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

HHS OIG Risk Alert • March 2018 • OEI-05-16-00510

Reliance on Unverified Patient Lists Creates a Vulnerability in Home Health Surveys

Executive Summary

Home health is a program area susceptible to fraud, waste, and abuse. To ensure that home health agencies (HHAs) comply with Medicare standards, Medicare requires them to undergo onsite surveys conducted by State survey agencies or accrediting organizations prior to initial enrollment and at least once every 36 months thereafter. As part of this process, however, surveyors use HHA-supplied lists to select patients for review, prompting concern that HHAs could manipulate these lists to avoid scrutiny of certain patients.

Key Takeaway
Home health surveyors rely on lists supplied by HHAs to select patients for review, which creates a vulnerability because HHAs could conceal fraudulent activity or health and safety violations by omitting patients from those lists. Some HHA-supplied patient lists we reviewed were, in fact, missing Medicare beneficiaries, although we do not know the reasons for these omissions.

We found that some HHA-supplied patient lists in our review were missing Medicare beneficiaries, allowing them to be excluded from surveyor reviews. We also found that surveyors cannot comprehensively verify that HHA-supplied patient lists are complete at the time they conduct their surveys. However, existing data sources may be useful tools both for surveyors and the Centers for Medicare & Medicaid Services (CMS).

The Office of Inspector General (OIG) encourages CMS to explore actions to mitigate this vulnerability, including using existing data to provide better information for surveyors and conducting retrospective reviews.

Background

Medicare Home Health Benefit

The Medicare home health benefit is available to qualifying homebound individuals and covers skilled nursing care, home-based assistance, and

therapeutic services.[1] The goal is to treat illness or injury in the convenience of a patient's home, which is usually less expensive than doing so at a hospital or skilled nursing facility. In 2016, Medicare covered home health care for more than 3.4 million patients, resulting in total payments of $18.2 billion to more than 11,000 HHAs.[2]

Home Health Fraud Concerns

Home health has long been recognized by OIG and CMS 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 yielded $975 million for fiscal years 2011–2015.[3] Additionally, CMS has imposed moratoria on new HHA applications in selected geographic areas since 2013, citing a high risk of fraud, waste, and abuse.[4] While home health fraud schemes vary in nature, OIG investigations commonly find that HHAs are billing for services that are not medically necessary and/or not provided.[5] For example, in April 2016 a Dallas physician and three HHA owners were convicted for their participation in a nearly $375 million fraud scheme that included falsifying documentation to make it appear as though beneficiaries qualified for home health care and that skilled nursing services were provided.[6]

Home Health Survey Process

The home health survey process is an important safeguard to ensure that HHAs comply with Medicare standards. Onsite surveys determine whether HHAs' services meet minimum health and safety requirements, which are detailed in the Medicare Conditions of Participation.[7] HHAs may choose either to have their surveys conducted by State survey agencies on behalf of CMS, or—for a fee—by CMS-approved accrediting organizations.[8] (In this report, we refer to State survey agencies and accrediting organizations as "surveyors.") Surveyors conduct a survey prior to an HHA's initial enrollment and conduct recertification surveys at least once every 36 months thereafter. Home health surveys are unannounced, which enables surveyors to observe the conditions and care practices that are typically present at the HHA.

Patient Lists

When conducting a home health survey, surveyors choose a sample of patients to review from patient lists (supplied by the HHA) and information compiled prior to the survey. According to CMS's *State Operations Manual*, surveyors should use HHA-supplied patient lists to help choose a sample of patients.[9] Surveyors generally ask HHAs to supply patient lists, including the following:

- a roster, which is a list of all active patients at the time of the survey; and
- an admissions list, which is a list of patient admissions prior to the survey.

To help choose a patient sample, surveyors use these patient lists and information they have compiled prior to the survey, such as past complaints against the HHA and reports based on Outcome and Assessment Information Set (OASIS) data.[10] For example, if an OASIS report noted a high rate of injury caused by falls or home accidents at an HHA, the surveyor might select a patient with such an injury for review. After completion of the survey, surveyors may retain HHA-supplied patient lists, but they do not always do so.

Patient Reviews

For the patients in the sample, surveyors conduct either record reviews only or record reviews with home visits.[11] Record reviews involve examining documentation related to a patient's care. Surveyors may, for example, check whether services provided are consistent with a patient's diagnosis and plan of care. Home visits, which bring an additional level of scrutiny, involve observing how HHA staff deliver care in the patient's home, and may include patient interviews. Prior to a home visit, a HHA staff member will typically call the patient for verbal consent. Surveyors can conduct record reviews for inactive as well as active patients, whereas they conduct record reviews with home visits for active patients only.

Methodology

To complete this study, we conducted interviews on the survey process and did a retrospective comparison of HHA-supplied patient lists and Medicare claims data. In March 2017, we interviewed five State survey agencies (California, Illinois, Florida, Michigan, and Texas), the four CMS regional offices associated with those five States, the three CMS-approved accrediting organizations, and the CMS central office. We asked surveyors questions about their processes for surveying HHAs and whether they retain HHA-supplied patient lists after completing surveys. Of the eight surveyors (five survey agencies and three accrediting organizations) we interviewed, only three (survey agencies in California, Florida, and Texas) reported retaining HHA-supplied patient lists. For a selection of high-risk HHAs in these States, we collected patient lists (including rosters and admission lists, where available) from recertification surveys conducted by survey agencies in calendar years 2014–2016.[12] We ended up with patient lists for 28 surveys in our review. Using claims data, we identified the HHAs' Medicare beneficiaries who were active on the roster date. We then compared these beneficiary names against HHA-supplied rosters to identify any missing beneficiaries. In doing so, we checked additional Medicare data for potential explanations as to why active beneficiaries might be absent from rosters. We also determined whether beneficiaries who were missing from rosters were absent from available HHA-supplied admissions lists.

For further details on our methodology, see Appendix A.

Limitations

Our results are based on a selection of HHAs that is not representative, and therefore cannot be generalized to the overall population of HHAs. Additionally, our results cannot speak to whether beneficiaries were missing from rosters as a result of intentional, rather than accidental, omission.

Standards

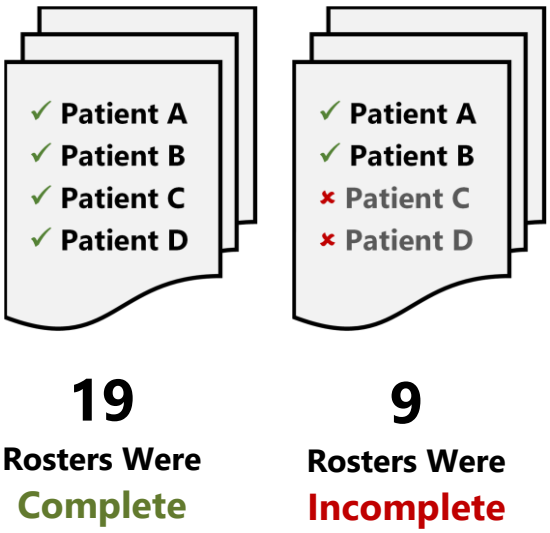
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

ANALYSIS RESULTS

Some HHAs Supplied Incomplete Lists, Allowing Patients To Be Excluded From Surveyor Reviews

Nine of the 28 HHA-supplied rosters we reviewed were incomplete. Each of these nine rosters was missing one or more Medicare beneficiaries who, per claims data, were active on the roster date. Two of the 9 rosters were missing 10 or more active beneficiaries, including 1 roster that was missing more than 150—or nearly 90 percent—of the HHA's active beneficiaries.

Exhibit 1: Results of Roster Review



Source: OIG analysis, 2017.

Because these nine rosters were incomplete, the missing beneficiaries would have been excluded from consideration for record reviews with home visits, the higher level of patient review. To select patients for this level of review, surveyors use the HHA-supplied roster of the HHA's active patients. Accordingly, any active patients missing from rosters—including the missing Medicare beneficiaries we identified—would not be considered for record reviews with home visits.[13]

One HHA was missing over 150—or nearly 90 percent—of its active beneficiaries

For two of the nine rosters, missing beneficiaries would have been excluded from consideration for review altogether. These two rosters were missing one or more beneficiaries who were also absent from HHA-supplied admissions lists. The surveyor would therefore have been unaware that those beneficiaries had ever been patients of the HHAs, and accordingly would have excluded them from consideration for both levels of review—record reviews with home visits and record reviews only.

Our analysis could not determine the reasons why beneficiaries were missing from the rosters we reviewed. There are many possible reasons why patients might be missing from HHA-supplied lists, ranging from inadvertent errors to intentional omissions aimed at avoiding surveyor

scrutiny. The likelihood of intentional omissions may be greater for the rosters in our review, however, given the high-risk nature of the HHAs we selected. Moreover, omitting patient names from rosters is not the only tactic that an HHA might use to avoid surveyor scrutiny of certain patients—see the Related Issue box below for more information.

Related Issue: One HHA may have discharged patients to avoid surveyor scrutiny

- For one of our selected HHAs, four Medicare beneficiaries were discharged on the roster date, but readmitted to the HHA later in the year.
- The beneficiaries did not have other claims that would explain the break in care, such as being admitted to a hospital, a skilled nursing facility, or another HHA between the discharge and readmission.
- These discharges may reflect an intentional effort to avoid surveyor scrutiny of the beneficiaries, rather than appropriate decisions made on the basis of clinical condition and care needs.
- In a June 2016 data brief (OEI-05-16-00031), OIG highlighted frequent discharging and readmitting of beneficiaries as a common characteristic in home health fraud cases.[14]

Surveyors Cannot Comprehensively Verify Patient Lists, but Existing Data Sources May Be Useful Tools

Surveyors are unable to verify that HHA-supplied patient lists are complete, creating a vulnerability that could be exploited by unscrupulous HHAs seeking to avoid scrutiny of certain patients. In interviews, surveyors and CMS both confirmed that patient lists cannot be comprehensively verified at the time of the survey, meaning that surveyors rely on HHAs to provide correct information. HHAs that wish to avoid scrutiny of certain patients—for example, to conceal fraudulent activity or health and safety violations—could intentionally omit those patients from the lists they supply to surveyors. While our analysis of patient lists cannot speak to the intent of the selected HHAs, the nine rosters that we found to be missing Medicare beneficiaries demonstrate that surveyors have received incomplete patient lists in past surveys.

In discussing whether and how HHA-supplied patient lists could be verified, surveyors and CMS noted two existing data sources as potentially useful tools. First, surveyors and CMS suggested that HHA-supplied patient lists could be checked against reports based on OASIS data. HHAs are required to submit OASIS data for assessments of all Medicare and Medicaid beneficiaries, and Medicare will pay home health claims only when a valid OASIS submission has been received.[15] Second, one surveyor suggested that HHA-supplied patient lists could be checked against data from home

health claims, and reported having explored the idea of using Medicaid claims data in that capacity.

While neither data source is sufficient to comprehensively verify HHA-supplied patient lists at the time of the survey (because of allowable delays in data submission), both data sources can still be useful tools for surveyors and CMS. HHAs are allowed to submit both OASIS data and home health claims within established timeframes following patient assessments and episodes of care, respectively.[16, 17] Accordingly, neither data source can be expected to reliably reflect all of an HHA's current Medicare and Medicaid beneficiaries at a given point (i.e., at the time of the survey), because the HHA may not yet have made OASIS or claims submissions for beneficiaries admitted recently. Even with this limitation, however, both data sources can still be useful tools. OASIS data should reflect most of an HHA's beneficiaries at the time of the survey (i.e., all those except recent admissions), and could thus be used to verify that most, if not all, of an HHA's beneficiaries are included on the HHA-supplied patient list. Additionally, both OASIS data and claims data could be used to comprehensively verify HHA-supplied patient lists retroactively, once all submissions have been received from the HHA.

In the absence of comprehensive verification, some surveyors noted other possible ways to limit potential HHA manipulation of patient lists. Specifically, one surveyor suggested that monitoring HHA staff as they retrieve or compile patient lists during unannounced surveys could discourage attempts to omit patients. Another surveyor suggested that direct access to HHAs' electronic health records could allow surveyors to compile patient lists themselves, thereby lessening the likelihood that HHA staff would be able to omit patients.

LOOKING AHEAD

Our review found that some patient lists from the selected HHAs were missing Medicare beneficiaries. Because surveyors cannot comprehensively verify that HHA-supplied patient lists are complete at the time of the survey, these results highlight an underlying vulnerability in the survey process that could be exploited to conceal fraudulent activity or health and safety violations. It is important to note, however, that failing to furnish records or other information to surveyors necessary to verify compliance with Medicare's Conditions of Participation may be grounds for termination from the program.[18]

While this vulnerability could undermine broader program integrity efforts in the area of home health, CMS has opportunities to mitigate the risk that the vulnerability poses. OIG has identified some potential strategies, described below, and we encourage CMS to explore the costs and benefits of these and other actions to protect Medicare and its beneficiaries.

Potential Strategies To Mitigate Risk

- Create new OASIS-based reports or adapt existing reports for surveyors

  For example, CMS could develop new OASIS-based reports (or adapt existing reports) that match the parameters of HHA-supplied patient lists, and could make those reports available to surveyors at the time of the survey.[19] While such reports would be limited by the absence of some recently admitted patients, they would represent an improvement over relying on HHA-supplied patient lists alone.

- Conduct retrospective reviews using claims data

  Additionally, CMS could conduct retrospective reviews of patient lists using OASIS data or Medicare and Medicaid claims data, similar to what we did in this study, to test for completeness. Such reviews could, for instance, identify HHAs to be investigated or approached with a higher level of scrutiny at the next survey. To facilitate these reviews, CMS would first need to ensure that surveyors retain HHA-supplied patient lists after completing their surveys.

Potential Strategies To Mitigate Risk (Continued)

- Direct surveyors to monitor HHA staff as they retrieve patient lists

  CMS could also consider directing surveyors to proactively monitor HHA staff as they generate or retrieve patient lists. CMS's *State Operations Manual* currently advises that if surveyors have suspicions or concerns about a given HHA, they should directly obtain patient consent for home visits, rather than rely on HHA staff to do so, as is the standard practice.[20] CMS could add similar language with respect to monitoring how HHAs generate or retrieve patient lists.

- Direct surveyors to confirm that patient lists include a subset of active patients

  Finally, CMS could consider directing surveyors to interview a randomly selected nurse or aide working for the HHA, so that the surveyor can obtain information about all patients whom that individual is currently treating. The surveyor could then check those patients against HHA-supplied patient lists to ensure that none are missing. CMS staff presented this strategy to OIG as one that it may explore. While the approach would not comprehensively verify HHA-supplied patient lists, we agree that it would provide greater assurance that the lists are complete.

APPENDIX A: Detailed Methodology

State Selection

We selected five States using the results of our June 2016 data brief and data from CMS's Certification and Survey Provider Enhanced Reporting (CASPER) system. We started with the 562 HHAs from the data brief that were outliers with regard to 2 or more characteristics commonly found in OIG home health fraud investigations; we consider these HHAs to be "high risk."[21] We used data from CMS's CASPER system to determine which of these 562 HHAs had received a recertification survey during calendar years (CYs) 2014–2016.[22] Finally, we grouped these HHAs by State, and purposively selected the five States with the greatest number of identified HHAs (Texas, Michigan, Florida, California, and Illinois). Please see a summary of this information in Exhibit 2.

Exhibit 2: Selected States With the Most High-Risk HHAs

State	CMS Region	High-Risk HHAs With Recertification Surveys in CYs 2014–2016		
		Surveyed by State survey agencies	Surveyed by accrediting organizations	Total
Texas	6	172	52	224
Michigan	5	19	39	58
Florida	4	9	32	41
California	9	7	14	21
Illinois	5	16	0	16

Source: OIG analysis of results from June 2016 data brief and data from CMS's CASPER system.

Interviews

We interviewed the survey agencies for the five selected States, the four associated CMS regional offices, the three accrediting organizations approved by CMS to survey HHAs, and the CMS central office. In the interviews, we inquired about surveyors' survey processes, focusing on whether and how they use HHA-supplied patient lists to identify HHA patients for review. We inquired about any tools or processes that the surveyors or CMS use to independently verify the accuracy of HHA-supplied patient lists. As part of the interviews, we also determined whether each surveyor retains HHA-supplied patient lists after completing surveys. None of the accrediting organizations and only three of the five State survey agencies (Florida, Texas, and California) reported retaining patient lists.

Patient List Comparison

We requested patient lists from completed HHA recertification surveys, ultimately including patient lists for 28 distinct surveys in our review. We selected 30 recertification surveys of high-risk HHAs that were conducted by the survey agencies in Texas, Florida, and California—the survey agencies that reported retaining HHA-supplied patient lists—in calendar years 2014–2016. Specifically, we selected 18 of the 172 surveys in Texas, 7 of the 9 surveys in Florida, and 5 of the 7 surveys in California (see Exhibit 2).[23] We also invited each survey agency to submit patient lists from up to five additional recertification surveys for HHAs that it considered to be high risk, and we received patient lists for nine additional surveys in total. We excluded three surveys from our review because they did not meet our criteria, and we excluded an additional eight surveys because we did not receive a roster.[24]

We then compared Medicare claims data to HHA-supplied rosters for the 28 surveys to identify missing Medicare patients. Using Medicare claims data, we identified HHA beneficiaries who were active on the roster date. We then checked whether those active beneficiaries appeared on the rosters. For active beneficiaries who did not appear on the rosters, we checked additional Medicare data for several potential explanations for their absence: having been admitted to or discharged from the HHA on the roster date; having been an inpatient in a hospital or skilled nursing facility on the roster date; or having died on the roster date. If an active beneficiary who did not appear on the roster did not fit into any of these categories, we considered him or her to be missing. We also checked admissions lists, where available, to see if beneficiaries who were missing from rosters were absent from these documents as well.

ACKNOWLEDGMENTS

Adam Freeman served as the team leader for this study, and Lauren Anderson served as the lead analyst. Office of Evaluation and Inspections staff who provided support include Joe Chiarenzelli, Althea Hosein, and Christine Moritz.

This report was prepared under the direction of Thomas Komaniecki, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Laura Kordish, Deputy Regional Inspector General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ENDNOTES

[1] Social Security Act, §§ 1812(a)(3), 1814(a)(2)(C), 1832(a)(2)(A), 1835(a)(2)(A) and 1861(m).
[2] OIG analysis of Medicare claims data, 2017.
[3] This total includes investigative receivables due to HHS as well as non-HHS investigative receivables (e.g., amounts due to State Medicaid programs and private health care programs).
[4] 83 Fed. Reg. 4147–4151 (January 30, 2018).
[5] OIG, *Alert: Improper Arrangements and Conduct Involving Home Health Agencies and Physicians* (June 2016). Accessed at https://oig.hhs.gov/compliance/alerts/guidance/HHA_%20Alert2016.pdf on November 22, 2016.
[6] Department of Justice, *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-rusnning-large on August 15, 2017.
[7] See 42 CFR pt. 488, subpt. I and 42 CFR pt. 484.
[8] CMS, *State Operations Manual*, ch. 2, ch. 10, and Appendix B, issued with Survey & Certification Memorandum 14-4-HHA (May 2014). Accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-14.pdf on November 9, 2016. The three accrediting organizations approved by CMS to survey HHAs are the Joint Commission, the Community Health Accreditation Program, and the Accreditation Commission for Health Care, Inc.
[9] CMS, *State Operations Manual*, Appendix B (May 2014), pp. 19–23.
[10] OASIS is a group of data elements that cover a comprehensive assessment for a home care patient and form the basis for measuring patient outcomes (CMS, *OASIS Background*. Accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Background.html on September 28, 2017). Although OASIS data submissions are required only for Medicare and Medicaid patients, any HHA patient is eligible to be included in a surveyor's patient review (CMS, *State Operations Manual*, Appendix B (May 2014), p. 19).
[11] Surveyors conduct record reviews only for half of the patients in the sample, and conduct record reviews with home visits for the other half of patients in the sample. See CMS, *State Operations Manual*, Appendix B (May 2014), p. 22.
[12] Surveyors provided us with additional types of HHA-supplied documents, including discharge lists, visit schedules, and complaint logs, which we did not include in our review.
[13] It is possible that missing beneficiaries might have been considered for review if surveyors identified them through other means, such as inclusion on an OASIS report.
[14] OIG, *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases*, OEI-05-16-00031, June 2016.
[15] See 42 CFR §§ 484.20(a) and 484.210(e).
[16] OASIS data may be submitted up to 30 days after the assessment is completed. See 42 CFR § 484.20(a).
[17] Medicare pays for home health services on the basis of 60-day episodes of care. Claims may be submitted up to one year after the end of an episode of care. See CMS, *Medicare Claims Processing Manual*, ch. 1, § 70.
[18] CMS may terminate provider agreements for refusal to permit access by CMS (or on behalf of CMS) to fiscal or other records as necessary for verification of information furnished as a basis for payment under Medicare, or for refusal to permit copying of any records or other information by CMS (or on behalf of CMS) as necessary to determine or verify compliance with participation requirements. See 42 CFR §§ 489.53(a)(5) and 489.53(a)(13).
[19] An OASIS-based "HHA Roster" report is currently available, but its parameters do not match the *State Operations Manual*'s parameters for the HHA-supplied roster. Use of this report is also not required for surveyors.
[20] CMS, *State Operations Manual*, Appendix B (May 2014), p. 27.
[21] OIG, *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases*, OEI-05-16-00031, June 2016.
[22] We chose this 3-year timeframe because recertification surveys are required every 36 months for HHAs.
[23] We purposively chose the number of surveys to select for each State, but randomly selected the specific HHAs within each State.
[24] Surveys that did not meet our criteria were conducted by accrediting organizations even though CASPER data had indicated that they were conducted by State survey agencies.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.