U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

HHS OIG Data Brief • August 2019 • A-05-17-00035

The Centers for Medicare & Medicaid Services Could Use Comprehensive Error Rate Testing Data To Identify High-Risk Home Health Agencies

What Is Comprehensive Error Rate Testing?

The Centers for Medicare & Medicaid Services (CMS) implemented the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare fee-for-service (FFS) program. CERT is designed to comply with the Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA).

Key Takeaways:

- ✓ *Focusing on high-risk home health agencies (HHAs) identified using CERT data could provide CMS with opportunities to reduce improper payments and the HHA error rate.*
- ✓ *We identified 87 high-risk HHAs, which in the CERT sample had an improper payment rate of 78 percent. During this same period, Medicare paid these HHAs more than $4 billion for services.*
- ✓ *The majority of the HHA errors were related to the requirements that focus on the physician's role in determining the need for HHA services. Specifically, the majority of HHA errors were associated with the face-to-face (FTF) evaluation requirement or physician certification and recertification of patients' eligibility.*

Purpose of This Data Brief

The purpose of this data brief was to 1) examine CERT data for fiscal years (FYs) 2014 through 2017 to identify high-risk HHAs—those with potentially high rates of improper payments in CERT—as well as the common types of errors that caused improperly paid claims; and 2) provide CMS with information it can replicate and use to identify high-risk HHAs in its enforcement and educational efforts to reduce improper HHA payments and HHA error rates.

Introduction

Medicare Home Health

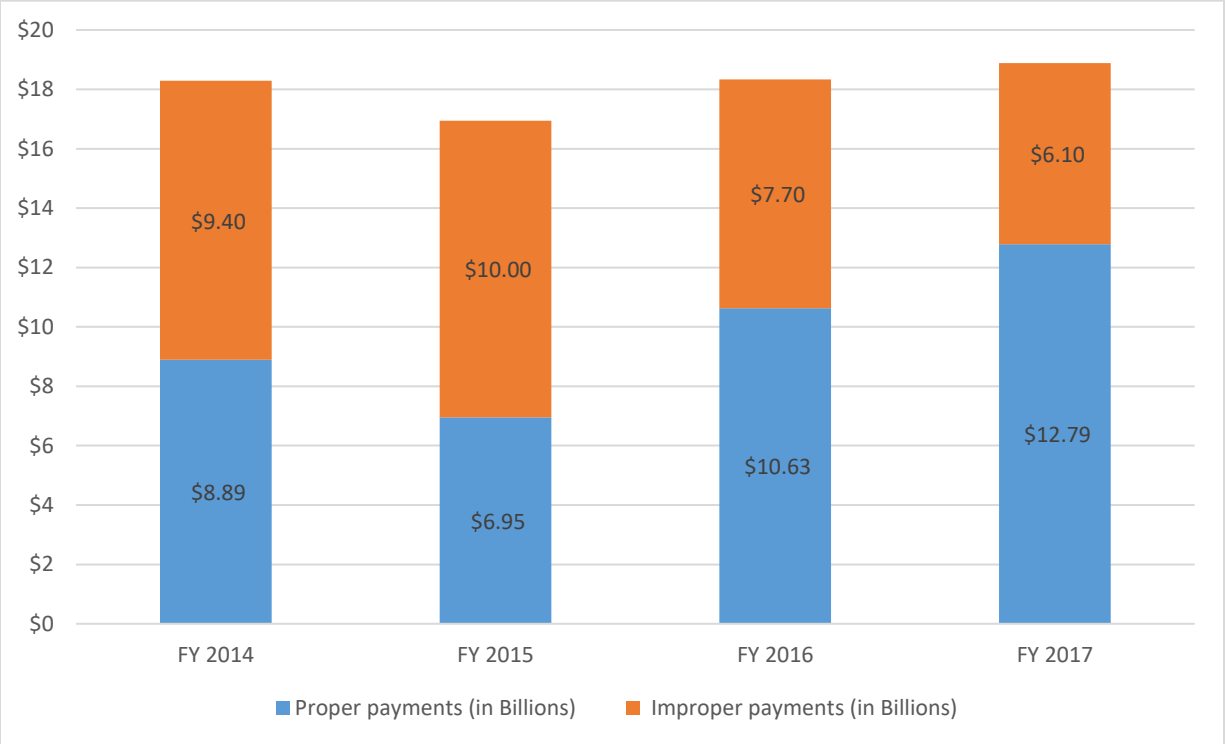
Medicare home health benefits include skilled nursing care, home-based assistance, and therapeutic services for qualifying homebound individuals. Medicare generally reimburses HHAs for 60-day episodes of care and does not limit the number of episodes that a beneficiary may receive. In FY 2017, Medicare reimbursed more than 11,000 HHAs for nearly 7 million claims for home healthcare, totaling about $18 billion.

The CERT Program

Through the CERT Program, CMS calculates the Medicare fee-for-service (FFS) improper payment rate. CMS randomly selects claims for review and sends a letter to selected providers requesting medical documentation for the claims. Independent medical reviewers review medical record documentation to determine whether the claims are paid properly under Medicare coverage, coding, and billing rules. The randomly selected claims and determinations are captured by CMS and this information is known as the CERT data.

CMS reported that estimates of improper HHA Medicare payments decreased from about $9 billion (a 51-percent error rate) in FY 2014 to about $6 billion (a 32-percent error rate) in FY 2017, as shown in the CERT program data in Figure 1. These improper HHA Medicare payments relate to claims submitted for reimbursement from July 1, 2012, through June 30, 2016.

Figure 1: Estimates of Improper Home Health Agency Payments as Reported by Comprehensive Error Rate Testing



Although there is no definitive or exhaustive list of high-risk HHA providers, CERT data are a valuable source of information. Analysis of CERT data is beneficial as it allows us to use claims data that have been reviewed by an independent medical reviewer to determine whether a claim has met Medicare necessity and coding requirements and whether it was referred for proper adjudication by the CMS payment contractors. As such, CERT data can be used in combination with other methods to identify high-risk HHA providers, reduce improper payments, and reduce the HHA CERT error rate. And although the CERT data are not definitive

or exhaustive, the CERT data do have significant value as part of a multifaceted approach to identify HHAs that represent a high risk for improper payments. The number of HHA claims that CMS samples on a yearly basis for the CERT program is limited to the minimum number of claims necessary to statistically determine the estimate of improper payments. For example, about 1,200 of the approximately 7 million HHA claims were sampled by CERT in FY 2017. With approximately 11,000 HHAs nation-wide, a large majority of smaller HHAs will not be included in the sample or will not have enough claims in the sample to identify whether they are at risk. As a result, the list of high-risk HHAs that can be identified through the CERT data is not exhaustive. In addition, identification of a provider as high-risk by using the CERT data does not guarantee that a provider will have a higher error rate overall.

Because no definitive or exhaustive list of high-risk providers exists, it is important to leverage all significant data sources available, including the CERT data. For example, CMS can identify HHAs that have three or more improperly paid claims identified by CERT data from FYs 2014 through 2017 and a CERT sample error rate greater than the national error rate for the same timeframe.[1] HHAs identified through this type of analysis are more likely to have higher improper payment rates than HHAs in general and warrant further review.

We did not review medical records or other documentation. (For a detailed methodology, see Appendix A.) Although some improper payments may be the result of fraud, improper payments are not necessarily a result of fraud. We are reporting on improper payments found in the annual CMS CERT report and not drawing conclusions about fraud. For additional background information, see Appendix B.

Results of Analysis

Home healthcare has long been recognized as a program area vulnerable to fraud, waste, and abuse. Our analysis of the CERT data identified high-risk HHAs with high rates of improper payments as well as the common types of errors that caused improperly paid claims. CMS could replicate our analysis as part of additional oversight to significantly reduce the annual HHA error rate.

Using Medicare program data in combination with CERT data from FYs 2014 through 2017, we determined that Medicare paid more than $4 billion to 87 high-risk HHAs. We found that about 78 percent[2] of the CERT-reviewed payments to these HHAs were improper. Our analysis also

[1] Each November, CERT reports improper payment information related to claims that span as far back as 18 months. For example, the FY 2017 reporting period covers claims that HHAs submitted from July 1, 2015, through June 30, 2016.

[2] The 78-percent sample error rate cannot be extrapolated to the $4 billion in total payments that were made to the 87 high-risk HHAs. The CERT data are based on a statistical sample, but standard estimation methods are not applicable when targeting the subset of a statistical sample that has a higher error rate. We would expect the

determined that the majority of the errors were related to the requirements that focus on the physician's role in determining the need for HHA services. Of the errors, 49 percent were associated with the FTF evaluation requirement and 16 percent with physician certification or recertification of patients' eligibility for services.[3]

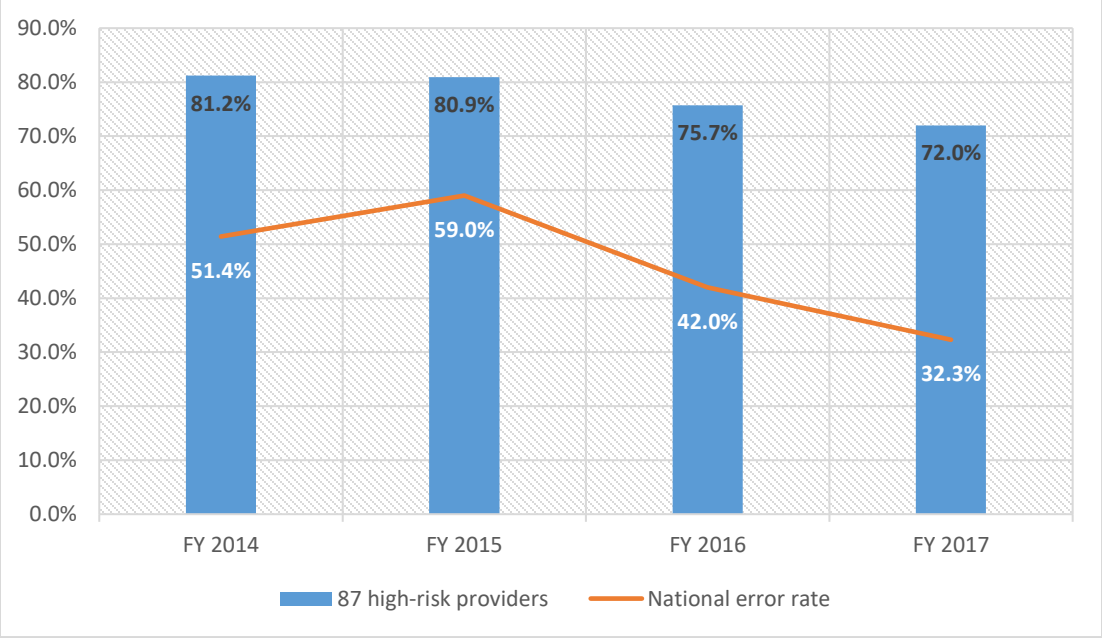
Medicare Paid $4 Billion to 87 High-Risk Home Health Agencies

Using CERT data for FYs 2014 through 2017, we identified 87 high-risk HHAs, all of which had both a high percentage of sampled claims in error and high improper payment amounts. Of 488 sampled claims associated with these providers, 342 were improper, reflecting an improper payment rate of about 78 percent[4] and approximately $1 million in actual improper payments.

Using Medicare program data during this same period, we determined that Medicare paid more than $4 billion to these 87 high-risk HHAs.

Yearly, the improper payment rate at the 87 high-risk HHAs in the CERT sample was significantly higher than the estimated national HHA error rate, as shown in Figure 2.

Figure 2: The 87 High-Risk Home Health Agencies' Error Rate Compared With the Home Health Agency National Error Rate



actual error rate for the high-risk population to be greater than the error rate across all providers but less than the error rate observed in the sample.

[3] For a complete list of HHA claim requirements, see Appendix C.

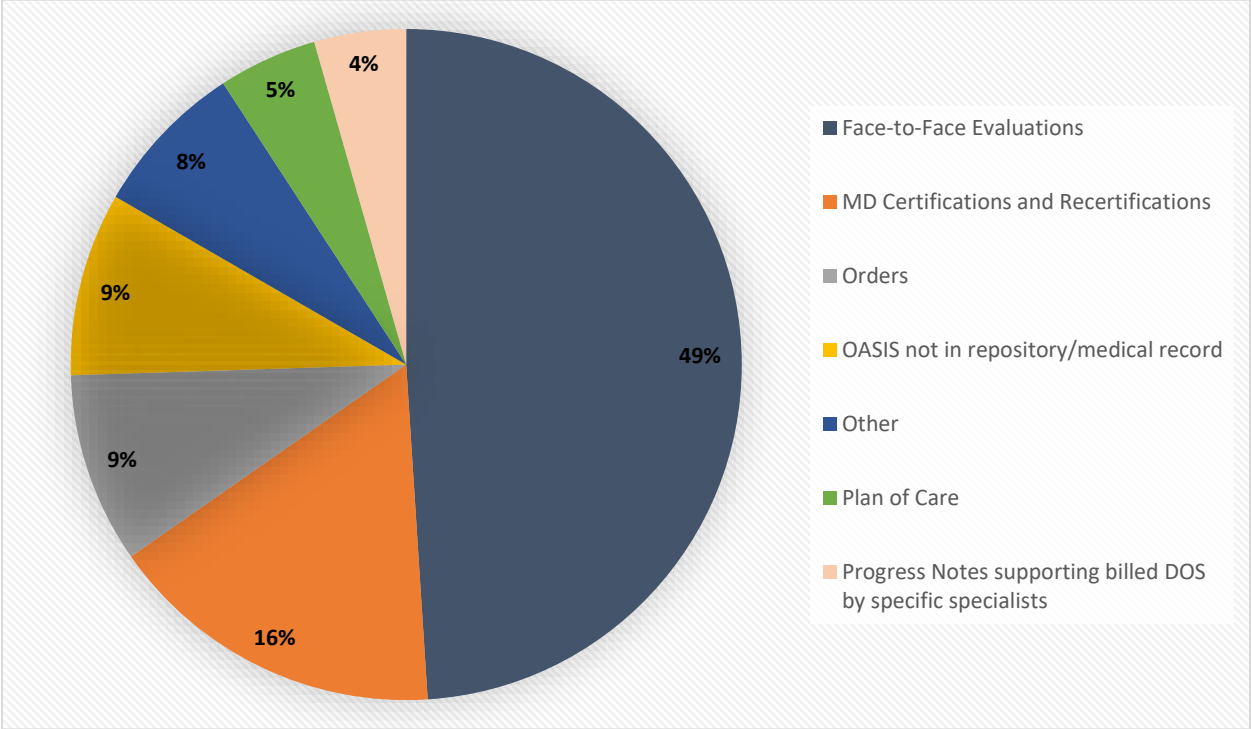
[4] CERT reviews from FYs 2014 through 2017 found errors totaling $995,504 of the $1,278,574 (78 percent) reviewed for the 87 high-risk HHAs.

Majority of Claim Errors Caused by Insufficient Documentation

The CERT program found that insufficient documentation accounted for more than 90 percent of the errors for HHA claims in FYs 2014 through 2017. HHA claims have many documentation requirements that need to be met before the claims are paid. A claim is considered to be in error because of insufficient documentation if the CERT review contractor, using the documentation provided, cannot conclude that the billed service or item was actually provided, was provided at the level billed, or was medically necessary; or when a specific documentation element that is required as a condition of payment is missing.

Within the insufficient documentation category, the majority of HHA errors were associated with the FTF evaluation requirement (49 percent) or the physician certification and recertification requirement (16 percent), as shown in Figure 3 on the next page. The FTF encounter and physician certification and recertification requirements are Medicare conditions of payment that document that the FTF encounter occurred and was related to the primary reason the beneficiary required HHA care. Other HHA insufficient documentation errors, such as incomplete physician orders or lack of all required assessment information regarding the measurement of patient outcomes, accounted for a lesser percentage of the HHA errors.

Figure 3: Percentage Breakdown of CERT Error Subcategory for Improper Claims Caused by Insufficient Documentation From FYs 2014 Through 2017



Conclusion

CMS could use the CERT data to identify high-risk HHAs as a part of a multifaceted approach that includes targeted probe and educate reviews as well as aspects of its Fraud Prevention System to further reduce improper payments and the error rate for claims paid to HHAs. Using nationally reported CERT program data for FYs 2014 through 2017, we identified 87 high-risk HHAs, which in the CERT sample had an improper payment rate of about 78 percent and approximately $1 million in actual improper payments. Using Medicare program data during this same period, we determined that Medicare paid these 87 HHAs more than $4 billion for services.

Given the amount of Medicare dollars paid to these providers and the high error rate observed in the CERT sample, focusing oversight on high-risk HHAs and the prevalent types of errors could significantly improve the effectiveness of CMS's efforts to reduce both HHA improper payments and the CERT error rate.

In addition to this data brief focused on HHAs, our office will issue a report related to CMS's overall efforts to use CERT data to identify high-risk providers of all types in the Medicare program. That report will contain appropriate recommendations for action to further reduce overall CERT improper payments and CERT error rates.

CMS Comments

In written comments on our data brief, CMS recognized that HHA claims are a major source of improper payments and described past and future corrective actions that address this issue. These corrective actions include identifying high-risk HHAs by using CMS's Fraud Prevention System, probe-and-educate reviews and targeted probe-and-educate reviews, and a new Home Health Review Choice Demonstration in Illinois. CMS stated that these sustained efforts have decreased the home health improper payment rate from 59 percent in FY 2015 to 17.6 percent in FY 2018 and are reliable and effective.

CMS stated that it does not believe that our methodology for identifying high-risk HHAs is valid, as the CERT data are not designed to be precise at the provider level. CMS indicated that providers with a higher number of claims billed are much more likely to be selected by the CERT review. Additionally, CMS stated that in the past it has attempted to use CERT data to identify high-risk providers but has found these data to be misleading and ineffective. Therefore, CMS discontinued the practice of using CERT data to identify high-risk providers. CMS also stated that its payment contractors have more accurate data at the provider level. CMS's comments are included in their entirety as Appendix D.

Office of Inspector General Response

We recognize that CMS's efforts over the past several years have contributed to the reduction of improper HHA payments. However, the HHA improper payment rate remains higher than the national error rate of 8.1 percent in 2018 for all provider types. Moreover, none of CMS's current work precludes the use of CERT data to improve oversight efforts.

Although we agree there are limitations to the CERT data, our analysis for identifying high-risk HHA providers is valid and can be used to identify areas of potential risk, including specific HHAs that are high-risk providers needing CMS's attention from either the enforcement or provider education perspective. Because no perfect dataset exists for identifying potential improper payments and to increase the identification of high-risk providers, CMS should leverage all significant sources, including the CERT data, as part of its efforts to reduce the improper payment rate.

We disagree with CMS that our method for identifying high-risk HHA providers is misleading and ineffective. Although we don't dispute that CMS and its payment contractors may have additional information employed in its program integrity efforts, our methodology for identifying high-risk HHA providers is valid. We used valid CERT-sampled data to identify a valid dataset of HHA providers with high error rates. We maintain that CMS can use CERT data as an additional tool in its targeted enforcement and education efforts to effectively reduce improper payments and CERT error rates. The report that we will issue related to CMS's overall efforts to use CERT data to identify high-risk providers of all types will contain appropriate recommendations for action to further reduce overall improper payments and CERT error rates.

APPENDIX A: SCOPE AND METHODOLOGY

Scope

We analyzed HHA claims data sampled in CMS's CERT program for FYs 2014 through 2017. Each sampled claim contained information about the certifying physician, beneficiary, HHA, enrollment date, discharge date, and diagnosis codes.

Methodology

To achieve our objective, we:

- reviewed Federal requirements for estimating and reporting improper Medicare fee-for-service payments;
- obtained CERT data for FYs 2014 through 2017 from CMS;
- identified CERT data for HHA providers;
- analyzed data from the Claims Data Warehouse to determine the number of high-risk HHAs, which we defined as HHAs that had three or more CERT sampled paid claims identified as improperly paid and whose error rate was greater than the average national HHA CERT error rate from FYs 2014 through 2017;
- identified the top HHA error subcategories as reported in the CERT report;
- summarized the HHA CERT errors by error code and identified the seven common types of subcategory HHA errors; and
- discussed the results of our review with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: HISTORY OF HOME HEALTH AND CERT PROGRAM

BACKGROUND

Medicare Home Health

The Medicare home health benefit covers skilled nursing care, home-based assistance, and therapeutic services for qualifying homebound individuals. In calendar year 2017, Medicare reimbursed more than 11,000 HHAs for nearly 7 million episodes of home healthcare, totaling about $18 billion.

Home healthcare has long been recognized as a program area vulnerable to fraud, waste, and abuse. Office of Inspector General (OIG) HHA investigations for FYs 2011 through 2015 have resulted in more than 350 criminal and civil actions, and the Federal Government has recovered more than $975 million. Additionally, previous reports by OIG and the Government Accountability Office have raised concerns about questionable billing patterns, compliance problems, and improper payments. CMS has estimated that in FY 2017, Medicare made more than $6 billion in improper payments to HHAs. The Office of Evaluation and Inspections (OEI) published in 2016 a data brief identifying common characteristics in OIG home healthcare fraud cases.[5]

Medicare Integrity Challenge

OIG has identified the integrity of Medicare payments as one of the top management challenges facing the Department of Health and Human Services. OIG's efforts in addressing this challenge are aimed at identifying and recommending methods to minimize improper payments; holding providers accountable for fraud, waste, and abuse; identifying ways to close exploited loopholes; and examining payment and pricing methods to ensure that Medicare, its beneficiaries, and taxpayers realize value for program expenditures.

Estimating Improper Medicare Payments

The IPIA, P.L. No. 107-300, requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimate of improper payments. In addition, for any program or activity with estimated improper payments exceeding $10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments.

[5] Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases–OEI-05-16-00031 https://oig.hhs.gov/oei/reports/oei-05-16-00031.asp, issued June 2016.

IPERA, P.L. No. 111-204, which replaced and consolidated the requirements of both IPIA and the Recovery Audit Act, retained the core provisions of the IPIA while requiring improvements in agency improper payment estimation methodologies and improper payment reduction plans. IPERA also significantly expanded the scope and reporting requirements of recovery audit programs.

The IPERIA, P.L. No. 112-248, was enacted to intensify efforts to identify and prevent payment error, waste, fraud, and abuse within Federal spending and to recover improper payments. The IPERIA requires agencies to identify high-priority Federal programs that have the highest dollar value or rate of improper payments and to provide greater levels of oversight and review.

Through the CERT program,[6] CMS calculates the Medicare fee-for-service (FFS) improper payment rate. The CERT program also calculates improper payment rates for various Medicare services, including home health services.[7] Each year, the CERT program evaluates a statistically valid stratified random sample of Medicare FFS claims to determine whether they were paid properly under Medicare coverage, coding, and billing rules.

Under the CERT program, CMS randomly selects Medicare FFS claims for CERT review and sends a letter to selected providers requesting medical documentation for the claims. For home healthcare recertifications of home health benefit eligibility and subsequent episodes of care that are selected as part of the CERT program's review, the CERT letter requests that the original FTF encounter documentation and original certification be submitted with any other documentation that supports the recertification, subsequent episodes of care, or both.

Independent medical reviewers review medical record documentation to determine whether claims are paid properly under Medicare coverage, coding, and billing rules. If the documentation does not support that the rules were met, the medical reviewer counts a payment as either a total or partial improper payment and then places the improper payment into one of five CERT improper payment categories: (1) no documentation, (2) insufficient documentation, (3) medical necessity, (4) incorrect coding, or (5) other.

[6] The CMS CERT report and additional details can be found at www.cms.gov/cert.

[7] For FYs 1996 through 2002, OIG estimated and reported improper Medicare FFS payments and national error rates. In November 2003, CMS assumed this responsibility, and OIG began providing oversight of the error rate process. OIG reports related to the error rate process include:

- A-05-08-00080, https://oig.hhs.gov/oas/reports/region5/50800080.pdf, issued October 7, 2010;
- A-01-09-00511, https://oig.hhs.gov/oas/reports/region1/11100511.pdf, issued September 29, 2009;
- A-01-09-00500, https://oig.hhs.gov/oas/reports/region1/11500500.asp, issued May 12, 2009; and
- A-01-07-00508, https://oig.hhs.gov/oas/reports/region1/10700508.pdf, issued August 22, 2008.

In the most recent reporting period (2017), the FTF encounter documentation subcategory made up the majority of HHA CERT errors. When claims have errors related to the FTF encounter, CMS denies them, and the full Medicare payment is recovered. FTF errors include insufficient FTF documentation from the physician to support the patient's homebound status and need for skilled services.

APPENDIX C: HOME HEALTH REQUIREMENTS

REQUIREMENTS OF HOME HEALTH AGENCY SERVICES

Medicare generally reimburses HHAs using a Home Health Prospective Payment System, as per § 1895 of the Social Security Act, for 60-day episodes of care (60-day episode payment) and does not limit the number of episodes that a beneficiary may receive. The Medicare payment for these 60-day episodes covers six types of services: (1) skilled nursing services, (2) home health aide services, (3) physical therapy, (4) speech-language pathology services, (5) occupational therapy, and (6) medical social services. Durable medical equipment (DME) items are excluded from the 60-day episode payment; HHAs bill for DME items separately.

To be eligible for Medicare home health services, a patient must have Medicare Part A or Part B, or both, and per §§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act, must:

- be confined to the home,
- need skilled services,
- be under the care of a physician,
- receive services under a plan of care established and reviewed by a physician, and
- have had an FTF encounter with a physician or allowed non-physician practitioner.

Care must be furnished by or under arrangements made by a Medicare-participating HHA.

The Face-to-Face Requirement

A certifying physician must document an FTF encounter with a patient. The HHA must obtain documentation that the FTF encounter with the patient occurred and that the encounter was related to the primary reason the beneficiary needs home healthcare. The FTF requirement is a Medicare condition of payment, and if the certifying physician does not complete the documentation correctly, CMS may deny the HHA payment. CMS holds the HHA financially accountable for ensuring that the documentation from the physician meets the applicable criteria. If the FTF requirement is not met, CMS may deny the HHA payment.

Physician Certification and Recertification

For a beneficiary to qualify for home health services, a physician or clinician must certify and recertify every 60 days that a Medicare beneficiary is (1) homebound; (2) needing intermittent skilled nursing care, physical therapy, or speech therapy, or continuing occupational therapy;

(3) under the care of a physician; and (4) under a plan of care that has been established and periodically reviewed by a physician. If the physician certification or recertification requirement is not met, CMS may deny the HHA payment.

Common Subcategory Error Code Types

We used CERT error codes[8] to identify specific issues for each improper claim. We identified seven common types of HHA errors specifically related to insufficient documentation:

- missing or insufficient FTF evaluations;
- missing or insufficient doctor certification or recertification of patients' eligibility for services;
- missing or insufficient orders;
- outcome and assessment information not in the Outcome and Assessment Information Set (OASIS)[9] repository or medical record;
- missing or insufficient progress notes supporting billed dates of service by specific specialists;
- missing or insufficient plans of care; and
- other insufficient documentation, such as an incorrect Healthcare Common Procedure Coding System code, no physical therapy initial evaluation, or no plan of care for therapy services.

[8] For this analysis, error codes are subcategory codes identified in the CERT program data. These subcategories are a more specific breakdown of errors than the publicly reported error types used by the independent medical reviewers.

[9] The OASIS contains data items developed for measuring patient outcomes for the purpose of performance improvement in home healthcare. OASIS assessments are collected at specified time points for adult (18 years old or older) Medicare and Medicaid patients. The assessments are required of all HHAs certified to receive Medicare and Medicaid payments.

APPENDIX D: AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 25 2019

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Data Brief: Using Comprehensive Error Rate Testing Data to Assess High-Risk Home Health Agencies (A-05-17-00035)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft data brief. Due to the concerns laid out below, CMS requests that this response be included in the published final data brief.

CMS recognizes that Home Health Agency (HHA) claims are a major source of improper payments. The Department of Health and Human Services (HHS) has identified home health as a service area driving improper payments and has detailed corrective actions to address this issue in HHS Agency Financial Reports, including the most recent report.[1] As a result of CMS's sustained efforts in this area, the home health improper payment rate decreased from 59 percent in Fiscal Year (FY) 2015 to 17.6 percent in FY 2018.

In its data brief, OIG attempted to identify error-prone HHAs through Comprehensive Error Rate Testing (CERT) data. OIG examined CERT data for HHA providers from FY 2014 through 2017 and identified HHAs that had three or more CERT-sampled paid claims identified as improperly paid and whose error rate was greater than the average national HHA CERT improper payment rate from the same time period. OIG then labeled these HHAs as "error-prone HHAs."

CMS does not believe this methodology for identifying error-prone HHAs is valid. The CERT program calculates the improper payment rate for the entire Medicare Fee-for-Service program by evaluating a statistically valid stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. The CERT sampling methodology meets the Medicare FFS program precision requirements as required by law and implemented by the Office of Management and Budget A-123, Appendix C.[2] However, the service-type improper payment rates do not have similar precision requirements and therefore the CERT data is not precise at the provider level.

[1] https://www.hhs.gov/sites/default/files/fy-2018-hhs-agency-financial-report.pdf

[2] The Improper Payments Information Act of 2002, Pub. L. No. 107-300, as amended by the Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, and the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248.

In addition, relying on CERT claims to identify error-prone providers artificially restricts the universe of providers being scrutinized. As OIG notes, only 1 in 5,800 HHA claims are sampled for the CERT program, representing 0.00017 percent of all HHA claims. This means that large providers are far more likely to have multiple claims sampled for CERT over a four-year period. CMS believes it would be more helpful to use methods that can identify error-prone providers of all sizes.

CMS previously attempted to use CERT data to identify error-prone providers, but found that CERT data was ineffective for this purpose and discontinued the practice. Specifically, in response to previous OIG recommendations,[3] from 2013 to 2017 CMS provided the Medicare Administrative Contractors (MACs) analyses of error-prone providers identified through CERT data. But because, as noted above, CERT data is not precise at the provider level and because MACs had more accurate data on providers in their jurisdictions, CMS found the practice ineffective and discontinued it.

CMS is committed to identifying error-prone providers and reducing improper payments. CMS currently identifies error-prone providers, including error-prone HHAs, through a variety of methods. CMS uses the Fraud Prevention System to identify, at the time of claim submission, when mistakes or intentional behavior may lead to improper payments or indicate fraud. Currently, CMS has 18 Fraud Prevention System models analyzing HHA claims.

In addition, CMS has conducted two Probe and Educate review projects with HHAs. In the first project, CMS conducted pre-payment reviews of home health claims for episodes that began on or after August 1, 2015.[4] Home Health MACs selected a sample of 5 claims for pre-payment review from each HHA within their jurisdiction. Based on the results of these initial reviews, MACs conducted provider specific educational outreach. For those providers identified as having moderate or major concerns, MACs repeated the Probe and Educate process for dates of services occurring after education had been provided.

The second Probe and Educate project, known as Targeted Probe and Educate, is ongoing. As a part of this broader Targeted Probe and Educate process, which now applies to all items and services, MACs focus on specific HHAs that have been identified through data analysis as being a potential risk to the Medicare Trust Funds or that exhibit aberrant billing compared to all HHAs. MACs review 20-40 claims per round, for a total of up to three rounds of review per HHA. After each round of review, providers are offered individualized education based on the results of these reviews. HHAs with continued high error rates after three rounds of review may be referred to CMS for additional action, which may include 100 percent prepayment review, extrapolation, or referral to the Home Health Recovery Audit Contractor. Providers may be removed from the review process if they demonstrate low error rates or sufficient improvement

[3] Centers for Medicare & Medicaid Services' Use of Medicare Fee-For-Service Error Rate Data to Identify and Focus on Error-Prone Providers (A-05-08-00080), Department of Health and Human Services, Office of Inspector General, October 2010. https://oig.hhs.gov/oas/reports/region5/50800080.pdf.

[4] Selecting Home Health Claims for Probe and Educate Review: Episodes that Begin on or After August 1, 2015, MLN Matters, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1524.pdf

in error rates. Since the nationwide Targeted Probe and Educate process began in October 2017, approximately 3,000 HHA providers have been reviewed.

In addition, CMS is beginning the Home Health Review Choice Demonstration in Illinois on June 1, 2019. HHAs will select from three initial choices: pre-claim review, postpayment review, or minimal postpayment review with a 25 percent payment reduction. All episodes of care starting on or after June 1 will be subject to the requirements of the choice selected. After a 6-month period, HHAs demonstrating compliance with Medicare rules through pre-claim review or postpayment review will have additional choices, including relief from most reviews except for a review of a small sample of claims. This demonstration will assist in developing improved procedures to identify and prevent fraud, protect beneficiaries from harm, and safeguard taxpayer dollars.

We believe the methods CMS currently uses to ensure the integrity of the Medicare program and identify error-prone providers are reliable and effective. While we appreciate OIG's efforts on this issue and are open to improvements in our program, we maintain that the method highlighted to identify error-prone providers in this data brief is misleading and ineffective. We will continue to work with OIG on ways to identify and reduce improper payments.