Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

NOV 27 2007

Report Number: A-01-07-00503

Mr. Christopher M. Attaya
President
Partners Home Care
281 Winters Street, Suite 240
Waltham, MA 02451

Dear Mr. Attaya:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicare Payments to Partners Home Care for Home Health Services Preceded by a Hospital Discharge." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make the final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are generally made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-07-00503 in all correspondence.

Sincerely,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
For Audit Services

Enclosure

Direct Reply to HHS Action Official:

Thomas W. Lenz
Consortium Administrator
Consortium for Financial Management and Fee-for-Service Operations
Centers for Medicare & Medicaid Services
Room 235
601 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS TO PARTNERS HOME CARE FOR HOME HEALTH SERVICES PRECEDED BY A HOSPITAL DISCHARGE

Daniel R. Levinson
Inspector General

November 2007
A-01-07-00503

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system for home health agencies (HHA) on October 1, 2000. Under the prospective payment system, CMS requires HHAs to identify all facilities that discharged the beneficiary in the 14 days preceding the home health episode. Medicare pays more for an episode preceded only by a discharge from a postacute care facility (a skilled nursing or rehabilitation facility) than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility or from only an acute care hospital.

On April 1, 2004, CMS implemented prepayment edits in its Common Working File to prevent overpayments to HHAs that bill incorrectly for services for beneficiaries who were recently discharged from acute care hospitals.

OBJECTIVE

Our objective was to determine whether Partners Home Care (the agency) complied with Medicare requirements in billing for fiscal year 2004 and 2005 services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days.

SUMMARY OF FINDING

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days. Specifically, the agency incorrectly coded 231 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. These errors occurred because the agency had not established adequate controls to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged the beneficiary within the 14-day period. CMS's prepayment edit corrected 155 of the 231 claims. Overpayments for the 76 claims not identified by the edit totaled $29,894. After the start of our review, the provider corrected the coding for 28 of the overpaid claims, which accounted for $13,451 of the total overpayment amount. The 48 remaining unadjusted claims represent overpayments of $16,443.

RECOMMENDATIONS

We recommend that the agency:

- ensure that its adjustments to reimburse Medicare for the $13,451 in overpayments associated with 28 claims were processed by the regional home health intermediary,

- return the $16,443 in overpayments associated with the remaining 48 unadjusted claims to the regional home health intermediary, and

- further educate its staff regarding the importance of identifying all facilities that had discharged the beneficiary within 14 days of the home health episode and determining which of these facilities were acute care (including long-term care) hospitals.

PARTNERS HOME CARE'S COMMENTS

In its response to our draft report, the agency acknowledged that it had received overpayments from the fiscal intermediary. However, the agency maintained that the overpayments were caused by the Medicare claims submission system and systemic errors that led to billing errors nationwide. The agency provided the status of adjustments and overpayments pertaining to our recommendations but recommended that we ask the fiscal intermediary to adjust the outstanding claims so that the agency may retain its right to appeal. We have included the agency's comments in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We stand by our finding that the agency did not always comply with Medicare billing requirements. We will provide the CMS action official with a copy of our final report, which includes the agency's comments. The CMS action official will determine what actions should be taken.

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INTRODUCTION

BACKGROUND

Home Health Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system for home health agencies (HHA) on October 1, 2000. CMS contracts with four regional home health intermediaries to assist in administering this payment system.

Under the Medicare prospective payment system, HHAs use a data instrument called the Outcome and Assessment Information Set (OASIS) to measure the care that each beneficiary needs over a 60-day service period known as an episode. Various items reported on the OASIS, including the beneficiary's use of inpatient services in the 14 days preceding admission to home care, determine the appropriate prospective payment.

According to CMS's research (65 Federal Register 41127, July 3, 2000), the cost of a home health episode is higher for beneficiaries discharged only from a postacute care facility (a skilled nursing or rehabilitation facility) than for beneficiaries discharged from both an acute care hospital and a postacute care facility or from only an acute care facility in the preceding 14 days. As a result, Medicare pays less for a home health episode of care preceded by a discharge from an acute care hospital. CMS requires that HHAs use specific codes to identify beneficiaries who were discharged from acute care facilities (including long-term care hospitals) in the 14 days preceding admission to home health care.

Centers for Medicare & Medicaid Services Actions to Prevent and Detect Overpayments

On April 1, 2004, CMS implemented prepayment edits in its Common Working File to prevent overpayments to HHAs that bill incorrectly for services for beneficiaries who were recently discharged from acute care hospitals. The prepayment edit now compares incoming claims that contain codes indicating that the beneficiary was not discharged from an acute care hospital in the preceding 14 days with the beneficiary's hospital claims history. If the edit determines that an acute care hospital submitted a claim on behalf of the beneficiary within 14 days of the home health episode, the claims processing system corrects the codes and pays the claims appropriately.

In addition, on April 20, 2004, CMS issued a special-edition "Medlearns Matters," number SE0410, which presents an overview of resources available to HHAs for researching inpatient discharges within 14 days of a home health admission and describes how to accurately count the 14-day period.

Partners Home Care

Partners Home Care (the agency) is a nonprofit home health agency with locations throughout Eastern Massachusetts offering the following services: skilled nursing, physical therapy,

occupational therapy, speech language therapy, home care aide services, medical social work, and nutrition counseling.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the agency complied with Medicare requirements in billing for fiscal year (FY) 2004 and 2005 services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days.

Scope

We reviewed 231 home health claims with discharge dates during FYs 2004 and 2005 that the agency submitted with codes indicating that the beneficiary had not had an acute care hospital stay in the 14 days before the start of the HHA episode.

Our objective did not require an understanding or assessment of the complete internal control structure at CMS, the regional home health intermediaries, or the agency. We limited consideration of the internal control structure to the payment controls in place within the Common Working File and the regional home health intermediaries' claims processing systems. We also limited our consideration of the internal control structure at the agency to those controls pertaining to developing and submitting Medicare claims. We did not assess the completeness of data extracted from CMS's National Claims History file.

We conducted our fieldwork at the agency's office in Rockland, Massachusetts, from November 2006 through September 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and other requirements;

- extracted the agency's paid claims data from the National Claims History file for FYs 2004 and 2005 and identified claims submitted with codes designating that the beneficiary had not been discharged from an acute care hospital within 14 days of the home health admission;

- compared data from those claims with acute care hospital data in the National Claims History file for the same beneficiaries and identified 231 claims made on behalf of beneficiaries who had been discharged from hospitals within 14 days of the home health episode;

- obtained the Common Working File data for the sampled claims and for the corresponding acute care hospital claims;

- contacted the regional home health intermediary to determine how to identify claims that had been corrected by the newly implemented edit;

- recalculated the payments using CMS's Home Health Prospective Payment System Pricer Program to determine the overpayment amounts.

We conducted our review in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the previous 14 days. Specifically, the agency incorrectly coded 231 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. These errors occurred because the agency had not established adequate controls to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged the beneficiary within the 14-day period. CMS's prepayment edit corrected 155 of the 231 claims. Overpayments for the 76 claims not identified by the edit totaled $29,894. After the start of our review, the provider corrected the coding for 28 of the overpaid claims, which accounted for $13,451 of the total overpayment amount. The 48 remaining unadjusted claims represent overpayments of $16,443.

PROSPECTIVE PAYMENT SYSTEM REQUIREMENTS

Pursuant to 42 CFR § 484.55, HHAs must complete, for each beneficiary, a comprehensive assessment that accurately reflects the beneficiary's current health status. HHAs use the OASIS to assess the beneficiary's home care needs. Medicare prospective payments to HHAs are based, in part, on a home health case-mix system that uses selected information from the OASIS (42 CFR § 484.210(e)).

Question M0175 on the OASIS requires HHAs to identify all facilities that discharged the beneficiary in the 14 days before the home health episode. (See the "OASIS Implementation Manual.") The response to this question directly affects the amount of Medicare reimbursement. Medicare pays more for an episode preceded only by a discharge from a postacute care facility than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility or from only an acute care hospital.

INCORRECTLY CODED CLAIMS

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days. Specifically, the agency incorrectly coded 231 claims as if the beneficiary had not been discharged from an acute care hospital in the 14 days before the home health episode.

BILLING CONTROLS NOT ESTABLISHED

The agency had not established the controls necessary to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged the beneficiary in the 14 days preceding the home health episode. Although the agency had educated its staff about the significance of identifying on the OASIS all inpatient facilities that had discharged the beneficiary in the 14 days before the home health admission and correctly noting the type of facility, clinicians who completed the OASIS either:

- did not identify all facilities that had discharged the beneficiary in the 14 days before the home health episode or

- did not recognize some of the facilities as long-term care hospitals, which are subject to the payment limitation of the 14-day rule.

MEDICARE OVERPAYMENTS

The agency submitted 231 incorrectly coded claims during FYs 2004 and 2005. The prepayment edit detected 155 of these claims, and the claims processing system corrected the codes and paid the claims appropriately.

The prepayment edit could not detect the remaining 76 claims because the agency either:

- submitted the incorrectly coded claims before the edit was implemented or

- received payment for the incorrectly coded claims before the discharge hospitals submitted their claims.

Overpayments for the 76 claims not identified by the edit totaled $29,894. After the start of our review, the provider corrected the coding for 28 of these overpaid claims, which accounted for $13,451 of the total overpayment amount. The 48 remaining unadjusted claims represented overpayments of $16,443.

RECOMMENDATIONS

We recommend that the agency:

- ensure that its adjustments to reimburse Medicare for the $13,451 in overpayments associated with 28 claims were processed by the regional home health intermediary,

- return the $16,443 in overpayments associated with the remaining 48 unadjusted claims to the regional home health intermediary, and

- further educate its staff regarding the importance of identifying all facilities that had discharged the beneficiary within 14 days of the home health episode and determining which of these facilities were acute care (including long-term care) hospitals.

PARTNERS HOME CARE'S COMMENTS

In its response to our draft report, the agency acknowledged that it had submitted incorrectly coded claims that resulted in overpayments. However, the agency took issue with our statement that it "did not always comply with Medicare requirements in billing for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days." The agency stated that it took all reasonable and prudent steps to identify the existence of any inpatient hospital stay, including a review of available health care records, calls to the referring facility billing office, and accessing the Common Working File.

The agency maintained that the overpayments were generally not the agency's fault. Rather, the agency stated, the overpayments were caused by inaccuracies in the Medicare claims submission system. The agency asserted that neither a home health agency nor a prepayment edit could identify erroneous M0175 OASIS data because the Common Working File does not provide timely information regarding beneficiaries' inpatient stays. The agency also stated that CMS's elimination of M0175 as a data collection item for reimbursement for episodes of care beginning January 1, 2008, is evidence that CMS has reached the same conclusion.

In response to our recommendations, the agency provided us with the current status of the overpayments associated with the 76 claims and requested that we ask the fiscal intermediary to adjust the outstanding claims so that the agency may retain its right to appeal. We have included the agency's comments in their entirety in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We stand by our finding that the agency did not always comply with Medicare billing requirements. Although the agency stated that it had taken all reasonable and prudent steps to obtain correct information on beneficiaries' previous discharges, the beneficiaries in 55 of the 76 claims (72 percent) were referred to Partners Home Care by Partners Health Care facilities.

The agency failed to note that, in addition to a prepayment edit, CMS implemented a postpayment review process to facilitate home health agency compliance with Medicare billing requirements. This postpayment review process addresses those cases where inpatient data is not available in the Common Working File at the time the agency is attempting to determine if the beneficiary had an inpatient hospital stay in the 14 days preceding the home health episode.

Although CMS is changing its billing system on January 1, 2008, CMS will continue to require home health agencies to determine whether the beneficiary had an acute care hospitalization in the 14 days preceding the home health episode. In addition, as noted in the Federal Register (72 Federal Register 49976, August 29, 2007), CMS will continue to collect overpayments made under the current billing system. The Federal Register article stated: "The retrospective M0175 audits are still necessary to correct payments that were made inappropriately under the original HH PPS."

We will provide the CMS action official with a copy of our final report, which includes the agency's comments. The CMS action official will determine what actions should be taken.

APPENDIX

October 31, 2007

Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General
U.S. Department of Health and Human Services
JFK Federal Building
Boston, Massachusetts 02203

Re: Report Number: A-01-07-00503, Partners Home Care

Dear Mr. Armstrong:

This letter is in response to the draft report entitled "Review of Medicare Payments to Partners Home Care for Home Health Services Preceded by a Hospital Discharge," as transmitted to Partners Home Care on October 3, 2007.

As noted in the draft report, Partners Home Care has provided extensive internal education of its staff about the significance of identifying on the OASIS all inpatient facilities that had discharged the beneficiary in 14 days before the home health admissions and correctly noting the type of facility. Partners is well aware of the requirements regarding OASIS question MO175 and its importance relative to the level of payment for services provided to Medicare beneficiaries.

We believe that the extremely low percentage of our claims and related billing identified in this audit is evidence of the effectiveness of these controls. The seventy six (76) claims identified in the audit represents only one quarter of one percent (0.26%) of total Medicare episodes billed by Partners Home Care and is less than one half of one percent (0.04%) of associated total Medicare revenue. With regard to the 48 not yet corrected, this represents less than one quarter of one percent (0.16%) of the total billed, and is less than one quarter of one percent (0.02%) of total Medicare revenue for this same time period.

Partners takes issue with the finding that it "did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days."

At the time of the submission of the claim to the Medicare home health regional intermediary, Partners Home Care took all reasonable and prudent steps to identify the existence of any inpatient hospital stay of a Medicare beneficiary within 14 days prior to the admission to home health services. Those steps included an inquiry to the patient

and/or patient's family, a review of available health care records pertinent to the patient's care prior to the home health admission, calls to the facility billing offices to ascertain the classification of specific beds and units and in some cases accessing the common working file. It is well known by the Centers for Medicare and Medicaid Services that 100 percent accuracy with respect to MO175 is not possible given weaknesses in patient recollections, the availability of pre-home health services medical records, and serious shortcomings in the timeliness of Common Working File data.

As the report notes, the MO175 OASIS deficits led CMS to institute a claim edit prior to payment. With respect to the claims made by Partners Home Care, that edit failed to identify erroneous MO175 OASIS data in 76 of 231 claims. The primary reason for the failure of the CMS edit, as well as the inaccuracies of Partners Home Care MO175 data, is that the Common Working File does not accurately reflect the existence of inpatient hospital services prior to a beneficiary's admission to home health services. This inaccuracy occurs because home health agency claim submission and the CMS edit of the claim may precede the completion of the bill processing for any claim submitted by a hospital. With the extended period of time available for the submission of a bill by a hospital, the Common Working File may not be accurate until 27 months after the inpatient stay.

The OIG fails to appropriately note that MO175 errors are generally not the fault of Partners Home Care or any other Medicare-participating home health agency. Instead, the cause of MO175 inaccuracies is the Medicare claim submission system. It is virtually impossible for the Common Working File to be a reliable data source for home health agencies to utilize given the billing period allowable to providers of services.

Partners Home Care has thoroughly evaluated its responsibilities and obligations, has reviewed the recommendations provided and has taken the following actions;

- We have confirmed that twenty seven of the twenty eight claims identified as resulting in overpayments of $13,451 have been processed by the Fiscal Intermediary.

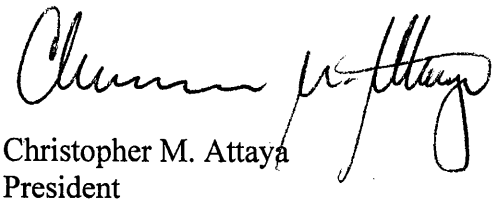
- In relation to the remaining forty eight (48) claims stated as resulting in overpayments of $16,443, we have identified two claims which had already been adjusted for a total of $392.96 which reduces the stated liability to $16,050.03.

To the extent that the remainder of the claims requires adjustment, Partners Home Care recommends that the OIG issue a request to the Fiscal Intermediary to follow their

normal process for claims adjustment and to issue an official determination in order that Partners Home Care can preserve the rights to appeal.

Rather than assessing fault to Partners Home Care, we believe the OIG report should focus on the systemic weaknesses that have led to inaccuracies in MO175 responses by home health agencies throughout the nation. This would seem to be the conclusion of CMS as the MO175 has been eliminated as a data collection item for reimbursement for episodes of care that begin January 1, 2008.

Very truly yours,



Christopher M. Attaya
President
Partners Home Care

CC: Judy Flynn
Chief Clinical and Compliance Officer
Partners Home Care

Federal Register

Wednesday,
August 29, 2007

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Part 484

Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 484

[CMS–1541–FC]

RIN 0938–AO32

Medicare Program; Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008

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

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period sets forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare prospective payment system for home health services, effective on January 1, 2008. As part of this final rule with comment period, we are also rebasing and revising the home health market basket to ensure it continues to adequately reflect the price changes of efficiently providing home health services. This final rule with comment period also sets forth the refinements to the payment system. In addition, this final rule with comment period establishes new quality of care data collection requirements.

Finally, this final rule with comment period allows for further public comment on the 2.71 percent reduction to the home health prospective payment system payment rates that are scheduled to occur in 2011, to account for changes in coding that were not related to an underlying change in patient health status (section III.B.6).

DATES: *Effective date:* These regulations are effective on January 1, 2008.

Comment date: We will consider public comments on the provisions in section III.B.6 that deal with the 2.71 percent reduction to payment rates in 2011. To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on October 29, 2007.

ADDRESSES: In commenting, please refer to file code CMS–1541–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1541–FC, P.O. Box 8012, Baltimore, MD 21244–8012.

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 (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1541–FC, 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 (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH 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.)

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 mailing your comments to the addresses provided 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. Sharon Ventura, (410) 786–1985 and Katie Lucas, (410) 786–7723 (for general issues). Kathy Walch, (410) 786–7970 (for clinical OASIS issues). Doug Brown, (410) 786–0028 (for quality issues). Mollie Knight, (410) 786–7948; and Heidi Oumarou, (410) 786–7942 (for market basket issues).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the 2.71 percent reduction to the Home Health Prospective Payment System (HH PPS) rates for 2011, as set forth in this final rule with comment period, to assist us in fully considering this issue and developing policies.

Inspection of Public Comments: All comments received before the close of the comment period will be available for viewing by the public, including any personally identifiable or confidential business information that is included in the 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.cms.hhs.gov/eRulemaking.* Click on the link "Electronic Comments on CMS Regulations" 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 and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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III. Analysis of and Responses to Public Comments on the CY 2008 Proposed Rule

In response to the publication of the CY 2008 HH PPS proposed rule, we received approximately 150 items of correspondence from the public. We received numerous comments from various trade associations and major organizations. Comments also originated from HHAs, hospitals, other providers, suppliers, practitioners, advocacy groups, consulting firms, and private citizens. The following discussion, arranged by subject area, includes our responses to the comments and, where appropriate, a brief summary as to whether or not we are implementing the proposed provision or some variation thereof.

A. General Comments on the CY 2008 HH PPS Proposed Rule

1. Operational Issues

Overall, commenters were pleased with the proposed changes to the HH PPS. However, commenters did express concerns over the burden they perceived that would be placed on HHAs to accomplish a number of the proposed changes.

Comment: Commenters generally appreciated CMS's plan to automatically adjust claims to reflect the actual amount of therapy provided versus that initially reported in OASIS item M0826, Therapy Need, but two commenters noted that for payment adjustments to be made accurately, Medicare's Common Working File (CWF) system must contain timely, accurate information. Numerous commenters were concerned that the creation of M0110 (Episode Timing) would be burdensome, as agencies do not have the information to complete them. The commenters did not want to be penalized if M0110 was answered incorrectly, and wanted to avoid administrative burden from having to cancel and resubmit final claims and Request for Anticipated Payments (RAPs).

Response: CMS has made efforts over the last several years to reduce internal processing delays and ensure that the CWF is updated with claim receipts more quickly overall. While new errors may arise that delay processing, we will seek to correct them as swiftly as possible in light of all the competing demands on our systems.

The factor that most affects the timeliness and accuracy of the CWF is how promptly within the 15 to 27 month timely filing period each provider submits its claims. Medicare systems can only process to the greatest degree of accuracy based on the information received to date. In all instances where we foresee submission or processing lags affecting the accuracy of claim payments under the refined system, we are designing processes to retrospectively adjust paid claims at the point when the delayed information is received. For example, the CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M0826) when submitted information is found to be incorrect.

No cancelling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.

Comment: Most commenters supported the elimination of OASIS item M0175 from the case-mix model, as they sometimes found it difficult to code accurately. Some commenters thought that we were eliminating M0175 from the OASIS entirely, and supported that. Several recommended that we also stop retrospective M0175 audits. One asked that we keep M0175 as a case-mix variable, and apply the points to patients who have been admitted directly from a hospital.

Response: We appreciate the support of our decision to eliminate M0175 as a case-mix variable. We are not eliminating M0175 from the OASIS, as is explained in section III.E.4, but only removing it from the case-mix model. The M0175 item's results across the four equations were difficult to interpret, and the item's explanatory power (with respect to contribution to the R-squared statistic) was small. Therefore, M0175 was not included as a case-mix variable in our final case-mix model.

The M0175 item is part of the original HH PPS case-mix model and was reflected in the determination of payments under that system. The retrospective M0175 audits are still necessary to correct payments that were made inappropriately under the original HH PPS. These payment corrections have been repeatedly recommended to CMS by HHS's Office of Inspector General.

Comment: One commenter proposed that the timeliness of information on Medicare systems would be increased by the removal of the option to submit no-RAP LUPA claims. The commenter believes that requiring RAPs for all episodes will speed submission of episodes to Medicare.

Response: The no-RAP LUPA billing mechanism was created as part of the original implementation of the HH PPS in response to concerns from the home health industry that requiring RAPs for brief LUPA episodes presented an administrative burden. Absent consistent feedback throughout the home health industry that the benefits of removing this billing mechanism would outweigh the costs, we plan to retain the no-RAP LUPA process. However, we note this billing mechanism is an operational issue and we have not received many comments on this issue. It should be further noted that requiring the submission of RAPs for all episodes will not necessarily speed the submission of those RAPs in all cases. RAPs, like no-RAP LUPAs, can also be submitted at any point in the timely filing period.

Comment: One commenter asked whether home health services received when a beneficiary is enrolled in a Medicare Advantage (MA) Plan will be considered in determining the sequence of adjacent episodes in cases where the beneficiary has disenrolled from the MA Plan and resumes his or her coverage under the Medicare fee-for-service program.

Response: Medicare does not typically receive claim-by-claim or individual service data on beneficiaries enrolled in MA Plans. As a result, the information is not available to determine whether a beneficiary has been receiving home health services under the plan or for how long. Medicare systems will determine sequences of adjacent episodes based on the fee-for-service episode information currently housed in the CWF and accessible to Medicare providers through eligibility inquiry transactions.

Comment: A commenter believed that the addition of multiple payment tiers based on therapy usage would create a problem concerning beneficiary notification of their financial obligation to pay for home health services. Many beneficiaries are now enrolled in Medicare replacement plans that require a co-pay on the episodic rate. The Medicare Conditions of Participation (CoPs) at 42 CFR 484.10 require that the HHA notify the patient in advance of his or her liability for payment. The commenter believed some consideration needs to be made about the obligations of HHAs to meet this requirement as it is virtually impossible to calculate the rate and provide notices of the changing rate prior to providing service.

Response: The provisions of this rule apply to Medicare's fee-for-service HH PPS and do not apply to Medicare Advantage/Medicare Choice plans where co-pays for home health services provided under the plan may exist. As

CMS is not eliminating M0175

Massachusetts is listed as 1.0661 in the proposed rule but that it should be 1.1661.

Response: This was an inadvertent typographical error in the proposed rule. The HH PPS Pricer for CY 2007 contains the correct value of 1.1661. Accordingly, payments made to HHAs who serve patients residing in rural areas of Massachusetts are being paid based upon the correct wage index value of 1.1661.

For the CY 2008 update to home health payment rates, we are finalizing the wage index and associated policies in that we will continue to use the most recent pre-floor and pre-reclassified hospital wage index. In addition, we note that we plan to evaluate any policies adopted in the FY 2008 IPPS final rule that affect the wage index, including how we treat certain New England hospitals under § 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21). We continue to believe that the use of the pre-floor and pre-reclassified hospital wage index data for HH PPS results in the appropriate adjustment to the labor portion of the costs as required by statute.

4. Home Health Care Quality Improvement

Section 5201(c)(2) of the DRA added section 1895(b)(3)(B)(v)(II) to the Act, requiring 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, as also added by section 5201(c)(2) of the DRA, 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 subclause (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."

The OASIS data currently provide consumers and HHAs with 10 publicly-reported home health quality measures which have been endorsed by the National Quality Forum (NQF). Reporting these quality data has also required the development of several supporting mechanisms such as the HAVEN software used to encode and transmit data using a CMS standard electronic record layout, edit specifications, and data dictionary. The HAVEN software includes the required OASIS data set that has become a standard part of HHA operations. These early investments in data infrastructure and supporting software that CMS and HHAs have made over the past several years in order to create this quality reporting structure have been successful in making quality reporting and measurement an integral component of the HHA industry. For CY 2007, we specified 10 OASIS quality measures as appropriate for measurements of health care quality. These measures were to be submitted by HHAs to meet their statutory requirement to submit quality data for a full increase in their market basket percentage increase amount. The 10 measures are:

(1) Improvement in ambulation/locomotion
(2) Improvement in bathing
(3) Improvement in transferring
(4) Improvement in management of oral medications
(5) Improvement in pain interfering with activity
(6) Acute care hospitalization
(7) Emergent care
(8) Improvement in dyspnea
(9) Improvement in urinary incontinence
(10) Discharge to community

For CY 2007, we specified 10 OASIS quality measures as appropriate for measurements of health care quality. These measures were to be submitted by HHAs to meet their statutory requirement to submit quality data for a full increase in their market basket percentage increase amount. For CY 2008, we proposed to expand the existing set of 10 quality measures by adding up to 2 NQF-endorsed measures. The proposed additional measures for 2008 were:

- Emergent Care for Wound Infections, Deteriorating Wound Status
- Improvement in the Status of Surgical Wounds (For a complete list and description of the quality measure requirements see the proposed rule (72 FR 25449–25452)).

Comment: Several commenters suggested that CMS continue to refine and enhance the OASIS assessment instrument and associated Quality Measures, and suggested item-specific or quality measure-specific items in use in the home health quality reporting requirement.

Response: CMS is constantly working to improve the OASIS instrument and the quality measures that are built upon it. We will continue to pursue improving the assessment instrument's accuracy in reflecting both the health status and improvements in condition of our beneficiaries. On July 27, 2007, a notice was published in the **Federal Register** (CMS–10238) which seeks public comment on a version of the OASIS that we plan to begin testing in early 2008 (72 FR 41328).

Comment: A number of commenters requested that we eliminate OASIS item M0175. Commenters also requested numerous item-specific revisions to the OASIS.

Response: We are presently unable to accommodate the request to delete OASIS item M0175. OASIS item M0175 has a critical role in risk adjusting many quality measures as it is used to determine the type of facility the patient was discharged from in the previous 14 days before HH admission. However, we will continue to look for ways to reduce the overall burden to providers and determine if this information can be obtained in a more simplified or automated manner as we re-examine the OASIS instrument.

The remainder of the item-specific comments received relate to data items that will be addressed in an upcoming notice concerning revisions of the OASIS mentioned above. These revisions are currently planned for an OASIS update in calendar year 2009. These changes are responsive to the comments we have received, and reflect months of development and analysis, as well as industry input and concerns.

On July 27, 2007, a notice was published in the **Federal Register** (CMS–10238) which seeks public comment on a version of the OASIS that we plan to begin testing in early 2008. Based on the finding from the testing, we may pursue adopting the commenter's suggested changes in future payment rule notices.

Comment: Some commenters were concerned about the proposed quality measure regarding emergent care for wound infections.

Response: We note that the title and description of the quality measure do not fully reflect the breadth of the issue being measured. Specifically, the quality measure entitled "Emergent Care for Wound Infections, Deteriorating Wound Status" is calculated using a data item that includes new pressure ulcers and lesions, and therefore the title of the measure may cause some confusion. Nonetheless, we feel that the quality measure is an important indicator and we intend to conform the title of the measure to more accurately reflect the concepts being measured.

Comment: Several commenters suggested that we delete two quality items to compensate for the two new quality items added. Some also suggested that we reduce the total number of OASIS items. Another suggested we develop quality measures for fall prevention.

CMS Comment that it is unable to eliminate M0175