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OASIS Alert

OASIS News: OASIS Outcomes Are Central To Pay For Performance

Are you ready to bet your profits on your OASIS accuracy?

The **Medicare Payment Advisory Commission** wants your Medicare payments to stem from OASIS-based patient outcomes. MedPAC is poised to recommend to Congress that home health agencies' payments be linked to performance via outcomes, according to the advisory body's Dec. 9 meeting in Washington, DC.

At first, only 1 to 2 percent of payments would hinge on outcomes. But that ratio would increase over time, MedPAC implied at the meeting.

The commission plans to recommend functional improvement and stabilization measures as well as clinical improvement measures as a "starter set" for payment consideration, staffer **Susan Cheng** noted. But adverse events such as rehospitalization and emergency room use and process-based or patient satisfaction measures are candidates for later inclusion, Cheng added.

Whether you're ready or not, pay for performance is looming on the horizon, warned **Amanda Twiss** from Seattle-based **Outcome Concept Systems,** speaking at the October **National Association for Home Care & Hospice's** annual meeting in Phoenix.

But there are problems with extending the OASIS data to yet another use, experts agree. OASIS accuracy, reliability studies, proposed changes in the OASIS assessment tool and risk adjustment issues still need to be addressed, they say.

In other MedPAC news, outliers are a focus of the commission's concern. If an HHA's cost to furnish a visit is below the outlier per-visit rate, "then agencies could have an incentive to provide the maximum number of visits once they've qualified for an outlier episode," Cheng said at the Commission's Nov. 16 meeting. MedPAC is concerned about outliers in part because proprietary agencies record a higher incidence of the cases - 3.3 percent - than other types of agencies, Cheng pointed out in the meeting.

But that scenario is unlikely, because costs per visit are generally higher than the outlier per visit rate and the percentage of outlier patients account for only two to three per cent of episodes, industry experts say.

1. **Beginning July 1, the Centers for Medicare & Medicaid Services will require** home health agencies to deliver a termination notice every time a beneficiary's Medicare services come to an end, the agency said in the Nov. 26 Federal Register. If beneficiaries don't agree their Medicare services should end, they can file a 72-hour appeal with a Quality Improvement Organization.

   When a beneficiary elects expedited review, the QIO contacts the agency the day after it issues the first-step, generic termination notice. Then the HHA must issue a second, more detailed notice to the beneficiary explaining the reason for termination by the end of the day, CMS spells out in the final rule.

   And the agency must forward all relevant records to the QIO that day as well. And CMS directs providers to continue furnishing services during the three-day process. The final rule is at www.access.gpo.gov/su_docs/fedreg/a041126c.html.

2. **HHAs' reluctance to participate in the homebound demonstration project comes as no surprise,** home care

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experts told CMS in the Dec. 9 Home Health Open Door Forum. The demo continues to have only one patient identified, CMS said.

Agencies cited one reason for their lack of interest: Medicare beneficiaries are entitled to receive up to 35 hours of services, including aide services, before another payer such as Medicaid takes over. HHAs are not eager to sign up to furnish this level of aide services to patients who may qualify under the demonstration for home care.

3. **A new survey initiative will collect data** on "provider satisfaction with and perceptions about the services provided by Medicare [fee for service] claims processing fiscal intermediaries (FIs) and carriers," CMS says.

   A pilot survey will go to about 7,400 providers starting in January. The survey will give providers the opportunity to rate their contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review and provider reimbursement, CMS says.

   More information on the initiative, termed the Medicare Con-tractor Provider Satisfaction Survey, is at www.cms.hhs.gov/providers/mcpss/default.asp.

4. **CMS has issued new guidelines** on the practice of HHAs using "drop sites, workstations, way stations, convenience sites, or satellites," according to a Nov. 12 memo to surveyors (S&C-05-07). As long as state and local laws permit drop sites, CMS has no problem with them, the agency says in the memo.

   But agencies must be very careful to make sure the drop sites don't wander into unauthorized branch territory. "HHAs that allow these locations to cross the line from drop site to branch are out of compliance with the Medicare requirements," CMS warns.

   Assigning staff to drop sites, accepting referrals at the locations, advertising them as a part of the HHA, or operating them "in any other way as branches of the HHA" is strictly off limits, CMS makes clear in the memo available at www.cms.hhs.gov/medicaid/surveycert/sc0507.pdf.

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