



Montana Association of Home Health Agencies

May 28, 2002

Thank you, Senator Baucus and the Senate Finance Committee for inviting me to present testimony on regulatory relief issues for Medicare. On behalf of the Montana Association of Home Health Agencies, I would like to address the issue of the regulatory burdens for Home Health Agencies. I am pleased to know that the Senate Finance Committee is working for health care providers, thus allowing us to focus our energies and resources on what we are trained and love to do...“provide care for people”.

The new Prospective Payment System for home health (PPS), OASIS data collection and submission, OBQI reports and requirements, HIPAA compliance, the Home Health Advance Beneficiary Notices, Medical Review and denials, complex billing systems and the Culturally and Linguistically Appropriate Services Standard are some of the formidable and daunting burdens facing home health care delivery this year. The amount of resources that agencies are required to expend to implement all of these regulatory burdens is very overwhelming to all providers. These resources include money and staff time for education, policy implementation, development of quality assurance tools, and capital expenditures necessary to handle additional electronic data.

OASIS

OASIS requires that all Medicare certified home health agencies obtain assessment information on all home health beneficiaries with the exception of those who are pregnant or less than 18 years of age. To give you an idea of the volume involved, the OASIS regulation manual consists of three parts. Part I of the implementation manual comprises six 3.5 floppy discs. Part II is 168 pages and covers the data submission process for agencies. Part III is an optional section that deals with the free governmental software. OASIS answers are used to determine our PPS payment rate and to monitor outcomes. Thus, accuracy of OASIS assessments is essential. This has required extensive staff training sessions and the implementation of quality improvement auditing processes.

The OASIS data collection is very time consuming. One agency in Montana performed a time study in early 2001 to identify the actual time spent. They found that the average time taken for staff to complete and document their OASIS assessments ranged from 42 minutes for discharge assessments to one hour and 44 minutes for the start of care OASIS assessments. In addition,

they found that the average training time for new staff on proper comprehensive assessments and completion of the form was 10 hours and 45 minutes. The average time for clinical supervisory or Quality Improvement staff to review each assessment to validate the information before it is transmitted to the state was 54 minutes.

Montana Home Health providers would like to recommend the following regulatory reform for OASIS:

1) Limit the collection of OASIS data to Medicare patients only.

- In addition to the fact that Medicare does not pay for the services delivered to other patients, agencies must frequently make nonbillable visits to patients with other payors to collect the OASIS-required data. This is such an intrusive practice that it requires the explanation of the OASIS Privacy Statements, an additional piece of paper and an expense that is not reimbursed to agencies from CMS.
- The primary rationale for OASIS is to use this information for payment for services utilized by Medicare beneficiaries (as noted in the final regulation).

2) Modify the time points at which the OASIS data collection must be done.

- Increase the length of a hospital stay (from 24 to 72 hours) before a Resumption of Care must be done.
- Modify the current requirement for Significant Change in Condition (SCIC), eliminating the need to process a SCIC for “unanticipated improvement.” This happens so rarely and only confuses the already overly complex issue. Require a SCIC only if the agency wants to process one to adjust the reimbursement rate when indicated.
- Eliminate OASIS when a known low utilization payment adjustment (LUPA) will occur.
- Eliminate nonbillable visits to collect OASIS data; make it allowable on the next billable visit.
- Eliminate the need to do both a resumption of care and a recertification OASIS if their timepoints overlap in the last 5 days of the episode (when 2 separate HHRGs are necessary). The only reason to do two right now is to answer question #M0825; this is unnecessary and redundant. The information could be consolidated.

3) Allow any qualifying service to conduct the initial OASIS assessment, based on the required patient care.

- If a patient needs Physical Therapy (PT) immediately after getting home, but Skilled Nursing (SN) is ordered only to remove staples in 3 days, PT cannot do the OASIS. The SN must go in and perform a nonbillable visit solely for the purpose of conducting the OASIS. Clearly this is for regulatory reasons only, and does not enhance the clinical care of the patient. It adds to agency expense without necessarily affecting the patient’s outcome.

4) Modify the complete and lock dates from the current timelines.

- Many of our agencies have small support staffs. If the OASIS is done on a Friday, it can use up 2-3 days over the weekend, several more days for quality review and/or corrections (depending on availability of the reviewer/clinician), and then if the part-time

staff has the day off, 7 calendar days is unreasonable for a data entry timeline. Extend the completion requirement to 10 calendar days, and the lock timeline to 14 days from day of completion.

5) Allow use of a single form for all OASIS time points.

- This would minimize agency resources necessary to provide multiple forms, staff confusion over which form to use, etc. Items could be consolidated, reduced (see below), or only used initially unless changed.

6) Address Agency expenses to collect, enter, file, and maintain OASIS data.

- The sheer number of OASIS data that must be collected and processed has increased agency expenses far beyond the token, one-time CMS reimbursement to supposedly compensate for OASIS expenses. This payment came once; the OASIS requirements are multitudinous and ongoing.
- Purchase of hardware and software was/is required by many agencies to meet OASIS data requirements.
- Microfilming costs to store data has more than doubled for certain agencies; physical space required for storage of hard copies is outpacing agency capabilities.
- Several agencies have reported staff retention issues related to increasing paperwork burdens (one agency reports a 33% loss of nursing staff due to paperwork/OASIS). Productivity expectations have not changed with the implementation of OASIS and PPS (which has increased the time points that OASIS is required), and nurses are vacating their home health positions for more reasonable environments.
- With an increasing crisis in nursing work force shortages (as well as other providers), the infrastructure of our entire industry is in danger of collapse. Hospitals are already experiencing increased lengths of stay in some states due to inability of agencies to accept patients. We are also competing against increasing compensation in acute care settings, which cannot be matched, by our current reimbursement levels.

PPS Issues

While home health providers recognized the need for home health payment reform and participated in the development of PPS, it has created many layers of additional regulatory complexities for agencies to deal with. Home Health Agencies have had to request literally hundreds of clarifications from CMS since the implementation of PPS. One of the primary examples of this is the “bundling” of medical supplies into the PPS payment. PPS requires that home health agencies provide all supplies to the beneficiary during an episode of care, regardless of whether they are on the plan of care or needed by home health agency staff to carry out the plan of care. In many instances, the patient was using these supplies prior to the initiation of home health services. Requiring the home health agency to provide these supplies results in a disruption between the patient and the prior medical supplier. Educating patients about this new requirement, ordering, stocking, delivering these supplies and the additional burden of contracting with and paying new vendors has made this new requirement quite cumbersome.

Our recommendation is that home health agencies only be responsible for providing medical supplies that are directly related to the patients’ current treatment plan.

In addition to bundling of medical supplies, PPS bundles outpatient therapy services into the home health payment. This requires us to be aware of when patients receive these services (easier said than done), contract for, bill, and pay providers for all the outpatient procedures that get bundled into the home health episode. For example, if one of our patients requires a video-fluoroscopy swallow study, the home health agency must cover the speech therapist's component of that test. This frequently requires that we have contracts with speech therapists whom are working in a hospital and not even working for a home health agency. This has caused more time to monitor and manage than I am sure CMS realized when these regulations were developed.

Billing problems with PPS have increased staff time. On almost a weekly basis, our clerical staff informs me of some new claims processing problem. These problems hold up claims processing and payment for weeks to months at a time.

Medical Review, Denials, Edits

Medical review of claims has increased with PPS. Agencies can be subject to Automated Edits, Beneficiary Specific Edits, Follow Up edits, New Provider Edits, Random Edits, Referral Edits, Routine Edits, Targeted Review Edits, and Universal Edits. In addition, denials for technical reasons are just as time-consuming to appeal and correct as substantive denials. Prepayment reviews can involve a high percentage of claims each month and a great deal of staff time to copy each page, and can hold up payment for a significant amount of the agency's billed revenue. **Our recommendation is that prepayment review should only apply after a provider has demonstrated non-compliance.**

The vast majority of home health claims that are denied are rejected because they do not meet one or more of the technical requirements set out by the Medicare program. Technical denials include such things as failure to record the verbal order date on a plan of care or not securing physician signatures on all verbal orders prior to billing (including orders for minor treatment changes). While these technical errors can easily be corrected, CMS forces this type of denial into the time consuming and expensive appeals process that is used for all denials. This delays payment by months to in some cases, over a year. **Our recommendation would be that CMS allow for resubmission of a claim when it is technically correct, rather than requiring the claim go through the appeals process.** I want to thank you, Senator Baucus, for introducing the Medicare Appeals, Regulatory and Contracting Improvement Act (MARCIA), as it addresses some of the issues I have mentioned with OASIS and this issue with technical denials. It is our hope that the Marcia bill (S.1738) will be marked up by the Finance Committee soon and passed this session.

Local Medical Review Policies (LMRP) are often more restrictive than the coverage policy dictates, complicating coverage decisions even further. LMRP's are developed by each intermediary and are often inconsistent from one intermediary to the next. Our agency has appealed several denials related to diabetic patients who need regular foot care. The denials were based on our intermediary's assertion that they did not meet their LMRP for foot care. In all cases, these denials were taken to an Administrative Law Judge, found to meet Medicare's home health regulations, and were paid. This process was very time consuming for our agency. **Our recommendation is that LMRP's be eliminated.**

Home Health Advance Beneficiary Notice (HHABN)

Formal written notice is required to advise Medicare beneficiaries when the home health services they need will not be covered under Medicare, either in whole or in part. The HHABN is CMS's mandatory form for this notification. After several false starts, the HHABN was implemented in March of 2001. Since then, it has been under constant revision. This requirement is especially cumbersome when the patient has both Medicare and Medicaid covering different aspects of care. The process imposes an additional paperwork burden on HHA's, which must complete Medicare paperwork for patients who, in fact, are not eligible for Medicare services or Medicare payment.

Culturally and Linguistically Appropriate Services (CLAS) Standard

This standard was released in December 2000 and now requires that home health agencies have a plan to assess the needs of non-English speaking people in our community, have translation available at our expense, and to not use family members due to confidentiality. We have very few non-English speaking people residing in rural Montana, and translators who are not related to the patient are often not available. This is an unrealistic expectation for rural America. **Our recommendation would be that this standard be eliminated or at least allow a "waiver" for populations in which this is not a problem.**

15% cut in PPS reimbursement to become effective October 1, 2002

I would be remiss in my testimony if I did not at least touch upon one additional issue that weighs heavily on home health providers nationwide--that of the 15 percent cut currently scheduled for October 2002. This related to regulatory reform because our regulations continue to increase without adequate reimbursement to cover the costs of education, implementation, follow-up and the data analysis that comes with cumbersome regulations. The GAO recently released data analyzing the potential impact of the scheduled 15 percent cut affecting Medicare PPS rates. As a result, CMS is in favor of keeping this 15 percent cut; as they assert that home health agencies are making a profit of \$700 per episode. I can tell you that this is not the experience of Montana home health providers. I would like to respond to the problems with this GAO study.

First of all, I find it truly incomprehensible that the GAO thinks it can accurately predict the costs per episode of care under PPS, since the cost reports have been postponed for months now, due to inaccurate data on the PS&R statements supplied by Medicare Intermediaries. They can't and their projections are dangerously flawed.

The GAO analysis is a result of wholesale reliance on data proxies and assumptions, using statistics that, do not relate to actual costs or revenue. In the GAO's hasty attempt to analyze the financial status of home health agencies under PPS, the GAO relies on averaging.

The diversity of home health patients, the variation of agency costs, and the inconsistency of the home care market place makes averaging extremely dangerous. The GAO data sources have inherent errors and weaknesses. For example, the visit volume data is suspect given that CMS has expressed that accurate data is not available. Over the last five years, CMS, the Congressional Budget Office (CBO) and GAO have consistently based analyses on faulty assumptions regarding home health agency behavioral reactions to reimbursement changes. The GAO relies on an inflation rate applied to 1996-97 data. That approach ignores significant changes in home care including the increased use of information technology, telehealth services, specialist nurses, and alternative profession disciplines. The GAO uses a simplistic approach that fails to account for basic crucial revenue adjustment. These include partial episode payment (PEP) adjustments, significant change in condition (SCIC) adjustments, case mix downcoding, and low utilization payment adjustment (LUPA) losses. Home Health Agencies are experiencing that these adjustments affect approximately 25 percent of all episodes. In summary, the GAO understates expenses, overstates payments and we believe the \$700 profit figure is inaccurate.

We greatly appreciate that you, Senator Baucus, have always been sensitive to issues affecting rural providers. We wish to thank you for your recent introduction of the MARCIA bill, which addresses many of the issues I have mentioned. It is also important for you to understand that our agency and others in Montana are at risk of closing if this 15% cut is allowed to go forward. In rural areas, further agency closures will severely limit patients' access to necessary home medical services. **We recommend that the 15 percent cut be eliminated.**

As you can see from the testimony above, all of this red tape that home health agencies must now comply with drives up costs. For this reason, we greatly appreciate your continued support, Senator Baucus, of the 10% add-on reimbursement for rural agencies. In addition, it is important that Congress restore the 1.1% cut in the market basket.

We believe in being accountable for our actions and to those we serve. However, we as an industry are slowly suffocating from the weight of these burdens that have been placed on us. Many agencies in Montana lack the necessary funding and staff to ensure that adequate compliance with all of these requirements is met. It is a sad commentary that home health nurses spend more time on paperwork and other regulatory requirements than they do on patient care. It is a sad commentary that agencies are expending their sparse educational dollars toward compliance and understanding of the regulations rather than enhancing their clinician's skills to provide quality care for those we serve.

Putting on my hospice provider hat for a minute, I would like to address a few issues related to government regulations for hospice. First, for home health and hospice providers, the limitation that only physicians can sign the plan of care and give us orders is quite restrictive in rural areas. In small, rural communities, there are days at a time when only a nurse practitioner or physician assistant are available to give orders for our patients. **My recommendation would be that both the home health and hospice regulations be changed to allow these advance practitioners to**

write orders and sign a plan of care. Senator Max Cleland is working on a bill that would allow nurse practitioners or physician assistants to sign home health and hospice plans of care. **I would ask that you, Senator Baucus, and other members of the Senate Finance Committee support this bill when it is introduced.**

The second issue for hospice that some hospice providers in Montana are experiencing difficulty with has to do with taking care of hospice patients in a Skilled Nursing Facility (SNF). The SNF rules sometimes are in conflict with providing appropriate palliative care. For example, there is a list of drugs that are considered inappropriate for residents of a SNF. Many of these drugs are utilized for good pain and symptom management for hospice patients. These triggers for poor care in the nursing homes may be indicators of a need for hospice, not necessarily reflective of poor care in the facility. **This regulation should be eased when the patient is terminal and hospice care should be offered to these residents when a change in status reveals that hospice is appropriate.**

In closing, thank you, Senator Baucus, for this opportunity to address the regulatory burdens of Medicare on home health agencies in Montana and across the nation. I hope that the recommendations we have suggested here are useful as Congress and CMS attempt to reform the system to a more “user-friendly” one.

Sincerely,

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