HHS Issues Semi-annual Regulatory Agenda

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On October 29, 1997, the Department of Health and Human Services (HHS) published its semi-annual regulatory agenda. There are several notices of interest to health information management professionals.

Under the proposed rule stage, the Health Care Financing Administration (HCFA) is planning to publish a notice of proposed rule making in May 1998 to update the conditions of participation for rural health clinics. At press time, a notice of proposed rule making for the long-awaited revisions to the Medicare Hospital Conditions of Participation was planned for December 1997. The End Stage Renal Disease (ESRD) Conditions for Coverage is scheduled for publication in February 1998. A proposed rule to eliminate the requirement that Peer Review Organizations (PROs) conduct quarterly random sample reviews of hospital discharges is scheduled for September 1998. This rule would also change the period for PRO contracts from two years to three years and would eliminate certain notification requirements regarding contract awards. A notice of proposed rule making regarding revisions to the conditions for coverage for ambulatory service centers is expected in April 1998.

Under the final rule stage for resident assessment in long-term care facilities, HCFA plans to address the requirement to electronically report MDS data and to provide support for the computerization of the MDS. A final rule to revise the Home Health Agency Conditions of Participation is scheduled for June 1998. The use of OASIS as part of the Conditions of Participation for home health agencies is also scheduled for June 1998.

Additionally, there are a number of proposed rules and long-term actions that are under consideration. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of HHS adopt standards for administrative simplification by February 1998. It is anticipated that a number of proposed rules addressing these standards will be published shortly. Capital Currents will keep you updated as these notices are published.

Hearings Held on Home Health Fraud and Abuse

The Subcommittee on Oversight and Investigations of the House Commerce Committee held a hearing on October 29, 1997, to review numerous issues related to home health fraud, waste, and abuse. Chaired by Congressman Joe Barton (R-TX), the subcommittee has the responsibility for oversight of Medicare and Medicaid.

Home Health Audit

In June 1997, the HHS Office of the Inspector General (OIG) released a report: *Review of Medicare Home Health Services in California, Illinois, New York and Texas*. The audit found that 40 percent of the claims paid during the 15-month period ending March 31, 1996, were paid in error. This equates to a $2.6 billion loss for the Medicare program in the aforementioned states. According to the audit, the incorrect claims reimbursement is attributed to four factors: unnecessary services, patients who are not homebound, inadequate physician authorization, and lack of documentation. In a later audit, it was discovered that the entire Medicare program maintains a 14 percent error rate.

Although home health has received much attention over the past several years, the four-state audit appears to have prompted action from both the Clinton administration and Congress to address fraud, waste, and abuse in the home health program. Congress made numerous legislative changes to the home health program in the Balanced Budget Act of 1997 (PL 105-33) and President Clinton announced a moratorium on new home health agencies entering the program in September 1997.

Hearing

In response to the recent developments with the home health program, Barton convened the hearing to explore several issues:

- The need to define "home health" and its purpose

- Determining whether the home health moratorium is good or bad
- The current situation regarding home health fraud, waste, and abuse
- The OIG audit reports

Subcommittee members attending the hearing included Rep. Ron Klink (D-PA), ranking minority member; Rep. Tom Coburn (R-OK); Rep. Eliot Engel (D-NY); Rep. Greg Ganske (R-IA); and Rep. Bart Stupak (D-MI).

Opening statements from the subcommittee members were fairly consistent with Bartons' intentions. Coburn, an Oklahoma physician who says the home health program "is designed for fraud," offered the most critical analysis. His recommendation was to redesign home health based on its original intent.

The first two panels consisted of four witnesses from the administration:

- June Gibbs Brown, inspector general, HHS
- Charles S. Owens, financial crimes section, Federal Bureau of Investigation (FBI)
- Linda A. Ruiz, director of program integrity, HCFA
- William J. Scanlon, director, health financing and systems issues, Health, Education and Human Services Division of the US General Accounting Office

Testimony presented from the administration personnel was fairly consistent. The witnesses all offered their support for the home health moratorium and the additional steps enacted in the Balanced Budget Act of 1997.

According to June Gibbs Brown, HHS Inspector General, waste, fraud, and abuse in the home health program can be attributed to unjustifiable payment variation, improper payments, problem providers, and outright fraud. Citing the negative results of the home health audit, Brown offered these recommendations to combat fraud, waste, and abuse:

- Establish a prospective payment system (PPS) for home health
- Keep problem providers out of the program
- Improve program controls

Two additional actions recommended by Brown include eliminating inappropriate bankruptcy protections and strengthening the physician's role in the program. According to Brown's testimony, home health agencies' ability to discharge Medicare debt through bankruptcy should be eliminated. She explained that "bankruptcy is used subsequent to a fine or penalty to allow the agency to avoid any financial responsibility for wrongdoing." Physician recommendations include examining all patients before the patients are certified, modifying the certification forms to define eligibility requirements more clearly, and implementing a physician attestation.

Nearly unanimous support existed for the creation of a PPS for home healthcare but universal concern existed for the difficulty with developing such a system. According to Ruiz, HCFA hopes to have a sense of direction by April 1998. After intense questioning from Klink, Ruiz said that HCFA would submit a timeline to the subcommittee that contains objectives for the development of a PPS for home health.

During the hearing, Ruiz was questioned further on HCFA's plan to reduce the 40 percent claims payment error rate. However, Barton was not pleased with HCFA's goal to reduce the Medicare program's overall 14 percent error rate by a total of 4 percent over the next five years. He contended that a greater focus should be on reducing home health's 40 percent error rate—no less than 10 percent per year. Coburn expressed the most concern about developing a PPS for home health. In his view, a PPS will shift care away from the ones who need it most—the chronically ill. He believes a home health system should be developed to work outside the Medicare program.

Conclusion

The fraud issue is not one that will depart the congressional agenda anytime soon. The Subcommittee on Oversight and Investigations and HCFA have had numerous meetings on the issue. Nancy Ann-Min Deparle, HCFA's yet-to-be-confirmed administrator, and Barton have met and pledged to work together to root out the fraud dilemma facing the Medicare program.

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