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HHS Agency Financial Report Provides Insight Into "Improper" Payments

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The Department of Health and Human Services (HHS) recently issued its 2021 Agency Financial Report (AFR), summarizing HHS' fiscal and high-level program results to allow assessment of the agency's performance over the prior fiscal year. HHS continues to focus on reducing "improper" payments and expanding its arsenal of tools to try to address areas it deems high risk.

Section 3 of the AFR contains a "Payment Integrity Report," which discusses in detail HHS' efforts to ensure payment accuracy and to prevent, detect, and reduce improper payments. Specifically, the agency identified what it considers its "risk susceptible" programs, with Medicare Fee-For-Service (FFS), Medicare Part C and Medicare Part D as the first three identified on the list. This article focuses on the Medicare Part A and Part B analysis.

HHS used the Comprehensive Error Rate Testing (CERT) program to "estimate" Medicare FFS improper payments for claims submitted during the fiscal year (FY) 2021 report period (claims submitted from July 1, 2019, through June 30, 2020). The CERT program sampled the following categories:

- Home health, Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and hospice claims
- Part A hospital IPPS claims
- Part B claims including physician, laboratory, and ambulance services, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

HHS sampled approximately 42,000 Part A and Part B claims during the FY 2021 report period. The agency acknowledged that, due to COVID-19, the CERT program stopped requesting medical documentation from providers and supplier for four months during the FY 2021 report period. Based on this sample, HHS concluded that the Medicare fee-for-service program properly paid an estimated 93.74 percent of total outlays or $374.74 billion in FY 2021.

The "improper" payment estimate for FY 2021 was 6.26 percent of total outlays or $25.03 billion. The "improper" payment estimate, due to lacking or insufficient documentation, was 4.32 percent or $17.26 billion, representing 68.95 percent of the total improper payments. The AFR specifically highlighted improper payments for hospital outpatient, SNF, home health, and hospice claims, commenting that these claims "were major contributing factors to the FY 2021 Medicare FFS estimate, comprising 38.34 percent of the overall estimate." According to HHS, the primary causes for improper payments "continue to be insufficient documentation and medical necessity errors."

The AFR identified, in part, the following results.

- Hospital outpatient: The improper payment estimate increased from 4.02 percent in FY 2020 to 4.57 percent in FY 2021. The primary reason cited for these errors was missing documentation to support

the order, or the intent to order for certain services.

- SNF: The improper payment estimate for SNF claims increased from 5.43 percent in FY 2020 to 7.79 percent in FY 2021. The primary reason cited for these errors was missing or insufficient documentation to support certification or recertification.

- Home Health: The improper payment estimate for home health claims increased from 9.30 percent in FY 2020 to 10.24 percent in FY 2021. The primary reason cited for these errors was missing or insufficient documentation to support the certification of home health eligibility requirements.

- Hospice: The improper estimate for hospice claims increased from 6.69 percent in FY 2020 to 7.7 percent in FY 2021. The primary reason for these errors was missing or insufficient documentation to support certification or recertification. Medicare coverage of hospice services requires physician certification that the individual is terminally ill and must meet coverage criteria.

Corrective Actions Conducted and What Can Be Expected in the Future

The AFR pointed to "corrective actions" it has taken and will take to assess the improper payments across all service areas. These include the following actions by the Medicare program:

Medicare FFS Action Plan

Corrective Actions Across Service Areas

- Medical Review: Medicare Administrative Contractors (MACs) primarily conducted service-specific post-payment medical reviews.

- Targeted Probe and Educate (TPE): As of September 21, 2021, HHS reinstated the TPE process, which consists of up to three rounds of review (20-40 claims per round), with one-on-one education provided at the end of each round. This process is used for hospital outpatient, IRF, SNF, home health, hospice and DMEPOS services.

- Supplemental Medical Review Contractor (SMRC) Reviews: In FY 2021, the SMRC conducted post-payment medical reviews for hospital outpatient, IRF, SNF, hospice and DMEPOS claims.

- Recovery Audit Contractor (RAC) Reviews: RACs were used in FY 2021 to identify and collect improper payments related to hospital outpatient, IRF, SNF, home health, and DMEPOS claims.

- Provider and Supplier Screening: Providers and suppliers in the limited risk category undergo verification of licensure and database checks. Providers and suppliers in the moderate risk category are also subject to unannounced site visits. Providers and suppliers in the high-risk category are also subject to fingerprint-based criminal background checks. The AFR stated that 29,618 site visits were conducted for non-DME providers and suppliers, and 13,240 site visits were conducted for Medicare DME suppliers.

Targeted Corrective Actions

- Hospital Outpatient:

  - Prior Authorization: In FY 2021, HHS added Implanted Spinal Neurostimulators and Cervical Fusion with Disc Removal to the nationwide prior authorization process for hospital outpatient

department services. These services were added to the existing list of services requiring prior authorization, which include Biepharoplasty, Botulinum Toxin Injection, Rhinoplasty, Panniculectomy and Vein Ablation.
  - Medical Review/TPE
  - SMRC Hospital Outpatient Reviews: The AFR cited FY 2021 medical reviews for hospital outpatient claims, such as Electrodiagnostic Testing, Spinal Cord Stimulator, Outpatient Hyperbaric Oxygen (HBO) services, Polysomnography services Intravenous Immunoglobulin (IVIG), Specimen Validity Urine Testing, Vitamin D Testing, Botulinum Toxins, Therapy (Physical, Occupational, and Speech-language), Carotid Artery Screening, Audio-Only Telehealth, and Transforaminal Epidural Injections (TEI).
  - RAC Outpatient Reviews: HHS cited in its AFR that 36.1 percent of all Medicare FFS RAC collections were for hospital outpatient overpayments. The AFR cited insufficient documentation as a factor.

- SNF:
  - SMRC post payment medical review activities related to SNF claims
  - RAC SNF Reviews: The AFR referenced medical necessity and insufficient documentation as factors leading to 8.3 percent of all Medicare FFS RAC collections.

- Home Health:
  - Review Choice Demonstration: This demonstration gives Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas an initial choice of three options (i.e., pre-claim review, post-payment review or minimal post-payment review with a 25 percent payment reduction for all home health services). A provider's compliance with Medicare billing, coding and coverage requirements would determine the provider's next steps under the demonstration.
  - Medical Review/TPE: In FY 2021, MACs reviewed 4,039 HHA providers on a service-specific post-payment basis.
  - Elimination of Home Health Requests for Anticipated Payment

- Hospice:
  - Medical Review/TPE: In FY 2021, MACs reviewed 1,419 hospice providers on a service-specific post-payment basis.
  - SMRC Hospice Review: Post-payment medical review was conducted on general inpatient levels of care, services provided in a SNF and services provided in an Assisted Living Facility. These reviews included hospice services that do not provide all levels of hospice care.
  - RAC Hospice Review

- DMEPOS:
  - Prior Authorization: The list of items requiring prior authorization was expanded to include six lower limb prosthetic codes, with additional plans to expand the items subject to prior authorization in FY 2022.
  - Medical Review/TPE: In FY 2021, MACs reviewed 23,666 DME providers on a service-specific post-payment basis.
  - SMRC DME Reviews

- RAC DME Reviews: The AFR referenced the RAC DME reviews for medical necessity, insufficient documentation to support DME items billed, missing valid orders and if items/services were rendered.
- DMEPOS Supplier Education: HHS pointed to education through Medicare Learning articles called Provider Compliance Tips.

- Ambulance:

  - Prior Authorization: HHS announced on November 20, 2020, a nationwide expansion of the prior authorization model for repetitive scheduled non-emergent ambulance transport. On August 27, 2021, HHS published an additional notice announcing the implementation dates for all remaining states and territories for the national expansion.

HHS stated in the AFR that it believes "implementing targeted corrective actions will prevent and reduce improper payments." Providers and suppliers should remain vigilant about maintaining and collecting documentation and take seriously the above review and audit activities of the agency.

For more information, please contact Stephen Azia or any member of Baker Donelson's Reimbursement Team.