Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases

Results at a Glance

Home health fraud in Medicare continues to warrant scrutiny

- ✓ *More than 500 HHAs and 4,500 physicians were outliers on multiple characteristics commonly found in OIG-investigated cases of home health fraud*
- ✓ *27 geographic areas in 12 States emerged as hotspots for characteristics commonly found in OIG-investigated cases of home health fraud*

Why Home Health?

Significant Part of Medicare Program

- o *$18.4 billion paid to more than 11,000 HHAs in CY 2015*

Fraud, Waste, and Abuse Vulnerabilities

- o *Over $10 billion in improper payments estimated in FY 2015*
- o *Previous reports highlighting compliance and billing concerns*
- o *More than 350 criminal and civil actions and $975 million in investigative receivables for FYs 2011–2015*

In this data brief, the Office of Inspector General (OIG) examines Medicare claims data for calendar years (CYs) 2014–2015 to identify home health agencies (HHAs), supervising physicians, and geographic areas whose Medicare claims have characteristics similar to those observed by OIG in cases of home health fraud. While these characteristics are not necessarily indicative of fraudulent activity, they can be useful in identifying providers and geographic areas that warrant greater scrutiny.

The Medicare home health benefit covers skilled nursing care, home-based assistance, and therapeutic services for qualifying homebound individuals.[1] Medicare generally reimburses HHAs for 60-day episodes of care, and there is no limit to the number of episodes that a beneficiary can receive. In CY 2015, Medicare reimbursed more than 11,000 HHAs for almost 7 million episodes of home health care, totaling approximately $18.4 billion.[2] This represents a decrease of more than $1 billion in annual Medicare home health spending since CY 2010.

Home health has long been recognized as a program area vulnerable to fraud, waste, and abuse. OIG home health investigations have resulted in more than 350 criminal and civil actions and $975 million in receivables for fiscal years (FYs) 2011–2015.[3] Additionally, previous reports from OIG and the Government Accountability Office (GAO) have raised concerns about questionable billing patterns, compliance problems, and improper payments in home health.[4] The Centers for Medicare &

Medicaid Services (CMS) has estimated that in FY 2015 Medicare made more than $10 billion in improper payments to HHAs.[5] Since July 2013, CMS has imposed moratoria on new HHA enrollments in selected geographic areas to prevent fraud, waste, and abuse.[6]

While cases of home health fraud investigated by OIG vary in nature, they generally involve HHAs that bill for services that are not medically necessary and/or not provided. For example, in April 2016 a Dallas physician and three HHA owners were convicted for their roles in a $375 million fraud scheme.[7] As part of the scheme, the perpetrators recruited patients from a homeless shelter in Dallas to sign up for Medicare home health services. The physician falsely certified and recertified beneficiaries as being eligible for home health care, and the owners and office staff falsified medical documentation to support the eligibility certifications and services that were never provided. Two additional HHA owners and an office manager previously pleaded guilty for their roles in this scheme.[8] This case was investigated jointly by OIG and the Department of Justice (DOJ) as part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a partnership that operates "Strike Force" teams in areas known for high rates of Medicare fraud.[9]

This data brief assesses the national prevalence and distribution of selected characteristics commonly found in OIG-investigated cases of home health fraud. Using details of recent such cases, we determined five distinct characteristics common to them:[10]
1. High percentage of episodes for which the beneficiary had no recent visits with the supervising physician
2. High percentage of episodes that were not preceded by a hospital or nursing home stay
3. High percentage of episodes with a primary diagnosis of diabetes or hypertension
4. High percentage of beneficiaries with claims from multiple HHAs
5. High percentage of beneficiaries with multiple home health readmissions in a short period of time

We then identified HHAs and supervising physicians that were statistical outliers with regard to those characteristics in comparison to their peers nationally. To do this, we used a standard technique known as the Tukey method. We also identified geographic "hotspots" that were either statistical outliers on the characteristics compared to other areas nationally or contained significant numbers of HHA or physician outliers. See the Methodology on page 10 for a more detailed description of our analysis. Our analysis was not designed to make determinations of actual fraud. Accordingly, the individual HHAs and physicians that we identified were not necessarily engaged in fraudulent activity.[11]

This data brief is being released in tandem with an OIG Alert on improper arrangements and conduct by HHAs and physicians.

RESULTS

More than 500 HHAs and 4,500 physicians were outliers on two or more characteristics commonly found in OIG home health fraud cases

Our analysis identified 562 HHAs, or about 5 percent of all HHAs, that were statistical outliers on 2 or more characteristics commonly found in OIG-investigated cases of home health fraud. In CY 2015, Medicare reimbursed these HHAs for more than 100,000 home health episodes, totaling $273 million.

Our analysis also identified 4,502 physicians, or about 1 percent of all physicians who supervise home health care, who were statistical outliers on 2 or more characteristics commonly found in OIG-investigated cases of home health fraud. Physicians have a key role in the delivery of home health care and act as "gatekeepers" by certifying beneficiaries' eligibility and managing their care plans. OIG investigations have frequently found physicians to be principal conspirators in home health fraud schemes—for example, by approving medically unnecessary home health care in exchange for kickbacks.

While there may be legitimate explanations as to why any of these specific HHAs and physicians were outliers on characteristics commonly found in OIG-investigated cases of home health fraud, further scrutiny is warranted. Our results are based on analysis of claims data and cannot conclusively demonstrate that fraudulent activity has occurred. However, the HHAs and physicians that we identified differed considerably in their billing patterns from their peers nationally—in some cases, by very wide margins.

While most of the HHAs and physicians discussed above were outliers on just two characteristics commonly found in OIG-investigated cases of home health fraud, some were outliers on three, four, or all five characteristics. Table 1 shows the 562 HHAs and 4,502 physicians by the number of characteristics on which they were outliers compared to their peers nationally.

Table 1: HHA and Physician Outliers by Number of Characteristics

Provider Type	Outliers on 2 characteristics	Outliers on 3 characteristics	Outliers on 4 characteristics	Outliers on 5 characteristics	Total
HHAs	469	84	9	-	**562**
Physicians	3,844	570	86	2	**4,502**

Source: OIG analysis of Medicare claims data, 2016.

Table 2, on the next page, provides summary information regarding each of our five characteristics, including (1) the national median percentages for HHAs and physicians; (2) the threshold percentages above which HHAs and physicians were considered to be outliers; and (3) the numbers and percentages of HHA and physician outliers for each of our five characteristics. Following Table 2, we discuss our results for each characteristic and the implications of those results.

Table 2: National Medians and Outlier Thresholds for HHAs and Physicians

Characteristic	Provider Type	National Median	Threshold for Outliers	Number of Outliers	Outliers as a Percentage of Total
No recent visit with the supervising physician	HHAs	22.6%	62.5%	470	3.9%
	Physicians	11.8%	54.6%	16,789	4.9%
No hospital or nursing home stay	HHAs	49.5%	-	-	-
	Physicians	35.7%	97.1%	1,751	0.5%
Diabetes or hypertension diagnosis	HHAs	10.1%	45.1%	483	4.0%
	Physicians	5.3%	28.8%	7,937	2.3%
Beneficiaries with claims from multiple HHAs	HHAs	6.3%	25.9%	770	6.5%
	Physicians	0.0%	13.9%	7,510	2.2%
Readmission shortly after discharge	HHAs	5.6%	19.3%	778	6.5%
	Physicians	3.6%	19.1%	3,822	1.1%

Source: OIG analysis of Medicare claims data, 2016.

> ➢ **Almost 500 HHAs and more than 16,500 physicians had an unusually high percentage of home health episodes for which the beneficiary had no recent visits with the supervising physician**

A total of 470 HHAs and 16,789 physicians were outliers on the percentage of home health episodes for which the beneficiary had no evaluation and management claims from the supervising physician in the preceding 6 months. For these 470 HHA outliers, at least 63 percent of home health episodes fit this description, compared to a national median of 23 percent. For the 16,789 physician outliers, at least 55 percent of home health episodes fit this description, compared to a national median of 12 percent.

This characteristic is common in OIG-investigated cases of home health fraud and may indicate that the supervising physician did not appropriately evaluate the beneficiary's medical condition. OIG investigations have found that home health fraud schemes commonly involve HHAs paying "recruiters" to collect beneficiaries' Medicare numbers for use in fraudulent billing. In these cases, supervising physicians often colluded in the fraud schemes and did not conduct proper evaluations, if any, of beneficiaries' conditions before certifying their eligibility for home health care.[12]

➢ **More than 1,700 physicians had an unusually high percentage of home health episodes that were not preceded by a hospital or nursing home stay**

A total of 1,751 physicians were outliers on the percentage of home health episodes that did not shortly follow a hospital inpatient discharge or skilled nursing facility discharge within the previous 30 days. For these 1,751 physician outliers, at least 97 percent of their home health episodes fit this description, compared to a national median of 36 percent. Our analysis identified no HHA outliers for this characteristic.[13]

This characteristic is common in OIG-investigated cases of home health fraud and may indicate that home health care is not medically necessary. While beneficiaries may legitimately need home health care in situations other than discharges from institutional care, fraudulent home health services are also commonly billed without a preceding hospital or nursing home stay. For example, OIG investigations have found that recruiters have solicited beneficiaries from within a community to receive home health care, regardless of whether such care is medically necessary.

➢ **Almost 500 HHAs and 8,000 physicians had an unusually high percentage of home health episodes with a primary diagnosis of diabetes or hypertension**

A total of 483 HHAs and 7,937 physicians were outliers on the percentage of home health episodes for which the beneficiary's primary diagnosis code was diabetes or hypertension. For these 483 HHA outliers, at least 45 percent of home health episodes fit this description, compared to a national median of 10 percent. For the 7,937 physician outliers, at least 29 percent of home health episodes fit this description, compared to a national median of 5 percent.

This characteristic is common in OIG-investigated cases of home health fraud and may indicate that home health care is not medically necessary. While some beneficiaries legitimately need home health care related to these diagnoses, home health claims with these primary diagnosis codes may also reflect medically unnecessary services. Past OIG-investigated cases of home health fraud have involved HHAs and physicians with home health case mixes that were disproportionately composed of these primary diagnoses.[14]

➢ **Almost 800 HHAs and more than 7,500 physicians had an unusually high percentage of beneficiaries with claims from multiple HHAs**

A total of 770 HHAs and 7,510 physicians were outliers on the percentage of beneficiaries who received home health care from 3 or more HHAs over the course of 2 years. For these 770 HHA outliers, at least 26 percent of their beneficiaries fit this description, compared to a national median of 6 percent. For the 7,510 physician outliers, at least 14 percent of their beneficiaries fit this description, compared to a national median of 0 percent.

This characteristic is common in OIG-investigated cases of home health fraud. In past cases that OIG has investigated, recruiters moved beneficiaries between HHAs to avoid suspicion or obtain more favorable financial arrangements for fraudulent billing. Some beneficiaries were colluding in these fraud schemes, but others were unaware of the fraudulent activity. In our analysis, we identified 6 beneficiaries who received services from 10 or more different HHAs over the course of 2 years.

Six beneficiaries received services from 10 or more different HHAs over 2 years

➢ **Almost 800 HHAs and 4,000 physicians had an unusually high percentage of beneficiaries with multiple home health readmissions in a short period of time**

A total of 778 HHAs and 3,822 physicians were outliers on the percentage of beneficiaries with 2 or more home health readmissions shortly following a home health discharge over the course of 2 years. For both the 778 HHA outliers and the 3,822 physician outliers, at least 19 percent of their beneficiaries fit this description, compared to national medians of 6 percent and 4 percent, respectively.

This characteristic is common in OIG-investigated cases of home health fraud. Past OIG fraud investigations have uncovered incidents in which HHAs provided—and physicians supervised—unnecessary care over a long period of time and tried to conceal the duration of that care by periodically discharging and re-enrolling their beneficiaries.

Twenty-seven geographic areas in 12 States emerged as hotspots for characteristics commonly found in OIG home health fraud cases

Another way to describe the extent to which characteristics commonly found in OIG-investigated cases of home health fraud are present across the country is to identify geographic hotspots. To identify hotspots, we examined Medicare claims data by location to identify areas that—when compared with other areas nationally—were statistical outliers on two or more of these characteristics. We also looked for geographic areas where numerous HHAs and/or physicians that were outliers on two or more characteristics were located. Figure 1, on the next page, details the three criteria we used to identify hotspots.

Our analysis identified 27 hotspots in 12 States (Arizona, California, Florida, Illinois, Louisiana, Michigan, Nevada, New York, Oklahoma, Pennsylvania, Texas, and Utah). Seven of the hotspots met multiple criteria, including two—Miami, Florida, and Detroit, Michigan—that met all three criteria. Figure 2 shows the locations of all 27 hotspots. Table A-1 in the Appendix describes the criteria each of these hotspots met; the number of HHAs and physicians per hotspot that were outliers on two or more characteristics; and the extent of home health services provided in these hotspots in CY 2015.

Figure 1: Criteria Used to Identify Geographic Areas as Hotspots of Characteristics Commonly Found in OIG Home Health Fraud Cases
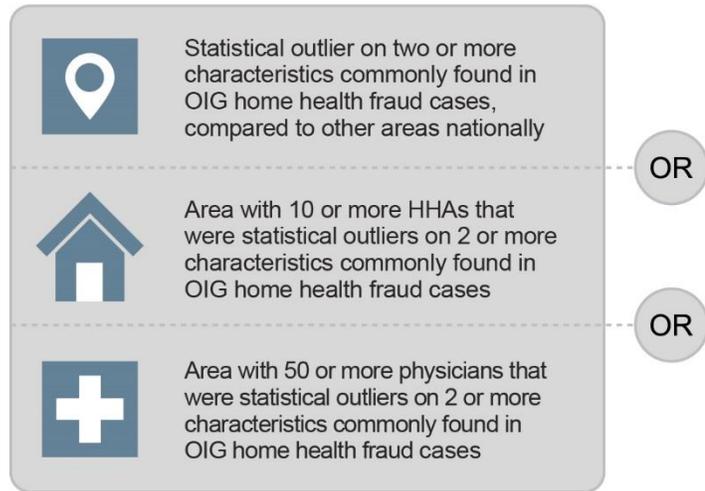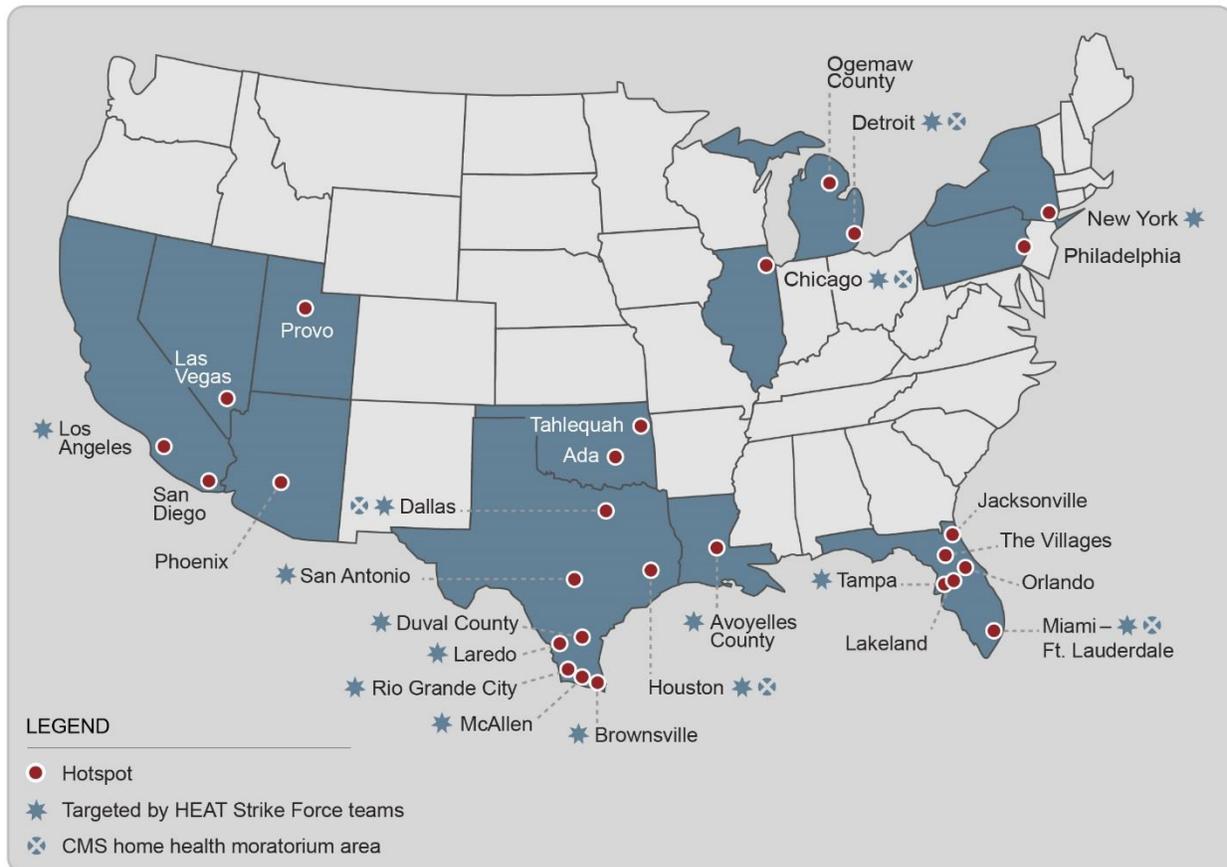

Figure 2: Geographic Hotspots for Characteristics Commonly Found in OIG Home Health Fraud Cases

Source: OIG analysis of Medicare claims data, 2016.

In 2015, 35 percent of all home health episodes and 37 percent of all home health spending occurred in geographic hotspots

In CY 2015, Medicare reimbursed HHAs for nearly 2.4 million home health episodes, totaling $6.9 billion, in the 27 geographic hotspots. This represents approximately 35 percent of home health episodes and 37 percent of home health expenditures nationally.

Many of the 27 geographic hotspots we identified are areas that are generally recognized as having high rates of Medicare fraud, including home health fraud. For example, many of the areas that we identified as hotspots for characteristics commonly found in OIG-investigated cases of home health fraud are areas targeted by HEAT Strike Force teams.[15] Similarly, several of the areas that we identified as hotspots are also areas in which CMS has imposed a moratorium on new HHA enrollments.[16]

The results of our hotspot analysis suggest that, despite numerous successful investigations by HEAT Strike Force teams, home health fraud is an ongoing concern. HEAT Strike Force teams have conducted numerous investigations of HHAs and physicians in several hotspots, including recent cases in Chicago, Illinois; Dallas, Texas; Detroit, Michigan; Houston, Texas; and Miami, Florida.[17] These cases have resulted in the successful prosecution of participants in home health fraud schemes and in the recovery of millions of dollars to Medicare.

Some of the geographic hotspots we identified have not previously been the focus of targeted anti-fraud efforts in Medicare. However, our analysis indicates that characteristics commonly found in OIG-investigated cases of home health fraud are prevalent in these areas. Examples of such hotspots include Las Vegas, Nevada; Orlando, Florida; San Diego, California; Phoenix, Arizona; Provo, Utah; and Ada, Oklahoma.

CONCLUSION

Our analysis identified a substantial number of providers—more than 500 HHAs and 4,500 physicians—that were outliers in comparison to their peers nationally with respect to multiple characteristics commonly found in OIG-investigated cases of home health fraud. It is important to note that our analysis does not demonstrate that these providers were engaged in fraudulent activity; there may be legitimate explanations for any of these specific providers' practices. However, because these providers differ considerably from their peers with respect to common fraud characteristics—often by substantial margins—they warrant further scrutiny to ensure the integrity of the Medicare home health benefit. OIG will conduct investigations and audits of these providers and/or refer them to CMS for followup, as appropriate.

Our analysis also identified 27 geographic hotspots in 12 States—i.e., areas where characteristics commonly found in OIG-investigated cases of home health fraud were prevalent. Many of these hotspots are areas already recognized as having high rates of Medicare fraud, which suggests that home health fraud in these areas is an ongoing concern and that enforcement and program integrity efforts should continue. Other hotspots have not been previously recognized as areas prone to home health fraud, which suggests that they may warrant the dedication of additional anti-fraud tools and resources.

Along with OIG's existing body of work, the results presented in this data brief demonstrate that home health fraud in Medicare continues to warrant scrutiny and attention from OIG, its law enforcement partners, and CMS. Past OIG and CMS efforts have been successful in reducing Medicare home health spending, and OIG is committed to continuing its fight against home health fraud, waste, and abuse through additional investigations, audits, evaluations, and enforcement actions. It is also essential for CMS to continue to use the tools at its disposal to prevent home health fraud and to assess whether further actions are needed. OIG looks forward to continued collaboration with CMS, DOJ, States, and private-sector partners on this critical work.

METHODOLOGY

This data brief is based on our analysis of Medicare claims from CMS's National Claims History (NCH) datasets. To facilitate this analysis, we created multiple datasets, including a primary dataset and supporting datasets. Our primary dataset was composed of all final paid fee-for-service claims for home health services that started in CY 2014 or 2015. Each home health claim contains information about the supervising physician, beneficiary, HHA, enrollment date, discharge date, and diagnosis codes. Our supporting datasets were composed of Part B (physician) claims, hospital outpatient claims, hospital inpatient claims, and skilled nursing facility (SNF) claims for the beneficiaries included in our primary dataset.

We use the term "episode" to refer to the 60-day episodes of care by which HHAs are reimbursed, and we use the term "first episode" to refer to the first of multiple consecutive episodes of home health care for the same beneficiary.[18] When an HHA submits claims for multiple consecutive episodes of care for the same beneficiary, only the last episode is associated with a discharge date.[19]

We use the terms "supervising physician" and "physician" to refer to the attending physician listed on each home health claim. The attending physician always signs plans of care for home health beneficiaries and almost always certifies that beneficiaries meet the requirements for home health services.[20]

We defined geographic areas as either Core-Based Statistical Areas (CBSAs) or rural counties.[21] We used the service location ZIP code on each claim to identify the relevant CBSA or (if the ZIP code was not associated with a CBSA) the rural county. In our results, we simplified CBSA names to reflect only the primary city included in the CBSA (e.g., "Chicago, Illinois" instead of "Chicago-Naperville-Joliet, IL-IN-WI"). Table A-1 in the Appendix lists full CBSA names.

Measures for Characteristics Commonly Found in OIG Home Health Fraud Cases
We identified five distinct characteristics commonly found in OIG-investigated cases of home health fraud. We then developed measures to assess these characteristics using the NCH datasets. The measures for each characteristic are defined as follows:

1. *No recent visit with the supervising physician*. For the measure corresponding to this characteristic, we identified home health episodes for which the beneficiary had no claims for in-person visits with the supervising physician in the 180 days preceding the start of the episode. We defined claims for in-person visits as claims for evaluation and management (E&M) services or claims for surgical services for which global payments cover E&M activities, and we used our Part B (physician) and hospital outpatient supporting datasets to identify these claims. In identifying episodes for this measure, we considered only first episodes of home health care.

   We then created a percentage for each HHA, physician, and geographic area by dividing the number of identified episodes by the total number of first episodes for the HHA, physician, or geographic area.

2. *No hospital or nursing home stay.* For the measure corresponding to this characteristic, we identified home health episodes for which the beneficiary had no claims for hospital inpatient stays or SNF stays with a discharge date in the 30 days preceding the start of the episode. We considered only first episodes of home health care for this measure.

   We then created a percentage for each HHA, physician, and geographic area by dividing the number of identified episodes by the total number of first episodes for the HHA, physician, or geographic area.

3. *Diabetes or hypertension diagnosis.* For the measure corresponding to this characteristic, we identified home health episodes for which the beneficiary had a primary diagnosis code for diabetes or hypertension. We considered only the primary diagnosis code because it represents the code most related to the beneficiary's home health plan of care.[22] We defined diabetes diagnosis codes as any ICD-9 code beginning with 249 or 250 or any ICD-10 code beginning with E08, E09, E10, E11, or E13. We defined hypertension diagnosis codes as any ICD-9 code beginning with 401 or 405 or any ICD-10 code beginning with I10 or I15. We considered all episodes of home health care for this measure.

   We then created a percentage for each HHA, physician, and geographic area by dividing the number of identified episodes by the total number of episodes for the HHA, physician, or geographic area.

4. *Beneficiaries with claims from multiple HHAs.* For the measure corresponding to this characteristic, we identified beneficiaries with claims from three or more HHAs during CYs 2014 and 2015.

   We then created a percentage for each HHA, physician, and geographic area by dividing the number of identified beneficiaries by the total number of beneficiaries for the HHA, physician, or geographic area.

5. *Readmission shortly after discharge.* For the measure corresponding to this characteristic, we identified beneficiaries who, during CYs 2014 and 2015, had two or more first episodes of home health care that started within 60 days of a previous home health discharge.

   We then created a percentage for each HHA, physician, and geographic area by dividing the number of identified beneficiaries by the total number of beneficiaries for the HHA, physician, or geographic area.

Identifying Outliers

For each measure, we used a standard technique known as the Tukey method to identify HHAs, physicians, and geographic areas that were statistical outliers. Specifically, we identified an HHA, physician, or geographic area as an outlier if its percentage for a given measure was above the 75th percentile plus one and a half times the interquartile range on the distribution of percentages across all HHAs, physicians, and geographic areas, respectively.[23]

Prior to performing the outlier analyses, we excluded HHAs, physicians, and geographic areas with low volumes of home health services. For the first three measures, we excluded HHAs, physicians, and geographic areas with fewer than 10 total episodes of home health care. For the fourth and fifth measures, we excluded HHAs, physicians, and geographic areas with fewer than 10 home health beneficiaries. For all measures, we further excluded geographic areas with fewer than five HHAs.

Identifying Hotspots

We identified hotspots as geographic areas that were:
- o   outliers on 2 or more measures, or
- o   areas with 10 or more HHAs that were outliers on 2 or more measures, or
- o   areas with 50 or more physicians that were outliers on 2 or more measures.

We assigned each HHA and each physician to one geographic area using the service location ZIP codes on home health claims. When HHAs or physicians had home health claims spanning multiple geographic areas, we assigned them to the geographic area in which they had the most claims.

Limitations

This data brief is based on analysis of Medicare claims data only; we did not review medical records or other documentation. Moreover, our measures were designed to assess characteristics commonly found in OIG-investigated cases of home health fraud, not to accurately predict or reveal fraudulent activity. Accordingly, our analysis should not be interpreted as demonstrating that specific providers were engaged in fraud.

We did not independently validate the accuracy or completeness of the Medicare claims data that we analyzed. Any errors or omissions, such as incorrect identification numbers or services that were provided but not billed for, may affect our results.

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.

Table A-1: Detailed Information for Geographic Hotspots

CBSA or Rural County	Geographic Outlier*	10 or more HHA Outliers*	50 or more Physician Outliers*	Number of HHA Outliers	Number of Physician Outliers	Total Number of Episodes of Care in CY 2015	Total Amount Paid in CY 2015
Chicago-Naperville-Joliet, IL-IN-WI		🏠	✚	37	257	348,261	$934,729,586
Los Angeles-Long Beach-Santa Ana, CA		🏠	✚	43	366	272,861	$861,749,599
New York-Northern New Jersey-Long Island, NY-NJ-PA			✚	1	119	272,138	$836,390,898
Dallas-Fort Worth-Arlington, TX		🏠	✚	52	174	313,269	$821,220,916
Miami-Fort Lauderdale-Pompano Beach, FL	📍	🏠	✚	59	675	224,513	$772,403,832
Houston-Sugar Land-Baytown, TX		🏠	✚	191	204	178,611	$475,554,067
Detroit-Warren-Livonia, MI	📍	🏠	✚	116	364	147,292	$420,220,465
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD			✚	-	56	123,545	$362,054,098
Tampa-St. Petersburg-Clearwater, FL			✚	9	167	109,610	$324,398,176
Orlando-Kissimmee-Sanford, FL			✚	3	85	54,622	$159,874,437
Las Vegas-Paradise, NV		🏠	✚	17	91	50,546	$153,541,797
San Diego-Carlsbad-San Marcos, CA			✚	1	56	44,401	$139,286,424
San Antonio-New Braunfels, TX			✚	4	84	50,487	$124,072,476
Jacksonville, FL			✚	-	54	42,485	$121,795,749
Phoenix-Mesa-Glendale, AZ			✚	-	51	42,279	$120,424,214
McAllen-Edinburg-Mission, TX	📍			4	40	52,980	$107,597,598
Laredo, TX	📍			-	10	20,570	$45,761,832
Lakeland-Winter Haven, FL	📍			-	15	12,971	$34,974,385
Brownsville-Harlingen, TX	📍			2	20	15,448	$29,832,272
Provo-Orem, UT	📍			-	6	6,566	$19,818,206
Avoyelles County, LA	📍			-	1	6,107	$11,923,007
Rio Grande City-Roma, TX	📍			1	3	3,563	$6,834,088
Tahlequah, OK	📍			-	-	3,139	$6,493,366
Ada, OK	📍			-	-	2,320	$4,929,154
Duval County, TX	📍			1	-	2,749	$4,834,979
The Villages, FL	📍			-	1	1,558	$4,645,014
Ogemaw County, MI	📍			-	1	1,743	$3,950,716

Source: OIG analysis of Medicare claims data, 2016.

* Symbol in column is explained in detail in Figure 1 on page 7.

ACKNOWLEDGMENTS

ENDNOTES

[1] See 42 U.S.C. § 1395f(a)(2)(C) and 42 U.S.C. § 1395n(a)(2)(A).

[2] OIG analysis of Medicare claims data, 2016.

[3] This total includes investigative receivables due to the U.S. Department of Health and Human Services (HHS) as well as non-HHS investigative receivables (e.g., amounts due to State Medicaid programs and private health care programs).

[4] See:

    OIG, *Limited Compliance With Medicare's Home Health Face-To-Face Documentation Requirements*, OEI-01-12-00390, April 2014.

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

    GAO, *Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185, February 2009.

[5] HHS, *Medicare Fee-for-Service 2015 Improper Payments Report*, December 2015. See Appendix D, Table D3. Improper payments include payments for services that were not medically necessary as well as payments for services lacking sufficient documentation.

[6] 78 Fed. Reg 46339 (July 31, 2013).

[7] See U.S. Department of Justice (DOJ), *Dallas Doctor and Three Dallas-Area Home Health Agency Owners Convicted for Running Large-Scale, Sophisticated Health Care Fraud Scheme*, April 13, 2016. Accessed at https://www.justice.gov/usao-ndtx/pr/dallas-doctor-and-three-dallas-area-home-health-agency-owners-convicted-running-large on April 18, 2016.

[8] DOJ, *Registered Nurse Co-Owner of Ultimate Care Home Health Services, Inc. Sentenced to 10 Years in Federal Prison for Role in Healthcare Fraud Conspiracy*, January 19, 2016. Accessed at https://www.justice.gov/usao-ndtx/pr/registered-nurse-co-owner-ultimate-care-home-health-services-inc-sentenced-10-years on May 23, 2016.

[9] OIG, *Semiannual Report to Congress*, page iv. Accessed at http://oig.hhs.gov/reports-and-publications/archives/semiannual/2016/SAR_Spring_2016.pdf on June 6, 2016.

[10] Because we used different measures in previous work, the results are not comparable. Any change in the number of HHAs that we have identified, for example, does not necessarily represent a change in the prevalence of potential fraud.

[11] Some HHAs or physicians may be outliers on our characteristics for legitimate reasons. For example, a physician may specialize in diabetes care and therefore have a disproportionately high caseload of patients with a diabetes diagnosis.

[12] See, e.g., DOJ, *New Orleans Jury Convicts Company Owner and Doctor for Roles in $34 Million Fraud Scheme*, March 18, 2016. Accessed at https://www.justice.gov/opa/pr/new-orleans-jury-convicts-company-owner-and-doctor-roles-34-million-fraud-scheme on May 24, 2016.

[13] The distribution of HHAs' percentages on this measure did not yield any statistical outliers. Not all distributions assessed by the Tukey method will have statistical outliers.

[14] See, e.g., DOJ, *Miami Doctor Sentenced to 24 Months in Prison for Role in $37 Million Medicare Fraud Scheme Involving Miami-Area Home Health Agencies*, March 25, 2011. Accessed at https://www.justice.gov/opa/pr/miami-doctor-sentenced-24-months-prison-role-37-million-medicare-fraud-scheme-involving-miami on May 24, 2016.

[15] The nine areas targeted by HEAT Strike Force teams include Miami, Florida; Los Angeles, California; Detroit, Michigan; southern Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

[16] The six moratorium areas include Fort Lauderdale, Florida; Miami, Florida; Detroit, Michigan; Dallas, Texas: Houston, Texas; and Chicago, Illinois. See 81 Fed. Reg. 5444–5447 (February 2, 2016).

[17] See, e.g.:

DOJ, *Home Health Care Agency Owner Pleads Guilty in $4 Million Detroit-Area Medicare Fraud Scheme,* April 11, 2016. Accessed at https://www.justice.gov/opa/pr/home-health-care-agency-owner-pleads-guilty-4-million-detroit-area-medicare-fraud-scheme on April 27, 2016.

DOJ, *Patient Recruiter and Staffing Company Employee Convicted of $2 Million Home Health Care Fraud Scheme,* April 1, 2016. Accessed at https://www.justice.gov/opa/pr/patient-recruiter-and-staffing-company-employee-convicted-2-million-home-health-care-fraud on April 27, 2016.

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[18] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch 10, § 10.1.5.

[19] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch 10, § 10.1.14.

[20] CMS, *Medicare Claims Processing Manual*, Pub. 100-04, Transmittal 2833, Change Request 8441, December 6, 2013. See page 3.

[21] U.S. Census Bureau, *Geographic Terms and Concepts – Core Based Statistical Areas and Related Statistical Areas.* Accessed at https://www.census.gov/geo/reference/gtc/gtc_cbsa.html on May 2, 2016. CBSAs consist of the county or counties or equivalent entities associated with at least one core (urbanized area or urban cluster) of at least 10,000 in population, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties associated with the core.

[22] CMS, *One-Time Notification*, Pub. 100-20, Transmittal 1405, Change Request 8813, August 1, 2014. See page 2.

[23] See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.