



Andrea L. Devoti, MSN, MBA, RN  
*Chairman of the Board*

NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE  
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Val J. Halamandaris, JD  
*President*

June 29, 2012

The Honorable Max Baucus, Chair

The Honorable Orrin G. Hatch, Ranking Member

The Honorable Ron Wyden

The Honorable Tom Coburn

The Honorable Tom Carper

The Honorable Charles E. Grassley

United States Senate

Committee on Finance

Washington, D.C. 20510-6200

Via: [ProgramIntegrityWhitePapers@finance.senate.gov](mailto:ProgramIntegrityWhitePapers@finance.senate.gov)

Re: Program Integrity Reforms

Dear Senators:

Thank you for the opportunity to provide recommendations on ways that fraud, waste, and abuse can be reduced and eliminated in Medicare and Medicaid. It is essential that these vital programs operate with integrity and compliance as millions of Americans depend on them every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare and Medicaid. The National Association for Home Care & Hospice fully supports your efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards

of the limited resources available in Medicare and Medicaid. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

The National Association for Home care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen program integrity.

In that spirit, we offer ten recommendations that we believe can significantly reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that your well-warranted concerns on fraud and abuse exist---the system permits bad actors and parties without adequate competencies to enter Medicare and Medicaid programs. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are targeted to address two distinct concerns: fraudulent and abusive providers of care intending to cause harm and providers that cause harm through ignorance or a lack of competencies.

A number of the recommendations are tied to program integrity measures that have been enacted previously by Congress. These measures can be strengthened to significantly improve their intended impact. Other measures are built on the industry-designed safeguard against abusive claims for “outlier” payments in the Medicare home health benefit. In 2010, Congress and the Centers for Medicare and Medicaid Services (CMS) enacted and implemented a cap on the revenue that home health agencies could receive for patients that meet standards for outlier payments. Serious abuses of the outlier payments existed in certain isolated parts of the country, mainly Miami-Dade County where nearly half of all outlier payments in the nation were made. With the “outlier cap” a \$1 billion annual abuse in Medicare has been wiped out almost immediately and with negligible administrative cost. We sincere hope that the recommendations presented here can have comparable effects: efficient elimination of abuse, targeted to bad actors only, and without fallout harm to Medicare beneficiaries.

Our recommendations are set out in greater detail in **Attachment A** to this letter. We also include a side-by-side outlining the status of some of the recent program safeguards that have been established as **Attachment B**. Our new recommendations combined with these existing improvements are important advances in the efforts to address the fraud, waste, and abuse that threaten the future of Medicare and Medicaid.

We recommend the following:

1. Implement a targeted, temporary moratorium on new home health agencies
2. Require credentialing of home health agency executives
3. Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care

4. Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan
5. Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment , prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors
6. Establish targeted systemic payment safeguards focused on abusive utilization of home health services
7. Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries
8. Require criminal background checks on home health agency owners, significant financial investors, and management
9. Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight
10. Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards

We are available at any time to discuss these recommendations. If it would be helpful, we can provide you with draft legislative or regulatory language for consideration. For further information, please contact William A. Dombi, Vice President for Law at 202-547-5262 or [wad@nahc.org](mailto:wad@nahc.org).

Thank you again for your efforts to improve Medicare and Medicaid program integrity.

Very truly yours,

Andrea L. Devoti, MSN., MBA, RN

Chairman of the Board

Val J. Halamandaris, JD

President

## **IMPLEMENT TARGETED, TEMPORARY MORATORIUM ON NEW HOME HEALTH AGENCIES**

**ISSUE:** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. In addition, Medicare spending and utilization of home health services is highly correlated with the number of providers in a geographic area. As a result, there is disproportionate Medicare spending in certain locales in comparison to home health spending in the rest of the country.

In response to industry concerns, Congress authorized CMS to adopt a targeted, temporary moratorium in any sector of providers or suppliers of Medicare or Medicaid services. CMS issued a final rule governing these provisions. CMS does not propose in this rule to put any moratorium in place. Instead, CMS lays out criteria for issuing a moratorium.

CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. For example, a recent MedPAC report indicates that Texas averaged 9.6 home health agencies per 10,000 Medicare beneficiaries while New Jersey averaged 0.4 agencies per 10,000 beneficiaries. New Jersey reports no difficulties in care access while home health spending in Texas far exceeds national averages.

### **RECOMMENDATION:**

- 1) Mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area;
- 2) Apply certain standard exceptions to a moratorium such as where: a) the state has a Certificate of Need program and the state determines that there is a need for additional providers; b) the provider is establishing a branch office or multiple locations within its geographic service area; or c) the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.

**RATIONALE:** The home care industry strongly supports the use of a temporary home health agency moratorium in targeted geographic areas. In the past decade, certain areas of the country have had dramatic growth in the number of home health agencies. Evidence suggests that in certain areas the demand for home health services follows the supply of the agencies with utilization levels far in excess of other parts of the country. A temporary targeted moratorium can be implemented while other systemic program integrity reforms that address concerns with new providers are developed and instituted. While participation in Medicare should be open to all interested and qualified parties, strengthened qualification standards will take time to fully implement.

## **REQUIRE CREDENTIALING OF HOME HEALTH AGENCY EXECUTIVES**

**ISSUE:** Owners and managers of health care providers are central elements in achieving program integrity. Currently, the qualifications for a Home Health Agency administrator are limited to either a medical background (physician or registered nurse) or training and experience in health services administration. The type and amount of training required is not defined. Home health services may be supervised by either a physician or registered nurse. There are no requirements to demonstrate competence in management of health care service delivery, business operations, or knowledge of Medicare & Medicaid coverage and billing. Medicare and Medicaid approved home health agency administrators and managers are not required to demonstrate the knowledge and experience necessary to ensure safe, effective, efficient, and ethical services and good business practices. Further, there are no requirements related to competencies or experience applicable to qualify an individual for ownership of a home health agency.

**RECOMMENDATION:** Strengthen Medicare program participation standards to include experience, credentialing and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.

**RATIONALE:** Credentialing requirements will help to reduce or eliminate Medicare waste and unintentional abuse that is founded in ignorance or inaccurate understanding of standards of compliance. In addition, credentialing will act as a deterrent to those who wish to intentionally abuse Medicare privileges or engage in fraudulent activities. The compliant provision of home health services begins with effective and high quality leadership by the home care or hospice executive. Credentialing is a proven for increasing ethical and compliant conduct. Further, management competence is essential in light of the increased complexity and technical nature of health care services at home.

## **EXPEDITE REFINEMENTS TO THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM**

**ISSUE:** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with the therapy visits. Reimbursement for episodes increases incrementally as the number therapy visits increase. Over the years the number of patients receiving the highest threshold amount of therapy visits, 20 or more, has increased significantly. This payment system provides agencies with a financial incentive for unnecessary therapy utilization.

**RECOMMENDATIONS:** The current case mix adjustment model for home health services payment should be modified to eliminate the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

**RATIONALE:** Since the implementation of the HHPPS, the Centers for Medicare & Medicaid Services (CMS) has struggled with designing a model that appropriately reimburses home health agencies for the cost of providing care. Initially, agencies received higher reimbursement for episodes that had 10 or greater therapy visits. Trends in therapy utilization suggested that agencies were deliberately assigning at least 10 therapy visits for episodes with therapy. In 2008, CMS implemented changes to the HHPPS that resulted in increased payment for episodes with therapy visits in the 6 to 9 and the 14 to 20 visit ranges. Episodes with 6 to 9 therapy visits increased 43 percent, while episode with 14 or more visits increased 27 percent, reflecting the largest one- year shift in therapy volume since the implementation of the HHPPS. (MedPAC: Report to Congress, March 2012).

In 2011, a Senate Finance Committee investigation concluded that several large home health care companies conducted abusive, and potentially fraudulent, practices regarding therapy utilization. For payment year 2012, CMS made changes to the case mix weights to decrease reimbursement rates for episodes with high number of therapy visits while increasing payments for episodes with no therapy. It is too soon to know the impact of these changes on therapy utilization, however, concerns remain that the HHPPS continues to reimburse home health agencies based on the number of therapy visits as part of the payment model.

Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. In an effort to eliminate financial incentives for providing unnecessary therapy, CMS should refine the HHPPS and remove payments based on number of therapy visits and base payments on patient characteristics for therapy and non-therapy cases.

## **IMPLEMENT CORPORATE COMPLIANCE PLAN REQUIREMENTS FOR HOME HEALTH AGENCIES**

**ISSUE:** The Affordable Care Act (ACA) requires health care providers to develop and maintain a compliance program as a condition of participation for Medicare, Medicaid and the Children's Health Insurance Program. In September of 2010, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule which included a solicitation for input on how to structure and develop compliance programs for health care providers. CMS indicated that a separate proposed rule would be issued concerning compliance program requirements. CMS has yet to pursue implementation of compliance program requirements through a separate proposed rule, and HHS has not determined a compliance program implementation date as required by ACA. As a result, home health agencies are currently not required to institute a compliance plan to ensure adherence to federal and state laws and regulations.

**RECOMMENDATION:** Require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following:

1. Corporate compliance plan frameworks should be based on the elements put forth in the Sentencing Guidelines.
2. Compliance plans should be tailored to address specific risk areas.
3. Compliance plans should be periodically re-evaluated.
4. Compliance program costs should be taken into consideration by CMS when making payment rate changes.
5. CMS should engage in outreach and education activities for providers to implement a compliance plan.
6. CMS should allow 12 months for home health agencies to fully implement a compliance plan following the publication of any rule.

**RATIONALE:** Compliance plans are used as an internal mechanism to ensure adherence to federal and state program requirements. The HHS Office of the Inspector General has long encouraged home health agencies to voluntarily adopt corporate compliance plans to combat waste and fraud. In addition, compliance plans provide an additional step to prevent unscrupulous providers from participating in federal and state programs.

## **STRENGTHEN ADMISSION STANDARDS FOR NEW HOME HEALTH**

**ISSUE:** The number of home health agencies in the country has grown from 6,500 in 1998 to over 11,900 in 2012. Commensurate with this growth is increasing concern about inappropriate and fraudulent Medicare billing. The reasons for inappropriate billing range from ignorance of Medicare regulations and policies to fraud and abuse. A disproportionate share of home health agencies that have been convicted of fraudulent billing practices have been in the Medicare program for a limited period of time.

Little capital is required to start a home health agency since facility and equipment costs are minimal. CMS imposed capitalization requirements whereby a new home health agency must demonstrate that it has sufficient initial reserve operating funds for three months of operation. However, the amount is calculated based on projected visits and cost per visit data from comparable home health agencies. The methodology does not protect against rapid and unlimited growth in billing by new agencies. In addition, the application fee to become a new Medicare participating home health agency is less than \$500.

CMS has taken some steps to ensure that newly approved home health agencies comply with quality standards. For example, any home health agency approved for less than 3 years are placed on a 12 month resurvey cycle, rather than 36 months, resurvey cycle. However, there is limited oversight of agency operations and practices during the first year of operation, and even longer in States where funding is insufficient to meet federal survey requirements.

No training and testing requirements are in place for new providers admitted to the Medicare program. Therefore, many providers enter the program without a basic understanding of coverage, billing and payment requirements. Although Medicare Administrative Contractors (MAC) are instructed to analyze data to identify patterns of billing aberrancies of providers new to the Medicare program they have the option of performing prepayment or post-payment review of claims submitted by new providers. Limited prepayment review is conducted. The percent of claims from all home health agencies that are subject to review has remained at about 4%.

CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end.

### **RECOMMENDATIONS:**

- Increase the new provider application fee for Medicare home health
- Increase the initial capitalization requirements to the equivalent of one year operation



- Establish a “probationary enrollment” for new providers during which all new home health agencies are subject to 100% medical review for at least 30 days, followed by a minimum of 10% medical review for the first year in the program.
- Establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.
- Conduct State Agency full resurveys of all new home health agencies at 6 months of operation.
- Require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.

**RATIONALE:** As in any industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients. Since federal resources for oversight are limited, efforts designed to prevent potentially problem providers from getting into the system in the first place and oversight efforts targeted at the early stage of Medicare participation targets those providers with the highest likelihood of inappropriate practices and limits Medicare risks by controlling noncompliant activities quickly.

## **ESTABLISH TARGETED PAYMENT SAFEGUARDS FOCUSED ON ABUSIVE UTILIZATION OF HOME HEALTH SERVICES**

**ISSUE:** A certain limited number of home health agencies provide care far in excess of national, regional, and state averages of utilization. There are pockets of home health utilization that are more than double the national average utilization while patient acuties do not justify such variation. Further, some home health agencies report that competing providers admit patients that had been discharged from their care with all clinical goals met and without further need for home health care. Claims review resources to evaluate and reject payment for unnecessary care are inadequate to address widespread overutilization by the few offending providers among the more than 12,000 Medicare participating home health agencies.

**RECOMMENDATION:** Congress should establish a payment safeguard in the form of an aggregate cap on payment for 60 day episodes of care that reflects a reasonable multiple of the average level of utilization. This cap would not be applied to individual Medicare beneficiary entitlement to coverage of necessary services. Instead, it would apply to provider payment for care in excess of the set cap.

The episode caps should be set at separate levels for rural and non-rural areas to account for disparities in health care services. In addition, the caps should be set at sufficient levels to account for variations in patient needs that are within the existing scope of the Medicare home health benefit.

The recommended caps should include a manner of application that prevents the overpayment on the front-end to the greatest degree feasible with end-of-the-year payment reconciliation necessary for a minor share of any potential overpayments. This would mean applying the cap on a real-time basis as each claim is processed rather than requiring post-payment collections.

The caps should also include safeguards against improper application by providers that discriminate against longer stay patients who are entitled to Medicare coverage.

**RATIONALE:** The industry-devised cap on Medicare home health outlier revenues is a model that can be adapted to abnormal utilization of episodes of care. With the outlier revenue cap, obviously abusive outlier payment practices have ceased categorically. A cap on episode payment would eliminate abusive care utilization without necessitating the employment of costly claims review systems that are beyond Medicare budget capacities.

## **CREATE A JOINT HOME HEALTH BENEFIT PROGRAM INTEGRITY COUNCIL**

**ISSUE:** Health care providers can be useful partners with government in strengthening program integrity in Medicare and Medicaid. These programs do not have unlimited resources nor do they have a monopoly on knowing programmatic integrity weaknesses and solutions. Providers of services strongly share with Medicare and Medicaid an interest in ferreting out fraud and eliminating waste.

**RECOMMENDATION:** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council. Its purpose is to:

- (1) Evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations
- (2) Recommend compliance oversight system improvements that should be developed and implemented by the Secretary
- (3) Evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations
- (4) Recommend compliance oversight system improvements that should be developed and implemented by home health agencies

The Council membership shall be appointed by the Secretary of HHS with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice.

The Council may evaluate any and all areas of compliance with respect to home health services. These may include, but are not limited to—

- (1) The method of payment
- (2) Benefit coverage standards, including documentation of service
- (3) Provider participation requirements, including the use of provisional participation for new providers
- (4) The use of targeted oversight methods, including claims review and quality of care compliance

The Council shall issue a report to the Secretary on its findings and recommendations no later than 12 months after the Council is appointed, and annually thereafter. No later than three months after issuance of the Council's reports, the Secretary shall submit a report to Congress setting out its plan of action with respect to the Council's recommendations.

**RATIONALE:** Home health agencies and their representatives have unique insights into program integrity weakness in Medicare and Medicaid. These insights come from actually operating a home care business rather than observing its operation at a distance through data reviews. As an example, it was the home care industry that uncovered abusive growth in in home health outlier payments and developed a solution to this abuse that wiped it out immediately, reducing abuses by nearly \$1 billion in the first year alone. The Advisory Council would establish a platform for constructive dialogue between providers, patients, and government on the nature of risk areas, existing abuses, and how to prevent and address fraud, waste and abuse.

## **REQUIRE CRIMINAL BACKGROUND CHECKS ON HOME HEALTH AGENCY OWNERS AND MANAGERS**

**ISSUE:** A key to program integrity in Medicare and Medicaid home care starts at the top. Individuals with criminal backgrounds should not be afforded the privilege of owning and operating a home care company that provides publicly funded care. Currently, federal standards do not require background checks for those individuals seeking to open and operate a home health agency. In addition, there is little or no evaluation of “shadow owners” and the criminal background of those individuals.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 included a provision that called for the establishment in certain selected states of “a pilot program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees.” The Affordable Care Act expanded this pilot program nationwide. The pilot program is open to all States that wish to participate and grant funding is available. The background checks are limited to those with direct patient access thereby leaving out owners and managers.

### **RECOMMENDATION:**

- 1) Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency.
- 2) Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.

**RATIONALE:** As the demand for high quality home care increases, it is critical that all services are delivered with care and compassion and that Medicare be protected from fraudulent misuse of Medicare funds. Fraud and abuse cannot be tolerated in any form. The care environment must be safe for patients and caregivers and free of abuse, exploitation and inappropriate care. Criminal background checks help ensure consumer safety as well as protecting the Medicare program.

## **ESTABLISH SELF-POLICING AUTHORITY FOR HOME HEALTH COMPLIANCE ENFORCEMENT**

**ISSUE:** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Often, the need to prioritize allocation of resources leaves open unfettered opportunities for abusive activities. For example, certain violations of health care fraud and abuse laws go untouched by federal authorities because the value of enforcement is outweighed by the cost of enforcement.

**RECOMMENDATION:** Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency.

The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance.

The entities would have audit authority in order to engage in an investigation of alleged noncompliance.

**RATIONALE:** Industry self-policing is not a new concept. It can be used effectively in federal health care programs to address resource and priority limitations. Medicare and Medicaid are huge government programs that can greatly benefit from additional enforcement activities by parties that have direct, extensive knowledge on the inner-workings of their specific health care sector.

## **ENHANCEMENT OF EDUCATION AND TRAINING OF HOME HEALTH AGENCY STAFF THROUGH JOINT EFFORTS WITH REGULATORS**

**ISSUE:** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. For example, State Surveyors may have a different interpretation of the same Condition of Participation, and medical reviewers at the various claims processing contractors often have different interpretations of the coverage and payment rules. In addition, CMS contractors develop local coverage decisions (LCD), for the purpose of clarifying Medicare coverage policies. As a result, home health utilization and coverage varies dramatically among regions. In many instances CMS contractors create their own set of policies. Confusion among providers on how the rules are to be applied leaves the program vulnerable to abuses.

**RECOMMENDATION:** Ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors.

1. Develop education sessions to be conducted nationally and open to all stakeholders
2. Provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies.
3. Require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies.
4. Abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

**RATIONALE:** Unintentional abuses within the home health program are often the result of misinterpreting federal regulations and policies. Ensuring all stakeholders are hearing the same message at the same time, and have access to the same resources for interpretation will go a long way to achieving compliance with Medicare requirements, while alleviating frustrations among providers and regulators.