

**HOME HEALTH CARE: WILL THE NEW PAYMENT  
SYSTEM AND REGULATORY OVERKILL HURT  
OUR SENIORS?**

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**HEARING**

BEFORE THE  
PERMANENT  
SUBCOMMITTEE ON INVESTIGATIONS  
OF THE  
COMMITTEE ON  
GOVERNMENTAL AFFAIRS  
UNITED STATES SENATE  
ONE HUNDRED SIXTH CONGRESS  
FIRST SESSION

—————  
JUNE 10, 1999  
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# HOME HEALTH CARE: WILL THE NEW PAYMENT SYSTEM AND REGULATORY OVERKILL HURT OUR SENIORS?

THURSDAY, JUNE 10, 1999

U.S. SENATE,  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS,  
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,  
*Washington, DC.*

The Subcommittee met, pursuant to notice, at 2:05 p.m., in room SD-342, Dirksen Senate Office Building, Hon. Susan M. Collins (Chairman of the Subcommittee) presiding.

Present: Senators Collins, Domenici, Levin, Cleland, and Edwards.

Staff Present: K. Lee Blalack, Chief Counsel and Staff Director; Mary D. Robertson, Chief Clerk; Glynn Parde, Chief Investigator and Senior Counsel; Karina Lynch, Counsel; Priscilla Hanley and Felicia Knight, (Senator Collins); Linda Gustitus, Minority Chief Counsel; Michael Loesch (Senator Cochran); Ed Hild (Senator Domenici); Andrea Haer and Nicole Quon (Senator Specter); Laura Stuber (Senator Levin); Marianne Upton, Annamarie Murphy, and Angela Benander (Senator Durbin); Lynn Kimmerly, Jane Greares, and Donna Turner (Senator Cleland); and Lori Armstrong (Senator Edwards).

## OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. The Subcommittee will please come to order.

Good afternoon. We thank all of you for being here with us today.

America's home health agencies provide an invaluable service that has enabled a growing number of our most frail and vulnerable Medicare beneficiaries to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

In 1996, home health was the fastest-growing component of Medicare spending, consuming 1 out of every 11 Medicare dollars, compared with 1 out of every 40 in 1989. The program grew at an average annual rate of more than 25 percent from 1990 to 1997. As a consequence, the number of home health beneficiaries more than doubled, and Medicare home health spending soared from \$2.5 billion in 1989 to \$18.1 billion in 1996.

This rapid growth in home health care spending understandably prompted Congress and the administration as part of the Balanced Budget Act of 1997 to initiate changes that were intended to make the program more cost-effective and efficient. There was wide-

spread support for the provision in the Balanced Budget Act of 1997 which called for the implementation of a prospective payment system for home health care. Until this system can be implemented, home health agencies are being paid according to an interim payment system, or IPS.

In trying to get a handle on costs, however, Congress and the administration created a system that penalizes lower-cost, efficient agencies and that may be restricting access for the very Medicare beneficiaries who need care the most—the sicker patients with complex chronic care needs, like diabetic wound patients or I.V. therapy patients who require multiple visits.

I accompanied a home health care nurse on a home visit once when I was in northern Maine, and we visited an elderly couple who were living in their very modest home, both of whom were in their eighties. The woman was being treated for a surgical wound that was not healing well as a result of her diabetes. She was confined to a wheelchair. I could see what a difference home health care made in their lives. For one thing, it allowed them to stay together rather than having this woman be in a nursing home. I was offered by the nurse to observe her cleaning the wound, but I passed up that part of the visit.

That visit brought home first-hand to me what an essential service good home health care is for our Nation's elderly.

Unfortunately, the interim payment system is critically flawed. It effectively rewards the agencies that provide the most visits and spent the most Medicare dollars in 1994, the base year, while it penalizes low-cost, more efficient providers and, I fear, their patients.

None of us should tolerate wasteful or fraudulent expenditures, but neither should we impede the delivery of necessary services by low-cost providers. Home health care agencies in the Northeast and the Midwest have been among those particularly hard-hit by the interim payment system. As *The Wall Street Journal* observed last year, "If New England had just been a little greedier, its home health industry would be a lot better off now. Ironically, the region is getting clobbered by the system because of its tradition of non-profit community service and efficiency."

Even more troubling, this flawed system may force our most cost-efficient providers to stop accepting Medicare patients with the most serious and complex health care needs.

According to a recent survey by the Medicare Payment Advisory Commission, almost 40 percent of the home health agencies surveyed indicated that there were patients whom they previously would have accepted whom they no longer accept due to the IPS. Thirty-one percent of the agencies surveyed admitted that they had discharged patients due to the IPS. According to these agencies, the discharged patients tended to be those very patients with chronic care needs who required a large number of visits and were expensive to serve. As a consequence, these patients caused the agencies to exceed their aggregate per-beneficiary caps under the very complex formula in the law.

I simply do not believe that Congress intended to construct a payment system that inevitably discourages home health agencies from caring for those seniors who most need the care. Last year's omnibus appropriations bill did provide a small measure of relief

for home health agencies. While I am pleased that we were able to take some initial steps to address this issue, I am very concerned that the proposal did not go far enough to relieve the financial distress that cost-effective agencies are experiencing. As a result, I will soon join with my colleagues in introducing legislation in the hope of remedying the remaining problems.

These problems are all the more pressing given the fact that the Health Care Financing Administration was unable to meet the initial deadline for implementing a prospective payment system. As a result, home health care agencies will struggle under the IPS for far longer than Congress envisioned when it enacted the Balanced Budget Act.

Moreover, it now appears that Congress greatly underestimated the savings stemming from the BBA. Medicare spending for home health fell by nearly 15 percent last year, and the Congressional Budget Office now projects post-BBA reductions in home care spending at \$48 billion in fiscal year 98-02. This is a whopping three time greater than the \$16 billion CBO originally estimated for that time period.

As a consequence, cost-efficient home health agencies across the country are experiencing acute financial difficulties and cash flow problems which will inhibit eventually, if not already, their ability to deliver much needed care, particularly to chronically ill patients with complex needs who need home health care the most.

Some agencies have closed because the reimbursement levels under Medicare fall so short of their actual operating costs. Others are laying off staff or are declining to accept new patients with more serious health problems. This points to the most central and critical issue, and that is that cuts of this magnitude simply cannot be sustained without ultimately affecting care for our most vulnerable seniors.

Moreover, these payment problems have been exacerbated by a number of new regulatory requirements imposed by HCFA, including the implementation of OASIS, the new Outcome and Assessment Data Set, sequential billing, IPS overpayment recoupment, and the new 15-minute increment home health reporting requirement. One home health nurse told me she felt more like a lawyer billing by the hour than a nurse taking care of essential health care needs because of that new requirement.

Today's hearing will examine how payment reductions under the IPS, coupled with these new regulatory requirements, are affecting home health agencies' ability to meet their patients' needs, because that is the bottom line.

I think the following quote which was provided to me by the director of a New York home health agency summarizes the problems faced by many providers. She wrote: "I have to prepare for Y2K and have everything ready by August 1. That has cost me \$100,000. My accounts receivable are now tied up for 4 months due to sequential billing. HCFA has called a halt to sequential billing as of July 1, which is great. But I need 2 months' notice to change my computer system, and the vendors are not responding. I implemented OASIS. The first year cost \$100,000, and now it is \$50,000 a year maintenance. I spent time trying to get a surety bond. The time and effort cost me \$8,000 to \$9,000. Had I been able to get

one, it would have cost \$216,000. I just spent \$300,000 toward the payback of my recoupment of overcharges, which is \$1 million. My rates have been cut by IPS by 30 percent, and my per-beneficiary cap is \$2,200. And last but not least, the 15-minute increment will cost \$20,000 to \$30,000 to implement, and worst of all, I will probably lose all my good nurses.”

This comment aptly reflects the concerns that I have heard from many home health agencies in my State as they struggle to cope with an onerous payment and regulatory system. I look forward to hearing the testimony of all of our witnesses today in our quest to better understand and then solve this problem which threatens the care that we provide to many of our elderly citizens.

I would now like to call on Senator Cleland for any comments that he might have.

#### **OPENING STATEMENT OF SENATOR CLELAND**

Senator CLELAND. Thank you very much, Madam Chairman. I cannot tell you how much I appreciate your having this hearing to flesh out some of the challenges that we in the Congress and HCFA and those involved in caring for our elderly citizens and our disabled have under the current system and under the current law.

We have all read the stories about the toll that the Balanced Budget Act has taken on patients across the country, headlines like “Medicare Cutbacks Prove Painful,” “Nursing Homes Shun Some Medicare Patients,” “Patients Face a Limit on Benefits for Therapy,” and so on.

Let me just say that the Balanced Budget Act of 1997 has produced some positive results. We do have a balanced budget, and Medicare’s fiscal health has been extended for many years—but at a cost. BBA has brought with it unintended consequences, and these consequences have a decidedly human face, as our distinguished panelists well know. It is the face of the Nation’s most vulnerable elderly citizens, Madam Chairman, as you point out, and their caregivers. It is the face of the 73-year-old cancer patient who relies on a feeding tube and I.V.s and who cannot find a nursing home that will accept her because her medical needs are too costly. It is the face of the 67-year-old woman who lost her leg to diabetes complications and received an artificial limb but was stopped short of her goal of walking with only one cane, because she hit her \$1,500 a year physical therapy limit. And as someone who spent a lot of time in physical therapy, I am a cosponsor with Senator Grassley to lift this limit, because I happen to believe not only in home health care but in physical therapy and rehabilitation as well. It is the face of children and parents of patients who must make the difficult choice of whether to care for their loved ones at home or seek care in a nursing home. It is the face of some of you in this room, the nurses and other dedicated employees of home health care agencies, who have devoted your lives literally to caring for the sick.

I think many of you are really unsung heroes who serve in some of the most rural areas of the country—a place like my State, the State of Georgia, has so many rural areas in need of your care. Many of you manage the sickest and most frail patients with no means of payment other than Medicare.

Last July, the Small Business Committee on which I serve held a hearing on home health care and whether it can survive the new BBA regulations. At that time, I stated that the government should allow us to make every effort to allow Medicare recipients to live in their own homes. I can remember after being wounded in Vietnam, I spent a year and a half in military and VA hospitals and rehabilitation facilities, but ultimately, I wanted to be in my own home. I guess that is what has made me a passionate devotee of home health care.

However, despite good intentions, those of us in government can sometimes become part of the problem we seek to correct. I think the interim payment system is such an example. Congress enacted the IPS to encourage providers to cut costs while becoming more efficient—a very laudable goal. In practice, however, we are seeing efficient agencies being driven out of business while some less well-managed agencies have been able to survive. Many of you know that story.

Last summer, we heard that 800 small and medium-sized home care agencies had been forced out of business by BBA regulations—that was just last summer. That number has now jumped to more than 2,000 agencies driven out of business.

How many patients are being denied services now? How many patients are being forced into nursing homes, at a higher cost, I might add, to our government, because 2,000 of America's home health care agencies have been forced to close their doors? All of us—the Congress, agency owners and employees and HCFA—must work together on this critical issue. We all have the same objectives—to keep Medicare solvent, to weed out fraud and abuse in the system, and more importantly, to carry out Medicare's mandate to ensure that our most vulnerable citizens have access to the health care they need.

Madam Chairman, I welcome this hearing, and I look forward to the information that will be provided today by the distinguished panelists, and I hope we can come to some kind of consensus here about the answers that are needed in the best interest of America's senior citizens. Thank you.

[The prepared statement of Senator Cleland follows:]

#### PREPARED STATEMENT OF SENATOR CLELAND

I want to thank the Chair and state how important this hearing is. All of us have read front page stories about the toll the Balanced Budget Act is taking on patients across the country. The headlines say it all: "Medicare Cutbacks Prove Painful," "Nursing Homes Shun Some Medicare Patients," "Patients Face a Limit on Benefits for Therapy." Let me say that the Balanced Budget Act of 1997 has produced some positive results—we have a balanced budget, and Medicare's fiscal health has been extended by many years. But the BBA has brought with it unintended consequences—and these consequences have a decidedly human face.

It is the face of the Nation's most vulnerable elderly citizens and their caregivers. It is the face of the 73-year-old cancer patient who relies on a feeding tube and I.V.'s—and who cannot find a nursing home that will accept her because her medical needs are too costly. It is the face of the 67-year-old woman who lost her leg to diabetes complications—who received an artificial limb, but was stopped short of her goal of walking with only one cane because she hit her \$1,500 a year physical therapy limit.

It is the face of the children and parents of patients who must make the difficult choice of whether to care for their loved ones at home or seek care in a nursing home. It is the face of some of you in this room today—the nurses and other dedi-

cated employees of home health care agencies who have devoted your lives to caring for the sick. Many of you are unsung heroes, who serve in some of the most rural areas of the country, who manage the sickest, most frail patients, with no means of payment other than Medicare.

Last July the Small Business Committee, on which I serve, held a hearing on home health care and whether it can survive the new BBA regulations. At that time, I stated that the government should make every effort to allow Medicare recipients to live in their own homes for as long as possible. However, despite good intentions, those of us in government can sometimes become part of the problem we seek to correct.

The Interim Payment System is such an example. Congress enacted the IPS to encourage providers to cut costs by becoming more efficient—a laudable goal. In practice, however, we are seeing efficient agencies being driven out of business, while some less well managed agencies have been able to survive. Last summer we heard that 800 small- and medium-sized home care agencies had been forced out of business by BBA regulations. That number has now jumped to more than 2,000 agencies. How many patients are being denied service—how many patients are being forced into nursing homes—because 2,000 of America’s home health agencies have been forced to close their doors?

All of us—the Congress, agency owners and employees, and HCFA—must work together on this critically important issue. We all have the same objectives: To keep Medicare solvent, to weed out fraud and abuse from the system, and most importantly, to carry our Medicare’s mandate to ensure that our most vulnerable citizens have access to the health care they need. I welcome this hearing. I look forward to the information that will be shared today, and hope that we will get answers that are in the best interests of America’s senior citizens.

Senator COLLINS. Thank you very much, Senator Cleland.

I am now pleased to yield to the Senator from New Mexico, Senator Domenici.

#### **OPENING STATEMENT OF SENATOR DOMENICI**

Senator DOMENICI. Thank you very much, Madam Chairman, for conducting this hearing. I wish I could stay longer, but I will just be able to be here for half an hour or so.

I heard your opening remarks, and I would like to say that I think you have covered almost every issue that I would have covered, and I commend you for raising those and laying them on the table. Some of those issues must be resolved. Some involve over-regulation by HCFA. I hope this hearing will send a signal to them that where changes can be made, they ought to do so.

It is patent and obvious in my State, where I have a task force on health issues, that home health care, in an effort to save money, has become entangled in a web of new rules and regulations that for some who have spoken with me, it is almost impossible to deliver the kind of care that they want to deliver. In addition, costs are not coming down. As you place all those burdens on, the costs of keeping businesses going, whether they are nonprofits or profit-making, are going up, and payments are coming down.

Obviously, in a State like mine and perhaps yours, Madam Chairperson, we have a lot of rural areas, and rural areas have a very difficult problem not only because there are so few patients and such big distances, but also payment was presumed to be an average of the high costs and the low costs, and essentially, most of the rural ones are high-cost and long-term need patients, so the rural home health care facilities, if they are isolated and have just rural areas, cannot make it because what we figured as a cost is just out of kilter with the reality of the abundance of high-cost patients.

Obviously, we are going to have to resolve some of these things, and I look forward to working with you on that. Some, I think can be solved with this Subcommittee and others just telling HCFA in no uncertain terms that overregulation is not necessarily synonymous with better care or with lower cost. Quite to the contrary—in this industry, it is proving to be very, very much the opposite.

Madam Chairman, I would ask that you put my remarks, which go into more detail, in the record.

Senator COLLINS. We would be happy to. Without objection, they will be entered in full in the record.

Senator DOMENICI. Thank you very much.

[The prepared opening statement of Senator Domenici follows:]

#### PREPARED OPENING STATEMENT OF SENATOR DOMENICI

It is a pleasure to be here this afternoon and I want to start by commending the Chairwoman, Senator Collins for holding a hearing on this very important issue.

I too have been working on the problems facing home health for some time now. I would also note that when I attended a recent meeting of my New Mexico Health Care Task Force, the concerns raised by home health care providers were identical to those being raised today.

While the Balanced Budget Act of 1997 (BBA) has produced a number of positive results, I am concerned about the impact of the Interim Payment System (IPS) on seniors living in rural areas.

More to the point, I am unsure whether the IPS adequately takes into account the unique needs of our rural areas. I would submit the premise of the IPS was sound: Home health agencies would have a blend of short term and long term patients whose costs would average out to the per beneficiary limit.

However, home health agencies in rural areas often do not have a choice because these areas tend to have low volume and mostly high cost patients.

For instance in New Mexico, Catron County is almost 7,000 square miles in size, but has a population of less than 3,000 people. There is not even a home health agency in Catron County and for people living in Datil the nearest agency is 164 miles away in Silver City.

Let's say this agency must see a patient in Glenwood, Datil, and Salt Lake that is a round trip of almost 400 miles that the IPS does not take into account. Moreover, with roughly less than one-half of a person per square mile, I would submit that a home health agency will have a hard time because they will have very few patients and no control over their condition.

I think a recent GAO report reinforces this point: "Low-volume agencies may have less ability to stay below their caps: A few high-cost patients can affect them more because they have a smaller pool of beneficiaries over which to average their costs."

Again thank you, Madame Chairwoman, for holding this hearing and I look forward to participating.

Senator COLLINS. I would now like to yield to the Ranking Minority Member of the Subcommittee, Senator Levin.

#### OPENING STATEMENT OF SENATOR LEVIN

Senator LEVIN. Thank you, Madam Chairman, for convening these hearings and for your continued leadership in a very critical area. Our constituents, American citizens, are very much looking to us for leadership in helping to make sure that they are provided with an essential service, and that is what home health care is.

You again are playing a critical role in making sure that that happens, and I want to commend you for that.

Today we are looking at how the home health care industry is surviving the so-called "reforms" of the Balanced Budget Act (BBA) of 1997. Having received some 1,500 letters in 1998 from both providers and beneficiaries concerning problems the home health care

industry is facing, I think the answer to that question is: "Not well."

Not only is the Interim Payment System harming home health agencies in Michigan and other cost-efficient areas, but additional regulatory hurdles have been put in the way of agencies, making it difficult for these agencies to continue providing quality care.

Home health agencies provide a critical service for our Medicare beneficiaries. According to the General Accounting Office, there are over 1.3 million Medicare beneficiaries in my State of Michigan alone. Well over 100,000 of those beneficiaries use the services of Michigan's 220 home health agencies. These beneficiaries receive much-needed services within the comfort and security of their own homes. It is common knowledge that most people prefer recuperating from an illness in their own home rather than in a nursing home and that the overall cost savings of home health care compared to nursing home care are dramatic.

I think that probably each of us has had instances in our own families where this need, this very human need, to have care at home if possible has been proven. I know I have had such instances in my own family.

In February 1998, I sat down with representatives from the home health agencies in Michigan to discuss the interim payment system, and the health care leaders, including one whom we have with us today, Linda Stock, voiced serious concerns about the interim payment system which penalizes cost-efficient home health providers while rewarding the higher-cost agencies.

Let me just give you one example. In Michigan, the 1998 average cost of receiving home health care services per patient was about \$3,300, while the national average was about \$4,000. Ms. Stock's agency, Home Health Outreach in Rochester Hills, Michigan, is operating under a per-beneficiary limit of about \$2,500. This is more than \$1,000 below the national average, and her agency is essentially being penalized for having been cost-efficient for the Medicare program in 1994.

So we have that plus many other areas that we want to explore here today, including some of the new regulations which have been imposed by HCFA which are extremely burdensome.

The Outcome and Assessment Information Set, OASIS, sequential billing, overpayment recoupment, and the 15-minute increment home health reporting requirement are simply too burdensome. I know that some of these regulations have been disbanded or suspended, but they have not all been, and in the process of preparing for the implementation of the ones that I have just described, a huge amount of time and effort has been wasted.

So in our battle to protect Medicare from waste, fraud and abuse, we have to ensure that the great benefits of home health care are not lost. Yes, we need to have reasonable controls in place to avoid abuses, but at the same time, we have to make sure these critical services remain available to those who need them.

I hope today's hearing will help to bring HCFA and the industry together to work on a payment system and on regulations that make sense for the people of the United States, for whom home health care is so important. Thank you.

[The prepared statement of Senator Levin follows:]

## PREPARED STATEMENT OF SENATOR LEVIN

Today we are looking at how the home health industry is surviving the so-called "reforms" of the Balanced Budget Act (BBA) of 1997. Having received some 1,500 letters in 1998 from both providers and beneficiaries concerning problems the home health care industry is facing, I think the answer to that question is, "not well."

Not only is the Interim Payment System (IPS) harming home health agencies in Michigan and other cost efficient regions, but additional regulatory hurdles have been put in the way of the agencies, making it difficult for these agencies to continue providing quality care.

Home health agencies provide a critical service for our Medicare beneficiaries. According to the GAO, there are over 1.3 million Medicare beneficiaries in my State of Michigan. Well over 100,000 of those beneficiaries use the services of Michigan's 223 home health agencies. These beneficiaries receive much needed services within the comfort and security of their own homes. It is common knowledge that people prefer recuperating from an illness in their own home rather than in a nursing home and that the overall cost savings of home health care compared to nursing home care are dramatic.

Some changes certainly needed to be made in the home health industry. From 1989 to 1996 Medicare home health payments grew at an average rate of 33 percent, while the number of home health agencies swelled from about 5,700 in 1989 to more than 10,000 in 1997. During this time, home health care was also one of Medicare's fastest growing benefits. Medicare spent \$3.7 billion to pay for home health visits in 1990 compared to \$17.8 billion in 1997 according to the GAO. In response to this rapid cost growth and some concerns about alleged abuses, the Balanced Budget Act included a number of changes in home health payment policies.

One significant change we made in that Act was requiring HCFA to move to a different payment mechanism, a prospective payment system (PPS), which under the Balanced Budget Act was supposed to have been in place by October 1, 1999. In the meantime, the Balanced Budget Act provided for a temporary payment mechanism, or interim payment system, which has turned out to be quite problematic.

In February of 1998 I sat down with representatives from the home health industry in Michigan to discuss the interim payment system. These health care leaders voiced serious concerns about the interim payment system, which, they said, penalizes cost-efficient home health providers while rewarding higher-cost agencies. Michigan providers, on average, have lower per-patient costs than their counterparts in other regions. By paying home health agencies at rates calculated from 1994 cost reports, the interim payment system penalizes those agencies that attempted to keep their costs down in 1994. The formula is regional as well as agency specific which penalizes those regions, like the Northeast and the Midwest, who were historically more efficient with their Medicare dollars in 1994.

Let me give you an example. In Michigan the 1998 average cost of receiving home health care services per patient was \$3,285 while the national average was \$3,987. Linda Stock's agency, Home Health Outreach in Rochester Hills, Michigan, is operating under a per beneficiary limit of \$2,531. This is more than \$1,000 below the national average. Ms. Stock's agency is essentially being penalized for having been cost efficient for the Medicare program in 1994.

With unfair reimbursement gaps such as that experienced by Ms. Stock's agency, no wonder the Medicare home health benefit has already experienced significant cost savings well beyond the amount anticipated. The original projected savings in 1998 to Medicare as a result of the changes in home health care was \$16 billion over 5 years. Yet in March of this year, CBO baseline figures for home health projected a five-year savings of \$48 billion. That's \$32 billion in unexpected savings. While GAO says its review doesn't show that persons who deserve home health care services aren't getting them because of the Balanced Budget Act changes, that \$32 billion is pretty good evidence that that may be the case. It is very possible that such savings are coming from people like Ms. Stock, at the expense of both Medicare beneficiaries and providers.

On top of the severe reduction in payments, I am concerned that some of the new regulations being imposed by HCFA are too burdensome. Michigan agencies have been critical of the Outcome and Assessment Information Set (OASIS), sequential billing, overpayment recoupment, and a 15-minute increment home health reporting requirement. Some of these regulations have been disbanded or suspended, but in the process of preparing for their implementation, time and effort has been wasted.

In our battle to protect Medicare from waste, fraud and abuse, we have to ensure that the great benefits of home health care aren't lost. Yes, we need to place reasonable controls to avoid abuses, but at the same time, we have to make sure that these important services remain available to those who need them. I hope today's

hearing can help bring HCFA and the industry together to work on a payment system and regulations that make sense for the people of the United States for whom home health care is so important.

Senator COLLINS. Thank you very much, Senator Levin.

Due to time constraints, the Subcommittee was unable to invite everyone who wanted to testify at this hearing. As you can imagine, we were beseeched with many requests. We will, therefore, leave the hearing record open for 30 days for anyone who wishes to submit a written statement. In that regard, we have already received a written statement from the Home Health Services and Staffing Association, and without objection, that statement will be included in the printed hearing record.<sup>1</sup>

I am now pleased to welcome our first panel of witnesses this afternoon. I am particularly pleased to welcome a constituent of mine, Maryanna Arsenault, who is the CEO of the Visiting Nurse Service in Saco, Maine, and who is also testifying today on behalf of the Visiting Nurse Associations of America.

We are also pleased to have Mary Suther, who is both chairman of the board of the National Association of Home Care as well as president and CEO of the Visiting Nurse Association of Dallas, Texas.

Also with us is Linda Stock, Senator Levin's constituent, who is executive director of Home Health Outreach of Rochester Hills, Michigan.

Finally, we would like to express our appreciation to Barbara Markham Smith who is here with us today. Ms. Smith is a senior research staff scientist with the Center for Health Services Research and Policy at George Washington University, which is part of the School of Public Health at George Washington University Medical Center.

I want to acknowledge that the Subcommittee is aware that Ms. Smith's testimony today is based on the findings of a study that she is conducting that has not yet been completed, so her findings are preliminary. It is not her usual practice to discuss her findings at this stage of her research, so I want to acknowledge that fact and express our appreciation to Ms. Smith's agreeing to share her very important preliminary finding with the Subcommittee today. It is my understanding that this will be the first public discussion of Ms. Smith's results.

Pursuant to Rule 6 of the Subcommittee, all witnesses who testify are required to be sworn in, so at this time, I will ask that you all rise and raise your right hand.

Do you swear that the testimony you are about to give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. ARSENAULT. I do.

Ms. SUTHER. I do.

Ms. STOCK. I do.

Ms. SMITH. I do.

Senator COLLINS. Thank you.

I am going to ask that each of you try to limit your oral testimony to about 5 minutes each. If you need to go a little beyond

<sup>1</sup>The prepared statement of the Home Health Services and Staffing Association appears in the Appendix as Exhibit No. 4 on page 174.

that, feel free to do so, but we want to make sure we have plenty of time for questions. We will be using a timing system this afternoon, so be aware that approximately 1 minute before the red light comes on, you will see the lights change from green to orange, and that will give you the opportunity to conclude your testimony.

Your written testimony, however, will be included in the printed record in its entirety.

Ms. Arsenault, we are going to start with you.

**TESTIMONY OF MARYANNA ARSENAULT,<sup>1</sup> CHIEF EXECUTIVE OFFICER, VISITING NURSE SERVICE, SACO, MAINE, REPRESENTING THE VISITING NURSE ASSOCIATION OF AMERICA**

Ms. ARSENAULT. Thank you, Madam Chairwoman and Members of the Subcommittee. My name is Maryanna Arsenault, and I am chief executive officer of the Visiting Nurse Service which is located in Saco, Maine. The Visiting Nurse Service is an independent, Medicare-certified home health agency serving southern Maine and seacoast New Hampshire.

I am pleased to be here today to present the views of the Visiting Nurse Associations of America (VNAA), regarding the difficulties that VNAA members, including the VNS, are currently experiencing in meeting the health care needs of patients within the current Federal regulatory environment.

We are grateful to you, Madam Chairwoman and Subcommittee Members, for your interest in determining how the Medicare home health Interim Payment System, IPS, and several new regulatory requirements are making it difficult for the VNS and other VNAs to meet our patients' health care needs.

We believe that this hearing is being held at a critical time, because evidence of harmful effects on Medicare beneficiaries is beginning to emerge, particularly involving those with chronic health and disability conditions.

VNAA believes that it is essential to look at the combined effect of IPS and regulatory requirements such as OASIS on providers and their patients. IPS alone has forced VNAs to cut costs by an average 20 percent to stay under the IPS per-beneficiary and per-visit cost limits. On top of these cuts, new regulations have increased home health providers' costs significantly.

For example, OASIS implementation has cost our agency more than \$300,000. The combined effect of IPS cost limits and OASIS implementation has caused the VNS to exceed its per-visit cost limit for the first time ever.

While the VNS had consistently maintained per-visit costs 25 percent less than our per-visit cost limits, we are now over the limits by 3 percent in the aggregate. Our skilled nursing per-visit cost increased from \$79 in 1998 to \$91 in 1999 because (1) IPS decreased the per-visit cost limit by 16.5 percent; (2) OASIS increased our nursing per-visit cost by \$7; (3) the IPS decreased our average per patient reimbursement by \$600 in 1 year, causing utilization to drop and costs per visit to increase; and (4) because other time-

<sup>1</sup>The prepared statement of Ms. Arsenault appears in the Appendix on page 46.

consuming and costly regulations, including fraud and abuse initiatives, have added to overall costs.

How has patient care been affected by the budget cuts at VNS? During this past year, the decreased number of staff has meant a decrease in staff continuity for patients because staff must now cover a greater geographic area. Elderly patients have had to adjust to new staff more frequently, which has jeopardized the establishment of a trusting relationship.

Our monthly patient satisfaction surveys show a decreased level of patient satisfaction. This problem will be exacerbated in July when we close a branch office. In addition, four surrounding agencies have closed, affecting access and requiring further expansion and dilution of our services and discretionary moneys to meet community needs—once again increasing staff travel time and costs.

In order to manage the per-beneficiary cost limit, our average number of visits per VNS patient has decreased from 56 to 45 in 1 year. This reduction has been compounded by two significant recent changes in Medicare coverage which have severely curtailed access for patients with medically complex conditions.

First, the criteria for whether Medicare will cover a skilled nurse's management and evaluation of a patient's plan of care are now being more stringently interpreted by the fiscal intermediaries. Medicare must approve a skilled nurse's coordination of extended interdisciplinary care in order for individuals with a multiplicity of functional needs to receive such care. Such coverage has increasingly been denied.

Second, the Balanced Budget Act reduced the "part-time or intermittent skilled nursing care" eligibility criteria from 56 to 35 hours per week, which has curtailed our ability to meet the needs of this patient population.

The following two case examples provide a closer look at the access to care issue:

Doris is an 85-year-old woman who lives alone in rural Maine with no indoor plumbing and no telephone. Her two living family members live outside the State. Doris is unable to manage her medications independently. However, her need for medication management no longer qualifies her for coordinated services by a registered nurse. The weekly service of an RN to assess Doris and assist with medication management had previously enabled Doris to live at home free of hospital admissions.

Marjorie is also 85 and has received VNS services since 1996. She has brittle chronic obstructive pulmonary disease, an anxiety disorder, and cardiac arrhythmia requiring regular venipuncture for coumadin management. Marjorie is homebound. We are planning to discharge her because she no longer qualifies for skilled RN services. Marjorie has also avoided hospitalization for several years. She does not qualify for Medicaid services and will lose her home health aide. Marjorie will be at high risk for continuous hospital admissions.

As the costs to VNS increased due to IPS and new regulatory changes and interpretations, we were forced to curtail non-Medicare services to patients. Discretionary moneys previously used to meet patient needs not covered by Medicare are now being used to subsidize Medicare.

The VNS closed a much-needed personal care service that had been subsidized by discretionary funds. Family members of 100 patients receiving care were forced to provide personal care to elderly patients and very sick children, which in turn affected their work schedules and job security.

On July 1, home health agencies will have to comply with another costly and burdensome regulation mandated by the BBA—the 15-minute increment recording requirement. The changes to billing forms and software will be costly, and the information collected may not be useful in terms of correlating clinical time with patient assessment and outcome information.

VNAA believes that it is important to have standardized accountability of processes, but we feel that this information would only be meaningful if it captures total patient care time in relation to patient results. HCFA's proposed 15-minute requirement will not provide this information because it is encumbered by a stop-watch recording method and does not account for a clinician's activities outside the home that are directly related to patient care, and it ignores any travel time.

It is my understanding that this provision will be implemented because OASIS has been suspended and may be used as a method to assess reimbursement. The home health industry cannot withstand one more change where the information may or may not be needed.

Senator COLLINS. If you could conclude your statement in the next few minutes, that would be great. Thank you.

Ms. ARSENAULT. Very quickly—I will not read the rest of my statement—we need relief regarding the cost limits, both the per-beneficiary and the per-visit. The 15-minute increment is going to be a terrible burden for home health agencies.

That is about it. I thank you very much.

Senator COLLINS. Thank you very much. Ms. Suther.

**TESTIMONY OF MARY SUTHER,<sup>1</sup> CHAIRMAN OF THE BOARD,  
NATIONAL ASSOCIATION OF HOME CARE, WASHINGTON, DC,  
AND PRESIDENT AND CEO, VISITING NURSE ASSOCIATION  
OF TEXAS, DALLAS TEXAS**

Ms. SUTHER. Thank you very much for this opportunity to appear before you today to testify.

My name is Mary Suther. I am president and CEO of the Visiting Nurse Association of Texas, which is a 65-year-old charitable organization serving people in rural and urban areas. We serve about 50 counties, and that changes daily because we have had to close offices. In the past year, we eliminated one branch that served eight counties that we can no longer serve. I am also chairman of the board of the National Association for Home Care.

We are deeply appreciative of the attention the Members of this Subcommittee have shown to the problems created by the home health provisions of the Balanced Budget Act and the regulatory burdens imposed by HCFA.

<sup>1</sup>The prepared statement of Ms. Suther with attachments appears in the Appendix on page 52.

The CBO originally reported that the effect of the BBA would be to reduce home health care expenditures by \$16.1 billion over 5 years. Revised projections indicate that reductions will exceed \$47 billion. I am sure you remember that one reason Congress directed that the reductions had to be so great was because a two-thirds behavioral adjustment was made to the projection, and therefore required greater cuts than would normally be necessary.

We look back now, and we think we were right to begin with, because the expenditure is along the lines had there been no behavioral adjustments. I am confident that Congress will restore home care for their constituents.

The financial viability of home health agencies is now being threatened by the cost of legislative and regulatory changes, as you have heard. The access to beneficiaries is being greatly reduced. These changes include the line-item billings, increased medical review, itemized bills to patients on demand, billing in 15-minute increments, sequential billing, OASIS.

You may have heard that sequential billing has been suspended. It is and it is not. You can still send the bills in, but they will not be paid until the claim in question has cleared medical review. Also, for the 15-minute increment, you may hear that that has been suspended, too, but only temporarily.

These items have all increased costs due to increased staff requirements; computer programming; printing; upgrading computer hardware capacity; increased postage and shipping; increase in data line costs; and coupled with that, all of the Y2K compliance that we have to do in home care. HCFA got extra budget for their Y2K compliance, but we have had no additional add-ons for our Y2K compliance, and we do have to comply with Y2K. For my own agency, it cost \$1.5 million for that compliance.

Increased cost is only one aspect. Nurses have to complete on the average an additional 45 pages of paperwork per patient. I have copies of admission folders here if any of you would like to look at those. OASIS questions number more than the questions asked of a quadruple bypass patient being served by a hospital.

Patients are angry that we are asking them these questions, especially some of the very personal information, and often, they are too sick to go through this entire questionnaire and assessment process. That is not to say that I do not believe, nor does our association, that we should be gathering unified data and certainly, data elements upon which we do base costs or should base costs in the future.

An even more devastating effect of the increased administrative burden—and this is a recent finding—is that nurses are leaving nursing, but nurses are leaving home health at a greater rate because they say they did not go into nursing to be clerks or secretaries but to provide nursing care to patients.

We are now experiencing nursing shortages. The weekend before last, our agency, which is the largest home health agency in the area, had to close admissions because we did not have staff. Baylor Health Care is the second-largest serving our area, and they had to close admissions.

I spoke with someone at Johns Hopkins, and she said that several hospital home health agencies in the Baltimore area also had

to close admissions because of lack of staff in that area. This is not in my written testimony, because I just found this out.

Sequential billing has caused severe cash flow problems and duplicative handling of claims. Billing in 15-minute increments not only increases costs, but beneficiaries are going to be extremely angry if a nurse comes in, and after she has been there for 8 minutes, pulls her stopwatch out and starts turning it off and on if the patient gets a phone call during that time period—off; if the patient goes to the bathroom during that time period—off. Patients are going to be extremely angry with us because we will not be able to adequately explain to them—think about trying to explain this to your grandmother. These changes coupled with IPS, which produced for most home health agencies a 14 to 22 percent decrease in the per-visit reimbursement—and in my own agency, that was 27 percent—at a time when costs are increasing—you heard the previous witness talk about the increase, and the costs in our agency have increased proportionately to those in hers—the low aggregate beneficiary limit with no provision for increased limits for medically complex, high-cost patients, and also the elimination of venipuncture as a qualifying benefit. In one county that our agency services, of all the patients discharged as a result of the elimination of this benefit, one-third were admitted directly into a nursing home on the day of discharge.

Venipuncture patients were included in the base year for cost analysis; however, it changes the cost analysis when you take those patients out of the base year cost materials, which I do not think anyone has thought of. There are threatening letters going to physicians which cause them to decrease or eliminate referrals for patients. In our area, several doctors have sent a blanket letter to all home health agencies and to their patients, saying we will no longer admit you to a home health agency because it may subject us to criminal charges, and therefore, we cannot take that liability on.

Alarming letters go to patients about their Medicare bills regarding fraud and abuse. In many areas, the Health Care Financing Administration's regional determinations regarding strict, archaic rules for branch offices, which increase costs and cause offices to close. In our area, we have had to eliminate one office already that served eight counties because of this rule, and we are threatened with having to close another one that serves 15 counties because of this. They do not understand that we have telephones and fax machines and computers to assist in running those offices.

I would like to give you an example of some access problems—and I will submit this testimony for the record, because I did not have this information earlier. I found out that in Texas prior to BBA, there were 15 counties with no home health agency. Now, as of April 1, we have 40 counties with no home health agency in Texas. Two of those counties have areas greater than 4,500 square miles, and each of those is bordered by another county that has no home health agency. So, access is being severely affected in Texas.

My time is up, so I will just conclude by saying that in many instances, the Balanced Budget Act has certainly lengthened the life of Medicare, but sometimes, the cure is worse than the disease. The effects of the BBA have produced many unintentional con-

sequences. We are relying on your interest in this problem to help repair that damage. Thank you.

Senator COLLINS. Thank you very much. Ms. Stock.

**TESTIMONY OF ROSALIND L. STOCK,<sup>1</sup> VICE PRESIDENT, HOME HEALTH SERVICES, HOME HEALTH OUTREACH, ROCHESTER HILLS, MICHIGAN**

Ms. STOCK. Chairman Collins, Senator Levin and Senator Edwards and the staff, thank you for this opportunity to discuss the effects of the 11 mandates of BBA on home health patients and their providers since October 1, 1997.

I am Linda Stock, vice president of Home Health Services and a director of the Michigan Home Health Association, and I speak for the majority of providers who want to be part of the solution and not part of the problem.

Each mandate is unfunded if the provider is at, or above, their per beneficiary cost limits. Home health is the only Medicare benefit for which patients pay all the costs at the site of care. So any recurrent calls for copayments are unconscionable.

As a home care provider for over 18 years, I am saddened to see peers close their doors or eliminate Center of Excellence programs for wounds, strokes, and diabetes in response to the severe cut-backs.

Home Health Outreach is a system-affiliated home care agency, serving urban and rural areas. In 1998, we admitted 934 Medicare patients. Because our per beneficiary limit is so low, we depleted our expenses and cut anything that was deemed nonessential to short-term survival. Staffing expenses were reduced by 19 percent.

Our Y2K budget was cut to two PCs and their software, one fully dedicated to OASIS. Y2K has made that a very short-term decision.

Just one of our home care patients with complex wound care costs us over \$25,000 a year. Balancing these costs and patient service is next to impossible. I have personally seen the anxiety of an elderly patient being taught how to give their own intravenous care.

Access to care is becoming a greater issue for Michigan. Over 10 percent of our agencies have closed, and others are limiting their admission criteria. We have case managers who will confirm that they are prolonging discharges from hospitals because they cannot find care for complex cases.

Please eliminate the 15 percent additional reduction due in October of this year and mandate a rational PPS by October 1, 2000.

Hastily enacted surety bonds, sequential billing and OASIS mandates created serious operational and financial problems and then were suspended. What a waste of time and resources for the Federal Government and for providers.

In April, HCFA implemented OASIS, and the 79 OASIS admission questions added 17 pages to our assessment. Separate data is also required on readmission, change of patient condition, recertification, transfer, discharge, and death.

Protection of clients' right to confidentiality and participation in their care decisions has not been adequately addressed by OASIS.

<sup>1</sup>The prepared statement of Ms. Stock appears in the Appendix on page 88.

The benefits should not be denied if the patient refuses to answer the questions. Non-Medicare patients show greater resistance to the personal aspects of the questions. HCFA should not have the authority to mandate data collection for services they do not pay for.

Here are some examples of OASIS-related situations. A patient with severe lung disease develops such shortness of breath during the OASIS assessment that the interview had to be suspended so the nurse could intervene.

A confused elderly man was also unable to answer for himself, and his caregiver, a neighbor, knew nothing about him, so the assessment is meaningless.

An elderly female patient hospitalized twice in the first 2 weeks of OASIS was being subjected to her third OASIS interview. Weak and tired, she voiced her frustration by saying she would not go back in the hospital if she had to answer those questions again.

During the nurse's first contact with the patient, asking, "Are you having thoughts of suicide?" is a totally unacceptable entry into the psychological assessment of a patient. Will it be perceived as a suggestion? Will it trigger anger or rejection of service?

Providers do not oppose collection of outcome measurements. We oppose inefficient data collection which jeopardizes patient rights and implements a system without adequate provider input or funding.

For OASIS, HCFA prepared three manuals of instructions coming to 512 pages—just for OASIS. Our agency's projected OASIS cost for the first year is \$126,000. In the last week before OASIS was suspended, our HCFA OASIS software froze, and all the data to date was lost.

We recommend delaying the OASIS implementation until patient rights, funding, and data volume and frequency issues are addressed, and we also ask that OASIS not apply to non-Medicare patients. The new 15-minute increment reporting mandate on home health care claims becomes effective in just 20 days. Providers anticipated a simpler formula, and we knew we had to report visit time, but now our staff will need stopwatches to delete the items that HCFA arbitrarily determined do not constitute allowable time, such as charting and dishwashing by an aide.

Now, the HIM 11 says both of these items are allowable in the content of a visit, but they are being eliminated. Even OASIS is being eliminated.

Agencies will need to run concurrent time studies, one for payroll and one for the new mandate. They must revise their software and establish a new tracking system.

Was it Congress' intent that the 15-minute increment be labor-intensive and micromanaged? I do not think so.

Because of Y2K complications, we recommend delayed implementation of the 15-minute reporting until a simpler, less costly formula can be designed.

In conclusion, I believe that mandates have already impacted patients by diverting limited resources away from direct care. Congress did not mandate this minutiae. There is provider support for practical, effective regulations for each of these mandates. My hope

is that together we can replace reactive fixes for current problems with a more efficiently designed home care benefit.

My thanks to those who helped me prepare for today's session and to this Subcommittee for addressing this critical issue.

Senator COLLINS. Thank you very much. Ms. Smith.

**TESTIMONY OF BARBARA MARKHAM SMITH,<sup>1</sup> SENIOR RESEARCHER, CENTER FOR HEALTH SERVICES RESEARCH AND POLICY, THE GEORGE WASHINGTON UNIVERSITY, WASHINGTON, DC**

Ms. SMITH. Good afternoon, Madam Chairman, and Senators. Thank you for inviting me here today to testify on a matter that affects not only Medicare beneficiaries who may need home health services now and in the future but indeed affects the coherence and viability of the Medicare program itself.

My testimony, based on the preliminary findings of our study, will suggest today that as a result of the Balanced Budget Act of 1997, home health agencies in general are driven to change the case mix of their patients and alter the patterns of practice of the care they deliver to conform to reimbursement constraints. These constraints appear to be creating substantial tension with meeting the clinical needs of some patients. As a result, many seriously ill patients, especially diabetics, appear to have been displaced from Medicare home care. Other patients are experiencing significant changes in services, with effects on health status that are unknown, but suggest greater risk as a result of greater fragmentation of services.

I am going to flip through my testimony in order to expedite it, but I think it is important to recognize that even though we are in the midst of this study now, I would say that the biggest methodological problem that we have is that it is still too early to fully assess all of the impact, so that these findings should be regarded as signals of greater effects yet to come.

I want to put the findings in some context. We do have outcome studies that have been funded by HCFA recently, very large, that I would regard as flagship studies, on the effects of home care on patient health status. Basically, these studies show that patients with more home health care have better outcomes both in terms of improved functioning and reduced hospitalizations. These studies specifically warn that an attempt to force patients into a short-term care model could have very adverse consequences on the health status of beneficiaries.

In addition, the studies show that the regional variation in home health utilization correlates to the health status of beneficiaries in home health care in those regions. For example, the mortality rates among beneficiaries in high-utilization regions are 34 percent higher 30 days after discharge from home care than patients in low-utilization regions.

This is not a reflection of the quality of care, because it happens 30 days after discharge; it is a reflection of the fragility of the patient's health status in the system.

<sup>1</sup>The prepared statement of Ms. Smith with attachments appears in the Appendix on page 132.

With those outcomes studies in mind, I would like to go straight to my specific findings. First, just to backtrack, what that means is that it is very important not to confuse low cost with efficiency. An agency can be low-cost and be inefficient because it has a very healthy patient mix, or it can be high-cost and be very efficient because it is taking care of critically ill patients. So I think it is important to bear that in mind throughout an analysis of this problem.

The key preliminary findings of our studies suggest significant potential effects on beneficiaries, particularly those with unstable chronic illness or who have even short-term intensive needs. It appears that these patients are being displaced from home care or are experiencing significant changes in services. These changes appear to be driven by reimbursement policies and intermediary scrutiny, rather than clinical considerations. And let me just state the findings for you one by one.

Home health agencies in general are moving fairly aggressively to adjust their case mixes and/or their practice patterns to conform utilization to reimbursement. While intermediary practices have also clearly had an effect on both utilization and case mix, reimbursement changes appear to be the dominant driver of practice in case mix changes.

A number of agencies have achieved virtual reversals in their short stay/long stay ratios through changes in their patient mix. Other agencies with very sick patient mixes have significantly reduced visits and clinical staffing levels even as they dramatically increase their patient census, raising serious quality concerns.

These significant reductions in care in agencies with very adverse patient mixes are driven almost exclusively by reimbursement considerations and are most notable among agencies operating under national median limits in traditionally high-cost areas.

Both the interim payment system and fiscal intermediary policies have created a stratification of beneficiary desirability among providers. Orthopedic rehabilitation patients, particularly joint replacements, coronary artery bypass graft, also known as CABG patients, nondiabetic post-operative wound care, pneumonia-type infectious disease patients have become the "Brahmins" of desirable patients and are the focus of competition among agencies.

Diabetics, particularly brittle diabetics, appear to have experienced the most displacement from home care. The extent to which complex diabetics are even being admitted to home care has declined significantly among the study agencies. Among diabetics already in care, agencies report very aggressive efforts to discharge them.

The extent of the decline in the home care diabetic census among the study agencies, as well as the reductions in care, raise concerns about the long-term health status and outcomes of this population.

Similar patterns of aggressively seeking discharge or avoidance of congestive heart failure patients and chronic obstructive pulmonary disease also appear, although to a lesser extent.

Patients who require two visits daily or even one visit daily, even for very short periods of time, seem to be experiencing significant displacement from home care. This was a surprising finding, and it has affected short-term I.V. therapy patients in particular, who

need care for only 3 to 6 weeks and whose care is unquestionably post-hospitalization and very acute. A number of agencies report overt screening to exclude or time-limit these patients specifically.

Mental health services are also experiencing some exclusion and decline in services, either because they do not want to keep the patients in long enough to—I see my time has expired; I have a few more findings and some implications. Should I go ahead and proceed?

Senator COLLINS. If you could summarize those quickly, that would be great.

Ms. SMITH. OK. Foley catheter patients do not appear to be experiencing displacement because while they are very long-term, they are also low-intensity. Home care's perception of their mission has changed dramatically from preventing hospitalization and preventing acute exacerbation to discharging people as quickly as possible.

Agencies appear to be applying eligibility standards in a manner to exclude patients rather than to include them, bending over backwards to exclude them from Medicare rather than bending over backwards to qualify them for Medicare. And a lot more patients are paying 100 percent out of pocket for services they previously received in Medicare as a result.

The findings are listed in my testimony, and I am going to quickly flip to some myths and implications. One of the myths that I think is important to dispel is that these patients cannot go right into Medicaid and receive Medicaid services. The functional and financial qualification standards are very stringent, and even dually-eligible beneficiaries frequently do not qualify for these programs.

For the home and community-based waiver programs, they do not often provide skilled services, and their limited services are provided on a queued basis, so that patients do not make a straight walk from Medicare home care into Medicaid services.

The implications of this are profound, looking at the big picture. Among the study agencies, the number of Medicare beneficiaries in home care has declined 20 percent since 1997, but the number of Medicare beneficiaries since 1994 has expanded by 2 million beneficiaries. Those numbers alone should tell us that something is seriously wrong here.

My main concern is that we are carving out a wedge of people who are chronically ill and have intensive service needs services who are not going to have a reliable source of care in any sector. They are becoming the health care system's untouchables.

The other important consideration is that it should be clearly understood that many of the sickest patients may already be out of the system, and therefore, any PPS system which is based on the utilization data from 1998, I think, would be seriously flawed because I believe that that utilization data will not adequately express the needs of the population.

I'll stop there and take questions. I appreciate your time and consideration.

Senator COLLINS. Thank you very much, Ms. Smith.

We now will start a 10-minute round of questions, but I want to start by thanking you all very much for your very insightful and illuminating testimony.

As I mentioned in my opening statement, my primary concern is to evaluate what impact the changes in the payment system and in the regulatory system are having on our most vulnerable senior citizens. In that regard, your testimony is very interesting because it seems to contrast greatly with the testimony that we are going to hear later this afternoon from HCFA.

I want to read you three statements from the written testimony that is going to be presented by HCFA later today.

The first statement is: "We are diligently monitoring the impact of these changes and thus far do not have evidence that access to care has been compromised."

The second statement is: "Again, we have not seen objective evidence that closures have affected access."

And the third statement is: "We to date do not have objective evidence that beneficiary access to care has been compromised."

In other words, three times in the testimony, HCFA officials are maintaining that our seniors are not experiencing any problems getting access to home care. That does not seem to be what I am hearing from any of you, nor is it what I am hearing from my home health agencies throughout the State of Maine.

So to set the record straight on that issue, since you are out there on the front lines, I would like to hear your reaction to the three statements that I have just read, and I will start with Ms. Arsenault.

Ms. ARSENAULT. From where my agency sits providing care, we are basically one of the only organizations providing care in a very large geographic area, and I would have to say that we do admit patients if we find them to be eligible, but interpretations have become much more stringent. So today, we are admitting fewer patients because we are willing to take the risk. We have already been under 50 percent review by Medicare. So whereas a year ago, we would have said yes, let us admit this patient; we believe we can fight and win, today we know that we cannot win, so we are indeed seeing patients with access problems.

Senator COLLINS. So you would disagree with HCFA officials, and you believe that care and access have already been compromised. Would it be fair to say that you believe it will become worse if, for example, the 15 percent payment cut goes into effect?

Ms. ARSENAULT. If the 15 percent payment cut goes into effect, it will definitely get worse.

Senator COLLINS. Ms. Suther.

Ms. SUTHER. In the area that I serve, access has been impaired in several ways. Many agencies in our area, rural and urban, have closed. It is not the agencies that have caused the access as much as other things. Base year, we provided over 450,000 visits for Medicare clients. This year, we will provide under 200,000 visits at a time when other agencies are closing.

The difference is that the patients we serve are getting and receiving care. We are not turning anyone away. Our agency has used donations to offset our losses and has subsidized the Medicare program, and even though Dallas and its surrounding counties are a very generous community, they said enough is enough, that they cannot continue to do this.

So I do not know what we are going to do after this year. We are having to cut back on specialty care. For instance, we had seven enterostomal therapists who take care of very severe wound care patients, and it has been our experience that a wound care specialist can treat a patient for a shorter period of time, get out of the home, and the patient will have the same results as having a generalist treat the patient for a longer period of time. But we cannot do that under IPS because the per-visit limit is exceeded. We are over the per-visit limit, but we are \$3 million under the per-beneficiary limit, but we cannot use our judgment in using a specialist—we have to use generalists in order to get reimbursed. So patients are not getting the best care.

There are many agencies in our area that are asking us to see their long-term patients, and we are admitting them because we had a very low utilization rate before, and the way the formula is, we got a little piece of the State rate which had a high beneficiary limit, so therefore we can admit some of their patients.

But this is all going to go away, and in fact, our board of trustees met yesterday, and if there is a 15 percent cut, we will probably go out of business—and we have been doing this for 65 years.

Senator COLLINS. I think you have raised a very important point, because I am hearing from home health care agencies in my State, as well, that are turning to private fundraising to subsidize Medicare. Prior to that, the fundraising efforts were used to provide non-Medicare service to elderly people, but now we have a situation where private fundraising is being used to make up the deficit because of the problems with the regulatory rates and with the cost of regulation. So I think that is a good point.

Ms. SUTHER. One more remark. I don't know the specifics of this case, but I believe there was a case in North Carolina in which HCFA even said they would pay for the care, but they could not find an agency that would provide it. And I cannot give the specifics, but I will get the specifics for you, because the patient was such a high utilizer.

Senator COLLINS. Ms. Stock.

Ms. STOCK. I see the access issue in three areas that I know of in our State, and I think we are just at the tip of the iceberg, Senator, because the majority of the State is on the December 31 year-end for their cost reporting period and are just finishing their cost reports now, and when they see their bottom lines, they will be closing their doors in much, much higher numbers than we saw before.

But I see access being affected in three ways. There are patients who are not being admitted to care. We are seeing that, and we can validate that with case managers at hospitals. There are also patients who are being discharged earlier and end up rehospitalized, end up in the emergency room, end up going to a nursing home.

The third thing we are seeing is underutilization. We are skimping on the visits so much that patients are having to subsidize that with their own funds or private community resources to pay for services that they are entitled to by the Medicare benefit.

Senator COLLINS. Ms. Smith?

Ms. SMITH. I think the evidence that contradicts that first and foremost is the fact that we have seen a negative growth rate of

15 percent in the claims in this industry. You really do not need to know anything else to know that you probably have an access problem when you see negative growth of 15 percent in 1 year. It is unprecedented in recent health care history.

The other evidence of course would come from the fact that agencies are overtly screening patients and admit to very early discharge of patients whom they would previously keep, describing this as discharging them at the first signs of stabilization, often precipitating readmissions to hospitals, readmissions to emergency rooms, and also applying these eligibility standards quite strictly.

I think also the number of people who need skilled care and are being discharged into basically nonskilled environments would also tell you that there is a significant access problem.

Senator COLLINS. Ms. Smith, I want to follow up on that point, because in your written testimony you mentioned that diabetics, particularly brittle diabetics, appear to be experiencing considerable displacement from home care.

Ms. SMITH. Right.

Senator COLLINS. What do you think is happening to those patients? One of the issues here is that home care is a much more cost-effective way to care for people than hospitalization or nursing home care.

Do you think that a lot of these people are going to get sicker because of the lack of home care and will end up having to be admitted into hospitals or nursing homes, ironically, costing the Medicare system far more than if we had cared for them adequately through the home care system?

Ms. SMITH. The short answer is that we do not know where these people are. I said to one person that if I were going to put this testimony to music, it would be, "Where Have All the Diabetics Gone?"

My suspicion is that what we are seeing is much more fragmentation of care, that they are basically bouncing between different types of health care providers and experiencing more periods of deterioration between getting care from those different types of health care providers.

Senator COLLINS. Is there any tracking of patients who have been discharged from the system?

Ms. SMITH. I am not aware of any tracking, and I know that the GAO study specifically did not track specific patients.

Senator COLLINS. My concern, for example, is the two 85-year-old women who have been receiving services in Maine. What is going to happen to them? It seems to me that they are at risk of getting sicker, of being hospitalized. It is just of tremendous concern to me.

I want to ask one final question on this round about the OASIS issue. Ms. Arsenault, I am going to direct this to you. In HCFA's prepared testimony, they state that once providers learn to use OASIS, it actually "slightly reduces the total time it takes to conduct and document a thorough patient assessment." In your testimony, however, you state that OASIS has actually increased your agency's per-visit nursing cost by, I believe, an additional \$7. Is that correct?

Ms. ARSENAULT. That is correct.

Senator COLLINS. That seems inconsistent with HCFA's statement that OASIS actually saves time—and maybe I will quickly go across the three home health agency representatives that we have here. Time is obviously money. You have actually quantified it in your agency. Do you disagree with HCFA's assessment?

Ms. ARSENAULT. I disagree with the fact that it will take us less time to do an assessment with—and I can never remember if it is 92 or 102 extra data elements. But we already have an assessment, and we added data elements to that assessment. Some of them were the same questions, but most of them were not. No, I do not agree with that at all.

As an example, for our organization, on the first visit, which is the visit when we admit a patient, we have always done an assessment and we begin our teaching. When patients began to fall asleep, we had to divide that and do the assessment on visit one and the teaching on visit two.

Senator COLLINS. Very quickly, because my time has expired—Ms. Suther, do you agree with HCFA that once you get used to the system, it is going to actually save you money?

Ms. SUTHER. I do not know what they mean by getting used to it. We were a test agency, and we were involved in the research on this, and we have been completing it for a long time, and time required has never decreased beyond about 10 minutes.

Senator COLLINS. Ms. Stock.

Ms. STOCK. The only other thing I would like to add is that since you have to do it so many times in the intervention with the patient, it adds enormous volume. You cannot add 79 questions and not take more time.

Senator COLLINS. Thank you very much. Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

Ms. Stock, you said in response to the question about access being reduced, that you can demonstrate through experience that patients are not getting the benefits that they are entitled to under the Medicare system, that you can actually demonstrate that to HCFA. Are you saying that Medicare is refusing to pay for benefits that are rightfully covered by Medicare, or are you saying that even though Medicare will pay, nobody is willing to provide the service—or both?

Ms. STOCK. The latter, Senator. I think what we are saying is that we are more than willing to do what we have commissioned ourselves over the years to do. We cannot afford to do it for the money that we are being paid. We cannot offer the services. We cannot admit a patient unless we have adequate resources to provide that care, so that is deterring us from accepting or continuing needed care that is covered by Medicare.

Senator LEVIN. Each of you, in response to the Chairman's question, indicated that access is indeed being impaired by the recent Balanced Budget Amendment changes, and the regulatory changes. The General Accounting Office and HCFA have said that the opposite has occurred. The headline of the GAO report is: "Closures Continue with Little Evidence Beneficiary Access is Impaired."

Some of their findings are, for instance, that "The decline in visits per user between 1996 and 1998 is consistent with IPS incentives and does not necessarily imply a beneficiary access problem."

And then, a few lines later, they say that “Certain patterns are consistent with the IPS incentives to constrain the costs of care for each beneficiary but not necessarily the number of users.”

There seems to be a real gap between your experience in the real world and what HCFA interprets is going on or what the GAO is interpreting is going on, because I have no doubt that you know what is going on. These studies are fine, and they are useful, but they have certain limits, and one of the limits is that if folks who are out there delivering services have a real world experience that is as yours has been, and where we have people who are entitled to benefits and need benefits and we want to have benefits for human reasons as well as for financial reasons so we can save the costs of having them in the hospital or in a nursing home, that we are not somehow or other connecting your experience with HCFA’s, or with the GAO for that matter.

What is your experience in dealing with HCFA? Why is there this apparent gap between what they see and transmit to us and what you know and transmit to us?

Ms. Arsenault, maybe we could start with you.

Ms. ARSENAULT. It is my understanding that the particular study that you are referring to was done early on when IPS was first implemented. I think a lot of what we are telling you today is the experience that we have out in the field in our home States, and I think it is too early to truly quantify in a study format what the two effects are going to be.

Senator LEVIN. It is more than “are going to be”; it is “already have been.” That is my point.

Ms. ARSENAULT. You cannot study only the first 3 months of IPS and project for the future or even know truly what is going on right now.

We have a lot of experience with studies coming out that either used false methodology or concentrated in areas—for example, the fraud and abuse study, I think it was the GAO. They concentrated their assessment in a number of States that were known to have fraudulent providers and then extrapolated that to the entire Nation.

Senator LEVIN. Ms. Suther.

Ms. SUTHER. I think she is on the right track. I think it is that we are talking in real time, and the study was done right at the beginning of IPS. It was January 1, 1998, before you even knew what your cost caps were going to be, even though it was implemented October 1, 1997.

Second, providers did not know what their per-beneficiary caps were. HCFA was not even directed that they had to do it before April 1. Many people were already into that year. And then, many agencies did not get their per-beneficiary limits for over a year after they were on IPS, so they did not know where they stood during that time period, and they are just now finding out where they stand, and they are just now beginning to turn patients way. I think there is a definite access problem, and all you have to do is be in the churches and the clubs and the community to see exactly what that access problem is. People who really need it are not being served.

Senator LEVIN. And if you invited HCFA to come out and sit with you for a day and talk to people who are providing services, would their response be positive? Would they come out and sit with you and join you in the real world or not?

Ms. SUTHER. I do not know, but I would love for them to come. We have a State senator who has been out doing visits because he is very concerned about this, and he looked at patients who were high-utilization patients to see what would happen to them over time, he has been following these patients over time, and we have been documenting for him the amount of care we are giving beyond what normally we could afford if we were not being subsidized by the community.

Senator LEVIN. Thank you. Ms. Stock.

Ms. STOCK. Senator, your question regarding HCFA's willingness to work with the industry is really tantamount to the heart of the issue. They have waived the requirements for comment periods on some of these mandates. They have also underestimated the costs, especially of OASIS, and also, the Paperwork Reduction Act issues.

They have had some meetings with us, Senator, but I do not think it is a two-way communication, and we have been working on PPS either through the work group or our State and national associations since 1993, always willing to give our input—you know how talkative we are—but it is not always a two-way conversation. We would be glad to fix the problems. We think there are some solutions.

Senator LEVIN. For instance, Ms. Suther gave us the statistic that one-third of the people, as I wrote it down, after they are discharged from home health care are going to nursing homes within a matter of days, I think you said.

Ms. SUTHER. This was a specific instance with venipuncture alone, and this is in one county in which we discharged the patients who no longer qualified for service because venipuncture was the sole qualifying service, and we discharged those patients specifically directly into nursing homes. That is not the case in every county, and that is not the case with all discharges from home care.

Senator LEVIN. In that specific case, we surely lost a lot of money, I assume.

Ms. SUTHER. Right.

Senator LEVIN. Ms. Stock, let me ask you a question about the regional disparities that exist here. In your prepared testimony, and I think in your oral testimony as well, you indicated that your agency's per-beneficiary limit was \$2,531 for 1998, which is more than \$1,000 below the national average of \$3,987. The agency limits are based on 1994 cost reports, so I have two parts to my question.

How did you keep costs low in 1994, because that now is causing you a big loss; and how much have your actual costs increased since 1994? Basically, are you being punished for being efficient in 1994, and if so, how did you do it in 1994, and what has gone on since then?

Ms. STOCK. Am I taking it personally? Yes. Because we have been involved in the PPS project since 1993, we have been planning for managed care, planning for PPS, and trying to limit our

cost. It was intentional to be below the cost limits all along. We did not max our caps as some of the people in the industry went to seminars about, and I think very few providers try to do that.

Actually, what we try to do is use good resources. We are business people, and we are trying to provide good care. What has happened since that reduction is that our resources are limited, and we now have less than we had in 1994. We are treating more highly technical patients than we did in 1994. We are seeing more early discharges from the hospitals, and those patients are intense and complex. The diabetics are an issue for us, wound care is an issue for us. So a lot of creative and really dedicated people have tried to cut what we really need.

Senator LEVIN. But those who limited costs in effect really worked at it back in 1994 compared to those who did not, as you put it, maximize their caps in 1994. The ones who were careful to limit their costs are now in effect being punished for that. Is that accurate?

Ms. STOCK. That is correct, and eventually, we will be out of business. If we do not have relief, we will not survive to the year 2000.

Senator LEVIN. And does HCFA understand, then, the negative incentive that that created, in effect, the reward for inefficiency or lack of constraints back in 1994? Is that something you have raised with HCFA, and if so, what is their response?

Ms. STOCK. I believe the issue has been raised. I do not know the conscience of HCFA about their response to that, but I would say that they think that because we are going to PPS, this is a temporary solution, but some of us will not make it to PPS.

Senator LEVIN. I am reminded that that is a statutory matter, but if they agreed with you, HCFA could of course, make a recommendation to us for a statutory change.

Ms. STOCK. For which we would have been grateful.

Senator LEVIN. My time is up. Thank you.

Senator COLLINS. Thank you, Senator Levin.

Senator Edwards, welcome. We are glad to have you with us.

#### OPENING STATEMENT OF SENATOR EDWARDS

Senator EDWARDS. Thank you, Madam Chairman. I am glad to be here.

Ms. Stock, if I could just follow up on that last question, and then I have some general questions I want to ask. If I understand this correctly—and I have talked with a lot of folks about it—the bottom line is if you were efficient in 1994, you are punished for that now—this is what Senator Levin just asked about. If you were inefficient, you are rewarded for it. Isn't that the bottom line?

Ms. STOCK. That is, as long as you make the distinction, Senator, that many agencies that had high costs per patient were treating a very complex population or were in rural areas where their expenses were higher. But yes, there were people who got more money.

Senator EDWARDS. And that is the point Ms. Smith was making when she said low cost does not indicate efficiency. It depends on your patient.

Ms. STOCK. Right. Efficiency is efficiency. It may be high or low cost.

Senator EDWARDS. I have three concerns, and I will address questions to a number of you. One is my concern about unnecessary and inefficient bureaucracy, and I have this OASIS questionnaire in front of me right now which I want to ask you some questions about.

The second is loss of service—people who do not have access to home health care and so desperately need it, particularly diabetic patients, as Ms. Smith keeps making reference to.

The third thing—and Senator Collins made reference to this—is when we are trying to be efficient in the spending of our Medicare dollars, which I think all of us are concerned about whether we are doing that or not, and particularly whether we are doing it when often prevention is in the long term the lowest-cost thing we can do, and home health care is the most efficient means of prevention.

I presume most of you would agree with that; is that true?

[Panel members nodding.]

Senator EDWARDS. OK. Let me start with this OASIS form and ask a simple question first—and maybe this is too simple, but I feel like I need to establish it.

Ms. SUTHER, I will start with you. Do you all need to fill out this big, long form in order to treat the patient?

Ms. SUTHER. That is just part of it. That is the OASIS part. But there are other questions—

Senator EDWARDS. Oh, there is more to it than this?

Ms. SUTHER. There are other questions and information that must be collected in addition to that, plus information that you must share on advance directives and all sorts of other things with patients.

No, you do not need all the information. Yes, we do need a data set that collects information that is relative to cost and can predict cost, but we do not need all of that information. That questionnaire had to be integrated into your regular assessment methodology, and that is what I was referring to when I said 45 additional pages, because 17 were on admission, and then there was readmission, and when I looked at the length of time in the program for the average patient, the average number of times that one had to complete that set, that is where I came up with the 45. And in our agency, that equates to over \$1 per visit. The larger the agency, the less it costs per visit to do it because of the start-up costs in the first year.

Senator EDWARDS. I understand.

Ms. Stock, did I understand you to say that big notebook that you have in front of you is all of the manual, or is there more to it than that?

Ms. STOCK. Our agency has three manuals, 512 pages, and this is just the instructions. But HCFA did allow us \$170 per patient to in-service our staff on it, so reading it would not cover \$170.

Senator EDWARDS. I presume all three of you would agree that all this information that you are gathering for purposes of OASIS is not all medically necessary for the treatment of your patients; is that true?

Ms. STOCK. That is correct.

Senator EDWARDS. Now let me ask you a different question. Looking through this form, I see some things—for example, there is a question about life expectancy. Is life expectancy generally considered a medical diagnosis, and is that something that nurses are normally trained to offer medical opinions about? Any of you can answer that.

Ms. ARSENAULT. That would be a question if someone had a terminal illness, and we were looking at them for hospice benefits, but not for normal treatment.

Senator EDWARDS. How about you, Ms. Suther?

Ms SUTHER. I do not have any nurses who are actuaries, nor do any of them pretend to be. [Laughter.]

Senator EDWARDS. That is what I thought. Ms. Stock.

Ms. STOCK. We are often accused of practicing medicine without a license when we make recommendations to physicians, but that is not one I would make.

Senator EDWARDS. In reading through some of these questions and forms and knowing less than you do, but knowing the real world and some of the concerns that I have had expressed to me by people in North Carolina—what do you do when patients either cannot or will not answer these questions? And I guess I will ask you a very practical question, do you find that sometimes your caregiver is put in the position of trying to figure out the answer themselves, even though they cannot get the patient to respond directly?

Ms. ARSENAULT. No. We would document that the patient refused to answer the question.

Senator EDWARDS. Do you know whether that occurs, Ms. Arsenault, what I just described?

Ms. ARSENAULT. It does occur. I could not give you any data on that, though.

Senator EDWARDS. Ms. Suther, how about you?

Ms. SUTHER. I think it probably does occur. Our staff has been instructed that if patients refuse to answer the information, they must document that, and that if they do not document that and attempt to fill in the blanks, they will be fired on the spot, and we will turn them in to the Board of Nursing.

Senator EDWARDS. Ms. Stock.

Ms. STOCK. I think the instructions say that you can answer some questions by observation, but I would hesitate to have my staff do that if they can get direct information from the patient.

Senator EDWARDS. I am told that when HCFA did their study and demonstration on the answers to these questions on the OASIS form, they had folks out in the field with a laptop computer in place, answering the questions. Would I be correct in presuming that you all are not able to send out laptop computers with all of your health care providers when they go out to see their patients?

Ms. Stock.

Ms. STOCK. I cannot afford that.

Senator EDWARDS. How about you, Ms. Arsenault?

Ms. ARSENAULT. We cannot afford to implement laptop computers.

Senator EDWARDS. Ms. Suther.

Ms. SUTHER. We do not have laptop computers. However, I had not heard that HCFA was doing that. I know some agencies do have laptop computers and do complete the forms that way, but I had not heard that HCFA had done that.

Senator EDWARDS. I do not know whether it is accurate or not; it is just some information that I had.

Let me go to another question, and Ms. Smith, this is an issue which is of tremendous concern to me, and I wish I could find the quote. You said that the home health care industry's perception of its mission has changed so that it is now discharging people as quickly as possible.

Ms. SMITH. Right.

Senator EDWARDS. That is of tremendous concern to me, particularly if they are discharging folks who need ongoing home health care. I wish you would elaborate on that.

Ms. SMITH. Part of the study that we conducted—in addition to the survey, we do about an hour and a half telephone interview with the agencies—and they indicated that they no longer consider it part of their mission to provide preventive care or try to keep the patient out of the hospital; that their job is now an immediate, short-term perspective which is to stabilize for the condition at hand for which they were admitted at that moment, and then to get out.

So I would describe the mission as one of getting patients out of home care as quickly as possible, as opposed to keeping them out of other sources of care.

Senator EDWARDS. Ms. Stock, is that healthy?

Ms. STOCK. It is not healthy, but one more thing that impacts on that which we did not address in our testimony is that each patient is only counted once a year in aggregate, and if they are admitted 25 times a year, you still have to provide service.

So to your issue, we close them if we can as precipitously as we can that is safe, so the next time they come that year, we have some resources to use for them on the aggregate. HCFA will say that that is not true for each patient, but you do have to take that into consideration when you are admitting a patient—if they are chronically unstable, they will be with you many times.

Ms. SMITH. If I could just respond to that.

Senator EDWARDS. Absolutely.

Ms. SMITH. A couple of agencies have indicated that one of the things that they are doing in marketing for their referrals is to try to figure out a way to avoid readmission of patients to home care because they regard readmission as a marker, obviously, for more complex patients. So they are trying to direct their marketing to referring providers in a way that avoids their getting patients back.

Senator EDWARDS. Let me ask this question—and I presume I know the answer to this question. It sounds like all of you believe that there are people who do not have access to home health care now who need it. Is that a fair statement?

[Panel members nodding.]

Senator EDWARDS. And I also presume that if this 15 percent cut goes into effect in the fall, that would be dramatically increased; is that a fair statement?

Ms. SMITH. I think so, unquestionably.

Senator EDWARDS. Ms. Stock.

Ms. STOCK. No question.

Senator EDWARDS. And Ms. Suther?

Ms. SUTHER. No question.

Senator EDWARDS. Ms. Arsenault, do you agree with that also?

Ms. ARSENAULT. I do.

Senator EDWARDS. And finally, if I can ask a general question for each one of you to comment on, if I could get you to talk from your perspective about knowing that one of our responsibilities is to be efficient with taxpayer money and making sure that these Medicare dollars are being spent in the best way they can be, from your perspective, the way the system operates now and particularly if folks are not getting the kind of home health care that they need, how that impacts the long-term Medicare/health care costs associated with that patient—i.e., how can we most efficiently spend our Medicare health dollars?

Ms. Smith, I want to start with you.

Ms. SMITH. I think the risk of creating greatly exacerbated costs in other sectors, particularly hospitals and skilled nursing facilities, is substantial. I would also point out that the Federal Government pays a very large share of Medicaid costs as well. So I think the attempted—and I think largely unsuccessful—cost-shift to Medicaid will have a similar effect.

The other point I would like to make is that one of Medicare's missions is to assure a reliable source of care to sick people. If we are not doing that, then it seems to me we have failed in our essential mission.

Senator EDWARDS. Thank you. Ms. Stock.

Ms. STOCK. I think I would limit it to two suggestions—first, to try to direct HCFA to limit the scope of their regulations for your mandates to your intent; and second, to include providers in the development and implementation phases of those requirements to preclude some of the problems that we have seen, and then they got suspended, and we all paid the money.

Senator EDWARDS. Those are very good suggestions. Ms. Suther.

Ms. SUTHER. I have 35 years' experience in home care, and I feel like I know a little about this. I think there is a short-term solution, and that is to make some corrections in the IPS. And then I think there is a long-term solution, and that is to make certain that PPS is properly done. Thus far, the providers have not had an opportunity to look at the provisions for implementing PPS to assure that appropriate information for making the decisions as to what the cost therefore reimbursement should be for the future.

Senator EDWARDS. Thank you. Ms. Arsenault.

Ms. ARSENAULT. I would say that it is foolish to skimp on home care. It is very foolish to eliminate seeing an 85-year-old woman one time a week to manage her medications. That individual's health will deteriorate, and we have talked a lot about inpatient care, but none of us talked about how many times that 85-year-old woman will see someone in an emergency room—probably more frequently than the inpatient admissions. And we all know that emergency room care is very, very expensive.

The accelerated rate that regulations are coming forward from HCFA has placed tremendous burdens on home health agencies.

We could reduce the number of regulations, and we have all talked about them. Regulations come forward, then are suspended. This 15-minute increment—we have not even received regulations, and we have to implement that on July 1. We are working in a crazy world. Home health care can be very cost-effective and can save the Nation tremendous amounts of money.

Senator EDWARDS. I see my time is up. Let me just say that you all being willing to come here and tell us these stories is critically important so that the country and the Congress can hear what basically all of us have been hearing back home when we move across our States and talk to folks. What you have said today is completely consistent with what I have been hearing from people who are on the front line back in North Carolina. So I thank you very much for taking the time to be here.

Thank you, Madam Chairman.

Senator COLLINS. Thank you, Senator Edwards.

I want to thank the panel also for your very valuable testimony. Both your written and your oral testimony it seems to me have suggested three very important issues for us to pursue.

The first is the issue of the impact on our senior citizens, and the evidence you have given us suggests that Medicare beneficiaries with chronic conditions—those most in need of care—are going to be most hurt by this system, that they are already starting to feel the impact, and that is only going to get worse unless the administration and Congress step in and rectify the situation.

Second, the current IPS system is clearly unfair to those historically low-cost agencies. In Maine, I am particularly sensitive to this issue because 85 percent of our home health agencies in Maine are below the national medium costs. So we have been hit very hard, and as with Ms. Stock's agency, and I am sure Ms. Suther's as well, we are penalizing those agencies which have been most prudent in their use of Medicare resources, so the system is truly perverse when that is the result.

And third, it seems to me that we have a state of regulatory chaos at HCFA. Ms. Arsenault in her written testimony described a system of "implement and suspend," a costly system where regulations are implemented by agencies, and the costs are somehow taken care of, only to be suspended later when the problems become evident. I think part of the reason for that is HCFA's failure to fully consult with the industry in developing these regulations.

Those are three issues that I have taken from your testimony today, and I want to thank you very much for sharing your direct, front-line experience with us. And Ms. Smith, thank you again for sharing the preliminary results of your study. We hope that you will share your final findings with us as well.

Ms. SMITH. I look forward to that. Thank you, Senator.

Senator COLLINS. Thank you very much.

I would like to call up our second panel of witnesses this afternoon. Representing the Health Care Financing Administration are Kathleen A. Buto, who is deputy director of the Center for Health Plans and Providers, and Mary R. Vienna, the director of the Clinical Standards Group.

I look forward to your testimony and your recommendations on how we can solve some of the problems that we have just heard

described. Before you get too comfortable, I am going to ask that you stand, since I do need to swear you in.

Do you swear that the testimony that you are about to give to the Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Ms. BUTO. I do.

Ms. VIENNA. I do.

Senator COLLINS. Thank you.

As you know, I had asked the previous witnesses to limit their testimony to 5 minutes, but I am going to give you additional time since a lot of issues have been raised. I would ask, Ms. Buto, that you limit your oral testimony to no more than 15 minutes—we are giving you three times as much—and we will be using the timing system, which I believe you are familiar with.

It is my understanding, Ms. Buto, that you are going to be presenting the testimony, and that Ms. Vienna is available for questions but will not be presenting a formal statement. Is that correct?

Ms. BUTO. That is correct.

Senator COLLINS. Please proceed.

**TESTIMONY OF KATHLEEN A. BUTO,<sup>1</sup> DEPUTY DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY MARY R. VIENNA, DIRECTOR, CLINICAL STANDARDS GROUP, HEALTH CARE FINANCING ADMINISTRATION**

Ms. BUTO. Thank you. I hope I can complete my oral statement in less than 15 minutes so we can get to the questions, because I sense that there are a lot of questions waiting to be asked.

Chairperson Collins, Senator Levin, and distinguished Subcommittee Members who have asked a number of questions that I hope we will get a chance to respond to, thank you for inviting us to discuss the impact of home health care payment reforms. I am accompanied this afternoon by Mary Vienna, from our Office of Clinical Standards and Quality. She is both a registered nurse and an expert in the new OASIS home health patient assessment system which will help us to improve the quality of care and pay for it accurately.

Home health is an essential benefit for millions of beneficiaries. Unfortunately, as you have already pointed out, Madam Chairperson, the expenditures have been growing at an unsustainable rate, and several studies have documented widespread fraud, abuse and waste.

Between 1990 and 1997 when the Balanced Budget Act was enacted, the number of beneficiaries receiving home care doubled from 2 to 4 million while expenditures more than tripled, from \$4.7 billion to \$17.8 billion. This is something that you have already pointed out.

The Balanced Budget Act addressed these concerns by closing loopholes, raising standards and creating incentives to deliver care efficiently. The payment reforms require agencies to change past behavior and eliminate unnecessary and uncovered services. The

<sup>1</sup>The prepared statement of Ms. Buto appears in the Appendix on page 148.

incentive to supply virtually unlimited visits is gone. This should not mean that care is compromised for any patient.

Home health spending is down for other reasons as well. Home health is one of the initial targets in our aggressive and highly successful fight against fraud, waste and abuse, and these efforts have had an enormous impact. We have focused on reducing erroneous Medicare payments and bringing down the error rate in this area of home health spending.

Also, some apparent home health savings are temporary effects of slower claims processing. A September 1998 CBO report concludes that program integrity efforts, demographic changes, lower than expected inflation and other factors, not related to the BBA, account for the difference between savings projections when the BBA was enacted and the total spending since then.

I understand that in testimony this morning before the Senate Finance Committee, the Congressional Budget Office projected annual increases of 7½ percent for home health agencies once the new prospective payment system is implemented on October 1, 2000. There has been an expected market correction in the total number of home health agencies serving Medicare, along with an increase in mergers among agencies. Most closures were in areas that had the sharpest growth in the number of providers and many areas where there were questionable billings before the Balanced Budget Act.

Importantly, monitoring by us and by the General Accounting Office has not found that beneficiary access to care has been compromised, and I would also say, just to correct an impression, that the GAO report actually goes up through the beginning of 1999, so it covers most of 1998. It was not just the first couple of months of 1998.

We are continuing to proactively monitor the BBA's impact on access. We have instructed our regional offices to gather extensive information. We are tracking the Bureau of Labor Statistics data on home health employment trends, and the Inspector General of the Department of HHS will survey hospital discharge planners to determine whether there are problems in finding home health placements.

Last year, Congress raised the limits on costs somewhat in an effort to help agencies, and we are on a schedule to implement the prospective payment system in October 2000. But given the magnitude of the changes, it is understandable that concerns remain.

We are committed to giving providers as much flexibility as our authority and responsibility allow. We are giving agencies up to a year to repay overpayments resulting from the interim payment system, interest-free. We have limited pre-payment medical reviews where appropriate, and we are ending a sequential billing policy which had raised cash flow concerns for some agencies. This is the policy, by the way, that was necessitated by the A/B shift in home health spending so that we could account for some of the BBA changes in home health.

At the same time, we are implementing the Outcome and Assessment Information Set, now known as OASIS. We are required by law to monitor the quality of home care with a "standardized, reproducible assessment instrument." OASIS will help home health

agencies determine what patients need. It will help improve the quality of care, and it is essential for accurate payment under prospective payment. Our entire payment system for PPS is really built on the OASIS system.

We are committed to continuing our efforts to monitor access to care and to taking administrative steps to help agencies adjust to the BBA reforms and other changes.

We appreciate this Subcommittee's attention to the issue, and we look forward to continuing to work with you to ensure that beneficiaries who qualify for Medicare's home care benefit receive efficient, high-quality care.

I will stop there and take questions.

Senator COLLINS. Thank you very much for your testimony.

I want to start by actually commending, believe it or not, HCFA on its increased efforts to combat fraud in the Medicare program, particularly in the home health care area. As you are well aware, this Subcommittee has held several hearings on fraud in the Medicare program, and indeed next week, Senator Durbin and I are going to be introducing legislation that comes from the hearings we held last year on this area.

I mention this because I think it is very important as we talk about this to distinguish between legitimate efforts to squeeze fraud, waste and abuse out of the program versus regulations and cutbacks that have the result of impeding the delivery of necessary services to our elderly by completely honest providers. And we know that the vast majority of health care providers in this country are honest and ethical and committed to serving the needs of their patients.

In your written testimony, you said that a lot of the regulations that you have implemented come from the fraud effort, but unfortunately in the attempt, perhaps, to crack down on inappropriate payments, I think you have implemented regulations that are doing what none of us wants—which is making it very difficult for home health care agencies to deliver services and driving up their costs in complying with regulations at the very time that their reimbursement levels are being curtailed.

One of the ways that could have been avoided is through more consultation with the industry. We have heard the example of numerous regulations that have been implemented and then suspended, creating, as I said, an environment of regulatory chaos.

Why didn't HCFA spend more time consulting with the industry on how to do this job more effectively?

Ms. BUTO. Well, it is hard—and I do not want to sound defensive about this—but if you think back to the Balanced Budget Act, it was really enacted in August 1997. The interim payment system actually went into effect in October 1997, even though we were not required to issue regulations until January for the per-visit limits and then April for the per-beneficiary limits. The law actually did some things that we were not prepared for, to be quite honest.

For example, it is very prescriptive about the blend in the per-beneficiary cap between the per-agency amounts back to 1994, and with the regional amount. We did not have regional amounts. We had to gather the data and move very quickly in that respect.

I can only say, having been at HCFA for a long time and working on most of the major changes in statute over the years, that the Balanced Budget Act presented the greatest challenge we have ever had to face, and particularly in home health, we had a very short turnaround time between August and April to get a lot of the rules written. And a lot of it was driven by a formula that said you had to come up with the 75 percent agency-specific and then 25 percent regional aggregate per beneficiary limit. We had to gather the data and synthesize it.

On things like the home health agency bond issue, again a statutory requirement, there was a lot of pressure coming from the Operation Restore Trust effort to get a bond requirement out there. And I agree with you that it would have been better to take more time. We certainly recognize that now. The administrator, Nancy-Ann Min DeParle, asked us to suspend that rule and meet with the industry to talk about the very issues you are suggesting.

There are some things that we definitely could have done better in that regard, but I have to say that the time frames for implementation for the IPS were extremely short for the complexity involved.

Senator COLLINS. My response to that would be that HCFA was very involved in all those negotiations during the Balanced Budget Act. Many of the provisions that were in there came directly from HCFA.

Ms. BUTO. But not the biggest data gathering exercise, which is the regional blend. We did not have a data base, and we had to create that by pulling in the data. That was something that was added as part of the conference discussion and was not part of our proposal.

Senator COLLINS. It is also HCFA's obligation to come back to us in Congress if you think something is not working. I have had a lot of conversations with Nancy-Ann Min DeParle about the problems with the formula penalizing the historically cost-efficient agencies, which just seems like such a reverse of what it should be doing.

I have talked with Secretary Shalala about it, I have yet to see a concrete plan from the administration on how to solve this problem. When might we receive the recommendations from you?

Ms. BUTO. Let me first address your concern and then talk about how we get from here to there.

I think the concern comes from the fact that as in so many areas of Medicare, and it is also true in managed care, we have such variation in the spending patterns and utilization patterns around the country. I think the tough thing for Congress certainly in devising the formula for an interim system was do you take down, if you will, or try to average the utilization and the caps across the country, or do you try to keep people more or less where they are, with some reductions, which is what was happening, realizing that is going to have some inequities of its own. And I think that it is always a difficult thing when you also know that you are going to try to move to something else.

It is hard to justify those kinds of issues when you have very conservative agencies that feel they have been especially penalized. But the alternative would have been to either spend a lot of money

to bring them up to the national average or to bring down agencies around the country where the spending was higher. We sensed, and it was certainly discussed, there was not a willingness to do that. So that was very hard. I do not think it is easy to justify, but that is the way the formula works.

What we obviously want to do is move to a formula that will reward agencies for the complexities of the individuals they actually see, so that they begin to get payment appropriately for higher-risk, higher-acuity patients. That is really what we need to move to, and again, we were going to do that by October 2000 for a lot of folks. That is some way away, and we realize that.

Senator COLLINS. We have heard very strong testimony today that those patients that you have just described, those with chronic conditions, with complex cases, who are most in need of quality home care, are being most affected by the problems in the current system. And that recommendation, or that finding, rather, is consistent across the board. GAO says that they are most at risk. Ms. Smith's findings are that they are most at risk. The recent MedPAC report expresses concern that the Medicare patients who are sicker and more expensive to care for are going to have the most difficulty. Every one of our witnesses agrees that that is the case.

What is HCFA going to do about that? Are you going to develop some sort of system for outliers for the expensive cases—because we have heard very clearly today, and it is a unanimous finding, that if we do not take care of those expensive cases and in some way develop a system for recognizing them, home health care agencies feel that they have no choice but to essentially cherry-pick and take the healthier patients to care for. And that is contrary to the whole purpose of the system.

Ms. BUTO. I totally agree with you. I think the difficulty—and this gets to another kind of unpopular topic, OASIS—is that we do not have a standardized system right now for being able to say that among the home health care population, these are the characteristics or the individuals whom we can identify and also associate a higher payment for. That is exactly what we are doing with the payment system—we are going to associate higher payment with individuals who are more clinically complex, who are more functionally complex, and who require more services.

I would like to ask Mary to comment on that, because she is more of an expert on OASIS, but that is exactly where we are trying to go with the payment system.

Ms. VIENNA. I would agree with Ms. Buto. And I wanted to say that contrary to some of the other rules that we have promulgated around IPS, OASIS was developed with extensive consultation with the industry. It took about 5 years to develop through a contract with the University of Colorado and was developed by clinicians. It was also proposed as a rule, and we got extensive public comment on the instrument, and it has had, prior to the rule, at least, a broad base of support. As a matter of fact, the National Association for Home Care distributed it to home care agencies for their voluntary use back in 1996 and 1997.

So it is an instrument that was developed by clinicians, is useful in determining what kinds of services patients need and what kind

of quality of care and outcomes patients are experiencing. And serendipitously, it turned out to be very useful in predicting the types of services that patients would need under a prospective payment system.

Senator COLLINS. Ms. Buto, I want to go back to the point that you made that you recognize that we do need to somehow take care of the outlier case or the complex, chronic case that is expensive to treat, so that we do not create these perverse incentives. But I think that what you are telling me is that we need to wait until the prospective payment system is in place, which will not be until October 1 of the year 2000, to take care of this.

We have heard today from agencies that are providing low-cost quality care, but they are not going to be around by October 1, 2000 if we do not remedy the system right now.

What can we do in the interim to correct this problem?

Ms. BUTO. Senator Collins, I was listening very carefully, and in fact, I thought there were some very good comments about some of the burden issues, and we will certainly take a look at those.

In terms of outliers, we really do not have a way to provide an outlier under the current structure. The statute is very specific. I think we do need to look at and continue to monitor the access issues.

Although studies are remote, they are helpful. What we have also asked—and I would just suggest to the panelists who were here—is that anecdotes help us identify areas where we might be able to see if there are things that we can do under current authority or not.

We have invited the National Rural Health Association and other providers to actually provide us with specifics so we can go out and look at particular cases for agencies that are experiencing trouble, and for beneficiaries who are having trouble. We are also working through our Center for Beneficiary Services, and we have State organizations that counsel Medicare patients.

This has not been a big issue among the State agencies that are counseling Medicare patients, i.e., that they are being displaced, but we have asked them particularly to be alert to this, because we are concerned, and we are hearing of some anecdotes and some instances of individuals who are having difficulty and need help.

So we have our antennae out there, and we would appreciate any intelligence these groups can give us, but yes, we are looking at the outlier issue in relation to the PPS system.

Senator COLLINS. You have heard some pretty powerful testimony today from people who are on the front lines, who have told us, and told you, that there is a problem now and that it is only going to get worse. We also have the evidence of the MedPAC survey, and we have the preliminary findings of the George Washington University study.

Has that changed your view on whether there is a problem here?

Ms. BUTO. I have never discounted that providers are having a problem and that some beneficiaries may be having problems. I have never ruled that out, and as I said, both through our regional offices, through the State counseling organizations and our 1-800 Medicare line, we are really trying to find out the extent of the problem and what is happening.

We are also, as you are, looking at legislation and what kind of legislative changes we might want to suggest. We do not have those to give you today, but those are the kind of things that we are certainly looking at.

Also, I think issues of burden are important. And if there are areas where we have some ability to loosen the burden, we should. We have taken some steps to do this. For example, the sequential billing requirement which led to claims processing hold-up, will be removed as of July 1. We have provided for the extended repayment plan which is interest-free for 12 months. That is unprecedented in Medicare. We want to give these agencies some breathing room to deal with the changes.

So we are looking at changes, but I do not have a set of legislative recommendations that we could present to you today.

Senator COLLINS. On the overpayment problem, I think it is important for the record to show that HCFA helped create that problem by being very slow in giving agencies their per-beneficiary caps.

Ms. BUTO. Yes, we acknowledge that. There is no question, and we actually got started just about the time the Balanced Budget Act was enacted, and we started to get information about what we would have to do to get our systems ready. The coincidence of this year and last year with our Y2K renovation efforts was really unfortunate. We were trying to renovate and certify our systems at a time when we had to change them and get the intermediaries to start doing different things, and they were torn in several ways. So I agree with you; we wish we could have done that more quickly, but they were under unbelievable pressure last year.

Senator COLLINS. I would like to ask you about some specific recommendations that our witnesses have made for reforms. All of our witnesses have said that if the 15 percent across-the-board cut is allowed to go into effect, the results will be devastating for home care agencies and their clients. Similarly this morning, at the Finance Committee hearing, Bill Scanlon of the General Accounting Office expressed support for some sort of adjustment in the planned 15 percent reduction. He also raised a very important point, which is that another one of these across-the-board approaches only further penalizes the low-cost agency once again.

Since I know you share my concern about not hurting those agencies that have been conservative and prudent with their use of Medicare dollars, that did not have excessive visits, that did not overutilize the benefit, how can we implement a cut of this nature? We know it is unfair, we know it is wrong, we know it is going to hurt patients. Is the administration prepared to support the repeal of that provision?

Ms. BUTO. I cannot speak to that right now. That is part of the consideration we are now undergoing about the legislation. But if I could, there are two issues I want to bring back to your attention.

One, it is a 15 percent reduction. It would not be, in a Gramm-Rudman-Hollings fashion, an across-the-board reduction of the type I think you are talking about. What we are talking about is that that reduction would be against the base that we use to compute the prospective payment rates.

I do not think that makes it any easier to swallow, quite frankly, for agencies that it is not just an across-the-board reduction, but it takes money out of the base. I think that what everybody is considering whether it is a good idea to include a 15 percent reduction as part of the prospective payment system.

Senator COLLINS. In that regard, CBO testified this morning that, "The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies."

Since we know that the savings are far greater than Congress or the administration ever anticipated, why, given the problems we have heard about, would we impose a further 15 percent cut on the system?

Ms. BUTO. I think that this is one of the issues that everybody is looking at, including the administration. As you are well aware, the CBO and our actuaries estimate savings and costs relative to the current law baseline. They do not adjust savings or cost estimates, either, from year to year, even after changes have been made, and say that we are either spending too much vis-a-vis what we thought or that we are saving too much vis-a-vis what we thought. They are usually making projections 2 or 3 years ahead of time. But it is an issue that is clearly important when thinking about this.

Senator COLLINS. Another issue that has been raised in the written testimony of the VNAA is the recommendation that Congress reinstate the periodic interim payment system. There have been considerable cash flow problems caused by the sequential billing system—which I realize has been suspended, but it did a lot of damage in the meantime—and the PIP reimbursement, particularly for smaller agencies, has been important. Are you giving any consideration to reinstating that?

Ms. BUTO. We are looking at that in the context of everything else, but in the context of the 2000 budget and the prospective payment system, I think some of those issues really should be very different because of the way that payment will be made on a per-episode basis for the individuals who are being served, rather than on a claim-by-claim basis. So some of the cash flow problems may be ameliorated, but we obviously need to look at the whole package. In fact, I think we need to look at the interactions among the various proposals to see what makes sense.

Senator COLLINS. Another recommendation made by our witnesses is to postpone or repeal the implementation of the 15-minute interval rule. Would you comment on that as well—the stopwatch rule.

Ms. BUTO. That is clearly in the Balanced Budget Act, and we have been criticized for actually not implementing that provision on schedule. It was to go into effect in October 1998. Again, because of the difficulties around the year 2000 systems renovation and some proposals that were too complex were delayed. The uniform billing committee looks at making these kinds of billing changes for all insurers, and we got a late start. We could not come up with a proposal that was easy enough to do under our current system. So this ended up being delayed over its original effective date.

This is an area where I heard some testimony that I had not heard about what is counted and what is not counted, and I certainly want to go back and look at that, but we really do not feel that we have the discretion to waive implementation of the 15-minute increment. We are going ahead with it.

As people in the audience probably know, it goes into effect July 1, but there is basically a 3-month grace period so that agencies can fully come up-to-speed and use it, and we are giving them the extra time. But we are basically several months behind in implementing this provision.

Senator COLLINS. There is no doubt that Congress shares in the blame for the problems that we have created here. However, HCFA has taken the statutory provisions to an extreme in almost every single case, whether it is the surety bond or the implementation of the 15-minute rule.

What I am asking from you is to give us a specific set of recommendations so that we can work together in a bipartisan, cooperative, nonpartisan way to solve what is a very real problem for our cost-effective home health agencies, such as the ones that we have in Maine and that you apparently have in Michigan, as well as in many other States, and to ensure that we are not disrupting care for frail, vulnerable, sick, elderly people whom all of us care a great deal about.

We need your help to do that job right. I have been disappointed that despite the many conversations I have had with administration officials at the highest levels of about this that we still do not have a proposal from the administration. We can learn from the mistakes that we both have made in this area. We can learn from the testimony we have heard today. We can learn by listening to the researchers and MedPAC and those home health agencies and nurses who are on the front lines. But we need your help to solve this problem, and we cannot wait until October 1, 2000 to do so.

Ms. BUTO. Well, we would like to work with you, Madam Chairman, and as soon as we have some proposals that we can discuss with you, we would be glad to do that.

Senator COLLINS. Thank you. Senator Levin.

Senator LEVIN. Thank you, Madam Chairman.

I know you have already talked about the origin of the problem and the fact that there is some mutuality in terms of causation and who participated in the Balanced Budget Agreement and so forth. I do not think that that is really the issue now. The issue now is, as the Chairman said, what can we now do to correct the flaws in the Balanced Budget Agreement. There are obviously flaws, and whether they should have been foreseen or not is no longer the point. And by the way, even if Congress mandated it, which I am sure we did in many cases, HCFA can recommend changes in the law. You are able to make any suggestion just as any other American citizen.

The administration could come forward and, if there is a mistake in the law, regardless of how it got there, suggest changes. It is equally important to work with the industry, with the providers, to understand what is happening at the grassroots level in the real world, and what are the real world impacts of what we have done. There seems to be a huge disconnect here between your conclusions

and GAO's conclusions and what legitimate, honest providers of essential services to vulnerable people are facing in the real world.

Since there is a vote on, I am going to be very brief. First, on Linda Stock's testimony that 10 percent of our State-certified agencies have withdrawn from the Medicare program, why are so many agencies withdrawing in your judgment?

Ms. BUTO. Well, it is a combination of two things. Some are withdrawing because they think the payment system is not favorable to them to continue to participate. Some are merging. There have been a lot of mergers of home health agencies with other home health agencies—consolidations.

A third reason is that also in the Balanced Budget Act is a provision that says that payments for services to individuals will be based on where they live as opposed to where the agency is. In some cases, the agencies have chosen to pull back some of their satellite offices that are in areas that would now be receiving lower payments. So it is a combination of things.

Senator LEVIN. But some of those are very undesirable, I would assume, from your perspective; is that not true?

Ms. BUTO. Some of the pullouts are undesirable?

Senator LEVIN. Yes. If these areas are underserved, would that not be undesirable?

Ms. BUTO. It would be undesirable if the areas were underserved, but we found, as GAO has, that most of the home health agencies are pulling out where there are lots of other home health agencies, and that it is where there has been the most growth over the last 2 or 3 years in agencies—in urban areas, actually—that is occurring to the greatest extent.

Senator LEVIN. If you found that in a significant number of cases, people who are no longer eligible or are removed from eligibility immediately moved into nursing homes, would that trouble you?

Ms. BUTO. That would trouble me, but we do not have any evidence of that, including in our—

Senator LEVIN. You heard this sort of evidence this afternoon.

Ms. BUTO. I heard the testimony, and I heard it was related to venipuncture. And of course, patients who were solely eligible because of the need for venipuncture are those who are now not eligible under the Balanced Budget Act for home health services.

Senator LEVIN. I understand, but back to my question of moving them directly into nursing homes; would that then trouble you?

Ms. BUTO. It does trouble me, but again, we have not seen—and the Inspector General is helping us do an analysis of what is happening with admissions to nursing homes with discharges from hospitals to see if we are seeing any of these patterns—and we have not seen anything like this so far.

Senator LEVIN. I am glad you were here this afternoon.

Ms. BUTO. Again, I welcome specifics, because I asked the last panel if they have got the specifics, we would like to have them so we can look into it further.

Senator LEVIN. I hope that when you do look into it, and if you do find that information is accurate, your answer would then be that indeed you are troubled by it and that together we should try

to see what the solution is. In any event, let me move on to the next question.

I was very much struck by Ms. Stock's statement about sick people not getting benefits that they are entitled to under Medicare, not because Medicare will not pay for the service but because no agency would provide the service. I just want to make sure you heard that.

Ms. BUTO. I did hear that, but we are not finding that. Again, I would like to know where this happens.

Senator LEVIN. Again, you heard this from a very credible source who will be happy to show it to you.

Ms. BUTO. I believe it.

Senator LEVIN. I think it is important that you do see it and ask to see it and want to see it.

Ms. BUTO. Absolutely.

Senator LEVIN. Would you agree with Ms. Stock's point that the interim payment system tends to penalize those who were the most efficient or the least costly in 1994—for whatever reason.

Ms. BUTO. I tried to address this a minute ago. The interim payment system, because it is what it is, when it was constructed, the decision was made not to move money from the higher-paying areas to the areas that were below the national average. Had we done that, that would have helped the areas that had held down their costs. It would have hurt home health agencies in other areas, and Congress just decided not to do that.

Senator LEVIN. What was your recommendation at the time—different from what we came up with?

Ms. BUTO. I will turn to our legislative staff to see whether we had one on that. We will have to get back to you for the record on that issue.

Senator LEVIN. Would you let us know what your recommendation would be now in order to correct that negative incentive. This is not the way we want to deal with people, I would hope.

Finally, if you have not already commented on it, what can you offer these agencies with respect to the 15-minute reporting regulation, if you have not already answered that question.

Ms. BUTO. Again, we have already delayed that. It is required under the Balanced Budget Act, and it is going into effect in July. What we have said is that we are going to give a grace period until the end of September to implement it—

Senator LEVIN. Are you going to recommend to Congress that the 15-minute reporting be changed? Or is that a regulation?

Ms. BUTO. No. It is in the statute. We are looking at a whole package of issues around the statute, and we are also looking to see what can we do in areas of cash flow to provide relief. So we are really looking at the areas where we have some control.

I think the issues that were raised by one of the panelists about what is counted in the 15-minute increment is something we could definitely look at, but not the—

Senator LEVIN. You do not want folks with stopwatches, which is the way it would have to be under the existing regulations. It seems to me that that is what we are forcing people to do, or it is an absurdity which would have to be ignored. Neither one is acceptable, so I would hope you would come up with something which

is workable. If it takes a change in law, let us know. That is our responsibility. But it is your responsibility, it seems to me, to make recommendations and to tell us what needs to be done to avoid those outcomes which are unacceptable. In the real world setting, they are either not going to do it or they are going to do it with stopwatches; neither one makes sense. You do not want someone with a stopwatch at each moment, and you do not want someone to pretend to be complying if they are not.

Thank you.

Senator COLLINS. Thank you very much, Senator Levin, for your usual excellent presentation in our oversight hearing.

I want to thank all the witnesses for being with us today.

Ms. Buto, I hope you will take back to your department our overwhelming concern about the impact of the system, and I hope that this Subcommittee will receive from the administration a concrete list of recommendations for statutory changes no later than the Fourth of July. I think Independence Day would be a good day for us to receive those changes.<sup>1</sup>

This is a serious subject, and we do need to take swift action to correct the problems that have been very eloquently described today. We need your partnership in doing that, we need to work together, and we need to get the job done this year.

I want to thank all of our witnesses for their testimony today.

Finally, I also want to thank my staff for their excellent work, particularly Priscilla Hanley, Karina Lynch, Lee Blalack, and Mary Robertson. They worked very hard to put this hearing together, and I thank them for their contributions as well. I also want to thank the minority staff for their excellent work on this hearing.

Thank you. This hearing is now adjourned.

[Whereupon, at 4:25 p.m., the Subcommittee was adjourned.]

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<sup>1</sup>See Exhibit No. 10 which appears in the Appendix on page 197.

## A P P E N D I X

### PREPARED STATEMENT OF SENATOR TORRICELLI

I would like to thank and acknowledge the distinguished Chairman of the Permanent Subcommittee on Investigations, Senator Collins, and the distinguished Ranking Member, Senator Levin, for holding this hearing to discuss the affect of Medicare cuts on the delivery of home health care services. This issue is of particular concern to the 100,000 patients who rely on home health services in my State of New Jersey.

Despite these times of unparalleled economic prosperity, home health care agencies located in New Jersey are on the verge of financial collapse. This precipitous economic decline is not the result of mismanagement or inefficiency. Rather, it can be attributed, in part, to the unintended consequences of the Interim Payment System (IPS) included in the Balance Budget Act (BBA) of 1997. Indeed, the BBA was vital to the long-term strength of the Medicare program; however, the original estimated reductions of \$25 million which are now estimated to be much higher, that New Jersey home health agencies will ultimately face will be economically devastating. In fact, three separate agencies in New Jersey have already been forced to close and others will undoubtedly follow.

The fundamental flaw in the IPS is the requirement that home health services be reimbursed based upon their average cost per visit and the average number of visits in FY 1994. For States such as New Jersey, who had an average 39.7 home care visits in 1994, this payment methodology penalizes them for being diligent and efficient in the delivery of services. This inequity is best illustrated when States like New Jersey are compared with other States whose average home health visits are over 100 for 1994. The result is that New Jersey home health agencies are receiving only slightly more than \$2,500 per patient annually, instead of the \$4,000 per patient which reflects the actual costs of providing services.

Making matters worse, the Health Care Financing Administration (HCFA) has developed burdensome regulations to implement the IPS which are compounding the economic pain for home health agencies. These regulations include a new 15-minute visit increment reporting requirement, increased claim reviews, additional audits, post-payment reviews, and branch office restrictions. Perhaps most troubling is HCFA's decision to use the Outcome and Assessment Information Set (OASIS) requirements in the development of a case-mix adjustor for a home health prospective payment system (PPS). It appears that HCFA may have significantly underestimated the cost to home health agencies to implement these requirements. In New Jersey, home health agencies have already incurred OASIS related costs estimated at \$100,000.

These legislative and regulatory requirements are having a very real impact for thousands of patients in my State who rely on home health services because they are unable to care for themselves. Every day, I hear the stories of my constituents who are forced to go without needed care. These stories include Mr. Faltisco of Morris County, New Jersey, who at 93 and suffering from Alzheimer's disease, recently had his home health aide visits cut from 20 hours per week to 90 minutes a week. It is Mr. Faltisco's family who must now struggle to provide the care he desperately needs. In many other cases, however, patients have no family to provide care.

Thus, it is imperative that Congress now seize the opportunity to provide relief to home health agencies in States like New Jersey where efficiency has been rewarded with payment reductions. Last year, the FY 1999 Omnibus Appropriations Bill included some corrections to the inequalities created by IPS; however, we have a long way to go to reverse these dangerous trends. I look forward to working with the Committee and others in the Senate in supporting a legislative solution to home health care crisis.

Again, I would like to thank Chairman Collins and Ranking Member Levin for their commitment and attention to this important issue.

At the Heart of home health care



**STATEMENT OF THE VISITING NURSE ASSOCIATIONS OF AMERICA**

**TO THE**

**PERMANENT SUBCOMMITTEE ON INVESTIGATIONS**

**COMMITTEE ON GOVERNMENTAL AFFAIRS**

**UNITED STATES SENATE**

**PRESENTED BY**

**MARYANNA ARSENAULT**

**CHIEF EXECUTIVE OFFICER**

**VISITING NURSE SERVICE**

**SACO, MAINE**

**JUNE 10, 1999**

**2:00 P.M.**

Ms. Chairwoman and Members of the Subcommittee:

My name is Maryanna Arsenault, and I am Chief Executive Officer of the Visiting Nurse Service, which is located in Saco, Maine. The Visiting Nurse Service is an independent, Medicare-certified home health agency serving southern Maine and southern New Hampshire. We provide all Medicare skilled services directly -- nursing, rehabilitation, medical social service, and home health aides. We are one of the few agencies in Maine providing comprehensive specialty services -- mental health, pediatrics, intravenous therapy, enterostomal therapy, and hospice. We have been providing cost-efficient, high quality care for more than a century.

I am pleased to be here today to present the views of the Visiting Nurse Associations of America (VNAA) regarding the difficulties that VNAA members, including the VNS, are currently experiencing in meeting the health care needs of patients within the current federal regulatory environment. The Visiting Nurse Associations of America (VNAA) is the national association for Visiting Nurse Agencies (VNAs), which are non-profit, community-based home health agencies. VNAs created home health care over one hundred years ago and today provide care to approximately 10 million people annually. It is our hope and intention to continue to provide cost-effective, compassionate, and community-based home health care for at least the next one hundred years.

We are grateful to you Ms. Chairwoman and Subcommittee Members for your interest in determining how the Medicare Home Health Interim Payment System (IPS) and several new regulatory requirements are making it difficult for the VNS and other VNAs to meet our patients' health care needs. We believe that this hearing is being held at a critical time because evidence of harmful effects on Medicare beneficiaries is beginning to emerge, particularly involving those with chronic health and disability conditions.

During a April 30, 1999, meeting of the Medicare Payment Advisory Commission (MedPAC), MedPAC staff reported that 38.9% of home health agencies whom they interviewed in a recent study are, due to IPS, no longer admitting patients whom they had previously admitted. In addition, 31.1% of the agencies interviewed have had to discharge patients due to IPS. Those patients who lost access to home health services fell into the following categories: long-term, venipuncture, chronic, diabetic, expensive, and wound care. Twenty-two percent of these patients are believed to not be receiving any care at all. The General Accounting Office (GAO) concluded in its May 1999 Report to Congress that as "HHAs change their operations in response to the IPS, beneficiaries who are likely to be costlier than average to treat may have increased difficulty obtaining home health care."

VNAA believes that it is essential to look at the combined effect of IPS and regulatory requirements, such as OASIS, on providers and their patients. The IPS alone has forced VNAs to cut costs by an average 20% to stay under the IPS per-beneficiary and per-visit cost limits. In order to cut budgets by this magnitude, most VNAs have had to reduce clinical and

administrative staff, reduce staff benefits, eliminate some patient services, and evaluate and adjust patient case-mix. When an agency's average cost per patient is already under the national average, it is not possible to cut an entire budget by 20% without affecting patient care. The most significant effect on patient care that we have seen is the decision by many agencies to no longer admit patients with intensive care needs.

At the same time that home health agencies are being forced to significantly cut their budgets, the costs to comply with new regulatory requirements have increased. The numerous changes and regulations promulgated since the passage of the Balanced Budget Act of 1997 have been complex, ambiguous, and often costly. "Implement and suspend" regulations have become the norm, which have drained agency resources. And, although regulatory deadlines are rarely met, there is zero tolerance for agency error.

For example, OASIS implementation increased my agency's per-visit nursing cost by \$7. The total cost to implement OASIS within the VNS exceeded \$300,000. The combined effect of reduced IPS cost limits, our below average per beneficiary limit, and costs to implement and maintain OASIS, has caused the VNS to exceed its per-visit cost limit for the first time ever. While the VNS had consistently maintained per-visit costs 25% less than our per-visit cost limits, we are now over the limits by 3% in the aggregate. Our skilled nursing per-visit cost increased from \$79 in 1998 to \$91 in 1999 because: 1) IPS decreased the per-visit cost limit by 16.5%; 2) OASIS increased our nursing per-visit cost by \$7; 3) the IPS decreased our average per-patient reimbursement by \$600 in one year, causing utilization to drop and costs per visit to increase; and 4) because other time-consuming and costly regulations (including fraud and abuse initiatives) have added to overall costs.

The VNS has had to take the following actions to reduce our budget. During the past year, we decreased our number of employees from 417 to 297 during the past year. We also eliminated the retirement contribution for staff and reduced benefits by 2%. Again this year, beginning July 1, 1999, we will not fund our pension plan. On that same date, we will eliminate all clinical middle management, creating a manager/employee ratio of 1:45, and close 1 of our 3 branches.

*How have these changes regarding the VNS staff affected our patients?*

During this past year, the decreased number of staff has meant a decrease in staff continuity for patients because staff must now cover a greater geographic area. Elderly patients have had to adjust to new staff, which has jeopardized the establishment of a trusting relationship. Our monthly patient satisfaction surveys show a decreased level of patient satisfaction. This problem will be exacerbated in July when we close a branch office. In addition, four surrounding agencies have closed, affecting access and requiring further expansion and dilution of our services to meet community needs -- once again increasing staff travel time and costs.

In order to manage the per-beneficiary cost limit, our average number of visits per VNS patient has decreased from 56 to 45 in one year. This reduction has been compounded by two significant recent changes in Medicare coverage, which have severely curtailed access for patients with medically complex conditions.

First, the criteria for whether Medicare will cover a skilled nurse's management and evaluation of a patient's plan of care are now being more stringently interpreted by the fiscal intermediaries. Medicare must approve a skilled nurse's coordination of extended interdisciplinary care in order for individuals with a multiplicity of functional needs to receive such care. Such coverage has increasingly been denied. Second, the Balanced Budget Act of 1997 reduced the "Part-time or Intermittent Skilled Nursing Care" eligibility criteria from 56 to 35 hours per week, which has curtailed our ability to meet the needs of this patient population.

The following two case-examples provide a closer look at the access to care issue:

Doris is an 85 year old woman who lives alone in rural Maine with no indoor plumbing or telephone. Her two living family members live out of state. Doris is unable to manage her medications independently. This need did not meet the criteria for covered coordinated services by a registered nurse. The weekly service of an RN to assess Doris and assist with medication management had previously enabled Doris to live at home free of hospital admissions.

Marjorie is also 85 and has received VNS services since 1996. She has brittle COPD (Chronic Obstructive Pulmonary Disease), an anxiety disorder, and a cardiac arrhythmia requiring regular venipuncture for coumadon management. Marjorie is homebound. We are planning to discharge Marjorie because she no longer qualifies for skilled RN services. Marjorie has also avoided hospitalization for several years. She does not qualify for Medicaid services and will lose her home health aide.

As the costs to VNS increased due to IPS and new regulatory changes and interpretations, we were forced to curtail non-Medicare services to patients. All discretionary monies had previously been used to subsidize Medicare. The VNS closed a much needed personal care service that had been funded by discretionary funds. Family members of the 100 patients receiving care were forced to provide personal care to elderly parents and very sick children, which in turn affected their work schedules and job security.

*The following is another example of decreased access to VNA care:*

The VNA of Fox Valley in Aurora, Illinois, has had to discharge its highest cost patients. Since 1918, this VNA took pride in serving as the "Safety Net" for community residents who exist in poverty, are uninsured or underinsured. The VNA has partnered with funders like the United Way, foundations and individual contributors to make services available for these individuals. However, the impact of the IPS made it impossible for the VNA to continue to be the safety net in the community. One 73 year-old cancer patient who was discharged must completely rely on his wife for health care. She vows to keep him out of a nursing home, but struggles and is uncomfortable with giving him injections and other skilled care formerly provided by nurses.

The VNA of Fox Valley found that it didn't take very many of the highest cost patients to destabilize the ratio between high cost and low cost patients and put the agency above its per-beneficiary cost limit of \$3180. A 15% reduction in reimbursement to an agency that was already operating "at the bone" did in fact adversely affect patient care.

*What is the impact of other federal regulatory requirements?*

Recoupment of IPS-related overpayments has also been problematic for many VNAs. In 1998, the VNA of Southwestern Indiana's average annual cost per patient was roughly \$4,000, which was the nation's average cost per patient in calendar year 1994. Prior to IPS implementation, the VNA's costs were \$12,858,615 under the Medicare cost limits. Under BBA'97, the VNA's reimbursement was reduced to an aggregate \$2,664 per patient, producing a \$1,336 per patient deficit. The VNA did not receive its \$2,664 per-beneficiary limit (PBL) notice until six months after the law went into effect. Prior to - and following - receipt of the notice, Medicare based reimbursement to the VNA on its historical average \$4,000 cost per patient data. HCFA now wants to collect the \$3.9 million "overpayment."

The FY 1999 Omnibus Appropriations Bill increased the VNA of Southwestern Indiana's PBL limit by 8% to \$2,827; however, the VNA continues to have a per-patient deficit -- now at \$1,113. To reduce costs to survive under the PBL, the VNA has cut staff (21 positions) and services. The VNA no longer provides the following services: 1) non-routine infusion services; 2) occupational therapy; and 3) speech therapy.

The BBA'97 15-minute interval recording requirement will be effective July 1, 1999. As currently proposed by HCFA, home health clinicians would be required to record a numeric code that identifies the discipline of service and the elapsed time of the visit in 15 minute increments, excluding interrupted in-home time of two or more minutes, a clinician's charting time, the clinician's travel time or waiting time if the patient is late for the appointment, and all external time that is directly related to patient care (e.g., consultation with the patient's physician). In addition, clinical services that last less than 8 minutes are omitted from the time recording requirement.

VNAA believes that HCFA's proposed implementation of the BBA'97 provision that requires claims to contain "a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments," is overly burdensome in relation to the intent of the statutory provision. The changes to billing forms and software will be costly and the information collected may not be useful in terms of correlating clinical time with patient assessment and outcome information.

VNAA believes that it is important to have some standardized accountability of the process of service delivery but we feel that this information would only be meaningful if it captures total patient care time in relation to patient results. HCFA's proposed 15-minute requirement will not provide this information because it is encumbered by a "stop watch" recording method and does not account for a clinician's activities outside the home that are directly related to patient care.

It is my understanding that this provision will be implemented because OASIS has been suspended, and may be used as a method to assess reimbursement. The home health industry cannot withstand one more change where the information may or may not be needed.

**VNAA Recommendations:**

1) We urge Congress to pass legislation this year that will eliminate the 15% payment cut (scheduled for 10/1/2000). Before the introduction of the Interim Payment System (IPS), Congress and the Administration based arguments for significant home health payment reforms on expected outlays of \$127 billion over a 5-year period, starting 10/1/97 and ending 9/30/02. At that time it was determined that home health spending would be cut by \$16 billion over the 5-year period of time.

New data from the Health Care Financing Administration's (HCFA) Office of the Actuary confirm Medicare home health outlays dropped between fiscal years 1997 and 1998. And, in fact, in March 1999, the Congressional Budget Office (CBO) re-estimated such outlays to be \$79.1 billion over five years. It appears that home health savings over the 5-year period of time will exceed the \$16 billion target by \$32 billion. Today, I believe we can say with confidence, that the \$16 billion in savings has been accomplished in just two years.

2) We urge Congress to give HCFA the authority (and require HCFA) to increase HHAs' Medicare cost limits by the percentage that OASIS implementation has added to those costs (either on a per-patient or per-visit basis depending on the cost limit to which an agency is subjected). While the VNAA and VNS believe that OASIS must be reimplemented to ensure that the home health prospective payment system is based on sufficient patient case-mix data, we strongly believe that the cost of implementation must be reimbursed by Medicare.

3) VNAA recommends that Congress implement an outlier payment system under IPS so that patients with the most intensive care needs retain access to home health care services (as recommended by MedPAC's recent draft report to Congress.)

4) We recommend that Congress further increase the per-beneficiary cost limit for low-cost home health agencies and the per-visit cost limit for all home health agencies.

5) VNAA urges Congress to re-instate Periodic Interim Payments (PIP) for the home health PPS. We have learned from our members' participation in the PPS demonstration projects that PIP reimbursement is necessary to ensure cash flow at least during the first year of PPS implementation. We understand that new legislation must be passed for PIP to continue.

6) We also recommend that the July 1 implementation date for the 15-minute interval reporting be postponed while Congress, HCFA and representatives of the home health industry develop an alternative process for visit accountability that will work in concert with OASIS and PPS. A home health accounting methodology that is tied to patient outcomes and reimbursement would put the home health industry more squarely on track with managed care, which is currently being done with other health care industries. Ultimately, the home health PPS will be based on standardized clinical time, process of care delivery and patient outcomes. Perhaps an alternative should be developed when HCFA publishes the home health PPS proposed rule. We would then be able to determine how time recording would best interface with PPS and OASIS data.

HCFA data from the PPS Per-Episode Demonstration Project includes incremental time recording information in over 4,000 visit logs from participating agencies. This information may be useful for the purpose of developing an alternative to the current HCFA 15-minute proposal. We urge Congress to require HCFA to indicate the value of the data to PPS.

Thank you for providing this opportunity for VNAA and the VNS to submit comments to the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs. I would be pleased to answer any questions you may have about my testimony.

**TESTIMONY BEFORE THE  
GOVERNMENT AFFAIRS COMMITTEE  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
UNITED STATES SENATE**

**HOME HEALTH CARE: WILL THE NEW  
PAYMENT SYSTEM & REGULATORY OVERKILL  
HURT OUR SENIORS?**

**June 10, 1999  
2:00 p.m.**

presented by

**MARY SUTHER  
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**ON BEHALF OF THE  
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Thank you for the opportunity to present testimony today on issues relating to the Medicare home health benefit. My name is Mary Suther. I am the Chairman and CEO of the Visiting Nurse Association (VNA) of Texas. I am also chairman of the Board of Directors of the National Association for Home Care (NAHC).

NAHC is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies.

NAHC is deeply appreciative of the attention the Members of this Committee have shown to the problems created by the home health provisions of the Balanced Budget Act of 1997 (BBA97) and the regulatory burdens imposed by the Health Care Financing Administration (HCFA).

The Medicare home health benefit has undergone tremendous change as the result of BBA97 and recent program requirement changes. Home health providers are finding it increasingly difficult to serve the same population of beneficiaries they served even two years ago. Many providers have left the Medicare program, and those remaining have reduced clients, staff, service areas, and made other changes in an effort to remain financially viable. These dramatic changes have compelled providers, beneficiaries, and their advocates to press for relief.

NAHC has received reports from home care providers, beneficiaries, and from media throughout the nation that have showcased individual cases where access to care has become a serious problem. Real people who are in need of and eligible for home health services are going without care. Attached to this testimony are some examples of these reports.

At the time of BBA97's enactment, the Congressional Budget Office (CBO) originally reported that the effect of BBA97 would be to reduce home health care expenditures by \$16.1 billion between fiscal years 1998 and 2002. CBO's revised analysis now projects those reductions to exceed \$47 billion--nearly three times the expected savings. CBO projected that home health expenditures in 1998 would be \$20 billion, and in fact those expenditures ended up at less than \$15 billion. Congress now has the hard evidence necessary to take action to put an end to the dismantling of the home health benefit.

#### REGULATORY BURDENS

Home health agencies are under severe financial strain due to the interim payment system (IPS) reductions. Virtually all agencies are being reimbursed less than the actual costs they incur in providing care to Medicare beneficiaries. More and more new and costly demands associated with HCFA regulations are increasing agencies' financial and operational burdens and are straining agencies' ability to deliver quality care to their patients. These include requirements associated with implementation of OASIS, 15-minute visit increment reporting, increased claims reviews, expanded compliance surveys, surety bonds, sampling procedures for post-payment and audit reviews, sequential billing, and branch office restrictions. Many of these

changes have been developed without adherence to regulatory procedural requirements. The cumulative effect of these regulatory initiatives has been devastating to providers and has had a profound impact on beneficiaries as well.

1. 15-minute visit increment reporting

BBA97 required that claims for home health services contain a code that identifies the length of time for each service visit, measured in 15-minute increments. HCFA issued instructions to the home health fiscal intermediaries (FI) on February 18, 1999, directing them to initiate necessary steps to implement this new billing requirement for all home health agencies (HHA) participating in the Medicare program by July 1. (Transmittal No. A-99).

This new administrative burden imposes a complex time-keeping requirement for agencies to stop the in-home clock when an interruption in active treatment occurs. The HCFA transmittal defines the "time of service visit" to begin at the beneficiary's place of residence, when delivery of services has actively begun.

Since the time counted must be actual treatment time, providers are expected to discount time spent on non-treatment related interruptions during the in-home visit. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service time.

In-home time represents only a portion of the total time invested by an agency in caring for a patient. Numerous activities required by the Medicare Conditions of Participation and needed to ensure effective patient care often performed outside the home, including communication with physicians and family members, coordination of services with other home health personnel and community agencies, care planning, and clinical documentation. In order for home care treatment time to be meaningfully quantified, visit time must be better defined and recognized as only part of the resource cost involved in providing home care services.

Neither Congress nor HCFA has indicated how this information will be used. Its value is questionable in light of the ongoing move from a cost-based reimbursement system to a prospectively set per-episode payment that is not tied to number of visits or visit length. In light of the substantial financial and administrative strains already being experienced by agencies, we urge you to revisit this requirement.

2. The Outcome and Assessment Information Set (OASIS) requirements

NAHC has long supported the use of a uniform data set for collecting data and measuring, and ultimately improving, patient outcomes in home care. Over 10 years ago, HCFA proposed the development of the Outcome and Assessment Information Set (OASIS), a data set aimed at accomplishing these goals. NAHC has demonstrated its support of OASIS development and use for outcomes measurement and quality improvement in its educational programming and publications.

More recently, HCFA determined that OASIS data would be useful in development of a case-mix adjustor for a home health prospective payment system (PPS).

While NAHC acknowledges the many benefits that may accrue from OASIS, we continue to believe that several actions must be taken before home care providers can adequately undertake OASIS data collection and reporting requirements.

HCFA has seriously underestimated the costs of OASIS-related requirements with respect to: 1) initial start-up (hardware, software, clinical and administrative staff training); 2) data collection (additional time required for patient assessment and reassessment, printing and supply costs); 3) transmission of OASIS data; and 4) the willingness of third party payers to share in the burden of OASIS start-up costs.

Home care providers have reported that it costs them from one to three dollars per visit to comply with the requirement, whereas HCFA has allowed only three cents per visit by way of reimbursement. Further, reimbursement is tied to per-visit cost limits. Only agencies that have not already reached the per beneficiary limits will benefit from the per-visit adjustment; HCFA estimates that about 70% of agencies will **not** receive an adjustment for OASIS costs. There has been no adjustment in the per beneficiary limits to address the increased costs of OASIS. Agencies are unable to absorb the costs of OASIS, given that over 90% of agencies are being reimbursed less by Medicare than their actual costs of providing care and, on average, home health agencies are receiving 30% less in reimbursement than they were prior to implementation of the interim payment system in October 1997. In addition, third party payers are unaware of the value of OASIS and are unwilling to compensate agencies the additional cost of OASIS implementation, data collection and reporting.

By way of comparison, in 1987, HCFA increased the home health cost limits when changes were made to the forms for HHA billing and verification. This series of forms is known as the 485 series as it encompasses today's plan of treatment, the medical information form and the medical information request form (485, 486, 487, and 488). In establishing reimbursement rates, HCFA was required to take into account the cost of this new series of forms by increasing the base limit values for per-visit reimbursement to the HHAs beginning July 1, 1986, by \$.37, and by \$.39 in 1987 (52 Federal Register 25562, July 7, 1987). The average cost of all Medicare home health visits in 1987 was \$48. The OASIS paperwork burden is greater than that imposed by the 485 series of forms. But even performing a simple projection of the 485 series add-on for 1987 to OASIS in 1997, the increase to HHA reimbursement by HCFA would be, at a minimum, \$.61/visit.

NAHC believes that agencies should be reimbursed the **full** costs associated with meeting OASIS requirements. HCFA should conduct further study regarding costs of OASIS and adapt its reimbursement structure to reflect the real costs agencies are incurring. If HCFA lacks the authority to adjust the per-beneficiary limits, Congressional action should be taken to empower HCFA to make the necessary adjustments. HCFA and the Congress should also ensure that rates of payment under the forthcoming home health PPS reflect the costs of OASIS. HCFA

should allow agencies adequate time to ensure payment from third party payers that will cover the cost of meeting OASIS requirements for non-Medicare, non-Medicaid patients.

HCFA has determined that OASIS data must be collected and transmitted for all patients receiving skilled and/or personal care services, regardless of payer or patient health status. This determination has added substantially to the regulatory burdens under which home health agencies are currently operating.

NAHC believes that at least initially, OASIS data collection requirements should be limited to Medicare and Medicaid patients who are receiving intermittent skilled services. Additional study should be conducted to support the uses and usefulness of such data before HCFA mandates collection and transmission of OASIS data for patients receiving intermittent skilled services who have third party payers.

Patient privacy rights remain a serious concern throughout the country. OASIS represents a vast collection of patient information that, if used inappropriately, could cause great harm to patients. Additionally, patients may be at risk of not receiving needed care if they refuse to supply specific information or provide approval for the release of this information.

NAHC believes that HCFA should develop privacy protections such that patients are assured that confidential medical information will remain confidential. These protections should include the development of encryption software by HCFA before transmission is required for non-Medicare, non-Medicaid patient OASIS data. There should be no transmission of patient-identifiable information by a home health agency without the written consent of the patient. No patient should be refused services on the basis of an unwillingness to consent to the transmission of confidential information.

### 3. Medical claims review/sequential billing

Home health providers are experiencing increasing difficulties in processing claims through the FIs for services provided to Medicare beneficiaries. Problems cited by agencies include increased inappropriate and excessive random and focused medical reviews, medical review inconsistencies, technical denials, and sequential billing.

A wide variety of inconsistencies exists in payment decisions by the FIs reviewing medical claims. Differences in interpretation of homebound, technical requirements, and medical necessity requirements have resulted in confusion among many home care providers. In addition, local medical review policies are often more restrictive than the coverage policy dictates, complicating coverage decisions further.

In response to a growing Medicare home health program, HCFA earmarked increased funding for medical review activities which have increased random and focused medical reviews, targeted audits, and fraud and abuse initiatives, such as ORT and Wedge audits. Providers thought they would receive relief from medical review levels ranging from 25% to 100% when

they received a HCFA letter stating that no more than 10% of a provider's claims would be subject to random review edits. At HCFA's urging, however, FIs have instituted other types of medical review edits. As a result, agencies are being subjected to multiple edits at one time, slowing payments significantly and exacerbating financial difficulties for providers. In addition, many of the denials issued as a result of medical review are for technical reasons which have no bearing on patient's eligibility or delivery of medically necessary services.

HCFA instituted the sequential billing policy to ensure proper allocation of home health expenditures to Medicare A and B. This has meant that home care agencies have not been reimbursed for services recently given to a Medicare patient if there are any outstanding claims, or if a dispute exists over previous services offered to the same patient. NAHC and others have worked since early 1998 to convince HCFA to suspend its sequential billing and payment policies on the grounds that they were unnecessary and caused harmful cash flow problems for financially strapped home health agencies. HCFA has ordered a halt to sequential billing by July 1 which is greatly appreciated, but the repercussions of this ill-advised policy will continue for some time. Agencies have missed payroll and further damaged their fragile credit ratings.

Given the current financial uncertainties related to intensified audits and disallowances and inconsistent medical reviews, thousands of Medicare claims are currently in dispute or on appeal. This has created severe cash flow problems for many providers. Agencies are under severe financial hardships when payments are delayed weeks or months while under review and appeal.

#### 4. Surety bonds

BBA97 mandated that all home health agencies participating in Medicare and/or Medicaid secure a minimum surety bond of \$50,000 in order to protect the programs from fraud. HCFA published implementing regulations that went far beyond the intent of Congress. In the wake of overwhelming Congressional objection HCFA withdrew its regulations and agreed to develop new regulations.

The House Government Reform and Oversight Subcommittee on Human Resources released a report highly critical of the HCFA and its handling of the BBA97 surety bond requirement for home health agencies. The report describes HCFA's surety bond rulemaking process as "inadequate" and "technically flawed"; HCFA, for the most part, did not take into account recommendations or technical expertise offered by the home health and surety bond industries. Similarly, the Small Business Administration (SBA) filed a petition to HCFA that was extremely critical of the agency's process in developing the surety bond regulations. In part, the SBA stated that the agency "changed the rule into a vehicle for punishing legitimate HHAs and for securing overpayments to Medicare rather than a vehicle to discourage bad actors from entering the Medicare program."

It appears that throughout the regulatory process there has been a significant lack of understanding of surety companies' practices, the principles behind surety bonds, and their uses.

HCFA should establish surety bond regulations in accord with the intent of Congress -- as a vehicle to keep "fly-by-night" operators from participating in the Medicare program. As recommended by a recent GAO report, the bond value should not exceed \$50,000 and only one bond should be required to cover both Medicare and Medicaid. The bond should not be used as a vehicle to recoup overpayment, but rather as a means to ensure that an agency does not pose an unreasonable risk to the program. As the bond requirement is a condition of Medicare participation, it should be reimbursable. Agencies that have proven track records in the Medicare program should not be required to purchase bonds on a continuing basis.

HCFA has much greater flexibility to tailor the surety bond regulation so that it is not onerous or harmful to small businesses, and should avail itself of that flexibility when redrafting the requirements.

5. Statistical sampling methodology for post-payment review

In March 1999, HCFA published an FI manual update outlining new procedures for comprehensive medical review using statistical sampling (Transmittal Number 1770). The updated instructions provide details for conducting comprehensive medical reviews, medical review audits, and for statistical sampling and overpayment projections.

The use of sampling procedures involves the FI identifying a specific portion of claims from among an agency's claims submitted during a specified period of time. The proportion of denied claims in the sample would be extrapolated to all claims for the period, resulting in denial of claims that were never reviewed individually.

Sampling imposes significant risks to agencies and eliminates some provider's appeal rights. Under HCFA's sampling policy, the overpayments projected through the claims reviews are recouped by Medicare prior to any rights of appeals. Since the projection can involve millions of dollars, home health agencies are unlikely to survive long enough to access the appeals process. Appeals are important because reversals of claims have routinely exceeded 80% over the years.

The HCFA Region V Associate Regional Administrator registered a protest alleging that the statistical methodology used is invalid and irresponsible. This claim is supported by the Region V statistician and the statistical consultant to the Department of Justice in Chicago. Documents have been submitted to this committee regarding this allegation. With an improper sampling methodology the risk of erroneous overpayment projection is dramatically heightened.

HCFA has rejected the majority of recommendations made by home care providers to stop sampling and overpayment projections. In addition to opposing the use of statistical sampling, NAHC objects to the manner in which HCFA implemented this policy. At a minimum, policy changes of this nature should be subject to public review and comment as required under the Administrative Procedures Act, before it is finalized. NAHC recommends

that HCFA suspend its instructions to the FIs on statistical sampling of home health claims until appropriate modifications are made in policy.

6. Branch offices

HCFA has established new criteria for branch offices that limit driving time to about one hour from a parent agency and require daily onsite supervision of the branch office. The policy does not recognize the use of modern methods of communication such as faxes, telephones, pagers and telecommunications that are used by every other business in the country as acceptable methods of communication and supervision. HCFA's branch office policies are contrary to regulatory reform initiatives and the proposed conditions of participation which espouse the need to change from structure-based requirements to a focus on outcomes and quality of care. In many cases agencies have closed branch offices because of the added costs of complying with the conflicting and unnecessarily restrictive branch office policies, producing access problems for beneficiaries. NAHC drafted a petition for rulemaking on behalf of Medicare certified home health agencies, requesting HCFA to institute a new rulemaking procedure and establish a single set of national criteria for defining "branch office" of a home health agency under the Medicare program.

7. Physician referrals

The "Health Insurance Portability and Accountability Act of 1996" (Public Law 104-191) included a provision that imposes severe civil monetary penalties on any physician who certifies a patient as eligible for the Medicare home health benefit who does not meet the eligibility requirements. This has produced a chilling effect on physician referrals. Although the statute limits liability only to those cases where the physician "knowingly" certifies an ineligible patient, HCFA has created such an environment of fear with its overzealous anti-fraud campaign that doctors are afraid to refer patients for home health services. NAHC has received numerous reports that for many patients this is limiting access to home health services for which they are, in fact, eligible.

HCFA has not adequately informed physicians of their role, coverage criteria, and clear definitions of the terms "homebound," "medically necessary," and "terminally ill." In order for physicians to take an active and responsible role in ordering and gatekeeping home health services, they must be fully informed of the breadth of the benefit and eligibility requirements.

8. Itemized bill on demand

The BBA97 required that home health agencies provide patients with an itemized bill on demand. The staff time and computer programming required for this is an additional cost not accounted for in setting both the per visit cost limits and the per beneficiary limits.

## INTERIM PAYMENT SYSTEM

The most devastating change for home health agencies under the BBA97 has been the enactment and implementation of IPS. The severe payment reductions under IPS coupled with other HCFA initiatives have had severe repercussions for home health providers and beneficiaries alike. Thousands of agencies have gone out of business, jeopardizing access to needed home care services. Agencies who have survived have, in many cases, been forced to refuse to take on patients with more intensive care needs, lest they risk financial ruin. Despite some measure of relief in the last Congressional session, severe problems remain, which must be dealt with in this Congress to ensure the continued viability of the home care program.

1. Medically complex patients

A 1998 study conducted by The Lewin Group entitled "Implications of the Medicare Home Health Interim Payment System (IPS) of the 1997 Balanced Budget Act" and a 1998 study by the Center for Health Policy Research of the George Washington University entitled "Medicare Home Health Services: An Analysis of the Implications of the Balanced Budget Act of 1997 for Access and Quality" both found that IPS curtails access to covered services for the sickest, most frail Medicare patients. Under IPS, HHAs have strong financial disincentives to care for patients with more intensive care needs because taking on these patients could threaten the financial stability of the agency.

HCFA has taken the position that there is no statutory authorization for exceptions to the annual aggregate per beneficiary limit. Since the base year for the per beneficiary limits is fiscal year 1994, agencies are using data from 1993 as their base year. Many agencies have experienced significant changes in case mix and services provided since that base year. Currently, no adequate case mix adjuster exists which reflects the patient characteristics that influence cost. IPS uses agency-specific data in establishing the per beneficiary limits as a proxy for case mix under the theory that an agency's case mix does not vary significantly from one year to the next. The validity of this assumption is severely tested when utilizing base year data that is four to five years old.

Technological advances in recent years have vastly expanded the scope of services that can be provided to Medicare beneficiaries in their homes. Services such as parenteral and enteral nutrition, chemotherapy and care of ventilator/trach-dependent patients, which used to be provided only on an inpatient basis, can now be provided in the home, thus reducing the need for more costly hospitalization. These services are costly for the home health agency to provide, however. These services often require nursing staff who have had additional training in administration of drugs and procedures, as well as patient monitoring. In addition, such services require prolonged visits in the patients' homes, as well as high standby costs, extensive case management, transition discharge planning and other activities that add further to the cost per visit.

A type of outlier provision is needed for purposes of recognition of the higher cost of serving certain patients who qualify for Medicare home health services.

2. Per beneficiary limits

CBO, in estimating savings that would result from implementation of IPS, used an unprecedented 2/3 behavioral offset. What this means is that CBO directed Congress to cut \$48 billion to yield \$16 billion in savings over five years. To yield \$48 billion in savings, Congress was forced to go all the way back to FY94 data for the base year in determining per beneficiary limits. It is now painfully clear, given recent CBO data, that this was completely unnecessary. But this mistake has had devastating consequences. The per beneficiary limits, based on 1993-94 data, clearly do not reflect changes that have occurred in the population served by home care or the types of services agencies are providing today. Further, IPS fails to distinguish between efficient cost-effective HHAs and providers that have high visit utilization and per-visit costs. In some circumstances, the use of a per beneficiary limit based upon agency-specific data perpetuates Medicare expenditures for overutilization. The lack of an effective case mix adjuster which distinguishes patients based upon needs and service costs prevents IPS from properly setting reimbursement limits. As a result, historically efficient HHAs may have lower payment limits than historically high cost providers. Agencies who serve a greater number of medically-complex patients may have limits insufficient to care for those patients, despite higher per beneficiary limits.

3. Per visit limits

BBA97 reduced the per visit cost limits from 112% of the mean to 105% of the median per visit costs for freestanding agencies. As a result, agencies have been forced to dramatically reduce the costs of delivering home health services. In many cases, agencies are reducing expenditures by reducing the number of visits they provide. However, as the number of services provided in a visit increases, costs per visit go up. Given the reduction in the per visit limits under BBA, many providers, in an attempt to stay within the per beneficiary limit, are being caught by the per visit limit.

Under the 1998 Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESAA), the per visit limits were raised from 105% to 106% of the median. This 1% increase was insufficient to help HHAs who are operating under cost limits that have been reduced by between 14 and 22% under BBA97. The current cost limits are inadequate to cover the costs of providing care and to account for the increased administrative costs of participation in the Medicare program.

Reduced per visit cost limits jeopardize patients' access to necessary home health services. Under IPS, many HHAs have been forced to be more selective about the patients they accept, especially with respect to patients in rural or inner-city areas and those who have special needs and require more intensive care. Especially vulnerable have been individuals who need therapy services to restore their ability to care for themselves and inner-city residents for whom

caregivers may require security escorts and language translators. Agencies in rural areas have been particularly hard hit by reductions. Their costs tend to exceed national averages because of longer travel times between visits and higher wages resulting from the lingering personnel shortages in rural areas.

#### 4. Overpayments

BBA97 did not require HCFA to publish information on calculating the per visit limits until January 1, 1998, even though the limits went into effect beginning October 1, 1997. Likewise, HCFA was not required to publish information related to calculation of agencies' annual aggregate per beneficiary limits until April 1, 1998, despite an October 1, 1997, start date. More than a year after IPS began, many agencies had not yet received notice from their FIs providing the visit and per beneficiary limits under which they were expected to operate.

In other cases, where agency limits were provided, the FIs' calculations of agencies' limits were wrong due to the use of faulty data. Additionally, most of the FIs never modified agencies' payments to reflect the IPS reductions; rather, they continued to pay agencies according to the previous year's levels, resulting in significant overpayments to many HHAs across the country.

The BBA97 home health reductions were so deep and occurred so quickly that many agencies were not aware of the full impact the cuts would have on their reimbursements, particularly since most agencies did not even know their reimbursement limits until months after care was delivered. More importantly, most agencies continued full access to care within the scope of the Medicare benefit rather than terminate care to patients.

FIs have been issuing notices of overpayments to agencies and demanding repayment. The IPS reductions make it near impossible for agencies to provide high quality, appropriate care to Medicare beneficiaries and to comply with repayment requests. These overpayments are not the result of abuse or inefficiency. Rather, most overpayments have occurred because HHAs continued to serve high-cost patients within the scope of Medicare coverage and the payments have already been used to provide legitimate needed care to eligible beneficiaries. Without some relief from these overpayments, it can be expected that agency closures, and the attendant access problems, will accelerate.

#### 5. Mandatory 15% reduction in home health limits

Under the BBA97, expenditures under PPS were to be equal to an amount that would be reimbursed if the cost limits and per beneficiary limits were reduced 15%. Even if PPS was not ready to be implemented on October 1, 1999, the Health and Human Services Secretary was required to reduce the cost limits and per beneficiary limits in effect on September 30, 1999, by 15%. OCSAA delayed the 15% reduction for all HHAs until October 1, 2000.

IPS already significantly reduces the reimbursement rates for providers. On average, agencies are receiving 31% less in reimbursement under IPS than they did previously. HCFA has projected that nearly all HHAs under IPS will receive reimbursements that are lower than their actual costs of providing care. Given CBO's estimates of outlay reductions far in excess of those anticipated (nearly \$48 billion as opposed to the expected \$16 billion), further cuts to home health of 15% would be devastating to providers, severely jeopardize the ability of beneficiaries to access care, and restrict the level of care beneficiaries could receive.

#### 6. Proration

BBA97 stipulates that the per beneficiary limit will be prorated among agencies when a patient receives services from more than one agency. This provision is unnecessary and too complicated for routine administration of the payment system.

The per beneficiary limit is calculated from the 1994 fiscal year where patients were also served by more than one agency. Therefore, the per beneficiary limits already account for patients being served by more than one agency and prorating of fees is unnecessary. However, it is recognized that one method of circumventing the per beneficiary limits would be to transfer patients to another agency. HCFA should have a mechanism to deal with these situations if they arise.

The tracking required to comply with this provision would be problematic for both providers and HCFA. HHAs do not have access to the information that would allow them to sufficiently track beneficiaries' use of other home health services and do not have control over where patients receive services before and after the home care they provide. Prorating becomes even more complicated given that agencies have different limits and fiscal years over which those limits are applied. Further, proration of the limits would interfere with a patient's right of choice of an HHA and potential access to care. A patient previously served by another provider may bring high-cost care needs and a reduced payment limit, thereby discouraging the patient's admission.

#### 7. Periodic interim payments (PIP)

Medicare allows for periodic interim payments (PIP) for many Medicare providers in order to maintain a steady cash flow for services rendered on behalf of Medicare beneficiaries. PIP payments to HHAs are based on volume experience which is adjusted on a quarterly basis.

BBA97 eliminated PIP for HHAs effective for cost reporting periods beginning on or after October 1, 1999, a date intended to coincide with implementation of PPS for home health. OCSAA extended PIP to fiscal year 2001, eliminating it for portions of cost reporting periods occurring on or after October 1, 2000.

Under IPS, maintaining PIP is more important than ever in allowing agencies to serve Medicare beneficiaries effectively. The cash flow generated by PIP is critical to the financial

viability of small HHAs that do not have large cash reserves to support delayed payments from HCFA. Congress should maintain PIP or, at a minimum, extend it at least one year beyond implementation of PPS.

CONCLUSION

Thank you again, Madam Chairman, for the opportunity to present our views. You and the Committee have our thanks for bringing home health issues to this level of consideration. We look forward to working closely with you to resolve these issues.

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### Home care for thousands threatened

By Al Andry, Post staff reporter

A financial crisis affecting United Home Care may mean drastic cuts in home-care services for thousands of homebound elderly and disabled or closing of the agency, its director says.

Harmon 'Ted' Clingner, the agency's president, said federal actions mean a \$1.5 million revenue shortfall that must be made up in the next few months.

The non-profit, private agency has launched a massive mailing, soliciting donations from individuals, corporations and foundations.

'I'm confident we'll get the money,' he said. 'If we don't get the money, it will be difficult for us to provide care.'

The agency, which also operates the Visiting Nurses Association, employs about 400 people. Its budget this year is \$10 million, of which \$1.1 million comes from the United Way. The agency gets the remainder of its budget from a variety of sources, including Medicare, Medicaid and private insurance companies.

'In 90 years of delivering home care, we've never had this problem before,' Clingner said.

Last week, Clingner met with United Way officials and representatives of eight foundations to explain the financial crisis and ask for their support.

In the letter soliciting financial help, United Home Care states United Way has agreed to lead a communitywide fund-raising effort for it.

United Way president Richard Aft could not be reached for comment; and other United Way officials declined comment.

United Home Care's budget grew from \$4 million in 1987 to \$11 million in 1994. Of the 4,610 people it served last year, 1,500 received free or subsidized care. Clingner blamed the crisis on Congress' Balanced Budget Act of 1997 which was an attempt to control Medicaid spending. Because of changes in the act affecting home health care, 2,000 of 10,000 home health care agencies in the country have shut down, he said.

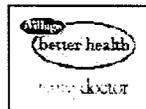
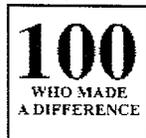
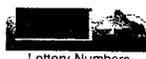
Part of the act, which went into effect Jan. 1, included massive changes in the way home care is paid for and in the amount the federal government will pay for services, he said.

The act based 1998 reimbursement amounts on 1993 costs, Clingner said.

'Congress' goal was to save \$16 billion over the next five years in the home health program. The changes were so drastic that the Congressional Budget Office said the actual savings would be \$48 billion over five years. In 1998, the federal government spent \$14 billion less on home health care than in 1997,' he said.

In the letter soliciting financial help, the agency said that its reimbursement for a skilled nursing visit went from \$100.86 in 1997 to \$84 in 1998. The letter also said that the federal government increased pressure on doctors not to refer Medicare patients to home health care.

'We ended up with a massive decrease in the number of people getting home



health care under Medicare,' he added, saying visits by patients declined by 62 percent in 1998.

The letter said that the agency faces three scenarios:

**The need to raise \$2 million in charitable donations.**

**Sell the agency to a for-profit company.**

**Bankruptcy and closure.**

**A closer look**

United Home Care, in Mt. Auburn, is one of the largest social service agencies in Hamilton County.

**It provides** home health and other services to the homebound elderly and disabled. It also provides nursing care.

**Last year,** it served 4,610 people.

**The United Way agency** receives local, state and federal money.

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<b>Special Reports</b>	<b>Insight: Home health care firms fold or fall on hard times</b>						
<b>News Links</b>	Sunday, February 07, 1999						
<b>Photo Journal</b>	By Diana Block, Post-Gazette Staff Writer						
<b>AP Wire</b>	Jack Kavanaugh went to his staff last summer to explain why they hadn't received their paychecks. He knew Medicare changes were hurting his home health care business, but he didn't realize the extent of the problem until a woman sitting on the floor started to cry.						
<b>Sports</b>							
<b>Classifieds</b>	"We were trying to get her to tell us what was wrong. She had not eaten in a day and a half and was having terrible hunger pangs." A co-worker gave her a sandwich, and Kavanaugh called the Salvation Army and arranged for food to be given to more than 30 employees.						
<b>Weather</b>	"I was shaken," he said. "It was terrible ... to see people that you know, who are working for you, and you can't give them a paycheck. And they can't get food on their table."						
<b>Zines</b>	Sandra Burt is a nurse with the Visiting Nurse Association, one of the home health agencies serving the Pittsburgh region. Since Medicare payments changed in October 1997, 1,240 home health agencies across the country have closed. (Martha Rial, Post-Gazette)						
<b>City Guide</b>	Kavanaugh is president of five home health agencies in the Midwest, two of which have recently filed for Chapter 11 bankruptcy. The staff of one of the bankrupt agencies, the Community Nursing Network based in Washington, Pa., worked without full pay for several months to keep the company operating.						
<b>PG Store</b>	The same Medicare payment changes that have affected Kavanaugh's operation have been even more devastating elsewhere in the country. Within the last year, 1,240 agencies and branches nationwide have closed.						
<b>PG Delivery</b>	What turned the home health care industry on its head were changes made by Congress in the Balanced Budget Act of October 1997. The act was primarily a cost-cutting						
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**The payment formula**

measure, intended to curb the skyrocketing expenses of home health care, the fastest-growing segment of Medicare.

At the time, Medicare was projected to go bankrupt by 2001, and home health care was its fastest-growing component, having expanded more than 700 percent between 1989 and 1997. If that didn't make the industry a big enough target for cuts, the Department of Health and Human Services inspector general had just finished an investigation that found that 40 percent of the reimbursement claims made by agencies in three states were improper.

As a result, Congress passed a bill that has now hamstrung an industry that offers cheaper care for frail elderly than putting them in nursing homes or personal care facilities.

#### Home care preferable

The home health care payment restrictions were imposed at the very time that most experts on aging have emphasized the importance of taking care of older people in their homes instead of institutions. It allows people to keep their homes and assets, it costs less, and it's often better for patients physically and psychologically, they say.

While home health care is cheaper than institutional services, though, the current Medicare payment system is not paying agencies enough for basic services for many patients, home care advocates say.

"The [current] payment system was an absolute disaster for Pennsylvania," said Terry Stark, executive director of the Pennsylvania Association of Home Health Agencies. While the inspector general quickly backed away from any allegations of fraud in the system, Congress cut the budget without considering the impact on patient care, she said. "The decisions were made as economic decisions, not as health care decisions."

The home health agencies supported some change. Everyone involved seemed to favor a shift away from the old cost-based system, which paid for each service provided and therefore encouraged extraneous treatment.

The payment setup that is putting the squeeze on home health agencies reads about as smoothly as a section of the tax code. For each client, it says, the government will pay the lowest of three costs:

The agency's actual expenses for care.

The per-visit limit, which is 106 percent of the national median per-visit cost, adjusted for costs in each region.

The aggregate per-beneficiary limit, which uses 98 percent of the agency's expenses per patient in 1994 (counting for 75 percent of the formula), and combines it with a current regional average (25 percent of the formula). To help agencies that have lower costs than in other parts of the nation, the government will then take this final figure and add 1/3 of the difference between the agency's per-beneficiary limit and the national median.

Once the government figures out the limits for each patient an agency has, it adds them together to create an aggregate limit and pays that amount. That means agencies can spend more than the calculated limit for a certain patient, but will either have to absorb that extra cost or make it up by spending less on other patients.

#### Related article:

[Numbers of home health workers double, but many clients still on waiting list](#)

The goal was a plan in which Medicare would reimburse agencies based

on the patient's diagnosis, similar to the system it now uses to pay hospitals.

The Health Care Financing Administration, which administers Medicare, plans to devise a formula for a diagnosis-based payment system by October of next year.

In the meantime, it has been using the interim payment system, which has been widely criticized for its inequities.

One of the biggest problems is that payments in each state are based partly on the average reimbursements home health agencies received under the old system. That means that agencies that were more cost-conscious, such as those in Pennsylvania, have been penalized.

Under the temporary system, therefore, caregivers in Louisiana can receive twice as much reimbursement money as their Pennsylvania counterparts. The system was altered in October to help some of the lowest-paid states, but people in the industry say it is still unfair.

"This is a travesty. Especially Western Pennsylvania will be paid the least because they were the most efficient. We are going to continue to see agencies falling by the wayside. They're significantly cutting back on their services," said Cathy Frasca, vice president of home health services for the South Hills Health System Home Health Agency.

Even big agencies suffer

While the new guidelines may protect Medicare from some fraud, they are creating huge holes in the budgets of many agencies that have always prided themselves on their efficiency. More than half of all home health agencies nationally have seen their budgets cut more than 22 percent by the interim payment system, according to one home health association.

This year, the South Hills Health System's agency will run a budget deficit for the first time since it began in 1963.

"We were millions of dollars under the cost caps [under the previous payment system], and now we're well over," said Frasca. "We are significantly reducing costs, trying to reduce our management staff, reducing just about everything, going to bare bones to try to reduce costs that don't impact patient care. And this has been very, very difficult."

Medicare requires that the agencies offer clients all the care they need, but agencies are finding it harder to accept clients who require significantly more care than average.

"One of the brutal realities of this is that the sickest of the patients out there are the ones who are seeing the most harm. This probably is particularly acute in Pennsylvania, because we are in a region which is seeing one of the lowest per beneficiary caps in the country," said Don McClure, director of government affairs for the Pennsylvania Association of Home Health Agencies.

So far, though, the numbers show Pennsylvania has not had as many agencies closing as other states. As of last October, Texas had seen 450 home health agencies close, but only 13 had closed in Pennsylvania.

This is partly because most agencies in this area use fiscal years with later starting dates, so their first fiscal year under the interim system hasn't ended. (Kavanaugh's companies are an exception to this trend; they have already begun their second year under the system.)

Agencies in this area also tend to be larger, with more cash reserves than the many smaller branch organizations in states such as Texas. Some say it's primarily the for-profit agencies that have abandoned the marketplace under the tougher payment system, whereas Pennsylvania is dominated by nonprofit caregivers.

Still, most agencies here agree that there will soon be fewer companies operating.

Patients may be excluded

Health Care Financing Administration spokesman Chris Peacock said the payment system may not allow every agency to survive. "Our concern is not the number of home health agencies. It's that the home health agencies that are out there continue to bring access to the beneficiaries who need it."

But even the more established agencies face hard times.

"If we are not successful in turning this around by March or April, then you are going to see some very serious access problems to patients who need home care services across the United States, and in Western Pennsylvania in particular," South Hills' Frasca said.

And if a new diagnosis-based payment system can't be implemented by next year, the government plans to cut reimbursements to agencies another 15 percent across the board. Most experts couldn't explain this proposed cut, but it will strangle agencies even further.

Several congressmen, including U.S. Rep. William Coyne, D-Oakland, have said they will fight to make the system fairer for Pennsylvania.

"The inequity that was built into it was a result of the Balanced Budget Act, which was done pretty much behind closed doors," Coyne said. "They did it in such a hurry that I don't think they really recognized the effect that it was going to have."

Because Medicare reimburses rather than prepays, most local home health providers don't know what they will be paid for this year's services.

As the man responsible for five different agencies, Kavanaugh is angry and frustrated that Medicare won't close the book on past cases.

"How do you run a business moving forward when you don't know what you're going to be paid for last year yet?" he asked.

One family scrambled

Some patients, such as George Smith, have had to scramble because of the new system.

Smith, of Bulger, has a neurological disorder that has left him almost

completely paralyzed. His wife made numerous calls when his services were reduced by the small agency that was caring for him. She finally signed her husband up with a larger agency that could afford a client with greater needs.

While government spokesmen say access to care should not change, state officials are aware that as agencies begin to feel the full impact of the temporary system, more clients might be turned away.

"We haven't had long enough to experience how this is going to affect us," said Darlene Burlazzi, bureau chief for direct services at the Allegheny County Area Agency on Aging. The state has asked county aging service providers to report agencies who deny people health care, partly for fear these patients may turn to the county agencies for help, Burlazzi said.

She said that although the county was mandated to provide basic care, "We certainly can't fill all of their needs all of the time. Any kind of skilled service is a very expensive service. And any resources we might have might be eaten up by that."

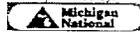
The current Medicare funding system seems punitive to many providers.

"It gets sort of tiresome after a while that you're always threatened with punishment for taking care of the sick and the elderly," said Andrew Peacock, executive director and chief executive officer of VNA Healthcare Services in Allegheny County. The agency will lose more than 15 percent of its budget this year, a million-dollar deficit that will have to come from limited cash reserves.

"I want to still feel that what we're doing is really important, but it is tough. When we keep getting beat up, it is tough to maintain our enthusiasm and concern. But we all come back, day after day, because we know that we're needed. And that's what matters."



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## Home health care agencies struggle for survival

Sunday, April, 11, 1999

By **Linda Todaro**  
 Staff Writer

Sept. 3 was a bleak day at Great Lakes Home Health Care in Jackson. That's when the company's 200 employees were told they would have to take a 10 percent pay cut for three months.

William Deary III, company president, already had slashed his operating budget to the bone. Coffee and bottled water were no longer provided to employees and dozens of other office expenses were cut or eliminated.

Cutting salaries was by far the most drastic step taken.

"It was the most difficult situation and biggest business challenge Great Lakes Home Health has ever faced," Deary said.

The alternative was even worse. He knew his company would go out of business without the salary cuts.

Great Lakes is one of four Medicare-certified home health care companies in Jackson. Those agencies - as well as their counterparts around the country - were hit hard by drastic Medicare cuts during 1998.

In Deary's case, the story has a happy ending.

"Every person in our company stood behind us," said Deary. "They didn't jump ship."

Deary was able to not only stay in business, but also to repay his employees the money withheld from their pay.

Not all companies fared as well, however. An estimated 1,200 home health care companies across the country have closed.

In some cases, agencies that serve both Medicare and non-Medicare patients have been forced to use profits from private-pay patients to cover the cost of caring for Medicare patients. Some closed the Medicare part of their business rather than taking that step.

"We've all taken a financial hit," said Michelle Masta, regional general manager of IHS Home Care who oversees offices in Battle Creek.

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Pull Down

Grand Ledge, Coldwater and Jackson. "I tell everybody. If you don't like roller coasters, you probably shouldn't be in health care."

The trouble began more than 18 months ago when Congress cut Medicare spending on home-health care by \$16.2 billion through fiscal 2002.

"It threw the whole industry into chaos and we still have not seen the end of it," said Don Gillespie, contract administrator of Foote Home Care Services in Jackson.

"We've done a lot of reorganizing, a lot of streamlining," said Mary Moburg, manager of Foote Home Care Services.

"Our goal was to go through this change and reduce our costs without having a negative impact on patient care," Gillespie added. "In order to do that, we really had to look at all of our systems."

The Balanced Budget Act, passed in August 1997, created a new reimbursement plan for home-health care companies. Part of that plan involved an interim payment system that rolled back payments to 1993-94 levels minus another 2 percent.

"We have very efficient Michigan agencies," said Jill Eldred, chairwoman of the Michigan Home Health Association's public policy committee and president of Visiting Nurse and Hospice Services of Southwest Michigan. "The real efficient ones were the ones that suffered the most, because reimbursement was based on many, many years ago."

The rollback, referred to as an "interim payment system," was designed to be temporary. But so far, there is no sign it will end anytime soon.

"It was supposed to be only a year," Deary said. "Now no one knows how long it's going to last."

The Balanced Budget legislation also reduced the maximum a home-care agency can bill Medicare for any treatment by about 15 percent, and per-patient spending was temporarily capped at 1993 levels.

The cuts, Eldred said, were designed to save about \$17 billion through fiscal year 2002. As it turned out, more than \$48 billion was saved the first year alone.

"To me, that means agencies lost money and patients were not served as well as they could have been," she said.

For one thing, she said, the cap on per-patient spending forces agencies to discharge patients as soon as possible.

"Long-term patients are becoming a thing of the past," Masta said. "So now we worry about how can we get that patient healed quicker and still provide excellent quality of care."

Nurses, she said, are adding another role to their job description. "We will always be caregivers, but we need to think of ourselves as being coaches too," she said.

As "coaches," home-care nurses teach patients to care for themselves and to take advantage of community resources they can turn to when they no longer are receiving home care.

Eldred suspects the cuts have also forced some chronically ill patients into nursing homes or the hospital - both of which are more expensive than home care.

For now, at least, it appears the worst is over. A 10 percent increase that went into effect for this fiscal year has eased the crisis a little.

"That has brought some modest relief," Eldred said. "We're trying to let the dust settle. Some of the Michigan agencies are doing a little bit better this year, but many of them are really in trouble. They are suffering from the effects."

And, there may be more to come.

A 15-percent reduction, originally scheduled to take effect this year as part of the Balanced Budget Act, has been pushed back to Oct. 2000.

"We've already taken one 15 to 18 percent hit, if we have to take another one, there will be a lot of companies going out of business," Gillespie said. "If that 15 percent cut comes, it's going to be devastating."



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April 26, 1999

### Fed regulations threaten home health services

Lyn Danninger PBN Staff Reporter

Straub Clinic and Hospital Inc.'s home health-care agency is the latest casualty in a nationwide trend toward closure of such operations.

In Hawaii, four home health-care agencies have been shuttered in the past year: Kahuku Hospital Home Health Agency; Kapiolani Home Health Services; Waianae Coast Comprehensive Home Health Care Service; and state-run Maluhia Home Health Care.

Straub Home Health Agency will cease operations May 8.

Katie Shigemitsu, director of the hospital's home health-care program, said Straub had been looking at closing the program for some time because of decreased reimbursements and implementation of a time-consuming government reporting system.

Potential problems related to quality of care and liability issues also led to the decision.

Shigemitsu estimated that her agency, which averages about 150 patients at any given time, had suffered a 24 percent decrease in reimbursements, not including the 15 percent reduction that would take effect with the new regulations.

Shigemitsu said Straub's home health patients have been referred to the St. Francis home health-care program for future care.

#### Highly touted

Home health care refers to a spectrum of health and support services for homebound patients. The services must be ordered by a physician.

Such care has long been touted as a more effective, less costly alternative to prolonged hospitalization. Those advocating it claim it reduces expensive hospital stays and keeps patients from being confined to long-term facilities such as nursing homes.

They point to studies indicating that patients recover more quickly at home and are likely to be more independent there.

#### What went wrong

Local home health-care providers say onerous federal regulations, decreasing insurance reimbursements and dwindling numbers of referrals from health-care providers have made it increasingly difficult for such operations to stay in business.

Nationally, home health-care agencies are either closing their doors or are no longer treating the main beneficiaries of home health care -- elderly patients covered under Medicare.

\* [ In response to these problems, the National Association for Home Care filed a lawsuit last year against the Health Care Financing Administration, a federal agency that oversees Medicare.

The suit charged that the agency's implementation of new rules, intended originally to slow the pace of increases in home health-care expenditures, had hurt both patients and providers by drastically cutting reimbursements and placing limitations on patients' access to care.

The situation has become even more critical, with 2,000 home health-care agencies going out of business in the past year, according to the National Association for Home Care. Another, unofficial, estimate put the number at closer to 4,000.

#### **A popular alternative**

Home health care has been a covered benefit under Medicare since 1966, as well as being covered under most private insurance plans. However, the popularity of such care as an alternative to prolonged hospitalization increased in 1984 when acute-care hospital reimbursements for Medicare recipients, predominantly the elderly, decreased.

Under the so-called "prospective payment" system implemented by the Health Care Financing Administration in the early 1980s, hospitals received set amounts per Medicare patient per hospitalization, based on type of disease or illness rather than a percentage of per-day/per-service costs.

The goal was to encourage more efficient, cost-effective delivery of health-care services. But, rather than face decreasing reimbursements, hospitals reacted by discharging Medicare patients earlier and referring them to home health-care agencies for at-home follow up.

They also opened their own home health-care agencies in order to continue following patients and shift costs.

Private home health-care agencies also proliferated, spawning a variety of administrative and oversight problems for the Health Care Financing Association. Eventually, the situation attracted the attention of Congress.

A number of high-profile Medicare fraud and abuse cases created further problems for the industry, leading to a series of Congressional hearings and rulings that, among other things, sharply decreased reimbursements under the Balanced Budget Act of 1997.

#### **The government's solution**

Just as with hospitals in the 1980s, to encourage more cost-efficient care, the Health Care Financing Administration targeted the way home health-care agencies were reimbursed.

With payments based on 1993 levels of service, reimbursement amounts declined substantially -- at least 20 percent in the past year under the so-called "interim payment" system, a temporary payment system that will eventually develop into the prospective payment system. HCFA hopes to implement the method in mid-2000. But providers say an anticipated further 15 percent decrease in payments under the prospective payment system will lead to more home health agency closures and compromise patient care even further.

The Health Care Financing Administration also targeted home health-care agencies to collect overpayments made in the past year as agencies continued to serve many of the increasing number of high-cost home health patients.

#### **Unintended consequences**

A Congressional Budget Office analysis of anticipated Medicare program expenditures revealed a dramatic reduction in the Medicare home health program.

as well as some unintended consequences.

Instead of a projected \$16.1 billion reduction between 1998 and 2002, the Congressional Budget Office figures showed a decline of more than \$47 billion.

Home health expenditures for 1998 were projected at \$20 million, but expenditures ended up at less than \$15 million.

Critics have charged that what was supposed to be a modest reduction in the rate of growth of home health care ended up being a steep decline in benefits that left those most in need of care vulnerable.

Estimates are that more than 700,000 fewer Medicare members received home health services in 1997 and 1998 than in previous years.

#### **HCFA's response**

Mary Rydell, local representative for the Health Care Financing Administration's Pacific area, acknowledged that Medicare changes have had a serious effect on some local home health-care providers.

"When the Balanced Budget Act was passed by Congress in 1997, it seemed to hit smaller businesses that rely on steady reimbursement the hardest," she said.

But she hopes some of the regulations will be re-examined -- especially reimbursements called "outlier" payments.

The term refers to additional payments for patients who take longer to recover and require more treatment than originally projected.

"You don't have any outlier payments for those services that fall outside the norm, so one of the things we are looking at is addressing that problem," Rydell said.

But Rydell she said the prospective payment system implementation likely will be delayed until around June 2000 because the Health Care Financing Administration is still working on its year-2000 computer problems.

Meanwhile, she is hopeful Congress will address some of the home health-care agency problems and complaints, although she is not sure it will do so soon enough to help other home health-care agencies experiencing financial difficulties.

#### **Local providers affected**

At Maluhia Home Health Care, payments for a home health visits decreased from \$104 to \$99 to \$87 since the interim payment system was implemented. Moreover, it would have experienced a further decrease in reimbursement under the proposed prospective payment system if it had stayed in business, said Kathy Kam, who ran the Maluhia program.

In addition, critics say the Health Care Financing Administration imposed a lengthy, time-consuming reporting system on home health-care providers to determine what a prospective payment system would entail.

The Outcome Assessment Information System, or O.A.S.I.S., amounts to a 21-page report required for each home patient, according to local home health-care agencies.

"Suddenly [the Health Care Financing Administration] has asked home health agencies to become experts in research. In my entire career, I've never seen anything as ill-conceived as this," said Judy Walden, administrator for local home health agency Kokua Nurses.

Walden said her company had suffered a 27 percent decrease in reimbursements from 1997 to 1998. Another problem for Walden is the way payments are allocated. The new reimbursement rate schedule received in June 1998 was

substantially less than anticipated.

Because the rate was retroactive to January 1998, Walden was forced to return nearly \$100,000 that Medicare said it had overpaid.

"I asked for an installment plan, but the interest rate was so high that even [Medicare] discouraged me from extended payment," she said.

Walden said that the only way companies like hers can survive is to get the Medicare portion of their business down to less than 10 percent.

Walden acknowledged that some highly publicized cases of fraud and abuse in the home health-care business had created problems and hurt the industry. Those problems in turn led to increased government oversight.

"In Louisiana, the number of home health-care agency visits had averaged around 200 visits per patient, whereas in Hawaii, the number of visits ranged between 20 and 25," she said. But Walden believes the government's response is not the answer.

"I think HCFA is going after the wrong people. They should close those agencies instead of punishing the entire business," she said.

#### **Tough to stay**

Rose Ann Poyzer, executive director of the Hawaii Association for Homecare, acknowledged it is difficult for home health-care agencies to stay in business, given the new rules and anticipated cuts in reimbursement.

"No one wants to stay in this business unless they are providing quality care," she said.

Poyzer said some nurses have resigned because of the increased amount of paperwork required by the Health Care Financing Administration. She criticized the O.A.S.I.S. reporting system and the kind of information being gathered.

"The data will be flawed. It's more research-based than quality-care based. The person who developed it doesn't seem to understand how home health care works," Poyzer said.

She acknowledged that home health care has become increasingly less cost-effective over the years. But she said part of the problem stems from caring for patients who, on discharge from the hospital, require more complicated care because they are sicker when they leave the acute care hospital setting. As a result, home health-care agencies are now providing increasingly more extensive and sophisticated care.

"At one point, [home health care] was cost-effective, but now we are seeing patients who are sicker" Poyzer said. "We have become a hospital without walls."

She wonders what will happen to elderly Medicare patients as declining reimbursements make it more difficult for them to be treated.

"The very grave concern is, who is going to deliver this care, how will it be monitored and how will it be reimbursed," Poyzer said, noting that there is already a shortage of skilled nursing facility beds in Hawaii.

Richard Meiers, president and chief executive officer of the Healthcare Association of Hawaii, which represents area hospitals, said home health-care agencies and the health-care industry in general will be further affected by future changes and decisions resulting from the Balanced Budget Act.

"We're very unhappy with what we've seen," Meiers said. "Home health care is a very important part in the continuum of health care, and there will probably be more and more decisions made along these lines that will impact other home health-care agencies, nursing homes and hospitals."

"The Balanced Budget Act has seriously damaged health care," he said.

Meiers said home health care helped reduce in-hospital costs, but those costs will rise if home health-care agencies can't afford to stay in business.

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BY REFORMS IN HOME CARECUTS, CAPS FORCING  
MEDICARE AGENCIES OUT OF  
BUSINESSBy **Judith Graham**, Tribune Staff Writer.*Published: Sunday, December 27, 1998**Section: NEWS**Page: 1*

Randy Walk is approaching the new year with a sense of dread.

A week ago, the Medicare home health aides who helped him live independently in an apartment in Cincinnati for the last several years walked out the door for the last time.

Now, this 42-year-old quadriplegic--who cannot transfer himself from his bed to his electric wheelchair, nor bathe or dress himself, nor clean and flush his catheter--must find other sources of help.

He has called 14 Medicare home health agencies in his area, but none has agreed to provide him with care in the afternoons. Walk has nearly exhausted his small pension paying out of his pocket for aides in the mornings. Asked what he is going to do, Walk replied quietly, "I don't know."

Increasingly over the last year, since the government sharply reduced payments for many Medicare home health agencies, reports are surfacing of Medicare beneficiaries who have lost home health services, have seen them cut back significantly, or cannot get care when they are discharged from a hospital.

Hit hardest are Medicare beneficiaries who use home health care the most, consumer advocates say: the chronically ill and disabled who are disproportionately poor, very old or living alone and members of minority groups.

"There's a growing crisis in access to Medicare-covered home health care, particularly for people with complex and long-term medical conditions" such as congestive heart disease, multiple sclerosis, severe diabetes, spinal injuries, Alzheimer's disease and the aftereffects of a stroke, said Diane Paulson, manager attorney for the Medicare Advocacy Project at Greater Boston Legal Services.

The crisis affects one of the most popular benefits under Medicare, the federal government's \$224 billion health program for the elderly and disabled.

Nationally, 3.6 million people used Medicare home

health services in 1996. Many are middle class. They qualify for Medicare home health if they need skilled medical help and are homebound.

The need for such services is compelling: Research shows that about one-third of Medicare's 38 million beneficiaries cannot perform basic tasks for themselves, such as dressing, feeding, bathing, taking medications or handling their bathroom needs, because they are too sick or too old.

But increasingly, Medicare home health agencies say they cannot afford to care for the most vulnerable group of all, people with complicated medical needs who need lots of services.

In the last 15 months, between 850 and 1,200 Medicare-certified home health agencies--or nearly 1 out of every 10 Medicare agencies in the nation--have closed, citing stingy government payments, according to various estimates. In Illinois, 36 Medicare agencies have shut their doors, out of a total of 382 providers.

The root of the problem, advocates and industry sources say, is Medicare's new interim payment system for home health, enacted as part of last year's Balanced Budget Act.

The rocky transition from the traditional, largely uncontrolled system of payments to next year's system with better controls illustrates just how difficult it is to reform Medicare and rein in spending without causing painful dislocations that hurt people in unanticipated ways. Without reform, Medicare is expected to go broke in about a decade; a national commission is examining Medicare reform options.

The interim home health system was designed to save Medicare billions of dollars. It cuts average payments per visit by about 20 percent and for the first time caps what Medicare will pay agencies for treating beneficiaries.

Industry officials call these controversial "per beneficiary caps," which range from an average \$2,700 a year to \$5,500 depending on the age and location of an agency, a form of health-care rationing. People who require far more care than the caps allow are at special risk of losing services, officials warn.

Walk would qualify under the beneficiary cap for \$2,615. If Walk received services seven days a week for two hours at a time, as he had been getting, his care would exceed that amount in just over a month, making him a money-losing proposition after that.

The Health Care Financing Administration, counters that the caps create incentives for agencies to be efficient. Spokesman Chris Peacock says beneficiaries still should get all care that is medically necessary. Agencies should be able to balance high-cost clients with large numbers of low-cost clients, he suggests, making the capped amounts stretch further.

Furthermore, Peacock says, better financial controls are necessary to protect Medicare's future, safeguard benefits for all its members and root out fraud.

Even as the number of Medicare beneficiaries receiving home care services has more than doubled since the mid-1980s, annual costs for Medicare home health have soared to about \$18 billion, up from \$2 billion in 1985.

This huge pot of money has attracted unscrupulous operations. In a much-cited July 1997 report, federal investigators found that about 40 percent of all Medicare home health bills should not have been paid either because doctors' orders were not in place or because services could not be justified medically or because paperwork was not in order, among other factors. Just last week, the government announced it broke up a major home health fraud ring in South Florida that had bilked the government out of \$42 million.

Still, the sharp rise in Medicare's home health spending cannot be attributed solely or even largely to fraud, and efforts to constrain spending are running smack into a countervailing trend. New medical technologies have made home care a viable option for people who a few years ago would have received long-term care in nursing homes. Home care is cheaper than nursing home care and far preferred by most elderly and disabled people. And over time, Medicare's home health program has become something of a long-term care safety net for people with chronic illnesses.

But now this safety net is being rent. Consider the Gilberto family of Wakefield, Mass.

Their 37-year-old daughter, Laurie, has multiple sclerosis and has been wheelchair-bound for six years. Medications help control the tremors and muscle spasms that rack her body. Her speech is blurred beyond recognition; she cannot hold a pen. (She qualifies for Medicare because of her disability.)

So it was Laurie Gilberto's parents, Pete and Rosemary, who went to bat for her when her home health agency cut her services in half in November 1997 to two hours a day, Monday through Friday, just after the interim payment system was established. Although her doctors, who had authorized Medicare home care services for her for many years, intervened, their appeals did not succeed.

After re-evaluating Gilberto in May, the agency decided she didn't need skilled care at all, one of the conditions of receiving Medicare home health benefits. Since then, she has received no services, including the physical therapy she used to get twice a week.

"She's deteriorated quite a bit," her mother, Rosemary, said in a telephone interview. "We just don't know how much longer we'll be able to keep her at home."

Given these kinds of dislocations, it's no surprise that at least seven lawsuits have been filed against the government, challenging the changes. (Cases brought by home care agencies on constitutional grounds have been dismissed; at least two suits brought by beneficiaries are outstanding.)

The General Accounting Office and Medicare's official advisory commission are looking into the impact of

program changes on beneficiaries. In September, industry and consumer groups marched on Washington to highlight the issue, bearing a 2-mile-long petition. Several members of Congress have promised to take up the matter after the holiday break if impeachment proceedings against President Clinton allow for action to be taken. (Minor modifications were made in November, but they did not increase payments substantially.)

Meanwhile, experts warn that problems will intensify in the coming months as thousands of home care agencies across the country receive letters demanding that they pay back money--often more than \$100,000--to Medicare. Many of these overpayment requests are a direct consequence of the interim payment system and could force large numbers of agencies to file for bankruptcy protection, policymakers and lawyers said.

Simply put, the government has paid agencies throughout most of the year at old rates, even though new lower rates were in effect. Now, it wants back the amounts it overpaid.

Arlene Maxim, who owns a small agency specializing in medically complex cases in Grand Rapids, Mich., received her overpayment letter, asking her to return \$97,900 to Medicare, in the second week of December.

Several weeks before, she had discharged all but one of her 60 patients and released most of her 20 staffers. "I just can't make it anymore on what Medicare is paying," she said, adding that she expects to file bankruptcy soon.

"Year 1 of the interim payment system was bad, but Year 2 will be much, much worse unless some relief is forthcoming," said Gary Bowers, a Baltimore consultant and former Health Care Financing Administration audit director.

According to the National Association for Home Care, the number of Medicare beneficiaries using home health services appears to be dropping for the first time in years. It estimates that Medicare's home health care rolls have declined by 800,000 beneficiaries, said William Dombi, vice president of law. While the government disputes those figures, its data show that the average number of visits per beneficiary is declining "significantly" this year, a spokesman said.

To the extent that fewer home care operators are pushing unneeded services on seniors who think the visits are free--a relatively common type of fraud--that's a desirable trend. But to the extent that people with significant medical needs are being affected, problems are arising.

Roland Cote, 49, a blind diabetic who had a kidney transplant and a toe amputated last year, has been entirely on his own in dealing with Medicare hassles.

Cote, who lives in Norwich, Conn., had been getting visits seven days a week from home health aides who were checking on his circulation. Once a month, a nurse evaluated him and checked his medications.

One day this year, Cote remembers, he got a call from his agency telling him skilled services were no longer necessary. His aides were cut to four days a week, then two, then they stopped coming.

Cote asked whomever he could, "my friends and neighbors, people from church," to help out, but in his nearly total isolation, things didn't go well. He stopped eating properly, missed medications, and several times had severe insulin reactions. Eventually, with the help of an advocate, he succeeded in regaining services twice a week but only after he signed a paper promising that he would pay whatever Medicare didn't pay.

Several experts suggest there is help available to people such as Cote if they would consume their assets and qualify for Medicaid, the joint federal/state health program for the poor. Medicaid is the main payer of long-term care in the U.S., including nursing homes and home health care.

But Medicaid officials blanch at the prospect of paying for services that Medicare won't cover now and seeing state health-care budgets swell. Several states have very limited home care benefits available.

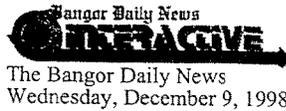
One way state Medicaid directors have kept budgets in check over the last several years is by aggressively encouraging beneficiaries who also qualify for Medicare home health to get those services first and use Medicaid to supplement whatever Medicare won't pay.

That cost-shifting strategy won't help agencies such as Gibson Health Services of East St. Louis, Ill., whose elderly, poor, mostly minority patients are almost all on Medicare. The agency has reduced staff, cut benefits and slashed visits to patients, but it is losing money under the interim payment system.

Just before Christmas, Gibson's staff planned to tell clients with complex conditions like diabetes, heart failure and dementia that it no longer has the resources to supply them with services. Although agencies cannot deny Medicare beneficiaries benefits to which they are entitled, they can decline to offer services if they do not have sufficient staff or other resources.

"Our patients are poorer than most, sicker than most, and most do not have support systems to back them up. The only alternative for them that I can think of is a nursing home," said Pat Gibson, a nurse and the agency's chief executive. "Which is sad because most of them have been living independently successfully, with help, until now."

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#### Visiting Nurses restructures staffing

By Wayne Brown, Of the NEWS Staff -- CARIBOU - A federal cap placed on per-patient costs for home-health care could affect the services some patients receive. It already has affected the jobs of some of the people who provide those services. Visiting Nurses of Aroostook has had to restructure the jobs of some of its employees. As a result, some of them will be working fewer hours. "We don't have the work for them we did in the past," said Sandra Scott-Adams, the chief executive officer for VNA, on Tuesday.

VNA has about 300 employees and operates five offices throughout the county. About 25 people have been affected by the job restructuring.

Scott-Adams said no one has been fired, but "there are people who will leave because they don't have the hours to stay. We just don't have the work for everybody."

The problem is the federal Balanced Budget Act. As home health care has grown, so have demands on the federal Medicare system.

At the same time, the nation's population as a whole is getting older, thus requiring more services. Often, those services are provided in the home, including skilled nursing care, therapy, and home-health aid. Agencies like VNA provide those services and are reimbursed by Medicare.

According to Scott-Adams, the federal government placed a cap on the amount that it will reimburse agencies like VNA in a given year.

In Maine, the average ranges from \$1,600 to a maximum of \$4,000 per patient.

In Aroostook County, the average needed is more in the range of \$4,000 to \$4,500 per patient.

"We've had to look carefully at the services we're providing," said Scott-Adams.

The area of home-health aid, which includes such things as giving people baths and helping them with exercises, will be hardest hit as a result of the VNA job restructuring, she said.

Also, VNA staff will no longer be able to take blood samples for patients in their homes.

Instead, those people will have to go to their own doctors or the hospital.

"In a rural area, that's really difficult," she said.

The reimbursement caps set by the federal government are based on 1994 cost figures and can vary from region to region of the country.

New England, which has tended to be conservative in its home-care spending, Scott-Adams said, has been particularly hard hit as a result of the Medicare caps. On the other hand, states that traditionally have had higher costs have been able to retain more money.

"The travesty is, depending on where people live, they may or may not be getting services," said Scott-Adams.

While some services may have to be cut back to some clients, Scott-Adams said VNA would do what it could to make sure that clients get the services they need. She said some of those clients could be referred to other agencies, such as Aroostook Home Health Services in Caribou and Madigan Home Health Care in Houlton.

Jim Brown, business manager for Madigan, said Tuesday that MHHC also has felt the Medicare pinch, though not as drastically as perhaps VNA has.

Madigan provides both long-term and acute care, while many other agencies, like VNA, provide only acute care, a fact that Brown says has helped Madigan.

"We've had to scrutinize our utilization much more than in the past," he said. "But if we have to deal with an influx of new clients, we will have the resources to deal with them. We have a large organization."

Scott-Adams said she doesn't think the Medicare cap is short term.

"We wouldn't have done this if we didn't think it was going to be permanent," she said. "I don't think Congress knew what it was doing or the impact it would have when they passed [the Balanced Budget Act]."



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## Albuquerque Journal

04/25/1998

Main Topics: Medicare; Health Care; agencies; providers; surety; reimbursements; Pollan

By Elizabeth Keest Sedrel Assistant Business Editor

### Home Health Agencies Cut Back

Rules May Force Closures in N.M. New federal rules are forcing many New Mexico home health agencies to cut patient services and lay off employees -- and could cause some to close, operators and industry officials say.

"They're very scared," Joie Glenn, executive director of the New Mexico Association for Home Health Care, said of home health agency owners. "They just keep waiting for someone to hit them again. There's many agencies across the state that are afraid they're going to have to close."

Glenn said the 1997 Balanced Budget Act dealt her industry a triple blow:

First, new limits on Medicare reimbursements are based on costs from four years ago. Second, home health agencies that take Medicare and Medicaid cases must buy surety bonds -- a task that runs from expensive to impossible. And third, drawing blood, a common home health procedure, will no longer be reimbursed by Medicare.

She said the new rules are expected to cost the New Mexico industry more than \$30 million. Glenn's association has 125 members; 174 agencies are listed as home health providers in New Mexico.

Home health agencies provide in-home care by nurses, physical and occupational therapists, health aides, medical social workers and psychiatric nurses. In 1996, the last year for which figures are available, home health agencies served 148,400 Medicare patients in New Mexico.

"There are a lot of frail, elderly people out there who require a lot of care," said Glenn. "Home health care has kept them out of nursing homes. Home health care has kept them out of hospital stays."

The agencies say the new rules will force them to provide fewer patient visits. They also say the changes will be toughest on agencies in rural areas, where up to 95 percent of home health patients are on Medicare or Medicaid. That could leave patients in those areas having to travel to larger communities for care, providers say.

Glenn and others in the industry say Congress meant well, trying to address abuses in the business.

Nancy-Ann Min DeParle of the Health Care Financing Administration told the Senate Aging Committee last month: "Given the rapid growth, and the waste, fraud and abuse in the (Medicare home health) benefit, these major changes are needed."

But home health insiders say misguided lawmakers went too far, drafting rules that threaten efficient, honest providers.

The big hit, home health providers say, came from a new Medicare payment system.

Until last fall, Medicare reimbursements were based on providers' costs, within limits. By October 1999, Medicare will pay for plans of care based on specific diagnoses. Glenn said the industry has been asking for the new payment system for years; it's the transition that's creating problems.

An interim payment system that began last fall limits per-patient reimbursement to 1994 costs.

"The industry's saying, 'You can't go back to 1994,'" Glenn said. "Our figures suggest that the home health agencies in New Mexico will take a \$30 million hit based on the interim payment system."

That figure is about 40 percent of annual revenues, she said.

Steve Bourne, controller of Heritage Healthcare Services Inc., said his agency has laid off three of the 18 employees who deal with Medicare, cut the remaining employees' pay by 10 percent and cut back on patient visits.

"You have to go out there and cut costs," he said. "Where do you cut? If you're not of a critical mass, you don't have anywhere to go to cut costs, and you're not going to survive."

Bourne said Heritage has enough private business to stay alive. But he said statistics suggest that as many as two in five home health agencies in New Mexico, especially those not part of a larger health-care business, may have to close.

Frank Pollan, president of High Country Home Nursing in Cuba, said he could be one of those. Pollan said he has laid off seven of his 22 employees and may have to turn away patients.

"We are nervous about admitting chronic-care type patients because of the per-beneficiary limits," he said. "We are being forced to consider the

financial as well as clinical aspects when we get a patient referred to us."

He said he'll decide in the next few months whether to close his business.

"A lot of us are in that boat," he said.

The new rules also require home health agencies who serve Medicare patients to have surety bonds of \$50,000 or 15 percent of their Medicare revenues, whichever is greater. The agencies say that's tough, because they don't have the buildings or fleets of vehicles that other companies might list as assets.

Glenn said the minimum bonds cost between \$1,000 and \$2,500 and require up to \$25,000 in collateral -- if an agency can even get them.

Bourne said Heritage has been rejected six times.

"The bonding industry won't touch home health agencies in this capacity," he said. "There is no collateral in home health agencies."

Initially, companies were told they had to have surety bonds by Feb. 27. But the following week, the Health Care Financing Administration announced it would amend those rules.

Glenn said she's heard the amendments may come as soon as next week. Once they are published, companies will have 60 days to produce surety bonds.

Another concern is that as of Feb. 5, drawing blood is no longer a qualifying service. That means that if a home health worker goes to a patient's home to draw blood for tests and doesn't perform any other service, Medicare won't pay for the visit.

"This is going to force people to discharge their clients and force these clients to go somewhere else," Glenn said, adding that in rural areas getting to a doctor's office can be an ordeal.

Three federal lawsuits have been filed to fight the changes, one by the Texas Association for Home Health Care and two by the national association, Glenn said. And she said the national association is lobbying Congress to ease the new rules.

Bourne said that while things are tough, he is optimistic some of the new rules will be rescinded.

"I don't think they have a choice," he said. "There's an increasing elderly population, and those people vote. It's just a matter of time."

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Testimony of

**ROSALIND L. STOCK, RN BSN CHCE**

**VICE PRESIDENT, HOME HEALTH SERVICES**

**HOME HEALTH OUTREACH**

on

**HOME HEALTH CARE:**

**Will The New Payment System & Regulatory Overkill Hurt Our Seniors?**

before the

**US SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS**

of the

**US SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS**

**JUNE 10, 1999**

**Written Testimony**  
**Rosalind L. Stock, RN BSN CHCE**  
**Vice President, Home Health Service**  
**Home Health Outreach**  
**on**  
**Home Health Care:**  
**Will The New Payment System & Regulatory Overkill Hurt Seniors?**  
**before the**  
**US Senate Permanent Subcommittee on Investigations**  
**of the**  
**US Senate Committee on Governmental Affairs**

Chairman Collins and distinguish members of the Permanent Subcommittee on Investigations for the Senate Governmental Affairs and with special thanks to Senator Carl Levin of Michigan, I express my sincere appreciation for the opportunity to discuss frankly the issues which have brought us together today. Your understanding of the gravity of the cumulative effects of regulatory and legislative mandates on home health patients and their providers over the last 20 months and your willingness to call this hearing to address them is a tribute to this committee, its chair and staff.

As you are painfully aware, the home care industry has become very vocal about the unforeseen impact of these changes on the patients we serve and the financial crises our agencies have faced since October 1997.

I come today not just to testify to some of the cumulative effects which the multiple regulatory mandates have had on our patients and providers, but to offer constructive recommendations for your consideration. I speak not only for my own agency but for members of the Michigan Home Health Association who want to be part of the solutions and not part of the problem.

Because providers were not given comment periods on recent changes and because many of the comments provided on earlier mandates were never adequately explored by regulators to validate their impact or the potential benefit of alternate solutions offered, we have been faced with a series of **untested, unfunded**, and in some instances **impractical** and inefficient regulations which created costly patient, provider, fiscal intermediary, and state surveyor problems.

I hope that this distinguished committee can affect changes which continued reactive "fixes" for current problems but, instead, establishes guidelines for a more efficient, proactive governmental process for change implementation which requires industry participation in both developmental and implementation phases.

I have been a home health care provider for over 18 years. Many regulatory changes occurred which required innovative adaptations. In the last 2 years, I have spent the majority of my time administering system changes and cost containment resource management at the expense of the clinical support of the patient. It saddens me to see our limited resources devoted toward paper compliance and away from the provision of direct care, to see peer providers close their doors or eliminate center of excellence programs for wounds, strokes, or diabetes, in response to the demands of **unfunded or underfunded** regulatory mandates.

Home Health Outreach is a community-based, system affiliated home care agency. We are an independent, proprietary subsidiary of a non-profit system and may not rely on the system resources for financial support to subsidize losses incurred by reimbursement cut-backs. We serve a population in both urban and rural areas of two counties of Michigan. Through patient satisfaction surveys and ICAHO accreditation with Commendation we demonstrate our commitment to our patients. In 1998, we admitted 934 Medicare patients. In Michigan we are in the top twenty percent of Medicare certified agencies by size and in cost-effective, utilization control.

In 1993, the Michigan Home Health Association hosted and became one of the founding members of the Prospective Payment System Workgroup. I have been an active member of that group since its inception. The workgroup was formed to develop a program which would move home care reimbursement from the current lowest of cost, visit limit, or charge based system to a prospective payment system offering cost effective quality care to the Medicare home health program, while assuring access to qualified recipients including complex, chronically unstable patients, and providing equitable reimbursement for home care providers. National and state associations worked together to design and support a unified PPS plan.

In 1995 both houses of Congress passed legislation which contain many of the key elements of that unified plan. If that budget bill not been vetoed, we would already be under a home care PPS program. Our discussion today would not be about how to respond to the cumulative effects of the temporary fixes of IPS and regulatory micromanagement but, perhaps, on how to further improve both the system and the Medicare home health benefit based on the cost-savings experienced.

In March, the 1999 CBO baseline figures for home health projected a five year saving of \$48 billion - the original projected savings with IPS were \$16.1 billion. The additional \$32 billion savings will come directly at the expense of the Medicare home health beneficiaries and their providers.

The provisions of BBA 97 were also projected to slow the rate of growth in home health to 5.3% for FY 1998. CBO's data now indicates a real **decline in growth of 15%**.

As is common among providers in Michigan and other regions, Home Health Outreach believes that cost-effective quality is not an oxymoron. Even prior to implementation of the home care Interim Payment System, our agency prided itself on its cost-containment efforts and were hundreds of thousands of dollars below our per visit cost limits. The VNA of Kalamazoo (\$11 million revenue organization serving a large portion of western Michigan) prior to IPS was under its visit limit by \$1 million. This was not just an effort to save Medicare dollars (although we were conscientious about that), but a planned response to managed care and preparation for Medicare Prospective Payment System.

"Challenging" does not begin to describe the effects on the majority of home care patients and their providers of the multiple regulatory changes which have followed enactment of BBA 1997. "Devastating" is how we now describe the true patient impact of the increasing depletion of a patient's personal resources, rehospitalization, institutionalization, and out-of-pocket expenses are coupled with limited or no-access home care zones.

"Cumulative" is a key word because as each new regulatory interpretation of legislative directives is issued, agencies who serve these elderly homebound patients, find that their limited financial and human resources cannot adequately meet the labor and cost intensive requirements. In essence, regulations are incrementally eliminating covered services by creating **unfunded mandates** if the provider is already at or above their cost limits.

As requested, I would like to address each mandate by patient impact, provider impact, and recommendations for your consideration. HCFA representatives may say that the recommendations are simplistic. I do not mean to imply that there are easy fixes to the reimbursement for health care services, but we have been experiencing extremely complex and impractical mandates, which have placed unnecessary and costly barriers between patient-centered services and providers. Perhaps, it is time to simplify .....

For the homebound elderly, the Medicare home health benefit has proven to be a godsend. A week doesn't go by that we don't hear what a difference home care has made for a particular patient and their caregivers. The most frequently heard response is that it allowed the patient to remain independent and at home instead of in an acute or long-term setting.

When we think of the cost of the program to the taxpayers, we often forget what a financial burden it also places on the patients we serve. We forget that besides the drugs, non-covered equipment and supplies, specialized diet requirements they need to control their conditions, patients and their caregivers must actively participate in their own care, and foot the bill for the rent, heat, light, water, and linens that home care staff use each visit to provide the needed services.

We also don't consider the costs for caregiver services during the time between our visits. **Recurrent calls for a co-pay on the home care benefit create a tax on the sickest elderly and ignore the patient's current subsidy of the benefit since it is the only site of Medicare reimbursed care which does not occur on the provider's premises.** One might argue that home care patients would incur these expenses regardless of our services. But these costs are higher because of our presence. If the patient were unable to provide these support services, they would most likely be in a higher cost setting for care.

### **THE INTERIM PAYMENT SYSTEM**

#### **PATIENT IMPACT**

We could debate the direct and indirect impact of IPS on home care recipients. I am here to report the impact that I have seen in our communities, and examples provided by peers in our state.

When IPS became effective for us in January of 1998, we sent a letter to our patients to explain what changes had occurred in our reimbursement and to define the program we establish in response. Because we had always fostered patient independence, we heightened our case management efforts to evaluate individual patient visit frequency, disciplines and available community resources.

For every visit includes greater involvement of the patient/caregiver in the plan of care, each patient must, with our assistance, find an alternate method of providing those services. For example, if nursing services were providing wound care, the nurse must work with the patient and/or caregiver to insure their willingness, availability, and ability to competently perform the dressing change either themselves or by hired help. Although the learning curve of an ill elderly patient is diminished, every effort is made to include greater portions of the teaching plan into each visit. Regardless of the ability to find someone to do the wound care there is still the issue of the assessment of the wound for signs of infection or response to treatment which requires a skilled professional. Some agencies can no longer afford specialists such as enterostomal therapists who bring their expertise to wound care.

As a nurse, I have personally seen the anxiety raised in the elderly spouse or caregiver of a patient receiving intravenous antibiotic therapy as they are told they will be trained to give the treatment. Do I believe we make every effort to assure the safety of the care providers before considering them independent? Yes. Do I believe that such case management decisions sometimes result in patient complications or non-compliance. Unfortunately, yes.

When home health aide services are being weaned from post-hospitalization patients as their strength slowly returns, many patient/caregiver just do not perform the personal care we train them to provide between agency visits because the patient or caregiver fatigues too easily during the process.

While every effort is made to find alternative resources for patients, in reality the frail elderly do not generally have the financial resources to supplement their care. Our community has many fine programs for ongoing supportive services, but there are not enough qualified providers to provide the care. Having strangers in their home while they are weak and ill is also stressful to our patients. They are more comfortable with services provided by certified agencies than by privately hired individuals because they consider our services professional and safer.

**ACCESS** to care is becoming a greater issue in Michigan, not just because over 10% of our state certified agencies have withdrawn from the Medicare program but even in areas where there are several providers, agencies have increased their admission criteria. In the Kalamazoo area, case managers/discharge planners report delayed hospital discharges and must contact several agencies to place cases when an agency willing to care for complex, acute but long-term patients. Even the agency who serviced the patient prior to their hospital admission occasionally refuse to readmit the patients because of the very real financial burden such cases place on the agency resources.

Again, this demonstrates the insidious nature of the IPS formula which disenfranchises the sickest, most compromised frail elderly from a benefit for which they are clearly qualified.

**Venipuncture** cases were closed. The VNA of Kalamazoo reports closing over 70 of these patients. Despite excellent case management discharge efforts, where are they now?

For some qualifying patients whose home care services are curtailed, Medicaid may provide some relief. But the number of agencies accepting Medicaid in Michigan has dropped dramatically this year including the single largest Medicaid provider in the state because their cost per visit have risen so dramatically they can no longer provide the service for the Medicaid fee screens.

#### **PROVIDER IMPACT**

In the pre-IPS world, Home Health Outreach like many of our peers was significantly under its per visit cost limits. Because IPS was heavily based on use of our historical cost-effectiveness, we had to drastically reduce our expenses. In response to IPS, our cost-containment efforts were premised on a desire to minimize the impact on our patients. We made a commitment to admit all patients for whom we had adequate resources for care.

To accomplish this goal we had to create a second budget, and delete any expense not deemed essential for short-term survival. Because the largest portion of a home care budget is wage-related, staffing was hit the hardest. We reduced FTE costs for in office and field by the equivalent of 19%. We reduced benefit costs, lowered or froze raises, cross-trained internal positions to cover sick and vacation leaves, left vacated positions unfilled, and deleted or curtailed plans for program expansions.

We had a capital budget to replace our antiquated AS400 with a PC network system for Y2K compliance and improved efficiencies. This was replaced by the purchase of 2 PCs and related software. One of the PCs is solely dedicated to OASIS. We have delayed the additional hardware and software purchases, such as a scanner, needed for OASIS implementation because of its suspension. We know we will have to incur these costs when OASIS is resurrected.

Despite every cost containment effort we attempted in achieving a 17% reduction in our costs, there remained sufficient fixed overhead coupled with the reduced visit volume to create a 14.5% cost per visit increase in one year.

	1998 AVERAGE COST/PATIENT	AVERAGE VISITS/PATIENT
National	\$3,987	65.6
Our Region (E N Central)	\$3,272	51.5
Michigan	\$3,285	44.7
Our agency per beneficiary limit	\$2,531	
Our actual per beneficiary costs	\$2,518	34

Under the HCFA current IPS formula, Medicare home health became a regional and in some instances an agency specific benefit. Reimbursement directly affected patient care access both in admission practices related to high cost/complex cases and to volume and type of service when admission did occur. **Because of the BPL (Per Beneficiary Limit), it also went from a lowest of cost, visit limit, or charge based system to a de facto capitated system.**

Because we did not receive our official FI notice of the agency's specific Per Beneficiary Limit until six months into our fiscal year, we could only estimate our potential revenue. Since that revenue also depended on a non-duplicated census based on a year-long criteria, we could not accurately budget for total revenue potential and had to guess how many patients we would admit.

In 1997 our average cost/visit was \$63.99

In 1998 our average cost/visit was \$73.90

At the same time as the Per Beneficiary Limit was implemented, the aggregate per visit cost limit was reduced. So, as the cost-effective agencies struggle to survive under their below average PBL, they had to avoid hitting their visit limits. In Michigan, the majority of agencies were adversely affected by the PBL but a smaller percentage of providers found the new visit limit untenable. As agencies struggle to balance between these two restrictions, the reality of significant losses became apparent.

We went from providing 45,929 Medicare visits in 1997 to 31,748 in 1998. I remind the committee that our pre-IPS visits/patient was well below the national and regional averages.

The impact of the loss of each of these visits to the patients involved would require a post-discharge survey of home care patients which has been suggested. But, the damage is already done. If patients experienced complications, were rehospitalized, or institutionalized, or just left without needed services, the reality for them is that the system failed.

#### **RECOMMENDATION**

- Eliminate the additional 15% increase from both IPS and the proposed PPS.
- Revisit the PBL and visit limits for those agencies under the national average.
- Move to a rational PPS by 10/1/2000 which assures access to care for the frail elderly, minimizes agency system changes, and addresses allowances for the fact that the system in whatever form it takes will be untested and will need interim adjustments to accommodate unforeseen inequities.
- Require provider input in the developmental and implementation phases of the PPS program.
- Require HCFA compliance with the Paper Reduction Act and reporting and comment periods for proposed changes.

#### **PER BENEFICIARY LIMIT OVERPAYMENTS**

While we can only verify 20 provider numbers being discontinued as of late last year, that figure represents about 8.5% percent of the agencies in Michigan. Ohio lost 65 providers, Illinois 68, and Indiana 127 agencies. This number does not reflect those agencies which have closed but not turned in their provider numbers and those agencies which have just finalized their cost reports for fiscal year ending 12/1/98 and are faced with the severe losses they have incurred, the size of the overpayments they must make, and are actively considering withdrawal from the Medicare program. The fallout is just beginning and the impact of each new unfunded mandate stacks the deck against providers and the patients they serve.

One southeast Michigan agency, whose fiscal year began day one of IPS (10/1/97), did not receive their official FI notification of PBL until April of 1998. Our agency's fiscal year began 1/1/98 and we received our official PBL on June 15th, 1998, 6 months too late to make some necessary changes.

#### **RECOMMENDATION**

- **Direct HCFA to permit longer periods of repayments based on the failure of the FIs to notify providers in a timely manner of their PBL.**
- **Consider relief from interest on those repayments**

#### **SEQUENTIAL BILLING**

BBA 97 split the Medicare home health benefit between Part A and Part B. HCFA was directed to make this change seamless. HCFA mandated that to monitor the "A to B shift" home health agencies were required to submit claims in a sequential order to their fiscal intermediaries. This **unfunded mandate** (for those agencies at their cost limits) required costly software and process changes for agencies and FIs. This was one of the areas in which providers and the FIs were equally frustrated and mutually supportive of relief.

**Patient Impact** on this issue is indirect and currently immeasurable. But it is certain that the se administrative expenses draw funding away from direct patient care at the agency level.

#### **PROVIDER IMPACT**

Our agency had to redesign the billing process, adding steps and making computer changes to accommodate sequential billing. The cost of this **unfunded mandate** can only be recouped if the agency remains under its Per Beneficiary and Visit cost limits.

Because HCFA mandates line item billing, some claims had to be divided into two claims because of volume of visits and the first claim had to be processed and paid before the second half of the bill could be sent. This resulted in up to 120 days delay in payment for us.

The line item mandate by HCFA was made without implementing their own internal computer system changes so the claim can only handle 57 items. When claims are in medical review, the sequential billing's cumulative effect is substantial.

We had a complex wound care patient with over \$25K (**NOTE: this patient is well over our Per Beneficiary Limit** and our agency must offset this expense by savings in the provision of care in the aggregate) in outstanding claims for 165 days. On average we have \$46 K on hold due to sequential billing.

Because the sequential process required one claim to be paid before the next claim for that patient could be processed, serious cash flow problems developed for agencies. This effect was magnified if the agency also had claims under medical review. Agencies attempted to get bridge loans but for some this was not possible. The interest expense for those agencies who could qualify for a loan are again costs which must fit under the cost limits to be recouped. Even agencies on Periodic Interim Payments experienced cash flow problems related to the FI withhold based on prior year experience. Our agency has not yet received approximately \$20K for fiscal year 1998 which will not be released until our cost report is reviewed and accepted by UGS.

(As an aside, due to IPS the cost report forms and software needed to be revised and were not available to providers until April of 1999 which precipitated a 1 month delay the June 1, 1999 submission deadline.)

Because of the delays in payments, the original intent of monitoring visit counts for the "A to B Shift" was not possible. With great industry effort and congressional support HCFA has notified all FIs that effective July 1, 1999 sequential billing will cease. Its impact has been serious and will continue for months to come. HCFA now indicates that it will be able to project the shift of payments for home health visits from the A to the B trust fund by counting the visits in the order in which they are processed. A simple fix. Too bad that wasn't considered in the first place.

Again, the inefficiency of the program as designed created unforeseen problems whose short and long-term repercussions are currently immeasurable.

#### **RECOMMENDATION**

**Thank your for suspension of this mandate!**

#### **PRORATION**

BBA 97 mandated that the reimbursement for patients who in the course of a year are served by more than one agency be prorated between the agencies. No formula or guidelines for the proration were defined. The stated intent of this mandate was to prevent "gaming" by systems with multiple locations to transfer patients to a higher reimbursement service areas. So again, to prevent the deeds of a few, all agencies had to add internal systems to monitor the impact of this mandate.

**PATIENT IMPACT**

"Snowbirds" who for health reasons move to warmer climates in the winter, will experience access to care issues if they need services continued following their migration. If the patient maintains their homebound status, the transfer should not jeopardize their access to care. This is also true for elderly patients who move into a family member's home at some distance from their own residence which does not permit continuation of service by the original provider.

What about the patient who rotates between children so that each can participate in their care without burdening any one child?

What about patient choice, if they decide they are not happy with the services of an agency, will other agencies refuse admission because reimbursement is reduced.

**PROVIDER IMPACT**

Although the FIs still do not have clear instructions on how to administer this item. Agencies who served patients with a prior agency in the same year may well still face a repayment request at cost report settlement or later.

Without access to accurate current information, agencies cannot determine whether a patient has been under another agency's care. Should the second agency pay the price for an open admission policy? How will each agency track its portion of anticipated revenue for budget purposes? Will the proration delay claim payments or be cost report settled?

Because of the considerable burden placed on them, feedback from our FI has indicated that they would not object to the elimination of this mandate.

**RECOMMENDATION**

As proration was a legislative mandate, congress should eliminate this requirement unless intent to abuse the system can be proven

**SURETY BONDS****PATIENT IMPACT**

No direct patient impact can be identified since this regulation was suspended before impact could be evaluated.

**PROVIDER IMPACT**

There is provider support for a reasonable surety bond process particularly for new agencies entering the program. As HCFA often pointed out, the surety bond was a legislative mandate. The precipitous manner in which the regulation was drafted, with little regard for the issues raised by both the home care and insurance industries, and the failure to design the plan along other industry templates or congressional bill proposals, left agencies little choice but to comply or close their doors.

Agencies went to great length to find a HCFA-compliant bond for which they qualified, and whose cost was not prohibitive. Carriers, in some instances, would not even consider bonding under the rigorous demands of the regulation. Many agencies in Michigan not even obtain a bond. Ironically, non-profit agencies experienced some of the greatest challenges because they had little or no equity. Some proprietary agencies were required to put their personal homes and property up as collateral. The costs associated with the search for and acquisition of a surety bond were a needless expense. The removal of the onerous surety bond regulations as written was appreciated.

**RECOMMENDATION**

- Include providers in the developmental of the requirements
- Limit the bond to a set minimum figure
- Consider removal of the bond requirement for agencies with a history of compliance

**OIG AND OPERATION RESTORE TRUST (ORT)**

Increased efforts by OIG and ORT were mandated by BBA 97.

**PATIENT IMPACT**

OIG fraud and abuse alerts to physicians also directly impact access to care for qualified patients. I have spoken with physicians who are afraid or unwilling to order needed home care services to qualified Medicare patients in frustration with documentation requirements and fear of penalties or loss of their Medicare provider number.

**PROVIDER IMPACT**

As a provider I support both industry and regulatory efforts which assure consistent and fair practices to weed out providers guilty of fraud and abuse. I attended a town hall meeting at which Nancy-Ann Min De Parle spoke .

She commented that some regulatory changes occur which impact all providers when they are addressing a practice of a relatively small number of providers. How sad that we must incur the cost of paper chases for causes which might more readily be addressed by the ordinary review practices of the fiscal intermediary and OIG.

How does an individual get a provider number with no background check, no office, no charts, no qualified staff, and no proof of compliance with the Conditions of Participation?

**RECOMMENDATION**

- Develop standards of practice with provider input for OIG and ORT to assure the competency of the surveyors and consistency of their practices.
- Issue alerts which also identify a physician's requirement to order and sign for needed services for qualified recipients.
- Establishment of Home Health Corporate Compliance Plan guidelines

**MANDATE THAT HOSPITALS OFFER PATIENTS A CHOICE OF AGENCIES**

As a hospital affiliate, I was actively involved in our system's response to this mandate. We have a well-defined process which includes a written list of providers. We are hearing from some of our patients, who may have been admitted to other institutions that this right is being denied, there have been two cases in the last month where the patient insisted that they wished to remain with their current provider and were not offered that option.

We are also seeing, in pockets across the state, an increase in physician specified agency orders which do not allow for patient choice.

**RECOMMENDATION**

- Continue HCFA educational and oversight efforts to assure facility compliance
- Instruct HCFA to issue educational bulletins to physicians about their role in compliance with this regulation

**BUNDLING OF MEDICAL SUPPLIES INTO THE HOME HEALTH**

BBA 97 states that, in the case of home health services furnished... under the plan of care of a home health agency, payment shall be made to the agency. HCFA has interpreted this to mean that any durable medical equipment (dme) regardless of who furnished it is to be reimbursed through the home health agency.

**PATIENT IMPACT**

The confusion this planned mandate will cause for patients is significant. Who should they call for equipment problems? Must they order supplies through the home care agency or can they call the dme? What if some of the equipment and supplies are non-reimbursable items, must they order from two different places?

**PROVIDER IMPACT**

As we speak, HCFA staff are working on "bundling of durable medical equipment " into home health and without regard for supplier-patient relationships or the tremendous billing process, operational logistics, and software burden such a move will place on both home health agencies and durable equipment providers.

Given the shorter home health stay of most Medicare beneficiaries, it seems impractical for the home health agency to bill for one or two months of dme use and then transfer the billing to a dme. Worse yet, it is a needless **unfunded mandate** for (for agencies who are at their cost limits) to continue billing for a bed long after they have discontinued their own services. Our computer billing systems will need to be revised, billers retrained, we have no resources for access to dme from vendors who may be unwilling to wait for reimbursement until the home health agency with its financial challenges can send payment. How will this impact patient access to care? How will home health agencies assure the safety and maintenance of the equipment.?

Will this be yet another minutia-laden over-interpretation of BBA 97 intent?

**RECOMMENDATION**

- Congress should clarify the definition of "furnished" as it appeared in BBA 97
- Bundling should be postponed or eliminated until cost/value analysis can demonstrate that the process will not further erode resources from bedside care to administration.
- Direct HCFA to include both dme and home health providers in any development of such a process

**MEDICAL REVIEW**

As part of its integrity processes, HCFA has stepped up its medical review both focused and general. As mentioned under sequential billing the medical review process halts claims processing and while it is more devastating under sequential billing, it will still affect cash flow after sequential billing ends because the claim is not processed until the review is complete.

Medical Review concerns fall into three general categories:

1. Lack of adequate notification of both the review itself and of the documentation requested. It takes considerable extra billing oversight to identify claims in the medical review process but for which the agency has not received an ADR (Additional Development Request or 488)
2. Random screen generated focused reviews, which can result in multiple claims being reviewed at one time for an individual agency. No agency should have to experience more than 10% of their claims in review at any given time.

When a 488 (ADR) is received the provider has thirty days to copy requested records and forward related comments to the medical review team of their FI which then must process the response and issue a decision. Our experience has been about 60 days until payment or the decision is received.

If the claim is denied, the agency then must decide to accept the decision or pursue reconsideration. This process requires the consent of the patient for the agency to act as their representative in pursuit of reimbursement. Because of the delay in receipt of some 488s or because the patient is unwilling or unable to authorize this protection of their benefit, many rejection appeals cannot be undertaken.

If the reconsideration also results in a denial, the agency may take the appeal to the ALJ (administrative law judge) level. Ironically, when an agency has the resources of time (the process may take up to 2 years) and money to pursue the ALJ process, the vast majority of the appeals are adjudicated in favor of the beneficiary and provider. For example, medical review claims in Vermont rose from 713 in 1997 to 4,636 in 1998. Of the small percentage of claims that were denied, 83% of the denials were appealed, and 93% of the appealed denials were reverse.

3. Because multiple focused reviews are being run concurrently, and are not agency specific, some agencies have experienced a significant increase in reviews.

#### **PATIENT IMPACT**

If a patient's service is denied because the FI interprets the care as medically unnecessary, the patient may have qualifying services denied. Agencies may selectively deny admission to patients whose diagnosis trigger such denials and the prolonged appeal processes necessary to obtain reimbursement. This will lead to systematic disenfranchisement of beneficiaries primarily with complex, chronically unstable conditions from services covered under the home health benefit.

**RECOMMENDATION**

- Mandate HCFA adhere to a 10% limit on medical review per provider
- Authorize FIs to streamline the review process with provider input and standardize the guidelines for interpretation of benefit

**OASIS**

HCFA indicated that OASIS was essential to the design and implement of a Prospective Payment System. It announced OASIS regulations in early 1999 with an April 26, 1999 implementation date based on a small demonstration project whose participants received software and consulting services. HCFA now indicates that little or no information from OASIS will be used in the development of PPS.

The final plan as implemented was untested in several key areas which demonstration project participants indicate created serious challenges even for them. Most notable about these changes were the mandated time frames for collection, encoding, and transmission.

HCFA did make HAVEN software available to providers but agencies had to have PCs with specific memory and modem capability. State agents, in our case, the Michigan Department of Consumer & Industry Services (MDCIS) expended great time and financial resources to educate providers on the implementation. A common response from the MDCIS to provider questions regarding particular implementation features or situations was "We don't know." "The manual does not address that issue."

In its Interim final rule (Federal Register/Vol. 64, NO. 15/January 25, 1999), HCFA invoked a Waiver from Proposed Rulemaking Process on page 3755. HCFA provided its opinion about the impact of its rule as relates to the Regulatory Flexibility Act and the Unfunded Mandate Act of 1995 and its projected costs associated with the rule making on pages 3758 - 3762. Some key projections:

Agency Startup costs \$11.4 million (\$5.2 million in Medicare program costs)  
 Ongoing annual costs \$25 million (\$22 million for agencies/ \$3 million for states)  
 Approximately \$10.1 million of the \$22 million would be reimbursed by Medicare  
 \$3 million will be paid by HCFA for state agents

**Who pays the rest?**

Since these costs are subject to the PBL and visit cost limits an agency barely able to provide service under its limits will not be reimbursed for any OASIS costs over those limit. (An unfunded mandate).

Assumptions made for the estimates include:

- Half of the 10, 492 home health agencies already possess the required hardware for encoding and transmission for OASIS data.
- Since OASIS is mandated for non-Medicare patients, HCFA estimates that 54% of the costs will be absorbed by Medicaid, the beneficiaries themselves, and private insurance. (None of whom gave consent for this expense. Providers are not permitted to charge Medicare beneficiaries for our services our their related costs))
- Each agency was projected to have only \$170 in staff training costs

I refer you to the HCFA estimate costs in tables on page 3760 Attachment A

No consideration was given for learning curve time.

#### **PATIENT IMPACT**

Before OASIS, patients admitted to our services received a comprehensive assessment on admission, following hospitalization, and two weeks prior to recertification to permit determination of eligibility for continuing services and to allow sufficient time to obtain signed physician orders for the revised plan of care. In reality, each patient receives an all system assessment on each nursing visit. Our admission assessment sheet was 4 pages single sided (small print). The assessment passed survey and certification as meeting comprehensive assessment guidelines.

Our agency chose to use a pre-printed OASIS document purchased from a vendor so we could scan to reduce overhead costs for both input and encoding of OASIS. The admission form for that set is 20 pages long.

The 79 OASIS admission questions must be asked and answered as written for data on each admission. There are in addition separate OASIS data sets require on resumption of service following in-patient care, when the patient experiences a significant change in condition, upon transfer of the patient to a facility, and upon death or discharge. The data set must be incorporated into a comprehensive patient assessment. For our agency that meant an additional sheet which included such important information which is not part of OASIS data set as a patient's vital signs, documentation of skilled care provided, and other required items to meet Conditions of Participation and accreditation requirements.

#### **Clients Right to Confidentiality.**

Protection of client confidentiality has been under-researched for OASIS and threatens to undermine the confidence clients place in their providers who must guarantee under the conditions of participation protection from uncontrolled access to client data

The mandated transmission of the OASIS data without secure protections in place and fully explained to patient's before they agree to participate is essential.

#### **Client Right to Participate in Care Decisions**

As a condition of participation, home care providers must assure a patients right to participate in their care decisions, which would include the right to accept or decline the OASIS data set. Since agencies have provided comprehensive assessments for years, OASIS as written is not essential to be in compliance with the Condition of Participation which requires a comprehensive assessment. HCFA recently added the OASIS requirements to the Condition of Participation.

While Medicare patients should not be denied the right to refuse OASIS, non-Medicare patients experienced even greater resistance and objections to the quantity, and personal aspects of several of the questions such as toileting patterns and who lives with them. Original indications from HCFA were that the agency could not admit a patient to service (Medicare or Non-Medicare) who refused to permit collection, encoding, or transmission of OASIS. Agencies should not have to deny admission to care for patients who refuse to participate in the OASIS process.

Situations which developed in the brief but chaotic OASIS launch include but are not limited to the following:

A patient with severe COPD developed shortness of breath during the OASIS assessment process and the interview had to be postponed to permit nursing intervention. Technically speaking the patient was still in the process of being admitted and should not have received hands on care until the assessment determined patient eligibility, but the nurse wisely felt that the patient's condition warranted admission and intervention.

A confused elderly man was unable to answer for himself, while some questions could be answered through observation, the caregiver in the home was a neighbor unfamiliar with the patient, the assessment was at best inadequate.

An elderly female patient, was rehospitalized twice in the first two weeks following OASIS implementation. Once for planned treatments, and once for an unplanned complication. Upon her return the second time, she was subjected to her third OASIS interview in two weeks, weak and tired she voiced her frustration by saying she wouldn't go back to the hospital, if it meant going through that list again.

Many of these situations did occur during the demonstration project but guidelines related to these issues were not included in HCFA instructions for OASIS implementation.

HCFA instructions state that the provider need not ask each question but can answer some through observation, and to some extent that is true. Once, you leave that option to the discretion of the interviewer you open the opportunity for less direct patient validation of data and greater risk of inaccurate data.

As a nurse, I must voice a very personal concern about one particular question area M0590 Depressive Feelings Reported or Observed in Patient which includes "thoughts of suicide". The OASIS data collection, in most cases, is the practitioner's first contact with the patient, we are strangers, invited guests in the home, and the patient-nurse relationship is being established. Unless the patient casually mentions in conversation they have thoughts of suicide, the nurse or therapist must ask "Are you experiencing thoughts of suicide." This is a totally unacceptable entry into a very delicate psychological assessment. Will it be perceived as a suggestion or recommendation? Will it trigger anger or rejection of service? Shouldn't this question be reworded to ask "How are you coping?" perhaps with a gradation system.

Many questions are duplicative or could be combine to achieve the same goals. For example, Can the patient dress their upper body? Can the patient dress their lower body? These two sections could be replaced with "Can the patient dress themselves?" In either case the answer triggers a need for assistance with dressing.

#### **PROVIDER IMPACT**

**Providers do not oppose collection of outcome data.**

We do oppose inefficient, duplicative, non-essential data collection, encoding and transmission which jeopardizes patient confidentiality, infringes on patient rights to participate in their care decisions. We oppose the implementation of such a system without adequate testing or the opportunity for response to provider comments, and most importantly we oppose lack of reimbursement for the total costs of implementation..

I have available for incorporation into the record copies of three different Michigan agency formats for OASIS. Each agency had to research, develop and/or purchase new forms, provide training to all applicable staff, and implement tracking, encoding, and transmission processes.

Again, a **unfunded mandate** (for agencies who have reached their cost limits) was imposed on the home care providers, already reeling from IPS, sequential billing, increased focused medical review. HCFA provided three manuals of instructions for each provider and Y2K. (See **attachment B Tables of Content for the three volume manual totaling 512 pages**). The cost just in paper for the Oasis manuals is significant. But the additional expense of reading, processing, and inservicing staff members on the requirements was far greater than HCFA predicted.

HCFA did, however, indicate that agencies may need to appoint a staff member to assure accuracy of OASIS data as part of their quality assurance. The cost of this staff member is not included in HCFA projections. See **attachment C for the letter we sent to HCFA during the comment period on our actual and estimated costs for the OASIS mandate.**

I would like to explore the funding issue a little deeper since it cuts to the heart of diverted limited resources from patient care to administration overhead.

In the Federal Register/Volume 64 No.15/Monday January 25, 1999, pages 3748 -3784, HCFA published its Interim Final Rule. The rule included the new Conditions of Participation related to reporting, encoding, and transmittal of OASIS data.

The requirements of OASIS are too numerous to address at this time, but one other area of concern should be mentioned. The recertification OASIS assessment must be completed between days 57 - 62 of service. Most agencies perform a reassessment visit two weeks prior to recertification to determine if the patient qualifies for continuing care and to obtain the signed orders of the physician needed for the changes in the plan of care as mandated.

Visiting the patient again between the 57 - 62 day adds the administrative costs of a visit which may not be needed and which the physician may not feel is warranted and for which he/she will not give orders.

**If the timeframe for the recertification OASIS was changed to the 44-48th day of service both issues could be addressed.**

To implement OASIS both clinical and billing operations had to completely revise our record processing systems and clerks had to be assigned schedules for OASIS encoding to maximize computer time and efficiency.

In the last week before OASIS was suspended, our agency's OASIS dedicated computer "froze" and all input to that date was lost. We had to purchase a software program called ACCESS (\$371) and a new zip drive and diskettes (\$270) which allowed us to recreate the lost data.

Had that not been possible we would have been out of compliance with the encoding timeframes and would have had to reenter weeks of data.

#### **RECOMMENDATION**

##### **Delay OASIS until:**

- Congress passes legislation on Patients Rights
- CBO with provider input analyzes cost/value ratio
- HCFA with provider input can reduce OASIS to a minimum data set at fewer intervals and more realistic timeframes for collection, encoding, and transmission

##### **Require OASIS on Medicare patients only**

**Do not condition provision of service on patient acceptance of the OASIS process**

#### **15 MINUTE INCREMENT VISIT REPORTING**

In the April 28, 1999 HCFA (UNITED GOVERNMENT SERVICES, LLC) HCFA Medicare Memo agencies were notified of the statutory requirements for home health service claims to include a 15 minute increment reporting provision (Section 4603 (c) BBA 97 effective 7/1/1999).

While we anticipated a mandate to report visit time, agencies expected a simpler methodology. Agencies have, as a practical matter historically maintained time studies of both visit and non-visit activities for payroll as well as quality assurance purposes.

A simple "time in/time out" formula would require minimal system changes.

It is my understanding that BBA 's intent in this area was to assure that patient services were not adversely affected by either IPS or PPS.

Was it congress's intent that the 15 minute requirement be labor-intensive and micro-managed? Did HCFA exceed congressional intent? Was there provider input to address both identified problems and potential solutions?

HCFA has indicated that they require the specificity of the data in order to assign dollar amounts to the case mix adjustment categories of PPS.

A visit is defined as an encounter of personal contact with the patient by the staff of the HHA or those under contract with the HHA, for purposes of providing covered home health services.

Each discipline will be given an assigned code and must record the elapsed time of the visit in 15 minute increments. HCFA has added 6 new (HCPCS) procedure codes in addition to those discipline specific revenue codes which are already used. This seemingly minor detail will require increased computer software, and data entry staff costs.

The requirement of time verification is not the concern, it is the exceptions which will require field staff to stop and start their "stopwatches" in order to delete the items HCFA has arbitrarily determined do not constitute allowable time.

HCFA instructions indicate that travel time and administrative services such as charting are not included. Only time actively "treating" the patient should be counted.

Additional HCFA examples of non-allowed time include a patient telephone call over 3 minutes, washing dishes by a home health aide, contacts with the physician from outside of the patient's home.

Each visit must be reported on a separate line excluding services less than 8 minutes. Time intervals are to be reported on separate lines for each visit in "units" defined in a HCFA chart. The sum of the allowable minutes must be converted to units before entry on the claim (UB92).

#### **PATIENT IMPACT**

Time studies will disrupt patient care activity and distract providers from their primary purpose. Patients may feel rushed if they answer the phone from a caregiver.

#### **PROVIDER IMPACT**

There are several operational issues as well as philosophical ones related to counting only "active patient treatment" time during a home care visit. Many cases involve care coordination of phone contacts with physicians, labs, equipment companies, case managers, therapists, and other community resources.

The HIM 11 clearly identifies the components of care which constitute a Medicare visit. charting is included in that definition. Charting time in the home must be included as skilled care.

Exclusion of dishwashing by the aide who also performed a bath and meal preparation is again in conflict with the HIM11 section 206.2 which states that the incidental provision of household tasks is permitted under the home health services provision. To leave dirty dishes would be unsanitary.

Travel time is not counted but in rural areas and in grid-locked urban areas time is money and time impacts patient care costs.

Again, we have an **unfunded, untested mandate** if providers are already at their cost limits. To implement this mandate agencies must create a new time documentation sheet, run concurrent time studies (one for payroll and quality assurance purposes and one for this new mandate, revise their UB92 software, inservice both field and billing staff, establish a new tracking system to collect, calculate, and data input the individual visit "units".

How will compliance by field staff in accurately recording allowable time be monitored?

Will this be yet another fiasco of a regulatory process which requires a "fix?"

#### **RECOMMENDATION**

- Because of the software and data entry implications in this Y2K year delay implementation for the proposed 15 minute increment rules until a cost/value analysis can be completed and a simpler, less costly format can be designed with provider input
- Use a simple time in/time out visit calculation
- Eliminate the duplicity of the HCPCS codes since revenue codes already exist

#### **CONCLUSION**

Will the new payment system and regulatory overkill hurt our seniors?

I believe the answer is "they already have." The cumulative effect of the minutia laden rules and regulations will continue to erode the home health benefit and access to it, especially for the frailest, most ill elderly.

In the name of Medicare "cost-containment" we are seeing dramatic increases in cost-shifting to beneficiaries, their caregivers, home health providers, Medicaid, and in-patient settings, emergent care, extended care facilities, and other community resources. This subsidy of the benefit is both unfair and in the long-term will be more costly. Older Americans already spend about 20% of their incomes on health care, compared with 8% for working Americans.

I ask your committee in its oversight role of governmental affairs to let providers partner with legislative and regulatory bodies to fix what is broken and begin proactively creating a cost-effective, efficient home health benefit.

Let us jointly commit to maximizing dollars spent on direct care and minimizing inefficient, impractical, and unnecessary regulatory mandates.

I would like to recognize the efforts of the staff of Home Health Outreach and members of the Michigan Home Health Association who contributed to the preparation of this testimony.

Again thank you Chairman Collins, Senator Levin, and members of this subcommittee for your attention to this crucial issue.....

The following tables show our estimates of national costs for OASIS reporting.

## ATTACHMENT A

TABLE I.—NATIONAL START-UP COSTS FOR OASIS REPORTING

FY	Number of agencies incurring start-up costs	Start-up costs (in millions) <sup>1</sup>	Medicare costs (in millions)	Costs to other sources (in millions) <sup>3</sup>
1999 and 2000 <sup>1</sup>	10,492	\$11.4 <sup>4</sup>	\$5.2	\$6.2
2001	0	0	0	0
2002	0	0	0	0
2003	0	0	0	0

TABLE II.—NATIONAL COSTS FOR OASIS REPORTING

FY	Number of HHAs	Total on-going costs (in millions) <sup>5</sup>	State Admin Costs (in millions) <sup>2</sup>	On-going Costs @ \$2,097 per HHA (in millions)	Medicare Costs (in millions)	Costs to Other sources (in millions) <sup>3</sup>
1999 <sup>1</sup>	10,492	\$25.0	\$3.0	\$22.0	\$10.1	\$11.9
2000 <sup>1</sup>	10,492	25.0	3.0	22.0	10.1	11.9
2001	10,492	25.0	3.0	22.0	10.1	11.9
2002	10,492	25.0	3.0	22.0	10.1	11.9
2003	10,492	25.0	3.0	22.0	10.1	11.9

Tables I and II reflect estimates of total costs versus incremental costs. These costs are based on the following assumptions:

- <sup>1</sup> Implementation will be in Fiscal years 1999 and 2000.
- <sup>2</sup> Expected to be absorbed within HCFA's program management appropriation.
- <sup>3</sup> Medicare will reimburse HHAs for their reasonable start-up and ongoing costs, subject to cost limits, based on the estimate that approximately 46% of HHA patients are Medicare beneficiaries. This estimate is reflected in Table I by indicating that 46% of \$11.4 million (or \$5.2 million) will be reimbursable by Medicare for start up costs. This estimate is also reflected in Table II by indicating that 46% of \$22.0 million (or \$10.1 million) will be reimbursable by Medicare for annual ongoing costs. These estimates may be overstated to the extent that reasonable cost determinations and application of cost limits reduce this expense. The remaining 54% of the start-up costs, or \$6.2 million in Table I, and the remaining 54% of the ongoing costs in Table II, or \$11.9 million annually may be absorbed by a combination of the Medicaid program, private insurers, and beneficiaries. Because approximately 23% of HHA patients are Medicaid beneficiaries, we expect HHAs to try to have the Medicaid programs absorb up to 23% of the \$11.4 million in start-up costs or \$2.6 million. Subtracting \$2.6 million from the remaining \$6.2 million start-up costs leaves \$3.6 million in start-up costs to be passed along to private insurers and beneficiaries. In a similar way, we expect HHAs to have the Medicaid programs absorb up to 23 per cent of the annual \$22.0 million in ongoing costs, or \$5.1 million. Subtracting \$5.1 million from the remaining \$11.9 million annual ongoing costs leaves \$6.8 million in annual ongoing costs. However, after implementation, ongoing costs become part of the HHA's base history.
- <sup>4</sup> See Table I—Estimated start-up costs include \$170.00 for training expenses x 10,492 HHAs (\$1.8 million). We estimate approximately \$1,829 per HHA to purchase computers x 5,246 HHAs because an estimated one half of the 10,492 HHAs already have the necessary computer equipment (\$9.6 million). Therefore, \$1.8 million + \$9.6 million = \$11.4 million.
- <sup>5</sup> The total of start up costs and ongoing costs equals \$61.4 million. This is based on an estimated start up cost of \$11.4 million for Fiscal years 1999 and 2000, and ongoing costs of \$25 million per year, for those two years.

• **Hardware:** We estimate total hardware costs associated with automating the OASIS to be approximately \$1,829 for a typical HHA, which includes the computer and communications components capable of running OASIS software and transmitting OASIS assessments, and a laser printer. This estimate is based on the most recent cost data available for a system that includes an Intel Pentium processor. This system typically would use Windows 95 or Windows NT 4.0, and include at least 32 megabytes of RAM, 2 gigabytes disk space, a 3.5 floppy disk drive, CD-ROM drive, a color SVGA monitor, a mouse, a laser printer, and a 56 kbps modem connected to a dedicated telephone line. The cost estimate is based on the optimal system we anticipate that many HHAs will choose to purchase. However, at a minimum, HHAs should

have at least a 486-50 personal computer in a Windows 3.1 environment with 8 megabytes of RAM, at least 100 megabytes of available hard disk space, a VGA color monitor, keyboard, mouse, a 3.5 floppy drive, and a laser printer. All HHAs should have at least a 28.8 kbps modem for telecommunications of the data, as well as web browser software that supports dial-up communications for the transmission of HHA assessment data to the State. The communications capability must meet our specifications related to transmission of OASIS data.

• **Software:** HHAs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing) or other regulatory requirements for reporting patient information. However, HCFA has developed an OASIS data

entry system (that is, Home Assessment Validation and Entry, or "HAVEN") that is available to HHAs at no charge through HCFA's website at <http://www.hcfa.gov/medicare/hsqb/oasis/oasisshmp.htm>. HHAs may also request HAVEN on CD-ROM. Therefore, HHAs who plan to use HAVEN will need either Internet access (for example, a dial-up Internet Service Provider (ISP) account) or a CD-ROM drive in order to obtain and install the software. HAVEN will offer users the ability to collect OASIS assessments data in a database and transmit the data in a HCFA-standard format to State databases. The data entry software will import and export data in standard OASIS record format, maintain agency, patient, and employee information, enforce data integrity through rigorous edit checks, and provide comprehensive on-line help. It is recommended that the

Windows operating system be operated at a screen resolution of 800x600 for HAVEN. While HAVEN will operate at 640x480 resolution, the data entry forms will not be completely visible on the screen, and the user will need to scroll to view some of the variables.

- **Supplies:** Supplies necessary for collection and transmission of data, including forms, diskettes, computer paper, and toner, will vary according to the size of the agency, the number of patients served, and the number of assessments conducted. We anticipate that an average HHA with 486 admissions per year will incur approximately \$250 in costs for supplies.

- **Maintenance:** There are costs associated with normal maintenance of computer equipment such as the replacement of disk drives or memory chips. Typically, such maintenance is provided through extended warranty agreements with the original equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than \$100 per year.

- **Training:** HHA staff will require training on encoding assessments and compiling OASIS data for electronic submission. One person in each agency should be trained in data entry and data transmission procedures and requirements. We expect that this initial training will require about 5.5 hours of staff time, and will cost an average HHA about \$170 based on an average hourly rate of \$12.50 for technical staff. This cost also includes travel expenses and travel time, since facility staff may need to travel to a centralized training site within the State (we anticipate that training will be provided in multiple sites in the State once the system is implemented). We expect that the State survey agencies will supply this training.

- **Data Entry:** HHAs have flexibility in choosing the method used to collect OASIS data, but the method must comply with our requirement for safeguarding the confidentiality of clinical records. HHAs must collect and transmit OASIS data to the State survey agency, at a minimum, on a monthly basis. The data may be entered directly by a technical staff member from a paper document completed by a clinical staff member, or by a data entry operator under contract to the HHA to key in data. Additionally, HHAs must allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks at the State data-editing level. We estimate that an average HHA with 486 admissions per year will incur an

annual data entry cost of \$1,557 per year, based on an estimate of 2.5 assessments per admission and an hourly rate for data entry costs of \$12.50. This cost includes data review and entry, as well as a (recommended) 15 minute monthly data entry audit for quality assurance purposes.

- **Ongoing Data Transmission:** HHAs will fund the cost of transmitting OASIS data to their respective State agencies. HHA staff must also manage the data transmission function, correct communications problems, and manage report logs and validation reports transmitted from the State. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program. This staff time will cost an average size HHA about \$150 per year based on an hourly rate of \$12.50.

- Some States will opt to provide their HHAs with a toll-free line to use their transmitting their data. However, in the States that choose not to do so, we estimate that an average HHA will incur about \$36 per year to electronically report its OASIS data to the State.

#### States

We expect that overall responsibility for fulfilling requirements to operate the State OASIS system will rest with the State survey agency. OASIS data will be maintained on the standard State systems that currently house the MDS assessments being reported by all certified nursing homes. HCFA has already procured and installed this system in each State survey agency. It is currently being used to collect the MDS data and to configure reports that will be used by the State surveyors to better focus surveys. However, there are some States in which responsibility for the long term survey and certification functions are located in different components of the State agency than the home health survey and certification functions. HCFA will fund the purchase and installation of a computer workstation in these States, so that the non-long term care surveyors will have direct access to the OASIS data.

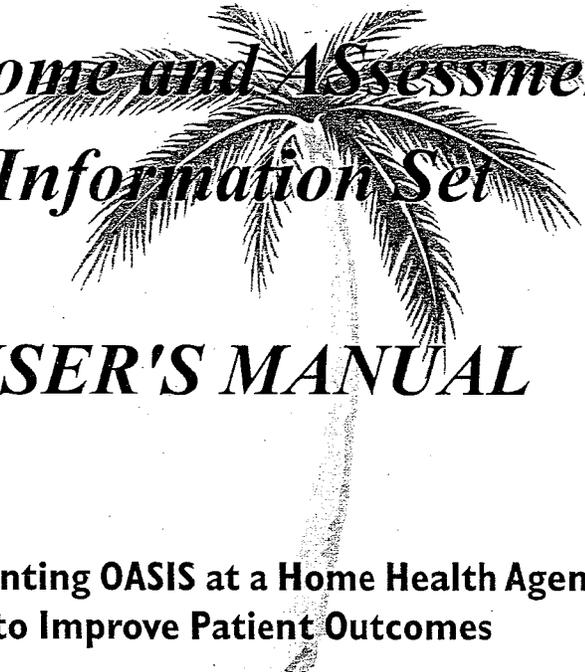
Since HCFA has already deployed computer hardware and software to the States to operate the MDS automated system, the entity operating the MDS system will also be responsible for day-to-day operations of the OASIS system. In most cases, the State is operating the system itself. However, several States have exercised their option to enter into an agreement with either the State Medicaid agency, another State component, or a private contractor to perform the day-to-day operations of the

MDS system. Just as we required for MDS data, prior to entering an agreement with a subcontractor to extend support for OASIS data, a State must receive approval from its respective HCFA regional office if the State OASIS system is to be operated by an entity other than the survey agency. If the State system is operated by an entity other than the State survey agency, the State must ensure that the survey agency has suitable access to this system to fully support all OASIS-driven functions that the State will require of the survey agency (for example, quality indicator reporting and survey targeting). The State is also responsible for maintaining OASIS data for retrieval by HCFA to a central repository to be established by HCFA.

States will use OASIS data primarily to focus the home health survey process and to provide HHAs and consumers with OASIS-driven information. As previously mentioned, the OASIS information will be maintained on the already existing MDS system which currently includes a database, communication, supporting file(s), and print servers for client workstations; local and wide area data networks; and application software for performing all aspects of MDS related functions and tasks. This system has been designed and developed within a broad class of systems known as Client/Server architecture.

We are providing the OASIS system to States primarily for use in the survey and certification program. As such, most Federally reimbursable costs incurred by the States for automating the OASIS will be funded through the Medicare survey and certification program. However, some States could also choose to use OASIS data in administering their Medicaid programs. When that is the case, Federal reimbursement is applicable to the extent that a State uses the OASIS for administering its Medicaid program. As a result, it may be appropriate for a State to allocate some OASIS costs to its Medicaid administrative cost claims.

When a State does use OASIS in administering its Medicaid programs, it should apportion Federal costs associated with automating the OASIS and operating the data system between the Medicare survey and certification program and the Medicaid program (as administrative costs, when applicable). The State should apportion OASIS costs to these programs based on the State's determination of each program's utilization of the OASIS system. The Federal financial participation rate for costs apportioned as Medicaid administrative costs is 50 percent. When



*Outcome and Assessment  
Information Set*

**USER'S MANUAL**

**Implementing OASIS at a Home Health Agency  
to Improve Patient Outcomes**

*1998*



## OUTCOME AND ASSESSMENT INFORMATION SET USER'S MANUAL

This manual is intended for use by home health agencies in implementing the HCFA regulations for comprehensive patient assessments, including data collection and data reporting using the Outcome and ASSessment Information Set (OASIS). It consists of three separate manuals in a single volume:

*Outcome and ASsessment Information Set Implementation Manual: Implementing OASIS at a Home Health Agency to Improve Patient Outcomes.*

This manual was prepared by the Center for Health Services and Policy Research, Denver, Colorado. It covers the overall OASIS implementation process from a clinical and management perspective and includes detailed information needed to train clinical staff to use OASIS as part of the comprehensive assessment and materials to assist operationally in the implementation of OASIS data collection and data reporting.

*Outcome and ASsessment Information Set (OASIS) National Automation Project: Home Health Agency System User's Guide.*

This manual was prepared by the Iowa Foundation for Medical Care, West Des Moines, Iowa. It covers the data submission process for home health agencies, including how to access the state system that will be used for electronic data submission, procedures for submitting data (including corrections of previously submitted data), and interpretation of feedback reports from the state system.

*OASIS Home Assessment Validation and Entry (HAVEN) System Reference Manual.*

This manual was prepared by Fu Associates, Arlington, Virginia. It covers the use of HAVEN software, which has been developed to provide home health agencies with software for data entry, editing, and validation of OASIS data. It includes information on setting up the software, defining agency and employee information, entering patient and assessment data, and data management functions.

*Outcome and ASsessment  
Information Set*

**IMPLEMENTATION  
MANUAL**

*Implementing OASIS  
at a Home Health Agency to  
Improve Patient Outcomes*

**1998**

*Department of Health and Human Services  
Health Care Financing Administration*

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OUTCOME AND ASSESSMENT INFORMATION SET (OASIS)

NATIONAL AUTOMATION PROJECT

HOME HEALTH AGENCY SYSTEM USER'S GUIDE

VERSION 1.0

October 1, 1998

Prepared for

Department of Health and Human Services  
Health Care Financing Administration  
7500 Security Boulevard, Building S2-11-07  
Baltimore, Maryland 21244

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*HAVEN System Software*

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*OASIS HOME ASSESSMENT VALIDATION AND  
ENTRY (HAVEN) SYSTEM REFERENCE MANUAL*

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*Production Version 1.00 Beta 3*

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*September 3, 1998*

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ATTACHMENT C

March 23, 1999

Health Care Financing Administration  
 Department of Health & Human Services  
 Attention HCFA-3006-IFC  
 P.O. Box 7517  
 Baltimore, Maryland 21244-1850

To Whom It May Concern:

In response to HCFA Regulations regarding 42CFR 484 and 488 the testing, transmission, information collection and encoding of OASIS data, we are submitting comments and recommendations as follows:

1. Federal register Volume 64 #15 Monday, January 25, 1999/Rules and Regulations, page 3760, table 1, example #3 indicates that "54% of the costs are to be covered by other payors and beneficiaries."

Comment: There is no requirement that third party payors be willing to assume this cost, especially since they did not request information. Beneficiaries do not incur any expense since HHAs are not allowed to bill for Medicare services. Recommend deletion of requirement for non-Medicare patients.

2. Page 3760 - Hardware

Comment: We are experiencing a need for significantly greater hard drive memory than predicted, resulting in a greater cost.

3. Page 3761 - Supplies

Comment: The projected cost of supplies prorated to our agency size (approximately twice the 486 admissions used to project cost) will be greater than \$500/year for our agency (see attached cost list).

4. Page 3761 - Training costs

Comment: HCFA's estimates do not include training costs for field RNs and Supervisors necessary for accuracy in data collection. Estimate for our agency: 4 meetings X 30 RNs X \$20/meeting = \$2400/annual. This estimate does not include on-going training or new hire training or Director and Computer Specialist inservices at state meetings. Cost \$50/for CS session and \$120 for Director training session in addition to hourly salaries totaling \$355 and mileage of 320 miles at approximately \$100.

*JCAHO Accreditation with Commendation*  
 1460 Walton, Suite 40 • Rochester Hills, MI 48309 • (248) 656-6757

## 5. Page 3761 - Data Entry

Comment: See agency cost estimates which reflect greater than 2.5 assessments per patient.

## 6. Page 3765

Comment: The requirement to implement OASIS nationally on such a tight time frame was explained as HCFA's need to have data for PPS. Sufficient accurate data will not be available for the April deadline to have PPS plan on Donna Shalala's desk.

## 7. Page 3769 - 3771 Standard: Update of Comprehensive Assessment

Comment: Inefficiency of 57-62 day requirement does require additional visits and costs since agencies must assess patient approximately 2 weeks prior to recert date in order to comply with timely return of physician signed orders for recert. Example: every 6 weeks patient with a foley, without aide services, extra visit required at a cost of approximately \$71/visit (including A & G costs).

Recommendation: Allow agency to collect recert OASIS at time of recert assessment for orders (approximately 18 to 14 days before expiration of certification).

Transfer to In Patient:

Recommendation: Eliminate this tool completely. The information can be obtained on reassessment OASIS following in-patient discharge from hospital.

Duplication of Demographic Data from OASIS assessment to OASIS assessment is unnecessary (i.e., age, race, S.S. number, etc.) Should be automatically transferable and not need to be written by clinician at each assessment.

## 8. Page 3775 - Unfunded Mandate Reform Act Section 202

Comment: Paperwork Reduction Act, HCFA did not comply with required comment period, citing requirement of need for "emergency review." How can a 10 year old project result in a need for emergency review? HCFA will not incur "harm to patients" since even the "emergency implementation of OASIS" will not provide sufficient reliable data for the development of a PPS for home care.

## 9. Page 3778 - Cost of forms

Comment: Cost of Forms: \$250 covers the printing cost for one months worth of 5 different required OASIS formats. Annual cost is \$3000/year.

- 10. Page 3778 - Additional time required to complete comprehensive assessment.

Comment: HCFA projected 2.5 minutes for additional OASIS assessment completion is a significant underestimate. Our experience is approximately 20 additional minutes is more accurate even after the learning curve period.

- 11. Page 3781

Comment: HCFA's estimate of only 3 additional pages is a severe underestimate since agencies must duplicate the 79 questions exactly as written in addition to incorporating into agency's comprehensive assessment in such essential areas as vital signs, etc. Our agencies pre OASIS/Comprehensive Assessment was 4 pages single sided. Our OASIS Assessment is 20 pages (10 pages double sided). This results in far greater than projected printing, filing, stapling costs than HCFA projected on page 3781 of the CFR.

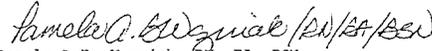
Recommendation: Cost reimbursement fully covered regardless of PBL or cost/visit limit as this is a non-budgeted mandate.

See attached agency breakdown of costs.

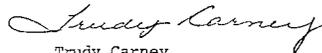
Respectfully Submitted,



Rosalind L. Stock, RN, BSN, CHCE  
Vice President Home Health Services



Pamela A.B. Wozniak, RN, BA, BSN  
Director of Clinical Services



Trudy Carney  
Director of Finance

LS/lms  
HCFAD

## ADDITIONAL AGENCY COSTS RELATED TO OASIS

1. Increased AG costs for non-reimbursable visits.
2. Increased cost/visit due to increased number of visits for recert of patients seen monthly or visit not planned at 57-62 days.
3. Clerical - additional time for filing.
  - a. Admission Assessment has increased from 4 pages (single side) to 20 pages (10 pages, double sided).
  - b. Additional two pages every time patient goes in to hospital.
  - c. Additional 20 pages every time current patient comes home from hospital.
  - d. Additional 12 pages every time patient recertified for service.
  - e. Additional 12 pages every time patient discharged from service.

Result potential additional 33 double sided pages for filling X 320 patients/month = additional 10,560 pages to be filed each month = a filing 4 pages/min. = additional 44 hours/month at \$8.50/hr = additional \$374.00/month or \$4,488/year. \*

\*Add this is only filing cost.

4. Scannable forms are not able to be NCR'd, thus field staff must make a copy for their files. 320 patients x additional 10,560 pages/month at .05 copy = \$528/month copy charge or \$6,336/year copy charge.
5. Printing fees 10,560 pages approximately \$250/month additional printing fees.
6. Staff must come in to office more frequently to submit paperwork in a timely manner to account for 48 hour time frames and 7 calendar day time frames for data entry. Staff previously in office average of once/week, now coming in 3 times/week. Additional mileage costs at .29/mile X 25 nurses X 20 additional miles = \$145/week = approximately \$600/month for additional miles.
7. Costs of purchasing scanner and software programs - \$12,000.
8. Additional clerical staff hours to encode data via scanner or data entry - 10 minutes/patient/month X 375 forms per month = 62.50 hours/month at \$9.00/hour = \$906/month to encode. Will results in 30 of overtime @ \$13.50/hr.

9. Additional QA/RN staff to review additional forms: 100 admissions/month, 75 recerts/month, 100 discharges/month, 100 hospitalizations/month (50 transfers in to hospital/50 resumption of care).

Additional paperwork to review:

	Previous	With OASIS
Admission	3 forms/10 pages	3 forms/26 pages
Recert	1 form/4 pages	2 forms/12 pages
Discharge	Not reviewed	1 form/12 pages
Hospitalization	Not reviewed	1 form/2 pages
Resumption	Not reviewed	1 form/20 pages
TOTAL	3 forms/14 pages/month	8 forms/52 pages/month

= approximately 3.5 times additional paperwork to review at \$19.00/hr X 60 hours/week approximately \$4,500/month

10. Additional storage - currently \$250/month at 3.5 X increase approximately \$800/month to store additional paperwork.
11. Additional phone costs to transmit data. Phone call .10/minute X 2 hours transmission per month = \$12/month.
12. Administrative time to review regulations, answer questions, arrange systems and products with vendors. 10 hr/week at \$23/hour - approximately \$12,000/year.
13. Postage additional pages for assessment for private insurance cases .55 X 30 month = \$16.50 month.
14. Purchase of new hardware:
- |         |         |
|---------|---------|
| PC      | \$2,000 |
| Printer | \$ 300  |
| Scanner | \$2,900 |
- Software:
- |          |       |
|----------|-------|
| Netscope | \$ 30 |
|----------|-------|

## ADDENDUM TO ATTACHMENT C

Per Unduplicated Patient = \$126,035.40 divided by 1146 = \$109.97 additional costs per patient.

	MONTH	YEAR
Filing (Payroll)*	374	4,488
Forms copying by staff	528	6,336
Printing	250	3,000
Mileage	600	7,200
Software for Scanner	1,000	12,000
Clerical (Payroll)*	697.50	8,370
QA (Payroll)*	4,500	54,000
Storage	800	9,600
Phone	12	144
Postage	16.50	198
Administrative Oversight (Payroll)*	1,000	12,000
Paper/Toner	35	420
*(Benefits)	689.95	8,279.40
TOTAL	10,502.95	126,035.40

OAC



SCHOOL OF PUBLIC HEALTH AND HEALTH SERVICES  
CENTER FOR HEALTH SERVICES RESEARCH & POLICY

**TESTIMONY OF BARBARA MARKHAM SMITH  
CENTER FOR HEALTH SERVICES RESEARCH AND POLICY  
GEORGE WASHINGTON UNIVERSITY**

**PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
COMMITTEE ON GOVERNMENTAL AFFAIRS  
JUNE 10, 1999**

Good morning, Madame Chairman, Senators. Thank you for inviting me here today to testify on a matter that not only affects Medicare beneficiaries who may need home health services now and in the future, but indeed affects the coherence and viability of the Medicare program itself.

My testimony, based on the preliminary findings of a study currently in progress, will suggest that as a result of the changes implemented in Medicare home health in the Balanced Budget Act of 1997, home health agencies in general are driven to change the case mix of their patients and alter the patterns of practice of the care they deliver to conform to reimbursement constraints. These constraints appear to be creating substantial tension with meeting the clinical needs of some patients. As a result, many seriously ill patients, especially diabetics, appear to have been displaced from Medicare home care. Other patients are experiencing significant

changes in services with effects on health status that are unknown but suggest greater risk as a result of fragmentation of services.

#### Background

The Center for Health Services Research and Policy at George Washington University is part of the School of Public Health of the George Washington University Medical Center. We operate as a non-profit, nonpartisan research institute within the university and are funded by grants from the federal and state governments, foundations, and private funders. The Center is currently conducting a descriptive study funded by the Home Health Services and Staffing Association and the National Association of Home Care on the effects of the changes in Medicare home health reimbursement on access to services and patterns of care. This study follows our previous analysis of the likely operation of the Medicare interim payment system for home health services released in 1998.<sup>1</sup>

#### The Study

The current study is designed to occur in two phases. The first, which is in progress now, is a detailed examination of the case mix, staffing patterns, and practice patterns of approximately 40 home health agencies in eight states from 1994 through 1998. Information on changes in practice patterns has been collected up through the present.

Because this phase of the study is not yet complete and is based on data provided from approximately half of the study agencies, I must strongly caution that the findings discussed in this

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<sup>1</sup>This study is available upon request from the Center for Health Services Research and Policy.

testimony are preliminary only and must be confirmed by the remainder of the study. Indeed, it is not our practice to discuss findings at this stage of the research, but I am presenting preliminary findings today at the request of the Committee. As a result, I will not be providing quantitative statistics but rather will focus on patterns and trends. It is also important to recognize that it is very soon after implementation of the BBA to be seeing large effects on beneficiaries; usually it takes time for providers to implement changes and then more time for the effects to be felt. Accordingly, these preliminary findings should be regarded as signals of what may lie ahead and may reflect a smaller impact than will be seen over time. The second phase of the study, which will be completed in the Fall, will focus on the spillover effects, if any, of Medicare home health reductions on other providers including other parts of the Medicare program and state Medicaid programs.

#### The Context for Understanding the Preliminary Findings

In order to understand the significance of the findings discussed, these findings need to be placed in the context of what we already know about home health outcomes and utilization. HCFA funded two major studies published in 1996 and 1998, by Georgetown University and Mathematica Policy Institute, Inc. looking at home health outcomes and regional variation in home care utilization. Taken together, those studies concluded that patients who received home care had significantly improved outcomes over similar patients who did not receive home care or those who received lesser amounts of home care. Further, the studies concluded that utilization generally, including regional variation in utilization, was generally appropriate to the health status of the beneficiaries served.

In other words, the Georgetown study found a strong dosage/outcome correlation in

home care. The Mathematica study demonstrated that high utilization regions generally had more patients with greater severity of illness than low use regions and that the difference in health status of the patients significantly accounted for the regional variations in home health use. In fact, the Mathematica study indicated that mortality rates 30-60 days after home care discharge were 34% higher in high use regions than in low use regions, confirming the fragility of the population in Medicare home care in those regions of the country. The Georgetown study specifically warned that, given the documented effects on health outcomes, models of reimbursement that attempted to force beneficiaries into a short-term model "should be implemented cautiously ... to assess the extent of possibly adverse effects on health...."

#### Preliminary Findings

With this context in mind regarding the ability of payment systems to adversely affect the health status of beneficiaries, the key preliminary findings of our study suggest significant potential effects on beneficiaries, particularly on those with unstable chronic illness or who have even short term intensive needs. It appears that those patients are being displaced from home care or are experiencing significant changes in services. These changes appear to be driven by reimbursement policies and intermediary scrutiny rather than clinical considerations. These preliminary findings can be summarized as follows.

- **Except for agencies whose utilization had dropped significantly below their 1994 averages by 1996, home health agencies in general are moving fairly aggressively to adjust their case mixes and/or their practice patterns to conform utilization to reimbursement; while intermediary practices have also clearly had an effect on both utilization and case mix, reimbursement changes appear to be the dominant driver**

of practice and case mix changes rather than clinical considerations. Some agencies use software that continuously modifies treatment guidelines for existing patients according to the reimbursement level of the agency. A number of agencies have achieved virtual reversals in their short stay/long stay ratios through changes in their patient mix. Other agencies that have been unable to change patient mixes characterized by large amounts of unstable chronic illness have significantly reduced visits and clinical staffing levels even as they have dramatically increased their patient census, raising serious quality concerns. These significant reductions in care in agencies with very adverse patient mixes are driven almost exclusively by reimbursement pressures and are most notable among agencies operating under national median limits in traditionally high cost regions.

- Both the interim payment system and fiscal intermediary policies have created a stratification of beneficiary desirability among providers: orthopedic rehabilitation patients, particularly joint replacements, coronary artery bypass graft (CABG) patients, non-diabetic post-operative wound care, and non-IV therapy, non-HIV infectious disease patients have become the "Brahmins" of desirable patients and are the focus of competition between agencies.
- Diabetics, particularly brittle diabetics, appear to have experienced the most displacement from home care. The extent to which complex diabetics are even being admitted to home care has declined significantly among the study agencies. A

substantial number of agencies report notable declines in their diabetic admissions. Among diabetics already in care, agencies report very aggressive efforts to discharge these patients to other sectors, some of which provide limited or capped amounts skilled care, others of which provide no skilled care. The extent of the decline in the home care diabetic census among the study agencies as well as the reductions in care to those in home care raise concerns about the long-term health status and outcomes of this population. Relatively low severity diabetics who simply require a few educational visits on diet and self-injection do not appear to be exposed to the same displacement. Agencies report carefully screening diabetics to assure that their needs will not exceed the agency's ability to care for them.

- Similar patterns of aggressively seeking discharge of congestive heart failure and chronic obstructive pulmonary disease also appear, although these patients do not appear to be subject to the same degree of exclusion. Some agencies report elimination of cardiac nurses from their staffs in order to avoid attracting referrals of these types of patients.
- Patients who require two or more visits daily or even one visit daily, even over a relatively short period of time, also appear to be experiencing significant home care displacement among the study agencies. Surprisingly, this has affected short-term IV therapy patients who may need care for only 3 to 6 weeks and whose care is unquestionably post-hospitalization and very acute. A number of agencies report

overt screening to exclude or limit care delivered to twice daily patients. This screening takes the form of declining these patients altogether on the basis of lack of capability to provide service or upon admission advising patients that the number of days care will be provided will be limited to a defined amount due to agency capabilities. The patient must have other care arrangements in place for early discharge at the time of home care admission. Some agencies report efforts to market their services in a way that avoids patients who require readmission to home care since the need for readmission is regarded as a marker for complex patients. Skin ulcer patients also appear to be experiencing adverse reductions in care as reported by the providers as a result of efforts to reduce the number of visits.

- While mental health services are not provided to a large degree in home care, many of the agencies that historically have provided such care are reducing or eliminating mental health services either because they do not intend to keep patients long enough to establish a therapeutic relationship or because they regard the staffing as too expensive a skill level. One agency characterized these services as a "luxury." Some agencies indicated that these patients can often be short stay patients who need simply some evaluation services or initial stabilization on medication and services for these patients appear to be unchanged.
- Surprisingly, foley catheter patients who are usually very long stay patients do not seem to be experiencing displacement. Agencies attributed this to the fact that while

these patients are long-stay patients, their intensity of care is fairly low enabling their care to be provided below whatever limits the agency is operating under.

- Home care agencies' perception of their mission has changed significantly; current treatment goals center around providing the minimum amount of care the patient needs to obtain stabilization in order to be discharged as quickly as possible; previous missions to prevent acute exacerbations of chronic illness or reduce hospitalizations have been sacrificed to a great extent.
- In many cases, agencies describe greater fragmentation of care that presents incrementally a new pattern: according to these agencies, patients are being discharged to home care in much sicker condition from hospitals, rapid discharge from home care is achieved upon first stabilization, the patient declines and returns to physician or hospital, and is then readmitted to home care. Some agencies report readmissions back and forth between hospital and home care. Whether this is a result of changes in hospital practice or home health agency practice cannot be determined in this study, but regardless of causation, it suggests greater fragmentation of care and provider avoidance of sicker patients.
- Agencies appear to be applying Medicare eligibility standards which require some judgment discretion more stringently to exclude patients that they previously would have qualified. This has been described as an effort to "bend over backwards not to

qualify a beneficiary" compared to previous efforts to "bend over backwards to qualify a beneficiary."

- Agencies report that some patients are paying 100% out of pocket for services that previously were covered by Medicare, particularly patients who are now excluded on the basis of failing to meet Medicare home care eligibility standards, venipuncture patients, and short-term intensive need patients. While beyond the scope of this testimony, there is evidence that venipuncture patients are experiencing substantial barriers to venipuncture services and paying out-of-pocket to maintain services.
- Except for agencies that have experienced large increases in their patient census or increases in patient severity, agencies generally are significantly reducing clinical and administrative staff. Physical therapists appear to be experiencing fewer staff reductions and in some cases increases, consistent with the healthier case mix agencies appear to be trying to achieve in emphasizing rehabilitation over nursing care. Many agencies indicate that they are having difficulty competing for nurses due to salary/benefit reductions combined with increased administrative responsibilities. This nursing shortage contributes to their need to screen patients.
- Agencies use different strategies to cut costs depending on their labor markets, service area epidemiology, demographics, agency size and availability of alternative

sources of care.

- While just appearing in a handful of agencies, there are some patterns that suggest harbingers of more serious problems. In particular, some non-profit agencies are relying on their endowments/foundations to support Medicare patients, indicating that reimbursement is not meeting the true costs of care and reducing their ability to provide charity care. Similarly, some hospital-based agencies have become "loss leaders" and their Medicare patients now are subsidized by other parts of the health systems in which they operate. How long their hospitals or the trustees of nonprofit free-standing agencies will continue to tolerate this cost-shifting is unclear. A refusal of the cost-shift in the future could further effect access to or quality of care. Finally, some agencies indicated that they are only accepting referrals from other agencies now because HCFA's methodology for proration is not in place. They indicated quite explicitly that that practice would stop if proration were implemented. Other agencies described current practices of accepting no referrals from other agencies. These changing practices could constrain access to care if beneficiaries mobility to obtain care is reduced.
- Physician referrals have declined dramatically in some areas for some home health agencies, apparently in response to fraud alert letters from HCFA. This has affected both the number of referrals and the scope of the referral. It is unclear whether or not this decline in referrals is clinically appropriate.

- **Anti-fraud measures, particularly increased intermediary scrutiny, have been effective in reducing utilization, although it appears that this scrutiny is creating some incentives for agencies to avoid patients whose health care needs/utilization might trigger a review.**
- **IPS has triggered some increased efficiencies and improvements in practice patterns. For example, agencies are working aggressively to get family members involved in care sooner, employing case managers to examine agency-wide practice patterns and manage more complex cases, and changing their emphasis from providing all the patient's care to encouraging independence and developing more strategies for independence. In addition, agencies are focusing more on achieving specific patient outcomes, although this tends to operate to attract more short-stay patients and exclude those with intractable chronic illnesses that are not a susceptible to specific outcomes. Agencies have also achieved significant reductions in administrative costs, although some of those reductions may create larger inefficiencies later on such as foregoing computer updating for Y2K or transferring administrative duties to clinical staff.**

#### Myths

The frequently expressed assumption that a large portion of the Medicare home health population can be or should be cared for in Medicaid nursing homes or home and community-

based waiver programs is without foundation. First, these programs have highly restrictive functional and financial requirements for participation that exceed the requirements for simple Medicaid eligibility and serve as significant barriers to qualifying for these services, even for dually-eligible beneficiaries. Variation between states is substantial. Most home and community-based waiver programs do not include skilled services. The fact that acute care needs drive most beneficiaries' presence in Medicare home care renders qualifying for Medicaid-related programs more difficult. States will not accept a burden that they define as Medicare's book of business.

Finally, except for nursing homes, these programs are not entitlements and beneficiaries — even if they can qualify — must queue to get services. For most Medicare beneficiaries, it is not a straight walk to Medicaid services. The alternatives are physician offices, emergency rooms, hospital care and SNFs in increasingly "bouncing ball" fashion, or no care at all which the preliminary finding of increasing fragmentation as well as anecdotal evidence certainly suggests.

#### Implications

The total number of Medicare patients admitted in 1998 to the agencies studied thus far has declined by almost 20% since 1994. Over the same time period, the Medicare population has increased by over 2 million beneficiaries. Home health claims nationally for 1998 actually experienced a net decline from 1997, a year in which the rate of growth of services had already dropped significantly. In a population that is aging and becoming more frail and in a health care environment that strongly disfavors hospitalization, this dramatic decline in beneficiaries receiving home care at all or experiencing reductions in services must raise serious concerns both for access to care and quality. It is safe to say that we really do not know where these patients are or how

their health status has been affected. Given the absence of more reassuring explanations such as the development of a cure for diabetes, the preliminary findings of this study suggest that barriers to care are operating in the system. Given the findings of previous outcomes studies, it is reasonable to assume that these barriers may be having significant impact on patient health status and may potentially create high costs in other Medicare sectors.

The preliminary findings strongly suggest that agencies are responding to IPS' incentives to avoid caring for the sickest and frailest beneficiaries, while relatively healthy beneficiaries may be experiencing improved access to more care. My concern is that we have carved out a wedge of the population who will find it increasingly difficult to get care in any sector, unwanted by hospitals, SNFs, or home health agencies because of the costs they generate to providers. The potential for an epidemic of unmanaged chronic illness and its resulting consequences is more than just speculative.

The preliminary findings suggest that IPS may be creating the illusion that we have controlled health care costs by acknowledging only the costs of taking care of relatively healthy people. It should be clearly understood that many of the sickest people may no longer be in the home care system. Accordingly, any PPS system that is based on utilization data from 1998 in my opinion may be deeply flawed and fail to address the true utilization needs of the eligible population. This in turn would have significant adverse consequences on beneficiary health status.

Given the payment incentives created by IPS, it is essential that previous outcomes studies be repeated to determine if adequate care is being provided in the current environment and if health status has suffered as a result of these changes. The absence of other quality assessment infrastructure during the implementation of fairly draconian changes in the program renders these studies all the more important.

I do appreciate your attention to this important issue and look forward to answering your questions.

H A N D O U T   P R E P A R E D   B Y

**Barbara Markham Smith**  
Senior Researcher, Center for Health Services Research and Policy  
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Washington, D. C.

**MEDICARE HOME CARE BENEFICIARIES  
KEY FACTS**

*Income*

All home care beneficiaries

14.3% - \$5000 or less  
55.5% - \$5001 - 15,000  
16.8% - \$15,001 - 25,000  
13.5% - \$25,001 or more

High use beneficiaries (defined as more than 200 visits)

19.0% - \$5000 or less  
61.0% - \$5001 - 15,000  
13.5% - \$15,001 - 25,000  
6.3% - \$25,001 or more

*Race*

All home care beneficiaries

White - 81.1%  
Black - 11.8%  
Hispanic - 5.6%  
Other - 1.6%

High users

White - 64.8%  
Black - 24.4%  
Hispanic - 8.8%  
Other - 1.9%

***Gender*****All home care beneficiaries**

Female - 68.1%

**High users**

Female - 76.4%

***Age*****All home care beneficiaries**

65-74 years - 27.6%

75-84 years - 40.1%

85+ years - 25.5%

**High users**

65-74 years - 23.0%

75-84 years - 41.3%

85+ years - 27.9%

***Functional status* (number of impairments in activities of daily living or ADLs)****All beneficiaries**

Mean number of ADLs	-	2.6
Percent with 0 ADLs	-	25.4
Percent with 5-6 ADLs	-	27.3

**High users**

Mean number of ADLs	-	4.0
Percent with 0 ADLs	-	4.8
Percent with 5-6 ADLs	-	52.0

*Clinical diagnoses associated with increased utilization*

Primary diagnosis: nonwhite, serious neuromuscular or degenerative disease, stroke, anemia, malnutrition or dehydration, peripheral vascular disease, urinary tract disorder (including incontinence), complicated wound (related to diabetes).

Secondary diagnosis: incontinence or neurological disease.

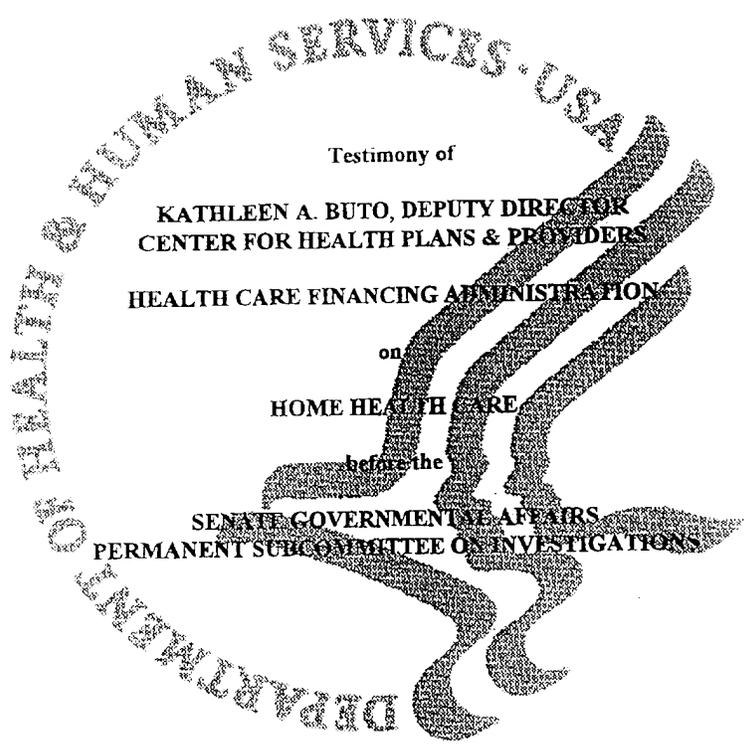
*Home health patient outcomes by region (percentage of home care population)*

Outcome	Pacific	Middle Atlantic	U.S. Overall	West South Central	East South Central
Readmitted to home care 31-60 days after home care discharge	8.4	8.9	11.0	13.5	19.3
Readmitted to hospital within 30 days of home care discharge	19.6	22.8	22.4	23.8	26.0
Died within 30 days of home care discharge	11.6	10.7	12.4	13.6	16.3

*Percentage by which adverse outcomes in high use regions exceed percentage of adverse outcomes in low use regions*

Outcome	Percentage of increased adverse outcomes in high use regions
Readmitted to home care 31-60 days after home care discharge	89.6
Readmitted to hospital within 30 days of home care discharge	17.5
Died within 30 days of home care discharge	34.0

Source of beneficiary diagnosis and outcomes data: Jennifer Schore, Mathematica Policy Research, *Regional Variation in Medicare Home Health Use: Taking a Closer Look (Findings in Brief)* (1996).



Testimony of

**KATHLEEN A. BUTO, DEPUTY DIRECTOR  
CENTER FOR HEALTH PLANS & PROVIDERS**

**HEALTH CARE FINANCING ADMINISTRATION**

on

**HOME HEALTH CARE**

before the

**SENATE GOVERNMENTAL AFFAIRS  
PERMANENT SUBCOMMITTEE ON INVESTIGATIONS**

JUNE 10, 1999



TESTIMONY  
KATHY BUTO, DEPUTY DIRECTOR  
CENTER FOR HEALTH PLANS & PROVIDERS  
HEALTH CARE FINANCING ADMINISTRATION  
on  
HOME HEALTH CARE PAYMENT REFORMS  
before the  
SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
JUNE 10, 1999

Chairman Collins, Senator Levin, distinguished Subcommittee members, thank you for inviting us to discuss the impact of home health care payment reforms. Home health is an essential benefit for millions of beneficiaries. Unfortunately, expenditures were growing at an unsustainable rate. Medicare home health spending more than tripled in the early to mid-1990s, while the number of beneficiaries receiving services doubled, and several studies documented widespread fraud, waste, and abuse.

The Balanced Budget Act addressed these concerns by closing loopholes, raising standards, and enacting incentives to deliver care efficiently. Aggressive efforts to fight fraud, waste and abuse are also having an effect. We are diligently monitoring the impact of these changes and, thus far, do not have evidence that access to care has been compromised.

There has been an expected market correction in the total number of home health agencies serving Medicare, along with an increase in mergers among agencies in order to improve efficiency. Most closures were in areas that had the sharpest growth in the number of providers and questionable billings before the BBA. Again, we have not seen objective evidence that closures have affected access.

We are proactively seeking information about the BBA impact on access, and have instructed our regional offices to gather extensive information so we can determine whether corrective action may be necessary. The HHS Inspector General has agreed to help by surveying hospital discharge planners to determine whether they are having problems in finding home health placements for patients leaving the hospital. This should help provide information in addition to a survey done for the Medicare Payment Advisory Commission of home health agencies which suggested that

some might be avoiding or prematurely discharging high-cost beneficiaries, and two General Accounting Office reports which conclude that beneficiary access to care has not been affected.

We know some providers who have always been efficient continue to have concerns about the interim payment system despite changes Congress made last year. Both the interim and prospective payment systems include incentives for efficiency that require home health agencies to change the way they conduct business. We are taking steps to help agencies adjust to these changes. We are giving agencies up to a year to repay overpayments resulting from the interim payment system. We have limited prepayment medical reviews where appropriate. And we are ending a sequential billing policy which had raised cash flow concerns for some agencies.

At the same time, we are implementing the Outcome and Assessment Information Set (OASIS). We are required by law to monitor the quality of home health care with a "standardized, reproducible assessment instrument." OASIS will help home health agencies determine what patients need. It will help improve the quality of care. And it is essential for accurate payment under prospective payment.

Given the magnitude of the changes in home health, it is understandable that concerns remain. We are committed to giving providers as much flexibility as our authority and responsibility allow. We are committed to diligently monitoring the impact of these changes to ensure that beneficiary access is not compromised. And we are committed to working with providers and Congress to ensure fairness and protect access to appropriate home care services.

#### **BACKGROUND**

The Medicare home health benefit is crucial to millions of beneficiaries confined to their homes. Congress stipulated that care provided under this benefit be related to the treatment of a specific illness or injury. Beneficiaries must be confined to the home and need intermittent skilled nursing

care, physical therapy, speech language pathology services, or have a continuing need for occupational therapy. If these requirements are met, Medicare will pay for: skilled nursing care on a part-time or intermittent basis, physical and occupational therapy; speech language pathology services; medical social services; home health aide services on a part-time or intermittent basis; and medical supplies and durable medical equipment.

Unfortunately, this important benefit has been subject to unsustainable growth and widespread fraud, waste, and abuse. Home health care accounted for just 2.9 percent of all Medicare benefit payments in 1990 but reached nearly 9 percent in 1997. Total home health spending rose from \$4.7 billion (in 1997 dollars) in 1990 to \$17.8 billion in 1997. During the same period, the number of beneficiaries receiving home health doubled from two million to four million, and the average number of visits per beneficiary jumped from 36 to 80. The number of agencies providing services to Medicare beneficiaries grew about 10 percent each year, from 5,656 in 1990 to 10,500 in 1997.

While some of this growth was due to changing demographics and medical advances, studies by the HHS Inspector General and the General Accounting Office document that a significant amount was due to waste, fraud and abuse.

- A July 1997 Inspector General's report, *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*, found that 40 percent of home care in these states was not covered by Medicare.
- Another July 1997 Inspector General's report, *Home Health: Problem Providers and Their Impact on Medicare*, found that one quarter of home health agencies in five states, accounting for 45 percent of spending in these states, were "problem" providers.
- In a June 1997 report, *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings*, the General Accounting Office found that 43 percent of 80 high-dollar claims reviewed should have been partially or totally denied.

Because of the widespread nature of integrity problems, home health was included in the Administration's highly successful crackdown on fraud, waste, and abuse. These efforts are

having a dramatic impact. The HHS Inspector General this year found that in the last two years the rate of erroneous Medicare home health payments declined by 50 percent. Program integrity efforts such as highly publicized investigations and prosecutions may also have discouraged inappropriate claims from being submitted in the first place.

### **BBA Reform**

Congress and the Administration addressed these issues in the Balanced Budget Act by closing loopholes, reforming payment, and requiring surety bonds. The BBA closed loopholes that had invited fraud, waste and abuse. For example, it stopped the practice of billing for care delivered in low cost, rural areas for care from urban offices at high urban-area rates. It also tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services.

The BBA payment reforms feature incentives for efficiency. It called for a prospective payment system, much like what is used to pay for inpatient hospital care, and an interim payment system to be used until the prospective system is ready. One of the primary reasons for the unsustainable growth in home health spending was that cost-based payment lacks incentives to provide care efficiently. Before the BBA, home health agencies were reimbursed based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to their limit. The number of home health visits and spending per beneficiary varied widely by state and region across the country. The BBA imposed a new, aggregate per beneficiary limit designed to provide incentives for efficiency until the prospective payment system can be implemented. The interim payment system locked into place the vastly different payment amounts agencies had been receiving, and created a national limit that was applied to agencies that did not have a full 12-month cost reporting period in fiscal year 1994. These differences have made attempts to address interim payment system issues in a budget neutral fashion unworkable as it merely creates new sets of winners and losers.

Both the prospective and interim payment systems require agencies to change past behavior and

eliminate unnecessary services. The incentive to supply virtually unlimited visits is gone. Instead, agencies must find the most efficient way to produce the best medical outcome. This should not mean that care is compromised for any patient. Agencies are bound by their participation agreement with Medicare to provide the appropriate level of care as prescribed by the physician.

Last year Congress raised the limits on costs somewhat in an effort to help agencies. We issued instructions to our claims processing contractors regarding the changes two weeks after they were enacted. Also last year, Congress postponed implementation of the prospective payment system so that it would not conflict with our essential Year 2000 computer work. We are proceeding with work to develop the prospective payment system, and expect to publish the proposed regulation this fall and implement it on schedule October 1, 2000.

We also expect to soon implement the BBA requirement that home health agencies obtain surety bonds. Until now, these agencies had to meet few standards, and we had no assurances that proper financial safeguards were in place. The BBA mandate has been on hold while we awaited a GAO report on how to best implement the requirement. That report is now out, and we expect to issue a proposed rule with comment period incorporating the GAO's recommendations, which should help agencies comply with the requirement. For example, agencies will be required to obtain bonds for no more than \$50,000, and one bond will suffice for both Medicare and Medicaid.

#### **Administrative Steps**

Also, as mentioned above, we are taking administrative steps to address cash flow concerns and help home health agencies adjust to the BBA changes. We are granting agencies a full year to repay overpayments resulting from the interim payment system. The time frame for implementation that was laid out in the statute caused some large interim payments to be made which must be paid back. If a home health agency has an overpayment as a result of the interim payment system, the agency may have 12 months to repay the money without interest. If an agency can demonstrate a financial hardship and show that Medicare stands a reasonable chance

of recovering the funds, an agency may obtain an extended repayment schedule. However, interest will be assessed for amounts not repaid within 12 months.

Also, as of July 1, 1999, we are discontinuing the sequential billing policy we had implemented to facilitate the transfer of payment for home health services not directly related to inpatient care from the Part A to Part B Medicare Trust Fund. Sequential billing requires claims to be paid in the same order in which services were provided. If a claim for any individual beneficiary is held for medical review, no further claims for that beneficiary can be paid until the claim being held is resolved. While we strongly encourage agencies to continue sequential billing, we are now able to allocate home health claims to the proper Trust Fund without this requirement.

And last July we instructed home health claims processing contractors to take several steps to limit the impact of medical review, which can delay payment on claims while documentation is analyzed to ensure that the claim is valid. We also told home health claims processing contractors to consider a constructive alternative, such as expedited review, for providers without a history of billing problems who may be having cash flow problems because of random medical review.

#### **OASIS**

We are required by law to monitor the quality of home health care with a "standardized, reproducible assessment instrument." This is important, because home health patients are among the most vulnerable Medicare and Medicaid beneficiaries, and the fact that care is delivered in the home makes monitoring the quality of that care more challenging. To improve care and comply with the law, we will be using the Outcome and Assessment Information Set (OASIS). We also will use OASIS data to pay accurately under the prospective payment system.

OASIS helps home health agencies determine what patients need, develop the right plan for their care, assess that care over the course of treatment, and learn how to improve the quality of that care. It provides a standardized format for the patient assessments that home health agencies have been doing all along. It does not require additional effort for agencies that have been

conducting the thorough patient assessments that are needed in order to provide appropriate care, as required by the home health conditions of participation

The 79 data elements in OASIS were developed by clinicians and are valid, reliable, and risk adjusted, taking into account characteristics of patient populations. This ensures that assessments done by different health care professionals consistently yield the same results. It also ensures that quality measurement takes into account whether agencies are caring for sicker patients and therefore might have what otherwise would appear to be poorer care or outcomes.

OASIS is supported by the American Academy of Home Care Physicians, the National Alliance for the Mentally Ill, and many home health care providers who are voluntarily using OASIS because of its unprecedented value in promoting high quality care and comprehensive, accurate, clinical record-keeping. Home health care professionals using OASIS report that it is helping them to be more focused on the needs of individual patients, and to provide better care in fewer visits and with fewer subsequent hospitalizations

We are taking great care to implement OASIS in a way that protects personal privacy. Steps we are taking in addition to Medicare's routine stringent privacy protections include:

- careful drafting of a notice for Medicare and Medicaid patients explaining why OASIS data are collected and informing patients of their right to see and request corrections;
- limiting "routine uses" of data under the Privacy Act so that personally identifiable data will only be used where statistical information is not sufficient;
- masking personally identifiable information on non-Medicare and non-Medicaid patients so it is not transmitted to the States or Medicare in personally identifiable form;
- eliminating transmission altogether for data on patient financial factors;
- accelerating efforts to encrypt data during transmission to provide yet another level of protection, and
- delaying the requirement to collect, encode, and transmit OASIS data on patients receiving only personal care services to evaluate issues pertaining to the content and

periodicity of OASIS relative to other reporting requirements.

We are also making special efforts to help home health agencies learn how to use this valuable tool. Once providers learn how to use OASIS, it actually slightly reduces the total time it takes to conduct and document a thorough patient assessment. Because OASIS is structured in a checklist format, staff spend less time writing out a narrative of their findings and more time with the patient.

More than 8,000 of the approximately 9,500 home health agencies participating in Medicare across the country have now received official OASIS training. Efforts to help providers through the OASIS learning curve include:

- ▶ a satellite broadcast last August to sites across the country reaching approximately 30,000 home health care professionals (tapes of this session are also available);
- ▶ numerous presentations at industry trade association meetings;
- ▶ distribution of a free, detailed manual on how to collect, process and report OASIS data;
- ▶ manuals, software, updates, and other additional assistance that can be downloaded from the Internet at [hcfa.gov/medicare/hsqb/oasis/oasishmp.htm](http://hcfa.gov/medicare/hsqb/oasis/oasishmp.htm);
- ▶ answers to questions on installing OASIS software via a toll-free telephone line at 1-877-201-4721 and via E-mail [haven\\_help@ifmc.org](mailto:haven_help@ifmc.org);
- ▶ establishing OASIS Educational Coordinators in all States;
- ▶ a week long conference last September to teach State personnel about OASIS; and
- ▶ a "train the trainer" program last October for all State OASIS Educational Coordinators.

We will develop a performance report for each home health agency based on its OASIS reports, including a comparison of its performance to the State and national average. These performance reports will allow home health agencies to identify their own weaknesses and improve quality. They also will allow us to increase scrutiny for agencies that need more oversight and assistance in improving quality. Eventually, we will share these performance reports with the public so consumers can make informed choices among agencies based on the quality of care they provide.

OASIS data also are critical to the home health prospective payment system. The comprehensive information which accurately determines the appropriate amount of care also pinpoints the right amount of payment for that care. We need comprehensive national OASIS data as soon as possible to develop prospective payment rates and estimate their impact. Doing so based on the limited research data available to us now could jeopardize our ability to pay accurately and to understand in advance how different types of agencies across the country will be affected.

Using one instrument, such as OASIS, to both determine accurate payment and assess quality helps to minimize the burden on home health agencies. It also helps fight fraud and abuse because it balances incentives. While prospective payment creates an incentive to “upcode” and say patients are sicker in order to receive higher payment, doing so with OASIS could result in poor quality indicators. That could trigger an investigation and result in a competitive disadvantage when agency profiles based on OASIS data are shared with the public. Also, using OASIS to monitor quality is even more essential under a prospective payment system, where incentives to provide care efficiently must not be allowed to reduce appropriate care.

#### **Spending Changes**

Unsustainable home health spending growth has been turned around, but only partially as a result of the BBA reforms. Home health was one of the initial targets in our aggressive and highly successful fight against fraud, waste, and abuse, and these efforts are having an enormous impact. Also, some apparent home health savings are temporary effects of slower claims processing. For example, billing procedure changes such as the sequential billing rule and the heightened level of medical review slowed payments to providers, pushing part of last year’s care into this year’s spending and thus making total spending last year seem artificially low.

Factors such as these were not included in projections of BBA home health savings by us or the Congressional Budget Office. The CBO agrees with our analysis. An April 1999 CBO report emphasizes that the “widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare’s payment rules.” And a

September 1998 CBO report concludes that program integrity efforts, demographic changes, lower-than-expected inflation, and other factors not related to the BBA account for the difference between savings projections when the BBA was enacted and total spending since.

#### **CONCLUSION**

BBA reforms and other changes in home health care have ended unsustainable growth, helped control what was widespread fraud, waste, and abuse, and put us in a position to better protect vulnerable beneficiaries and improve the quality of home health care. We to date do not have objective evidence that beneficiary access to care has been compromised. But we know we must continue to diligently monitor the impact of all these changes. We appreciate this Subcommittee's attention to this issue, and look forward to working with you as we continue to monitor the situation and work to ensure that beneficiaries who qualify for Medicare's home care benefit receive efficient, high quality care.

# # #

## M E M O R A N D U M

TO: PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
MEMBERSHIP LIAISONS

FROM: PRISCILLA HANLEY, <sup>PH</sup> Office of Senator Susan M. Collins  
KARINA V. LYNCH, Counsel <sup>KL</sup>  
Permanent Subcommittee on Investigations

RE: Permanent Subcommittee on Investigations hearing entitled, "**Home Health Care: Will the New Payment System and Regulatory Overkill Hurt Our Seniors?**," Thursday, June 10, 1999, at 2:00 PM in SD-342

DATE: June 8, 1999

## I. INTRODUCTION

Until 1998, home health care was one of Medicare's fastest growing benefits, consuming about \$1 out of every \$12 of Medicare outlays in fiscal year 1997, compared with \$1 in every \$40 in 1989. Medicare home health spending soared from \$2.5 billion in 1989 to \$17.8 billion in 1997. This rapid growth in home health spending prompted Congress and the Health Care Financing Administration ("HCFA"), as part of the Balanced Budget Act of 1997 ("BBA"), to initiate changes intended to make the program more cost-effective and efficient, and to protect it from fraud and abuse. In trying to get a handle on costs, however, Congress unintentionally created a system that penalizes historically cost-efficient agencies and may restrict access for the very Medicare beneficiaries who need the care most — the patients with complex, chronic care needs like diabetes, congestive heart failure, or IV therapy patients who require multiple visits.

Moreover, it now appears that Congress has underestimated the savings stemming from the BBA. Medicare spending for home health care fell nearly 15 percent last year, and the Congressional Budget Office ("CBO") now projects post-BBA reductions in home care spending to be \$48 billion in FY 1998-2000. This savings estimate is three times greater than the \$16 billion in savings the CBO originally estimated for that time period.

As a consequence of the changes mandated by the BBA, home health agencies ("HHAs") across the country are experiencing acute financial problems and are finding it increasingly difficult to cope with cash-flow problems, which may inhibit their ability to deliver much-needed care, particularly to chronically ill patients with complex needs. Moreover, these payment problems have been exacerbated by a number of new regulatory requirements imposed by HCFA, including the implementation of the Outcome and Assessment Information Set ("OASIS"), sequential billing, Interim Payment System ("IPS") overpayment recoupment, and a new 15-minute increment home health reporting requirement.

For example, according to a recent report by the Medicare Payment Advisory Commission ("MedPAC"), almost 40 percent of the home health agencies surveyed indicated that there were patients whom they previously would have admitted for Medicare home health services whom they no longer admit due to the IPS. Thirty-one percent of the agencies admitted that they had discharged patients due to IPS. The discharged patients tended to be those with difficult, chronic care needs who required a large number of visits and were expensive to serve. Thus, they caused agencies to exceed their aggregate per-beneficiary caps mandated by the IPS.

The following quote from a New York home health agency summarizes the central theme of the hearing from the agency perspective:

*"I have to prepare for Y2K and have everything ready by August 1 -- that's cost me \$100,000. My accounts receivable are now tied up for four months due to sequential billing. HCFA has called a halt to sequential billing as of July 1, which is great. But I need two months notice to change my computer system and the vendors aren't responding. I implemented OASIS. The first year cost \$100,000 and it's now \$50,000 a year maintenance. I spent time trying to get a surety bond. The time and effort cost me \$8,000 to \$9,000 . . . had I been able to get one, it would have cost \$216,000. I just spent \$300,000 toward the payback of my recoupment, which is \$1 million. My rates have been cut by IPS by 30 percent, and my per beneficiary cap is \$2,2000. And last, but not least, the 15-minute increment will cost \$20,000 to \$30,000 to implement, and I'll probably lose all my good nurses."*

The hearing will examine the combined effect that these payment reductions, coupled with the new regulatory requirements, have had on home health agencies' ability to meet their patients' needs.

## II. HEARING DESCRIPTION

### A. Panel One — Overview of the Problem

*Maryanna Arsenault, President and CEO of Visiting Nurse Service in Saco, Maine*, will testify on behalf of the Visiting Nurses Association of America ("VNAA"). She will testify about the challenges that not-for-profit home health agencies face in coping with cash-flow problems due to reductions in reimbursement, and how HCFA's new regulatory requirements have exacerbated those problems. In particular, she has been asked to focus on how these problems have affected her agency's ability to meet the needs of its patients, particularly those who are chronically ill and have complex care needs.

*Mary Suther, Chairman of the National Association for Home Care ("NAHC") and President and CEO, Visiting Nurse Association of Texas, Dallas, Texas*, will testify about the cumulative effect of the reductions in home health reimbursement coupled with the new regulatory

requirements on patient care. NAHC is the largest home health association and represents both non-profit and proprietary agencies.

*Linda Stock, Executive Director and V.P. of Home Health Outreach, Rochester Hills, Michigan*, will testify (at the request of Senator Levin) about the cumulative effect of reductions in home health reimbursement under IPS coupled with new regulatory requirements on patient care. Ms. Stock is the past president of the Michigan Home Health Association and currently sits on its Board of Directors.

*Barbara Markham Smith, Senior Research Staff, George Washington University Center for Health Policy Research, Washington, D.C.*, will testify about a new study she is conducting (scheduled for release in July) that reveals that patients with complex, chronic care needs are experiencing access problems. She also has observed that some home health agencies appear to be “cherry picking” and are seeking out only the healthiest patients (for example, patients recovering from hip-replacement surgery who need just short-term rehabilitation services), and are avoiding more expensive patients with complex care needs.

**Panel Two — HCFA**

*Kathleen A. Buto, Deputy Director of the Center for Health Plans and Providers*, will testify on behalf of HCFA. She has been asked to address HCFA’s efforts in implementing the BBA and likely will defend HCFA’s regulatory actions.

*Mary R. Vienna, Director, Clinical Standards Group, Office of Clinical Standards and Quality*, will also be present to support Ms. Buto in answering more technical and clinical questions. Ms. Vienna is the OASIS expert at HCFA.

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J U N E 1 9 9 9

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # \_\_\_\_\_

**REPORT TO THE CONGRESS:**

**Selected  
Medicare Issues**

**MEDPAC** Medicare  
Payment Advisory  
Commission

1730 K Street, N.W. • Suite 800 • Washington, DC 20006  
(202) 653-7220 • Fax: (202) 653-7238 • [www.medpac.gov](http://www.medpac.gov)

**R E C O M M E N D A T I O N S**

- 6A** The Secretary should speed the development of regulations that outline home health care coverage and eligibility criteria based on clinical characteristics of beneficiaries. The Secretary should report to the Congress recommending the legislation needed to accomplish the implementation of these regulations.

.....
- 6B** The Secretary should use criteria based on clinical characteristics of beneficiaries to monitor use of home health services.

.....
- 6C** If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits. Such a policy should be implemented in a budget-neutral manner.

.....
- 6D** The Secretary should establish a nationally uniform process to ensure that fiscal intermediaries have the training and ability to provide timely and accurate coverage and payment information to home health agencies.

.....
- 6E** The Secretary should improve the applicability of the Medicare fee-for-service appeals process for home health users and establish a mechanism for informing beneficiaries about their rights to appeal determinations of noncoverage by home health agencies.

## Access to home health services

In response to a decade of rapidly rising spending for Medicare home health services, the Balanced Budget Act of 1997 modified home health care payments. The Congress intended the interim payment system to be a temporary mechanism to control home health spending until a prospective payment system was developed. Beneficiary advocates and home health industry representatives contend that these Medicare payment limits restrict beneficiaries' access to home health care. In response, the Congress directed the Medicare Payment Advisory Commission to examine the impact of the interim payment system on access to home health services. Preliminary data suggest that fewer Medicare beneficiaries are receiving home health care than in the recent past, the number of visits per user has decreased, and the number of agencies has declined. Some agencies report that they no longer accept or are likely to discharge earlier certain types of patients because of the payment changes. Beneficiary representatives indicate that some beneficiaries are having more difficulty obtaining services to which they believe they are entitled under Medicare's benefit. However, the degree to which this can be attributed to the payment system cannot be ascertained because concurrent policy changes and other factors in the home health market also have contributed to the changes. Moreover, a lack of clinically based standards for home health use makes it impossible to assess the degree to which these changes are appropriate.

### In this chapter

- Home health payment policy
- Monitoring access to home health services

The Balanced Budget Act of 1997 (BBA) required the Health Care Financing Administration (HCFA) to carry out new payment policies aimed at controlling Medicare spending for home health services, then one of the fastest growing parts of the Medicare program. The BBA modified Medicare's payment policies by requiring that the existing cost-based system be replaced with a prospective payment system (PPS) beginning in October 1999.<sup>1</sup> To slow spending until the prospective payment system is in place, the BBA also modified the payment limits for home health services. This interim payment system (IPS) became effective for cost-reporting periods beginning October 1, 1997.

In response to concerns that the IPS was reducing agencies' ability to provide care to Medicare beneficiaries, the Congress modestly increased the payment limits beginning October 1998. It also directed the Medicare Payment Advisory Commission (MedPAC) to examine the impact of the interim payment system on access to care. In this chapter, the Commission describes the IPS and factors that may affect access to care, including the number of providers and responses of home health agencies' to the interim payment system. We also describe some of the access barriers reported by individuals familiar with beneficiaries using home health services. The Commission makes recommendations throughout the chapter on ways to ameliorate concerns raised.

**Home health payment policy**

Medicare payments for home health services rose to about \$17 billion in 1996 from about \$2 billion in 1988, an average annual increase of 31 percent (MedPAC 1998). This resulted from both an increase in the number of beneficiaries who received home health services and an increase in the number of visits they received. During this

period, the number of home health users doubled; by 1996, one in ten beneficiaries used Medicare home health care. For those who received services, annual visits increased from 23 to 79 between 1988 and 1996 (see Table 6-1). While payments per visit remained relatively stable during this period—increasing less than 2 percent annually—payments per user increased about 18 percent annually.

To some extent, Medicare's previous payment system fostered growth in spending because the program paid home health agencies their costs, up to a limit. These payment limits, applied in aggregate, encouraged home health agencies to boost their revenues by

providing more services and keeping their average costs per visit below the national limits.

The Congress mandated the IPS to reduce overall home health spending by controlling both spending per user and spending per visit. The IPS controls spending per user through an aggregate limit on agency spending. This limit, termed the aggregate per-beneficiary limit, is based on a blend of historical per-user costs for the agency and agencies in the region. Reducing the per-visit limits, which limited home health agency payments previously, continues to control spending per visit. (See text box on this page for a detailed explanation of how the IPS limits are calculated.)

**Calculating the interim payment system limits**

Before the BBA, Medicare paid home health agencies their actual costs up to an aggregate limit based on their per-visit costs. An agency's aggregate limit was calculated by multiplying the national per-visit limit for each of the six types of visits by the number of visits of each type the agency furnished. The national limit was set at 112 percent of the mean cost for each type of visit.

For example, assume an agency treated two Medicare beneficiaries during a cost-reporting period.

Further assume that the agency provided one skilled nursing visit and one physical therapy visit to Beneficiary A and ten skilled nursing visits and five physical therapy visits to Beneficiary B. Finally, assume the applicable per-visit limits for skilled nursing visits and physical therapy visits are \$100 and \$150, respectively. The first table below shows the aggregate per-visit cost limit for the agency would be \$2,000. Thus, the agency would receive the lower of its actual costs or \$2,000.

*Continued on page 109*

**TABLE 6-A Calculating aggregate per-visit limits**

Beneficiary	Number of visits		Per-visit limit	Contribution to aggregate per-visit limit
	Skilled nursing	Physical therapy		
A	1		\$100	\$100
A		1	150	150
B	10		100	1,000
B		5	150	750
Aggregate per-visit cost limit				\$2,000

Note: Payments are the lower of actual costs, the aggregate per-visit cost limit, or the aggregate per-visit limit.

<sup>1</sup> The Omnibus Consolidated and Emergency Supplemental Appropriations Act (PL 105-277) delayed the implementation of the prospective payment system until October 1, 2000.

**Calculating the interim payment system limits**

*Continued from page 108*

The BBA changed Medicare's home health payment method in two ways. First, it added an average per-beneficiary cost limit. This new limit was based on 98 percent of the average per-beneficiary patient costs for each agency in fiscal year 1994 (adjusted for price inflation for 1996-1998) and the average per-patient cost for agencies in the region. Seventy-five percent of an agency's historical costs are blended with 25 percent of the median costs of agencies in the same region. The average per-beneficiary limit for agencies that became Medicare certified after fiscal year 1994 was set at the national median of the limits for established agencies.

Second, the BBA decreased the per-visit cost limits from 112 percent of the national mean cost per visit to 105 percent of the national median. Because the medians were less than the means, this reduction was greater than 7 percent. For cost-reporting periods starting in fiscal year 1998, Medicare pays home health agencies the lower of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit.

Using the same simplified example and adding the assumptions that per-visit limits were 10 percent lower and the agency's per-beneficiary cap is \$850, Table 6-B shows the effect of the BBA policy. The aggregate per-visit limit for the agency would be \$1,800. The aggregate per-beneficiary limit is the number of beneficiaries multiplied by \$850—or in the case of this agency treating two beneficiaries, \$1,700. Thus, the agency would receive the lower of its actual costs or \$1,700.

In October 1998, the Congress made minor adjustments to the IPS for fiscal year 1999. It increased the per-visit limits to 106 percent of median costs per visit. The legislation also increased the per-beneficiary limits for established agencies that were under the national average by one-third of the difference between their limit under the original BBA formula and the national average. Per-beneficiary limits for agencies established between 1994 and 1998 will be based on 100 percent of the national rate instead of 98 percent. To discourage entry of new agencies into the market, agencies established in fiscal year 1999 or later will have their per-beneficiary limits set at 75 percent of the national median for established agencies, based on 98 percent of the national rate. ■

The per-beneficiary limits quickly became the most controversial element of the IPS. Because these limits are based on historical practice and expense patterns, many agencies may exceed their limits unless they reduce average costs. Last year, HCFA estimated that about 65 percent of freestanding home health agencies and about 40 percent of hospital-based agencies would exceed their aggregate per-beneficiary limits in 1998. HCFA also expected that these agencies' costs would exceed their limits on average by 11 percent and 6 percent, respectively (HCFA 1998). Some agencies may have kept their average costs below their limits by reducing the number of visits or by accepting new patients who need less expensive care. Some agencies whose case mix became more costly, however, may have difficulty reducing their costs sufficiently without eliminating appropriate services covered under the Medicare benefit.

**Monitoring access to home health services**

To analyze access to services, the Commission examined Medicare home health claims data, surveyed home health agencies, and convened a panel discussion with individuals familiar with beneficiaries' access problems. (Details of our study design are found in the box on the next page.)

We believe the home health environment has changed considerably in the past two years. For example, the number of home health agencies has decreased substantially compared with the number in the period immediately before the IPS.

\* Some home health agencies said they avoid patients whose care they expect or find to be expensive. Some agencies also said they provide fewer services per user than in the past. Participants in our panel said that some beneficiaries have been unable to receive the services to which they believe they are entitled under Medicare. Panelists also indicated that once patients are identified as having

**TABLE 6-B** Calculating aggregate per-visit limits (assuming a 10 percent reduction)

Beneficiary	Number of visits		Per-visit limit	Contribution to aggregate per-visit limit
	Skilled nursing	Physical therapy		
A	1		\$90	\$90
A		3	135	135
B	10		90	900
B		5	135	675
Aggregate per-visit cost limit				\$1,800

Note: Payments are the lower of actual costs, the aggregate per-beneficiary limit, or aggregate per-visit limit.

### Access to home health services: study design

The following sections describe MedPAC's survey of Medicare home health agencies and the panel of individuals knowledgeable about beneficiaries' access concerns.

#### Survey of Medicare-certified home health agencies

To learn about the impact of the IPS payment limits on the behavior of home health agencies, MedPAC contracted with Abt Associates Inc., a social science research firm based in Cambridge, MA, to survey by telephone about 1,000 home health agencies. The goal of the survey was to gather information about agencies' understanding of the IPS and whether the payment policies influenced how they provided home health services to Medicare beneficiaries.

Using a September 1998 extract of HCFA's Online Survey, Certification, and Reporting System (OSCAR), augmented by information about closures identified through January 1999, Abt selected a random sample of Medicare-certified home health agencies, stratified by census region and home health agency size. The number of Medicare patients served during 1997 defined agency size, and agencies that served a larger number of patients were slightly more likely to be chosen for the sample.

About a week before the telephone survey, MedPAC sent letters to home health agency administrators to explain the purpose of the survey and to encourage participation. To facilitate completion of the survey, MedPAC asked administrators to identify the individuals most knowledgeable about Medicare policies and tell them to expect a call.

To improve the reliability of the survey instrument, Abt trained interviewers and field-tested the instrument before implementing it.

Abt also sought to increase the survey response rate. Interviewers used phone numbers listed in the OSCAR to contact agencies in the sample, but if the OSCAR phone number had been disconnected, they consulted other sources. They also left messages on answering machines indicating that someone would call back. If the agency employee who was most knowledgeable about Medicare was unable to participate in the interview at the time of the initial call but agreed to participate in the survey, Abt scheduled an appointment at a time convenient for the employee.

Abt conducted the survey between February 23 and March 24, 1999. The response rate was approximately 80 percent, with 1,054 completed interviews.

#### Panel of individuals knowledgeable about beneficiaries' access concerns

To learn about beneficiary perspectives on access to home health services, MedPAC contracted with Abt Associates Inc. to convene a panel of individuals familiar with beneficiaries' access problems. The purpose of the panel was to learn more about the nature of home health access problems, not the extent to which they exist. Abt asked the panel to address the following questions:

- How have changes in Medicare payment policy affected beneficiary access to home health care?
- What happens to beneficiaries who have difficulty accessing home health services?

MedPAC intended panelists to have direct experience with Medicare beneficiaries having difficulty obtaining home health care. The panel was recruited using a "snowball"

sampling technique. First, Abt compiled a list of about 10 individuals and organizations considered to be informed about the IPS and Medicare beneficiaries' concerns. Next, Abt contacted these individuals and organizations to discuss their insights into the effects of the IPS on access to home care and to obtain names and contact information for other individuals and organizations knowledgeable on the issue. MedPAC concentrated on identifying individuals and organizations in areas where home health agencies reportedly had closed. But because of the extensive geographic variation in home health use, MedPAC also sought a national representation for the panel membership. In total, Abt contacted about 80 individuals as potential panelists.

From these potential participants, MedPAC selected 14 panel members. The goal was to obtain representation of a range of professionals from different geographic areas who are in contact with different types of Medicare beneficiaries who might use home health care (for example, those with specific diseases, frail elders, individuals with disabilities, minorities, and low-income beneficiaries).

The panel included three physicians (two geriatricians), one nurse, and one social worker. It also included four attorneys, two health and aging advocates, and one state government official who worked for a Medicaid home and community-based services program. The panelists represented seven of the nine census divisions and came from the District of Columbia and 12 states—Arkansas, California, Connecticut, Georgia, Indiana, Maryland, Massachusetts, Michigan, New York, Tennessee, Texas, and Virginia. Five of the panelists indicated they have direct experience and concern about home health care in rural areas. ■

**TABLE 6-1 Medicare home health use, 1988-1996**

Year	Number of beneficiaries receiving home health services (in thousands)	Number of visits (in thousands)	Visits per user	Payments per user
1988	1,582	32,130	23	1,287
1989	1,685	46,297	27	1,500
1990	1,940	69,389	36	1,986
1991	2,226	98,650	44	2,487
1992	2,523	132,892	53	2,967
1993	2,865	168,079	59	3,536
1994	3,175	220,495	69	4,179
1995	3,457	266,261	77	4,67
1996	3,583	283,936	79	4,879

Source: Health Care Financing Administration, Office of the Actuary, April 1999.

expensive care needs, agencies may discontinue their care abruptly and these patients may have difficulty obtaining care from other agencies. In effect, some home health agencies are making coverage decisions based on payment considerations.

Although these findings are suggestive, concurrent changes in the home health environment prevent us from drawing conclusions about the direct effect of the IPS on access to care. Other factors that may explain decreases in use include antifraud initiatives targeting home health care, the removal of venipuncture as a qualifying service for home health eligibility, more stringent Medicare claims review and sequential billing policies, and market forces affecting the supply of home health agency employees. Agencies also may be modifying their behavior, anticipating a prospective payment system.

Moreover, it is impossible to determine the degree to which the changes in use of home health services that have occurred in the past two years are appropriate. It is

difficult in part because Medicare's standards for eligibility and coverage are too loosely defined.

**RECOMMENDATION 6A**

**The Secretary should speed the development of regulations that outline home health care coverage and eligibility criteria based on clinical characteristics of beneficiaries. The Secretary should report to the Congress recommending the legislation needed to accomplish the implementation of these regulations.**

Medicare's current eligibility and coverage policies do not consider clinical characteristics of home health users. Current policy defines eligibility vaguely, and beneficiaries may be eligible for home care if they are homebound and need skilled services. Beneficiaries are considered homebound if they are normally unable to leave home, if leaving home requires a considerable and taxing effort, and if absences from the home are infrequent and relatively short. However, fiscal intermediaries apply considerable discretion in interpreting and applying the homebound definition (GAO 1996). As the BBA requires, the Secretary recently

issued a report on the homebound requirement and its application. While the Secretary did not recommend adopting a new definition, improving homebound determinations may be possible in the future, using patient-level data from the Outcomes and Assessment Information Set (OASIS).

Medicare's coverage standards allow for providing services part time or intermittently. Beneficiaries may receive services any number of days per week but for fewer than 8 hours each day and for 28 or fewer hours each week (or, subject to case-by-case review, for fewer than 8 hours each day and for 35 or fewer hours per week).

These guidelines, however, do not suggest appropriate levels of care. As the BBA requires, the Secretary is in the early stages of developing coverage standards for home health care use based on patient characteristics and need. The Commission believes that separate standards should be developed for patients with chronic care and those with acute care needs. Because the Secretary faced lawsuits regarding home health coverage and eligibility rules in the past, she should report to the Congress any legislative changes that would be helpful in implementing the new coverage standards.

**RECOMMENDATION 6B**

**The Secretary should use criteria based on clinical characteristics of beneficiaries to monitor use of home health services.**

Once HCFA establishes clinically based coverage standards for use of home health services, the agency also should use these standards to monitor access to home health care and appropriate use of services. HCFA could monitor these aspects of use through contracts with Medicare's quality improvement organizations as it is doing to monitor access and quality in skilled nursing facilities.<sup>2</sup>

<sup>2</sup> The organizations now prefer to be called quality improvement organizations because they believe this title denotes the scope and orientation of their current responsibilities better than does peer review organizations, the term used in statute and by HCFA.

### Ensuring beneficiaries have access to appropriate services

Provider supply is one of many aspects of measuring access to care. While a certain number of providers is necessary to furnish care, it is difficult to determine the appropriate number—enough so that care is available but not so many that care is furnished inefficiently. Moreover, supply relates to both the number of agencies and their capacity to provide care. Examination of certification data offers information on the number of agencies, and our survey of agencies furnished some insight into changes in agency capacity.

During most of the 1990s, the number of Medicare-certified home health agencies grew about 9 percent annually. Analysis of agency counts by MedPAC and by the General Accounting Office (GAO 1998) as well as findings from the Commission's survey of agencies suggest a consistent trend—a roughly 10 percent decline in the number of agencies in the year following implementation of the IPS, and even another 5 percent to 10 percent decline so far in fiscal year 1999.

Several factors in addition to the IPS are likely associated with declines in agency supply. For example, greater oversight of home health providers may have slowed agencies' entry into the market in the past two years. The Secretary imposed a four-month moratorium on the certification of new home health agencies in early 1998. Several months after she lifted this moratorium, the Omnibus Consolidated and Emergency Supplemental Appropriations Act (P.L. 105-277) required that new home health agencies (those certified on or after October 1, 1998), have per-beneficiary limits equal to 75 percent of the median for existing agencies. This new limit was intended to discourage the entry of agencies into the Medicare program.

Regardless of the causes, it is too early to assess the appropriateness of declines in agency supply. The Commission views some decline as an appropriate response to the rapid increase in home health agencies and service use during the 1990s.

MedPAC also examined whether changes in Medicare payment limits induced agencies to change how they deliver care to beneficiaries. The Commission expected that agencies would reduce their costs in response to the IPS in several ways. Because spending growth results in part from increases in the number of visits per user, we expected agencies to reduce the number of visits per person served. Agencies might attempt to lower average costs per person by eliminating discretionary visits, by substituting less costly visits for expensive care, or by providing a few specialized visits rather than a larger number of unspecialized visits. Because per-beneficiary limits are based on average costs, home health agencies need not reduce their costs for all patients uniformly. By averaging costs, the payment limits allow inexpensive patients to balance out the more expensive ones. With this in mind, home health agencies might attempt to attract more inexpensive patients or avoid patients with expensive needs.

Findings from an analysis of Medicare claims data suggest that home health agencies indeed have changed their practice patterns since the IPS was implemented. Claims data reveal that fewer Medicare beneficiaries received home health care in the first three months of calendar year 1998, compared with the number in the same quarter of the previous year.<sup>3</sup> Once admitted to home care, beneficiaries use fewer services. In particular, the number of more discretionary visits, such as those by home health aides, declined. We cannot determine the magnitude of

this change, but discussions with Medicare's fiscal intermediaries confirm that the number of users and the number of visits per user have declined. Because current data limitations make it difficult to determine the extent to which home health use has changed, the Commission will reexamine the use of home health services when better data are available.

Results from MedPAC's survey of home health agencies also follow this general trend (Table 6-2). The home health agencies that we surveyed report their Medicare caseload has decreased. They also provide fewer visits per user, fewer aide visits, and they have adopted more stringent admission and discharge practices because of the IPS. Because agencies worry about operating under the per-beneficiary limits, they report avoiding high-cost or seemingly high-cost patients. Nearly 40 percent of agencies surveyed responded that because of the IPS, they no longer admit all Medicare patients whom they would have admitted previously, and about 30 percent of agencies reported discharging certain Medicare patients because of the IPS. A recent study concerning costs of home health care found that patients using care for a long time were more costly than others (Gage 1999). Indeed, agencies most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged as a result of the IPS.

#### RECOMMENDATION 6C

**If the Congress is not confident that the Secretary can implement a prospective payment system for home health services by 2000, then it should explore the feasibility of establishing a process for agencies to exclude a small share of their patients from the aggregate per-beneficiary limits. Such a policy should be implemented in a budget-neutral manner.**

<sup>3</sup> While we are confident that the data characterize general trends in home health use, we are reluctant to publish specific results because HCFA is concerned that the data may be flawed. The agency maintains that problems in the way it administered the BBA required shift of some home health services to Medicare Part B may have resulted in underreported use during the period studied. HCFA is verifying its home health data and correcting them as needed.

**TABLE 6-2 Medicare caseload, patient visits, admissions, and discharges of home health agencies**

Survey question	Percent
Since your agency became subject to IPS, has the number of Medicare home health patients in your service:	
Increased	76%
Decreased	5%
Remained the same	14%
Since the Medicare main payment system was implemented, has the total number of Medicare patients that you manage increased or decreased?	
Increased	4%
Decreased	1%
Remained the same	91%
Are there patients whom you would previously have taken care of Medicare home health services that you no longer serve due to IPS?	
Yes	39%
No	57%
Have you discharged any Medicare patients due to IPS?	
Yes	17%
No	69%

Source: Medicare survey of 106 selected home health agencies conducted by AHA/Asklepios in February/March 1999.

The case-mix adjusted PPS being developed will not take effect before October 2000. In the meantime, an exclusion policy for very expensive patients could be implemented. The Commission suggests allowing agencies to exclude a small portion of their patients from the aggregate per-beneficiary payment limits to ensure that these beneficiaries will have access to needed services. Medicare would reimburse care for excluded patients based on the lesser of actual costs or the aggregate per-visit limits. Because the excluded patients would receive a disproportionate amount of services, HCFA may want to have medical reviewers focus their efforts on these high-use cases.

#### Providing timely information to agencies and beneficiaries

Agencies might inadvertently restrict services because of misunderstandings about antifraud initiatives, coverage rules, and the mechanics of the IPS. In particular, discussions with home health agency representatives revealed they did not always know their per-beneficiary limits or understand that the limits apply to average costs for all patients served. Some agencies had interpreted the limits as absolute caps on the amount they could spend on each beneficiary. This misunderstanding may have led some providers to unnecessarily reduce the services they furnish or to avoid certain patients.

#### RECOMMENDATION 6D

**The Secretary should establish a nationally uniform process to ensure that fiscal intermediaries have the training and ability to provide timely and accurate coverage and payment information to home health agencies.**

In the months prior to implementing the IPS, HCFA published a detailed description of the system in a program memorandum and in proposed and final rules implementing the new policy. The BBA allowed fiscal intermediaries several months to calculate and notify home health agencies of their payment limits under the IPS, though some fiscal intermediaries were late to comply with this requirement. By the time many agencies learned their individual limits, they were well into their fiscal year 1998 cost-reporting periods. As a result, they had to anticipate their limits for a portion of the year and, upon notification, adjust their practice patterns accordingly. This late notification caused confusion among agencies.

Anecdotal evidence also suggests that information provided by fiscal intermediaries and HCFA regional offices was confusing and inconsistent at times. Some agencies and physicians reported they received misleading information concerning Medicare eligibility, coverage, and payment for home health services. Because confusion about the payment system will also be a concern as HCFA implements a PPS for home health services, the Commission urges the Secretary to minimize misunderstanding so that agencies' responses do not threaten access to care.

Such an effort might include special notices to home health providers similar to the memorandum the HCTA Administrator sent to agencies to explain the IPS payment limits and agencies' responsibilities as Medicare providers. Under Medicare's conditions of participation, home health agencies must not discriminate against Medicare patients—if agencies provide care to non-

Medicare patients with health problems of a certain level of severity, they also must serve Medicare patients with the same severity of health problems. (DeParle 1998).

Pressures brought on by the IPS also have highlighted the importance of the Medicare appeals process and beneficiaries' understanding of it.

In Medicare's traditional program, beneficiaries may initiate an appeal for payment for home health services only after the agency submits a bill on their behalf and Medicare's fiscal intermediary rejects it. When agencies bar beneficiaries from admission, they cannot appeal the decision.

Even when beneficiaries are admitted to home health agencies, the current appeals process may not help them. Medicare requires home health agencies to inform beneficiaries when they believe Medicare no longer will cover the cost of their care. When agencies anticipate they will be financially liable for a patient's care and decide to discharge patients or reduce their services, beneficiaries have the right to "demand bill" Medicare. That is, beneficiaries can demand that the home health agencies submit bills on their behalf to determine if the service will be covered. In the meantime, however, beneficiaries are responsible for the cost of the care the agency provides.

#### RECOMMENDATION 6E

**The Secretary should improve the applicability of the Medicare fee-for-service appeals process for home health users and establish a mechanism for informing beneficiaries about their rights to appeal determinations of noncoverage by home health agencies.**

According to the panelists, beneficiaries often do not know about the appeals process or their right to demand bill. When the PPS for hospitals took effect, beneficiaries were given the right to appeal decisions to discharge them, although the hospitals did not always inform them of their rights to appeal (ProPAC 1986). A similar situation could be avoided by requiring home health agencies to inform beneficiaries of their rights upon admission. HCFA also could require agencies to use a standard form explaining the reasons for restricting or terminating services and listing steps for beneficiaries to follow to get a formal decision from the Medicare fiscal intermediary about coverage and eligibility. In the long term, peer review organizations could review discharges from home health agencies as they do for hospital discharges.

HCFA is working to improve its appeals process for home health users. The agency is in the early stages of developing regulations to make the Part A and Part B appeals processes consistent. These regulations will not address the denials described above. In response to litigation on this issue, the agency also is considering distributing new notification letters to beneficiaries to explain their appeal rights. However, limits on computer systems stemming from the year 2000 problem may be the deciding factor in determining whether this policy is implemented.

The Commission believes an improved appeals process is an important measure to protect rights of beneficiaries to home health services. Combined with the other recommendations in this chapter, it will help to ensure that Medicare beneficiaries have access to appropriate home health services. ■

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HOME HEALTH SERVICES & STAFFING ASSOCIATION

Senate Permanent Subcommittee  
on Investigations

EXHIBIT # 4



**Written Testimony of the Home Health Services & Staffing Association**

**Senate Permanent Subcommittee on Investigations**

**of the**

**Senate Committee on Governmental Affairs**

**Thursday, June 10, 1999**

The Home Health Services & Staffing Association (HHSSA) is a national trade association representing over 1500 home health providers in 48 states. HHSSA has observed a dramatic change in the home health environment in the last two years. Most of the changes impacting home health services resulted from either the implementation of the Balanced Budget Act of 1997(BBA 97), new regulations promulgated by the Health Care Financing Administration (HCFA), or changes in the market environment.

The impact on HHSSA members was revealed in a recent survey of the membership. In the survey, the members reported:

- The majority of HHSSA members have decreased their Medicare revenue from approximately 40% to less than 10% of their total revenues. Members cite significant decreases in physician referrals and the additional costs associated with the future of the Interim Payment System to pay the actual costs of medically necessary services.
- HHSSA members report closures of Medicare-certified offices in various regions of the country.
- All members participating in the Medicare home health program have stated the need to assess a Medicare beneficiary carefully to determine whether an agency has the resources to care for the beneficiary.
- HHSSA members report a reduction in the already tight administrative support personnel. Due to the decrease in administrative personnel, many home health agencies now lack the staff needed to implement additional regulations such as OASIS and the fifteen-minute interval.
- HHSSA members report an inability to recruit and retain home health employees including nurses, home health aides and personal care attendants. The providers cite increased paperwork as one of the largest obstacles in retaining home health nurses. Home health aides and personal care attendants are difficult to recruit in the competitive environment of non-professional job opportunities.

In the past two years, the home health industry has been hit by a myriad of issues negatively affecting medically-necessary services to home health patients. Most of the changes are the result of BBA 97. Other changes are the result of regulations issued by HCFA.

Some of the recent changes include:

- OASIS – HCFA maintains they must have OASIS data to implement a prospective payment system (PPS). However, they started to require collection of OASIS data from both Medicare and non-Medicare patients. HCFA estimates that OASIS, as proposed, will impose an additional \$45 million in costs in the first year and \$110 million in costs over 5 years. They also concede that 70% of agencies will receive no Medicare reimbursement for these costs. Thus, already scarce financial and personnel resources will be further diverted from patient care.
- Interim Payment System – BBA 97 changed the reimbursement system significantly for Medicare home health services, adversely impacting home health providers and patients. The changes included: a decrease in the per-visit cost limits, a new per-beneficiary limit, and elimination of venipuncture as a covered service. The impact of the new interim payment system has not yet been completely realized.

- Sequential Billing – BBA '97 split the Medicare home health program between Part A and Part B. Prior to BBA '97, home health services had been covered exclusively under Part A. The "A to B" shift requires home health agencies to submit claims in a sequential process to the fiscal intermediary. The new requirement has resulted in serious cash flow problems to the home health agencies. On July 1, 1999, HCFA notified all fiscal intermediaries that this policy will end, after causing many home health agencies to suffer financial loss.
- Fifteen-Minute Intervals – BBA '97 mandated home health agencies to record the amount of time involved in a home health visit in 15-minute intervals. This requirement was intended to establish data to better define a home health visit. HCFA is expected to implement the new requirement in July, 1999. However, as HCFA designs a per-episode prospective payment system, there will be no need for this additional and burdensome data collection on home health agencies.
- Physician Referrals – Under the Health Insurance Portability and Accountability Act, Congress held physicians accountable for prescribing home health services. If a physician knowingly certifies home health services under Medicare, and the patient does not qualify, the physician could be assessed a \$5000 civil penalty. Notices to this effect were mailed to physicians at the end of 1998 and the beginning of 1999. There has since been a significant decrease in physician referrals to home health agencies because physicians fear being subjected to civil penalties.
- Increased Claim and Cost Report Reviews – In response to the increased growth in home health services and concerns related to fraud and abuse, HCFA earmarked increased funding for medical review of claims. These activities included increased random and focused medical review of claims and increased field audits of cost reports. Home health agencies currently report that procedural safeguards established to ensure the accuracy of these reviews are not being followed by the fiscal intermediaries, and that inconsistency in interpretations occur from one fiscal intermediary to another.
- Surety Bonds – HHSA members strongly supported the enactment of a home health surety bond at a maximum of \$50,000. Congress enacted the new requirement under BBA '97. When HCFA implemented the new regulations in early 1998, the requirement was expanded to the greater of \$50,000 or 15% of Medicare revenues. The new requirement also permitted the use of the surety bond in Medicare recoupments. The cost of the surety bonds is not allowable Medicare cost, thereby ensuring that even the most cost-effective home health agencies will be reimbursed at less than the cost for services to Medicare beneficiaries.
- Per-Beneficiary Overpayments – The fiscal intermediaries have sent overpayment notices to home health agencies demanding the recoupment of alleged overpayments due to the retroactive application of the new limits under IPS. The overpayments can reach into the millions of dollars for a home health agency. Many home health agencies still have not been notified of their per-beneficiary limit.
- Implementation of Regulations – Home health agencies honestly striving to provide quality home health services to Medicare beneficiaries have been burdened by changing and arbitrary regulations. Here are some examples:

- Surety Bonds – HHSSA members purchased surety bonds to be in compliance with the new regulations implemented under HCFA. The bonds were later delayed and agencies were left wondering whether to recoup the bond that the agency had purchased. To date, many HHSSA members are still in a quandary with respect to their surety bond – increasing the costs to the agency on a regulation, which is no longer, required.
- Per-Beneficiary Limit – HHSSA members have reported that some offices still have not received their per-beneficiary limit from HCFA. The offices have been unable to plan their financial outlook without the proper information by HCFA.
- OASIS – In order to comply with the recent OASIS regulations, HHSSA members trained staff, purchased new computer systems and software, and hired additional staff or placed increased burdens on other staffers for the requirement. In April alone, HCFA sent out three different notices before suspending implementation altogether. Since HCFA failed to implement OASIS in a manner that addressed the concerns of patients and providers, home health agencies have had to incur unnecessary costs.

In addition to the disruption caused by these regulatory changes, home health agencies are facing even greater disruption from the following:

- Development of a Prospective Payment System – The most significant change to the Medicare home health benefit will be the development of a prospective payment system. As HCFA designs the new system, Congress and the Administration have the opportunity to influence the process and construct a Medicare home health benefit which will be instrumental in caring for the increasing aging population. The system should be sufficiently simple to permit efficient operation by agencies and monitoring by the government.
- Copayments – There continues to be an increasing threat to access for the sickest and most frail Medicare beneficiaries as Congress and the Administration consider implementation of a copayment for home health services. The home health industry has faced severe Medicare cuts in the past two years. The Congressional Budget Office (CBO) had projected that BBA 97 would produce a five year savings to the Medicare program of \$16.1 billion. A revised March, 1999 estimate by CBO projects a five year savings of \$48.8 billion. The new estimates are 300% higher than the original projection. At the same time, home health services suffered a 20% decrease in rate of growth in 1998 alone – from + 5.3% to –15%. The rate of growth was far lower than for any other health care service covered by Medicare. The impact results in a lack of access to home health services by the sickest and most frail Medicare beneficiaries. A copayment would further exacerbate the situation for home health patients and providers.

The recent chain of events has led the home health industry to experience a variety of additional problems. At a time when home health services should be enhanced and supported to provide cost-effective medical services to a growing aging population, the recent changes are curtailing medically-necessary and allowable services to eligible Medicare beneficiaries who need the services the most.

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Here are the statistics:

- In its June 1999 "Report to the Congress: Selected Medicare Issues," MedPAC finds that "nearly 40 percent of agencies surveyed responded that because of IPS, they no longer admit all Medicare patients whom they would have admitted previously, and about 30 percent of agencies reported discharging certain Medicare patients because of the IPS. ...agencies most frequently identified long term or chronic care patients as those they no longer admitted or have discharged as a result of IPS."
- According to HCFA's most recent utilization data for home health, the total number of claims received in fiscal year 1997 was 20,959,349 and the total number of claims received in fiscal year 1998 was 16,880,856 – about a 20% decrease in the number of claims received. (*HCFA Contractor Reporting of Workload Data*, February 1, 1999)
- 2,195 Medicare-certified home health agency offices have closed since January, 1998, according to a survey of state health licensure departments. Hardest hit was Texas, where 352 agencies and another 438 branch offices closed. Other states with large numbers of closures include: Louisiana with 250, California with 153, Florida with 97, Missouri with 91, Oklahoma with 87, Tennessee with 67 and Indiana with 60. (*Eli's Home Care Week*, Volume VIII, Number 6, February 8, 1999)
- Home care stocks dropped 43.8% in 1998, according to an annual survey by Hilton Head, South Carolina-based HealthCare Markets Group, Inc.
- Home care stocks dropped 55.8% between April 1, 1998 and March 31, 1999 according to a financial analysis of home care public companies by Houlihan, Lokey, Howard & Zukin Investment Bankers. (March 31, 1998)
- Home Health Corporation of America filed for Chapter 11 bankruptcy protection on February 18, 1999 citing Medicare cutbacks as one cause of its mounting debt. HHCA will not go out of business, but will downsize by releasing 300, or about 10 percent of its employees. (*HomeCare Monday*, February 22, 1999)
- Employment at freestanding home health agencies declined by 7,000 jobs in January 1999. Since September 1997, freestanding HHAs have lost 61,000 jobs— or 8.5% according to the Bureau of Labor Statistics. (*Eli's Home Care Week*, Volume VIII, Number 7, February 15, 1999)
- In Home Health Inc. reported a loss of \$132,000 on revenue of \$18.6 million in the quarter ended December 31. That compares with net income of \$186,000 on revenue of \$27.9 million during the same period the year before. (...*home health line*, February 15, 1999)
- Home care workers received only a .7 percent wage increase in 1997, while Americans as a whole saw a 3.4 percent increase, according to new Labor Department statistics. (*The Washington Times*, *Eli's Home Care Week*, Volume VIII, Number 6, February 8, 1999)

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- A Visiting Nurses Association branch in Illinois found that Medicare payments are now so low that it made the painful decision to abandon 25 patients who needed the most expensive care, rather than face the possibility of having to go out of business in a few months and strand some 300 patients. (The Washington Post, A1, May 10, 1999)
- Medicaid is picking up the slack for Medicare caused by the BBA, Christine Ferguson, director of Rhode Island's human services department testified at a May 12 Senate Finance Committee hearing on Medicare reform. "There has been a widespread decrease in access to home care services," and increased hospitalizations have resulted, she said. (*Eli's Home Care Week*, Volume VIII, May 24, 1999)
- By 2002, hospital-based HHAs will have seen a payment reduction of over \$5.5 billion – a 22 percent cut from pre-Balanced Budget Act levels, says a new study by Lewin Group. (*Eli's Home Care Week*, Volume VIII, May 24, 1999)

A chart has been included with this written testimony to show the recent Congressional Budget Office revised estimates, and the rate of growth compared to other health care sectors. HHSSA urges careful consideration of Congressional changes to the home health benefit. In order to substantially support home health services as a cost-effective alternative to other medical services, HHSSA would urge Congress to:

- ***Provide funding that is adequate to ensure access to all covered home health services for Medicare beneficiaries.***
- ***Eliminate the 15% reduction effective, regardless of whether a prospective payment system for home health services is developed, on October 1, 2000.***
- ***Develop a prospective payment system that is simple to administer and monitor and will permit covered services to be furnished to Medicare home health patients.***
- ***Avoid imposing any additional requirements on home health patients and providers including implementation of a home health copayment.***

Please note that HHSSA has moved its offices. The new address is 1875 Eye Street N.W. 12<sup>th</sup> floor, Washington D.C. 20006. Phone: 202-296-3800 Fax: 202-296-9675

## HOME HEALTH "SAVINGS" UNDER BBA '97

## CBO Estimates of Impact of BBA '97

Home Health Outlays in Billions					
Fiscal Year	1998	1999	2000	2001	2002
Jan. 1997 Baseline	\$21.1	\$23.1	\$25.3	\$27.5	\$29.9
Post BBA '97 Baseline	\$20.0	\$21.1	\$21.2	\$23.3	\$25.2
Cum. Savings from BBA'97	\$1.1	\$3.1	\$7.2	\$11.4	\$16.1
March 1999 Baseline	\$14.9	\$15.0	\$16.5	\$15.6	\$17.1
Revised Cum. Savings	\$6.2	\$14.3	\$23.1	\$35.0	\$48.8

5 year savings projected at time BBA'97 passed = \$16.1

5 year savings projected in March 1999 = \$48.8

5 year savings from BBA'97 are 300% higher than projected

## Rate of Growth in Home Health Expenditures Compared to Other Services (March 1999)

Fiscal Year	1998	1999	2000	2001	2002	5yr Average
Hosp.	-2.5%	-1.5%	5.7%	4.7%	4.5%	2.2%
SNF's	8.9%	-3.8%	1.7%	5.3%	5.1%	3.4%
Phys.	3%	.6%	4.2%	2.3%	2.4%	2.5%
HHA's	-14.9%	.8%	10.3%	-5.3%	10.1%	.2%

Average growth rate for other services = 2.7%

Average growth rate for Home Health = .2%

Home Health services have been subjected to far greater cuts than any other service covered by Medicare, and home health expenditures have a far lower growth rate than any other Medicare service.



*"The mission of the Coalition is to enhance consumer access to quality home care services, supplies, and equipment. The Coalition focuses on education and communications advocating the benefits of home care to policy makers and the public. The Coalition is a diverse group of organizations representing consumers/patients, family caregivers, health care professionals, providers, and manufacturers dedicated to serving people in their homes."*

Statement of the  
Home Care Coalition

Before the  
Governmental Affairs Committee  
Permanent Subcommittee on Investigations

On  
Medicare's Home Health Benefit

June 10, 1999

**Contact:**  
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The Home Care Coalition was formed in 1991 to enhance consumer access to quality home care services, supplies, and equipment. The members of the Coalition are drawn together by a united goal: to support home care as a cost-effective alternative to inpatient care. The Coalition focuses on addressing the needs of consumers, caregivers, and providers of home care services. The Coalition conducts education and communications activities advocating the benefits of home care to policy-makers and the public.

This testimony on home health consolidated billing is supported by the following organizations:

Advocates for the Elderly and Disabled  
American Association for the Continuity of Care  
American Association for Respiratory Care  
American Federation of HomeCare Providers  
Daughters of Charity National Healthcare System  
HIDA Home Care  
Home Health Services and Staffing Association  
Invacare Corporation  
National Alliance for Infusion Therapy  
National Association for Home Care  
National Association for Medical Equipment Services  
Sunrise Medical Home Healthcare Group  
Visiting Nurses Associations of America

On behalf of the Home Care Coalition, thank you for the opportunity to provide our views on the difficulties faced by home health providers. The Home Care Coalition was founded in 1991 to unite the efforts of home care providers, family caregivers, health care professionals, manufacturers, consumers, and consumer advocacy organizations. The Coalition has become a major voice in support of home health care, which is often patient-preferred and more cost-effective than institutional care. As the only national organization representing providers, consumers and manufacturers of home health services, we urge you to support the repeal of home health consolidated billing.

#### **Home Health Consolidated Billing**

Home health consolidated billing is a little-noticed provision tucked inside the legislative language implementing the home health agency (HHA) prospective payment system (PPS). This BBA provision (Section 4603(c)(2)(B)) states:

*In the case of home health services furnished to an individual who (at the time the item or service is furnished) is under the plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or under any other contracting or consulting agreement, or otherwise)."*

The rationale for this provision is unclear, and no public hearings or industry consultations on the issue have been conducted. This provision, which will impact all home care providers, will be implemented concurrent with the prospective payment system for home health agencies (October, 2000).

In effect, this provision would force home health agencies (HHAs) to take on a number of new responsibilities that are currently handled by other providers. Because the Social Security Act's definition of home health services includes a number of services, including "durable medical equipment" and "supplies," this payment bundling provision would include most durable medical equipment, prosthetic, orthotic, and supply (DMEPOS) services. Once this provision is enacted, DMEPOS providers would be prohibited from seeking reimbursement for services provided to any beneficiary who is under the plan of care of an HHA. Therefore, HHAs would be forced to become responsible and submit bills for these DMEPOS services, whether or not they are related to the therapy, nursing, or home aide services that the HHA benefit covers.

The Home Care Coalition is concerned that this provision ignores the inherent complexities of the home health market and the separate reimbursement systems established by Medicare for HHAs and DMEPOS providers. In addition, consolidated billing creates an artificial and burdensome rift in the provision of DMEPOS services which threatens the continuity of health care for homebound Medicare beneficiaries. We urge this Subcommittee to support the repeal of this provision for the following reasons:

*This Provision Radically Alters the Current Home Health Benefit.* Medicare DMEPOS providers are highly specialized healthcare organizations that offer important support services to their home care patients, such as preventative maintenance, patient education, 24-hour on call service, the professional care of respiratory and nutritional therapists, and the furnishing of supplies. In contrast, the majority of HHAs are not involved in the provision of equipment and supplies beyond incidentals such as bandages and catheters. Under this consolidated billing provision, therefore, HHAs would be forced to:

1. take on a wide array of new responsibilities and costs by entering into the supplies and services business, or;
2. take on new liabilities by entering into contracts with Part B service providers who are already serving the beneficiaries in their service area (if the HHA decides not to directly provide DMEPOS).

*Negative Impact on Patient Care.* Often, the need for DMEPOS services outlasts the need for the nursing, therapy or home health aide services provided by a home health agency (HHA). By bundling the payments for the two services, consolidated billing could impose an unnecessary break in the continuum of patient care. For instance, an DMEPOS provider supplying services to a Medicare beneficiary for a chronic condition (e.g., home oxygen therapy, dialysis equipment, enteral nutrition therapy) would be forced to stop providing those services if the beneficiary were to experience an acute episode that required the nursing/therapy/aide services of an HHA. The DMEPOS provider would not necessarily be aware that the beneficiary has entered into the plan of care of an HHA, and the agency may not necessarily be aware that it is taking on the responsibility for these long-standing DMEPOS services. However, once it was determined that the beneficiary has entered the plan of care of an HHA, the DMEPOS provider would be have to remove or stop the delivery of the equipment and supplies that they had been providing to the beneficiary. Once the acute episode is resolved and the beneficiary no longer requires the acute nursing/therapy/aide services, the HHA plan of care would end and the beneficiary would once again have to find a DMEPOS provider to meet their chronic equipment/supply needs (see attached timelines). This situation would cause an administrative burden for the DMEPOS provider, the HHA and the Medicare Program. Most importantly, the beneficiary could also be negatively impacted by these abrupt and repeated changes in providers.

*This Provision Contradicts Medicare Reimbursement Systems and Standards.* The provision of DMEPOS is not required in the HHA conditions of participation, and the vast majority of HHAs (which are reimbursed by the Regional Home Health Intermediaries) do not provide medical equipment and supply services to beneficiaries or submit claims to the Part B Durable Medical Equipment Regional Carriers (DMERCs). HHAs are typically not prepared to handle the complex Part B reimbursement system that is used exclusively for medical equipment and supply claims.

Furthermore, Medicare has wholly separate requirements that trigger coverage for HHA and DMEPOS services. In order to receive Medicare coverage for HHA services, a beneficiary must be homebound, under a physician's care, and require medically necessary skilled nursing or therapy services. In order to receive DMEPOS services, a beneficiary must have a prescription or doctor's order and, for certain services (e.g., home oxygen), must meet certain objective diagnostic guidelines (e.g., a certain level of oxygen saturation in the blood). Therefore, a beneficiary receiving Part B covered DMEPOS services often does not necessarily meet the qualifications needed to trigger the HHA benefit, and vice versa. By combining the responsibilities for the provision of nursing and equipment services, this provision contradicts the systems and standards of the Medicare Program, and threatens to add a considerable administrative burden to the Health Care Financing Administration.

*This change is not needed to implement the PPS system for HHAs.* The PPS system currently under development at HCFA applies to the nursing, therapy and home health aide services provided by HHAs and reimbursed by the regional home health intermediaries. The PPS rate will not include non-routine medical equipment and supply services. Therefore, the bundling of DMEPOS services into the HHA nursing/therapy/aide benefit is not needed to develop or implement a PPS rate. In fact, the complexities inherent in the implementation of this provision may hinder the PPS system.

#### **Conclusion**

The home health agency consolidated billing provision included in the BBA should be repealed. This provision ignores the separate coverage and reimbursement criteria developed by the Medicare Program for HHAs and DMEPOS providers. If this provision is enacted, HHAs will be forced into taking on considerable new responsibilities and liabilities, at the same time that they are adjusting to the PPS reimbursement system. Consolidated billing will not promote access to high quality home healthcare services. In fact, HHA consolidated billing will likely create an unnatural break in the provision of healthcare services by shifting Medicare payments back and forth between DMEPOS companies and HHAs. As this provision is not needed to implement the prospective payment system for HHAs, and is expected to cause problems for beneficiaries, healthcare providers and the Medicare Program, we urge you to support its repeal. The Home Care Coalition looks forward to working with this Subcommittee, please contact us with any questions or comments.

July 2, 1999

**Supplemental Questions for the Record  
Submitted to Senator Max Cleland (D-GA)**

**U.S. Senate Permanent Subcommittee On Investigations  
June 10, 1999  
Home Health Care: Will the new Payment System and  
Regulatory Overkill Hurt our Seniors?**

By Maryanna Arsenault  
Chief Executive Officer  
Visiting Nurse Service, Saco, Maine

1. How would you respond to charges that some home health agencies are "cherry picking" their patients and excluding those with the highest medical expenses?

The Visiting Nurse Service (VNS) is not engaging in the practice described as "cherry picking." It would be my guess that each home health agency has determined strategy to stay beneath the per beneficiary limits, since the alternative, exceeding the per beneficiary limits, would put the agency in financial peril, including bankruptcy. Simply not accepting patients with the highest expected medical expenses might be one strategy, although a poor one. The VNS is a nonprofit, visiting nurse agency committed to the individuals, families, and communities we serve. We are fortunate to have the financial support of our communities to help us through this most difficult time of adjustment.

Visiting Nurse Service has taken the strategy of reducing the average number of visits per patient. A number of years ago, anticipating decreased reimbursement through a perspective payment system, we began to systematically study practice to determine "best ways" to provide care to our patients. All professional staff now use standardized care plans, which help assure that all patients with the same needs receive the same good care. The number of visits per patient dropped by 10 from 7/1/98 to 7/1/99. This strategy has allowed us to provide care to the most costly patients – ventilator dependent patients, quadriplegics, debilitating diseases such as Multiple Sclerosis, complicated diabetics with wounds and/or cardiac anomalies, patients with Congestive Heart Failure (CHF), and chronic obstructive Pulmonary Disease (COPD).

And, although, our strategy has kept our costs below the per beneficiary limits, it has pushed them over the per cost limits. Our reduced visiting strategy, impacted by the regulatory demands of OASIS, has increased the length of each visit, thus increasing the cost of each visit. As we end this fiscal year, we will have accrued a deficit of approximately \$100,000.

2. Based on your experience, do you concur with GAO's finding that there is "little evidence to show that appropriate access to Medicare's home health benefit has been impaired?"

I believe the answer to this question is complicated, as is the multitude of regulations, and changes to regulations that home health agencies have had to respond to since the passage of the Balanced Budget Act of 1997.

First, the study examined beneficiary data comparing utilization in the first three months of 1988 with comparable periods in 1994 and 1996. It does not take into account the experience of those agencies, like the Visiting Nurse Service (VNS) that began the Interim Payment System (IPS) towards the end of 1998, nor does it take into effect the continuing cumulative effects of those agencies that began IPS as early as October 1, 1997.

Secondly, the conclusion -- that neither agency closures nor decreased utilization has significantly affected home health agencies' ability to provide services -- is contradicted by a number of assumptions put forward throughout the study.

- The report notes that beneficiaries needing intensive or long-term skilled care may find it increasingly difficult to access care. and
- The report stated, "beneficiaries who are likely to be costlier than average to treat are most at risk under IPS."

Third, the study does not take into account the deletion of venipuncture as a Medicare home health qualifying service, nor the changes that Fiscal Intermediaries have made in their interpretations of the regulations.

A female patient, discharged during May 1999, from VNS, between the ages of 75 and 84, wrote the following comment on her patient satisfaction survey:  
*Continuing nurse services to draw my blood and get it to a laboratory in preparation for chemotherapy treatments. Had to drive to Portland (not really feeling up to it) just to have my blood checked.*

Lastly, agencies have been forced by the increased oversight activities of HCFA, to stringently interpret the Medicare regulations. At the VNS fear of additional focused reviews by our Fiscal Intermediary have modified the behavior of our staff. In the past, if there might be the slightest doubt that a service would be covered, we erred in favor of the patient, now we will not provide the care. We cannot withstand the extraordinary expense related to audits and focused reviews.

**SUPPLEMENTAL QUESTIONS FOR THE RECORD  
SUBMITTED BY SENATOR MAX CLELAND (D-GA)**

Hearings Before The  
U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
June 19, 1999

***HOME HEALTH CARE: WILL THE NEW PAYMENT SYSTEM AND  
REGULATORY OVERKILL HURT OUR SENIORS?*****MARY SUTHER**

Chairman and Chief Executive Officer  
Visiting Nurse Association of Texas, Inc.  
Dallas, Texas

1. By your count, how many home health agencies in the nation have been forced to close their door as a result of the IPS coupled with the new regulatory requirements?

The National Association for Home Care (NAHC) is conducting periodic calls to the states to determine the number of agencies and branch offices that have closed their doors since the implementation of IPS and the imposition of new regulatory requirements. We have data obtained from 34 states early this year indicating that in those states 1408 agencies and 637 branches have closed. Although our data is incomplete, we believe MedPAC's recent report of a 10% decline in the number of agencies in the year following implementation of the IPS, and another 5 to 10% decline so far in fiscal year 1999, to be generally accurate. The closures thus far, when trended forward, would indicate that serious damage is being done to the home health care infrastructure. We anticipate that this trend will accelerate as more agencies are confronted with having to repay overpayments incurred because they exceeded their aggregate annual per beneficiary limit.

2. How many beneficiaries do you estimate have lost access to adequate home health services as a result of these closings?

One Medicare intermediary has reported that claims in its region had declined by about 25%. We are currently attempting to obtain claims data from all the intermediaries. It is not possible to know with certainty all the reasons for this decline; however, by extrapolating the decline in claims for this one intermediary to the universe, we believe that as many as 700,000 beneficiaries may have lost access to adequate home health services.

3. How many beneficiaries do you believe have been forced into nursing homes as a result?

NAHC is unable to quantify the number of beneficiaries who have been forced into nursing homes as a result of IPS and regulatory burdens. However, NAHC has received numerous anecdotal accounts of high hospitalization rates, long nursing home waiting lists and other circumstances that indicate there is a serious "domino effect" on other care settings as the result

of home health IPS. Attached is one such account. In recent testimony before the Senate Finance Committee, the Director of the Rhode Island Department of Human Services discussed this spillover effect of more hospitalizations and nursing home usage due to IPS.

4. Are there specific areas of the county - rural areas, for example -- which are experiencing a shortage of available home health services as a result of the IPS?

Areas of the country that have experienced the greatest number of closures are likely to be at greatest risk for being underserved. Reports are that rural areas in particular are experiencing a shortage of available home health services as a result of IPS and HCFA's restrictive branch office policies.

Mary Dalpe, RN  
Director, Department of Human Services  
Marlborough, MA  
508/460-3758

As Director of the Department of Human Services of the city of Marlborough, Massachusetts, and a registered nurse, as well as the wife of a man who was homebound because of multiple sclerosis, I feel I am in a unique position to understand the devastation caused by the Medicare interim payment system (IPS) both in my professional life as well as my personal life.

In my work, I frequently share the pain of senior citizens who call for guidance after they have been discharged from home care agencies that can no longer afford to give them care under the IPS. In my personal life, my husband Don and I faced this same devastation when we lost our home care last September because of IPS. Don was homebound but, with the assistance of our local home care agency and my family, we were able to keep the quality in our lives in a very cost effective manner. Don, an engineering manager, in his 50's, father of two daughters, now resides very sadly, and costly, in a nursing home, wishing every day he could return to his own home again.

There are around 600 to 700 residents in my area who need assistance from a VNA in order to stay in their own homes. Without that assistance, many of them will face entering a nursing home paid for by taxpayers. Is this cost effective? I don't think so.

Calls are coming in to my office and people are frightened, especially our senior citizens. If you are an 81-year-old female, taking care of an 82-year-old husband with the assistance of a VNA, and you lose those services, how long will it take before you both must enter a nursing home?

Home care agencies bloomed over the years when hospitals began discharging patients "sicker and quicker." Now, without community support systems in place like home care agencies, hospital costs are skyrocketing again because these frail elderly and disabled clients have to resort to the 911 system when they run into difficulty. Cost effective? I don't think so.

The Balanced Budget Act of 1997 was a necessary piece of legislation for the future well-being of the nation, but we must find a fix for IPS now so that our elderly and disabled family members, friends, and neighbors can receive the care they need and deserve.

In closing, I'm respectfully requesting that we put the word "Care" back in "Home Care." People have the right to die at home in dignity. People like my husband who worked hard, became educated, paid taxes, now can't even stay in their own homes in their time of greatest need. It is far more cost effective, not to mention humane, to allow these beautiful people to live a quality life only obtained in their own homes with loved ones.


 Senate Permanent Subcommittee  
 on Investigations

 EXHIBIT # 9

June 30, 1999

The Honorable Carl Levin  
 US Senator  
 459 Russell Senate Building  
 Washington, DC 20510

Dear Senator Levin,

Attached please find the response I have written to a supplemental question submitted by Senator Cleland following the Home Health hearing on June 10th. I have also enclosed my response to HCFA Deputy Director Buto's inquiry following the hearing. Thank you again for the opportunity to present my testimony on behalf of Michigan providers.

I would also like to take this opportunity to inform you that I have made the very difficult decision to resign my position at Home Health Outreach. This decision has been the result of months of soul-searching regarding how best to use my energies for the service of others and for my professional growth.

I was so optimistic when I testified and distinguished senators such as yourself clearly understood the devastating effects of the labor and cost-intensive effects of BBA 97 and the HCFA regulations mandated to implement them. As I indicated in my testimony, many of the components of OASIS, IPS, 15 minute increment reporting, sequential billing, etc. have had negative effects on both patient care and the dedicated staff who provide that care.

When I returned home and read the HCFA MEDICARE MEMO on resumption of OASIS and the new patient rights, I felt that I could not in good conscience ask my staff to make what I considered false statements to our patients, to deny non-Medicare patients the right to refuse to answer the questions. The rights as written do not allow any patient to refuse to have the information encoded or transmitted, and indicates that home care providers are to "answer the questions as best they can" if the patient refuses to answer. I question both the ethics and accuracy of any statistical assumptions made of the basis of such information.

I had hoped that Congress would have passed the Patient's Rights Act before re-initiation of OASIS so that it could be held to those standards.

On a personal note, our organization has had to make many cost-containment efforts which included reduction or elimination of both compensation increases and benefits. I cannot prepare for my own retirement under such constraints.

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The combination of frustration over non-essential, cost-prohibitive HCFA regulations which divert limited resources away from direct care into questionable paper chases and the clear limits for professional growth in home care at this time, I felt I must resign. I have no job waiting for me and intend to take time to renew my spirit before I determine what direction my future may take.

I will greatly miss the daily contact with our staff and the patients they serve, but I am convinced that they will re-dedicate their energies to their patient care mission.

The MICHIGAN HOME HEALTH ASSOCIATION has asked that I remain on its Board of Directors as the Public Policy Chair and in that capacity, I will still be available to you and your staff as a resource for resolution of home care related issues.

With sincere appreciation for your support of our industry's efforts to provide Medicare beneficiaries in Michigan with these essential services, I remain.....

Linda Stock, RN BSN CHCE

*Linda Stock RN BSN CHCE*

CC: Senator Susan Collins  
Laura Stuber, JD  
Karina Lynch



June 30, 1999

Ms. Kathleen A Buto  
 Deputy Director  
 Health Care Finance Administration  
 Center for Health Plans & Providers  
 7500 Security Blvd.  
 Baltimore, Maryland 2124

Dear Ms. Buto,

In response to your request for additional information on access to care problems for home care beneficiaries in Michigan, I am forwarding to you the following summary compiled from several members of the Michigan Home Health Association. While more than willing to respond to the access issue as it affected their patients, they requested anonymity for both their patients and their agencies. This request was honored. These examples are representative of the experience of my peers both in our state and throughout the country.

**Jackson, Michigan** agencies report that the discharge planning departments of a local hospital having difficulty (1) placing high-tech infusion cases and tend to place them in the county facility rather than at home, (2) experiencing a 5-10 day delay in discharge while trying to locate an agency willing to accept the high cost complex cases.

**A Muskegon, Michigan** agency reports inability to admit 18 Medicare patients in the last three months.

**A large metropolitan Detroit system agency** reports difficulty in placing Medicare cases with daily or twice a day wound care when patients who clearly qualify for the benefit but whose care costs are prohibitive under IPS.

**A Saginaw agency** reports (1) 23 patients who could not be admitted in late 1998 (2) 27 cases closed early (3) 11 cases transferred to other programs to continue care and (4) the agency started a foundation to support the costs of Medicare patients who qualify for the benefits but whose costs are prohibitive under IPS.

**A Kalamazoo agency** reports (1) the closure of over 50 chronically ill cases (2) delayed discharges from their system facilities at least twice a month when agencies refuse to accept back into care high cost complex Medicare beneficiaries, and (3) the agency received several direct requests from other agencies in the area to assume care for their high-cost patients (suggesting that the agency use its United Way funds to subsidize Medicare.

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A northern Michigan agency discharged 6 patients because of the venipuncture restriction. These rural home bound patients have no way to get to a facility for labs. At least 2 of these patients have been rehospitalized for conditions which may have been prevented had nursing been drawing these labs during an assessment visit.

A southeast Michigan facility was not able to admit 280 patients, 70% because of the high cost of their care. These patients are now at risk because neither home care nor ECF could meet their needs.

A southeast Michigan agency reports approximately 40 patients in a two month period were readmitted into acute care settings within one month of discharge from care due to the instability or complications.

The Michigan Peer Review Organization states, out of 23 home care agencies in the Diabetic universe, samples from 1996 were 29,703 patients compared to the 1998 figures of 23,008. This reflects a 23% decrease over two years.

A southwest Michigan agency reports closing high cost complex, chronically complex cases because their resources are not great enough to offset the disproportionately high cost of such care.

A southeast Michigan agency reports that 17 patients admitted since 1/1/99 were closed to goals and readmitted within one month due to hospitalization from complications. These chronically unstable patients used to be served under the case management code but were discontinued to control costs as their conditions temporally stabilized.

In gathering data for this communication, I was struck by the many individual stories of patients/caregivers adversely affected by decisions necessitated by resource conservation measures necessary for agencies to remain operational as a result of IPS and the burdensome costs of HCFA designed regulation mandates.

If additional information is requested, please contact me through the Michigan Home Health Association at (517) 349 8089, fax (517) 349 8090 at 2140 University Drive, Suite 220, Okemos, Michigan 48864-3974.

Thank you for your interest in the very real access impact IPS and the BBA 97 regulations have had on patients and agencies.

Sincerely,  
  
Linda Stock, RN BSN CHCE  
Vice President, Home Health Services

cc: Senator Levin/Laura Stuber  
Senator Collins/Karina Lynch

SUPPLEMENTAL QUESTION RESPONSE FOR THE RECORD  
SUBMITTED BY ROSALIND L. STOCK  
Vice President, Home Health Services  
Home Health Outreach  
Rochester Hills, Michigan

For June 10, 1999 Hearings before the  
US SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
on  
HOME HEALTH CARE: WILL THE NEW PAYMENT SYSTEM AND  
REGULATORY OVERKILL HURT OUR SENIORS?

QUESTION: How have home health agencies in your state had to cut back on Medicare services offered to their patients as a result of the IPS and new HCFA regulations?

For the record I am attaching a copy of the letter responding to Deputy Director Buto of HCFA following the June 10th hearing regarding access to care problems occurring in Michigan.

As I indicated in my written testimony, agencies in Michigan have tried to reduce their costs to stay under the IPS Per Beneficiary Limits, Reduced Cost Per Visit Limits, and fund the expensive, unfunded, HCFA mandated regulations such as sequential billing, proration, surety bonds, increased medical review, OASIS, and 15 minute increment reporting .

The effects of these drastic reimbursement constraints necessitated agencies to re-evaluate what resources they had to meet patient needs and how best to distribute those resources. The effect on patient services fell into the following categories:

1. Reduction or elimination of "center of excellence" programs such as wound care, diabetic management, and stroke care. This care has been more difficult to secure for newly diagnosed patients as agencies deny admissions based on tighter admission criteria. Thus, the most complex and sickest elderly are most affected by the denied admissions.
2. Agencies have closed all patients for whom venipuncture was the primary skill as mandated by BBA 97. In rural Michigan many of these patients who need this service to diagnose and treat their chronically unstable conditions (such as congestive heart failure) no longer receive these services at all.
3. Agencies are attempting to intensify the amount of skill provided in each visit to reduce the total number of visits per patient. This sometimes results in patient frustration for receiving too much information too quickly. It also can lead to early discharge when it appears the patient has stabilized but the patient has not and then develops complications requiring re-hospitalization.

4. Some agencies refuse to re-admit high-cost patients to service when they are hospitalized and discharge planners are finding it more difficult for placement of these patients.
5. Agencies that have United Way funding are receiving requests from agencies with high-cost patients to assume the care and thus subsidizing Medicare with charity funds. This is not an appropriate use of charity dollars.
6. Support services such as home health aide visit are often reduced earlier in the service period to prepare the family and patient for the reality of caring for themselves after the agency closes services. This denies the patient needed support during their early recovery period when the aide assistance can promote energy conservation and healing.
7. Some agencies have reduced their geographic coverage areas to limit costs which limits access to care for more remote patients.

Michigan agencies have every right to be proud of the effective cost-containment efforts which they have initiated to remain viable, but at what price to patients and their dedicated care providers who have had to cope with reduced incomes and increased regulatory requirements.



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

JUL 16 1999

Senate Permanent Subcommittee  
on InvestigationsEXHIBIT # 10

The Honorable Susan M. Collins  
Chairman, Permanent Subcommittee on Investigations  
Committee on Governmental Affairs  
United States Senate  
Washington, D.C. 20510

Dear Chairperson Collins:

Thank you for inviting the Health Care Financing Administration (HCFA) to testify before the Senate Permanent Subcommittee on Investigations on June 10 regarding the impact of the provisions in the Balanced Budget Act of 1997 (BBA) on home health agencies (HHAs). I believe the hearing was very useful and in particular raised very important issues related to beneficiary access to Medicare home health services. During the hearing, you requested that HCFA provide recommendations to address problems HHAs have experienced as a result of the changes in the BBA. Attached are responses to the written questions you and Senator Cleland submitted to HCFA after the hearing, as well as, HCFA's edits to the transcript.

I am pleased to inform you that as part of *The President's Plan to Modernize and Strengthen Medicare for the 21st Century*, we are taking new steps to help HHAs adapt to the BBA changes. The BBA included important changes to Medicare payment policies that have contributed to restraining cost growth through 2002 and extending the life of the Medicare Trust Fund through 2015. The BBA policies were developed in consultation with Medicare experts, Congressional members and staff, and many outside interest groups. They include strong and defensible policies that will help preserve and protect Medicare for the people it serves. However, some of the approximately 335 BBA policy changes may have unintended consequences. Given how recently these changes were enacted, the implications for providers and beneficiaries are not clear. HCFA, Medicare Payment Advisory Commission, General Accounting Office, and the Department of Health and Human Services Inspector General are all engaged in proactive efforts to monitor the impact of the BBA policies on beneficiaries' access to quality health care.

Recognizing that there may be a need to adjust and gradually phase-in some of the BBA policies, the President's Plan includes a "quality assurance fund" to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. This fund totals \$7.5 billion for FY 2000-09 and will be used to make appropriate and justified modifications to BBA policies. The Administration will work

Page 2 -- The Honorable Susan M. Collins

with Congress, Congressional advisory commissions, and provider and beneficiary groups to determine in an evidence-based manner what BBA policies have produced major access and quality problems for beneficiaries and/or made it excessively difficult for providers to deliver quality services. As we do so, we will develop with Congress specific policies that address problems in a fiscally prudent way.

The President's Plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers' ability to deliver quality services to beneficiaries. This includes immediate action to address concerns the home health industry and members of Congress have raised. First, we are increasing the time for repayment of overpayments related to the interim payment system (IPS) from one year to three years, the first year being interest free. HHAs may also request extended repayment schedules (ERS) beyond the 36 months. If these HHAs meet the financial need and ability to repay criteria, additional time will be provided and interest will be assessed. Currently, HHAs are provided with one year of interest-free ERS with the option to request an ERS beyond the 12 months, with interest, pending financial criteria are met. Second, we are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system (PPS). This will help ensure that overpayments related to the IPS will not be an obstacle to HHAs obtaining surety bonds.

Third, we are following the recommendation of the General Accounting Office by requiring all HHAs to obtain bonds of only \$50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier. Fourth, we have eliminated the sequential billing rule as of July 1, 1999. Many HHAs expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree. Finally, we are phasing in our instructions implementing the requirement that HHAs report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement BBA provisions. By allowing this degree of flexibility for a temporary period we will prevent agency cash flow problems or returned claims.

Congress mandated the IPS for HHAs as a temporary measure until a home health PPS that would pay HHAs appropriately according to resource needs of patients is implemented. We believe this new payment system will address concerns some HHAs have that are related to the IPS and we are committed to implementing PPS by October 1, 2000 as required by law. In fact, we are currently on schedule to publish the proposed rule by this fall for comments. The proposed rule will reflect our sensitivity to quality of care and equitable treatment of home health providers.

Page 3 -- The Honorable Susan M. Collins

Again, thank you for your interest in home health issues and the opportunity for HCFA to testify. We are committed to continual monitoring of the impact of BBA provisions on home health providers and beneficiary access to home health services.

Sincerely,



Kathleen A. Buto  
Deputy Director  
Center for Health Plans and Providers

Attachments

cc: The Honorable Carl Levin  
The Honorable Max Cleland

**SUPPLEMENTAL QUESTIONS and ANSWERS FOR THE RECORD  
SUBMITTED BY CHAIRMAN SUSAN M. COLLINS**  
Hearings Before the  
**U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS**  
June 10, 1999  
*Home Health Care: Will the New Payment System and  
Regulatory Overkill Hurt Our Seniors?*

- Q1.** We have heard a great deal today about the burdens that the IPS has put on home health agencies across the country. Many agencies feel that they cannot get to PPS fast enough. In fact, many agencies are worried that they will not be able to survive on the IPS and will be forced out of business before PPS takes effect. This is all the more worrisome, since Ms. Smith's testimony indicates that the closures we are seeing are just the "tip of the iceberg." Given the time constraints that HCFA is under to become Y2K compliant, and the fact that this has already pushed PPS implementation from October 1, 1999 to October 1, 2000, are you confident that HCFA will meet its new deadline of October 1, 2000? Your testimony states that you expect to publish the proposed regulation this fall. What challenges do you think HCFA faces in trying to meet that deadline? What is your timeline?
- A1.** We are on target for developing the home health prospective payment system on time for October 1, 2000, and that remains one of our top priorities. We expect the proposed rule to be published by October of this year for public comment and the final rule to be published by July of next year for the October 1, 2000 implementation date.
- Systems development for home health PPS has been given our highest priority after Y2K preparedness. We are developing a strategy for implementation and without any unforeseen Y2K problems, we believe we will meet the October 1, 2000 implementation date.
- Q2.** You mention in your testimony that OASIS data is critical to the home health prospective payment system. I understand that HCFA had originally planned for home health agencies to begin mandatory reporting of OASIS data at the end of April, but has since postponed that requirement. Will this cause a further delay in HCFA's ability to implement a prospective payment system? Are all of the elements in the OASIS data set necessary to the development of a prospective payment system? Will HCFA proceed with prospective payment

**even if it is unable to collect this data?**

- A2. Again, we are on target for developing the home health PPS as required by law. We expect the proposed rule to be published by October of this year for public comment and the final rule to be published by July of next year for the October 1, 2000 implementation date.

Mandatory collection and transmission of OASIS data were delayed to conduct a comprehensive review of the privacy issues because we believe important benefits of OASIS must be implemented in a way that protects personal privacy. We wanted to ensure the proper balance between preserving individual privacy and fulfilling the statutory requirement to improve quality and pay providers fairly.

Following a comprehensive review of privacy issues, two Federal Register notices were published on June 18, 1999 which allows HCFA to reinstate its OASIS requirements. The first is a system of records notice, required by the Privacy Act of 1974, that specifies circumstances where individual specific records may or may not be released. The second is a notice that explains steps Medicare is taking to ensure patient privacy. Agencies must now begin using OASIS by July 19, 1999 and begin transmitting OASIS data to states beginning August 25, 1999. Once the data is received, HCFA can begin using national OASIS data to develop the payment rates for the prospective payment system. We will also begin using the data to make sure that Medicare home health agencies are providing quality services to their patients.

It is crucial that we collect all of the OASIS items. These items are necessary in order to reflect as accurately as possible the changing needs of patients as we refine the home health PPS system. Once the PPS is initially implemented and evaluated, we may find that different or additional OASIS items will significantly improve the predictive power of the PPS case mix. In this case, we would want to be able to turn to other OASIS data items that may potentially be more useful for payment. If only some of the OASIS data items are collected, we will have no ability to refine the PPS.

The interaction of OASIS quality and payment data creates important checks and balances. Episode-based PPS systems create an incentive to reduce the amount of services patients receive as well as characterize patients as sicker than they actually are. It is important, therefore, to have a quality system in place both to assure that reductions in service do not compromise patient health as well as create a system which discourages the mischaracterization of patient conditions.

- Q3. The OASIS survey includes unprecedented questions about the most intimate and private details of patients' lives, including details about mental stability, possible substance abuse, financial status, and living arrangements. Obviously, confidentiality is of utmost concern, and I do understand that one of the reasons for the OASIS delay is to give HCFA the time to conduct an evaluation of these confidentiality concerns. What kinds of confidentiality protections has HCFA adopted - or does HCFA plan to adopt - relative to OASIS? Is there a requirement that patients give informed consent? What happens if a Medicare patient refuses to answer some or all of the questions? Is the home health benefit terminated? Is there any requirement that non-identifiable health information be used where possible? What kinds of safeguards are in place? Are there sanctions or penalties for improper use or disclosure of the information?**
- A3.** We're taking every step to protect patient privacy and confidentiality. We expect all home health agencies to protect the confidentiality of patient-specific information in accordance with Federal and State privacy requirements, and we obviously will do the same.

Home health agencies perform an OASIS assessment for each of their clients. The information is entered into their computer, and they must protect that confidential information -- as they protect other confidential information -- in accordance with federal and state privacy requirements. At all times, the data -- whether in hard copy or electronic form -- must be controlled and secure.

HHAs transmit the data to the states using a private dial-up network based on a direct telephone connection from the HHA. A security firewall protects the data at the state level. The states compile the data and send it to HCFA. At both the state and federal level, the data is subject to the requirements of the Federal Privacy Act. Access is strictly controlled at HCFA and the information can only be used under the narrow circumstances allowed under the "routine uses" of the Privacy Act published in the Federal Register. Anyone who violates the Privacy Act law could face fines and imprisonment.

At the request of Vice President Gore, we conducted a thorough review of OASIS to ensure that we struck the necessary balance between protecting privacy and fulfilling our statutory obligations to improve the quality of home care and to pay providers fairly. As a result, we've taken additional steps to further strengthen privacy protections and address the concerns raised by the Vice President and others. A comprehensive review of privacy issues has been completed and we

have adopted the following extra precautions as specified in the June 18, 1999 Federal Register notice:

- ▶ Providing a notice to Medicare and Medicaid patients at admission that explains why OASIS data is collected, and informing patients of their right to see and request corrections of the data.
- ▶ Limiting the “routine uses” of data under the Privacy Act, so that personally identifiable data will only be used where statistical information is not sufficient. Also, personally identifiable data will not be made available at all to accrediting organizations such as the Joint Commission for Accreditation of Health Organizations.
- ▶ Limiting the “routine uses” of data to other Federal and State agencies. Only those Federal and State agencies that (1) contribute to the accuracy of HCFA’s health insurance operations including payment, treatment, and coverage and/or (2) support State agencies in the evaluations and monitoring of care provided by home health agencies will have access to OASIS data.
- ▶ Requiring information on private-pay patients to be transmitted in a form that is not personally identifiable. We are currently developing an encryption system that masks identifiable data for these patients and we expect to complete this system by the spring of 2000. Until then, agencies will not be required to submit data for private-pay patients.
- ▶ Not reporting a question on patient financial factors from OASIS. After careful attention to each and every OASIS data items, we found that this particular data item is less critical to achieving program goals. However, we found that all other data items are necessary for assuring quality of care and appropriate reimbursement.
- ▶ Accelerating efforts to encrypt data during transmission to provide another level of protection. We expect to complete these efforts within a year.
- ▶ Delaying the collection of OASIS data for patients receiving only personal care services until the spring of 2000. Before then, HCFA will continue to work with the Administration on Aging to establish an alternative approach for the use of OASIS for this population. This would apply to all patients receiving personal care services for all payers including Home and Community Based Waiver programs, optional State plans, private pays, etc.

No Administration has been more committed to protecting medical privacy. HCFA has a solid track record of consistently safeguarding sensitive beneficiary information. In fact, we provide much greater protection than is generally afforded by many payers in the private sector. For OASIS, we are providing even more security than our usual, stringent protections.

- **Is there a requirement that patients give informed consent? What happens if a Medicare patient refuses to answer some or all of the questions? Is the home health benefit terminated?**

Patients will be informed of all their rights under the Privacy Act of 1974. Before skilled nurses or therapists conduct comprehensive assessments, the home health agency must tell patients about OASIS and explain their rights with respect to OASIS information. These rights include: 1) the right to be informed that OASIS information will be collected and for what purpose; 2) the right to have the information kept confidential and secure; 3) the right to be informed that OASIS information will not be disclosed except for legitimate purposes allowed by the Privacy Act; 4) the right to refuse to answer a specific question; and 5) the right to see, review, and request changes on their assessment. We have developed a notice to patients that explain these rights in plain language. This notice will be presented to beneficiaries before their initial OASIS assessment.

The privacy rights notice ensures that all home health patients fully understand their privacy rights, while allowing HCFA to fulfill its statutory obligations to improve the quality of care for those patients and to develop a reliable, accurate payment system. Patients do not give up any rights because they receive a privacy notice rather than informed consent. A patient may exercise any of these rights anytime.

If a patient refuses to answer a question he or she will continue to be able to get appropriate care. OASIS is not an interview or a survey. It is part of an assessment of the patient that must be conducted by a skilled nurse or health-care professional trained to make clinical assessments. Patients can refuse to answer any question put directly to them. OASIS makes exceptions for information that cannot be obtained through clinical observation. For example, if the patient is unwilling to share information with regard to high risk factors such as heavy smoking, alcohol dependency, or drug dependency, then the "Unknown" box can be checked and submitted. Health-care professionals are trained to assess the patient to the best of their ability in order to provide the best care possible. We need that information as an insurer so that we can know that we are paying accurately and that beneficiaries get the quality services that Medicare pays for.

- Q4. As you know, the Balanced Budget Act of 1997 eliminated the need for venipuncture as a qualifying condition for home health services. Medicare will continue to pay for blood draws, but these services will be covered under Part B rather than the home health benefit under Part A. I understand that if the beneficiary is unable to travel to a laboratory or a physician's office for the blood draw, Medicare will pay for a technician to travel to the beneficiary's residence to draw blood.**

**However, in rural States like Maine, there simply aren't the labs or personnel with technicians who can travel to beneficiaries' homes to perform these services. In Aroostook County, for instance, where I am from there are no lab technicians who can make home visits to draw blood. As a consequence, I have heard from providers that patients must now either travel by ambulance to their physician's office to receive venipuncture services or simply not have their blood levels checked. Is this true? Under these circumstances, wouldn't it make more sense to allow home health agencies to perform the blood draw and reimburse them for the service but, at the same time, not allow a patient to qualify for all other health services simply because they need venipuncture?**

- A4. I understand your concern that there may be inadequate resources in Maine's rural areas district to meet the needs of the truly homebound. Due to this concern, we did increase the payment of travel allowances under the part B laboratory benefit to a minimum of 75 cents a mile, when the average trip is longer than 20 miles round trip, or a minimum of \$7.50 one way, when the average trip is less than 20 miles. The travel allowance payment is pro-rated for blood drawn from non-Medicare patients. In addition, the travel allowance is only paid when a \$3 specimen collection fee is also paid.**

However, as you mentioned, there are still some rural areas that simply do not have the lab technicians available to make home visits to draw blood. There are a variety of other providers can also draw blood at a beneficiary's home. For example, while a physician conducts a home visit for evaluation and management, the physician may also draw a blood specimen. In addition to the physician fee schedule amount for the home visit, the physician may receive an additional amount under the Part B laboratory fee schedule for the specimen collection. The physician can also arrange for a nurse practitioner, physician assistant, or clinical nurse specialist to conduct a home visit and draw blood when he or she examines the beneficiary. These clinicians would be reimbursed at a rate equal to 85 percent of the physician fee schedule for a home visit plus an amount under the laboratory fee schedule for the specimen collection. The Part B laboratory travel allowance

is available only if the sole reason for the visit by the physician or the practitioners listed above is to draw blood. Please note that the appropriate Clinical Laboratory Improvement Amendment (CLIA) certification is required if a laboratory test, in addition to the blood draw, is performed.

Medicare may also pay for rural health clinic (RHC) services performed at the beneficiary's place of residence. In that case, the RHC can send the specimens to a reference laboratory, or do the laboratory services itself if it has certification under CLIA. When skilled nursing services are the reason for the RHC visit, venipuncture services would be included in the all-inclusive rate per visit.

Also, home health agencies (HHAs) that are CLIA-certified and have a Medicare laboratory provider identification number may receive reimbursement for laboratory tests they perform and the specimen collection and travel fees associated with those tests. HHAs that are solely performing blood draws, and not performing any laboratory tests on the blood sample, cannot bill Medicare Part B directly for the specimen collection and travel. However, an HHA could make arrangements with an independent laboratory that would allow the agency to collect blood samples for the laboratory. This would be an arrangement exclusively between the laboratory and the HHA, and Medicare payment, if applicable, would be made only to the laboratory.

- Q5. In your testimony, you quote two CBO reports - one from April 1999 and one from September 1998 - and conclude that lower-than-expected spending is due to program integrity efforts, demographic changes, lower-than-expected inflation, and other factors not related to the BBA. This morning, however, CBO's testimony before the Senate Finance Committee, stated:**

**The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies.**

**These statements appear to contradict one another. Could you help me reconcile them?**

- A5. We will have to defer your question to CBO for a response.**
- Q6. As a follow up to that question, CBO states in its testimony to the Finance Committee earlier this month that some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims - sequential billings. CBO's testimony also states that some agencies**

**may not understand the per-beneficiary limit. This raises the concern that some patients may not be getting care to which they are entitled simply because some agencies don't understand the IPS. Isn't it HCFA's responsibility, in conjunction with the fiscal intermediaries, to make sure that providers understand payment policy? What is HCFA doing to correct these mis-perceptions?**

- A6. We have taken several steps to accommodate concerns raised by providers that are related to the IPS. We have also made efforts to make sure that providers understand our payment policy.

In regards to per-beneficiary limits under the IPS, to ensure that home health agencies understand the changes in Medicare home health payment policy mandated by the BBA, we sent letters to home health agencies explaining the BBA provisions including the per-beneficiary limit policy under the interim payment system. However, since some agencies may not have acted responsibly, we sent a second letter to home health agencies on February 3, 1998 that reiterated their basic responsibilities under the Medicare Conditions of Participation.

The sequential billing rule was eliminated to alleviate cash flow problems experienced by some agencies. While we strongly encourage HHAs to continue billing sequentially, we have now determined we can appropriately allocate funds between the Part A and B trust funds without this requirement. We have directed contractors who pay home health claims to stop enforcing it no later than July 1, 1999, and sooner if systems allow.

**SUPPLEMENTAL QUESTIONS and ANSWERS FOR THE RECORD  
SUBMITTED BY SENATOR MAX CLELAND (D-GA)  
Hearings Before the  
U.S. SENATE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS  
June 10, 1999  
*Home Health Care: Will the New Payment System and  
Regulatory Overkill Hurt Our Seniors?***

**Q1. Is the prospective payment system for home health agencies still on track for implementation in 2000?**

**A1.** We are on target for developing the home health prospective payment system on time for October 1, 2000, and that remains one of our top priorities. The Federal Register notices published on June 18, 1999 keep us on track to publish a proposed rule in the fall, as planned. Agencies must use OASIS starting July 19, 1999 and begin encoding and transmitting OASIS data to States on August 25, 1999. This will give us sufficient national data to use to set PPS rates.

Systems development for home health PPS has been given our highest priority below Y2K preparedness. We are developing a strategy for implementation and without any unforeseen Y2K problems, we believe we will meet the October 1, 2000 implementation date.

**Q2. I have heard from home health agencies in my State that information provided to them by fiscal intermediaries and HCFA was confusing and even inconsistent. What is your response to MedPAC's recommendation that "the Secretary should establish a nationally uniform process to ensure that fiscal intermediaries have the training and ability to provide timely and accurate coverage and payment information to home health agencies?"**

**A2.** HCFA has made a strong effort to furnish providers with information concerning home health coverage and payment. We have prepared and sent to all providers a national article detailing our 15 minute increment reporting requirement as set forth in the Balanced Budget Act of 1997. A list of frequently asked questions (FAQ's) were prepared and disseminated to national provider organizations and all home health agencies (Attachment A & B). We met with representatives from the major home health organizations and trade organizations as part of a concerted effort to respond to their questions and concerns.

HCFA has recently established a pro-active plan to improve provider education and training. In order to promote consistency in communications, HCFA Central Office will prepare and issue national articles on major program issues, such as home health, to be published in contractor bulletins and conduct train the trainer sessions of intermediary staff. Traditional bulletins and seminars will also be supplemented with newer forms of technology, such as web-site posting, computer-based training modules, and satellite broadcasts. Medicare Program instructions on home health will include questions and answers, as well as illustrations to help clarify technical points. Additional features of these documents will include detailed indexes and cross referencing related materials and documents.

**Q3. Many agencies in Georgia are concerned over the new 15-minute increment home health reporting requirement and feel that this requirement is just another bureaucratic hurdle. What is the value of the information received from the 15-minute increment reporting regulation?**

**A3.** Section 4603 ( C ) of the Balanced Budget Act of 1997 required Medicare home health claims to report the number of 15 minute increments comprising each service visit as of October 1, 1998. Specifically, the statute states that

“ . . . no claim for such services may be paid unless . . . the claim contains a code (or codes) specified by the secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

Congress' intent for the 15 minute visit reporting requirement is to capture data that might be useful in the development or future refinement of a home health prospective payment system, now mandated for October 1, 2000 implementation. It will provide information regarding the relative intensity of therapeutic services provided to beneficiaries in the home.

**Q4. I understand that HCFA has ordered a halt to its sequential billing policy by July 1. However, I am told that many backlogged claims still exist, and home health agencies are understandably anxious to get the money owed them. How will HCFA ensure that backlogged claims will be paid promptly once sequential billing edits are removed?**

**A4.** Estimates vary widely regarding the number of backlogged claims that will be received as a result of the removal of sequential billing. Associated Hospital Services, our Regional Home Health Intermediary (RHHI) for several New

England states, removed the sequential billing requirement in May 1999. The volume of claims received by Associated since that time has shown no abnormal increase.

We have taken several steps to prepare for increased claims in case we do receive them. A comprehensive home health claims software release was installed in May that addressed the outstanding glitches in processing claims under the A/B trust fund shift. This release was thoroughly tested prior to installation and claims processing since the release has been smooth. Also, we have instructed RHHIs to monitor their claims volumes carefully in the coming weeks and to adjust their levels of medical review if necessary to avoid delaying a high number of claims. Our staff will continue to confer regularly with the RHHIs to identify any unforeseen issues and resolve them quickly.

**Q5. What plans does HCFA have to relieve the burden of high levels of medical review for providers with a history of few or no claim denials?**

- A5.** As you may be aware, the Health Insurance Portability and Accountability Act of 1996 and the BBA of 1997 gave us new tools and resources for stepping up program integrity activities. We use various strategies when conducting medical review. Some review is focused on a particular health provider because an analysis of the providers billing practices reveals aberrant patterns. As a result, providers with a history of few or no claim denials have a lesser chance of being subject to this type of medical review.

Other types of review are not specific to a particular provider, but rather specific to a type of service or services provided for a specific diagnosis. These reviews are known as "topic" reviews. Topic reviews are driven by the type of claim submitted without regard to a provider's billing pattern or claim denial rate.

A third type of medical review is "random review." This type of review is done purely by chance. Like the "topic" reviews, it is not data driven and therefore not contingent on claim denial rates or data analysis. This type of review gives every claim an equal chance of being reviewed. Providers found to be billing inappropriately in a topic or random review are educated on Medicare billing and coverage requirements. Providers who do not respond to education efforts, and continue to have a pattern of noncompliance are placed on focused review. For these providers, the intensity of claim review will increase. On the contrary, providers with a history of few or no claim denials generally will not be subjected to an intensified medical review effort.

**Frequently Asked Questions**  
**Regarding 15 Minute Increment Reporting of Home Health Visits**

**Q1: Why is 15 minute increment reporting of home health visits required? What will be the value and use of this information?**

Section 4603 ( C ) of the Balanced Budget Act of 1997 required Medicare home health claims to report the number of 15 minute increments comprising each service visit as of October 1, 1998. Specifically, the statute states that

"... no claim for such services may be paid unless ... the claim contains a code (or codes) specified by the secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

Congress' intent for the 15 minute visit reporting requirement is to capture data that might be useful in the development or future refinement of a home health prospective payment system, now mandated for October 1, 2000 implementation. It will provide information regarding the relative intensity of therapeutic services provided to beneficiaries in the home.

**Q2: The implementation date of this requirement was July 1, 1999. Has implementation been delayed?**

Since our instructions on 15 minute increment reporting were published in February 1999, we have been notified by many home health agencies that the demands of Y2K compliance were competing with their efforts to implement the new reporting requirement. In an effort to minimize the impact of these changes on home health agencies, HCFA has instructed the Regional Home Health Intermediaries (RHHIs) to implement this provision in a "phased in" manner.

Effective July 1, 1999, claims processing systems will be changed to accommodate the reporting of fifteen minute increments. However, if an agency cannot prepare its system to report the HCPCS codes associated with 15 minute increments by July 1, 1999, the system will allow their claims to be processed without them for a grace period that will end September 30, 1999. Special instructions have been issued that explain the billing procedures during this interim period. (See Program Memorandum A-99-29.) The key point is that each visit must be billed on an individual line. Multiple visits billed on one line will result in underpayments. Providers that follow these instructions will avoid any inaccurate payments or the need to submit adjustment bills. By allowing this degree of flexibility for a temporary period, providers can be assured that their cash flow will not be stopped by returned claims.

**Q3: Do I need to make a special application to my RHHI in order to take advantage of the grace period?**

No. The systems of all RHHIs will be programmed to accept home health claims without the

HCPCS codes until September 30, 1999. The grace period will be automatic. There is no special arrangement that you need to make.

**Q4: If my system can prepare for the new requirements, how should I submit claims for services performed before June 30, 1999? How should I submit claims for services performed after that date?**

Claims for services performed on or before June 30, 1999 should be submitted as they are currently. That is, they should be submitted without HCPCS codes and reporting a number of visits in the units field of the revenue code line. Claims submitted for services performed on or after July 1, 1999 should be submitted with each visit on a separate revenue code line. Each revenue code line should show the HCPCS code appropriate to the discipline of the service visit and should report a number of 15 minute increments in the units field. If you are reporting increments in this manner, it is expected that you will report them accurately. It is important to remember that you should bill June 1999 and July 1999 services on separate claims. Claims with dates in both of these months will be returned to you. You will need to split them into exclusive June and July claims before resubmitting them.

**Q5: If my system cannot prepare for the new requirements in time, how should I submit claims for services performed after July 1, 1999?**

The essential thing to remember is to bill each visit as a separate revenue code line. On each line, leave the HCPCS/Rates field blank. On each line report one unit in the units field, representing a visit. Bill June and July services on separate claims. Remember that effective October 1, 1999 the phase-in period ends and all providers will be required to submit both the number of increments and the associated HCPCS codes.

**Q6: Why are visits of less than eight minutes not to be reported? Are services provided during this period covered under Medicare?**

The first eight minutes of every visit are not and were never meant to be excluded from Medicare coverage. All medically necessary Medicare covered home health services will continue to be reimbursed, regardless of the length of the visit. Fifteen minute increment reporting is intended to provide data on the relative intensity of service utilization. To ensure the quality and accuracy of this data, our instructions set out definitions and limitations of reportable service time. Our goal was to ensure that all the time reported represented time spent in the active treatment of Medicare beneficiaries.

Providers were originally asked to begin recording of the first increment at 8 minutes in recognition that many aged and disabled beneficiaries require this time to prepare for treatment. It was also reasoned that a complete home health visit of less than 8 minutes was unlikely to occur, and, if it did, was unlikely to be a meaningful therapeutic encounter. Upon reconsideration, we have determined that the exclusion of shorter visits is not essential to this effort, at this time. Moreover, because this could be misinterpreted, we have issued a clarification which states that "visits of any length are to be reported" ( See Program

Memorandum A-99-31). A revised chart is being supplied to assist providers in converting time into reporting increments. This chart instructs them to report "1 minute to less than 23 minutes" as the initial increment. Subsequent measurements would be in 15 minute increments (i.e., 23 to < 38 minutes, 38 to < 53 minutes, etc.). The time 15 minute requirements in our instructions are consistent with commonly accepted coding conventions for therapy services provided in the CPT coding system.

**Q7: Home health providers feel that they are now required to carry a stopwatch in order to monitor included and excluded visit time. Is this HCFA's intent?**

It is important to remember that the fifteen minute increments are a reporting requirement and not a payment requirement. Home health services continue to be paid on a per visit basis. The number of time increments reported will not affect a provider's reimbursement. HCFA is not seeking to limit or restrict the amount of time an agency spends in the home. We are seeking to ensure that time spent in active treatment of beneficiaries is recorded accurately. We are aware that situations may occur that will interrupt treatment for brief periods. For example, our February 1999 instructions (Program Memorandum A-99-6) state that "if a beneficiary interrupts a treatment...for other than a minimal amount of time (less than three minutes)" that time should not be counted. A three minute interruption is cited as an illustration, not as a definition. It is not meant to indicate that services must be clocked on a stopwatch. What we are asking is for providers to be aware of interruptions in active care. They should then exercise judgement in taking those interruptions into account when calculating their service time into increments.

**Q8. How does the completion of the OASIS assessment fit into the 15 minute increment reporting policy?**

Completion of OASIS fits into this policy consistent with HCFA's longstanding policies regarding the billing of home health visits. That is, a visit made exclusively for the purpose of assessment or exclusively for administrative purposes has never counted as a visit -- and it would not be measured in 15 minute increments under the new policy.

On the other hand, a visit made for the provision of services included in the physician's plan of treatment is a covered visit and the services related to patient care performed in that visit are also covered. That is, a nursing visit could also include completion of the OASIS instrument and the time spent completing it would be considered as nursing care and be reported in 15 minute increments.

**Q9: Is the updating of medical records in the home, including charts and other treatment documentation, excluded from reporting?**

The model we have set out for OASIS assessments can be applied to other charting and documentation as well. If the completion of medical documentation is incorporated into treatment activities provided to a beneficiary in the home, this documentation time can be included in the counting of increments. Time spent updating charts and other medical records

outside of the home should not be reported. Additional billable visits should not be delivered exclusively for the completion of documentation.

**Q10: If documentation time spent outside the home is not to be reported, how will agencies be accurately compensated for administrative costs? These costs may be increased by the increase in required reporting.**

Again, it is important to remember that home health visits are not paid based upon the number of time increments reported. As a result, when certain types of time (such as administrative duties) are excluded as not reportable, this doesn't affect payment received by the home health agency for a visit. The reimbursement mechanism for an agency's administrative costs is not being changed. Covered administrative costs that agencies incur should continue to be included in their annual cost reports.

**Q11: How should agencies report the time of home health aide visits, when these visits also include performing some minor housekeeping services such as washing dishes after a meal, or putting in laundry? Should these services be excluded from reporting since they may not be viewed as active treatment?**

Fifteen minute increment reporting applies to all covered Medicare services performed during a home health visit. Current coverage of Medicare services is not being changed by this reporting requirement (including the provision of incidental services as described in the HHA manual). Home health aides should report the time spent in the home providing all covered services (including incidental services such as homemaking) in fifteen minute increments.

**Q12: Is there a basic definition of "active treatment"?**

Active treatment should be defined as the delivery of covered Medicare services in the home. If it is performed in the home, the maintenance of medical documentation during the delivery of those covered services is considered part of active treatment.

**Q13: How should agencies report the time associated with home health services provided at hospitals, skilled nursing facilities or rehabilitation centers (e.g., services involving equipment that is too cumbersome to bring to the home)?**

Fifteen minute increment reporting applies to all covered Medicare services performed during a home health visit. To be covered, home health services must be furnished in a beneficiary's home or an outpatient setting. For purposes of coverage of home health services, an outpatient setting may include a hospital, SNF, or rehabilitation center with which the HHA has an arrangement and that is used by the HHA to provide services that either require equipment that cannot be made available at the beneficiary's home or are furnished while the beneficiary is at the facility to receive services requiring the equipment described above. Time spent providing covered home health services to beneficiaries under a home health plan of care at hospitals, skilled nursing facilities or rehabilitation centers when they involve equipment too cumbersome to bring to the home should be reported in fifteen minute increments.

**Q14: An HHA staffer may have to spend time traveling to the location where care is given, or transporting a beneficiary to that location. Is travel time counted in the 15 minute increments?**

No. As we have noted, rules relating to whether or not services are part of a covered visit have not changed. Travel time continues to be recognized as a reasonable cost. For purposes of the 15 minute increment reporting, travel time would not be included in counting 15 minute increments.

**Q15: How will the Provider Statistical and Reimbursement (PS&R) system that supports cost report settlement be affected by these changes?**

Changes are being made to the PS&R system to count one visit for each visit-related revenue code line on the claim. By billing according to HCFA's instructions during and after the phase-in period, providers will avoid any impact to payment and any impact to PS&R reporting.

**Q16: Will medical record documentation have to be kept in 15 minute increments?**

No. The manner in which time is currently recorded on medical records will not be changed. These records may continue to show the start and end times of a visit.

## ATTACHMENT B

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**PROGRAM MEMORANDUM  
INTERMEDIARIES**


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Department of Health  
and Human ServicesHealth Care Financing  
Administration

Transmittal No. A-99-29

Date JUNE 1999

Change Request 914

**SUBJECT: Provider Education Information for Home Health Agencies--Regional Home Health Intermediaries (RHHIs) Only**

Stock Text for Home Health Provider Bulletin

Inform all home health agencies of the following in a special provider bulletin. You should also update any internet sites or bulletin boards you maintain immediately to correctly reflect this information.

"In provider bulletin number \_\_\_\_\_ dated \_\_\_\_\_ 1999 [insert intermediary name] informed home health agencies of the requirement to report home health visits in 15 minute increments beginning with service dates on or after July 1, 1999. Since that time, we have been notified by many home health agencies that the demands of Y2K compliance were competing with their efforts to implement the new reporting requirement. In recognition of this and in an effort to minimize the impact of these changes on home health agencies, HCFA has instructed [intermediary name] to implement fifteen minute increment reporting in the following "phased in" manner.

Effective July 1, 1999, claims processing systems will be changed to accommodate the reporting of the new home health specific HCFA Common Procedure Coding System (HCPCS) codes and the use of Form Locator 46 (service units) to report a number of fifteen minute increments rather than a number of service visits. In order to accommodate these changes, our claims processing system will be changing the way that total home health visits are counted. Rather than using the "service units" in Form Locator 46 on the claim, our system must count each line on the claim with a visit-related revenue code as one single, separate visit. Since claims are still paid per visit, payment will reflect the number of revenue lines on the claim, rather than the number of "service units" in Form Locator 46.

Home health agencies should make every effort to prepare their billing systems to conform to these changes by July 1, 1999. Agencies should bill each visit as a separate line item, with the appropriate HCPCS code and with the number of fifteen minute increments reported in Form Locator 46. If these instructions are followed, claims with "statement covers" dates (Form Locator 6) beginning on or after July 1, 1999 will process and be paid correctly. The HCPCS codes reported on the claim will be validated by the system and claims will be returned to provider (RTPd) if an incorrect HCPCS code is found.

If an agency cannot prepare their systems to report these HCPCS codes by July 1, 1999, the system will allow these claims to be processed without them for a grace period that will end September 30, 1999. However, these agencies should be aware that visits for all claims will be counted by our system based on the number of revenue line items. If an agency continues to report multiple visits (rather than 15 minute increments) in Form Locator 46 on any given revenue line, that line will be interpreted after July 1, 1999 to represent a single visit, and that provider may be underpaid. The agency would then need to submit an adjustment claim showing the additional visits as separate line items in order to receive the correct payment.

HCFA Pub. 60A

By allowing this degree of flexibility for a temporary period, providers can be assured that their cash flow will not be stopped by rejected claims. Some adjustment billing could be necessary, but this can be avoided by billing one visit per line. On or after October 1, 1999, all agencies will be expected to be in compliance with the new reporting requirement and any bill type 32x or 33x claim (for dates of service July 1, 1999 or after) without HCPCS coding will be RTPd.

Agencies should be aware of one additional caution. These changes in our claims processing systems are linked to "statement covers" dates on claims. Claims with statement dates prior to July 1, 1999 but received after that date will be processed according to the reporting requirements that were in effect as of the statement dates (i.e., for claims with dates prior to July 1, 1999, units will be interpreted by the system as visits). Therefore, the system will be programmed to RTP claims received with HCPCS codes for statement dates prior to July 1, 1999 in order to prevent the increments reported on those claims from being read as visits, resulting in an overpayment. Also, to ensure that these two processes operate separately, claims received with "statement covers" dates spanning June and July 1999 will be RTPd by the system, and providers will need to split these into two claims with statement dates exclusive to June and to July.

It is important that you bill your June and July 1999 services on separate bills in order to receive the correct reimbursement. The 15-minute increment reporting changes will change where the system looks for the total number of visits billed when calculating the reimbursement amount. For claims with services on or before June 30, 1999, the system will use the "Service Units" associated with revenue lines for disciplines identified as visits. For claims with services on or after July 1, 1999, the system will begin counting each detail line with revenue lines for disciplines identified (one visit per revenue line) to determine the number of visits for calculating reimbursement.

Examples:

A. Example of billing with HCPCS coding:

42 REV CD	43 DESCRIPTION	44 HCPCS RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 45 MIN.	G0154	070199	3
042x	PT VISIT FOR 1 HOUR	G0151	070599	4
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2
057x	HH AIDE VISIT FOR 1 HOUR	G0156	070199	4

This bill would not be returned to the provider.  
This provider would be reimbursed for 4 visits.

B. Example of billing without HCPCS coding:

42 REV CD	43 DESCRIPTION	44 HCPCS RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 45 MIN.		070199	1
042x	PT VISIT FOR 1 HOUR		070599	1
056x	MSW VISIT FOR 30 MIN.		070399	1
057x	HH AIDE VISIT FOR 1 HOUR		070199	1

This bill would not be returned to the provider.  
This provider would be reimbursed for 4 visits. This is based on the number of revenue code lines, not the number of units reported.

C. Example of billing with invalid HCPCS:

42 REV CD	43 DESCRIPTION	44 HCPCS RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 45 MIN.	G0159	070199	3
042x	PT VISIT FOR 1 HOUR	G0160	070599	4
056x	MSW VISIT FOR 30 MIN.	G0161	070399	2
057x	HH AIDE VISIT FOR 1 HOUR	G0152	070199	4

This bill would be returned to the provider, as the HCPCS codes are not valid for the revenue codes billed.  
This provider otherwise would have been reimbursed for 4 visits.

D. Example of billing with multiple visits on one day.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 45 MIN	G0154	070199	3
042x	PT VISIT FOR 1 HOUR	G0151	070599	4
042x	PT VISIT FOR 15 MIN	G0151	070599	1
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2
057x	HH/AIDE VISIT FOR 1 HOUR	G0156	070199	4

This bill would not be returned to the provider.  
This provider would be reimbursed for 5 visits.

Example of billing with June and July services:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 45 MIN	G0154	062899	1
055x	SKILLED NURSING FOR 1 HOUR	G0154	070299	1
042x	2 PT VISITS FOR 1 HOUR	G0151	063099	2
042x	PT VISIT FOR 15 MIN	G0151	070599	1
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2
057x	HH/AIDE VISIT FOR 1 HOUR	G0156	070199	1

This bill would be returned to the provider, as it contains services in June and July of 1999.

The provider would need to split the claim in example E as follows:

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING VISIT		062899	1
042x	2 PT VISITS		063099	2

The provider would be reimbursed for 3 visits.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATES	45 SERV DATE	46 SERV UNITS
055x	SKILLED NURSING FOR 1 HOUR	G0154	070299	4
042x	PT VISIT FOR 15 MIN	G0151	070599	1
056x	MSW VISIT FOR 30 MIN.	G0155	070399	2
057x	HH/AIDE VISIT FOR 1 HOUR	G0156	070199	4

The provider would be reimbursed for 4 visits."

Adapting the Text to Specific RHHI's Providers

References to "the system" in the above text may be changed by individual RHHIs to indicate the standard system of which they are a user, expressed as the name or acronym for that system that their providers are used to seeing in regular bulletins.

Also, RHHIs are free to add further illustrative examples that address specific billing practices of their providers if they deem it necessary.

*The implementation date for this Program Memorandum is July 1, 1999.*

**These instructions should be implemented within your current operating budget.**

**Contact person for this Program Memorandum is Wil Gehne at (410) 786-6148.**

**This Program Memorandum may be discarded October 1, 2000.**