Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

June 27, 2011

The Hon. Max Baucus, Chairman
The Hon. Orrin Hatch, Ranking Member
The Hon. Tom Carper
The Hon. Tom Coburn
The Hon. Charles Grassley
The Hon. Ron Wyden

Committee on Finance
United States Senate
Washington, DC 20510

Dear Senators,

On behalf of the Partnership for Quality Home Healthcare (the Partnership), it is my pleasure to respond to your May 2, 2012 letter to the health care community requesting specific solutions to combat fraud and abuse in and strengthen the integrity of the Medicare and Medicaid programs.

Background

The Partnership was established in 2010 to serve as a resource to government officials in their efforts to strengthen the integrity, quality, and efficiency of healthcare for our nation's seniors. Representing more than 1,500 skilled home healthcare agencies nationwide, the Partnership is dedicated to developing innovative reforms that will secure beneficiary access to quality home healthcare services.

As you know, nearly 3.5 million Americans currently receive Medicare home healthcare services. The anticipated demand for skilled home healthcare services is expected to rise due to U.S. Census data projecting significant growth of the nation's senior population, as well as the preference of the vast majority of seniors to receive care in their own home.

To meet seniors' needs and preference, the Medicare home healthcare benefit provides specialized acute, chronic and rehabilitative treatment to patients who are homebound and require skilled nursing or therapy services. Many healthcare treatments that were once only available in a hospital or other institutional settings are now being safely, effectively and cost-efficiently provided in patients' homes by skilled clinicians. In addition, home healthcare serves a critical role in America's rural communities, where other specialized care settings are less commonly available.

Skilled home healthcare has also been of significant benefit to taxpayers. Home healthcare has proven to be a cost-effective source of budgetary savings due to its lower cost and its ability to reduce patient admissions and readmissions to more costly treatment settings. For example, the Veterans Administration has reduced its health spending by a net 24% among veterans and dependents using comprehensive in-home care. Multiple demonstration programs and State reforms are now underway that are expected to provide equally powerful outcomes for the Medicare and Medicaid programs.

These clinical and fiscal advances are being delivered by more than 500,000 home health professionals nationwide. While already significant, the number of skilled home healthcare clinicians is projected to experience marked growth by 2020, according to the Bureau of Labor Statistics. In fact, recent employment data documents that the home health sector is generating thousands of new jobs all across America.

Program Integrity Solutions

Before responding to your request, we would like to express our deep appreciation to you for inviting provider participation in the process. Fraud and abuse have long plagued the Medicare and Medicaid programs, and although traditional efforts to curb such problems have had a measurable effect, bad actors continue to find a way to enter virtually every segment of these programs, prey on beneficiaries, and make off with billions of taxpayers' hard-earned money.

As we said on February 28th when news broke of Dr. Jacques Roy's alleged diversion of $375 million from the Medicare program, "Enough is enough. [The] indictment in Texas is proof that action is needed now to stop criminals from victimizing the Medicare and Medicaid programs and the vulnerable patient populations they serve."

It is for these reasons that your call to the health care community for innovative solutions is to be applauded. We are grateful to the many federal and state officials whose dedicated efforts have brought to justice many who have taken advantage of weaknesses in the Medicare and Medicaid programs. But we also realize that their battle will never fully be won until those weaknesses are corrected and the opportunity for fraud and abuse is eliminated. We therefore appreciate this opportunity to submit our ideas on how such an outcome can be achieved.

Partnership members have been working together for more than a year to develop policy solutions that we firmly believe will effectively combat fraud and abuse in the Medicare and Medicaid programs. Just as important, the targeted program and payment integrity reforms described below have been designed to protect beneficiaries, cost-efficient providers and taxpayers alike by *preventing* fraud and abuse before it begins.

The task of eradicating fraud and abuse from the home healthcare sector is aided by considerable evidence that the problem is largely isolated in defined pockets of the country. Indeed, federal data pinpoints where healthcare fraud and abuse is occurring. For example, Medicare claims data reveal that 60 percent of all the abuse in home healthcare relating to Medicare outlier claims in 2009 occurred in just two of the nation's 3,143 counties. Similarly, Medicare data indicates that nearly 90 percent of all aberrant home health reimbursement occurred in a minority of counties in just five states. [Exhibit A]

Coupled with MedPAC's annual list of the 25 counties in which excessive home healthcare episode utilization is occurring [Exhibit B], Medicare data analyses demonstrate that fraud and abuse can be pinpointed and, thus, effectively targeted. We urge Congress to enact a set of tough solutions to attack this targeted problem, while safeguarding patients and the communities that honest providers serve.

Our proposal is based on recent, successful precedent. In 2009, the home healthcare community proposed a 10 percent cap on Medicare outlier claims to stem what the community considered to be aberrant billing practices that were believed to be evidence of unchecked fraud and abuse. What made the outlier cap particularly meaningful is that it would *prevent* aberrant claims from being paid in the first place, thereby replacing the troubled "pay and chase" practice with a simple and logical "aberrant payment prevention" mechanism.

The community's proposal was adopted by CMS in its payment rules for 2010 and was included in the Patient Protection and Affordable Care Act. The result? According to analysis of Medicare claims data, this single reform saved $853 million in 2010 alone and is on track to generate a total of $11 billion in taxpayer savings over a 10-year period. Just as telling, this targeted reform caused outlier claims reimbursement to drop *70 percent in just one year* – from $1.2 billion in 2009 to $350 million in 2010 – all without impacting the 85 percent of providers who never filed an aberrant outlier claim. [Exhibit C]

Due to the success of the outlier cap, we have used it as a model for the payment reforms described below. We also propose a series of other improvements that we believe will be equally successful in preventing fraud and abuse by blocking criminal acts before they can occur.

In sum, we applaud your efforts to put an end to fraud and abuse. We believe your objective can be achieved through targeted reforms, and we hope that the solutions described below will help you in your efforts to secure seniors' access to clinically advanced, cost effective, patient preferred home healthcare — while stopping cold the bad actors who are preying on current weaknesses in the Medicare and Medicaid programs.

Skilled Home Healthcare Integrity and Program Savings Reforms

The Partnership's package of targeted reforms – called the "Skilled Home Healthcare Integrity and Program Savings" Act (SHHIPS) – consists of three critical categories:

- Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse
- Payment Integrity Reforms to Ensure Accuracy, Efficiency, and Value
- Quality and Outcomes Improvement

We believe these reform categories are essential to strengthening the program integrity, quality, and efficiency of the home healthcare benefit. The proposed reforms described below seek to fulfill this objective in a way that will eliminate the possibility of overpayment (a frequently documented problem plaguing the Medicare and Medicaid programs as a whole), help rationalize the supply of providers to a community's patient population, and ensure that payment is made solely for bona fide claims.

We are therefore pleased to offer the following reform proposals for the Committee's consideration in the hope that they will be a helpful resource as you work to achieve enactment of effective, common sense solutions to the nation's fraud and abuse problem.

<u>Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse</u>

Preventing Entry of Individuals with Criminal Backgrounds

- *We urge Congress to take action to prevent entry of individuals with criminal backgrounds by requiring criminal background checks for all home health employees with direct patient contact or access to patient records and for all owners and operators as a condition of participation. SHHIPS would also require contractors to obtain background checks on the same conditions, and any background check identifying past criminal behavior would be required to be reported so that prompt action can be taken.*

Verifying Competency through Improved Screening and Standards

- *Equally important to keeping criminals out of the programs is the necessity to ensure the competency of those allowed in. As a result, SHHIPS requires background screening of owners and managing employees to validate their competency according to standards set by the Secretary, including evaluation of an owner or manager's knowledge of Medicare participation requirements, benefit coverage standards, HIPAA protections, and reimbursement policies.*

Ensuring Operational Capability to Serve Beneficiaries

- *One of the problems identified by law enforcement officials is the penetration of certain markets by bad actors who enter the program solely to file claims, receive payment, and then disappear. Such "hit and run" acts must be stopped, and we believe they will be if all home health agencies with a new provider number are required to demonstrate proof of sufficient capital to operate for one year. Agencies issued a new provider number should also be required to provide a $100,000 surety bond to similarly confirm their intent and ability to operate for the long-term.*

Enforcing Provider Integrity through Compliance and Ethics Requirements

- *For years, the Health and Human Services Inspector General has issued recommendations for provider compliance and ethics programs. The Patient Protection and Affordable Care Act authorized the Secretary to require compliance and ethics programs, but that authority has not yet been exercised by the Secretary. The Partnership believes that requiring such a program would be an important check on fraud and abuse. As a result, SHHIPS directs the Secretary to work jointly with the Inspector General and promulgate rules requiring home health agencies to have in operation a compliance and ethics program designed to prevent and detect criminal, civil, and administrative violations.*

Temporary Entry Limitations to Prevent Excess Growth

- *We believe two data points make the moratorium case better than any description we could offer: there are more applicants awaiting home health provider numbers in Florida's Miami-Dade County than there are agencies in operation in the State of New York as a whole; and, Miami-Dade County is the site of some of the most egregious alleged fraud and abuse in America. To curb this, SHHIPS directs the Secretary to suspend the issuance of new home health provider numbers in counties with an over-penetration of providers (defined as those counties exceeding the 80th percentile of the number of agencies per 10,000 beneficiaries) for a period of two years or until such time as the final regulations implementing the SHHIPS reforms are issued, with limited exceptions for rural and frontier counties where access is determined to be an issue.*

<u>Payment Integrity Reforms to Ensure Accuracy, Efficiency, and Value</u>

Preventing the Payment of Aberrant Episode Claims

- *Nationally, the average number of episodes per Medicare beneficiary is 2.0. However, MedPAC and CMS report that some agencies in a small number of locations bill for average utilization levels that are twice that level and above. This example of abuse must be stopped. Modeled on the successful Outlier Limit, SHHIPS would limit reimbursement to an aggregate annual per-provider average of no more than 2.7 episodes per beneficiary in non-rural areas and 3.3 episodes per beneficiary in rural areas. (These limits were derived by calculating approximately 150% of the median Medicare home health utilization in these areas.) Based on data analysis by former CBO Director Douglas Holtz-Eakin with Dobson-DaVanzo Associates, we project this reform would generate savings of $13.8 billion over 10 years.*

Preventing the Payment of Aberrant LUPA Claims.

- *Nationally, 9% of all home health episodes entail 4 or fewer visits, due to factors including hospital readmission, a move to another provider or location, or death. These low-utilization episodes are subject to a Low Utilization Payment Adjustment (LUPA), which reduces payment considerably due to the low level of services and supplies utilized. Despite the prevalence of low-utilization episodes, 1,043 home health agencies in 2010 improbably claimed that they had <u>no</u> such episodes…and billed Medicare a total of $243 million. Modeled on the Outlier Limit, SHHIPS would impose a minimum annual LUPA rate of 5% into every provider's payable episodes in each calendar year and establish protections to ensure that all such LUPA episodes were in fact unavoidable. Based on the Holtz-Eakin/Dobson-DaVanzo analysis, this reform would generate an additional $1.4 billion in savings over 10 years.*

Ensuring the Accuracy of All Paid Claims

- *Setting strict limits to prevent the payment of aberrant claims is vitally important. So, too, is establishing a system for ensuring that all filed claims within those limits are accurate. SHHIPS directs the Secretary to implement a claims validation process either by a universal or sampling method, so that before payments are made, the Secretary will validate claims on the basis of the submission by a provider of the Outcomes and Assessment Information Set (OASIS) or other data set approved for skilled home health agencies. In addition, claims from new skilled home health agencies (including agencies that experience a change of ownership with a new provider number) would be subject to pre-payment claims review during their first year of operation.*

Removal of Therapy Thresholds from Payment System

- *The home health community has long expressed concern about the use of therapy thresholds within the Medicare program due to its vulnerability to abuse. As a result, SHHIPS directs the Secretary to eliminate these thresholds and instead implement case mix adjustment factors that do not include the level and amount of therapy visits in determining payment amounts.*

Quality and Outcomes Improvement

Patient Assessment and Medical Direction

- *SHHIPS also addresses the need for the most effective and efficient physician engagement possible. Based on discussions with the Centers for Medicare and Medicare Services, we propose that the existing face-to-face requirement be improved by requiring physician certification of the face-to-face encounter with all home health patients within 14 days of the initiation of home health services, excepting those individuals discharged from a Medicare-certified facility, residing in medically underserved areas, or meeting other criteria established by the Secretary to avoid impractical, infeasible, or unreasonable face-to-face encounters.*

Improved Care Planning for Medicare Skilled Home Healthcare Services

- *Finally, we share the concern held by physicians and other home healthcare specialists across the nation that beneficiary demand may soon overwhelm the supply of skilled providers. As a result, SHHIPS would permit non-physician providers (defined as nurse practitioners, clinical nurse specialists, certified nurse-midwives physician assistants) to complete the initial patient coverage certification or recertification for additional episodes. All such processes would be governed by the protections described above, and the reimbursement paid to non-physician providers for their completion of the initial patient coverage certification or recertification for additional episodes would be paid at a lower rate (85% of the physician payment rate).*

In closing, the Partnership for Quality Home Healthcare wishes to thank you again for this opportunity to present our recommended legislative solutions for combatting fraud and abuse in the Medicare and Medicaid programs. We hope that our proposals will be of value in your important work and stand ready to serve as a resource in any capacity needed.

Sincerely,

Eric S. Berger
CEO

Exhibit A

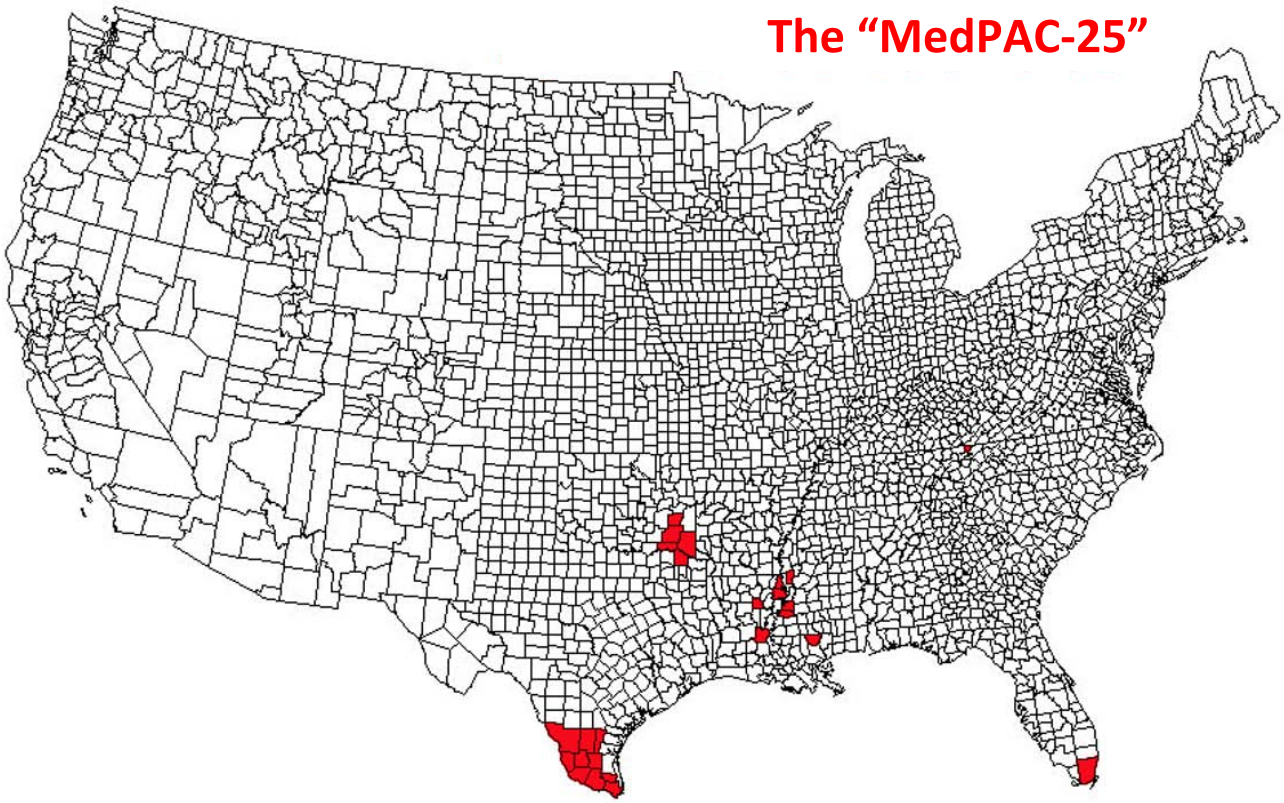
2010 Claims Data: Safeguard Limit Impact By State

Lupa Min: 5.0%
Epi/User Cap: 3.30/2.70

State	# Providers	# Episodes	Total Reimb	$ Impact Lupa Limit	$ Impact Episode Limit	$ Impact Both Limits	% Impact Both Limits
AK	13	3,016	10,211,616	17,619	0	17,619	0.2%
AL	148	149,157	386,050,392	184,835	1,014,464	1,199,298	0.3%
AR	168	73,291	175,693,848	323,473	755,642	1,079,115	0.6%
AZ	107	51,693	153,354,438	147,237	60,646	207,882	0.1%
CA	916	427,961	1,370,185,045	6,543,396	9,006,864	15,550,260	1.1%
CO	135	47,792	154,193,671	231,437	563,342	794,780	0.5%
CT	81	84,816	253,479,573	89,957	0	89,957	0.0%
DC	22	7,524	24,351,049	17,621	18,187	35,808	0.1%
DE	18	16,766	44,575,244	14,036	130,219	144,255	0.3%
Miami-Dade	658	157,246	599,143,486	18,954,549	42,956,791	61,911,340	10.3%
Rest of FL	684	532,305	1,672,196,056	3,951,971	11,802,650	15,754,621	0.9%
GA	101	159,962	464,485,281	196,845	1,020,883	1,217,728	0.3%
HI	12	3,343	10,225,478	0	0	0	0.0%
IA	171	32,814	79,755,292	161,029	3,058	164,088	0.2%
ID	44	17,484	50,212,032	57,272	45,328	102,600	0.2%
IL	674	433,789	1,245,085,886	10,126,941	126,379,681	136,506,621	11.0%
IN	198	112,080	332,724,898	1,232,940	11,779,145	13,012,085	3.9%
KS	130	36,825	109,565,260	200,743	567,518	768,261	0.7%
KY	100	120,347	317,119,986	56,153	2,308,487	2,364,640	0.7%
LA	213	256,815	613,887,317	3,789,657	90,812,091	94,601,748	15.4%
MA	137	186,202	535,339,160	559,116	5,417,621	5,976,737	1.1%
MD	54	79,782	242,721,823	48,305	0	48,305	0.0%
ME	28	29,054	74,429,645	10,545	0	10,545	0.0%
MI	588	299,926	896,518,713	2,576,188	9,767,053	12,343,240	1.4%
MN	181	42,657	118,946,778	102,098	462,017	564,115	0.5%
MO	170	108,866	286,445,705	406,413	1,282,910	1,689,323	0.6%
MS	53	153,251	377,520,760	1,511,576	17,275,595	18,787,171	5.0%
MT	34	9,505	24,228,225	34,681	0	34,681	0.1%
NC	168	172,461	465,950,085	0	0	0	0.0%
ND	21	6,095	12,459,462	1,281	4,329	5,611	0.0%
NE	70	22,520	61,697,097	91,418	282,212	373,630	0.6%
NH	34	27,914	76,404,070	15,317	0	15,317	0.0%
NJ	49	142,037	404,569,338	5,622	0	5,622	0.0%
NM	71	32,820	88,970,887	380,661	2,221,863	2,602,523	2.9%
NV	106	43,028	139,223,537	674,147	948,686	1,622,833	1.2%
NY	180	279,111	829,044,945	488,997	22,080	511,076	0.1%
OH	520	212,705	564,719,758	1,170,370	13,178,986	14,349,355	2.5%
OK	239	208,872	530,273,964	4,529,647	71,080,784	75,610,431	14.3%
OR	56	30,466	84,620,982	3,446	0	3,446	0.0%
PA	318	228,874	588,843,312	973,987	1,717,475	2,691,462	0.5%
RI	22	19,651	55,618,565	17,686	61,304	78,990	0.1%
SC	66	81,412	242,853,711	639	15,565	16,204	0.0%
SD	37	6,229	15,597,482	34,578	0	34,578	0.2%
TN	138	203,320	598,557,796	977,239	24,258,274	25,235,513	4.2%
TX *	2,348	1,126,150	3,055,820,547	32,455,985	500,516,913	532,972,898	17.4%
UT	86	33,733	117,207,346	659,394	2,421,693	3,081,087	2.6%
VA	196	142,567	389,260,558	305,088	4,559,202	4,864,290	1.2%
VT	12	18,013	42,842,409	0	0	0	0.0%
WA	58	62,001	192,868,919	0	83	83	0.0%
WI	112	49,019	128,110,094	32,902	38,148	71,050	0.1%
WV	56	34,688	87,848,199	0	77,347	77,347	0.1%
WY	28	4,855	13,583,702	22,267	0	22,267	0.2%
Territories	46	15,575	27,909,867	23,558	1,089	24,647	0.1%
Total	**10,875**	**6,838,385**	**19,437,503,286**	**94,410,862**	**954,836,224**	**1,049,247,086**	**5.4%**
Highlighted 5 States	4,816	2,715,177	7,716,407,255	73,808,750	843,548,910	917,357,660	**11.9%**
Percent of US	44.3%	39.7%	39.7%	78.2%	88.3%	87.4%	
Rest of US	6,059	4,123,208	11,721,096,031	20,602,113	111,287,314	131,889,427	**1.1%**

* 80% of the Texas impact occurs in 17 of the state's 176 counties with HHA's based in them

Exhibit B



STATE	COUNTY	EPISODES PER USER (nat'l avg=2)
Oklahoma	Latimer	4.6
Louisiana	Madison	4.5
Oklahoma	McCurtain	4.4
Louisiana	East Carroll	4.4
Texas	Duval	4.3
Texas	Zapata	4.3
Texas	Starr	4.2
Oklahoma	Choctaw	4.2
Louisiana	Avoyelles	4.2
Texas	Red River	4.2
Texas	Brooks	4
Texas	Jim Hogg	4
Texas	Jim Wells	4
Mississippi	Sharkey	4
Oklahoma	Pushmataha	4
Texas	Hidalgo	3.9
Texas	Willacy	3.8
Texas	Webb	3.8
Louisiana	Washington	3.8
Louisiana	St. Helena	3.8
Mississippi	Jefferson	3.7
Tennessee	Hancock	3.6
Texas	Cameron	3.5
Mississippi	Claiborne	2.9
Florida	Miami-Dade	2.6

Exhibit C

Outlier Dollars Cannot Exceed 10% of Total Reimbursement - Examples of Limit Effect										2010 ACTUAL EXPERIENCE (Source: CMS 2010 Claims Data File)					
State/ County	Example Provider #	Total # Episodes	Total Reimburse-ment	# Outlier Episodes	Outlier Reimburse-ment	% Outlier Reim-burse-ment	Outlier Max at 10% Limit	Difference Between Actual and Max	Outlier Savings (Diff/90%)	Total # Episodes	Total Reimburse-ment	# Outlier Episodes	Outlier Reimburse-ment	Change in Total Reimbursement	Outlier Savings
FL-Miami-Dade	108188	2,579	26,494,456	2,361	18,654,550	70.4%	2,649,446	16,005,105	17,783,450	4	9,656	1	966	26,484,800	18,653,584
FL-Miami-Dade	107653	2,713	16,506,670	718	6,647,510	40.3%	1,650,667	4,996,843	5,552,048	3,570	3,371,111	333	1,424,892	13,135,559	5,222,618
FL-Miami-Dade	108311	1,115	8,669,521	847	5,396,216	62.2%	866,952	4,529,264	5,032,515	800	3,094,422	83	299,381	5,575,099	5,096,835
FL-Miami-Dade	107712	1,057	8,171,401	619	4,403,147	53.9%	817,140	3,586,007	3,984,453	846	3,371,111	77	337,111	4,800,290	4,066,036
FL-Miami-Dade	108217	961	8,170,287	884	6,046,800	74.0%	817,029	5,229,771	5,810,857	472	1,276,871	33	127,687	6,893,416	5,919,113
Total 5 Providers		8,425	68,012,335	5,429	41,148,223	60.5%	6,801,233	34,346,990	38,163,322	5,692	11,123,171	527	2,190,037	56,889,164	38,958,186
TX-Hidalgo	459167	7,176	18,843,752	669	2,148,184	11.4%	1,884,375	263,809	293,121	5,445	12,651,936	244	797,585	6,191,816	1,350,599
TX-Hidalgo	453115	4,698	13,459,859	515	1,460,660	10.9%	1,345,986	114,674	127,416	3,199	8,411,094	238	753,480	5,048,765	707,180
TX-Hidalgo	459339	3,456	13,354,637	1,139	4,160,152	31.2%	1,335,464	2,824,689	3,138,543	2,307	6,312,073	164	566,313	7,042,564	3,593,839
TX-Hidalgo	679070	3,687	12,417,747	864	3,843,891	31.0%	1,241,775	2,602,116	2,891,240	3,252	8,532,845	213	781,082	3,884,902	3,062,809
TX-Hidalgo	679201	5,241	12,003,814	390	1,236,682	10.3%	1,200,381	36,300	40,334	4,294	9,984,213	286	910,906	2,019,601	325,776
Total 5 Providers		24,258	70,079,807	3,577	12,849,569	18.3%	7,007,981	5,841,588	6,490,653	18,497	45,892,161	1,145	3,809,366	24,187,646	9,040,203
VA-Roanoke	497275	2,668	7,839,556	13	10,282	0.1%	783,956	0	0	2,805	8,670,215	10	5,678	-830,659	4,604
VA-Roanoke	497429	1,292	4,090,331	10	6,911	0.2%	409,033	0	0	1,690	5,630,662	17	8,487	-1,540,331	-1,576
VA-Roanoke	497096	882	2,438,342	1	1,145	0.0%	243,834	0	0	1,061	2,972,938	0	0	-534,596	1,145
VA-Roanoke	497544	986	2,302,479	1	116	0.0%	230,248	0	0	807	1,989,793	1	685	312,686	-569
VA-Roanoke	497022	178	459,128	3	2,359	0.5%	45,913	0	0	41	93,727	0	0	365,401	2,359
Total 5 Providers		6,006	17,129,835	28	20,812	0.1%	1,712,984	0	0	6,404	19,357,335	28	14,850	-2,227,500	5,962
IA-Calhoun	167162	122	218,130	2	649	0.3%	21,813	0	0	79	140,980	1	1,008	77,150	-359
IA-Calhoun	167114	65	99,449	0	0	0.0%	9,945	0	0	69	102,268	0	0	-2,819	0
IA-Carroll	167213	510	1,431,514	14	18,574	1.3%	143,151	0	0	594	1,631,963	17	22,328	-200,449	-3,754
IA-Carroll	167207	83	168,027	0	0	0.0%	16,803	0	0	105	196,677	1	1,811	-28,650	-1,811
IA-Cass	167059	253	651,434	1	167	0.0%	65,143	0	0	211	550,313	1	787	101,121	-620
Total 5 Providers		1,033	2,568,555	17	19,390	0.8%	256,855	0	0	1,058	2,622,201	20	25,934	-53,646	-6,544
All Listed Providers		39,722	157,790,532	9,051	54,037,994	34.2%	15,779,053	40,188,578	44,653,975	31,651	78,994,868	1,720	6,040,187	78,795,664	47,997,807
National Total									**897,056,261**						**853,369,055**