# Eli's Rehab Report

## Fraud & Abuse: Expect Therapy Pay Changes in Wake of Senate Report

**Senate investigation blasts 3 of the 'big 4' companies for gaming the system.**

Regarding home health therapy utilization, the Senate's verdict is in -- and it's not good. All four publicly traded home care companies under investigation changed their therapy practice patterns to take advantage of Medicare reimbursement under the prospective payment system that took effect in 2000, says a new report released by Senate Finance Committee staff. And three of the so-called big four companies had documents showing they "encouraged therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns," the report notes.

National chains Amedisys Inc., Gentiva Health Services Inc., LHC Group Inc., and Almost Family Inc. all showed therapy utilization patterns that corresponded to PPS's 10-visit therapy threshold that began in 2000 and six-, 14-, and 20-visit thresholds that began in 2008, Senate Finance investigators found in the probe that began last year after a critical Wall Street Journal article.

In the industry overall, the Medicare Payment Advisory Commission found that "episodes with the number of therapy visits between 10 and 13 increased by about 90 percent between 2002 and 2007 at an annual rate of 13.8 percent," the report says. "However, the percentage of episodes just above and below the 10 to 13 therapy visit range remained relatively unchanged during the same period."

When the Centers for Medicare & Medicaid Services implemented the three-tier therapy threshold system in 2008, "home health agencies rapidly altered their treatment patterns to match the new system, producing what MedPAC called 'the swiftest one-year change in therapy utilization since PPS was implemented,'" the report observes.

According to MedPAC figures, "payment for episodes with 6 to 9 visits increased by 30 percent, and the share of these episodes increased from 8.6 percent to 11.6 percent," the report points out. "Payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 14.5 percent.'' And the number of episodes at the 10 to 13 therapy visit range dropped 28 percent.

Statistics from the big four all showed dramatic therapy utilization changes in response to PPS incentives.

**Controversial Documents Uncovered**

And managers at three of the big four -- Amedisys, Gentiva, and LHC -- pushed the therapy-increasing agenda, the report charges. "The home health therapy practices identified at Amedisys, LHC Group, and Gentiva at best represent abuses of the Medicare home health program," the report says. "At worst, they may be examples of for-profit companies defrauding the Medicare home health program at the expense of taxpayers."

Senate investigators include quotes from scores of company documents as proof of the companies' pressure to inappropriately maximize therapy utilization, and append many of the documents as exhibits in the report.

For example: Amedisys management pressured its staff to adhere to new patient care guidelines that aligned with the new therapy threshold numbers in 2008, the report alleges. "It is imperative that we are compliant with the clinical tracks for Rehab that were made available to your agency December 2007," one Area Vice President wrote in a February 2008 e-mail. "There are only 3 of the 14 Therapy Tracks that have less than 14 visits to be scheduled... (T)he Clinical Managers are to work with the therapists to obtain the accurate track selection."

Another example: ''I see the push to treat by metrics not by what the patients need,'' one departing Gentiva physical therapist said in a May 2010 letter to CEO **Tony Strange**. ''Treating by numbers is ... making the clinicians feel their

professional judgment is being questioned. Again, not sitting on plateaus is understandable but pushing to thresholds based on what their diagnosis is, not by what the patient needs is just wrong.''

Senators weigh in: "Elderly patients in the Medicare system should not be used as pawns to increase a company's profits," Senate Finance Chair **Max Baucus (D-Mont.)** says in a release. "We are going to continue to crack down on these companies to ensure taxpayer dollars are used efficiently and Medicare patients are protected."

"The reimbursement policy encourages gaming, and gaming is what's occurred," Senate Finance ranking member **Charles Grassley (R-Iowa)** says in the release. "Companies are doing everything they can to make as much money as possible, whether the patients need the care or not."

Many industry members protest that the problem isn't with the publicly traded home care companies or the other home care providers with similar strategies, but rather with a payment system that provides a financial incentive for furnishing therapy services. Lawmakers "create the rules, organizations operate within them, and then they are surprised by the behavior that is the rational and logical result of the incentives they provide," says a typical comment on the Wall Street Journal website.

"There have been systemic Medicare payment problems since its inception in 2000," notes **Val Halamandaris** with the National Association for Home Care & Hospice. "We have long been concerned that the current model discourages home health agencies from providing the care that was appropriate for the individual patient needs."

This idea gets some support from the lawmakers. "The federal government needs to fix the policy that lets Medicare money flow down the drain," Grassley says in the release. "This can't wait until tomorrow. It should have been done yesterday."

**Will Therapy Utilization Disappear Entirely From PPS?**

CMS has made some improvements in this area, the Senate Finance staff concede. It has toughened up therapy documentation and assessment rules. And it has proposed 2012 PPS changes that would "redistribute PPS dollars from high therapy payment groups to other payment groups including groups with little to no therapy," the report points out. (Those changes are still pending until the PPS 2012 final rule comes out, likely later this month.)

"CMS's home health PPS enhancements are moving in the right direction," the report praises. But it concludes that "CMS must move toward taking therapy out of the payment model."

Why? "Providers have broad discretion over the number of therapy visits to provide patients and therefore have control of the single-largest variable in determining reimbursement and overall margins," the report highlights.

Bottom line: "CMS should closely examine any approach that focuses on patient well-being and health characteristics, rather than the numerical utilization measures," Senate Finance urges. The industry has a mixed reaction to this suggestion. Some applaud the move. Since PPS began, "home health care has recommended that Medicare set payment rates based on the nature of the patient rather than the volume of services rendered, therapy or otherwise," Halamandaris says.

Removing "the level and amount of therapy as a determent in payment... [has] the full support of the home health community," Halamandaris maintains. "There are better ways to go than continued reliance on the number of therapy visits for determining the payment amount."

But CMS put the therapy-related pay bumps into PPS to begin with for a reason -- to make sure patients who need therapy receive it. Therapists tell **Eli** they are worried that therapy services won't be valued under a PPS that doesn't recognize the resource costs of furnishing the service. CMS tried testing PPS models without therapy when it made the refinements in 2008, and it couldn't find a model that predicted resource use as accurately as the current one. Whether the agency can come up with an accurate PPS model in the future without therapy is up in the air.

In the meantime, NAHC expresses reservations about the currently proposed 2012 therapy changes. "We are somewhat concerned with the Medicare proposal that increases payments if the patient receives no therapy, while decreasing

payments if they do," explains Halamandaris. "Patients should get what they medically need, not what a payment model directs... There should not be incentives to deny patients' care anymore that than we should encourage unnecessary care utilization through a payment model."

Note: The Senate Finance 670-page report is at http://finance.senate.gov/imo/media/doc/Home_Health_Report_Final.pdf.