Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

www.homehealth4america.org

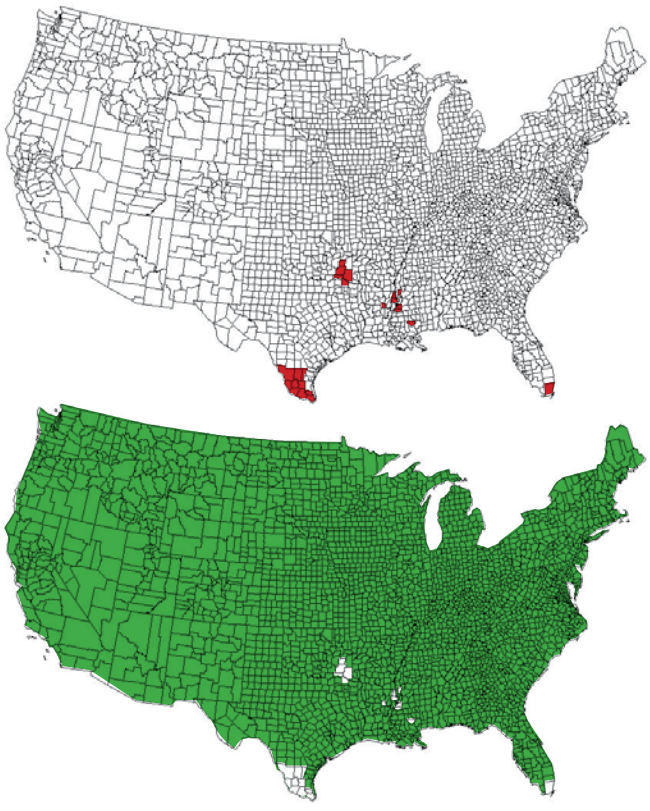
Medicare Fraud & Abuse:
An Isolated Problem in Need of a Targeted Solution

Medicare data indicate that fraudulent activity and abusive billing practices within home healthcare are extremely limited to select areas of the U.S. Of the nation's 3,143 counties, MedPAC has identified the 25 counties with the highest levels of Medicare utilization where suspected abuse is occurring.[1] These isolated pockets of fraudulent activity reside in just a handful of counties in five states, indicating that targeted Medicare reforms that focus on these areas of abusive behavior could have a significant impact on eliminating fraudulent activity.

"Federal data pinpoints where healthcare fraud is occurring. As a result, the federal government can target fraudulent activity, preventing it from occurring in the first place and protecting seniors and taxpayers alike."

– -Chairman Billy Tauzin & Senator John Breaux

A Stark Contrast:
MedPAC 25 vs. 3,118 Other Counties



TARGETING OUTLIERS:
A SUCCESS STORY

Medicare data indicates that a single payment reform relating to outlier claims that was proposed by the home healthcare community in 2009 achieved over $850 million in savings in 2010 alone – equivalent to nearly $11 billion in savings over the next 10 years.

PROPOSED TARGETED REFORMS

- Firm Limits on Episode Payments
- Firm Limits on Low-Utilization Payments

=$15.2 BILLION SAVED[3]

1. Medicare Payment Advisory Commission: Home Health Services. In Report to Congress: Medicare Payment Policy March 2012.
2. Ibid
3. Data analysis by Dobson DaVanzo Associates and Douglas Holtz–Eakin