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MEDICARE

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, Louisiana, 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 of the four 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.