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Committee on Small Businesses

Hearing
on

Health Care Financing Administration Paperwork Burdens

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On Behalf of the
The American Association for Homecare

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Mr. Chairman, my name is Craig Jeffries, President and CEO of HEALTHSPAN Services, Inc. I am pleased today to present testimony on behalf of the American Association for Homecare. AAHomecare is the only national association representing Homecare providers in every industry segment, including not for profit, proprietary, facility-based, and freestanding, home health agencies and home medical equipment providers.

HEALTHSPAN is an independent, for profit regional provider of home health care that services patients in eastern Tennessee, southwestern Virginia and western North Carolina. The company was founded in 1936 in Johnson City, Tennessee, and today provides a full range of home care including home health nursing and therapy services, home infusion pharmacy services, home medical equipment, and respiratory and specialized rehabilitation equipment. Approximately 35% of our total home care business is with Medicare, 25% is with TennCare (the Tennessee Medicaid program) and the remaining 40% of our business is primarily with private insurance. We provide needed home care to over 3,000 patients per month through more than 200 employees, and our annual payroll exceeds \$5 million.

HEALTHSPAN services are built upon a strong clinical foundation (including consulting pharmacists, nurses, therapists, and respiratory therapists) and are designed to achieve optimal patient outcomes with a sophisticated financial business support system to assure a cost effective outcome for patients, employers and physicians. HEALTHSPAN employs leading edge information and communications technology to achieve clinical productivity and improve the accuracy and timeliness of communication with health peers including physicians, case managers, and consumers.

The members of AAHomecare would like to express their gratitude to the Committee for initiating an in-depth review and analysis of the regulatory requirements imposed by the Health Care Financing Administration (HCFA) in administration of the Medicare program. This is an important first step toward addressing inefficiencies existent within the current structure and prescribing concrete solutions to promulgate more effective policy.

We have identified three areas where improvements are needed to reduce the information collection burdens on home care providers and patients and to increase the efficiency and effectiveness of the Medicare program in accordance with the requirements of the Paperwork Reduction Act. (44 U.S.C. § 3501(1) and § 3506(b))

1. Eliminate Unfair Burdens In Documenting Medical Necessity

One regulatory burden that has caused particular consternation among home medical equipment (HME) providers is the determination of medical necessity. It highlights the need to evaluate the multiple requirements that HCFA has developed and mandated. The CMN is a form to document the medical necessity of certain items of medical equipment. It is required by statute, and was approved by the Office of Management and Budget

(OMB) in accordance with the Paperwork Reduction Act. The CMN collects information necessary to determine whether the beneficiary meets Medicare coverage criteria for the item of medical equipment. In order to receive payment for a covered item of medical equipment, a provider's claim (HCFA - Form 1500) must be accompanied by a CMN signed by a treating physician. The original CMN must be maintained by the supplier and must be produced upon the request of the carrier, HCFA, or the Office of the Inspector General.

A supplier that submits a properly executed CMN has satisfied its legal obligation to document the medical necessity for an item of medical equipment. HCFA should be prohibited from requesting medical equipment suppliers to provide documentation in support of medical necessity beyond the scope of a properly executed CMN.

HCFA and the carriers ignore the original intent of Congress to designate the CMN as a tool to determine medical necessity. The carriers routinely require medical equipment suppliers to submit documentation of medical necessity *in addition* to the CMN. The requests for additional documentation are unpredictable and often require information that fails to be specified in current medical policy for the item. Additionally, Medicare auditors often request additional documentation for hundreds of claims simultaneously, creating an unreasonable administrative burden for suppliers. The carriers also request documentation supporting medical necessity from hospital and physician progress notes, although suppliers do not have access to a patient's confidential medical records. Further, medical equipment suppliers can be assessed overpayments when they fail to produce portions of these records.

Equally, medical equipment suppliers are subject to overpayment demands when they have obtained the appropriate medical documentation but the physician's notes contained therein are deemed inadequate for corroboration even though the physician, by acting as signatory, expressly certifies that the information on the CMN is "true, accurate and complete" and acknowledges that any "falsification, omission, or concealment of material fact" may subject him (the physician) to civil or criminal liability. Medicare auditors also assess overpayments for technical errors on CMNs even though these technical errors have no bearing on the documentation of medical necessity for the item.

The Medicare paperwork requirements are far in excess of the requirements by private insurance for comparable equipment. An additional FTE is required for every 80 new Medicare patients per month because of the CMN documentation requirements. For example, after we receive the initial order information for medical equipment, we need to call back the prescribing physician to get additional CMN information approximately 70% of the time for a Medicare patient compared to only approximately 50% of the time with respect to private orders. Additionally, it takes more time and labor to obtain the signed CMN back from a physician compared to getting a signed order for private care. Approximately, 95% of the signed orders for private insurance come back from the physician's office correct and ready to support a claim for payment. By contrast, approximately 70% of the signed CMNs for Medicare patients come back correct.

In short, the physician's office assumes a difficult burden in completing the required paperwork for Medicare correctly, and of course our company carries a similar burden in having to hire more staff to manage that Medicare paperwork in addition to the financial burden of carrying the accounts receivable for more days for Medicare than for private payors.

The Association recommends that HCFA use the CMN for its original intent as a tool to document medical necessity and eliminate the additional requirements for documentation.

2. Remove Non-Medicare and Non-Medicaid Patients from Participation in OASIS

A second example of where information collection requirements need to be simplified under the criteria of the Paperwork Reduction Act is the Outcomes and Assessment Information Set for home health services (commonly known as "OASIS"). HCFA requires home health agencies to collect extensive sensitive personal information on an 80 question OASIS survey form from every patient, regardless of whether they seek Medicare or Medicaid coverage, on admission, every 60 days, after any hospital discharge, whenever there is a significant change in condition, and on discharge from the home health agency. The OASIS assessment form requires elderly and disabled patients who are suffering from an illness or injury to disclose such information as whether they live alone, whether they go shopping alone or with someone else, whether they own their own residence, and whether they are sad or depressed.

AAHomecare understands that approximately 19 of the 80 OASIS survey questions are needed to implement the prospective payment system that went into effect on October 1, 2000.

We do not believe that it is necessary to collect the extensive data required by OASIS from non-Medicare and non-Medicaid patients who do not seek coverage or payment under those government insurance programs. In addition, it would seem that much of the data required to be collected from Medicare and Medicaid patients under OASIS is not necessary to administer Medicare and Medicaid benefits.

The OASIS data collection requirements have imposed a crippling administrative burden on home health agencies and the patients they serve. According to estimates from HCFA, home health agencies spend approximately 800,000 hours per year collecting OASIS data at a cost of approximately \$30 million. 64 Fed. Reg. at 3783 (January 25, 1999). This is on top of approximately 850,000 hours and \$17 million required to comply with the data collection requirements under the other Medicare conditions of participation. See supporting information for HCFA's request under the Paperwork Reduction Act to extend the data collection requirements of the Medicare conditions of participation. 66 Fed. Reg. 14157 (March 9, 2001). Accordingly, the data collection burdens on home health agencies for just OASIS and the other Medicare conditions of participation consume at least 1.7 million hours and nearly \$50 million annually. As the Department of Labor noted recently in its analysis of the impact of the ergonomics standards, the home health industry has the lowest profit margin of nearly any industry

(3.2% in 1996). Thus, the cost of data collection under Medicare can only be offset by reducing services to patients or reducing wages for employees.

The length and overuse of the OASIS assessment tool has, in fact, served as a key factor in the marked reduction of nurses interested in entering the field of home health. Additionally, many nurses already working in the industry are choosing to leave as a result of the procedural burden being placed on them due to increased OASIS requirements. Nurses leaving the field routinely state that they have become too removed from direct patient care and resent being required to spend excessive amounts of their time complying with data collection requirements.

Furthermore, many patients object to home health workers entering their homes and obtaining detailed personal data about them without their consent which is then reported, in fully identifiable form, to a federal and state data bank. Patients particularly object when the care they are seeking has no connection to the Medicare or Medicaid programs. This practice would appear to be inconsistent with the intent of the privacy rights set forth in the health information privacy regulations which became effective on April 14 of this year. 65 Fed. Reg. 82462 (December 28, 2000). This would also seem inconsistent with the requirement under the Paperwork Reduction Act that collection of information be consistent with “laws relating to privacy and confidentiality.” 44 U.S.C. § 3501(8).

The impact of Medicare paperwork requirements for OASIS are burdensome compared to HEALTHSPAN’s experience with private insurance. An additional FTE is required for the data entry and administrative support necessary to manage the OASIS paperwork. In addition, a field nurse has to almost double the amount of time he or she spends with a new Medicare admission compared to a private insurance admission because of the 80 OASIS questions. Obviously, with the current nurse shortage, this is time taken away from direct patient care. Additionally, during the initial months when OASIS became a new Medicare requirement, approximately 70% of the initial OASIS paperwork needed correction from the visiting nurse, impacting his or her their patient time again. I’m pleased that only about 30% of that Medicare paperwork requires correction by the nurse today, but that is still 30% more than required by private insurance. The expansion of the OASIS requirements to private insurance is very difficult for us because we have a large pediatric business and a special focus on developmentally disabled adults. The OASIS data collection form simply is not designed for these populations.

The Association recommends that the application of OASIS be limited to Medicare and Medicaid beneficiaries and the amount of OASIS data collected on Medicare and Medicaid patients be reduced to that which is essential to implement the prospective payment system.

3. Clarify Use of the Home Health Advanced Beneficiary Notices

The Home Health Advance Beneficiary Notice (HHABN) is given to Medicare patients when a home health agency believes that services prescribed by a patient's physician will not qualify for coverage under the Medicare home health benefit (65 Fed. Reg. 24217). AAHomecare supports the use of these standardized notices as a mechanism to accurately

inform patients of their Medicare rights. However, the Association has significant reservations concerning the applicability of the Home Health Advanced Beneficiary Notice (HHABN) as it relates to determining coverage under the Medicare and Medicaid programs. In certain states, Medicaid agencies have embarked on a Medicare maximization policy under which they retroactively deny millions of dollars of Medicaid claims until a home health provider can prove that the claims were not payable under Medicare. Some states have required that the providers produce a signed advance beneficiary notice for each patient.

Thus, in order to be paid for home health services provided to dually eligible individuals, a home health agency must submit patient paperwork *twice*, once to Medicare and again to Medicaid, before being eligible for Medicaid reimbursement. In many instances, agencies have been forced to hire a full-time staff person just to address these Medicaid resubmission requests.

Additionally, some states require home health agencies to appeal coverage denials by Medicare before being allowed to submit a claim to Medicaid. In these instances, home health agencies incur a huge burden of providing additional documentation to support a coverage decision on behalf of a patient.

We believe the HHABN can be helpful in informing the patients of their rights. However, we do not believe that an advance beneficiary notice or an appeal of a Medicare denial should be required in order to file a claim for reimbursement with Medicaid.

Conclusion

Finally, we note that several home health agencies are reporting efforts by intermediaries to get providers to complete forms that have not been approved for use as required under the Paperwork Reduction Act. We suggest that the Paperwork Reduction Act be amended to provide for fines for government contractors that fail to comply with its provisions.

We also commend the Committee for seeking information comparing the paperwork requirements of private insurers to the paperwork burdens imposed by Medicare. We believe that there should be a permanent requirement under the Paperwork Reduction Act for federal agencies to determine whether data is collected for a comparable purpose in the private sector, and if so, to provide an explanation if similar processes are not adopted.

AAHomecare appreciates the interest of this Committee to explore and address the significant administrative and paperwork burdens that the Medicare program places on providers. We look forward to working with members of Congress and HCFA officials to simplify administrative policy for the Medicare home health and durable medical equipment beneficiary provisions while preserving the overall integrity of the Medicare program.