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Breaking News on HHCAHPS from Deyta

CMS Update: HH PPS Final Rule Delays HHCAHPS Requirement by 6 months

On Friday, October 30th, 2009, CMS issued the Final Rule Changes for HHCAHPS as part of the final rule for HH PPS Rate Update CY 2010. The final rule will be published in the Federal Register on November 11, 2009.

In this Final Rule, CMS has stated their intention to move forward with the implementation of the HHCAHPS but has delayed this quality reporting requirement by six months. The Final Rule links the survey requirements to the CY 2012 payment update rather than to the CY 2011 payment update.

HHCAHPS will be a requirement for agencies to receive their full 2012 annual payment update.

The HHCAHPS survey is still being implemented on a voluntary basis for those agencies interested beginning in October 2009.

What Does this Mean for Agencies?

- HHAs will be required to do a dry run for at least one month in third quarter CY 2010, and to begin data collection on an ongoing basis starting October 1, 2010.
- Only Medicare and/or Medicaid patients will be eligible to receive the HHCAHPS survey.
- V codes may be submitted if ICD-9 codes are unavailable.

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CMS Update: Patient Eligibility Criteria for HHCAHPS as of 10/26/09

Only patients whose home health care is paid by Medicare and Medicaid will be included in the Home Health Care CAHPS Survey. This means that patients whose home health care is paid solely by sources other than Medicare or Medicaid, such as private health insurance, the Department of Veterans Affairs, TRICARE, etc., are not eligible to participate in the Home Health Care CAHPS Survey. Patients with payers in addition to Medicare or Medicaid are eligible for the survey.

Note that patients enrolled in a Medicare Advantage (MA) health plan such as a MA health maintenance organization, a MA preferred provider organization (PPO), or a Medicare private fee-for-service (PFFS) plan, are considered Medicare patients and are, therefore, eligible to be included in the survey. In addition, patients whose home health care is paid for by a Medicaid managed care plan are eligible to be included in the survey.

What Does This Mean for Your Agency?

- According to this new instruction from CMS, your agency does not need to survey patients whose care is NOT paid for by Medicare or Medicaid. However, your agency can survey all patients if it wants to do so to obtain a true representation of overall patient satisfaction.
- Deyta can exclude this group of non-Medicare and/or non-Medicaid patients for your agency as part of the data processing we conduct each month to generate the survey eligible patient sample.
- If your agency decides to survey its non-Medicare and non-Medicaid patients, Deyta will conduct those survey's but will not submit the data for those patients to the Home Health Care CAHPS Survey Data Center.
- Agencies that only wish to comply with the minimum CMS requirements only have to survey their Medicare and Medicaid patients.
- For agencies that are interested in a complete view of their patient satisfaction and use these scores to manage their operations, Deyta recommends surveying all of your patients. Deyta provides detailed reporting on the entire patient sample regardless of HHCAHPS eligibility. Only the HHCAHPS data is reported to CMS.

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CMS UPDATE: Diagnoses Codes Now Accepted for HHCAHPS as of 10/26/09

The previous rule as stated in The *Home Health Care CAHPS Survey Protocols and Guidelines Manual* indicated that agencies cannot provide V codes as the primary and other diagnoses codes on the monthly patient information files that they submit to their survey vendor. As of 10/26/09 and based on feedback from home health agencies, CMS has changed this requirement so that V-codes are now allowed to be included among the codes reported.

Home health agencies should note, however, that the reason for collecting diagnosis codes that are not V-codes is to distinguish patients who, because of their underlying condition, may have very different attitudes about the health care they receive and who may respond very differently to the questions about their health care, specifically to the CAHPS Survey items. Prior research has shown that patients rate the care they receive differently based on their characteristics. For example, older patients tend to rate more favorably than younger patients, and patients who are sicker tend to rate less favorably than those in better health.

Consider the case in which two patients are coded with one of the V57 rehab codes: one has had hip or knee surgery, and the other has had a stroke. These two patients will potentially have different perspectives and opinions about the home health care they receive and these will affect how they respond to the CAHPS Survey items, because one is inherently a sicker person than the other. The V-code does not indicate the underlying problem or its severity. In this example researchers would not be able to account for the fact that sicker patients rate their home health care less or more favorably than their healthier counterparts. For this reason, CMS urges survey vendors/home health agencies to provide numeric ICD-9 codes when possible so that survey results can be adjusted to account for any differences in responses based on patient characteristics.

What Does This Mean for Your Agency?

- CMS urges survey vendors/home health agencies to provide numeric ICD-9 codes when possible so that survey results can be adjusted to account for any differences in responses based on patient characteristics.