**DEPARTMENT OF HEALTH & HUMAN SERVICES** Centers for Medicare & Medicaid Services

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**DATE:** **April 30, 2001**

**FROM:** Director
Survey and Certification Group
Center for Medicaid and State Operations

**SUBJECT:** Potential Impact of the Home Health Prospective Payment System (HHPPS) on Services Provided by Home Health Agencies (HHAs)

**TO:** Associate Regional Administrators, DMSO
State Survey Agency Directors

The purpose of this memorandum is to provide information to regional office and state agency personnel who are involved with the survey and certification activities of HHAs. It does not impose any new survey tasks or revise any existing tasks.

**HHPPS Overview:**

The HHPPS has been in effect since October 1, 2000, to help ensure appropriate reimbursements for quality, efficient home health care. Additional information on the HHPPS can be found at the HCFA web site at www.hcfa.gov/medicare/hhmain.htm. The following are highlights of the HHPPS system:

- Medicare now pays HHAs for each covered 60-day episode of care. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. Payments cover skilled nursing, home health aide visits, covered therapy, medical social services and supplies.

- Medicare pays HHAs at a higher rate to care for those beneficiaries with greater needs. Payment rates are based on relevant data from the comprehensive assessment that includes the OASIS data items.

- To ensure that HHAs are paid adequately up front, HCFA will pay 60 percent of the initial episode payment when the HHA first accepts a new Medicare patient as part of a streamlined approval process. HHAs will receive the remaining 40 percent at the end of the first 60-day episode. For subsequent episodes, payments will be divided equally between the start and end of the episode.

- Payment rates will be adjusted to reflect significant changes in a patient's condition during each Medicare-covered episode of care.

- HHAs will receive less than the full 60-day episode rate if they provide only a minimal number of visits to beneficiaries.

**HHPPS and Provision of Therapy Services**

We have received many questions regarding the provision of therapy services as it relates to OASIS under the HHPPS and have answered them on our web site at http://www.hcfa.gov/medicaid/Oasis/hhqcat12.htm. All HHAs must provide skilled nursing services and at least one of the following other therapeutic services: physical, speech, or occupational therapy, medical social services, or home health aide services in a place of residence used as a patient's home. One qualifying service (i.e., skilled nursing, physical therapy or speech language pathology) must be provided in its entirety directly by HHA employees. The other qualifying services and any additional services may be provided either directly or under arrangements.

If an approved HHA chooses to add therapy services after their original certification, they must notify the state survey agency and their regional home health intermediary. The HHA may either provide the therapy services directly or "under arrangement," according to section 2180 of the State Operations Manual (SOM) and in accordance with 42 CFR 484.14(f). HHAs must ensure that hospitals, nursing facilities, and rehabilitation facilities who provide outpatient services included on the home health plan of care, and claim as part of consolidated billing, furnish services consistent with the home health conditions of participation (CoPs.) The HHA is responsible for clinical decision making and quality of care issues for the services furnished by these providers.

If a patient needs therapy services and is referred to an HHA that does not provide these services, the options are:

- the HHA should advise the patient that it cannot accept the patient because it cannot provide all the services needed to meet the patient's needs; and
- the HHA should advise the patient that the patient can elect to go to another HHA that provides therapy services; or
- the patient can decline the therapy services and receive only the other ordered HHA services. In this situation, the HHA must notify the physician if the patient refuses the ordered therapy service(s).

An HHA that is unable to provide therapy services to a patient who subsequently develops a need for therapy during the episode may transfer a patient to another HHA who can meet the total needs of the patient.

**Provider Compliance with the CoPs under HHPPS**

The PPS system did not change the eligibility requirements for receiving the home health benefit. Payments have been calculated so that they, on average, equal the amount of money paid previously under cost reimbursement. However, we have heard complaints about some providers providing fewer services than are ordered in the patient's plan of care, and some providers indiscriminately refusing to provide services to a certain group of patients. We would like surveyors to be aware of this and consider the following information if they discover this behavior during a survey:

- The Medicare CoP at 42 CFR 484.18 requires an HHA to accept patients for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. There is no basis in law to require any provider to accept a patient when it believes it does not have the capacity to serve the patient's need. However, the Medicare CoPs also require equal treatment of all patients. Medicare approved HHAs are required to comply with the provider agreement requirements at 42 CFR 489.53(a)(2). An HHA may not discriminate against Medicare patients and accept a private pay patient with the same home health needs. HHAs that provide services to non-Medicare patients while refusing services to similarly situated Medicare patients risk having their provider agreements terminated and being barred from billing Medicare for services.

- The CoPs also speak to the care provided by HHAs. The CoP at 42 CFR 484.18 requires the HHA to follow a plan of care for each patient that is established and periodically reviewed by a physician. Drugs and treatments must be administered by agency staff only as ordered by the physician.

- The patient rights CoP at 42 CFR 484.10, requires the HHA to provide accurate information to its patients about Medicare coverage and payment. Medicare beneficiaries must be informed about what services are and are not covered, and their right to participate in care planning.

**Discharge Requirements**

HHAs are required by the regulation at 42 CFR 484.18(b) to promptly alert the physician to any changes that suggest a need to alter the plan of care, and to include instructions for timely discharge or referral in the plan of care. In the situation where the patient progresses to the point where it is no longer reasonable and necessary to continue services, because the patient's medical, nursing, and rehabilitative needs have been met adequately by the HHA, the HHA may notify the physician and discharge the patient, even though the certification period has not ended. The clinical record should maintain documentation that the physician was notified of the discharge, but it does not need to contain a physician's order for discharge. If, however, an HHA has a policy to obtain a physician's order before discharging a patient, the agency would be expected to abide by this policy.

**Potential Areas for Surveyor Review**

Surveyors should be aware of these payment changes and alert to indications that patients may not be receiving the amount and/or type of services that are ordered by the physician and included in the plan of care. The following is a list of some potential behaviors that HHAs may engage in and the regulation that addresses the potential violation.

- Misinforming beneficiaries on what is covered under Medicare (484.10);
- Informing Medicare beneficiaries that Medicare will no longer pay for their services without providing an Advance Beneficiary Notice to the patient (484.10);
- Reducing services that are ordered in the plan of care without a physician's order (484.18);
- Discharging patients inappropriately before the plan of care is complete (484.18);

The following situations, if discovered or suspected, should be referred to the regional office for follow-up and/or referral to the regional home health intermediary for further investigation:

- Ordering more than 10 therapy visits for all Medicare patients regardless of diagnosis or need;
- Providing unnecessary fifth visits to beneficiaries who need only a minimal number of visits (to capitalize on the payment rates.) and/or
- Refusing to admit certain Medicare patients based on the payment rate and admitting similar non-Medicare patients (489.53);

Concerns regarding potential discriminatory practices should be referred to the appropriate regional office of the Department of Health and Human Services, Office of Civil Rights (http://www.hhs.gov/ocr/howtofile.html).

**Complaints**

Each state has a Medicare home health hotline which can be called by patients who are dissatisfied with the home health services they are receiving or other individuals with a complaint about a specific HHA. Under the Medicare CoP for Patient Rights at 42 CFR 484.10, HHAs are required to provide their patients with the hotline number for their state. Concerns about an HHA not complying with the CoPs, or reports that an HHA is misinforming beneficiaries or inappropriately terminating care for patients, can be referred to the state survey agency for investigation via the home health hotline. Concerned consumers may also call the state survey agency directly. A violation of the CoPs or the provider agreement could lead to termination of the HHA from the Medicare program.

**Effective Date:** The information contained in this memorandum is current policy and is in effect.

**Training:** This policy should be shared with all survey and certification staff, surveyors, their managers, and the state/regional office training coordinator.

I hope this information is helpful to you. If you would like to discuss this further, please contact your regional office home health representative.

/s/
Steven A. Pelovitz