BENESCH
Attorneys at Law

October 2011

# Health Care Bulletin

## SENATE FINANCE COMMITTEE REPORT ON THERAPY UTILIZATION IN HOME HEALTH: MORE BAD NEWS FOR HOME HEALTH PROVIDERS

Therapy utilization in home health episodes has long been an area of suspected abuse. This suspicion has only intensified since Centers for Medicare & Medicaid Services (CMS) "refined" the home health prospective payments system (PPS). In May 2010, the scrutiny reached a new level when the Senate Finance committee launched an investigation into the therapy utilization practices of the four largest home health providers in the country. This investigation arose as a result of a *Wall Street Journal* article alleging home health agencies were gaming the home health therapy payment system to improve their bottom lines. On October 3, 2011, the U.S. Senate Finance Committee released a 670-page report outlining the results of its investigation. The Committee's report and its recommendations are very important to home health providers and their attorneys, because the Committee's report reaches the same conclusion as the *Wall Street Journal* and CMS: the agencies intentionally manipulated therapy utilization during home health episodes to improve their financial performance.

Therapy utilization is an issue in home health because of how home health agencies are paid for providing services. Home health providers are paid through PPS. The home health progressive payment system pays providers an episodic payment for care during a sixty-day period. The amount of the episodic payment is adjusted using a "case mix adjustment" to reflect the patient's condition and utilization of resources. The case mix adjustment is determined through use of the Outcome and Assessment Information Set (OASIS), which is used to perform an assessment of the patient and determine a "case mix score." The case mix score then places the patient in a particular home health resource group (HHRG), which determines the adjusted episodic payment.

In addition to the adjusted episodic payment, episodes that include therapy modalities--PT, OT, and Speech--receive a separate "bonus payment" intended to cover the additional costs of providing therapy, which are not included in the episodic payment. Under the original home health PPS, agencies would receive a bonus payment for episodes in which a patient received ten or more therapy visits. CMS was always concerned that this bonus payment would lead to providers designing care plans and/or recruiting patients with the goal of getting to the ten visit threshold. CMS had this concern because going from nine therapy visits to ten therapy visits led to an average reimbursement increase of 97.5%.

In 2008, CMS implemented a new therapy bonus payment system. The new system is tiered with bonus payments available at six, fourteen, and twenty visits. According to the report, in 2009 a review of the home health therapy utilization statistics identified "the swiftest one year change in therapy utilization since PPS was implemented." The Committee assessed this change for each agency and the report includes charts for each agency showing the pre-2008 and post-2008 therapy utilization patterns. In all four cases, there is a decrease in the percentage of episodes in the ten-to-thirteen visit range, with corresponding increases in episodes in the six-visit, fourteen-visit, and twenty-visit ranges. In one case, the percentage of episodes with more than twenty therapy visits went from 3.4% of all therapy visits in 2007 to 9.6% of all therapy visits by 2008.

In addition to the noticeable and sudden change in visit patterns, the Committee lists numerous documents that it feels show these agencies intended to manipulate the system:

- One agency developed and distributed an internal document that listed diagnoses in order of profitability and laid out a strategy to increase therapy visits for certain therapy cases, add therapy visits into non-therapy cases, and to substitute therapy visits for skilled nursing visits.

- An agency training document outlined the increase in profits to the company of adding just six therapy visits to 3% of the agencies congestive heart failure patients.
- An agency slide show outlined how treating a wound care patient with fourteen or twenty therapy visits would double the Medicare reimbursement for that episode.
- An agency altered its clinical recommendations related to therapy visits after the 2008 therapy changes.
- Another agency developed a competitive ranking system that served to drive therapy visit patterns towards more profitable levels. The highest ranking teams received encouraging company-wide emails and monetary bonuses.
- An agency training document noted the number of five-visit episodes and asked, "Could we have done one more visit?" Another document showed an employee was tasked with building a case to substantiate increased therapy.
- Internal emails identified top managers, including the chief executive officer, who instructed employees to increase number of therapy visits provided.
- Another email focused on the "new ten visit threshold" as being six visits and stating LHC needed to move out of the zero to five range and up to the six and seven to nine buckets.

Although the Committee cites this as evidence of the agencies' efforts to game therapy visits for money, the Committee does not believe this effort is limited to the four targeted agencies.

The Committee applauded CMS 2011 PPS changes to therapy reimbursement. The Committee also recommended CMS go further and adopt a reimbursement system that "focuses on patient well being and health characteristics, rather than numerical utilization measures." This would most likely involve an effort to incorporate therapy reimbursement into the HHRG and likely result in lower reimbursement for providers. Providers should realize that any change in the therapy reimbursement system will be monitored for accompanying changes in utilization patterns, as was done here. Sudden changes will be viewed as evidence of efforts to game the new system.

This report also serves as a reminder to home health providers and their lawyers: if providers are not already routinely auditing therapy documentation and monitoring therapy utilization, they should be. Home health therapy utilization has been heavily scrutinized and audited for years. This report will only serve to increase the scrutiny.

---

For more information, please contact a member of Benesch's Health Care Department:

**Benesch's Health Care Practice Group**

**Cleveland**

**Harry Brown** (216) 363-4606 or hbrown@beneschlaw.com

**Greg Binford** (216) 363-4617 or gbinford@beneschlaw.com

**W. Cliff Mull** (216) 363-4198 or cmull@beneschlaw.com

**Daniel O'Brien** (216) 363-4691 or dobrien@beneschlaw.com

**Beth Rosenbaum** (216) 363-4519 or brosenbaum@beneschlaw.com

**Meredith Rosenbeck** (216) 363-4195 mrosenbeck@beneschlaw.com

**Alan Schabes** (216) 363-4589 or aschabes@beneschlaw.com

**Columbus**

**Frank Carsonie**, Chair (614) 223-9361 or fcarsonie@beneschlaw.com

**Janet Feldkamp** (614) 223-9328 or jfeldkamp@beneschlaw.com

**Benjamin Parsons** (614) 223-9366 or bparsons@beneschlaw.com

**Marty Sweterlitsch** (614) 223-9367 or msweterlitsch@beneschlaw.com

**Indianapolis**

**Robert W. Markette, Jr.** (317) 685-6128 or rmarkette@beneschlaw.com

**White Plains**

**Ari J. Markenson** (914) 682-6822 or amarkenson@beneschlaw.com