

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MANDATED ANALYSIS OF
HOME HEALTH
SERVICE UTILIZATION
FROM JANUARY 2016
THROUGH MARCH 2022**

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December 2022
A-05-20-00031

Office of Inspector General

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Report in Brief

Date: December 2022

Report No. A-05-20-00031

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



Why OIG Did This Audit

Medicare pays for home health services provided to beneficiaries who need skilled care for an illness or injury and are unable to leave their home. When providers furnish these services in rural areas, a percentage increase (rural add-on payment) is added to the standardized home health payment.

Under the Bipartisan Budget Act of 2018, Congress required the Centers for Medicare & Medicaid Services (CMS) to implement a new methodology for applying rural add-on payments beginning on January 1, 2019. Through the same legislation, Congress amended the Social Security Act to require, as a condition of payment, that all home health claims contain the code for the county (or equivalent area) where the service was furnished. Congress further required the Office of Inspector General to complete an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and make recommendations as appropriate.

How OIG Did This Audit

Our audit covered \$109,389,663,042 in Medicare payments to home health agencies (HHAs) for 45,417,624 claims. These claims were for home health services provided January 2016 through March 2022. We performed an analysis of service utilization by county and evaluated compliance with selected billing requirements.

Mandated Analysis of Home Health Service Utilization From January 2016 Through March 2022

What OIG Found

We determined that, during the audit period, beneficiary utilization of home health services decreased for urban counties and rural counties in the “high utilization” and “all other” categories, while utilization in the “low population density” category remained steady. We further determined that the number of home health episodes decreased for all urban and rural county categories. Many variables during the audit period may have affected utilization of services. Most notably, during calendar years 2020–2022, the Secretary of Health and Human Services declared a public health emergency in response to the COVID-19 pandemic. The pandemic affected utilization of services and presented staffing challenges for HHAs. Therefore, we could not determine the cause of any changes in utilization of services during this period.

Lawmakers designed the new rural add-on methodology to provide higher add-on percentages to rural counties in the “low population density” and “all other” categories. We determined that, during the audit period, the methodology shifted the distribution of add-on payments from the “high utilization” category to the “low population density” and “all other” categories.

We originally planned to use Federal Information Processing Standards (FIPS) data to analyze utilization from January 2016 through March 2022 but were unable to do so because the FIPS data was incomplete. This occurred because providers were not always applying the FIPS codes to claims, or the FIPS codes were invalid. Also, Medicare administrative contractors (MACs) did not always return claims with missing or invalid FIPS codes to providers for correction as required.

What OIG Recommends and CMS Comments

We recommend that CMS take the following steps to improve FIPS code reporting: (1) update the HH Pricer logic to check for missing and invalid FIPS codes on all home health claims and work with MACs to ensure that these claims are returned to providers for correction; and (2) re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

CMS concurred with our second recommendation but did not concur with our first recommendation. CMS provided information on the actions that it has taken and plans to take to address the second recommendation and the reasons it did not concur with the first recommendation. We maintain that our findings and recommendations are valid. CMS’s comments are summarized in the body of our report.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare pays for home health services provided to beneficiaries who need skilled care for an illness or injury and are unable to leave their home. When providers furnish these services in rural areas, a percentage increase (rural add-on payment) is added to the standardized home health payment. In a 2017 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) expressed a concern that rural add-on payments were poorly targeted. MedPAC stated, “The intent of the add-on is presumably to bolster access, but the high level of utilization in many rural areas results in the poor targeting of Medicare’s per episode add-on, with most payments made to areas with higher than average utilization.”¹ MedPAC recommended that Congress develop a more targeted approach that focuses rural add-on payments to areas with access problems (i.e., lower utilization areas).

Under the Bipartisan Budget Act of 2018 (BBA), Congress required CMS to implement a new methodology for applying rural add-on payments beginning on January 1, 2019. That methodology is designed to result in rural add-on payments that vary depending on the service utilization and population density of the rural county, which replaced a methodology that made no distinction among rural counties. The new methodology phases out these payments by reducing the add-on percentage each calendar year beginning January 1, 2020, and ending on December 31, 2022.

Through the same legislation, Congress amended the Social Security Act (the Act) to require, as a condition of payment, that all home health claims contain the code for the county (or equivalent area)² where the service was furnished.³ Congress further required the Office of Inspector General (OIG) to complete an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and make recommendations as appropriate.

OBJECTIVE

Our objective was to analyze home health claim data to determine utilization of home health services by county (or equivalent area) for calendar year (CY) 2016 through March 2022.

¹ [MedPAC, March 2017 Report to the Congress: Medicare Payment Policy, Chapter 9: Home Health Care Services.](#)

² Examples of county equivalent areas include parishes, municipalities, and boroughs.

³ Section 1895(c)(3) of the Act states, “With respect to home health services...no claim for such a service may be paid under this subchapter unless...[i]n the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.”

BACKGROUND

The Medicare Program and Payments for Home Health Services

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Parts A and B cover eligible home health services under a prospective payment system. Under the home health prospective payment system (HH PPS), CMS pays HHAs a national, standardized payment rate for each episode of care that a beneficiary receives. This payment rate is adjusted to account for differences in patient characteristics (case-mix) and the level of wages in the geographical area where services are provided (wage index). CMS contracts with four Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs. CMS maintains the Medicare home health claim processing system MACs use to process and pay claims. Within this system, CMS provides a home health Pricer (HH Pricer) for MACs to input claim information and calculate payment. MACs reimburse claims for home health services based on calculations made by the HH Pricer.⁴

Medicare Requirements for Reporting County Codes on Home Health Claims

There is a longstanding Medicare requirement that all home health claims include the Core Based Statistical Area (CBSA) code to indicate where the service was provided. The CBSA is a five-digit number corresponding to specific geographical areas, which include one or more counties, that are categorized as either urban or rural. The BBA⁵ added subsection (3) of section 1895(c) of the Act requiring that, “With respect to home health services...no claim for such a service may be paid under this subchapter unless...[i]n the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished.” CMS has instructed providers to use value code 85 to report the Federal Information Processing Standards (FIPS) code for the location where the home health service was provided. The FIPS code is a five-digit code that corresponds to each county in the United States. CMS directed MACs to use the reported FIPS code to determine the rural category and the rural add-on percentage, if any, that applies. CMS

⁴ The HH Pricer makes all payment calculations applicable under HH PPS, including claim payments for full periods of care, and all payment adjustments, including case-mix adjustments, wage index adjustments, rural add-on payment adjustments, low utilization payment adjustments, partial period payment adjustments, and outlier payments.

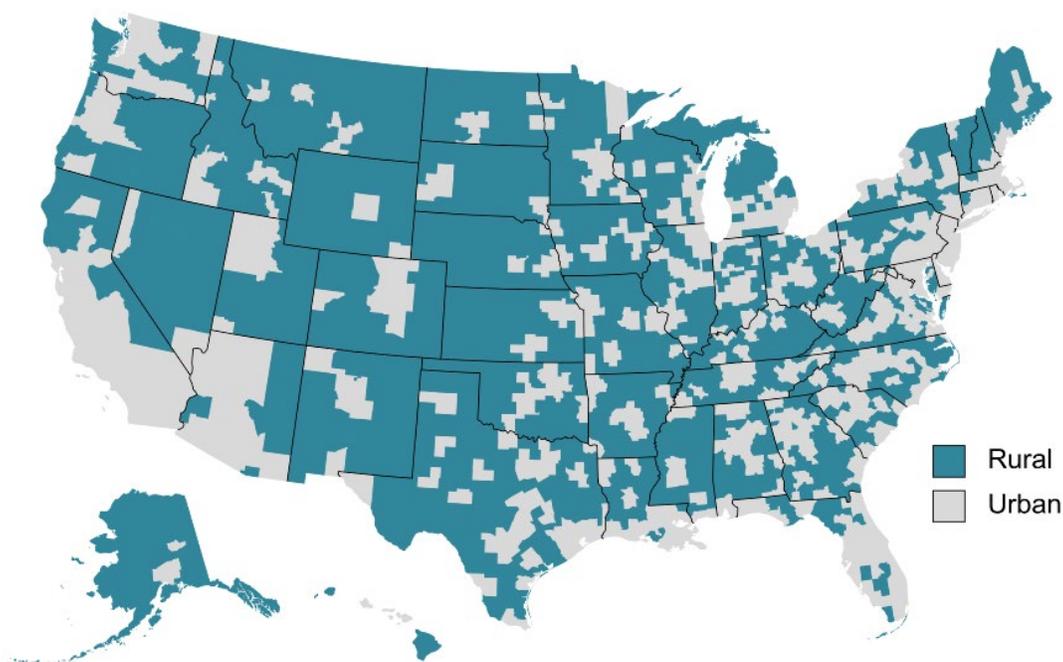
⁵ Bipartisan Budget Act of 2018 (BBA), P.L. No. 115-123, § 50208 (Feb. 9, 2018).

instructed MACs to return claims to providers for correction when the FIPS code is missing or invalid.⁶

Rural Add-On Payments, 2001 Through 2018

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and subsequent congressional Acts established and continued rural add-on payments from April 1, 2001, to December 31, 2018.^{7, 8} During this time, the same add-on percentage applied to all home health claims when the services were provided in a rural area. From 2001 to 2018, the amount of the rural add-on percentage fluctuated from zero to 10 percent, based on legislation and budgetary considerations. Figure 1, below, shows the geographic distribution of urban and rural areas as determined by CBSA code.

Figure 1: Map of Rural and Urban Areas Based on CBSA Code as of 2018



⁶ CMS's *Medicare Claims Processing Manual*, Transmittal 4190 (Change Request 10782, December 31, 2018), Business Requirement numbers 10782.5 and 10782.6 state the requirement that MACs apply return code 31 to home health claims when the county code is missing or invalid and return the claim to the provider for correction with a message indicating a missing or invalid FIPS code.

⁷ The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No. 106-554, App. F, § 508 (Dec. 21, 2000); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, § 421(a) (Dec. 8, 2003); Deficit Reduction Act of 2005, P.L. No. 109-171, § 5201(b) (Feb. 8, 2006); Patient Protection and Affordable Care Act, P.L. No. 111-148, § 3131(c) (March 23, 2010); and, Medicare Access and CHIP Reauthorization Act of 2015, P.L. No. 114-10, § 210 (April 16, 2015).

⁸ There were lapses in the rural add-on payment from April 1, 2003, to March 31, 2004, and April 1 to December 31, 2005.

Rural Add-On Payments, 2019 Through 2022

In 2019, CMS implemented the new rural add-on methodology to comply with the requirements of the BBA. Under this new methodology, rural add-on payments still apply to services provided in rural CBSAs, but the add-on percentage varies based on the county where the service was provided. CMS classified rural counties into one of three categories depending on the service utilization and population density of the county. The categories are “high utilization,” “low population density,” and “all other.” The new methodology, implemented by CMS, assigns different add-on percentages for each rural category. Once a rural county is categorized, the BBA requires that it remain in that category for the duration of the period 2019 through 2022. CMS used the following thresholds, established by the BBA, to determine the category to which each rural county is assigned:

1. **High utilization** – Rural counties in the highest quartile of all counties based on the number of Medicare home health episodes furnished per 100 individuals; 25 percent of rural counties fall into this category.
2. **Low population density** – Rural counties with a population density of six individuals or fewer per square mile of land area and not included in the “high utilization” category; 17 percent of rural counties fall into this category.
3. **All other** – Rural counties and equivalent areas not included in either the “high utilization” or “low population density” categories; 58 percent of rural counties fall into this category.

Figure 2: Map of New Rural County Categories Starting in 2019

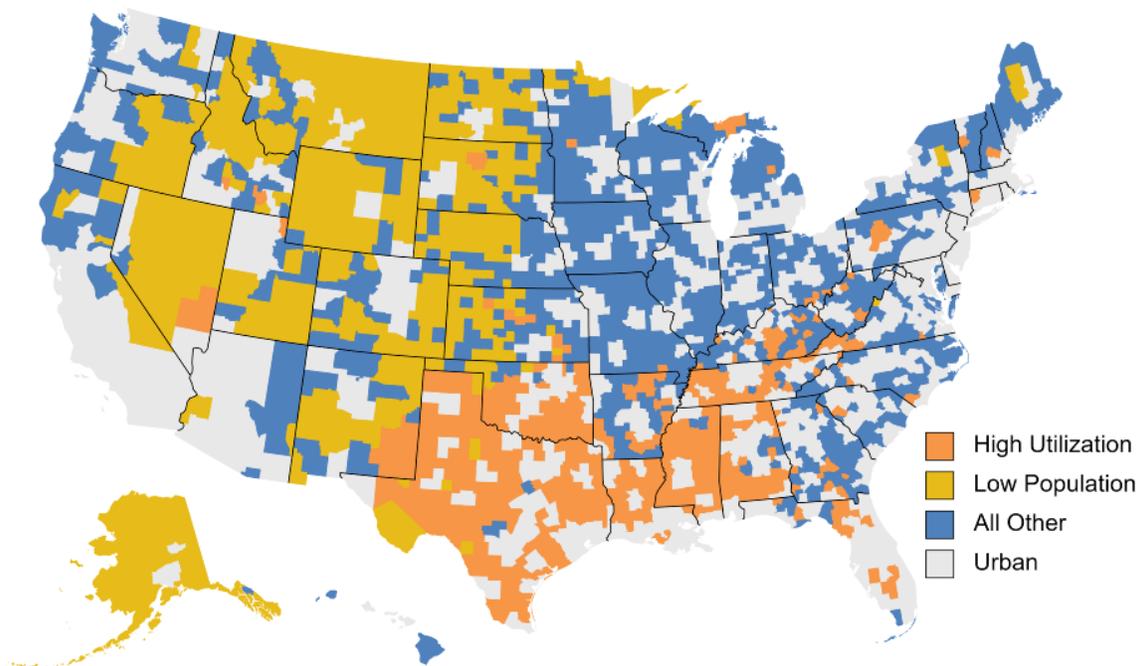


Table 1, below, shows the new rural add-on percentages by CY for each of the three rural categories as outlined in the BBA. The table also demonstrates the step-down approach to phasing out the percentage add-on in all rural areas by 2023.

Table 1: Rural Add-On Percentages by Category and Year

Rural Category	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
High utilization	1.5%	0.5%	None	None	None
All other	3.0%	2.0%	1.0%	None	None
Low population density	4.0%	3.0%	2.0%	1.0%	None

Rural add-on payments will terminate altogether after December 31, 2022. In the CY 2023 home health final rule, CMS requested comment on future approaches to health equity in the Expanded Home Health Value-Based Purchasing Model to remedy inequities in health care outcomes caused by several factors, including living in a rural area.⁹

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$109,389,663,042 in Medicare payments to HHAs for 45,417,624 claims. These claims were for home health services provided January 2016 through March 2022. We performed an analysis of service utilization by county and evaluated compliance with selected billing requirements.¹⁰

The BBA of 2018 required analysis of home health claim data to determine utilization by county and also required all home health claims to include the county code where the service was provided. We could not use the FIPS county code to conduct this analysis because the FIPS code was not required on claims until January 1, 2019, and FIPS data for claims after that date was incomplete. In addition, we could not use CBSA codes to perform an analysis by county because these codes represent geographical areas that can include more than one county. As an alternative, we used the Social Security Administration (SSA) county codes present in the claim data. Using the SSA code creates a limitation in our analysis as the SSA code indicates the State and county where the Medicare beneficiary resides, which is not always the location where the home health service was provided. We analyzed claim data from 2016 through March 2022 to provide a comparison of service utilization before and after implementation of the new rural add-on methodology.

⁹ 87 Fed. Reg. 66790, 66874-66876 (Nov. 4, 2022).

¹⁰ There are over 3,200 counties and equivalent areas in the United States and its territories. Information at this level of detail is not easily presented in a report format; therefore, we summarized service utilization by county category (e.g., urban, high utilization, low population density, and all other). We will provide a separate file in our report to Congress that details service utilization by county and equivalent area.

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 A contains the details of our scope and methodology.

FINDINGS

We determined that, during the audit period, beneficiary utilization of home health services decreased for urban counties and rural counties in the “high utilization” and “all other” categories, while utilization in the “low population density” category remained steady. We further determined that the number of home health episodes decreased for all urban and rural county categories. Many variables during the audit period may have affected utilization of services. Most notably, during calendar years 2020–2022, the Secretary of Health and Human Services (HHS) declared a public health emergency in response to the COVID-19 pandemic. The pandemic affected utilization of services and presented staffing challenges for HHAs. Therefore, we could not determine the cause of any changes in utilization of services during this period.

Lawmakers designed the new methodology to provide higher add-on percentages to rural counties in the “low population density” and “all other” categories. We determined that, during the audit period, the new methodology shifted the distribution of add-on payments from the “high utilization” category to the “low population density” and “all other” categories.

We originally planned to use FIPS data to analyze utilization from January 2016 through March 2022 but were unable to do so because the FIPS data was incomplete. This occurred because providers were not always applying the FIPS codes to claims, or the FIPS codes were invalid. Also, MACs did not always return claims with missing or invalid FIPS codes to providers for correction as required.

UTILIZATION OF HOME HEALTH SERVICES

We determined that, during the audit period, beneficiary utilization of home health services decreased noticeably for urban counties and rural counties in the “high utilization” and “all other” categories, while utilization in the “low population density” category remained steady. Specifically, from calendar year 2016 to 2021, the number of beneficiaries served decreased by more than 13 percent in urban counties, more than 20 percent in the “high utilization” rural category, and more than 10 percent in the “all other” rural category.¹¹ For the same period,

¹¹ For this measurement, we compared total beneficiaries served in each calendar year from 2016 to 2021. We did not include the claim data for 2022 as it was only 3 months of data.

the number of beneficiaries served in the “low population density” rural category increased by less than 1 percent.

We also determined that the number of home health episodes decreased noticeably for all urban and rural counties.¹² Specifically, from calendar year 2016 to 2021, the number of episodes decreased by more than 20 percent in urban counties, more than 25 percent in the “high utilization” rural category, more than 16 percent in the “all other” rural category, and more than 10 percent in the “low population density” rural category.¹³

While the changes in beneficiary utilization and number of episodes followed the pattern of change in rural add-on percentages for the “high utilization” and “all other” categories, the “low population density” category did not.

In addition to the rural add-on percentage, there are many variables during the audit period that may have impacted utilization of services. CMS adjusts payment rates for home health services annually and, during the audit period, it implemented phased reductions to the national standardized episode payment. In calendar year 2020, CMS implemented the new Patient Driven Groupings Model that changed the characteristics used to determine payment.¹⁴

Additionally, in March 2020, the Secretary of HHS declared a public health emergency in response to the COVID-19 pandemic that affected the utilization of services in all areas of health care. A recent OIG report found that home health agencies experienced many challenges to providing care during the COVID-19 pandemic, including staffing challenges.¹⁵ Insufficient staffing during the pandemic may have impacted the ability of HHAs to accept new patient referrals, which could affect beneficiary utilization of home health care. CMS stated that several factors may have contributed to the decrease in utilization, including the COVID-19 pandemic. Because of these variables, we could not determine whether the decrease in utilization of home health services was directly related to the new rural add-on methodology. To evaluate the true impact of the methodology, we would need to perform an analysis of claims outside of our audit period.

Figures 3–5 on the following page demonstrate the relationship between the rural add-on percentage and beneficiary utilization for each rural category during calendar years 2016 through 2021.

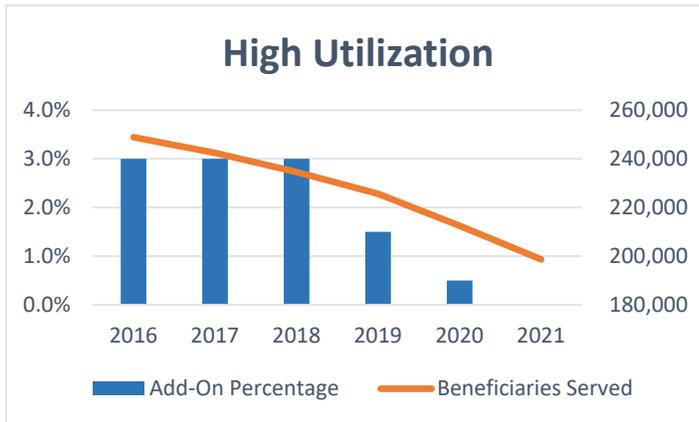
¹² For purposes of this report, we define an “episode” as a 30-day period during which home health services are provided.

¹³ For this measurement, we compared 30-day periods in each calendar year from 2016 to 2021. We did not include the claim data for 2022 as it was only 3 months of data.

¹⁴ CY 2019 HH PPS Final Rule with comment period, 83 Fed. Reg. 56406, 56446 (Nov. 13, 2018).

¹⁵ *Home Health Agencies Used Multiple Strategies To Respond to the COVID-19 Pandemic, Although Some Challenges Persist*, OEI-01-21-00110.

Figure 3: High Utilization – Add-On Percentage Compared to Beneficiaries Served



The number of beneficiaries served in high utilization rural counties dropped by approximately 50,000 over the period, a decrease of over 20 percent. During this time, the rural add-on percentage for high utilization counties decreased from 3 percent to 0 percent.

Figure 4: All Other – Add-On Percentage Compared to Beneficiaries Served

The number of beneficiaries served in all other rural counties dropped by approximately 37,000 over the period, a decrease of over 10 percent. During this time, the rural add-on percentage for all other counties decreased from 3 percent to 1 percent.

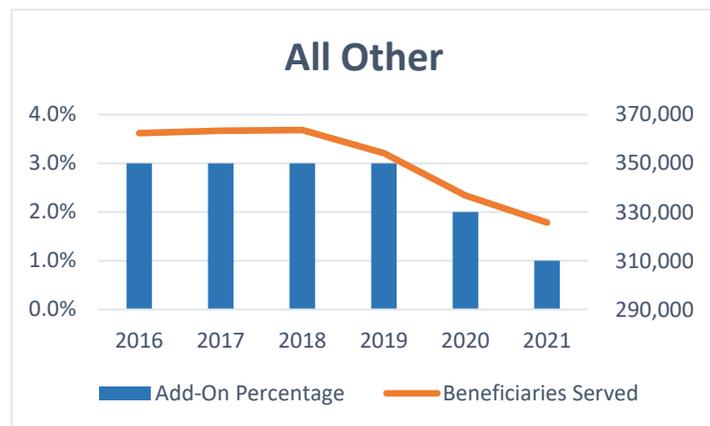
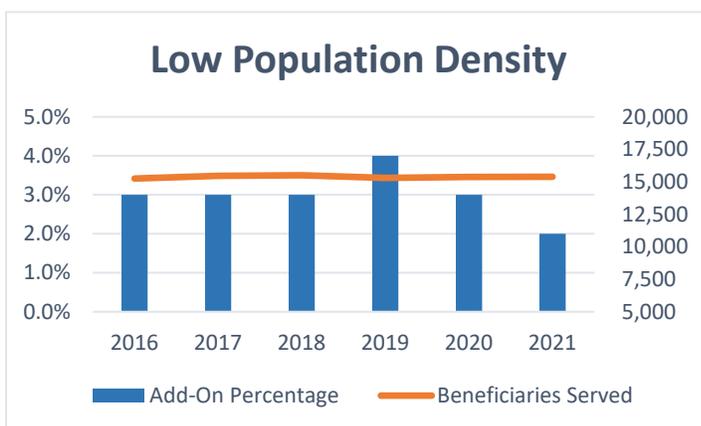


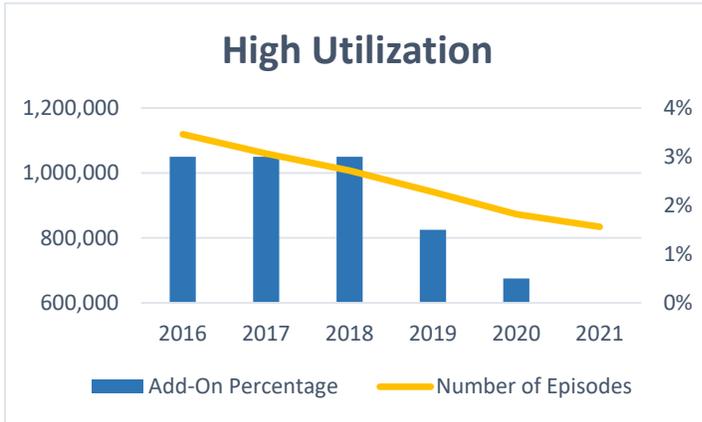
Figure 5: Low Population Density – Add-On Percentage Compared to Beneficiaries Served



The number of beneficiaries served in low population density rural counties increased by approximately 100 over the period, an increase of under 1 percent. During this time, the rural add-on percentage for low population density counties increased to 4 percent then decreased to 2 percent.

Figures 6–8 on the following pages demonstrate the relationship between the rural add-on percentage and number of home health episodes for each rural category during calendar years 2016 through 2021.

Figure 6: High Utilization – Add-On Percentage Compared to Number of Episodes



The number of episodes in high utilization rural counties dropped by approximately 285,000 over the period, a decrease of over 25 percent.¹⁶ During this time, the rural add-on percentage for high utilization counties decreased from 3 percent to 0 percent.

Figure 7: All Other – Add-On Percentage Compared to Number of Episodes

The number of episodes in all other rural counties dropped by approximately 165,000 over the period, a decrease of over 16 percent. During this time, the rural add-on percentage for all other counties decreased from 3 percent to 1 percent.

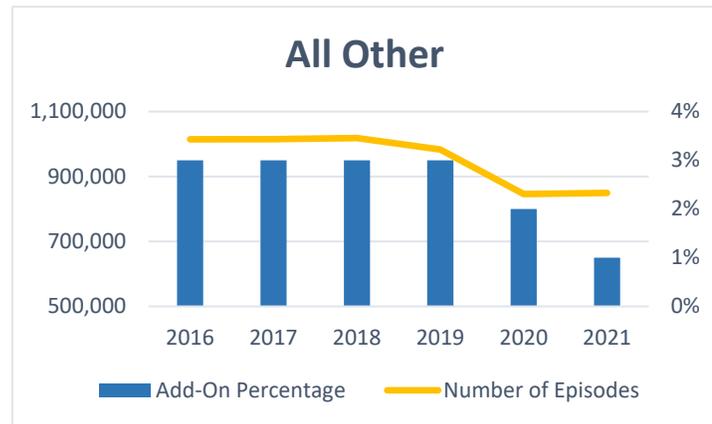
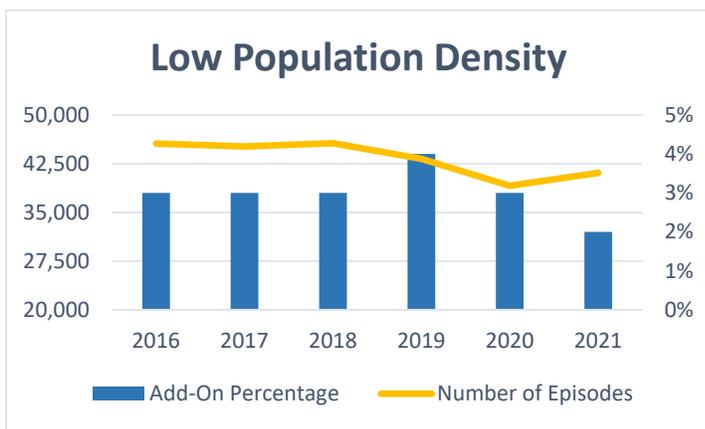


Figure 8: Low Population Density – Add-On Percentage Compared to Number of Episodes



The number of episodes in low population density rural counties decreased by approximately 4,500 over the period, a decrease of over 10 percent. During this time, the rural add-on percentage for low-population-density counties increased to 4 percent, then decreased to 2 percent.

¹⁶ Beginning in 2020, the billing period for home health services changed from a 60-day period to a 30-day period. To make the number of episodes comparable across our entire audit period, we have adjusted the claims in 2016 through 2019 to reflect the total number of 30-day periods billed. Therefore, each episode in the chart represents a 30-day billing period for home health services.

IMPACT OF NEW RURAL ADD-ON METHODOLOGY ON PAYMENT DISTRIBUTION

The development of the new rural add-on methodology came after MedPAC’s report that expressed concern over the targeting of rural add-on payments. The report stated that 77 percent of add-on payments were going to rural counties with utilization higher than the median for all counties, while just 2 percent of payments were going to counties in the lowest fifth of utilization. To demonstrate how the new methodology impacted payments, we analyzed the distribution of add-on payments between each rural category. We determined that, during the audit period, the new methodology shifted the distribution of add-on payments from the “high utilization” category to the “low population density” and “all other” categories.

Table 2, below, shows the percentage distribution of add-on payments by year for each of the three rural categories.

Table 2: Percentage of Add-on Payments by Year

	2016	2017	2018	2019	2020	2021	2022
High utilization	48%	47%	46%	29%	17%	0%	0%
All other	49%	51%	52%	67%	77%	91%	0%
Low population density	2%	2%	2%	4%	6%	9%	100%

FIPS DATA WAS INCOMPLETE

In the BBA of 2018, Congress required that OIG analyze home health claims to determine utilization of home health services by county. Congress also required that, beginning in 2019, all home health claims include the code for the county in which the service was provided. To implement this requirement, CMS instructed providers to report the FIPS county code using value code 85, defined as “County Where Service is Rendered.”

We originally planned to collect FIPS data from claims to analyze utilization of home health services by county. However, we could not use the FIPS data because some claims did not contain a FIPS code or the FIPS code was incorrect. This occurred because providers did not report FIPS codes or reported invalid FIPS codes on some claims, and CMS did not accurately configure the HH Pricer to detect and reject all claims with a missing or invalid FIPS code.¹⁷

As a result, we had to use SSA county codes associated with the beneficiary’s address, which may not be the location where the service was provided. Additionally, since 2017, SSA county codes are no longer being maintained and updated and are therefore less accurate and up to date than the FIPS codes, which continue to be maintained by the U.S. Census Bureau. Without complete FIPS data, which includes both urban and rural areas, Congress and other stakeholders may not have accurate information about home health service utilization to make decisions about future rural add-on payments.

¹⁷ CMS configured the HH Pricer to detect and reject only claims with both a rural CBSA and a missing FIPS code.

Providers Did Not Report a FIPS Code or Reported an Invalid FIPS Code on 4 Percent of Home Health Claims

During our audit, we noticed some deficiencies in the provider billing of FIPS codes. For the period January 2019 through March 2022, providers submitted 26,236,402 claims for home health services, totaling \$55 billion. We determined that providers submitted an invalid or missing FIPS code on 4 percent or 1,082,171 claims, totaling \$2.7 billion. Of those 1,082,171 claims, providers failed to report a FIPS code on 1,030,810 claims (95 percent). For the remaining 51,361 claims (5 percent), providers submitted an invalid FIPS code. Invalid FIPS codes included numbers that were too long, contained erroneous decimals, or did not match any FIPS code listed in the CMS FIPS County to CBSA Crosswalk file. In addition, we considered generic statewide FIPS codes to be invalid, as the Act requires providers to submit claims that indicate the specific county where the service was provided.

Missing and invalid FIPS codes can affect claim payment when the services are provided in rural areas. The FIPS code indicates the county where the service was provided and is used to decide the rural category, if any, that is assigned to the claim. The rural category determines the add-on percentage that is applied to the claim payment. The FIPS county code information is necessary in order to calculate the rural add-on payment.

Figure 9 shows a downward trend in annual payments for claims with missing or invalid FIPS, indicating a gradual improvement in provider submission of valid FIPS codes.

Figure 9: Annual HHA Payments for Missing and Invalid FIPS

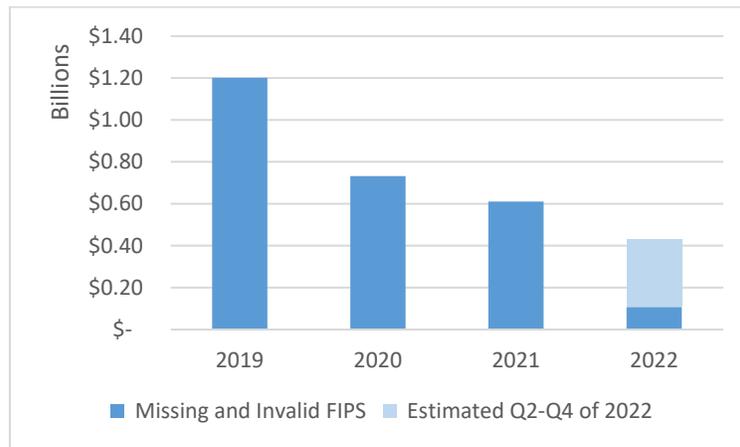
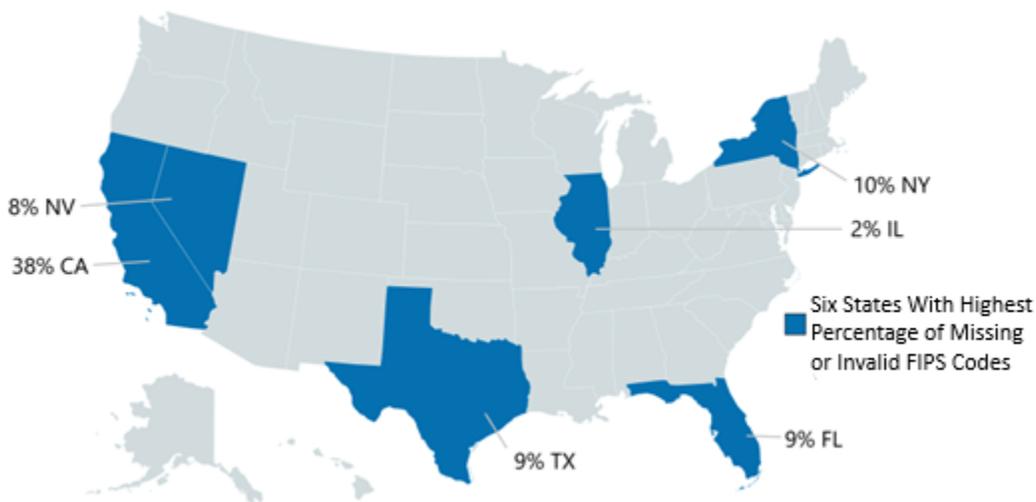


Figure 10, on the following page, indicates the six States that accounted for 76 percent of the claims submitted with invalid or missing FIPS codes.

Figure 10: Most Claims With Invalid or Missing FIPS Codes Were for Services Provided in Six States



California, New York, Texas, Florida, Nevada, and Illinois accounted for 76 percent of claims submitted with invalid or missing FIPS codes. The home health claims in these six States fall into two MAC jurisdictions. National Government Services processes claims in Jurisdiction 6, which includes California, New York, and Nevada. Palmetto GBA processes claims in Jurisdiction M, which includes Texas, Florida, and Illinois.

CMS’s HH Pricer Logic Does Not Check All Claims for Missing or Invalid FIPS Codes

The requirement to include county codes on all claims was added by section 50208(a)(2) of the BBA and codified at section 1895(c)(3) of the Act. The Act is clear that no payment shall be made for home health services unless the claim contains the code for the county in which the service was furnished. To comply with this requirement, CMS instructed HHAs to report the FIPS county code as value code 85, defined as “County Where Service is Rendered.” CMS further directed MACs to accept the FIPS code on home health claims received on or after January 1, 2019, and to return claims to providers for correction when there is a missing or invalid FIPS code. CMS has required MACs to use the reported FIPS code to determine the rural category and add-on percentage when processing claims.¹⁸ However, we determined that claims totaling \$2.7 billion were processed and paid with incorrect or missing FIPS codes.

Through discussions with CMS, we learned that the decision logic in the HH Pricer is not currently designed to check for missing FIPS codes unless the claim contains a rural CBSA. CMS acknowledged that its rules and guidance require FIPS codes to be reported on all claims. However, CMS stated that it designed the HH Pricer logic to reject only rural claims with a missing or invalid FIPS code, as those errors would affect payment. Specifically, the HH Pricer

¹⁸ CMS’s *Medicare Claims Processing Manual*, Transmittal 4190 (Change Request 10782, Dec. 31, 2018), Business Requirement numbers 10782.5 and 10782.6.

logic checks for a FIPS code when the claim contains a rural CBSA code (i.e., beginning with 999XX), and only those claims with a rural CBSA and missing FIPS code are returned to providers for correction. As a result, the FIPS data is incomplete for 4 percent of home health claims. This impacted our ability to perform the congressionally mandated analysis of service utilization by county and impedes future reviews of utilization by other stakeholders.

CONCLUSION

We determined that, during the audit period, beneficiary utilization of services decreased for urban counties and rural counties in the “high utilization” and “all other” categories while utilization in the “low population density” category remained steady. We further determined that the number of home health episodes decreased for all urban and rural county categories. Because of the many variables present during the audit period, it is difficult to determine the cause of the decrease in utilization of home health services and whether it was related to the phaseout of the rural add-on payments. To determine the true impact of this rural add-on methodology, we would need to conduct an analysis of claims beyond the scope of this audit period.

While performing the analysis of home health utilization, we determined that some providers were not billing claims in accordance with the Act and were submitting claims with invalid or missing FIPS codes. MACs were processing and paying these incorrectly billed claims instead of returning claims to providers for correction. Missing or invalid FIPS codes can have a payment effect when the claim includes services provided in a rural area. Furthermore, without complete FIPS county data, which includes both urban and rural areas, Congress and other stakeholders are unable to accurately determine home health service utilization. As a result, future decision making regarding rural add-ons could be negatively affected.

RECOMMENDATIONS

We recommend that CMS take the following steps to improve FIPS code reporting to ensure that complete data is available:

- update the HH Pricer logic to check for missing and invalid FIPS codes on all home health claims and work with MACs to ensure that these claims are returned to providers for correction and
- re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our second recommendation but did not concur with our first recommendation. CMS provided information on the actions that it has taken and plans to take to address the second recommendation and the reasons it did not concur with the first recommendation. CMS's comments are included in their entirety as Appendix B. A summary of CMS's comments and our response is below.

CMS COMMENTS

CMS concurred with our second recommendation to re-educate providers on the requirement for all home health claims to be submitted with the FIPS county code. Specifically, CMS stated that it would remind providers of the need to submit FIPS county codes on all home health claims. CMS has previously issued guidance to providers notifying them to use value code 85 to report the FIPS county code on all home health claims. CMS acknowledged that while the rural add-on payment is set to expire at the end of 2022, providers will continue to be required to submit FIPS codes on home health claims.

CMS agreed that the FIPS requirements apply to all claims, but it did not concur with our recommendation that the HH Pricer check for a FIPS code on all claims. Specifically, CMS stated, "Enforcing such an edit on all claims, and not just those claims where the rural add-on payment is impacted, may delay prompt payment for eligible home health services and would not affect the payment amount." In its comments, CMS recognized that the BBA of 2018 amended the Act to require that all home health claims contain the code for the county where the service was furnished. CMS stated that it issued guidance requiring providers to use value code 85 to report the FIPS county code on all home health claims and instructed MACs to return claims to providers when the FIPS code was missing or invalid. CMS also implemented claim processing controls through its HH Pricer to check for a FIPS code when the claim contains a rural CBSA.

OFFICE OF INSPECTOR GENERAL RESPONSE

We thank CMS for its comments and for the actions it has taken and plans to take in response to our second recommendation.

With respect to our first recommendation, we recognize that CMS designed its HH Pricer to check for a FIPS code only when a rural add-on would apply. However, we maintain that the Act requires that no payment shall be made for home health services unless the claim contains the code for the county where the service was furnished. There is no exemption to this requirement for services furnished in urban areas. Furthermore, as CMS stated in its comments, the FIPS county code requirement does not end with the expiration of the rural add-on payment at the end of 2022. Our findings show that, despite CMS's current HH Pricer logic, some claims are still being processed and paid without a FIPS code. We maintain there is

a need for more robust claim processing controls to ensure that all claims contain a valid FIPS code, as required by the Act.

We recognize that the majority of claims were submitted with a valid FIPS code. However, the claims with missing and invalid FIPS codes totaled \$2.7 billion in services that could not be categorized by county without the use of SSA county codes. Because the SSA county codes are no longer being maintained and updated, complete FIPS county data is necessary for future reviews of service utilization. Without complete FIPS data, Congress and other stakeholders may not have accurate information needed to perform analysis of service utilization and make decisions about future rural add-on payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$109,389,663,042 in Medicare payments to providers nationwide for 45,417,624 home health claims with service end dates from January 1, 2016, through March 31, 2022.

We evaluated compliance with the requirements set forth in the BBA of 2018, section 1895 of the Act, and 83 Fed. Reg. 56406 (Nov. 13, 2018).

We assessed CMS's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. Specifically, our review of internal controls focused on the control activities for processing and reviewing Medicare claims for home health services. We assessed whether CMS and MACs designed their information systems (i.e., system edits) to achieve objectives and respond to risks. We also assessed whether CMS implemented control activities through its policies. Our internal control review may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our audit from June 2020 through October 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal requirements related to rural-add on payments for home health claims,
- interviewed CMS officials regarding their policies and procedures for processing claims under the new rural add-on payment methodology,
- obtained home health claim data for our audit period,
- reviewed the claim data to determine whether providers appropriately applied FIPS codes to claims,
- analyzed the claim data to determine whether MACs used the reported FIPS code to determine rural category and add-on percentage and whether claims with missing or invalid FIPS codes were returned to providers for correction, and
- discussed the results of our audit 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: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: December 12, 2022

TO: Amy Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Chiquita Brooks-LaSure *Chiquita LaSure*
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report – Mandated Analysis of Home Health Service Utilization From January 2016 Through March 2022 (A-05-20-00031)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General’s (OIG) draft report. CMS recognizes the importance of providing people with Medicare access to medically necessary services, including home health services.

The Bipartisan Budget Act (BBA) of 2018 required the implementation of a rural add-on payment to home health payments beginning in Calendar Year (CY) 2019. Specifically, Section 50208(a) of the BBA of 2018 amended Section 421 of the Medicare Modernization Act (MMA) to increase the payment amount otherwise made under section 1895 of the Social Security Act (the Act) for Home Health (HH) services furnished in a rural area. Paragraph 50208(a)(2) of the BBA of 2018 also amended subsection 1895(c) of the Act. The section requires that in the case of home health services furnished on or after January 1, 2019, the claim contains the code for the county (or equivalent area) in which the home health service was furnished. In response to the BBA of 2018, in the CY 2019 HH Prospective Payment System (PPS) final rule,¹ CMS finalized a methodology for applying rural add-on payments for CYs 2019 through 2022. Unlike previous rural add-on payments, which were applied to all rural areas uniformly, the rural add-on extension provided varying add-on amounts depending on the rural county (or equivalent area) classification by classifying each rural county (or equivalent area) into one of three distinct categories as set forth in the BBA of 2018: (1) High Utilization, (2) Low Population Density, and (3) All Other.

In addition to language in the CY 2019 HH PPS final rule, CMS has communicated the revised policy with providers through various channels including the Medicare Learning Network (MLN) and MLN Connects weekly electronic newsletter. Specifically, CMS released two MLN Matters articles to notify providers of the requirement to report the county (or equivalent area)

¹ CMS, CY 2019 HH PPS final rule (83 FR 56406). Accessed at: <https://www.govinfo.gov/content/pkg/FR-2018-11-13/pdf/2018-24145.pdf>

and how CMS would calculate the rural add-on payment based on county of residence.² The articles explain that when home health services are provided in rural areas, a county-based rural add-on payment is applied. In order to calculate the rural add-on, value 85 and an associated Federal Information Processing Standards (FIPS) state and county code were needed. The articles also explain that home health agencies would be required to enter the FIPS state and county code where the beneficiary resides on each claim. CMS also issued claims processing guidance to the Medicare Administrative Contractors (MACs) and instructed them to return claims to providers when there was a missing or invalid FIPS code.³

OIG's recommendations and CMS' responses are below.

OIG Recommendation

OIG recommends that CMS take the following step to improve FIPS code reporting to ensure that complete data is available:

- update the HH Pricer logic to check for missing and invalid FIPS codes on all home health claims and work with MACs to ensure that these claims are returned to providers for correction and

CMS Response

CMS non-concurs with this recommendation. CMS's current HH Pricer logic was developed to ensure that home health claims are properly paid. While CMS strives to ensure accurate and complete data, CMS is cognizant of the burden on providers to submit information on claims and therefore limits claims edits to items that directly impact payment. The HH Pricer logic currently checks for a FIPS code when the claim contains a rural Core Based Statistical Area (CBSA) to ensure accurate application of rural payment rates. Enforcing such an edit on all claims, and not just those claims where the rural add-on payment is impacted, may delay prompt payment for eligible home health services and would not affect the payment amount. However, CMS plans on re-educating providers on the requirement to report the FIPS code on all claims to promote compliance with such reporting.

The Medicare Claims Processing Manual (Chapter 10, Section 40.2) states that the submission of the FIPS code is necessary where required by law or regulation. Further, in 2018, CMS issued Change Request (CR) 10782. In this CR, CMS instructed the MACs to accept value code 85 and an associated FIPS code on home health claims received on or after January 1, 2019 and to return claims to home health providers that have missing or invalid FIPS county code, for the purposes of calculating the rural add-on payment. CMS has also provided guidance to notify providers of how CMS would use value code 85 and an associated FIPS state and county code to determine a rural add-on payment.

² CMS, MLN Matters, Home Health Rural Add-on Payments Based on County of Residence, MM10782, November 16, 2018; Revised December 31, 2018, Accessed at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10782.pdf>; and CMS MLN Matters, Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2019, MM10992, November 16, 2018, Accessed at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10992.pdf>

³ CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 4106, Change Request 10782, August 3, 2018. Accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4106CP.pdf>

While the value code 85 and an associated FIPS state and county code must be reported on all home health claims, the value code and associated FIPS code is only necessary for payment in order to calculate the rural add-on payment. Therefore, CMS implemented a systems edit only for adjudicating claims for rural add-on payment purposes.

CMS believes that our instructions and guidance implement the condition of payment as required by the Act. The OIG noted in their report that 96 percent of home health claims meet the condition and there was improvement in provider submission of valid FIPS codes over the years of their study. CMS is encouraged to see this trend and as mentioned above will re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

OIG Recommendation

OIG recommends that CMS take the following step to improve FIPS code reporting to ensure that complete data is available:

- Re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided.

CMS Response

CMS concurs with this recommendation. CMS educated providers on reporting requirements, including the requirement to enter the FIPS state and county code on all home health claims, through MLN Matters Articles and MLN Connects messages. CMS will re-educate providers on the requirement for all home health claims to be submitted with the FIPS code for the county where the service was provided. Currently, the rural add-on payment is set to expire at the end of 2022; however, providers will still be required to submit FIPS codes on home health claims.