OIG Targets Home Health Improper Payments, EVV, Consumer-Directed Programs in Ongoing Watchdog Initiatives

By **Robert Holly** | April 12, 2024

In past years, Medicare-certified home health agencies and Medicaid personal care services providers have been big focus areas for government watchdogs.

While there's still plenty of oversight, the spotlight on home health and personal care providers appears to have dimmed somewhat. Instead of focusing on home health and personal care, watchdogs are increasingly targeting hospices, nursing homes and other areas.

The active work plan for the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) reflects this idea.

Publicly available online, the active work plan reflects OIG audits, evaluations and inspections that are underway or planned. As of March 2024, there were 241 items listed on OIG's active to-do list.

Of those 241 items, just five – or less than 3% of the total list – involve home health, personal care or related services, such as consumer-direct programs, according to a Home Health Care News review of the active work plan.

Among those efforts is a look at state electronic visit verification (EVV) policies and implementations for personal care and home health services. The 21st Century Cures Act mandated EVV for personal care by Jan. 1, 2020, and for home health by Jan. 1, 2023, with extensions given for the vast majority of states.

“Once implemented, EVV could increase the risk that Medicaid beneficiaries’ needs are not being met, potentially compromising their health and safety,” OIG’s work plan states.

Specifically, OIG is reviewing EVV progress in accordance with federal and state requirements, along with any developed policies and procedures for ensuring Medicaid beneficiaries receive their qualified in-home care services.

Despite significant reductions over the past decade, home health improper payment rates remain a focus for OIG as well.

In 2014, the improper payment error rate for home health claims was 51.4%, according to U.S. Centers for Medicare & Medicaid Services (CMS) data. That error rate was tied to about $9.4 billion in claims.

By 2021, however, the error rate had plummeted to 10.2%, with an estimated $1.84 billion in improper payments.

OIG in its active work plan said it’s more focused on individual home health agencies (HHAs) with a history of questionable claims.

“Recent OIG reports have similarly disclosed high error rates at individual HHAs,” the work plan explains. “Improper payments identified in these OIG reports consisted primarily of beneficiaries who were not homebound or who did not require skilled services. We will review compliance with various aspects of the home health prospective payment system and include medical review of the documentation required in support of the claims paid by Medicare.”

Another area of focus for OIG is Medicaid consumer-directed personal assistance programs.

Generally, consumer-directed programs provide an alternative way of receiving home care services, giving consumers more control over who

provides their care and how it is provided. Instead of working with a home care provider, the consumer, or the family member, friend, or guardian directing care, performs caregiving functions usually done by an agency.

Previous audits and investigations have found vulnerabilities in consumer-directed personal care programs. In some cases, individuals are reimbursed for furnishing services that are never rendered. In others, a consumer shouldn't have been eligible for the program in the first place.

"Let's say you hire your niece and your niece doesn't show up," Bill Hammond, a senior fellow for public policy at Empire Center, previously told HHCN. "Are you going to rat her out? Are you going to call the state and say, 'Don't pay my niece this week because she didn't show up?' In fact, your niece and you may have an agreement that she's not going to show up ever."

OIG's work plan says the watchdog is working to determine whether selected states made Medicaid payments for consumer-directed personal assistance program claims in accordance with applicable federal and state regulations.

Medicare's acute- and post-acute-care transfer policies are yet another focus area for OIG.

Effectively, Medicare pays hospitals a per diem rate for early discharges when beneficiaries are transferred to another prospective payment system hospital or to post-acute-care settings, including home health care. This is based on the presumption that hospitals should not receive full payments for beneficiaries discharged early and then admitted for additional care in other clinical settings.

Past OIG reviews found several instances where Medicare payments to hospitals did not comply with Medicare's post-acute-care transfer policy.

"Under the acute- and post-acute transfer policies, these hospital inpatient stays should have been paid a reduced amount," the work plan notes. "Additionally, we will assess the transfer policies to determine if they are adequately preventing cost shifting across health care settings."

In comparison to the relatively few mentions of "home health," the term "nursing home" comes up dozens of times in OIG's active work plan.