Home Health

BUSINESS REPORT

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A WEEKLY REPORT ON NEWS, TRENDS & STRATEGIES FOR THE HOME HEALTHCARE EXECUTIVE

GAO says HCFA lacks ability to track overpayments from HHAs

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – The **Health Care Financing Administration** (HCFA; Baltimore) is slow to identify overpayments that home health agencies owe Medicare, and the agency often winds up holding the bag for many of these payments, the **General Accounting Office** (GAO; Washington) concluded in a report released last week.

While the GAO examination was for overpayments made to agencies in Texas that have been closed, the GAO's findings may have ramifications for existing home health agencies throughout the country.

"I would be hard pressed to believe that they are treating overpayments for closed agencies differently than they are overpayments to open agencies," said veteran home healthcare attorney Elizabeth Hogue. "I can well imagine that there is some spillover, and I know, based on my own experience, that there are often issues about whether overpayments are handled appropriately."

Because these agencies receive interim payments based on estimates of their allowable costs, Medicare contractors adjust these payments based on cost reports. But since contractors take 18 months to make final determinations, little of this money is ever collected, reported the GAO.

Since passage of the Balanced Budget Act of 1997 and the implementation of the interim payment system, the GAO notes, HCFA estimates that 650 home health agencies have left the Medicare program in Texas alone, saddling the program with sizable overpayments. HCFA's original estimate of the collective amount owed by closed Texas home health agencies was $627 million.

But the GAO said its estimate of overpayments from the 15 closed home health agencies it examined in Texas differs substantially from estimates initially reported by HCFA. In fact, using the same definition of overpayment as HCFA, the GAO estimated that these agencies only owe

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NAHC weighs in on HCFA's revised guidelines for OASIS

By MATTHEW HAY
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WASHINGTON – The **National Association for Home Care** (NAHC; Washington) recently weighed in on the **Health Care Financing Administration**'s (HCFA; Baltimore) revised interpretive guidelines for the Outcome and Assessment Information Set (OASIS) requirements. NAHC reported that while the guidelines have yet to be made public, the association was given the chance to review and comment on the draft.

Given that the OASIS regulations will be modified with the home health prospective payment system and revised conditions of participation in just a few months, NAHC said, it will become "increasingly problematic and costly" to require nurses to perform the initial and comprehensive assessment when the therapy is the primary and first

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HCFA briefs state coordinators on OASIS progress at NAHC

By MATTHEW HAY
***HHBR* Washington Correspondent**

WASHINGTON – The **National Association for Home Care** (NAHC; Washington) reports that the **Health Care Financing Administration** (HCFA; Baltimore) said home health agencies held locked assessments of Outcome and Assessment Information Set (OASIS) data an average of 19.7 days prior to submission and that repository data is very similar to OASIS demonstration data.

The agency also noted that repository data contains more than 5 million assessments since August 1999 and

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Holiday schedule

Because *HHBR*'s offices were closed on Monday, May 29, for Memorial Day, fax subscribers are receiving this week's issue today.

INSIDE:

MANAGED CARE REPORT

• **PacifiCare Health Systems** (Santa Ana, CA) is being sued by a Fort Worth, TX, doctor who said it delayed paying claims for members of the Harris Methodist Health Plan as part of an attempt by PacifiCare and others to earn millions of dollars in interest on the money to be used for payments. The suit seeks class-action status representing all doctors whose payments were delayed after they treated members of Harris Methodist Health Plan, which PacifiCare bought Feb. 1, reported the *Orange County Register*. PacifiCare denied the accusations.

• **Concentra Medical Centers** will enter the Pittsburgh market under a new partnership with **UPMC Health System**, the company said last week. Plans include the opening of three new sites, which could bring 150 new jobs to the area. Concentra has a long-term goal of operating 15 to 20 sites in Pennsylvania over the next five years, the company said. Concentra will manage UPMC Health System's outpatient and on-site clinical occupational healthcare services and build on that existing business.

• **CCN** (San Diego) now offers a group health preferred provider network in Delaware. The expansion brings to 47 the number of states in which CCN offers networks, plus the District of Columbia. In developing its Delaware network, CCN partnered with **Medical Network Management Services of Delaware** to bring on board more than 450 physicians through three physician groups, New Castle County Physicians Organization, Eastern Sussex Physicians Organization, and Nanticoke Physicians Organization.

• **Amerigroup Corp**. (Virginia Beach, VA) said it has filed a registration statement with the **Securities and Exchange Commission** (Washington) for an initial public offering of its common stock. According to the filing, Amerigroup hopes to raise $86.2 million in the IPO, which would be completed as soon as is practicable, reported *Best's Insurance News*. The company plans to use $12.5 million to pay off preferred stock, use $7 million to pay down the company's term-loan facility, and use the rest of the proceeds for general business purposes, including acquisitions.

• **Oxford Health Plans** (Trumbull, CT) paid the $131 million balance of its bank term loan three years prior to the due date. The company said last week that the pre-payment included a premium of 2.5%, bringing the total payment to $134.3 million. ■

OASIS

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needed service.

According to NAHC, the draft guidelines also contain a statement that "if the initial assessment indicates that the patient is not eligible for Medicare (i.e., the patient is not homebound, has no skilled need, etc.), then there is no indication for the agency to conduct a comprehensive assessment or to collect, encode, or transmit OASIS data to the state."

But NAHC said that statement is confusing because the patient may not be Medicare eligible, but be a private pay patient or covered by Medicaid. In addition, NAHC noted that the OASIS Web site states that even a one-time skilled nursing visit would require an OASIS. "In these cases, however, the patient would not qualify for Medicare because he does not meet the intermittent skilled nursing requirement," noted the association.

In addition to the revised interpretive guidelines, NAHC noted that HCFA intends to revise the sections of the State Operations Manual dealing with separate entity determinations. NAHC also recommended that these determinations be confined to quality and operational considerations rather than fiscal and corporate law considerations, and that surveyors should follow the same procedures for identifying free-standing agencies that are part of a complex organization as they do when surveying hospital-based agencies.

The association added that when determining whether an agency is part of a larger organization, surveyors should base their decisions on the operation of the agency, consumer awareness, and staff awareness regarding this fact. ■

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COMPANIES IN THE NEWS

Beverly elects new board members

Beverly Enterprises' (Fort Smith, AR) stockholders, at the company's recent annual meeting, elected all nominees to the board and ratified the appointment of **Ernst and Young** as independent auditors for 2000.

Beverly also said that next year's annual meeting of stockholders tentatively has been set for Thursday, May 24, 2001.

Gentiva signs provider agreement with Nouvel

Gentiva Health Services (Melville, NY) signed a letter of intent with **Nouvel Pharma** to be the exclusive distributor of Nouvel's leading pharmaceutical therapy, Duodopa, an infusion therapy for advanced stage Parkinson's disease patients, upon the therapy's approval by the **Food and Drug Administration** (Washington). Gentiva also will begin providing staffing support and distribution for the forthcoming U.S.-based clinical trials for Doudopa and, upon the therapy's approval, will provide support for the product's launch in the United States.

The letter of intent represents the latest in a series of preferred and exclusive pharmaceutical distribution agreements between Gentiva and pharmaceutical manufacturers and biotechnology companies, Gentiva said.

Invacare declares cash dividend

Invacare's (Elyria, OH) board of directors declared a cash dividend of $.0125 per share on its common shares and $.011364 per share on its Class B common shares payable July 14, 2000, to shareholders of record on July 3, 2000.

Respironics teams with AHOM

Respironics (Pittsburgh) received a two-year contract to provide continuous positive airway pressure, bilevel, and noninvasive ventilation products to **American HomePatient** (Brentwood, TN). ■

BRIEFLY NOTED

• Given the choice, 54% of older Americans with acute illnesses would prefer to be cared for in a hospital instead of in their homes, even if the two options provide the same outcome, according to a new study released by Yale University's School of Medicine. The study's principal investigator, Terri Fried, said the finding of the study "dispels the myth that older persons are more interested in comfort than in cure." According to the study, home is a viable option for seniors only if it provides outcomes equally as good as the hospital. But if the home and hospital provide the same outcomes, many older people would still prefer to be cared for in the hospital, the study found. Those who said they would prefer hospital care were most likely to change their minds if physician housecalls were provided and if their doctors thought home care would be a better option for them. According to the study, there is a possibility that newly developing systems of care might not be meeting the needs and preferences of older patients.

• Home care revenues in FY99 were estimated at more than $42 billion, according to a recent report, *U.S. Home Health Care Markets*, from **Frost & Sullivan** (Mountain View, CA). Labor and nursing services accounted for about 95% of that total, the report stated. According to the report, as the number of elderly in the country increases, so does the demand for home care services, and advancing technologies are allowing more patients to receive that type of care. The firm's research indicates that labor and nursing services will continue to dominate revenue production throughout the forecast period, which is 1996-2006, while the product segments of DME, respiratory equipment, and infusion pumps will together collect only about 5% of total revenues by 2006. ■

HCFA

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that 95% of all agencies expected to submit OASIS data have complied. The remaining 5% are either being monitored with enforcement procedures initiated or have closed, NAHC said.

The agency released this information at the recent Annual OASIS Coordinators' Conference in New Orleans, where it updated state coordinators and surveyors on new information related to OASIS data collection, reporting, and outcomes.

NAHC also reported that HCFA plans to publish the final rule requiring masking of OASIS data on non-Medicare/non-Medicaid skilled patients on June 20, and delay "personal care only" patients for at least two years as previously announced.

According to NAHC, masking will apply only to non-Medicare/non-Medicaid patients and unmasked data on these patients will be rejected. HCFA's HAVEN 3.0 software includes the masking function and will be posted on the agency's OASIS Web site shortly.

According to NAHC, HCFA realizes that ICD-9 coding is less than accurate in some areas, such as the lack of acceptance of valid V codes and E codes, non-specific codes to allow for greater description. But HCFA emphasized that both OASIS and the prospective payment system will require revisions over time.

HCFA has drafted revisions to the interpretive guidelines for agencies incorporating surveyor instructions on OASIS (see related story), and those guidelines are currently available for surveyors as an official working draft, said NAHC. ■

Overpayments

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about one-third – or $68 million – of the $209 million HCFA originally estimated.

According to the GAO, two factors account for nearly all of the difference. The first is simply that errors were made by the contractor in entering data into one of HCFA's overpayment recording and tracking systems, such as a $4.6 million duplicate entry. The second is that HCFA's initial examination of the overpayment tracking system did not specify that superceded transactions be excluded from the reported overpayments. The GAO said that HCFA overstated one agency's overpayment by as much as $4 million.

In all, the GAO reported that about $43 million of the $68 million overpayment estimate stems primarily from unfiled cost reports. "Although it is likely that most of Medicare's payments were allowable, to provide agencies an incentive to file cost reports on time, HCFA deems the entire amount paid to an agency during the reporting period to be an overpayment when no cost report is filed," the GAO reported.

According to the GAO, HCFA's inability to accurately record and track overpayments has been a consistent weakness documented in its financial statement audits dating back to 1996. In FY98, the audit found that HCFA lacked an integrated financial management system to track overpayments and their collection, and that its procedures to ensure that overpayments were valid and supported were inadequate, the GAO noted.

"HCFA's contractors record and track overpayment activity for home health agencies and other providers using a variety of fragmented and overlapping computer systems, but do not always reconcile the data from these various systems," the GAO concluded. For example, the GAO said one contractor incorrectly keyed data into a HCFA system that erroneously reported $77 million in overpayments from one Texas home health agency alone in 1998.

"No edits are in place to identify such errors," the GAO said, adding that while HCFA implemented several interim measures last year to improve the reliability of its overpayment information, those measures could take years to implement.

Notably, HCFA generally concurred with the GAO's findings, as well as its conclusions. HCFA Administrator Nancy-Ann DeParle said that as a practical matter, agencies that decide to leave the Medicare program often do so without notifying the agency until it is too late for HCFA to act. Once that happens, she said, intermediaries quickly determine overpayments and begin withholding any future payments to recover that money.

But the GAO said that is "a more positive picture" than its examination uncovered. The GAO said contractors generally do not make final determinations until almost two years after agencies close. Moreover, there are seldom any interim reviews conducted.

DeParle responded that the Medicare Accounts Receivable System (MARS) system that HCFA plans to implement in 2001 should address the inflated figures reported by the GAO. She added that until a cost report is received, contractors are required to see to it that all payments made during the fiscal year are overpayments. When the cost report is submitted, HCFA's current system does not make a correction. But she said the new MARS system will include these edits and improve overpayment reporting.

Perhaps more important, DeParle said, moving to a prospective payment system for home health will resolve most of the overpayment problems. "Moving to a prospective payment system should eliminate the time delays associated with a cost reimbursement system and will increase certainty regarding Medicare payments," she told the GAO. ■

WASHINGTON UPDATE

• Concerns over the Balanced Budget Act of 1997 (BBA), as well as medical errors, are topping the list for this year's upcoming campaigns, according to a report in *Healthcare Executive* by John Ferman, the principal of **Health Policy Alternatives** (Washington). This year's campaigns to control the U.S. House of Representatives, the U.S. Senate, and the White House will greatly affect the outcomes of most public policy issues, including healthcare, during the last session of the 106th Congress, Ferman reported. The greatest effects on public policy issues will come from the Democrats' attempt to control the House. Ferman's report predicted what people are likely to see unfold in terms of federal, health-related legislative issues during the last legislative session, including the prediction that it is unlikely that Congress will approve across-the-board increases in spending, leaving Medicare providers with escalating payment reductions. In fact, Ferman reported, the latest baseline projections from the **Congressional Budget Office** (Washington) show Medicare spending to be $173 billion less between 2000 and 2002, compared to projections made before the BBA's passage. It is reasonable, however, to anticipate that Congress will enact targeted Medicare relief for certain providers, such as home health agencies, hospitals, and skilled nursing facilities, that were able to convince lawmakers that they continue to suffer adverse, unintended consequences of the BBA. These relief provisions will be played out in the context of the FY01 budget debate, according to Ferman's report. ■