



PAYMENT CHANGES FOR HOME HEALTH CARE:

CMS MAKES ALLOWANCES FOR PART A; CHALLENGES CONTINUE FOR PART B

Vernon Pertelle RRT MBA

The challenges that plague the home care/HME [Part B] industry continues with no apparent end in sight, while the home health [Part A] benefit seems to get more of an increase to improve beneficiary access to care and services. The disparity comes at a time when the home care/HME industry is in a perpetual position of explanation to support the importance of providers who administer the benefit. The difference in the approach is the result of the outcomes-based payment based system in home health care. Home health care is based on a fixed payment system for services (and certain supplies in 2008) rendered to Medicare beneficiaries, while the home care/HME benefit is based on reimbursement for the equipment alone. The fixed payment system was implemented in 2000 for home health services. It is called home health prospective payment system (HHPPS). In the system the determination of a payment category is dependent on the

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Outcome and Assessment Information Set (OASIS). This dataset includes coded information about the patient's diagnoses and functional status and also includes information about the anticipated patient's outcomes from services provided. There are currently 80 home health resource groups (HHRGs) that define the amount an agency receives for services provided to a beneficiary and the home health agency gets a payment for each 60 day block of service. The home care industry would do well to establish a similar outcomes-based payment system to mitigate issues associated with negative perceptions from policy makers of the industry while encouraging them to support home care/HME providers as viable components in the continuum of care.

The Centers for Medicare & Medicaid Services (CMS) recently published the final rule along with revisions (on October 9, 2007) that updates the manner in which PPS supports reimbursement for home healthcare services. Conversely the home care/HME industry is tasked with preparing bids to

participate in Part B program for beneficiaries who require durable medical equipment (DME). The final rule for Part A sets forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare PPS system for home health services, effective on January 1, 2008. Interestingly enough the revisions are based on a methodology that supports reimbursement to agencies in a manner that allows them to be paid for the services commensurate to adequately reflect the cost of doing business. Home health payment rates have been historically updated annually by either the full home health market basket, or by the home health market basket as adjusted by Congress. The home health market basket index measures inflation in the prices of an appropriate mix of items and services furnished by home healthcare agencies. This is a far cry from the approach that is taken with the home care/HME industry, which in my opinion is the direct result of the lack of outcomes-based services provided to patients - with a singular focus solely on the cost of equipment and not the labor associated with delivery and maintenance. The final rule for home healthcare changes in 2008 sets forth the new quality of care data collection requirements, which establish the groundwork for payment for performance. Home healthcare agencies have prepared for years for payment for performance through the collection and reporting of data utilizing the OASIS data sets. The groundwork has been laid by CMS and effective January 1, 2008, CMS plans to evaluate home health quality of care by using the submission of the OASIS assessments. Utilizing the OASIS eliminates the added burden of home healthcare agencies in reporting data and while not adding additional costs; it also leverages practices that have occurred for years to

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determine how a home health agency is paid. Payment will be based on quality improvements and outcomes. This approach must be implemented in the home care/HME industry if we are to eliminate the cuts and negative changes associated with competitive bidding, cap on equipment reimbursement and other changes that remain to be seen.

Although home health agencies report the data to CMS such a practice for home care/HME is considered by some as anathema because of the perceived proprietary information that would need to be reported. Quite the contrary is the case as it is of the utmost importance for the home care/HME industry to become more transparent and begin submitting outcomes related data similar to the data submitted by home healthcare agencies utilizing OASIS to support the services provided thus gain better reimbursement.

The annual assessment of home healthcare payment is based on an update of the "market basket" of a given geographical location and the quality data that agency's submit to CMS on select indicators. Home healthcare agencies that submit the quality data as required under current regulations will receive payments based on the full home health market basket update of three (3) percent for calendar year 2008. If a home health agency does not submit quality data, the home health market basket percentage increase will be reduced by two (2) percentage points and the agency will only receive a one (1) percent increase. The information about agencies and their quality is already reported on CMS' website and is available to the general public. The website allows anyone to review the quality scores of all home health agencies that participate in the Medicare program. The nationally accepted and approved quality measures are located on the CMS website and outline in detail those agencies that perform better than others as it relates to outcomes. It would be a significant change and benefit for HME providers to participate in a similar program thereby eliminating the negative perceptions of policy makers; in addition could also include certain equipment with a link to the FDA website to identify medical device corrective actions and their impact on patient quality. Well, I know what many of you are thinking now - - no way will this ever be the case for the HME industry. Of course this may seem to be far fetched but I believe is absolutely essential to the survival of the industry and quality comparisons of home care/HME providers are long over due. The quality measures are posted on the Medicare Home Health Compare website. The web address is www.Medicare.gov and includes a total of twelve (12) measures that must be reported by home health agencies. The changes proposed and soon to be implemented by CMS are budget-neutral and more importantly will accurately match home healthcare agency costs with payments received while encouraging quality care for beneficiaries.

Vernon R Pertelle, MBA, RRT, is senior director/assistant vice president for Tri-City Healthcare District, Home Care, Hospice, Occupational Health & Wellness, Rehabilitation Services and Center for Wound Care & Hyperbaric Medicine. He can be reached at VRPertelle@aol.com

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