

Operation Restore Trust Round Two May be Coming for Home Health

Mark P. Sharp, CPA
Rodney E. Dwyer, CPA
Karen A. Vance, OTR
BKD LLP
Springfield, MO

Are home health agencies facing round two of Operation Restore Trust (ORT)? Many still remember ORT. Launched by the Clinton administration in 1995, the anti-fraud and abuse initiative primarily targeted five states—California, Florida, Illinois, New York, and Texas—and focused on home health agencies, nursing homes, hospice agencies, and medical equipment suppliers.¹

Home health agencies that made it through ORT likely remember it as the beginning of the worst time in Medicare home health history. The government claims it identified more than \$187 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties. However, even more damaging to providers was the dark cloud painted with a broad brush over the entire home health industry. Even compliant home health providers—the majority—had to battle the shadow cast over the industry.

As if the dark cloud was not enough, ORT findings and publicity also influenced Congress to take action mandating the Medicare home health Interim Payment System (IPS) as part of the Balanced Budget Act of 1997. IPS was a planned bridge between cost-based reimbursement and the current Medicare Prospective Payment System (PPS) for home health. The bridge collapsed and nearly one-third of the home health agencies had to close their doors. Before the IPS implementation, there were more than 10,000 agencies. By the time PPS was implemented in 2000, the number of home health agencies dropped to approximately 6,800 providers.

The Stars May be Aligning

The stars may be aligning for ORT round two. Many factors contribute to the possibility of renewed governmental interest in home health compliance. Such factors include:

- *Influx of New Providers*—Since the implementation of PPS in 2000, there has been a rebound of interest in entering the home health business. Per Centers for Medicare & Medicaid Services (CMS) reports, there were more than 9,800 Medicare home health providers by the end of 2008,² nearing the total number of agencies before IPS.
- *Medicare Profit Margins*—According to MedPAC, the median profit margin on Medicare home health has been in double digits since the inception of PPS. In its 2008 report to Congress, MedPAC stated that Medicare home health margins averaged 16% from 2002 through 2006.³ Earlier this year, MedPAC



reported to Congress that the average Medicare home health margin in 2007 was in the same range—16.6%.⁴ The National Association for Home Care & Hospice (NAHC) argues that MedPAC's numbers are not entirely accurate because hospital-based agencies are not included in the calculations. NAHC also questions the accuracy of the cost reports submitted.

- *A New Era of Responsibility*—That is the title for President Obama's budget for 2010. The title alone suggests a focus on holding all parties accountable for government spending. In his budget, the president calls for \$37 billion in cuts to Medicare home health outlays over the next ten years to better match payments to costs.⁵
- *Old Face Reappears*—The administrator of the Health Care Financing Administration (now CMS) who oversaw ORT efforts in the 1990s is now overseeing federal healthcare programs. President Obama appointed Nancy-Ann DeParle director of the White House Office of Health Reform. Her experience as the “healthcare czar” during the ORT period may be used as a basis for future reform efforts.
- *CMS Concerns*—A number of changes were made in the home health PPS with the refinements implemented in 2008.⁶ Many of the changes were in response to a concern that agencies were “following the dollars” with patient assessments and utilization patterns that drive payment. Belief that agencies were gaming the system is evident in the introduction of a significant downward adjustment for case-mix creep and the elimination of a single-threshold therapy payment increase.
- *Targeted Markets*—Similar to the five-state focus of ORT, recent government initiatives to scrutinize home health practices have been targeted at specific markets of concern. Starting in 2007, CMS launched a demonstration project to study Medicare home health enrollment in the Houston, TX, and Los Angeles, CA, markets.⁷ In addition, the Office of Inspector General (OIG) set forth the intent to “examine billing patterns in geographic areas with high rate of home health visits for

insulin injections to determine the appropriateness of services billed.” Such geographic areas believed to be targets for the review are California, Florida, and Texas.

- *GAO Attention*—The Government Accountability Office (GAO) recently released a report of its findings on a study performed at the request of Congress on CMS’ performance in monitoring improper payments to home health providers.⁸ The GAO’s findings suggested that CMS has inadequate controls in place to limit fraud and abuse in Medicare home health.

Despite the Medicare home health landscape, a focus by the government to resolve currently far-reaching economic troubles may bring hope to home health providers that they will not face an ORT-comparable initiative. However, the environment in home health should not be overlooked.

Need for Maintaining Compliance

Now more than ever, it is time for home health agencies to ensure that they are operating in a compliant manner. Like other healthcare organizations, home health agencies face a complex and evolving regulatory environment. With multiple regulatory agencies, staying on top of compliance issues can be challenging.

Adding to the challenge, a changing home health payment model has been driving compliance issues. With changes in payment methodology come changes in fraud risk and therefore changes in the compliance areas of concern for the regulators. What was a hot topic under one payment system may not be relevant under another payment system. These changes have contributed to an ever-evolving compliance landscape.

The importance of maintaining active knowledge of this compliance landscape may arise on several levels. Primary importance is placed on compliance when a home health agency is being reviewed, audited, or surveyed by any governmental or related fiscal agency. The possibility of renewed government emphasis on home health agencies should alert agencies to ensure compliance. Other situations that bring compliance to the forefront include:

- Corporate integrity agreements with the OIG that include an annual requirement for a compliance review by an independent organization;
- Due diligence efforts in mergers and acquisitions; and
- The design of an effective and proactive corporate compliance program that includes routine compliance reviews.

The following is a discussion of some of the current compliance areas of concern for home health agencies.

Home Health Compliance Staples

Homebound Status—A unique requirement for a patient to be eligible to receive covered home health services is the patient is confined to his/her home. The homebound status is determined by the home health admitting clinician as part of the patient assessment. The requirement is met if leaving home would require a considerable and taxing effort from the patient. Identifying the patient as homebound at the beginning of the home

health episode is one of the criteria qualifying the patient for the home health benefit.⁹ However, all clinicians providing services to the patient must continue to confirm through convincing documentation that the patient requires considerable and taxing effort to leave the home throughout the episode.

When the documentation ceases to describe a homebound status, the patient ceases to qualify for the home health benefit. All visits by all disciplines following that point would be disallowed if discovered during medical review or other focused review.

Frequency of Ordered Services Not Followed—Services provided under a home health episode must be established by a plan of care.¹⁰ The plan of care, which is certified by a physician, must include the specific services to be provided, such as skilled nursing, rehabilitation therapy, or home health aide. The plan of care also must specify the frequency for which those services are to be provided. It is often found during additional development requests, medical reviews, and independent organization reviews that the services delivered to the patients did not follow the frequency established by the plan of care or other physician orders. The result is the disallowance of the visit(s) from the claim billed to Medicare.

Continued Skilled Need Beyond a Certain Point—For skilled nursing or rehabilitation therapy visits to be covered under Medicare home health PPS, agencies must demonstrate a skilled need in each visit delivered during the sixty-day episode. According to the Benefit Policy Manual, the services must require the skill of a registered nurse, licensed practical nurse, physical therapist, speech-language pathologist, or occupational therapist.¹¹ The services also must be reasonable and necessary to the treatment of the patient’s illness or injury. Medical reviewers and surveyors focus on this reasonable and necessary requirement when determining continued skilled need. In particular, a strong focus is often placed on the skilled need for therapy visits. In many cases, home health agencies are unable to document the continued need for skilled visits.

For example, if a patient began a sixty-day episode with a skilled need, then recovered after a few weeks and no longer required the skills of a nurse continuing skilled nursing visits would be inappropriate. Another example is teaching and training activities. As long as the teaching and training activities require skilled nursing personnel to teach the patient, family, or caregivers, and is appropriate to the patient’s functional loss, illness, or injury, the training would be covered. If it becomes apparent that the patient, family, or caregiver is not able to be trained, further teaching would no longer be reasonable and necessary. Any skilled nursing visits that were not reasonable and necessary to the patient’s treatment would be disallowed.

Recent Compliance Concerns

Single Nursing Visits With an OT Plan of Care—For a patient to initially qualify for the Medicare home health benefit, the patient must need skilled nursing care, physical therapy, or speech/language pathology services. These are considered qualifying services or disciplines. A continued need for occupational therapy services also qualifies the patient for the benefit once the initial criteria have been met.¹²

There has been added scrutiny for episodes in which the primary skilled need is for continuing occupational therapy after a single visit is made by skilled nursing. Regulators want to ensure that the initial qualifying visit by the skilled nurse was not inappropriately added to an episode just so that the continuing need for occupational therapy will be covered under Medicare home health PPS.

Therapy Utilization—The PPS formula for payment of a sixty-day episode began in 2000 with a consideration to add cost when therapy utilization exceeded a particular threshold. With limited data at that time, the threshold was set at ten combined therapy visits. With more time came more data, and the PPS refinements in 2008 provided a stair-step approach with multiple therapy thresholds for increased payment. Along with the multiple therapy thresholds came more scrutiny on reasonable and necessary therapy utilization.¹³ Electronic edits in fiscal intermediaries' software screen for trends in therapy utilization that routinely meet but rarely exceed the thresholds. Follow-up medical review combs the documentation looking for opportunities to deny any visits not reasonable and necessary to the treatment of the patient's illness or injury.

The OIG's Home Health Focus

Last fall, the OIG released its fiscal year 2009 work plan outlining the compliance issues it will focus on.¹⁴ The OIG's compliance areas of concern for home health agencies include:

- *Part B Therapy Payments for Home Health Beneficiaries*—Under the HHA PPS consolidated billing requirement established by the Balanced Budget Act, the home health agency that establishes the home health plan of care is responsible for the billing of all services covered by Medicare. Therapy services are considered covered services, and therefore fall under consolidated billing and are paid as part of the home health PPS episodic rate. For beneficiaries in a home health episode, the OIG will review Part B therapy payments to outside suppliers of therapy services. The OIG will determine the accuracy of payments to home health agencies for Part B therapy and the adequacy of controls to prevent duplicate payment to an outside therapy supplier while the patient was under a home health plan of care.
- *Accuracy of Coding and Claims for Medicare Home Health Resource Groups (HHRG)*—The episodic payment rate for home health is determined by several factors: where the patient lives, the patient's episode timing, the supply severity level, and the case-mix weight. The case-mix weight and the HHRG score are determined by the clinician's answers to questions on the Outcome and Assessment Information Set (OASIS) assessment, and therefore are highly subject to the individual clinician's OASIS coding accuracy. The OIG will be scrutinizing this accuracy. They will determine how accurately the HHRG codes billed to Medicare reflect the documentation in the medical record. In addition, the OIG will identify patterns of coding. Although not explicitly stated in the OIG work plan, they may be looking for OASIS coding pattern changes that would result in increased payment under the case-mix system that went into effect on January 1, 2008.
- *Physician Referrals for Home Health Agency Services*—One of the conditions of participation for home health agencies is

that physicians must establish plans of care. In addition, home health claims billed to Medicare are required to include an attending/referring physician identifier. The OIG will review Medicare payments for home health claims to identify potential inappropriate billing by referring physicians. They will examine trends in utilization patterns and Medicare reimbursement for services ordered by referring physicians. The OIG also will check to see if the referring physician established and certified the home health plan of care.

- *Medicare Home Health Payments for Insulin Injections*—Insulin injections are normally administered by the patient or a family member and are not considered covered under a home health episodic payment. However, when the patient is incapable of self-injections and there is no able or willing caregiver to administer the injections, the injections are considered a skilled need and can be covered under a home health episodic payment. When this happens, it is not uncommon for a home health agency to provide two visits per day to administer the injections. The estimated cost of making two visits per day will in most cases exceed the expected payment from Medicare for that episode. Once the estimated cost for an episode exceeds a certain threshold, Medicare will make an additional payment to the agency called an outlier payment. Once the agency has reached this outlier threshold, each additional visit results in an increased payment to the agency.

The OIG will examine billing patterns in geographic areas with high rates of home health visits for insulin injections to determine if outlier payments for these services were appropriate. Although the OIG does not identify the locations to be reviewed in the 2009 work plan, multiple agencies in the Florida area are currently under investigation related to their insulin injection outlier episodes. CMS has suspended all payments to several agencies until the investigation is resolved.

- *CERT Program Fiscal Year 2008 Home Health Agency Claims Error Rate*—Federal programs are required to develop statistically valid estimates of improper payments made under programs with significant risk of erroneous payments. The OIG will review a sample of claims selected by the CERT program. They will determine if the beneficiary met homebound criteria. They also will assess if home health services billed, such as skilled nursing, therapies, home health aides, and medical supplies were sufficiently documented, medically necessary, and correctly coded. The OIG will obtain medical records and may perform site visits to the home health agencies, beneficiaries, and referring physicians to obtain additional information.

Take Ownership of Compliance Matters

Industry leaders, including NAHC and its active membership, are very aware of the current landscape and the potential for increased scrutiny of home health providers. There appears to be consensus that the industry should take ownership of the issue and self-police through compliance education, advocacy, and awareness.

This is only a sampling of the many compliance issues facing the home health industry. Home health compliance is not a topic

that can be fully addressed in one article. It is important to stay abreast of industry compliance trends and dynamics in order to adequately address compliance concerns. For further information, seek a knowledgeable home healthcare advisor.

**Mark Sharp, a partner with BKD's Springfield office, is a member of BKD National Health Care Group and is BKD's Center of Excellence Coordinator for Home Care and Hospice. He has more than fifteen years experience assisting home care and hospice providers with audits, strategic planning, accounting, cost reports, projections, operating budgets, agency start-up, and mergers and acquisitions. His services include Medicare and Medicaid consulting, development of budgeting systems, and performing benchmarking and productivity studies. Mark serves on the Home Care and Hospice Financial Managers Association's workgroup and frequently presents workshops at national, regional, and state home care and hospice conferences.*

Rodney Dwyer, a senior consultant with BKD's Springfield office, is a member of the BKD National Health Care Group. He specializes in providing consulting services to home care and hospice providers, including financial and operational consulting services, benchmarking and operations analysis, due diligence procedures, and Medicare cost report preparation services. Rodney is also a member of the BKD healthcare billing services team that is responsible for managing more than \$40 million in revenues for home care and long term care providers.

Karen Vance, a supervising consultant with BKD's Springfield office, provides clinical and general operations consulting services to home care and hospice agencies. She helps home care and hospice providers with quality management practices, assessments, training, and consulting. Karen's home health experience includes time as an occupational therapist, then as a clinical and regulatory manager, where she was integrally involved in preparation of OASIS implementation and PPS. She has presented at home health seminars and contributed to several publications on home health.

- 1 See www.hhs.gov/news/press/1997pres/970520.html.
- 2 See www.nahc.org/Facts/2008hhas.pdf.
- 3 See www.medpac.gov/documents/Mar08_EntireReport.pdf.
- 4 See www.medpac.gov/documents/Mar09_EntireReport.pdf.
- 5 See www.whitehouse.gov/omb/budget.
- 6 See www.bkd.com/docs/industry/082907FinalHHPPSRule.pdf.
- 7 See www.hhs.gov/news/press/2007pres/07/20070717a.html.
- 8 See www.gao.gov/new.items/d09185.pdf.
- 9 See Medicare Benefit Policy Manual, Chapter 7, § 30.1.
- 10 See Medicare Benefit Policy Manual, Chapter 7, § 30.2.
- 11 See Medicare Benefit Policy Manual, Chapter 7, § 40.1.
- 12 See Medicare Benefit Policy Manual, Chapter 7, § 30.4.
- 13 See Medicare Benefit Policy Manual, Chapter 7, § 40.2.1 for guidance on reasonable and necessary principles for skilled therapy.
- 14 See <http://oig.hhs.gov/publications/workplan.asp>.

Long Term Care, Senior Housing, In-Home Care, and Rehabilitation Practice Group Leadership

Barbara L. Miltenberger, Chair
Husch Blackwell Sanders LLP
Jefferson City, MO
(573) 761-1105
barbara.miltenberger@husch.com



Barbara J. Duffy, Vice Chair – Publications
Lane Powell PC
Seattle, WA
(206) 223-7944
duffybl@lanepowell.com



Scot T. Hasselman, Vice Chair – Research
Reed Smith LLP
Washington, DC
(202) 414-9268
shasselman@reedsmith.com



Jennifer L. Hilliard, Vice Chair – Membership
American Association of Homes & Services for the Aging
Washington, DC
(202) 508-9444
jhilliard@aahsa.org



Joanne R. Lax, Vice Chair – Strategic Activities
Dykema Gossett PLLC
Bloomfield Hills, MI
(248) 203-0816
jlax@dykema.com



Ari J. Markenson, Vice Chair – Educational Programs
Cypress Health Care Management LLC
White Plains, NY
(914) 390-4366
armarkenson@cypresshealthcare.net



Richard E. Gardner, III, Listserve Moderator
Arnall Golden Gregory LLP
Atlanta, GA
(404) 873-8148
richard.gardner@agg.com



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American Health Lawyers Association

1025 Connecticut Avenue, NW, Suite 600

Washington, DC 20036

(202) 833-1100

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