

INTRODUCTION

Chairman Grassley and Members of the Committee, thank you for convening this hearing today to talk about a vital benefit for our Nation's seniors, Medicare home health. It is a pleasure to be here today to discuss the Health Care Financing Administration's (HCFA) implementation of the 1997 Balanced Budget Act provisions affecting home health. Together, on a bi-partisan basis, Congress and the Administration worked to produce this landmark budget agreement that strengthens and preserves the home health benefit, and Medicare overall.

Medicare's home health benefit is crucial to the 4 million beneficiaries who receive care at home. Home health beneficiaries receive services that greatly improve their quality of life. The benefit helps these patients recuperate in their own homes. Sophisticated medical treatments that were once only possible in a hospital are now available to patients at home.

Compared to the Medicare population as a whole, home health patients are more likely to be female and to live alone. These patients also tend to be poor; 43 percent have incomes below \$10,000. In addition, home health users are more likely to have 2 or more activities of daily living impairments, and rate their health status as poor.

Beneficiaries are receiving home health services from the Nation's 10,500 home health agencies. The majority of these agencies are managed by and employ honest, hard-working people who provide top-quality care to our beneficiaries. Yet, sadly, home health patients are particularly at risk of victimization by bad actors.

Congress designed the home health benefit to provide care that is related to the skilled treatment of a specific illness or injury. To receive home health, a beneficiary must be under the care of a physician who has certified that medical care in the home is necessary and who has established a plan of care. Furthermore, the beneficiary must be confined to the home and must need intermittent skilled nursing care, or physical therapy, or speech language pathology services, or have a continuing need for occupational therapy. If these requirements are met, Medicare will pay for:

- skilled nursing care on a part-time or intermittent basis
- physical and occupational therapy, speech language pathology services
- medical social services
- home health aide services for personal care related to the treatment of the beneficiary's illness or injury, on a part-time or intermittent basis
- medical supplies and durable medical equipment (DME has a 20 percent beneficiary co-insurance)

Home health is an essential benefit that unfortunately has been subject to runaway growth, and waste, fraud and abuse. Congress and the Administration addressed these problems with crucial changes, including those that are the subject of this hearing -- the interim payment system, venipuncture provision, and surety bonds. Much of the concern regarding these changes results from the challenges that often come with reform. The concern also seems to stem from misunderstandings of the changes, and the law that created and governs the benefit.

For example, the interim payment system presents challenges to home health agencies because they

need to change past behavior. For the first time agencies will operate under incentives to plan and provide care efficiently. A misunderstanding of the interim payment system involves the new, aggregate per beneficiary limit contained in the system. This limit does not cap the number of visits a patient may receive, nor does it limit the amount of money that can be spent on any one patient.

Another misunderstanding of the home health benefit involves the venipuncture provision. This provision closed a loophole that let beneficiaries who only needed blood drawn, receive virtually unlimited personal care services, such as help with bathing. Critics of this provision may not understand that the Social Security Act specifically says such services can be covered only when directly related to skilled treatment of an illness or injury. The new law simply brings policy in line with the law that governs the home health benefit.

The surety bond requirement helps us to recover Medicare and Medicaid funds -- taxpayers' money -- from agencies with overpayments, civil monetary penalties or other assessments. HCFA issued a regulation implementing the bond requirement on January 5, 1998. Many agencies were able to obtain surety bonds. However, we learned that some agencies experienced difficulties, suggesting the need for technical revisions. HCFA addressed these concerns through technical revisions contained in a notice issued on March 4.

GROWTH IN HOME HEALTH

Although home care meets genuine needs in the lives of beneficiaries, many problems have been identified. Spending on home health has soared, and the benefit is susceptible to waste, fraud and abuse. There also has been sizeable growth in the number of beneficiaries receiving the services, and the benefit underwent various legislative and judicial changes. While the majority of home health agencies are legitimate providers, this provider group has also experienced changes; an alarming number of unscrupulous agencies have entered the program.

Spending has grown significantly. In 1990, Medicare program payments for home health benefits totaled \$4.7 billion (in 1997 dollars) representing about 3 percent of all Medicare payments. By 1997, home health payments grew to \$17.2 billion, accounting for about 9 percent of all Medicare expenditures (Attachment 1). During the same time period, the number of beneficiaries receiving home health grew from 2 million to 4 million, and average visits per beneficiary more than doubled from 36 to 80 (Attachment 2). In addition, the number of participating home health agencies grew from 5,700 in 1990 to more than 10,500 in 1997 (Attachment 3). While some of this growth is due to changing demographics and medical advances, a significant amount cannot be explained by these factors alone.

A key turning point in the growth of the home health benefit was the Duggan v. Bowen lawsuit, settled in 1989. The outcome of the litigation, in effect, constrained HCFA's ability to deny inappropriate coverage and payments in many instances. There since has been steady growth in the number of home health visits per user and the number of users.

Growth in home health spending can also be attributed to a reduction in the number of claims HCFA is able to review for medical necessity. At a time when resources for claims review dropped, the number of claims soared. Consequently, while HCFA reviewed over 50 percent of home health claims in fiscal year 1988, by 1997, HCFA only could review about 2 percent of these claims. That is why we ask your support of the Administration's FY 1999 budget proposal to charge providers a fee to cover the costs of Medicare desk reviews, audits and cost settlement activities.

The OIG and the GAO have found high levels of inappropriate home health billings in numerous

studies. In the July 1997 report, *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*, OIG evaluated a sample of 3,745 services in 250 home health claims in four states and estimated that 40 percent of the services did not meet Medicare reimbursement requirements. Similarly, GAO noted significant levels of inappropriate billings in the June 1997 report, *Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings*. A review of 80 high-dollar claims in one state revealed that 43 percent of the claims should have been partially or totally denied, and the HCFA contractor subsequently denied them.

It is important to note that the OIG has found that HCFA's fiscal intermediaries made appropriate payments based on the documentation they received from the home health agencies in the sample. However, when the OIG further examined the documentation in detail, they found that the services provided in the sample did not meet Medicare reimbursement requirements. This degree of scrutiny is simply not affordable to Medicare contractors working under tight budget constraints.

Faced with evidence of increasing waste, fraud and abuse in the home health benefit, Congress and the Administration took steps to fight the problem. The Administration's anti-fraud initiatives, including Operation Restore Trust, are providing us with the tools to crackdown on fraud. For example, 83 home health agencies in one state have been reviewed under this project since 1995. About \$33 million was identified in inappropriate Medicare payments. The Health Insurance Portability and Accountability Act and the Balanced Budget Act gave us several other safeguards that already are proving successful in the fight against fraud. In addition, the anti-fraud initiatives undertaken by this Committee -- including the July 1997 hearing on "Medicare's Home Health Care Fraud and Abuse," the September home health fraud roundtable, and the resulting draft legislation that we are working with you on, the Home Health Preservation Act -- are powerful weapons to combat waste, fraud and abuse in the benefit.

THE BALANCED BUDGET ACT OF 1997

Many of the home health provisions in the Balanced Budget Act were framed in light of the benefit's changing nature. The role of the home health benefit has broadened significantly since its inception. Congress designed the benefit to provide care that is related to the skilled treatment of a specific illness or injury. The Social Security Act contains blanket exclusions of coverage for custodial care (personal care unrelated to skilled treatment of an illness or injury) and personal comfort items. Personal care services covered under the home health benefit, such as help with bathing, are intended to augment skilled care in the overall treatment of a beneficiary who needs skilled medical care.

In addition to the need for home care among individuals who require intermittent skilled nursing, or physical, speech, or occupational therapy, there also is a demand for both custodial care and personal care services that are not covered under Medicare. We believe that a good share of the increase in utilization reflects an attempt to meet these needs. Evidence shows that the increase in utilization is largely due to the rising number of home health aide visits for personal care in recent years.

With the support of many Members of this Committee, the Balanced Budget Act made the most significant changes in Medicare and Medicaid since they were enacted more than 30 years ago. This budget agreement is a major step forward by Congress and the Administration in the effort to preserve the home health benefit and strengthen Medicare overall. We are pleased to have the new authorities contained in the law, and are already putting in place significant new tools to control the runaway growth in home health spending, and waste, fraud and abuse. Among these authorities are the home health prospective payment system and the three provisions that are the focus of this hearing: the interim payment system, venipuncture, and surety bonds.

As HCFA implements the Balanced Budget Act, we are monitoring its impact closely. We continually meet with home health industry representatives to hear about the challenges they face in adjusting to the legislative changes. HCFA also has sent letters to each home health agency about the Balanced Budget Act. For example, in one letter we reminded agencies about their responsibility to advise patients accurately of their coverage under the home health benefit (Attachment 4). HCFA had grown concerned about reports that information on the legislative changes were misinterpreted by home health agencies.

INTERIM PAYMENT SYSTEM

The Balanced Budget Act includes major reforms in home health payment. Historically, home health agencies have been paid on the basis of their reasonable costs. Within the home health cost limits, HCFA was required to pay the agency the allowable cost it incurred in providing care. This type of payment, known as cost-based reimbursement, has been widely criticized. There is no incentive for operating efficiently, minimizing costs, or controlling the number of visits supplied. In fact, prior to the Balanced Budget Act, agencies had the incentive to maximize the number of visits to each beneficiary. More visits meant more payments to the agency.

The Congress, the Administration, and the home health industry all agree that Medicare home health should move to a prospective payment system to control costs and ensure quality and access to care. The Balanced Budget Act establishes such a system, to be implemented by October 1, 1999, a target HCFA is working hard to meet. Until then, Congress prescribed an interim payment system that took effect October 1, 1997.

Under a prospective payment system, efficient providers are rewarded while inefficient providers are penalized. In order for this payment system to work, differences in the severity of patients' conditions must be described. These differences must be explained by a "case-mix adjuster." Currently, a reliable case-mix adjuster does not exist for home health. The interim payment system was established to control the runaway growth in home health while HCFA works to develop an accurate case-mix adjuster.

The interim payment system will pay agencies the lower of their actual costs, or one of two cost limits. Home health agencies will continue to be paid on a cost basis, but the total payment to an agency is controlled by two limits. The first is the aggregate limit based on per visit costs. The second is a new aggregate per beneficiary limit. Together, the two limits are designed to tackle different problems with overuse, or waste of services, stemming from cost-based reimbursement. The aggregate limit based on per visit costs encourages agencies to provide services more efficiently during each visit than they did in the past. The aggregate per beneficiary limit promotes efficiency in planning and delivering total services to the patient through the entire home health stay. This limit also takes away the incentive to supply medically unnecessary visits to maximize Medicare payment, but it does not limit the actual number of visits to any one patient.

Prior to the Balanced Budget Act, only the aggregate limit based on per visit costs applied to home health agencies. The law reduces this limit from 112 percent of the mean per visit cost of care to 105 percent of the median per visit cost of care. The aggregate limit based on per visit costs encourages agencies to provide care efficiently in order to keep their costs within the limit. As required by the Balanced Budget Act, the regulation implementing the aggregate limit based on per visit costs was published in the *Federal Register* on January 2, 1998.

The new aggregate per beneficiary limit encourages agencies to plan and deliver care more efficiently by consolidating visits and eliminating unnecessary ones. This limit primarily is based upon the agency's own costs and patient mix -- its costs and patient mix in fiscal year 1994. The aggregate per beneficiary

cap is adjusted further to blend the agency's own costs with costs from the census region, to compress the range of extreme values that might otherwise result.

New home health agencies will have an aggregate per beneficiary limit that is the national median of the limits for existing agencies. This national median discourages further development of agencies in areas where utilization and costs are already high.

The interim payment system, like any payment reforms Congress has prescribed in the past, present challenges for providers. The home health reforms are designed to change agencies' past behavior. The incentive to supply virtually unlimited visits to patients regardless of medical outcome is gone. Instead, home health agencies now must make decisions based on the patient's medical outcome and on efficiency in planning and delivering care. The law creates incentives to scale back utilization to fiscal year 1994 levels. On average, this would be a reduction of about 12 visits per year, or 1 visit per patient each month. Of course, for any one agency, the actual experience could vary. Under the interim payment system, home health agencies now have an incentive to combine visits, eliminate unnecessary ones, or reduce overhead expenses.

The limit under the interim payment system that appears to be causing the most concern is the aggregate per beneficiary limit. This limit essentially charges agencies with the responsibility of operating within a global budget to provide Medicare covered services. The aggregate per beneficiary limit does not restrict the number of visits to individual patients, nor does it limit the amount of money a home health agency can spend in caring for any one patient.

Under the aggregate per beneficiary limit, agencies are still able to meet the varying health needs of their patient population. The limit simply captures, as an average, the full range of patients served in FY 1994. This includes high cost or sicker patients, and low cost patients. Although some claim that home health patients are being discharged from hospitals sooner than before, this argument does not apply to most beneficiaries receiving home health. A study published in *The New England Journal of Medicine* in August 1996 found, "less than a quarter of home health visits (22 percent) were preceded by a hospital stay within 30 days. Nearly half the visits (43 percent) were unassociated with an inpatient stay in the previous six months."

We believe home health agencies have the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within the aggregate per beneficiary limit. Applying the limit to the agency overall, not just to one patient, allows the agencies to balance the cost of caring for one patient against the cost of caring for others. Mandating that home health agencies operate within a global budget should not mean that care is compromised to any patient. Agencies are bound by their participation agreement with Medicare to provide the appropriate levels of care that the physician prescribes.

It is important to note that Medicare's home health benefit has always emphasized providing covered services in the fewest number of visits needed to achieve the goals of the patient's plan of care. Medicare also has always covered the teaching and training of the patient and his or her family to carry out services themselves. During the past several years, these principles seem to have been eroded by the perverse incentives inherent in cost-based reimbursement. We believe that returning to the principles of delivering covered care in the fewest number of visits to achieve the plan of care; teaching and training the patient and the family; planning and furnishing care efficiently; and enrolling truly eligible beneficiaries in home health, will enable home health agencies to operate within the new interim payment system.

VENIPUNCTURE

The venipuncture provision in the Balanced Budget Act closed a loophole in the home health benefit. Prior to the budget agreement, venipuncture for a blood draw triggered the potential for virtually unlimited home health visits even when the beneficiary did not require skilled medical care. However, under the Balanced Budget Act, only individuals needing other skilled therapy or nursing services in addition to venipuncture can continue to receive blood draws through the home health benefit.

Medicare still pays for blood draws that are not associated with home health services. This service is paid under the Part B laboratory benefit. If a beneficiary is unable to travel to a laboratory or a physician's office for the blood draw, Medicare Part B will pay for a technician to travel to the beneficiary's residence to draw blood. HCFA has heard concerns that in some parts of the country, the payment for technician travel may be inadequate. We are reviewing the payment policy to ensure that beneficiaries receive needed blood testing. As an alternative to technicians traveling to a beneficiary's residence, a physician, nurse practitioner, clinical nurse specialist or a physician assistant can conduct a home visit and draw blood when they examine the beneficiary.

Medical review staff at HCFA's contractors found numerous examples of abuse associated with venipuncture. For example, the contractors discovered cases where beneficiaries were taking a blood thinning drug, but needed no other skilled treatment. Physicians ordered skilled nursing visits to draw blood for laboratory testing (for adjustment of drug dose), and home health aide services for these individuals. In one case, there was no evidence that the patient needed skilled treatment but skilled nursing visits were prescribed 1-2 times per week, and a home health aide was ordered for 12 hours a day, 7 days a week to assist in showering, meal preparation, shopping, laundry, housekeeping, safety supervision, and escorting.

The venipuncture provision targets this inappropriate use of home health services. It also ensures that beneficiaries receive care that is covered under law by focusing limited Medicare resources on the mandate to serve persons with medical and remedial care needs, rather than those requiring only custodial care. The venipuncture provision went into effect February 5, 1998.

SURETY BONDS

The Medicare home health benefit is crucial for many beneficiaries but unfortunately, it has been abused by some unscrupulous providers. As a way of using market forces to protect beneficiaries and the Medicare and Medicaid programs, Congress enacted a provision in the Balanced Budget Act requiring home health agencies to obtain surety bonds. Many industries use surety bonds to protect consumers. For example, a "bonded" carpenter is hired to build bookshelves in a house. In the course of performing the work, the carpenter accidentally breaks a window. Should the carpenter refuse (or be unable) to pay, the homeowner can collect for the replacement of the window from the surety company. Medicare finds itself in a similar situation.

Because of the success of a surety bond requirement imposed by the Florida Medicaid program, we know that this approach works. This State bond requirement, combined with additional anti-fraud measures, resulted in savings of \$200 million over a two-year period for Florida. Although there has been a decline in the number of Medicaid home health agencies, the State of Florida has received no complaints from physicians or patients regarding access to care problems. The Federal surety bond requirement will help Medicare and Medicaid to recover funds from agencies who have incurred overpayments, or who have had civil monetary penalties or assessments imposed against them.

HCFA published a regulation to implement the surety bond requirement in the *Federal Register* on January 5, 1998. Our goal is to implement the most effective regulation possible to protect Medicare, Medicaid, and our beneficiaries. While many agencies already have obtained surety bonds, we learned that some agencies experienced difficulties. HCFA addressed these concerns through technical revisions.

These technical issues are detailed in a notice published in the *Federal Register* on March 4, 1998. They are in keeping with standard industry practice, and would help surety companies offer bonds at more affordable prices to agencies. The technical revisions will:

- **Limit liability to the bond in effect when it is determined that funds are owed to Medicare, regardless of when the overpayment or misdeed took place.**

Bond companies will be liable only for determinations made during the year for which the bond is written, or the "period of discovery." This ensures that bond companies are not responsible for money owed to Medicare for several years after a bond expires. Bond companies' actual risk will be easier to determine, making bonds more affordable.

- **Establish that bond companies have liability for an additional two years when a home health agency leaves Medicare and Medicaid.**

The term of the bond will automatically extend two years after the date an agency is terminated, voluntarily or not. This provides additional protection for Medicare and Medicaid, and sets a clear limit on bond companies' liability when an agency is terminated.

- **Give bond companies the right to appeal overpayment assessments if an agency fails to assign its right of appeal to the company.**

This technical revision recognizes that bond companies should have appeal rights. However, companies would not be able to appeal if an agency has appealed and lost.

The technical revisions in this *Federal Register* notice, and the comments on the original regulation published on January 5, will form the basis for a final rule. Our goal in the final rule is to protect Medicare and Medicaid without unduly burdening reputable providers.

The original regulation published on January 5, requires agencies to submit bonds to the Medicare fiscal intermediary that processes their claims by February 27. As noted, many agencies have already obtained surety bonds. For these agencies, the bond should be submitted to the fiscal intermediary. However, other home health agencies have been unable to obtain bonds. In the technical notice, agencies were asked to notify their fiscal intermediary or State Medicaid agency of this fact in writing by March 31. This allows us to make an accurate assessment of the number of home health agencies without bonds.

The original February 27 effective date has been extended in a rule, accompanying the technical notice, that also was published in the *Federal Register* on March 4. The new compliance deadline will be 60 days after the publication date of a final surety bond rule that incorporates comments on the January 5 regulation and the subsequent technical revisions. For home health agencies that have not furnished surety bonds, HCFA will not take action to terminate or withhold payment until the new compliance date.

CONCLUSION

The Balanced Budget Act of 1997 dramatically reforms the Medicare home health benefit. The budget agreement includes measures that achieve savings of \$17 billion in five years. The Balanced Budget Act also includes other provisions that go a long way to strengthen and preserve the benefit, including the surety bond requirement and the venipuncture provision.

Given the rapid growth, and the waste, fraud and abuse in the benefit, these major changes are needed. We know that often with change comes challenges. The Balanced Budget Act is no exception. Home health agencies are being asked to change past behavior by planning and delivering care more efficiently, and by providing only the services that are covered under law. Congress and the Administration also are asking agencies to be better managers of the taxpayers' money. We believe that the majority of our home health agencies can succeed in facing the challenges, and carry out the changes that will help safeguard the benefit.