

DEPARTMENT OF HEALTH AND HUMAN SERVICES

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE ENROLLMENT OF HOME
HEALTH PROVIDERS**



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OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine if the Centers for Medicare & Medicaid Services enrolled home health providers who were ineligible for participation in Medicare.

BACKGROUND

Medicare beneficiaries who are homebound and in need of qualifying skilled services on a part-time or intermittent basis are eligible for home health care. Such beneficiaries must be under the care of a physician who has established a plan of care. The beneficiaries may receive skilled nursing and home health aide services, as well as physical, speech, and occupational therapy. The home health benefit is unlimited as long as the services are considered medically necessary.

Prior reports by the Office of Inspector General and others, have shown that while most home health care providers are honest, some providers improperly billed Medicare for unqualified services and services not provided.

The Balanced Budget Act of 1997 required the Centers for Medicare & Medicaid Services (CMS) to deny Medicare enrollment to entities and individuals who had been excluded from Medicare by the Office of Inspector General or debarred from government program participation by the General Services Administration. The BBA also authorized CMS to deny enrollment to parties convicted of non-healthcare related felonies if the offense is determined to be inconsistent with the best interest of the Medicare program and its beneficiaries. Additionally, CMS regulations require denial of Medicare participation to providers who are undercapitalized.

This OIG report focuses on the effectiveness of CMS enrollment practices to keep ineligible home health care providers out of Medicare. We examined a sample of providers enrolled between October 1, 1997 and September 30, 2000.

FINDING

CMS Processes Seem to Have Effectively Prevented Enrollment of Ineligible Persons and Entities for Providing Home Health Care to Medicare Beneficiaries

Excluded or debarred persons or entities

During the period of our inspection, CMS enrolled 880 home health agencies with an estimated 4,273 owners and managers. We independently reviewed provider enrollment

for a sample of 272 of the 880 home health agencies. We also reviewed 1,190 owners or managers associated with those agencies. None of the agencies, owners, or managers we reviewed had been excluded from Medicare participation before they were enrolled to provide home health care.

Felons

We reviewed a sample of 492 of the estimated 4,273 home health agency owners or managers who were approved for Medicare participation during the period of our inspection. We found none who had a felony record when they were approved by CMS. Based on residential addresses, we searched criminal records in Federal and applicable State or local court jurisdictions.

Undercapitalized Agencies

For 95 of our sampled 272 agencies, we verified that Medicare contractors had determined they met minimum capitalization requirements before approval. The remaining 177 had enrolled in a prior period. Thus, a determination of capitalization levels was not applicable.

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INTRODUCTION

PURPOSE

To determine if the Centers for Medicare & Medicaid Services enrolled home health providers who were ineligible for participation in Medicare.

BACKGROUND

Providing Home Health Care to Medicare Beneficiaries

Home health services are provided to Medicare beneficiaries who are homebound and in need of qualifying skilled services on a part-time or intermittent basis. Such beneficiaries must be under the care of a physician who has established a plan of care.

Medicare beneficiaries may receive skilled nursing, home health aide services, and physical, speech, and occupational therapy. The home health benefit is unlimited as long as the services are considered medically necessary.

Medicare home health expenditures rose from \$3.7 billion in 1990 to \$17.8 billion in 1997. However, since 1997, both the costs and the number of home health agencies (HHAs) have continuously declined. To illustrate, by the end of Fiscal Year 2000, the cost of home health care had declined to \$9.2 billion. Likewise, 10,807 HHAs were participating in the Medicare program in 1997. That number had declined to 7,099 at the end of Calendar Year 2000.

The Centers for Medicare & Medicaid Services (CMS) attributed the decreases partly to the Balanced Budget Act of 1997. Among other things, the Act authorized more stringent HHA enrollment practices.

Prior Reviews Show Improper Activities by Many Home Health Care Providers

Prior Office of Inspector General (OIG) audits and investigations have routinely documented that, while most health care providers are honest, improper billing and payments continue to exist. For example, OIG audit reports in 1997 and 1999 showed improper payments for home health services at 40 percent and 19 percent, respectively, in four large States.

Likewise, since 1997, OIG investigations have led to numerous prosecutions of, or settlements with, HHA owners for fraudulent Medicare claims. For example, such claims included salaries, travel, and legal expenses that were not related to care of Medicare beneficiaries, and therefore unallowable. They also included services to

ineligible beneficiaries, particularly those not homebound. The resulting fines and settlements were often significant, including \$10 million at one firm.

CMS Can Deny Participation by Unscrupulous and Undercapitalized Home Health Care Providers

CMS can deny Medicare participation to unscrupulous home health providers and to those for whom successful performance is doubtful due to limited financial resources.

CMS must deny enrollment to HHAs if they, their owners or managers have been excluded from Medicare participation by the OIG or GSA. Also, family or household members of such a person must be denied participation.

The Balanced Budget Act of 1997 (BBA) authorized CMS to deny enrollment for Medicare participation to individuals and entities who have been convicted of a felony under Federal or State law for an offense which is inconsistent with the best interests of the Medicare program and its beneficiaries.

By regulation, CMS requires that a new HHA have enough funds on hand to operate for the first 3 months without reimbursement. The objective is to ensure financial stability of home health providers.

CMS regional offices have responsibility for final approval or denial determinations. The decision, however, should be based on findings and recommendations by Medicare contractors called Regional Home Health Intermediaries (RHHIs), and State licensing and certification agencies.

To obtain approval as a Medicare provider, a home health applicant must submit an application via a CMS 855 form. CMS provides guidance for provider enrollment in Section 3040 of the Medicare Intermediary Manual. Generally, applicants apply to State licensing and certification agencies. Those agencies forward applications to the appropriate RHHI for review.

When an RHHI recommends approval, the State licensing and certification agency verifies that HHA applicants meet the requirements aimed at protecting the health and safety of beneficiaries. An HHA must be licensed by a State before it can receive approval for Medicare participation.

METHODOLOGY

To determine whether or not CMS enrolled ineligible HHAs to provide services under Medicare, we reviewed CMS' enrollment process and results for a sample of 272 enrolled HHAs. Between October 1, 1997 and September 30, 2000 CMS enrolled 880 HHAs and an estimated 4,273 owners and managers associated with them.

We initially selected a random proportional stratified-cluster sample of 277. We reduced the sample size to 272 HHAs. This resulted in a sample of 1,190 HHA owners and managers. We dropped five HHAs from our sample because RHHIs could not locate files or RHHI logs contained incorrect enrollment data.

For each of the 272 HHAs and 1,190 owners or managers, we independently verified that none had been excluded from Medicare prior to CMS approving them for home health care to Medicare beneficiaries.

From our sample of owners and managers, we used a random sub-sample of 492 to determine whether CMS had approved any who had a prior felony record.

Finally, we verified that RHHIs had determined, where applicable, that home health applicants met minimum capitalization requirements before CMS approved them to provide home health care.

The appendix to this report describes our methodology in further detail.

We performed this inspection between December 2000 and October 2001. We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDING

CMS Processes Seemed to Effectively Prevent Enrollment of Ineligible Persons and Entities for Providing Home Health Care to Medicare Beneficiaries

Preventing enrollment of excluded or debarred persons or entities

To assure that no excluded individuals and entities are approved to provide home health care, RHHIs search two data sources. As required, RHHIs compare home health care applicants to both the OIG exclusion list and the GSA debarment list. CMS must deny Medicare participation to any HHA applicant appearing on either list.

From the universe of 880 HHAs, we independently reviewed provider enrollment information on 272, as well as 1,190 HHA owners and managers. We found none that had been previously excluded from Medicare participation.

We used three major automated data sources to identify excluded parties. First, we tested 272 HHAs and 1,190 HHA owners and managers against the OIG List of Excluded Individuals/Entities. The OIG exclusion list identifies individuals and entities that are excluded from participation in Medicare, Medicaid, and other Federal health programs. The list currently includes over 15,000 individuals and entities.

Second, we tested the same 272 HHAs and 1,190 HHA owners and managers by using the GSA List of Parties Excluded from Federal Procurement and Nonprocurement programs. The GSA debarment list identifies individuals and entities that are excluded from participation in Federal programs governmentwide. The basis for such actions can include criminal convictions or a civil judgement for fraud, false claims, or other offenses indicating a lack of business integrity.

Finally, we tested 1,181 HHA owners and managers¹ by using the Healthcare Integrity and Protection Databank (HIPDB). The Databank is a national database managed by the Health Resources and Services Administration, within the U.S. Department of Health and Human Services. It identifies prior actions that would be considered adverse to the provision of health care, including licensing and certification decisions, which may have resulted from criminal convictions, civil judgements, or similar events.

¹We were unable to obtain results for 9 of the 1,190 owners due to missing dates of birth.

Preventing enrollment of felons

CMS has the authority to deny Medicare participation for individuals and entities that had a felony conviction under Federal or State law for an offense which is inconsistent with the best interests of the Medicare program and its beneficiaries. Between October 1, 1997 and September 30, 2000, CMS enrolled 880 HHAs and an estimated 4,273 associated owners and managers.

The system used by CMS and its RHHIs seems to be effectively keeping felons from receiving approval to participate in Medicare. We searched for criminal records for a sub-sample of 492 HHA owners and managers connected with 115 HHAs. We found none who had a felony record over a 7-year period beginning in August 1994 and ending in July 2001. This period encompassed the date that CMS approved each of the selected home health agencies to provide care to Medicare beneficiaries.

Our sample of 272 HHAs had 1,190 owners and managers. From those owners and managers, we selected a sub-set of 492 owners and managers. We searched in Federal jurisdictions where each of the 492 members of our sample resided. Likewise, we searched applicable State or local court jurisdictions. Our search of criminal records covered both health care and non-health care crimes. Health care related felons might have been identified during our searches of OIG, GSA, and HIPDB electronic files, however, some non-health care crimes would not be identified from those files alone.

RHHIs do not systematically and routinely search criminal history records to deny Medicare participation for felons. Instead, they rely on their search for parties that have been excluded from Medicare participation. They search the DHHS Office of Inspector General's exclusion list, and the GSA debarred list. Some individuals that appear on these lists are there because of a felony act, particularly one which is health care related.

CMS allows RHHIs to specifically search criminal history data files when they have reason to suspect that an HHA applicant is a felon. However, each of the five RHHIs advised us that no such searches were done during the period of our inspection -- October 1, 1997 through September 30, 2000.

Preventing enrollment of undercapitalized agencies

For 95 of the 272 HHAs appearing in our sample, we verified that RHHIs did determine that they met minimum capitalization requirements before CMS enrolled them to provide home health care. The remaining 177 HHAs had already enrolled during a prior period. Therefore, an RHHI determination of minimum capitalization requirements did not apply. Typically, the 177 HHAs appeared in our sample because they had applied for approval for management, ownership, or other operational changes.

To prevent undercapitalized providers from enrolling in Medicare, RHHIs obtain the following documentation for each applicant.

- Applicants must submit a projection of home health visits during the first 3 months and the first year of operation.
- Applicants must submit a copy of bank statements and other evidence showing sufficient funding to meet minimum needs for the first 3 months of operation. At least 50 percent of that amount must be unencumbered, non-borrowed funds.
- A bank officer must provide an attestation showing that funds are in the accounts specified by applicants, and that the funds are immediately available. The attestation must accompany an applicant's bank statements.

We did not independently gather financial data on each application and determine that they met minimal capital requirements. Instead, we reviewed RHHI records for applicable HHAs and verified that the RHHI had collected the financial data and performed needed calculations to determine that the HHA applicants met minimal requirements.

APPENDIX

METHODOLOGY

Scope

Our study focused on determining whether or not CMS enrolled ineligible HHAs for Medicare participation² between October 1, 1997 and September 30, 2000. For our review, we sampled 272 applicant HHAs, and 1,190 owners and managers which were associated with them. We used SAS to select HHA applicants proportionately stratified by each RHHI jurisdiction. Table 1 shows our sample selections.

Table 1
Sample Selection

RHHI Locations	Universe of HHAs	Proportional Sample of RHHIs	Adjustments	Adjusted Sample	# of Owners and Managers Associated with HHA
Iowa	443	138	--	138	575
Wisconsin	148	47	-1	46	117
South Carolina	125	39	-4	35	163
California	113	36	--	36	267
Maine	51	17	--	17	68
TOTALS	880	277	-5*	272	1,190**

*We eliminated five HHAs because RHHIs could not locate files for four, and their enrollment logs contained incorrect information for one.

**This number is based on a non-distinct count of owners and managers for sampled HHAs. It represents each time an owner or manager appeared on an HHA application, and some were associated with more than one HHA.

²We used the term ineligible to refer to entities and individuals who were (1) excluded from Medicare by the OIG or debarred from government participation by the General Services Administration, (2) felons, and (3) undercapitalized parties. We recognize that providers may be ineligible for reasons other than the three addressed in this report.

Data Collection

Selecting HHAs For Our Inspection: To identify HHA applicants that CMS approved for Medicare participation between October 1, 1997 and September 30, 2000, we used tracking logs maintained by each RHHI. The logs contained names of applicant home health agencies, and dates applications were received, approved, returned, or denied. The logs showed that CMS approved 880 home health agencies. Table 2 below shows our estimated total number of owners and managers associated with the 880 HHAs in our universe. Our estimate is calculated based on the number of distinct HHA owners and managers, 1,070. Our analysis revealed that several HHA owners and managers appeared on multiple HHA enrollment applications. For example, one owner was the sole proprietor of five HHAs seeking enrollment. For our estimate of total owners and managers for the 880 approved HHAs, we counted duplicate owners and managers only once.

Table 2
Point Estimate of Approved Distinct Owners and Managers
Between October 1, 1997 and September 30, 2000

	Point Estimate	Lower 95% Confidence Interval	Upper 95% Confidence Interval
Total Owners & Managers	4,273	3,594	4,952

Some RHHI staff furnished testimonial and anecdotal information suggesting that more HHAs had been approved than those shown on the tracking logs. Therefore, the logs may not be totally correct. While we recognize that the logs could be incomplete, we relied on them for our sample. We did so because they contained specific data on HHA applications and resulting CMS decisions that we needed for our inspection.

Documenting CMS Decisions For Sampled HHAs: We obtained and reviewed key documentation from RHHIs leading to approval of the 272 HHA entities and the 1,190 owners or managers. For example, we obtained and reviewed copies of

- HHA applications contained on CMS forms 855 and related documentation,
- calculations by RHHI staff to determine if HHA applicants met minimum capitalization requirements,
- results of on-line screening by RHHIs to determine if HHA applicants had been excluded from Medicare participation by OIG or debarred from government program participation by GSA, and

-- RHHI recommendations to CMS regional offices for each HHA applicant.

Understanding CMS Enrollment Process: We reviewed CMS policies and procedures, and RHHI procedures, for enrolling Medicare providers. We did on-site inspections and interviews at four of the five RHHIs. We also conducted on-site interviews with staff at CMS headquarters and one regional office. We surveyed staff at the remaining eight CMS regional offices and at the remaining RHHI by e-mail. One CMS regional office did not respond to our requests for information.

Data Analysis

Identifying HHAs That Had Been Excluded From Medicare: CMS must deny enrollment to HHAs if they, their owners or managers have been excluded from Medicare participation by the OIG or GSA. Also, family or household members of such a person should be denied participation.

For each of our sampled 272 HHAs and the 1,190 owners or managers, we independently reviewed two data bases to ascertain if any had been excluded from Medicare participation before CMS approved their application to provide home health care to Medicare beneficiaries. We searched the OIG exclusion list and the GSA debarred list to identify any prior Medicare exclusions for all 1,190 owners or managers.

Also, for 1,181 of the 1,190 owners and managers, we searched the Healthcare Integrity and Protection Databank (HIPDB) to identify any who were, or should have been excluded because of improper acts. We were unable to complete this search for all 1,190 owners and managers because the date of birth was missing for 9 of them. In the HIPDB, the date of birth is critical for positive identification.

We verified all possible exclusions on the three data bases by cross referencing social security numbers for our sampled 1,190 owners and managers.

Identifying HHA Owners or Managers That Had a Felony Record: CMS has the authority to deny Medicare participation for individuals and entities that had a felony conviction under Federal or State law for an offense which is inconsistent with the best interests of the Medicare program and its beneficiaries.

We independently reviewed a sub-sample of 492 of the 1,190 owners and managers to identify any who had a felony record before CMS approved them to provide home health care to Medicare beneficiaries. We selected our sub-sample to provide proportionate representation of the five RHHIs.

We initially selected 500 HHA owners or managers, but dropped 8 because their addresses could not be located. The sub-sample represented 115 of the 880 home health agencies CMS approved between October 1, 1997 and September 30, 2000. To identify felons, we

used a contract research organization to search criminal records, for a 7-year period, in Federal and State jurisdictions where the members of our sample resided.

Documenting That RHHIs Determined Capitalization Levels For Approved HHAs:

We independently analyzed case files for 95 of the 272 HHAs to determine if RHHIs had collected needed financial data and determined that the HHAs met required capitalization levels before granting approval to serve Medicare beneficiaries. This determination was not applicable to the remaining 177 HHAs because they were already enrolled, and their initial 3 months of operation had transpired previously. The 177 HHAs appeared in our sample of 272 because they had applied for clearance of an ownership, management, or other operational change.