medicare nor Medicaid is paying for home health care (patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement),
- Those patients receiving pre- or post-partum services, or
- Those patients under the age of 18 years.

As set forth in the CY 2008 final rule at 72 FR 49863, agencies that become Medicare certified on or after May 31 of the preceding year (2009 for payments in 2011) are excluded from any payment penalty for quality reporting purposes for the following CY. Therefore, HHAs that are certified on or after May 1, 2010 are excluded from the quality reporting requirement for CY 2011 payments. These exclusions only affect quality reporting requirements and do not affect the HHA's reporting responsibilities under the CoP. HHAs that meet the quality data reporting requirements would be eligible for the full home health market basket percentage increase. HHAs that do not meet the reporting requirements would be subject to a 2 percent reduction to the home health market basket increase in conjunction with applicable provisions of The Affordable Care Act, as discussed in the section "Proposed CY 2011 Payment Update" of this rule.

Section 1895(b)(3)(B)(v)(III) of the Act further requires 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 home health agency 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." We propose to continue to use the subset of OASIS data that is utilized for quality measure development and publicly reported on Home Health Compare as the appropriate measure of home health quality.

To meet the requirement for making such data public, we propose to continue using the *Home Health Compare* Web site, which lists HHAs geographically. Currently, the Home Health Compare Web site lists 12 quality measures from the OASIS data set as described below. The Home Health Compare Web site, which will be redesigned by October 2010, is located at the following address: *http://www.medicare.gov/HHCompare/Home.asp.* Each HHA currently has pre-publication access, through the CMS contractor, to its own quality data that the contractor updates periodically. We propose to continue this process, to enable each agency to view its quality measures before public posting of data on *Home Health Compare.*

The following twelve outcome measures are currently publicly reported:

- Improvement in ambulation/locomotion,
- Improvement in bathing,
- Improvement in transferring,
- Improvement in management of oral medications,
- Improvement in pain interfering with activity,
- Acute care hospitalization,
- Emergent care,
- Discharge to community,
- Improvement in dyspnea,
- Improvement in urinary incontinence,
- Improvement in status of surgical wounds, and
- Emergent care for wound infections, deteriorating wound status.

We propose to continue to use specified measures derived from the OASIS data for purposes of measuring home health care quality. This would also ensure that providers would not have an additional burden of reporting quality of care measures through a separate mechanism, and that the costs associated with the development and testing of a new reporting mechanism would be avoided.

CMS proposes to change the set of OASIS outcome measures that will be publicly reported beginning in July 2011. One new outcome measure will be added:

- Increase in number of pressure ulcers.

This outcome measure is the percentage of patient episodes in which there was an increase in the number of unhealed pressure ulcers. This measure is viewed as important because pressure ulcers are key indicators of the effectiveness of care and are among the most common causes of harm to patients. Though consensus endorsement is not a requirement for public reporting of home health quality measures, this measure is endorsed by the National Quality Forum.

As previously stated, although NQF endorsement is not required for public reporting, CMS proposes to discontinue public reporting of certain outcome measures which were previously reported on Home Health Compare and are no longer endorsed by NQF. Those measures are—

- Discharge to community,
- Improvement in Urinary Incontinence, and
- Emergent Care for Wound Infections, Deteriorating Wound Status.

CMS welcomes comments regarding the public reporting of these measures. Additionally, the change to OASIS–C results in modifications to two of the outcome measures as shown below:

- *Improvement in bed transferring:* This measure replaces the previously reported measure improvement in transferring. It provides a more focused measurement of the ability to turn and position oneself in bed and transfer to and from the bed.
- *Emergency Department Use Without Hospitalization:* This measure replaces the previously reported measure: Emergent care. It excludes emergency department visits that result in a hospital admission because those visits are already captured in the acute care hospitalization measure.

To summarize, we propose that the following outcome measures, which comprise measurement of home health care quality, would be publicly reported beginning in July 2011:

- Improvement in ambulation/locomotion,
- Improvement in bathing,
- Improvement in bed transferring,
- Improvement in management of oral medications,
- Improvement in pain interfering with activity,
- Acute care hospitalization,
- Emergency Department Use without Hospitalization,
- Improvement in dyspnea,
- Improvement in status of surgical wounds,
- Increase in number of pressure ulcers.

We implemented use of the OASIS–C (Form Number CMS–R–245 (OMB# 0938–0760)) on January 1, 2010. This revision to OASIS was tested and has been distributed for public comment and other technical expert recommendations over the past few years. The OASIS–C can be found using

the following link: *http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage.*

As a result of changes to the OASIS data set, process of care measures will be available as additional measures of home health quality. CMS published information about new process measures in the **Federal Register** as a proposed rule on August 13, 2009 (74 FR 40960) and as a final rule with comment period on November 10, 2009 (74 FR 58096). We proposed and made final the decision to update *Home Health Compare* in October 2010 to reflect the addition of the following 13 new *process* measures:

- Timely initiation of care,
- Influenza immunization received for current flu season,
- Pneumococcal polysaccharide vaccine ever received,
- Heart failure symptoms addressed during short-term episodes,
- Diabetic foot care and patient education implemented during short-term episodes of care,
- Pain assessment conducted,
- Pain interventions implemented during short-term episodes,
- Depression assessment conducted,
- Drug education on all medications provided to patient/caregiver during short-term episodes.
- Falls risk assessment for patients 65 and older,
- Pressure ulcer prevention plans implemented,
- Pressure ulcer risk assessment conducted, and
- Pressure ulcer prevention included in the plan of care.

The implementation of OASIS–C impacts the schedule of quality measure reporting for CY 2010 and CY 2011. While sufficient OASIS–C data are collected and risk models are developed, the outcome reports (found on Home Health Compare and the contractor outcome reports used for HHA's performance improvement activities) will remain static with OASIS–B1 data. The last available OASIS B–1 reports will remain in the system and on the HHC site until they are replaced with OASIS–C reports. Sufficient numbers of patient episodes are needed in order to report measures based on new OASIS–C data. This is important because measures based on patient sample sizes taken over short periods of time can be inaccurate and misleading due to issues like seasonal variation and under-representation of long-stay home health patients. Once sufficient OASIS–C data have been collected and submitted to the national repository, CMS will begin producing new reports based on OASIS–C.

December 2009 was the last month for which OBQI/M data was calculated for OASIS B1 data and OASIS B1 OBQI/M reports will continue to be available after March 2010. OASIS–C process measures will be available to preview in September 2010 and will be publicly reported in October 2010. OASIS–C outcome measures will be available to preview in May 2011 and will be publicly reported in July 2011.

b. Home Health Care CAHPS Survey (HHCAHPS)

In the Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year 2010 Final Rule, published on November 10, 2009, we expanded the home health quality measures reporting requirements for Medicare-certified agencies to include the CAHPS® Home Health Care (HHCAHPS) Survey for the CY 2012 annual payment update. CMS is maintaining its existing policy as promulgated in the HH PPS Rate Update for Calendar Year 2010, and is moving forward with its plans for HHCAHPS linkage to the pay-for-reporting requirement affecting the HH PPS rate update for CY 2012.

As part of the U.S. Department of Health and Human Services' (DHHS) Transparency Initiative, CMS has 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. 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 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 would enable valid comparisons across all home health agencies (HHAs).

Background and Description of the HHCAHPS

AHRQ, in collaboration with its CAHPS grantees, developed the CAHPS® Home Health Care Survey with the assistance of many entities (for example, government agencies, professional stakeholders, consumer groups and other key individuals and organizations involved in home health care). The HHCAHPS survey was designed to measure and assess the experiences of those persons receiving home health care with the following three goals in mind:

- To produce comparable data on patients' perspectives of care that allow objective and meaningful comparisons between HHAs on domains that are important to consumers;
- To create incentives for agencies to improve their quality of care through public reporting of survey results; and
- To hold health care providers accountable by informing the public about the providers' quality of care.

The development process for the survey began in 2006 and included a public call for measures, review of the existing literature, consumer input, stakeholder input, public response to **Federal Register** notices, and a field test conducted by AHRQ. AHRQ conducted this field test to validate the length and content of the CAHPS® Home Health Care Survey. We submitted the survey to the National Quality Forum (NQF) for consideration and endorsement via their consensus process. NQF endorsement represents the consensus opinion of many healthcare providers, consumer groups, professional organizations, health care purchasers, Federal agencies and research and quality organizations. The survey received NQF endorsement on March 31, 2009. The HHCAHPS survey received clearance from OMB on July 18, 2009, and the OMB number is 0938–1066.

The HHCAHPS survey includes 34 questions covering topics such as specific types of care provided by home health providers, communication with providers, interactions with the HHA, and global ratings of the agency. For public reporting purposes, we will utilize composite measures and global ratings of care. Each composite measure consists of four or more questions regarding one of the following related topics:

1. Patient care;
2. Communications between providers and patients;
3. Specific care issues (medications, home safety and pain).

There are also two global ratings; the first rating asks the patient to assess the care given by the HHA's care providers; and the second asks the patient about his/her willingness to recommend the HHA to family and friends.

The survey is currently available in five languages. At the time of the Final Rule for CY 2010, we only provided HHCAHPS in English and Spanish translations. In the proposed rule for CY 2010, we proposed that CMS will provide additional translations of the

survey over time in response to suggestions for any additional language translations. We now offer HHCAHPS in English, Spanish, Chinese, Russian and Vietnamese languages. We will continue to consider additional translations of the HHCAHPS in response to the needs of the home health patient population.

The following types of home health care patients are eligible to participate in the HHCAHPS survey:

- Current or discharged Medicare and/or Medicaid patients who had at least one skilled home health visit at any time during the sample month;
- Patients who were at least 18 years of age at any time during the sample period, and are believed to be alive;
- Patients who received at least two skilled care visits from HHA personnel during a 2 month look-back period. (Note that the 2 month look-back period is defined as the 2 month period prior to and including the last day in the sample month);
- Patients who have not been selected for the monthly sample during any month in the current quarter or during the 5 months immediately prior to the sample month;
- Patients who are not currently receiving hospice care;
- Patients who do not have "maternity" as the primary reason for receiving home health care; and
- Patients who have not requested "no publicity status."

We are maintaining for the CY 2012 annual payment update the existing requirements for Medicare-certified agencies to contract with an approved HHCAHPS survey vendor. Beginning in summer 2009, interested vendors applied to become approved HHCAHPS vendors. The application process is delineated online at *https://www.homehealthcahps.org*. 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 42 approved HHCAHPS survey vendors. In this proposed rule, we propose to codify the requirements for HHCAHPS survey vendors for the CY 2013 annual payment update.

HHAs started to participate in HHCAHPS on a voluntary basis beginning in October 2009. CMS defines "voluntary participation" as meaning that HHCAHPS participation is not attached to the quality reporting requirement for the annual payment update. These agencies selected a vendor from the list of HHCAHPS approved survey vendors. This listing is on the Web site *https://www.homehealthcahps.org*.

Public Display of the Home Health Care CAHPS Survey Data

The Home Health Care CAHPS data will be incorporated into the Home Health Compare Web site to complement the clinical measures. The HHCAHPS data displays will be very similar to those of the Hospital CAHPS (HCAHPS) data displays and presentations on Hospital Compare, where the patients' perspectives of care data from HCAHPS are displayed along with the hospital clinical measures of quality. CMS believes that the HHCAHPS will enhance the information included in Home Health Compare by providing Medicare beneficiaries a greater ability to compare the quality of home health agencies. CMS anticipates that HHCAHPS data will first be reported sometime in spring/summer 2011. The first reporting of HHCAHPS data will include data that were collected in the voluntary period of HHCAHPS data collection and reporting, prior to the period when the HHCAHPS data count toward the 2012 APU.

Participation Requirements for CY 2012: The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey

In the HH PPS Final Rule for CY 2010, we stated that HHCAHPS would not be required for the annual payment update for CY 2011. However, we stated that data collection should take place beginning in CY 2010 in order to meet the HHCAHPS reporting requirement for the CY 2012 annual payment update as stated in the HH PPS Final Rule for CY 2010 (58078, 58099, 58100, 58103, and 58104). Medicare-certified agencies were asked to participate in a dry run for at least one month in third quarter of 2010, and begin continuous monthly data collection in October 2010 in accordance with the Protocols and Guidelines Manual located on the HHCAHPS Web site *https://www.homehealthcahps.org*.

The dry run data should be submitted to the Home Health CAHPS® Data Center by 11:59 p.m. EST on January 21, 2011. The dry run data will not be publicly reported on the CMS Home Health Compare Web site. The purpose of the dry run is to provide an opportunity for vendors and HHAs to acquire first-hand experience with data collection, including sampling and data submission to the Home Health CAHPS® Data Center. We previously stated that all Medicare-certified HHAs should continuously collect HHCAHPS survey data for every month in every quarter beginning with the fourth quarter (October, November, and December) of 2010, and submit these data for the fourth quarter of 2010 to the Home Health CAHPS® Data Center by 11:59 p.m. EST on April 21, 2011. These data submission deadlines are firm (that is, no late submissions will be accepted).

The period of data collection for the CY 2012 annual payment update includes the dry run data in the third quarter 2010, the fourth quarter 2010 (October, November and December 2010), and the first quarter 2011 (January, February and March 2011). The data from the three months of the first quarter 2011 should be submitted to the Home Health CAHPS® Data Center by 11:59 p.m. EST on July 21, 2011. These periods (a dry run in third quarter 2010, and six months of data from October 2010 through March 2011) have been deliberately chosen to comprise the HHCAHPS reporting requirements for the CY 2012 APU because they coincide with the OASIS–C reporting requirements that are due by June 30, 2011 for the CY 2012 APU. In the previous rule, we stated that the HHCAHPS survey data would be submitted and analyzed quarterly, and that the sample selection and data collection would occur on a monthly basis. HHAs would target 300 HHCAHPS survey completes annually. Smaller agencies that are unable to reach 300 survey completes by sampling would survey all HHCAHPS eligible patients.

We stated that survey vendors initiate the survey for each monthly sample within 3 weeks after the end of the sample month. We wrote that all data collection for each monthly sample would have to be completed within 6 weeks (42 calendar days) after data collection began. Three survey administration modes could be used: Mail only, telephone only, and mail with telephone follow-up (the "mixed mode"). We also conveyed that for mail-only and mixed-mode surveys, data collection for a monthly sample would have to end 6 weeks after the first questionnaire was mailed. We stated that for telephone-only surveys, data collection would have to end 6 weeks following the first telephone attempt. These criteria would remain the same for HHCAHPS to meet the CY 2012 annual payment update requirements.

As stated in the Home Health Prospective Payment System Rate Update for Calendar Year 2010; final rule (74 FR 58078), we would exempt Medicare-certified HHAs certified on or after April 1, 2011 from the HHCAHPS reporting requirement for CY 2012 as data submission and analysis will not be

possible for an agency this late in the CY 2012 reporting period.

We would also exempt Medicare-certified agencies from the HHCAHPS reporting requirements if they have fewer than 60 HHCAHPS eligible unique patients from April 1, 2009 through March 31, 2010. In the CY 2010 Final Rule, we stated that by June 16, 2010, HHAs would need to provide CMS with patient counts for the period of April 1, 2009 through March 31, 2010. We have posted a form that the HHAs need to use to submit their patient counts via the Web site *https://www.homehealthcahps.org.* This proposed requirement pertains only to Medicare-certified HHAs with fewer than 60 HHCAHPS eligible, unduplicated or unique patients for that time period. The aforementioned agencies would be exempt from conducting the HHCAHPS survey for the annual payment update in CY 2012. We propose to codify that if an HHA has less than 60 eligible unique HHCAHPS patients annually, then they must submit to CMS their total patient count in order to be exempt from the HHCAHPS reporting requirement.

For CY 2012, we maintain our policy that all HHAs, unless covered by specific exclusions, meet the quality reporting requirements or be subject to a 2 percentage point reduction in the home health market basket percentage increase in accordance with section 1895(b)(3)(B)(v)(I) of the Act.

A reconsiderations and appeals process is being developed for HHAs that fail to meet the HHCAHPS reporting requirements. We proposed that these procedures will be detailed in the CY 2012 home health payment rule, the period for which HHCAHPS would be linked to the home health market basket percentage increase. We propose that in September through October 2011, we would compile a list of HHAs that were not compliant with OASIS–C and/or HHCAHPS for the 2012 APU reporting requirements. These HHAs would receive explicit instructions about how to prepare a request for reconsideration of the CMS decision, and these HHAs would have 30 days to file their requests for reconsiderations to CMS. By December 31, 2011, we would provide our final determination for the quality reporting requirements for calendar year 2012 payment. HHAs have a right to appeal to the Prospective Reimbursement Review Board (PRRB) if they are not satisfied with the CMS determination.

Oversight Activities for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home Health Care Survey

We stated that vendors and HHAs would be 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 HHAs and approved survey vendors follow the Protocols and Guidelines Manual. It was stated that all approved survey vendors develop a Quality Assurance Plan (QAP) for survey administration in accordance with the Protocols and Guidelines Manual. The QAP should include the following:

- An organizational chart;
- A work plan for survey implementation;
- A description of survey procedures and quality controls;
- Quality assurance oversight of on-site work and of all subcontractors' work; and
- Confidentiality/Privacy and Security procedures in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

As part of the oversight activities the HHCAHPS Survey Coordination Team would conduct on-site visits and/or conference calls. The HHCAHPS Survey Coordination Team would review the survey vendor's survey systems, and would assess administration protocols based on the Protocols and Guidelines Manual posted on *https://www.homehealthcahps.org*. We stated that all materials relevant to survey administration would be subject to review. The systems and program review would include, but not be limited to: (a) Survey management and data systems; (b) printing and mailing materials and facilities; (c) data receipt, entry and storage facilities; and (d) written documentation of survey processes. Organizations would be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. Survey vendors would be subject to follow-up site visits as needed.

HHCAHPS Requirements for CY 2013

For the CY 2013 annual payment update, we propose to begin to require that four quarters of data be submitted for HHCAHPS. This would include second quarter 2011 through first quarter 2012. We propose that HHAs be required to submit data for the second quarter 2011 by 11:59 p.m. on October 21, 2011 to the Home Health CAHPS Data Center. We also propose that HHAs submit data for the third quarter 2011 by 11:59 p.m. EST January 21, 2012 to the Home Health CAHPS Data Center. We additionally propose that HHAs be required to submit data for the fourth quarter 2011 by 11:59 p.m. EST April 21, 2012 to the Home Health CAHPS Data Center. Finally, we propose that HHAs be required to submit data for the first quarter 2012 by 11:59 p.m. EST July 21, 2012 to the Home Health CAHPS Data Center.

We propose to exempt Medicare-certified HHAs certified on or after April 1, 2012 from the HHCAHPS reporting requirement for CY 2013, as data submission and analysis would not be possible for an agency this late in the CY 2013 reporting period. For the CY 2013 annual payment update, we propose that new Medicare-certified HHAs that open during the year begin HHCAHPS data collection the quarter following receipt of the CMS Certification Number (CCN).

We propose that all HHAs that have fewer than 60 HHCAHPS-eligible unduplicated or unique patients in the period of April 1, 2010 through March 31, 2011 be exempt from the HHCAHPS data collection requirements for the CY 2013 annual payment update. Agencies with fewer than 60 HHCAHPS-eligible, unduplicated or unique patients would be required to submit their counts on the form posted on *https://www.homehealthcahps.org,* the Web site of Home Health Care CAHPS by June 16, 2011. This would be a firm deadline as are all of the quarterly data submission deadlines.

We are proposing to codify the HHCAHPS survey vendor requirements in the CY 2013 rule. In our regulation, we would revise § 484.250(c)(2) to codify that all applying survey vendors would have to have been in business for a minimum of three years and have conducted surveys of individuals for at least two years immediately preceding the application to CMS to become a survey vendor for HHCAHPS. For purposes of the HHCAHPS, a "survey of individuals" would be defined as the collection of data from individuals selected by statistical sampling methods and the data collected are used for statistical purposes. An applicant organization must:

- Have conducted surveys of individuals responding about their own experiences, not of individuals responding on behalf of a business or organizations (establishment or institution surveys);
- Be able to demonstrate that a statistical sampling process (that is, simple random sampling [SRS],

proportionate stratified random sampling [PSRS], or disproportionate stratified random sampling [DSRS]) was used in the conduct of previously or currently conducted survey(s);

• Be able to demonstrate that it, as an organization, has conducted surveys where a sample of individuals was selected for at least two years. If staff within the applicant organization has relevant experience obtained while in the employment of a different organization, that experience may not be counted toward the 2 year minimum of survey experience; and

• Currently possess all required facilities and systems to implement the HHCAHPS Survey.

We are also proposing that the following examples of data collection activities would not satisfy the requirement of valid survey experience for vendors as defined for the HHCAHPS Survey, and these would not be considered as part of the experience that HHCAHPS will require:

• Polling questions administered to trainees or participants of training sessions or educational courses, seminars, or workshops;

• Focus groups, cognitive interviews, or any other qualitative data collection activities;

• Surveys of fewer than 600 individuals;

• Surveys conducted that did not involve using statistical sampling methods;

• Internet or Web-based surveys; and

• Interactive Voice Recognition Surveys.

We are proposing to codify the criteria about which organizations are ineligible to become HHCAHPS approved survey vendors. CMS is proposing that any organization that owns, operates, or provides staffing for a HHA not be permitted to administer its own Home Health Care CAHPS (HHCAHPS) Survey or administer the survey on behalf of any other HHA. CMS began the HHCAHPS with the belief, based on input from many stakeholders and the public, that an independent third party (such as a survey vendor) will be best able to solicit unbiased responses to the HHCAHPS Survey. Since home health patients receive care in their homes, this survey population is particularly vulnerable and dependent upon their HHA caregivers. Therefore, in § 484.250(c)(2) we are proposing that HHAs be required to contract only with an independent, approved HHCAHPS vendor to administer the HHCAHPS survey on their behalf.

Specifically, we are proposing that the following types of organizations would not be eligible to administer the HHCAHPS Survey as an approved HHCAHPS vendor:

• Organizations or divisions within organizations that own or operate a HHA or provide home health services, even if the division is run as a separate entity to the HHA;

• Organizations that provide telehealth, monitoring of home health patients, or teleprompting services for HHAs; and

• Organizations that provide staffing to HHAs for providing care to home health patients, whether personal care aides or skilled services staff.

For Further Information on the HHCAHPS Survey

We encourage HHAs interested in learning about the survey to view the HHCAHPS survey web site, at *https://www.homehealthcahps.org*. Agencies can also call toll-free (1–866–354–0985), or send an e-mail to the HHCAHPS Survey Coordination Team at *HHCAHPS@rti.org* for more information.

3. Home Health Wage Index

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services and to provide appropriate adjustments to the episode payment amounts 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 based on the site of service for the beneficiary (defined by section 1861(m) of the Act as the beneficiary's place of residence). Generally, we determine each HHA's labor market area based on definitions of Metropolitan Statistical Areas (MSAs) issued by the Office of Management and Budget (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 the appropriate adjustment to the labor portion of the costs as required by statute.

In the November 9, 2005 final rule for CY 2006 (70 FR 68132), we adopted revised labor market area definitions based on Core-Based Statistical Areas (CBSAs). At the time, we noted that these were the same labor market area definitions (based on OMB's new CBSA designations) implemented under the Hospital Inpatient Prospective Payment System (IPPS). In adopting the CBSA designations, we identified some geographic areas where there are no hospitals and, thus, no hospital wage data on which to base the calculation of the home health wage index. We continue to use the methodology discussed in the November 9, 2006 final rule for CY 2007 (71 FR 65884) to address the geographic areas that lack hospital wage data on which to base the calculation of their home health wage index. For rural areas that do not have IPPS hospitals, we use the average wage index from all contiguous CBSAs as a reasonable proxy. This methodology is used to calculate the wage index for rural Massachusetts. However, we could not apply this methodology to rural Puerto Rico 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. The only urban areas without IPPS hospital wage data are Anderson, South Carolina (CBSA 11340) and Hinesville-Fort Stewart, Georgia (CBSA 25980).

On December 1, 2009, OMB issued Bulletin No. 10–02 located at Web address *http://www.whitehouse.gov/omb/assets/bulletins/b10-02.pdf*. This bulletin highlights three geographic areas whose principal city has changed therefore causing the CBSA names to change and requiring new CBSA numbers. Bradenton-Sarasota-Venice, FL (CBSA 14600) is replaced by North Port-Bradenton-Sarasota, FL (CBSA 35840). Fort Walton Beach-Crestview-Destin, FL (CBSA 23020) is replaced by Crestview-Fort Walton Beach-Destin, FL (CBSA 18880). Weirton-Steubenville, WV-OH Metropolitan Statistical Area (CBSA 48260) is replaced by Steubenville-Weirton, OH-WV (CBSA 44600). The CBSAs and their associated wage index values are shown in Addendum B. The wage index values for rural areas are shown in Addendum A.

4. Proposed CY 2011 Payment Update

a. National Standardized 60-Day Episode Rate

The Medicare HH PPS has been in effect since October 1, 2000. As set forth in the final rule published July 3, 2000 in the **Federal Register** (65 FR 41128), the unit of payment under the Medicare HH PPS is a national standardized 60-day episode rate. As set forth in § 484.220, we adjust the national standardized 60-day episode rate by a case-mix relative weight and a wage index value based on the site of service for the beneficiary.

In the CY 2008 HH PPS final rule with comment period, we refined the case-mix methodology and also rebased and revised the home health market basket. The labor-related share of the case-mix adjusted 60-day episode rate is 77.082 percent and the non-labor-related share is 22.918 percent. The proposed CY 2011 HH PPS rates use the same case-mix methodology and application of the wage index adjustment to the labor portion of the HH PPS rates as set forth in the CY 2008 HH PPS final rule with comment period. We multiply the national 60-day episode rate by the patient's applicable case-mix weight. We divide the case-mix adjusted amount into a labor and non-labor portion. We multiply the labor portion by the applicable wage index based on the site of service of the beneficiary. We 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, we update the HH PPS rates annually in a separate **Federal Register** document. The HH PPS regulations at 42 CFR 484.225 set forth the specific annual percentage update methodology. In accordance with § 484.225(i), in the case of a HHA that does not submit home health 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 home health 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 taken into account in computing the prospective payment amount for a subsequent calendar year.

For CY 2011, 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. As discussed in the July 3, 2000 HH PPS final rule, for episodes with four or fewer visits, Medicare pays the national per-visit amount by discipline, referred to as a LUPA. We propose to update the national per-visit rates by discipline annually by the applicable home health market basket percentage. We propose to adjust the national per-visit rate by the appropriate wage index based on the site of service for the beneficiary, as set forth in § 484.230. We propose to adjust the labor portion of the updated national per-visit rates used to calculate LUPAs by the most recent pre-floor and pre-reclassified hospital wage index. We are also proposing to update the LUPA add-on payment amount and the NRS conversion factor by the proposed applicable home health market basket update of 1.4 percent for CY 2011.

Medicare pays the 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 would 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. Proposed Updated CY 2011 National Standardized 60-Day Episode Payment Rate

In calculating the annual update for the CY 2011 national standardized 60-day episode payment rates, we first look at the CY 2010 rates as a starting point. The CY 2010 national standardized 60-day episode payment rate is $2,312.94.

As previously discussed in section II.D. ("Outlier Policy") of this proposed rule, in our proposed policy of targeting outlier payments to be approximately 2.5 percent of total HH PPS payments in CY 2011, we are proposing to return 2.5 percent back into the HH PPS rates, to include the national standardized 60-day episode payment rate. Therefore, to calculate the proposed CY 2011 national standardized 60-day episode payment rate, we first increase the CY 2010 national standardized 60-day episode payment rate ($2,312.94) to adjust for the 2.5 percent set aside in CY 2010 for outlier payments. We then reduce that adjusted payment amount by 5 percent, for outlier payments as a percentage of total HH PPS payment as mandated by Section 3131 of The Affordable Care Act. Next, we update the payment amount by the current proposed CY 2011 home health market basket update of 1.4 percent.

As previously discussed in Section II.A. ("Case-Mix Measurement Analysis") of this proposed rule, our updated analysis of the change in case-mix that is not due to an underlying change in patient health status reveals additional increase in nominal change in case-mix. Therefore, we propose to reduce rates by 3.79 percent in CY 2011, resulting in a proposed updated CY 2011 national standardized 60-day episode payment rate of $2,198.58. The proposed updated CY 2011 national standardized 60-day episode payment rate for an HHA that submits the required quality data is shown in Table 4. The proposed updated CY 2011 national standardized 60-day episode payment rate for an HHA that does not submit the required quality data (home health market basket update of 1.4 percent is reduced by 2 percentage points) is shown in Table 5.

BILLING CODE 4120–01–P

Table 4					
Proposed National 60-Day Episode Payment Amount Updated by the Proposed Home Health Market Basket Update for CY 2011, Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary					
CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the proposed home health market basket update of 1.4%	Reduce by 3.79% for nominal change in case-mix	Proposed CY 2011 National Standardized 60-Day Episode Payment Rate.
$2,312.94	÷ 0.975	X 0.95	X 1.014	X 0.9621	$2,198.58

Table 5					
For HHAs that Do Not Submit the Quality Data -- Proposed National 60-Day Episode Payment Amount Updated by the Proposed Home Health Market Basket Update for CY 2011, Before Case-Mix Adjustment and Wage Adjustment Based on the Site of Service for the Beneficiary					
CY 2010 National Standardized 60-Day Episode Payment Rate	Adjusted to return the outlier funds that paid for the 2.5 % target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by the The Affordable Care Act	Multiply by the proposed home health market basket update of 1.4% minus 2% (-0.6%)	Reduce by 3.79% for nominal change in case-mix	Proposed CY 2011 National Standardized 60-Day Episode Payment Rate.
$2,312.94	÷ 0.975	X 0.95	X 0.994	X 0.9621	$2,155.21

BILLING CODE 4120–01–C

c. Proposed National Per-Visit Rates Used To Pay LUPAs and Compute Imputed Costs Used in Outlier Calculations

In calculating the proposed CY 2011 national per-visit rates used to calculate payments for LUPA episodes and to compute the imputed costs in outlier calculations, we start with the CY 2010 national per-visit rates. We first adjust the CY 2010 national per-visit rates to adjust for the 2.5 percent set aside during CY 2011 for outlier payments. We then reduce those national per-visit rates by 5 percent as mandated by section 1895(b)(3)(C) of the Act, as amended by Section 3131 of The Affordable Care Act. Next we update the national per-visit rates by the current proposed CY 2011 home health market basket update of 1.4 percent. National per-visit rates are not subject to the 3.79 percent reduction related to the nominal increase in case-mix. The proposed CY 2011 national per-visit rates per discipline are shown in Table 6. The six home health disciplines are Home Health Aide (HH aide), Medical Social Services (MSS), Occupational Therapy (OT), Physical Therapy (PT), Skilled Nursing (SN), and Speech Language Pathology Therapy (SLP).

BILLING CODE 4120–01–P

Table 6

Proposed National Per-Visit Amounts for LUPAs (Not including the LUPA Add-On Amount for a Beneficiary's Only Episode or the Initial Episode in a Sequence of Adjacent Episodes) and Outlier Calculations Updated by the Proposed CY 2011 Home Health Market Basket Update, Before Wage Index Adjustment

				For HHAs that DO submit the required quality data		For HHAs that DO NOT submit the required quality data	
Home Health Discipline Type	**CY 2010 Per-Visit Amounts Per 60-Day Episode**	**Adjusted to return the outlier funds that paid for the 2.5% target for outlier payments in CY 2010**	**Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act**	**Multiply by the proposed home health market basket update of 1.4%**	**CY 2011 per-visit payment amount f For HHAs that DO submit the required quality data**	**Multiply by the proposed home health market basket update of 1.4% minus 2 percent (-0.6%)**	**CY 2011 per-visit payment amount for HHAs that DO NOT submit the required quality data**
Home Health Aide	$51.18	÷ 0.975	X 0.95	X 1.014	$50.57	X 0.994	$49.57
Medical Social Services	$181.16	÷ 0.975	X 0.95	X 1.014	$178.99	X 0.994	$175.46
Occupational Therapy	$124.40	÷ 0.975	X 0.95	X 1.014	$122.91	X 0.994	$120.48
Physical Therapy	$123.57	÷ 0.975	X 0.95	X 1.014	$122.09	X 0.994	$119.68
Skilled Nursing	$113.01	÷ 0.975	X 0.95	X 1.014	$111.65	X 0.994	$109.45
Speech-Language Pathology	$134.27	÷ 0.975	X 0.95	X 1.014	$132.66	X 0.994	$130.04

BILLING CODE 4120–01–C

d. Proposed LUPA Add-On Payment Amount Update

Beginning in CY 2008, LUPA episodes that occur as the only episode or initial episode in a sequence of adjacent episodes are adjusted by adding an additional amount to the LUPA payment before adjusting for area wage differences. As previously discussed, we are returning 2.5 percent back into the LUPA add-on payment. We then reduce the LUPA add-on payment by 5 percent outlier adjustment as mandated by Section 1895(b)(3)(C) of the Act as amended by Section 3131 of The Affordable Care Act. Next we update the LUPA payment amount by the current proposed CY 2011 home health market basket update percentage of 1.4 percent. The LUPA add-on payment amount is not subject to the 3.79 percent reduction related to the nominal increase in case-mix. For CY 2011, we propose that the add-on to the LUPA payment to HHAs that submit the required quality data would be updated by the proposed home health market basket update of 1.4 percent. The proposed CY 2011 LUPA add-on payment amount is shown in Table 7 below. We propose that the add-on to the LUPA payment to HHAs that do not submit the required quality data would be updated by the home health market basket update (1.4 percent) minus two percentage points.

Table 7

Proposed CY 2011 LUPA Add-On Amounts

			For HHAs that DO submit the required quality data		**For HHAs that DO NOT submit the required quality data**	
CY 2010 LUPA Add-On Amount Adjusted to return the outlier funds, that paid for the original 5 % target for outliers	Adjusted to return the outlier funds that paid for the 2.5% target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by the The Affordable Care Act	Multiply by the proposed home health market basket update of 1.4%	Proposed CY 2011 LUPA Add-On Amount for HHAs that DO submit required quality data	Multiply by the proposed home health market basket update of 1.4% minus 2 percent (-0.6%)	Proposed CY 2011 LUPA Add-On Amount for HHAs that DO NOT submit required quality data
$94.72	÷ 0.975	X 0.95	X 1.014	$93.58	X 0.994	$91.74

e. Non-Routine Medical Supply Conversion Factor Update

Payments for non-routine medical supplies (NRS) are computed by multiplying the relative weight for a particular severity level by the NRS conversion factor. We first adjust the CY 2010 NRS conversion factor ($53.34) for the 2.5 percent set aside for outlier payments in CY 2010. We then reduce that amount by the 5 percent outlier adjustment as mandated by Section 1895(b)(3)(C), as amended by Section 3131 of The Affordable Care Act. Next we update by the proposed market basket update of 1.4 percent. Finally, we then reduce that adjusted payment amount by 3.79 percent to account for the increase in nominal case-mix. The final updated CY 2011 NRS conversion factor for CY 2011 in Table 8a below. For CY 2011, the proposed NRS conversion factor is $50.70.

Table 8a -- Proposed CY 2011 NRS Conversion Factor for HHAs that DO Submit the Required Quality Data

CY 2010 NRS Conversion Factor	Adjusted to return the outlier funds that paid for the 2.5% target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the proposed home health market basket update of 1.4%	Reduce by 3.79% for nominal change in case-mix	Proposed CY 2011 NRS Conversion Factor for HHAs that Do submit the Required Quality Data
$53.34	÷ 0.975	X 0.95	X 1.014	X 0.9621	$50.70

Using the proposed NRS conversion factor ($50.70) for CY 2011, the payment amounts for the various severity levels are shown in Table 8b.

Table 8b			
Relative Weights for the 6-Severity NRS System			
Severity Level	Points (Scoring)	Relative Weight	Proposed NRS Payment Amount
1	0	0.2698	$13.68
2	1 to 14	0.9742	$49.39
3	15 to 27	2.6712	$135.43
4	28 to 48	3.9686	$201.21
5	49 to 98	6.1198	$310.27
6	99+	10.5254	$533.64

For HHAs that do not submit the required quality data, we again begin with the CY 2010 NRS conversion factor. We first adjust the CY 2010 NRS conversion factor ($53.34) for the 2.5 percent set aside for outlier payments in CY 2010. We then reduce that amount by the 5 percent outlier adjustment as mandated by Section 1895(b)(3)(C) of the Act, as amended by Section 3131 of The Affordable Care Act. Next we update the conversion factor by the proposed CY 2011 home health market basket update percentage of 1.4 percent minus 2 percentage points. Finally, we reduce that adjusted payment amount by 3.79 percent to account for the increase in nominal case-mix. The proposed CY 2011 NRS conversion factor for HHAs that do not submit quality data is shown in Table 9a below.

Table 9a -- Proposed CY 2011 NRS Conversion Factor for HHAs that DO NOT Submit the Required Quality Data					
CY2010 NRS Conversion Factor	Adjusted to return the outlier funds that paid for the 2.5% target for outlier payments in CY 2010	Reduced by 5% due to the outlier adjustment mandated by The Affordable Care Act	Multiply by the proposed home health market basket update of 1.4% minus 2% (-0.6%)	Reduce by 3.79% for nominal change in case-mix	Proposed CY 2011 NRS Conversion Factor for HHAs that Do Not submit the Required Quality Data
$53.34	÷ 0.975	X 0.95	X 0.994	X 0.9621	$49.70

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 9b below.

Table 9b-- Relative Weights for the 6-Severity NRS System for HHAs that DO NOT Submit Quality Data			
Severity Level	Points (Scoring)	Relative Weight	Proposed NRS Payment Amount
1	0	0.2698	$13.41
2	1 to 14	0.9742	$48.42
3	15 to 27	2.6712	$132.76
4	28 to 48	3.9686	$197.24
5	49 to 98	6.1198	$304.15
6	99+	10.5254	$523.11

5. Rural Add-On

Section 3131(c) of The Affordable Care Act amended section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Pub. L. 108–173) as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Pub. L. 109–171). The amended section 421(a) of the MMA provides an increase of 3 percent of the payment amount otherwise made under section 1895 of the Act for home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Act), with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2016. The statute waives budget neutrality related to this provision as it specifically states that the Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Act applicable to home health services furnished during a period to offset the increase in payments resulting in the application of this section of the statute. The 3 percent rural add-on is applied to the national standardized 60-day episode rate, national per-visit rates, LUPA add-on payment, and NRS conversion factor when home health services are provided in rural (non-CBSA) areas. We implemented this provision for CY 2010, for episodes and visits ending on or after April 1, 2010 and ending before January 1, 2011 through Program Memorandum "Temporary 3 Percent Rural Add-On for the Home Health Prospective payment System (HH PPS)" (Transmittal #674/ Change Request #6955, issued April 23, 2010). Refer to Tables 10 thru 13b below for these payment rates.

Table 10 – CY 2011 Payment Amounts for 60-Day Episodes for Services Provided in a Rural Area Before Case-Mix and Wage Index Adjustment

For HHAs that Do Submit Quality Data			For HHAs that Do Not Submit Quality Data		
Proposed CY 2011 National Standardized 60-Day Episode Payment Rate	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 National Standardized 60-Day Episode Payment Rate**	**Proposed CY 2011 National Standardized 60-Day Episode Payment Rate**	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 National Standardized 60-Day Episode Payment Rate**
$2,198.58	X 1.03	$2,264.54	$2,155.210	X 1.03	$2,219.87

Table 11 -- Proposed Per-Visit Amounts for Services Provided in a Rural Area, Before Wage Index Adjustment						
	For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Home Health Discipline Type	**Proposed CY 2011 per-visit rate For HHAs that DO submit quality data**	**Multiply by the 3 Percent Rural Add-On**	**Proposed Total CY 2011 per-visit rate for Rural Areas**	**Proposed CY 2011 per-visit rate For HHAs that DO NOT submit quality data**	**Multiply by the 3 Percent Rural Add-On**	**Proposed Total CY 2011 per-visit rate for Rural Areas**
Home Health Aide	$50.57	X 1.03	$52.09	$49.57	X 1.03	$51.06
Medical Social Services	$178.99	X 1.03	$184.36	$175.46	X 1.03	$180.72
Occupational Therapy	$122.91	X 1.03	$126.60	$120.48	X 1.03	$124.09
Physical Therapy	$122.097	X 1.03	$125.75	$119.68	X 1.03	$123.27
Skilled Nursing	$111.65	X 1.03	$115.00	$109.45	X 1.03	$112.73
Speech-Language Pathology	$132.66	X 1.03	$136.64	$130.04	X 1.03	$133.94

Table 12 -- Total Proposed CY 2011 LUPA Add-On Amounts for Services Provided in Rural Areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Proposed CY 2011 LUPA Add-On Amount For HHAs that DO submit quality data	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 LUPA Add-On Amount for Rural Areas**	**Proposed CY 2011 LUPA Add-On Amount For HHAs that DO NOT submit quality data**	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 LUPA Add-On Amount for Rural Areas**
$93.58	X 1.03	$96.39	$91.74	X 1.03	$94.49

Table 13a -- Total Proposed CY 2011 Conversion Factor for Services Provided in Rural Areas					
For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Proposed CY 2011 Conversion Factor For HHAs that DO submit quality data	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 Conversion Factor for Rural Areas**	**Proposed CY 2011 Conversion Factor For HHAs that DO NOT submit quality data**	**Multiply by the 3 Percent Rural Add-On**	**Total Proposed CY 2011 Conversion Factor for Rural Areas**
$50.70	X 1.03	$52.22	$49.70	X 1.03	$51.19

Table 13b – Relative Weights for the 6-Severity NRS System for Services Provided in Rural Areas

		For HHAs that DO submit quality data			For HHAs that DO NOT submit quality data		
Severity Level	Points (Scoring)	Proposed NRS Payment Amount For HHAs that DO submit quality data	Multiply by the 3 Percent Rural Add-On	Total Proposed NRS Payment Amount for Rural Areas	Proposed NRS Payment Amount For HHAs that DO NOT submit quality data	Multiply by the 3 Percent Rural Add-On	Total Proposed NRS Payment Amount for Rural Areas
1	0	$13.68	X 1.03	$14.09	$13.41	X 1.03	$13.81
2	1 to 14	$49.39	X 1.03	$50.87	$48.42	X 1.03	$49.87
3	15 to 27	$135.43	X 1.03	$139.49	$132.76	X 1.03	$136.74
4	28 to 48	$201.21	X 1.03	$207.25	$197.24	X 1.03	$203.16
5	49 to 98	$310.27	X 1.03	$319.58	$304.15	X 1.03	$313.27
6	99+	$533.64	X 1.03	$549.65	$523.11	X 1.03	$538.80

G. Enrollment Provisions for HHAs

1. HHA Capitalization

On January 5, 1998, we published a final rule in the **Federal Register** (63 FR 291) requiring newly-enrolling HHAs to submit proof that they have available sufficient funds—or "initial reserve operating funds" (IROF)—to operate the HHA for the three-month period after its provider agreement becomes effective (exclusive of actual or projected accounts receivable from Medicare and other health insurers). This rule, which added a new section 42 CFR 489.28, was prompted by our concerns about underfunded HHAs entering the Medicare program. We elaborated on this point in the preamble to the final rule (63 FR 291, at 295 (Jan. 5, 1998)):

New HHAs generally are small businesses and have the same need for adequate capitalization as have other small businesses which are just starting. As with other small businesses, a lack of funds in reserve to operate the business until a stream of revenues can be established can seriously threaten the viability of the business. In addition, for new HHAs, which are in business to render patient care services, any condition threatening the viability of the new business can adversely affect the quality of care to their patients and, in turn, the health and safety of those patients. That is, if lack of funds forces an HHA to close its business, to reduce staff, or to skimp on patient care services because it lacks sufficient capital to pay for the services, the overall well-being of the HHA's patients could be compromised. In fact, there could be the risk of serious ill effects as a result of patients not receiving adequate services.

The level of services provided to an HHA's patients is of serious concern to us for the following reason. The process by which an HHA participates in the Medicare program is one that involves a survey by us or an accrediting organization. This survey is essentially a snapshot of the agency's activities. For a new agency that is undercapitalized, it may be unable to sustain the level of services it is able to provide at the time of the survey over the period of time necessary for it to begin receiving a steady stream of revenue from Medicare. The period in question could last as long as two or even three months. Since a survey has already been conducted, the new HHA's services are not routinely inspected during this period and so there is increased danger that lack of operating funds could result in inadequate care that is not discovered.

The preamble also cited a 1997 OIG report entitled: "Home Health: Problem Providers and their Impact on Medicare" (OEI–09–96–00110), in which the OIG expressed similar worries about undercapitalized HHAs. The OIG stated:

If it were not for Medicare accounts receivable, problem agencies would have almost nothing to report as assets. Agencies tend to lease their office space, equipment, and vehicles. They are not required by Medicare to own anything, and they are almost always undercapitalized. On average, cash on hand and fixed assets amount to only one-fourth of total assets for HHAs, while Medicare accounts receivable frequently equal 100 percent of total assets. These agencies are almost totally dependent on Medicare to pay their salaries and other operating expenses. For a home health agency, there are virtually no startup or capitalization requirements. In many instances, the problem agencies lease everything without collateral. They do not even have enough cash on hand to meet their first payroll.

Medicare contractors have been carrying out the provisions of 42 CFR 489.28 since their enactment in 1998. Traditionally, the contractor has determined the provider's compliance with 489.28 prior to making its recommendation for approval to the State Agency and the CMS Regional Office (RO), which can occur several months or more before the actual provider agreement is signed by a prospective home health agency. We have worked to ensure that our contractors are consistently applying its capitalization regulations found in 42 CFR 489.28(a) which states,

An HHA entering the Medicare program on or after January 1,1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term "initial reserve operating funds," to operate the HHA for the three month period after its Medicare provider agreement becomes effective, exclusive of actual or projected accounts receivable from Medicare or other health care insurers.

Verifying the capitalization amount at various points in the enrollment process

can help CMS ensure that a prospective home health agency will have sufficient funds to operate prior to receiving approval from CMS that it is approved to participate in the Medicare program and has been conferred Medicare billing privileges. In addition, confirming capitalization more than one time during the process would address our concern that a provider that may have redirected these funds—which had originally been secured exclusively to meet the capitalization requirements—for a purpose other than to operate the business. Indeed, situations have arisen in which the HHA no longer has sufficient capitalization at the time it signs its Medicare provider agreement. This circumstance completely defeats the policy behind § 489.28 which is to ensure that an HHA is adequately capitalized when it becomes a Medicare provider. Accordingly, we believe that a prospective HHA must meet and maintain adequate capitalization during the entire period between when it first submits its enrollment application to the Medicare contractor and when the contractor conveys Medicare billing privileges to the HHA. This will ensure that the home health agency has sufficient operating funds at the time of application submission, during the period in which a State Agency or deemed accrediting organization is ensuring that the HHA meets the Conditions of Participation, prior to the issuance of a provider agreement and the conveyance of Medicare billing privileges.

To that end, we propose to require a prospective HHA to meet the capitalization requirements from the time of application submission through three months past the conveyance of Medicare billing privileges by the Medicare contractor. Further, CMS and/or its Medicare contractor must be able to verify an applicant's capitalization data at any time prior to the point at which the Medicare contractor conveys billing privileges to the HHA as well as three months thereafter. Accordingly, we are proposing that a prospective HHA be required to submit verification of compliance with § 489.28: (1) At the time of application submission, (2) during the period in which a State Agency or CMS-approved accreditation organization is making a determination as to whether the provider is in compliance with the Conditions of Participation; and (3) within the three months immediately following the issuance of a Medicare billing privileges. And while we believe that a prospective HHA should submit verification of compliance with § 489.28 within 30 days of a Medicare contractor's request, we believe that the Medicare contractor should have the ability to request and verify that an HHA continues to meet the capitalization requirements. This final step is especially important, because it would allow CMS to verify that the HHA actually had—rather than simply projecting to have had—adequate funds during the three-month period following issuance of Medicare billing privileges.

We believe that a Medicare contractor should verify that the prospective HHA is in compliance with all enrollment requirements when an enrollment application is submitted, during the period in which it is undergoing a State survey or accreditation review to determine compliance with the HHA Conditions of Participation, and before and after the issuance of Medicare billing privileges and within three months thereafter. Moreover, if a prospective HHA is determined to be out of compliance with Medicare enrollment requirements, including not meeting capitalization requirements at any time prior to the issuance of Medicare billing privileges, we believe that the Medicare contractor may deny such privileges using the specific denial reason for failing to meet this requirement which can be found in 42 CFR 424.530(a)(8) and afford the HHA with applicable Medicare appeal rights pursuant to part 498. Finally, we believe if an enrolled HHA is determined to be out of compliance with the capitalization requirements within three months after we have conveyed Medicare billing privileges, then that the Medicare contractor can revoke Medicare billing privileges using the specific revocation reason for failing to meet this requirement which can be found in § 424.535(a)(11) and afford the HHA with applicable Medicare appeal rights.

Accordingly, we are proposing to revise § 489.28(a) to include additional capitalization verification by us or its Medicare contractor during the enrollment process. Specifically, we are proposing to revise § 489.28(a) to read as set out in the regulatory text of this proposed rule.

Since it is not possible for the Medicare program to assess whether a prospective HHA is receiving reimbursement for other health care insurers, we are proposing to remove, "or other health care insurers." from § 489.28(a). In addition, we do not believe that it is necessary to require HHAs to project the number of visits within the initial three month operating period because there are incentives for prospective HHAs to under report the number of visits in order to reduce the capitalization amount. Accordingly, rather than accepting the number of site visits furnished by a prospective HHA as the basis for capitalization amount, we believe that it would be more appropriate to compare a prospective HHA with similarly situated HHAs that are already enrolled in the Medicare program. Sections § 1815(a), 1833(e), and 1861(v)(1)(A) of the Act require that providers of services participating in the Medicare program submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Also, 42 CFR 413.20 requires cost reports from providers on an annual basis. In accordance with these provisions, all home health agencies (HHAs) must complete Form HCFA–1728–94, which provides data used by the fiscal intermediaries in determining program reimbursement.

We believe that this change will deter or limit the number of undercapitalized individuals and organizations from seeking to enroll in the Medicare program. In addition, we believe that this change will help to ensure that prospective HHAs establish and maintain the amount of capital to furnish quality services to eligible beneficiaries without reimbursement from the Medicare program during the first three months of operations.

In § 489.28(c), we propose to add a new paragraph (1) to emphasize that the Medicare contractor, in selecting comparative HHAs for the purpose of calculating the enrolling HHA's required level of capitalization, shall only select HHAs that have submitted cost reports to Medicare. By reviewing the cost report, a Medicare contractor can audit costs and reimbursements. Medicare contractors have been selecting comparable HHAs using this methodology for purposes of the current requirement, but we believe that the current language in paragraph (c) should be clarified.

In 489.28(g), we propose to amend this provision to establish that CMS will only convey Medicare billing privileges to an HHA that satisfies its initial reserve operating funds requirement.

In 42 CFR 424.510, we propose to add meeting the initial reserve operating funds requirement found in § 489.28(a) as an enrollment requirement for prospective home health providers.

In 42 CFR 424.530(a)(8), we propose to deny Medicare billing privileges to a prospective HHA if they cannot furnish supporting documentation within 30 days of a contractor request that verifies that the HHA meets the initial reserve operating funds requirement found in

42 CFR 489.28(a). In addition, we propose to deny Medicare billing privileges to a prospective home health provider that fails to meet the initial reserve operating funds requirement found in 489.28(a).

Similarly, at 42 CFR 424.535(a)(8), we propose to revoke Medicare billing privileges and the corresponding provider agreement if the enrolled HHA is not able to furnish supporting documentation within 30 days of a contractor request that verifies that the HHA meets the initial reserve operating funds requirement found in 42 CFR 489.28(a).

2. Change of Ownership

In last year's home health prospective payment system final rule titled, "Medicare Program: Home Health Prospective Payment System Rate Update for Calendar Year 2010," we finalized several home health program integrity provisions. Specifically, we finalized a provision in 42 CFR 424.550(b)(1) stating that if an owner of an HHA sells (including asset sales or stock transfers), transfers or relinquishes ownership of the HHA within 36 months after the effective date of the HHA's enrollment in Medicare, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead: (i) Enroll in the Medicare program as a new HHA under the provisions of § 424.510, and (ii) Obtain a State survey or an accreditation from an approved accreditation organization.

We received several comments supporting the establishment of the 36-month provision and did not receive any specific recommendations that we establish exceptions to the implementation of this provision.

However, since the implementation of 42 CFR 424.550(b)(1) in January 2010, we have received a number of comments regarding the impact of this provision on bona fide ownership transactions. Accordingly, we are proposing exemptions to the 36-month provision for certain legitimate transactions related to HHAs. In particular, we are proposing to revise 42 CFR 424.550(b) by adding subparagraph (2) as exemptions to 42 CFR 424.550(b)(1):

- A publicly-traded company is acquiring another HHA and both entities have submitted cost reports to Medicare for the previous five (5) years.
- An HHA parent company is undergoing an internal corporate restructuring, such as a merger or consolidation, and the HHA has submitted a cost report to Medicare for the previous five (5) years.
- The owners of an existing HHA decide to change the existing business structure (*e.g.,* partnership to a limited liability corporation or sole proprietorship to subchapter S corporation), the individual owners remain the same, and there is no change in majority ownership (*i.e.,* 50 percent or more ownership in the HHA.)
- The death of an owner who owns 49 percent or less (where several individuals and/or organizations are co-owners of an HHA and one of the owners dies) interest in an HHA.

It is important to note that while we are proposing the aforementioned exceptions, we remain concerned that a significant number of HHAs have—and will continue to attempt to—participate in a practice often referred to as a "certificate mill." Under this scenario, which we addressed in the 2010 HH PPS rule, entrepreneurs apply for Medicare certification, undergo a survey, and, become enrolled in Medicare, but then immediately sell the agency without having seen a single Medicare beneficiary or hired a single employee. These brokers, in other words, enroll in Medicare exclusively to sell the HHA, rather than to provide services to beneficiaries. This practice allows a purchaser of an HHA from the broker to enter the Medicare program without having to undergo a State survey, which, in turn, often leads to that owner selling the business very soon thereafter to someone else. The "flipping" mechanism is used to circumvent the State survey process. It is for this reason, that we maintain that 42 CFR 424.550(b)(1) is necessary to eliminate the "certificate mill" process.

3.

3. Change in Majority Ownership Within 36 Months of Initial Enrollment or Change in Ownership

Section 1124 of the Social Security Act requires that: (1) All persons and organizations with a 5 percent or greater ownership interest in the provider, and (2) all partners in a partnership (if, of course, the provider is established as a partnership), be reported to us. Accordingly, we believe that HHAs and other provider organizations must report a change of ownership of 5 percent of more of the equity in the company.

However, we recognize that in many cases a small change in ownership (*e.g.,* 5 percent) does not result in fundamental change of ownership by the majority owner or owner(s) and should not necessarily require a new enrollment and State survey or meet the deemed-accreditation status. However, we are concerned that prospective HHA owners can circumvent the spirit and intent of § 424.550(b)(1) by incrementally increasing their level of ownership to the point where they could effectively assume 51 percent or more ownership of an HHA without having to enroll as a new provider or undergo a State survey or obtain deemed accreditation status by a CMS-approved accreditation organization. For instance, an owner, with a 30 percent ownership interest could purchase an additional 20 percent, plus one (1) share stake in the company by submitting four separate changes of information to the Medicare contractor. The end result is that the HHA would then be owned by an individual or organization for whom—because of his or her ability to avoid having to undergo a State survey or obtain accreditation due to his or her incremental purchases—we cannot determine their commitment to furnishing quality services to Medicare beneficiaries.

Accordingly, in § 424.550(a)(1) we are proposing that any change in majority control and/or ownership during the first 36 months of when the HHA is initially conveyed Medicare billing privileges or the last change of ownership (including asset sale, stock transfer, merger or consolidation) would trigger the provisions of § 424.550(b)(1). We believe that this approach would allow individuals or organizations to purchase or sell an ownership interest in an HHA as long as it did not change majority ownership or control within the first 36 months of ownership.

Consequently, we are proposing a definition of "Change in Majority Ownership" to mean an individual or organization acquires more than 50 percent interest in an HHA during the 36 following the initial enrollment into the Medicare program or a change of ownership (including asset sale, stock transfer, merger, or consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, and/or mergers during a 36-month period.

H. Home Health Face-to-Face Encounter

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act require a plan of care for furnishing home health services be established and periodically reviewed by a physician in order for Medicare payments for those services to be made. The physician is responsible for certifying that the individual is confined to his or her home and needs skilled nursing care on an intermittent basis or physical or speech therapy. The

plan for furnishing such services has to be established, and updated when appropriate, by the beneficiary's physician.

In recent years MedPAC has reported that the Medicare eligibility criteria for the home health benefit are broad and open to different interpretations by clinicians. *See Report to the Congress: Medicare Payment Policy (March 2004).* The 2010 MedPAC report continues to cite the complexity of Medicare's requirements for home health eligibility, and recommends that physicians may benefit from the information gained by an in-person examination. MedPAC further states that "establishing clear expectations for the purpose of these examinations would be critical to ensuring their effectiveness" [MedPAC report dated March 2010, p. 216].

On March 23, 2010, the Patient Protection and Affordable Care Act (The Affordable Care Act) of 2010 (Pub. L. 111–148) was enacted. Section 6407(a) (amended by section 10605) of The Affordable Care Act amends the requirements for physician certification of home health services contained in Sections 1814(a)(2)(C) and 1835(a)(2)(A) by requiring that, prior to making such certification, the physician must document that the physician himself or herself or specified non-physician practitioner has had a face-to-face encounter (including through the use of telehealth, subject to the requirements in section 1834(m) of the Act), with the patient incident to the services involved.

The Affordable Care Act describes non-physician practitioners who may perform this face-to-face patient encounter as a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act), who is working in collaboration with the physician in accordance with State law, or a certified nurse-midwife (as defined in section 1861(gg) of the Act, as authorized by State law), or a physician assistant (as defined in section 1861(aa)(5) of the Act), in accordance with State law and under the supervision of the physician. The Affordable Care Act provision does not amend the statutory requirement that a physician must certify a patient's eligibility for Medicare's home health benefit. Rather the provision allows for specific non-physician practitioners to perform the face-to-face encounter with the patient in lieu of the certifying physician, and inform the physician making the initial certification for eligibility for the Medicare home health benefit. The certifying physician must document the face-to-face encounter regardless of whether the physician himself or herself or one of the permitted non-physician practitioners perform the face-to-face encounter. The Affordable Care Act gives the Secretary the discretion to set a reasonable timeframe for this encounter.

We believe that the face-to-face encounter statutory provision was enacted to strengthen physician accountability in certifying that home health patients meet home health eligibility requirements. We also believe that in order to achieve this goal, the encounter must occur close enough to the home health start of care to ensure that the clinical conditions exhibited by the patient during the encounter are related to the primary reason for the patient's need for home health care. As such, we believe that encounters would need to occur closer to the start of home health care than the six month period prior to certification recommended, but not required by The Affordable Care Act for Part B services. Therefore we propose revising § 424.22(a)(1)(v) such that for initial certifications, prior to a physician signing that certification and thus certifying a patient's eligibility for the Medicare home health benefit, the physician responsible for certifying the patient for home health services must document that a face-to-face patient encounter (including through the use of telehealth if appropriate) has occurred no more than 30 days prior to the home health start-of-care date by himself or herself, or by an authorized non-physician practitioner (as specified in sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act) working in collaboration with or under the supervision of the certifying physician as described above.

We believe that in many cases, a face-to-face encounter with a patient within the 30 days prior to the home health episode start of care will provide the certifying physician a current clinical presentation of the patient's condition such that the physician can accurately certify home health eligibility, and in conjunction with the home health agency, can establish an effective care plan. We also believe that a face-to-face encounter which occurs within 30 days prior to the home health start of care would be generally relevant to the reason for the patient's need for home health services, and therefore such a face-to-face would be sufficient to meet the goals of this statutory requirement. However, if a face-to-face encounter occurs within 30 days of the start of the home health episode, but the clinical condition of the patient changes significantly between the time of the face-to-face encounter and the home health episode of care such that the primary reason the patient requires home health care is unrelated to the patient's condition at the time of the face-to-face encounter, this encounter would not satisfy the requirement. Rather, in this case, we propose revising § 424.22(a)(1)(v)(B) such that the certifying physician, or authorized non-physician practitioner, must have another face-to-face encounter (which may include the use of telehealth, subject to the requirements in section 1834(m) of the Act and subject to the list of Medicare telehealth services established in the most recent year's physician fee schedule regulations) with the patient within two weeks after the start of the home health episode. The certifying physician must document the face-to-face encounter, along with the clinical findings of that encounter as part of the signed and dated certification. This documentation must be clearly titled, dated, and signed by the certifying physician. Because the patient's clinical condition significantly changed, we believe that a more contemporaneous visit is needed to ensure the certifying physician can accurately certify the patient's eligibility for services, and effectively plan the patient's care.

Similarly, we propose to revise § 424.22(a)(1)(v)(B) to reflect that if a home health patient has not seen the certifying physician or one of the specified non-physician practitioners as described above, in the 30 days prior to the home health episode start of care, the certifying physician or non-physician practitioner, would be required to have a face-to-face encounter (including the use of telehealth, subject to the requirements in section 1834(m) of the Act and subject to the list of Medicare telehealth services established in the most recent year's physician fee schedule regulations) with the patient within two weeks after the start of the home health episode to comply with the requirements for payment under the Medicare Program.

We also propose to revise § 424.22(a)(1)(v) so that the certifying physician's documentation of the face-to-face encounter would clearly state that either the certifying physician himself or herself, or the applicable non-physician practitioner has had a face-to-face encounter with the patient and would include the date of that encounter. The documentation would also describe how the clinical findings of that encounter supported the patient's eligibility for the Medicare home health benefit. Specifically, the physician would document how the clinical findings of the encounter supported findings that the patient was homebound and in need of intermittent

skilled nursing and/or therapy services, as defined in § 409.42(a) and § 409.42(c) respectively. The certifying physician would be required to sign and date the documentation entry into the certification and document the face-to-face encounter in his/her practice's medical record. As such the physician's medical keeping for that patient must be consistent with, and supportive of, the required documentation of the face-to-face encounter as part of the certification.

Again, the certifying physician's documentation of the face-to-face patient encounter would be either a separate and distinct area on the certification or a separate and distinct addendum to the certification that was easily identifiable and clearly titled.

If an allowed non-physician practitioner was conducting the face-to-face visit, that practitioner would have to document the clinical findings of the face-to-face patient encounter and communicate those findings to the certifying physician, so that the certifying physician could document the face-to-face encounter accordingly, as part of the signed certification. Section 409.41 of the CFR states that in order for home health services to qualify for payment under the Medicare program the physician certification requirements for home health services must be met in compliance with § 424.22. Therefore, if the patient's certifying physician did not document that a face-to-face encounter occurred no more than 30 days prior to the home health start of care date or two weeks after the start of care date, the services would not qualify for payment under the Medicare program.

Additionally our regulations at § 424.22 require a physician's signature for certification and recertification of the need for home health care. To strengthen our regulations to mirror our longstanding manual policy and to achieve consistency with the proposed timing and documentation of the face-to-face encounter, we propose to revise our certification and recertification requirements at § 424.22 to require that these documents must include the date and signature of the physician.

As defined in 42 CFR 411.354, certifying physicians are not permitted to have a financial relationship with the HHA, unless one of the exceptions in section 1877 of the Act is met. Similarly, we would preclude non-physician practitioners from performing a face-to-face encounter for the purpose of informing the certifying physician, as described in sections 1814 and 1835 of the Act, if the non-physician practitioner was an employee of the HHA. We propose to apply this prohibition by revising § 424.22(d) to not allow non-physician practitioners to perform a face-to-face encounter, if employed by the HHA, as defined by Section 210(j) of the Act.

When a physician is certifying a patient for home health services, the physician is certifying that the patient is confined to his home and in need of intermittent skilled nursing or therapy services. Therefore, physicians must utilize their intimate knowledge of the patient's medical condition to determine the patient's health care needs. We believe that physician involvement is very important in maintaining quality of care under the Medicare home health benefit and ensure appropriate use of the benefit. Thus, the fundamental goals of physician certification are strengthened by the new requirement for a face-to-face patient encounter.

As such, we are proposing to revise 42 CFR 424.22(a)(1) by adding language to set timing requirements for the face-to-face patient encounter, to ensure that the face-to-face patient encounter is related to the primary reason the patient requires home health services, and to set encounter documentation requirements. We are also proposing that non-physician practitioners be precluded from performing a face-to-face encounter for the purpose of informing the certifying physician, as described in sections 1814 and 1835 of the Act, if the non-physician practitioner is an employee of the HHA, as defined by Section 210(j) of the Act.

We propose implementing the above face-to-face patient encounters provisions as they relate to home health episodes beginning 1/1/2011 and later.

I. Solicitation of Comments: Future Plans to Group HH PPS Claims Centrally During Claims Processing

Generally speaking, Medicare makes payment under the HH PPS on the basis of a national standardized 60-day episode payment rate that is adjusted for case-mix and geographic wage variations. The national standardized 60-day episode payment rate includes the six home health disciplines (skilled nursing, home health aide, physical therapy, speech language pathology, occupational therapy, and medical social services) and non-routine medical supplies. Durable medical equipment covered under home health is paid for outside the HH PPS payment. To adjust for case-mix, the HH PPS uses a 153-category case-mix classification to assign patients to a home health resource group (HHRG). Clinical needs, functional status, and service utilization are computed from responses to selected data elements in the Outcome & Assessment Information Set (OASIS) instrument. On Medicare claims, the HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes.

At a patient's start of care, and at the start of each subsequent 60 day episode, and when a patient's condition changes significantly, the HHA is required to perform a comprehensive clinical assessment of the patient and complete the OASIS assessment instrument. The OASIS instrument collects data concerning 3 dimensions of the patient's condition: (1) Clinical severity (orthopedic, neurological or diabetic conditions, *etc.*), (2) Functional status (comprised of 6 activities of daily living {ADL}), and (3) Service utilization (therapy visits provided during episode). HHAs enter data collected from their patients' OASIS assessments into a data collection software tool. For Medicare patients, the data collection software invokes HH PPS Grouper software to assign a HIPPS code to the patient's OASIS assessment. The HHA includes this HIPPS code on the Medicare HH PPS bill, ultimately enabling CMS' claims processing system to reimburse the HHA for services provided to patients receiving Medicare's home health benefit.

Additionally, the HHA is required to electronically submit OASIS assessments for their Medicare and Medicaid patients to CMS via their State agency. On the HH PPS public Web site at *http://www.cms.gov/homehealthpps/01_overview.asp,* CMS provides a free OASIS assessment data collection tool (HAVEN) which includes the HH PPS grouper software, a separate HH PPS grouper program which can be incorporated into an HHA's own data collection software, and HH PPS data specifications for use by HHAs or software vendors desiring to build their own HH PPS grouper. Most HHAs do not use the HAVEN freeware, instead preferring to employ software vendors to create and maintain a customized assessment data collection tool which can be integrated into the HHA's billing software. Likewise, many vendors employed by HHAs do not utilize the HH PPS grouper freeware, instead preferring to build their own HH PPS grouper from the data specifications which CMS provides.

In 2008, CMS deployed the first refinements to the HH PPS since its inception in 2000. Prior to the 2008 refinements, CMS made infrequent, minor changes to the HH PPS grouper software. Effective with the refinements, the HH PPS grouper became more

complex and more sensitive to the yearly ICD–9–CM code changes. As a result, since 2008 HHAs have been required to update their HH PPS grouper software at least once each year. Most HHAs employ software vendors to effectuate these updates. HHAs have expressed concerns to CMS that the frequent grouper updates coupled with the additional complexity of the grouper has resulted in unexpected costs and an increased burden to them.

Also, since the 2008 refinements were implemented, CMS has identified a significant increase in OASIS assessments submitted with erroneous HIPPS codes. These errors occur when HHAs and/or their software vendors inaccurately replicate the HH PPS grouper algorithm into the HHA's customized software. The significant increase in these errors since 2008 suggests that many HHA software vendors are struggling to accurately replicate the complex algorithms in the HH PPS grouper. CMS informs HHAs when the submitted HIPPS on the OASIS is inaccurate and provides HHAs with the correct HIPPS to enable the HHA to accurately bill Medicare. However, HHAs have expressed concerns that the HH PPS grouper complexities increase their vulnerability to submit an inaccurate HIPPS code on the Medicare bill. Further, some HHAs have expressed concern that this vulnerability will further increase when CMS begins requiring use of ICD–10–CM codes instead of ICD–9–CM codes because the ICD–10–CM migration will require major changes to an already complex HH PPS grouper.

Because of these concerns, we have begun analyzing options to streamline the process which assigns HIPPS codes. We are analyzing options which would enable CMS to assign HIPPS codes to the HH PPS bills during claims processing. If we were successful in implementing this option, OASIS assessment data collection tools would no longer invoke HH PPS grouper software to assign HIPPS codes to the OASIS assessments. Further, HHAs would no longer be required to include HIPPS codes on HH PPS bills. Such a process would relieve the HHA of all responsibility associated with the HH PPS grouper. If we can centralize the assignment of the HIPPS code to the HH PPS bill during claims processing, we will achieve process efficiencies, improve payment accuracy by improving the accuracy of the bill's HIPPS code, decrease costs and burden to HHAs, while also better position HHAs and CMS for an easier transition from ICD–9 to ICD–10 codes in the future.

Several changes have occurred recently that allow us to consider this option. National claims coding standards have expanded the number of positions of data available in the treatment authorization field on the bill from 18 to 30. In addition, the National Uniform Billing Committee has created occurrence code 50 for assessment reference dates. This new code will allow a separate field for HHAs to report the M0090 assessment date currently carried in the treatment authorization field. These two changes provide enough space on the HH PPS bill for HHAs to encode all the OASIS payment items on the bill, potentially enabling CMS to compute the HIPPS code during claims processing.

However, a major challenge exists with the feasibility of computing the HH PPS group during claims processing. A centralized HH PPS grouper would look to the diagnoses on the HH PPS bill for grouping. The Health Insurance Portability and Accountability Act (HIPAA) authorized us to require that all diagnoses on the bill comply with ICD–9–CM coding guidelines as set out at 45 CFR 162.1002 (65 FR 50370, August 17, 2000). Currently, when certain conditions apply, to prevent the loss of case mix points, the HH PPS grouper will award case-mix points to some diagnoses reported as a secondary diagnosis when the assignment is performed to comply with ICD–9–CM coding requirements. CMS currently instructs HHAs to report these diagnoses in M1024 (previously M0246) on the OASIS to prevent loss of case mix points.

We provide detailed guidance on this topic in page 5 of Appendix D within the OASIS Implementation Manual, which can be accessed at *http://www.cms.gov/HomeHealthQualityInits/downloads/HHQIAttachmentD.pdf.* This coding guidance has been provided to prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis.

As required by 45 CFR 162.1002, those diagnoses currently encoded in M1024 (formerly M0246) which should not be reported as primary or secondary diagnoses cannot be reported on the bill. In an attempt to solve this challenge, CMS is analyzing options to map diagnoses currently reported in M1024 (formerly M0246) to diagnoses that are reportable as primary and secondary diagnoses in the home health setting, per ICD–9–CM coding guidelines. We have been encouraged with our ability to map some trauma codes reported in M1024 to after-care codes which are reportable as primary and secondary diagnoses in the home health setting. However, additional analysis and mapping are needed to fully resolve this challenge.

We are soliciting public comment on this potential enhancement, described above, to assign the HIPPS code to the HH PPS bill during claim processing. This would require HHAs to report all the OASIS items necessary to group the episode on the HH PPS bill. As stated above, doing so would address the costs and burden HHAs currently experience with regards to frequent updates of a complex HH PPS grouper, address vulnerabilities that HHAs have associated with the possible submission of inaccurate HIPPS codes on the claim, while better positioning HHAs and CMS for the ICD–9 to ICD–10 transition. We are in the early stages of assessing the feasibility of such changes, and wanted to seize the opportunity to solicit the public for their comments on this topic.

J. Proposed New Requirements Affecting Hospice Certifications and Recertifications

In its March 2009 *Report to Congress,* MedPAC wrote that additional controls are needed to ensure adequate accountability for the hospice benefit. MedPAC reported that greater physician engagement is needed in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit. The Commission reported that measures to ensure accountability would also help ensure that hospice is used to provide the most appropriate care for eligible patients. They recommended these measures be directed at hospices that tend to enroll very long-stay patients. Specifically, MedPAC recommended that a hospice physician or advanced practice nurse visit the patient to determine continued eligibility prior to the 180-day recertification and each subsequent recertification, and attest that such visits took place. MedPAC, *Report to the Congress: Medicare Payment Policy,* Chapter 6, March 2009, pp. 365–371.

Section 3132 of The Affordable Care Act requires hospices to adopt MedPAC's hospice program eligibility recertification recommendations. Specifically, the bill amends section 1814(a)(7) of the Social Security Act to require that on and after January 1, 2011, a hospice physician or nurse practitioner (NP) must have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient prior to the 180-day recertification, and prior to each subsequent recertification. Furthermore, the bill requires that the hospice physician or NP attest that such

a visit took place, in accordance with procedures established by the Secretary of the Department of Health and Human Services. The Affordable Care Act provision does not amend the statutory requirement that a physician must certify and recertify a patient's terminal illness, and thus NPs continue to not be allowed to certify the terminal illness. Rather, the provision allows for a NP to furnish a face-to-face encounter; the NP would then provide the clinical findings from that encounter to the physician who is considering recertifying the patient. This new statutory requirement will better enable hospices to comply with hospice eligibility criteria, and to identify and discharge patients who do not meet those criteria.

Hospices which admit a patient who received hospice services previously (from the admitting hospice or from another hospice) must consider the patient's entire Medicare hospice stay to determine which benefit period the patient is in, and whether a face-to-face visit will be required for recertification.

As required by the Affordable Care Act, we are making several proposals regarding 42 CFR 418.22(a)(3), (a)(4), (b)(3), (b)(4), and (b)(5) in order to implement this new statutory requirement. Required visits should be fairly close to the recertification date, so that the visit allows a current assessment of the patient's continued eligibility for hospice services. These visits can be scheduled in advance, particularly for those patients with diagnoses where life expectancy is harder to predict. At § 418.22(a)(4) we propose that hospice physicians or NPs make these required visits no more than 15 calendar days prior to the 180-day recertifications and subsequent recertifications, and that the visit findings be used by the certifying physician to determine continued eligibility for hospice care. This 15-day timeframe also aligns the timeframes for recertification visits with that required for the comprehensive assessment update, as specified in our Conditions of Participation (CoPs) at § 418.54(d). This timeframe requirement is also consistent with the timeframe required for the review of the plan of care, as specified in our CoPs at § 418.56(d). The 15-day timeframe provides a balance between flexibility in scheduling the visit, and enabling a relatively current assessment of continued eligibility while also allowing efficiency in update and review processes as required by the hospice CoPs.

As noted above, the statute requires that the face-to-face encounter be used to determine the patient's continued eligibility for hospice services. We propose that the clinical findings gathered by the NP or by the physician during the face-to-face encounter with the patient be used in the physician narrative to justify why the physician believes that the patient has a life expectancy of 6 months or less. We propose to add this requirement to 418.22(b)(3) as subparagraph(v).

The statute also requires the hospice physician or NP to attest that the face-to-face encounter occurred. Again we reiterate that while NPs can make these visits and attest to them, by statute only a physician may certify the terminal illness. Therefore, at § 418.22(b)(4) we propose that the face-to-face attestation and signature be either a separate and distinct area on the recertification form, or a separate and distinct addendum to the recertification form, that is easily identifiable and clearly titled. We also propose that the attestation language be located directly above the physician or NP signature and date line.

The attestation is a statement from the physician or NP which attests that he or she had a face-to-face encounter with the patient, and that the clinical findings of that encounter have been provided to the certifying physician for use in determining continued eligibility for hospice care. The attestation should include the name of the patient visited, the date of the visit, and be signed and dated by the NP or physician who made the visit. Hospices are free to use other attestation language, provided that it incorporates these required elements. These elements would be suitable whether the visit is made by an NP or a physician. It is possible that the certifying hospice physician is the same physician who made the visit.

We propose revising our regulations at § 418.22 to incorporate these requirements. Specifically, we propose adding subsections (a)(4) and (b)(4) to implement the requirements for a face-to-face encounter with long-stay hospice patients and the attestation of that face-to-face encounter.

In proposing a required timeframe in which the face-to-face encounter must occur, for consistency, we believe it is important to also propose to clarify required timeframes for all certifications and recertifications. Long-standing guidance in our Medicare Benefit Policy Manual's chapter on hospice benefit policy allows the initial certification to be completed up to 14 days in advance of the election, but is silent on the timeframe for advance completion of recertifications (*see* CMS Pub. No. 100–02, chapter 9, section 20.1). To clarify our policy in the regulations, and to be consistent with the proposed timeframe for the newly legislated face-to-face encounter for recertifications, we propose that both certifications and recertifications must be completed no more than 15 calendar days prior to either the effective date of hospice election (for initial certifications), or the start date of a subsequent benefit period (for recertifications). This proposal is also in keeping with the CoP timeframe for updating the comprehensive assessment (418.56(d)), and with the CoP timeframe for reviewing the plan of care (418.54(d)). Finally, this proposed 15-day advance certification or recertification timeframe would also help ensure that the decision to recertify is based on current clinical findings, enabling greater compliance with Medicare eligibility criteria. Congress' desire for increased compliance with Medicare eligibility criteria is one factor which we believe led to the new statutory requirements. We propose to revise § 418.22(a)(3) to reflect the above proposals.

Furthermore, longstanding manual guidance stipulates that the physician(s) must sign and date the certification or recertification. However, the HHS Office of Inspector General recently found that certifications for some hospice patients failed to meet Federal requirements, including those with no signatures [HHS OIG, "Medicare Hospice Care for Beneficiaries in Nursing Facilities: Compliance with Medicare Coverage Requirements, September 2009"]. In keeping with Congress's desire for increased compliance with Medicare eligibility criteria, and to achieve consistency with the proposed 180-day recertification attestation requirements, we propose to add language to the certification requirements in our regulations to clarify that these documents must include the signature(s) of the physician(s) and the date each physician signed.

With the new statutory requirements for a face-to-face encounter prior to the 180-day recertification, and for every recertification thereafter, it is important for hospices to easily identify which benefit periods require a recertification visit. Because hospice patients are allowed two 90-day benefit periods followed by an unlimited number of 60-day benefit periods, every 60-day benefit period is by definition beyond the 180-day recertification. We do not currently require that certifications or recertifications show the dates of the benefit period to which they apply, so we propose to add language to our certification and recertification regulations to make this a requirement for all hospices. While many hospices already include this information, there are some that do not. Having the benefit

period dates on the certification makes it easier for the hospice to identify those benefit periods which require a face-to-face encounter and will ease enforcement of this new statutory requirement.

A valid certification or recertification is a requirement for Medicare coverage under the Social Security Act at section 1814(a)(7)(A). Additionally, the Act at 1814(a)(7)(D) now also requires a face-to-face encounter with patients who reach the 180-day recertification. Changing our regulations to require the physician's signature(s), date signed, and benefit period dates on the certification or recertification is necessary to determine if these documents are valid, and to ease the implementation of the new statutory requirements. Because we believe these proposed requirements establish in regulation that which are current practice in the hospice industry, we do not believe that these proposals will be burdensome to hospices. As such, we propose adding § 418.22(b)(5) to our regulations to incorporate these signature and date requirements.

III. 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 (COI) 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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Therapy Coverage Requirements

As described previously in this proposed rule, we are clarifying our coverage requirements for skilled services provided by therapists, which are described in 42 CFR 409.44(c). Our proposed clarifications include requirements to: document necessity for a course of therapy (§ 409.44(c)(1)); include clinic notes which reflect progress toward goals, which incorporate the functional assessment and reassessments, which justify medical necessity, which describe the content of progress notes, and which include objective evidence of the expectation that the patient's condition will improve (§ 409.44(c)(2)(i)); document any variable factors that influence the patient's condition or affect the patient's response to treatment, and include objective measurements of progress toward goals in the clinical record (409.44(c)(2)(iv)).

These proposed clarifications to our coverage requirements in § 409.44(c) are already part of our current Conditions of Participation (CoPs) and are approved under OMB# 0938–1083. The current CoPs at § 484.12 already require that the HHA and its staff comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Those accepted professional standards include complete and effective documentation, such as we described in our proposals. Additionally, § 484.32 of the CoPs already requires in part that the therapist prepare clinical and progress notes. Section 484.55 of the CoPs already requires that HHAs provide a comprehensive assessment that "accurately reflects the patient's current health status and includes information that may be used to demonstrate progress toward achievement of desired outcomes". Because these proposed clarifications to our coverage requirements in § 409.44(c) reflect longstanding policy from our CoPs as well as from accepted standards of clinical practice, we believe that these proposed requirements will not create any additional burden on HHAs.

Additionally, our coverage regulations at § 409.44(c)(2)(i) already mandate that for therapy services to be covered in the home health setting, the services must be considered under accepted practice to be a specific, safe, and effective treatment for the beneficiary's condition. We proposed revising § 409.44(c)(2)(i) to require a functional assessment on the 13th and 19th therapy visit, and at least every 30 days, to determine continued need for therapy services, and to ensure material progress toward goals. The functional assessment does not require a special visit to the patient, but is conducted as part of a regularly scheduled therapy visit. Functional assessments are necessary to demonstrate progress (or the lack thereof) toward therapy goals, and are already part of accepted standards of clinical practice, which include assessing a patient's function on an ongoing basis as part of each visit.

Our current CoPs at § 484.55 already require that HHAs "identify the patient's continuing need for home care * * *". Functional assessments of therapy need guide HHAs in determining whether continued therapy is necessary. Therefore, we believe that the proposed requirement to perform a functional assessment at the 13th and 19th visits, and at least every 30 days, will also not create any burden on HHAs. Rather, we have clarified the minimum timeframes for functional assessments in the coverage regulations. Longstanding CoP policy at § 484.55 requires HHAs to document progress toward goals; therefore, we again do not believe that performing or documenting functional assessments at these 3 time-points would create a new burden. Both the functional assessment and its accompanying documentation are already part of existing HHA practices and accepted standards of clinical practice, and are approved under OMB# 0938–1083. Therefore, we do not believe these proposed requirements place any new documentation requirements on HHAs. We also believe that a prudent home health agency would self-impose these requirements in the course of doing business.

We are revising the currently approved PRA package (OMB #0938–1083) to describe these clarifications to the regulatory text.

B. ICRs Regarding HHA Capitalization

As stated above, we propose to revise § 489.28(a) to clarify that a newly enrolling HHA must consistently maintain sufficient capitalization between the time it submits its enrollment application until three months after its provider agreement becomes effective. This means the HHA will be required to submit proof of capitalization at multiple points during this period. For purposes of these collection requirements only, we estimate that a newly enrolling HHA will be required to submit such proof 3 times prior to receiving Medicare billing privileges, and that the burden involved in doing so will be 1.5 hours on each occasion. We further project that 500 newly enrolling HHAs (of which 200 will ultimately become enrolled) will be asked to provide this data. The total annual burden will therefore be 2,250 hours (500 HHAs × 3 submissions × 1.5 hours), as reflected in Table 14 below.

TABLE 14 - ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN					
OMB #	Requirement	Respondents	Responses	Hr. Burden	Total
None	489.28(a)	500	500	4.5	2,250

C. ICRs Regarding the Home Health Face-To-Face Encounter Requirement

The Affordable Care Act of 2010 amends the requirements for physician certification of home health services contained in sections 1814(a)(2)(C) and 1835(a)(2)(A) by requiring that prior to certifying a patient as eligible for home health services, the physician must document that the physician himself or herself or specified non-physician practitioner has had a face-to-face encounter (including through the use of telehealth). The Affordable Care Act provision does not amend the statutory requirement that a physician must certify a patient's eligibility for Medicare's home health benefit (*see* sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act). In this proposed rule, we propose that § 424.22(a)(1)(v) require the certifying physician sign and date the documentation entry into the certification that the face-to-face patient encounter occurred no more than thirty days prior to the home health start of care date by himself or herself, or by an allowed non-physician practitioner for initial certifications. We are proposing that the certifying physician's documentation of the face-to-face patient encounter be either a separate and distinct area on the certification, or a separate and distinct addendum to the certification, that is easily identifiable and clearly titled, dated, and signed by the certifying physician, and that it include the clinical findings of that encounter.

The burden associated with the documentation requirement for the patient's face-to-face encounter by the physician and certain allowed non-physician practitioners includes the time for each home health agency to develop a revised certification form or certification addendum which the HHA provides to the physician. The revised certification form or addendum to the certification must allow the physician to record that a face-to-face patient encounter has occurred. The revised form or addendum must also include the patient's name, a designated space for the physician to provide the date of the patient encounter, a designated space for the physician's documentation of the face-to-face encounter, and a designated space for the physician to provide his/her signature and the date signed.

There were 9,432 home health agencies that filed claims in CY 2008. We estimate it would take each HHA 15 minutes of the home health administrator's time to develop and review the above described form language and 15 minutes of clerical time for each HHA to revise their existing initial certification form or to create an addendum with that form language. The estimated total one-time burden for developing the patient encounter form would be 4,716 hours.

The certifying physician's burden for composing the face-to-face documentation which includes how the clinical findings of the encounter support eligibility; writing, typing, or dictating the face-to-face documentation; signing, and dating the patient's face-to-face encounter is estimated at 5 minutes for each certification. We estimate that there would be 2,926,420 initial home health episodes in a year based on our 2008 claims data. As such, the estimated burden for documenting, signing, and dating the patient's face-to-face encounter would be 243,868 hours for CY 2011.

We reiterate that our longstanding policy has been that physicians must sign and date the certification statement that the patient is in need of home health services and meets the eligibility requirements to receive the benefit. Therefore, our making this requirement explicit in the regulation poses no additional burden to home health agencies.

Additionally, it has been our longstanding manual policy that physicians must sign and date the certification and any recertifications. Our current regulations only address the physician's signing of the certification and recertification. In this rulemaking, we are proposing to strengthen our regulations at § 424.22 to achieve consistency with the proposed timing and documentation of the face-to-face encounter and to mirror our longstanding manual policy by revising our regulations to make it a requirement that physicians not only sign, but also date certifications and recertifications. Because it has been our longstanding manual policy that physicians sign and date certifications and recertifications, and we are merely making this requirement explicit in our regulations, there is no additional burden to physicians.

Based on the criteria for payment of physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency as stipulated in the description of HCPC code G0181, our making the patient encounter requirement explicit in the regulation poses no additional burden to physician offices. Table 15a and 16a below summarizes the burden estimate associated with these requirements.

TABLE 15a. ESTIMATED ONE-Time FORM DEVELOPMENT BURDEN					
OMB#	Requirement	HHAs	Responses	Hr. Burden	Total
0938-1083	424.22(a)(1)(v)	9,432	1	.5 hours	4,716 hours

TABLE 16a. ESTIMATED PHYSICIANS BURDEN for DOCUMENTING, SIGNING AND DATING ENCOUNTER					
OMB#	Requirement	Patients	Responses	Hr. Burden	Total
0938-1083	424.22(a)(1)(v)	2,926,420	1	.0833333	243,868 hours

Details of our burden estimates are available in the Paperwork Reduction Act (PRA) package approved under OMB# 0938–1083. We are revising this currently approved package to incorporate these requirements.

D. ICRs Regarding the Requirements for Hospice Certification Changes

As described previously in this proposed rule, as of January 1, 2011 the Affordable Care Act requires physicians or NPs to attest that they determined continued hospice eligibility through a face-to-face encounter with all hospice patients prior to the 180-day recertification. We proposed that § 418.22(b)(4) require the physician or NP to sign and date an attestation statement that he or she had a face-to-face encounter with the patient, and include the date of that visit. This attestation would be a separate and distinct part of the physician recertification, or an addendum to the physician recertification.

The burden associated with this attestation requirement would be the time for each hospice to develop simple attestation language to attach as an addendum or include as part of the recertification document, and the time for the physician or NP to include the patient name, the date that the patient was visited, the visiting physician or NP signature, and the date signed. As of February 2010, there were 3,429 hospices with claims filed in FY 2009. We estimate it would take each hospice 15 minutes of administrative time to develop and review the attestation language, and 15 minutes of clerical time to revise their existing recertification form or to create an addendum. The estimated total one-time burden for developing the attestation form would be 1,714 hours.

The burden for completing the attestation form is estimated at 30 seconds for each recertification at 180 days or beyond. We used the distribution of lengths of stay from hospice claims data to estimate the percentage of patients who required recertification at 180 days, and at subsequent 60-day benefit periods. We estimated that there would be 457,382 recertifications at 180 days or beyond, each of which requires an attestation. We assume that ninety percent of the visits were performed by physicians and ten percent by nurse practitioners, based on our analysis of FY 2009 physician and NP hospice billing data, with 30 seconds time allowed to sign and date the attestation statement, and to write in the name of the patient and the date of the visit, resulting in an estimated total burden to complete the attestation form of 3,811 hours for CY 2011. In the FY 2010 hospice rule (74 FR 39384) we finalized a requirement that the recertifying physician include a brief narrative explanation of the clinical findings which support continued hospice eligibility. Effective January 1, 2011 we propose regulation text changes that this narrative would describe why the clinical findings of the face-to-face encounter, occurring at the 180-day recertification and all subsequent recertifications, continue to support hospice eligibility. However, these proposed regulation changes are for clarification. The narrative requirement finalized in FY 2010 requires that the narrative include why the clinical findings of any physician/NP/patient encounter support continued hospice eligibility. Therefore, the only documentation burden associated with this requirement is the signed and dated attestation that the encounter occurred.

We reiterate that our longstanding policy has been that physicians must sign and date the certification and any recertifications. Therefore, our making this requirement explicit in the regulation poses no additional burden to hospices. We also proposed to clarify the timeframe which the certifications and recertifications cover by requiring physicians to include the dates of the benefit period to which the certification or recertification applies. We believe this is already standard practice at nearly all hospices, but are addressing it in regulation. Using the distribution of lengths of stay from 2007 and 2008 claims data, we estimate that there would be 1,733,663 initial certifications and recertifications during the course of a year. We estimate that it would take a physician 30 seconds at most to include the benefit period dates. We estimate that the time to require physicians to include the benefit period dates on the certification or recertification would be 30 seconds per certification or recertification, for a total burden of 14,447 hours for CY 2011. Table 17 below summarizes the burden estimate associated with these requirements.

TABLE 17. ESTIMATED ANNUAL RECORDKEEPING BURDEN					
OMB#	Requirements	Units	Responses	Hr.Burden	Total
0938-1067	418.22(b)(4)	3,429 hospices	1	0.50	1,714
0938-1067	418.22(b)(4)	457,382 ≥180-day recerts.	1	0.0083333	3,811
0938-1067	418.22(b)(5)	1,733,663 All certs. & recerts.	1	0.0083333	14,447

Details of our burden estimates are available in the PRA package approved under OMB# 0938–1067. We are revising this currently approved package to incorporate these requirements.

E. ICRs Regarding the Home Health Care CAHPS Survey (HHCAHPS)

As part of the DHHS Transparency Initiative on Quality Reporting, CMS is implementing a process to measure and publicly report patients' experiences with home health care they receive from Medicare-certified home health agencies with the Home Health Care CAHPS (HHCAHPS) survey. The HHCAHPS was developed and tested by the Agency for Healthcare Research and Quality (AHRQ) and is part of the family of CAHPS surveys, is a standardized survey for home health patients to assess their home health care providers and the quality of the home health care they received. Prior to the HHCAHPS, there was no national standard for collecting data about home health care patients' perspectives of their home health care.

It is proposed that Section 484.250, Patient Assessment Data, will require an HHA to submit to CMS HHCAHPS data in order for CMS 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 HHA to submit the HHCAHPS data, the patient burden to respond to the survey, and the cost to the HHA to pay the survey vendor to collect the data on their behalf. This burden is currently accounted for under OMB# 0938–1066.

The HHCAHPS survey received OMB clearance on July 18, 2009, and the number is 0938–1066. In that PRA package, we did not state the burden to the HHAs concerning the hours that they would need to secure an approved HHCAHPS vendor and to pay for that vendor. In this proposed rule, we have included the burden directly affecting HHAs, which is the burden to select a survey vendor from *http://www.homehealthcahps.org* and to sign a contract with that survey vendor, that will conduct HHCAHPS on behalf of the HHA. We have determined that this would take 16.0 hours for each HHA. It is noted that 91% of all HHAs (9,890 HHAs of a total of 10,998 HHAs) would be conducting HHCAHPS, since about 9% of HHAs will be exempt from conducting HHCAHPS because they have less than 60 eligible patients in the year. In TABLE 18, we have listed this burden to the HHAs:

TABLE 18. ESTIMATED ANNUAL BURDEN on HHAs for Vendor Selection					
OMB #	Requirements	Units	Responses	Hr. Burden	Total
0938-1066	484.250(c)(2)	9,890	1	16.0	158,240

OMB Number 0938–1066 will be revised to reflect the update concerning burden to the HHAs for vendor services for HHCAHPS.

On February 8, 2006, the Deficit Reduction Act of 2005 (Pub. L. 109–171) (DRA) was enacted. Section 5201 of the DRA requires HHAs to submit data for purposes of measuring health care quality, and links the quality data submission to payment. This requirement is applicable for CY 2007 and each subsequent year. If an HHA does not submit quality data, the home health market basket percentage increase will be reduced 2 percentage points. In accordance with the statute, we published a final rule (71 FR 65884, 65935) in the **Federal Register** on November 9, 2006, to implement the pay-for-reporting requirement of the DRA, codified at 42 CFR 484.225(h) and (i).

In the Home Health Prospective Payment System Rate Update for Calendar Year 2010 (August 13, 2009), we proposed to expand the home health quality measures reporting requirements to include the CAHPS® Home Health Care (HHCAHPS) Survey, as initially discussed in the May 4, 2007, proposed rule (72 FR 25356, 25452) and in the November 3, 2008, Notice (73 FR 65357, 65358). As part of the DHHS Transparency Initiative, we proposed to implement a process to measure and publicly report patient experiences with home health care using a survey developed by AHRQ in its CAHPS® program. In the Final Rule for CY 2010, published on November 10, 2009, we stated our intention to move forward with the HHCAHPS and link the survey to the CY 2012 annual payment update under the DRA "pay-for-reporting" requirement.

As part of this requirement, each HHA sponsoring a HHCAHPS Survey must

prepare and submit to its survey vendor a file containing patient data on patients served the preceding month that will be used by the survey vendor to select the sample and field the survey. This file (essentially the sampling frame) for most home health agencies can be generated from existing databases with minimal effort. For some small HHAs, preparation of a monthly sample frame may require more time. However, data elements needed on the sample frame will be kept at a minimum to reduce the burden on all HHAs.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget.

Attention: CMS Desk Officer [CMS–1510–P];

Fax: (202) 395–6974; or

E-mail: *OIRA_submission@omb.eop.gov.*

IV. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 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 Order 12866 directs 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). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate that this rulemaking is "economically significant" as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

1. CY 2011 Update

The update set forth in this proposed rule applies to Medicare payments under HH PPS in CY 2011. Accordingly, the following analysis describes the impact in CY 2011 only. We estimate that the net impact of the proposals in this rule is approximately $900 million in CY 2011 savings. The $900 million impact to the proposed CY 2011 HH PPS reflects the distributional effects of an updated wage index ($20 million increase), the 1.4 percent home health market basket update ($270 million increase), the 3.79 percent case-mix adjustment applicable to the national standardized 60-day episode rates and the NRS conversion factor ($700 million decrease), as well as the 2.5 percent returned from the outlier provisions of the Affordable Care Act ($490 million decrease). The $900 million in savings is reflected in the first row of column 3 of Table 15 below as a 4.63 percent decrease in expenditures when comparing the current CY 2010 HH PPS to the proposed CY 2011 HH PPS.

The RFA requires agencies to analyze options for regulatory relief of small businesses, 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. The Secretary has determined that this proposed rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis 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 603. 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 proposed rule applies to HHAs. Therefore, the Secretary has determined that this proposed rule would 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 2010, that threshold is approximately $135 million. This proposed rule is not anticipated to have an effect on State, local, or Tribal governments in the aggregate, or by the private sector, of $135 million or more.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent 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 proposed rule under the threshold criteria of Executive Order 13132, Federalism, and have determined that it would not have substantial direct effects on the rights, roles, and responsibilities of States, local or Tribal governments.

B. Anticipated Effects

This proposed rule sets forth updates to the HH PPS rates contained in the CY 2010 notice published on November 10, 2009. The impact analysis of this proposed rule presents the estimated expenditure effects of policy changes proposed in this rule. We use the latest data and best analysis available, but we do not make adjustments for future changes in such variable as number of visits or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare home health benefit, based on Medicare claims from 2008. 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 BBA, the BBRA, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the MMA, the DRA, The Affordable Care Act of 2020, or new statutory provision. 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 15 below represents how HHA revenues are likely to be affected by the policy changes proposed in this rule. For this analysis, we used linked home

health claims and OASIS assessments; the claims represented a 20-percent sample of 60-day episodes occurring in CY 2008. The first column of Table 15 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 only. The third column shows the payment effects of all the proposed policies outlined earlier in this rule. For CY 2011, the average impact for all HHAs is a .11 percent increase in payments due to the effects of the wage index. The overall impact, for all HHAs, in estimated total payments from CY 2010 to CY 2011, is a decrease of approximately 4.75 percent.

Section 3131(c) of the Affordable Care Act amended section 421(a) of the MMA of 2003. The amended section 421(a) provides an increase of 3 percent of the payment amount otherwise made for home health services furnished in a rural area, with respect to episodes and visits ending on or after April 1, 2010 and before January 1, 2016. Column 3 of Table 19 displays a comparison of estimated payments in CY 2010, including a 3 percent rural add-on for the last three quarters of CY 2010, to estimated payments in CY 2011, including a 3 percent rural add-on for all four quarters of CY 2011.

BILLING CODE 4120–01–P

Table 19--IMPACTS BY AGENCY TYPE		
Group	Comparisons	
	Percent change due to the effects of the updated wage index only	Impact of all CY 2011 Policies[1]
All Agencies	0.11%	-4.63%
Type of Facility		
Free-Standing/Other Vol/NP	-0.12%	-4.80%
Free-Standing/Other Proprietary	0.22%	-4.57%
Free-Standing/Other Government	-0.25%	-4.78%
Facility-Based Vol/NP	-0.09%	-4.76%
Facility-Based Proprietary	0.23%	-4.43%
Facility-Based Government	-0.04%	-4.63%
Subtotal: Freestanding	0.14%	-4.62%
Subtotal: Facility-based	-0.06%	-4.71%
Subtotal: Vol/NP	-0.11%	-4.78%
Subtotal: Proprietary	0.22%	-4.56%
Subtotal: Government	-0.15%	-4.71%
TOTAL	0.11%	-4.63%
Type of Facility (Rural * Only)		
Free-Standing/Other Vol/NP	-0.11%	-4.64%
Free-Standing/Other Proprietary	0.37%	-4.27%
Free-Standing/Other Government	-0.41%	-4.74%
Facility-Based Vol/NP	-0.01%	-4.41%
Facility-Based Proprietary	0.30%	-4.23%
Facility-Based Government	-0.06%	-4.50%
Type of Facility (Urban * Only)		
Free-Standing/Other Vol/NP	-0.12%	-4.81%
Free-Standing/Other Proprietary	0.20%	-4.61%
Free-Standing/Other Government	-0.06%	-4.81%
Facility-Based Vol/NP	-0.12%	-4.83%
Facility-Based Proprietary	0.19%	-4.55%
Facility-Based Government	-0.01%	-4.75%
Type of Facility (Urban* or Rural*)		
Rural	0.16%	-4.38%
Urban	0.10%	-4.67%

Facility Location: Region*		
North	-0.39%	-5.02%
South	0.23%	-4.53%
Midwest	0.07%	-4.71%
West	0.28%	-4.50%
Outlying	0.14%	-4.59%
Facility Location: Area of the Country		
New England	-0.51%	-5.14%
Mid Atlantic	-0.34%	-4.96%
South Atlantic	0.13%	-4.65%
East South Central	-0.28%	-5.00%
West South Central	0.52%	-4.24%
East North Central	0.14%	-4.66%
West North Central	-0.21%	-4.90%
Mountain	-0.26%	-4.93%
Pacific	0.51%	-4.31%
Outlying	0.14%	-4.59%
Facility Size: (Number of First Episodes)		
< 19	0.33%	-4.53%
20 to 49	0.30%	-4.53%
50 to 99	0.29%	-4.50%
100 to 199	0.31%	-4.45%
200 or More	0.02%	-4.70%

Note: Based on a 20% sample of CY 2008 claims linked to OASIS assessments.
*Urban / rural status, for the purposes of these simulations, is based on the wage index on which episode payment is based. The wage index is based on the site of service of the beneficiary.

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

[1] Percent change due to the effects of the update wage index, the 1.4% home health market basket update, the 3.79% reduction to the national standardized episode rates, the national per-visit rates, the LUPA add-on payment amount, and the NRS conversion factor for nominal increase in case-mix, the 5% decrease in the rates due The Affordable Care Act, the new approximate 2.5% target for outliers as a percentage of total HH PPS payments, a 0.67 FDL ratio, 10% outlier cap, and the 3% rural add-on.

BILLING CODE 4120–01–C

C. Accounting Statement and Table

Whenever a rule is considered a significant rule under Executive Order 12866, we are required to develop an Accounting Statement showing the classification of the expenditures associated with the provisions of this proposed rule.

Table 20 below provides our best estimate of the decrease in Medicare payments under the HH PPS as a result of the changes presented in this proposed rule based on the best available data. The expenditures are classified as a transfer to the Federal Government of $930 million.

Table 20--Accounting Statement: Classification of Estimated Expenditures, From the 21010 HH PPS Calendar Year to the 2011 HH PPS Calendar Year

Category	Transfers
Annualized Monetized Transfers	Negative transfer-Estimated decrease in expenditures: $900 million
From Whom to Whom	Federal Government to HH providers

D. Conclusion

In conclusion, we estimate that the net impact of the proposals in this rule is approximately $900 million in CY 2011 savings. The $900 million impact to the proposed CY 2011 HH PPS reflects the distributional effects of an updated wage index ($20 million increase), the 1.4 percent home health market basket update ($270 million increase), the 3.79 percent case-mix adjustment applicable to the national standardized 60-day episode rates and the NRS conversion factor ($700 million decrease), as well as the 2.5 percent returned from the outlier provisions of The Affordable Care Act ($490 million decrease). This analysis above, together with the remainder of this preamble, provides a Regulatory Impact Analysis.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 409—HOSPITAL INSURANCE BENEFITS: GENERAL PROVISIONS

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Amend § 409.44 by—

A. Revising paragraph (c)(1).

B. Republishing paragraph (c)(2) introductory text.

C. Revising paragraph (c)(2)(i).

D. Revising paragraph (c)(2)(iii).

E. Revising paragraph (c)(2)(iv).

The revisions read as follows:

§ 409.44 Skilled services requirements.

* * * * *

(c) * * *

(1) Speech-language pathology services and physical or occupational therapy services must relate directly and specifically to a treatment regimen (established by the physician, after any needed consultation with the qualified therapist) that is designed to treat the beneficiary's illness or injury. Services related to activities for the general physical welfare of beneficiaries (for example, exercises to promote overall fitness) do not constitute physical therapy, occupational therapy, or speech-language pathology services for Medicare purposes. To be covered by Medicare, all of the requirements apply as follows:

(i) The patient's plan of care must describe a course of therapy treatment and therapy goals which are consistent with the evaluation of the patient's function, and both must be included in the clinical record.

(ii) The patient's clinical record must include documentation describing how the course of therapy treatment for the patient's illness or injury is in accordance with accepted standards of clinical practice.

(iii) Therapy treatment goals described in the plan of care must be measurable, and must pertain directly to the patient's illness or injury, and the patient's resultant functional impairments.

(iv) The patient's clinical record must demonstrate that the method used to assess a patient's function included objective measurements of function in accordance with accepted standards of clinical practice, enabling comparison of successive measurements to determine progress.

(2) Physical and occupational therapy and speech-language pathology services must be reasonable and necessary. To be considered reasonable and necessary, the following conditions must be met:

(i) The services must be considered under accepted standards of clinical practice to be a specific, safe, and effective treatment for the beneficiary's condition. Each of the following requirements must also be met:

(A) The patient's function must be initially assessed and periodically reassessed by a qualified therapist, using a method which would include objective measurement of function and progress as described in paragraph (c)(1)(iv) of this section. The measurement results and corresponding progress, or lack of progress, must be documented in the clinical record.

(B) If a patient requires 13 or 19 therapy visits, at a minimum, the patient must be functionally reassessed by a qualified therapist on the 13th and 19th therapy visits and at least every 30 days. Subsequent therapy visits will not be covered until:

(*1*) The qualified therapist has completed the reassessment and

objectively measured progress (or lack of progress), towards therapy goals.

(*2*) The qualified therapist has determined if goals have been achieved or require updating.

(*3*) The qualified therapist has documented measurement results and corresponding therapy progress in the clinical record in accordance with paragraph (c)(2)(i)(D) of this section.

(*4*) If the objective measurements of the reassessment do not reveal progress toward goals, the qualified therapist together with the physician have determined whether the therapy is still effective or should be discontinued. If therapy is to be continued in accordance with paragraph (c)(2)(iv)(B)(*1*) of this section, the clinical record must document with a clinically supportable statement why there is an expectation that anticipated improvement is attainable in a reasonable and generally predictable period of time in accordance with paragraph (c)(2)(iii)(A) of this section.

(C) Clinical notes written by therapy assistants may supplement the clinical record, and if included, must include the date written, the signature and job title of the writer, and objective measurements or description of changes in status (if any) relative to each goal being addressed by treatment. Assistants may not make clinical judgments about why progress was or was not made, but must report the progress (or lack thereof) objectively.

(D) Progress documentation by a qualified therapist must include:

(*1*) The therapist's assessment of improvement and extent of progress (or lack thereof) toward each therapy goal;

(*2*) Plans for continuing or discontinuing treatment with reference to evaluation results and or treatment plan revisions;

(*3*) Changes to therapy goals or an updated plan of care that is sent to the physician for signature or discharge;

(*4*) Documentation of objective evidence or a clinically supportable statement of expectation that the patient's condition has the potential to improve or is improving in response to therapy or that maximum improvement is yet to be attained, and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.

* * * * *

(iii) For therapy services to be covered in the home health setting, one of the following three criteria must be met:

(A) There must be an expectation that the beneficiary's condition will improve materially in a reasonable (and generally predictable) period of time based on the physician's assessment of the beneficiary's restoration potential and unique medical condition.

(*1*) Material improvement requires that the clinical record demonstrate that the patient is making functional improvements that are ongoing, as well as of practical value, when measured against his or her condition at the start of treatment.

(*2*) Covered therapy services under the home health benefit shall be rehabilitative therapy service unless they meet the criteria for maintenance therapy in paragraph (c)(2)(iii)(B) or (c)(2)(iii)(C) of this section.

(*3*) Therapy is covered as rehabilitative therapy when the skills of a therapist are necessary to safely and effectively furnish or supervise a recognized therapy service whose goal is improvement of an impairment or functional limitation. Rehabilitative therapy includes recovery or improvement in function and, when possible, restoration to a previous level of health and well being.

(*4*) If an individual's expected rehabilitation potential would be insignificant in relation to the extent and duration of therapy services required to achieve such potential, therapy would not be considered reasonable and necessary, and thus would not be covered as rehabilitative therapy services.

(*5*) Where a patient suffers a transient and easily reversible loss or reduction of function which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities, therapy would not be considered reasonable and necessary and the services would not be covered.

(B) The specialized skills, knowledge, and judgment of a qualified therapist may be required to design or establish a safe and effective maintenance program required in connection with a specific disease, ensure patient safety, train the patient, family members and/or unskilled personnel, and make periodic reevaluations of the maintenance program.

(*1*) When indicated, the therapist may develop a maintenance program to maintain functional status or to prevent decline in function, during the last visit(s) for rehabilitative therapy.

(*2*) When a patient qualifies for Medicare's home health benefit based on an intermittent skilled nursing need, a qualified therapist may develop a maintenance program to maintain functional status or to prevent decline in function, at any point in the episode.

(*3*) Where the establishment of a maintenance program is initiated after the rehabilitative therapy program has been completed, development of a maintenance program would not be considered reasonable and necessary for the treatment of the patient's condition.

(*4*) If the services are for the establishment of a maintenance program, they must include the design of the program, the instruction of the beneficiary, family, or home health aides, and the necessary periodic reevaluations of the beneficiary and the program to the degree that the specialized knowledge and judgment of a physical therapist, speech-language pathologist, or occupational therapist is required.

(C) The skills of a therapist must be necessary to perform a safe and effective maintenance program required in connection with a specific disease. Where the clinical condition of the patient is such that the services required to maintain function involve the use of complex and sophisticated therapy procedures to be delivered by the therapist himself/herself (and not an assistant) in order to ensure the patient's safety and to provide both a safe and effective maintenance program, then those reasonable and necessary services shall be covered.

(iv) The amount, frequency, and duration of the services must be reasonable and necessary, as determined by a qualified therapist and/or physician, using accepted standards of clinical practice.

(A) Where factors exist that would influence the amount, frequency or duration of therapy services, especially factors that influence the clinical decisions to provide more services than are typical for the patient's condition, those factors must be included in the plan of care and/or functional assessment.

(B) Clinical records must include documentation using objective measures that the patient continues to progress towards goals. If progress cannot be measured, and continued improvement cannot be expected, therapy services cease to be covered except when

(*1*) Therapy progress regresses or plateaus, and the reasons for lack of progress are documented to include justification that continued therapy treatment will lead to resumption of progress toward goals; or

(*2*) Therapy can be considered reasonable and necessary when maintenance therapy is established or provided, as described in paragraph (c)(2)(iii)(B) or (C) of this section.

PART 418—HOSPICE CARE

3. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

4. Amend § 418.22 by—

A. Revising paragraph (a)(3).

B. Adding paragraphs (a)(4), (b)(3)(v), (b)(4), and (b)(5).

The revisions and additions read as follows:

§ 418.22 Certification of terminal illness.

(a) * * *

(3) *Exceptions.* (i) If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

(ii) Certifications may be completed no more than 15 calendar days prior to the effective date of election.

(iii) Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

(4) *Face-to-face encounter.* As of January 1, 2011, a hospice physician or hospice nurse practitioner must visit each hospice patient, whose total stay across all hospices is anticipated to reach 180 days, no more than 15 calendar days prior to the 180-day recertification, and must continue to visit that patient no more than 15 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

(b) * * *

(3) * * *

(v) The narrative associated with the 180-day recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

(4) The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section, must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.

(5) All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

5. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

6. Amend § 424.22 by—

A. Adding paragraph (a)(1)(v).

B. Revising paragraph (a)(2).

C. Revising paragraph (b)(1) introductory text.

D. Revising paragraph (d).

The revisions and additions read as follows:

§ 424.22 Requirements for home health services.

* * * * *

(a) * * *

(1) * * *

(v) The physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than thirty days prior to the home health start of care date or within two weeks of the start of the home health care by including the date of the encounter, and including an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services as defined in § 409.42(a) and (c) respectively. The physician's documentation of the face-to-face encounter in his/her practice's medical recordkeeping for that patient must be consistent with, and supportive of, the required documentation of the face-to-face encounter as part of the certification. Pursuant to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, the face-to-face encounter must be performed by the certifying physician himself or herself or by a nurse practitioner, a clinical nurse specialist (as those terms are defined in section 1861(aa)(5) of the Act) who is working in collaboration with the physician in accordance with State law, a certified nurse midwife (as defined in section 1861(gg)of the Act) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5) of the Act) under the supervision of the physician. The documentation of the face-to-face patient encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician.

(A) The non-physician practitioner performing the face-to-face encounter must document the clinical findings of that face-to-face patient encounter and communicate those findings to the certifying physician.

(B) If a face-to-face patient encounter occurred within 30 days of the start of care but is not related to the primary reason the patient requires home health services, or the patient has not seen the certifying physician or allowed non-physician practitioner within the 30 days prior to the start of the home health episode, the certifying physician or non-physician practitioner must have a face to face encounter with the patient within two weeks of the start of the home health care.

(C) The face-to-face patient encounter may occur through telehealth, in compliance with Section 1834(m) of the *Act* and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

(D) To assure clinical correlation between the face-to-face patient encounter and the associated home health episode of care, the physician responsible for certifying the patient for home care must document the face-to-face encounter on the certification itself, or as an addendum to the certification (as described in paragraph (a)(1)(v) of this section), that the condition for which the patient was being treated in the face-to-face patient encounter is related to the primary reason the patient requires home health services, and why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services as defined in § 409.42(a) and (c) of this chapter respectively. The documentation must be clearly titled, dated and signed by the certifying physician.

(2) *Timing & signature.* The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.

(b) * * *

(1) *Timing and signature of recertification.* Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed and dated by the physician who reviews the plan

of care. The recertification is required at least every 60 days when there is a—

* * * * *

(d) *Limitation of the performance of physician certification and plan of care functions.* The need for home health services to be provided by an HHA may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who has a financial relationship as defined in § 411.354 of this chapter, with that HHA, unless the physician's relationship meets one of the exceptions in section 1877 of the Act, which sets forth general exceptions to the referral prohibition related to both ownership/investment and compensation; exceptions to the referral prohibition related to ownership or investment interests; and exceptions to the referral prohibition related to compensation arrangements. Non-physician practitioners would be precluded from performing a face-to-face encounter for the purpose of informing the certifying physician, as described in sections 1814 and 1835 of the Act, if the non-physician practitioner is an employee of the HHA, as defined by Section 210(j) of the Act.

7. Amend § 424.502 by adding the definition of "Change in majority ownership" to read as follows:

§ 424.502 Definitions.

* * * * *

Change in majority ownership occurs when an individual or organization acquires more than 50 percent interest in an HHA during the 36 following the initial enrollment into the Medicare program or a change of ownership (including asset sale, stock transfer, merger, or consolidation). This includes an individual or organization that acquires majority ownership in an HHA through the cumulative effect of asset sales, stock transfers, consolidations, mergers during a 36 month period.

* * * * *

8. Section 424.510 is amended by adding paragraph (d)(9) to read as follows:

§ 424.510 Requirements for enrolling in the Medicare program.

* * * * *

(d) * * *

(9) In order to obtain enrollment and to maintain enrollment for the first three months after Medicare billing privileges are conveyed, a home health provider must satisfy the home health "initial reserve operating funds" requirement as set forth in § 489.28 of this chapter.

* * * * *

9. Section 424.530 is amended by adding paragraph (a)(8) to read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(8) *Initial reserve operating funds.* (i) CMS or its designated Medicare contractor may deny Medicare billing privileges if within 30 days of a CMS or Medicare contractor request, a home health agency cannot furnish supporting documentation which verifies that the HHA meets the initial reserve operating funds requirement found in 42 CFR 489.28(a).

(ii) CMS may deny Medicare billing privileges upon an HHA applicant's failure to satisfy the initial reserve operating funds requirement found in 42 CFR 489.28(a)

* * * * *

10. Section 424.535 is amended by adding paragraph (a)(11) to read as follows:

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) * * *

(11) *Initial reserve operating funds.* CMS or its designated Medicare contractor may revoke the Medicare billing privileges of a home health agency (HHA) and the corresponding provider agreement if within 30 days of a CMS or Medicare contractor request, the HHA cannot furnish supporting documentation verifying that the HHA meets the initial reserve operating funds requirement found in 42 CFR 489.28(a).

* * * * *

11. Section 424.550 is amended by adding paragraphs (b)(1) and (b)(2) to read as follows:

§ 424.550 Prohibitions on the sale or transfer of billing privileges.

(b) * * *

(1) Unless an exception in paragraph (b)(2) of this section applies, if there is a change in majority ownership of a home health agency by sale (including asset sales, stock transfers, mergers, consolidations) within 36 months after the effective date of the HHA's enrollment in Medicare, the provider agreement and Medicare billing privileges do not convey to the new owner. The prospective provider/owner of the HHA must instead:

(i) Enroll in the Medicare program as a new HHA under the provisions of § 424.510.

(ii) Obtain a State survey or an accreditation from an approved accreditation organization.

(2)(i) A publicly-traded company is acquiring another HHA and both entities have submitted cost reports to Medicare for the previous five (5) years.

(ii) An HHA's parent company is undergoing an internal corporate restructuring, such as a merger or consolidation, and the HHA has submitted a cost report to Medicare for the previous five (5) years.

(iii) The owners of an existing HHA decide to change the existing business structure (for example, partnership to a limited liability corporation or sole proprietorship to subchapter S corporation), the individual owners remain the same, and there is no change in majority ownership.

(iv) The death of an owner who owns 49 percent or less interest in an HHA (where several individuals and/or organizations are co-owners of an HHA and one of the owners dies).

* * * * *

PART 484—HOME HEALTH SERVICES

12. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart E—Prospective Payment System for HHAs

13. Revise § 484.250 to read as follows:

§ 484.250 Patient assessment data.

(a) An HHA must submit to CMS the OASIS–C data described at § 484.55 (b)(1) and Home Health Care CAHPS data in order for CMS to administer the payment rate methodologies described in §§ 484.215, 484.230, and 484.235, and meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Act.

(b) An HHA that has less than 60 eligible unique HHCAHPS patients annually must submit to CMS their total HHCAHPS patient count to CMS in order to be exempt from the HHCAHPS reporting requirements.

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

(1) CMS approves an HHCAHPS survey vendor if such applicant has been in business for a minimum of three years and has conducted surveys of individuals and samples for at least two years. For HHCAHPS, a "survey of individuals" is defined as the collection of data from at least 600 individuals selected by statistical sampling methods and the data collected are used for statistical purposes. All applicants that meet these requirements will be approved by CMS.

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

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

14. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102, 1819, 1820(e), 1861, 1864(m), 1866, 1869, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395i–3, 1395x, 1395aa(m), 1395cc, 1395ff, and 1395hh).

15. Amend § 489.28 by—

A. Revising paragraph (a).

B. Adding paragraph (c)(1).

B. Adding and reserving paragraph (c)(2).

C. Revising paragraph (g).

The addition and revisions read as follows:

§ 489.28 Special capitalization requirements for HHAs.

(a) *Basic rule.* An HHA entering the Medicare program on or after January 1, 1998, including a new HHA as a result of a change of ownership, if the change of ownership results in a new provider number being issued, must have available sufficient funds, which we term "initial reserve operating funds," at the time of application submission and at all times during the enrollment process to operate the HHA for the three month period after Medicare billing privileges are conveyed by the Medicare contractor, exclusive of actual or projected accounts receivable from Medicare.

* * * * *

(c) * * *

(1) In selecting the comparative HHAs as described in this paragraph (c), the CMS contractor shall only select HHAs that have provided cost reports to Medicare.

(2)[Reserved]

* * * * *

(g) *Billing privileges.* (1) CMS may deny Medicare billing privileges to an HHA unless the HHA meets the initial reserve operating funds requirement of this section.

(2) CMS may revoke the Medicare billing privileges of an HHA that fails to meet the initial reserve operations funds requirements of this section within three months of receiving its billing privileges.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: May 18, 2010.

Marilyn Tavenner,

Acting Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services.

Approved: July 14, 2010.

Kathleen Sebelius,

Secretary.

Note: The following addenda will not be published in the Code of Federal Regulations.

BILLING CODE 4120–01–P

ADDENDUM A. CY 2011 WAGE INDEX FOR RURAL AREAS BY CBSA; APPLICABLE PRE-FLOOR AND PRE-RECLASSIFIED HOSPITAL WAGE INDEX

CBSA Code	Nonurban Area	Wage Index
01	Alabama	0.7376
02	Alaska	1.2646
03	Arizona	0.9094
04	Arkansas	0.7234
05	California	1.2456
06	Colorado	0.9949
07	Connecticut	1.1139
08	Delaware	0.9771
10	Florida	0.8422
11	Georgia	0.7567
12	Hawaii	1.1100
13	Idaho	0.7568
14	Illinois	0.8357
15	Indiana	0.8404
16	Iowa	0.8584
17	Kansas	0.7994
18	Kentucky	0.7827
19	Louisiana	0.7724
20	Maine	0.8602
21	Maryland	0.9189
22	Massachusetts[1]	1.1788
23	Michigan	0.8569
24	Minnesota	0.9053
25	Mississippi	0.7647
26	Missouri	0.7648
27	Montana	0.8531
28	Nebraska	0.8920
29	Nevada	0.9365
30	New Hampshire	0.9894
31	New Jersey[1]	------
32	New Mexico	0.8948
33	New York	0.8198
34	North Carolina	0.8379
35	North Dakota	0.6842
36	Ohio	0.8542
37	Oklahoma	0.7867
38	Oregon	1.0045
39	Pennsylvania	0.8482
40	Puerto Rico[1]	0.4047
41	Rhode Island[1]	------
42	South Carolina	0.8431
43	South Dakota	0.8549
44	Tennessee	0.7879
45	Texas	0.7818
46	Utah	0.8663
47	Vermont	0.9606
48	Virgin Islands	0.7416
49	Virginia	0.7853

1 All counties within the State are classified as urban, with the exception of Massachusetts and Puerto Rico. Massachusetts and Puerto Rico have areas designated as rural, however, no short-term, acute care hospitals are located in the area(s) for CY 2011

CBSA Code	Nonurban Area	Wage Index
50	Washington	1.0200
51	West Virginia	0.7484
52	Wisconsin	0.8976
53	Wyoming	0.9544
65	Guam	0.9611

ADDENDUM B.- CY 2011 WAGE INDEX FOR URBAN AREAS BY CBSA; APPLICABLE PRE-FLOOR AND PRE-RECLASSIFIED HOSPITAL WAGE INDEX

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8016
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.3476
10420	Akron, OH Portage County, OH Summit County, OH	0.8857
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9050
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.8667
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9454
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8008
10900	Allentown-Bethlehem-Easton, PA-NJ Warren County, NJ Carbon County, PA Lehigh County, PA Northampton County, PA	0.9178
11020	Altoona, PA Blair County, PA	0.8634
11100	Amarillo, TX Armstrong County, TX Carson County, TX Potter County, TX Randall County, TX	0.8658
11180	Ames, IA Story County, IA	0.9986
11260	Anchorage, AK Anchorage Municipality, AK Matanuska-Susitna Borough, AK	1.1984
11300	Anderson, IN Madison County, IN	0.9207

CBSA Code	Urban Area (Constituent Counties)	Wage Index
11340[2]	Anderson, SC Anderson County, SC	0.8969
11460	Ann Arbor, MI Washtenaw County, MI	1.0140
11500	Anniston-Oxford, AL Calhoun County, AL	0.7931
11540	Appleton, WI Calumet County, WI Outagamie County, WI	0.9376
11700	Asheville, NC Buncombe County, NC Haywood County, NC Henderson County, NC Madison County, NC	0.9016
12020	Athens-Clarke County, GA Clarke County, GA Madison County, GA Oconee County, GA Oglethorpe County, GA	0.9546
12060	Atlanta-Sandy Springs-Marietta, GA Barrow County, GA Bartow County, GA Butts County, GA Carroll County, GA Cherokee County, GA Clayton County, GA Cobb County, GA Coweta County, GA Dawson County, GA DeKalb County, GA Douglas County, GA Fayette County, GA Forsyth County, GA Fulton County, GA Gwinnett County, GA Haralson County, GA Heard County, GA Henry County, GA Jasper County, GA Lamar County, GA Meriwether County, GA Newton County, GA Paulding County, GA Pickens County, GA Pike County, GA Rockdale County, GA Spalding County, GA Walton County, GA	0.9566
12100	Atlantic City-Hammonton, NJ Atlantic County, NJ	1.1147
12220	Auburn-Opelika, AL Lee County, AL	0.7255

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12260	Augusta-Richmond County, GA-SC Burke County, GA Columbia County, GA McDuffie County, GA Richmond County, GA Aiken County, SC Edgefield County, SC	0.9522
12420	Austin-Round Rock-San Marcos, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	0.9529
12540	Bakersfield-Delano, CA Kern County, CA	1.1655
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0267
12620	Bangor, ME Penobscot County, ME	0.9793
12700	Barnstable Town, MA Barnstable County, MA	1.2844
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8597
12980	Battle Creek, MI Calhoun County, MI	0.9671
13020	Bay City, MI Bay County, MI	0.9235
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8502
13380	Bellingham, WA Whatcom County, WA	1.1408
13460	Bend, OR Deschutes County, OR	1.1388
13644	Bethesda-Rockville-Frederick, MD Frederick County, MD Montgomery County, MD	1.0542
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8688
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8733
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8616
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7360
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8328
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9004

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14060	Bloomington-Normal, IL McLean County, IL	0.9455
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9288
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2215
14500	Boulder, CO Boulder County, CO	1.0081
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8680
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0684
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2567
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9188
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9224
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.9545
15500	Burlington, NC Alamance County, NC	0.8878
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	0.9963
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1268
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0403
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8761
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9191
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.8905
16180	Carson City, NV Carson City, NV	1.0482
16220	Casper, WY Natrona County, WY	0.9670
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8858
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0251
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.7908
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9345

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16740	Charlotte-Gastonia-Rock Hill, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9435
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9358
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.8755
16940	Cheyenne, WY Laramie County, WY	0.9408
16974	Chicago-Joliet-Naperville, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.0573
17020	Chico, CA Butte County, CA	1.1572
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	0.9714
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.7898
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.7744
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9052
17660	Coeur d'Alene, ID Kootenai County, ID	0.9379
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	0.9604
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	0.9497

CBSA Code	Urban Area (Constituent Counties)	Wage Index
17860	Columbia, MO Boone County, MO Howard County, MO	0.8295
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.8721
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9042
18020	Columbus, IN Bartholomew County, IN	0.9449
18140	Columbus, OH Delaware County, OH Fairfield County, OH Franklin County, OH Licking County, OH Madison County, OH Morrow County, OH Pickaway County, OH Union County, OH	1.0157
18580	Corpus Christi, TX Aransas County, TX Nueces County, TX San Patricio County, TX	0.8599
18700	Corvallis, OR Benton County, OR	1.0472
18880	Crestview-Fort Walton Beach-Destin, FL Okaloosa County, FL	0.8856
19060	Cumberland, MD-WV Allegany County, MD Mineral County, WV	0.8199

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19124	Dallas-Plano-Irving, TX Collin County, TX Dallas County, TX Delta County, TX Denton County, TX Ellis County, TX Hunt County, TX Kaufman County, TX Rockwall County, TX	0.9848
19140	Dalton, GA Murray County, GA Whitfield County, GA	0.8610
19180	Danville, IL Vermilion County, IL	0.9708
19260	Danville, VA Pittsylvania County, VA Danville City, VA	0.8182
19340	Davenport-Moline-Rock Island, IA-IL Henry County, IL Mercer County, IL Rock Island County, IL Scott County, IA	0.8414
19380	Dayton, OH Greene County, OH Miami County, OH Montgomery County, OH Preble County, OH	0.9155
19460	Decatur, AL Lawrence County, AL Morgan County, AL	0.7618
19500	Decatur, IL Macon County, IL	0.7929
19660	Deltona-Daytona Beach-Ormond Beach, FL Volusia County, FL	0.8750

CBSA Code	Urban Area (Constituent Counties)	Wage Index
19740	Denver-Aurora-Broomfield, CO Adams County, CO Arapahoe County, CO Broomfield County, CO Clear Creek County, CO Denver County, CO Douglas County, CO Elbert County, CO Gilpin County, CO Jefferson County, CO Park County, CO	1.0735
19780	Des Moines-West Des Moines, IA Dallas County, IA Guthrie County, IA Madison County, IA Polk County, IA Warren County, IA	0.9637
19804	Detroit-Livonia-Dearborn, MI Wayne County, MI	0.9702
20020	Dothan, AL Geneva County, AL Henry County, AL Houston County, AL	0.7635
20100	Dover, DE Kent County, DE	0.9937
20220	Dubuque, IA Dubuque County, IA	0.8788
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.0469
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	0.9680
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	0.9655
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1022
20940	El Centro, CA Imperial County, CA	0.9273
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8463
21140	Elkhart-Goshen, IN Elkhart County, IN	0.9480
21300	Elmira, NY Chemung County, NY	0.8459
21340	El Paso, TX El Paso County, TX	0.8489
21500	Erie, PA Erie County, PA	0.8371
21660	Eugene-Springfield, OR Lane County, OR	1.1402
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.8446
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1098
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.3889
22020	Fargo, ND-MN Clay County, MN Cass County, ND	0.8049
22140	Farmington, NM San Juan County, NM	0.8000

CBSA Code	Urban Area (Constituent Counties)	Wage Index
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9339
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.8630
22380	Flagstaff, AZ Coconino County, AZ	1.2463
22420	Flint, MI Genesee County, MI	1.1515
22500	Florence, SC Darlington County, SC Florence County, SC	0.8264
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8058
22540	Fond du Lac, WI Fond du Lac County, WI	0.9238
22660	Fort Collins-Loveland, CO Larimer County, CO	0.9908
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0170
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.7601
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9322
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	0.9490

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23420	Fresno, CA Fresno County, CA	1.1439
23460	Gadsden, AL Etowah County, AL	0.7028
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9175
23580	Gainesville, GA Hall County, GA	0.9386
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9099
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8521
24140	Goldsboro, NC Wayne County, NC	0.9081
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.7729
24300	Grand Junction, CO Mesa County, CO	0.9866
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9183
24500	Great Falls, MT Cascade County, MT	0.8303
24540	Greeley, CO Weld County, CO	0.9511
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9601

CBSA Code	Urban Area (Constituent Counties)	Wage Index
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.8897
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9385
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	0.9563
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3692
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8990
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9269
25260	Hanford-Corcoran, CA Kings County, CA	1.1223
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9311
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9173
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.0936
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7727

CBSA Code	Urban Area (Constituent Counties)	Wage Index
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8707
25980[2]	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.8955
26100	Holland-Grand Haven, MI Ottawa County, MI	0.8646
26180	Honolulu, HI Honolulu County, HI	1.1801
26300	Hot Springs, AR Garland County, AR	0.9166
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7865
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	0.9838
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.8967
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9130
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9678

CBSA Code	Urban Area (Constituent Counties)	Wage Index
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	0.9687
26980	Iowa City, IA Johnson County, IA Washington County, IA	0.9672
27060	Ithaca, NY Tompkins County, NY	0.9858
27100	Jackson, MI Jackson County, MI	0.9170
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8105
27180	Jackson, TN Chester County, TN Madison County, TN	0.8418
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.8899
27340	Jacksonville, NC Onslow County, NC	0.7819
27500	Janesville, WI Rock County, WI	0.9430
27620	Jefferson City, MO Callaway County, MO Cole County, MO Moniteau County, MO Osage County, MO	0.8448
27740	Johnson City, TN Carter County, TN Unicoi County, TN Washington County, TN	0.7269
27780	Johnstown, PA Cambria County, PA	0.8103
27860	Jonesboro, AR Craighead County, AR Poinsett County, AR	0.7770
27900	Joplin, MO Jasper County, MO Newton County, MO	0.8227
28020	Kalamazoo-Portage, MI Kalamazoo County, MI Van Buren County, MI	1.0309
28100	Kankakee-Bradley, IL Kankakee County, IL	1.0636

CBSA Code	Urban Area (Constituent Counties)	Wage Index
28140	Kansas City, MO-KS Franklin County, KS Johnson County, KS Leavenworth County, KS Linn County, KS Miami County, KS Wyandotte County, KS Bates County, MO Caldwell County, MO Cass County, MO Clay County, MO Clinton County, MO Jackson County, MO Lafayette County, MO Platte County, MO Ray County, MO	0.9667
28420	Kennewick-Pasco-Richland, WA Benton County, WA Franklin County, WA	0.9992
28660	Killeen-Temple-Fort Hood, TX Bell County, TX Coryell County, TX Lampasas County, TX	0.8711
28700	Kingsport-Bristol-Bristol, TN-VA Hawkins County, TN Sullivan County, TN Bristol City, VA Scott County, VA Washington County, VA	0.7596
28740	Kingston, NY Ulster County, NY	0.9089
28940	Knoxville, TN Anderson County, TN Blount County, TN Knox County, TN Loudon County, TN Union County, TN	0.7856
29020	Kokomo, IN Howard County, IN Tipton County, IN	0.9134
29100	La Crosse, WI-MN Houston County, MN La Crosse County, WI	0.9819
29140	Lafayette, IN Benton County, IN Carroll County, IN Tippecanoe County, IN	0.9304
29180	Lafayette, LA Lafayette Parish, LA St. Martin Parish, LA	0.8499
29340	Lake Charles, LA Calcasieu Parish, LA Cameron Parish, LA	0.8209
29404	Lake County-Kenosha County, IL-WI Lake County, IL Kenosha County, WI	1.0799
29420	Lake Havasu City-Kingman, AZ Mohave County, AZ	1.0252
29460	Lakeland-Winter Haven, FL Polk County, FL	0.8461
29540	Lancaster, PA Lancaster County, PA	0.9359
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0315
29700	Laredo, TX Webb County, TX	0.7927
29740	Las Cruces, NM Dona Ana County, NM	0.9311
29820	Las Vegas-Paradise, NV Clark County, NV	1.2119
29940	Lawrence, KS Douglas County, KS	0.8547
30020	Lawton, OK Comanche County, OK	0.8298
30140	Lebanon, PA Lebanon County, PA	0.7820

CBSA Code	Urban Area (Constituent Counties)	Wage Index
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	0.9373
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.8917
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.8832
30620	Lima, OH Allen County, OH	0.9285
30700	Lincoln, NE Lancaster County, NE Seward County, NE	0.9633
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.8542
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.8808
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8582
31020	Longview, WA Cowlitz County, WA	1.0313
31084	Los Angeles-Long Beach-Glendale, CA Los Angeles County, CA	1.2054
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Jefferson County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.8898
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.8862
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.8679
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	0.9044
31460	Madera-Chowchilla, CA Madera County, CA	0.7999
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1307
31700	Manchester-Nashua, NH Hillsborough County, NH	0.9885
31740	Manhattan, KS Geary County, KS	0.7860

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Pottawatomie County, KS Riley County, KS	
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9098
31900	Mansfield, OH Richland County, OH	0.8932
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.3646
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.8852
32780	Medford, OR Jackson County, OR	1.0077
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9205
32900	Merced, CA Merced County, CA	1.2241
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0144
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9485
33260	Midland, TX Midland County, TX	0.9727
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0200
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1161
33540	Missoula, MT Missoula County, MT	0.8935
33660	Mobile, AL Mobile County, AL	0.7949
33700	Modesto, CA Stanislaus County, CA	1.2123
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8008
33780	Monroe, MI Monroe County, MI	0.8698
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8346
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8150
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7046
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.0379

CBSA Code	Urban Area (Constituent Counties)	Wage Index
34620	Muncie, IN Delaware County, IN	0.8219
34740	Muskegon-Norton Shores, MI Muskegon County, MI	0.9805
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.8726
34900	Napa, CA Napa County, CA	1.4628
34940	Naples-Marco Island, FL Collier County, FL	0.9714
34980	Nashville-Davidson—Murfreesboro-Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	0.9390
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.2333
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.1461
35300	New Haven-Milford, CT New Haven County, CT	1.1534
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9085
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.2949
35660	Niles-Benton Harbor, MI Berrien County, MI	0.8887
35840	North Port-Bradenton-Sarasota, FL Manatee County, FL Sarasota County, FL	0.9495
35980	Norwich-New London, CT New London County, CT	1.1234
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.6374
36100	Ocala, FL Marion County, FL	0.8482
36140	Ocean City, NJ Cape May County, NJ	1.0896
36220	Odessa, TX Ector County, TX	0.9451
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9282

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36420	Oklahoma City, OK Canadian County, OK Cleveland County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.8892
36500	Olympia, WA Thurston County, WA	1.1287
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	0.9599
36740	Orlando-Kissimmee-Sanford, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9159
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9582
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8384
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.2397
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9226
37380	Palm Coast, FL Flagler County, FL	0.8419
37460	Panama City-Lynn Haven-Panama City Beach, FL Bay County, FL	0.7967
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.7467
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8312
37764	Peabody, MA Essex County, MA	1.0996
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8267
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9163
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.0818
38060	Phoenix-Mesa-Glendale, AZ Maricopa County, AZ Pinal County, AZ	1.0662
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.8025
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.8619

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38340	Pittsfield, MA Berkshire County, MA	1.0388
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9523
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.4320
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	0.9905
38900	Portland-Vancouver-Hillsboro, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.1495
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0740
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1350
39140	Prescott, AZ Yavapai County, AZ	1.2253
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.0731
39340	Provo-Orem, UT Juab County, UT Utah County, UT	0.9336
39380	Pueblo, CO Pueblo County, CO	0.8735
39460	Punta Gorda, FL Charlotte County, FL	0.8773
39540	Racine, WI Racine County, WI	1.0597
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	0.9827
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0459
39740	Reading, PA Berks County, PA	0.8918
39820	Redding, CA Shasta County, CA	1.4146
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0436

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	0.9677
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1553
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.8841
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.0960
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.8609
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0049
40484	Rockingham County-Strafford County, NH Rockingham County, NH Strafford County, NH	1.0042
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9049
40660	Rome, GA Floyd County, GA	0.8817
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.3949
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.8742
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1060
41100	St. George, UT Washington County, UT	0.9148
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0318

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9105
41420	Salem, OR Marion County, OR Polk County, OR	1.1151
41500	Salinas, CA Monterey County, CA	1.5711
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9020
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9281
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8317
41700	San Antonio-New Braunfels, TX Atascosa County, TX Bandera County, TX Bexar County, TX Comal County, TX Guadalupe County, TX Kendall County, TX Medina County, TX Wilson County, TX	0.9013
41740	San Diego-Carlsbad-San Marcos, CA San Diego County, CA	1.1858
41780	Sandusky, OH Erie County, OH	0.8700
41884	San Francisco-San Mateo-Redwood City, CA Marin County, CA San Francisco County, CA San Mateo County, CA	1.5740
41900	San Germán-Cabo Rojo, PR Cabo Rojo Municipio, PR Lajas Municipio, PR Sabana Grande Municipio, PR San Germán Municipio, PR	0.4567
41940	San Jose-Sunnyvale-Santa Clara, CA San Benito County, CA Santa Clara County, CA	1.6730
41980	San Juan-Caguas-Guaynabo, PR Aguas Buenas Municipio, PR Aibonito Municipio, PR Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR	0.4303

CBSA Code	Urban Area (Constituent Counties)	Wage Index
	Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.2927
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2181
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.1986
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.6768
42140	Santa Fe, NM Santa Fe County, NM	1.0864
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6167
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.8918
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8252
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1574
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9111
43100	Sheboygan, WI Sheboygan County, WI	0.9248
43300	Sherman-Denison, TX Grayson County, TX	0.8292
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8550
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9106
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9314
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	0.9964
43900	Spartanburg, SC Spartanburg County, SC	0.9268
44060	Spokane, WA Spokane County, WA	1.0588

CBSA Code	Urban Area (Constituent Counties)	Wage Index
44100	Springfield, IL Menard County, IL Sangamon County, IL	0.9145
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0236
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8271
44220	Springfield, OH Clark County, OH	0.9249
44300	State College, PA Centre County, PA	0.8793
44600	Steubenville-Weirton, OH-WV Jefferson County, OH Brooke County, WV Hancock County, WV	0.7326
44700	Stockton, CA San Joaquin County, CA	1.2576
44940	Sumter, SC Sumter County, SC	0.7873
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	0.9631
45104	Tacoma, WA Pierce County, WA	1.1362
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8820

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9068
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9220
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.7654
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	0.9447
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.8967
45940	Trenton-Ewing, NJ Mercer County, NJ	1.0167
46060	Tucson, AZ Pima County, AZ	0.9495
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.8802

CBSA Code	Urban Area (Constituent Counties)	Wage Index
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.8003
46340	Tyler, TX Smith County, TX	0.8078
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8485
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.7937
46700	Vallejo-Fairfield, CA Solano County, CA	1.4939
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8232
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0432
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.8975
47300	Visalia-Porterville, CA Tulare County, CA	1.0756
47380	Waco, TX McLennan County, TX	0.8417
47580	Warner Robins, GA Houston County, GA	0.7951
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	0.9662
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.0722
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8476
48140	Wausau, WI Marathon County, WI	0.9358

CBSA Code	Urban Area (Constituent Counties)	Wage Index
48300	Wenatchee-East Wenatchee, WA Chelan County, WA Douglas County, WA	0.9631
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	0.9949
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.6686
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.8913
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9581
48700	Williamsport, PA Lycoming County, PA	0.7267
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0597
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9150
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0018
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.8953
49340	Worcester, MA Worcester County, MA	1.1030
49420	Yakima, WA Yakima County, WA	1.0083
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.3542
49620	York-Hanover, PA York County, PA	0.9542
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8639
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.1061
49740	Yuma, AZ Yuma County, AZ	0.9298

[2]At this time, there are no hospitals in these urban areas on which to base a wage index. Therefore, the urban wage index value is based on the average wage index of all urban areas within the State.

[FR Doc. 2010–17753 Filed 7–16–10; 4:15 pm]

BILLING CODE 4120–01–C