Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SURETY BONDS REMAIN AN UNUSED TOOL TO PROTECT MEDICARE FROM HOME HEALTH OVERPAYMENTS

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Inspector General

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OEI-03-12-00070

EXECUTIVE SUMMARY: SURETY BONDS REMAIN AN UNUSED TOOL TO PROTECT MEDICARE FROM HOME HEALTH OVERPAYMENTS
OEI-03-12-00070

WHY WE DID THIS STUDY

In January 1998, the Centers for Medicare & Medicaid Services (CMS) promulgated a final rule requiring each home health agency (HHA) to obtain a surety bond in the amount of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented after nearly 15 years. The surety bond requirement is an important program integrity tool that provides a sentinel effect of keeping fraudulent providers out of the program and a means for Medicare to guarantee recoupment of some overpayments. Not implementing this tool leaves Medicare at risk of losing millions of dollars in overpayments.

HOW WE DID THIS STUDY

We collected information from CMS on overpayments to HHAs identified from 2007 through 2011. For each year, CMS provided the total amount of debt (outstanding overpayments plus any accrued interest) still owed by HHAs as of February 29, 2012. We calculated the amount that CMS could have recovered if HHAs had each been required to obtain a $50,000 surety bond.

WHAT WE FOUND

As of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately $408 million for $590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least $39 million between 2007 and 2011 if it had required each HHA to obtain a $50,000 surety bond. Of the 2,004 HHAs, 21 percent still had overpayment amounts, excluding interest, of more than $50,000 each, and more than a quarter of these HHAs had outstanding overpayments of greater than $500,000.

WHAT WE RECOMMEND

We recommend that CMS implement the HHA surety bond requirement. To recoup a higher percentage of overpayments made to HHAs, CMS should consider increasing surety bond amounts above $50,000 for those HHAs with high overall Medicare payment amounts. CMS concurred with the recommendation.

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OBJECTIVE

To determine how much in overpayments the Centers for Medicare & Medicaid Services (CMS) could have recovered had the home health agency (HHA) surety bond requirement been implemented.

BACKGROUND

To strengthen the integrity of Medicare's home health benefit, the Balanced Budget Act (BBA) of 1997 established a surety bond requirement for HHAs. The surety bond requirement is an important program integrity tool that provides a sentinel effect of keeping fraudulent providers out of the program and a means for Medicare to guarantee recoupment of some overpayments. However, the BBA requirement remains unimplemented after nearly 15 years.

In the years since enactment of the BBA of 1997, the home health benefit has remained highly vulnerable to fraud. In recent years, numerous individuals were indicted on charges of fraudulently billing Medicare for millions in home health services. In addition, the number of HHAs and the amount of home health care expenditures have increased since 1997. Not using the surety bond as a program integrity tool leaves Medicare at risk for losing millions of dollars in overpayments to HHAs.

Medicare covers home health services for beneficiaries who need part-time or intermittent care. Home health care services include skilled nursing services, physical or occupational therapy, speech therapy, medical social services, and home health aide services.[1]

To qualify for home health services, Medicare beneficiaries must be:

- homebound (i.e., confined to the home);
- in need of home health care services on a part-time or intermittent basis; [2]
- under a physician's care; and

[1] The authority for coverage of home health services by Parts A and B is found throughout the Social Security Act. Sections 1812(a) and 1832(a) establish home health services as a benefit under, respectively, Part A and Part B. Section 1861(o) defines "home health agency" and establishes certain administrative requirements for participation in Medicare, including the submission of a surety bond. Sections 1814(a)(2) and 1835(a)(2) establish certain limits on payment for services, including the requirement that the beneficiary be homebound. Finally, section 1891 establishes the conditions of Medicare participation for home health agencies.

[2] Intermittent means skilled nursing care that is provided or needed fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less. Social Security Act, § 1861(m).

- under a plan of care established and reviewed periodically by a physician.[3]

As of 2011, a physician must also certify through a face-to-face encounter that a beneficiary needs home health services. This encounter must occur no more than 90 days before or 30 days after services begin.[4]

Home health services are covered under Part A and Part B of Medicare. Most Medicare services require beneficiary copayments; home health services do not.[5]

Growth and Vulnerabilities Related to Home Health Care

Medicare expenditures for home health services grew considerably from 1990 to 1997, increasing from $4 billion to $18 billion. During the same period, the number of HHAs nearly doubled. This growth led to concerns from Congress regarding fraud and abuse, increased spending, and inadequate oversight. In particular, concern arose that unscrupulous HHAs were being allowed to participate in Medicare. Some HHAs accumulated large overpayments that could not be recovered because the HHAs had closed or declared bankruptcy.[6]

In recent years, Medicare expenditures and the number of HHAs have grown to levels exceeding the highs they reached in 1997. In 2009, Medicare paid $19.3 billion for home health care, and in 2010, the number of HHAs reached 11,488.[7, 8]

CMS continues to cite home health care as an area "highly vulnerable to waste, fraud, and abuse."[9] To address this vulnerability, CMS has established new enrollment requirements for moderate- and high-risk providers and has also established payment caps.[10] However, the recent

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[3] Social Security Act, §§ 1814(a)(2)(C) and 1835(a)(2)(A).

[4] *Medicare Benefit Policy Manual* (MBPM), Pub. 100-02, ch. 7 § 30.5.1.1.

[5] Social Security Act § 1813 and 1833 and MBPM, Pub. 100-02, ch.7, § 60.3.

[6] General Accounting Office (now the Government Accountability Office) (GAO), *Medicare Home Health Agencies: Overpayments Are Hard To Identify and Even Harder to Collect*, GAO/HEHS/AIMD-00-132, April 2000.

[7] Medicare Payment Advisory Committee (MedPAC), *Home Health Care Services Payment System*, October 2011. Accessed at http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_HHA.pdf on June 22, 2012.

[8] MedPAC, *Report to the Congress: Medicare Payment Policy*, ch. 8, March 2011. Accessed at http://www.medpac.gov/chapters/Mar11_Ch08.pdf on June 22, 2012 .

[9] *Reducing Fraud, Waste, and Abuse in Medicare: Hearing Before the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, Subcommittee on Oversight*, 112 Cong. (2011) (Statement of Kimberly Brandt, Director, Program Integrity Group, Office of Financial Management, CMS, U.S. Department of Health and Human Services).

[10] 42 CFR § 424.518.

indictments of numerous individuals for fraudulently billing Medicare for home health services illustrate the need for additional oversight of the HHA benefit. For instance, a Texas physician was indicted in February 2012 for allegedly certifying beneficiaries' plans of care so that HHAs were able to bill Medicare for home health services that were not medically necessary and not provided. This physician also allegedly performed unnecessary home visits and ordered unnecessary medical services. This is the largest home health fraud indictment in U.S. history, involving more than $350 million in allegedly fraudulent Medicare payments.[11]

Collection of Overpayments

Medicare Administrative Contractors (MAC) are responsible for processing claims for home health services. Overpayments may be identified by MACs or other Medicare contractors, such as Zone Program Integrity Contractors. The recovery of overpayments is part of the MACs' claims processing responsibilities. Overpayments may be recovered through methods such as the establishment of a repayment plan, reduction of Medicare payments by the amount owed, or suspension of payments.

Surety bonds are a method for recovering outstanding overpayments when established methods are unsuccessful. A surety bond is issued by a company, known as a surety, guaranteeing that the bond purchaser will fulfill its financial obligation to Medicare. The surety bond guarantees that the surety will pay CMS the amount of any overpayments, civil monetary penalties, or assessments, plus accrued interest, for which the purchaser (e.g., an HHA) is responsible, up to the surety's maximum obligation.[12] Surety bonds have been a condition of enrollment for certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) since 2009.[13]

Use of Surety Bonds to Limit Medicare Vulnerability

To address concerns created by growth in home health care, the BBA of 1997 amended the Social Security Act to require HHAs to obtain surety bonds.[14] To implement the BBA requirement, CMS promulgated a final rule on January 5, 1998, requiring each HHA to obtain a surety bond that

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[11] Department of Justice, *Justice News: Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme*, February 28, 2012. Accessed at http://www.justice.gov/opa/pr/2012/February/12-crm-260.html on June 22, 2012.

[12] 42 CFR § 489.66(a).

[13] 42 CFR § 424.57(d)(1).

[14] BBA of 1997, § 4312(b), amending the Social Security Act, § 1861(o).

is the greater of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare.[15]

Certain members of Congress objected to some provisions of CMS's surety bond rule, such as the requirement that some HHAs obtain bonds equal to 15 percent of the amount paid to the HHA by Medicare. Members of Congress also objected to requirements that all HHAs—not just new ones—obtain bonds and that HHAs must obtain bonds every year. A joint resolution expressing disapproval of CMS's rule was ultimately introduced in the Senate and House. Although the resolution was never voted upon, in July 1998, CMS indefinitely postponed the implementation dates for HHAs to comply with the surety bond requirement.[16]

GAO issued a report in January 1999 concluding that a surety bond requirement would increase scrutiny of HHAs entering Medicare and provide them with incentives to avoid overpayments. GAO recommended that CMS revise the original regulation so that each HHA, regardless of its total payments from Medicare, would be required to obtain a $50,000 surety bond. Although CMS agreed with this recommendation, the HHA surety bond requirement has remained unimplemented.

The Patient Protection and Affordable Care Act (ACA) of 2010 adds language to the Social Security Act stating that the amount of the surety bond can be set based on the HHA's billing volume.[17] In 2011, CMS staff testified before Congress that the agency would issue additional surety bond requirements established under the ACA for home health agencies.[18] However, CMS has not yet done so.

CMS is drafting a proposed rule that, among other topics, addresses the issue of surety bonds for HHAs. As of July 2012, the agency does not have an estimate as to when this proposed rule will be completed.

Related Office of Inspector General Work

The Office of Inspector General (OIG) has issued reports identifying vulnerabilities in the home health care benefit and weaknesses in CMS's use of surety bonds to recover overpayments from DMEPOS suppliers.

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[15] 42 CFR § 489.65, 63 Fed. Reg. 292 (Jan. 5, 1998).

[16] 63 Fed. Reg. 41170 (July 31, 1998).

[17] ACA § 6402(g), amending the Social Security Act, § 1861(o).

[18] *New Tools for Curbing Waste and Fraud in Medicare and Medicaid: Hearing Before the U.S. Senate Committee on Homeland Security and Governmental Affairs*, 112 Cong. (2011) (Statement of Peter Budetti, Deputy Administrator and Director, Center for Program Integrity, CMS, U.S. Department of Health and Human Services).

A 2006 report found that improperly coded claims for home health services led to $48 million in overpayments. CMS had not established the controls needed to code claims correctly. OIG recommended that CMS establish needed controls and recover these overpayments.[19]

In a 2009 report, OIG found aberrant outlier payments to HHAs in Miami-Dade County, Florida, and 23 other counties nationwide, indicating that home health is an area vulnerable to fraud. The report recommended strengthening enrollment standards for HHAs to prevent illegitimate agencies from obtaining Medicare billing privileges.[20]

In a September 2011 memorandum report, OIG found that CMS did not have finalized procedures for recovering DMEPOS overpayments through surety bonds. In addition, as of July 2011, no overpayments had been recovered through surety bonds since the surety bond requirement became effective for all DMEPOS suppliers in October 2009.[21]

In 2012, OIG reviewed home health medical records for a sample of 495 beneficiaries to determine whether Medicare coverage requirements were met. OIG found that HHAs submitted 22 percent of claims in error in 2008 because services were unnecessary or claims were coded inaccurately, resulting in $432 million in improper payments.[22]

OIG has also collaborated with the Department of Justice on a number of investigations of fraudulent home health providers. In one case, a provider pleaded guilty to falsifying patient records and billing Medicare for unneeded services. The provider paid cash kickbacks to a doctor for referring patients to the provider for services.[23] In another case, a provider fraudulently billed $20 million to Medicare by falsifying patient records and paying kickbacks to patient recruiters.[24]

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[19] OIG, *Review of Home Health Agencies' Billing for Services Preceded by a Hospital Discharge*, A-01-04-00527, March 2006.

[20] OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, December 2009.

[21] OIG, *Use of Surety Bonds to Recover Overpayments Made to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies: Early Findings*, OEI-03-11-00351, September 2011.

[22] OIG, *Documentation of Coverage Requirements for Medicare Home Health Claims*, OEI-01-08-00390, March 2012.

[23] Department of Justice, *Home Health Care Administrator Pleads Guilty to Federal Healthcare Fraud and Scheme*, April 20, 2012. Accessed at http://www.justice.gov/usao/iln/pr/rockford/2012/pr0420_01.pdf on April 23, 2012.

[24] Department of Justice, *Two Owners and Two Employees of Miami Home Health Company Plead Guilty in $20 Million Health Care Fraud Scheme*, April 2, 2012. Accessed at http://www.justice.gov/opa/pr/2012/April/12-crm-420.html on April 23, 2012.

METHODOLOGY

Data Collection and Analysis

We collected information from CMS on HHA overpayments identified from 2007 through 2011 that were still outstanding as of February 29, 2012. For each calendar year and for each HHA, CMS provided the total amount of overpayments identified, the total amount of any current outstanding overpayments, and the total amount of debt (i.e., outstanding overpayments plus accrued interest) as of February 29, 2012.

We calculated the amount that CMS could have recovered—based on the amount of each HHA's debt—if each HHA had been required to obtain a $50,000 surety bond. For those HHAs that owed less than $50,000 in a given year, we used the debt amount (outstanding overpayments plus accrued interest) as the amount CMS could have recovered from the HHA.

For those HHAs that owed $50,000 or more, we used $50,000—the base amount for a surety bond—as the amount that CMS could have recovered. Had we instead used a recovery amount equal to 15 percent of an HHA's annual payments from Medicare, the total estimate of potential recoveries would have been greater. For that reason, our estimate of potential recoveries is a conservative one.

We also determined the number of HHAs with outstanding overpayments (not including accrued interest) greater than $50,000 and calculated the amount of outstanding overpayments.

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.

FINDINGS

CMS could have recovered at least $39 million between 2007 and 2011 if it had required HHAs to obtain $50,000 surety bonds

As of February 29, 2012, 2,004 HHAs still owed CMS a total of approximately $408 million for $590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. Of these HHAs, 198 had overpayments identified in multiple years. Table 1 provides the amount of overpayments CMS identified for each year from 2007 through 2011 as well as potential recoveries. If CMS had required each HHA to obtain a $50,000 surety bond, the agency could have potentially recovered a minimum of $39 million.

Table 1: Potential Recoveries if HHAs With Overpayment Debt Had a $50,000 Surety Bond

Year	Number of HHAs	Total Overpayments	Total Outstanding Overpayments	Total Accrued Interest	Total Debt[1] (Amount Owed to CMS)	Potential Recoveries if Each HHA Had a $50,000 Surety Bond
2007	1,087	$102,584,189	$34,604,552	$15,345,161	$49,949,713	$17,526,563
2008	118	$48,338,042	$28,533,239	$8,594,117	$37,127,357	$2,435,444
2009	161	$91,177,813	$55,989,749	$10,036,756	$66,026,505	$4,220,852
2010	217	$149,449,406	$116,028,090	$12,299,595	$128,327,685	$5,760,193
2011	421	$198,351,973	$119,190,213	$7,001,053	$126,191,266	$9,160,602
Total	**2,004**	**$589,901,423**	**$354,345,843**	**$53,276,682**	**$407,622,526**	**$39,103,654**

Source: OIG analysis of CMS overpayment data, 2012.
[1] As of February 29, 2012.

Twenty-one percent of HHAs had outstanding overpayment amounts, excluding interest, of more than $50,000

Four hundred fourteen HHAs each had outstanding overpayment amounts (excluding accrued interest) of more than $50,000 in at least 1 year. Thirty-four HHAs each had outstanding overpayments of more than $50,000 for multiple years. As shown in Table 2, the 414 HHAs had outstanding overpayments totaling $341 million.[25] If each of these 414 HHAs had a surety bond of $50,000, CMS would have recovered

[25] With the addition of accrued interest, these HHAs owed a total of $388 million to CMS.

$21 million, which is only 6 percent of the $341 million outstanding overpayment amount.

Table 2: Outstanding Overpayments for HHAs

Year	Number of HHAs With $50,000 or Less in Outstanding Overpayments	Total Outstanding Overpayments	Number of HHAs With More Than $50,000 in Outstanding Overpayments	Total Outstanding Overpayments
2007	975	$8,071,071	112	$26,533,481
2008	89	$743,732	29	$27,789,508
2009	100	$932,882	61	$55,056,867
2010	131	$1,223,020	86	$114,805,071
2011	295	$2,746,598	126	$116,443,615
Total	**1,590**	**$13,717,303**	**414**	**$340,628,542**

Source: OIG analysis of CMS overpayment data, 2012.

Many of these HHAs (281 of 414) had outstanding overpayment amounts of more than twice the standard surety bond amount of $50,000. Within this group, 130 HHAs had outstanding overpayments of over $500,000.

For the 414 HHAs, the lowest amount owed in a single year was $52,881 and the highest amount owed was $16,360,555. The average debt was $937,337 and the median debt was $217,822.

CMS's final rule on the surety bond requirement stated that HHAs were to obtain a surety bond that is the greater of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare. For an HHA to be required to obtain a surety bond greater than $50,000, its annual Medicare payments would need to be greater than $333,333. Between 2007 and 2011, 144 HHAs had outstanding overpayments alone totaling more than $333,333.[26] The total amount of outstanding overpayments for these HHAs is $306 million. As of February 29, 2012, these HHAs owed a total of $344 million (outstanding overpayments plus accrued interest).

[26] An overpayment may not have necessarily occurred in the same year it was identified.

CONCLUSION AND RECOMMENDATION

The BBA of 1997 mandated the use of surety bonds for HHAs to strengthen program integrity over home health services. In 1999, GAO concluded that a surety bond requirement would increase scrutiny of HHAs entering Medicare and provide them with incentives to return overpayments. However, the HHA surety bond requirement remains unimplemented and home health expenditures and the number of HHAs in Medicare have increased.

Medicare continues to lose millions of dollars in outstanding HHA overpayments. From 2007 through 2011, CMS identified $590 million in HHA overpayments that were still outstanding as of February 29, 2012. The total debt still owed to Medicare was approximately $408 million. In addition, 21 percent of HHAs had outstanding overpayment amounts (excluding accrued interest) of more than $50,000 in at least 1 year.

In the past, OIG has conducted work on CMS's tracking and collection of overpayments, identifying vulnerabilities that highlight the need for CMS to be more effective in its recoupment efforts. The surety bond requirement is not the only tool that CMS can use to protect the program from vulnerabilities in the home health benefit. However, requiring the use of surety bonds would discourage fraudulent HHAs' entry into the program and guarantee CMS's ability to recoup some portion of overpayments.

We recommend that CMS:

Implement the HHA Surety Bond Requirement

CMS suspended its implementation of the surety bond requirement in 1998. CMS should promulgate a new implementation date for the existing regulations or promulgate new regulations that implement the statutory requirement for HHAs to obtain surety bonds. The regulation published in 1998 required HHAs to obtain a surety bond that is the greater of $50,000 or 15 percent of the annual amount paid to the HHA by Medicare. We found that many of the HHAs with outstanding overpayments each owed more than twice the $50,000 surety bond amount.

The ACA further amended the surety bond requirement by allowing CMS to establish the surety bond amount based on the HHA's billing volume. To provide CMS with the ability to recoup a higher percentage of overpayments made to HHAs, CMS should consider increasing surety bond amounts above $50,000 for those HHAs with high overall Medicare payment amounts.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred that implementing a surety bond requirement for HHAs may help reduce potential payment vulnerabilities. It stated that it is evaluating its options in implementing this requirement.

The full text of CMS's comments is provided in Appendix A.

APPENDIX A

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 2 2 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments" (OEI-03-12-00070)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the OIG draft report entitled, "Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments."

To strengthen the integrity of Medicare's home health benefit, the Balanced Budget Act of 1997 established a surety bond requirement for home health agencies (HHA) enrolling in Medicare. Requiring surety bonds is an important program integrity tool that not only helps to keep fraudulent providers out of the program, but also provides a means for Medicare to guarantee recoupment of some overpayments.

The Affordable Care Act further strengthens CMS's ability to address fraud in higher risk entities such as HHAs and provides CMS with important new tools to combat fraud and abuse, including enhanced provider and supplier screening requirements, authority to suspend payments pending investigations of credible allegations of fraud and, when necessary, the authority to impose moratoria on new providers and suppliers. One such tool CMS implemented was a face-to-face encounter requirement as a condition of payment for Medicare home health services. In addition, the Affordable Care Act expands CMS's authority to require surety bonds.

The Affordable Care Act amended the existing home health surety bond requirement at section 1861(o)(7)(C) of the Social Security Act to require a bond amount that is commensurate with the volume of the HHA's billing. Given the agency's prior experience with a surety bond requirement, which as described in the report was met with significant resistance, CMS is carefully evaluating the best way to implement a HHA surety bond. Whereas CMS is clearly committed to identifying and preventing fraud and improper payments, CMS is also mindful of the impact that our initiatives have on legitimate providers and suppliers, particularly smaller entities.

The CMS agrees that home health care is an important area on which to focus a variety of oversight and intervention initiatives. In fact, CMS and law enforcement have concentrated on this area extensively. CMS's program integrity contractors, in collaboration with OIG, have pursued numerous administrative actions, including revocations of billing privileges and payment suspensions. In February 2012, CMS announced the suspension of payments to 78 HHAs involved in an alleged fraud scheme in Dallas that was part of the February 28, 2012, Health Care Prevention Action Team Strike Force takedown.

We appreciate OIG's efforts in working with CMS to help ensure that HHAs do not continue to be vulnerable to abuse. Our response to the OIG recommendation follows.

OIG Recommendation

The CMS should implement the HHA surety bond requirement.

CMS Response

The CMS concurs that implementing a surety bond requirement for HHAs may help reduce potential program vulnerabilities. CMS is currently evaluating its options in implementing this requirement.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General.

Tanaz Dutia served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Philadelphia regional office who conducted the study include Nancy Molyneaux and Russell Tisinger. Central office staff who provided support include Scott Manley and Christine Moritz.

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