Home Health Line

Regulatory news, benchmarks and best practices
to build profitable home care agencies

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IN THIS ISSUE

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To transfer even a 5% HHA share within 36 months of Medicare's OK is not OK

CMS has issued new instructions against the sale of agencies within 36 months of enrollment. Those instructions could be worse than consultants and accountants feared.

But a clarification CMS is expected to issue could make the 36-month rule less onerous than it now appears, CMS staffers have indicated to the National Association for Home Care & Hospice.

As stated in Dec. 18 instructions CMS gave its regional home health intermediaries (RHHIs), ownership changes that would require an agency to be re-certified by Medicare include:

- **Sale of stocks or assets** involving as little as a 5% interest in an HHA

(continued on page 6)

Any cuts mean `decisions I would rather not make.'

Senate bill shrinks home health cut and offers PPS help with high-cost patients

The health care reform bill that finally passed in the Senate on Dec. 24 is better news for home health agencies than the House-passed version. Still, agencies fear the impact of possible payment cuts.

The Senate bill would postpone rebasing Medicare's home health rates until 2014 while the House calls for rebasing as soon as 2011. The Senate version also omits any home health cuts prior to the rebasing, while the House bill calls for payment reductions potentially equal to a 4% net payment reduction in 2011 (*HHL 7/20/09*).

Other favorable provisions in the Senate bill include a 3% rural add-on, which would start April 1, 2010, and continue through 2015, (*HHL 11/23/09*) and a mandate for CMS to test paying more money for high-cost home health patients. (*See side-by-side comparison of the bills, p. 3.*)

However, any possible cuts "will start forcing me to make decisions I would rather not make," says Barbara Lund, director of home care at 120-patient Gunnison Valley Hospital's home health unit in Gunnison, Utah.

One decision Lund would have to make: Whether to discontinue care to patients in remote parts of Gunnison's rural service area. In some cases, Gunnison Valley is paying a nurse for two hours of travel time in addition to routine visit costs to see only one or two patients, she notes.

The changes in the Senate bill mean HHAs overall would be getting $39.4 billion less in Medicare payments over 10 years. That's an approximately $13 billion smaller reduction than called for under the House bill.

In response, a group of 25 House members is urging Speaker Nancy Pelosi (D-Calif.) to accept the Senate's smaller home health reduction. Home health representatives expect a final bill close to the Senate version, given that Senate Democrats don't have a vote to spare for the 60 they need to prevent delaying tactics by minority Republicans. That fragile margin could be jeopardized by any big changes.

CMS to pay more for costly patients

The Senate bill calls for CMS to test a PPS overhaul that would channel extra Medicare dollars to patients who cost HHAs more than Medicare reimburses them. Such patients often have "multiple discontinuous home health episodes," the bill notes.

High-cost factors also can include catheter changes, vitamin B-12 injections and the loss of caregiver. As urged by the Visiting Nurse Associations of America – whose members commonly have an above-average share of high-cost patients – and the National Association for Home Care & Hospice, the bill would back those recommended ideas with $500 million allotted to demonstrate their effectiveness.

Despite the likelihood of no payoff from the research until 2014, the prospect of special attention to high-cost patients is "thrilling" to Mary Ann Christopher, CEO of 3,400-patient VNA of Central New Jersey. Care for 15% to 18% of her agency's Medicare patients costs $2,000 to $3,000 more per episode than Medicare pays, Christopher says.

One example of how patient costs can shoot up unexpectedly for VNA of Central New Jersey: A 70-year-old patient who suffered multiple wounds in a fall from his roof and now is a quadriplegic in need of a Foley catheter and daily visits that are involving "every single discipline." Now in his third episode, his care costs are

Subscriber Information ▸ Have questions on a story? Call or email us.

EDITORIAL

Have questions on a story? Call or email:

Vice President: Corinne Denlinger, 1-301-287-2363
cdenlinger@decisionhealth.com

Executive Editor: Marci Heydt, 1-301-287-2299
mheydt@decisionhealth.com

Senior Editor: Burt Schorr, 1-301-287-2258
bschorr@decisionhealth.com

Associate Editor: Karen Long, 1-301-287-2331
klong@decisionhealth.com

Associate Editor: Sara Jackson, 1-540-872-9440
sjackson@decisionhealth.com

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How the House and Senate bills compare on key home health issues	
Senate *(Ten-year Medicare savings: $39.4 billion)*	**House** *(Ten-year Medicare savings: $54.7 billion)*
Market basket update reduced by 1 percentage point in 2011, 2012, and 2013.	Zero market basket update for 2010.
Rebased PPS rates phased in over four years, starting in 2014, with the rebasing reduction in rates limited to no more than 3.5% per year. HHS must report by March 1, 2011, on how rebasing affects home health access and quality.	Rebasing 100% effective in 2011 with a 5% rate reduction guaranteed. CMS's 2010 and 2011 case-mix creep reductions combined for 2010.
3% rural add-on, starting April 1, 2010, and continuing through Dec. 31, 2015.	No rural add-on.
Annual productivity adjustment, starting in 2015, estimated to save $5.2 billion over 10 years.	Annual productivity adjustment, starting in 2011, estimated to save $14.4 billion over 10 years.
Reduced hospital payments for re-admissions	Reduce payments to post-acute providers for hospital re-admissions.
Pilot program by 2013 for bundling post-acute payments.	HHS has three years develop a pilot post-acute bundling program.
HHS plan for value-based home health payments submitted to Congress by Oct. 1, 2011.	No provision.
HHS recommendations for PPS changes when patients are low income, in medically underserved areas and/or have high levels of severity, due by March 1, 2014. $500 million allotted for test of whether such payment adjustments substantially improve access to care for such patients.	No provision.
Sourece: Adapted from a side-by-side comparison of Senate and House bills developed by NAHC	

exceeding reimbursement by approximately $2,000 or more per episode, Christopher says

Create a new payment advisory board

In cooperation with the Medicare Payment Advisory Commission (MedPAC), a new independent advisory board would have authority to propose Medicare rate changes starting in 2014 under the Senate bill.

Proposed changes would be based on whether spending targets have been exceeded. Starting in 2020, the independent board's recommendations would be binding unless rejected by Congress under procedures that limit debate and favor approval.

One industry concern: Hospitals and hospices currently would be exempt from such decisions and also could be in the future – but not home health. That means the board "will have to distribute [any] cut across a smaller base, leading to bigger cuts from non-exempt providers," such as home health, VNAA says.

As noted by Simione Consultants, the pending bills also mean opportunities and challenges for home health, such as the demonstration of bundled post-acute payments the House and Senate bills both would authorize *(HHL 7/13/09)* and the chronic care management demo in the Senate bill *(HHL 4/13/09)*.

Other features of the final Senate bill:

- **Reduce the home health inflation update by 1 percentage point** in 2011, 2012 and 2013. The House bill is estimated to do approximately the same thing through productivity adjustments.

- **Allow a physicians' assistants, non-physician practitioners and nurse practitioners**, as well as physicians, perform face-to-face interviews with home health candidates. The interviews would meet a new pre-admission requirement.

- **Shrink hospice payments less than originally proposed.** The 0.5 percentage-point reduction in the 2013 hospice market basket update called for by the original Senate bill would be only a 0.3 percentage-point reduction under the final bill. For each of the seven years beginning in 2013, the bill also would trim the hospice market basket update by a productivity adjustment estimated to be about 1 percentage point.

- **CMS will study concurrent care for hospice patients.** A three-year, 15-hospice Medicare Hospice Concurrent Care demonstration project will examine whether allowing hospice patients to continue receiving other Medicare-covered services improves patient care, quality of life and cost-effectiveness for Medicare, the Senate bill states. – *Burt Schorr (bschorr@decisionhealth.com)*

Agencies owed thousands from PEP problem; fix scheduled for March

Agencies are tracking thousands of dollars tied up in incorrect partial-episode payments (PEPs) and might have to wait until as late as March for a resolution.

The problem involves all PEP claims and results in payment for one day of the partial episode rather than all of the days of service, says Vickie Elkins, Medicare reimbursement support analyst for American Nursing Care, based in Milford, Ohio.

The issue has been ongoing since October, and "the amount of money is starting to mount," says Mary Carr, associate director for regulatory affairs at the National Association for Home Care & Hospice.

American Nursing Care, for example, has $124,000 for 75 claims tied up in this problem for its 22-branch agency, Elkins says. For one claim, the agency was paid $29 rather than the $1,800 it was owed.

Agencies will start seeing correct PEP payments in March, a CMS spokesman tells *HHL*. In the meantime, American Nursing Care's billers have to scour McKesson software-generated reports to determine which claims are affected by the error and then enter the incorrect payments on an Excel spreadsheet, Elkins explains. They'll continue doing this until the RHHIs fix the problem.

More news from the RHHIs:

- **All RHHIs –** Payments for some services billed by home health agencies could be affected by the uncertainty about physician fee schedule rates for 2010. Outpatient therapy services, for example, are paid under the physician fee schedule. But CMS is holding rates close to 2009 rates through Feb. 28 to allow Congress time to decide whether they should change payments in 2010. Without the hold, the fee schedule rates would have gone down 21% on Jan. 1.

- **Cahaba –** The intermediary will look at claims for nursing services with lengths of stay longer than two years. Claims will be checked for "compliance with CMS guidelines, contractor local coverage determinations (LCDs) and correct billing and coding," the RHHI states in its January provider newsletter.

- **Palmetto** – Disproportionately high home health costs for one county in Florida and three counties in Texas have prompted Palmetto actions that include sending comparative billing reports to high-utilization providers, encouraging review of agency controls that ensure they meet Medicare regulations and recommending work with agency compliance officers to reconcile any overpayments, according to Palmetto's January alert.

- **Palmetto –** Claims with dates of service starting Jan. 1, 2010, will be held through Jan. 14 to ensure the quarterly update is installed properly, a Palmetto email announcement states. To show that the claim is on hold, claims will include reason code 37230 in the "SMHOME" status location. Claims will be released "on or about Jan. 14, 2010, to continue processing," Palmetto states.

- **Palmetto –** The intermediary has determined that some hospices are missing the attestation statement that was required with the physician narrative on certifications and recertifications of patients' terminal illnesses, starting October 2009 (*HHL 12/14/09*). Claims that do not have the attestation statement will be denied, the intermediary says. – *Karen Long (klong@decisionhealth.com)*

Salaried RNs provide top productivity for same cost, HHA finds

For many agencies, choosing a clinician compensation model also means choosing between quality outcomes and improved productivity.

But for Celtic Health Care, paying its nurses a salary has helped the agency achieve both, says Bill Gammie, VP of business operations for Celtic Health Care in Mars, Pa.

Offering a salary, rather than paying per visit, "gives us more control over clinical quality and outcomes" and helps the agency score the same as or better than the average for eight of the twelve Home Health Compare Outcomes.

Careful management also helps the agency maintain its baseline productivity expectation of six visits per day.

Manage salaried staff tightly for best results

- **Track caseloads not visits**. Celtic's nurses manage caseloads of about 30 patients and are expected to provide about 30 visits per week. How they get there can vary. For example, a nurse with an established patient group might have a higher number of low-weight, 30-minute follow-up visits in a day. Another clinician may have only two to three longer admission, wound care or therapy-heavy visits that run two hours each, Gammie explains.

When a clinician gets overloaded, performance improvement staff makes recommendations to the intake department to adjust clinicians' visit balance, he notes.

WOCN releases new OASIS-C wound guidance

When clinicians complete the new OASIS-C wound questions, be sure they're using the latest definitions provided by the Wound Ostomy and Continence Nurses (WOCN) Society.

In general, the WOCN reiterates a lot of the old definitions with the exception of three ***new*** definitions for the terms "newly epithelialized," "non-epithelialized" and "unhealed," says Judy Adams, president of Adams Home Care Consulting in Chapel Hill, N.C. (*View the WOCN's OASIS-C guidance at www.wocn.org/pdfs/GuidanceOASIS-C.pdf.*)

However, the industry was expecting a lot more guidance – not just definitions – to clear up the confusion the new OASIS-C wound terms have created, says Adams.

The work of the WOCN OASIS-C taskforce is not over, says Dianne Mackey, certified WOCN and member of the three-person WOCN OASIS taskforce. The group continues to submit questions to CMS to clarify its guidance.

Newly epithelialized: Same definition, different uses

Consider that "newly epthelialized" has the same definition – wound bed ***completely*** covered with new epithelium – for pressure ulcers, stasis ulcers and surgical wounds, but the application of the term changes according to the type of ulcer or wound, says Adams. Use the following tips, recommended by Adams, in deciding when it is appropriate to use "newly epithelialized." – *Maria Tsigas (mtsigas@decisionhealth.com), executive editor for the OASIS-C and Outcomes Solutions newsletter*

	Use	Don't use
Pressure ulcers	"Newly epithelialized" for ***closed*** stage 3 and stage 4 pressure ulcers. Closed stage 3 and stage 4 pressure ulcers can never be fully healed (the underlying tissue is abnormal and never goes back to full normality even if it closes), Adams says. However, those ulcers are considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue, according to the OASIS-C guidance manual.	"Newly epithelialized" for healed stage 1 and stage 2 pressure ulcers. Once these pressure ulcers have epithelialized, they are no longer considered present, according to the OASIS-C guidance manual.
Stasis Ulcers		"Newly epithelialized" for healed stasis ulcers as completely epithelialized stasis ulcers are considered healed and should not be reported on OASIS-C, according to CMS's October 2009 Q&As.
Surgical wounds	"Newly epithelialized" only after the wound bed has completely epithelialized. ***But,*** surgical wounds that are completely epithelialized (wound bed ***completely*** covered with new epithelium) for ***30 days***, are no longer considered surgical wounds and should not be counted in the OASIS-C skin items, according to the OASIS-C guidance manual. ***Important note*:** The terms "completely epithelialized" and "newly epithelialized" can be used interchangeably – they are the same, says Mackey.	

- **Base visit weights on acuity, not just visit type**. You have to get beyond the traditional admission versus non-admission model for weighting visits, Gammie says. For example, Celtic gives nurses extra credit for visits with high-acuity patients, such as those who require intensive wound care services. And clinicians receive less credit for those visits where they get help from paraprofessionals, such as LPNs and PT assistants, Gammie explains.

- **Use dashboards to track your success**. Gammie uses a clinician-based dashboard to track visit levels, historic performance and changes in caseload, he notes.

- **Put performance improvement staff in charge**. Celtic's performance improvement group works with clinicians to project the number of visits, and their probable length, based on the agency's disease-management and case-management protocols, Gammie says. That ensures clinical staff doesn't get stuck doing high-intensity, high-cost visits on patients who don't need them.

- **Give guidelines to the intake department**. Celtic's intake staff is trained to monitor nurse caseloads and to view visit levels over the entire episode, not just for the week ahead. When monitoring and assigning visits, intake staff consider whether visits are front-loaded, for example, and will thus lighten up in future weeks, Gammie explains.

- **Offer bonuses for productivity pickup**. Part of the productivity driver is clinicians' ability to earn bonuses if they consistently overshoot the six-visit mark, Gammie explains. "We have one nurse who blows the door off on visits, and earns up to 20% on top of her salary," he says. – *Sara Jackson (sjackson@decisionhealth.com)*

To transfer even a 5% HHA

(continued from page 1)

- "**A change in partners**, regardless of the percentage of ownership involved" *(HHL 11/23/09)*

By applying the rule to situations involving less than a 100% ownership interest, CMS is jeopardizing common ownership arrangements, says CPA Ted Cuppet of Dixon Hughes, a Morgantown, W. Va., accounting firm with many home health clients.

A particular target for CMS is the "turn-key" agency created to be sold quickly to a purchaser who wants to avoid the long wait for Medicare certification in areas that already have an oversupply of agencies.

Common transactions could be affected

One situation Cuppett has in mind, though, is an investor who purchases a 10-year-old agency – far beyond the rule's 36-month period – and wants to transfer an ownership interest to his son over time. A stock transfer as small as 5% would mandate recertification if it occurs within 36 months of the father's original purchase of the long-established agency, Cuppett notes.

Other common transactions Cuppett sees blocked by CMS's interpretation of the rule include issuance of

BENCHMARK of the Week

Staff compensation models by type of agency

Hospital-based agencies are nearly three times as likely as freestanding agencies to use an hourly compensation model for clinicians. Freestanding agencies, however, are five times more likely to use a pay-per-visit approach than hospital-based agencies.

The data are based on a national study of 900 home health CEOs. The study was sponsored by the National Association for Home Care & Hospice, the Hospital Home Care Association of America, RIM (the maker of Blackberry) and Fazzi Associates. *(See story, page 4.)*

	Salary	Hourly	Per Visit	Other
Freestanding	24.0%	25.3%	44.0%	6.7%
Hospital-based	13.4%	73.2%	9.6%	3.8%
Hospital-affiliated	17.1%	46.5%	22.5%	14.0%
Total	21.5%	35.1%	36.2%	7.1%

Source: Fazzi Associates in Northampton, Mass.

shares to a new investor, reducing the ownership interest of other shareholders and agreements that require a shareholder to offer his stock for purchase by the agency or other shareholders before offering it to outsiders.

For attorney Robert Markette, the question is whether CMS has changed the provision in the final 2010 PPS rule without allowing public comment.

The transmittal "transforms the 36-months rule from a one-time issue for new agencies into an ongoing issue for any agency that changes hands," adds Markette of Gilliland and Markette in Indianapolis. It's a move that may "have blindsided" some providers, he says.

What about the patients?

Because the 36-month rule requires operating agencies to re-apply for billing privileges, it forces affected HHAs to discharge their Medicare patients.

Home health consultant Arlene Maxim of A. D. Maxim Associates in Troy, Mich., for one, has three agency clients whose billing privileges ran out Dec. 31 and have had to find replacement agencies for some of their 100 Medicare patients.

The wait for the recertification can be up to a year if the HHA owner chooses to pay an accrediting organization to do it or at least two years for a state survey.

Maxim has notified CMS of the problem, but the federal Medicare agency hasn't responded so far, she says.

Pending ownership changes could be exempt

CMS staffers have indicated in their discussions with NAHC that they might reverse the transmittal's instructions and would exempt pending ownership changes from the 36-month rule.

The CMS transmittal currently states that the prohibition applies to ownership-change applications that were pending as of Dec. 31, 2009, as well as those received after Jan. 1, 2010. Because of the time required for the ownership change process, there were a number of ownership changes still pending Jan. 1 that now will be subjected to the 36-month rule, attorney Markette notes.

It also appears likely that replacement of partners who have resigned or died and transactions involving more than a 5% interest in an agency also will be allowed and won't be subject to the 36-month rule. But CMS still is weighing what the maximum allowable percent should be, says Bill Dombi, NAHC VP for law. – *Burt Schorr (bschorr@decisionhealth.com)*

Editor's Note: *See Transmittal 318, www.cms.hhs.gov/transmittals/downloads/R318PI.pdf.*

Get OASIS-C wound guidance

- Prevent incorrect answers to OASIS-C wound items by registering for the **"OASIS-C Wound Guidance: Interpret and Apply New Rules and Definitions"** audio conference on Jan. 14 from 1 to 2:30 p.m. For more details, link to: *www.decisionhealth.com/conferences/A1907/home.html.*

NAHC's concern: How CMS actually will calculate the 10% outlier cap

CMS's instructions on enforcing the 10% outlier cap have raised concern that they might shortchange high-outlier agencies by lowering the cap to less than 10% of total Medicare payments.

The issue was raised by the National Association for Home Care & Hospice. But a CMS spokesman ascribes the NAHC concern to "a misunderstanding" of what CMS says in a Dec. 23 transmittal to regional home health intermediaries about enforcing the cap. CMS's intention is to base the cap on "the total amount of HH PPS payments that have been made to [an] HHA during the current calendar year," as the 2010 PPS rule requires, the spokesman tells *HHL*.

To Bill Dombi, NAHC VP for law, the transmittal seemed to say that the cap would be based on non-outlier payments only, producing a payment cutoff equal to 9% or so of total payments. CMS intends to revise that language in a future transmittal in order to avoid "any other misunderstandings," the spokesman adds.

Whatever the calculation method, you won't receive an outlier payment if the total outlier reimbursement already paid equals 10% or more of your total Medicare payments, CMS states in its Dec. 23 transmittal explaining the changes. For such cases, the RHHIs will include reason code 45 in the remittance advice, indicating that the outlier payments haven't been paid.

While CMS expects the outlier cap to affect less than 2 percent of all Medicare HHAs, the reduced "fixed-dollar loss ratio" will mean that more episodes could qualify for outlier payments in 2010, warns John Reisinger, owner of Innovative Financial Solutions for Home Health in Tampa, Fla.

That could force some agencies to take extreme measures and stop taking all patients that could result in outlier episodes, Reisinger says. But agencies should be careful because such actions put agencies at risk for "alienating key referral sources."

HHA accepts outliers on a case-by-case basis

The outlier cap will force First Choice Home Health and Hospice to look at "how we accept patients," says Beau Sorensen, director of finance and operations for the agency in Orem, Utah.

The agency would have been over the outlier cap in 2009. In anticipation of the new requirement, it has moved to decrease its visit numbers by aggressively finding caregiver options and better educating major outlier referral sources, Sorensen says.

While referral sources weren't happy at first, the agency explained the situation and used the Federal Register to educate them about the new requirement.

In the future, the agency is considering adding outliers on a case-by-case basis, "but only if we feel that we can take care of them without compromising the care of our other patients," Sorensen says.

CMS will reconcile payments quarterly

Payments for subsequent claims may change whether agencies exceed the 10% cap. To account for those possible payment changes, the RHHIs will reconcile payments on a quarterly basis in February, May, August and November.

At that time, the RHHIs will reprocess all claims that originally included a calculated outlier amount but weren't paid. Payments will be adjusted to include the outlier amount if it should be paid at that time.

Some agencies have wondered whether episodes that span 2010 will count towards the outlier cap. CMS told *HHL* that episodes that have their last chargeable visits in 2010 will be reimbursed based on the 2010 PPS rule and will be subject to the 10% outlier cap. – *Marci Heydt (mheydt@decisionhealth.com)*

Editor's Note: *View the complete transmittal at: www.cms.hhs.gov/transmittals/downloads/R1883CP.pdf.*

Training opportunities:

Don't let the new outlier cap cost you patients

CMS's new outlier cap will cause some agencies to stop accepting potential outlier patients. Such actions could ruin referral relationships if not handled carefully. Join *HHL* for **"Managing Outliers Under CMS's 10% Cap"** audio conference to learn how to educate referral sources about the new requirement and how to educate patients about creative equipment and disease-management techniques that can prevent outlier episodes. For more details, link to: *www.decisionhealth.com/conferences/A1917/home.html*.

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