

**Memorandum**

JUL 28 1997

Date

June Gibbs Brown

From

Inspector General

June G Brown

Subject

Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas (A-04-96-02121)

To

Bruce C. Vladeck

Administrator

Health Care Financing Administration

Attached are two copies of our final report entitled *Review of Medicare Home Health Services in California, Illinois, New York and Texas*. The audit was performed under the auspices of Operation Restore Trust (ORT). The audit objective was to determine whether Medicare payments to home health agencies (HHA) met Medicare reimbursement requirements.

Our review disclosed 40 percent of the total services contained in 146 of 250 HHA claims reviewed did not meet Medicare reimbursement requirements. Our sample was selected from claims approved for payment by fiscal intermediaries servicing California, Illinois, New York and Texas during the 15-month period ended March 31, 1996. The services did not meet Medicare reimbursement requirements because:

- ☛ 793 services contained in 65 claims were for services not reasonable and necessary. The unnecessary services included skilled or aide services that, in the opinion of intermediary medical personnel, were not medically necessary.
- ☛ 499 services contained in 46 claims were for services to beneficiaries who were not homebound. According to intermediary medical personnel, the beneficiaries or their families, these beneficiaries could leave home without considerable effort.
- ☛ 239 services contained in 31 claims were for services that did not have valid physician orders. These services were performed without evidence of timely written or verbal physician approval.
- ☛ 8 services contained in 4 claims were for services without supporting documentation. The HHA had no documented evidence that the services were performed.

We estimate for the 15-months ended March 31, 1996, the intermediaries approved unallowable claims with charges totaling about \$2.6 billion out of the 4 State universe of \$6.7 billion.

We believe there are several reasons why inappropriate claims were submitted by HHA providers and approved by intermediaries. These reasons include: (1) physicians did not always review or actively participate in developing the plans of care they signed; (2) at the time of our review, beneficiaries were not aware of the cost of the home health services; and (3) medical reviews of claims for HHA services were not effective in curbing abuse.

We are recommending the Health Care Financing Administration (HCFA) take actions we believe will help address the abuses we have noted in the HHA program. Specifically, we are recommending HCFA:

- ▶ Consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system; (2) placing limitations on the number of visits; (3) establishing a system of pre-authorizations; (4) establishing a copayment; and (5) a case management system.
- ▶ Emphasize the definition of homebound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."
- ▶ Revise Medicare regulations to require the physician to examine the patient before ordering home health services. Also, HCFA should require the patient to see the recertifying physician at least once every 60 days. The HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. Also, an outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.
- ▶ Require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.
- ▶ Instruct intermediaries to augment focused medical reviews with physician and beneficiary interviews to verify services were provided and properly prescribed.

Page 3 - Bruce C. Vladeck

In its written response to our draft report, HCFA concurred with four of the five recommendations. The HCFA agreed in principle with the other recommendation, and is continuing to examine the issue. The complete text of HCFA's response is presented as Appendix D to this report.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions or need clarification on the report, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-96-02121 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**RESULTS OF THE
OPERATION RESTORE TRUST AUDIT
OF MEDICARE HOME HEALTH SERVICES
IN CALIFORNIA, ILLINOIS, NEW YORK
AND TEXAS**



**JUNE GIBBS BROWN
Inspector General**

**JULY 1997
A-04-96-02121**



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June Gibbs Brown
Inspector General

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Results of the Operation Restore Trust Audit of Medicare Home Health Services in
California, Illinois, New York and Texas (A-04-96-02121)

To

Bruce C. Vladeck
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. The audit was performed under the auspices of Operation Restore Trust (ORT).

OBJECTIVE

The audit objective was to determine whether Medicare payments to home health agencies (HHA) met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

Our review disclosed that 40 percent of the total services contained in 146 of 250 HHA claims reviewed did not meet Medicare reimbursement requirements. Our sample was selected from claims approved for payment by fiscal intermediaries servicing California, Illinois, New York and Texas during the 15-month period ended March 31, 1996. The services did not meet Medicare reimbursement requirements because:

- ☛ 793 services contained in 65 claims were for services not reasonable and necessary. The unnecessary services included skilled or aide services that, in the opinion of intermediary medical personnel, were not medically necessary. For example, in many cases the home health nurses provided no skilled service, only observation and assessment of the patients' condition.
- ☛ 499 services contained in 46 claims were for services to beneficiaries who were not homebound. According to intermediary medical personnel, the beneficiaries or their families, these beneficiaries could leave home without considerable effort. One beneficiary told us he went shopping on a daily basis during the elapsed time HHA services were provided to him.
- ☛ 239 services contained in 31 claims were for services that did not have valid physician orders. These services were performed without evidence of timely written or verbal physician approval. For example, we found instances where (1) there was no signature on the plan of care; (2) the plan of care was signed

and dated after the services began; or (3) the plan of care was signed by a nurse, an office manager, a physician's assistant or a doctor's secretary in the name of the physician. Also, in some instances the plan of care did not include an order for a skilled service.

- ☛ 8 services contained in 4 claims were for services without supporting documentation. The HHA had no documented evidence that the services were performed.

We estimate for the 15 months ended March 31, 1996, the intermediaries approved unallowable claims with charges totaling about \$2.6 billion out of the 4 State universe of \$6.7 billion.

In order for home health services to be covered by Medicare, beneficiaries must be:

- confined to their homes;
- under the care of a physician; and
- in need of skilled nursing services on an intermittent basis or skilled physical, speech, or occupational therapy.

We believe there are several reasons why inappropriate claims were submitted by HHA providers and approved by intermediaries. These reasons include:

- 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.
- At the time of our review, beneficiaries were not aware of the cost of the home health services. We believe, had the beneficiaries been aware of the cost, they may have questioned the intermediary about services claimed on their behalf. As of October 1, 1996, the Health Care Financing Administration (HCFA) took steps to improve on this by instructing the Regional Home Health Intermediaries (RHHI) to generate a beneficiary notification system for home health services.
- Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, the reviews will continue to produce limited results because the focused medical reviews do not include beneficiary and physician interviews.

Since 1990, the Medicare expenditures for HHA services have increased dramatically from about \$3.3 billion to an estimated \$16.9 billion for 1996. We believe the results from our work strongly support the need for major changes in providing and paying for HHA services. Based on joint work with HCFA, we believe implementing such recommendations as the following will help address the abuses we have noted in the HHA program.

We therefore recommend HCFA:

- ▶ Consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system; (2) placing limitations on the number of visits; (3) establishing a system of pre-authorizations; (4) establishing a copayment; and (5) a case management system.
- ▶ Emphasize the definition of homebound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."
- ▶ Revise Medicare regulations to require the physician to examine the patient before ordering home health services. Also, HCFA should require the patient to see the recertifying physician at least once every 60 days. The HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. Also, an outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.
- ▶ Require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.
- ▶ Instruct intermediaries to augment focused medical reviews with physician and beneficiary interviews to verify services were provided and properly prescribed.

In its written response to our draft report, HCFA concurred with four of the five recommendations. The HCFA agreed in principle with the other recommendation, and is continuing to examine the issue. The complete text of HCFA's response is presented as Appendix D to this report.

BACKGROUND

Operation Restore Trust

The Secretary of the Department of Health and Human Services initiated ORT to address growing concerns over rising costs in the health care industry. The ORT concentrated on benefits for: home health, nursing homes, hospices, and durable medical equipment in five States - California, Florida, Illinois, New York, and Texas. Together, these states account for a large percentage of the Nation's Medicare and Medicaid beneficiaries. This audit focused on the home health services in California, Illinois, New York, and Texas.

Under the auspices of ORT, the Office of Inspector General (OIG) previously conducted a statewide review of HHA services in Florida and has reviewed HHA services provided by individual HHAs in Texas, Florida, California and New York. The ORT Project has initiated proposals presented in the President's Budget that will improve program integrity and oversight activities.

Home Health Services

Home health services allow people with limited mobility to live independently while still receiving professional health care services. 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 our review, HHAs were reimbursed on an interim basis under the periodic interim payment (PIP) or the estimated cost methods. Payments under both methods approximate the cost of covered services rendered by the provider. Interim payments are adjusted to actual costs based on annual cost reports.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in § 1814, § 1835, and § 1861 of the Social Security Act; governing regulations are found in Title 42 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Intermediary Manual.

Home health is one of the fastest growing segments of health care. In 1995, Medicare paid \$15.1 billion for home health services nationwide. The HCFA, Office of the Actuary estimates expenditures will exceed \$27.2 billion in the year 2000.

According to data provided by HCFA, in 1995 approximately 28¹ percent of all HHA reimbursements nationwide were to HHAs servicing California, Illinois, New York and Texas.

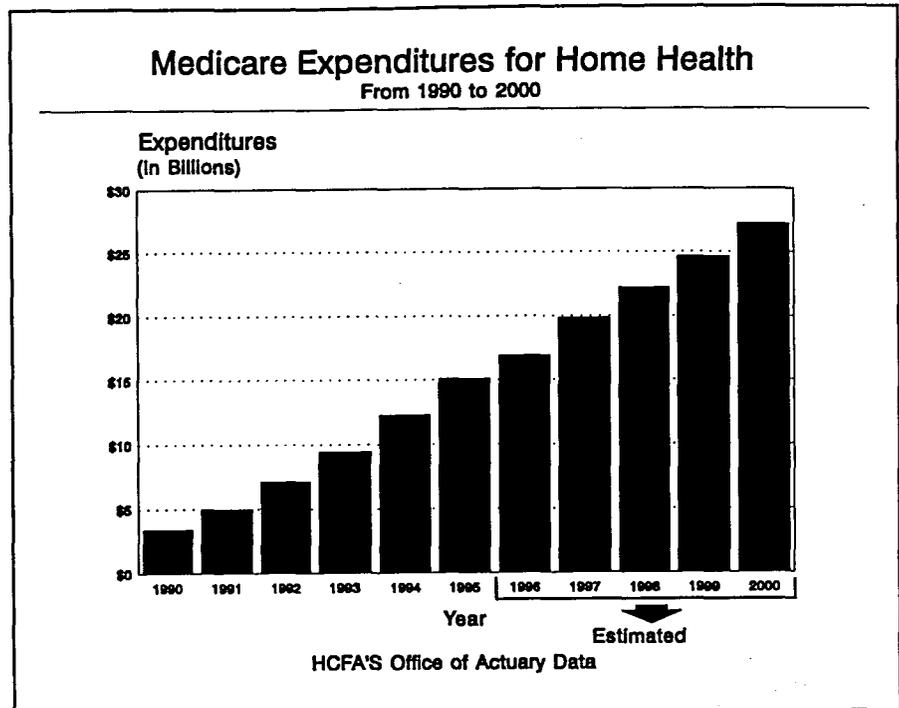
Intermediary Responsibility

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, Illinois, New York, and Texas are Blue Cross of California, Health Care Service Corporation, United Government Services, and Palmetto Government Benefits Administrators, respectively. The alternate intermediary for the four States is IASD Health Services Corp. In addition to the principal and alternate intermediaries, there were other intermediaries that processed less than 10 percent of the HHA claims in the four ORT States.

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.



¹ This figure represents fee-for-service home health reimbursements and does not include services provided by health maintenance organizations.

SCOPE

The objective of our audit was to determine whether Medicare payments to HHAs in the four ORT States met Medicare reimbursement requirements.

Our sample was selected from the claims processed by the principal intermediary for each State and the alternate intermediary for the four ORT States. Including only the principal and alternate intermediaries, we simplified the sampling plan and assured that we had over 90 percent of the HHA charges included. During the 15 months ended March 31, 1996, the 5 fiscal intermediaries approved for payment 4,787,911 HHA claims from the 4 ORT States with about \$6.7 billion in charges. We reviewed a statistical sample of 250 claims with \$374,143 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.

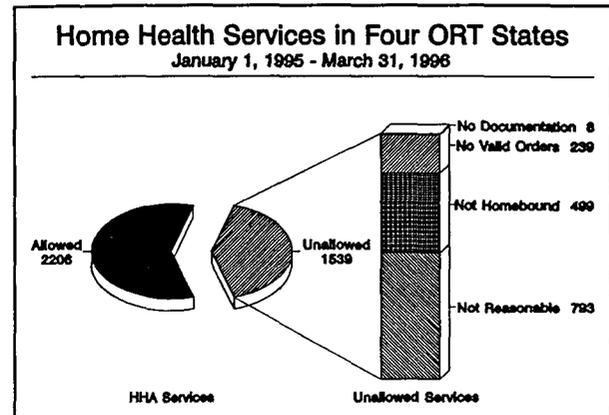
Generally, for each of the 250 claims, we interviewed the beneficiary, family member or a knowledgeable acquaintance. We also interviewed the physician who certified the plan of care. We obtained supporting medical records maintained by the HHAs for the 250 claims and requested the intermediaries' medical 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. Our internal control review was limited to information obtained during a prior audit of HHA claims in Florida. During our audit in Florida, we obtained an understanding of three of the five intermediaries' claims processing systems such as pre and post-payment reviews of claims and provider audit activities. During our audit we discussed current policies and procedures with representatives from all five intermediaries. We did not test the intermediaries' internal controls because the objective of our review was accomplished through substantive testing.

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 HHA's administrative offices, physicians' offices and beneficiaries' residences. The field work was conducted from July 1996 to January 1997.

DETAILED RESULTS OF REVIEW

Our audit showed 1539 of the 3745 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 five intermediaries for California, Illinois, New York and Texas, we estimate 40 percent of the services contained in the claims did not meet Medicare reimbursement requirements. The percentage was computed using a stratified cluster sampling methodology. See Appendices A and B for the details on our sampling results.



Based on a stratified random sample, we estimate the five intermediaries approved claims for payment with charges totaling approximately \$2.6 billion that did not meet Medicare reimbursement requirements.

We believe there are several reasons why inappropriate claims were submitted by HHA providers and approved by intermediaries. These reasons include:

- 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.
- At the time of our review, beneficiaries were not aware of the cost of the home health services. We believe, had the beneficiaries been aware of the cost, they may have questioned the intermediary about services claimed on their behalf. As of October 1, 1996, the HCFA took steps to improve on this by instructing the RHHI to generate a beneficiary notification system for home health services.
- Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, the reviews will continue to produce limited results because the focused medical reviews do not include beneficiary and physician interviews.

Criteria for Certification of Home Health Services

Title 42 CFR § 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."

In an effort to make physicians more accountable for certifying an individual meets the requirements for home health services, Congress added Section 232 to the Health Insurance Portability and Accountability Act of 1996. Public Law 104-191, § 232 states, "any physician who executes a document ...with respect to an individual knowing that all of the requirements referred to ... are not met with respect to the individual shall be subject to a civil monetary penalty..."

Services Not Reasonable and Necessary

Our review disclosed 793 services included in 65 claims were for services that 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.

Section 3116.1 of the Medicare Intermediary Manual (MIM) states the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary.

The MIM § 3118.1 further states a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled service although a skilled nurse actually provides the service.

The HCFA Publication 11, § 206.2 states in order to be considered for coverage, home health aide services must be: medically reasonable and necessary, provided to a homebound beneficiary, rendered under the supervision of a registered health professional, in conjunction with skilled services, and rendered when there is no family member or support system able, available or willing to provide these services.

The unallowable services included claims for skilled nursing services not considered reasonable or medically necessary by the intermediaries' medical experts. For example, one

beneficiary received two nursing visits for congestive heart failure for which the intermediary's medical review staff determined were not necessary.

In another case, a beneficiary received 9 skilled nursing services, 5 physical therapy services and 31 aide visits during 1 month. The intermediary's medical review staff concluded no skilled services were performed, only caregiver services. Also, the physical therapy was unnecessary. Therefore, because there were no allowable skilled services provided, the aide services were also not reasonable and necessary.

The physicians who certified home services on 33 of the 65 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 review disclosed 499 services included on 46 claims were for services 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 this determination.

Title XVIII of the Social Security Act, § 1861(m) established home health services could be provided to beneficiaries who are confined to their home (homebound). The MIM § 3117.1 states a beneficiary will be considered homebound:

- (a) if a health condition restricts his ability to leave his place of residence except with the aide of supporting devices (i.e. crutches, canes, wheelchairs, special transitional equipment, or the assistance of another person), or
- (b) if he has a condition which makes leaving his home medically contraindicated. An individual does not have to be bedridden to be considered homebound. However, a normal inability to leave home requiring a considerable and taxing effort from the beneficiary must exist.

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. For example:

- HHA records for one beneficiary indicated the beneficiary was frequently not home for scheduled nursing visits, went shopping on a daily basis and on weekends would visit his daughter who lived in another State.

- One beneficiary stated she was not physically homebound but needed custodial care. However, she was able to leave her home on a regular basis for non-medical reasons. In fact, she was attending a social club once a week.
- One beneficiary stated after she switched to a new physician closer to her home, the physician immediately signed her up for home health services. She further stated, other than arthritis in her hands, she had no restrictions in her routine activities such as shopping and getting groceries.

Interviews of 43 physicians who signed plans of care for beneficiaries who were not homebound disclosed 30 physicians relied on the HHA to prepare the plan of care with little or no input from physicians. Six physicians signed plans of care including homebound certifications for patients they were not familiar with and 25 physicians were not aware of the homebound requirements for HHA services. In addition, after reading the criteria for homebound status, six physicians did not think their patients were homebound.

Services Without Valid Physician Orders

Our audit showed 239 services included in 31 claims were for services that 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. 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.

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 on one claim for five nursing visits and seven aide visits were unallowable because the physician never signed the recertification plan of care. In another case, eight services were considered unallowable because the physician's assistant signed the plan of care rather than the physician. In addition, the physician was not familiar with the beneficiary. Two physicians who signed the plans of care were not familiar with the patients.

Services Not Documented

Our review showed eight services included in four claims were for services that were not documented. In these cases, the HHA records showed no evidence the home health services were performed.

Title 42 CFR § 409.42 (e) states that services must be furnished by, or under arrangements by, a participating HHA. Section 484.48 further requires, "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains ...activity orders; signed and dated clinical and progress notes..." Section 484.48 also requires records to be maintained for 5 years after the month the cost report is filed.

Effect

We estimate during the 15 months ended March 31, 1996, the intermediaries approved unallowable claims with charges totaling about \$2.6 billion out of the 4 State universe of \$6.7 billion.

Causes

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 abdicated their responsibility to the HHAs. Additionally, because of funding constraints HCFA reduced the intermediaries' medical review requirements for home health claims. We also found 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.

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 Courts have 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 136 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 11 instances, the physicians signed the plans of care without having knowledge of the patients condition.
- In 82 instances, the physicians were not aware of the homebound requirement for home services.
- In 88 instances, the physicians relied on the HHA to prepare the plan of care.

Currently, 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. Public Law 104-191, § 232 made physicians more accountable for certifying individuals met the requirements for home health services and subjected them to civil monetary penalties.

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.

Intermediaries' Limited Review of Home Health Claims

We found most claim documentation from providers appeared to be legitimate and could on the surface withstand medical review. However, most of the problems we found with HHA claims were detected when we interviewed beneficiaries and physicians. In our opinion, HCFA needs to develop procedures for intermediaries to contact beneficiaries to verify services were provided and to contact physicians to verify whether services were ordered.

We also found HCFA limited the claims reviewed each year by the fiscal intermediaries. For example, in 1988, HCFA required the intermediaries to review 50 percent of all HHA claims. By 1995, HCFA had reduced the intermediary's target review efforts to 3.2 percent and the minimum acceptable review level of 1 percent. In 1996, HCFA required the intermediaries to set their own goals for medical review in their budget request.

Medical reviews of claims for HHA services were not effective in curbing abuse. The HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was

reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, we believe the reviews will continue to be ineffective because the focused medical reviews do not include beneficiary and physician interviews.

Beneficiaries Not Aware of HHA Services Claimed on Their Behalf

We also found at the time of our review, the intermediaries did not notify beneficiaries of the claims submitted by the providers. Thus, beneficiaries did not know what the HHAs were claiming on their behalf and did not provide feedback to the intermediaries on unnecessary home services.

For services other than home health, Part A intermediaries and Part B carriers are required to notify beneficiaries of actions taken on their behalf (MIM Sec.3718 and Medicare Carrier Manual Sec. 7000). Medicare Benefit Notices and Explanation of Medicare Benefits are sent by intermediaries and carriers to provide beneficiaries with a record of services billed to Medicare and information about coinsurance, deductibles, limits of services, and disallowed charges. The beneficiaries did not receive benefit notices for home health services because there was no Medicare requirement for deductibles, coinsurance, or lifetime limit of services.

A pilot study conducted by Aetna Florida in Fiscal Year 1995 indicated providing home health service information to beneficiaries aided in the detection and deterrence of fraudulent billing practices for home health services. As a result, HCFA instructed the RHHIs to generate a beneficiary notification system for home health services effective October 1, 1996. The beneficiary notification contains the number and type of visits claimed by the HHA during the month on behalf of the beneficiary. The notification requests the beneficiary contact the intermediary if the information is not correct.

CONCLUSIONS AND RECOMMENDATIONS

The results of this review and our previous eligibility reviews (see Appendix C) have identified systemic problems inherent in the Medicare HHA program. These problems included HHA services: (1) that were not reasonable and necessary, (2) provided to beneficiaries who were not homebound, (3) that did not have valid physician orders, (4) that were not provided, and (5) that were not documented.

The nature of the delivering of a service in a home setting makes the benefit vulnerable to fraud and abusive activity. The large increases in HHA expenditure growth has outpaced HCFA's ability to adequately fund program integrity and oversight activities. Since 1990 the Medicare expenditures for home health services have increased dramatically from about \$3.3 billion to an estimated \$16.9 billion for 1996. We believe implementing our recommendations below will help to address the abuses we have noted in providing for home health services. Our Office of Evaluation and Inspections will be issuing a report

shortly that further discusses changes that should be considered based on their evaluation work.

In the President's Fiscal Year 1998 proposed budget, payment reforms are proposed to help limit overutilization and bring some control to the home health benefit. The budget also presents additional reform which will lead to a prospective payment system for HHAs. Our audits indicate that actions such as those proposed by the President are needed to help curtail the overutilization and inappropriate use of HHA services.

The HCFA currently has a demonstration project underway to test an HHA prospective payment system. This system is focused on making payments based on a per episode of care. The approach involves determining the amount or volume of HHA services needed based on the diagnosis that indicated the need for skilled intermittent home based care.

We recommend HCFA:

- ▶ Consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system that is based on expenditure levels that correct for known problems; (2) placing limitations on the number of visits that could be made to a beneficiary; (3) establishing a system of pre-authorizations for home health services if a pre-established limit per beneficiary was exceeded; (4) establishing a copayment that would be required of the beneficiary for each visit or after a certain level of visits were reached in a year; and (5) a case management system.
- ▶ Emphasize the definition of homebound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."
- ▶ Revise Medicare regulations to require the physician to examine the patient before they order home health services. Also, require the patient to see the recertifying physician at least once every 60 days. The HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. An outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.
- ▶ Require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.

- ▶ Instruct intermediaries to perform focused medical reviews augmented with physicians and beneficiary interviews to verify services were provided and properly prescribed.

In its written response to our draft report, HCFA concurred with four of the five recommendations. The HCFA agreed in principle with the other recommendation, and is continuing to examine the issue. The complete text of HCFA's response is presented as Appendix D to this report.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE

To determine if HHA services were provided as claimed, and if so, to determine if the services met Medicare reimbursement guidelines.

POPULATION

We used the universe of HHA claims approved for payment by the principal RHHI servicing California, Illinois, New York and Texas (ORT States) and the alternate RHHI for the 4 ORT States during the 15 months ended March 31, 1996 as follows:

<u>Stratum Number</u>	<u>RHHI</u>	<u>State</u>	<u>Number of Claims</u>	<u>Charges</u>
1	UGS	NY	891,502	\$1,460,645,817.81
2	HCSC	IL	657,358	699,730,817.78
3	IASD Hlth Srvc	all	531,110	873,453,368.12
4	Palmetto	TX	1,631,195	2,120,026,308.57
5	BC-California	CA	<u>1,076,746</u>	<u>1,555,141,147.16</u>
TOTAL			<u>4,787,911</u>	<u>\$6,708,997,459.44</u>

SAMPLE UNIT

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

SAMPLE DESIGN

A stratified random sample was used.

SAMPLE SIZE

A sample of 50 claims from each stratum. There are five strata.

ESTIMATION METHODOLOGY

Using the HHS-OIG-OAS Variable Appraisal Program, we projected the overpayment for services that either were not reasonable or necessary, not to homebound beneficiaries, did not have valid physician orders, or did not have documentation.

In addition, we projected the percentage of services that did not meet Medicare requirements. This projection was made using the HHS-OIG-OAS Stratified Cluster Attribute Appraisal Program. For this appraisal each claim was considered to be a cluster of services.

PROJECTIONS**RESULTS OF 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>	<u>Number of Services</u>	<u>Services in Error</u>
1	891,502	50	\$60,910.33	28	\$16,664.20	702	202
2	657,358	50	59,336.44	36	46,905.93	598	478
3	531,110	50	103,697.31	26	32,417.41	1,044	356
4	1,631,195	50	59,325.35	28	22,275.51	610	243
5	<u>1,076,746</u>	<u>50</u>	<u>90,873.76</u>	<u>28</u>	<u>27,867.79</u>	<u>791</u>	<u>260</u>
Total:	<u>4,787,911</u>	<u>250</u>	<u>\$374,143.19</u>	<u>146</u>	<u>\$146,130.84</u>	<u>3,745</u>	<u>1,539</u>

VARIABLES PROJECTIONS:

Errors Identified in the Sample	146
Value of Errors Identified in the Sample	\$146,131
Point Estimate	\$2,584,991,971
At the 90% Confidence Level:	
Lower Limit	\$2,119,449,933
Upper Limit	\$3,050,534,009

ATTRIBUTES PROJECTIONS:

Services in Sample	3,745
Number of Services in Error	1,539
Point Estimate	39.56%
At the 90% Confidence Level:	
Lower Limit	37.31%
Upper Limit	41.82%

**HHA ELIGIBILITY REVIEWS
ERROR RATES ON REPORTS ISSUED TO DATE**

<u>HHA</u>	<u>Claims Reviewed</u>	<u>Claims In Error</u>	<u>Services In Error</u>
Florida - A	100	40%	41%
Florida - B	100	32%	22%
Florida - C	100	24%	24%
Florida - D	100	32%	20%
Florida - E	100	44%	23%



DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

DATE: JUN 27 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck 
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Operation Restore Trust Report:
"Review of Medicare Home Health Services in California, Illinois,
New York and Texas," (A-04-96-02121)

We reviewed the above-referenced report concerning whether Medicare payments to home health agencies (HHAs) met Medicare reimbursement requirements.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG)
Draft Report: "Results of the Operation Restore Trust
Audit of Medicare Home Health Services in
California, Illinois, New York, and Texas"
(A-04-96-02121)

OIG Recommendation #1

HCFA should consider the following alternatives in restructuring the home health reimbursement methodology: (1) a prospective payment system that is based on expenditure levels that correct for known problems; (2) placing limitations on the number of visits that could be made to a beneficiary; (3) establishing a system of pre-authorizations for home health services if a pre-established limit per beneficiary was exceeded; (4) establishing a copayment that would be required of the beneficiary for each visit or after a certain level of visits were reached in a year; and (5) a case management system.

HCFA Response

We concur. We agree the Medicare home health benefit is in need of some structural payment reforms. The Administration, in its fiscal year (FY) 1998 budget, proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. These reforms include the following:

(1) Prospective Payment System (PPS): The President's 1998 budget proposal would constrain growth in expenditures through an interim home health payment method until a fully prospective payment system is in place October 1, 1999. The interim home health payment method would establish an agency-specific annual dollar cap per beneficiary. Payment for services would be the lesser of actual costs, the revised per-visit cost limits, or the agency-specific per beneficiary annual cap. We are prepared to begin implementation of this system upon receipt of the necessary statutory authority.

The Administration is committed to implementing PPS for home health in 1999. The payment amounts would be case-mix adjusted. Currently, HCFA is conducting research to develop a case-mix adjuster to explain significant variation in costs per case. This would save billions of dollars and reduce incentives for overutilization.

(2) Placing limitations on the number of visits: Since visits are covered for eligible beneficiaries for as long as the visits are medically reasonable and necessary, limitations on the number of visits would require a statutory change. The interim home health payment method, an agency-specific per beneficiary cap, would provide an incentive to

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control visits. Additionally, the President's budget proposal includes a provision that would allow the Secretary to apply a normative number of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain further control over excessive utilization.

(3) Establishing pre-authorizations: This would require a change in the law.

(4) Establishing a copayment: HCFA is concerned about the impact that higher per beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries. Poorer beneficiaries spend a greater proportion of their income in out-of-pocket costs. Our proposed interim home health payment method should adequately curb growth in service use.

(5) Case Management System: While we would not oppose requiring case management of home health agency (HHA) services, this recommendation would require a change in the law. We recommend this approach be considered as part of PPS reform. There are many issues that would need to be addressed to design and implement such a system. One issue would be the cost of the system.

OIG Recommendation #2

Emphasize the definition of home bound in the Medicare HHA Manual and include additional guidance on the standards for defining "considerable and taxing effort" and "infrequent or for periods of relatively short duration."

HCFA Response

We concur. The FY 1998 budget proposal redefines the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly unable to leave the home.

OIG Recommendation #3

Revise Medicare regulations to require the physician to examine the patient before ordering home health services. Also, require the patient to see the recertifying physician at least once every 60 days. HCFA should ensure the treating physicians establish the plan of care and specifically prescribe the type and frequency of home health services needed. An outreach program should be established to re-educate the physicians on the home health eligibility requirements so they do not have to rely on the HHA determination.

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HCFA Response

We agree in principle that physicians should only certify home health care on the basis of personal knowledge of the patient's condition and also that recertifications should only be made when that knowledge is updated. At this time, we do not support the imposition of specific service requirements or time frames, but we are continuing to examine both coverage rules and conditions of participation in order to develop the discipline necessary to ensure proper certifications. We recommended language parallel to the Health Insurance Portability and Accountability Act of 1996 requirements that OIG cited be enacted for other benefits.

OIG Recommendation #4

HCFA should require intermediaries reviewing claims to continue to notify beneficiaries when HHA claims are paid on their behalf and use information provided by the beneficiaries to target abusive HHAs for focused medical review.

HCFA Response

We concur. HCFA conducted a four state pilot test of the Notice of Utilization (NOU) for home health services in March 1995. The NOU provides Medicare beneficiaries with information concerning home health services billed to Medicare by their HHAs. We initiated national implementation of the NOU in October 1996. As a result of the pilot, regional home health intermediaries are already using this process to identify providers that should be targeted for focused medical review.

OIG Recommendation #5

HCFA should instruct intermediaries to perform focused medical reviews augmented with physician and beneficiary interviews to verify services were provided and properly prescribed.

HCFA Response

We concur. HCFA instructs fiscal intermediaries to confirm pertinent information during the focused medical review process. This could include physician and beneficiary interviews. In fact, we believe the implementation of the NOU process for Medicare beneficiaries is an initial step in seeking beneficiary input in verifying services. We are currently considering options for national distribution of NOUs to physicians who prescribe home health services. This process will strengthen our efforts to validate services and ensure they are properly prescribed by the HHA.