Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ABERRANT MEDICARE HOME HEALTH OUTLIER PAYMENT PATTERNS IN MIAMI-DADE COUNTY AND OTHER GEOGRAPHIC AREAS IN 2008

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EXECUTIVE SUMMARY

OBJECTIVE

To identify geographic areas that exhibited aberrant Medicare home health outlier payment patterns in 2008.

BACKGROUND

In December 2008, the Centers for Medicare & Medicaid Services (CMS) announced its continuing efforts to fight Medicare fraud, waste, and abuse by home health providers in the Miami-Dade County area by suspending provider payments and taking other payment and review actions. To date, CMS has placed 33 Miami-Dade home health agencies on payment suspension. In May 2009, the Department of Health and Human Services and the Department of Justice created an interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat health care fraud nationwide.

In 2008, Medicare paid approximately $15 billion for home health services. Home health care has grown in recent years for reasons including advances in medicine and technology as well as beneficiaries' preference to receive treatment at home rather than in a hospital or nursing home. However, the recent growth in home health care services relative to the number of eligible beneficiaries indicates that it may be subject to fraud.

In October 2000, CMS instituted a prospective payment system (PPS) that pays a predetermined rate for 60-day episodes of home health care. The payments are adjusted for beneficiaries' health conditions and care needs, as well as geographical wage differences. There are no limits to the number of 60-day episodes eligible beneficiaries may receive.

Medicare makes additional payments, known as outlier payments, to home health providers that supply services to beneficiaries who incur unusually large costs. Although CMS does not limit, or cap, outlier payments to individual providers, total outlier payments for home health services may not exceed 5 percent of annual projected total home health payments. In August 2009, CMS issued a home health PPS proposed rule for 2010. Among other things, the proposed rule would cap outlier payments to individual home health providers at 10 percent. CMS estimates that an individual provider cap will reduce national outlier payments to no more than 2.5 percent of total home health payments.

We analyzed all Medicare home health claims that were submitted and fully paid in 2008 to identify geographic areas that exhibited aberrant Medicare home health outlier payment patterns. We define aberrant to be at least twice the national average for three or more of the five payment characteristics we reviewed.

FINDINGS

Miami-Dade County accounted for more home health outlier payments in 2008 than the rest of the Nation combined. In 2008, Miami-Dade County accounted for 52 percent of the approximately $1 billion Medicare paid nationally in home health outlier payments, while only 2 percent of all Medicare beneficiaries receiving home health services resided there. In addition, 86 percent (25 of 29) of home health providers that received outlier payments over $100,000 per beneficiary in 2008 were located in Miami-Dade County. Further, 67 percent (174 of 259) of home health providers that received total outlier payments over $1 million in 2008 were located in Miami-Dade County.

In Miami-Dade County, Medicare outlier payments for home health claims with a primary diagnosis related to diabetes were eight times the national average. Medicare outlier payments for claims with a primary diagnosis related to diabetes accounted for 6 percent of all home health payments. In Miami-Dade County, Medicare outlier payments for home health visits with a primary diagnosis related to diabetes accounted for 50 percent—or eight times the national average—of total home health payments. Further, the percentage of outlier payments in Miami-Dade County exceeded that of other Florida counties with higher rates of diabetes.

Twenty-three counties nationwide exhibited aberrant home health outlier payment patterns similar to that of Miami-Dade County but to a lesser extent. Medicare payments in Miami-Dade County were at least twice the national average for all five home health outlier payment characteristics we reviewed. An additional 23 counties nationwide had payments that were at least twice the national average for three or more of the five characteristics. In addition, 59 percent (850 of 1,432) of the total home health providers in Miami-Dade County and the 23 other counties with similar characteristics were paid at least twice the national average for three or more of the five outlier payment characteristics we reviewed.

RECOMMENDATIONS

Our findings demonstrate that home health services in Miami-Dade County, as well as 23 additional counties nationwide, warrant additional review as part of ongoing antifraud activities, such as HEAT, in the Medicare program.

To address our findings, we recommend that CMS:

Continue with efforts to institute a cap on the total outlier payments an individual home health provider may receive annually.

Review home health providers that exhibit aberrant outlier payment patterns and respond appropriately based on the findings.

Continue with efforts to strengthen enrollment standards for home health providers to prevent illegitimate home health agencies from obtaining billing privileges.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three recommendations. At the time of its comments, CMS was analyzing public comments on the home health PPS proposed rule which would, among other things, cap outlier payments at 10 percent per agency. The final rule was published in the Federal Register on November 10, 2009, and is effective January 1, 2010. CMS has also taken steps to address widespread abuse of Medicare outlier payments to home health agencies in Miami-Dade County.

We support CMS's efforts to address these issues and encourage it to continue making progress in these areas. We made technical changes to the report based on CMS's comments.

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INTRODUCTION

OBJECTIVE

To identify geographic areas that exhibited aberrant Medicare home health outlier payment patterns in 2008.

BACKGROUND

In December 2008, the Centers for Medicare & Medicaid Services (CMS) announced its continuing efforts to fight Medicare fraud, waste, and abuse by home health providers in the Miami-Dade County area by suspending provider payments and taking other payment and review actions.[1] To date, CMS has placed 33 Miami-Dade home health agencies on payment suspension.

In addition to suspending payments, CMS has visited Medicare beneficiaries to investigate the medical necessity of home health services they received.[2] These visits indicated, among other things, that services related to diabetes may represent a payment vulnerability in the Medicare program. For example, some home health providers received Medicare payments for reportedly providing insulin injections to beneficiaries who did not qualify for home health services because they were not confined to their home.

Medicare Home Health Services

In 2008, Medicare paid approximately $15 billion for home health services.[3] Home health care has grown in recent years for reasons including medical and technological advances. Growth in home health care can also be attributed to beneficiaries' preference to stay at home rather than seek treatment in a hospital or nursing home. However, the recent growth in home health care services relative to the number of eligible beneficiaries indicates that these services may be subject to increased fraud.

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[1] CMS, "CMS Strengthens Efforts to Fight Medicare Waste, Fraud and Abuse." Press Release, December 29, 2008. Available online at http://www.cms.hhs.gov/apps/media/press_releases.asp. Accessed on June 22, 2009.

[2] USA Today, "Sleuths go door to door to sniff out Medicare fraud." Available online at http://www.usatoday.com/news/health/2008-10-05-fraud-inside_N.htm. Accessed on May 14, 2009.

[3] Office of Inspector General (OIG) analysis of 2008 Medicare home health claims. This figure reflects all claims that were submitted and fully paid in 2008. We consider a claim to be fully paid if both the initial partial payment of the estimated rate for a full 60-day episode of care and remaining payment, including any outlier payments, at the end of the 60-day episode have been made on the claim.

To qualify for home health services, Medicare beneficiaries must (1) be confined to the home; (2) need intermittent skilled nursing services, physical or speech therapy, or continuing occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care prescribed and periodically reviewed by a physician.[4]

Medicare Home Health Billing Requirements

To obtain Medicare billing privileges, home health providers must submit a completed application and supporting documentation to CMS.[5] The application requires information such as personal details about the provider (e.g., adverse legal actions and convictions); the provider's practice location; and the names of individuals having ownership or managing control of the provider's business. By signing and submitting the application, the provider agrees to follow all Medicare laws, regulations, and program instructions. Further, providers are required to provide documentation demonstrating that they have sufficient reserve funds to operate for their first 3 months as Medicare providers.

Once approved, home health providers may bill for all home health services excluding durable medical equipment.[6] [7] Providers must include beneficiaries' diagnosis codes on all claims. The primary diagnosis is based on a beneficiary's condition most related to the current plan of care.[8] This code must relate to home health services rendered by the provider. For example, if a provider assists a beneficiary with administering insulin only, a diabetes-related diagnosis code should be listed as the primary diagnosis code on the claim.

Medicare Payment System for Home Health Services

In October 2000, CMS instituted a prospective payment system (PPS) that pays a predetermined rate for 60-day episodes of home health

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[4] 42 CFR § 409.42.

[5] CMS, "Medicare Enrollment Application: Institutional Providers." Available online at http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf. Accessed on June 16, 2009.

[6] CMS, "Home Health PPS: Overview." Available online at http://www.cms.hhs.gov/HomeHealthPPS/. Accessed on June 16, 2009.

[7] Some home health providers may also be certified to bill Medicare for durable medical equipment. Durable medical equipment includes items such as canes, knee braces, and wheelchairs.

[8] CMS, "Medicare Home Health Diagnosis Coding." Available online at http://www.cms.hhs.gov/HomeHealthPPS/Downloads/v_code_rev_stmt2.pdf. Accessed on June 16, 2009.

care.[9] The payments are adjusted for beneficiaries' health conditions and care needs, as well as geographical wage differences. There are no limits to the number of 60-day episodes eligible beneficiaries may receive.[10]

Home health providers receive an initial partial payment of the estimated rate for a full 60-day episode of care when the CMS contractor servicing their area receives their claims.[11] [12] Providers receive the remaining payment at the end of the 60-day episode. The total payment is the sum of the initial and remaining payments, unless there is an applicable adjustment.[13] [14] Beneficiaries do not make copayments for home health services.

Medicare makes additional payments, known as outlier payments, to home health providers that supply services to beneficiaries who incur unusually high costs.[15] There is currently no limit, or cap, on outlier payments an individual home health provider may receive. However, total outlier payments for home health services may not exceed 5 percent of annual projected total home health payments.[16] [17]

In August 2009, CMS issued a home health PPS proposed rule for 2010. Among other things, the proposed rule would cap outlier payments to individual home health providers at 10 percent.[18] CMS estimates that an individual provider cap will reduce national outlier payments to no more than 2.5 percent of total home health payments.

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[9] CMS, "Home Health PPS: Overview." Available online at http://www.cms.hhs.gov/HomeHealthPPS/. Accessed on June 16, 2009.

[10] Ibid.

[11] Ibid.

[12] CMS contracts with regional home health intermediaries to pay claims submitted by home health providers.

[13] CMS, "Home Health PPS: Overview." Available online at http://www.cms.hhs.gov/HomeHealthPPS/. Accessed on June 16, 2009.

[14] An example of a payment adjustment is a partial episode payment adjustment that occurs when a beneficiary transfers to another home health provider during a 60-day episode.

[15] CMS, "Home Health PPS: Overview." Available online at http://www.cms.hhs.gov/HomeHealthPPS/. Accessed on June 16, 2009.

[16] The Balanced Budget Act of 1997, P.L. No. 105-33, 42 U.S.C. 1395fff(b)(5).

[17] If total outlier payments exceed 5 percent in a given year, CMS may adjust its cost-payment variables (e.g., fixed-dollar loss ratio) to meet the 5-percent requirement for the subsequent year.

[18] 74 Fed. Reg. 40947 (Aug. 13, 2009).

Health Care Fraud Prevention and Enforcement Action Team

In 2007, the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) established joint Medicare Fraud Strike Force teams in South Florida and Los Angeles to combat Medicare fraud.[19] As of May 2009, the team operating in South Florida has convicted 146 people and secured $186 million in criminal fines and civil recoveries.[20] The Medicare Fraud Strike Force was designed to combat fraud through the use of Medicare data analysis and an increased focus on community policing.[21] HHS and DOJ recently announced the establishment of an interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat health care fraud nationwide.[22]

The HEAT team is focusing on fraud prevention and building on prior OIG and CMS reviews of durable medical equipment providers.[23] The HEAT team will also undertake initiatives including increased training for providers on Medicare compliance, improving data sharing between CMS and law enforcement, and strengthening program integrity monitoring. In June 2009, HHS announced that as part of the HEAT initiative, 53 people in Miami, Detroit, and Denver were indicted for schemes to submit more than $50 million in false Medicare claims.[24]

Related Work

OIG has issued several reports related to home health care. These reports have addressed various topics, including variation in Medicare

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[19] HHS, "Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team." News Release, May 20, 2009. Available online at http://www.hhs.gov/news/press/2009pres/05/20090520a.html. Accessed on June 19, 2009.

[20] Ibid.

[21] HHS, "Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More than $50 Million in Alleged False Billing in Detroit." News Release, June 24, 2009. Available online at http://www.hhs.gov/news/press/2009pres/06/20090624a.html. Accessed on June 25, 2009.

[22] HHS, "Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team." News Release, May 20, 2009. Available online at http://www.hhs.gov/news/press/2009pres/05/20090520a.html. Accessed on June 19, 2009.

[23] Ibid.

[24] HHS, "Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More than $50 Million in Alleged False Billing in Detroit." News Release, June 24, 2009. Available online at http://www.hhs.gov/news/press/2009pres/06/20090624a.html. Accessed on June 25, 2009.

payments for home health services,[25] problem providers and their impact on Medicare,[26] and geographical variation in the average number of visits provided by home health agencies.[27] In addition, other OIG work has uncovered potential health care fraud in South Florida, specifically in Miami-Dade County.[28] [29] [30]

In February 2009, the Government Accountability Office (GAO) issued a report on improvements needed to address improper payments in home health.[31] GAO determined that compared to the rest of the country, a large percentage of home health cases in Miami-Dade County involved diabetic beneficiaries. Specifically, 50 percent of all Medicare beneficiaries in Miami-Dade County who received home health services had a diagnosis of diabetes compared to an average of 16 percent for all other counties included in the analysis.

METHODOLOGY

Scope

We reviewed all Medicare home health claims that were submitted and fully paid in 2008.[32]

Data Source, Collection, and Analysis

We obtained the National Claims History file containing the home health claims included in this study from CMS. We used the home health provider identification numbers on the claims and information in CMS's Online Survey, Certification, and Reporting database to determine the providers' ZIP Codes. Next, we matched the providers'

[25] OEI-04-93-00260, "Variation Among Home Health Agencies in Medicare Payments for Home Health Services," July 1995.

[26] OEI-09-96-00110, "Home Health: Problem Providers and Their Impact on Medicare," July 1997.

[27] OEI-04-93-00262, "Geographical Variation in Visits Provided by Home Health Agencies," September 1995.

[28] OEI-01-08-00100, "Medicare Part B Billing for Ultrasound," July 2009.

[29] OEI-09-07-00030, "Aberrant Billing in South Florida for Beneficiaries with HIV/AIDS," September 2007.

[30] OEI-03-07-00150, "South Florida Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits," March 2007.

[31] GAO-09-185, "Medicare: Improvements Needed to Address Improper Payments in Home Health."

[32] We consider a claim to be fully paid if both the initial partial payment of the estimated rate for a full 60-day episode of care and remaining payment, including any outlier payments, at the end of the 60-day episode have been made on the claim.

ZIP Codes to the corresponding counties using SAS computer software and determined the total number of home health providers in each county.[33] Similarly, we repeated the matching process using beneficiaries' ZIP Codes listed on the claims to determine the total number of beneficiaries who received home health services in each county.[34] We also determined the total number of claims submitted from each county where home health providers were located.

For each county, we calculated the total amount Medicare paid for the home health claims and determined the outlier paid amounts included in those payments. For each provider, we also calculated the total outlier amount Medicare paid per beneficiary. In addition, we calculated the total outlier amount Medicare paid in each county for claims with a primary diagnosis related to diabetes.[35] Using this information, we calculated the following five payment characteristics nationally, as well as for each county and home health provider listed on the claims:[36]

1. average outlier payment per provider;[37]
2. average outlier payment per beneficiary;[38]
3. average outlier payment per claim;
4. outlier payment rates (i.e., outlier payments as a percentage of total home health payments); and
5. outlier payment rates for claims with a primary diagnosis related to diabetes (i.e., outlier payments for claims with a primary diagnosis related to diabetes as a percentage of total home health payments).

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[33] SAS uses a ZIP Code's geographic center to match the ZIP Code to its corresponding county.

[34] We counted each beneficiary only once.

[35] We considered all services with a Common Procedure Terminology (CPT) code with a prefix of 250 to be diabetes related. CPT codes are used to categorize medical procedures and services.

[36] According to the U.S. Census Bureau, there were 3,141 counties or county equivalents in the United States in 2007. There were 2,158 counties or county equivalents listed on the claims we reviewed.

[37] This value is the equivalent of total outlier payments for an individual home health provider.

[38] Some beneficiaries received services from more than one home health provider. These beneficiaries were counted more than once when calculating the average outlier payment per beneficiary for each home health provider.

We define payments as aberrant if they are at least twice the national average for three or more of the above five payment characteristics.

Limitations

Some ZIP Codes span multiple counties. However, in this study, ZIP Codes were matched to only one corresponding county. Therefore, some providers, beneficiaries, and claims associated with a particular county in our analysis may have actually been associated with a neighboring county.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" approved by the Council of the Inspectors General on Integrity and Efficiency.

Miami-Dade County accounted for more home health outlier payments in 2008 than the rest of the Nation combined

In 2008, Miami-Dade County accounted for 52 percent of the approximately $1 billion Medicare paid nationally in home health outlier payments, while only 2 percent of all Medicare beneficiaries receiving home health services resided there. In addition, outlier payments constituted 59 percent of total home health payments in Miami-Dade County, but constituted only 7 percent of total home health payments, on average, nationally.

As shown in Table 1, the average outlier payment per beneficiary for home health providers located in Miami-Dade County was 32 times the corresponding 2008 national average. The average outlier payment per claim in Miami-Dade County was 22 times the national average. Further, the average payment per provider in Miami-Dade County was 14 times the national average.

Table 1: Summary of 2008 Medicare Home Health Outlier Payments

Home Health Outlier Payments	National Average	Miami-Dade County Average	Ratio of Miami-Dade County Average to National Average*
Payment per beneficiary	$378	$11,928	32:1
Payment per claim	$190	$4,100	22:1
Payment per provider	$110,785	$1,581,608	14:1
Outlier payment rate**	7%	59%	8:1

* Rounded to the closest whole number.

** Based on total 2008 Medicare home health payments.

Source: OIG analysis of 2008 Medicare home health claims.

Over 85 percent of home health providers that received outlier payments over $100,000 per beneficiary in 2008 were located in Miami-Dade County

In 2008, Medicare paid over $100,000 each for home health services provided to 33 beneficiaries nationally. The total payment for these services exceeded $3 million. Services for the 33 beneficiaries were provided by 29 home health providers. Of these providers, 86 percent (25 of 29) were located in Miami-Dade County.

Home health providers in Miami-Dade County also represented the majority of providers that received Medicare payments per beneficiary at amounts over $75,000. Providers in Miami-Dade County accounted for 70 percent (111 of 158) of home health providers nationwide that received Medicare payments from $75,001 to $100,000 per beneficiary.

Table 2 shows total outlier payments per beneficiary, the number of home health providers receiving those payments in the entire Nation and Miami-Dade County, and the percentage of providers in Miami-Dade County receiving those payments.

Table 2: Home Health Outlier Payments Per Beneficiary in 2008

Total Outlier Payment Amount Per Beneficiary	Number of Providers in All Counties (including Miami-Dade County)*	Number of Providers in Miami-Dade County*	Miami-Dade Providers as a Percentage of Providers in All Counties**
Up to $25,000	5,782	327	6%
$25,001 to $50,000	1,400	280	20%
$50,001 to $75,000	468	232	50%
$75,001 to $100,000	158	111	70%
Over $100,000	29	25	86%
Total	**7,837**	**975**	**12%**

* Some providers may be included in more than one category.

** Rounded to the closest whole number.

Source: OIG analysis of 2008 Medicare home health claims.

Sixty-seven percent of home health providers that received total outlier payments over $1 million in 2008 were located in Miami-Dade County

In 2008, a total of 829 providers nationwide received Medicare home health outlier payments. Of the providers that received outlier payments over $1 million, 67 percent (174 of 259) were located in Miami-Dade County. Twenty-two providers nationwide received outlier payments over $5 million in 2008. Of these providers, 91 percent (20 of 22) were located in Miami-Dade County.

Table 3 shows the number of home health providers receiving total outlier payments over $1 million in the entire Nation and Miami-Dade County and the percentage of providers in Miami-Dade County receiving those payments in 2008.

Table 3: Total Home Health Outlier Payments Over $1 Million in 2008

Total Outlier Payment Amount	Number of Providers in All Counties (including Miami-Dade County)	Number of Providers in Miami-Dade County	Miami-Dade Providers as a Percentage of Providers in All Counties*
Over $1 million to $5 million	237	154	65%
Over $5 million to $10 million	21	19	90%
Over $10 million	1	1	100%
Total	**259**	**174**	**67%**

* Rounded to the closest whole number.

Source: OIG analysis of 2008 Medicare home health claims.

In Miami-Dade County, Medicare outlier payments for home health claims with a primary diagnosis related to diabetes were eight times the national average

The primary diagnosis associated with almost one-quarter of all home health visits nationally in 2008 was related to diabetes.[39] Medicare outlier payments for these visits accounted for 6 percent of all home health payments. In Miami-Dade County, Medicare outlier payments for home health visits with a primary diagnosis related to diabetes accounted for 50 percent—or eight times the national average—of total home health payments. Further, the percentage of outlier payments in Miami-Dade County exceeded that of other Florida counties with higher rates of diabetes.[40] [41]

[39] The beneficiaries may have also received other services for conditions unrelated to diabetes during these visits.

[40] We obtained diabetes rates among Florida adults over the age of 20 years from the Centers for Disease Control and Prevention. These rates were for 2005, the most recent year available at the time of our review. Available online at http://apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?StateId=12. Accessed on June 16, 2009.

[41] We ranked Florida counties according to the number of adults with diabetes and selected the four counties with the largest populations of adults with diabetes as well as a diabetes rate exceeding that in Miami-Dade County.

Table 4 shows a comparison of the most recently available rates of diabetes among adults over age 20 in Miami-Dade County and four other Florida counties and the corresponding outlier payment rates for home health claims with a primary diagnosis related to diabetes in each county in 2008.

Table 4: Comparison of Adult Diabetes Rates and Medicare Outlier Payments for Home Health Claims With a Primary Diagnosis Related to Diabetes in Five Florida Counties

County	Number of Adults With Diabetes*	Adult Diabetes Rate*†	Medicare Outlier Payment Rate for Claims With a Primary Diagnosis Related to Diabetes**
Miami-Dade	129,100	7.5%	50%
Hillsborough	73,810	9.1%	4%
Duval	50,260	8.6%	1%
Pinellas	66,280	9.1%	1%
Palm Beach	84,500	8.8%	1%

* Source: The Centers for Disease Control and Prevention. The data were for 2005, the most recent year available at the time of our review.

† In 2005, the rate of diabetes in Florida was 17.1 percent in adults aged 65–74 years and 15.7 percent in adults aged 75 or older. Rates were based on the total population of adults aged 18 years or older.

** Source: OIG analysis of 2008 Medicare home health claims.

Twenty-three counties nationwide exhibited aberrant home health outlier payment patterns similar to that of Miami-Dade County but to a lesser extent

Medicare payments in Miami-Dade County were at least twice the national average for all five home health outlier payment characteristics we reviewed. An additional 23 counties nationwide had payments that were at least twice the national average for three or more of the five characteristics.[42] See Appendix A for a summary of the Medicare home health outlier payments for each of the five payment characteristics we reviewed in Miami-Dade County and the other 23 counties.

[42] We do not identify the 23 counties because they may be subject to future OIG and HEAT reviews.

Of the total home health providers in Miami-Dade County and the other 23 counties, 59 percent (850 of 1,432) were paid at least twice the national average for three or more of the five payment characteristics we reviewed. See Appendix B for additional details on the number of providers that were paid at least twice the national average for three or more payment characteristics, as well as the total number of providers in each county.

RECOMMENDATIONS

South Florida has been the focus of efforts to combat Medicare fraud, waste, and abuse in recent years. In addition, in May 2009, HHS and DOJ established an interagency HEAT team to combat health care fraud nationwide. Our findings demonstrate that home health services in Miami-Dade County, as well as in 23 additional counties nationwide, warrant additional review as a part of ongoing antifraud activities in the Medicare program.

We found that Miami-Dade County accounted for more home health outlier payments in 2008 than the rest of the Nation combined. Over 85 percent of home health providers that received outlier payments over $100,000 per beneficiary were located in Miami-Dade County. In addition, 67 percent of home health providers that received total outlier payments over $1 million were located in Miami-Dade County. We also found that in Miami-Dade County, Medicare outlier payments for home health claims with a primary diagnosis related to diabetes were eight times the national average.

In addition, we found that 23 other counties exhibited aberrant home health payment patterns similar to that of Miami-Dade County but to a lesser extent. Over half of the total home health providers in Miami-Dade County and the 23 other counties we identified were paid at least twice the national average for three or more of the five payment characteristics we reviewed.

To address our findings, we recommend that CMS:

Continue With Efforts To Institute a Cap on the Total Outlier Payments an Individual Home Health Provider May Receive Annually

In August 2009, CMS issued a home health PPS proposed rule for 2010 to cap outlier payments to individual home health providers at 10 percent, thus reducing national outlier payments to an estimated 2.5 percent of total home health payments. Capping outlier payments to individual home health providers may make the area of home health services less prone to fraudulent activity by mitigating potential inappropriate billing vulnerabilities. Currently, CMS imposes a cap on the payments a hospice agency may receive based on the number of Medicare beneficiaries the agency serves.

Review Home Health Providers That Exhibit Aberrant Outlier Payment Patterns and Respond Appropriately Based on the Findings

For example, CMS could develop a method of determining thresholds for a number of characteristics that would trigger an immediate, prepayment review. These characteristics may include the factor by which a provider's average outlier payment exceeds the national average.

To assist CMS, we provided information under separate cover on the specific providers in this report that were paid at least twice the national average for three or more of the five payment characteristics we reviewed.

Continue With Efforts To Strengthen Enrollment Standards for Home Health Providers To Prevent Illegitimate Home Health Agencies From Obtaining Billing Privileges

In its August 2009 home health PPS proposed rule, CMS described methods for limiting enrollment of home health agencies having characteristics associated with fraudulent activity (e.g., sharing the same practice location, selling or transferring ownership of the agency within 3 years of enrollment). We encourage CMS to continue to pursue these methods for limiting the enrollment of home health providers.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three recommendations. At the time of its comments, CMS was analyzing public comments on the home health PPS proposed rule which would, among other things, cap outlier payments at 10 percent per agency. The final rule was published in the Federal Register on November 10, 2009, and is effective January 1, 2010. CMS has also taken steps to address widespread abuse of Medicare outlier payments to home health agencies in Miami-Dade County. Specifically, CMS is (1) suspending home health agencies with high amounts of outlier payments, (2) enhancing visits to beneficiaries in their homes to verify that they qualify for home health services, and (3) utilizing auto-denial edits for beneficiaries who do not qualify for home health services.

Further, CMS initiated a new process in January 2009 to deny the enrollment of a home health agency if the owner has an existing overpayment that has not been fully repaid or has been placed under Medicare payment suspension. As of January 2009, CMS contractors

are required to perform additional verification of home health agencies having certain characteristics (i.e., agencies that change their practice locations, banking information, special payment addresses, or reactivate their Medicare billing privileges). In the home health PPS final rule, effective January 1, 2010, CMS also established methods for limiting enrollment of home health agencies based on certain characteristics.

We support CMS's efforts to address these issues and encourage it to continue making progress in these areas. We made technical changes to the report based on CMS's comments. For the full text of CMS's comments, see Appendix C.

Counties in Which Medicare Home Health Payments Were At Least Twice the National Average for Three or More of the Five Characteristics We Reviewed

County	Average Outlier Payment Per Provider	Average Outlier Payment Per Beneficiary	Average Outlier Payment Per Claims	Outlier Payment Rates *	Outlier Payment Rates for Claims With a Primary Diagnosis Related to Diabetes*	Total Number of Payment Characteristics At Least Twice the National Average
All counties (National Average)	$110,785	$378	$190	7%	6%	
Miami-Dade	**$1,581,608**	**$11,928**	**$4,100**	**59%**	**50%**	5
1	**$295,223**	**$1,617**	**$807**	**22%**	**20%**	5
2	**$355,417**	**$1,379**	**$682**	**19%**	**15%**	5
3	**$267,941**	**$1,396**	**$575**	**26%**	**21%**	5
4	**$233,407**	**$1,496**	**$538**	**17%**	**14%**	5
5	**$541,411**	**$785**	**$490**	**15%**	**14%**	5
6	**$628,018**	**$10,129**	**$2,166**	**53%**	**52%**	5
7	**$245,482**	**$1,504**	**$644**	**18%**	**17%**	5
8	**$416,053**	**$2,057**	**$1,117**	**25%**	**23%**	5
9	$143,841	**$812**	**$453**	**14%**	**13%**	4
10	**$307,569**	**$1,728**	**$559**	**14%**	10%	4
11	**$945,903**	$736	**$709**	**20%**	**16%**	4
12	$176,877	**$1,961**	**$605**	**19%**	**18%**	4
13	**$334,637**	**$1,949**	$348	**16%**	**12%**	4
14	**$415,415**	$751	**$463**	**17%**	**15%**	4
15	**$359,730**	$590	**$440**	**18%**	**15%**	4
16	$200,225	**$1,267**	**$448**	**17%**	**16%**	4
17	**$258,952**	$494	**$646**	**18%**	**18%**	4
18	$201,032	**$1,369**	**$420**	13%	**12%**	3
19	$24,416	**$1,436**	**$740**	**29%**	--	3
20	$26,399	$89	**$471**	**14%**	**14%**	3
21	$199,801	**$776**	**$487**	**21%**	11%	3
22	$196,123	**$805**	$372	**14%**	**13%**	3
23	$98,316	$603	**$557**	**16%**	**15%**	3

* Rates are based on total 2008 Medicare home health payments.

** Characters in bold indicate payment characteristics at least twice the national average.

Source: Office of Inspector General analysis of 2008 Medicare home health claims.

APPENDIX B

Home Health Providers in the Miami-Dade County and the 23 Counties That Were Paid At Least Twice the National Average for Three or More of the Five Payment Characteristics We Reviewed

County	Number of Providers With Three or More Payment Characteristics At Least Twice the National Average			Total Number of Providers With Three or More Payment Characteristics At Least Twice the National Average	Total Number of Providers
	Three Characteristics	Four Characteristics	Five Characteristics		
Miami-Dade	4	56	248	308	335
1	12	60	164	236	399
2	7	13	18	38	87
3	0	0	1	1	1
4	2	7	22	31	98
5	0	0	1	1	2
6	0	0	1	1	1
7	1	2	5	8	36
8	1	0	5	6	11
9	1	6	10	17	46
10	1	0	0	1	1
11	0	1	6	7	14
12	10	74	81	165	328
13	0	0	1	1	3
14	0	0	1	1	3
15	0	0	1	1	3
16	1	1	1	3	6
17	0	0	1	1	6
18	0	0	1	1	5
19	1	0	0	1	1
20	1	0	0	1	1
21	0	0	1	1	3
22	1	8	9	18	39
23	0	0	1	1	3
Total (24 Counties)	**43**	**228**	**579**	**850**	**1,432**

Source: Office of Inspector General analysis of 2008 Medicare home health claims.

APPENDIX ~ C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 27 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General Draft Report: "Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008," (OEI-04-08-00570)

Thank you for the opportunity to review and comment on the above referenced Office of Inspector General (OIG) draft report. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort and resources the OIG has invested to research and report on Medicare's home health benefit. CMS has been closely monitoring this issue.

The CMS has taken steps to address widespread abuse of outlier payments to Medicare certified home health agencies (HHAs) in Miami-Dade County, Florida. CMS allows outlier payments for situations that occur infrequently within a normal case-mix. However, there are more than 300 HHAs in South Florida that have come to rely upon outlier payments as a predominant part of their overall reimbursement. The outlier payments in Miami are approximately 58 percent (2007 data) of the HHAs overall reimbursement, the highest percentage of outlier payments in the country, compared to a national outlier payment of 6 percent.

The outlier payment was never intended to be such a large part of HHA reimbursement. To address this problem, CMS has taken a number of steps: (1) Suspending HHAs with high amounts of outlier payments; (2) Enhancing visits to beneficiaries in their homes to verify that the beneficiaries qualify for the benefit; and (3) Utilizing auto-denial edits for beneficiaries who do not qualify for the home health benefit. CMS will continue to perform ongoing beneficiary and physician interviews, as well as onsite visits to HHAs in Miami-Dade, which can result in edits, revocation, deactivation, and other actions.

Additionally, in 2007, CMS developed an enrollment demonstration project for HHAs in other geographically high-risk areas of the country (California and Texas) to address high-risk services and providers. This demonstration involved strengthening initial provider and supplier enrollment and revalidation of enrollment to prevent potentially fraudulent providers from entering the Medicare program. The demonstration also incorporated criminal background checks of owners and managing employees into the provider enrollment process. Although criminal background checks have not yet produced substantial results, mandatory reenrollment

reviews and site visits have resulted in referral of 37 HHAs for revocation of their Medicare billing privileges.

- Together these efforts have resulted in 33 HHAs being placed on payment suspension, and the billing privileges of 37 HHAs being revoked. The HHAs for which billing privileges have been revoked from the Medicare program received in calendar year (CY) 2007 approximately $6.1 million in Medicare reimbursement.

Although the demonstration project terminates at the end of October 2009, CMS plans to use its increased funding for program integrity efforts to continue these efforts in South Florida, Texas, and California.

Technical Comments

Page i, Background, Executive Summary - The first paragraph has been changed since the Exit Conference call for which CMS initially provided comments. The revision does not appropriately highlight the activities CMS has undertaken to address home health fraud.

Page 1, Background, 1st paragraph – Insert the following after the 1st sentence:

"To date, CMS has placed 33 Miami-Dade Home Health Agencies on payment suspension."

Page 1, Background, Last line of the first paragraph – The last line states that providers were paid for "reportedly providing beneficiaries with insulin injections although the beneficiaries did not have diabetes." We believe this is an inaccurate statement.

We suggest revising the sentence as follows:

"For example, some home health providers receive Medicare payments for reportedly providing insulin injections to beneficiaries who did not qualify for home health because they were not homebound and/or they could self-inject, (that is, they were not in need of skilled nursing services). Moreover, some of the insulin vials did not have the missing volume expected for beneficiaries who supposedly had been receiving regular doses of insulin. These visits also indicated that many beneficiaries were receiving monetary kickbacks and/or were using home health aides as glorified maids provided by the HHA."

Page 1, Background, Medicare Home Health Services - The third sentence refers to treatments that could once be performed only in a hospital and that are now being performed in the home "usually at a reduced cost."

We believe this sentence should be removed because it is misleading and is not indicative of services in Miami-Dade.

OIG Recommendation

Continue with efforts to institute a cap on the total outlier payments an individual home health provider may receive annually.

CMS Response

We concur with the OIG's recommendation to continue with efforts to institute an outlier policy. In the CY 2010 Home Health Prospective Payment System (HH PPS) proposed rule, we proposed to address potential fraud and abuse with regard to outlier payments under the HH PPS by modifying the outlier policy. Currently, home health agencies receive additional payments (outlier payments) for 60-day home health episodes of care that carry unusually high costs. We proposed to cap outlier payments at 10 percent per agency.

The comment period for the CY 2010 HH PPS proposed rule ended on September 28, 2009. We are currently analyzing the comments we received on the proposed rule, and hope to issue a final rule sometime in late October or early November to address these comments.

OIG Recommendation

Review home health providers that exhibit aberrant outlier payment patterns and respond appropriately based on the findings of the reviews.

CMS Response

We concur with the OIG's recommendation. We thank the OIG for the information in the report on specific providers that were paid at least twice the national average for three or more of the five payment characteristics. Beyond identifying claims which require prepayment review, our experience has shown that it is the interview of a beneficiary that best determines if the beneficiary does not qualify for services. CMS is continuously considering regulation, manual, and new edit proposals, as well as testing new approaches through initiatives at the Miami Field Office and with our Zone Program Integrity Contractors.

OIG Recommendation

Continue with efforts to strengthen enrollment standards for home health providers to prevent illegitimate home health agencies from obtaining billing privileges.

CMS Response

We concur with the OIG's recommendation. CMS is committed to continually reviewing and refining our processes to improve the Medicare program. As a result, within the past several months, CMS has taken a number of steps to address potential fraud across Medicare, including fraud in the home health benefit. CMS has initiated a new enrollment process that will impact HHAs as well as other Medicare providers. Effective January 1, 2009, and pursuant to Federal regulations at 42 CFR §424.530(a)(6) and (a)(7), an organizational provider (including an HHA)

HHAs as well as other Medicare providers. Effective January 1, 2009, and pursuant to Federal regulations at 42 CFR §424.530(a)(6) and (a)(7), an organizational provider (including an HHA) can be denied enrollment if the owner: (1) Has an existing overpayment that has not been repaid in full; or (2) Has been placed under a Medicare payment suspension. CMS Change Request #6097, effective January 20, 2009, requires contractors to undertake certain additional verification activities for providers (including HHAs) that are changing their practice locations, banking information, special payment addresses, or are reactivating their Medicare billing privileges.

In addition, in the CY 2010 Home Health Prospective Payment System proposed rule, we proposed methods for limiting enrollment of HHAs based on certain characteristics. We are currently analyzing the comments we received on the proposed rule and hope to issue a final rule in late October or early November to address these comments.

We believe that these activities, as they relate to HHAs, will assist us in halting questionable HHA behavior and help ensure that HHAs cannot enroll or reenroll in Medicare without having satisfied their existing obligations to the Medicare program.

The CMS thanks the OIG for its efforts on this report and for highlighting potential vulnerabilities in the Medicare home health benefit. We look forward to continuing to work with the OIG to identify and prevent fraud, waste, and abuse in the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne F. Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office.

Mary-Elizabeth Harmon served as the team leader for this study, and Gerius Patterson served as the Lead Analyst. Other principal Office of Evaluation and Inspections staff from the Atlanta regional office who contributed to the report include Jaime Durley. Central office staff who contributed include Rita Wurm; Robert A. Vito from the Philadelphia regional office also contributed.