COMMITTEE ON FINANCE
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For Immediate Release
May 13, 2009

Contact: Scott Mulhauser/Erin Shields (Baucus)
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(202) 224-4515

BAUCUS, GRASSLEY QUESTION FOR-PROFIT HOME HEALTH AGENCIES ON RELATIONSHIP BETWEEN OPERATING PROCEDURES AND REIMBURSEMENTS

Finance leaders begin investigation after data suggests agencies intentionally increased the frequency of home health visits to trigger higher reimbursement rates

Washington, DC – Senate Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Chuck Grassley (R-Iowa) today sent a letter to the four largest for-profit home health care agencies, asking questions about the relationship between the number of home health therapy visits they provided and the Medicare reimbursement rate for those visits. The Senators' letters come after a recent *Wall Street Journal* analysis, which found that as the Medicare reimbursement rate for home health care changed, companies changed their business practices to achieve higher reimbursements.

Baucus and Grassley also questioned the companies regarding their promotional material, after the Committee obtained a patient questionnaire that appeared to be designed to help the company target Medicare patients for which it could be reimbursed.

"Too many Americans count on Medicare to provide quality health care to allow the program to be manipulated for somebody else's profit," said Baucus. **"If for-profit companies want to work with the Medicare program, we have to hold them to a very high standard. Companies that work with Medicare should not be allowed to target seniors just because they have Medicare or adjust the way they care for patients simply to increase profits. I intend to closely review the practices of these and all companies working with the Medicare program to stop fraud, waste and abuse and ensure every dollar is used appropriately."**

"Every dollar wasted is taken away from Medicare beneficiaries," Grassley said. **"We need to make sure care is provided based on patients' best interests, not profit margins. So far, it appears that either the home health care reimbursement policy is flawed, some companies are gaming the system, or both. As the Senate committee of jurisdiction, we're working to figure out what's going on."**

The Senators asked Amedisys, Almost Family, Inc., Gentiva Health Services, Inc., and the LHC Group, Inc. to answer questions related to their internal policies and guidelines regarding the number of visits provided to each patient, after data indicated a connection between the number of visits and the rate of reimbursement. According to the *Journal's* analysis, after Medicare rates increased for patients receiving more than nine visits, the number of Amedisys patients who received 10 visits was three times the number of patients who received nine visits. Baucus and Grassley also asked the companies about changes to their policies following changes to Medicare reimbursement rates in 2008, changes that were described by both the *Journal's* data and a March 2010 analysis by the Medicare Payment Advisory Commission (MedPAC). When the basis for Medicare payments shifted to 6, 14 or 20 visits, Amedisys patients getting 10 visits dropped by 50 percent, patients getting 14 visits rose 33 percent, and patients getting 20 visits increased 41 percent.

The Senators also asked the companies to provide marketing materials and guidelines for patients and physicians as well as the clinical criteria used in developing those materials. The Senators expressed concern that these companies were using marketing tactics to target seniors 65 years old and older so the companies could take advantage of Medicare payments to improve profits.

The full text of the Senators' letters to the agencies follows here.

May 12, 2010

William F. Bourne
Chief Executive Officer
Amedisys, Inc.
5959 South Sherwood Forest Blvd
Baton Rouge, LA 70816

Via Electronic Transmission

Dear Mr. Bourne:

As the Chairman and Ranking Member of the Senate Committee on Finance (Committee), we have a responsibility to the more than 45 million Americans who receive health care under the Medicare program to monitor whether safe and appropriate care is provided to beneficiaries and to ensure that program dollars are spent appropriately. This includes monitoring healthcare providers participating in the Medicare program, including home health agencies. While Medicare's home health benefit is essential to the more than three million beneficiaries who receive health care services within the comfort of their own homes, it has been vulnerable over the years to fraud, waste and abuse.

A recent article in the *Wall Street Journal* explored the relationship between the Centers for Medicare & Medicaid Services (CMS) home health payment policies and the utilization rates of some home health agencies (HHAs). The Medicare data reviewed for the article suggest HHAs intentionally increased utilization for the purpose of triggering higher reimbursements.

From 2000 through 2007, under the Medicare home health prospective payment system (PPS), home health agencies received an additional $2,200 in addition to the base reimbursement rate when HHAs made over nine therapy visits. During this period, the *Wall Street* Journal, reported that the number of patients Amedisys visited 10 times was three times higher than the number of beneficiaries visited nine times. In fact, a former employee of Amedisys stated that she had to "have ten visits to get paid" and "the tenth visit was not always medically necessary."

Starting in 2008, CMS revised home health PPS rules to provide additional payments at six, 14, and 20 therapy visits. These additional payments also became graduated within these intervals. The home health industry apparently changed their utilization patterns as a result of these payment policy changes. In March 2010, the Medicare Payment Advisory Commission (MedPAC) found:

> In 2008, the share of therapy episodes with decreased payments under the new system – those in the range of 10 to 13 therapy visits – dropped by about one-third…Conversely, volume increased for therapy episodes that have higher payment under the revisions. For example, in 2008 payment episodes with six to nine visits increased by 30 percent, and the share of the these episodes increased from 9 percent to 12 percent. At the higher end of the visit distribution, payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 15 percent. The immediate change in utilization demonstrates that home health providers can quickly adjust services to payment changes in the therapy visit thresholds.

According to an analysis by the *Wall Street Journal*, therapy visits by HHAs followed these shifts. For example, "In 2008, the percentage of Amedisys patients getting 10 visits dropped by 50%, while the percentage that got six visits increased 8%. The percentage of patients getting 14 visits rose 33% and the percentage getting 20 visits increased 41%."

The findings reported in the *Wall Street Journal* article are of great concern to us, especially since they appear to be confirmed by MedPAC's research. These findings suggest that HHAs are basing the number of therapy visits they provide on how much Medicare will pay them instead of what is in the best interests of patients.

We are also interested in "Balanced For Life," a "fall management" program which utilizes home health therapy visits paid for by Medicare. Our staffs have obtained a copy of the physician referral form for this program (Attached) which asks the patient, "Are you 65 years or older?" As 65 years is the age of eligibility for Medicare, the referral form raises concerns that the program may be taking advantage of Medicare payments in order to improve company profits.

In order to assist us in understanding more about these issues, please make the following available:

1) For each calendar year from 2006 through 2009, provide data showing the distribution in one day intervals from 1 to 30 of therapy visits for therapy episodes (episodes which include at least one therapy visit) by both number and percentage.

2) For each year from calendar 2006 through 2009, provide data showing the average score at admission for Medicare patients that received therapy visits for each of the following activities of daily living as reported in the Outcomes and Assessment Information Set (OASIS):
    a. Walking/Ambulation;
    b. Hygiene;
    c. Continence;
    d. Dressing;
    e. Eating;
    f. Toileting; and
    g. Transferring.

3) For each calendar year from 2006 through 2009, also provide:
    a. The total number of Medicare home health patients that received therapy visits from your company for that year;
    b. The total amount of Medicare reimbursement your company received for home health episodes that qualified for additional payments because of therapy visits provided; and
    c. The total amount of Medicare reimbursement your company received.

4) All internal documents, records, and communications relating to the 2008 Medicare payment revisions for home health therapy visits from January 1, 2007 to the present. Please include all communications regarding changes to the Amedisys Medical Software applications as a result of the 2008 Medicare payment revisions. In addition, include copies of all audit reports conducted internally and externally including draft and unfinished versions.

5) All internal policies and guidelines regarding the number of therapy visits provided per home health episode. Please include any prior policies and guidelines from January 1, 2007 to the present, including all modifications to those policies.

6) For each state in which you provide home health services, provide a list of the 10 physicians from whom you received the highest number of referrals for home health services in each of the calendar years 2006, 2007, 2008, and 2009. For each physician, please include the physician's specialty, location, and the number of referrals.

7) For each physician identified in the response to question 6, please provide all payments or transfers of value from your company, or any entity acting at your company's direction, to that physician for calendar years 2006, 2007, 2008, and 2009. This information should include:
    a. The recipient's name, business address, and specialty;
    b. A description of the form of payment or transfer of value (cash, stock, travel, meals, etcetera);
    c. A description of the nature of payment or transfer of value (royalty, consulting, speaking fee, gift, etcetera); and
    d. The date of payment.

8) Provide copies of all marketing materials produced for patients and physicians for calendar years 2006, 2007, 2008, and 2009.

9) Provide all copies of guidance or instructions to marketing staff on appropriate physician and patient marketing practices (including payments and transfers of value to physicians) for calendar years 2006, 2007, 2008 and 2009.

10) Indicate whether your company has a compliance program, and if so:
    a. Indicate whether you provide a toll free number for purposes of reporting inappropriate marketing activities;
    b. Indicate the number of times in each of the calendar years 2006, 2007, 2008 and 2009 complaints were received regarding marketing activities as well as the nature and resolution of each complaint;
    c. Provide documentation on the compliance program including previous policies from 2006 to the present.

11) Provide copies of all physician attestation forms with an explanation of the process for physician attestations for calendar years 2006, 2007, 2008, and 2009.

12) Please explain the clinical criteria consulted by Amedisys in drafting each patient question on the Balanced for Life – Fall Risk Assessment physician attestation form. (Attached)

13) Indicate whether you have medical directors serve each of your home health agencies. If so, please provide the following:
    a. Identify the duties and responsibilities of medical directors for your home health agencies;
    b. The average number as well as range of physicians that serve your home health agencies;
    c. The five most common specialties that are represented by medical directors across all your home health agencies;
    d. The average number of physicians in each of the specialties identified in question 12.b. that serve as medical directors at a home health agency of your company;
    e. The percentage of medical directors that are employees of your company and the percentage of medical directors that serve under contractual arrangement; and
    f. For medical directors that serve under contractual arrangement, identify the method of compensation as well as the average number and range of hours worked per week.

We would appreciate a response from you no later than June 2, 2010. In cooperating with the Committee's review, no documents, records, data or information related to these matters shall be destroyed, modified, removed or otherwise made inaccessible to the Committee.

Thank you for your attention to this important matter. Should you have any questions regarding this letter, please contact [Senate Finance Committee staff]. All formal correspondence should be sent electronically in PDF format to [staff].

Sincerely,

Charles E. Grassley
Ranking Member

Max Baucus
Chairman

May 12, 2010

William B. Yarmuth
Chairman and Chief Executive Officer
Almost Family, Inc.
9510 Ormsby Station Road
Suite 300
Louisville, KY 40223

Via Electronic Transmission

Dear Mr. Yarmuth:

As the Chairman and Ranking Member of the Senate Committee on Finance (Committee), we have a responsibility to the more than 45 million Americans who receive health care under the Medicare program to monitor whether safe and appropriate care is provided to beneficiaries and to ensure that program dollars are spent appropriately. This includes monitoring healthcare providers participating in the Medicare program, including home health agencies. While Medicare's home health benefit is essential to the more than three million beneficiaries who receive health care services within the comfort of their own homes, it has been vulnerable over the years to fraud, waste and abuse.

A recent article in the *Wall Street Journal* explored the relationship between the Centers for Medicare & Medicaid Services (CMS) home health payment policies and the utilization rates of some home health agencies (HHAs). The Medicare data reviewed for the article suggest HHAs intentionally increased utilization for the purpose of triggering higher reimbursements.

From 2000 through 2007, under the Medicare home health prospective payment system (PPS), home health agencies received an additional $2,200 in addition to the base reimbursement rate when HHAs made over nine therapy visits. During this period, the *Wall Street* Journal, reported that the number of patients a certain home health company visited 10 times was three times higher than the number of beneficiaries visited nine times. In fact, a former employee of this home health company stated that she had to "have ten visits to get paid" and "the tenth visit was not always medically necessary."

Starting in 2008, CMS revised home health PPS rules to provide additional payments at six, 14, and 20 therapy visits. These additional payments also became graduated within these intervals. The home health industry apparently changed their utilization patterns as a result of these payment policy changes. In March 2010, the Medicare Payment Advisory Commission (MedPAC) found:

> In 2008, the share of therapy episodes with decreased payments under the new system – those in the range of 10 to 13 therapy visits – dropped by about one-third…Conversely, volume increased for therapy episodes that have higher payment under the revisions. For example, in 2008 payment episodes with six to nine visits increased by 30 percent, and the share of the these episodes increased from 9 percent to 12 percent. At the higher end of the visit distribution, payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 15 percent. The immediate change in utilization demonstrates that home health providers can quickly adjust services to payment changes in the therapy visit thresholds.

According to an analysis by the *Wall Street Journal*, therapy visits by one of the leading home health companies followed these shifts. Apparently, the percentage of patients getting 10 therapy visits from one home health company dropped by 64 percent in 2008 from 2007. Also, the percentage of "patients of another home health company getting 10 visits dropped by 50 percent, while the percentage that got six visits increased 8 percent. The percentage of patients getting 14 visits rose 33 percent and the percentage getting 20 visits increased 41 percent."

The findings reported in the *Wall Street Journal* article are of great concern to us, especially since they appear to be confirmed by MedPAC's research. These findings suggest that HHAs are basing the number of therapy visits they provide on how much Medicare will pay them instead of what is in the best interests of patients.

In order to assist us in understanding more about these issues, please make the following available:

1) For each calendar year from 2006 through 2009, provide data showing the distribution in one day intervals from 1 to 30 of therapy visits for therapy episodes (episodes which include at least one therapy visit) by both number and percentage.

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    a. Walking/Ambulation;
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    g. Transferring.

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4) All internal documents, records, and communications relating to the 2008 Medicare payment revisions for home health therapy visits from January 1, 2007 to the present. Include copies of all audit reports conducted internally and externally including draft and unfinished versions.

5) All internal policies and guidelines regarding the number of therapy visits provided per home health episode. Please include any prior policies and guidelines from January 1, 2007 to the present, including all modifications to those policies.

6) For each state in which you provide home health services, provide a list of the 10 physicians from whom you received the highest number of referrals for home health services in each of the calendar years 2006, 2007, 2008, and 2009. For each physician, please include the physician's specialty, location, and the number of referrals.

7) For each physician identified in the response to question 6, please provide all payments or transfers of value from your company, or any entity acting at your company's direction, to that physician for calendar years 2006, 2007, 2008, and 2009. This information should include:
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12) Indicate whether your home health agency employs medical directors. If so, please provide the following:
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Sincerely,

Charles E. Grassley
Ranking Member

Max Baucus
Chairman

May 12, 2010

Tony Strange
Chief Executive Officer and President
Gentiva Health Services Inc
3350 Riverwood Parkway, Suite 1400
Atlanta, GA 30339

Via Electronic Transmission

Dear Mr. Strange:

As the Chairman and Ranking Member of the Senate Committee on Finance (Committee), we have a responsibility to the more than 45 million Americans who receive health care under the Medicare program to monitor whether safe and appropriate care is provided to beneficiaries and to ensure that program dollars are spent appropriately. This includes monitoring healthcare providers participating in the Medicare program, including home health agencies. While Medicare's home health benefit is essential to the more than three million beneficiaries who receive health care services within the comfort of their own homes, it has been vulnerable over the years to fraud, waste and abuse.

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The findings reported in the *Wall Street Journal* article are of great concern to us, especially since they appear to be confirmed by MedPAC's research. These findings suggest that HHAs are basing the number of therapy visits they provide on how much Medicare will pay them instead of what is in the best interests of patients.

In order to assist us in understanding more about these issues, please make the following available:

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Sincerely,

Charles E. Grassley
Ranking Member

Max Baucus
Chairman

May 12, 2010

Keith G. Myers
Chief Executive Officer
LHC Group, Inc.
420 West Pinhook Road, Suite A
Lafayette, LA 70503

Via Electronic Transmission

Dear Mr. Myers:

As the Chairman and Ranking Member of the Senate Committee on Finance (Committee), we have a responsibility to the more than 45 million Americans who receive health care under the Medicare program to monitor whether safe and appropriate care is provided to beneficiaries and to ensure that program dollars are spent appropriately. This includes monitoring healthcare providers participating in the Medicare program, including home health agencies. While Medicare's home health benefit is essential to the more than three million beneficiaries who receive health care services within the comfort of their own homes, it has been vulnerable over the years to fraud, waste and abuse.

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    e. The percentage of medical directors that are full or part-time employees of your company and the percentage of medical directors that serve under contractual arrangement; and
    f. For medical directors that serve under contractual arrangements, identify the method of compensation as well as the average number and range of hours worked per week.

We would appreciate a response from you no later than June 2, 2010. In cooperating with the Committee's review, no documents, records, data or information related to these matters shall be destroyed, modified, removed or otherwise made inaccessible to the Committee.

Thank you for your attention to this important matter. Should you have any questions regarding this letter, please contact [Senate Finance Committee staff]. All formal correspondence should be sent electronically in PDF format to [staff].

Sincerely,

Charles E. Grassley
Ranking Member

Max Baucus
Chairman

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