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Report to the Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate

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MEDICARE

Need to Hold Home Health Agencies More Accountable for Inappropriate Billings

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Health, Education, and
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June 13, 1997

The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health
and Human Services, Education,
and Related Agencies
Committee on Appropriations
United States Senate

Dear Senator Harkin:

Medicare, the nation's health insurance program for the elderly and disabled, is the single largest payer for home health services. Between 1988 and 1996 Medicare spending for home health grew from $2.1 billion to $18 billion and by the year 2000 is projected to exceed $21 billion. Along with increasing expenditures, the number of home health agencies has also increased—from about 5,800 to over 9,000.

This growth and accompanying reports of overutilization of home health services have raised questions about Medicare's ability to detect and prevent inappropriate payments for this component of the Medicare program. Congressional committees have held hearings this year on proposals to control the growth in home health billings. Under any proposal adopted, however, there would be a continued need to monitor Medicare payments effectively.

At your request, we (1) examined the weaknesses of existing Medicare controls over the home health benefit, (2) identified lessons learned from examining private insurers' controls over home health payments and recent federal antifraud initiatives, and (3) identified a management approach that could improve Medicare's ability to avoid substantial payments attributable to abusive billing practices.

To conduct our study, we selected a sample of 80 high-dollar home health claims that had been processed in May 1995 and had been approved without review. We asked a Medicare claims-processing contractor to review the sample for the appropriateness of the charges and services claimed. We also analyzed information obtained from officials of the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services (HHS) responsible for administering Medicare; data obtained from Medicare's claims-processing

contractors; and information from the HHS Office of the Inspector General. In addition, we analyzed information obtained from officials of private insurance companies and the Office of Personnel Management, which oversees the Federal Employees Health Benefits Program. (See app. I for a more detailed description of our scope and methodology.)

Results in Brief

We and others have reported on several occasions about problems with Medicare's review of home health benefits (see the list of related products at the end of this report). Yet, in spite of the need for increased scrutiny indicated by these reports and by the growth in home health expenditures, Medicare's review of home health claims decreased in the 1990s. In our test of just 80 high-dollar claims that had been processed without review, the Medicare claims-processing contractor, after examining each claim and supporting documentation, denied more than $135,000 in charges (about 43 percent of total charges) for 46 of the claims. The reasons for the denials included failure to substantiate medical necessity, noncoverage of services or supplies, and inadequate documentation, including the absence of physician orders. These findings are consistent with prior federal investigations, one of which estimated that in the month of February 1993 alone, Medicare paid $16.6 million for home health claims in Florida that should have been disallowed.

The five private insurers we contacted use controls that, although not readily adaptable to Medicare's coverage terms or billing rules, are nevertheless instructive regarding the monitoring of claims. The insurers employ professional staff, such as nurses, to determine in advance the legitimacy of the request for home health services. In contrast, HCFA relies on home health agencies' compliance with administrative procedures, such as obtaining a physician's signature for ordered services, to safeguard against the submission of improper claims. While Medicare does not have sufficient administrative funds to undertake the intensity of claims monitoring done by the private insurers we reviewed, the vigilance of private insurers suggests the value of applying more scrutiny in this area.

Reduced funding for payment safeguards in recent years helps explain the marked absence of adequate claims reviews by Medicare contractors. Ten years ago, over 60 percent of home health claims were reviewed. In 1996, Medicare intermediaries reviewed only 2 percent of all claims. New and more stable funding provided through the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) should help improve Medicare's performance in monitoring home health payments, but HCFA

also needs an enforcement tool—a preventive approach—that will make providers accountable for the propriety of their claims. Therefore, we are suggesting that the Congress consider directing HCFA to test an approach that would systematically identify and penalize providers that habitually bill Medicare inappropriately. Under this approach, billing offenders would be identified and, if found to have excessively high billing errors, those offenders, rather than the taxpayer, would be required to shoulder the cost burden of investigative claims reviews. We believe that such an approach could also serve as a deterrent to future billing abuses.

Background

Medicare is a health insurance program that covers over 38 million elderly and disabled people. The program, authorized by title XVIII of the Social Security Act, provides coverage under two parts. Part A, the hospital insurance program, covers inpatient hospital services, posthospital care in skilled nursing homes, and care in patients' homes. Part B, the supplementary medical insurance program, covers primarily physician services but also a number of other services, including home health care for beneficiaries not covered under part A. Almost all Medicare payments for home health care are made under part A.

Beneficiary Eligibility for Home Health Benefit

Since the late 1980s when a court decision obligated HCFA to interpret more liberally Medicare's eligibility and coverage criteria, beneficiaries have more easily obtained home health coverage than previously. To qualify, individuals must be confined to their residences (be "homebound"), be under a physician's care, and need part-time or intermittent skilled nursing care and/or physical or speech therapy. In meeting these requirements, beneficiaries are covered for visits by home health aides, medical social workers, and occupational therapists. Required medical supplies are also covered.

Services must be furnished under a plan of care prescribed and periodically reviewed by a physician. As long as the care is reasonable and necessary, there are no limits on the number of visits or length of coverage. Medicare does not require copayments or deductibles for home health care, except for durable medical equipment.

Home Health Agency Participation Requirements

Medicare law requires that home health agencies be certified to serve Medicare beneficiaries. The agencies obtain certification by meeting specific requirements, commonly referred to as conditions of

participation. These requirements cover the agency's qualifications and capacity to perform such administrative functions as appropriate recordkeeping, including patient privacy protections, and such provider functions as the administering of skilled nursing services.

Typically, HCFA contracts with state public health agencies to conduct certification and recertification surveys of home health agencies. Generally, home health agencies found to be out of compliance are provided an opportunity to develop a corrective action plan. If the state agency and HCFA approve the plan, the home health agency can continue to participate in Medicare; it can maintain certification if the plan results in correction of the problems identified.

Oversight of Home Health Payments

Regional claims-processing contractors, called intermediaries, process and pay claims submitted by over 9,000 home health agencies, which are paid on the basis of the costs they incur up to predetermined cost limits. In 1995, claims received from home health agencies represented about 14 percent of all part A claims and 13 percent of part A expenditures.

Intermediaries are responsible for ensuring that Medicare does not pay home health claims when beneficiaries do not meet the Medicare home health criteria, when services claimed are not reasonable or necessary, or when the intensity of services exceeds the level called for in an approved plan of treatment. They carry out these responsibilities through medical reviews of claims.

Medical review can be performed either before or after a claim is approved for payment and involves obtaining home health agency documentation, such as the beneficiary's plan of care and medical records. Occasionally, intermediaries conduct site visits—a postpayment review at the location of a home health agency, where reviewers can examine plans of care and other medical documentation. Because of budgetary constraints in recent years, intermediaries review only about 1 to 3 percent of all claims. They typically only target providers that have high unexplained utilization rates.

Medicare Lacks Adequate Controls to Effectively Monitor Home Health Payments

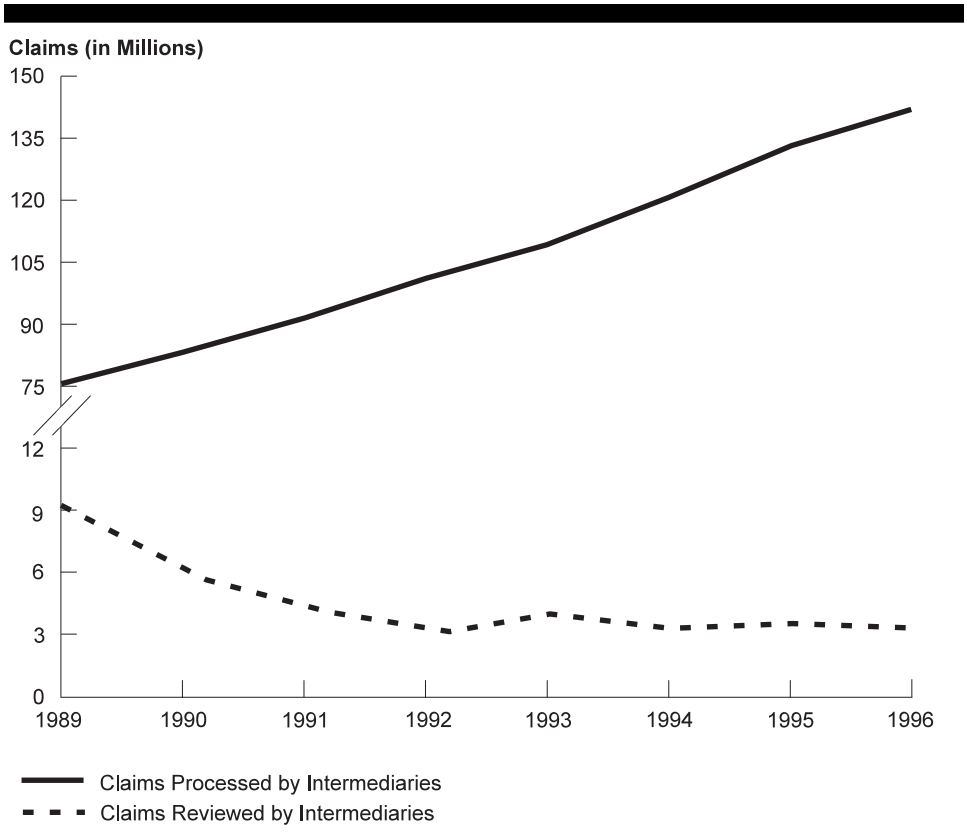
Our work in recent years has shown that because of insufficient funding of payment safeguards, HCFA's monitoring has been unable to keep pace with the increasing volume of home health claims submitted to Medicare. This situation may be one of the factors contributing to the rapid growth in Medicare's home health expenditures.

Funding Constraints Limit Medical Review of Claims

The relationship between funding levels and claims reviewed helps explain Medicare's current predicament. In 1985, legislation more than doubled claims review funding, enabling intermediaries to review over 60 percent of the home health claims processed in fiscal years 1986 and 1987. By 1995, however, when payment safeguard funding for part A medical review had substantially declined (from $61 million in 1989 to $33 million in 1995), the intermediaries' claims review target had been lowered to 3.2 percent for all part A claims (or even lower, depending on available resources, to a required minimum of 1 percent).[1] During this period, the number of home health agencies participating in Medicare increased by more than a third, and the volume of home health claims processed more than tripled. Figure 1 illustrates how the total number of claims processed by intermediaries has risen since 1989, while the number of claims reviewed has generally declined.

[1]Because this review target is the minimum for part A claims as a group, the actual percentage of home health claims reviewed could be higher or lower than the target level specified.

Figure 1: Numbers of Claims Processed and Reviewed by Intermediaries Since 1989



Note: Numbers are for all part A claims, including home health claims. Data for claims processed are by fiscal year; data for claims reviewed are by calendar year.

Source: HCFA data.

In our March 1996 report on the deterioration of Medicare's home health payment controls, we noted the effects of reduced funding on efforts to deter abusive billing.[2] We found that the infrequency of the intermediaries' medical review of claims and limited physician involvement in overseeing home health agencies' plans of care made it nearly impossible to determine whether the beneficiary receiving home health services qualified for the benefit, needed the care being delivered, or even received the services being billed to Medicare. Also, because of the small percentage of claims selected for review, home health agencies that billed

[2]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

for noncovered services were less likely to be identified than was the case a decade earlier.

HIPAA, which now ensures funding for program safeguards through 2003, allows HCFA to count on stable funding in the coming years. However, per-claim expenditures for medical review and other controls will remain below the 1989 level after adjusting for inflation. We project that in 2003, payment safeguard spending as authorized by the act will be just over half of the 1989 per-claim level, after adjusting for inflation.

Better Controls Over Payments Needed

In recent years, we have reported on the marked absence of HCFA guidance for intermediaries on monitoring high-dollar claims despite postpayment reviews that have found Medicare paying substantial sums for claims not satisfying key payment criteria. In a recent test, we asked one regional intermediary—Blue Cross of California—to do medical reviews for a sample of high-dollar home health claims that it had originally processed and approved without review.

We selected 80 claims from the universe of home health claims processed by the California intermediary in May 1995 (see app. I for a more detailed description of how these claims were selected). The intermediary found that 46 of the 80 claims submitted by 26 home health agencies should have been partially or totally denied and subsequently did deny them. For the 46 claims totaling $313,655 in charges for services and supplies, about 43 percent, or $135,640, were denied. The intermediary's reasons for the denials included failure to substantiate medical necessity, noncoverage of services or supplies, and inadequate documentation, including the absence of physician orders. Specifically, the intermediary found the following:

- Of $18,132 in charges for the care of a beneficiary's decubitus ulcer (open wound) for 30 days, 36 percent ($6,483) were denied, including charges for almost half of the skilled nursing visits (four per day) that were not considered medically necessary.
- Of $4,100 in charges for supplies related to care provided over 4 weeks, 31 percent were not adequately documented in the medical records or should have been part of the paid nurse's visit and not billed separately. About half of the amount denied was for supplies never received by the beneficiary.
- Of $17,953 in charges for medical supplies related to the treatment of a beneficiary's salivary gland disease, the intermediary denied the entire amount because the medical documentation and the itemized list of

supplies provided were not consistent and did not support the supplies the agency billed for.

- Nine of the 80 claims—representing nearly half ($61,250) of the total dollars disapproved—were denied because the home health agencies did not submit any of the medical records the intermediary had requested for the review.

The California intermediary also visited a home health agency where it reviewed supporting documentation for a random sample of 464 claims. The agency had been targeted for a comprehensive review because of its high billings. The review team found that the agency's claims for $39,384 were appropriate; however, claims for $27,834 were considered not medically necessary and were denied, and claims in the amount of $330,444 were denied for nonmedical reasons, including undated or otherwise invalid plans of care, no plan of care, and billing for supplies not covered.

The findings from our test sample of claims subjected to medical review are consistent with reports by the HHS Inspector General on home health agency fraud and abuse. A 1995 Inspector General report on home health services in Florida found that an estimated 26 percent of home health claims did not meet Medicare reimbursement requirements.[3] On that basis, the Inspector General estimated that $16.6 million of the $78 million in claims approved for payment by intermediaries in February 1993 were unallowable. Claims did not meet reimbursement requirements because beneficiaries were not homebound, services were considered unnecessary, and visits were not documented in the medical records.

Private Insurers' Approaches and Federal Initiatives Emphasize Need for Accountability

The various approaches to control home health payments used by five private insurers we examined collectively underscore the importance of implementing measures to help prevent abusive billings and also hold providers accountable for services billed. Recent federal fraud-fighting efforts targeting abusive billers in the home health industry have also demonstrated the need for greater claims scrutiny.

Private Insurer Strategies Instructive, but Not Easily Adapted to Medicare

Because of differences in beneficiary population, claims volume, and specific benefit provisions, the controls used by private insurers to contain home health costs would not be easily adapted to the Medicare program.

[3]Results of the Audit of Medicare Home Health Services in Florida (HHS/OIG, A-04-94-02087, June 16, 1985).

The five insurers we contacted use some combination of patient cost-sharing (deductibles and copayments) and caps on the number of allowed visits to help control home health utilization; however, cost-sharing and preset utilization limits are not permissible under Medicare's home health benefit provisions.

In addition, all five of the insurers routinely verify the basis for proposed plans of home care and oversee, using professional staff, how the care plans are implemented. Company-employed or contract nurses typically interview the home health agency's nurses, the discharge planner (when the patient has been hospitalized), the patient, and sometimes the family. They attempt to determine in advance the legitimacy of the patient's need for home-based medical services. Often the insurers employ utilization review nursing staffs or insurance company caseworkers to monitor and approve visits on an incremental basis. For example, one insurer approves visits in increments of 10 or fewer, or in time intervals of 2 to 4 weeks. For high-cost cases, all the insurers we examined used some form of case management that typically involved monitoring by nurses. As case managers, they track the volume of services provided, the outcomes being achieved, and the appropriateness of continuing care.

In contrast, the sheer volume of Medicare's home health claims and scarce funds for monitoring payments have resulted in an approach that relies substantially on the home health agencies themselves. In 1996, more than 10 percent of Medicare beneficiaries—roughly 4 million people—received home health services. To cope with this caseload, HCFA relies on the home health agencies to rely, in turn, on attending physicians to monitor patient progress, the proper development and periodic review of plans of care, and the medical necessity of services delivered.

Unlike their private insurer counterparts, Medicare intermediaries are not responsible for approving the plans of care developed by the home health agencies. The physician's signature on a plan of care is intended to serve as a quality control, but in practice the certifying physician may not have ever seen the patient for whom the care plan is designed. Moreover, the intermediaries' relatively few medical reviews of claims generally do not include an independent verification of the documentation prepared and submitted by the home health agencies. Likewise, although Medicare requires home health agencies to update a beneficiary's plan of care at least every 62 days, the intermediary does not routinely review updated plans. As for high-cost cases, nearly 40 percent of Medicare's home health beneficiaries receive more than 30 visits. Because of the prohibitive costs,

intermediaries cannot systematically monitor such long-term or otherwise expensive cases to ensure the care being delivered is appropriate to the patients' needs.

Federal Antifraud Efforts Target Home Health Payments

Given the growth in Medicare spending for home health services, nursing home services, and medical equipment and supplies, the HHS Inspector General and other federal and state agencies banded together to target fraudulent and abusive billing practices in these industries. This effort, called Operation Restore Trust, was conducted initially in five states and reported identifying almost $188 million in inappropriate payments in its 2 years of operation.

Among the lessons learned to date from Operation Restore Trust is the importance of coordination among the various program and enforcement agencies involved at the federal, state, and local levels. Coordination, for example, between Medicare intermediaries and state surveyors in the project's several states resulted in the decertification of many of the targeted home health agencies and in the recovery of substantial sums in inappropriate payments.[4]

For example, in investigations conducted in Louisiana and Texas, the Medicare intermediary trained state surveyors on billing and beneficiary coverage issues. The intermediary also provided a list of agencies that it believed to be billing improperly. In turn, the surveyors passed on to the intermediary information obtained from their site visits to home health agencies and beneficiaries. This exchange of information allowed the intermediary to identify claims that (1) were made on behalf of beneficiaries who were obviously not homebound, (2) billed for services not provided, and (3) billed inappropriately for supplies. The Secretary of HHS recently announced that Operation Restore Trust will be expanded to 12 additional states.

HCFA also sponsored pilot projects as part of a "Home Health Initiative" that assessed the extent to which the detection of abusive billing can be fostered by educating beneficiaries about home health coverage and eligibility and by formally notifying beneficiaries and physicians of benefits provided.

[4]State certification surveys generally do not look at coverage and eligibility issues, although state surveyors can identify patients who are not homebound and services and supplies that are billed but not provided.

Medicare's Existing Safeguard Apparatus Presents Opportunity to Exercise Greater Accountability

HCFA's education initiatives may improve beneficiary and physician awareness of improper billing practices, but HCFA needs to hold home health agencies more directly accountable for submitting proper claims. In the past, when seeking recovery of inappropriate payments, intermediaries have used two approaches to assess overpayment amounts. One is to audit a universe of claims submitted by the provider and total the charges disallowed. However, the large volume of claims submitted by the average provider and the time involved in reviewing a claim make this approach impractical in most cases. The second approach is to audit a statistically valid sample of the provider's claims and estimate total charges disallowed by projecting the sampling results. Because of the scarcity of funds to audit claims, it has been difficult to pursue either approach in recent years.

Currently, Medicare's intermediaries are responsible for focusing medical reviews on claims from home health agencies that seem likely to be billing inappropriately.[5] Given the funding provided under HIPAA, the expectation is that HCFA will be better able to carry out these focused medical reviews. However, this funding may not be sufficient to do the follow-up audit work required once improper billing identifies an agency as an abusive biller and to conduct enough focused reviews for other home health agencies also deemed likely to be billing improperly. Consequently, Medicare would be prevented from taking the steps necessary to recover a greater proportion of payments that have been made inappropriately.

One option to help finance Medicare's audits of claims would be to assess home health agencies that are found to be abusive billers for the costs of performing follow-up audit work. The home health agency could choose whether to have a review based on the universe of its claims for a particular period or a statistically valid sample. HCFA would estimate the costs and withhold some percentage of the agency's current Medicare payments, unless the agency negotiated an alternative payment method, to ensure that the audit costs (as well as any assessed overpayment) could be recovered from the agency. By earmarking monies from the assessed audit costs for payment safeguard activities, performing such claims audits could be made financially feasible for HCFA. (Under current law, such assessments would be returned to the general Treasury.)

[5]Under sec. 202 of HIPAA, the HHS Secretary is authorized to enter into contracts with additional entities to perform payment safeguard activities. Such activities would include, for example, medical reviews on claims from home health agencies that seem likely to be billing inappropriately. This authority became effective Aug. 21, 1996, but HCFA has not yet entered into any contracts of this type.

This option, which would require authorizing legislation, would build on HCFA's existing safeguard apparatus and should enable it to broaden its claims reviews. The approach, which could be piloted in one or more regions, would also require HCFA to establish procedures for identifying abusive billers that would be required to reimburse HCFA for the costs of additional claims reviews.

Conclusions

Given the rapid growth in Medicare home health spending, the importance of careful vigilance over payments for this benefit cannot be overstated. Some home health agencies continue to abuse the Medicare benefit by providing services that do not meet program coverage requirements or are not medically necessary. Limited oversight by HCFA allows abusive billings from these home health agencies to go undetected.

Recent federal antifraud efforts illustrate the value of effective claims oversight. Building on its current oversight efforts, HCFA could implement an enforcement mechanism that would hold home health providers accountable for meeting their responsibilities to provide beneficiaries with only necessary and appropriate covered services. Such a mechanism would include a means to recover from abusive billers some of HCFA's costs in conducting this oversight. This approach would not only help finance claims audits but also help deter further abusive billing.

Matters for Consideration by the Congress

To hold home health agencies more directly accountable for billing Medicare appropriately, the Congress may wish to consider enacting legislation directing HCFA to carry out a pilot demonstration to address the issue of abusive billing practices by home health agencies. Under such a demonstration, once improper billing has been detected that identifies an agency as an abusive biller, follow-up audit work would be conducted and the cost of this follow-up work would be assessed against the home health agency. To make such claims audits financially feasible, the Congress may wish to earmark monies from the assessed audit costs for HCFA's payment safeguard activities.

Agency Comments

On June 11, 1997, HCFA officials provided us with comments on a draft of this report. Those officials agreed that the concept presented in our report could be effective. On the basis of our discussion, it appears that this concept would fit well with HCFA's current efforts to strengthen program safeguards on the home health and skilled nursing facility benefits. They

noted that a number of details would need to be worked out to increase the likelihood that the demonstration project would be successful.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 10 days after the date of this letter. At that time, we will send copies of this report to the Secretary and the Inspector General of HHS, the Administrator of HCFA, and other interested parties. We also will make copies available to others upon request.

If you or your staff have any questions, please call me on (202) 512-6806 or William Scanlon, Director of our Health Financing and Systems issue area, at (202) 512-4561. Other major contributors to this report include Leslie Aronovitz, Lisanne Bradley, Marco Gomez, Sam Mattes, Barry Tice, and Don Walthall.

Sincerely yours,

Richard L. Hembra
Assistant Comptroller General

Contents

Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
OPM	Office of Personnel Management

Scope and Methodology

To examine and compare Medicare controls over the home health benefit with those used by private insurers and to identify Medicare initiatives associated with appropriate payments for home health services, we reviewed information obtained from officials at HCFA headquarters, its San Francisco regional office, and the regional home health intermediaries responsible for paying Medicare home health claims.

We also reviewed information obtained from officials at the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits Program; five private health plans under contract with OPM to provide health care services;[6] and three private companies that perform utilization review and case management for private health plans. Additionally, we reviewed relevant GAO, HHS Office of the Inspector General, Operation Restore Trust, and intermediary reports on controls over the use of Medicare's home health benefit. We also reviewed manuals and criteria HCFA and private insurers use to administer and control the home health benefit.

To gain insight into Medicare controls over the home health benefit, we visited two judgmentally selected home health intermediaries: Blue Cross of California and Palmetto Government Benefits Administrators. To supplement work performed at these locations and to broaden our areas of analysis, we obtained additional information on home health claims and controls from the remaining home health intermediaries.

In addition, to determine whether the records supported the need for services or items billed to Medicare, we requested that one intermediary—Blue Cross of California—review the medical records, an itemized list of supplies, and other documentation for 80 high-dollar claims. The intermediary requested this supporting documentation from 26 home health agencies. We limited our request to 80 claims so that we would not overburden the intermediary's normal workload.

To select the 80 claims to be reviewed, the intermediary identified the universe of home health claims processed from May 1 to May 31, 1995. From this universe, the intermediary identified the top 10 providers in terms of dollars billed, per beneficiary, for specific home health benefit categories (medical supplies, surgical dressings, physical therapy, and skilled nursing). For each of these providers, the 20 largest claims in terms of dollars billed per service category were identified. From the specific

[6]The five private plans are the Blue Cross and Blue Shield Service Benefit Plan, Mail Handlers, Government Employees Hospital Association, National Association of Letter Carriers, and the American Postal Workers Union plans.

service categories, we judgmentally selected 80 claims. In selecting the 80 claims for intermediary review, we considered information on total charges, average per-day charge, total days charged, and diagnosis.

For each selected claim, the intermediary reviewed the total charges for all services on the claim. Consequently, even though we did not specifically select any claims for four types of home health services (speech therapy, occupational therapy, medical social worker, and home health aide), many of our selected claims had these services. Therefore, the intermediary also reviewed the appropriateness of these services.

We performed our work between January 1996 and June 1997 in accordance with generally accepted government auditing standards.

GAO Related Products

Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T-HEHS-97-106, Apr. 9, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997).

Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

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