

authority, we have maintained limits on home health agency (HHA) per-visit costs since 1979. The limits may be applied to direct and indirect overall costs or to the costs incurred for specific items or services furnished by the provider. Implementing regulations appear at 42 CFR 413.30. Additional statutory provisions governing the limits applicable to HHAs are contained at section 1861(v)(1)(L) of the Act. Section 1861(v)(1)(L)(i) of the Act specifies that the cost limits are not to exceed 112 percent of the mean of the labor-related and nonlabor per-visit costs for freestanding HHAs. For cost reporting periods beginning before October 1, 1993, section 1861(v)(1)(L)(ii) of the Act requires that the Secretary make an adjustment to the cost limits for the administrative and general (A&G) costs of hospital-based HHAs. Section 1861(v)(1)(L)(iii) of the Act requires that the Secretary establish HHA cost limits on an annual basis for cost reporting periods beginning on or after July 1 of each year.

Accordingly, we published a notice with comment period that appeared in the July 8, 1993, issue of the **Federal Register** (58 FR 36748), which set forth a schedule of limits on HHA costs for cost reporting periods beginning on or after July 1, 1993. The limits were computed using the actual cost per-visit data from cost reporting periods ending on or after June 30, 1989, and before May 31, 1991, and were adjusted by the latest estimates in the "market basket" index to reflect changes in the price of goods and services furnished by HHAs.

#### *B. Omnibus Budget Reconciliation Act of 1993*

On August 10, 1993, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) (Public Law 103-66) was enacted. Section 13564(a) of OBRA '93 amended section 1861(v)(1)(L)(iii) of the Act to provide that there be no changes in the HHA per-visit cost limits (except as may be necessary to take into account the elimination of the A&G add-on for hospital-based HHAs) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. In addition, section 13564(b) of OBRA '93 amended section 1861(v)(1)(L)(ii) of the Act to require that, effective for cost reporting periods beginning on or after October 1, 1993, we no longer include a payment adjustment for A&G costs of hospital-based HHAs in computing the HHA limits. The A&G per-visit add-on for hospital-based HHAs had been applied since 1980. Under this provision, hospital-based HHAs and freestanding HHAs will be treated identically for payment purposes.

On January 6, 1994, we published a notice with comment period in the **Federal Register** to announce the elimination of the A&G add-on for hospital-based HHAs (59 FR 760). In that notice, we stated that in computing a hospital-based HHA's cost limits for cost reporting periods beginning on or after October 1, 1993, the A&G add-on amounts that were to apply, as set forth in Table II of the July 8, 1993 notice (58 FR 36753), will not be used. We also stated that we would publish a separate **Federal Register** notice to explain the effects of the requirement under section 13564(a) of OBRA '93 that there be no changes in the per-visit cost limits for home health services for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996.

## **II. Discussion of Public Comments**

### *A. Response to Public Comments Received On the July 8, 1993 Notice With Comment Period*

We received 28 items of timely correspondence on our HHA cost limits notice issued in the **Federal Register** on July 8, 1993 (58 FR 36748). A discussion of the comments we received on that notice and our responses to those comments is set forth below.

#### **1. Cost Limits**

*Comment:* Many commenters stated that the per-discipline cost limits for skilled nursing and home health aides are inadequate. They believe that the cost limits are arbitrary and not at the level required by law. In addition, two commenters suggested that the limits effective July 1, 1993 should be phased in.

*Response:* Section 1861(v)(1)(L) of the Act governs the methodology for computing the HHA limits. As noted in section I.A of this notice, section 1861(v)(1)(L)(i) of the Act specifies that the HHA per-visit cost limits are not to exceed 112 percent of the mean of the labor-related and nonlabor per-visit costs for freestanding HHAs. Section 1861(v)(1)(L)(iii) of the Act requires that we establish cost limits on an annual basis for cost reporting periods beginning on or after July 1 of each year (except for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996) and that we use the current hospital wage index to calculate the limits.

Thus, in calculating the limits, we use actual cost-per-visit data from the latest available settled Medicare cost reports. From those data, we compute an average per-visit cost for each Medicare covered home health service. The labor portion of the average per-visit cost is adjusted,

using the current hospital wage index, to account for variations in area wage levels. We then apply a statistically valid methodology for eliminating outlier costs to the average per-visit costs for each service. The resulting average per-visit costs are increased by 112 percent, the maximum the statute allows. We believe the methodology used to calculate the cost limits correctly implements the statute and results in a statistically valid national average of the costs estimated to be necessary in the efficient delivery of needed home health services under the Medicare program.

In summary, the implementation of the schedule of limits set forth in our July 8, 1993 notice and the methodology for developing the limits are in full compliance with statutory directives. In developing these limits, we have made no changes, beyond those directly required by OBRA '93, in the methodology used in setting the limits effective July 1, 1991 and July 1, 1992. Finally, the statute does not provide for a phase-in of the limits.

#### **2. Database**

*Comment:* Several commenters questioned the database used to develop the cost limits. Some commenters raised concerns about the possible omission of providers from California. Others suggested that the provider database used to develop the limits was not representative because HCFA relies only on settled cost reports to compute the HHA cost limits.

*Response:* The data used in the calculations of the cost limits effective July 1, 1993, were actual cost per-visit data extracted from settled Medicare cost reports, for cost reporting periods ending on or after June 30, 1989, and before May 31, 1991. This resulted in a database of 2602 freestanding agencies located throughout the country. Due to concerns with under-representation of HHAs, we reviewed the Provider of Services (POS) file to determine the number of HHAs that were Medicare-certified as of November, 1992 (the cut-off date of the HHA database used to develop the HHA cost limits effective for cost reporting periods beginning on or after July 1, 1993). Our review showed that the POS file contained all HHA providers of service, including terminated providers, existing providers, and new providers. However, the POS file does not indicate whether a HHA needs to file a cost report, or if a cost report is due from an HHA.

Accordingly, we extended our review. We instructed the nine regional home health intermediaries (RHHIs) servicing the freestanding HHAs to review their