

# HHS Fact Sheet

U.S. Department of Health and Human Services



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Tuesday, July 17, 2007

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## **Medicare Provider Enrollment Home Health Agency Demonstration in High-Risk Areas**

On July 17, 2007, the U.S. Department of Health and Human Services announced plans to implement a two-year demonstration project that involves the enrollment of home health agencies (HHAs) into the Medicare program. The goal of the project is to strengthen the ability of the Centers for Medicare & Medicaid Services (CMS) to detect and prevent fraudulent activity and will focus on HHA providers in Harris County, Texas, and four counties in California: Los Angeles, Orange, Riverside, and San Bernardino.

### ***Background***

The fraudulent business practices of unscrupulous HHAs continue to cost the Medicare program billions of dollars nationwide. Within the last 12 months, CMS, the HHS Office of Inspector General (OIG) and the U.S. Department of Justice have identified and documented a significant number of problems involving HHAs in Harris County and the four California counties identified above.

### **Los Angeles, Orange, Riverside, and San Bernardino Counties in California**

As of May 2007, in the State of California, there were a total of 668 HHAs. In Los Angeles County, there were approximately 348 HHAs, 26 in Orange County, 28 in Riverside County, and 40 in San Bernardino County. With 66 percent of the state's HHAs located in this four-county area and almost \$1.9 billion in claims submitted by California HHAs in fiscal year (FY) 2006, HHAs in the Los Angeles area billed Medicare for approximately \$1.15 billion in FY 2006. Based upon these dollar values, it is particularly imperative that claims are only paid to qualified HHAs. The problem is magnified when considering that the number of HHAs in California has jumped by well over 50 percent since October, 2002, when there were 409 HHAs enrolled in the state. Moreover, there has been a marked increase in HHA billings to Medicare, both in California in general and the Los Angeles area in particular. As the chart below shows, billings between FY 2003 and FY 2006 rose by almost 62 percent in Los Angeles County, almost 61 percent in Riverside and San Bernardino Counties (combined), and by 19 percent in the State of California.

	<b>FY 2003</b>	<b>FY 2004</b>	<b>FY 2005</b>	<b>FY 2006</b>	<b>FY 2007 *</b>
California	\$1,520,240,440	\$1,598,532,220	\$1,654,121,121	\$1,877,370,508	\$410,537,489
Los Angeles County	\$569,555,731	\$703,526,768	\$783,268,484	\$921,414,346	\$195,495,102
Orange County	\$64,510,692	\$66,841,659	\$67,295,912	\$65,372,211	\$14,296,842
Riverside/San Bernardino Counties **	\$95,605,745	\$116,017,555	\$128,033,238	\$157,562,922	\$36,707,963
<p>* The figures for FY 2007 are as of March 31, 2007.  ** The dollar amounts for Riverside and San Bernardino Counties are combined.</p>					

Harris County, Texas

The chart below shows that the number of HHAs in Texas has doubled in the past four years, while the number of HHAs in Harris County has increased by 150 percent during this same period. These figures are not consistent with the associated changes in the beneficiary population or the recorded demand for HHA services in Texas or Harris County. This raises questions regarding the proliferation of HHAs in these two jurisdictions.

With respect to Harris County and the State of Texas as a whole, consider the following statistics:

	<b># HHAs FY 2003</b>	<b># HHAs FY 2004</b>	<b># HHAs FY 2005</b>	<b># HHAs FY 2006</b>	<b># HHAs FY 2007</b>
Harris County	151	195	248	303	372
State of Texas	859	1,019	1,191	1,405	1,731

Note: The numbers of HHAs denoted on this chart are as of the first day (October 1) of each fiscal year.

As of May 9, 2007, there were 403 HHAs in Harris County and 1,766 HHAs in Texas.

The rapid and unexplained increases in the number of HHAs in California and Texas makes the aforementioned counties appropriate locales in which to focus this demonstration.

### ***The Demonstration***

Section 402(a)(1)(J), 42 U.S.C. § 1395b-1(a)(1)(J), of the Social Security Amendments of 1967 permits the Secretary to “develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.” Pursuant to this authority, therefore, CMS will implement the above-referenced demonstration project, which CMS believes will assist in developing and demonstrating improved methods for the investigation and prosecution of fraud occurring among HHAs.

There are four major components to this demonstration:

1. **Immediate submission of CMS-855A application** -- Each HHA in the five aforementioned counties (the “demonstration locales”) will be required to submit a CMS-855A Medicare enrollment application to the applicable Medicare contractor within 60 days after the contractor requests such data.
2. **Revocation of billing privileges** - - Under this demonstration, an HHA’s Medicare billing privileges will be revoked in the following circumstances:
  - The HHA failed to submit a CMS-855A application within the aforementioned 60-day timeframe.
  - The HHA failed to report a change of ownership or address change within 30 days.
  - The HHA has an owner, partner, director, or managing employee that has had a felony conviction within the last 10 years.
  - The HHA no longer meets the HHA conditions of participation or any other requirement for enrollment as an HHA.

If the provider’s billing privileges are revoked, CMS will implement recoupment measures.

3. **State Surveys** – The applicable State agency will conduct a survey of any HHA that has changed ownership within the last two years.
4. **Onsite Reviews** - As part of the Medicare contractor’s review of the updated provider enrollment applications, the contractor will conduct an onsite review of each HHA in the demonstration locales to determine if the HHA is located at the address identified on the provider’s CMS-855A application.

### ***Evaluation***

CMS will evaluate the effectiveness of this demonstration project by analyzing the degree to which HHAs within the demonstration locales are in compliance with the enhanced enrollment requirements for HHAs as well as existing enrollment procedures. The demonstration will analyze data relating to these HHAs for the past five years and compare it to data gathered during the demonstration period. The following criteria will be used:

- The total number of revocations;
- The percentage of reviewed HHA providers whose billing privileges were revoked;
- The state survey results on HHA providers that had changed ownership within the past two years; and
- The average length of time it takes for the Medicare contractor to review enrollment applications.

Moreover, CMS will determine if the enrollment process utilized in the demonstration could and should be implemented in other parts of the country as a means of deterring fraudulent conduct.

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