

**Memorandum**

NOV - 1 1998

Date June Gibbs Brown  
From Inspector General *June G Brown*

Subject Office of Inspector General Final Reports on Home Health

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Attached for your review are two final reports that examine the home health error rate and assess the effect of the interim payment system on access to home health agencies.

The first report, "Review of Medicare Home Health Services in California, Illinois, New York, and Texas" (A-04-99-01194), is a repeat of our earlier examination of the home health care error rate. The prior review, released in 1997, showed a 40 percent improper payment rate in four States with large Medicare expenditures--California, Illinois, Texas, and New York. The current review, using Fiscal Year 1998 data for the same four States, reveals a drop in the rate of improper or highly questionable services to 19 percent. The errors represent services not reasonable and necessary, services to beneficiaries who were not homebound, services without a valid physician order, services not documented, and services at terminated home health agencies for which medical records could not be found. In response to our draft report, the Health Care Financing Administration (HCFA) noted it was pleased with the progress made to reduce the payment errors in home health care. The HCFA raised concerns about the errors we identified relating to terminated home health agencies and agreed to do further work with us to obtain more information on the terminated agencies. The HCFA generally concurred with our concerns about inadequate physician involvement in assessing patient needs and homebound status and agreed to collect the identified overpayments. The HCFA did not agree with our recommendations to consider our findings when determining the prospective payment rates for home health agencies.

The second report, "Medicare Beneficiary Access to Home Health Agencies" (OEI-02-99-00530) assesses how the interim payment system for home health agencies is affecting Medicare beneficiaries' access to home health care for patients discharged from hospitals. Our analysis is based on Medicare home health data and a survey of a national random sample of 181 hospital discharge planners. We found that 85 percent of discharge planners report that Medicare patients are able to obtain home health care when they need it, three quarters of the discharge planners needed to contact on average only one home health care agency to obtain care for their patients, and 83 percent say home health care agencies either never or infrequently refuse to take Medicare patients. We also learned that home health agencies have changed their admissions practices over the past two years by requiring more

information before accepting a prospective patient. Those discharge planners who indicated that they had problems in placing some home health care patients attributed it to Medicare eligibility requirements as well as other factors including the interim payment rates and the limited capacity or absence of home health agencies in the area. In its comments, HCFA was glad to note that the overwhelming majority of Medicare beneficiaries are receiving the home health care they need. At the same time, they requested us to continue our work in this area. This work is currently underway.

Thank you for your comments on the draft of these reports. We would appreciate your views and information on the status of action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me, George Grob, Deputy Inspector General for Evaluation and Inspections at (202) 619-0480, or George Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

#### Attachments

cc:

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**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE  
HOME HEALTH SERVICES IN  
CALIFORNIA, ILLINOIS, NEW YORK,  
AND TEXAS**



**JUNE GIBBS BROWN**  
Inspector General

**OCTOBER 1999**  
**A-04-99-01194**

**Memorandum**

Date NOV - 1 1998  
From June Gibbs Brown  
Inspector General *June G Brown*  
Subject Review of Medicare Home Health Services in California, Illinois, New York, and Texas  
(A-04-99-01194)  
To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

This final report provides you with the results of our audit of Medicare home health services in California, Illinois, New York, and Texas and compares the results to an earlier audit reported as "*Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*" (A-04-96-02121). This current audit was performed at the specific request of the Administrator of the Health Care Financing Administration (HCFA).

**OBJECTIVE**

The objectives of our current audit were to determine whether Medicare payments to home health agencies (HHA) in the four States during the 9-month period ending September 1998 met Medicare reimbursement requirements and to evaluate the implications of our results on current as well as future HHA payments.

**SUMMARY OF FINDINGS**

Our current review found the error rate in home health claims has been significantly reduced in comparison to the error rate found in our prior review, but is still far too high. In our current review, we estimate 19 percent of the services in the four States during the 9-month period ending September 30, 1998 were improper or highly questionable and did not meet Medicare reimbursement requirements. We estimate during that time period the intermediaries approved unallowable or highly questionable claims with charges totaling about \$675.4 million out of the four State universe of \$2.3 billion in charges. This compares to our prior audit in which we estimated 40 percent of the services in the same four States during the 15-month period ending March 31, 1996 did not meet Medicare reimbursement requirements. Since our prior review covered a 15-month period and our current review covered a 9-month period the projections of total dollar amounts of overpayments are not comparable.

When comparing the results of our two reviews, we note there has been a dramatic decrease in the error rate for services which were not reasonable and necessary (6 percent error rate in current review and 18 percent error rate in our prior review), for services rendered to beneficiaries who were not homebound (3 percent error rate in current review

and 11 percent error rate in our prior review), and for services without valid physician orders (4 percent error rate in our current review and 10 percent error rate in our prior review).

Although the error rate has been significantly reduced, we are concerned that the 19 percent rate of improper or highly questionable services is still very significant. In comparison, our review of all of Medicare's Fiscal Year (FY) 1998 fee-for-service payments as part of the financial statement audit estimated an error rate of only 7.1 percent.

In our opinion, the majority of the unallowable services continued to be provided because of inadequate physician involvement. We found physicians did not always review or actively participate in developing the plans of care they signed.

Furthermore, we are aware there are discussions underway to possibly increase current amounts paid to HHAs. We believe the 19 percent rate of improper or highly questionable services needs to be one of the factors to consider in determining whether any increase in the current amounts are warranted.

In addition, we are concerned that the rate setting methodologies HCFA used to develop the new HHA prospective payment system (PPS) did not adequately adjust for the types of improper payments found in our reviews. We are, therefore, concerned that the HHA PPS rates are inflated.

We, therefore, recommend HCFA:

- ▶ Revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.
- ▶ Consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current HHA payments.
- ▶ Consider making an equitable adjustment to the proposed HHA PPS rates or update factors to take into account the improper and highly questionable payments that were included in the rate calculations.
- ▶ Instruct the intermediaries to collect the overpayments identified in our sample.

In response to our draft report, HCFA noted it was pleased with the progress made to reduce the payment errors in home health claims. The HCFA raised concerns about the errors we identified relating to terminated HHAs. The HCFA generally concurred with our concerns about inadequate physician involvement in assessing patient needs and homebound status and agreed to collect the identified overpayments. However, HCFA did not agree with our recommendations to consider our findings when determining the prospective HHA payment rates. The full text of

HCFA's response is included as APPENDIX E of our report. Please see page 13 of this report for a discussion of HCFA's comments and our related response.

## **BACKGROUND**

### ***Home Health Services***

Home health services allow people with limited mobility to live independently while still receiving professional health care services. In order for home health services to be covered by Medicare, beneficiaries must be confined to their home; under the care of a physician; and in need of skilled nursing services on an intermittent basis or skilled physical, speech, or occupational therapy. An HHA is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis.

During the period of our current review, January 1998 through September 1998, HHAs were reimbursed under the interim payment system (IPS). Under IPS, HHAs are paid the lesser of (1) actual costs, (2) per-visit limits, or (3) per-beneficiary limits. The IPS will be used to pay HHAs until the implementation of the PPS which is tentatively scheduled to begin October 2000.

### ***Intermediary Responsibility***

The HCFA contracts with intermediaries, usually large insurance companies, to assist them in administering the home health benefits program. The principal intermediaries for HHAs in California and New York are Blue Cross of California and United Government Services. Illinois and Texas are serviced by Palmetto Government Benefits Administrators. The alternate intermediary for the four States is Wellmark, Inc.

The intermediaries are responsible for:

- processing claims for HHA services,
- administering payment safeguard activities,
- performing liaison activities between HCFA and HHAs,
- making interim payments to HHAs, and
- conducting audits of cost reports submitted by HHAs.

### ***Prior and Current Audits***

In 1995, the Secretary of the Department of Health and Human Services initiated the Operation Restore Trust (ORT) Project to reduce the incidence of fraud, waste, and abuse in the Medicare and Medicaid programs. Under the auspices of ORT, in 1997 we completed an audit of the home

health services in California, Illinois, New York, and Texas for the 15-month period ending March 31, 1996.<sup>1</sup> That audit disclosed substantial problems in the Medicare home health program. In that review, we disclosed 40 percent of the total services contained in a sample of claims did not meet Medicare reimbursement requirements.

Subsequently, several changes have been made to Medicare's HHA program. In order to determine whether these changes improved the program by reducing the substantial errors uncovered and reported in the earlier audit, the HCFA Administrator requested us to replicate the earlier audit using a more current period specified by HCFA.

### ***Recent Legislation***

Prior to the Balanced Budget Act (BBA) of 1997, Medicare reimbursed participating HHAs on the basis of reasonable costs, up to specific per-visit limits. The BBA mandated a number of changes in the way Medicare pays for home health services, including the creation of an IPS and a PPS for home health services. Section 4602 of the BBA required implementation of the IPS until the PPS is implemented. The IPS imposed two sets of cost constraints on HHAs--it reduced the existing home health per-visit cost limit and subjected HHAs to an aggregate per-beneficiary cost limit. Under IPS, HHAs are paid the lesser of (1) actual costs, (2) the per-visit limits, or (3) the per-beneficiary limit.

The BBA, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, Public Law 105-277, required the Secretary to develop and implement a PPS for home health services effective on or after October 1, 2000. The HCFA plans to fully implement the HHA PPS on October 1, 2000. The proposed rule establishing the requirements for the HHA PPS was published in the Federal Register on October 28, 1999.

The BBA required the computation of the standard PPS amount be initially based on the most recent available audited cost report data. To implement this requirement, HCFA conducted audits of the cost reports submitted by a sample of HHAs whose cost-reporting periods ended in FY 1997 (October 1, 1996 through September 30, 1997). This sample of 567 audited cost reports, which included the review of HHA accounting records, was the basis of the HHA PPS rate calculations. Although cost report audits can identify unallowable specific cost items, the reviews did not extend to an analysis of medical records at the HHA nor were beneficiaries or applicable physicians contacted.

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<sup>1</sup>*Results of Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas (A-04-96-02121), July 1997.*

## SCOPE

The objectives of our audit were to determine whether Medicare payments to HHAs in the four States met Medicare reimbursement requirements and to evaluate the implications of our results on current as well as future HHA payments.

Our sample was selected from the claims processed by the principal intermediary for each State and the alternate intermediary for the four States of California, Illinois, New York, and Texas. During the 9-month period ending September 30, 1998, the fiscal intermediaries approved for payment 2,399,413 HHA claims from the 4 States totaling about \$2.3 billion in charges. We reviewed a statistical sample of 250 claims with \$267,699 in charges. APPENDIX A contains the details on our sampling methodology. APPENDIX B contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by the HHAs met the reimbursement requirements.

We determined the percent of services that were improper or highly questionable by using a stratified cluster approach. See APPENDIX C for details.

Generally, for each of the 250 claims, we:

- interviewed the beneficiary, family member, or a knowledgeable acquaintance,
- interviewed the physician who certified the plan of care,
- obtained supporting medical records maintained by the HHAs, and
- requested the intermediaries' medical review personnel to determine whether the beneficiaries were homebound and the services were medically necessary.

We did not review the overall internal control structure of the intermediaries or of the Medicare program. We did not test the internal controls because the objective of our review was accomplished through substantive testing.

The methodologies used in the current audit regarding statistical sampling, sample testing, interviews of beneficiaries, interviews of physicians, review of intermediary HHA records, and use of intermediary medical review personnel were, to the maximum extent possible, identical to those methodologies used in the prior audit. To complete the current audit we also used these additional procedures:

- discussed the impending regulations of the BBA with HCFA officials, and
- discussed with HCFA officials the methodologies they used to derive the HHA PPS payment rates.



Appendix D lists prior audit reports issued by the OIG pertaining to Medicare reimbursements for HHAs.

Our audit was made in accordance with generally accepted government auditing standards. Field work was performed in California, Illinois, New York, and Texas and included visiting the HHAs' administrative offices, physicians' offices, and beneficiaries' residences. The field work was conducted from December 1998 to September 1999.

**DETAILED RESULTS OF REVIEW**

Our current review found that the rate of improper or highly questionable services in home health claims has been significantly reduced in comparison to the error rate found in our prior review, but is still far too high. As shown in the chart below, there has been a dramatic decrease in services which were (a) not reasonable and necessary, (b) rendered to beneficiaries who were not homebound, and (c) not supported with a valid physician order.

**COMPARISON OF TYPES OF FINDINGS**

	<b>CURRENT REVIEW</b>	<b>PRIOR REVIEW</b>
<b>Types of Findings</b>	Percentage*	Percentage*
Services Not Reasonable and Necessary	5.51%	18.33%
Beneficiary Not Homebound	3.00%	10.67%
Services Without Valid Physician Orders	3.57%	10.38%
Services Not Documented	0.96%	0.19%
No Documentation at Terminated HHAs	5.80%	**
<b>TOTAL</b>	<b>19% ***</b>	<b>40%***</b>

\* Percentages were developed by statistical projections based on a stratified cluster methodology. For these appraisals, we considered each claim to be a cluster of services.

\*\* This category of findings was not identified in our prior review.

\*\*\* Rounded to the nearest whole percentage.

Our current audit showed 772 of the 3,472 services in 90 of the 250 claims included in our random sample were improper or highly questionable and did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the intermediaries

for California, Illinois, New York, and Texas during the 9-month period ending September 1998, we estimate 19 percent of the services contained in the claims were improper or highly questionable. The percentage was computed using a stratified cluster sampling methodology. See APPENDICES A and C for the details on our sampling results.

This compares with our prior audit which showed that 1,539 of the 3,745 services included in 146 of the 250 claims in our random sample did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the same intermediaries for the same States during the 15-month period ending March 31, 1996, we estimated 40 percent of the services contained in the claims did not meet Medicare reimbursement requirements.

We believe the majority of unallowable HHA services continues to be provided because of inadequate physician involvement. In our current review, we found physicians did not always review or actively participate in developing the plans of care they signed. They relied heavily on HHAs to make homebound determinations and develop the plans of care for home health services. Medicare regulations do not require physicians to personally examine beneficiaries or review medical records before signing certifications stating beneficiaries need home health care.

In our previous review, we found inadequate physician involvement, lack of knowledge of beneficiaries of the claims being submitted, and limited medical reviews were the underlying causes of the unallowable services being claimed. Currently, HCFA informs the beneficiaries of the health services by sending them a detailed Medicare Summary Notice form for all services. In addition, HCFA has resumed funding of medical reviews at the intermediaries. However, the lack of adequate physician involvement issue has never been completely addressed.

In comparison to the findings in our prior review, our current review found the error rate has been significantly reduced. However, we are concerned that the error rate is still very significant. The 19 percent rate of improper or highly questionable HHA services is almost three times larger than the overall Medicare error rate noted as part of the financial statement audit.

Furthermore, we are aware there are discussions underway to possibly increase current amounts paid to HHAs. We believe the 19 percent rate of improper or highly questionable services needs to be one of the factors to consider in determining whether any increase in the current amounts are warranted.

Last, but not least, we are concerned about the implications of our findings on the payment rates that were derived for the impending HHA PPS. The prospective HHA payment rates were based on the 1997 cost reporting period. We appreciate that our prior HHA review was done prior to the 1997 base year and our current HHA review was done subsequent to the base year period. Furthermore, both audits were restricted to four large States. However, our significant findings in both reviews, as well as other reviews we have performed including our FYs 1996, 1997, and

1998 financial statement audits<sup>2</sup>, indicate substantial overpayments have been made to HHAs. We are concerned that the 1997 base period also contains significant overpayments causing the PPS rates to be inflated.

We acknowledge that HCFA has done extensive work in designing the HHA PPS. To validate the base period used in the rate calculations, HCFA audited a sample of 567 cost reports. However, HCFA did not examine the medical services claimed on these cost reports. As a result, unallowable costs brought about by unallowable medical services would not have been detected and excluded from the base year costs. Based on this and the results of our audit work, we believe the computed HHA PPS rates are inflated.

### ***Criteria for Certification of Home Health Services***

Title 42 CFR section 424.22 states: "Medicare Part A or Part B pays for home health services only if a physician certifies and recertified..." that "(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine..." and "(iv) the services were furnished while the individual was under the care of a physician..." The regulations require a physician to sign a plan of care that serves as a certification that the services are medically necessary and the beneficiary is homebound. However, the regulations do not require the same physician perform all the responsibilities nor do they provide guidance to determine the meaning of "under the care of a physician."

### ***Services Not Reasonable and Necessary***

Our current review disclosed that 373 services, included in 30 claims, were not reasonable and necessary. These claims included services for skilled and aide services that were determined to be medically unnecessary by the intermediaries' medical review personnel. This compares with 793 services in 65 claims that were found to be not reasonable or necessary in our prior review.

Many of the physicians who certified home health services on the 30 claims that included services not reasonable and necessary stated the HHAs determined the type and frequency of home care for the beneficiaries. The physician involvement in the preparation of plans of care was limited to signing the forms prepared by the HHAs.

### ***Services to Beneficiaries Who Were Not Homebound***

Our current review disclosed that 66 services, included in 7 claims, were provided to beneficiaries who were not homebound. We found Medicare reimbursement criteria regarding the homebound status of the beneficiaries was not always met because physicians did not make

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<sup>2</sup>See APPENDIX D for a listing of our prior reports addressing improper payments made to HHAs. Details on most of these audits can be found on the OIG web site. We would be glad to provide details of the reports not on our web site.

this determination. This compares with our prior review which found that 499 services included on 46 claims were provided to beneficiaries who were not homebound.

During our interviews, the beneficiaries, their families, or HHA records indicated the beneficiaries could leave their homes without considerable effort at the time HHA services were provided. In our review, the determination on the homebound status of the beneficiary was made by the intermediaries' medical review personnel.

### ***Services Without Valid Physician Orders***

Our current review disclosed that 180 services, included in 24 claims, did not have valid physician orders. For these claims, the physicians had not signed and/or dated the plans of care or the plans of care were incomplete. In some instances, the plans of care were signed and dated after the services were performed and after the claims were submitted for payment. In other instances, the plans of care were signed by a nurse, an office manager, a physician's assistant, or a doctor's secretary in the name of the physician. This compares with our prior audit which showed that 239 services included in 31 claims were for services that did not have valid physician orders.

Medicare regulations require a plan of care and a certification of medical necessity be signed by the same physician and the individual receiving the care be under the care of a physician.

### ***Services Not Documented***

Our current review disclosed that 27 services, included in 17 claims, were not documented. In these cases, the HHA records showed no evidence the home health services were performed. This compares with our prior review which showed eight services, included in four claims, were for services that were not documented.

### ***No Documentation at Terminated HHAs***

The sample in our current review included 34 claims from HHAs which had terminated their Medicare contracts. Even though they were no longer in business, we were able to find medical records for 451 services, included in 22 of these 34 claims. However, we were unable to locate medical records for 126 services, included in the other 12 claims, from 12 HHAs that had terminated their Medicare contracts and had gone out of business. Numerous attempts were made to locate the records. Examples of our efforts include:

- Office space at the address on the provider listing had been vacated. No forwarding information had been left at that address. The provider's phone number was called and there was no response. The provider's toll free number had been given to another business. Another address, provided by the intermediary, was visited. This address turned out to be a mini-storage facility where the agency apparently rented a mail box.

They were no longer renting the mailbox. The beneficiary's wife and his doctor were visited, but neither had any information on where the agency might be located.

- In a 6-day period, our auditors made 12 attempts at contacting the owners of an agency at 6 different addresses we had located. None of those attempts were successful. We were also unable to contact the certifying physician in this case. We later determined that this HHA was under investigation by law enforcement.

Since the medical records for these HHAs could not be located, we recorded these highly questionable services provided by these HHAs as unallowable.

### *Effect*

We estimate during the 9-month period ending September 30, 1998, the intermediaries approved unallowable and highly questionable claims with charges totaling about \$675.4 million out of the four State universe of \$2.3 billion in charges.

### *Causes*

We believe the unallowable home services disclosed by our review occurred because of the inadequacy of existing controls to ensure claims approved for payment were for allowable services. The HCFA relied on the treating physicians to ensure services were provided only to eligible beneficiaries. However, the physicians in many cases did not fulfill their responsibility to Medicare, its beneficiaries, or the HHAs.

Additional causes identified in our prior review included funding constraints HCFA had imposed on the intermediaries' medical review requirements for home health claims and that beneficiaries did not receive notice of Medicare benefits for home health services, and thus, did not provide the intermediary with feedback regarding services claimed by providers. We believe subsequent actions taken by HCFA have lessened the impact of these causes.

### **Inadequate Physician Involvement**

The Medicare program recognized the physician would have an important role in determining utilization of services. The law requires payment can be made only if a physician certifies the need for services and establishes a plan of care.

In court decisions, the U.S. District Court has relied heavily on the physician's certifications under the "treating physician rule." This rule has been the turning point in court cases where home health services, previously disallowed by the intermediaries and administrative law judges, were allowed by the court. The rule places a significant reliance on the informed opinion of a treating physician, even if contradicted by substantial evidence because the treating physician is considered to be more familiar with the patient's medical condition than other sources.

We interviewed 85 physicians who signed the plans of care associated with the unallowable claims found in our review. Our audit disclosed too often the physicians' involvement in home health care was limited to signing plans of care prepared by the HHAs without proper evaluation of the patients to assess their needs and homebound status. We found HHAs were determining the need, type, and the frequency of home health services without physician participation.

The physicians' interviews disclosed inadequate involvement in the preparation of plans of care or the determination of homebound status. For example:

- In five instances, the physicians signed the plans of care without having knowledge of the patients' condition. This compares with 11 instances in our prior review.
- In 31 instances, the physicians were not aware of the homebound requirement for home services. This compares with 82 instances in our prior review.
- In 67 instances, the physicians relied on the HHA to prepare the plan of care. This compares with 88 instances in our prior review.

As we found in our prior review, Medicare does not require physicians to personally examine their patients before signing certifications for home care. Thus, the failure of physicians to personally examine their patients does not render the home care unallowable. However, we believe the lack of physician involvement in the assessment of their patients' needs and homebound status was a leading cause of the unallowable services disclosed by our review.

The certification signed by the physicians clearly states the physician considered the beneficiary homebound. However, our review showed the physicians deferred to HHAs on the homebound determination.

### ***Medicare PPS Rates***

We are concerned about the implications of our findings on the payment rates that were derived for the impending HHA PPS. Both of our four State HHA reviews have found substantial overpayments were made to HHAs before and after the base year period used to derive the HHA PPS rates. In addition, other reviews we have done on individual HHAs prior to the base year have found substantial overpayments. Our financial statement audits for the base year and prior years have found significant overpayments. We are, therefore, concerned about the reliability of the base year data used in the HHA PPS rate calculations.

According to HCFA's proposed regulations implementing the HHA PPS and our discussions with HCFA officials, base year cost data used to construct the rates were not adjusted to take into account the types of errors found in our reviews. Specifically, we are concerned our work has demonstrated that overpayments and highly questionable payments have occurred in Medicare

reimbursements for HHA services and these overpayments are too significant to be ignored. As a result, we are concerned the HHA PPS rates are inflated.

Although HCFA audited 567 cost reports for base year 1997 to derive the HHA PPS payment rates, these audits were somewhat limited in their scope since they only looked at the allowability of expenditures in the accounting records but did not review whether the beneficiary was homebound and if the services were medically necessary and properly authorized. We believe these types of unallowable costs would not have been detected and excluded from the base year costs, and the computed HHA PPS rates are excessive. The use of inflated rates may enable HHA providers to realize windfall profits and will further weaken the precarious financial stability of the Medicare trust funds.

### **CONCLUSIONS AND RECOMMENDATIONS**

As indicated in our audits of home health services, the error rate of unallowable services provided by HHAs has been significantly reduced. However, we found significant improper and highly questionable payments relating to the provision of these services still remain.

We are aware there are current discussions to amend the IPS and increase payments to HHAs. We believe the results of our current review need to be considered as a factor before making changes which would increase payments to HHAs.

Also, since HCFA officials did not adjust the HHA PPS 1997 base year to eliminate costs due to unallowable services into account, we are concerned that the FY 1997 base year data used to calculate future PPS rates was inflated. Accordingly, we believe the application of these inflated rates will result in excessive payments to HHAs. Therefore, we believe this should be considered when deciding if any changes should be made to future HHA payment rates.

We are recommending that HCFA:

- ▶ Revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.
- ▶ Consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current payments under the IPS.
- ▶ Consider making an equitable adjustment to the proposed HHA PPS rates or update factors to take into account the improper and highly questionable payments that were included in the base year calculations.
- ▶ Instruct the intermediaries to collect the overpayments identified in our sample.

### **HCFA's Response**

In response to our draft report, HCFA noted it was pleased with the progress made to reduce the payment errors in home health claims. The HCFA raised concerns about the errors we identified relating to terminated HHAs. The HCFA generally concurred with our concerns about inadequate physician involvement in assessing patient needs and homebound status and agreed to collect the identified overpayments. However, HCFA did not agree with our recommendations to consider our findings when determining the HHA PPS payment rates. The full text of HCFA's response is included as APPENDIX E of our report.

Regarding the errors we identified because we could not locate medical records at 12 HHAs which had terminated from the Medicare program, HCFA agreed that it is a problem that these records could not be located and had concerns that terminated providers leave the Medicare program with uncollected overpayments being owed the Medicare program. In fact, subsequent to the issuance of our draft report, HCFA provided us information from HCFA's Provider Overpayment Reporting System which indicates these 12 terminated HHAs left the program leaving *current overpayments totaling almost \$29 million*. We will work with HCFA to try to obtain further information on these HHAs.

A summary of HCFA's response to our recommendations and our comments follows:

### **OIG Recommendation**

The HCFA should revise the Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

### **HCFA Response**

The HCFA generally concurred with the concept of involving physicians more in the certification role and stated that they are considering several options to encourage better physician involvement relating to HHA services.

### **OIG Recommendation**

The HCFA should consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current payments under the IPS.

### **HCFA Response**

The HCFA stated under current law it has no authority to make changes to the IPS, and it has not recommended any changes to the IPS at this time.



### **OIG Comment**

Our recommendation was made in the context of current budgetary discussions to possibly make changes to the IPS. It is with regards to these discussions that we made this recommendation. We continue to recommend that HCFA share our findings in any future discussions to adjust the IPS.

### **OIG Recommendation**

The HCFA should consider making an equitable adjustment to the proposed HHA PPS rates or update factors to take into account the improper and highly questionable payments that were included in the rate calculations.

### **HCFA Response**

The HCFA disagreed with this recommendation because it believes actions have already been taken to ensure accurate and fair payments, but agreed our recommendation had merit for further review. The HCFA believes three factors combine to nullify any need for further payment rate changes. The factors include that HCFA's cost report audits were extensive and accurately portray the cost of HHA services, the OIG report demonstrates that the overall error rate has decreased significantly, and the imposition by Congress of a 15 percent reduction in future HHA payments.

### **OIG Comment**

While these factors exist, we continue to believe the base year data for the proposed HHA PPS payments rates contains improper payments causing the rates to be inflated. Although HCFA states the cost report audits were extensive, the audits did not include beneficiary interviews nor reviews of medical records to determine if the services provided met Medicare reimbursement guidelines. We believe these audits did not identify the types of errors found in our review which as noted amounted to an estimated \$675 million in unallowable or highly questionable payments during the 9-month period ending September 30, 1998. We acknowledge that legislation requires additional reductions, however these reductions do not fully account for the errors inherently included in the base period since HCFA's review of the base period was limited to cost report issues. We, therefore, continue to believe the PPS rates are inflated.

### **OIG Recommendation**

The HCFA should instruct the intermediaries to collect the overpayments identified in our sample.

### **HCFA Response**

Officials at HCFA generally concurred with this recommendation.

## **APPENDICES**

## SAMPLING METHODOLOGY

### OBJECTIVE

The objective of this assignment, related to sampling and estimating, was to determine whether Medicare payments for services provided by HHAs in California, Illinois, New York, and Texas met the Medicare eligibility and reimbursement requirements.

### POPULATION

The population was the claims approved for payment by the principal regional home health intermediaries (RHHI) for the States of California, Illinois, New York, and Texas (original ORT pilot states), and the alternate RHHI for the four original ORT pilot States for the period January 1, 1998 through September 30, 1998.

Each of the four RHHIs provided a computer file of the home health claims approved for payment from the State for which the RHHI had principal responsibility during the 9-month period ended September 30, 1998. The number of claims per computer file was:

<u>Stratum Number</u>	<u>RHHI</u>	<u>State</u>	<u>Number of Claims</u>	<u>Charges</u>
1	BC of CA	CA	444,955	\$ 421,228,522
2	Palmetto GBA	IL	354,289	269,205,328
3	UGS	NY	476,811	527,111,298
4	Palmetto	TX	922,783	860,569,800
5	Wellmark	CA, IL, NY, TX	200,575	\$ 211,949,485
TOTAL			<u>2,399,413</u>	<u>\$2,290,064,433</u>

### SAMPLE UNIT

The sample unit was be a home health claim approved for a payment for a Medicare beneficiary. An approved claim includes multiple visits and items of cost for the home health services provided.

### SAMPLE DESIGN

A stratified random sample was used.

### **SAMPLE SIZE**

A sample of 50 claims from each stratum was selected. There are 5 strata, with a total sample size of 250 claims.

### **ESTIMATION METHODOLOGY**

Using the HHS-OIG-OAS Variable Appraisal Program for stratified samples, we projected the overpayment for services that either were not reasonable or necessary, not to homebound beneficiaries, did not have valid physician orders, did not have documentation, or were not available due to closure of the HHA. Using the HHS OIG OAS Attributes Appraisal Program for stratified cluster sampling, we projected the occurrence of certain types of errors.

## VARIABLES PROJECTIONS

**RESULTS OF 1998 SAMPLE:**

The results of our review are as follows:

<u>Stratum Number</u>	<u>Number of Claims</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
1	444,955	50	\$ 49,232.32	14	\$10,080.93
2	354,289	50	40,204.29	19	10,215.90
3	476,811	50	74,151.93	24	15,441.58
4	922,783	50	47,569.71	17	12,324.87
5	<u>200,575</u>	<u>50</u>	<u>56,540.40</u>	<u>16</u>	<u>34,544.10</u>
<b>Total:</b>	<b><u>2,399,413</u></b>	<b><u>250</u></b>	<b><u>\$267,698.65</u></b>	<b><u>90</u></b>	<b><u>\$82,607.38</u></b>

Point Estimate	\$675,390,396
At the 90% Confidence Interval:	
Lower Limit	\$487,398,399
Upper Limit	\$863,382,392

**VARIABLES PROJECTIONS**

**RESULTS OF 1996 SAMPLE:**

The results of our review are as follows:

<u>Stratum Number</u>	<u>Number of Claims</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
1	891,502	50	\$ 60,910.33	28	\$ 16,664.20
2	657,358	50	59,336.44	36	46,905.93
3	531,110	50	103,697.31	26	32,417.41
4	1,631,195	50	59,325.35	28	22,275.51
5	<u>1,076,746</u>	<u>50</u>	<u>90,873.76</u>	<u>28</u>	<u>27,867.79</u>
Total:	<u>4,787,911</u>	<u>250</u>	<u>\$374,143.19</u>	<u>146</u>	<u>\$146,130.84</u>

Point Estimate	\$2,584,991,971
90% Confidence Interval	
Lower Limit	\$2,119,449,933
Upper Limit	\$3,050,534,009

**STRATIFIED CLUSTER ATTRIBUTES PROJECTION**

**For the 9-Month Period Ending September 30, 1998**

We used our random sample of 250 claims, 50 from each of RHHIs servicing the 4 States, to project the occurrence of certain types of errors. Since the sample was taken of claims, we used the HHS, OIG, RAT-STAT Stratified Cluster Attribute Appraisal Program to project the percentage of services in error. For this appraisal, we considered each claim to be a cluster of services. The results of these projections are presented below:

Services That Were Not Reasonable or Medically Necessary

Quantity of Services in Error	373
Point Estimate	5.51%
90% Confidence Interval	
Lower Limit	4.68%
Upper Limit	6.35%

Beneficiary was Not Homebound

Quantity of Services in Error	66
Point Estimate	3.00%
90% Confidence Interval	
Lower Limit	2.68%
Upper Limit	3.31%

Services That Lacked Proper Physician Authorization

Quantity of Services in Error	180
Point Estimate	3.57%
90% Confidence Interval	
Lower Limit	3.16%
Upper Limit	3.98%

Services Not Documented

Quantity of Services in Error	27
Point Estimate	.96%
90% Confidence Interval	
Lower Limit	.85%
Upper Limit	1.06%

Services at Terminated HHAs

Quantity of Services in Error	126
Point Estimate	5.80%
90% Confidence Interval	
Lower Limit	5.14%
Upper Limit	6.47%

**For the 15-Month Period Ending March 30, 1996**

We used our random sample of 250 claims, 50 from each of the RHHIs servicing the 4 States, to project the occurrence of certain types of errors. Since the sample was taken of claims, we used the HHS, OIG, RAT-STATS Stratified Cluster Attribute Appraisal Program to project the percentage of services in error. For this appraisal, we considered each claim to be a cluster of services. The results of these projections are presented below:

Services That Were Not Reasonable or Medically Necessary

Quantity of Services in Error	793
Point Estimate	18.33%
90% Confidence Interval	
Lower Limit	16.40%
Upper Limit	20.25%

Beneficiary was Not Homebound

Quantity of Services in Error	499
Point Estimate	10.67%
90% Confidence Interval	
Lower Limit	9.21%
Upper Limit	12.13%

Services That Lacked Proper Physician Authorization

Quantity of Services in Error	239
Point Estimate	10.38%
90% Confidence Interval	
Lower Limit	9.20%
Upper Limit	11.56%

Services Not Documented

Quantity of Services in Error	8
Point Estimate	.19%
90% Confidence Interval	
Lower Limit	.11%
Upper Limit	.27%



## HOME HEALTH AGENCY REVIEWS

<i>Home Health Agency</i>	<i>Amount Questioned</i>	<i>Audit Period</i>
St. Johns Home Health Agency (A-04-94-02078) Issued February 1995	\$25,877,579	7/1/92-6/30/93
Home Health Services in Florida (A-04-94-02087) Issued June 1995	16,551,410	2/1/93-2/28/93
Pro-Med Home Health, Inc. (A-04-95-01106) Issued March 1996	1,176,345	1/1/93-4/30/95
Visiting Nurse Association Dade County, Inc. (A-04-95-01103) Issued May 1996	1,325,105	1/1/93-12/31/93
American Health Care Services (A-04-95-01104) Issued June 1996	1,248,747	1/1/93-12/31/93
Home Health Care Services South Florida, Inc. (A-04-95-01105) Issued September 1996	1,656,320	1/1/93-12/31/93
Home Health Care Inc. (A-04-95-01107) Issued September 1996	1,179,157	1/1/93-12/31/93
First American Health Care, Inc. (A-03-95-00011) Issued November 1996	2,471,047	1/1/95-4/30/95
Home Health Services in California, Illinois, New York and Texas (A-04-96-02121) Issued July 1997	2,584,991,971	1/1/95-3/31/96
MedCare Home Health Services, Inc. (A-04-97-01170) Issued April 1999	2,196,385	1/1/96-12/31/96
MedTech Home Health Services, Inc. (A-04-97-01169) Issued April 1999	1,922,366	1/1/96-12/31/96
Staff Builders Home Health Care, Inc. (A-04-97-01166) Issued April 1999	2,332,293	1/1/96-12/31/96
Homebound Medical Care, Inc. (A-04-98-01184) Issued September 1999	1,860,760	7/1/94-6/30/96
Dr Pila Foundation Home Care Program (A-02-97-01034) Issued September 1999	857,208	7/1/95-6/30/96
Eddy Visiting Nurse Association (A-02-97-01026) Issued September 1999	1,131,593	1/1/96-12/31/96

## FINANCIAL STATEMENT AUDITS

Improper Fiscal Year 1998 Medicare Fee-for-Service Payments (A-17-99-00099) Issued February 1999

Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997 (A-17-97-00097) Issued April 1998

Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996 (A-17-95-00096) Issued July 1997



OCT 26 1999

DATE:

TO: June Gibbs Brown  
Inspector General

FROM: Michael M. Hash *Michael M. Hash*  
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," (A-04-99-01194) and "Medicare Beneficiary Access to Home Health Agencies," (OEI-02-99-00530)

We appreciate the opportunity to comment on the above-referenced reports. Both studies were conducted at our request, and they address important questions for us and home care beneficiaries, providers, and advocates regarding program integrity and access to care.

In the past year, we have taken a series of steps to strengthen the home health benefit for Medicare beneficiaries. Home health care enables seniors and disabled Americans, and the frailest beneficiaries, to receive many services in their homes as covered under Medicare law. We are committed to protecting the benefit for those who qualify for it.

General Comments

The Balanced Budget Act of 1997 (BBA) addressed a number of concerns regarding Medicare payment for home health services. For example, it stopped the practice of billing for care delivered in low cost, rural areas from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And, it created an interim payment system to be used while we develop a prospective payment system. We expect to publish a proposed regulation by the end of this month and to have the prospective payment system in place by the October 1, 2000 statutory deadline.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to the limits. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency that will be continued under the episode-based prospective payment system. Last year Congress increased the cost limits in an effort to help agencies during the transition to

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
OCIG	<input checked="" type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	10-27

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prospective payment. We are also taking the steps discussed above to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. Another is scheduled for this November.

To date, evaluations by the Government Accounting Office (GAO) and Department of Health and Human Services have found that BBA changes are not causing significant quality or access problems. Our monitoring of employment data shows that freestanding home health agencies have made small reductions in their workforce, back to the level seen in 1996. However, we have heard reports from beneficiary groups, our regional offices, and others regarding home health agencies that have inappropriately denied or curtailed care, and incorrectly told beneficiaries that they are not eligible for services. We are also hearing reports from beneficiary advocates and others that some high cost patients are having trouble finding home health agencies to provide the care they need. This may result from a misunderstanding of the new incentives to provide care efficiently. The Congressional Budget Office attributes some of the lower home health spending to the fact that agencies are incorrectly treating the new aggregate per beneficiary limit as though it applies to each individual patient.

We have, therefore, provided home health agencies with guidance on the new incentives and their obligation to serve all beneficiaries equitably. We have instructed our claims processing contractors to work with agencies to further help them understand how the limits work. Because home health beneficiaries are among the most vulnerable, we are continuing ongoing detailed monitoring of beneficiary access and agency closures.

Our specific comments on each report are attached.

Attachment

**“Review of Medicare Home Health Services in California, Illinois, New York, and Texas.” (A-04-99-01194)**

We believe we have made great progress in reducing payment errors in home health in the four states studied. As with the national error rate reflected in the 1998 Chief Financial Officers Act report, the payment error rate has been reduced by more than half in just two years. More progress must be made on this front, but the increased compliance with Medicare rules reflects the hard work of many partners in the system--home health providers themselves, contractors, agency employees, law enforcement, and beneficiaries--to ensure that we pay correctly.

The nature of the errors identified is instructive and helpful in our efforts to continue to assure that we pay Medicare claims properly. Errors resulting from services not reasonable and necessary declined 70 percent, as did errors resulting from determinations that the beneficiary was not homebound and errors resulting from a lack of physician orders. However, these were partially offset in the OIG's calculations by a new error category. A number of errors in the sample (128, or 5.8 percent as a component of the 19 percent error rate) are attributable to a lack of response from home health agencies that have left the program. Because the OIG could not locate these agencies or their owners, they failed to provide any medical records at all. Our records reflect that these home health agencies have merged with other operations or have closed altogether, generally ceasing operations in the earlier part of 1999.

We agree that it is a problem that these records could not be obtained. Typically, when records are not produced to substantiate a claim, the claim is determined to be an error. But in these cases, we can not establish that the agency management or owners received the request for the records, because the OIG could not locate them. The report does not provide detail on the steps taken by the OIG to obtain a current address, though it does say that the auditors made numerous attempts to find the agencies, even going so far as to contact beneficiaries themselves.

We are particularly concerned about this finding because it represents the most significant error category in the OIG's audit, and because agencies leaving the program with uncollected overpayments has been of concern to us. Most of the 12 agencies in this category, according to our records, do have outstanding overpayments and we will be unable to collect on these overpayments if we cannot locate the owners.

Further, if these agencies were located and their records reviewed, it is possible that the error rate estimate by the OIG would have been lower. For example, if the records from these agencies contained the same percentage of errors as those in the sample as a whole, the error rate estimate could have dropped several points. Therefore, we plan to work with the OIG to obtain further information on these agencies and determine if the

## Page 2 - Attachment

available sources at contractors, survey agencies and regional offices can yield further data to assist us in obtaining records and updated addresses for owners and records retention sites.

### OIG Recommendation

HCFA should revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

### HCFA Response

We agree with the OIG's concern for the importance of the physician role and share their concern that some errors can be attributed to the lack of adequate physician supervision. We will be considering options to address this issue in the near future including increased physician education as well as other mechanisms to encourage physician involvement. While we agree with the need for more physician involvement, this requirement would require a change in a law and potentially increase program costs. We would need to consider the impact on beneficiaries, particularly in rural areas. We will need to determine whether payment errors occur more frequently, and with what impact, when physicians do not examine patients prior to signing a plan of care than when they do provide such an examination. We also believe our reliance on composite review of Outcome and Assessment Information Set data and physician plans of care in medical review will cause agencies and physicians to form clearer relationships in care planning and service delivery.

### OIG Recommendation

HCFA should consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current payments under the interim payment system (IPS).

### HCFA Response

Under current law, we lack the statutory authority to make changes to current payments under IPS. As a result, we have not recommended any changes to the IPS at this time.

### OIG Recommendation

HCFA should consider making an equitable adjustment to the proposed home health agency prospective payment system rates or update factors to take into account the improper and highly questionable payments that were included in the base year calculations.

## Page 3 - Attachment

HCFA Response

We do not concur with the recommendation because HCFA has already taken several steps to ensure accurate and fair payments. First, the law requires us to use most recent audited cost report data available for the base year. In this connection, we conducted a statistically representative sample of home health agency cost reports. We conducted comprehensive audits of the cost reports submitted by the sample home health agencies. The scope of these audits went well beyond our usual level of effort and the industry has complained that this level of audit resulted in a higher level of disallowances than ordinarily would be the case. Thus, we believe that the cost report data we are using to establish the costs of individual service components of the rates has been properly analyzed and does not reflect significant excess cost.

Second, we believe that the OIG's current report demonstrates that agency responses to the IPS have significantly reduced the level of questionable claims and payments. The combination of these two factors and the imposition of an additional 15 percent reduction in payments as required by law appears to us to create a payment situation in which further examination and manipulation of the cost base is no longer necessary for pricing the services. Instead, we believe that the Congress has set the overall price of services and intends that it be updated annually by a market basket adjustment. On the other hand, we recognize that this is an issue that merits further review and we are asking for further comments on it in the Notice of Proposed Rule Making we are publishing.

OIG Recommendation

HCFA should instruct the intermediaries to collect the overpayment identified in our sample.

HCFA Response

We concur, subject to the need for further development of claims for terminated home health agencies, as discussed above.

**"Medicare Beneficiary Access to Home Health Agencies." (OEI-02-99-00530)**

We are encouraged that this report documents that access to home health services have, in large measure, been maintained. As noted above, we are undertaking a number of activities to assess and monitor access to care and appreciate the data presented in this report. It adds to the other information we have and are gathering in order to allow us to understand and develop appropriate responses to access problems if and when they occur. We reiterate our commitment to ensuring beneficiaries have access to Medicare covered benefits.

**Page 4 - Attachment**

Access to care must be viewed in the context of historical coverage and utilization. Unfortunately, there are always instances when a beneficiary with one set of needs does not find a home health agency available which can meet them. These situations occurred even before IPS. However, we do not have an "access" baseline to which we can now compare changes. Available data such as expenditure levels or total numbers of home health providers are not appropriate proxies. For example, as evidenced by the companion OIG report being issued, inappropriate utilization has decreased by more than 50 percent over a period of a few years. We believe that the reasons home health agencies may be giving for declining patients who they may previously have accepted for care must be understood in this context.

We continue to collect and analyze data relating to access, not only for home health beneficiaries who are discharged from the hospital, but also for those home health beneficiaries who come from the community. We encourage the OIG as well as the GAO, to continue working with us on these issues.

We are particularly interested in knowing more about the concerns of discharge planners suggesting some agencies may not be providing adequate services to the Medicare beneficiaries under their care. We urge OIG to study, as we will do, the available data to determine if home health patients are returning to the hospital more frequently than in the past.

Medicare law and regulations require that home health agencies provide all Medicare covered care when they agree to care for a beneficiary who qualifies for the home health benefit. We have reminded agencies repeatedly of this responsibility since we implemented the changes in the payment system required by the BBA. In addition, to assure the quality of home care, we now require agencies to use a standard assessment tool that will allow both Medicare and the agencies to identify patterns involving the quality of care that individual agencies provide and the outcomes for their patients. That tool will help us identify and take appropriate steps to ensure the quality of care for beneficiaries.