6%–24% of Home Health Care Spending (0.12% of Total Health Spending)

Reforming Home Health Care Coverage to Reduce Fraud

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Issue Summary: The US Medicare program currently spends approximately $18 billion for home health services by skilled nursing agencies (Medicare Payment Advisory Commission 2020, 251).[1] While the promise of home health care services is great—to keep frail people out of the hospital or nursing home by supporting them in their house—so also is the potential for fraud and "gray area" use of visits with little value to health. Indeed, home health care has traditionally been one of the key industries with large-scale fraudulent activities, particularly in specific cities such as Miami, Houston, and McAllen, Texas (Katzenstein et al. 2018; O'Malley et al. 2020).

Policy Proposal: This proposal describes four actionable policy changes that could lead to a significant reduction in fraud and spillover savings for other insurance programs, in part by addressing the information gaps that have helped allow for the growth in home health fraud. First, we recommend requiring that Medicare revise a form that is commonly abused so that physicians make clearer representations that patients have the clinical conditions necessary for home health care. The document they are signing would include a clearly stated legal definition of "medical necessity." Second, physicians who approve home health services would receive ongoing reports of the money spent on home care services billed for their patients. Third, the government should take actions to deter physicians and their employers from waiving copayments for services related to home health, thereby ensuring that patients would be aware of bills that might alert them to fraud committed in their name. Fourth, Medicare should more actively pursue preemptive policies and audits in regions where, despite continued efforts, there is evidence of unwarranted home health expenditures.

Total Savings: Estimates of overall health care fraud are as much as $100 billion, and home health care is well understood as one of the major sources of fraudulent behavior (Rudman et al. 2009). Based on our recommendations, we estimate potential savings to be between 6% and 24% of total home health care spending, or $1.2 billion to $4.4 billion. There is no evidence that such reductions at the margin would cause harm to patients (Doyle et al. 2017).

Related Literature and Evidence

Uncovering Waste in US Healthcare: Evidence from Ambulance Referral Patterns (2017). *Journal of Health Economics* 54: 25-39 (Joseph J. Doyle Jr., John A. Graves, and Jonathan Gruber).

Recent Trends in Criminal Health Care Fraud Prosecutions (2018). *US Attorneys Bulletin* 66 (5): 29-50 (Ranee A. Katzenstein, Diidri Robinson, Benjamin Barron, Ashwin Janakiram, and Alexander F. Porter).

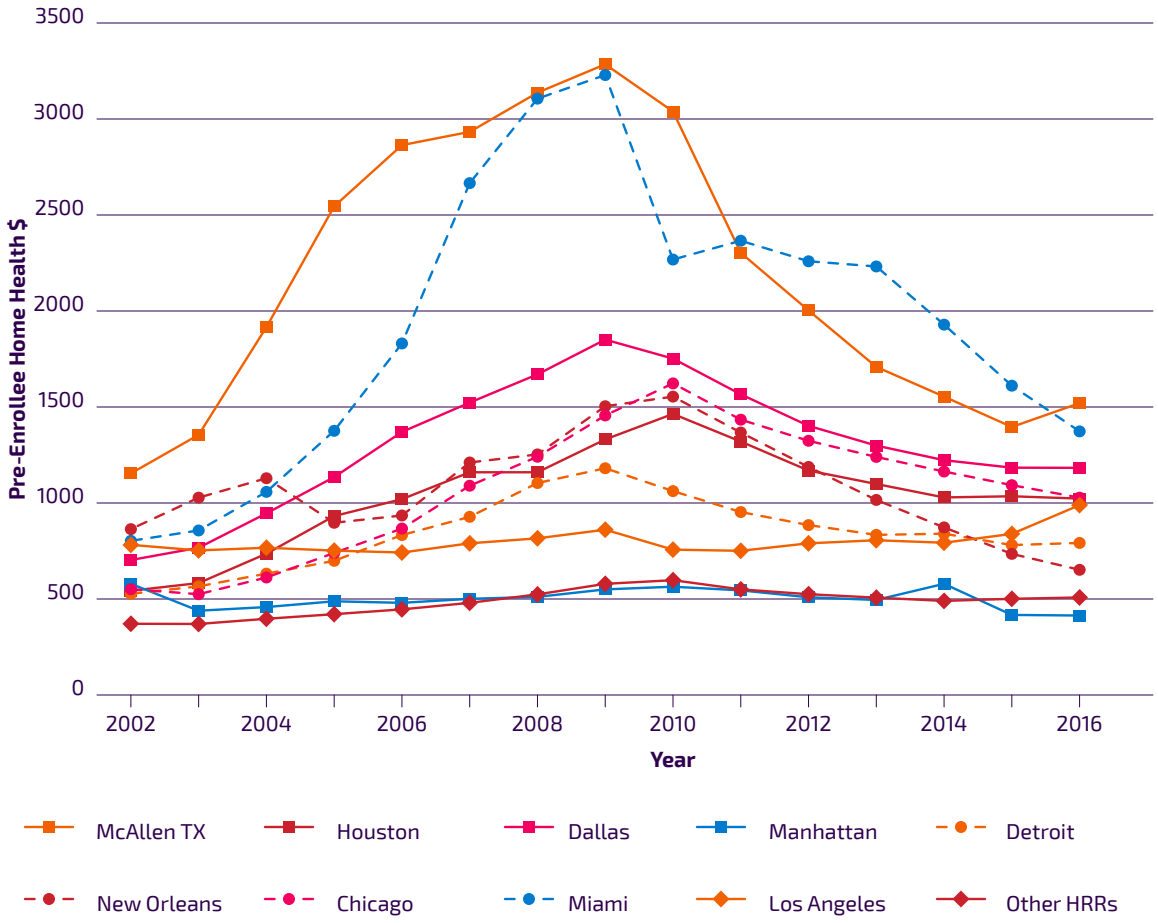
The Diffusion of Medicare Fraud: A Network Analysis (2020). *Working Paper, Dartmouth College* (James O'Malley, Thomas Bubolz, and Jonathan Skinner).

Introduction

The US Medicare program currently spends approximately $18 billion for home health services, with considerably more paid for Medicaid patients, commercial patients, and out-of-pocket spending (Medicare Payment Advisory Commission 2020, 251).[2] While the promise of home health care services is great—to keep frail people out of the hospital or nursing home by supporting them in their house—so also is the potential for fraud and "gray area" use of visits with little value to health. Indeed, home health care has traditionally been one of the key industries with large-scale fraudulent activities in specific cities such as Miami, Houston, and McAllen, Texas.

The spatial clustering of home health care fraud has been noticed by the Department of Justice (DOJ). Between 2007 and 2016, the DOJ placed nine local "strike force" offices in specific districts to pursue fraud of all types, but most of these nine regions also correspond to unusually high levels of home health care spending. Figure 1 shows the per-enrollee level of Medicare expenditures for home health care from 2000 to 2016, drawn from the Dartmouth Atlas Project database, for nine representative Hospital Referral Regions (HRRs) contained within the DOJ strike force districts (O'Malley et al. 2020). These data are adjusted for differences across regions in age, sex, race, and cost of living (e.g., local price differences in wages and rents). They are also adjusted for inflation and expressed in 2016 dollars. There are clear regional "hot spots," with spending in the McAllen, TX HRR and Miami, FL HRR an order of magnitude above spending in other regions (such as Manhattan and Los Angeles, which show less evidence of home health care fraud).[3]

Figure 1: Per-Enrollee Home Health Expenditures, 2000–2016, by Selected Hospital Referral Region



Note: Regions chosen if the DOJ had established a Medicare fraud office by 2016; "Other HRRs" is the weighted average of the HRRs not included in the DOJ strike force. All expenditures in constant 2016 dollars (O'Malley et al. 2020).

Despite the recognition that home health care can be used inappropriately, there has been only modest attenuation in billing in "hot spot" cities compared to other regions. For example, in the McAllen, Texas HRR, average price-adjusted spending per Medicare enrollee was $1,520 in 2016, more than three times the median ($460), and an order of magnitude higher than the HRR with the lowest regional spending ($87 in Bismarck, ND). Aggregate home health care expenditures since 2016 have remained roughly constant, and the DOJ has since opened several more strike force offices in other US cities with an additional focus on opioid fraud (Health and Human Services and Department of Justice 2019). While fraudulent behavior has likely scaled back from the late 2000s, there clearly remains the potential for further cost savings.

Can Home Health Care Expenditures Be Reduced without Harming Patients?

Should we be worried that cutting back on health care expenditures might harm patients? One certainly might be concerned about a national cut in reimbursement rates, for example, since doing so affects all home health care agencies, whether they are in low- or high-use regions. For this reason, we propose targeting home health agencies most likely to be providing either fraudulent or low-value care. One recent study, for example, suggested that hospitals relying more heavily on post-acute care (such as home health care) experienced worse outcomes for their patients (Doyle et al. 2017). Another study found that home health care expenditure reductions had no impact on health outcomes (McKnight 2006). Certainly for cases in which home health care is fraudulently billed for nonexistent services, we need not be overly concerned that spending less will harm patients. In particular, based on one author's experience, many of the patients who are used in home health schemes are simply getting routine checkups of chronic conditions and would not suffer if those checkups were ceased.

Current Fraud Reduction Strategies

There continues to be fraudulent activity in home health care, with extensive efforts to prosecute such activities.[4] According to the Fiscal Year 2019 report on the variety of cooperative programs to combat fraud between the DOJ and Health and Human Services (HHS), more than 1,000 new criminal health care investigations were opened, and there were 485 cases with criminal charges leading to 528 convicted defendants. As well, there were 1,112 new civil health care fraud investigations opened; on net, $2.5 billion was transferred to the Medicare Trust Fund (HHS and DOJ 2019).

In many respects, the sheer number of cases being brought is indicative of the continued profitability of fraudulent activities in home health care, with successful prosecution often hobbled by antiquated Medicare rules that lead to a system of "pay and chase" by which Medicare is obligated to pay for claims soon after submission and only afterwards consider criminal prosecution. Furthermore, these cases are likely to be only the tip of the iceberg. For these reasons we consider several proposals that could make it easier to identify and prosecute fraud or unwarranted prescribing, and thereby reduce overall fraudulent activities by preventing them in the first place.

Strategies to Reduce Fraudulent Home Health Care

A measure of success would be to observe a decline in the number and extent of new criminal and civil investigations, along with a decline in the extent of home health care expenditure. To do this, HHS and DOJ can take steps to more effectively reduce the ability of home health care agencies to reap profits and evade prosecution. Here are several approaches:

Increasing the Accountability of Providers

In the experience of one of the authors, physicians and other health care providers, when confronted with evidence of fraudulent home health billing, claim that they didn't actually know about such activities and even claim that they did not understand the actual requirements for home health care. This often occurs when a company or individual running a home health care agency, instead of waiting for a legitimate referral, will seek out patients who don't care if they are signed up, go behind the back of the primary care physician, and then find a doctor who will go along and sign off on everything.[5] This occurs for home health as well as other services such as durable medical equipment. When caught, physicians who signed off on what amounted to huge numbers of Medicare expenditures say that they did not know what the qualifications were for such expenditures and had no idea there were questionable activities involved. In some instances, the physician escapes responsibility for involvement in massive fraud.

To address this type of fraud, we recommend requiring referring physicians to sign a document with more explicit statements that their patient has the clinical conditions necessary for home health care (or the specified service). With the current Form 485, a physician certifies that the patient is "confined to the home," but there is no definition of this term, and there is no reference to the Medicare benefit definition. Citing the definition would be a nudge that would make a physician aware of the requirements so that the physician could no longer plead ignorance in the event of prosecution.

Reducing Information Gaps

The root of home health care fraud is typically not the physician but rather the agency that administers home health care. Home health agencies typically get paid thousands of dollars for an episode of home health care while a complicit physician typically gets paid just hundreds in the form of related Medicare claims or illegal kickbacks. But much of this is invisible to physicians and to the patients. For an office visit and other services that a physician might bill, the patient will receive a form with an explanation of benefits, while the physician will receive remittance information. By contrast, for home health care, the physician never receives information about how much is being billed in their name by other people, and the patient never sees how much the nursing agencies are getting paid. Thus they don't see how much money the home health agencies are making. Many physicians don't realize that they've signed off on $5–$10 million worth of care—a fact that, if known, would certainly get their attention.

To address this information gap, we recommend that each physician who approves primary care on a Form 485 would receive quarterly summaries, by patient, of the home health care payments authorized in their name, which the ordering/responsible physician would need to sign and authorize. This would be another nudge that would put the physician who signs stacks of 485s on notice that he or she is responsible for millions of dollars in payments.

Auditing Copayments and Deductibles

Medicare does not charge copayments for home health services provided by skilled nursing agencies, a policy that might have been well intentioned but has helped allow for massive fraud to occur in this area. Medicare does still charge copayments for physicians who certify patients for home health and who bill for services that often are related to home health fraud, but the companies employing such physicians typically waive patients' cost sharing. Absent cost sharing, patients have no incentive to avoid or report excess or fraudulent home health services and are often not even aware of the fraud that is occurring in their name. (In one author's experience, many patients receiving home health care have been told that home health is a service that all Medicare patients are entitled to free of charge, which leaves out the crucial point that the service is meant only for those patients who are "confined to the home" and actually need skilled nursing care.) In order to reduce home health fraud, we recommend that firms report and verify the amounts they collect in patient cost sharing for home health services (National Health Care Anti-Fraud Association). We also recommend an audit program to verify that the amounts collected from patients approximate what should have been paid. These nudges would deter some from waiving copayments, would get some patients to cut off unnecessary home health services themselves, and would make it easier for the government to prosecute those who waive copayments and lie about doing so.

Accountability at the Regional Level

It is difficult to estimate the precise savings from the measures above, but guaranteed savings can be realized by a focus on preemptive auditing and payment withholds (Skinner et al. 2012) to reduce the frequency of Medicare paying first and then having to chase after potentially fraudulent agencies to recover the money. The Centers for Medicare and Medicaid Services' "Review Choice Demonstration" is a promising first step toward this goal, but it has been successively delayed (Centers for Medicare and Medicaid Services). A program of audits and payment withholds could be triggered locally by unwarranted high rates of per-Medicare-enrollee home health care expenditures in a given county or region, along the lines of the current DOJ/HHS local strike forces. Rather than auditing all agencies in a region, such audits could focus on home health agencies based on data-driven red flags, such as (1) a pattern of discharging large numbers of patients and then readmitting them soon afterward, (2) a high percentage of patients who have not had recent hospital stays and are allegedly receiving home health services for chronic conditions, or (3) a high percentage of patients who are going to physicians' offices during periods when they were allegedly confined to the home. With a return on investment of $4 in fines and recovered funds per $1 of enforcement costs (and likely even larger effects on fraudulent behavior) (HHS and DOJ 2019), increased enforcement would be implemented until overall home health care expenditures at the regional level were reduced to a preset spending level.

Savings from Addressing Fraud in Home Health

We anticipate that strengthening the federal government's hand in prosecuting Medicare fraud targeted to specific areas of the US—and thus leaving alone unaffected regions with little evidence of fraudulent

behavior—would save substantial federal funds. As an optimistic estimate of savings, we consider the reduction in Medicare spending that would occur if every HRR that exceeds the median spending were to be reduced to the median of those HRRs that were not targeted by the DOJ ($451 per Medicare enrollee); this would reduce 2016 expenditures by 24%, or $4.4 billion in total. Many large regions with disadvantaged elderly populations are already well under this median level; 2016 home health care spending in the Bronx, New York, was $279 and in Savannah, Georgia, was $379. A less ambitious target would be to reduce home health expenditures to the 75th percentile ($2.3 billion saved). The least ambitious would be to scale back to just the 90th percentile of non-targeted regions ($771), which would save $1.2 billion (O'Malley et al. 2020).[6]

Footnotes

1. Estimates from National Health Expenditures for Medicare expenditures on home health care were $40 billion, and for total spending on home health care were $110 billion in 2018. We instead adopt the more conservative estimate from the Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 2020. See http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch9_sec.pdf?sfvrsn=0 and https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData.

2. See Footnote 1.

3. The sharp decline in home health billing in Miami between 2009 and 2010 was the direct consequence of a change in the regulations regarding billing for "outlier" or unusually expensive home health patients. In the mid-2000s, nearly half of all outlier payments in the United States occurred in Miami-Dade County (Benzio 2010).

4. An example of a recent case is as follows: "In January 2019, the owner and operator of Amex Medical Clinic and a doctor in Texas were convicted of charges resulting from their involvement in a Medicare fraud scheme. … The owner sold medical orders and other documents signed by the doctor to HHAs in and around Houston. In these medical orders, the doctor falsely certified information about the patient's medical condition and need for home health services. Co-conspirators at HHAs then used the false paperwork to bill to, and receive payment from, Medicare for services that were not medically necessary or not provided. The owner also caused Amex to bill Medicare for purported physician services that were actually provided by an unlicensed practitioner, if at all. The individuals were sentenced to a combined 55 years in prison and ordered to pay up to $26.7 million in restitution, jointly and severally." (HHS and DOJ 2019, 24).

5. For example, "In May 2019, a patient recruiter for multiple Houston-area home health agencies and owner of Circuit Wide was sentenced to 188 months in prison, followed by three years of supervised release, and was ordered to pay $12.9 million in restitution. The charges stem from a $20 million scheme to pay illegal health care kickbacks to physicians and Medicare beneficiaries in order to fraudulently bill for medically unnecessary home health services and to launder the proceeds." (HHS and DOJ 2019, 24).

6. These are percentiles weighted by the Medicare population.

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