

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OFFICE OF
INSPECTOR GENERAL**

**The Physician's Role
in Medicare Home Health
2001**



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INSPECTOR GENERAL**

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EXECUTIVE SUMMARY

PURPOSE

To describe physicians' practices in prescribing, certifying, and monitoring Medicare home health services within the context of the Centers for Medicare and Medicaid Services' expectations.

BACKGROUND

The home health care environment has undergone a great deal of change within the last few years. This inspection is part of a larger body of work that the Office of Inspector General is conducting on Medicare home health services. For this study, we mailed questionnaires to 600 physicians who signed Medicare home health plans of care in the last 6 months of 2000. We supplemented these data with survey data from Medicare beneficiaries and home health agencies, as well as the Centers for Medicare and Medicaid Services (CMS) claims data.

FINDINGS

Physicians Play a Key Role in Medicare's Home Health Benefit

Virtually all physicians (97 percent) report that they have some familiarity with most patients for whom they sign a home health plan of care. Most physicians also say they are involved in identifying the specific home health services their patients need, with over half reporting that they work jointly with home health agencies or hospital staff to make these determinations. Eighty-six percent of physicians report that they see their patients at least once a month while they are receiving home health services.

Physicians Report a Lack of Knowledge of Medicare Home Health Rules

Physicians report that they are not clear on key Medicare rules. For example, 38 percent of physicians report that they are unclear on the Medicare criteria for "homebound." Half say that they are not clear on the definition to apply when certifying medical necessity.

Physicians Believe Not All Medicare Expectations of Them Can be Met

We found that most physicians know what CMS expects of them but many believe they are not able to provide this level of oversight of Medicare home health patients. For example, while 83 percent of physicians believe that Medicare expects them to ensure that only medically necessary services are on the plan of care, only 48 percent say they are able to ensure that this is the case. There is also a large difference between the percentage of physicians that believe Medicare expects them to ensure that home health

patients are homebound, and the number that believe they are able to do this (59 versus 26 percent). In addition to reporting concerns about their ability to meet CMS' oversight expectations, some physicians report being confused about the degree to which they can be held liable for inappropriate home health certifications.

Over Half of Medicare Physicians Are Unaware of New Home Health Prospective Payment System

About 60 percent of physicians report they have never heard of the Medicare home health prospective payment system, which went into effect October 1, 2000.

Effectiveness of Physician Payments is Questionable

Beginning in 1995, physicians were permitted to bill for care plan oversight in an effort to encourage additional physician involvement. Recent claims data indicate that physicians bill for care plan oversight at a rate of less than three percent of total home health claims. Regarding newly available payments for certification and re-certification of the plan of care, data for the first quarter of 2001 reveal that physicians billed for these payments at a rate of less than five percent. These low billing rates indicate that, at present, there is little willingness on the part of physicians to pursue these payments. Physicians report that there is too much paperwork involved in submitting these claims, and the payment amount is not high enough to make it worthwhile.

RECOMMENDATIONS

Physicians are currently playing an important role in initiating, certifying and monitoring the care for Medicare home health beneficiaries. However, they are doing so despite limited knowledge of key Medicare rules as well as discomfort with CMS' expectations. At present, the availability of reimbursement for their oversight role does not seem to be having a significant impact on physicians who care for Medicare home health patients. In order to address physician concerns and improve the Medicare home health services, we recommend the following.

- ▶ The Centers for Medicare & Medicaid Services should review relevant informational materials available to Medicare physicians to determine areas where improvements and clarifications can be made.
- ▶ The Centers for Medicare & Medicaid Services should establish a workgroup composed of physicians, home health representatives, and departmental designees, or utilize an existing workgroup such as the Practicing Physicians Advisory Council or the Physician Regulatory Issues Team to discuss issues related to Medicare home health care. We offer the following issues for consideration by the workgroup.

- The need for more effective and widespread home health education for physicians;
- Further clarification of payment and coverage policies, including the home health definitions for “homebound” and “medically necessary;”
- The simplification of home health certification forms;
- An analysis of the costs and benefits associated with the promotion of physician home visits;
- The possibility of requiring home health agencies to employ medical directors;
- The consideration of whether CMS oversight expectations of physicians can be realistically met; and,
- The creation of a system enabling patients to appeal if they feel they are receiving inadequate care.

COMMENTS

We received comments on our draft report from several physician and home health organizations: The American Academy of Home Care Physicians, The American College of Physicians-American Society of Internal Medicine, The American Medical Association, and The National Association for Home Care. These organizations generally agreed with our findings and recommendations. They also provided specific suggestions on how to increase physician understanding of the Medicare home health benefit and to promote further physician involvement with their home care patients. (We include these organizations' comments in full in Appendix E.)

We also received comments on our draft report from the Centers for Medicare & Medicaid Services (CMS). The CMS concurred with our findings and also made a number of technical comments that we incorporated into the report when appropriate. In addition, CMS had two methodological concerns. First, they expressed concern that our sampling time frame did not include a long enough period of time when the prospective payment system (PPS) was in effect. We acknowledge that our work occurred in the early stages of PPS implementation. However, it is important to note that physician knowledge of PPS is only one issue among several that we sought to address. Second, CMS stated that our sample may be biased against respondents who have had enough experience signing plans of care. We were also concerned about this. Therefore, in our methodology we included only physicians who signed two or more home health plans of care during the 6 month sampling time frame.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	i
INTRODUCTION	1
FINDINGS	
Physicians Play a Key Role	10
Physicians Report a Lack of Knowledge	11
Physicians Believe Not All Expectations Can be Met	13
Over Half of Medicare Physicians Are Unaware of PPS	15
Effectiveness of Physician Payments is Questionable	15
RECOMMENDATIONS	17
APPENDICES	
A: Selected List of Recent OIG Home Health Inspections	19
B: Chi-Square Test For Urban/Rural Differences	20
C: Confidence Intervals For Key Findings	21
D: Physician Non-Respondent Analysis	22
E: Comments	24

INTRODUCTION

PURPOSE

To describe physicians' practices in prescribing, certifying, and monitoring Medicare home health services within the context of the Centers for Medicare and Medicaid Services' expectations.

BACKGROUND

The home health care environment has undergone a great deal of change within the last few years. This inspection is part of a current series of four Office of Inspector General (OIG) inspections about Medicare home health care. *Medicare Beneficiary Experiences With Home Health Care OEI-02-00-00560*, looks at the experiences of Medicare beneficiaries in accessing and receiving home health care. *Access to Home Health Care After Hospital Discharge 2001 OEI-02-01-00180*, assesses the effects of the prospective payment system on access to home health care for Medicare beneficiaries who are discharged from the hospital. *Medicare Home Health Care- Beneficiaries From The Community OEI-02-01-00070*, looks at access to home health for beneficiaries who have not recently been in the hospital. See Appendix A for a list of other recent OIG reports relating to home health care.

This inspection also follows up on a June 1995 study on the physician role in providing home health care. In that earlier report, the OIG found that physicians were most involved in referring patients, approving plans of care, and monitoring the progress of complex patients. However, both home health agencies and physicians identified obstacles to effective physician involvement.

Medicare Home Health Care

Home health services consist of skilled nursing, therapy (physical, occupational and speech), and certain related services, including social work and aide services, all furnished in a patient's home. Services are typically provided by registered nurses, therapists, social workers, or home health aides employed by or under contract to a home health agency (HHA). These agencies can be free-standing or hospital-based and are classified as not-for-profit, proprietary, or governmental.

Medicare will pay for home health care only if it is reasonable and necessary for the treatment of the patient's illness or injury. In order to be eligible for services, a beneficiary must be homebound, be under the care of a physician who has established a plan of care, **and** need at least one of the following intermittent and not full time skilled

services: skilled nursing care, physical therapy, speech therapy, and continued occupational therapy at the start of care. (Occupational therapy alone does not constitute a skilled need. However, after care has begun and other skilled services are discontinued, continued occupational therapy is a skilled need.) Home health aide visits are covered to the extent that the aide services support the skilled need of the beneficiary. There are no specific limits on the number of visits or length of coverage and no co-payments or deductibles apply.

Trends in Medicare Home Health Care

After a history of increases, Medicare home health expenditures have dropped since 1998. Between Fiscal Years 1991 and 1997, Medicare home health care annual expenditures rose from \$4.7 billion to \$17.6 billion. This was due to an increase in both the number of beneficiaries receiving home health services and the number of visits they received. In 1998, however, spending for home health services began to drop and in Fiscal Year 1999 was about \$8.7 billion. Furthermore, the average home health length of stay has declined from 98 days in 1997 to 58 days in 1999, and the number of beneficiaries served has decreased by 22 percent¹.

A number of factors have contributed to the recent decrease in Medicare home health spending. These include interim payment limits created by the Balanced Budget Act of 1997, as well as several initiatives that were implemented in response to concerns about fraud and abuse. Specifically, the Health Insurance Portability and Accountability Act substantially increased financial support to the OIG's fraud control efforts.

The Physician's Role in Home Health Care

Physician as the "Gatekeeper"

The Centers for Medicare and Medicaid Services (CMS) require that a physician sign every patient's individual plan of care certifying that the patient is homebound and the planned services are medically necessary in order for the home health agency to be reimbursed for Medicare covered services.² This role that CMS is relying on physicians to fulfill is sometimes thought of as a "gatekeeper." Historically, many physicians have focused their attention on the determination of their patients' medical needs and have been less comfortable with the "gatekeeper" role.

Physician liability fraud alert

In January 1999, the OIG released a special fraud alert directed to the physician community that addressed their role in certifying Medicare home health services for their patients. The Fraud Alert was issued "because physicians may not appreciate the legal

¹Comparisons are between the first 2 months of 1997 and the analogous period in 1999.

²Medicare home health regulations, 42 CFR 484.18, require physicians to establish, sign, and periodically review a plan of care specifying all services the patient is to receive. The plan of care must be re-certified every 60 days.

and programmatic significance of certifications they make in connection with the ordering of home health care for Medicare beneficiaries.” It stresses the significance of their responsibility as the party who certifies the medical necessity for home health care, signs off on the level of services needed, and certifies that the patient is homebound. The Fraud Alert also emphasizes the need for the certifying physician to have firsthand knowledge of the relevant patient.

The Fraud Alert notes that “a physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence,” but that “knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties.” However, in our pre-inspection discussions with physicians, it was apparent that there is a significant amount of confusion surrounding the physician liability issue. Many physicians were aware of the fraud alert and mistakenly thought that it held them personally liable in all cases. Some physician groups and home health agencies indicate that physicians have become less willing to sign off on Medicare plans of care as a result of the Fraud Alert. The OIG recently issued the final version of the Compliance Program Guidance for Individual and Small Group Physician Practices. A major focus of this guidance is on the difference between “erroneous claims” and “fraudulent claims.”

The physician’s role under the prospective payment system

Recent changes in the way Medicare reimburses home health agencies have affected the physician role in home health care envisioned by CMS. The Balanced Budget Act of 1997 required that the existing cost-based home health payment system be replaced with a prospective payment system (PPS) of fixed, predetermined rates. Prior to the implementation of PPS on October 1, 2000, home health agencies were reimbursed based on what it costs to provide services to Medicare beneficiaries. As a result, there was a financial incentive for HHAs to provide more services than might be necessary. As indicated earlier, under this system the physician was seen as the “gatekeeper,” responsible for ensuring that patients only received services that were medically necessary. Under the new prospective payment system, financial incentives have changed somewhat, and physicians are now being asked to fulfill a dual role. The CMS is still relying on physicians to ensure that Medicare beneficiaries are homebound and have a need for medical services. However, because agencies are now paid fixed, pre-determined rates, there may be an incentive for some home health agencies to limit the services provided within a given episode of care. As a result, physicians are now also being called upon to ensure that patients get appropriate care, as well as a sufficient amount of care.

In a recent directive sent to Medicare Carriers, CMS provided guidance on this new physician role and directed the Carriers to alert physicians about their new responsibilities under the prospective payment system. This program memorandum indicated that “physician responsibility in the PPS environment is to be the determiner of the patient’s health care needs and advocate for the services required to meet those needs.” The physician’s role is no longer simply that of a “gatekeeper” for the duration of home care

services. Instead, under PPS the physician role has become one of “gatekeeper” at the onset, ensuring that the patient is eligible for Medicare home health services, then, subsequent to the start of home health, physicians are expected to ensure that the patient is not short-changed with regard to the services that Medicare is paying the agency to provide. It is worth noting that there are no specific guidelines as to what level of service a given type of Medicare beneficiary should receive. The physician is expected to make this determination as the patient’s advocate.

Prospective Payment System Reimbursement

Under the new prospective payment system, reimbursement is based on each 60-day episode of care. For initial episodes, the home health agency receives 60 percent of its estimated payment for services up front when it submits a Request for Anticipated Payment. Although a physician signed plan of care is not required prior to the submission of the Request for Anticipated Payment, home health agencies must receive and substantiate a physician order before this request can be made. This can be done through one of three alternative processes set out in recently revised CMS regulations. One alternative is for agencies to record the physician’s verbal order in the patient’s plan of care, including a physician description of the patient’s condition and the services to be provided. This verbal order must be signed and dated by the agency’s registered nurse or therapist and a copy of the plan of care must be immediately submitted to the physician. A second alternative is for the physician to write out a prescription for services, again including the patient’s condition and the services to be provided. Finally, agencies can follow the previously established procedure and have the physician sign the plan of care prior to submitting the Request for Anticipated Payment. Under the new procedure, a signed plan of care is required by the end of the 60-day episode in order for the HHA to receive the remaining 40 percent payment.

Physician Payments for Oversight and Certification of the Plan of Care

Payment for care plan oversight

In an effort to encourage additional physician involvement, beginning in 1995, CMS regulations have provided for physician reimbursement for care plan oversight. Physicians (as well as nurse practitioners, physician assistants, and clinical nurse specialists) may bill Medicare for this under CPT code 99375.³ On January 1, 2001, the national average payment rose from \$99 to \$122.

³ Since 1995, the code used to bill for home health care plan oversight has changed a number of times for a variety of reasons. As of January 1, 2001, the code is temporary HCPCS code G0181.

In order to bill for care plan oversight, the following conditions must be met:

1. the beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
2. the care plan oversight services should be furnished during the period in which the beneficiary is receiving Medicare covered home health care services;
3. the physician who bills for care plan oversight must be the same physician who signed the home health plan of care;
4. the physician must furnish at least 30 minutes of care plan oversight within the calendar month for which payment is claimed; and,
5. no other physician can be paid for care plan oversight for the same patient during the relevant month.

The CMS representatives indicate that the number of physicians claiming care plan oversight reimbursement has been below projections. Some believe this indicates that the availability of this reimbursement has not increased physician involvement in the way it was hoped. This has led to ongoing discussions about other approaches that might be effective in increasing physician involvement.

New payment for certification of plan of care

Another change related to physicians with home health patients involves new payments for physician certification and re-certification of patients' plans of care. As of January 1, 2001, physicians are able to bill for these services under HCPCS code G0180, for certification, and HCPCS code G0179, for re-certification. The final rule establishing these payments indicates that the "certification (and re-certification) services being paid for include creation and review of a plan of care for a patient and verification that the home health agency initially complies with the physician's plan of care." In addition, these payments include "the physician's work in reviewing data collected in the home health agency's patient assessment, including Outcome and Assessment Information Set (OASIS) data." CMS does not require physicians to review the OASIS, but if they do, this work is included in the payment for certification or re-certification.

The CMS introduced these new payments in hopes of increasing physician involvement, particularly given the implementation of the prospective payment system. Physicians will be able to claim these payments in addition to reimbursement claimed for care plan oversight. Unlike care plan oversight, nurse practitioners, physician assistants and clinical nurse specialists cannot bill for certification or re-certification of the home health plan of care. Physician payments for these services will be, on average, \$73 and \$61, respectively.

Physician Group Established by the Centers for Medicare and Medicaid Services

The Physician Regulatory Issues Team was created by CMS in 1998 to help make Medicare rules clear and reasonable for physicians. The Team provides physicians with a forum to discuss how Medicare regulations and other program rules and guidelines affect their practices and their patients. One of its main goals is to reduce the regulatory burden on physicians.

Prior OIG Work on Physician Involvement in Home Health Care

Two previous OIG studies have examined physician involvement in Medicare home health care. As indicated earlier, *The Physician's Role in Home Health Care*, OEI-02-94-00170, surveyed both home health agencies and the physicians who referred patients to them. The study provided a description of physicians' involvement in home health at the time. It found that physicians were most involved in referring patients, approving plans of care, and monitoring the progress of complex patients. They appear to have been less involved in coordinating services, visiting patients at home, and participating in interdisciplinary conferences. Physicians and agencies both cited problems in communicating with each other and difficulties in getting the plan of care signed. Some agencies felt physicians lacked adequate education in home health care and an understanding of the home health benefit.

Another OIG report issued in 1996, *Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York, and Texas*, A-04-96-02121, found that 40 percent of services in a sub-sample of the home health claims reviewed did not meet Medicare reimbursement requirements. These inappropriate claims included services not reasonable and necessary, services to beneficiaries who were not homebound, services that did not have a valid physician's order, and services that did not have supporting documentation. The study found the majority of physicians relied on home health agencies to assess their patients' needs and to make the homebound determination. The audit report suggested that inadequate physician involvement was a leading cause of the unallowable services identified in the audit. In a follow-up audit conducted in 1998, *Review of Medicare Home Health Services in California, Illinois, New York, and Texas*, A-04-99-01194, the OIG found that the error rate for inappropriate home health services dropped to 19 percent; however, the error rate associated with payments for these services was higher at 30 percent.

Related Work

The American Medical Association (AMA) released a report in 1993 discussing two potential conflicts of interest physicians may come across in referring patients to home health care. In some instances, home health agencies may offer payment to physicians for their services or referrals. The AMA advises physicians not to accept these payments, as they may compromise physician objectivity in choosing the most appropriate home health agency for their patients' needs. Physicians may also come across situations where they may want to refer patients to agencies in which they have an ownership interest. The

AMA advises against this practice of self-referral unless the physician provides direct care under the agency or there is a community need for the agency and no alternative financing is available. In 1998, the AMA published a report entitled *Medical Management of the Home Care Patient: Guidelines for Physicians*. It provides an overview of the physician's role in home health care and discusses related Medicare policies and fraudulent practices.

A 1998 report released by the Massachusetts Medical Society, entitled *Physician's Practice Patterns, Attitudes Towards, and Perceptions of Home Health Care*, found that physicians in their sample were less than moderately involved in the selection of the home health agency. These physicians also reported a low level of knowledge of home care payments and regulations. At the same time, the physicians acknowledged the importance of improving physician education in these areas. Very few physicians reported submitting care plan oversight charges. The majority were not aware they could charge for oversight services. Only 39 percent of sample respondents reported making home visits. The study suggested that "while respondents are not satisfied with their current level of oversight, and would like to see a greater level of control, they don't wish to undertake this themselves."

METHODOLOGY

We obtained data for this study from a number of different sources. These included the following: a physician mail survey; a mail survey of home health care beneficiaries; a telephone survey of home health agencies; and, CMS claims data.

We conducted our mail surveys subsequent to the implementation of the home health prospective payment system which went into effect on October 1, 2000. In addition, our physician survey was conducted after the implementation of the calendar year 2001 physician payment fee schedule, which authorizes payments for certification and re-certification of the home health plan of care.

Sample Selection

Using the CMS National Claims History File, we identified all Medicare beneficiary HHA claims for services begun during the last 6 months of calendar year 2000⁴. Based on CMS data, we identified all physicians who signed the home health plan of care associated with the claim. To assure we had physicians that refer beneficiaries to home health with some frequency, we eliminated physicians who signed home health plans of care for only one beneficiary during the six month period. After eliminating duplicate physicians and invalid provider numbers, we then selected a simple random sample of 600 physicians.

⁴This sample was pulled during the third week of February 2001.

Physician Mail Survey

A self-administered mail questionnaire was sent to all 600 sample physicians. Our questions focused primarily on the experiences of physicians when ordering and overseeing Medicare home health services; obstacles they face in performing this function; whether the availability of additional Medicare payments provides sufficient incentive for physicians to be more involved in the provision of home health services to their patients; and, how, if at all, the physician role has changed since the implementation of the home health prospective payment system. In order to maximize our response rate, we sent a letter prior to the questionnaire, reminder postcards after the questionnaire, and a second mailing of questionnaires to non-respondents. We received responses back from 349 physicians, giving us an overall response rate of 58 percent.

Beneficiary Mail Survey

For this study, we included a limited number of questions as part of a larger self-administered mail questionnaire being sent by the OIG to a separate sample of Medicare home health beneficiaries. This questionnaire was sent to 700 beneficiaries with a usable address. Our questions focused primarily on beneficiary experiences with their physicians at the time home health care was ordered, as well as during their home health episode. The overall response rate for that survey was 74 percent.

Home Health Agency Survey

We conducted telephone interviews with a random sample of 30 home health agencies. Our questions focused on their perception of the physician's role in home health care. Due to the small sample size we consider these data descriptive in nature and do not project to the universe based on this data.

Analysis of Claims

We used the five percent sample of Part B claims from CMS' National Claims History File to determine how often physicians bill for care plan oversight. Our analysis involved looking at the percentage of HHA claims that had a physician care plan oversight bill associated with them in 1999 (as a proportion of all home health claims in that year). We also analyzed data from prior years to identify whether this percentage is increasing, decreasing, or remaining constant. Similarly, we identified the percentage of physicians who submitted claims for the certification or re-certification of care plans in the first few months of 2001, the year these payments became available.

In addition, we used National Claims Data to determine how familiar physicians are with their patients prior to signing their plans of care, as well as how much they remain involved with patients after they start receiving home health care. To do this, we identified **all** beneficiaries who started home health services in the last 6 months of 2000. We analyzed the number of patient visits billed to Medicare by the physician who signed the plan of care in the 12 month period preceding their signature on the care plan.

Similarly, we analyzed physicians' involvement once home health services began by looking at the number of patient visits billed by the physician for the duration of the patient's stay in home health, up to 3 months⁵.

Limitations

Our sample selection methodology focused on physicians who signed multiple plans of care in an effort to ensure that respondents had sufficient experience to answer our questions. Therefore, our results are projectable to physicians who sign more than one plan of care in a given 6 month period.

In addition, for all analyses where CMS claims data are utilized, data for more recent periods will be somewhat less complete than prior period data.

⁵Please note that **not** all beneficiaries included in this analysis received home health care for the entire 3 month period.

FINDINGS

Physicians play a key role in Medicare's home health benefit

A majority of physicians have had contact with patients prior to signing the plan of care

Virtually all physicians in our sample (97 percent) report that they have some familiarity with most of the patients for whom they sign a home health plan of care. A majority of Medicare patients (82 percent) concur with physicians, reporting that they know the doctor who ordered their home health. Recent claims data are consistent with the reported experiences of physicians and patients. These data show that 85 percent of all beneficiaries saw the physician who signed their plan of care at least once in the 12 months prior to the start of their home health care.⁶ At present, there is no requirement that physicians see patients before signing their care plan.

Physicians help determine and initiate home health services

Most physicians are involved in identifying the specific home health services their patients need. Over half report working jointly with home health agencies or hospital staff to determine the services their patients will receive. Another quarter say they do this themselves, while 15 percent leave the determination of what a patient needs to the home health agency.

Many physicians are also involved in finalizing the initial plan of care. Just under a third report they sometimes make changes to the plan of care. The majority of those who make changes do so when the home health agencies include different services than they think are appropriate. They also make changes to plans of care when they believe there are too many or too few services listed, or when a change in medication or patient needs occurs.

Recent changes in Medicare guidelines allow home health agencies to begin services immediately after receiving a physician verbal order or a signed prescription. Previously, agencies were required to wait for physicians to sign the plan of care to commence services. About half of physicians report they currently initiate services by providing a verbal order describing the services needed with just under a quarter saying they are providing a prescription. Only 21 percent say they sign the plan of care to initiate services⁷. The 30 home health agencies we spoke with also report that most physicians are now providing a verbal order to initiate home health services. It should be noted that all physicians are still required to sign the finalized care plans for their Medicare patients.

⁶Note that any additional claims that were submitted by physicians after 2/28/01 are not reflected in this analysis, possibly understating this percentage.

⁷Nine percent report that they initiate services in some "other way."

Physicians remain involved with their home health patients

Almost all physicians (86 percent) report that they see their patients at least once a month while they are receiving home health services. These visits include both office and home visits. Claims data generally support the reported experiences of physicians. Claims data indicate that during the 3 month period following the start of home health care, at least 60 percent of beneficiaries received services from the physician who signed their plan of care.⁸

Additionally, physicians report they spend some time communicating with home health agencies and reviewing their patients' records. About a third say they spend at least half an hour a month doing this for each patient, while 60 percent spend less than half an hour. Only 7 percent report that they do not spend any time communicating with home health agencies or reviewing their patients' records.

Overall, physicians are satisfied with the home health care their patients are receiving. Fifty-four percent report they are somewhat satisfied with their patients' care, while another 37 percent report they are very satisfied.

Few urban and rural differences

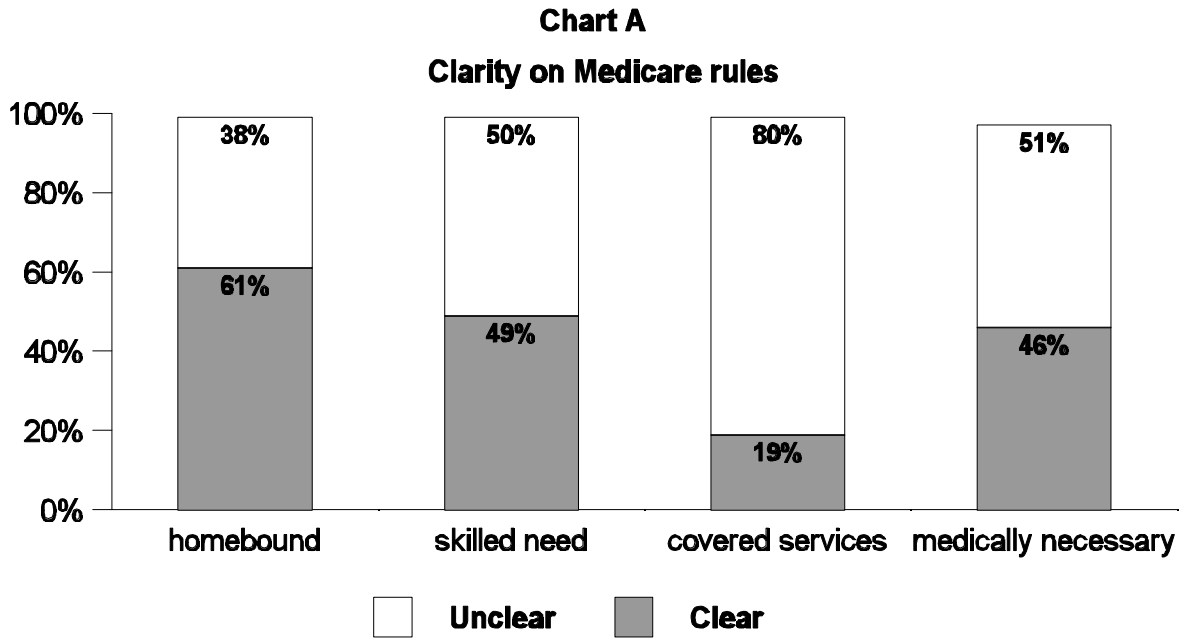
Because there is some concern that the experiences of home health patients differ by geographical region, we looked for differences in opinions and reported practices of the physicians in our sample that practice in rural versus urban areas. We found only two statistically significant differences in our key findings. First, more rural physicians report making the initial determination that Medicare home health services are needed, while more urban physicians report that someone other than the physician makes this determination. Secondly, more rural physicians report they would prefer that the oversight of home health patients be done by physicians, while more urban physicians report they would prefer the oversight role be performed by someone else. (See Appendix B for more information.)

Physicians report a lack of knowledge of Medicare home health rules

As indicated earlier, the Centers for Medicare and Medicaid Services require that all Medicare home health patients be certified by a physician as homebound to be eligible for home health services. However, as indicated in the chart on the next page, 38 percent of physicians report that they are unclear on the Medicare criteria for "homebound." In addition, just under half of all Medicare physicians report that they are not clear on the

⁸Note that additional claims that were submitted by physicians after 2/28/01 are not reflected in this analysis possibly understating this percentage and not all beneficiaries received home health services for the entire 3 month period.

definition they are expected to apply when certifying that planned home health services are medically necessary. Although Medicare does not explicitly require physicians to certify that a given patient has a “skilled need” or that a given medical service is, in fact, covered by Medicare, in practice there is a need for physicians to have knowledge of Medicare rules in these areas. However, a full 80 percent report that they are unclear on what services are covered by Medicare and 50 percent do not know what Medicare considers a “skilled need.”



* Note: percentages do not total 100 in each case due to non-response

Source: OEI physician survey, 2001.

Physicians rely on several sources for home health information

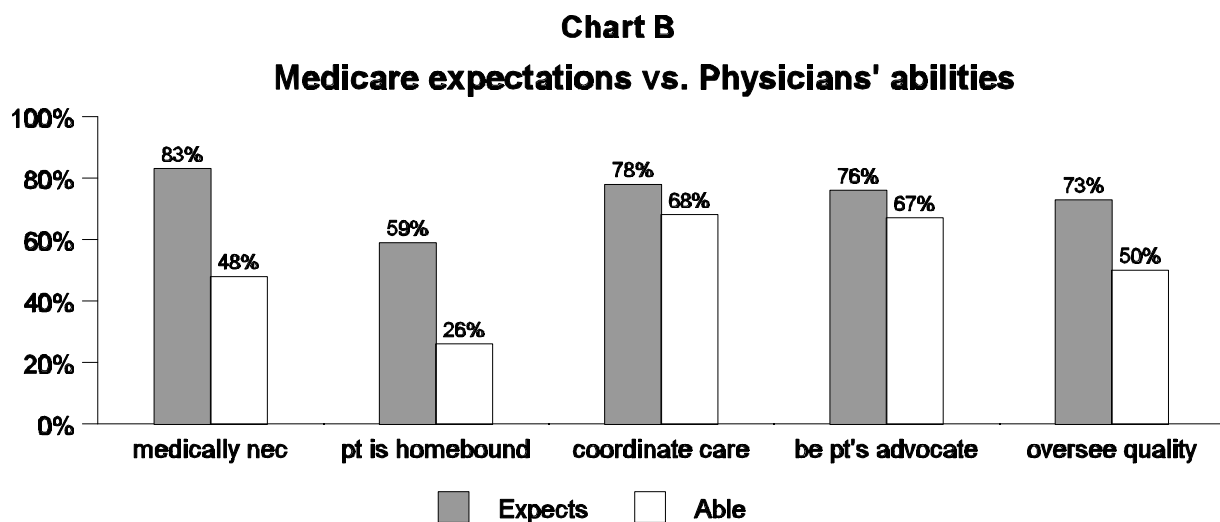
We asked physicians what guidance on home health, if any, had been most helpful to them. It is worth noting that the majority of physicians do not obtain their information from CMS. The top three answers they gave were: guidance from hospital staff such as discharge planners (76 percent), guidance provided by home health agencies (55 percent), and guidance from physician publications that cover home health issues periodically (16 percent). At present, only 11 percent of physicians report relying on program memoranda issued to physicians by Medicare Carriers. The number of doctors that report getting information from the Medicare website or Medicare conferences is also low, 1 percent and 5 percent respectively. When we asked physicians what suggestions they have for future initiatives to provide them with guidance about Medicare home health rules, just over 20 percent volunteered that they would like simplified information and more concise literature.

Physicians believe not all Medicare expectations of them can be met

Under the home health prospective payment system, the Centers for Medicare and Medicaid Services are relying on physicians to fulfill two distinct expectations. First, physicians are required to certify that Medicare beneficiaries are homebound and have a medical need for services. Secondly, because agencies are now paid fixed rates, possibly providing an incentive for some home health agencies to limit services, physicians are being relied upon to help ensure that patients get all of the care for which they are eligible. A recent CMS program memorandum indicated that “physician responsibility in the PPS environment is to be the determiner of the patient’s health care needs and advocate for the services required to meet those needs.”

Most physicians know what CMS expects of them but many believe they are not able to provide this oversight

We asked physicians a number of questions about the functions Medicare expects them to perform with regard to home health patients. In addition, we asked them whether they believe they are able to perform these functions. There is wide discrepancy between what physicians believe they are expected to do and what they believe they are able to do. For example, while 83 percent of physicians believe that Medicare expects them to ensure that only medically necessary services are on the plan of care, only 48 percent believe they are able to ensure that this is the case. There is also a large difference between the percentage of physicians that believe Medicare expects them to ensure that home health patients are homebound and the number that believe that they are able to ensure this (59 versus 26 percent). Chart B, below, provides additional information on the differences that exist between what physicians believe Medicare expects them to do and what they believe they are able to do.



Source: OEI physician survey, 2001

Interestingly, the 30 home health agencies we spoke with were more likely to say that physicians can fulfill CMS expectations than physicians were. Returning to the issue of whether physicians are able to ensure that only medically necessary services are on the plan of care, 24 of the 30 home health agencies we spoke to say “yes.” As indicated above, only 48 percent of physicians say they are able to do this. Sixteen of the home health agencies report that physicians can ensure patients are homebound, while only 26 percent of physicians report that this is the case.

Concerns over physician liability

In addition to reporting concerns about their ability to meet CMS’ oversight expectations, some physicians are confused about the degree to which they can be held liable for inappropriate certifications. One quarter of physicians report that they have heard about the 1999 Fraud Alert issued by the Office of Inspector General that addresses physician liability for home health certification. Of physicians aware of this directive, 24 percent volunteer concerns about being held personally liable for well intentioned certifications of their patients’ home health care. Another 10 percent report that they have been made nervous by the Fraud Alert.

In addition to finding concerns among physicians who are aware of the Fraud Alert, we found a large degree of misunderstanding on the part of all physicians. Only 25 percent correctly report that physicians can be held liable for inappropriate certifications only when they knowingly sign false or misleading certifications. The balance of physicians report incorrectly that they can be held liable for any inappropriate certifications they sign (41 percent) or that they have no clear understanding of what their liability may be (27 percent).

Physicians divided on who should perform the oversight role

Despite the fact that physicians report reservations about their ability to fulfill the role Medicare expects of them, there is no consensus on the issue of who should perform this function. Forty-one percent of physicians report that they would like to see independent case managers, an unspecified person, home health agency medical directors, or independent ombudsman perform this function⁹. However, 56 percent report that the oversight of home health patients should not be done by someone other than the physician.

⁹Three percent of physicians did not respond to this question on the survey instrument.

Over half of Medicare physicians are unaware of new home health prospective payment system

As indicated earlier, under the prospective payment system, physicians are being relied upon to ensure that patients get all the care for which they are eligible. We asked physicians whether or not they were aware of the new prospective payment system. About 60 percent of physicians report they have never heard of the Medicare home health prospective payment system (PPS), which went into effect October 1, 2000. Physicians who have heard of it, report having learned about it through physician publications, home health agencies, and hospital staff.

We asked physicians who are aware of PPS if the implementation of the prospective payment system has changed their interactions with home health agencies or Medicare beneficiaries. Seventy-three percent report that it has not affected their interactions with agencies or beneficiaries.

Effectiveness of physician payments is questionable

Beginning in 1995, physicians were permitted to bill for care plan oversight. Reasons for the implementation of this payment include a desire on the part of the Centers for Medicare and Medicaid Services to recognize work physicians were performing, as well as to encourage additional physician involvement. Recent claims data indicate that physicians bill for care plan oversight at a rate of less than 3 percent of total home health claims. This low billing rate indicates that, at present, there is little willingness on the part of physicians to pursue these payments. Historic data show that these billings have been consistently low since they became available in 1995.

Over two-thirds of all physicians report that they either do not know what constitutes home health care plan oversight or are not aware that they can bill for it. Of those physicians that report being aware that they can submit these bills, 82 percent say they choose not to. Physicians report that there is too much paperwork involved in submitting these claims and the payment amount is not high enough to make it worthwhile. In addition, many claim that it is unclear what Medicare requirements physicians must meet in order to qualify for reimbursement. In fact, a full one-third of the small number of physicians who are submitting bills to Medicare for home health care plan oversight report being unclear about requirements.

A similar story is unfolding with regard to newly available payments for certification and re-certification of the plan of care. We analyzed early data on physician billings for these payments. Data for the first quarter of 2001 reveal that physicians billed for these payments at a rate of less than 3 percent each.¹⁰ Ninety percent of physicians report being

¹⁰Based on physician claims received by April 30, 2001. Denominator is total number of Medicare home health claims submitted for the same period.

unclear on the requirements associated with certification/re-certification payments at the present time. Interestingly, despite a low initial billing rate and confusion about billing requirements, one-third of physicians report that they plan to submit bills to Medicare for these payments in the future.

We asked home health agencies if they believe the amount of time physicians spend with their home health patients has increased, decreased or remained the same since CMS' 1995 implementation of the care plan oversight payment. Fifteen agencies say it has remained the same; nine say the amount of time physicians spend with their home health patients has increased; one agency reports that the amount of time has decreased; and, five say they "don't know."

Physicians report desire for simplified rules and cite obstacles to more effective physician involvement

As indicated earlier, just over 20 percent of physicians volunteered that they would like to see simplified Medicare rules related to their role in certifying home health and more concise guidance on the subject. When asked what obstacles they see to increased physician involvement in monitoring Medicare home health patients, physicians cite burdensome paperwork, a lack of time, and limited Medicare reimbursement.

RECOMMENDATIONS

Physicians are currently playing an important role in initiating, certifying and monitoring the care for Medicare home health beneficiaries. However, they are doing so despite limited knowledge of key Medicare rules as well as discomfort with CMS' expectations. At present, the availability of reimbursement for their oversight role does not seem to be having a significant impact on physicians who care for Medicare home health patients. In order to address physician concerns and improve the Medicare home health services, we recommend the following.

- ▶ The Centers for Medicare & Medicaid Services should review relevant informational materials available to Medicare physicians to determine areas where improvements and clarifications can be made.
- ▶ The Centers for Medicare & Medicaid Services should establish a workgroup composed of physicians, home health representatives, and departmental designees, or utilize an existing workgroup such as the Practicing Physicians Advisory Council or the Physician Regulatory Issues Team to discuss issues related to Medicare home health care. We offer the following issues for consideration by the workgroup.
 - The need for more effective and widespread home health education for physicians;
 - Further clarification of payment and coverage policies, including the home health definitions for “homebound” and “medically necessary;”
 - The simplification of home health certification forms;
 - An analysis of the costs and benefits associated with the promotion of physician home visits;
 - The possibility of requiring home health agencies to employ medical directors;
 - The consideration of whether CMS oversight expectations of physicians can be realistically met; and,
 - The creation of a system enabling patients to appeal if they feel they are receiving inadequate care.

COMMENTS

We received comments on our draft report from several physician and home health organizations: The American Academy of Home Care Physicians, The American College of Physicians-American Society of Internal Medicine, The American Medical Association, and The National Association for Home Care. These organizations generally agreed with our findings and recommendations. They also provided specific suggestions on how to increase physician understanding of the Medicare home health benefit and to promote further physician involvement with their home care patients. (We include these organizations' comments in full in Appendix E.)

We also received comments on our draft report from the Centers for Medicare & Medicaid Services (CMS). The CMS concurred with our findings and also made a number of technical comments that we incorporated into the report when appropriate. In addition, CMS had two methodological concerns. First, they expressed concern that our sampling time frame did not include a long enough period of time when the prospective payment system (PPS) was in effect. We acknowledge that our work occurred in the early stages of PPS implementation. However, it is important to note that physician knowledge of PPS is only one issue among several that we sought to address. Second, CMS stated that our sample may be biased against respondents who have had enough experience signing plans of care. We were also concerned about this. Therefore, in our methodology we included only physicians who signed two or more home health plans of care during the 6 month sampling time frame.

Selected List of Recent Office of Inspector General Home Health Inspections

Office of Inspector General, US Department of Health and Human Services, “The Physician’s Role in Home Health Care,” OEI-02-94-00170, June 1995.

Office of Inspector General, US Department of Health and Human Services, “Medicare Beneficiary Access to Home Health Agencies,” OEI-02-99-00530, October 1999.

Office of Inspector General, US Department of Health and Human Services, “Medicare Beneficiary Access to Home Health Agencies 2000,” OEI-02-00-00320, September 2000.

Office of Inspector General, US Department of Health and Human Services, “Adequacy of Home Health Services: Hospital Re-Admissions and Emergency Room Visits,” OEI-02-99-00531, September 2000.

Office of Inspector General, US Department of Health and Human Services, “ Medicare Home Health Services: Survey and Certification Deficiencies,” OEI-02-99-00532, September 2000.

Chi-Square Test for Urban/Rural Differences

We computed Chi-square values for differences in physicians’ geographical place of work. All variables were analyzed at the 95 percent confidence level. As shown in the table below, only two variables showed statistically significant differences.

**Chi-Square Values for Testing Significance
of Geographic Place of Work**

Variable	Percents	Degrees of Freedom	Chi-Square	Probability	Significant?
Determination that patient needs home health: Physician Non-physician	<u>Rural</u> <u>Urban</u> 71% 57% 29% 43%	1*	4.45	.03	Y
Preference of person responsible for oversight: Physician Non-physician	<u>Rural</u> <u>Urban</u> 68% 55% 32% 46%	1*	4.00	.05	Y
Familiarity with patients prior to home health		3	1.65	.65	N
Time spent each month with a typical home health patient		1*	2.48	.12	N
Awareness of care plan oversight payment		3	0.35	.95	N
Knowledge of home health PPS		1*	1.97	.06	N
Ability to ensure patient is homebound		3	5.56	.13	N

* When testing for urban rural differences, response categories were combined in some instances in order to better understand any differences.

Confidence Intervals For Key Findings *

We calculated confidence intervals for key findings for physicians. The point estimate and 95 percent confidence interval are given for each of the following:

Key Findings	N	Point Estimate	
Virtually all physicians report that they have some familiarity with the patients for whom they sign a home health plan of care.	343	97%	+/- 1.8
Over half report working jointly with home health agencies or hospital staff to determine services for their patients.	343	55%	+/- 5.3
Almost all physicians see their patients at least once a month while they are receiving home health services.	343	86%	+/- 3.7
Thirty-eight percent of physicians report that they are unclear on the Medicare criteria for "homebound."	343	38%	+/- 5.1
Eighty-three percent of physicians believe that Medicare expects them to ensure that only medically necessary services are on the plan of care.	343	83%	+/- 4.0
Only 48 percent of physicians believe they are able to ensure that only medically necessary services are on the plan of care.	343	48%	+/- 5.3
Fifty-nine percent of physicians believe Medicare expects them to ensure that home health patients are homebound.	343	59%	+/- 5.2
Twenty-six percent of physicians believe they are able to ensure that home health patients are homebound.	343	26%	+/- 4.6
Of the physicians who are aware of the Fraud Alert, 24 percent volunteer concerns about being held personally liable for well intentioned certifications of their patients' home health care.	84	24%	+/- 9.1
Twenty-five percent of physicians correctly report that physicians can be held liable for inappropriate certifications only when they knowingly sign false or misleading certifications.	343	25%	+/- 4.6

* Note: The N values above include item non-respondents. Item non-respondents were included in the denominator used to calculate point estimates. These item non-respondents do not include those survey respondents who were instructed to skip the question at issue. In the majority of the findings above, item non-respondents numbered less than 10.

Physician Non-Respondent Analysis

We tested for the presence of any non-response bias in our sample. For this analysis, a physician who did not complete and return the survey is a non-respondent. We dropped six physicians from the overall sample who told us they did not sign plans of care.

To test for non-response bias in our sample, we analyzed two variables which might influence whether an individual would respond to the survey or that might affect his or her responses: geographical place of work and the number of home health plans of care signed by the physicians within a given 6 month period.

For the purpose of this analysis, geographical place of work was divided into urban and rural. For the number of home health plans of care signed within a given 6 month period, we divided the physicians into three categories:

1. Physicians with an average of less than one plan of care signed a month,
2. Physicians with an average of one but less than two plans of care signed a month, and
3. Physicians with an average of two or more plans of care signed a month.

These categorical variables were tested using Chi-square with the appropriate degrees of freedom. In order for the results to be statistically significant at the 95 percent confidence interval, the Chi-square value must be higher than 3.84 with 1 degree of freedom.

The results of this analysis are presented in Tables A and B. The Chi-square values given in the tables provide a test of difference between the distribution of respondents and of non-respondents for the variable of interest. Also provided in the tables are the response rates by the different values of the variables.

Tables A and B show no statistically significant differences between respondents and non-respondents for either geographical place of work or the number of home health plans of care signed by the physicians.

Table A
Geographical Place of Work*

	Respondents	Non-Respondents	Total	Percent
Urban	252 (46%)	193 (35%)	445	81%
Rural	70 (13%)	37 (7%)	107	19%
Total	322	230	552	58%
Chi-square= 2.74 Degrees of freedom= 1				

* The overall sample size is only 552 because there were no matches on the urban/rural indicator for 42 physicians.

Table B
Average Home Health Plans of Care Signed a Month

	Respondents	Non-Respondents	Total	
< 1 /month	206 (35%)	139 (23%)	345	58%
1-2 /month	83 (14%)	66 (11%)	149	25%
> 2 /month	54 (9%)	46 (8%)	100	17%
Total	343	251	594	58%
Chi-square= 1.38 Degrees of freedom= 2				

Comments

In this appendix, we present in full the comments from the Centers for Medicare and Medicaid Services, the American Academy of Home Care Physicians, the American College of Physicians-American Society of Internal Medicine, the American Medical Association, and the National Association for Home Care.



RECEIVED

Deputy Administrator
Washington, D.C. 20201

DATE: SEP 18 2001

2001 SEP 25 PM 2: 28

TO: Janet Rehnquist
Inspector General

OFFICE OF INSPECTOR
GENERAL

FROM: Ruben J. King-Shaw, Jr.
Chief Operating Officer and Deputy Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *The Physician's Role in Medicare Home Health 2001* (OEI-02-00-00620)

Thank you for the opportunity to review and comment on the above-referenced draft report regarding physicians' practices in prescribing, certifying, and monitoring Medicare home health services.

The OIG reports that physicians are currently playing a key role in initiating, certifying, and monitoring the care of Medicare home health beneficiaries, and they are doing so despite limited knowledge of Medicare home health rules as well as discomfort with the Centers for Medicare & Medicaid Services' (CMS) expectations. OIG also found that the availability of reimbursement for their oversight role does not seem to be having a significant impact on physicians who care for Medicare home health patients.

As a result, OIG recommends that CMS establish a working group composed of both physicians and departmental designees to improve communication and to consider modifying the physicians' home health oversight role. OIG further recommends that CMS review relevant informational materials available to physicians to determine areas where improvements and clarifications can be made.

One of the challenges that CMS faces is the need to provide education on the home health prospective payment system (PPS) to physicians who order the services infrequently. We have found that physicians who use home care infrequently rely on home health agencies (HHAs) and/or discharge planners for assistance in meeting Medicare requirements and, therefore, do not feel the need for home health PPS training.

In order to provide timely and consistent national training for physicians, HHAs, and our Medicare contractors, CMS has developed a national "train the trainer" program: a computer based training module quick reference guide, and a 5-hour satellite broadcast. We have also placed an article, "The Physician's Role In Home Health PPS," in carrier bulletins that were mailed to over 600,000 physicians.

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EAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
CCG	<input type="checkbox"/>
SpecSec	<input checked="" type="checkbox"/>
Date Sent	9-25-01

The Health Care Financing Administration (HCFA) was renamed to the Centers for Medicare & Medicaid Services (CMS). We are exercising fiscal restraint by exhausting our stock of stationery.

CMS provides one-on-one assistance over our toll-free help lines. Nearly 300,000 of the 2 million calls that our four regional home health intermediaries receive each month are physician calls. Toll-free calls are a major part of our educational and customer service strategies, but unfortunately, were not referenced in the OIG's report.

In October, we will begin a series of satellite training broadcasts for provider and customer service education at Medicare contractors. Once every quarter, a broadcast will focus on the training needs of staff at the regional home health intermediaries. We will use this network to work with our Customer Service Representatives including Medicare contractors, within budget limitations, to develop learning objectives around the four Medicare rules outlined in Chart A on page 12 of the OIG's report as follows: Homebound, Skilled Need, Coverage of Home Health Services, and Medical Necessity.

We believe it would be unrealistic to expect this change to happen within the next few months. Thus, while it can be reasonably expected that significant numbers of physicians reported an inadequate knowledge based on recent changes in home health and have not billed for plan of care certification or recertification, this could also be expected due to the magnitude of educating all the physicians in a short timeframe. The study also makes it clear that our efforts to better inform and enlist support from the physician community must compete with the many other priorities in a physician's practice.

On the whole, we believe the report appropriately challenges CMS to reach out more effectively to understand physician issues relative to home health and to redouble our efforts to make Medicare information, particularly regarding new program issues, more uniformly available. We have already undertaken initiatives with all provider groups, including physicians, to achieve a more responsive dialog as well as to simplify and reduce provider burden. In this context, we welcome the specific recommendations of this study.

OIG Recommendation:

Establish a working group composed of both physicians and departmental designees to improve communication with regard to the Medicare home health program. This would be particularly appropriate for consideration by the Physician Regulatory Issues Team (PRIT), which the Secretary has recently announced would be given a more prominent role.

CMS Response:

CMS is dedicated to working with physicians and other providers to clarify the physician's role in the Medicare home health program. The PRIT team has already begun addressing this issue and has given us some valuable feedback. The PRIT conducts a monthly conference call with representatives of state and specialty medical societies to discuss ways to improve the relationship between CMS and physicians. This issue will be placed on the agenda for an upcoming call. We will ask the director of the Practicing Physicians Advisory Council (PPAC), a committee mandated by Congress to advise CMS, to consider this item for an upcoming meeting. Finally, we note that both the PRIT and PPAC will be working with the Administrator in the Agency's New Open Door Initiative. This will be a third avenue for communications. We will assess the effectiveness of these efforts before forming an additional working group.

OIG Recommendation:

In conjunction with the above, the CMS should review relevant informational materials available to Medicare physicians to determine areas where improvements and clarifications can be made.

CMS Response:

CMS is renewing its commitment to improving communications with providers in the health care industry including expanding educational opportunities for those who serve Medicare beneficiaries. We have greatly expanded the resources available to physicians through our provider outreach Web page, at www.hcfa.gov/medlearn.

CMS's Provider Education and Training Division continues to work to improve physician understanding of the Medicare home health benefit. Toward that end, CMS has created a free on-line computer-based training course titled "Medicare Home Health Benefit, A Physician Guide." Physicians may access the guide from our Web site. In addition, we are in the process of writing a clarifying program memorandum on the Current Procedural Terminology code for care plan oversight. We are also planning a special mailing to physicians in October to remind them that they can bill for providing home care oversight services.

CONCLUSION:

We are fully committed to meeting the Medicare educational needs of physicians and other health care professionals. We see the OIG report as an important baseline against which we can measure our progress. We plan to request the Office of Management and Budget's (OMB) approval for a customer satisfaction survey of HHAs that we expect to launch in the Spring of 2002. We would appreciate a copy of OIG's instrument and would like to know when the respondents answered the survey.

METHODOLOGICAL CONCERNS:

The information in the draft raises some methodological questions. The sampling frame for the selection of physicians is based on the universal plans of care between July 2000 and December 2000. This period includes only 3 months during which home health PPS was in effect. Since 65 percent of the respondents sign less than one plan of care per month, this suggests that the sample may be biased against respondents who have had any experience with home health prospective payment system plans of care. We see some indication in the study that, as with Medicare beneficiaries, program knowledge is highly correlated with experience.

For instance, the following statistics are derived from the data included in the chart of the OIG report:

- Of the 83 percent of respondents who believed that they knew Medicare's expectations about medical necessity, 48 percent believed that it was possible to comply. (Pages 13 – 14)
- Of the 59 percent who believed they understood our expectations on "homebound," 26 percent believed that they could comply. (Pages 13 – 14)

- Two thirds of the respondents who submit bills for oversight are clear on CMS requirements. (Page 15)
- One third of respondents plan to submit oversight bills. (This would be a ten-fold increase over the estimate that OIG derived from early data.) (Page 15)
- The top three answers on where respondents get their information were discharge planners, HHAs and trade publications. (In future studies, we hope to shed some light on where the discharge planners, HHAs and publications get their information. We suspect that these intermediate sources of information get their information from CMS.) (Page 12)
- Only 20 percent of respondents identified simplified information from CMS as a priority. (Page 12)

TECHNICAL COMMENTS:

On page 4, last paragraph: the OIG might want to point out that physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) are only paid 85 percent of what a physician would be paid for care plan oversight. We are developing plans to provide additional clarification on PA, NP, and CNS billing for care plan oversight.

On page 5, third paragraph: the OIG might want to clarify that the physician is not required to review the OASIS, but if he or she does, this work is included in the payment for certification or recertification.

On page 11, second paragraph: we note that simply having a physician communicate with home health agencies does not describe the service of care plan oversight.



American
Academy of
Home Care
Physicians

ACADEMY of
AMERICAN HOME CARE
PHYSICIANS

September 14, 2001

Michael F. Mangano
Principal Deputy Inspector General
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RECEIVED
2001 SEP 21 AM 10:32
OFFICE OF INSPECTOR
GENERAL

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Baltimore, MD

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Treasurer

C. Gresham Bayne, M.D.
San Diego, CA

Secretary

Alan P. Abrams, M.D., M.P.H.
Cambridge, MA

Executive Director

Constance F. Row, FACHE

Dear Mr. Mangano,

Thank you for providing the American Academy of Home Care Physicians the opportunity to comment on the draft report "The Physician's Role In Medicare Home Health 2001."

As the professional society serving physicians committed to fostering the "art, science, and practice of medicine in the home", we are pleased to see that the Office of Inspector General has added this informative report to its previous work on physician involvement in home care.

Our Academy sadly concurs with the analysis of the data in the report. The report demonstrates clearly what our leadership has heard anecdotally about most physicians' lack of knowledge about and commitment to home care issues. The report also documents an outcome we feared and predicted when the Fraud Alert was issued - greatly reduced physician referrals to and involvement in home care.

The Academy strongly endorses the two recommendations in the report. Enhanced collaboration between the Centers for Medicare and Medicaid Services (CMS) and physicians interested in home care through a working group would be a valuable tool in improving education for physicians in this subject. We believe that such a working group should include representatives from relevant physician professional societies such as our Academy, home health agencies (HHAs) and CMS staff.

At the same time, we believe that the data in the report clearly points towards the need for a comprehensive set of strategies to improve physician involvement in management of home care for Medicare beneficiaries. As knowledgeable physicians who actively manage home care, we are certain that such physician involvement serves the interests of CMS and Medicare beneficiaries.

We describe below a number of strategies that address specific problems described in the report. In addition, the working group should be encouraged to develop additional recommendations.

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IG	_____
EAIG	_____
PDIG	_____
DIG-AS	_____
DIG-EI	_____
DIG-OI	_____
DIG-MP	_____
OCIG	_____
ExecSec	_____
Date Sent	9-21

American
Academy of
Home Care
Physicians



First, we recommend that the wide range of educational materials regarding home care that our Academy has already created, for our member newsletter, for our widely circulated journal, and for our other educational programs and initiatives, be disseminated even more widely. To accomplish this, we suggest that the CMS convene a meeting of relevant medical organizations to develop a plan for mass medical education through existing societies, associations, and medical schools.

President

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Second, we believe that all Medicare certified home health agencies should be able to assure that there is medical care for patients who do not have an ongoing relationship with a physician. This should be accomplished by requiring agencies to employ a medical director for such a purpose or by requiring relationships with physicians in the community to provide such care, even if it requires home visits to patients. Evidence for such a need is found in the report's statistics. It was noted that 15% of home care patients have not seen the physician who signed the home care certification in the year prior to home care and 40% of patients do not see a doctor over the 2 months after home care is initiated. This is inconsistent with standards for long-term care in other programs, such as nursing facilities or hospice. The unexpectedly low cost to Medicare for Care Plan Oversight (CPO) and certification / recertification of home care should allow CMS to provide HHAs with the additional resources needed to develop appropriate relationships with physicians.

Third, home health agencies should be enabled and encouraged to educate referring physicians regarding appropriate management of home care. This could be accomplished through CMS sponsorship of educational materials that HHAs could distribute. Our Academy would be pleased to assist in creation of such materials.

Fourth, barriers to performance of physician home visits should be reduced. Ideal oversight of home care services by physicians includes an in-person assessment in the home. We have identified four such barriers that are related to CMS policy and practice: 1) Medicare reimbursement for home visits should include costs associated with travel; 2) Reimbursement for physician visits to patients receiving home care in assisted living facilities and other domiciliary settings should be raised to previous levels, consistent with the costs of such visits; 3) Routine denials, audits, and requests for additional documentation related to home visits by Medicare carriers should be reduced to levels consistent with other types of outpatient activities; and 4) The primary care exemption for residency training programs' clinical practices should be expanded to include home visits. We have studied these matters in detail over the past few years and have developed solutions that we think are fiscally reasonable and operationally practical.

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Fifth, any existing linkage between certification of home care and reimbursement for CPO should be removed. Often a hospital-based physician will order home care and be asked to sign a certification form. An office-based (or home-care based) physician or nurse practitioner then manages the patient during the home care episode. To encourage active management and oversight of home care, there should be no requirement that CPO reimbursement is only available to the certifying physician (as described in the report).

Sixth, HHAs should be required to clearly identify on certification and recertification paperwork sent to referring physicians that a patient is receiving skilled services reimbursed by Medicare. There is a barrier to billing Medicare appropriately for certification / recertification due to the use of identical paperwork by HHAs for patients receiving Medicare skilled care and for those receiving custodial or skilled home care service reimbursed by Medicaid or other payers.

Finally, patients should be empowered to advocate for themselves in their relationship with HHAs. There are two complementary ways this could be accomplished. Both approaches place some responsibility on the patient to ask for assistance. One approach would be to require that HHAs inform patients of the role of the physician in ultimately determining the plan of care and time of discharge. Patients could be informed that they should contact their physician if they think they need more or longer home health services. Physicians, even with improved education, can not realistically be expected to recognize a problem with under-service by a HHA without such prompting. The other approach is through a formal appeals process. Peer Review Organizations (PRO) already play a role in responding to patients' concerns about premature hospital discharges. A similar role for the PRO in responding to complaints about premature home health discharges could be created.

As the only physician professional society committed specifically to home care, we appreciate the opportunity to comment on the report, and would be pleased to provide further information as desired. I will be in Washington, D.C. later this month and would be available to meet either on the afternoon of September 24th or early morning on the 26th.

Sincerely,

A handwritten signature in cursive script that reads 'Edward Ratner M.D.'.

Edward Ratner, MD
President
American Academy of Home Care Physicians

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September 25, 2001

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OFFICE OF INSPECTOR
GENERAL

Michael F. Mangano
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HHS/Office of Inspector General
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Dear Mr. Mangano:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 115,000 physicians who practice internal medicine and medical students, is pleased to respond to your August 14, 2001 letter inviting us to comment on your draft inspection report, "The Physician's Role in Medicare Home Health 2001." As you know, the College worked with the Office of Inspector General (OIG) in identifying key issues this study should focus on from a physician's perspective, as well as offering input on the physician survey instrument used by the OIG to gather data for this report.

Overall, ACP-ASIM finds the draft inspection report both accurate and troubling. Most physicians do indeed want to provide a high level of care and supervision of their homebound patients. At the same time, physicians find the guidance, policies, rules, and certification/re-certification forms governing home health care issued by the Centers for Medicare and Medicaid Services (CMS) confusing and unwieldy. This undermines physicians' ability to properly authorize and effectively oversee home health care. We thus urge CMS to substantially improve its technical guidance and educational materials offered to physicians to address the following problem areas:

- CMS's criteria for determining a patient's homebound status need to be much more clearly spelled out, offering some clinical examples as further guidance;
- CMS needs to list precisely which home health services and durable medical equipment qualify as medically necessary, including guidelines on intensity and duration of service;
- CMS needs to simplify home health certification/re-certification forms so that only information essential about the patient's need for home health services is presented on the forms' face page;
- CMS needs to publish an explicit statement of its expectations for what constitutes appropriate physician care plan oversight of their homebound patients;

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Letter to Mike Mangano, page 2



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- In order to encourage greater physician participation in overseeing home health patients, CMS needs to publicize it now offers payment for rendering home health certification and re-certification decisions, as well as enhanced payment for care plan oversight;
- In order to deter a home health agency's incentive to underprovide care as a result of the shift to a home health prospective payment system, CMS needs to alert physicians to this potential problem and enlist their heightened vigilance to ensure patients receive an appropriate level of service from their home health agencies.

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ACP-ASIM has enjoyed a very positive, cooperative working relationship with the OIG over the last two and a half years, and hopes the comments provided above are helpful and can be included in the final version of your inspection report. Please contact Mark Gorden of our Washington staff at (202) 261-4544 if you have any questions pertaining to this correspondence.

Sincerely,

C. Anderson Hedberg, MD
C. Anderson Hedberg, MD, FACP
Chair
Medical Service Committee

American Medical Association
Physicians dedicated to the health of America

Robert W. Gilmore, MD 515 North State Street 312 464-5000
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September 19, 2001

Michael F. Mangano
Principal Deputy Inspector General
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Dear Mr. Mangano:

Thank you for the opportunity to review and comment on the draft inspection report on *The Physician's Role in Medicare Home Health 2001* (OEI-02-00-00620, July 2001).

The role of the physician in ensuring safe, appropriate and high quality care for patients in their own homes has been an issue of concern for the American Medical Association (AMA) for many years, as witnessed by over 30 resolutions before the House of Delegates, many reports, panels, and publications. This very timely report confirms much of the information we have received from our members as to the problems they encounter in trying to provide quality home health care. Our comments may be summarized as follows:

- The AMA is pleased that this survey establishes, without doubt, the commitment of practicing physicians to their patients and their universal involvement with their patients receiving home health care services – including identifying the need for the services and frequent observation of the patient (usually in the office), in the event of an illness that necessitates the home health services.
- The AMA continues to recommend that Medicare require the position of a paid (not volunteer) medical director for every home health agency. The current expectations that individual physicians can police the home health agency's provision of services are completely unrealistic. No other health care delivery system functions without a strong internal administrative structure for physician oversight of appropriateness and quality of care.
- The AMA believes that the establishment of a working group may be a good idea if the charge is more comprehensive than "improving communication." Instead, such a group, with representatives from physician professional societies, home care agencies and CMS staff, should examine the need for structural changes and solutions to the current extremely complex, ambiguous and inadequate processes and policies.

- Particular attention should be directed to the following issues raised by the report:
 - 1) Physician liability issues – physicians are required to sign every patient’s individual plan of care certifying that the patient is “homebound” (despite significant confusion about the criteria for homebound) and that the services are medically necessary. Why are physicians more at risk when referring a patient to home health care than when referring them to a hospital or nursing home? The wording of the certification is unclear and the expectations of the physician’s oversight abilities are excessive and unrealistic;
 - 2) Requiring home health agencies to have medical directors, who would be responsible for comprehensive oversight of processes of care and have the ability to investigate concerns raised by practicing physicians, implement corrective actions, and provide supervision of agency-wide programs to ensure appropriate care; and
 - 3) Improving general education of physicians in Medicare’s home health care benefit, and specifically providing clear definitions and instructions about payment and coverage policies.

Unfortunately, the lack of clear communication to physicians about Medicare’s home health policies is the rule, not the exception. A recent study by the U.S. General Accounting Office (GAO) found that 85% of the answers provided by Medicare carriers to GAO officials concerning frequently-asked questions were inaccurate or incomplete. Surveys by the AMA confirm that home health policies are among the most problematic of the many Medicare policies that have not been well-communicated to physicians.

The confusion surrounding the home health fraud alert also typifies the pervasive view within the physician community that the government’s attitude is that physicians are criminals trying to steal from the Medicare Trust Funds and their patients. The standards that are used by the OIG, CMS, and others to differentiate between fraudulent behavior and innocent mistakes have not been clearly articulated, leading even the most well-intentioned and diligent physicians to feel as if they could easily become the target of a criminal investigation. The AMA deeply appreciates the commitment of Secretary Thompson and other Bush Administration officials to reducing the bureaucratic complexity of the Medicare program and putting a stop to the criminalization of honest mistakes.

A more detailed discussion of the report is attached. Please contact Sandy Marks in our Washington office at 202-789-4585 if you have any questions regarding our comments on this report. Again, we appreciate the opportunity to review it in draft form.

Respectfully,


Robert W. Gilmore, MD



Mary Suther
Chairman of the Board
Val J. Halamandaris
President

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Honorable Frank E. Moss
Senior Counsel
Stanley M. Brand
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September 13, 2001

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RE: "The Physicians Role in Medicare Home Health 2001"

Dear Mr. Mangano:

Thank you for the opportunity to review the draft inspection report, "The Physicians Role in Medicare Home Health 2001." The Office of Inspector General plays a pivotal role in evaluating issues related to the Medicare Home Health Benefit. In past years, the OIG has made important contributions to improving the administration of the home health benefit. We believe that this report will help further refine the role played by physicians in providing home health services.

The report highlights the vastly differing views that physicians hold relative to their role as caregivers and gatekeepers for the Medicare program. The results of your evaluations strongly demonstrate that physicians take their role as the key figure in determining the plan of care for home health patients very seriously. Nearly all physicians indicated that they actively develop or participate in the development of the home health care plan of treatment. However, the evaluation results show a significantly different acceptance of the gatekeeping role that the Medicare program has placed on physicians. Not surprisingly, physicians expressed confusion regarding this role in terms of knowledge of the coverage standards and risks of sanctions or liability.

These results are consistent with the experiences of home health agencies nationwide. Physicians embrace their responsibilities as caregivers and are confused



regarding their role as Medicare coverage gatekeepers. In fact, home health agencies report that physicians are, at times, hostile to the imposed responsibilities as the supposed protectors of Medicare trust funds.

The report offers an alarming indication of the potential impact that occurs as a result of the physicians' confusion. It is notable that merely 25 percent of responding physicians correctly report that a physician can be held liable for inappropriate certifications only when they knowingly sign false or misleading certifications. Further, 24 percent of physicians aware of the OIG Fraud Alert volunteered unfounded concerns about being held personally liable for well-intentioned certifications of their patients' home health care. NAHC is aware that home health agencies and their patients have experienced increased hesitation by physicians in referring patients to home health services because of a fear of sanctions or liability. While the law is clear that physicians are held liable only for knowingly signing false or misleading certifications, it is apparent that the physicians' impression is that liability risk exists even for routine, non-coverage circumstances. The apprehension of physicians resulting from that misunderstanding causes adverse effects on patients' access to home health services.

The report offers limited recommendations for addressing any concerns raised by the findings. NAHC agrees with these recommendations and offers the following additional suggestions:

1. The recommended working group should include representatives from the Medicare home health community in addition to physicians and departmental designees. Improved communications are more likely achieved if all parties affected by those communications are involved.
2. CMS should not only review relevant informational materials available to Medicare physicians but also develop an active educational program which ensures expanded exposure of the physicians to information about the Medicare home health benefit. The program should involve home care providers.
3. The OIG should issue a revised and clarified Alert (not a Fraud Alert) explicitly informing physicians of the limited liability risks providing certification under the home health benefit.
4. CMS should evaluate whether the physicians' gatekeeping role should be altered or eliminated. Physicians cannot be expected to administer the Medicare home health benefit by providing expert application of such ambiguous coverage standards as the homebound requirement.
5. CMS should analyze the benefits and detriments to expanding physician certification authorization to nurse practitioners and physicians' assistants.

Mr. Michael F. Mangano
September 13, 2001
Page 3



With the implementation of the home health prospective payment system, the role of the physician in care oversight and planning takes on a heightened importance. The gatekeeping role of physicians on Medicare coverage issues is significantly subordinated to their role of insuring that patients receive an appropriate level of care to achieve the desired clinical outcomes. The change in provider incentives triggered by PPS means that overutilization risks are minimized. The report demonstrates that physicians are well prepared to maintain their role as patient care managers.

Thank you again for the opportunity to review this draft report.

Sincerely,

Val J. Halamandaris
Val J. Halamandaris (LMB)
President