

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS AND CONTRACTOR
OVERSIGHT OF HOME
HEALTH AGENCIES**



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EXECUTIVE SUMMARY: CMS AND CONTRACTOR OVERSIGHT OF HOME HEALTH AGENCIES

OEI-04-11-00220

WHY WE DID THIS STUDY

In 2010, Medicare paid \$19.5 billion to 11,203 home health agencies (HHA) for home health services provided to 3.4 million beneficiaries. HHAs are considered to be particularly vulnerable to fraud, waste, and abuse. The Centers for Medicare & Medicaid Services (CMS) designated newly enrolling HHAs as high-risk providers in March 2011, citing their record of fraud, waste, and abuse. A 2012 Office of Inspector General (OIG) report also found that one in four HHAs had questionable billing, which was concentrated in certain geographic areas where Federal investigators and analysts have focused their efforts to combat fraud, waste, and abuse. Other OIG studies have found vulnerabilities in Medicare contractors' efforts to identify and investigate potential fraud and abuse, as well as limitations in CMS's oversight of these contractors.

HOW WE DID THIS STUDY

We collected information and supporting documentation from CMS, selected Medicare Administrative Contractors (MAC), and selected Zone Program Integrity Contractors (ZPIC) regarding activities to prevent improper payments on home health claims and to detect and deter potential HHA fraud in 2011. In addition, we identified geographic areas prone to HHA fraud, waste, and abuse and determined whether contractor activities focused on these areas. We also analyzed claims data to determine whether Medicare paid HHAs that were suspended or had their billing privileges revoked, and we examined the timeliness with which CMS and its contractors acted on revocation recommendations.

WHAT WE FOUND

In 2011, the 2 MACs we reviewed collectively prevented \$275 million in improper payments and referred 14 instances of potential fraud. The four ZPICs we reviewed did not identify any HHA vulnerabilities and varied substantially in their efforts to detect and deter fraud. In 2011, Medicare also inappropriately paid five HHAs with suspended or revoked billing privileges; additionally, CMS did not act on all revocation recommendations.

WHAT WE RECOMMEND

We recommend that CMS (1) establish additional contractor performance standards for high-risk providers in fraud-prone areas, (2) develop a system to track revocation recommendations and respond to them in a timely manner, and (3) follow up on and prevent inappropriate payments made to HHAs with suspended or revoked billing privileges. CMS concurred with all three recommendations.

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OBJECTIVES

To determine the extent to which:

1. the Centers for Medicare & Medicaid Services (CMS) and its contractors performed activities to prevent improper payments and to detect and deter potential fraud among home health agencies (HHA) in 2011 and
2. HHAs with suspended or revoked billing privileges received inappropriate Medicare payments in 2011.

BACKGROUND

In 2010, the Medicare program paid \$19.5 billion to 11,203 HHAs for home health services provided to 3.4 million beneficiaries.¹ Home health services are covered under Parts A and B of Medicare. Part A covers home health services for individuals enrolled in Part A only, and Part B covers home health services for individuals enrolled in Part B only.² For individuals enrolled in Parts A and B, Part A covers postinstitutional home health services for up to 100 visits and Part B covers services if the individual exhausts the 100-visit limit.³ Home health services include part-time or intermittent skilled nursing services, physical therapy, occupational therapy, speech language pathology services, part-time or intermittent home health aide services, medical social services, and medical supplies and durable medical equipment.^{4,5} Although there are copayments for most other Medicare services, there are generally no beneficiary copayments for home health services.

¹ Office of Inspector General (OIG) analysis of 2010 National Claims History (NCH) Part A Standard Analytical File.

² Social Security Act, § 1812(a)(3), 42 U.S.C. § 1395d(a)(3); *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 60.3.

³ Social Security Act, § 1812(a)(3), 42 U.S.C. § 1395d(a)(3); *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 60.1. Home health services are postinstitutional if they are initiated within 14 days of discharge from an inpatient hospital stay lasting at least 3 consecutive days or within 14 days of discharge from a skilled nursing facility in which the individual was provided posthospital extended care services. Social Security Act, § 1861(tt)(1), 42 U.S.C. § 1395x(tt)(1); *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 60.1. If an individual is enrolled in Parts A and B but does not meet the 3-consecutive-day stay requirement or the 14-day initiation of care requirement, home health services are covered under Medicare Part B. *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 60.2.

⁴ Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

⁵ Part-time or intermittent skilled nursing or home health aide services are furnished for a total of fewer than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, fewer than 8 hours each day and 35 or fewer hours per week). Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

Medicare Home Health Coverage Criteria

To qualify for home health services, Medicare beneficiaries must:

- be confined to the home (i.e., homebound);
- be in need of intermittent skilled nursing care or physical, speech, or continuing occupational therapy;
- be under the care of a physician; and
- be under a plan of care established and periodically reviewed by a physician.^{6, 7, 8}

For home health care starting on or after January 1, 2011, the certifying physician or nonphysician practitioner must document a face-to-face encounter with the beneficiary prior to certifying his or her eligibility.^{9, 10}

Fraud in the Home Health Benefit

CMS designated newly enrolling HHAs as high-risk providers in March 2011, citing their record of fraud, waste, and abuse.¹¹ Findings from OIG reports and results of Federal investigations also indicate that HHAs may be vulnerable to fraud. Further, they indicate that certain geographic areas may be more prone to HHA fraud than others. For example, a 2012 OIG report found that one in four HHAs nationwide had questionable billing

⁶ Social Security Act, §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 U.S.C. §§ 1395f(a)(2)(C) and 1395n(a)(2)(A).

⁷ A beneficiary is considered to be homebound when he or she has a condition because of an illness or injury that restricts his or her ability to leave his or her residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person; or if leaving home is medically contraindicated. CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 30.1.1.

⁸ For purposes of benefit eligibility, “intermittent skilled nursing care” means care that is provided or needed fewer than 7 days each week or fewer than 8 hours of each day for periods of 21 or fewer days (with extensions in exceptional circumstances when the need for additional care is finite and predictable). Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

⁹ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 30.5.1. Starting on or after January 1, 2012, for patients receiving home health care immediately after an acute or a postacute stay, a physician who cared for the patient in an acute or a postacute facility can inform the certifying physician regarding face-to-face encounters with the patient. 42 CFR § 424.22(a)(1)(v), as amended by final rule entitled *Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012* (76 Fed. Reg. 68526 (Nov. 4, 2011)), effective January 1, 2012.

¹⁰ CMS, *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 7, § 30.5.1.1. This encounter must occur no more than 90 days before the start of home health care or within 30 days after the start of care.

¹¹ CMS, Testimony of Ted Doolittle entitled *Protecting Medicare and Medicaid: Efforts to Prevent, Investigate and Prosecute Health Care Fraud*, before Committee on the Judiciary, Subcommittee on Crime and Terrorism, U.S. Senate, March 2012; 42 CFR § 424.518(c)(i).

and eight States had high percentages of HHAs with questionable billing.¹²

Federal investigators and analysts have focused their efforts to combat Medicare fraud, waste, and abuse on certain geographic areas of Florida, Texas, Louisiana, California, Illinois, New York, and Michigan that are at a high-risk for fraud.¹³ These efforts have included Medicare Strike Force (Strike Force) investigations and cases. The Strike Force is an essential component of the Health Care Fraud Prevention and Enforcement Action Team, a joint effort of the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) to prevent, deter, and aggressively prosecute health care fraud. Strike Forces are designed to identify and investigate fraud and to prosecute perpetrators quickly. Strike Force teams are composed of Federal prosecutors and law enforcement personnel and, in some cases, State and local law enforcement personnel. These teams are supported by data analysts and CMS program experts.¹⁴

Strike Force investigations have led to charges against individuals for billing Medicare for potentially fraudulent home health services in 2011. For example, owners of an HHA in Miami were charged with conspiring to commit health care fraud, money laundering, and payment of kickbacks in July 2011.¹⁵ These owners allegedly submitted fraudulent claims to Medicare for home health services from August 2006 to March 2009 amounting to more than \$11 million. Additionally, these owners allegedly paid kickbacks to recruiters and instructed nurses to falsify patient medical records to make it appear that Medicare beneficiaries qualified for and received home health services that were not medically necessary or were not provided.

States identified as having high percentages of questionable billing HHAs in the prior OIG report also coincided with Strike Force cities where individuals were charged for billing potentially fraudulent HHA services in 2011. Using these three criteria, we identified certain areas prone to HHA fraud (Figure 1). Specifically, OIG defined fraud-prone areas as those that (1) are Strike Force cities, (2) are Strike Force cities where individuals had been charged with billing potentially fraudulent home

¹² OIG, *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012.

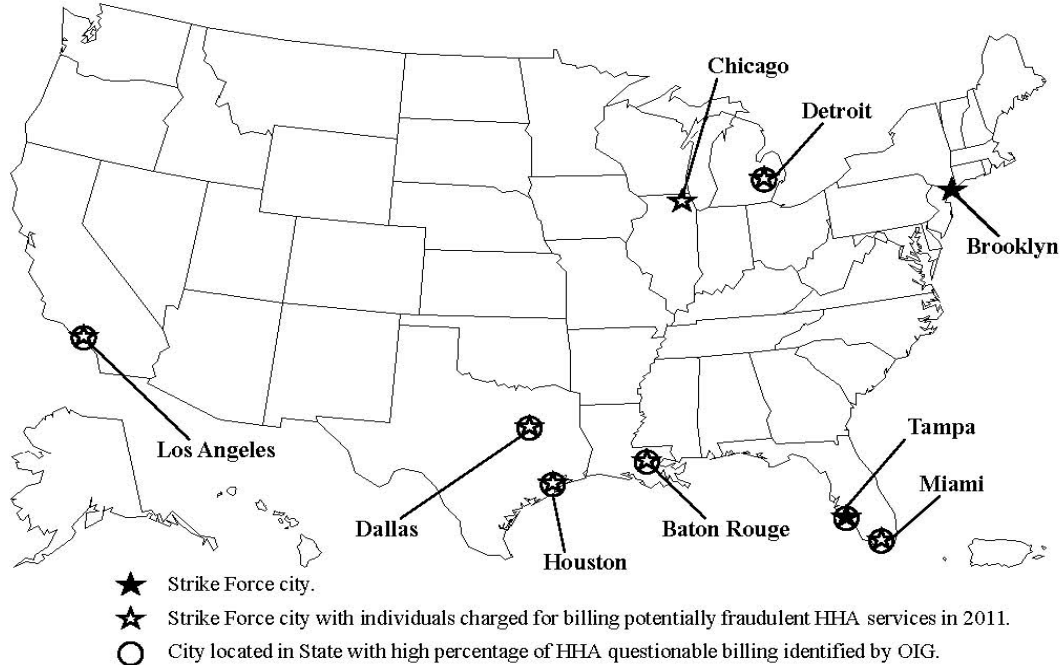
¹³ OIG, Testimony of Daniel R. Levinson entitled *Anatomy of a Fraud Bust: From Investigation to Conviction* before the U.S. Senate Committee on Finance, April 2012.

¹⁴ Ibid.

¹⁵ U.S. Attorney's Office, Southern District of Florida, *Miami Husband and Wife Charged with Home Health Care Fraud*, July 27, 2011. Accessed at <http://www.justice.gov/usao/fls/PressReleases/110727-03.html> on February 16, 2012.

health services in 2011, and (3) are located in a State that had a high percentage of HHAs with questionable billing identified by OIG.

Figure 1: Fraud-Prone Areas



Sources: OIG analysis of Health Care Fraud Prevention and Enforcement Action Team Strike Force cities, DOJ press releases, and HHAs with questionable billing.

Medicare Program Administration and Oversight Contractors

CMS uses contractors to assist in the administration and oversight of Medicare. Administration activities include preventing improper Medicare payments, and oversight activities include detecting and deterring fraud. CMS provides direction and technical guidance to these contractors by publishing program manuals and statements of work, which govern contractor duties. In addition, contractor oversight is a current HHS top management challenge, and OIG has identified issues with CMS contractor oversight in previous reports.¹⁶

Medicare Administrative Contractors

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandated that CMS replace claims processing contractors (fiscal intermediaries and carriers) with Medicare Administrative Contractors

¹⁶ OIG, *2011 Top Management and Performance Challenges, Management Issue 7: Oversight of CMS Program and Benefit Integrity Contractors; Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011; and *Medicare's Program Safeguard Contractors: Performance Evaluation Reports*, OEI-03-04-00050, March 2006.

(MAC).¹⁷ As a part of this contracting reform, CMS established four regions in which MACs process and pay Medicare Parts A and B home health claims.¹⁸ Each region covers multiple States.¹⁹ As of December 2012, CMS had awarded contracts for all four regions, and three of the four regions were operational.²⁰ Appendix A provides a map of the MAC regions and lists the States in each region.

Claims Processing. MACs are responsible for making correct, reliable, and timely payment of Medicare home health claims.²¹ To accomplish this, MACs are expected to use computerized edits, analyze and review claims to prevent improper payments, and educate providers submitting improper claims.

Claims Review To Prevent or Identify Improper Payments. To prevent or identify improper payments, MACs conduct both complex and noncomplex reviews of claims.²² Complex reviews involve requesting, receiving, and conducting medical record reviews of documentation associated with claims. Noncomplex reviews occur when the MAC makes a claim determination without conducting clinical review of medical documentation submitted by the provider. Review of claims may occur either before payment or after payment.

Additionally, MACs implement computerized edits to prevent improper payments for claims submitted by providers that have been excluded, have been suspended, or have had their Medicare billing privileges revoked. For example, MACs collaborate with benefit integrity contractors, such as Program Safeguard Contractors (PSC) and Zone Program Integrity Contractors (ZPIC), to implement computerized edits to ensure that suspended HHAs do not receive Medicare payments.²³ MACs also

¹⁷ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173, § 911; Social Security Act, § 1874A.

¹⁸ These four MAC regions also process and pay hospice claims. CMS, *Medicare Administrative Contractor Jurisdictions Fact Sheet*. Accessed at <https://www.cms.gov/MedicareContractingReform/Downloads/MACJurisdictionFactsheet.pdf> on March 18, 2011.

¹⁹ MAC regions also cover territories, such as Puerto Rico.

²⁰ The three MACs operational in June 2012 were Regions A (operational as of December 2010), C (January 2011), and B (June 2011). CMS awarded the contract for the Region D MAC in September 2012 but the contract is currently under protest.

²¹ CMS, *Part A and Part B MAC Statement of Work*, ch. 4, § 4.4b, September 2011.

²² CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.3.1.

²³ Contractors implement edits in their claims processing systems to verify and validate claims data by detecting errors or potential errors. Edits also verify that certain data are consistent and appropriate. CMS, *Medicare Administrative Contractor Workload Implementation Handbook (Legacy-to-MAC)*, ch. 4, § 4.10.3.2. Accessed at <http://www.cms.gov/MedicareContractingReform/Downloads/Legacy2MACImp.pdf> on February 3, 2012.

approve or deny recommendations to revoke an HHA's Medicare billing privileges.²⁴ Once a MAC approves a revocation recommendation, it implements an edit to ensure that the HHA does not receive Medicare payment during the revocation period.

Referrals To Investigate Potential Fraud. MACs must refer any instances of suspected fraud they encounter during their claims reviews to benefit integrity contractors.²⁵ After investigating MAC referrals, benefit integrity contractors determine the proper actions to take to address the potential fraud. Actions may include referring the provider to law enforcement or recommending administrative actions.

ZPICs

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 required CMS to implement Medicare contracting reform. As part of contracting reform, CMS is replacing the Medicare Parts A and B Program PSCs with ZPICs. CMS established seven zones in which ZPICs will operate, and each zone covers multiple States.²⁶ As of June 2012, CMS had awarded the contracts for all seven zones, and six were operational.²⁷ Appendix B provides a map of the ZPIC zones and lists the States in each zone.

ZPICs are responsible for preventing, detecting, and deterring fraud in Medicare, including fraud among HHAs.²⁸

Identifying Vulnerabilities To Prevent Fraud. One of the ways ZPICs help prevent fraud, waste, and abuse is identifying program vulnerabilities through the analysis and management of provider, supplier, and beneficiary data.^{29, 30} Program vulnerabilities may also be identified through other sources, such as audits, fraud alerts, and information from

²⁴ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2. CMS approves or denies revocation recommendations in which the providers or suppliers submit claims for services or supplies that could not have been furnished to specific individuals on the dates of service. MACs approve or deny revocation recommendations for other reasons, such as HHAs' not maintaining appropriate physical facilities (e.g., facilities are not located at the addresses on file with CMS or are not open during business hours). Revocation recommendations may originate from contractors (e.g., ZPICs) or CMS.

²⁵ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, § 3.6.A.

²⁶ ZPIC zones also cover territories, such as Puerto Rico.

²⁷ The six ZPICs operational in June 2012 were Zones 1 (operational as of December 2010), 2 (February 2011), 3 (April 2012), 4 (February 2009), 5 (December 2009), and 7 (February 2009). The Zone 6 ZPIC contract was awarded in September 2011, but was not operational as of September 2012.

²⁸ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.2.2.

²⁹ Ibid.

³⁰ CMS, *Medicare Benefit Vulnerability Reporting*, Transmittal 211, Change Request 5581, June 2007.

OIG. Examples of vulnerabilities may include providers receiving improper payments because of incorrect coding or billing for more than the allowed number of services. ZPICs submit identified program vulnerabilities to CMS in a report that includes information on how each vulnerability was discovered, a summary of the vulnerability issues, a description of the methodology, recommendations for resolving the vulnerability, and any action taken to resolve it.³¹ Some methods through which program vulnerabilities may be resolved are claims processing edits, provider education, or issuance of new regulations.

Analysis To Detect Fraud. ZPICs are expected to detect potential fraud by analyzing information from internal or external sources.³² Internal sources may include proactive data analysis of claims, while external sources may include beneficiary complaints or referrals from law enforcement and MACs.³³

Once potential fraud has been identified, ZPICs open investigations.³⁴ Investigations may include interviews with beneficiaries to determine whether they are homebound or medical reviews of potentially fraudulent home health claims to determine whether services were medically necessary.³⁵

Administrative Actions To Deter Fraud. ZPICs are expected to recommend appropriate administrative actions to CMS or its contractors when they identify reliable evidence of fraud.³⁶ Administrative actions may include payment suspension or revocation of a provider's billing privileges, edits for prepayment review of claims, overpayment recoupment, civil monetary penalties, and deactivation of a provider's billing privileges.³⁷ However, these recommendations are not always the result of investigations. For instance, ZPICs may receive a request from law enforcement to recommend a provider payment suspension. ZPICs may also refer certain providers or beneficiaries to claims processing contractors (e.g., MACs) for outreach and education.

³¹ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, § 4.31.

³² *Ibid.*, § 4.2.2.

³³ *Ibid.*

³⁴ *Ibid.*, § 4.7.

³⁵ *Ibid.*, § 4.7.1.

³⁶ *Ibid.*, § 4.2.2.

³⁷ A provider's billing privileges may be deactivated for many reasons, including not submitting a Medicare claim for 12 consecutive months, failing to report a change to information supplied on an enrollment application to CMS within 90 calendar days of the change, or failing to report a change in ownership or control to CMS within 30 calendar days of the change. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 25.27.1.

CMS must approve certain administrative actions that ZPICs recommend before they can be implemented. For instance, CMS must approve or deny recommendations to suspend Medicare payments to providers.³⁸ While they are suspended, providers should not receive Medicare payments. In some instances, CMS must also approve or deny recommendations to revoke billing privileges of providers that do not comply with Medicare requirements.³⁹ Provider billing privileges may be revoked for 1 to 3 years, and providers are barred from reenrolling in Medicare or receiving payment during that time.⁴⁰ Providers must apply to reenroll in Medicare after the expiration of the reenrollment bar.

ZPICs may also deter fraud by referring cases to law enforcement for further development.⁴¹

Related OIG Work

Previous OIG reports have identified billing and coding as problems among HHAs. For instance, in 2012, OIG found one out of four HHAs had questionable billing and eight States had high percentages of HHAs with questionable billing.⁴²

In 2012, OIG found that 98 percent of medical records for home health claims documented that Medicare beneficiaries met coverage requirements for home health services.⁴³ However, HHAs submitted 22 percent of claims in error because services were unnecessary or claims were coded inaccurately, resulting in \$432 million in improper payments. That review assessed HHAs' medical records for beneficiaries but did not determine whether those records accurately reflected beneficiaries' medical

³⁸ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 8, § 8.3.2.1. The initial approval is for a payment suspension period of up to 180 days, with the option to extend for an additional 180 days.

³⁹ CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.3.1. CMS approves or denies revocation recommendations in which the providers or suppliers submit claims for services or supplies that could not have been furnished to specific individuals on the dates of service.

⁴⁰ 42 CFR § 424.535(a)(12)(ii)(c).

⁴¹ Law enforcement may include the OIG/Office of Investigations, Federal Bureau of Investigation, Civilian Health and Medical Program of the Uniformed Services (now TRICARE), Railroad Retirement Beneficiaries OIG, and/or the Medicaid Fraud Control Units. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, §§ 4.18.1 and 4.18.1.5.3. Certain allegations are referred directly to law enforcement without a ZPIC investigation, such as specific allegations that indicate HHAs are involved with organized crime. These referrals are known as immediate advisements. However, immediate advisements are not considered case referrals to law enforcement. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 4, §§ 4.18.1.2, 4.8.

⁴² OIG, *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012.

⁴³ OIG, *Coverage Requirements and Payment Accuracy for Medicare Home Health Claims*, OEI-01-08-00390, March 2012.

conditions. It did not involve visiting beneficiaries to confirm their homebound status, nor did it determine whether the care provided was medically necessary.

In 2009, OIG found that Miami-Dade County, Florida, accounted for more home health outlier payments in 2008 than the rest of the Nation combined and that 67 percent of HHAs that received outlier payments greater than \$1 million were located in Miami-Dade County.⁴⁴

Previous OIG studies have also found vulnerabilities in Medicare contractors' efforts to identify and investigate potential fraud and abuse, as well as limitations in CMS's oversight of these contractors. For instance, in 2007, OIG found that PSCs performed substantially different levels of activities to detect and deter fraud across jurisdictions.⁴⁵ In 2010, OIG found that only one of three Recovery Audit Contractors (RAC) referred a total of two cases of potential fraud to CMS during a demonstration project between 2005 and 2008.⁴⁶ However, CMS reported that it received no specific provider referrals from Recovery Audit Contractors during this time.

METHODOLOGY

We reviewed the home health administration and oversight activities that MACs, ZPICs, and CMS performed from January to October 2011, hereinafter referred to as 2011.⁴⁷ We included MACs from Regions A and C and ZPICs from Zones 1, 4, 5, and 7. We did not include the remaining MACs and ZPICs because they were not fully operational during our evaluation timeframe.

We selected 2011 because it was the first period in which MACs and ZPICs were operational in HHA fraud-prone areas. OIG defined fraud-prone areas as those that (1) are Strike Force cities, (2) are Strike Force cities where individuals had been charged with billing potentially fraudulent home health services in 2011, and (3) are located in a State that

⁴⁴ OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, November 2009. CMS makes additional payments, known as outlier payments, to HHAs that supply services to beneficiaries who incur unusually large costs.

⁴⁵ OIG, *Medicare's Program Safeguard Contractors: Activities To Detect and Deter Fraud and Abuse*, OEI-03-06-00010, July 2007.

⁴⁶ OIG, *Recovery Audit Contractors' Fraud Referrals*, OEI-03-09-00130, February 2010. CMS contracts with RACs to identify improper payments from Medicare Parts A and B claims that have been paid by claims processing contractors.

⁴⁷ We did not include November and December 2011 in our review timeframe because we collected data from CMS and its contractors in November 2011.

had a high percentage of HHAs with questionable billing identified by OIG.

Data Collection

We requested information from MACs, ZPICs, and CMS on activities performed to prevent improper payments on home health claims and to detect and deter potential fraud among HHAs in 2011. We requested that respondents submit documentation to support their responses. If we did not receive documentation supporting the reported activities, we did not include them in our report.

Data Analysis

For each MAC region and ZPIC zone, we also analyzed 2011 home health claims data to determine the total number of HHAs, the total number of home health claims paid, and the total amount Medicare paid for these claims. Finally, to determine the extent to which HHAs with suspended or revoked billing privileges received improper payments, we analyzed home health claims data from CMS's Part A Standard Analytic File for 2011.

We reviewed responses and documentation to determine the number and type of contractor activities to prevent improper payments and detect and deter potential fraud in 2011.

MACs' Activities To Prevent Improper Payments Among Home Health Claims. We identified the methods (e.g., proactive data analysis or medical review) each MAC used to prevent improper payments. We then calculated the number and dollar amount of home health claims for which each MAC prevented payment as a result of each method. However, we did not determine whether HHAs appealed improper payments the MACs prevented. We also asked MACs to specify the number of instances of potential home health fraud they referred to benefit integrity contractors in 2011. We then determined whether activities and efforts varied across MAC regions and fraud-prone areas.

ZPICs' Activities To Prevent, Detect, and Deter Fraud Among HHAs. We asked ZPICs to specify how many and what type of vulnerabilities they reported to CMS in 2011. We also asked ZPICs to specify which methods they used to identify potential fraud and initiate investigations on HHAs in 2011. We then determined how many HHA investigations were initiated

in 2011 in each ZPIC zone and whether the investigations resulted from internal or external sources.⁴⁸

We asked ZPICs to specify which administrative actions they recommended to CMS and/or MACs to address potential fraud. Administrative actions included recoupment of overpayments, prepayment edits, revocation of billing privileges, payment suspensions, unannounced site visits, provider education referrals, and requests for anticipated payment suppressions.⁴⁹ We also determined the number of case referrals ZPICs made to law enforcement. Finally, we determined whether activities and efforts varied across ZPIC zones and fraud-prone areas.

Improper Payments to HHAs With Suspended or Revoked Billing Privileges. We determined the number of HHAs that ZPICs recommended for payment suspension or revocation of billing privileges. We then determined whether these recommendations had been approved or denied by CMS or MACs. For approved recommendations, we determined the dates on which HHAs were suspended or had billing privileges revoked and the time it took for approval.⁵⁰ For recommendations not approved or pending, we asked why these HHAs were not suspended or did not have their billing privileges revoked. Additionally, we reviewed home health claims data to determine whether Medicare paid HHAs that were suspended, had billing privileges revoked, or were recommended for revocation.

Limitations

While we substantiated responses from our information request using documentation submitted by CMS and its contractors, these data were self-reported. Our findings also cannot be projected to all MACs and ZPICs because not all were operational at the time of our review. Additionally, the fraud-prone areas identified in this report are not intended to be a comprehensive list of areas in which HHA fraud, waste, and abuse may be occurring.

⁴⁸ We did not account for investigations initiated before or after our timeframe. In addition, one ZPIC zone reported that it sometimes initiated multiple investigations on the same HHA. Therefore, we determined the number of unique HHA investigations initiated in this zone. Finally, we did not determine whether an investigation was closed or open at the conclusion of our review timeframe.

⁴⁹ Payment for home health episodes is typically made in two parts. The initial payment is made at the start of the episode and the final payment is made at the end of the episode. To receive initial payments, HHAs must submit a request for anticipated payment (RAP) to claims processing contractors. One ZPIC in our evaluation recommended that CMS suppress RAPs for multiple HHAs because of the potential for fraud, significant overpayments, or inappropriate payments.

⁵⁰ To determine the dates that HHA billing privileges were revoked, we used the revocation dates that contractors reported. If multiple revocation dates were reported, we used the latest.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

In 2011, the two MACs we reviewed collectively prevented \$275 million in improper payments and referred 14 instances of potential fraud

MACs' primary responsibility is to process and pay Medicare claims submitted by a variety of providers, including HHAs. MACs are also required to prevent payment for improper claims and refer instances of potential fraud to benefit integrity contractors. Collectively, the two MACs in our review prevented \$275 million in improper payments, with one MAC accounting for approximately 98 percent of these improper payments. In addition, the MACs referred 14 instances of potential home health fraud to benefit integrity contractors for further investigation.

The Region A MAC prevented approximately 98 percent of improper payments

The two MACs in our review performed data analyses and prepayment medical review of home health claims to prevent \$275 million in improper payments in 2011.⁵¹ The Region A MAC accounted for approximately 98 percent (\$268 million of \$275 million) of improper payments prevented by the two MACs in our review. This region included 5 percent (326 of 7,138) of HHAs in these two MAC regions.

In contrast, the Region C MAC, which included the HHA fraud-prone areas of Miami, Baton Rouge, Dallas, and Houston, accounted for the remaining 2 percent (\$6 million of \$275 million) of improper payments prevented by these two MACs. This MAC region contained 95 percent (6,812 of 7,138) of HHAs in our review. See Table 1 for improper payments by MAC region.

⁵¹ MACs may also use other methods to prevent improper payments (e.g., postpayment review of claims). However, the MACs in our review did not report using these methods.

Table 1: Improper Payments by MAC Region, 2011*

Region	Number of HHAs**	Total Home Health Claims Reviewed	Total Home Health Claims With Improper Payments	Total Improper Payments Prevented	Percentage of Improper Payments Prevented	Fraud-Prone Areas
MAC A	326	59,446	55,499	\$268,424,685	98%	--
MAC C***	6,812	6,525	2,718	\$6,170,817	2%	Miami, Baton Rouge, Dallas, Houston
Total	7,138	65,971	58,217	\$274,595,502	100%	

*Our review timeframe was from January to October 2011. We did not include November and December 2011 in our review timeframe because we collected data from CMS and its contractors in November 2011.

**This number includes HHAs with paid claims in 2011.

***The Region C MAC reported that it prevented 220 improper payments because of proactive data analysis; however, it was unable to provide us with documentation to substantiate this, and we did not include these improper payments in our analysis.

Source: OIG analysis of MAC claims processing workload data and home health claims data, 2011.

MACs referred 14 instances of potential fraud to benefit integrity contractors

The Region A MAC referred 11 of 14 HHAs and the Region C MAC referred the remaining 3 HHAs to benefit integrity contractors. Seven of the eleven HHAs that the Region A MAC referred to benefit integrity contractors allegedly altered advance beneficiary notices (ABN).⁵² The MAC uncovered this potential fraud through medical review. The Region A MAC referred the remaining 4 HHAs on the basis of complaints from beneficiaries or other HHAs alleging that these HHAs billed for services that were not provided. In 2011, Medicare paid these 11 HHAs approximately \$61 million.

The Region C MAC referred 3 HHAs to benefit integrity contractors for various reasons, such as consistently billing high numbers of therapy visits. In 2011, Medicare paid approximately \$2.2 million to two of these HHAs.

⁵² An ABN must be issued when a provider believes that Medicare may not pay for an item or service that it usually covers because the item or service is not considered medically reasonable and necessary. In these cases, the beneficiary must pay the provider directly for any noncovered services. CMS, *Advance Beneficiary Notice of Noncoverage, Part A and Part B*.

In 2011, the four ZPICs we reviewed did not identify any HHA vulnerabilities and varied substantially in their efforts to detect and deter fraud

ZPICs are responsible for preventing fraud by identifying program vulnerabilities.⁵³ They are also responsible for detecting and investigating potential fraud identified through external and internal sources, as well as deterring Medicare fraud by recommending appropriate administrative actions to CMS or MACs or referring cases of potential fraud to law enforcement.

In 2011, ZPICs did not identify any HHA-specific vulnerabilities.⁵⁴ Additionally, ZPICs in different geographic zones and fraud-prone areas did not perform similar levels of activities to detect and deter fraud among HHAs in 2011.

The Zone 7 ZPIC initiated over half of investigations on HHAs in 2011

In 2011, the four ZPICs in our review initiated investigations on 255 of 6,796 (4 percent) HHAs located in these zones. Table 2 shows the number and percentage of HHAs for which investigations were initiated by ZPIC zone.

Table 2: Number and Percentage of HHAs for Which ZPICs Initiated Investigations, 2011

Zone	Number of HHAs*	Number of HHAs for Which Investigations Were Initiated	Percentage of HHAs for Which Investigations Were Initiated	Percentage of Total HHAs With Investigations Initiated	Fraud-Prone Areas
ZPIC 1	1,115	44	4%	17%	Los Angeles
ZPIC 4	2,886	31	1%	12%	Dallas, Houston
ZPIC 5	1,351	33	2%	13%	Baton Rouge
ZPIC 7**	1,444	147	10%	58%	Miami
Total	6,796	255	4%	100%	

*This number includes HHAs with paid claims in 2011. However, some HHAs on which ZPICs initiated investigations in 2011 may have submitted claims that were not paid during this timeframe and are therefore not included in this number.

**The Zone 7 ZPIC reported that it initiated multiple investigations of the same HHAs. We determined the number of unique HHAs for which investigations were initiated in this zone.

Source: OIG analysis of ZPIC benefit integrity workload data and home health claims data, 2011.

⁵³ Vulnerabilities may include issues such as providers receiving increased Medicare payments because of incorrect coding.

⁵⁴ ZPIC Zone 5 reported that it identified and submitted two vulnerabilities to CMS in May 2011 that were not specific to home health but had the potential to affect home health. As of June 2012, this ZPIC reported that CMS had not responded to these vulnerabilities.

The Zone 7 ZPIC, which includes the HHA fraud-prone area of Miami, initiated investigations on 147 HHAs in 2011. These investigations accounted for over half (58 percent) of all investigations initiated. This ZPIC used investigative methods including site visits to determine whether HHAs were operational at their business addresses and beneficiary interviews to determine whether beneficiaries receiving home health services were homebound. The other three ZPICs, which included the fraud-prone areas of Dallas, Houston, Los Angeles, and Baton Rouge, initiated investigations on the remaining 108 HHAs; each initiated 17 percent or less of total investigations.

All ZPICs used external or internal sources to initiate investigations on HHAs. Overall, ZPICs initiated more investigations on HHAs from external than internal sources in 2011. Specifically, the investigations of 192 of 255 (75 percent) HHAs were initiated from external sources. Examples of external sources included beneficiary complaints of kickbacks or billing for services that were not provided. Internal sources included proactive data analysis of HHA claims and research that uncovered potential beneficiary sharing between HHAs and other providers.⁵⁵ Appendix C provides the number and percentage of HHAs for which investigations were initiated from external and internal sources by ZPIC zone in 2011.

The Zones 4 and 7 ZPICs recommended administrative actions and referred law enforcement cases for the majority of HHAs in 2011

ZPICs recommended administrative actions to CMS or MACs to address potential fraud or to prevent and recover inappropriate payments.⁵⁶ Recommended administrative actions included recoupment of overpayments, prepayment edits, revocation of billing privileges, payment suspensions, unannounced site visits, provider education referrals, and requests for anticipated payment suppressions. In addition, ZPICs referred cases to law enforcement agencies that could pursue civil, criminal, and administrative remedies for fraud.

The Zones 4 and 7 ZPICs, which include the fraud-prone areas of Dallas, Houston, and Miami, recommended administrative actions and referred law enforcement cases for the majority of HHAs (219 of 248) in 2011.

⁵⁵ Beneficiary sharing occurs when multiple providers fraudulently bill Medicare for the same beneficiary.

⁵⁶ We determined the number of administrative actions recommended and law enforcement cases referred for unique HHAs within each zone. ZPICs may have recommended multiple administrative actions and/or referred law enforcement cases for the same HHA.

Together, these two ZPICs recommended administrative actions and referred law enforcement cases for approximately eight times the number of HHAs of the two other ZPIC zones in our review, which also included fraud-prone areas.

Table 3 shows the number and percentage of HHAs for which administrative actions were recommended and law enforcement cases were referred by ZPIC zone. Appendix D provides the number and percentage of HHAs for which ZPICs recommended specific administrative actions and referred law enforcement cases in 2011.

Table 3: Number and Percentage of HHAs for Which ZPICs Recommended Administrative Actions and Referred Law Enforcement Cases, 2011

Zone	Number of HHAs*	Number of HHAs for Which ZPICs Recommended Administrative Actions and Referred Law Enforcement Cases**	Percentage of HHAs for Which ZPICs Recommended Administrative Actions and Referred Law Enforcement Cases	Fraud-Prone Areas
ZPIC 1	1,115	19	8%	Los Angeles
ZPIC 4	2,886	72	29%	Dallas, Houston
ZPIC 5	1,351	10	4%	Baton Rouge
ZPIC 7	1,444	147	59%	Miami
Total	6,796	248	100%	

*This number includes HHAs with paid claims in 2011. However, some HHAs on which ZPICs initiated investigations in 2011 may have submitted claims that were not paid during this timeframe and are therefore not included in this number.

**We counted the unique HHAs that had administrative actions and/or law enforcement case referrals in 2011 because certain ZPICs recommended multiple administrative actions and/or referred multiple law enforcement cases for the same HHA.

Source: OIG analysis of ZPIC benefit integrity workload data and home health claims data, 2011.

In 2011, Medicare inappropriately paid five HHAs with suspended or revoked billing privileges; additionally, CMS did not act on all revocation recommendations

Medicare inappropriately paid four HHAs after they had been suspended and one HHA after its billing privileges had been revoked in 2011. In addition, revocation review delays resulted in CMS' not acting on 5 revocation recommendations in 2011. As a result, Medicare paid \$651,777 in 2011 to two HHAs whose billing privileges had been recommended for revocation.

Medicare inappropriately paid approximately \$137,000 to four suspended HHAs and one HHA that had its billing privileges revoked

CMS approved ZPIC recommendations to suspend payments to 15 of 16 HHAs in 2011.⁵⁷ The HHAs were suspended for a variety of reasons, including misrepresentation of services billed to Medicare, improper certification of beneficiaries, or involvement in a conspiracy to commit fraud. Medicare inappropriately paid \$79,933 to 4 of these 15 HHAs in 2011 after the suspensions were effective.

The Region C MAC also revoked the billing privileges of 16 of 17 HHAs in 2011.⁵⁸ Fourteen were revoked for not maintaining appropriate physical facilities (e.g., facilities were not located at the addresses on file with CMS or were not open during business hours). The remaining HHAs' billing privileges were revoked because they did not maintain appropriate physical facilities and the owners were alleged or convicted felons.⁵⁹ Medicare inappropriately paid \$57,349 to one of the 16 HHAs in 2011 after its billing privileges were revoked.

CMS did not act on five revocation recommendations

In 2011, the Zone 7 ZPIC recommended the revocation of 17 HHAs' billing privileges in Florida. These recommendations were sent directly to the Region C MAC, which took action on all of them. Specifically, the Region C MAC approved 16 of these 17 revocation recommendations in an average of 12 days.

In contrast, the Zone 4 ZPIC sent five revocation recommendations to CMS from May to September 2011 for HHAs in Texas. However, CMS did not take action on these recommendations and, in October 2011, instructed the Zone 4 ZPIC to submit them to the Region C MAC. As a result, Medicare paid two HHAs a total of \$651,777 after receiving the recommendations that their billing privileges be revoked.

As of May 2012, the Zone 4 ZPIC reported that it had submitted two revocation recommendations to the Region C MAC. It also reported that the remaining revocation recommendations had not been submitted because of time and resource constraints.

⁵⁷ CMS approved the remaining payment suspension outside our review timeframe.

⁵⁸ The MAC did not revoke the billing privileges of one HHA because it voluntarily terminated its participation in Medicare before the recommended revocation date.

⁵⁹ If the owner of a provider or supplier has been convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries 10 years before enrollment or revalidation of enrollment, the billing privileges of the provider or supplier may be revoked. CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 15.27.2.

CONCLUSION AND RECOMMENDATIONS

HHAs are considered to be particularly vulnerable to fraud, waste, and abuse. CMS designated newly enrolling HHAs as high-risk providers in March 2011, citing their record of fraud, waste, and abuse. Additionally, previous OIG work has identified questionable billing patterns among HHAs, particularly in specific fraud-prone areas. Despite these risks, our evaluation found potential issues with CMS's and its contractors' ability to identify and respond to potential fraud.

In 2011, the two MACs we reviewed collectively prevented \$275 million in improper payments and referred 14 instances of potential fraud. Further, the four ZPICs we reviewed did not identify any HHA vulnerabilities and varied substantially in their efforts to detect and deter fraud. In 2011, Medicare inappropriately paid five HHAs with suspended or revoked billing privileges; additionally, CMS did not act on all revocation recommendations.

We therefore recommend that CMS:

Establish Additional Contractor Performance Standards for High-Risk Providers in Fraud-Prone Areas

CMS should establish additional performance standards for contractor activities to ensure that they are providing oversight commensurate with risks posed by high-risk providers, including newly enrolled HHAs, in fraud-prone areas. To do this, CMS could work with contractors to identify current fraud schemes in each jurisdiction and annually develop contractor performance standards specific to those fraud schemes. However, contractors would need to maintain flexibility to oversee all types of providers in their jurisdictions. Therefore, these performance standards could guide contractors in focusing their activities on specific types of providers that are exhibiting high levels of potential fraud and that need particular oversight emphasis, such as HHAs as identified in this and previous OIG work. While these standards should not be the only measure of contractor performance, they could provide important information on contractor performance and ensure contractors are factoring current fraud schemes into their oversight activities.

Develop a System To Track Revocation Recommendations and Respond to Them in a Timely Manner

CMS should develop a system to track revocation recommendations. This system should flag recommendations to which CMS or its contractors have not responded within a specified timeframe (e.g., within 30 days of receipt) and require documentation to justify why any cases exceed this timeframe. For revocation recommendations that exceed this timeframe, CMS should consider implementing safeguards (e.g., prepayment reviews,

payment suspensions) to prevent payments to providers recommended for revocation while it determines whether to revoke their billing privileges. Finally, CMS should educate contractors on how to properly submit revocation recommendations to CMS or its contractors to ensure they are submitted and processed in a consistent and timely manner.

Follow Up on and Prevent Future Inappropriate Payments Made to HHAs With Suspended or Revoked Billing Privileges

CMS should follow up on these inappropriate payments made to HHAs to determine the reasons for them. CMS should also ensure that edits are in place or are functioning properly to prevent inappropriate Medicare payments to HHAs with suspended or revoked billing privileges. We have provided CMS separately with additional information on the HHAs with inappropriate payments identified in our report.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with all three recommendations. CMS acknowledged that home health services have historically been vulnerable to fraud, waste, and abuse. For this reason, CMS indicated that it is taking additional steps to address vulnerabilities in the HHA enrollment and claims payment process using authorities granted under the Affordable Care Act. CMS stated that it is building models in its Fraud Prevention System (FPS) that can detect and generate alerts for suspicious billing by all major provider types, including HHAs.

With regard to our first recommendation, CMS stated that it has established categories for enrollment screening on the basis of risk of fraud. In addition, CMS stated that it uses the FPS to identify high risk providers, and provides alerts on these providers identified as potentially fraudulent. Program integrity contractors are required to review and investigate all FPS alerts, and CMS is modifying the statement of work for all ZPICs to clarify processes to be used in this work.

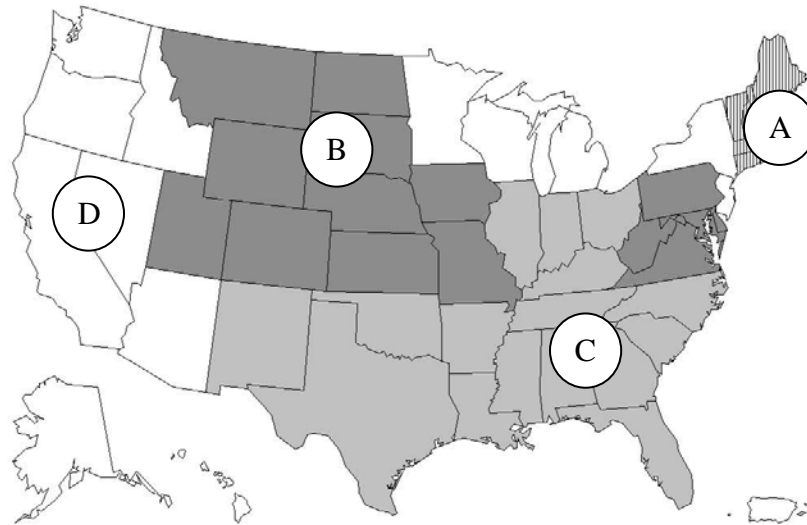
With regard to our second recommendation, CMS stated that it has established guidelines to ensure that revocation recommendations are addressed in a timely manner. Additionally, CMS stated that it has implemented a tracking system that includes revocation-specific tasks, status, request dates, contact dates, and other applicable information.

With regard to our final recommendation, CMS stated that it will follow up and forward additional information on the HHAs with improper payments to the appropriate contractors. CMS also stated that it has ensured that edits are in place and are functioning properly to prevent inappropriate payments to HHAs identified in our report. According to CMS, when a revocation is entered into the Provider Enrollment, Chain, and Ownership System (PECOS), edits are triggered in the appropriate claims systems to prevent claims from being paid with dates of service on or after the date of revocation.

We support CMS's efforts to address these issues and encourage continued progress. For the full text of CMS's comments, see Appendix E.

APPENDIX A

Map of Medicare Administrative Contractors



Medicare Administrative Contactors, Regions, and Operational Dates:

Region A, National Heritage Insurance Corporation, December 2010:

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

Region B,* CIGNA Government Services, June 2011: Colorado, Delaware, District of Columbia, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, Pennsylvania, South Dakota, Utah, Virginia, West Virginia, and Wyoming.

Region C, Palmetto Government Benefits Administrator, January 2011:

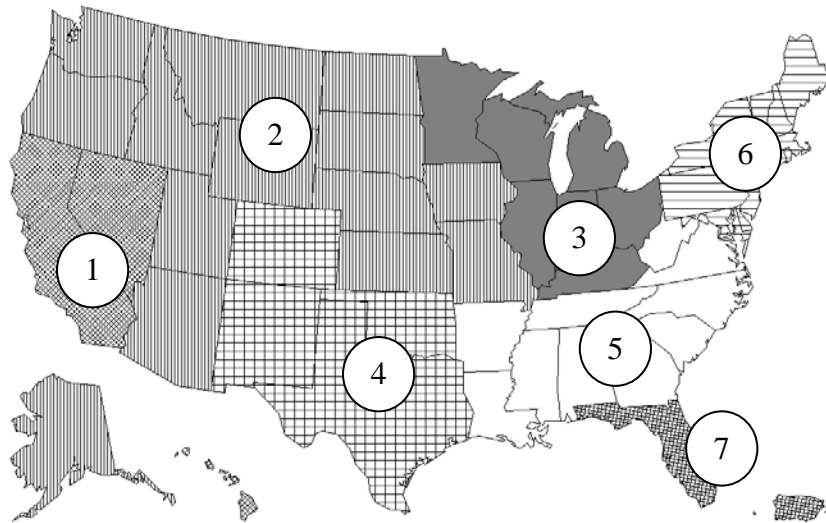
Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas.

Region D,* Noridian Administrative Services, Not Yet Operational: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Michigan, Minnesota, Nevada, New Jersey, New York, Northern Mariana Islands, Oregon, Puerto Rico, U.S. Virgin Islands, Washington, and Wisconsin.

*This region was not included in our review because it was not fully operational during our study timeframe, which extended from January to October 2011.

APPENDIX B

Map of Zone Program Integrity Contractors



Zone Program Integrity Contractors, Zones, and Operational Dates:

Zone 1, Safeguard Services, LLC, December 2010: American Samoa, California, Guam, Hawaii, Nevada, and the Northern Mariana Islands.

Zone 2,* AdvanceMed Corporation, February 2011: Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

Zone 3,* Cahaba Safeguard Administrators, April 2012: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Zone 4, Health Integrity, LLC, February 2009: Colorado, New Mexico, Oklahoma, and Texas.

Zone 5, AdvanceMed Corporation, December 2009: Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Zone 6,* Cahaba Safeguard Administrators, Not Yet Operational: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

Zone 7, Safeguard Services, LLC, February 2009: Florida, Puerto Rico, and U.S. Virgin Islands.

*This zone was not included in our review because it was not operational during our study timeframe, which extended from January to October 2011.

APPENDIX C

Number and Percentage of Home Health Agencies for Which Zone Program Integrity Contractors Initiated Investigations From External and Internal Sources in 2011*

Zone Program Integrity Contractor (ZPIC) Zone	Number of Home Health Agencies (HHA)**	Number of HHAs for Which Investigations Were Initiated From External Sources	Percentage of Total HHAs for Which Investigations Were Initiated From External Sources	Number of HHAs for Which Investigations Were Initiated From Internal Sources	Percentage of Total HHAs for Which Investigations Were Initiated From Internal Sources***	Fraud-Prone Areas
ZPIC 1	1,115	28	11%	16	6%	Los Angeles
ZPIC 4	2,886	26	10%	5	2%	Dallas, Houston
ZPIC 5	1,351	30	12%	3	1%	Baton Rouge
ZPIC 7†	1,444	108	42%	39	15%	Miami
Total	6,796	192	75%	63	25%	

*Internal sources may include proactive data analysis of claims, while external sources may include beneficiary complaints or referrals from law enforcement and MACs.

**This number includes HHAs with paid claims in 2011. However, some HHAs on which ZPICs initiated investigations in 2011 may have submitted claims that were not paid during this timeframe and are therefore not included in this number.

***Column does not sum to total because of rounding.

†The Zone 7 ZPIC reported that it initiated multiple investigations of the same HHAs. We determined the number of unique HHAs for which investigations were initiated in this zone. We used the source of the first investigation initiated as the source (i.e., external, internal) for any HHAs on which this ZPIC initiated multiple investigations.

Source: Office of Inspector General analysis of ZPIC benefit integrity workload data and home health claims data, 2011.

APPENDIX D

Number and Percentage of Home Health Agencies for Which Zone Program Integrity Contractors Recommended Specific Administrative Actions and Referred Law Enforcement Cases in 2011

Zone Program Integrity Contractor (ZPIC) Zone	Number of Home Health Agencies (HHA) Recommended for Overpayment Recoupment	Number of HHAs Recommended for Prepayment Edits	Number of HHAs Recommended for Revocation of Billing Privileges	Number of HHAs Recommended for Payment Suspension	Number of HHAs Referred to Law Enforcement	Number of HHAs Recommended for Other Administrative Actions*	Number of HHAs for Which ZPICs Recommended Administrative Actions and Referred Law Enforcement Cases**	Percentage of Total HHAs for Which ZPICs Recommended Administrative Actions and Referred Law Enforcement Cases	Fraud-Prone Areas
ZPIC 1	11	7	0	2	0	2	19	8%	Los Angeles
ZPIC 4	58	0	5	8	8	2	72	29%	Dallas, Houston
ZPIC 5	5	1	0	3	1	1	10	4%	Baton Rouge
ZPIC 7	72	71	17	3	10	9	147	59%	Miami
Total	146	79	22	16	19	14	248	100%	

*ZPICs reported that other administrative actions included requests for unannounced site visits, referrals for provider education, and requests for anticipated payment suppressions. In addition, while we did not include these administrative actions, ZPIC Zones 1, 4, and 7 added beneficiaries to existing autodenial edits. ZPIC Zone 4 also added one provider to a new autodenial edit.

**Rows do not sum to totals because we counted the unique HHAs that had administrative actions and/or law enforcement case referrals in 2011. Certain ZPICs recommended multiple administrative actions and/or referred law enforcement cases for the same HHA.

Source: Office of Inspector General analysis of ZPIC benefit integrity workload data and home health claims data, 2011.

APPENDIX E

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: NOV 05 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavanner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "CMS and Contractor Oversight of Home Health Agencies" (OEI-04-11-00220)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG draft report entitled, "CMS and Contractor Oversight of Home Health Agencies." The objectives of the draft report were to determine the extent to which: 1) CMS and its contractors performed activities to prevent improper payments and to detect and deter potential fraud among home health agencies (HHA) in 2011, and 2) HHAs with suspended or revoked billing privileges received inappropriate Medicare payments in 2011.

As stated in the OIG report, Medicare paid \$19.5 billion to 11,203 HHAs in 2010. HHA services have historically been vulnerable to fraud, waste, and abuse. As such, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group using the authorities granted under the Affordable Care Act¹. Under the new screening regulations², all newly enrolling HHAs are considered a high risk provider/supplier and are therefore subject to the highest level of screening, including unannounced site visits. As part of CMS's revalidation efforts, all currently enrolled HHAs were sent revalidation notices prior to December 31, 2011, and are currently in process. In addition, all HHAs are subject to an unannounced physical site visit as part of the revalidation process.

The Affordable Care Act also enhanced CMS's authority to suspend payments for credible allegations of fraud. CMS is using this new authority to coordinate administrative actions with law enforcement activities. For example, in February 2012, CMS announced the suspension of payments to 78 HHAs involved in an alleged fraud scheme in Dallas that was part of the February 28, 2012, Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force takedown. In October 2012, CMS suspended or took other administrative action against 30

¹ Section 6401 of the Affordable Care Act provided the Secretary with authority to perform categorical risk-based screening on providers and suppliers at enrollment and upon revalidation.

² CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

health care providers, including HHAs, in coordination with a nationwide HEAT activity that resulted in the arrests of 91 individuals charged in fraud schemes related to home health, durable medical equipment, and ambulance transports.

In addition, CMS implemented the Fraud Prevention System (FPS) in June 2011, which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service, including HHA and durable medical equipment, prosthetics, orthotics, and supplies claims prior to payment. CMS uses FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. CMS is building reliable models in FPS that can detect and generate alerts for suspicious billing behavior by all major provider types, including HHAs.

The CMS has established a set of guidelines to ensure revocation recommendations are addressed in a timely manner. In addition, CMS has ensured that edits are in place and are functioning properly to prevent inappropriate Medicare payments to HHAs with revoked billing privileges. When a revocation is entered into the Provider Enrollment, Chain, and Ownership System (PECOS), edits are triggered in the appropriate claims systems which prevent claims from being paid with dates of service on or after the date of revocation.

The CMS would like to express our gratitude to OIG for conducting this evaluation. CMS's responses to the OIG recommendations follow.

OIG Recommendation

The CMS shall establish additional contractor performance standards for high risk providers in fraud-prone areas.

CMS Response

The CMS concurs with this recommendation. CMS agrees that it is important to focus program integrity efforts and initiatives on providers and suppliers that exhibit behavior indicating a high risk of fraud. We have established two significant approaches to focus on high risk behavior. First, pursuant to our regulations, CMS established categories of enrollment screening based on risk of fraud — the higher the risk of fraud, the more rigorous the screening. In addition, as a central component of FPS, CMS has established approaches for the identification and monitoring of high risk providers and suppliers. FPS identifies high risk providers through sophisticated analytic models applied to all Medicare claims on a prepayment basis and provides alerts on those providers identified as potentially fraudulent. Our program integrity contractors are required to review and investigate all of the FPS alerts among their top workload priorities. Through this analysis and risk scoring approach, CMS identifies providers and suppliers that require review and investigation processes by our program integrity contractors. In addition, CMS is in the process of modifying the statement of work for all zone program integrity contractors to clarify the processes to be used in this work.

The CMS is actively exploring improvements for establishing contractor performance standards and would welcome any specific suggestions from OIG in this area.

OIG Recommendation

The CMS shall develop a system to track revocation recommendations and respond to them in a timely manner.

CMS Response

The CMS concurs with this recommendation. CMS has established a set of guidelines to ensure revocation recommendations are addressed in a timely manner. The guidelines include a revocation e-mail mailbox, which ensures requests are addressed accurately and consistently. In addition, CMS has developed and implemented a tracking system used by the revocation team, which delineates the revocation specific tasks, status, request dates, contact dates, etc.

OIG Recommendation

The CMS shall follow up on inappropriate payments made to HHAs with suspended or revoked billing privileges.

CMS Response

The CMS concurs with this recommendation. CMS will follow up and will forward the additional information on the HHAs with inappropriate payments to the appropriate Medicare Administrative Contractor. In addition, CMS has ensured that edits are in place and are functioning properly to prevent inappropriate Medicare payments to HHAs with revoked billing privileges. When a revocation is entered into PECOS, edits are triggered in the appropriate claims systems, which prevent claims from being paid with dates of service on or after the date of revocation.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

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

David Samchok served as the lead analyst for this study. Other Office of Evaluation and Inspections staff from the Atlanta regional office who conducted this study include Rachel Daiber. Central office staff who provided support include Kevin Farber, Scott Manley, and Debra Roush.

Office of Inspector General

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