OASIS Alert

Industry Notes: WAYS & MEANS CALLS FOR COPAY AND OASIS TASK FORCE

Despite vigorous industry protest, Medicare reform legislation recently passed by the House Ways & Means Committee contains the dreaded home health copay.

The Ways & Means package includes a $40 copay for 2003 and a copay of 1.5 percent of the "national average payment" in later years.

The legislation would exempt low-income beneficiaries and low utilization payment adjustment episodes of four or fewer visits from the $40 copay requirement.

Another Medicare reform package, passed by the House Commerce and Energy Committee, omits the copay requirement. As observers predicted, the copay issue was dropped from the final, reconciled bill, due to vociferous opposition from both provider and beneficiary groups.

The Ways & Means bill also calls for establishment of an OASIS task force. The group would be composed of **Centers for Medicare & Medicid Services** officials, industry representatives, post-acute care experts and beneficiary advocates. This task force would be responsible for reviewing OASIS and making recommendations "to improve and simplify data collection."

Specifically, the task force would examine OASIS in light of home health service quality, consistent home health resource group (HHRG) classification, the 41 outcome measures, the timing and frequency of data collection and the collection of information on comobidities and clinical indicators, according to the bill.

The task force would report its findings to the **Department of Health and Human Services** within 18 months, then disband.

While waiting on the report, CMS would suspend OASIS collection and transmission requirements for all non-Medicare and non-Medicaid patients, giving agencies a welcome breather.

If you receive an additional development request from your intermediary, youd better be sure to include the OASIS assessments used to generate the HIPPS code during the period in question, confirms **Palmetto GBA** in a recent question-and-answer set.

Along with those assessments, home health agencies must submit the plan of treatment, all supplemental orders, discipline notes, laboratory values (if applicable), other documentation to support medical necessity, itemized supply and/or durable medical equipment list, statement of endpoint when nurse visits are expected to decrease to fewer than seven days a week (if visits are at least daily) and a breakdown of hours if nurse and aide visits combined number more than two daily.

The Joint Commission on Accreditation of Healthcare Organizations is zeroing in on home care in its "Speak Up" campaign for patient safety. The effort aims to encourage patients "to become active, involved and informed participants of the health care team," JCAHO says. Accredited HHAs will receive sample brochures customized for home care and "Speak Up" buttons.

The U.S. Comptroller General has appointed former CMS Administrator **Nancy-Ann DeParle** to a three-year term on the **Medicare Payment Advisory Committee**.

Medicare contractors will start charging providers for paper copies of their bulletins and newsletters. CMS has instructed contractors to discontinue the printing and mailing of any newsletters beginning July 1, regional home health intermediary **Cahaba GBA** says in a recent posting to its Web site.

Providers will be able to access the newsletters on contractors Web sites for free.

CMS has instructed fiscal intermediaries to grant extended repayment schedules of up to 36 months automatically to home health agencies with repayments due on cost reports for years ending Sept. 30, 2000 through Aug. 31, 2001.

However, FIs automatically will grant those ERSs only if the provider received a periodic interim payment (PIP) to help transition to the prospective payment system, CMS notes in June 24 program memorandum A-02-055.

The Benefits Improvement and Protection Act of 2000 mandated the lump sum PIP payments, which equaled four times the last full PIP payment made to the home health agency under the interim payment system.

To qualify for the automatic ERS, agencies must not: be a terminated provider; be in default on any Medicare debt, including previous ERSs; be on payment suspension; have been referred to the **Department of Treasury** for "cross servicing"; or currently be involved in a bankruptcy proceeding, according to the memo.