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**MEDICARE HOME
HEALTH BENEFIT**

**Congressional and HCFA
Actions Begin to Address
Chronic Oversight
Weaknesses**

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Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting us today as you discuss fraud and abuse in the home health industry. As you know, home health care is an important Medicare benefit enabling beneficiaries with acute-care needs, such as recovery from hip replacement, and chronic-care conditions, such as congestive heart failure, to receive care in their homes rather than in more costly settings, such as nursing homes and hospitals. However, home health care has attracted much attention because of the publicized abuses of certain providers.

Periodically, we have reported on Medicare's vulnerabilities with regard to oversight of the home health benefit. Today, I would like to provide a synopsis of this work as a prelude to the specific problems identified by the case that my colleague in our Office of Special Investigations is about to discuss.¹ In doing so, I will focus on (1) the general nature of beneficiary eligibility criteria, which opportunists exploit to provide excessive services; (2) diminished Medicare contractor review and audit effort, which makes it less likely that abusers will be caught; (3) weaknesses in Medicare's home health provider certification process; and (4) new tools the Congress provided to strengthen oversight of the home health benefit. My remarks are based on our issued and ongoing work on Medicare's home health services. (See Related GAO Products list at the end of this statement.)

In brief, several historical factors have produced an environment that, until recently, has enabled improper billing and cost-reporting practices to grow unchecked. First, legislation and coverage policy changes in response to court decisions in the 1980s made it easier for beneficiaries to obtain home health coverage and harder for Medicare claims reviewers to deny questionable claims. Second, from 1989 until recently, the volume of claims reviews and cost-report audits plummeted, reducing the likelihood that improprieties would be detected. Third, because of the laxity of Medicare's survey and certification process, agencies with no experience or proof of capability were certified as providers. Moreover, home health agencies were unlikely to be terminated or penalized even when they were cited repeatedly for providing substandard care or otherwise failed to comply with conditions of participation.

¹Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998; GAO/OSI-98-5, Mar. 12, 1998).

Recent legislation has enhanced the Health Care Financing Administration's (HCFA) ability to improve its oversight of the home health benefit. In 1995, a multiagency government effort known as Operation Restore Trust launched a new anti-fraud-and-abuse campaign, targeting home health services, among others, for investigation. The following year, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, provided dedicated funding to finance, in part, the investigative efforts of the Department of Health and Human Services' (HHS) Office of the Inspector General and other federal agencies. A year later, the Balanced Budget Act of 1997 (BBA) mandated reforming Medicare's method of paying for home health services and contained additional provisions designed to tighten the use and oversight of the home health benefit.

Background

The Medicare statute divides benefits into two parts: (1) "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services, and (2) "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. Part B can also cover home health services under certain conditions.

In 1996, Medicare paid approximately \$18 billion for both part A and part B home health services. By fiscal year 1998, Medicare's home health spending is estimated to total nearly \$22 billion, representing a 700-percent increase from 1989 when spending was \$2.7 billion. During this period, coverage requirements changed so that more beneficiaries qualified for home health services. In addition, advances in medical technologies and changes in practice patterns resulted in more beneficiaries needing these services. The number of home health agencies certified to care for Medicare beneficiaries has also grown rapidly since 1989—from 5,700 to more than 10,000 in September 1997.

Medicare's Coverage of the Home Health Benefit

To qualify for home health care, individuals must be homebound, that is, confined to their residences; be under a physician's care; and need intermittent skilled nursing care or physical or speech therapy. Once qualified, beneficiaries may receive those services and visits by home health aides, medical social workers, and occupational therapists on a

part-time or intermittent basis. Required medical supplies are also covered.²

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

Oversight of the Home Health Benefit

HCFA, the agency within HHS responsible for administering Medicare, uses six regional claims processing contractors (which are insurance companies) to process and pay home health claims. These contractors—called regional home health intermediaries (RHHI)—process the claims submitted by the 10,000-strong home health agencies, which are paid on the basis of the costs they incur up to predetermined cost limits.

RHHIs are responsible for ensuring that Medicare does not pay home health claims when beneficiaries do not meet the Medicare home health criteria, when services claimed are not reasonable or necessary, or when the volume of services exceeds the level called for in an approved plan of treatment. They carry out these responsibilities through medical reviews of claims. HHS' Office of the Inspector General has emphasized the importance of medical reviews. In the Office's sampling of claims—which included not just home health but all Medicare services—it found that 99 percent of the improper payments the Office identified appeared to be correct on the surface and were detected only through medical record reviews.³

Medical reviews can be performed either before or after a claim is approved for payment. Occasionally, RHHIs conduct site visits—a postpayment review at the home health agency where reviewers can examine plans of care and other medical documentation; RHHIs may also visit beneficiaries under the care of the agency. In principle, RHHIs target

²For purposes of qualifying for intermittent skilled care, "intermittent" is defined as skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances). For purposes of receiving home health services, "part-time or intermittent" is defined as skilled nursing and home health aide services furnished any number of days per week as long as they were furnished (combined) less than 8 hours each day and 28 or fewer hours each week (with extensions in exceptional circumstances).

³Medicare Fraud and Abuse, testimony of John E. Hartwig, Deputy Inspector General for Investigations, HHS, before the Senate Committee on Governmental Affairs, Permanent Subcommittee on Investigations (Washington, D.C.: HHS, Office of the Inspector General, Jan. 29, 1998).

their reviews on providers that have unexplained utilization patterns. A similar kind of analysis led our Office of Special Investigations to identify the case being discussed today.

Eligibility Criteria Permit Easy Access to the Home Health Benefit

Since Medicare's inception, the home health benefit has undergone several changes in which coverage criteria and their enforcement have alternately tightened and relaxed. The net effect of the changes was that home health care became available to more beneficiaries, for less acute conditions, and for longer periods of time.

The benefit was legislatively liberalized in 1980 when limits on the number of services and cost-sharing requirements were eliminated. When prospective payment for hospital services was initiated in 1983, the use of home health services was expected to increase significantly because of incentives for hospitals to discharge patients more quickly. However, HCFA's relatively stringent interpretation of coverage criteria and emphasis on medical record review kept home health growth in check.

Then in 1989, coverage rules relaxed following a court case brought in 1988 that challenged HCFA's interpretation that individuals had to satisfy both the part-time and intermittent criteria to qualify for the home health benefit (Duggan v. Bowen).⁴ HCFA was obliged to revise its coverage guidelines to allow individuals to qualify by satisfying either criterion, which, as we reported in 1996,⁵ enabled home health agencies to increase the frequency of home visits. The requirements were also changed so that patients qualified for skilled observation by a nurse or therapist if a reasonable potential for complications or possible need to change treatment existed. The skilled observation, in turn, qualified the beneficiary for home health aide visits. The benefit also allowed maintenance therapy when therapy services were required to simply maintain function; previously, patients had to show improvement from such services to be covered.

In that same report, we also noted problems interpreting the definition of "homebound." HCFA's Medicare Home Health Agency Manual qualifies the concept of "confined to the home" as follows:

⁴Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

⁵See Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

An individual does not have to be bedridden. . . [But] the condition of these patients should be such that there exists a normal inability to leave home, and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration or are attributable to the need to receive medical treatment.

In our interviews for the 1996 study, HCFA and intermediary officials said that few denials were made on the basis that the beneficiary was not homebound. In particular, the “infrequent” and “short duration” language qualifying permissible absences from the home would likely result in the reversal of homebound-criterion-based denials at the reconsideration or appeals level.⁶ My colleague’s statement on improper activities by Mid-Delta Home Health describes patients whose eligibility on the basis of being homebound was highly questionable.

Diminished Oversight Ripened Opportunity for Exploitation

The relationship between the funding levels for payment safeguard activities and the proportion of claims reviewed helps explain the weak oversight of Medicare’s home health benefit in the 1990s. In 1985, legislation more than doubled funding for contractors to conduct claims reviews, enabling intermediaries to review over 60 percent of the home health claims processed in 1986 and 1987. By 1995, however, when payment safeguard funding for medical review of all Medicare-covered part A services had substantially declined (from \$61 million in 1989 to \$33 million in 1995), RHHIS reviewed about 1 percent of home health claims. As a result of decreased review, agencies were less likely to be caught if they abused the home health benefit. During this period, however, the number of home health agencies participating in Medicare increased by more than a third, and the volume of home health claims processed more than tripled. In January 1998, HCFA announced an increase in the number of claims reviews to about 1.3 percent—still far short of the peak levels of the mid-1980s.

Little Scrutiny of Claims on a Prepayment Basis

For years, we have reported on the need for HCFA to improve the strategies and methods contractors use to review claims prior to payment. Contractors are largely autonomous in their prepayment claims screening

⁶As we noted in the 1996 report, HCFA in 1991 attempted to develop numerical parameters to better define the terms “infrequent,” “short duration,” and “confined to the home.” However, HCFA’s proposal received so many negative responses during the comment period—from intermediaries as well as home health agencies—that this proposal was never implemented. Many home health agencies expressed concerns that such absolute limits would rob them of flexibility in interpreting the benefit.

efforts, and HCFA has not routinely given guidance on best practices. For example, HCFA has not issued any guidance suggesting that claims for unusually high dollar amounts per beneficiary trigger prepayment reviews. In a recent study of home health claims reviews,⁷ we conducted a test of 80 high-dollar claims at one RHHI. The RHHI had initially processed and approved the claims without review but denied them subsequent to our test. The following examples illustrate the importance of careful prepayment review:

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

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

Postpayment Reviews Inadequate Relative to Volume of Improper Payments

Postpayment oversight activity also waned in the 1990s—including on-site medical record reviews of home health agencies and audits of cost reports. Medical reviews are used to identify noncovered services paid by Medicare. Reviews conducted at the site of the home health agency give contractor staff ready access to such records as providers' plans of care and documentation of visits. In fiscal year 1994, fewer than 1 percent of all Medicare-certified home health agencies had received on-site medical record reviews, and although more recent data on on-site agency reviews are not readily available, there is no evidence to suggest that this level

⁷Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

would have increased before the recent infusion of new payment safeguard funds through HIPAA.

Cost-report audits help identify providers' attempts to shift inappropriate or unnecessary costs to the program. Providers paid under Medicare's cost-based reimbursement systems—including home health agencies—are reimbursed not on the basis of a fee schedule or the charge for a service but on the basis of the actual cost to provide the service, subject to certain limits.

RHHIS reimburse cost providers in several steps, including making periodic interim payments based on the provider's historical costs and current cost estimates, determining an end of the year tentative settlement based on a report the provider submits that details operating costs and the share related to the provision of Medicare services, and—in relatively few cases—conducting a detailed review (audit) of the cost report to determine the appropriate final settlement amounts.

Between 1991 and 1996, the chances, on average, that a provider's cost report would be subject to an audit fell from about 1 in 6 to about 1 in 13. Much of our statement on Mid-Delta Home Health centers on improperly claimed and reimbursed costs included in cost reports that had not received an in-depth audit until our investigation prompted a closer look. In January 1998, HCFA announced its plans to double the number of comprehensive home health agency audits it performs each year—from about 900 to 1,800.

Little Monitoring of Care Provided

HCFA conducts almost no oversight of the actual care provided. Such oversight is particularly difficult because these services are not provided in a traditional health care setting. The sheer volume of Medicare's home health claims and scarce funds for monitoring have resulted in an approach that relies substantially on the home health agencies themselves. In 1996, more than 10 percent of Medicare beneficiaries—roughly 4 million people—received home health services. To cope with this caseload, HCFA relies on the home health agencies and attending physicians to monitor patient progress, the proper development and periodic review of plans of care, and the medical necessity of services delivered. Although the physician's signature on a plan of care is intended to serve as a quality control, in practice, the certifying physician may not have ever seen the patient for whom the care plan is designed. Moreover, updated plans of

care—required at least every 62 days—are not routinely reviewed by an independent party, such as Medicare’s RHHIS.

Certification Process Ineffective in Excluding Problem Providers

In our December 1997 report on the home health survey and certification process,⁸ we noted that becoming a Medicare-certified home health agency has been too easy, particularly in light of the number of problem agencies identified in various studies in recent years. Until recently, there was little screening of those seeking Medicare certification. We found that the initial survey of an applicant occurred too soon after the agency began operating, offering little assurance that the agency was providing or capable of providing quality care. For example, Medicare certified an agency owned by an individual with no home health experience who turned out to be a convicted drug felon and who later pled guilty with an associate to having defrauded Medicare of over \$2.5 million.

Rarely were new home health agencies found to fail Medicare’s certification requirements, which call for agencies to (1) be financially solvent, (2) comply with antidiscrimination provisions in title VI of the Civil Rights Act of 1964, and (3) meet Medicare’s conditions of participation. Home health agencies self-certify their solvency, agree to comply with the act, and undergo a very limited survey that few fail. Until less than a year ago, HCFA had been certifying about 100 new home health agencies each month. Once certified, it was unlikely that home health agencies would be terminated from the program or otherwise penalized, even when they had been repeatedly cited for not meeting Medicare’s conditions of participation or for providing substandard care.

From September 15, 1997, until January 13, 1998, the Administration placed a moratorium on admitting new agencies into the Medicare program. The moratorium was intended to stop the admission of untrustworthy providers while HCFA strengthened its requirements for entering the program. HCFA used this period of time to develop new surety bond regulations (as mandated by BBA), capital requirements to ensure adequate operating funds, and procedures to better scrutinize the integrity of home health agency applicants. HCFA plans to issue additional provider certification and renewal regulations in the coming months.

⁸Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997).

Recent Legislation Fosters Greater Oversight, Introduces Payment Reforms

With the passage of HIPAA and BBA, the Congress recently provided important new resources and tools to fight fraud and abuse in general and home health care offenses in particular. In addition to earmarking funds for anti-fraud-and-abuse activities, the legislation offers specific civil and criminal penalties against health care fraud as well as opportunities to improve detection capabilities. For example, HIPAA makes health care fraud a separate criminal offense and establishes fines and other penalties for federal health care offenses. BBA stiffens the exclusion penalties for individuals convicted of health care fraud. It also establishes civil monetary penalties for such offenses as contracting with an excluded provider, failing to report adverse actions under the new health care data collection program, and violating the antikickback statute.

With respect to the home health benefit in particular, BBA targets historical abuses. For example, in an egregious case of home health fraud that our Office of Special Investigations reported on in 1995, the HHS Inspector General charged ABC Home Health Care with billing Medicare for items that were solely for the owner's or his family's personal use, including condominium utility expenses, maid services, and automobile lease payments.⁹ BBA mandates the elimination of cost-based reimbursement and its replacement by a prospective payment method. Under this method, home health providers will be expected to deliver care for a fixed payment, thus breaking the link in the future between the home health agency's costs and Medicare's payments.

While closing off some opportunities for exploitation, however, prospective payment creates others. As we stated before this Subcommittee last October,¹⁰ several design issues have implications for beneficiary and taxpayer protection, as follows:

- Unit of service: If an episode of care rather than a visit is used when paying for home health prospectively, the system's design will need to guard against the incentive to lower the number of visits per episode and the incentive to pad patient volume with individuals who need relatively few services, some of whom may not even qualify for benefits.
- Case-mix adjuster: The system design will need to incorporate a method for adjusting payments to account for the differences in the kinds of patients treated by home health agencies; an effective case-mix adjuster is needed to protect against the incentive to shun patients needing a high

⁹Medicare: Allegations Against ABC Home Health Care ([GAO/OSI-95-17](#), July 19, 1995).

¹⁰Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation ([GAO/T-HEHS-98-41](#), Oct. 29, 1997).

level of care in favor of those who would be less expensive to treat. The adjuster would not only protect access to care but would also help ensure that Medicare was paying agencies more appropriately.

- Base-rate development: Because HCFA intends to use historical data on cost of services to calculate a base rate of an episode of care, it must take care to avoid incorporating the inflated costs identified in the cost reports of problem home health agencies. For example, in 1995 we reported on a number of problems with payments by intermediaries for surgical dressing supplies, indicating that excessive costs are being included and not removed from home health agency cost reports.¹¹ We have suggested at several hearings that HCFA audit thoroughly a projectable sample of home health agency cost reports so that the results could be used to adjust HCFA's cost database to help ensure that unallowable costs are not included in the base for setting prospective rates.

Until October 1999, when the law requires prospective payment for home health services to be implemented, Medicare will continue to reimburse for home health services on a cost basis. Addressing this situation, BBA prohibits Medicare payments for items that have historically been associated with inflated cost reports, such as entertainment, gifts, donations, educational expenses, and the personal use of automobiles. It also tightens per-visit limits and imposes new ones based on historical per-beneficiary costs.

Other BBA provisions designed to improve home health oversight include clarifying the terms "part-time" and "intermittent" nursing care; requiring the HHS Secretary to recommend by October 1, 1998, criteria to clarify the term "homebound"; and requiring a \$50,000-minimum surety bond from home health agencies.

Conclusions

The very nature of the home health benefit makes judgments on eligibility difficult and overseeing services provided in the home problematic. Our Office of Special Investigation's inquiry into the operations of a home health agency in Mississippi graphically illustrates how agencies find creative ways to add patients of questionable eligibility to their rolls and include questionable items in their cost reports. This is consistent with our findings. Scant medical reviews of claims and lack of cost-report auditing have allowed opportunists to receive improper payments with little chance of their being caught. Untrustworthy providers have been admitted to

¹¹Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

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Medicare because of little scrutiny during the certification process. While HIPAA and BBA have given HCFA greater resources and tools to fight fraud and abuse, the home health benefit will continue to require concerted oversight.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or the Subcommittee Members may have.

Related GAO Products

Medicare: Improper Activities by Mid-Delta Home Health ([GAO/T-OSI-98-6](#), Mar. 19, 1998; [GAO/OSI-98-5](#), Mar. 12, 1998).

Long-Term Care: Baby Boom Generation Presents Financing Challenges ([GAO/T-HEHS-98-107](#), Mar. 9, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies ([GAO/HEHS-98-29](#), Dec. 16, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation ([GAO/T-HEHS-98-41](#), Oct. 29, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 ([GAO/HEHS-98-18R](#), Oct. 9, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings ([GAO/HEHS-97-108](#), Jun. 13, 1997).

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

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

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements ([GAO/HEHS-95-171](#), Aug. 8, 1995).

Medicare: Allegations Against ABC Home Health Care ([GAO/OSI-95-17](#), July 19, 1995).

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