United States Government Accountability Office

GAO

Report to the Ranking Member, Committee on Finance, U.S. Senate

February 2009

MEDICARE

Improvements Needed to Address Improper Payments in Home Health

On May 12, 2009, we revised the report to correct the percentage growth in the number of home health agencies that billed Medicare. Specifically, revisions were made to relevant portions of the highlights; text on pages 1, 4, 11, and 13; figure 3 on page 14; and table 4 on pages 37 and 38. Text on page 3, as well as figure notes and table notes throughout the report, were revised to more clearly describe our methodology.

GAO-09-185

February 2009

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Improvements Needed to Address Improper Payments in Home Health

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-09-185, a report to the Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicare spending on home health totaled $12.9 billion in 2006, up 44 percent from 2002. Concerns have been raised that improper payments from practices indicating fraud and abuse may have contributed to Medicare home health spending and utilization. The Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, is responsible for minimizing improper payments made on behalf of Medicare beneficiaries. GAO was asked to examine the growth in Medicare home health spending and utilization and the benefit's vulnerability to improper payments. GAO focused on states with the highest growth in Medicare home health spending or utilization; fraudulent and abusive practices contributing to recent spending and utilization; and administrative issues that make it vulnerable to improper payments. GAO analyzed Medicare claims data; reviewed Medicare laws and regulations and CMS documents; and interviewed stakeholders and contractors that administer and protect the home health benefit.

What GAO Recommends

CMS stated it would consider two of our four recommendations—to amend regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges and to provide physicians who certify or recertify plans of care with a statement of services received by beneficiaries. CMS provided comments on, but neither agreed nor disagreed with our other two recommendations.

View GAO-09-185 or key components.
For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

California, Florida, Nevada, Oklahoma, Texas, and Utah were identified as experiencing the highest growth in Medicare home health spending or utilization from 2002 through 2006. These states ranked among the three highest in one or more of four spending and utilization indicators. Florida and Texas were among the top three on three or more indicators. Texas, Florida, and Nevada—the states with the highest percentage growth in Medicare home health spending from 2002 through 2006—had more than double the national spending growth rate of 44 percent during this period.

Upcoding—overstating the severity of a beneficiary's condition—by home health agencies (HHA) and other fraudulent and abusive practices contributed to Medicare home health spending and utilization. For example, a CMS contractor found that only 9 percent of claims were properly coded for 670 Houston beneficiaries who had the most severe clinical rating and who were served by potentially fraudulent HHAs. Court cases and Department of Health and Human Services Office of Inspector General actions illustrated that kickbacks and billing for services not rendered also contributed to Medicare spending and utilization. Stakeholders identified these practices as common types of home health fraud and abuse.

Inadequate administration of the Medicare home health benefit leaves the benefit vulnerable to improper payments. Although CMS policy charges its contractors, known as Regional Home Health Intermediaries (RHHI), with the responsibility of screening applications from prospective Medicare HHAs, CMS does not require RHHIs to verify the criminal history of persons named on the application. CMS does not generally include physicians, who are in a position to detect certain types of improper billing, in the agency's efforts to detect improper payments. For instance, CMS does not provide physicians responsible for authorizing home health care with information that would enable them to determine whether an HHA was billing for unauthorized care. Current CMS regulations provide for the removal of HHAs or HHA officials from Medicare for one type of abusive billing—billing for services that could not have been rendered. However, the agency has yet to address the removal of HHAs or HHA officials engaging in other types of abusive or improper billing.

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Abbreviations

CERT	Comprehensive Error Rate Testing
CMP	civil monetary penalty
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of Need
HHA	home health agency
HHS	Department of Health and Human Services
MAC	Medicare Administrative Contractors
MedPAC	Medicare Payment Advisory Commission
OIG	Office of Inspector General
PPS	prospective payment system
PSC	Program Safeguard Contractor
RAP	Request for Anticipated Payment
RHHI	Regional Home Health Intermediary
USAO	U.S. Attorneys' Offices
ZPIC	Zone Program Integrity Contractors

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

February 27, 2009

The Honorable Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate

Dear Senator Grassley:

In 2006, Medicare spent $12.9 billion for the 2.8 million beneficiaries receiving home health care—in-home services provided to beneficiaries who need care following discharge from a hospital or who have chronic conditions that require continuing but intermittent care. Spending on the Medicare home health benefit grew about 44 percent from 2002 through 2006, despite an increase of just less than 17 percent in the number of beneficiaries using the benefit during that 5-year period. In addition, the number of home health agencies (HHA) that billed Medicare increased from 6,507 in 2002 to 8,412 in 2006, with more than half of the increase occurring in just two states—Florida and Texas. The Medicare Payment Advisory Commission (MedPAC)[1] reported higher profit margins for HHAs for this period compared to other types of Medicare providers as well. MedPAC estimated average profit margins of 15.4 percent for freestanding HHAs in 2006, compared with profit margins of 13.1 percent for skilled nursing facilities, 12.4 percent for inpatient rehabilitation facilities, and 5.9 percent for outpatient dialysis centers.

The rapid growth in Medicare home health spending and the growth in the number of HHAs have led to concerns about whether improper payments to HHAs contributed to the high home health spending. Improper payments can be due to mistakes on the part of HHAs, as well as fraud and

[1]MedPAC is an agency that advises Congress on issues affecting the Medicare program.

abuse.[2] For example, improper payments can occur when an HHA submits claims on behalf of beneficiaries who do not meet Medicare's coverage criteria, for services that are not reasonable and necessary, or for services that are not delivered.

For the 12-month period ending September 30, 2007, the Comprehensive Error Rate Testing (CERT) program—a program that monitors payment accuracy in the Medicare fee-for-service program—estimated that approximately 1.4 percent of Medicare home health claims were improperly paid, resulting in more than $209 million of improper payments. However, fraudulent claims may not be reflected in the CERT error rate estimate. Because the program uses a random sample to select claims, reviewers are unable to see provider billing patterns that indicate potential fraud when making payment determinations.[3]

One of the responsibilities of the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—is to minimize improper payments made on behalf of its beneficiaries. GAO previously reported on CMS's lack of controls over the Medicare home health benefit and its susceptibility to improper payments, including fraud and abuse.[4]

[2]Generally, fraud involves intentional acts of deception or representation to deceive with knowledge that the action or representation could result in gain. Abuse typically involves actions that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost. Officials from the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—and stakeholders, including officials with national and state associations of home health care providers and the Department of Health and Human Services (HHS) Office of Inspector General (OIG), use the broad term "fraud and abuse" to describe a wide range of activities for which sanctions may be imposed under the Social Security Act, including submitting claims that are known (or should be known) to be false or fraudulent, are for a pattern of services that are not medically necessary, or are for services that were not provided as claimed. In this report we use the term to describe these types of activities.

[3]For example, a recent report from the HHS OIG found that the CERT error rate for durable medical equipment may be understated because claims for items that were considered proper by the CERT contractor were found to be not medically necessary or not delivered when additional documentation was reviewed by an OIG contractor. See HHS OIG, *Medical Review of Claims for the Fiscal Year 2006 Comprehensive Error Rate Testing Program*, report A-01-07-00508 (Aug. 22, 2008).

[4]See GAO, *Medicare: Home Health Services: A Difficult Program to Control*, GAO/HRD-81-155 (Sept. 25, 1981); *Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs*, GAO/HRD-87-9 (Dec. 2, 1986); and *Medicare: Home Health Utilization Expands While Program Controls Deteriorate*, GAO/HEHS-96-16 (Mar. 27, 1996).

GAO has designated Medicare a high-risk program since 1990 because of the program's vulnerability to improper payments.

You expressed questions about the recent growth in Medicare home health spending and utilization and about whether the Medicare home health benefit was vulnerable to certain types of improper payments, specifically those that may indicate fraud and abuse. In this report we examined both home health spending and utilization growth and the vulnerability of the Medicare home health benefit to improper payments. Specifically, we identified: (1) the states where home health spending or utilization growth has been the highest; (2) the fraudulent and abusive practices that may have contributed to home health spending and utilization; (3) aspects of the Medicare home health benefit's administration that make it susceptible to improper payments; and (4) lessons learned from recent CMS initiatives to reduce fraud and abuse in the home health benefit.

To identify the states with the greatest home health spending or utilization growth from 2002 to 2006, we analyzed Medicare home health claims data for the 50 states and Washington, D.C., on various indexes, including growth in total spending; growth in percentage of beneficiaries using the benefit; growth in the number of HHAs that billed Medicare; and the number of home health cases qualifying for outlier payments, which are additional payments for particularly expensive beneficiaries.[5] We assessed the reliability of the 2002 and 2006 claims data from CMS by reviewing existing information about the data and the systems that produced them, and interviewing a CMS contractor about the data. We determined that these data were sufficiently reliable for the purposes of this report.

To identify the types of fraud and abuse that may have contributed to home health spending and utilization, we interviewed stakeholders, including CMS officials, CMS contractors responsible for processing home health claims and home health program safeguard activities, Department of Health and Human Services (HHS) Office of Inspector General (OIG) officials,[6] and officials with national and state associations of home health

[5]Medicare claims data for 2006 were the most recent data available when we began our work. The number of HHAs that billed Medicare by state was based on the location of the HHA. The other indexes were based on the location of the beneficiary residence.

[6]The OIG's mission is to protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions performed by OIG components.

care providers. We analyzed Medicare home health claims for the 50 states and Washington, D.C., from 2006, specifically those claims for beneficiaries receiving home health care for diabetes because some stakeholders expressed concerns about the legitimacy of payments for diabetic beneficiaries. We also reviewed information from court cases and OIG actions related to Medicare home health fraud and abuse.

To identify aspects of the Medicare home health benefit and its administration that make it susceptible to improper payments, we reviewed CMS policies and procedures and relevant Medicare laws and regulations. We also reviewed relevant MedPAC and OIG reports about the Medicare home health benefit. In addition, we conducted site visits to one of the three CMS contractors responsible for processing Medicare home health claims and one of the four CMS contractors responsible for Medicare home health program safeguard activities. We also interviewed stakeholders to get their insights into aspects of the Medicare home health benefit that make it susceptible to fraud and abuse.

To identify lessons learned from recent CMS initiatives to reduce fraud and abuse in the home health benefit, we interviewed knowledgeable CMS officials and reviewed documentation regarding the identified initiatives. We also conducted site visits to the CMS contractors to learn about their involvement in CMS's recent initiatives.

We conducted our work from July 2007 through February 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain appropriate, sufficient evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

We identified six states—California, Florida, Nevada, Oklahoma, Texas, and Utah—as experiencing the highest Medicare home health spending or utilization growth from 2002 through 2006. These six states were among the three highest in one or more of the four spending and utilization indicators we examined using Medicare claims data. Two of the seven states—Florida and Texas—ranked in the top three on three or more indicators. Texas, Florida, and Nevada—the states with the highest percentage growth in Medicare home health spending from 2002 to 2006—had more than double the national spending growth, and Texas's increase in spending was more than three times the national growth rate.

Upcoding—overstating the severity of a beneficiary's condition—by HHAs and other fraudulent and abusive practices contributed to Medicare home health spending and utilization. For instance, a CMS contractor found that only 9 percent of claims were properly coded for 670 Houston beneficiaries who had the most severe clinical rating and who were served by potentially fraudulent HHAs. In addition, court cases and OIG actions illustrated how other fraudulent and abusive practices, including payments to physicians for referrals, payments by HHAs to beneficiaries for use of their Medicare identification numbers, and billing for services not rendered, contributed to spending and utilization. Stakeholders also identified these practices as common types of home health fraud and abuse, although some stakeholders acknowledged that they were difficult to prove.

Inadequate administration of the Medicare home health benefit leaves the benefit vulnerable to improper payments. Although CMS policy charges its contractors, known as Regional Home Health Intermediaries (RHHI), with the responsibility of screening applications from prospective Medicare HHAs, CMS does not require its contractors to verify the criminal history of persons named on the application. CMS regulations require that HHAs undergo revalidation—which requires providers to resubmit enrollment information for reverification—at least once every 5 years. However, HHAs are not routinely subjected to revalidation. CMS also generally does not include physicians, who are in a position to detect certain types of improper billing, in the agency's efforts to detect improper payments. For example, CMS does not routinely provide physicians authorizing home health care with information that would enable them to detect whether an HHA was billing for unauthorized services. Furthermore, current CMS regulations provide for the removal of HHAs or HHA officials from Medicare for just one narrowly defined type of abusive billing—billing for services that could not have been rendered.

In recent CMS and contractor initiatives, CMS learned that revalidation and targeted enforcement efforts adapted to local billing practices show the potential to reduce home health fraud and abuse. For example, beginning in late 2007, CMS initiated a demonstration project requiring all HHAs in Houston and the greater Los Angeles area to undergo revalidation by resubmitting the CMS enrollment application for screening. Those HHAs that failed to resubmit their application had their billing privileges revoked. As of October 2008, 37 HHAs—out of approximately 845, which billed for approximately $6.1 million in fiscal year 2007—had their billing privileges revoked as part of the demonstration for failure to resubmit their information for revalidation. A contractor's efforts in Houston and

Miami also showed the potential to save money by adapting to local patterns of fraud and abuse. For instance, in Miami, the contractor worked with physicians to identify HHA overpayments in excess of $9 million.

To help reduce improper payments to Medicare HHAs, we are recommending that the Administrator of CMS take four actions. The recommended actions will enable CMS to more effectively screen HHAs and HHA officials participating in the Medicare program, more effectively partner with physicians to identify potentially fraudulent and abusive activities, and more effectively sanction providers engaging in improper billing practices.

In comments on a draft of this report, CMS stated it would consider two of our four recommendations—to amend regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges and to provide physicians who certify or recertify plans of care with a statement of services received by beneficiaries. CMS provided comments on, but neither agreed nor disagreed with our other two recommendations. In addition to its comments on our recommendations, CMS highlighted its recent initiatives to address improper payments to HHAs, but also noted that resource constraints prevented contractors from engaging in certain activities discussed in our report. CMS also stated that the report only briefly mentions Certificates of Need (CON) requirements that are in place in some states to control health care capacity increases, which CMS believes could stem the increase of HHAs in high vulnerability areas. However, it was beyond the scope of this report to evaluate whether CMS's resources were adequate to conduct these activities and to assess the impact of CON requirements, which states impose. CMS also provided comments pertaining to specific sections of the report, and we incorporated these comments where appropriate.

Background

Medicare requires that covered services be reasonable and medically necessary.[7] To qualify for home health care, Medicare beneficiaries must

[7]Medicare-covered services generally must be reasonable and medically necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part.

(1) be homebound;[8] (2) need skilled nursing services on an intermittent basis,[9] or physical or speech therapy, or have a continuing need for occupational therapy; (3) be under the care of a physician; and (4) be receiving services under a plan of care established and periodically reviewed by a physician. Beneficiaries who qualify for home health care may also receive medical social services and home health aide services if these services are part of the beneficiary's plan of care.

HHA Requirements and Payments

An HHA becomes a Medicare-certified provider by meeting a series of requirements. First, the HHA must submit an enrollment application for screening by a Medicare contractor. The enrollment application includes information about key officials,[10] operating capital, and practice location. The Medicare contractor reviews the application and, if the application meets the standards, recommends approval to the HHA's state survey agency and CMS. Second, a state survey agency reviews the HHA to determine if the HHA is compliant with the federal conditions of participation, or an approved accrediting organization can accredit the HHA. The conditions of participation for HHAs include requirements concerning organizational structure, administration, patient rights, medical supervision, and patient assessment. The HHA must also meet the statutory and regulatory requirements in the state in which it is located, which may include licensure requirements or approval under a CON.[11]

[8]Homebound means the patient's condition is such that the patient is generally confined to home, and consequently leaving home would require a considerable and taxing effort. If the patient leaves the home, the patient may still be considered homebound if the absences from the home are infrequent or of relatively short duration, or the absences are due to the need to receive health care treatment. See 42 U.S.C. §§ 1395f(a)(2)(C), (8); 1395n(a)(2)(A).

[9]Intermittent means skilled nursing care that is either provided or needed on fewer than 7 days each week or fewer than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). See 42 U.S.C. §1395x(m)(7).

[10]Key officials must be named on an enrollment application. These individuals are owners, directors (if the HHA is a corporation), managing employees, partners, and authorized and delegated officials. An authorized official is an appointed official (for example, chief executive officer or chairman of the board) with the legal authority to enroll an organization in the Medicare program, make changes or updates to the organization's status in the Medicare program, and commit the organization to fully abide by Medicare statutes and regulations. Delegated officials are those authorized to report changes and updates to the organization's enrollment record.

[11]State laws or regulations that require prior approval for state health care capacity increases are commonly referred to as CON requirements.

Third, if the HHA passes the state survey or receives accreditation, the HHA must sign a provider agreement with CMS. If the provider agreement is accepted by CMS, the HHA is enrolled and obtains Medicare billing privileges. To maintain billing privileges, an HHA must revalidate its enrollment information every 5 years by resubmitting and recertifying the accuracy of its enrollment information.[12]

HHAs are paid using a prospective payment system (PPS) for 60 days of care, called an episode. The amount of payment is based on an assessment of the patient's needs at the beginning of the episode. The payment for each beneficiary is based on the national average cost of home health care services, adjusted by the beneficiary's categorization into a payment group and the costliness of patients in each payment group relative to the average payment. Classification into a payment group is based on the severity of the beneficiary's condition along three domains—clinical, functional, and service use.[13] HHAs receive an up-front payment for each episode, based on submission of a Request for Anticipated Payment (RAP), which is 50 or 60 percent of the expected total payment.[14] The HHA receives the balance of the payment after the episode is complete. Special payment adjustments exist for HHAs with beneficiaries who have few visits during an episode or who have partial episodes, and for HHAs with outlier beneficiaries. CMS significantly refined the home health PPS effective January 1, 2008.[15]

[12]CMS may require an HHA to revalidate more frequently based on complaints or compliance concerns. Providers must also resubmit their enrollment application under certain circumstances, for example, if certain information, such as their address, changes, or if they wish to reactivate their Medicare billing privileges. As of January 20, 2009, CMS requires contractors to undertake additional verification activities for providers who are changing certain information or who are reactivating their Medicare billing privileges.

[13]The clinical domain measures whether the beneficiary has one or more clinical conditions, such as presence of wounds, problems with vision, or pain. The functional domain measures the beneficiary's ability to perform activities of daily living, such as bathing, dressing oneself, or walking. The service use domain is based on the number of therapy visits provided and the episode's sequence in a series of consecutive episodes.

[14]HHAs receive a 60 percent up-front payment for initial episodes and a 50 percent up-front payment for subsequent episodes for beneficiaries who receive multiple episodes of care.

[15]See 42 C.F.R. pt. 484 (2007), 72 Fed. Reg. 49762 (Aug. 29, 2007). The refinements to the payment system were designed to make home health payments more accurate. Changes included revisions to and expansion of the patient classification system and replacement of the single 10-therapy-visit threshold with three graduated therapy thresholds.

CMS Contractor Roles and Responsibilities in Home Health

As of November 2008, CMS contracted with three Regional Home Health Intermediaries (RHHI) to process and pay home health claims.[16] In processing and paying claims, RHHIs are responsible for minimizing improper payments. The RHHIs also are responsible for screening HHA enrollment applications and making recommendations to CMS and state survey agencies about whether the applications should be approved.

As of November 2008, CMS contracted with four Program Safeguard Contractors (PSC) that are responsible for preventing, detecting, and deterring fraud in the Medicare home health benefit through benefit integrity investigations and referrals to law enforcement.[17] PSCs coordinate their activities with the RHHI responsible for claims processing in their jurisdiction. PSCs also work with the OIG and other law enforcement organizations to pursue criminal or civil penalties. Specific activities undertaken by PSCs to identify and prevent fraud and abuse include analysis of claims data to identify improper billing that may indicate fraud or abuse and on-site visits to beneficiaries and providers.

Medical review, performed either before or after a claim is approved for payment, is one way that RHHIs and PSCs ensure that claims are being paid correctly.[18] Medical review involves obtaining HHA documentation, such as the beneficiary's plan of care and medical records, to determine whether the beneficiary meets Medicare's coverage criteria for home health services, whether the care provided was reasonable and necessary, and whether the claim was coded properly.

[16]The RHHIs are responsible for processing claims and enrolling providers in a given jurisdiction. In November 2008, the three RHHIs were National Government Services, Palmetto GBA, and Cahaba Government Benefit Administrators, LLC. CMS is currently restructuring its operations by contracting with 15 Medicare Administrative Contractors (MAC) that will be responsible for claims processing, provider enrollment, provider customer service, and other activities within a given jurisdiction. Four of the 15 MACs will be responsible for home health.

[17]Each PSC is responsible for a separate jurisdiction. The four PSCs were TriCenturion; New England Benefit Integrity Support Center; TrustSolutions, LLC; and Cahaba Safeguard Administrators, LLC. CMS is transitioning its benefit integrity work from PSCs to Zone Program Integrity Contractors (ZPIC). ZPICs will be responsible for benefit integrity for all aspects of the Medicare benefit, whereas PSCs work on specific parts of the Medicare benefit. Two ZPIC contracts were awarded in September 2008, and CMS estimates the transition to ZPICs will be complete by the end of calendar year 2009.

[18]Prepayment medical reviews occur after the up-front payment has been made, but before the final payment for the episode. Postpayment reviews occur after the final payment.

Actions in Response to Improper Billing

CMS and its contractors can take a series of actions against HHAs with a pattern of improper billing or that are suspected of engaging in fraud or abuse. Initially, an RHHI can educate an HHA about proper billing if the HHA's billing pattern appears to be aberrant. RHHIs can flag a percentage of the HHA's submitted claims for medical review if the HHA's billing pattern appears aberrant or there is knowledge of abuse in the service area. RHHIs can also require the HHA to return any money it received in excess of the proper amount (called an overpayment) or hold payment for current claims while an overpayment is calculated if there is reason to believe that the HHA has engaged in fraud or has been overpaid in the past (called a payment suspension). Finally, if CMS or its contractors determine that an HHA billed Medicare for a service that could not have been provided on the date claimed, CMS can revoke the HHA's Medicare billing privileges and it would be barred from re-enrolling in the Medicare program for 1 to 3 years.

If an HHA is suspected of engaging in fraud or other type of unlawful activity, PSCs must refer the HHA to the OIG. Under the Social Security Act, the OIG may take certain administrative actions against individuals and HHAs, including those found to have submitted false or fraudulent claims. The OIG may impose sanctions including the assessment of civil monetary penalties (CMP) and exclusion of an individual or organization from participation in federal health programs for a period of time. The Social Security Act also provides for criminal penalties for certain activities, including certain false statements and kickbacks, which are payments to physicians or others to induce referrals or in return for referrals.[19] The OIG and PSCs may also refer cases to other law enforcement entities such as the Federal Bureau of Investigation or state law enforcement agencies. Upon investigation, these entities can decide whether to pursue civil or criminal prosecution.

Past GAO Work

We have reported for more than two decades on program weaknesses in Medicare's home health benefit. Previous reports attributed improper billing in Medicare home health to

[19]In general, the so-called anti-kickback statute provides for criminal penalties against those who knowingly and willfully solicit, receive, offer, or pay remuneration to induce or in return for referring an individual to a person for the furnishing or arranging for the furnishing of items or services for which payment may be made under a federal health care program. See 42 U.S.C. §§ 1320a-7b(b).

- vagueness in the coverage criteria, particularly uncertainty over the exact meaning of terms such as homebound and intermittent care;[20]
- insufficient physician involvement and inadequate monitoring of beneficiary status;[21]
- insufficient information being submitted with the claims upon which to base a coverage decision;[22] and
- the difficulty RHHIs have in assessing, from paper review alone, whether a beneficiary meets the eligibility criteria, whether the services received are appropriate given the beneficiary's current condition, and whether the beneficiary is actually receiving the services billed to Medicare.[23]

Six States Identified as Experiencing Highest Medicare Home Health Spending or Utilization Growth from 2002 through 2006

Medicare home health spending or utilization growth from 2002 through 2006 was highest in California, Florida, Nevada, Oklahoma, Texas, and Utah. These states ranked among the top three in at least one of four spending and utilization indicators. Two states—Florida and Texas—ranked in the top three on three or more indicators.

States with the highest percentage growth in Medicare home health spending from 2002 through 2006 were Texas (144 percent), Florida (90 percent), and Nevada (88 percent). All three states had at least double the national growth rate of 44 percent, and Texas's increase in spending was more than three times the national growth rate. (See fig. 1.) (See app. I for the growth rates for all individual states.)

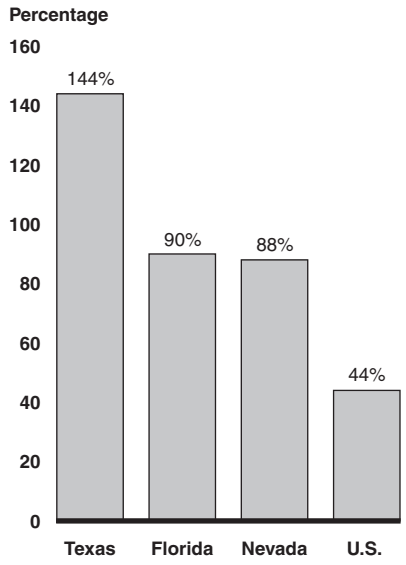
[20]See GAO/HRD-81-155 and GAO/HRD-87-9.

[21]See GAO/HRD-81-155.

[22]See GAO/HEHS-96-16.

[23]See GAO/HEHS-96-16.

Figure 1: States with the Highest Percentage Growth in Medicare Home Health Spending from 2002 through 2006

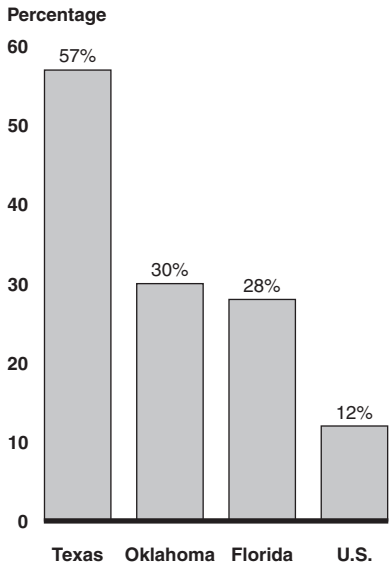


Source: GAO analysis of CMS data.

Note: Analysis based on location of beneficiary residence. If the analysis was based on HHA location, the top three states would remain the same but the growth rates would change slightly: Texas (143 percent), Florida (89 percent), Nevada (88 percent), and the U.S. average (43 percent).

Texas (57 percent), Oklahoma (30 percent), and Florida (28 percent) had the highest percentage growth in the percentage of Medicare beneficiaries who used home health services from 2002 through 2006. The U.S. percentage growth was 12 percent. (See fig. 2.) (See app. I for the percentage growth in percentage of all Medicare beneficiaries who used home health services, for all individual states.)

Figure 2: States with the Highest Percentage Growth in the Percentage of Beneficiaries Who Used Home Health Services from 2002 through 2006

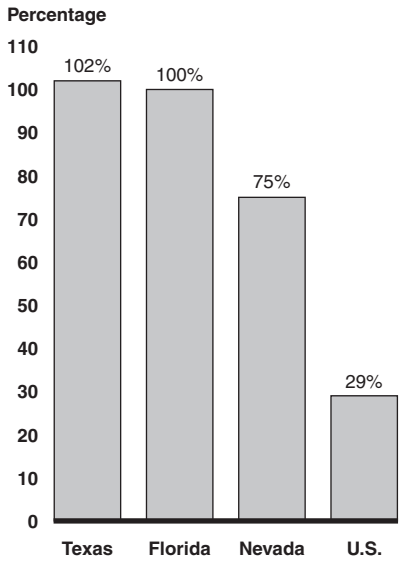


Source: GAO analysis of CMS data.

Note: Analysis based on location of beneficiary residence.

Texas (102 percent), Florida (100 percent), and Nevada (75 percent) had the highest percentage growth in the number of HHAs that billed Medicare from 2002 through 2006. In comparison, the national growth rate was 29 percent. (See fig. 3.) (See app. I for the percentage growth in number of HHAs that billed Medicare for all individual states.)

Figure 3: States with the Highest Percentage Growth in the Number of HHAs that Billed Medicare from 2002 through 2006

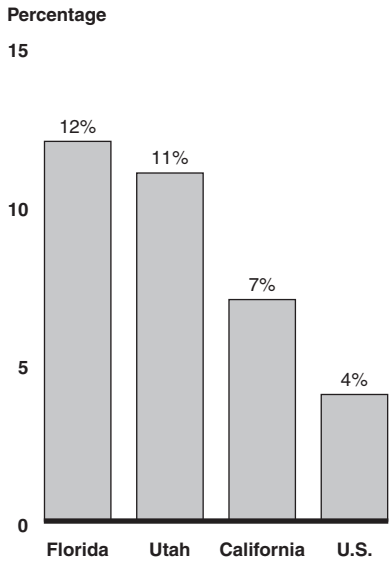


Source: GAO analysis of CMS data.

Note: Analysis based on location of HHA.

States with the highest percentage of home health episodes that were outliers in 2006 were Florida (12 percent), Utah (11 percent), and California (7 percent). The percentage of outlier cases nationwide was 4 percent. (See fig. 4.) (See app. I for the percentage of outlier cases for all individual states.)

Figure 4: States with the Highest Percentage of Outlier Cases in 2006



Source: GAO analysis of CMS data.

Note: Analysis based on location of beneficiary residence.

Upcoding and Other Fraudulent and Abusive Practices Contributed to Home Health Spending and Utilization

Upcoding, or overstating the severity of a beneficiary's condition, and other fraudulent and abusive practices were problems in some areas and contributed to Medicare home health spending and utilization. Data analyses that we, CMS, and one PSC conducted showed that upcoding and billing for unnecessary care contributed to spending and utilization.[24] Stakeholders also told us that common types of upcoding and billing for unnecessary care in home health were billing for outlier cases when this level of care was not required, billing for beneficiaries who were not homebound, and billing for therapy visits that may have been medically unnecessary.[25] Other fraudulent and abusive practices, including kickbacks, payments from HHAs to beneficiaries for use of their Medicare

[24]While HHA providers could bill for care that they do not realize is unnecessary, this report's discussion of billing for unnecessary care refers to billing patterns that suggest the HHA is intentionally engaging in a fraudulent and abusive practice.

[25]Under the PPS, one way that Medicare home health beneficiaries are grouped along the service utilization dimension is by the number of therapy visits. Prior to 2008, HHAs serving beneficiaries that received 10 or more therapy visits received higher payments than HHAs serving beneficiaries who received fewer visits. See Medicare Program: Prospective Payment System for Home Health Agencies, 65 Fed. Reg. 41,128 (July 3, 2000).

identification numbers, and billing for services not rendered, also contributed to Medicare home health spending and utilization.[26] Court cases and OIG actions illustrate how these practices contributed to improper HHA spending and utilization. In addition, stakeholders identified these practices as common types of home health fraud and abuse, although some stakeholders acknowledged that they were difficult to prove.

Medicare home health spending and utilization was due in part to upcoding Medicare claims by billing for outlier cases that qualified for additional payments, although beneficiaries did not require this level of care. For example, in Miami-Dade County, a pattern of an unusually high number of outlier cases in 2007 indicated fraudulent upcoding of Medicare home health claims. According to one PSC's analysis, in 2007, 57.5 percent of home health cases in Miami-Dade County were outlier cases, compared with 0.4 percent in Chicago, 8.6 percent in Dallas, 2.2 percent in Houston, and 2.2 percent in Atlanta.[27] The PSC's analysis showed that Miami-Dade HHAs received more than $550 million in outlier payments in 2007—an amount more than four times greater than the combined total paid to HHAs in Chicago, Dallas, Houston, and Atlanta, even though there were more people over age 65 in each of the other four metropolitan areas.

The PSC also reported in its written analysis to CMS that many Miami-Dade County HHAs provided daily skilled nursing visits to administer insulin injections for diabetic beneficiaries,[28] which resulted in higher costs per beneficiary and outlier payments, although beneficiaries may not have required this level of care.[29] In a November 2007 report to CMS, this PSC stated that Miami-Dade County beneficiaries and their caregivers had

[26]While an HHA could unintentionally bill for a service that is not rendered, this report's discussion of billing for services not rendered refers to billing patterns that suggest the HHA is knowingly engaged in a fraudulent and abusive practice.

[27]Outlier payments may not exceed 5 percent of the national total of Medicare home health payments projected or estimated in a given fiscal year.

[28]Medicare beneficiaries can receive skilled nursing services from an HHA for insulin injections if they cannot inject themselves and no other person is willing and able to administer the injections.

[29]A recently enacted Florida law requires all HHAs to report to the state survey agency, on a quarterly basis, the number of insulin-dependent diabetic patients receiving insulin-injection services from the HHA and the number of patients receiving home health services from that agency. The first report was due October 15, 2008, for the period from July 2008 through September 2008. See Fla. Stat. Ann. § 400.474(6)(f)1.3. (West 2008).

been coached in how to respond to investigators verifying whether the skilled nursing services for insulin injections were necessary. For example, according to the PSC representatives, some beneficiaries said that they were unable to administer their own injection due to poor vision, yet they were able to read the investigators' business cards.

Our study of 2006 Medicare home health data from U.S. counties with 100 or more home health episodes confirmed the PSC's analysis by indicating that, compared with the rest of the country, a large percentage of home health cases in Miami-Dade County involved diabetic beneficiaries. Nearly 50 percent of all Medicare beneficiaries in Miami-Dade County who received home health services in 2006 had a diagnosis of diabetes. The average for all counties included in the analysis, about 16 percent, was significantly lower. Total Medicare payments for diabetes episodes in Miami-Dade County exceeded $221 million in 2006. This figure was almost double the diabetes-related payments in Los Angeles County, which had nearly twice as many Medicare beneficiaries using home health services as Miami. The average diabetes payment among all counties with at least one beneficiary who had a diabetes home health episode was less than $1 million.

In addition to fraudulent and abusive practices involving outlier payments, stakeholders reported that before CMS amended its payment methodology in 2008, some HHAs billed for 10 or more therapy visits in order to qualify for additional Medicare payments, even though these visits may not have been medically necessary.[30] CMS concluded that the 10-therapy-visit threshold, established during the implementation of the PPS in 2000, distorted service delivery patterns by creating financial incentives for HHAs to bill for 10 therapy visits. CMS analysis showed that, prior to implementation of the PPS, the highest concentration of therapy visits per episode ranged from 5 to 7 visits. After implementation of the PPS, the highest concentration of therapy visits grew to 10 to 13 visits per episode.

Some stakeholders reported another type of fraud and abuse in which HHAs submitted claims for beneficiaries who were not homebound or who required fewer services than were provided. For example, several

[30]Effective January 1, 2008, CMS amended its home health PPS. One change was the creation of additional therapy thresholds "to reduce the undesirable emphasis in treatment planning on a single therapy visit threshold, and to restore the primacy of clinical considerations in treatment planning for rehabilitation patients." 72 Fed. Reg. 25356, 25363 (May 4, 2007).

Houston HHAs had an unusually high percentage of patients with the most severe clinical rating.[31] One PSC interviewed 670 Houston beneficiaries who had the most severe clinical rating and who were patients of HHAs identified by the PSC as having aberrant billing patterns. The PSC found 91 percent of claims for these beneficiaries to be in error. Nearly 50 percent of the beneficiaries were not homebound and therefore were not eligible to receive any Medicare home health services. The investigators also found that while 39 percent of the beneficiaries they interviewed were eligible for the benefit, their clinical severity had been exaggerated. The PSC concluded that only 9 percent of claims for the 670 beneficiaries were properly coded.[32] In addition, the PSC found that other home health beneficiaries it interviewed were not homebound; for instance, some were mowing their lawns when investigators came to interview them.

In addition, court cases and OIG actions illustrate how other fraudulent and abusive practices such as kickbacks, payments by HHAs to beneficiaries for use of their Medicare identification numbers, and billing for services not rendered contributed to Medicare home health spending and utilization. For example, in October 2004, a registered nurse who owned the two largest HHAs in California pled guilty to defrauding Medicare of $40 million by billing for services not rendered or medically unnecessary; falsifying medical records to support fraudulent claims; and paying kickbacks.[33] In addition, a Pennsylvania HHA agreed to pay $300,000 and enter into a settlement agreement with the OIG to resolve its liability in May 2005 for alleged kickbacks. The HHA allegedly paid Pennsylvania and Florida physicians kickbacks in the form of loans, consulting fees, and rental space payments to induce them to refer beneficiaries requiring home health services or durable medical equipment, or both, paid for by Medicare. (See table 1 for examples of court cases and OIG actions.)

[31]HHAs receive higher payments for claims for patients with this rating than they receive for claims for patients with less severe ratings.

[32]The PSC found that the remaining claims were denied due to services that were not rendered, not reasonable or necessary, or for other reasons.

[33]The HHA owner's actions were investigated after a payroll clerk at one of the HHAs filed a lawsuit against the HHAs, the owner, and her husband.

Table 1: Examples of Medicare Home Health Court Cases and OIG Actions

Case/OIG action, state, date	Description
Court Case Florida March 2008	Three defendants who owned four Miami health care corporations were convicted of defrauding Medicare of more than $14 million by, among other things, providing unnecessary medical services, home health services, and durable medical equipment. The owners were also found guilty of receiving kickbacks in exchange for beneficiary referrals.
OIG Settlement Florida March 2008	A Florida HHA agreed to pay $178,000 to settle a case in which it was alleged that the HHA paid kickbacks for beneficiary referrals.
Court Case Louisiana December 2007	The owner of a Louisiana HHA was found guilty of defrauding Medicare over a 5-year period and was ordered to pay more than $4.6 million in damages and penalties. Among other charges, the owner was convicted of making illegal payments to physicians for referrals. The physicians were members of the company's advisory board.
OIG Settlement Texas December 2007	A Texas HHA agreed to pay $86,327 to settle a case in which it was alleged that the HHA paid kickbacks. The OIG alleged that the HHA supplied free nursing and community development services to providers in order to induce them to refer patients for home health services.
Court Case California May 2006	A California HHA owner was sentenced to 2 years in prison and ordered to pay Medicare $600,000 in restitution for Medicare fraud. The HHA owner pled guilty to, among other things, paying kickbacks to physicians to provide unnecessary services, billing Medicare for home health services that were medically unnecessary or not performed as claimed, and falsifying medical records to conceal the fraud.
OIG Settlement Pennsylvania May 2005	A Pennsylvania HHA agreed to pay $300,000 to settle a case in which it was alleged that the HHA had paid kickbacks under Medicare. The OIG alleged that from February 1997 through May 1998, the HHA made payments in the form of loans, consulting fees, and monthly space rental payments to physicians in Pennsylvania and Florida to induce their referral of Medicare beneficiaries.
OIG Settlement Florida February 2005	A nationwide HHA agreed to pay $130,000 to resolve its liability for kickbacks allegedly paid by one of its franchisees. The OIG alleged that the franchisee paid commissions to nonemployees for each patient referred. The amounts of the commissions were allegedly based on the type of services utilized by the referred patients.
Court Case California October 2004	The owner of the two largest HHAs in California pled guilty to defrauding Medicare of approximately $40 million and filing false tax returns to conceal the illegal income. Among other things, the HHAs were alleged to have made illegal payments to marketers, physicians, patients, and nurses and then to have billed Medicare for services that were not medically necessary or not performed.

Source: GAO analysis of information from U.S. Attorneys' Offices and the HHS OIG.

Note: Data are from the sources' respective Web sites.

Stakeholders, including industry representatives, also identified kickbacks, payments by HHAs to beneficiaries for use of their Medicare identification numbers, and billing for services not rendered as common types of home health fraud and abuse. For example, a CMS official and representatives from an RHHI, PSCs, and HHA associations told us that some HHAs offered physicians kickbacks. For instance, representatives from home health associations said that physician kickbacks were so common in some parts of Florida that many physicians expected payment for referrals and inquired how much the HHAs paid for referrals. Stakeholders also told us that, based on their experience, some HHAs hired physicians to serve as medical directors to disguise payments for referrals by those physicians and that some HHAs had as many as 20 or 30 medical directors.[34]

In addition, stakeholders told us that some HHAs offered kickbacks to nurses, hospital discharge planners, and assisted living facility managers for beneficiary referrals. For example, a CMS official and a PSC representative told us that when some nurses were hired by a new HHA employer, the nurses moved their patients from their former HHA employer to the new one and received bonuses according to the number of beneficiaries they brought with them. The PSC representative said that beneficiaries were often very loyal to their nurses and often did not realize they were being shifted among HHAs. In another practice reported by a Florida home health association representative, HHAs allegedly paid managers at senior housing projects and assisted living facilities above-market rent in exchange for beneficiary referrals.

According to stakeholders, HHAs that billed Medicare for services that were not rendered may have paid beneficiaries for use of their Medicare identification numbers. Stakeholders said that HHAs offered beneficiaries payments in the form of cash or other goods, such as cigarettes or alcohol. In addition, a CMS official told us that some Miami beneficiaries reported that HHA nurses had given them insulin injections that investigators suspected they did not actually receive. This official also reported that

[34]CMS does not require HHAs to have medical directors and does not ask HHAs to specify the names and number of medical directors it employs on its enrollment application. However, Florida recently enacted a law that allows the state survey agency to deny, revoke, or suspend the license of an HHA that contracts with more than one medical director. The law also prohibits HHAs from giving remuneration to a physician unless there is a medical director contract in effect. The law, which went into effect July 1, 2008, also carries a $5,000 fine. See Fla. Stat. Ann. § 400.476(6)(h), (i). (West 2008).

Miami HHAs have submitted claims for visits that were probably not provided, such as claims for visits that allegedly occurred when hurricanes were in the area.

Stakeholders told us that kickbacks, payments to beneficiaries for illegal use of their Medicare identification numbers, and billing for services not rendered were difficult to prove. For example, one PSC representative noted that in the past, the PSC could have relied on either beneficiaries or physicians to testify about the HHA activity and thereby to act as a safeguard against fraud and abuse, but with all parties involved in the practices, this type of cooperation is less likely. An official from the OIG's Miami Office of Investigations echoed these concerns, stating that some South Florida beneficiaries purportedly received more income in illegal HHA payments than from their monthly disability checks and therefore were less likely to be truthful about HHA fraudulent and abusive practices.

Inadequate Screening, Monitoring, Investigation, and Enforcement Procedures Leave Home Health Benefit Vulnerable to Improper Payments

Inadequate administration of the Medicare home health benefit leaves the benefit vulnerable to improper payments. Although CMS policy charges RHHIs with the responsibility of screening applications from prospective Medicare HHAs, CMS does not require RHHIs to verify the criminal history of persons named on the application. Furthermore, while CMS regulations require that HHAs undergo revalidation at least once every 5 years, HHAs are not routinely subjected to revalidation. CMS generally does not include physicians, who are in a position to detect certain types of improper billing, in CMS efforts to detect improper payments. CMS does not routinely provide physicians authorizing home health care with the information needed to detect billing for unauthorized services.

Inadequate Screening May Allow Problem Providers to Enter Medicare

Gaps in screening potential and current HHAs may allow problem providers to enter and remain in the Medicare program. Although CMS policy charges RHHIs with the responsibility of screening applications from prospective Medicare HHAs, CMS does not require RHHIs to verify the criminal history of persons named on the initial enrollment application.[35] An application is subject to denial if an owner has been

[35]Criminal history that must be reported on the enrollment application includes convictions and guilty pleas for selected felonies within 10 years of enrollment or reenrollment and convictions for misdemeanors.

convicted of certain types of felonies within the past 10 years or if the application contains false or misleading information.[36] Because RHHIs do not verify the criminal history responses, it is impossible for them to identify false or misleading information or owners who have been convicted of a felony within the past 10 years.

CMS regulations require that HHAs resubmit and recertify the accuracy of their enrollment information every 5 years,[37] but HHAs are not routinely subjected to this revalidation. CMS adopted the revalidation requirement in 2006 as a systematic means of collecting updated information about the nation's Medicare providers and reexamining their enrollment eligibility. Revalidation requires that the HHA submit a new enrollment application and any supporting documentation, and the RHHIs to validate the information provided and, in some cases, to make an on-site inspection of the HHA. In the preamble to the rule establishing the revalidation requirement, CMS noted that revalidation will "ensure that Medicare beneficiaries are receiving services furnished only by legitimate providers and suppliers, and strengthen [CMS's] ability to protect the Medicare Trust Funds."[38]

Gaps in Monitoring Claims Make It Easy for Improper Payments to Occur

CMS generally does not include physicians, who are in a position to detect certain types of improper billing, in CMS efforts to detect improper payments. CMS does not routinely provide physicians authorizing home health care with information that would allow the physicians to detect billing for unauthorized services. Physicians must authorize the type and frequency of home health visits but do not receive verification of the visits included in the HHA's claim to ensure that those claimed were consistent with those authorized. Stakeholders reported to us numerous instances of HHAs billing for services unauthorized by the physician.

[36]42 C.F.R. §§ 424.530(a)(3), (4) (2007). Other grounds for denial of enrollment include noncompliance with Medicare enrollment requirements and a determination by CMS that the provider is not operational. As of January 1, 2009, providers also may be denied enrollment if the owner has an overpayment at the time the application is filed that has not been repaid in full or has been placed under payment suspension. 42 C.F.R. §§ 424.530(a)(6), (7) (2008).

[37]42 C.F.R. § 424.515 (2007).

[38]71 Fed. Reg. 20754, 20758-9 (Apr. 21, 2006).

RHHIs are responsible for monitoring home health claims, but limitations in the number of medical reviews they conduct leave the benefit vulnerable to improper payments, including payments resulting from fraud and abuse. Two of the three RHHIs told us they are limited by CMS budget constraints in the number of medical reviews they can conduct. In fiscal year 2007, 0.5 percent of the more than 8.7 million HHA claims processed were subjected to prepayment medical review by RHHIs. The RHHIs told us they primarily focus on those claims submitted by HHAs whose billing patterns exhibit differences from their peers on such measures as average number of nursing visits per episode, episodes per beneficiary, and cost per episode. The RHHIs reported to us that in fiscal year 2007 they denied, in whole or in part, 41 percent of nearly 44,000 claims reviewed prior to payment and 24 percent of the total submitted charges, for $23 million in savings.

RHHIs rarely conduct postpayment medical reviews to recover funds previously paid in error, even when an HHA is identified as billing improperly through prepayment review. The RHHIs reported to us that in fiscal year 2007 they conducted postpayment medical review on 640 of the over 8.7 million claims processed, recouping $486,000 in overpayments. According to a CMS official, the emphasis on prepayment review is to avoid pursuing payments after they have been made.

Challenges in Investigation and Enforcement Leave Home Health Benefit Vulnerable to Improper Payments

Investigation and enforcement challenges restrict the number of HHAs that are investigated and sanctioned for improper billing. Substantiating improper payments for the home health benefit is time consuming and labor intensive. PSCs identify HHAs to investigate based on referrals from the RHHIs, other contractors, law enforcement entities, or from data analysis. Their investigations can be based either on claims already paid or on RAP submissions. For instance, one PSC noted that evidence to substantiate medically unnecessary services or possible upcoding is best gathered as close to the date the beneficiary was assessed as possible. This requires coordination between the RHHI and the PSC so that the PSC can assess the beneficiaries, in person, within days of submission of the RAP to the RHHI. Once improper billing is established, the PSC must also determine the amount of improper payments the HHA has already received.[39] One PSC told us that a nurse could conduct medical review of

[39]In fiscal year 2007, through medical review of 1,296 claims, the PSCs identified $28.1 million in HHA overpayments for recoupment by the RHHIs.

about four home health claims per week due to the amount of information that can comprise a 60-day episode. Once the PSC has gathered sufficient evidence, it may refer the HHA to the OIG. If the OIG does not accept the referral within a certain period of time, the PSC may present the case to other law enforcement agencies for further investigation.

Current CMS regulations provide for the removal of providers or HHA officials from the program for abuse of billing privileges in limited circumstances. Those removed may not reenroll for a minimum of 1 year and a maximum of 3 years.[40] Prior to August 26, 2008, the regulations provided for CMS to revoke a provider's billing privileges, but only for reasons other than improper billing, such as conviction for certain felonies or submission of false or misleading information on the enrollment application. Effective August 26, 2008, CMS may also revoke a provider's billing privileges for one narrowly defined type of abusive billing—submission of claims for services that could not have been furnished on the date claimed. This would include claims for services provided to deceased beneficiaries and claims for services when the physician or beneficiary was not in the state or not in the country when services were furnished.[41] Discussing the new provision, CMS stated that the expanded regulation was not intended to be used for isolated occurrences or accidental billing errors, but was directed at those "providers and suppliers who are engaging in a pattern of improper billing" and further explained that it would revoke billing privileges only when there were at least three instances of abusive billing. CMS also stated that it might propose other provisions related to revocation of provider and supplier billing privileges in the future.[42]

While the OIG may remove providers from the Medicare program for fraudulent billing, the OIG has rarely used its authority to exclude in the absence of conviction for fraud. If an HHA or individual is convicted of a crime related to the delivery of an item or service under Medicare, federal law requires the OIG to exclude them from participating in any federal health care program. The OIG also has the discretionary authority to exclude HHAs and individuals based on the OIG's determination that the HHA paid kickbacks, submitted claims for services that were not provided

[40]73 Fed. Reg. 36448, 36461 (June 27, 2008) (to be codified at 42 C.F.R. § 424.535(c)).

[41]73 Fed. Reg. 36461 (June 27, 2008) (to be codified at 42 C.F.R. § 424.535(a)(8)).

[42]73 Fed. Reg. 36455, 36457 (June 27, 2008).

as claimed or were unnecessary, or submitted false or fraudulent claims. HHAs that furnish services in excess of the needs of patients or who make false representations of material facts in support of a claim may also be excluded under the OIG's discretionary authority. The OIG has rarely used its discretion to exclude on the basis of fraudulent billing in the absence of a conviction for fraud. In calendar year 2007, less than half of 1 percent of all individual exclusions were for submitting false claims, submitting claims for services that were not medically necessary, or making false representations of material facts on a claim or documentation used to support a claim.[43] Rather than exclude on the basis of an OIG determination or refer these cases for prosecution,[44] the OIG may impose a CMP or seek a settlement. Under a settlement agreement, the provider or entity consents to the obligations specified by the OIG in exchange for the OIG's agreement not to seek exclusion.

Revalidation and Targeted Local Efforts Show Potential to Reduce Home Health Fraud and Abuse

In recent CMS and contractor initiatives, CMS learned that revalidation and targeted efforts adapted to local circumstances show the potential to reduce home health fraud and abuse. For example, as part of a 2-year demonstration, CMS is requiring all HHAs in Houston and the greater Los Angeles area to undergo revalidation at least once during the demonstration. As of October 2008, 37 HHAs (out of approximately 845) in the areas have had their billing privileges revoked for failure to resubmit their information. These 37 HHAs billed for approximately $6.1 million in fiscal year 2007. PSC efforts in Houston and Miami have also shown the potential to save Medicare money. The PSC needed to adapt its strategies to the different identified fraudulent and abusive practices in the two

[43]In calendar year 2007, the HHS OIG excluded 3,127 individuals. Ninety-eight percent of the exclusions of individuals in 2007 were based on a conviction, license revocation, or suspension. Less than 2 percent were based on default of student loan obligations. In the same year, the HHS OIG excluded 138 entities, including 12 entities on the basis of the OIG's determination that the provider submitted false claims, submitted claims for services that were not medically necessary, or made false representations of material facts on a claim or documentation used to support a claim. None of the 12 was an HHA.

[44]U.S. Attorneys, responsible for prosecuting Medicare fraud under both civil and criminal statutes, are unable to accept all matters and have a substantial backlog of pending cases. According to the Health Care Fraud and Abuse Control Program Annual Report for fiscal year 2006 by HHS and the Department of Justice, at the end of fiscal year 2006, the U.S. Attorneys' Offices (USAO) had 1,677 health care fraud criminal matters pending (2,713 defendants) and 1,268 civil health care fraud matters pending. A referral to the USAOs remains a pending matter until an indictment or information is filed or it is declined for prosecution.

communities. For instance, in Miami the PSC worked with physicians to identify HHA overpayments in excess of $9 million.

Revalidation Can Help Ensure Legitimacy of Home Health Providers

An ongoing CMS demonstration project shows that revalidation may be an effective method of ensuring the legitimacy of HHAs. CMS is currently conducting a 2-year demonstration that, in part, requires HHAs to undergo revalidation at least once during the demonstration. The demonstration, which began in late 2007, is being conducted in two areas with a history of fraudulent home health activity—greater Los Angeles and Houston.[45] HHAs that fail to resubmit their enrollment application within 60 days of receiving notice have their billing privileges revoked. As of October 2008, 37 HHAs out of approximately 845 had their billing privileges revoked as part of the demonstration. These 37 HHAs billed for approximately $6.1 million in fiscal year 2007. According to a CMS official, all of these agencies failed to resubmit the enrollment application.

Other parts of the demonstration will give CMS the ability to evaluate other actions aimed at reducing and deterring fraudulent or abusive HHA billing. In addition to revalidation, the demonstration requires state survey agencies to conduct surveys of any HHA that underwent an ownership change within the previous 2 years. RHHIs will also conduct a site visit to all HHAs to verify that the HHA is located at the address identified on the application. Billing privileges will be revoked for HHAs that fail to report an ownership or address change; have key officials with a felony conviction within the prior 10 years as determined by a background check; or no longer meet all Medicare conditions of participation. As of May 2008, the RHHIs responsible for California and Texas had begun conducting site visits to HHAs to verify the address information on the enrollment applications; state surveys of HHAs with an ownership change had not begun.

Targeted Local Efforts Show Potential to Deter Fraud and Abuse and Save Medicare Dollars

One PSC's recent efforts to detect and deter home health fraud and abuse in two areas show that targeted efforts based on local fraudulent and abusive practices can deter these activities and save the Medicare program money. In Houston, the PSC targeted those HHAs that billed more than 50 percent of their claims at the most severe clinical level, because the

[45]The greater Los Angeles area includes Los Angeles, Orange, Riverside, and San Bernardino counties in California. The Houston area is Harris County in Texas.

PSC's experience showed that such billing patterns were indicative of substantial upcoding. To identify potentially fraudulent claims, the PSC monitored the submission of RAPs for the targeted HHAs. Once enough beneficiaries were identified, the PSC sent teams of investigators, including nurses, to Houston for on-site interviews with beneficiaries to assess their health condition, including whether they were indeed homebound, and then compared these results with the information submitted by the HHA. Once an HHA reached a threshold percentage of submitting upcoded claims or claims for beneficiaries who were not homebound, the PSC worked with CMS to cancel the HHA's RAP privileges, meaning that the agency would only be paid at the end of the episode following the submission of a valid claim. According to the PSC officials, the cancellation of RAP privileges was particularly effective in Houston because these HHAs relied on the RAP payments to cover their expenses. Medicare payments for claims at the most severe clinical level for 24 targeted HHAs decreased from nearly $1.9 million in January 2007 to $34,461 in September 2007.

In Miami, the PSC identified a different practice that could not be addressed through the cancellation of RAP privileges; instead, the PSC worked with physicians to identify overpayments. This practice involved the submission of high numbers of outlier claims for beneficiaries with diabetes. The PSC told us that canceling RAP privileges would not have been appropriate in Miami because outlier payments are determined at the end of the episode; therefore, the HHAs in Miami were getting only a small amount of the total episode payment from the up-front payment that is based on the RAP submission. Also, the sheer volume of claims that nurses would have had to review in Miami was prohibitive. Instead of focusing on the suppression of RAP privileges, the PSC addressed the outlier problems in Miami through collaboration with referring physicians. The PSC sent letters to physicians that had referred beneficiaries whose care resulted in high HHA reimbursements from outlier claims with the names of the Medicare beneficiaries they had referred and the amount of payment the HHAs had received based on those referrals. According to the PSC officials, some of the referring physicians became concerned about the amount of money the HHAs had received and collaborated with the PSC. Some of the physicians indicated, for instance, that their signature had been forged or that they did not realize the amount of care they were authorizing. As a result of interviews with 31 of the physicians who responded to the letters, nearly 950 plans of care were disavowed by the physicians, resulting in overpayment assessments against HHAs in excess of $9 million as of March 2008.

Despite the different strategies needed in Houston and Miami to address the fraud and abuse concerns, the PSC found that city site visits, which included beneficiary interviews, were necessary in both locations. According to a PSC official, beneficiary interviews are needed so that they have a basis on which to deny a claim. The official noted that medical reviews that use only the medical records provided by the HHA are limited because providers may know how to falsify records so that they can pass a review. The PSC conducted 10 weeks of site visits in Houston between March 2007 and February 2008, using between 6 and 24 staff per city site visit, attempting 959 beneficiary interviews and completing 670. In Miami, the PSC completed 118 beneficiary interviews during 6 week-long site visits between mid-November 2007 and early March 2008 and 31 interviews with physicians with high referral rates to targeted HHAs.

In October 2008, CMS announced new initiatives to further address issues identified in Miami-Dade County. CMS officials from CMS's Miami field office are conducting beneficiary interviews with beneficiaries from HHAs with either a high percentage of outlier episodes or a high dollar amount of outlier payments. The beneficiaries will be visited at home to determine if they qualified for the services they received and if they received all the services for which Medicare was billed. Additionally, CMS is considering implementing a trigger in Miami-Dade County that will flag an HHA for increased scrutiny when more than 5 percent of the HHA's claims are outliers. Beneficiaries from these HHAs would be targeted for interviews and the HHA's claims would also be targeted for pre- or post-payment medical review. According to CMS officials, as of December 2008, 13 HHAs were subject to a 180-day payment suspension based on CMS's examination of outlier data.

Conclusions

Gaps in CMS's administration of the $12.9 billion Medicare home health benefit have left the agency vulnerable to improper payments, including payments for claims resulting from fraudulent and abusive practices. While we have reported for more than two decades about the lack of controls over the Medicare home health benefit, CMS's administration of the benefit continues to be unable to prevent HHAs from billing for services that are not medically necessary or that are not rendered.

The screening process RHHIs use for HHAs that have submitted applications to participate in Medicare does not routinely include verification of the criminal history of applicants. Without this information, individuals and businesses that misrepresent their criminal histories or

have a history of relevant convictions, such as for fraud, could be allowed to enter the Medicare program.

Physicians certifying home health plans of care are not currently given the information needed for them to play a significant role in aiding CMS efforts to reduce home health care fraud and abuse. Physicians lack information about the care Medicare is billed for based on their authorization. The PSC's experience in Miami showed that giving physicians more information about the care provided a beneficiary led to the identification of HHAs that were falsifying physician authorizations or providing levels of care in excess of patient needs.

RHHI monitoring of home health claims relies on medical reviews, but these reviews could be improved to more effectively recoup potential overpayments. Currently, RHHIs focus medical review efforts on prepayment reviews. However, when prepayment medical reviews identify HHAs as billing improperly, only rarely do RHHIs perform postpayment medical reviews to recoup potential overpayments

CMS rarely removes those HHAs or key officials at HHAs that engage in a pattern of abusive billing from Medicare. CMS recently issued regulations authorizing the revocation of Medicare billing privileges of providers engaging in one narrowly defined type of improper billing—billing for services that could not have been rendered. While this is a step in the right direction, CMS has yet to address the removal of HHAs or HHA officials engaging in other types of improper or abusive billing.

Recent initiatives by CMS and PSCs show the potential of protecting Medicare dollars with concerted efforts tailored to local conditions. However, CMS has not taken advantage of opportunities to further prevent and deter fraud and abuse as well as effectively sanction those engaging in fraud and abuse. In the absence of greater prevention, detection, and enforcement efforts, the Medicare home health benefit will continue to be a ready target for fraud and abuse.

Recommendations for Executive Action

To strengthen the controls on improper payments in the Medicare home health benefit, we recommend that the Administrator of CMS take the following four actions:

- Assess the feasibility of verifying the criminal history of all key officials named on an HHA enrollment application.

- Provide physicians whose identification number was used to certify or recertify a plan of care with a statement of services the HHA provided to that beneficiary based on the physician's certification.

- Direct CMS contractors to conduct postpayment medical reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review.

- Amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. Grounds for revocation could include a pattern of submitting claims that are falsified, for persons who do not meet Medicare's coverage criteria, or for services that are not medically necessary.

Agency Comments and Our Evaluation

CMS reviewed a draft of this report and provided written comments, which appear in appendix II.

In responding to our draft report, CMS stated it would consider two of our four recommendations. CMS provided comments on, but neither agreed nor disagreed, our other two recommendations. In considering our recommendation that physicians who certify or recertify plans of care be provided a statement of services received by beneficiaries, CMS noted that this sort of physician cross-checking may not result in a payment change on most claims since home health payments are calculated on the basis of the number of days of care and the number of visits rather than by the services provided. CMS suggested an alternative approach in which it would target physician cross-checking for beneficiaries who receive a large number of therapy visits and outlier claims. While we believe that all physicians who certify or recertify plans of care should be provided a statement of services, CMS's alternative approach would be a reasonable way to begin to implement this recommendation. CMS also stated that it would consider our recommendation to amend regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges.

CMS commented on, but neither agreed nor disagreed with our other two recommendations. In response to our recommendation that CMS assess the feasibility of verifying the adverse legal histories of key officials named on enrollment applications, CMS stated that GAO's use of the term "adverse legal histories" was too broad. We have changed this term in our report to "criminal history." In response to our recommendation that CMS direct its contractors to conduct postpayment medical reviews on claims

submitted by HHAs with high rates of improper billing, CMS stated that contractors may already review these claims when they conduct reviews for HHAs with high utilization. CMS also commented that contractors must consider the costs and availability of resources when they prioritize their work. While we agree that contractors must prioritize their work, we believe that the claims submitted by HHAs already identified as having high improper billing rates would have a high probability of improper payments.

CMS highlighted its recent initiatives to address improper payments to HHAs, noting that it has initiated new enrollment processes for Medicare providers, such as denying enrollment to providers with payment suspensions. It also commented that it has taken steps to address improper outlier payments in Miami and developed a demonstration project in California and Texas to address high-risk services and providers. Our draft report discussed the projects in Miami, California, and Texas and we added information about the new enrollment procedures.

CMS noted that the report only briefly mentioned the CON requirement in some states. CMS believes CON requirements could stem the increase of HHAs in high vulnerability areas of the country. While this could be the case, CON requirements are a function of state laws or regulations, and therefore outside the scope of our report, which focused on CMS's efforts to address improper payments.

In addition, CMS commented that resource constraints prevented contractors from engaging in certain activities, such as conducting criminal background checks on persons named on the HHA enrollment applications. While some stakeholders told us that resource constraints were an issue, it was beyond the scope of this report to evaluate whether CMS's resources were adequate to conduct these activities or to evaluate how CMS allocates its program integrity funds.

CMS suggested we add a paragraph on the nature and extent of CMS's activities involving physicians. We did not include this paragraph, which discussed several CMS initiatives involving ordering physicians. These initiatives either were related to durable medical equipment, which was outside our scope, or limited to the Miami area and already discussed in the appropriate section of our report.

In response to our statement that CMS does not generally collect information on the names and number of medical directors an HHA employs, CMS stated that nearly every medical director qualifies as a

managing employee and information on managing employees is collected on the enrollment application. We modified our statement to reflect that the form does not ask HHAs to specify the names and number of medical directors it employs. Therefore, CMS would have no way of knowing which managing employees were medical directors and if all medical directors had been named on the form.

CMS also requested that the report indicate that the OIG should more robustly utilize its authority to exclude HHAs and impose monetary penalties. We did not include these comments in our report since they fall outside of our scope, which focuses on CMS's efforts to address improper payments.

CMS also provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Administrator of CMS, committees, and others. The report also will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

Sincerely yours,

James C. Cosgrove
Director, Health Care

Appendix I: Medicare Home Health Spending and Utilization Growth in the United States, 2002 through 2006

For our analysis of 2002 and 2006 Medicare home health claims data for the 50 states and Washington, D.C., we used the following four spending and utilization indicators: percentage growth in Medicare home health spending from 2002 through 2006 (table 2), percentage growth in the percentage of Medicare beneficiaries who used home health services from 2002 through 2006 (table 3), percentage growth in the number of home health agencies (HHA) that billed Medicare from 2002 through 2006 (table 4), and percentage of outlier cases in 2006 (table 5).

Table 2: Percentage Growth in Medicare Home Health Spending from 2002 through 2006, States in Descending Order

State	Growth in Medicare HHA spending (percent)
Texas[a]	144
Florida[a]	90
Nevada[a]	88
Oklahoma[a]	65
Illinois	62
Indiana	44
Michigan	42
Louisiana	41
New Mexico	39
Mississippi	38
Idaho	34
Alaska	34
California[a]	34
Ohio	33
Arkansas	32
Georgia	31
Arizona	31
Tennessee	31
Alabama	30
Minnesota	30
Kansas	30
Massachusetts	30
New Hampshire	28
Colorado	27
Washington	26
South Carolina	24

State	Growth in Medicare HHA spending (percent)
Utah[a]	24
North Carolina	23
Missouri	22
Virginia	22
Wisconsin	19
Nebraska	17
Connecticut	16
Iowa	15
Maryland	15
Delaware	14
Maine	13
New York	13
South Dakota	12
Vermont	12
Kentucky	12
Rhode Island	10
New Jersey	8
Wyoming	7
District of Columbia	2
Pennsylvania	2
Montana	1
Oregon	0
West Virginia	-1
Hawaii	-5
North Dakota	-8
United States	**42**

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data.

[a]These states ranked among the top three in at least one of four spending and utilization indicators.

Note: Analysis based on beneficiary location. When the analysis was done using HHA location instead, spending growth changed by less than 5 percentage points for all but five states: Alaska, District of Columbia, Delaware, Kansas, and Missouri. The growth in spending in these states based on HHA location was 27 percent in Alaska, -14 percent in the District of Columbia, 1 percent in Delaware, 44 percent in Kansas, and 17 percent in Missouri.

Table 3: Percentage Growth in the Percentage of Medicare Beneficiaries Who Used HHA Services from 2002 through 2006, States in Descending Order

State	Growth in Part A beneficiaries who use HHA services (percent)
Texas[a]	57
Oklahoma[a]	30
Florida[a]	28
Nevada[a]	25
Illinois	23
Louisiana	23
Minnesota	22
Michigan	19
Mississippi	18
Indiana	17
Alabama	15
Georgia	14
Tennessee	14
Ohio	14
Utah[a]	12
Arkansas	10
Kansas	10
Idaho	10
North Carolina	9
Massachusetts	7
Wisconsin	7
New Mexico	5
New Hampshire	5
Connecticut	4
Alaska	4
Arizona	4
New York	4
Virginia	3
Kentucky	3
South Carolina	2
District of Columbia	2
Maine	2
Delaware	1
New Jersey	1

State	Growth in Part A beneficiaries who use HHA services (percent)
Colorado	0
Iowa	0
California[a]	-1
Missouri	-2
Pennsylvania	-2
Maryland	-3
Rhode Island	-3
Vermont	-5
Nebraska	-6
West Virginia	-6
Washington	-6
Montana	-6
North Dakota	-7
Wyoming	-8
Hawaii	-12
Oregon	-12
South Dakota	-15
United States	**12**

Source: GAO analysis of CMS data.

[a]These states ranked among the top three in at least one of four spending and utilization indicators.

Note: Analysis based on location of beneficiary residence.

Table 4: Percentage Growth in the Number of HHAs that Billed Medicare from 2002 through 2006, States in Descending Order

State	Growth in number of HHAs (percent)
Texas[a]	102
Florida[a]	100
Nevada[a]	75
District of Columbia	67
Michigan	62
Illinois	59
Utah[a]	44
Ohio	42
Arizona	32
California[a]	23
Oklahoma[a]	21
Virginia	18
Colorado	17
New Mexico	16
Alaska	14
Delaware	14
Maryland	11
Indiana	10
Hawaii	8
Pennsylvania	8
Vermont	8
Massachusetts	8
Georgia	7
Nebraska	7
Missouri	5
Alabama	4
Washington	4
North Carolina	3
New Hampshire	3
Idaho	2
Kansas	2
Iowa	1
Minnesota	0
Oregon	0

State	Growth in number of HHAs (percent)
West Virginia	0
Connecticut	-1
Tennessee	-1
South Carolina	-1
Arkansas	-2
New Jersey	-2
Wisconsin	-3
Rhode Island	-4
Kentucky	-6
Louisiana	-6
New York	-9
Mississippi	-11
Wyoming	-13
South Dakota	-13
Maine	-15
Montana	-18
North Dakota	-19
United States	**29**

Source: GAO analysis of CMS data.

[a]These states ranked among the top three in at least one of four spending and utilization indicators.

Note: Analysis based on location of HHA.

Table 5: Percentage of Outlier Cases, States in Descending Order, 2006

State	Average percentage of outlier cases (percent)
Florida[a]	12
Utah[a]	11
California[a]	7
New York	7
Texas[a]	6
Connecticut	5
Massachusetts	4
Colorado	4
Oklahoma[a]	4
Nevada[a]	3
New Hampshire	3
Wyoming	3
Wisconsin	3
Vermont	3
Ohio	3
Kansas	3
Arkansas	3
Rhode Island	3
Maine	3
Idaho	3
Iowa	3
Minnesota	3
Arizona	2
Montana	2
Virginia	2
Georgia	2
Nebraska	2
Delaware	2
Alaska	2
New Mexico	2
Missouri	2
District of Columbia	2
Indiana	2
Tennessee	2
New Jersey	2

State	Average percentage of outlier cases (percent)
Pennsylvania	2
Kentucky	2
North Carolina	2
Louisiana	2
North Dakota	1
Maryland	1
West Virginia	1
Michigan	1
Alabama	1
Washington	1
South Dakota	1
Illinois	1
Oregon	1
South Carolina	1
Hawaii	1
Mississippi	0
United States	4

Source: GAO analysis of CMS data.

[a]These states ranked among the top three in at least one of four spending and utilization indicators.

Note: Analysis based on location of beneficiary residence.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JAN 29 2009

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "Medicare: Improvements Needed to Address Improper Payments in Home Health" (GAO 09-185).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JAN 2 9 2009

TO: Barbara Pisaro Clark
Acting Assistant Secretary for Legislation
Office of the Secretary

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office Draft Report: "MEDICARE: Improvements Needed to Address Improper Payments in Home Health" (GAO-09-185)

Thank you for the opportunity to review and comment on the Government Accountability Office (GAO) draft report, "MEDICARE: Improvement Needed to Address Payments in Home Health." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the GAO has invested to research and report on Medicare's Home Health benefit.

The CMS is committed to continually reviewing and refining our processes to improve the Medicare program. As a result, within the past several months, CMS has taken a number of steps to address improper payments in home health that will strengthen anti-fraud efforts across Medicare, including the Home Health benefit. CMS has begun by initiating new enrollment processes that will impact home health agencies (HHA) as well as other Medicare providers. Effective January 1, 2009, and pursuant to Federal regulations at 42 CFR §424.530(a)(6) and (a)(7), an organizational provider (including a HHA, can be denied enrollment if the owner: (1) has an existing overpayment that has not been repaid in full, or (2) has been placed under a Medicare payment suspension. CMS Change Request #6097, which went into effect on January 20, 2009, requires contractors to undertake certain additional verification activities for providers (including HHAs) that are changing their practice location, banking information, special payment address, or are reactivating their Medicare billing privileges. We believe that these two activities, as they relate to HHAs, will assist us in halting questionable HHA behavior and help ensure that HHAs cannot enroll in Medicare without having satisfied their existing obligations to the Medicare program.

In addition, CMS has taken steps to address widespread abuse of outlier payments to Medicare certified HHAs in Miami-Dade County, Florida. Outlier payments are allowed by CMS for situations that occur infrequently within a normal case-mix, but there are

over 300 HHAs in South Florida and they have come to rely upon outlier payments as a predominant part of their overall reimbursement. The outlier payments in Miami are about 58 percent (2007 data) of the HHAs overall reimbursement, the highest percentage of outlier payments in the country. That compares to a national outlier payment of 6 percent. The outlier payment was never intended to be such a large part of HHA reimbursement. To address this problem, CMS has taken a number of steps: it is suspending HHAs with high amounts of outlier payments; enhancing visits to beneficiaries in their homes to verify that the beneficiaries qualify for the benefit; and utilizing autodenial edits for beneficiaries that do not qualify for the home health benefit. CMS will continue to perform ongoing beneficiary and physician interviews as well as onsite visits to HHAs in Miami-Dade that can result in edits, revocation, deactivation and other actions.

In 2007, CMS developed a Demonstration Project for HHAs in geographically high-risk areas of the country (California and Texas) to address high-risk services and providers. This demonstration involved strengthening initial provider and supplier enrollment and revalidation of enrollment to prevent "bad" providers from entering the program. The demonstration also incorporated criminal background checks of owners and managing employees into the provider enrollment process. Although criminal background checks have not yet produced substantial results, mandatory reenrollment reviews and site visits have resulted in referral of 55 HHAs for revocation of their Medicare billing privileges. The first year accomplishments of the HHA demonstration project demonstrates the effectiveness of intensified provider enrollment and enhanced program integrity resources. Contingent on additional funding, CMS plans on expanding the HHA demonstration to Miami-Dade County in light of increasing HHA fraud in South Florida.

The report only briefly mentions the requirement of a Certificate of Need (CON), which CMS believes would have a significant impact on stemming the increase of HHAs in high vulnerability areas of the country. The two States (Texas and Florida) with the highest percentage growth in Medicare Home Health spending from 2002–2006 are States without a CON requirement. Moreover, neither California nor Utah has a CON, and these two States are also included in the top seven States mentioned in the Draft Report as experiencing the highest percentage growth in Home Health spending from 2002–2006. CMS believes this is an area that the GAO should further explore.

We note the following specific comments should be addressed in this report:

Specific Comments

1. Under "What GAO Found" on the Highlights page, the GAO states in the third paragraph that "... CMS does not include physicians, who are in a position to detect certain types of improper billing, in the agency's efforts to detect improper payments."

   The CMS and its contractors **do** include physician interviews, as well as data analysis, on the top-ordering Home Health physicians. TriCenturion interviewed 76 such physicians in the Miami area, resulting in the disavowing of

approximately 1,000 plans of care and overpayments near $11 million. The GAO report later acknowledges on page 7 that "… in Miami, the contractor worked with physicians to identify HHA overpayments in excess of $9 million."

2. Page 2, last paragraph, last sentence should be revised to say:

   "However, fraudulent claims are often not reflected in the CERT error rate estimate. Since the program uses a random sample to select claims, reviewers are unable to see provider billing patterns that indicate potential fraud when making payment determinations."

Now page 5.

3. Page 6, last paragraph: The following sentence should be inserted immediately after the sentence identified in the previous comment: "CMS officials cited Regional Home Health Intermediary (RHHI) resource constraints as the reason for the lack of contractor activity in this area." CMS believes it is important to explain the reason why criminal background checks have not been routinely performed. A similar sentence appears to have originally been inserted in the first paragraph of page 7, but seems to have been stricken. It should be reinserted as described in this comment.

Now page 5.

4. Page 7, 1st paragraph: The sentence "However, HHAs are generally not subjected to revalidation" is incorrect and should be revised to read: "HHAs are subjected to revalidation to the extent that RHHI resources are available."

Now page 5.

5. Page 7, 1st paragraph, last two sentences: For clarity, CMS suggests that the GAO should indicate that the physicians being referenced in the report are the physicians who are ordering the Home Health services and/or signing the plans of care. CMS refers to them as "ordering physicians." For accuracy, CMS suggests that the GAO revise its report to include the language below regarding the extent and nature of CMS' activities involving ordering physicians:

   "The CMS' Field Offices and Program Safeguard Contractors (PSCs) are identifying high risk ordering and referring physicians for a number of high risk services, such as durable medical equipment (DME), diagnostic tests, and HHA services, and interviewing those physicians. Based on the interviews and signed attestations that the doctors never ordered the services/equipment, Medicare contractors have implemented a number of highly effective administrative actions, such as autodenial edits, prepay review, payment suspension, revocation, and referral to law enforcement. CMS Field Offices and PSCs have also identified and interviewed high utilizing beneficiaries and implemented similar actions based on their feedback that services were not rendered. CMS' current 7-State DME Stop Gap Plan addresses both high utilizing ordering physicians and beneficiaries. For instance, in Miami, the contractor worked with physicians to identify HHA overpayments in excess of $9 million."

Now page 8.

6. Page 10, footnote 13: We suggest the GAO make the distinction between what the service domain level determination took into account before and after the refinements of 2008. Specifically, with regards to the following sentence in footnote 13: "The service use domain is based on the anticipated number of therapy visits a beneficiary will receive and whether the beneficiary was recently in a hospital or rehabilitation facility." We recommend revising the above sentence to read, "In the original HH PPS, the service use domain was based on the anticipated number of therapy visits a beneficiary will receive and whether the beneficiary was recently in a hospital or rehabilitation facility." This change was proposed in the proposed rule at 72 FR 25361 and finalized in the final rule at 72 FR 49838.

Now page 9.

7. Page 11, 1st paragraph: The GAO states that RHHIs are "… responsible for screening HHA enrollment applications and making recommendations to CMS … whether the applications should be approved."

   The GAO has noted in the past that it is difficult to assess beneficiary eligibility for home health or whether services are reasonable and necessary based on paper review alone. The same theory holds true for determining if an application should be approved by individuals reviewing paper alone. The RHHI should, at a minimum, inform CMS or the Zone Program Integrity Contractor of new applications being considered so that they can perform a site visit.

Now page 10.

8. Page 13, 1st paragraph: Please delete "1 to 3 years." The 1-to-3 year period refers to the enrollment bar under 42 CFR §424.535(c), which does not necessarily equate to the period of revocation. They are two related, but distinct, concepts.

   In addition, while the GAO statement is true, it is not the only reason for revocation. The GAO report should state that there are other reasons CMS will revoke.

Now page 20.

9. Pages 23-24, footnote: The information is not accurate. The CMS-855A collects information on all managing employees of the HHA. Since virtually every medical director of an HHA will qualify as a managing employee, it follows that CMS will, in fact, capture information on HHA medical directors.

Now page 21.

10. Page 25, last paragraph: "….CMS does not require RHHIs to verify the criminal backgrounds of persons named on the application." The following sentence should be inserted immediately after this sentence identified in the previous comment: "CMS officials cited RHHI resource constraints as the reason for the lack of contractor activity in this area."

    In addition, the GAO should clarify in the next sentence of this paragraph that HHAs are subjected to revalidation to the extent that the RHHIs' resources permit it.

Now page 21.

11. Page 26, 1st paragraph: The following sentence should be inserted immediately after the language "…on the initial enrollment application." "CMS officials cited RHHI resource constraints as the reason for the lack of contractor activity in this area."

Now page 21-22.

12. Page 26, 1st paragraph: Please revise the sentence that begins "An application is subject to…" to read as follows: "An application is subject to denial for reasons including, but not limited to: (1) the provider, supplier, or an owner thereof has been convicted of certain types of felonies within the past 10 years; (2) the application contains false and misleading information; (3) noncompliance with Medicare enrollment requirements; and (4) the provider is not operational."

Now page 22.

13. Page 26, 1st paragraph: Regarding the sentence that begins "Because RHHIs…," the fact that criminal background checks have usually not been performed has little relation to the contractor's ability to detect false or misleading information. Contractors verify other information on the form, including State licensure data and information on whether the provider is excluded or debarred from Medicare and have denied applications based on the falsification of data other than that which relates to felony convictions. This sentence should be revised to read as follows: "RHHIs are not required to verify the criminal backgrounds of persons named on the application. CMS officials cited RHHI resource constraints as the reason for the lack of contractor activity in this area."

Now page 22.

14. Page 26, 2nd paragraph: The language "….but HHAs are generally not subjected to this revalidation" is inaccurate. As stated previously, HHAs are subjected to revalidation to the extent that the RHHIs' resources permit it.

Now page 24.

15. Pages 30-31: The GAO discusses Office of Inspector General (OIG) exclusions, including the finding that OIG rarely uses its authority to exclude in the absence of conviction for fraud.

    The CMS requests that the report indicate that CMS agrees that OIG should more robustly utilize its discretionary exclusion authority and imposition of civil monetary penalty authority against HHAs.

Now page 28.

16. Page 36, first paragraph: The report should be updated to indicate that CMS suspended 13 HHA agencies by December, 2008.

Now page 28.

17. Page 36, 2nd full paragraph: Consistent with previous comments, the language "…backgrounds of applicants" should be followed by "…due to resource constraints."

GAO Recommendation

Assess the feasibility of verifying the adverse legal history of all key officials named in an HHA enrollment application.

CMS Response
The CMS believes that the statement "assess the feasibility of verifying the adverse legal history…" is misleading. The term "adverse legal history" is very broad and, with the exception of criminal convictions, RHHIs do verify a number of the adverse actions identified in Section 3 of the CMS-855. These include GSA debarments, OIG exclusions, and license suspensions and revocations. We therefore suggest that the term "adverse legal history" be changed to "criminal history."

GAO Recommendation:
Provide physicians whose identification number was used to certify or recertify a plan of care with a statement of services the HHA provided to that beneficiary based on the physician's certification.

CMS Response:
We will consider this recommendation. Physicians play a critical role in determining patient eligibility for home care and developing care plans that reflect a reasonable and necessary mix of home health services. HHAs are paid a prospectively-set payment for a 60-day episode of care, with additional payment for beneficiaries receiving 6 or more therapy visits. Outlier payments are available for high-cost episodes but are computed based on the number of visits provided. Therefore, this sort of physician cross-checking may not result in a payment change for most HHA claims. An alternative approach would be to target the physician cross-checking for beneficiaries who receive a large number of therapy services or for claims resulting in outlier payments.

GAO Recommendation:
Direct CMS contractors to conduct postpayment medical reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review.

CMS Response:
Based on the data analysis, contractors currently conduct prepay and postpay medical reviews for any HHAs with high utilization, which may include the particular claims referenced by the GAO. However, contractors must consider the costs and the availability of resources as they prioritize their work and consider conducting additional reviews.

GAO Recommendation:
Amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. Grounds for revocation could include a pattern of submitting claims that are falsified, for persons who do not meet Medicare's coverage criteria, or for services that are not medically necessary.

CMS Response:
The CMS will take the GAO's recommendation under consideration as we continue to further analyze and develop strategies to better screen home health providers and to identify and prevent fraudulent activity in the home health program.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, Christine Brudevold, Assistant Director; Lori Achman; Carrie Davidson; Joanna Hiatt; Julian Klazkin; Daniel Lee; Elizabeth T. Morrison; and Amanda Pusey made major contributions to this report.