94th Congress
2d Session

COMMITTEE PRINT

PROBLEMS ASSOCIATED WITH HOME HEALTH CARE AGENCIES AND MEDICARE PROGRAM IN THE STATE OF FLORIDA

REPORT

PREPARED BY THE

SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES, EFFICIENCY, AND OPEN GOVERNMENT

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS
UNITED STATES SENATE

AUGUST 1976

for the use of the Committee on Government Operations

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1976

LETTER OF TRANSMITTAL

U.S. SENATE,
COMMITTEE ON GOVERNMENT OPERATIONS,
SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES,
EFFICIENCY, AND OPEN GOVERNMENT,
Washington, D.C.

Hon. ABRAHAM RIBICOFF,
Chairman, Committee on Government Operations,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Subcommittee on Federal Spending Practices, Efficiency, and Open Government of the Government Operations Committee, conducted investigations and inquiries into the inefficiencies of the medicare payments to Home Health Agencies, particularly in the State of Florida.

It was our desire to use the Florida situation as a case study to hopefully provide valuable insight on the problems that have arisen all over the country with regards to the private, nonprofit home health care agencies. These agencies are practically self-regulatory and completely independent of meaningful guidelines for operation.

The subcommittee found an urgent need for administrative and possibly legislative overhaul in three major operational areas—claims processing, utilization review, and provider audit and reimbursement.

In anticipation of further congressional action in this matter, I am hereby transmitting for publication as a committee print the report by the subcommittee on Home Health Agencies and Medicare payments.

Sincerely,

LAWTON CHILES, *Chairman.*

CONTENTS

Introduction

The intent and validity of home health care programs is, without a doubt, a vital and important part of the lives of millions of elderly persons all over this country. The payment for those services, as provided by the law, under medicare is also of great importance to the persons most involved—the American taxpayer. The concern for quality home health care was and is uppermost in the minds of the subcommittee. There was considerable concern over the administration of the agencies. Concerns which were expressed by the chairman, Senator Lawton Chiles. We have disturbing reports about some health care in Florida involving private, nonprofit home health agencies and medicare payments, which include:

Reports that persons were tested for respiratory function tests when they were not physically able to do so.

Reports that medicare has had trouble collecting from an agency which has a vast amount of money owed to medicare.

Reports that somehow real costs are hidden in some agency reports and claims to medicare.

Reports that bribes and rebates are all too common in the referral of medicare payments.

The tremendous proliferation of home health agencies in the State.

Overutilization of services allowed by medicare simply because they are allowed.

Reports that some medical supply companies advertise in the media about "cost free" equipment for medicare patients.

Reports that oxygen abuses are continuing in spite of the fact that medicare authorities have been notified about this abuse.

Reports that in New Jersey, for instance, a wheelchair that cost $168 to purchase was rented for 72 months at a total cost of $1,080.

A hospital bed that cost $283.50 was rented for 58 months at a cost of $1,654.20—medicare funds pay 80 percent of rental cost.

Although these are perhaps isolated items they underscore the potential abuse that can exist in the rental of equipment.

Perhaps one solution is to raise the amount that the law allows for full, immediate reimbursement for equipment from $59 or less to a higher figure. When we consider the fact that the amendment allowing $50 was passed in 1968, illustrates that Congress in this respect has not kept pace with rising costs.

At any rate we need to close the "end" on equipment rentals.

Finally, I think the Congress is committed to provide high-quality health care for the elderly and closing the loopholes that presently exist in the medicare/home health field.[1]

[1] From Senator Chiles' opening statement at Tampa, Fla., hearing, dated Apr. 12, 1976.

In hearings held in Tampa and Miami, Fla., the subcommittee heard from a total of 28 witnesses. The theme remained the same: abuses and illegalities are certainly present in the program and proper safeguards are not!

The subcommittee felt that several key and important aspects of the investigation should be developed in the hearings. Those special areas were:

(1) The great discrepancy between the "cost of operation" of public and private nonprofit home health agencies. The particular costs which were most obvious were skilled nursing care, nursing aide care, administrative salaries, pension plans, et cetera.

(2) The illegal payments of rebates, referral fees, bribes and kickbacks with involving false medical reports and highly questionable medical practices.

(3) The overutilization of home visits by private, nonprofit home health agencies often to the detriment of the patients involved. The investigation by subcommittee staffers turned up instances where many patients were forced to turn to public agencies after being dropped by the private agencies after their allotted medicare visits had been exhausted.

(4) The overutilization of durable medical equipment to the extent that many times the original cost of the item has been greatly exceeded in the payment of rental fees.

(5) The steady proliferation of private, nonprofit home health agencies in Florida because of the ease involved in the establishment of such an agency.

(6) The possible conflict of interest that exists when a doctor owns or has substantial vested interest in a home health agency where he refers patient/clients.

(7) The deliberate evasion of certain aspects of the law in order to gain an unfair competitive advantage by some durable medical equipment dealers. Prime example of this type of practice is the agreement that the DME dealers customarily forgive the 20 percent co-pay and instead turn it over to the private, nonprofit home health agency "for doing the necessary paperwork."

(8) The addition of an "administrative markup" to the DME providers invoice by home health agencies and the submission of the larger figure to the Bureau of Health Insurance for payment. Such a "markup" is in violation of BHI regulations.

(9) The self-regulatory aspect of private, nonprofit health agencies.

The subcommittee chairman, Senator Chiles, added one other concern: "That the patient will not become the 'forgotten person' during the entire controversy, that the importance of proper home health care for the elderly will ultimately gain from this investigation." [2]

[2] Remarks from Miami press conference, May 5, 1976.

5

HISTORICAL PERSPECTIVE

The growth of private, non-profit home health agencies in Florida:

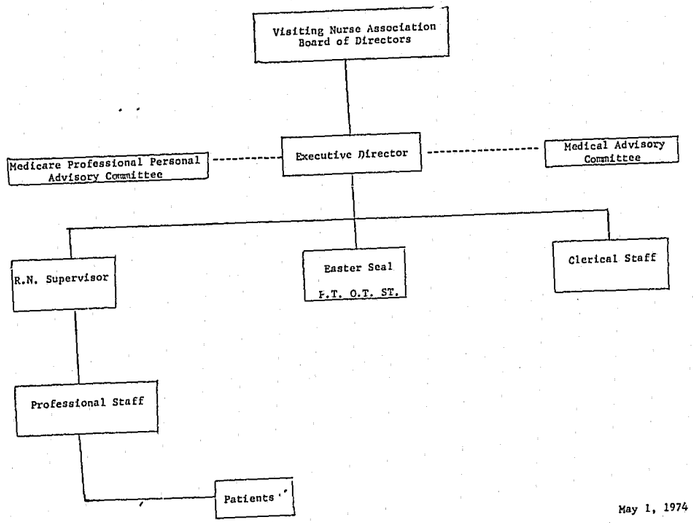
Year	Number of Agencies eligible for payment	Amount	Average Cost Per
1969			
1970	5	$1,702,958.51	$58
1971		1,120,100.72	54
1972		1,066,902.54	57
1973		1,442,167.28	67
1974		3,050,690.82	108
1975	82	9,847,823.57	179
1976	*220	22,900,369.61	226
		*45,217,000.00	*450

* Committee's projection based on mid 1975 growth patterns and the implementation Florida licensure procedures.

Most of the pre-1973 home health care agencies were County Nurses and Visiting Nurses A-sociations. These associations operated under an organization similar to the example below:

(taken from the testimony of Ms. Judith Travis, R.N. Executive Director of Hillsborough County's Visiting Nurses Association - April 12, 1976 in Tampa, Florida)

TABLE OF ORGANIZATION
VISITING NURSE ASSOCIATION OF HILLSBOROUGH COUNTY, INC.



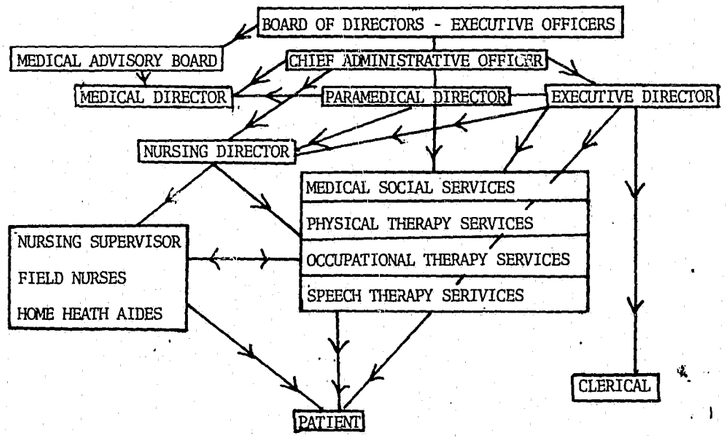
May 1, 1974

Basically, these public non-profit organizations were instituted out of a communicy need to provide nursing care for the low-income elderly that were unable to do so for themselves.

Most Visiting Nurses Associations collect fees from those patients who can afford to pay for services rendered from Medicare and Medicaid and the United Way or other community oriented contributors. The central point is that the public non-profit home health agencies do not get 100% funding from medicare and medicaid, in fact, the average for federal funds received by VNA's range from 59% to 84%.

The hearings in Tampa and Miami explored the health care problems and solutions of VNA's in testimony from several directors from the State of Florida. Their testimony will be dealt with later in this report.

Many of the private non-profit Home Health Agencies have a structure such as the one listed below:



The growth of these types of agencies is illustrated by the testimony of Mr. Paul R. Meyers, vice president of medicare, Part A: Affairs for Blue Cross of Florida before the Government Operations Subcommittee on Federal Spending Practices, Efficiency and Open Government in Miami on May 5, 1976—Blue Cross of Florida acts as the medicare "A" intermediary for 208 hospitals, 29 skilled nursing facilities and 64 home health agencies.

Specifically, Mr. Meyers stated:

> Regulations have been forthcoming relating to compensation of owners of proprietary hospitals and skilled nursing facilities, and to the profit which may be considered as reasonable and reimbursible under the medicare program.
>
> These are relatively clear and understandable to providers and intermediaries alike.
>
> In the area of owners' compensation, the guidelines generally allow the same salary for the owner as he would receive in a comparable situation in a comparable not-for-profit institution.
>
> Until about 3 years ago, almost all home health agency services were provided by visiting nurses associations and county or city health departments.
>
> They were reimbursed under the medicare program on the basis of reasonable costs and the reasonableness of administrative salaries was not an issue because these were generally determined in the marketplace.
>
> If an item of cost would seem to be unreasonable or not allowable the provider simply met that cost with revenue from nonmedicare patients.
>
> To the extent that the allocations of costs between medicare and nonmedicare patients is done equitably, there is little fault to find with this system.
>
> During the last 3 to 4 years, a new type of home health agency has appeared on the scene.
>
> These organizations are generally categorized as private not-for-profit home health agencies.
>
> These agencies while technically not-for-profit, have all the aspects of entrepreneurship.
>
> They normally are controlled by one person or a very small group of persons who hold the top administrative positions, such as executive director, administrator, director of nursing services and sometimes medical director.
>
> These same people comprise a very small board of directors not responsible to any larger association or corporate body.
>
> As is readily apparent, there is great potential for the payment of apparently unreasonable salaries to those persons controlling the organization. We have observed pension plan contributions amounting to as much as 25 percent of the employees' salary for this type of home health agency.

Many of the witnesses who testified noted that the general uncontrolled growth on nonprofit home health agencies played the most important part in the "laxity" of monitoring and control that does exist.

Testimony given on May 5, 1976 before the subcommittee by Mr. Robert Wilson, associate director of the Health Planning Council, Inc. of West Palm Beach, discussed the proliferation of private nonprofit Home Health agencies thusly:

Proliferation of home health agencies

The second problem concerns the proliferation of home health agencies in Florida. Reports indicate that at the end of 1972 there were only 29 medicare-certified home health agencies, while there were 83 as of April 2, 1976. The majority are "private, nonprofit" agencies established only to serve medicare beneficiaries. It can be argued that these agencies were established to serve a need for noninstitutional health care. I question, however, how many would have been started if tax dollars were not available to pay for services. As with other programs funded with an infusion of Federal tax dollars, it produced an environment which allowed many persons to feel they had found their pot of gold. People from all walks of life suddenly became experts in home health care. Congress, in its attempt to provide for a needed, less expensive, level of health care opened a Pandora's box by not establishing a mechanism which would balance resources with real unmet needs. This same problem occurred with the Hill-Burton hospital program and the medicare nursing home program.

Congress has attempted to rectify the proliferation of hospitals and nursing homes by establishing a mechanism requiring what is called a "Certificate of Need." The certificate of need operates through a designated planning agency at the State level with appropriate input from the local health systems agency. Public Law 92-603, and in particular, section 1122 of the Social Security Act, established this mechanism. Although home health agencies were included in section 1122, Florida's designated planning agency has not required new home health agencies to obtain a certificate of need even though the establishment of a new service was one of the criteria which necessitated a certificate of need.

Florida last year passed a law which requires home health agencies to be licensed. Prior to the issuance of the license, the Department of Health and Rehabilitative Services shall obtain a statement from the local health systems agency attesting to the need for the agency. It is ironic that proprietary home health agencies were the most vocal in support of the licensure law so that they could participate in the medicare program. While a statement attesting to the need for a home health agency as required by the State licensure law is good, it does not have the same effect as the certificate of need required under Federal law.

Under current regulations, home health agencies must be certified annually to participate in the medicare program. It would appear logical to dovetail the State licensure procedure with the medicare certification procedure and that a

statement attesting to the need from the local health systems agency be used for both programs. There is a precedent for this in the public health service programs. For some years now the local health systems agency has reviewed the appropriateness and need for local health service programs funded by the Public Health Service Act. We have had experience in determining the need for these programs, the appropriateness of the budget, and the capability of the agency to provide the service. Extending this function to include home health agencies funded by tax dollars, would prevent the problems that proliferation has created.

The recommendation in regards to the problem is as follows:

"That the local health systems agency review and comment on each home health agency's application for their health service area in regards to determining need for the home health agency prior to annual certification by the State agency."

PRIVATE, NONPROFIT AGENCIES—A CLOUDY DEFINITION

The subcommittee heard testimony that the term generally used to describe agencies that are considered nonprofit are usually supported by public moneys to assist the established institutions in dealing with indigent clients. A most important consideration is that the nonprofit corporation does not accumulate capital, does not make investments, does not provide services for the expressed intent of making money.

Private, nonprofit home health agencies have generally engaged in the kind of practices that have caused some doubts about whether they should be classified as "nonprofit".

In the hearing in Tampa on April 12, 1976 Mr. Douglass Richards stated:

> *IRS tax exempt status*
>
> Proprietary organizations may participate as HHA's in medicare only if State law licenses proprietary HHA's. There is some concern that IRS may be granting nonprofit status under section 50 of the Internal Revenue Code of 1954 that are really proprietary. Central office staff has discussed tax exempt status of franchised agencies and chains with IRS. IRS has indicated that they do not believe their current policies require revision; however, IRS advised us they would accept for review any questionable cases of tax exempt status where there are high salaries or other high administrative costs that are out of line with the services rendered indicating possible abuse of tax exempt status.
>
> Personnel of the RO have met with IRS officials in Atlanta to discuss the tax exempt status of nonprofit HHA's which claim high administrative salaries and pension compensation. The RO is in the process of gathering cost reports on such situations for IRS to examine. They have also recently uncovered situations where HHA's may be incorporated as "profit-making" entities in Florida and have illegally obtained tax exempt status. If these situations are verified by investigation, they will be referred to IRS for action.

In a widely circulated report, issued in January of 1976, Amitai Etzioni and Pamela Doty made these assertions about profit in not-for-profit institutions:

> The essence of the not-for-profit organizational structure is that the pecuniary interests of the trustees and staff be decoupled from the rises and falls in the output and income of the corporation. This, in turn, allows them to concentrate on the public or client needs, without concern that this will affect their income. A conflict of interest between trustees and staff

on the one hand and the public and clients on the other is basically avoided by paying the trustees and staff salaries, wages, or fees not dependent on the client's payments, and by disallowing compensation for ownership and capital investment. This is the reason these corporations have no stockholders and pay no dividends, and their trustees receive no or only nominal compensation.

Our central thesis is that existing laws and regulations governing not-for-profit corporations are insufficient to safeguard the underlying legitimate purpose of these corporations. For instance, the HEW guidelines for not-for-profit corporations; eleborated over 65 pages, define a not-for-profit corporation as one "* * * which is not organized primarily for profit and which uses all income exceeding costs to maintain, improve, and/or expand its operations." The term "primarily" leaves open the door to profitmaking (if it is not "primary") and the question, how much is "not-primarily"—10 percent, 20 percent, 40 percent?

That this ambiguity is not a hypothetical one is illustrated by the following case: in *Anateas Lineal Inc., 1948 vs. U.S.* 366 F. Supp. 118 (W.D. Ark. 1973), a Federal district court ruled that a commercial pathology laboratory was a not-for-profit corporation for Federal tax purposes, because aside from its highly lucrative pathology services to various hospitals, it provided training to high school and medical students.

The Georgia code states " 'nonprofit corporation' means a corporation no part of the income or profit of which is distributable to its members, directors or officers." [Georgia Code, Ann. No. 22–2102(a) (1970).] As we see it, the intentions of those who formed the corporation is not a sufficient criterion, as even if their purposes were pure of any profit considerations, later they—or those who succeed them—may change their minds. However, the main difficulty is with the phrase "no distribution of income." As the staff is being paid and not working as volunteers, it is necessary to determine where their income is a reasonable compensation for work or services rendered. and where it exceeds this level and becomes but a veiled form of profitmaking. The cited codes do not cover this issue. Nor does the often cited section 501(c)(3) of the 1954 IRS code: "* * * no part of the net earnings of which inures to the benefit of any private shareholder or individual." The notion of a net as definition of profit, as derived from the difference of expenditures and revenue, is borrowed from profitmaking corporations. In a not-for-profit corporation, illicit gains are made by the staff and trustees, we shall see, when expenditures are smaller, equal to, or larger than revenues—even when there is no "net" at all. Our definition attempts to get at this matter by defining explicitly what distributions are allowed: a not-for-profit corporation will provide to persons associated with it (such as trustees, managers, staff and employees) no benefits apart from reasonable and customary fees, salaries and fringe benefits. To put it differently: while the existing definitions cited above are "exclusive" or "negative" in the sense that they characterize what may not be done, ours is "inclusive" or "positive" in the sense that it defines which allotments are proper. Of course the two definitions may be combined.

A 1959 survey of 2,434 American hospitals found that approximately 70 percent of radiologists, 45 percent of pathologists, 49 percent of physicians specializing in EKG, BMR and related readings, 22 percent of specialists in physical medicine, 19 percent of internists, and 14 percent of anaesthesiologists earned their income exclusively from such a "percentage of the take." A 1969 study found that 46 percent of pathologists and 60 percent of radiologists practicing at the hospitals surveyed were paid a percentage of their department's income. A 1972 survey, based on a comparable universe of hospitals (N=1,798) found 52 percent of pathologists and 62 percent of radiologists receiving their remuneration in the form of a percentage of departmental income.

The percentage of gross or net income was found in general to be more lucrative for the specialists than straight salary or, in some cases, fee-for-service. The following table indicates the median salary ranges found by the 1972 survey for pathologists and radiologists according to the four methods of compensation:

MEDIAN EARNINGS

Arrangement	Chief pathologist	Chief radiologist
1. Percentage of net	$47,000–$67,000	$47,000–$67,000
2. Percentage of gross	47,000–67,000	26,000–46,000
3. Strainght salary	26,000–46,000	26,000–46,000
4. Fee-for-service	[1] 25,000	47,000–67,000

[1] Or less.

In addition, it is not uncommon for specialists to draw a salary from one not-for-profit corporation while providing services on a "concession" basis to several others.

A recent General Accounting Office study of compensation arrangements for pathology and radiology specialists at 17 hospitals in Washington, D.C. and Missouri found that the nine pathologists with percentage of gross arrangements earned an average of $80,000 over annual periods ending between December and April 1972. In contrast, the four pathologists earning salaries averaged $26,000.

Why do we hold that these arrangements, known in the for-profit corporations as "profit sharing," are incompatible with the basic concept of not-for-profit corporations? Because as long as the income of the staff rises as more services are rendered, the motivation to provide the services may not be the clients' or public's needs but the desire of the provider to increase his or her income. Overutilization tends to result, causing both unnecessary financial burdens on the client and

taxpayer, and unnecessary health risks which medical interventions entail.

When the income of the staff is tied to provision of fewer services, the opposite effect—underutilization—may result; that is, clients will receive less than their needs call for, which again calls for separating the income of the provider from the needs of the client. Thus, in some not-for-profit health maintenance organizations physicians receive a bonus, above their salary, calculated as a percentage of the organizations' net surplus. The fewer services rendered, the higher the surplus, all other factors remaining equal.

Self-dealing refers to business transactions in which the same persons (or their kin) appear on both sides of the transaction, once as the staff or trustee of a not-for-profit corporation, once as a profitmaking provider of goods or service to the other side (the not-for-profit corporation).

In 1972 a number of practices of this sort were reported in Washington, D.C.'s largest not-for-profit hospital, the Washington Medical Center. A member of the administrative staff in charge of data processing had decided that the existing facilities at the hospital for billing, keeping track of patient records and accounting through the hospital's computer were inadequate. His solution was to hire an outside for-profit firm to furnish these services, and selected one he had started himself—with the help of a $50,000 deposit from the hospital. The hospital administrator received stock in the new company free of charge; five other top administrators of the hospital bought stock at $1 a share. Following public disclosure of these relationships, most of the administrators disposed of their stock. In 1974, however, when the General Accounting Office included the Washington Medical Center in a review of self-dealing transactions in 19 hospitals, it found that 4 hospital officials and several relatives of another official owned stock in the same computer firm; a physician employed by the hospital provided consultant services to the firm; and the firm's president was a hospital consultant and a member of the hospital's action committee. The GAO also found that it was not until mid-1973 that the Washington Medical Center requested competitive bids for computer services. According to the hospital administrator the other bids were not comparable with the present firm's services for a number of reasons, thus the hospital decided to continue retaining the firm's services for 12 to 18 months during which time a "more specific request for bids would be developed." The GAO report concluded that the overlapping interests of the hospital officers with the firm were likely to continue to give the firm an advantage over potential competitors.

In addition, at this same hospital, the official in charge of managing the institution's finances placed hospital funds in an interest-free account at a bank where he was vice president. The hospital's account balance is reported to have generally hovered around $1 million, sometimes going as high as

$1.8 million; a conservative estimate placed the hospital's annual loss of interest because of this account at $50,000. That hospital staff gained something from these transactions is suggested by the fact that the hospital's administrator admitted this bank had lent him money at a low interest rate.

More recently, medicare officials disclosed that millions of dollars in Federal and private funds entrusted to Blue Cross and Blue Shield are being channeled through banks with officers who serve on the boards of trustees of these not-for-profit health organizations.

The easiest way to violate the essence of a corporation's not-for-profit status is to provide its staff or officers with unreasonable and uncustomarily high fees, salaries, or fringe benefits. In principle, income is not a violation of the not-for-profit concept, and as it is rather difficult to establish what is proper and what is exaggerated compensation, this area is rather difficult to regulate. Attention must hence focus on those situations in which the income provided is manifest.

One such example is a hospital paying for the poetry and drama lessons of the physicians' children. No reasonable person would define such fringe benefits as typical, common or legitimate. That a not-for-profit hospital can provide such benefits is ironic: this case involves New York City voluntary hospitals that have contracted with the city's municipal hospitals to be paid for providing the municipalities with such services as physician and nursing assistance and laboratory work. These affiliation contracts were entered into by the city because it could not attract the needed qualified personnel for its own hospitals. By paying the voluntaries, however, they are perpetuating the problem, since the voluntaries use the contract money to pay for the education of doctors' children and for poetry and drama lessons, terming these fringe benefits. Thus, the city is paying the voluntaries because it cannot attract good personnel, and the voluntaries use this money to attract the personnel via benefits the city cannot match.

The ambiguities of the law and regulations concerning not-for-profit status of a corporation are illustrated by the trial and appellate decisions in *American Automobile Association* vs. *Bureau of Revenue*, 525 P. 2d 929, 86 N.M. 569 (1974).

The AAA claimed tax exempt status as a not-for-profit corporation despite many discounts and other benefits it distributes to its members. The court held—525 P. at 932—that "Profit does not necessarily mean a direct return by way of dividend, interest, capital allocation or salaries. A saving of expense which would otherwise necessarily be incurred is also a profit to the person benefited." However, the New Mexico Court of Appeals rejected this analysis because there was no income or dividends, the corporation was chartered without capital stock, and the corporation's purpose was not profit so that any benefit conferred upon its members was "wholly irrelevant." As we see it, a third position seems worthy of consideration: some benefits to members are not, prima facie,

evidence of profit, as of course salary is not. However, unreasonable and uncustomary benefits are, because they are but a different form of what in effect amounts to sharing of profit.

An example of out-of-line salary seems to be provided by a prepaid health plan contractor who employed a physician as plan administrator at an annual salary of $120,000 plus expenses. The contract with the physician read:

"Employer recognizes employee is involved in other medically related ventures such as inhalation therapy contracts and other nonmedically related business ventures. These ventures shall at all times remain under the strict control and ownership of the employee."

That one can establish what reasonable and customary salaries are is illustrated by court cases which have on a number of occasions disallowed salaries and fringe benefits in part because they failed to satisfy criteria of reasonableness. While the only cases we have come across deal with profitmaking corporations, we see no reason the same procedures may not be applied to not-for-profits.

The impact of total medicare participation is of great importance to the committee because providers/suppliers operate on behalf of different type health facilities.

SOCIAL SECURITY ADMINISTRATION
Office of Research and Statistics

PARTICIPATING HEALTH FACILITIES UNDER MEDICARE:
NUMBER AND TYPE OF FACILITIES BY STATE,
June 1975

This report presents data on the number of providers/suppliers of services certified to participate in the Medicare program as of June 15, 1975. Figures are shown separately for hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, independent laboratories, portable X-ray, and renal disease facilities. Data are reported for each administrative region and State.

The report is intended to provide information, for administrative use, on the number and location of certified providers/suppliers of services.

The data are derived from applications to participate in the Medicare program submitted by providers/suppliers of service and certification forms completed by State agencies and regional offices. The figures reported reflect information from these forms recorded in the master records in Baltimore as of the middle of June 1975

Division of Health Insurance Studies
Program Statistics
August 1975 RS:H-1

HIGHLIGHTS

1. The table below shows the changes in the number of providers/suppliers of services participating in the Medicare program between June 1974 and June 1975. Figures are shown separately for each type of provider. The number of beds located in facilities are also shown, where applicable.

Type of provider	Facilities				
	June 1974	September 1974	December 1974	March 1975	June 1975
Hospitals 1/.....	6,733	6,721	6,707	6,727	6,773
Short-stay.....	6,102	6,095	6,084	6,075	6,107
Tuberculosis.....	56	52	45	44	43
Psychiatric.....	357	356	358	375	385
Other long-stay....	218	218	220	233	238
Skilled nursing facilities 1/.....	3,952	3,813	3,892	3,890	3,932
Home health agencies.....	2,248	2,237	2,254	2,262	2,242
Independent laboratories.....	3,029	2,952	2,994	3,024	3,048
Outpatient physical therapy.....	116	108	115	113	117
Portable X-ray.....	113	121	131	131	132
	Beds				
Hospitals.....	1,143,664	1,139,062	1,132,435	1,137,935	1,140,395
Short-stay.....	882,496	884,693	884,187	896,032	901,757
Tuberculosis.....	11,303	10,616	9,211	8,086	6,823
Psychiatric.....	215,513	211,822	206,663	201,165	198,802
Other long-stay....	34,352	31,931	32,374	32,652	33,013
Skilled nursing facilities.....	294,000	287,201	289,416	286,077	287,479

1/ Excludes Christian Science sanatoriums.

2. Between June 1974 and June 1975, the number of participating hospitals registered a net increase of 40, while the number of beds decreased by 3,300. Beds in psychiatric hospitals continued to

decrease substantially--a net loss of 16,700. Short-stay hospitals increased by 5 but showed a substantial gain (19,300) in the number of certified beds. Net losses of 20 skilled nursing facilities and 6,500 beds were recorded between June 1974 and June 1975. Participating home health agencies showed a net decrease of 6, while the net number of participating independent laboratories rose by 19.

3. In June 1975, 176 hospitals were certified on an interim basis to provide kidney transplants. In addition, 607 hospitals and 136 free-standing facilities were authorized to furnish renal dialysis services. The number of facilities approved for kidney transplant and/or renal dialysis services by administrative region are shown below.

Region	Hospital based		Free-standing dialysis facilities
	Transplant facilities	Dialysis facilities	
All regions.....	176	607	136
Boston.....	12	35	5
New York.....	28	87	8
Philadelphia.....	20	77	18
Atlanta.....	21	72	36
Chicago.....	39	110	14
Dallas.....	16	76	18
Kansas City.....	12	36	4
Denver.....	2	26	2
San Francisco.....	23	76	28
Seattle.....	3	12	3

4. Detailed State data on the number of providers/suppliers of services are shown in general tables 1 and 2.

Table 1.--Number of participating hospitals and beds, by type of hospital, region, and State, June 1975--Continued

Region and State	Short-stay		Tuberculosis		Psychiatric		Other long-stay	
	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds	Hospitals	Beds
Iowa	140	14,707	1	93	5	1,459	25	1,002
Kansas	152	12,190	1	40	5	2,177	27	904
Missouri	157	25,539	--	--	10	4,801	8	931
Nebraska	103	8,090	--	--	5	658	13	596
Denver region	315	25,467	--	--	8	3,351	8	546
Colorado	79	9,889	--	--	4	1,559	5	332
Montana	60	3,477	--	--	1	124	--	--
North Dakota	53	3,473	--	--	1	943	2	162
South Dakota	59	3,465	--	--	--	--	1	52
Utah	37	3,551	--	--	1	357	--	--
Wyoming	27	1,612	--	--	1	368	--	--
San Francisco region	648	91,762	2	274	44	12,459	15	4,892
American Samoa	1	145	--	--	--	--	--	--
Arizona	59	7,759	--	--	3	1,080	--	--
California	544	78,815	2	274	38	10,554	11	4,629
Guam	1	236	--	--	--	--	--	--
Hawaii	22	2,178	--	--	1	350	4	263
Nevada	21	2,629	--	--	2	475	--	--
Seattle region	256	22,812	2	160	11	3,845	2	59
Alaska	21	833	--	--	1	200	--	--
Idaho	46	2,548	--	--	--	--	--	--
Oregon	78	7,793	--	--	5	1,734	2	59
Washington	111	11,638	2	160	5	1,911	--	--

Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975

Region and State	Skilled nursing facilities		Home health agencies	Independent laboratories	Outpatient physical therapy	Portable X-ray
	Number	Beds				
All regions.....	3,932	287,479	2,242	3,048	117	132
Boston region.....	304	21,206	334	209	11	11
Connecticut.....	130	11,680	87	58	7	6
Maine.....	17	687	19	--	--	--
Massachusetts.....	95	5,880	159	124	2	4
New Hampshire.....	20	1,006	40	4	2	--
Rhode Island.....	21	1,133	13	21	--	1
Vermont.....	21	820	16	2	--	--
New York region.....	487	55,298	182	400	6	15
New Jersey.....	125	9,249	44	112	2	4
New York.....	357	45,690	124	240	3	11
Puerto Rico.....	5	359	13	48	1	--
Virgin Islands.....	--	--	1	--	--	--
Philadelphia region.....	319	22,548	253	268	13	5
Delaware.....	11	632	6	10	1	--
District of Columbia....	5	641	3	4	--	--
Maryland.....	67	5,490	26	70	1	--
Pennsylvania.....	172	12,569	101	143	7	5
Virginia.....	36	1,498	99	30	2	--
West Virginia.....	28	1,718	18	11	2	--

Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975--Continued

Region and State	Skilled nursing facilities		Home health agencies	Independent laboratories	Outpatient physical therapy	Portable X-ray
	Number	Beds				
Kansas City region.....	131	6,140	144	108	2	--
Iowa.....	32	915	64	14	1	--
Kansas.....	29	1,564	34	23	--	--
Missouri.....	55	2,855	34	64	1	--
Nebraska.....	15	806	12	7	--	--
Denver region.....	117	5,573	89	83	8	1
Colorado.....	62	3,772	29	39	6	--
Montana.....	26	870	10	7	1	--
North Dakota.....	3	46	9	9	--	--
South Dakota.....	10	326	21	6	--	--
Utah.....	14	431	9	18	--	1
Wyoming.....	2	128	11	4	1	--
San Francisco region....	988	81,970	107	839	8	62
American Samoa.....	--	--	--	--	--	--
Arizona.....	19	1,000	11	48	2	3
California.....	933	78,895	88	754	5	58
Guam.....	1	33	1	--	--	--
Hawaii.....	16	1,413	4	17	--	1
Nevada.....	19	629	3	20	1	--
Seattle region.....	173	7,010	57	112	1	3

Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975--Continued

Region and State	Skilled nursing facilities		Home health agencies	Independent laboratories	Outpatient physical therapy	Portable X-ray
	Number	Beds				
Atlanta region.....	583	35,590	429	273	22	8
Alabama.....	89	5,372	70	18	3	--
Florida.....	146	9,185	42	123	11	7
Georgia.....	47	2,787	16	32	2	1
Kentucky.....	84	5,289	40	36	--	--
Mississippi.....	19	755	89	15	2	--
North Carolina.....	89	6,086	61	11	1	--
South Carolina.....	71	4,733	15	15	--	--
Tennessee.....	38	1,383	96	23	3	--
Chicago region.....	747	46,663	390	483	31	25
Illinois.....	173	7,919	81	202	10	9
Indiana.....	108	5,189	29	35	4	--
Michigan.....	144	11,906	48	115	3	7
Minnesota.....	83	4,301	61	15	4	3
Ohio.....	183	14,229	103	97	7	2
Wisconsin.....	56	3,119	68	19	3	4
Dallas region.....	83	5,481	257	273	15	2
Arkansas.....	10	557	78	11	1	--
Louisiana.....	11	1,127	74	35	3	--
New Mexico.....	7	323	7	25	2	1
Oklahoma.....	7	434	51	47	1	--
Texas.....	48	3,040	47	155	8	1

Table 2.--Number of participating skilled nursing facilities and beds, home health agencies, independent laboratories, outpatient physical therapy, and portable X-ray services, by region and State, June 1975--Continued

Region and State	Skilled nursing facilities		Home health agencies	Independent laboratories	Outpatient physical therapy	Portable X-ray
	Number	Beds				
Alaska.....	4	166	1	2	1	--
Idaho.....	28	1,588	9	6	--	--
Oregon.....	51	2,150	25	41	--	1
Washington.....	90	3,106	22	63	--	2

Some administrators claimed that fees are a reflection of their business success or lack of it and for that reason the fees are unstable.

Raymond Bishop of Alaris Home Health explained his "business venture" in the following terms: The home-health care business is unique and distinctive. It was sort of a mastonian call. We have been giving quality service, and it had certainly perpetuated itself in referrals. I would like to say something about—something was said about the expenditure of visits. To my knowledge we have not had any patients who have run out of visits. We have on the other hand assisted the health department in Pinellas County especially in the teaching of new diabetics because their budget would not permit them to send nurses out. We have used their personnel to assist us in teaching of our home-health aides in the care of patients. We have worked cooperatively with the Pinellas County Health Department.

Our rates are as follows presently: Skilled nursing $35 per visit; home-health aide $15 per hour; speech therapy, $20; all therapeutic services you will notice is $20 per visit.

At the early stages of the agency's existence we charged $18.50 for skilled nursing, and with the mileage involved many times and the cost, we could not make it. So we had to go up to the $35.

Mr. Bishop's outlook on his future business expansion was characterized as "bright." Alaris agencies already exist in three different counties in Florida.

Senator Chiles drew the careful line of distinction that made this "business" unique in this exchange with Dr. Samuel Leone during the subcommittee hearings in Miami on May 5, 1975:

> Dr. Leone. Yes, I refer them (patients) to my agency, as I would eat in the same restaurant that I own if I know what I am doing is good.
>
> Senator Chiles. Well, when you eat in a restaurant that you own, you are not using taxpayer dollars.

Mr. Paul Meyers expanded on that particular aspect of the "business" when he stated:

> There is one further aspect of the operations of the private not-for-profit home-health agencies that should be clearly recognized because of its impact on the medicare program. These agencies accept only medicare patients and have no other source of revenue than the medicare program. Additionally, there is literally no equity capital involved and only minimal physical assets owned by the provider. When these three facts are considered together it becomes evident that at all times the allowable reimbursement from the medicare program and all of the costs being incurred by the home-health agency must be in exact balance. An underpayment by the program is intolerable to the provider since he will not receive sufficient revenue to cover costs. An overpayment is intolerable to the medicare program since the only source of money to repay the overpayment is the medicare program itself. In other words, future payments for covered services are used to recoup past payments for noncovered services or costs. Regulations or possibly legislation are needed.

ILLEGALITIES AND IRREGULARITIES

The most revealing testimony concerning outright fraud and illegalities was dealt with in the first of the State hearings in Tampa, Florida on April 12, 1976.

Two excellent investigative reporters from the Tampa Tribune submitted testimony in the form of news articles as well as orally. The news items carried prime examples of the type and kind of fraudulent action that Mr. Etzioni and Ms. Doty wrote about in their report.

Specifically, Dan Ruth and Charles Hendrick were concerned about (1) kickbacks and referral fees being paid to doctors out of medicare funds and (2) obvious lack of controls on medicare funds to home-health agencies.

Ruth and Hendrick clearly outlined the problems in news articles published August 24 and 25, 1975.

KICKBACKS AND REFERRAL FEE PAYMENTS

The subcommittee explored the evidence accumulated by Tampa Tribune reporters Dan Ruth and Charles Hendrick. The newsmen testified before the subcommittee in Tampa on April 12, 1976.

After a month-long investigation, the reporters issued their first story on August 24, 1976. The first story contained the following allegations:

(1) That thousands of dollars in medicare funds had been paid as "referral fees" to osteopaths and chiropractors through three Tampa based medical-laboratory firms in violation of medicare regulations.

(2) That some osteopaths and chiropractors interviewed by the reporters candidly called the payments "kickbacks" or "fee-splitting," a practice banned by medicare law under certain conditions.

(3) That the three firms involved—Feegal and Howard Doctors Laboratories, Inc., F. & W. Corp. and Medicine In Motion—all had an interlocking link—Ernest A. Winkle. It was alleged that Winkle was president of Medicine In Motion, Secretary-Treasurer of F. & W. and a top level employee of Feegal and Howard labs.

(4) That Mr. Winkle's background in other States, should have disqualified him from participating in the medicare program. Medicare investigators had investigated Mr. Winkle's previous involvement in New York and New Jersey where "gross abuse" had occurred in firms operated by Mr. Winkle during the period 1972–1974.

The reporters were concerned that medicare officials had no continuing link with persons who left one geographical area, under a cloud of suspicion, only to turn up in another area to revive the same scheme.

It was reported that the medicare officials in the New York area were proud that Winkle had been forced to leave, even without prosecution.

The Tribune investigation also learned, at that time, that:

(1) The U.S. Department of Justice and the General Accounting Office have been brought into the investigation of the three firms by medicare, and a Federal grand jury may be asked to review evidence in the case.

(2) Contrary to medicare regulations, medical lab work for chiropractors has been billed to medicare.

(3) In at least one instance, respiratory function tests were performed by F. & W. Corp. employees on about 60 nursing home patients without consent of their doctor.

(4) X-ray machines rejected by a State examiner as not fit for use in the State of Florida, were used by Medicine In Motion employees examining patients and employees of nursing homes.

(5) Medicare officials have made demand on Winkle, as president of Medicine In Motion and Integrated Health Services, Ltd., for repay-

ment of medicare of $34,101 paid the firms in New York and New Jersey in the period 1972–74.

(6) Medicare officials stopped payment on $150,000 in claims by the two firms operated by Winkle in New York and New Jersey after medicare agents said they found "gross abuse" in operations of the firms.

The Tribune story further stated: "Osteopaths and chiropractors who said they promised payments or who had received them called the referral plan 'an attractive provision'."

Basically, the plan worked thusly:

The agency of the firm involved contacts the doctor, the doctor upon assuring the patient that no cost is involved, obtains the patient's signature on a medicare claim form. The doctors would then be free to order as many clinical tests as desired without concern for cost. All the billing would be handled by the firm. The firm then bills medicare for cost pus profits and submits payments to the doctors to cover their services to the patients.

The plan was called a referral fee program and was called legal by representatives of the firm. The subcommittee investigators presented the plan to several doctors who said that they were very sure that it was a kickback and as such was disallowed under section 1877(c) of the Social Security Act.

Section 1877(c) is as follows:

> Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers or receives any: (1) Kickbacks or bribes in connection with the furnishing of such items or services or; (2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services—shall be guilty of a misdemeanor.

The penalty for this offense is a fine of up to $10,000 or 1 year in jail upon conviction of the misdemeanor.

The medical doctors, osteopaths, and chiropractors were led to believe that they would receive rebates from the labs amounting to twice the standard fee because of the high rates the labs would charge medicare.

From early 1974 until mid-1975 the three firms submitted medicare claims totaling approximately $227,000.

On August 25, 1975 the followup story by Tribune reporters stated that at least 21 Tampa area medical men were involved in the referral fee scheme. Although some of the chiropractors, osteopaths, and medical doctors had questions about the ethics involved in the scheme, they regarded it—the referral fee program—as a way boon to patients and the elimination of dreaded paperwork by the doctors.

In the continuing investigation the reporters discovered that the firms who hatched the scheme for referral fees had also participated in an unauthorized testing of patients at a Tampa nursing home. The patient's doctors were not informed of the test, did not desire the test for their patients and did not authorize the test.

The unauthorized testing scheme produced gross billings to medicare for approximately $48,979.

The intermediary could offer little explanation as to why the inhalation plan was adopted.

The scope of the investigation by the reporters expanded to include home health care agencies. The focus on home health care agencies involved the great degree of variance on charges per visit between the public and private agencies.

The problem concerning overutilization in the State was vividly demonstrated by figures submitted in the November 30, 1975 article in the Tampa Tribune.

Figures show for 7 months of this year that 27 nonprofit firms made 358,908 visits to 28,130 patients at a cost of $9.1 million.

The 23 visiting nurses associations made 94,653 to 15,220 patients at a cost of $1.2 million.

The subcommittee's random survey showed that VNA's and county nurses averaged about 5.9 visits per patient while the private nonprofit home health agencies averaged 13.1 visits per patient. This problem will be explored later in the report.

The Tampa Tribune investigation added fuel to the investigation started by the subcommittee, probably prompted action by the medicare investigators and led to grand jury action by the local U.S. attorney and other officials.

Because similar allegations concerning referral fees, rebates and kickbacks were raised in other sections of Florida as well as other sections of the country, the subcommittee felt the report from articles appearing in the Tampa Tribune would be of immeasurable illustrative value.

Allegations surfaced in Miami, Cocoa Beach, Fort Lauderdale, West Palm Beach, and Hollywood. Nationwide, the allegations have surfaced in Los Angeles and Chicago, as well as other areas.

Subcommittee investigators were able to answer inquiries from news reporters and law enforcement personnel which could be helpful in their successfully apprehending persons engaged in this practice.

In testimony submitted in Tampa, Mr. Richard gave a breakout of the cases under investigation by the Bureau of Health Insurance regional office:

Information on investigative activities in program evaluation

I. Total fraud cases, all categories: regionwide, 463; Florida, 273; percent of region, 59; Miami, 190; percentage of Florida, 62.

II. Cases identified as having investigative potential: regionwide, 117; Florida, 65; percent of region, 56; Miami, 56; percentage of Florida, 86.

III. Cases actively being investigated: regionwide, 18; Florida, 13; percent of region, 72; Miami, 10; percentage of Florida, 77.

IV. Cases pending with U.S. attorney for criminal prosecution: regionwide, 22; Florida, 11; percent of region, 50; Miami, 6; percentage of Florida, 55.

V. Total fraud receipts in calendar year 1975: Region wide, 723; Florida, 413; percent of region, 57; Miami; [1] percent of Florida.[1]

[1] Figures not available.

VI. Number of investigators in region IV and State assignment:

Miami	2
Remainder of Florida and North Carolina	1
Georgia and Mississippi	1
Alabama and South Carolina	1
Tennessee and Kentucky	1
Total	6

NOTE.—In commenting on the volume of work these six investigators do, you should note that the cases pending with U.S. attorneys are active litigation cases and consume a predominant portion of each investigator's time. It is not unusual for a program integrity specialist to work full time on one of these cases for several weeks—to the exclusion of everything else.

Overutilization—Abusive practices in home health care agencies (private, nonprofit)

The problem of overutilization was perhaps the most common abuse cited by home health care personnel in investigative interviews as well as the practice perhaps most difficult to substantiate according to Mr. Paul Meyers, vice president of Blue Cross of Florida. (P. 7, 3d paragraph.)

"There is competition for patients and we have heard many allegations concerning how patients are gotten: We have head of allegations about the solicitation of doctors and hospital personnel for patients."

The most illustrative testimony concerning the problem of "overutilization" was submitted by Ms. Delores Wennlund, representative of the State Department of Health and Rehabilitative Services.

STATE OF FLORIDA

DEPARTMENT OF Reubin O'D Askew, Governor

Health & Rehabilitative Services

1323 WINEWOOD BOULEVARD TALLAHASSEE, FLORIDA 32301

Senator Chiles, members of the committee, and others, I wish to express my appreciation for the opportunity to address you.

Prior to the enactment of the Title XVIII Medicare Act, home health services were delivered almost exclusively by voluntary or official nursing agencies and sometimes a combination of both. Services were provided to those who needed them, were known or referred to the agency, and who had medical supervision. The need for care was determined mutually by the family or patient, the nurse, guided by agency policy in keeping with nursing privileges and standards, and the attending physician. Costs were met in voluntary agencies by fees, graded according to the ability to pay, contracts with third party payers, e.g., Veteran's Administration, and contributions and endowments. Tax money supported these services in official agencies.

The philosophy of these agencies focused on self-help whenever safe and feasible. Therefore goals and services related to restorative and educational measures for patients with a potential for improvement and maintenance of as high a level of self-help for as long as possible for those patients with progressive pathology. Families were expected and taught to provide care between nursing visits and take over full care when competent to do so. This philosophy persists today and is incorporated in the standards for nursing practice.

The Medicare regulations precipitated some difficulties for these agencies in their failure to reimburse agencies for long term subacute care which constitutes a fair portion of the caseload. However, the popular notion that all health services for the elderly would be covered resulted in drastic cutbacks in community contributions. Smaller agencies could not continue to provide services to those unable to pay full fee and were not eligible for Medicare. Several went out of business or combined with Health Departments.

During the past five years we have witnessed the decline in the numbers of certified voluntary and official home health agencies and the growth of private non-profit agencies. In 1970 there were 41 County Health Departments certified for Medicare

reimbursement, 12 Visiting Nurse Associations, and 6 private non-profit home health agencies who limited their caseloads to Medicare eligible patients. In 1975, there were 22 County Health Departments, 8 Visiting Nurse Associations, and 56 private agencies. When I last checked a few weeks ago, there were 70 or more private agencies (Attachment 1).

Complaints began to come in to the Division of Health (presently known as the Health Program Office) and Public Health Nursing Section regarding the business practices of the private agencies. Complaints generally related to solicitation of patients and physicians, abandonment of patients after benefits were exhausted or referral of these patients to a voluntary or public agency for free care, and that patients and families were not taught nor encouraged to assume responsibility for their own care.

Comparative studies showed that voluntary and official agencies made on an average close to half the number of visits made by private agencies. Despite the fact that professional nursing visits outnumbered non-professional visits by 5 or 6 to 1, while the private agencies were closer to 1 to 1, the costs per visit by the private agencies were higher, (Attachments 2, 3 and 4).

Legislation to develop, establish, and enforce minimum standards for safe and adequate care of persons receiving health services in their homes under plans of treatment established by the attending physician, was enacted by the 1975 legislature. Rules to implement this law were developed by the Public Health Nursing Section with the advisement and assistance of representatives of each type of provider agency as well as other involved or related state agencies. The rules are in the final phase of promulgation.

I will highlight those sections of the rules that received the most attention or needed explanation.

First, we had to differentiate the services and training of the home health aide from the homemaker. Misconceptions were prevalent and there was some resistence to limitations of the functions of these two non-professional workers.

Secondly, the part-time intermittent characteristic of home health services in the definition was challenged by agencies that provide continuous care in the home. The legislation does not address services provided by private duty nurses wherever they are performed. Agencies that provide continuous aide or homemaker services can contract with licensed home health services agencies for professional care and supervision if desired. If they wish to participate as a licensed home health agency then they are required to comply with the regulations.

Qualifications of staff and ratios between supervisors, staff nurses and non-professional personnel were established as minimum reflections of existing patterns in Florida and nationwide. We require that the executive director have at least 3 years executive or supervisory experience in a health agency. A nursing supervisor shall be responsible for no more than 15 full time or 18 part time personnel. There is a maximum ratio of five non-professional to one professional worker.

Other efforts to assure the safety, quality, and continuity of care are demonstrated in those rules defining policies for the acceptance of patients, plan of treatment, plans for termination of care, and utilization review.

Licensure procedures include an on-site survey to ascertain compliance with the rules, evidence of fiscal responsibility, and a certificate of need from the areawide health planning council. Separate licenses are required for each county in which an agency operates and for autonomous dubdivisions. We are anticipating enabling legislation to allow areawide health planning councils to issue certificates of need.

Enforcement procedures include consultative services, surveys, inspections of records and patients, annual reports, renewal of applications, and denial, suspension and revocation procedures.

Throughout the rules, we have attempted to avoid conflict or contradictions with the Medicare regulations while remaining responsive to the needs of patients in relatively stable dependent conditions. The amount and frequency of professional care is often diminished in these circumstances. However, restorative, educative and protective measures must be incorporated in maintenance care during these stabilized periods. Chronically ill and aging persons receiving health services in their homes are the most vulnerable of all health care consumers. We hope that the Home Health Service Rules will protect these persons from abuse and exploitation and assure them of safe, competent, necessary care.

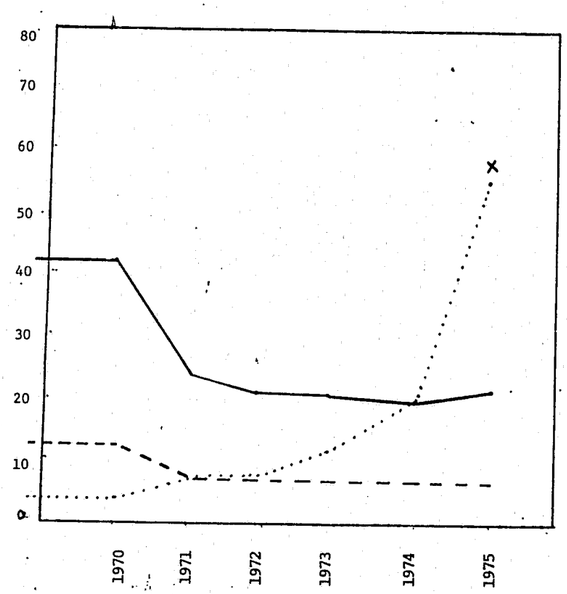
However, these rules will not do much to assist those agencies who offer care to all those who are referred despite ability to pay. Factually their status will be worsened since we now have close to 80 proprietary agencies awaiting licensure in addition to the non-profit agencies. Licensure opens the door to Medicare certification. Given the present numbers we will have about 150 agencies taking only patients with a full payment source and 30 agencies who accept part fee and free patients. If the proprietary agencies follow the pattern set by the non-profit agencies they will cluster in the southeast or Tampa Bay area of the state, creating geographic maldistribution as well, (Attachment 5).

If home health services are to be a reasonable alternative to institutional care then a system that reimburses for long term care for the chronically ill needs to be worked out. Standards of care to meet the nursing needs of such persons are already established by the American Nurses Association. Reimbursement for the services of certified nurse practitioners and clinical nursing specialists as co-managers of patient care with medical endorsement should be instituted.

Thank you for permitting me to address this committee today. I join you in seeking the improvement in the delivery of health care.

Attachment 1

Comparative Growth Rates of Certified Home Health Services Agencies from 1970 - 1975



	CHDs	VNAs	HHAs
1970	41	12	6
1971	24	8	8
1972	21	8	8
1973	21	8	11
1974	20	8	20
1975	22	8	56

57 Proprietary Agencies including branches requesting licensure in 1975.

XXXX Proprietary Agencies

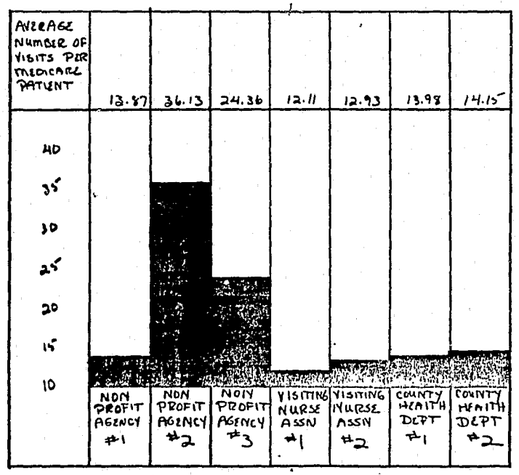
..... Private Non-Profit Agencies

- - - Voluntary Nursing Agencies

——— County Health Departments

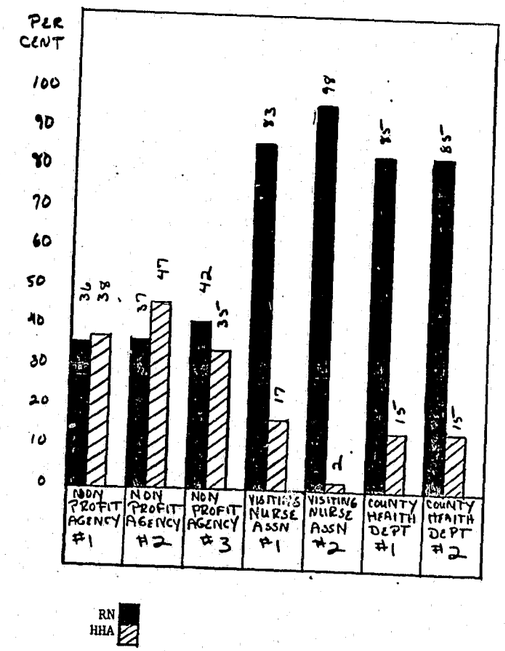
ATTACHMENT 2

COMPARISON OF AVERAGE NUMBER OF VISITS TO MEDICARE PATIENTS BY SELECTED HOME HEALTH AGENCIES



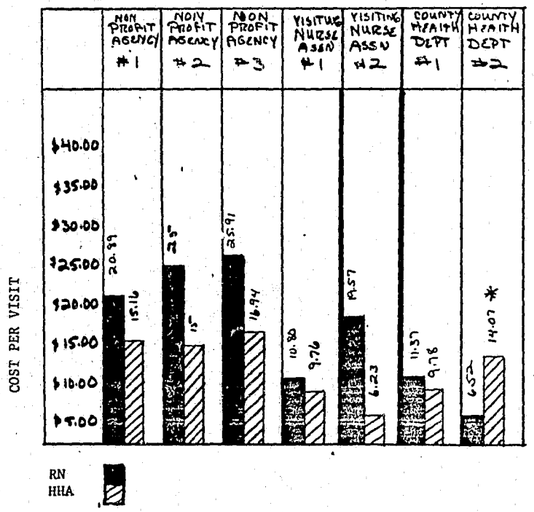
ATTACHMENT 3

COMPARISON OF RATIO OF RN VISITS TO HOME HEALTH AIDE VISITS BY TYPE OF AGENCY



ATTACHment 4

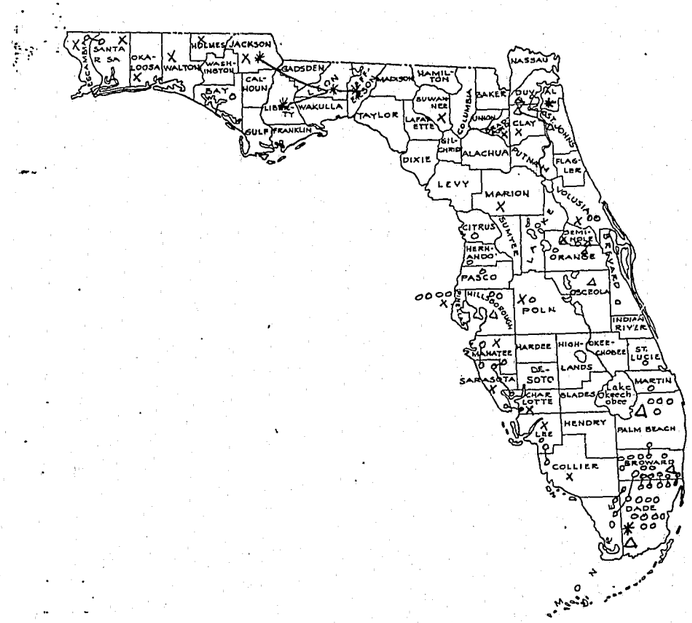
COMPARISON OF AVERAGE COST PER VISIT BY REGISTERED NURSE AND HOME HEALTH AIDES IN SELECTED HOME HEALTH AGENCIES



* Home Health Aides are used for lengthy visits (upto 3-4 hours) in this county.

ATTACHment 5 Location of Home Health Agencies Participating in Medicare : 1975

STATE OF FLORIDA



Legend:
- o PRIVATE Not for Profit Agencies
- x County Health Depts
- Δ Visiting Nurse Associations
- * Hospital Based Agencies

Douglas Richard of the Bureau of Health Insurance, Atlanta regional office, explained how the program operates and what conditions should exist in order for service to be rendered.

The pertinent part of Mr. Richard's testimony follows:

> The Medicare Act specifies that these services can be furnished to homebound individuals under the care of a physician, by a home health agency under a plan established and periodically reviewed by a physician. These services are to be provided generally on a visiting basis in a place of residence used as such individual's home.
>
> Home health services covered under medicare are furnished by home health agencies which must meet specific requirements of the act to participate in the program. The act defines a home health agency as a public agency or private organization which is primarily engaged in providing skilled nursing services and other therapeutic services.
>
> To be eligible for coverage for home health care under medicare a person must be essentially confined to his residence, be under the care of a physician, and need parttime or intermittent skilled nursing service and/or physical or speech therapy. The need for such care must be prescribed by a physician. If these requirements are met, a person is also eligible to receive other covered home health services. To qualify for home health care benefits under hospital insurance (part A of medicare), a person must have been in a hospital for at least 3 consecutive days prior to entry into home care.
>
> The care to be provided must be for a condition for which the person received services as a bed patient in the hospital and must be provided within the year following hospitalization or after a covered stay in a skilled nursing home following such hospitalization. Under part A, a person's coverage is limited to 100 home health visits in that 1-year period after the start of one spell of illness and before the beginning of another. A person may qualify for home health care benefits under medical insurance (part B of medicare), without prior institutionalization provided certain conditions are met. In such cases a person is limited to 100 home health visits in any one calendar year.
>
> The Bureau of Health Insurance (BHI) of SSA is responsible for establishing policy, and developing operating guidelines, and in collaboration with the Public Health Service, for prescribing standards for the participation of home health agencies under medicare. SSA has entered into agreements with public and private organizations and agencies to act as fiscal intermediaries in the administration of home health care benefits under part A and part B. Among other things, these fiscal intermediaries are responsible for (1) making determinations as to the coverage of services and making payments for services provided, (2) communicating to home health agencies information or instructions furnished by BHI and serving as a channel of communication between home health agencies and BHI, and (3) assisting home health agencies in establishing and applying safeguards against unnecessary use of services under the program.[1]

A hospital coordinator and a speech therapist who have had extensive experience in various home health agencies, related the most common abusive tactics to the subcommittee staff.

Speaking during an interview session immediately after the Miami hearings, the two home health agency personnel agreed that the following abuses were fairly common in many agencies and have generally gone undetected and uncorrected:

One: Home health agency patients are often kept longer than needed—patients given 5-day-a-week care and almost never decreased, causing the patient to become dependent on the agency. It becomes difficult for the home health agency to pull out even when skilled care is no longer needed.

Two: There have been instances where registered nurses in diabetic cases will visit for several weeks even if there are no complications—never utilizing teaching and fast rehabilitative practices. Again, the "maximum visits code" is practiced.

Three: Doctors on the agency board have been known to change diagnoses and often order prolonged care for patients. One patient [Broward County] was admitted in May for hypertension, was seen two times a week and never had any specialized care. The same patient was still being seen in July for osteoarthritis and internal bleeding. The physical therapist refused to give hotpacks to a patient bleeding internally so the doctor changed the diagnosis and order so the registered nurse would see the patient 3 times a week and initially daily for 4 days. This doctor also referred patients for chronic problems: One patient was receiving physical therapy, his wife wanted it so this doctor ordered physical therapy for the wife who had leg deformities for over 20 years.

Four: The executive director often overrides professional personnel in their judgments of what is indicated. The director—agency in Broward County—would tell the staff to add vital signs, monitoring, and other services and could not decrease patient care without her approval. The executive director of this same agency has no medical background.

Five: The executive director has told registered nurses to change notes and add orders; that is, monitor diet, to the plan of treatment which is mailed to the doctor to sign. The director then uses the excuse that the doctor signed it so we are covered.

Patient charts were changed with liquid paper as needed, Xeroxed copies sent to Jacksonville were undetected as liquid paper not visible on copy.

Constantly personnel are told to stretch the limit: One owning doctor told a staff conference "have to fudge a little." Staff are told in agency meetings: "Everyone rips off medicare" and felt there was nothing wrong with that. Staff is often told it's very important to use the "proper wording so medicare will pay."

Often when visits are nearing the 200 mark, the administrator will arrange to have patients readmitted for 3 days so that care can be resumed.

---

[1] From testimony by Mr. Douglas Richard of the Bureau of Health Insurance.

In initial stages at Broward, a patient was admitted for physical therapy to receive hotpacks—there was no physical therapist at that time—the director of nursing instructed staff nurse to write a visit that she put hotpacks on the patient. No visit was ever made by a registered nurse or physical therapist and medicare was billed for the treatment.

Aides instructed to spend more time than actually needed—if only one-half hour is needed told to say 1½ hours.

Told to "stretch the limit."

A patient discharged after 6 visits and no further problem told it doesn't look good.

On a patient basically constipated, the doctor ordered an enema. The director of nursing instructed the registered nurse to chart high colonic enema given because medicare will cover that.[2]

The end product of overutilization was spelled out by the panel of executive directors of visiting nurses associations in testimony in Miami as they told of having to take on patients whose "visits" had been used up and had to depend on the public agencies for assistance.

The subcommittee found no reason to believe that the total number of visits authorized by medicare—200—was inappropriate but rather that the patient was often "exploited" in the use of visits simply so that the agency could attain the maximum number of visits authorized by law.

The letter submitted in evidence at the hearings in Tampa on April 15, 1976, typifies the problem that overutilization often brings:

SEPTEMBER 15, 1975.

Mr. _____,
Bureau of Health Insurance,
Atlanta, Ga.

DEAR MR. _____: I appreciate your call last Friday and enjoyed talking with you. Per request I am enclosing descriptions of some of the events that you transpired which you may find of interest.

I am afraid that some of the impact will be lost without a personal interpretation, and, of course, these are copies as I collected them with only a few comments added to aid in clarification.

The patterns we have seen in dealing with (another home health agency) have been primarily (1) their aggressiveness, in securing patients by being ever present in hospital clinics, on hospital wards, and in physicians' offices even to the extent of opening records on known VNA patients and (2) the amazing accuracy with which a patient's maximum rehab potential is forecast which almost without fail parallels the exhaustion of MCA benefits on a 2½ to 3 month period. An excellent example of course is (patient) whom we discussed, who received 39 visits in August (having received 97 MCA visits through 31 August) and miraculously improved so that her record could be closed on 5 September by telephone.

You may wish to contact manager of the Medical Division of J. B. Hickey. His phone number is ____.

When I receive more information which I feel may be of interest to you, I'll send it along. In the meanwhile I hope you find the enclosed of at least some help.

Sincerely,

(MRS.) JUDITH TRAVIS, R.N.

Senator Chiles inquired as to the frequency of that problem—overutilization—for the public agencies during hearings in Miami:

> Senator CHILES. Have you all had any patients referred to you that had expended as charitable patients, their 200 visits expended under medicare?

[2] From interview with home health agency personnel in Broward County and Dade County by subcommittee investigators.

Mrs. ADAIR. We all have had that experience.

Senator CHILES. Would you tell me what kind of frequency and what kind of detail or if you cannot today, would you furnish that to me for our records?

Mrs. ADAIR. Yes; we would be glad to.

We have an average of one request a day to see a patient who has been cared for by another agency, has used up all the medicare visits, or maybe there are just a few visits left where we can receive payment from medicare, or a patient who does not need what is termed as skilled nursing care, so that medicare will not reimburse the other agency, so that patient is referred to us.

Senator CHILES. So, you have an average of one case a day which has used up their 200 visits?

Mrs. ADAIR. Yes.

Senator CHILES. And then, they are dumped into the—they are deemed charitable patients?

Mr. ADAIR. They may not have used up 200 visits, no, because medicare is very careful as to what they will pay for, you know, whether it is skilled nursing or not.

If the patient has, sometimes they have used up 100 visits, sometimes they have used up 200, but I cannot tell you how many or like that.

Mrs. BROWN. It works pretty well the same way.

The patient is pretty much custodial by the time we get there.

We have got two referrals from the other agencies to go in and give the care, but most of them come directly from the patients themselves.

Senator CHILES. What kind of frequency do you experience?

Mrs. BROWN. About once a week is what we are getting.

Senator CHILES. And that is Palm Beach County?

Mrs. BROWN. Right.

Mrs. DEAGAN. I cannot give you any definite answer, because when this proliferation first started, we had a social worker call us from one of the other agencies to inform us that they were dropping the patient and that patient from her checking out of his financial situation would be free.

This, we do not do. We do our own evaluation of whether a person can pay part or all because we are entrusted with United Way's monies, which we have to be answerable to the donors for, as well as we feel that we should be answerable to our own taxpayers.

ADMINISTRATIVE ABUSES THAT WERE LISTED BY HOME HEALTH AGENCY PERSONNEL

REFERRALS

The following ways of abusing medicare have been observed:

(1) When the registered nurse calls the doctor, she will get a diagnosis. The doctor will, at times, tell the registered nurse to "see what you can do." Then, she will write the referral with her own orders—"monitor vital signs, monitor diet and elimination, monitor medication"—even before seeing the patient, the orders are written by the office R.N. often to include home health aide visits 5–7 times a week.

(2) The doctor may order physical therapy evaluation or just physical therapy—before the therapist sees the patient—the office registered nurse will write orders—"gait training, ambulation techniques—improve mobility." The registered nurse often suggests to the doctor—the patient may need physical therapy. Often, physical therapy is obtained for chronic problems—chronic arthritis—then the diagnosis is recorded using the word acute—"acute flare-up of old arthritis or acute exacerbation."

(3) Equipment is often ordered before the patient is admitted. This equipment is often unnecessary.

(4) The office registered nurse will be sure to write the referral for the maximum number of visits—the doctor rarely indicates the amount of visits per week or he may say—"let the registered nurse evaluate." The referral is then writtten—registered nurse evaluate, see patient, 3–5 times a week—the field nurse is told to see the patient 5 times a week and decrease gradually—always use the maximum.

(5) Home-health aide visits are written on the referral before the need for care is determined by the field nurse. The patient or family is usually promised an aide on the phone before care starts. The family is distraught if an aide is not assigned at the time of admission even if it is explained that there is no need for one—it is not uncommon for the patient to seek another agency where they will get an aide.

(6) Orders have been received for vitamins B–12 shots with diagnosis of hemolytic anemia—not covered by medicare—the administrator then told the nurse to change the diagnosis to megalablastic or pernicious anemia and write a note to the doctor telling him why it was changed so the patient could be covered.

(7) Orders received for physical therapy on a patient with a prostrate disorder.

(8) On a patient, the doctor gave no orders—he told the registered nurse she needed someone to prepare meals, et cetera, and only needs an aide—the doctor related no skilled care needed several minutes later, the executive director (local home health) called the doctor and gave the registered nurse orders to monitor vital signs, meds, and fluid

intake. The E.D. was not a registered nurse and frequently did this—actually taking verbal phone orders from doctors.

(9) In several instances, the doctor will tell the registered nurse—will sign anything sent to him after the nurse sees the patient. He relies on the registered nurse to do a fair evaluation—if care is not indicated, the orders are sent to the doctor—including monitor vital signs, medicine, and home-health agencies.

(10) The office registered nurse will often question the doctor if the patient has hypertension or diabetes or heart disease if one of them is present, the registered nurse will tell the doctor "we can see the patient for this" regardless if the problem is chronic. Long standing diabetes cases are picked up to monitor diet and medicine. Stabilized hypertension and heart disease are picked up to monitor vital signs and medicines.

(11) Patients that are not homebound are seen for therapy at home after it is suggested to them if they would like therapy at home rather than going out.

(12) Examples:

(*a*) Patient with diabetes for several years and controlled and hypertension controlled was admitted after hearing a speech by the agency. Patient's son wanted someone to stay with the patient for an hour every day for a while, while his wife was in the hospital. The registered nurse went to monitor medicine, the aide went five times a week after several days, the son's wife came home and he canceled care—patient no longer needed it.

(*b*) A patient with diagnosis of acute arthritis had a CVA 2 years ago was explained to the office that homebound was a requirement. This patient went out for speech and physical therapy. The admitting doctor—connected with the agency—ordered passive range of motion. It was explained that this was not covered under medicare—the doctor changed the orders and insisted on the admission. The patient was receiving speech therapy for the primary diagnosis of arthritis—was not homebound and preferred to get therapy at home rather than go out—also it was free this way.

(*c*) The order was received with diagnosis of arthritis. The executive director changed the diagnosis to acute arthritis so medicare would cover. This patient's doctor is also on the review committee of the agency—several days later he changed the diagnosis to degenerative arthritis with acute exacerbation and needs physical therapy for ambulation purposes. This patient was not homebound—took the bus weekly to see the doctor—this patient seen five times weekly for physical therapy.

(*d*) Charts backdated so they will be eligible for plan "A." If patient can be admitted within several days of the 14-day period, chart can be backdated—explained to family they can have 200 visits.

(*e*) Patients seen without receiving orders from physician. The field nurse calls the doctor with a question and he wants to know what you are seeing the patient for—he never gave orders.

(*f*) The nurse is told by the executive director to always add vital signs to plan of care so there will be a skilled care.

(13) After a doctor is appointed to the board, his patient referrals start to come in rapidly and often with little thought given to eligibility.

74-599 O - 76 - 4

One doctor ordered care on a patient who had a foley catheter for years—he ordered special care—the office was told not to see the patient at certain times because the patient went out to eat and won't be home then.

This same doctor ordered registered nurses daily on another catheter patient and also physical therapy. Also ordered another patient to have daily physical therapy on a chronic arthritic. All referrals came in within 1 day of his board appointment.

On referrals, the registered nurse in the office or administrator are sure to speak to the doctor or his nurse and suggest some means to see the patient.

DISCHARGES

The order is constantly given to home health personnel not to discharge the patient too soon as medicare will get suspicious.

One agency will not allow the registered nurse to call the doctor regarding a discharge—the administrator will review the chart and decide when the patient should be discharged. This administrator (BHHA) felt there were too many discharges in 1 week—she told the registered nurse when a doctor orders a discharge she should not write discharge patient—she should write "doctor is suggesting discharge in future." She, the administrator, would explain to the doctors that medicare requires the care to be taken away slowly.

If there is an end to the skilled care and the home health agency is still going in—the care must continue until the aide can be gradually decreased.

Some patients are kept so long that doctors call and ask why the patient is still being seen or concerned patients dismiss the care themselves.

Often care is prolonged for discharge planning—started too late—care then extended so a patient turnover to a custodial agency can take place.

AUDIT ABUSES

Personnel at several home health agencies identified problems dealing with improper auditing procedures used by private home health agencies.

Those problems were: (1) A complete review and rewriting of doctors' orders on patients to conform to actions already taken that the doctors did not authorize; (2) persons—usually registered nurses—who never saw the patients gave detailed instructions or filled out charts themselves to reflect skilled nursing care when unskilled care was, in fact, administered to the patient; (3) nurses were instructed to fill in items that were "medicare covered" on all visits made to patients when, in fact, some visits would not have been covered by medicare; and (4) some visits are upgraded to reflect different time spent on a visit or one visit of 1 hour is reflected on two different days although only 1 day was actually spent in the patient's home.

REASONABLE COST

The comparison between visiting nurses associations and private home health agencies in salaries, pension plans, and visit charges

raised anew the allegation that the private agencies were abusive in their treatment of total cost.

Mr. Richard's testimony dealt with the special problems encountered by the Bureau of Health Insurance when home health agencies are established:

Interim rates and periodic interim payments

When a new HHA is established it submits a projected budget to the intermediary. Based on this and estimated visits to be made, a cost per visit rate is established. Of course, if the budget contains unreasonable costs which are not reduced, an excessive interim cost per visit rate may be set and, as claims for visits are paid, overpayments can occur. Therefore, it is important to examine the projected budgets closely, rather than waiting until cost reports are filed and audited at the end of the year.

In recognition of problems in this area, BHI CO issued an alert dated February 12, 1976, to all intermediaries [attachment 2] to carefully review the reasonableness of projected overhead costs. The teletype message requested "that intermediaries bring to bear an immediate careful scrutiny of such reimbursement" with regard to newly established HHA's.

The alert also directed close intermediary examination of requests by new HHA's for periodic interim payment (PIP). PIP (periodic checks mailed to an HHA based on the interim rate established and on the projected medicare utilization) has the potential of causing overpayment to new HHA's where it turns out that the estimated costs are unreasonable and/or their projected volume does not materialize. In other words interim rates and PIP require close monitoring rather than expecting the cost report and actual medicare utilization to coincide with what was estimated.

The reasonableness of administrative expenses claimed by "100 percent medicare" HHA's is one of the more serious issues uncovered. For example, the RO found three members of a family operating two HHA's and claiming salaries from both facilities (including deferred compensation of 25 percent) totaling over $118,000 per year. We have instructed the intermediary not to settle the cost report for this provider without clearance from us.

When the RO became aware of the high amount of some of the administrative salaries, all intermediaries were requested to send a copy of the most recently audited cost report for each HHA they serve. Because of the four different methods under which cost reports of HHA's may be filed, and the fact that all cost items are not reported identically within the particular line items of a cost report, meaningful comparisons were not possible. Therefore, in late October the RO designed a survey form and requested intermediaries to survey all Florida HHA's with respect to salaries and deferred compensation.

Preliminary analyses of the survey data disclose a wide salary range in "nonprofit" HHA's in Florida. Administra-

tors' salaries (adjusted to a 40-hour week) vary from $13,500 a year to $42,000, with an average of $23,726. Executive directors vary from $15,000 to $40,000 (average $24,790). Nursing directors vary from $10,800 to $26,400 (averaging $17,114). Administrative assistants vary from $3,456 to $28,000 (average $15,256). Not only do specific salaries vary, but also the number of major administrative positions (and costs); for example, one HHA has five key positions paid a total of $136,533; another has three receiving $86,631; and still another has two being paid $57,200. Deferred compensation plans also varied from 0 to 25 percent of yearly salary. This compensation and "overhead" does not always seem to be related to relative administrative responsibilities.

The RO survey results are being used to develop guidelines regarding salaries and deferred compensation similar to what is done with respect to owner's compensation guidelines for proprietary hospitals and SNF's. When completed, they will be forwarded to the BHI central office for review prior to implementation.

However, even with the compensation guidelines, the RO has no illusions that the problems end there. For example, when unreasonably high salaries paid by one HHA were uncovered, at RO direction the intermediary made large cost reductions. In October 1975, the RO notified the intermediary to use the same cost reduction rationale when determining reasonableness of cost claimed by other HHA's. One HHA has retained counsel and has appealed the reductions. The attorney has requested and received copies of the RO salary surveys. In other words, indications are that cost reductions will be vigorously appealed. This appeal will be heard in April.

BHI has also been concerned about the cost of management services furnished by some organizations. Central office is working on cost reimbursement policies applicable to management services. In the meantime, the RO is following up on indications that one organization may not be furnishing all the management services as outlined in their contracts. Further information is also being obtained on the fees and services of an attorney who is setting up and selling HHA's in Florida.

The most recent action on administrative salaries and pension costs occurred on March 25, 1976, when the Atlanta RO held a meeting of provider reimbursement representatives from intermediaries servicing Florida and from their home offices. Representatives from Aetna Life and Casualty, Blue Cross of Florida, Travelers Insurance Company of America, Blue Cross of America, the Division of Direct Reimbursement of BHI, and the regional office met in Atlanta. The objectives were to disseminate and discuss the preliminary results of the recent RO salary survey of Florida HHA's, to exchange experiences, and to establish some degree of uniformity among intermediaries in the resolution of the problems and issues relating to reasonable cost reimbursement.

Methodology was agreed on at the March 25 meeting to use in making salary adjustments (until the survey results are

finalized and cleared). In addition, Florida Blue Cross has surveyed the pension plans of facilities in the Tampa SMSA. The average of all facilities with pension plans was about 7 percent. Nine percent is paid by State hospitals in Florida, which is the largest group of hospitals in the State. The group agreed that no more than 9 percent will be allowed for pension plans of HHA's, since there seems to be no reason why these costs should vary by type of facility. Florida Blue Cross will furnish the RO with a copy of its survey which will be furnished to the Florida intermediaries in support of reasonable cost reductions to the 9 percent level. Florida Blue Cross will also provide the RO with a draft of a pension-cost survey form. This will be distributed to the other intermediaries. We will then ask the intermediaries to survey all providers in the State in order to further document this approach.

Section 223 of the 1972 amendments to the Social Security Act can be used to limit program reimbursement to costs that would be incurred by a reasonably prudent and cost conscious management. The implemented regulations published to date have placed absolute dollar limits on the routine inpatient service costs of hospitals. The Atlanta regional office has recommended to CO that similar limits be developed and placed on HHA's (memorandum dated April 2, 1976). This is in recognition of a basic problem in applying reasonable cost concepts to some HHA's who have no social incentive to control costs an who have a strong personal economic incentive to maximize costs.

The RO plans to hold a future meeting (similar to the March 25 one) for reimbursement personnel from other-than-Florida intermediaries to insure uniformity in dealing with HHA problems.

TABLE_____

SALARY AND CHARGE COMPARISONS

REASONABLE COST - A LEGITIMATE CONTROVERSY
(Partial Survey of Home Health Agencies)

	*Skilled Nursing Care	*Physical Therapy	*Speech Therapy	*Aide
Home Health Services of Dade County (No. Bay Village)	$35.00	$35.00	$35.00	$12.00
Visiting Nurses Association of Dade County (Miami)	19.00	13.80	15.00	9.50
Alaris Home Health of St. Petersburg	35.00	20.00	20.00	15.00
Visiting Nurses Association of Hillsborough County (Tampa)	15.00			8.00
South Dade Home Health Services, Inc. (Miami)	35.00	35.00	35.00	12.00 (hourly)
Medi-Health, Inc. (Ft. Lauderdale)	22.55	29.20	25.55	11.45 (hourly)
Home Health Services (Sarasota)	20.02	20.02	20.02	
Nurses' Professional Registry (West Palm Beach)	12.50 (hourly)			
Visiting Nurses Association of Broward County (Ft. Lauderdale)	17.50	17.50	17.50	9.50
Palm Beach Regional Visiting Nurses' Association (West Palm Beach)	25.00			

*Cost per visit

TABLE_____(CONT.)

	*Skilled Nursing Care	*Physical Therapy	*Speech Therapy	*Aide
Florida Home Nursing Care, Inc. (Miami)	$30.00	$45.00	$45.00	$15.00
Broward Home Health Agency, Inc. (Ft. Lauderdale)	30.00	45.00	45.00	15.00
A Associated Home Health Agency, Inc. (Miami)	28.00	30.00	30.00	12.00 (hourly)
Hollywood Home Health Agency, Inc. (Hollywood)	30.35	45.00	45.00	15.00
Metropolitan Dade County Dept. of Human Resources (Miami)	19.00	13.80	35.00 1st visit 15.00 all others	9.50
Unicare, Inc. (Miami)	30.00	13.80	35.00	15.00
Gulf Coast Home Health Services (St. Petersburg)				22.00
Unicare, Inc. of Ft. Lauderdale	30.00	13.80	35.00	11.50 (hourly)
Manasota Home Health Agency (Manatee)	27.00	Contract	Contract	12.00 (hourly)
Home Health Services of U. S., Inc. (Hallendale)	30.00	45.00		12.00 (hourly)
Gold Coast Home Health Services, Inc. (Pompano Beach)	28.94			22.61

*Cost per visit

TABLE_____(CONT.)

	*Skilled Nursing Care	*Physical Therapy	*Speech Therapy	*Aide
Florida Home Health Services, Inc. (Miami)	22.00			11.50
Florida Home Health Services, Inc. (Miami)	22.00	13.80 Contract		18.00
Bay Area Home Health (Pinellas Park)	26.94	30.00	30.00	13.00 (hourly)
Tampa Gulf Coast Home Health, Inc. (Tampa)	30.00	30.00	30.00	15.00
Florida Health Related & Professional Services (Coral Gables)	30.00	35.00	35.00	12.00
Bay Home Health Care Agency, Inc.	35.00	43.00		20.00

*Cost per visit

The subcommittee tried to determine why the cost per visit was so much higher among private, nonprofit agencies than among the public agencies.

During the interviews that were held by subcommittee investigators, the one theme seemed to be that overhead cost by the private agencies justified higher charges per visit.

Medicare officials were somewhat reluctant to deny these charges as the private nonprofits were in accord with prices established by other private, nonprofit agencies.

AREA A
(Pinellas, Pasco, Hernando, Sarasota and Manatee Counties)

AGENCY CODE #	MEDICAL DIRECTOR	ADMINISTRATOR	EXECUTIVE DIRECTOR	NURSING DIRECTOR	AGENCY CODE #	COMPTROLLER	ADMINISTRATIVE ASSISTANT	CLERICAL (AVERAGE)	OTHER-OFFICE MGR.	ASSOCIATE DIRECTOR-NURSING	HOSPITAL COORDINATOR
1	$ 37,794		$ 22,831	$ 14,359	1			$ 5,060			
2	14,040	$ 33,333	40,000	30,000	2	$ 20,000	$ 26,666	8,320	$22,500	$ 23,846	
3	16,000	25,000	15,000	20,000	3	16,000	20,000	6,666	16,666	14,286	
4	16,000	40,000	20,000	12,500	4	26,667	20,000	6,666	9,333	12,500	
8			26,667	16,000	8	20,267		6,649			$12,800
17	80,000	14,400	20,000	14,400	17	20,000		6,900			
24	22,464	33,333	40,000	29,000	24	20,000	21428	8,320	21,875	16,154	
51	47,333	41,915	29,800		51	18,000		5,753		14,916	11,212

AREA B
(Dade, Broward and Palm Beach Counties)

AGENCY CODE #	MEDICAL DIRECTOR	ADMINISTRATOR	EXECUTIVE DIRECTOR	NURSING DIRECTOR	AGENCY CODE #	COMPTROLLER	ADMINISTRATIVE ASSISTANT	CLERICAL (AVERAGE)	OTHER-OFFICE MGR.	ASSOCIATE DIRECTOR-NURSING	HOSPITAL COORDINATOR
9	$ 30,000	$ 15,000	$ 25,000	$ 15,000	9	$ 15,000		$ 5,557			
			15,000 [1]		11	13,500		6,344			
11	52,000	13,500	24,000		13			7,800			
12	60,000		24,000	17,829	14			7,211			$11,840
			12,000 [2]		16			7,280			
13	75,000		20,000	13,000	18	18,000		4,286			
14	76,800	21,333		17,067	19			7,800			
16	24,000	20,000	25,000	18,000	20	23,400		5,756			
18	24,012	24,008	26,000	17,640	21	20,000	$ 28,000	4,380			
19	50,000	20,000		15,000	22		11,550	7,294	$12,000	$16,700	12,200
20		36,400		20,800	23	24,533		8,141			14,080
21	35,000	42,000		16,800	"	(27,733 Vice-President/Treasurer for Code #23)					
22	60,400	60,400	29,200	26,400	12						
	36,000 [3]										
23	75,000	26,667	38,400	24,533							

AREA C
(Bay, Seminole, Orange, Duval and Escambia Counties)

AGENCY CODE #	MEDICAL DIRECTOR	ADMINISTRATOR	EXECUTIVE DIRECTOR	NURSING DIRECTOR	NUMBER OF POSITIONS	AGENCY CODE #	COMPTROLLER	ADMINISTRATIVE ASSISTANT	CLERICAL (AVERAGE)	OTHER-OFFICE MGR.	ASSOCIATE DIRECTOR-NURSING	HOSPITAL COORDINATOR
5	$ 96,000	$ 22,500	$ 22,500	$ 10,488	9	5	$ 22,500		$ 7,200			
6	54,995		16,213	14,400	37	6			6,298			
7	59,987		24,533	16,000	59	7			8,434			
10	48,000	18,000	26,000		80	10			7,800	$14,500		
15	96,000	18,000		10,800	21	15			4,513			

Salary ranges for administrators of private nonprofit home health agencies was from $13,500 yearly to $60,400. The only guideline administrators had to follow was to be sure that they took in enough clients to cover their salaries.

Salary ranges for executive directors of private, nonprofit home health agencies are based from $12,000 to a high of $40,000 yearly.

The projected salary for medical directors—if rates are used for a 40-hour week—would range from a low of $14,000 to a high of $96,000.

Nursing directors are salaried from $12,500 to $30,000 yearly.

The range for comptrollers are from $13,500 to $26,667.

The range for hospital coordinators are from $11,212 to $14,080.

The range for administrative assistant was from $11,500 to $28,000.

For associate nursing directors the range was from $12,500 to $23,846.

One agency with approximately 100 personnel, a 25-percent pension plan paid its comptroller $20,000; administrative assistant $26,666; its office manager $22,500; its associate nursing director $23,846; its medical director $14,040; its administrator $33,333; its executive director $40,000; and its nursing director $30,000. A total of $210,052 all with medicare funds.

ABUSES WITH DURABLE MEDICAL EQUIPMENT

The abuses involving medical equipment were first brought to the subcommittee's attention by Mr. Paul Kraemer, president of Medical Home Products and Medicare Systems Consultants, of Hollywood, Fla. Mr. Kraemer illustrated the situation that has been standard operational procedure for many durable medical equipment dealers concerning the false billing to medicare for oxygen which was not continuously supplied but continuously billed.

The exposure of the oxygen abuse situation led investigators to an examination of the billing procedure used by medical equipment suppliers and approved by the Bureau of Health Insurance, Social Security Administration.

Without Mr. Kraemer's persistence and knowledgeable contribution, the early work of the subcommittee investigators would have been extremely difficult and exploratory.

In his testimony before the subcommittee in Tampa, Mr. Kraemer outlined several areas of abuse in the medical equipment field.

The circular pattern that the subcommittee found was an agency that was particularly aggressive would increase its clientele to the extent that more personnel would have to be hired so that the funds would not be classified as "profit," because private nonprofit agencies only used other private nonprofit agencies for comparative analysis.

So, new agencies automatically started up with high projections on both administrative salaries and visitation charges. Therefore, "reasonable" salaries and charges are "reasonable" only because they are compared to other already posted but high cost.

The subcommittee compared the base salaries and costs to visiting nurses associations and county groups and found that private, nonprofit agencies were twice as expensive as the public agencies.

What kinds of questions and problems am I talking about? Let me give you some examples.

A typical situation would be as follows: Dealer A has been supplying oxygen and a hospital bed to Mr. Jones for a few months. Mr. Jones needs hospitalization for a couple of days, and when he comes home he receives the services of an HHA and, therefore, is entitled to receive his bed and oxygen under medicare part A 100 percent reimbursement through the agency. Dealer A is quite satisfied to bill the HHA and comply, but either the nurse or patient tells him that he must remove his equipment because the agency has an arrangement with another dealer who will immediately substitute his equipment. The HHA will not accept billing from dealer A. The act at section 1801 guarantees freedom of choice by the patient. This guarantee is negated by these arrangements between dealers and agencies.

In this same situation, dealer A, in order to save his business, contemplated the possibility of offering the patient to continue billing under medicare part B, but to forget the 20-percent bill he would normally have sent to the patient. He asked us about the propriety of such a practice, and we advised him not to do it. But, as you can see, because of the agency involvement, the dealer loses his business and is frustrated by the rules he should follow.

The problem of the 20 percent and the $60 deductible goes much further. Of late, through our own personal experience and the experience of others as well, more dramatic control of DME dealers by some HHA's has come to light. These HHA's have realized that there is supposedly no profit to be made in the including of DME in their plans and billing, therefore, they don't want to be bothered with the paperwork. On the other hand, many patients have become sophisticated enough to know that there should be no cost to them while nursing services are being received, so, to remain in the highly competitive market that now exists, the HHA forgives the 20 percent and frequently the $60 deductible. If the dealer refuses to go along, he gets no business from the agency. In such a case the HHA really asks the dealer to ignore the intent of the act and not to comply with regulations to bill under part B. It also, in effect, asks the dealer, a profitmaking concern, to do away with 20 percent of the reimbursement of allowable charges to which medicare says he is entitled. You remember, gentlemen, that DME dealers do not work on a cost-plus basis as an HHA does, but rather with charges as decided by medicare when he accepts medicare payment.

There is a multistate DME company that has taken the approach of soliciting HHA business by blanketly forgiving the deductible and 20 percent to all agency patients. BHI has been notified of this and has done nothing about it. The same company uses other questionable practices such as oxygen cycle billing, a practice that Bob Harris well understands, and billing to intermediaries outside the patient service area—collecting incorrect rates. BHI has known of these practices for several months and has done nothing. Frustration!

We are aware of HHA's taking providers' bills which are attributable directly to a single patient, adding a markup to the providers' invoices, and submitting the marked-up figure for reimbursement to medicare. BHI in Baltimore agrees that this is wrong. Just last week, I received a report that when this was turned in to the Philadelphia regional BHI office, they agreed that it was wrong, but weren't con-

cerned because the reimbursement is on cost, not submitted bills. A week before that, a BHI employee from the Atlanta region told me that he doubted that such things would ever be found on audit if the auditors were not told to look for the markups. He stated that until now they have not been instructed to look for such things. A portion of the Moreland Act Commission on Nursing Homes report, released last week, talked of "cursory" audits of medicaid nursing homes in New York. Should we assume that the quality of medicare audits of HHA's is better considering the differences between the Philadelphia and Atlanta region statements?

CONFLICT OF INTEREST

The subcommittee explored the opportunity for abuse and overutilization because of a doctor's ownership and involvement with a private, nonprofit health agency.

In the Miami hearing, Senator Chiles raised the question of conflict of interest with Dr. Samuel Leone, a doctor involved with several home health agencies in south Florida.

Senator CHILES. The issue of doctors owning home health care agencies has come up.

There is a feeling that when doctors own agencies, they tend to make referrals to those agencies which they own, therefore, creating a conflict-of-interest situation.

What is your response to that?

Dr. LEONE. My response is direct: I am an orthopedic surgeon. I refer my patients to the Hollywood Home Health Agency unless there is a geographic problem.

I do this because my patients need good physiotherapy and rehabilitation, and this is my forte.

My physiotherapist is a registered physiotherapist, is excellent in his field. These are my patients who need this service.

Rather than keeping them in the hospital at $200 a day, I can let Hollywood Home Health Agency refer them there, because I discuss with my therapist.

So, what you are asking me and referring to agencies, yes, I refer them to my agency, as I would eat in the same restaurant that I own if I know what I am doing is good.

Senator CHILES. Well, when you eat in a restaurant that you own, you are using taxpayers' dollars.

Dr. LEONE. The reason for it, as I told you, I know what my agency can do and my therapy department can do for my patients.

Senator CHILES. Is there a potential for conflict?

Dr. LEONE. Yes, I can see a potential conflict. I can see a conflict.

Senator CHILES. If we are going to allow it to happen, if we are going to allow doctors to involve themselves how do we protect the public and how do we convince the public that there is no conflict?

What kind of guidelines or code do you need if you are going to allow it to happen?

You know, it was not sufficient that Caesar's wife was chaste; she had to appear to be chaste.

Dr. LEONE. Well, I am prejudiced by saying I have faith in the doctor who refers to the agency he is "owning."

Senator CHILES. But I have got to protect the taxpayers. That is the job I am supposed to handle.

Dr. LEONE. I would like to say that the agency is doing the job and doing it the way it should be done, and then I would see no reason why that doctor, if he owns the agency—I do not like the word "ownership," because I own nothing but notes in a bank that I have to pay.

Senator CHILES. If we were dealing, you know, in a private arm's-length issue where people are paying for these services, and where there is competition and all, then I would not see particularly the problem, maybe.

But now, we are dealing with taxpayers' funds, and we are dealing with the potential of a doctor—you are taking $14,000 a year out, but we have people that are taking, you know, much, much more than that.

Dr. LEONE. I believe I should take more for the time I put in, too, but it is not there.

Senator CHILES. Maybe you are going to start doing it.

Did you get yourself enough coordinators around? [Laughter.]

Dr. LEONE. No, no, Senator.

I practice in the same area that this agency of Hollywood practices, on the same floor of the building.

My income, my livelihood has been orthopedic surgery. I am not going, for $15,000 a year, to jeopardize my $85,000-or-better salary as an orthopedic surgeon.

Senator CHILES. Doctor, I want you to understand I am not trying to cast aspersions on you personally or how you conduct your business or what your own ethics are.

I am only here looking at a problem and trying to determine which controls and guidelines need to be placed on that; and, if so, what kind of guidelines.

Is there a potential for conflict? If the potential is there, how do you cover it and that is the reason for me asking you these questions.

Dr. LEONE. I honestly do not see a conflict or problem developing in a situation where a doctor refers his patients to an agency that he has input.

I cannot see a problem there; I really cannot.

If he was overutilizing it, just for the sake of sending a patient to the agency, then you are talking about a patient who does not need any agency; you are talking about a patient who has no need for it.

Then, yes, there is a conflict.

Senator CHILES. When you tell me you are an orthopedic surgeon, I know you are probably paying so much money in taxes, and you do not want to spend much more money; but every doctor does not exactly fit into that field and would not necessarily be an orthopedic surgeon.

I happen to differ from you: I do see a potential for conflict and I see a potential, a strong potential for the loss of public credibility for a program wherein you have a doctor also sort of a proprietor or the owner of the program, and in a position where he can benefit from referring his patients.

Dr. LEONE. I would be satisfied with your explanation, but I am prejudiced because I can only see it from my point of view.

Senator CHILES. Thank you very much for your testimony, Doctor.

THE PROPRIETARY AGENCIES

Because the implementation of Florida's new licensure law will make proprietary agencies eligible to receive payments for medicare patients, the subcommittee in each of its hearings invited representatives from the proprietary agencies in Florida so that a view of their operation and expectations could be ascertained.

There are approximately 45 proprietary agencies in Florida. Homemakers Upjohn with 18 offices is by far the State's largest corporate concern.

Mr. William E. Madsen testified on behalf of Homemakers Upjohn in the Tampa hearings. In presenting the case for proprietary agencies, Madsen stated:

> I think the prime consideration is our availability of service, quality of service and cost of service. I think that service should be bought on a bid basis. If somebody can do it better and less expensive and more economically than Homemakers-Upjohn, they should do it.
>
> Senator CHILES. You are talking about competition and putting the element of competition into it?
>
> Mr. MADSEN. Yes, sir, and I have been driving Chevrolets since 1949, and I like Chevrolets. I like General Motors products.
>
> Senator CHILES. How many agencies does Homemakers-Upjohn have in Florida, and would this increase with the application of the new law?
>
> Mr. MADSEN. We have 18 agencies located throughout the State of Florida.
>
> If they did increase it would not—they would not increase appreciably. Specifically by appreciably I doubt there would be any more than two or three.
>
> Senator CHILES. What about your charges?
>
> Mr. MADSEN. What do you want to know about them, sir?
>
> Senator CHILES. Would they increase?
>
> Mr. MADSEN. No, sir. I don't see why they would, sir.
>
> Senator CHILES. What are your charges for a nurse's visit now?
>
> Mr. MADSEN. We charge by the hour. We charge approximately $6.95 an hour for an R.N., $4.95 for an L.P.N., $3.95 for a nurse aide per hour.
>
> Senator CHILES. How about a physical therapist?
>
> Mr. MADSEN. In the State of Florida we are not currently using physical therapists. We will in the future. I anticipate we will.

During the hearings in Miami, Ms. Diane Feinzig of Dade County Home Health Services, Inc. testified before the subcommittee along with Mr. John Smith of Medical Services Personnel Pool.

Ms. Feinzig commented on total services provided by her agency and salaries of their personnel thusly:

> I would like to point out that our company does not require a minimum of service. We provide service to any patient for a total of from 1 hour to a maximum of 24 hours, day and night, per week or for an indefinite period of time.
>
> The salary levels of our personnel ranges from $2.50 per hour for a homemaker-nurse's aide, to $4.75 for a L.P.N. and $5.90 for an R.N.
>
> Our charges for these comparable services to the individual would be $4 for the homemaker or nurse's aide, $7.60 for the L.P.N., and $9.50 for the R.N., which is a legitimate mark-up in order to run a proprietary.
>
> Senator CHILES. Do you charge transportation fees?
>
> Ms. FEINZIG. No, they deliver themselves.
>
> The insurance companies, I heard it mentioned, under major medical will pay 80 percent if people have that kind of coverage, but only for an L.P.N. or an R.N., but nothing for a nurse's aide.
>
> You have asked if I have any suggestions. Well, I will skip this part because I know you are in a hurry but I would like to go into something that to me is very important, a methodology of correcting some of the problems I have been listening to all day.
>
> I have always been a great believer in purchase of service as opposed to bureaucratic spending.
>
> On January 5, 1976, the Federal Medicare and Medicaid Guide No. 168, page 2, states that, "Nonprofit home health agencies will be allowed to make arrangements with proprietary agencies for the provision of such services as physical, speech, and occupational therapy, social services, or home health aides."
>
> With this in mind, I have approached most of the nonprofit agencies in Dade County with a third-party contract, and four agencies have signed this contract with Home Care Services; but to date, I have had very little response.
>
> The contract price for a home health aide is $4 an hour. It is my belief that instead of having 30 or 40 home health aides on staff on a 40-hour week, when they perhaps work only 4 to 6 hours a day, it would be more economical to pay only for the hours worked.
>
> How can the nonprofit justify a charge of $15 per hour for this service when they only pay $4?
>
> Should a third-party contract between nonprofit and proprietary agencies be made mandatory to best utilize existing personnel?
>
> You have heard a lot about existing personnel. The amount of office space required for a home health agency operating under third-party contract would be cut in half.
>
> The need for rental space at $1,200 to $1,500 a month is totally unnecessary.

74-599 O - 76 - 5

There is an abundance of qualified home health aides, registered nurses and L.P.N.'s registered with proprietary agencies to fully utilize this arrangement.

Mr. John Smith of the Medical Service pool testified on the visits that his agency was concerned with.

Mr. SMITH. We have been in business since 1966, and we presently have 100 nursing service offices throughout the country.

We have 12 in the State of Florida, and we do not presently participate as a certified medicaid provider in Florida.

Now, with the passage of the Florida Licensing Law, we will welcome licensing and maybe we will become medicare-certified in some of our offices, but we do not intend to leap into the program with both feet at this time.

In 1975, we employed approximately 5,000 people in the State of Florida and provided approximately 1½ million hours of patient care.

Since the private patient pays out of pocket for our services, we truly must have reasonable costs or we would lose our clientele.

For example, in one of our large offices in Fort Lauderdale, our administrator is paid $21,000 a year. Our director of nursing is paid $14,000, our bookkeeper is paid $8,000, and we developed what we feel is to be a very effective manual, bookkeeping and billing system to avoid the additional expenses of computerization.

Senator CHILES. What are your charges for a nurse's visit, R.N.?

Mr. SMITH. For a registered nurse the charge is $7.95.

Senator CHILES. Is that a minimum?

Mr. SMITH. In many cases, we anticipate a 4-hour visit, but we are very flexible.

We do bend a little.

Senator CHILES. Do you anticipate or do you require a 4-hour minimum?

Mr. SMITH. Normally, we look in terms of a requirement of normal would be a 4-hour visit.

You see, we are dealing with a private client and actually, these people are interested in long term visits, even around-the-clock care; so that for the most part, our visits, of course, do average longer than medicare provides.

Our charge for a licensed practical nurse is $6.45 an hour.

Our total office staff consists of 10 employees. In 1975 we employed 847 nurses and home health aides.

Now, you might ask about the service charges, whether our services include the same components of care that typical home health agencies might include.

I wish to assure you, Senator, and the committee that our services at least equal typical home health aide services being furnished in the community.

Our services include supervisory visits to our private patients. We perform written patient care audits. We have written employee evaluations and we keep a full scope of current records wherever that is required.

Senator CHILES. We thank you very much and we will incorporate your statement in full in the record.

The testimony given by the proprietary home health agencies would suggest that the "for-pay" agencies at this time are operating on a far less expensive basis than are the so-called nonprofit home health agencies. However to suggest that the proprietary agencies would not put their companies on a parity with other home health agencies in terms of cost and salaries is to virtually ignore human nature.

Still, the supposition that higher prices and salaries would naturally evolve with medicare certification is still only a supposition.

Regulations and legislation must be adequately enforced or any newly certified agency will be left to devise its own salaries, costs and mode of operation. That includes proprietary agencies.

James Rutherford, in his testimony before the subcommittee in Tampa, raised the prospect of a large proprietary company limiting competition and creating a monopoly in the health delivery industry.

GENERAL FINDINGS AND RECOMMENDATIONS

The subcommittee found that the additional action which should be taken included the following provisions either to be instituted through proper legislation or guidelines from the Bureau of Health Insurance:

(1) That there should be adequate formal—education—training for full-time administrators in the health care agencies. That education should be in one of the health fields with experience in administration of a health facility. Many of the agency administrators interviewed in hearings and through the investigation had backgrounds in totally unrelated fields to that of health care service.

(2) That the membership of the governing body or the advisory committee of a home health agency be comprised of legal residents within the geographical area served by the home health agency. This action would eliminate administrative expenses such as transportation and lodging which are now charged to medicare.

The number of high-salaried administrators must be limited. One agency in the survey by the subcommittee defined nine persons in an agency of less than 100 as top administrative personnel.

Medical directors who can be classified as "in-house" should be restricted in the percent of the total clients that he can refer to "his" agency. No more than 25 percent would be reasonable.

(3) Special investigation by the fraud and abuse section—should include careful scrutiny to identify those agencies which:

(1) Knowingly provide services to patients not truly "homebound," which also add services to those initially requested by the patient's doctors, and permit personnel to do those things not included in needed services.

(2) Solicit discounts and kickbacks.

(3) Arbitrarily add "administrative markups" to bills for goods purchased by them or services performed for them.

Agencies that are identified as conducting these abusive practices should be penalized either by immediate nonacceptance of claims or by placement in a probationary status for a stipulated time period which could result in a "nonacceptance" status. Where actual attempts at fraud is obvious the administrator should be quickly prosecuted.

The subcommittee thoroughly investigated the situation and found that the inter-relationship of durable medical equipment suppliers and home health agencies often led to abusive practices.

Acceptable legislation should result in the following results:

(4) 100 percent reimbursement for durable medical equipment under part B either to the patient or to the dealer accepting assignment when the patient's request and authorizes the need for the equipment and is entitled to and receiving home health care from a licensed agency.

(5) The role of a home health agency should be strictly defined in the hospital discharged process. An agency, either public or private, should be definitely restricted from doing the actual discharging of medicare patients but instead should be available for service if called by the hospital.

(6) In the area of contracted service personnel, contracts should be limited to those personnel providing skilled services dealing directly with the patient, such as a physical therapist or speech therapist.

(7) Franchise fees should not be viewed as reimbursable by medicare but rather as an administrative expense incurred by the agency.

(8) Total office expenses including initial furnishings, rent and space size should have the same limiting criteria, including geographical considerations as previously stated for charges, salaries, et cetera.

Further luxury automobiles and sports cars should be prohibited for agency rental and use to be billed to medicare. Documental cases of abuses in this area includes rental of Corvettes and other sports cars by private, nonprofit agencies.

(9) Any financial relationships between durable medical equipment dealers and home health agencies should be entirely forbidden.

(10) The dealer should be required to present the option of purchase or rental of equipment to the patient. The option agreed to should be in writing and properly submitted to the intermediary for reimbursement.

(11) Cases where the period of use will exceed the present retail price, sale of the item should be encouraged and the offer of sale should be properly documented.

(12) Certain items should never be sold.

These items should require documentation in writing of reasonable followup procedures on a regular basis for the established rental fee, or require emergency backup at all times.

Durable medical equipment to be rented only

Dialysis equipment
Flowmeters
Fluidic breathing assistors
Humidifiers (oxygen)
Infusion pumps
IPPB machines
Iron lungs
Nebulizers
Oxygen humidifiers
Demurrage on oxygen tanks
Oxygen regulators (medical)
Oxygen tents
Oxygen walker systems
Respirators
Suction equipment

Durable medical equipment to be sold only

(When need is for more than 1 month)

Bed pans (autoclavable hospital type)
Canes
Commodes
Crutches
Face masks and cannulas (oxygen)
Gel flotation pads for wheelchairs
Heating pads
Heat lamps
Masks (oxygen)
Oxygen
Postural drainage boards
Quad canes
Sitz baths
Traction equipment
Urinals (autoclavable hospital type)
Vaporizers
Walkers

Durable medical equipment to be sold or rented

Alternating pressure pads and mattresses
Bed side rails
Gel flotation mattresses
Hospital beds
Pneumatic appliances
Pneumatic compressor (lymphedema pump)
Lymphedema pumps (nonsegmental therapy type)
Mattress, with hospital bed only
Patient lifts
Rollabout chairs
Trapeze bars
Water and pressure pads and mattresses
Wheelchairs

Further, the subcommitee found that in instances where sales are made, those sales should carry restrictions and conditions similar to those previously listed. Sales should be made as follows:

(1) Dealers should be required to offer to the patient to sell or rent.

(2) Intermediaries should be required to notify dealers the allowable sales price on all items of equipment.

(3) Lumpsum payments by the intermediary should be made to the dealer or to the beneficiary at the time of sale, and that payment should not be subject to the annual deductible or coinsurance.

(4) The patient should be allowed to use an amount up to the prevailing price disclosed by the intermediary toward the purchase of any quality of equipment that the patient wants.

Example 1—The medicare allowable price for a wheelchair is $175. The patient could use $50 of this and buy and pay in full for a used chair.

Example 2—The patient could apply this $175 toward the purchase of a new, $350 wheelchair and pay the difference to the dealer himself.

(5) The dealer should be required to document the offer of sale and the transaction.

(6) The determination of the validity of the sale should be the patient or the patient's own physician.

(7) Provision should be made for repairs on items previously sold through medicare.

FINDINGS AND CONCLUSIONS

FINDING NO. 1

As evidenced by the committee's report and testimony heard by the subcommittee, the subcommittee submits that there is a decided absence of heard, specific guidelines and instructions from the Bureau of Health Insurance (Social Security Administration).

The fact that many agencies seized the opportunity caused by the absence of specific guidelines to raise salaries to unreasonable levels was totally indefensible.

The private nonprofit administrators set salary levels for themselves and other supervisory personnel at those high levels because they (the administrators) could not show the funds received as "profit."

Conclusion

The Bureau of Health Insurance (SAA) should develop guidelines which would limit or place a "cap" on the charges that the Home Health Agency can impose for skilled nursing care, home health aide visits, as well as those for physical therapist, speech therapist, et cetera. Limits which should be placed on the salary for administrators of private, nonprofit home health agencies could be based on the comparison of the executive directors of visiting nurses associations or the administrators of 50-bed hospitals.

Unquestionably, the salary of administrators and top personnel should completely divorced from the gross revenue that the agency takes in.

Changes in present system

This change would not demand changes in legislation but would demand guidelines from the Bureau of Health Insurance (SSA).

FINDING NO. 2

Gross irregularities in administrative procedures were alleged by home health care personnel. Backdating and alterations of records by home health personnel with the primary purpose of defrauding the U.S. Government, were claimed to be fairly common occurrences. General administrative coverups included the forging of client records, claims being billed for visits never made, diagnosis being made by unqualified persons, nurses aides and general office staff—general abuses of car allowances and gas allotment.

Conclusion

The need for aggressive monitoring of the administrative claims by the Bureau of Health Insurance is paramount. The prevailing feeling among many private nonprofit home health agencies was that any cost could be charged because the present monitoring system would not pick up the irregularities that occur.

Changes in the present system

An enlargement in the fraud and abuse section of the Bureau of Health Insurance so that investigators could closely monitor alleged abuses. The system for checking and auditing records should not involve 3 weeks to a month prior notice. Auditing should be done on short notice so that tampering with official records could not be adequately accomplished.

FINDING NO. 3

Pension plans for the employees of private nonprofit home health agencies are not designed to conform to any specific guidelines and limitations.

Conclusion

Pension plans should have ceilings imposed to assure that conditions the subcommittee learned about are not continued nor repeated. The subcommittee feels that an 8 percent limit would be more than sufficient but would defer the Bureau of Health Insurance guidelines on the matter.

Change in the system

No guidelines on pension plans presently exist. The Bureau of Health Insurance should develop those guidelines and submit recommendations for legislation.

FINDING NO. 4

Private nonprofit agencies do not have to establish financial stability on order to start soliciting clients and go into business. Franchise fees, initial ocnsulating fees, should not be reimbursable items from medicare.

Conclusion

Either a proper bonding procedure should be established or a private, nonprofit home health agency should have to document the existence of substantial permanent capital to cover possible overpayment to the agency.

Change in the present system

The basic change in the reimbursable system to accommodate the above conclusion must be achieved by statute.

FINDING NO. 5

Under present legislation a private, nonprofit home health agency generally excludes all patients except medicare eligibles.

Currently, all administrative expenses are charged to medicare. The committee found that some of the exepnses billed to medicare were very dubious.

Conclusion

By statute, a requirement that at least 25 percent of the patients of a provider be other than medicare eligibles in order for certification to be granted. Justification for such legislation can be found in the statutory requirement relating to the formation and operation

of health maintenance organizations—50 percent of the participants in an HMD must be under the age of 65.

Changes in the present system

The significant change in the system to conform to the above conclusion must be by statute.

FINDING NO. 6

The subcommittee found that durable medical equipment suppliers and some private nonprofit home health agencies have entered into agreements to circumvent the law, particularly in providing for an administrative markup on items sold by the suppliers on referral by the agencies.

Conclusion

The actual cost for items should be documented by having a copy of such items attached to claims submitted.

Change in the present system

Guidelines could be established by the Bureau of Health Insurance, or appropriate legislation.

FINDING NO. 7

The subcommittee found that many items were rented to patients at a total cost for in excess of the total cost of the item in many cases. This abuse has been documented through appropriate records in the SSA as well as interviews with suppliers and clients.

Conclusion

Provisions should be made for the lump sum reimbursement for the purchase of durable medical equipment where long-term need has been clearly documented by the attending physician.

Changes in the present system

By the appropriate statute.

FINDING NO. 8

The subcommittee found proliferation of private, nonprofit home health agencies to be a definite problem.

The tremendous growth of this type of agency—private, nonprofit—with little or no controls attached to their certification requirement doubtlessly led to some of the abusive practices that occurred.

Conclusion

A certificate of need provision must be included in the requirement for certification by the private, nonprofit home health agencies.

Change in the system

By statute, the certificate of need should be required on a national basis.

FINDING NO. 9

The subcommittee found that normal investigative procedures for the fraud and abuse section of the Bureau of Health Insurance depend

solely upon responding to a complaint. The section does not, it seems, allow investigators to act on their own initiative.

Conclusion

The fraud and abuse section does not presently have the manpower capability to properly investigate instances of alleged abuses and illegalities that have been reported in the home health care field.

Change in the system

By guidelines from the Social Security Administration or appropriate legislation.

FINDING NO. 10

The subcommittee found that many problems existed in determining which services were truly needed that were being administered to clients under the guise of needed services. Many agencies overprescribed services and had no accountability to the State after certification.

Conclusions

In order to help restore public credibility in the area of home health care, private nonprofit home health agencies must be required to:

Undergo periodic review of a State home health agency advisory council, appointed by the Governor, which would also advise the public nursing section or any other official health agency in matters relating to regulations, standards of care, policies governing services, and expansion of home health care programs in the State.

The Council would be composed of a licensed physician, a registered nurse, a physical therapist, a speech pathologist, a medical social worker, an occupational therapist and three citizens interested in the development of home health care programs. Such a council will provide representation from the various disciplines rendering service who have expertise in these areas and are knowledgable about standards of care and operational procedures for their professions.

Agencies should also organize their board of directors to conform to having at least seven members, no more than two of which are relatives.

FINAL RECOMMENDATIONS

Additional recommendations that the subcommittee found include the following:

(1) The administrative records of an agency that does not deal with the individual patient should be open to public inspection, such as administrative salary levels, charges for visits, amount paid the agency by the intermediary, etc.

(2) The utilization review program performed by the intermediary be expanded to conduct, not only onsite inspections but a complete followup concerning assurances from the patient's doctor as well as a comprehensive number of patients that the services rendered were both needed and requested by the patient's doctor.

(3) The large body of regulations and guidelines that are established, and will be established, be made available to every agency licensed by the State so that the limitations placed on cost can be

uniformly applicable. Agencies can only adhere to "reasonable" cost when they (the agency) know what "reasonable cost" are.

(4) Rental arrangements between doctors and laboratories or doctors and home health agencies or doctors and pharmacies or any other above combination should be carefully reviewed by the Bureau of Health Insurance with the stated power of the Bureau to terminate such agreements when medicare payments are in any way involved.

(5) That any form of compensation in terms of rewards, prizes, gifts, and so forth shall be considered a kickback when it involves a medical supplier and/or a home health agency receiving Federal funds for medical care.

ADDITIONAL VIEWS OF SENATOR LAWTON CHILES

The image of a nonprofit home health care agency has historically been that based on the actions of organizations such as the Visiting Nurses Association. Characteristically, the public nonprofit organizations like the VNA and the County Nurses Association have operated on the principle thesis of providing services to the poor and the elderly at minimal cost to community and the taxpayer.

The supreme dedication of many of these public spirited and highly motivated persons has led to not only a high level of care for many patients, but also a firm appreciation for the worth of these agencies to the communities in which they serve.

From all the evidence presented by the subcommittee, I have been extremely impressed with the quality of services provided by the public, nonprofit organizations and even more impressed with the sincerity of effort put forth by the public nonprofit agencies. The subcommittee investigators held hours of interviews with clients and other personnel involved in home health care and generally conceded that those persons who staffed and maintained the public agencies were of high caliber and expertise.

Although I was not in the Congress during the enactment of the original medicare bill, I am assured that Congress had the image of public agencies involved when they wrote the provision for the private, nonprofit agencies.

During the almost year-long investigation of home health agencies, the continuing story of gross irregularities and administrative coverups by agency administrators was repeated over and over again. We heard evidence of records were forged, claims were billed for visits never made, personnel wrote in diagnosis for patients before they were seen and reports prepared for doctors who merely signed sheets depiciting actions never, in effect, taken.

Medicare officials were billed for some expenses that defy explanation—such as the Christmas party by Unicare, Inc. of Miami. While the total expenses of some $4,000 was not a tremendous amount it represents the idea that as long as medicare pays, it doesn't matter what the expense is billed for.

The entire question of the interrelationships of persons involved in home health agencies must be clearly defined. Doctors who own home health care agencies must allow for complete disclosure of that ownership and the patient and medicare officials must take special note of that ownership. Monitoring procedures by the intermediary must be particularly stringent for these agencies. Because of the abuse in overutilization and referrals by doctors themselves, medical firms, hospitals and/or nursing homes should be restricted to involvement in only one area of patient care which is reimbursed by the medicare program or National Health Insurance Act.

The subcommittee investigated the entire scope of involvement and interrelationships of medical supply companies of medical supply companies and home health agencies. The abuses concerned with central billing procedures, signed and/or vocal agreements to actually circumvent the law by forgiving the 20 percent co-insurance and annual deductible were widespread and accepted practices. Any medical supply company that blanketly forgives the deductible or co-insurance to a specific category of patient or agency should be considered guilty of an abuse of the act and subject to the penalties provided by the act. Intermediaries should be carefully instructed to insure against incorrect payments to chain medical supply companies using central office billing procedures.

The subcommittee lends its support to a certificate of need requirement as developed by the Florida Department of Health and Rehabilitative Services.

Medicare officials must begin to establish some limits on salaries, pension plans, and charges that are uniform and reasonable. The Bureau's current policy is much too lenient and leaves too much to agencies to decide.

The practice of comparing private, nonprofit agencies to one another is not practical. First of all, it establishes a false charge and salary rate. Normal competition practices do not apply because the private nonprofit agencies do not have to justify costs to the customer but rather to the Government which is not the customer but is the payee. So as long as agencies are allowed to set their own rates, those rates will be excessive.

It is the imperative that the governmental agency responsible for correct monitoring be allowed to establish proper rates for charges and salaries.

The private, nonprofits, or so-called 100 percenters, have absolutely nothing to lose by going into business at total government expense. The current system of cost reimbursement provides no incentive for efficiency. In order to establish some type of financial security, a bonding process must be established. In the present situation, private nonprofit agencies may manipulate charges and submit cost estimates that are far out of the realm of reasonableness and secure funds under the interim payments that can be used by them for any purpose. The repayment of those funds is interest-free and comes from a deduction of their medicare account. This entire process can lead to definite abuses. The beneficiaries receiving the services have no idea as to the amounts reimbursed since notices to the beneficiaries list only the number of visits and no amount of reimbursement per visit. Therefore, the beneficiary does not act as a damper on overutilization.

The obviously profit-motivation of the so-called nonprofit agencies has been more than substantiated in testimony and other inquiries made before the Subcommittee on Federal Spending Practices, Efficiency, and Open Government. I am now more convinced than ever, that real reform has to be properly instituted if the program is to be saved for those persons most in need—the elderly—by those most concerned—the taxpayers.

Specific guidelines and regulations along with legislation may not eliminate all of the problems we face with the administration of this

program. However, I feel that public support and credibility can be restored if public officials and medicare administrators implement the desired changes in the program recommended in this report.

Further, I want to reiterate my support for quality health care for the elderly through the medicare program. Such care is vital to the well-being of many of the elderly in the state of Florida and across the nation. The very fact that this care is so vital makes it even more important that it becomes as fraud-free as possible.

The subcommittee is indebted to those persons whose primary interest goes beyond job security and cooperated with subcommittee investigators on this inquiry.

If the projection for medicare as a program is to be a healthy one, then abuses and illegalities have no place in this prognosis.

LAWTON CHILES.

SUPPLEMENTAL VIEWS OF CONGRESSMAN CLAUDE PEPPER

[Taken from testimony given before the Subcommittee on May 5, in Miami, Fla.]

My subcommittee has held joint hearings with Senator Moss' Subcommittee on Health in the Senate, and I am particularly honored on behalf of my subcommittee to meet in joint sessions with you.

About 19 percent of the population of Dade County consists of people over 62 years of age.

One of our—The House Committee on Aging—points of principal emphasis is this matter of home care for the elderly, the support of a comprehensive plan that will provide all necessary services in the homes of the elderly, avoiding the necessity and in many instances if not most, of those people having to go into a hospital or having to go into a nursing home.

Without intending in any way to disparage the quality and the character of nursing homes, in general, my beloved mother many times said to me in her late years, "Son, don't ever let them put me in one of those nursing homes."

What she meant was, she was accustomed to her own bed, her own room, her own home, her own neighbors, her own neighborhood, her own environment, and to have to be uprooted from those accustomed environmental associations and put into the necessary discipline of a strange institution, with strange people at a very much advanced age, is obviously a great shock to the individuals in that category.

As has been said, our own committee has confirmed exactly what your hearings have confirmed, that in the long run, it would be cheaper in all probability for the Government to provide home care for the elderly rather than to have them to have to go to hospitals or nursing homes where they have to be cared for at great expense.

So, our committee joins you and will join you in every way we can in the promoting of legislation which you offer to implement the hearings and the recommendations of your committee.

When we mean home care, we do not exclusively refer to home health care, although that is primarily the concern of our committees in these inquiries, but I think it should include home services that will provide companionship, primarily somebody to provide a meal if necessary, to clean up the house, to render either practical nursing as well as registered nursing care, and the other services that are necessary for the care of people in their respective homes.

So, it is very unfortunate, as I am sure you are going to emphasize here, Senator, that circumstances for today's inquiry result from some unfortunate practices which have begun to emerge in providing c services in the very important home health field.

I know that you, as well as all of us are interested and active in nurturing this rather infant field of medical and other services to many of our people in need.

We want to see these unscrupulous practices corrected and ended at once.

It was shocking for me to discover, as you have discovered, that some of those private agencies providing home health care services may have improperly collected $1 out of every $2 paid to them by medicare for reimbursement last year.

It was equally shocking for me to discover through the news media that these overpayments in some cases went toward extremely high executive salaries and other benefits not consistent with the aims and goals of proper home health care programs.

The spotlight of publicity focused on your earlier hearing in Tampa and this one today in Miami will, I am sure, serve to erase these abuses in a very short time.

My own subcommittee on health and long-term care will take note of your findings and assist in every way in the House of Representatives to see to it that corrective action is taken legislatively to protect those in need of home health care services from the abuses which are coming to light.

Organized home health care is a young industry—if we should call it that—even if the concept dates back to the beginning of man.

Home health care agencies began to flourish and grow from 1967, the year that medicare and medicaid became operative and, as with any new concept, it has suffered growing pains.

Unscrupulous people now threaten to set back the noble goals that responsible committees in the House and Senate are trying to achieve.

As you know, my subcommittee recently introduced a package of 12 bills in the House to implement the recommendations of our subcommittee's recent report entitled, "New Prospectives in Health Care for Older Americans."

We will look forward to the findings from the Senate hearings to determine areas of safeguards which may be necessary to insulate a comprehensive program against abuses.

APPENDIX

74-599 O - 76 - 6

VISITING NURSE ASSOCIATION OF BROWARD COUNTY

1000 SOUTH FEDERAL HIGHWAY
FORT LAUDERDALE, FLORIDA 33316

NURSING OFFICE
525-1551

BUSINESS OFFICE
525-5081

March 26, 1976

The Honorable Lawton Chiles
The United States Senate
Washington, D. C. 20510

Attention Mr. Robert Harris, Administrative Assistant of the Subcomm. Hec On Federal Spending Practices.

Dear Senator Chiles:

The Visiting Nurse Association Hospital Coordinator, Mrs. Rooney, and I were privileged to meet your very fine administrative assistant, Mr. Bob Harris, at the Visiting Nurse Association office on 25 February. He was introduced by Mr. Kramer, who has been interested in trying to bring some of the abuses of Medicare into focus so that controls can be applied. We had a constructive discussion and I was requested to make some input into possible legislation which might help.

A situation has risen which points up very strongly to me the need for Federal controls being strengthened on certification of Home Health Agencies. The Visiting Nurse Associations have been trying for over three years to get legislation requiring a Certificate of Need and licensing for home health agencies at the state level. Much work was done and legislation drawn up toward this end. It contained quality control criteria which is badly needed when care is given in the home. The legislation was written to start in July 1975, but I now understand that it has been called back into committee for further study, leaving the way open for more agencies in this area.

Until June of 1974 there were two agencies serving Broward County. The Visiting Nurse Association of Broward County established in 1952 to serve all citizens of all ages, under all types of funding and Gold Coast Home Health Agency established around 1971 to serve Medicare patients only, were adequately serving the County. Since then 10 to 12 more agencies, serving Medicare reimbursable patients only, have been certified. They have met the Medicare requirements for certification and without a control, such as a Certificate of Need based on population needs instead of the $100,000 requirement made of institutions, they are presenting many of the problems we face. I would like to suggest that with the implementation of Regional Health Systems Agencies in April 1976 that such a Certificate of Need could be required through Federal legislation as part of the certification process. This would eliminate the tremendous over concentration in urban areas and hopefully increase home care in smaller and rural areas where it is so badly needed.

A UNITED WAY AGENCY

CONTINUED

1 OF 2

The situation which precipitated this letter was a call from Biscayne Medical Center stating that through an "administrative decision" the Visiting Nurse Association of Broward County was to be removed from the rotation list with no other explanation. In conversation with some of the other home health agencies we found that all but three agencies had been removed. From what I have been able to ascertain, these three agencies are ones who serve Medicare patients only and all three are owned by physicians. I am not acquainted with the legality of this situation, but do feel this is extremely unethical. By excluding Visiting Nurse Association, they have eliminated the only agency in Broward County who accepts Medicare as well as all other fundings and seemingly have restricted their discharge planning to only the Medicare reimbursable patient.

We wrote to the hospital on March 9 and as of yet have not received the courtesy of a reply. Gold Coast Home Health Agency stated that they received a reply stating that something had to be done because of the great multiplicity of agencies. I can well understand their dilemma since this hospital, formerly Golden Isles Hospital, serves both Dade and Broward counties, but I feel that physician ownership of home health agencies constitutes as much of a conflict of interest as does ownership of pharmacies or ambulances.

I am enclosing the letter sent to Biscayne Medical Center and three policy memoranda from hospitals, including Golden Isles.

I hope also for your support in defeating the Medicaid Home Health Services Regulations. First of all I resent my Medicare dollar being used to support a huge profit-making agency, apparently trying to circumvent state licensing laws and set up two sets of standards. Mostly I am concerned with the lack of quality control this regulation would allow. I have been in home health care too long and am too familiar with what abuses can occur without strict and adequate quality controls.

I am sending a copy of this letter to W. H. Purcell, Program Validations Specialist, Bureau of Health Insurance from Atlanta. I understand he is heading the group that is currently looking into abuses in this area.

Thank you for your attention to these matters and we would be pleased to have yourself and/or your Administrative Assistant visit with us.

Very sincerely yours,

Dorothy J. Deegan

(Mrs.) Dorothy J. Deegan, R. N.
Executive Director

jcb
Enclosures

VISITING NURSE ASSOCIATION OF BROWARD COUNTY

1000 SOUTH FEDERAL HIGHWAY
FORT LAUDERDALE, FLORIDA 33316

NURSING OFFICE
525-1551

BUSINESS OFFICE
525-5081

March 9, 1976

Mr. Byron Arbeit
Assistant Administrator
Biscayne Medical Center
2801 Northeast 209th Street
Miami, Florida 33180

Dear Mr. Arbeit:

This letter is in response to our telephone conversation on March 4, 1976, in which you stated that the Visiting Nurse Association of Broward County would be removed from the rotation list at Biscayne Medical Center. After speaking briefly to you regarding the structure and philosophy of the V.N.A., you suggested that I write to the administration. Hopefully I can convince you to put us back on your rotation list!

I believe that I have worked very closely with your Social Service Department and have never visited any floor in your hospital to see a patient without first seeing your Social Service workers and being asked to do so.

The Visiting Nurse Association of Broward County is a voluntary, nonprofit, charitable organization, partially funded by the United Way. We are in no way funded by County tax monies. We serve all ages and are the only agency in the county who will accept all fundings - Medicare, Medicaid, V.A., Workman's Comp., private insurance, and fee for service (on a sliding scale, if necessary.) We were chartered in 1952 and were the first to receive a Medicare contract in 1966. Approximately 30% of our patients are private and approximately one half of these are either free or on a part pay status.

Our rejection rate from Medicare is and has been less than 1%. We provide the same health service to the community that any other agency provides and I feel strongly that we have not over utilized Medicare monies. If Medicare home visits are depleted or if Medicare visits must be discontinued because there is no further skilled care, we do not discontinue service if the need is still there.

A UNITED WAY AGENCY

Mr. Byron Arbeit Page 2

For many years we were the only agency providing community Health Care, servicing the many M. D.'s and hospitals and we hope to continue to do so.

We are asking you to please reconsider eliminating us from your rotation list for Medicare patients, so that we may continue to serve the community and your hospital.

We cannot understand why an agency such as ours, who serves all people regardless of race, color or creed, or ability to pay, has been removed from your rotation list.

Trust that we will hear from you soon.

Very sincerely yours,

Doris Rooney RN

(Mrs.) Doris Rooney, R. N.
Public Relations and Hospital Coordinator

jb
Enclosure

MEMO

Date: July 10,1974

To: Home Health Agencies

From: Patricia Berman NASW, Director of Social Work Patricia Berman

Subject: Policy Concerning Home Health Agencies

Any individual or representative of an agency must have the permission of the Social Worker before visiting any patient, family, or Nurse's Station in the hospital. All services are to be co-ordinated through the Social Work Department. (In the absence of the Social Worker, permission will be granted by the Director of Nursing).

It is essential that the Social Work Department be advised, by the Agency when receiving a case, of a patient in the hospital, from a source other than the Worker. This will eliminate duplication of agencies and services and will promote continuity of services to the patient.

An appointment has been made for the Co-ordinator of each agency to visit the hospital on a particular day and the agency will receive the cases available on that day. Efforts are being made to utilize agencies on a rotating basis, unless otherwise indicated by the family, patient, or physician. Optimal service to the patient is also a prime consideration in utilizing Home Health Agencies.

pc:
Visiting Nurse Association of Broward County
Visiting Nurse Association of Dade County
Unicare Home Health Services
Gold Coast Home Health Services
Florida Home Health Services, Inc.
Hollywood Home Health Agency, Inc.
Home Health Service of the United States, Inc.
Ronald S. Silvers, Assistant Administrator, Golden Isles Hospital
Wilma Whitby R.N., Director of Nursing, Golden Isles Hospital

MEMORIAL HOSPITAL
Hollywood, Florida

MEMORANDUM

July 26, 1974

TO: Home Health Agencies

SUBJECT: Home Health Service Referrals

We are finding that the referral system we have been using for home health services is not as equitable or practical as we hoped. The system of assigning a day for each nursing coordinator to visit the Social Work Department and pick up on any available referrals has resulted in uneven distribution of referrals, considerable disruption for our department and insufficient time for casework services. Our new referral procedure will begin as of this date.

After assessment of a patient's situation and needs by one of our social workers, the determining factors for home health referrals will be:

1) Agency already specified by physician
2) Unique need of patient best met by one agency
3) Patient receiving home care from an agency prior to admission
4) All other Medicare referrals will be made on a rotating basis to each agency in turn. Each worker will check our list before making a referral.

This will make it unecessary for an agency to send the Nurse Coordinator to this hospital unless a referred patient is to be seen. The Nursing Office has asked us to have the Coordinator check in with the Social Work Secretary to determine if a visit to the floor is convenient before checking on the patient's pre-discharge status. This will also allow us to keep track of outside referrals so as to avoid multiple referral of the same patient. We hope this will save your coordinators and our workers time and effort, and will distribute cases on an equitable basis. We would appreciate your cooperation.

Gene C. Davis

(Mrs.) Gene C. Davis, ACSW
Director of Social Work
GCD/d

cc: Mr. S. Mudano, Administrator
Miss V. Dressler, R.N., Director of Nursing
Mr. G. Sterling, Assistant Administrator
Gold Coast Home Health Services, Inc.
Hollywood Home Health Agency, Inc.
Home Health Services of the United States, Inc.
Unicare, Inc.
✓Visiting Nurse Association of Broward County

BROWARD GENERAL MEDICAL CENTER
1600 SOUTH ANDREWS AVENUE
FORT LAUDERDALE, FLORIDA
33316
TELEPHONE 525-5411

August 13, 1974

Visiting Nurse Association of
Broward County
1000 S. Federal Highway
Ft. Lauderdale, Florida 33316

RE: Hospital Evaluation of Home Health Care Patinets

This is to advise you that the Medical Staff Committee of Broward General Medical Center recently voted against establishing a policy allowing representatives from Home Health Care Agencies to review an in-patient's medical record prior to discharge. If the attending physician leaves an order for your review of his patient's chart, this of course, would be honored.

For this reason, the Social Service Staff will continue to work closely with you and serve as a liason for each referral. It is still permissible for you to visit the patient in our hospital and also to discuss specific details of home care with the charge nurse.

Due to the increase in agencies providing home health care services to the patients in our area, we would also request that you call our department prior to your hospital rounds. All referrals to our department are handled on a rotating basis to each of the agencies unless a specific request is made by the patient, family or physician. Hopefully, we could save you and our staff some time if there are no new referrals.

We are also in the process of an in-service education program for both physicians on staff and our nursing personnel to make them more aware of the services you can provide for our patients. We fee' this will increase the number of referrals but this, of course, will take time and we ask your continued cooperation.

Sincerely,

G.L. Schevis

(Mrs.) G. L. Schevis,
Social Service Director

April 21, 1976

Editor
Tampa Tribune
202 S. Parker
Tampa, Fla. 33606

Dear Sir:

I have read with great interest your reports and editorial on Medicare over-payments to some Home Health Agencies. It is disheartening to learn that these agencies who serve the sick and elderly can degrade such a worthwhile program. Those who require this service look to them as professionals, above reproach. However, it appears that greed and fraud can infiltrate even this community service.

One cannot help but question, why can't the Department of Health, Education and Welfare recover this money? If these agencies are defrauding the government, they should be expected to make full restitution. This kind of organization can ruin the good work and reputation of other Home Health Agencies and HEW doesn't have enough people to "police" the many agencies of this state.

The Florida Association of Home Health Agencies, Inc. has recently created a Code of Ethics. This will be helpful in "self policing". However, this can only be possible when agencies belong to the association. Those who claim to be the Medicare Agencies and are receiving Federal Funding to provide Medicare service should be directly under government scrutiny. It would seem the "Non-Profit" corporations are anything but that; instead have developed a pathetic attitude of "Get it while the getting is good". What has happened to the integrity of people?

Senator Lawton Chiles predicted that unless new regulations are drawn that will put an end to this abuse, the Medicare Home Health Program could end. Where would this leave the people who so desperately need and depend on it?

Sometime ago, my mother suffered a severe illness. After months of hospital and nursing home care, she progressed enough to come home. In seeking help, we were informed that Visiting Nurse Association of Hillsborough County, Inc. was a Medicare Agency. I contacted their office and was assured they would be available for as long as my mother had need of their services. We have found V.N.A. very dependable, with a dedicated staff to help with instructions and care of an invalid patient.

I feel sure there are many agencies who render the same service. It takes only a few to give a bad name to all. Hopefully, the government will have those "few" get their act together or get out, so that others can get on with the program of caring for those who need them.

Sincerely,

(Mrs.) Lee Blowers
5502 S. Elkins St.
Tampa, Fla. 33611

MEDICARE • NURSING • THERAPY ••• AT HOME

A ASSOCIATED HOME HEALTH AGENCY, INC.
(305) 561-9260 • 3587 N.W. 9TH AVENUE, FORT LAUDERDALE, FLORIDA 33309

June 4, 1976

The Honorable Lawton Chiles
United States Senator
New Senate Office Building
Washington, D. C. 20510

Dear Senator Chiles:

Last month I attended your investigative session of South Florida Home Health Services at the Miami Court House.

Area reaction to said investigation was covered broadly by the Communication media. Interpretations, as well as implications, were assumed by an uninformed public, of great benefits and monetary gains all Home Health Agencies were taking from the Government. There was no attempt to impart any actual statistics supporting the health services extended to persons in their homes; no attempt to inform the public of persons who have been restored to actual independence of daily living; no attempt to inform the public of deferred costly admissions to hospitals. These statistics are available, and as Government is representative of the people, it would seem that every effort on your part to be fair would have presented a more balanced view of the Services. Yours as well as our services are tax-supported, and are accountable for such.

Florida has been placed in a negative light to the general public regarding quality home health services, but it has a rightful pride in services rendered to the populace. Scrutiny and accountability strenthens organizations and promotes improvement and direction. There is no need for false pride, and certainly no place for excusing apparent abuses on the part of some existent agencies, but rules and regulations have to be written and reviewed by Professionals. Those who can recognize loop-holes, and yet have the vision necessary for improvement and expansion of services for health needs. Restriction of health services inevitably effects all of us as citizens. Making oneself the recipient of such quality services, either as the patient or personally involved as a family member, distinguishes need from vested interest abuse.

Respectfully yours,

Anne R. Villerot, R.N.

Anne Villerot, R.N.,
Inservice

ARV/ds

cc: J. Schack
L. DeGraaf

William J. Page, Jr., Secretary
Reubin O'D Askew, Governor

DIVISION OF HEALTH
POST OFFICE BOX 210 • JACKSONVILLE, FLORIDA 32201 • PHONE (904) 354-3961
E. Charlton Prather, M.D., M.P.H., Director
1323 Winewood Blvd.
Tallahassee, Fl 32301

MEMORANDUM

November 24, 1975

TO : Luci Hadi, Chief, Executive Staff

THROUGH : James A. Alford, M.D., Assistant Secretary for Program Planning and Development

FROM : E. Charlton Prather, M.D., Program Staff Director, Health Program Office

SUBJECT : PROPOSAL

The Ad Hoc Home Health Services Advisory Committee will reconvene December 1, to review the revised rules. This committee has been expanded to include other concerned groups, namely the Florida Board of Nursing, Homemakers-Upjohn and Home Care, Inc., and the West Coast Comprehensive Health Planning Council. A second public hearing will be scheduled.

The objections of the two proprietary agencies are rooted in a conceptual difference in determining what services constitute home health services. Companionship, homemaking and "baby-sitting" are important supportive services to dependent persons and are sometimes essential adjuncts to health services. Agencies that provide only these services on a continuing or intermittent basis are not home health agencies. Those agencies that provide both supportive and health services should seek licensure for only that unit within the agency that provides health services.

Home health services has been the major and often the sole interest of voluntary and public health nursing agencies for the past 75 years. It would be strange not to find many of the standards that they have collectively developed nationally in the proposed rules for Chapter 75-233. The staff ratios, for example, reflect common practice in Florida as well as a national sample.

The question of continuous care presents some questions. Mr. Toth describes a professional registry or employment agency rather than

(continued)

a home health agency. Medical Pool Personnel assigns nurses and nursing assistants to hospitals and nursing homes as well as to private pay patients in their homes. The General Rules and Regulations cite the need "to observe and respect the rules and regulations of the hospital, nursing home, or retirement home" (page 1, item 2). It would be consistent to contract with licensed home health agencies in the community when continuous service is needed.

There is another component of continuing care that is very bothersome. In one of the several communications with proprietary agencies the wage of a nurses aide was cited as $3.85 per hour. When 24 hour care is provided "week after week, month after month, and year after year" as noted by Mr. Toth, this adds up to:

$ 92.40	per day
$ 646.80	per week
$ 2,772.00	per month (30 days)
$33,726.00	per year

This is incredibly expensive for hygiene and comfort services that could probably be met more successfully and less expensively in a nursing home. At least in that setting the patient would be visible and have greater access to professional services when needed. I'm sure that the problem Mr. Toth describes affects very few people. It would be irresponsible to expend public monies on such select services when less expensive alternatives are available except in the most unusual circumstances. Under these conditions home health services are not a reasonable alternative to nursing homes. Home health services become an important alternative only when services can be provided on an intermittant basis or when continuous care would be confined to a specific limited period.

It is my hope that the problems related to developing Home Health Agency Standards will be resolved without sacrificing or undermining the quality of care that is presently available.

ECP/DW:pb

cc: Jerry Conger
Dolores Wennlund
Dorothy Hilderbrand

PUBLIC HEALTH NURSING SECTION

DOLORES M. WENNLUND
Administrator

There are two overall responsibilities of the Public Health Nursing Section: improvement of health personnel competence and administration of the Home Health Services program.

Components of the programs to improve health personnel competence include consultative visits to county health departments and health related agencies; planning and evaluating resources, programs and needs through scheduled conferences, meetings and contact with personnel of other bureaus, sections, divisions, and health related groups and agencies; planning conducting and/or participating in continuing education programs included orientation and maintaining, updating and upgrading professional skills by participating and attending professional seminars, conferences and educational programs. These activities are performed in both generalized and specialized approaches. The professional staff deliver generalized public health nursing services in assigned regions and their particular specialities on a statewide basis. There were seven Public Health Nursing Consultants during this year. The program activities of the Administrator and Assistant Administrator are included in the following data:

Consultant visits	505
Survey Visits	70
Planning & Evaluation Meetings	367
Continuing Education Programs Offered	217
Continuing Education Programs Attended	143
Total	1,302

Distribution of Public Health Nursing Consultants Activities

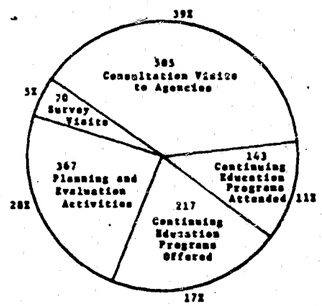


TABLE 1

NUMBER OF PUBLIC HEALTH NURSING SECTION ACTIVITIES ACCORDING TO PROGRAM.

	Consultation Visits	Planning & Evaluation Meetings	Continuing Ed. Programs Offered	Continuing Ed. Programs Attended	Total Activities in Program
Adult Health & Chronic Disease	5	21	43		69
Child Health General including Retardation	17	34	23	6	80
School Health	5	40	16		61
Maternal Health & Family Planning	9	34	39	4	86
Preventable Disease including TB & Imm.	6	5	9	21	41
Total Specialized Activities	42	134	114	31	337
Total Generalized Activities	289	233	103	112	737

Home Health Services

The program staff consists of a Program Specialist, 1/10 FTE Public Health Nursing Consultant, 5/12 FTE Public Health Nurse Supervisor and a fiscal assistant. This staff coordinated Medicare certification of and consultation to 49 home health agencies, 12 outpatient physical therapy facilities, 8 outpatient speech therapy facilities, and 45 physical therapists in independent practice.

Total Number of Activities in Home Health Services . . 244

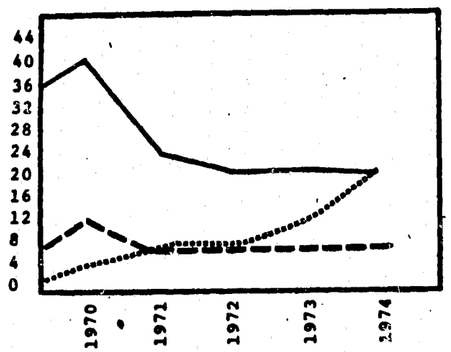
Home Health Agencies	
Survey visits for certification	56
Consultation visits	171
Outpatient Rehabilitation Agencies	
Survey visits	14
Consultation visits	3

During this past year, there has been a decline in the number of county health departments certified for Medicare with a steady growth in private home health agencies.

Number of Certified County Health Departments, Voluntary Nursing Agencies and Home Health Agencies

	CHDs	VNAs	HHAs
1970	41	12	6
1971	24	8	8
1972	21	8	8
1973	21	8	11
1974	20	8	20
1975	20	8	36

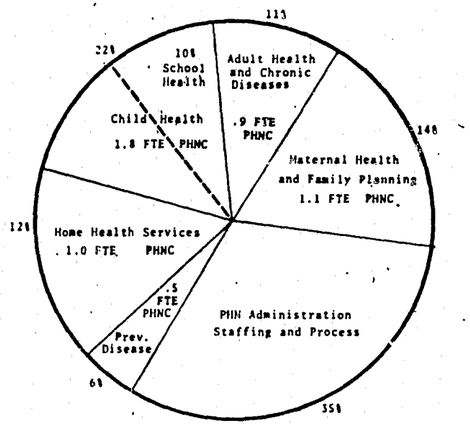
Comparative Growth Rates of Certified Home Health Service Agencies from 1970-74



The Public Health Nursing Consultants review, evaluate and counsel about all program services during their generalized activities. These data are reported in trip reports and other memoranda. However, they are not readily retrievable for reporting purposes. Therefore, the unassigned general activities have been prorated among the major program areas including Home Health Services and added to the designated program activities to demonstrate public health nursing activities in these programs. It must be noted that in many instances, the activities and goals of one program may be absorbed or integrated in another program e.g. the Nurse-Midwife Consultant conducted 20 teaching sessions on the correct way to do Pap smears. This activity was counted as Maternal Health but it is readily seen that both Adult Health and

Chronic Disease and the Laboratory can gain through this effort. As mentioned before, efforts in the Immunization Program are submerged in Child Health. Counseling and advisement on Home Health Services are frequently illustrated through the principles and nursing standards of Adult Health and Chronic Disease. The following graph depicts the distribution of the activities in the major program areas and the full-time equivalents of consultants needed to perform these activities:

Distribution of Public Health Nursing Consultants Activities in Major Programs



Accomplishments

30 per cent of the county health departments report that the standards for Public Health Nursing in Schools are being phased into practice.

The Nursing Information System has been tested in four counties and is ready for selective operational implementation.

The Public Health Nurse Orientation Program is being redeveloped as a joint project with Florida Regional Medical Program.

Careful scrutiny of county health department time and cost study reports as related to Blue Cross audits has resulted in saving close to $49,000 among at least seven county health departments.

School Health Services were interpreted sufficiently well to secure the assignment of that program for the Division of Health.

74-599 O - 76 - 7

57 lay midwives licensed to practice, a decrease of six from last year. 17 certified nurse-midwives registered, the same number as last year.

The rules and regulations concerning midwifery were re-promulgated January 1, 1975, after public hearing.

24 family planning nurse practitioners have been trained through the joint efforts of the Section, Bureau of Maternal Health and Family Planning and University Hospital.

14 orientees were trained in the orientation centers.

Issues

The reclassification of the Public Health Nursing series with the elimination of advanced academic preparation for administrative positions has made inordinate demands on the administrators of this Section. Distortion of Section recommendations for staff position reclassifications has resulted in many problems.

Massachusetts Association of Community Health Agencies

55 DIMOCK STREET • BOSTON, MASSACHUSETTS 02119 • (617) 445-1826

June 8, 1976

Senator Lawton Chiles
U.S. Senate
Washington, D.C. 20510

Dear Senator Chiles:

The Mass. Association of Community Health Agencies (MACHA) represents the concerns of home health care providers. We strongly oppose the suggested deletion of home health agencies from the certificate of need requirement under PL 93-641.

We believe that controls such as the certificate of need requirement must be encouraged to insure the proper distribution of home health services. Effective home health service programs must be distributed so that agencies meet the needs of the consumer. Unchecked development would create--or even add to, in some instances--maldistribution of services with the resultant loss of cost containment.

We are further concerned as to why congressional intent was not followed when Public Health Service formulated the proposed regulation.

Our association has urged the department of Health Education and Welfare to reconsider its position. We strongly urge the inclusion of home health services in the certificate of need provisions required by the National Health Planning and Resources Development Act. (PL 93-641).

We seek to enlist your support in encouraging the inclusion of home health care in the certificate of need requirement under PL 93-641.

Sincerely,

Alexine L. Janiszewski

Alexine L. Janiszewski
President, Board of Directors

ALJ/ad

BAY HOME HEALTH CARE AGENCY, INC.
1815 WEST 15TH STREET, SUITE 19
PANAMA CITY, FLORIDA 32401

J. C. PARMER JR.
DIRECTOR

April 21, 1976

Mr. Bob Harris
Office of US Senator Lawton Chiles
Room 2107 Dirksen Senate Office Bldg.
Washington, D. C. 20510

Dear Mr. Harris:

Attached hereto is information requested per your letter of April 7, 1976. I apologize for its late arrival, and hope it will be beneficial to your subcommittee research.

As I previously stated in our conversation, there are problems within our industry which need to come to light, good or bad be the outcome. My cohorts and myself in this area of the state are trying to provide the best care available at the most reasonable cost possible. The remainder of the state I can only make supposition of the same attitude.

If I can be of further assistance, please call me.

Very truly yours,

Jim Parmer

J. C. Parmer, Jr.
President

JCP/cb

December 1975 603 visits, total costs- $13,787-- cost per visit $22.86

March 1976 775 visits, total costs $14,304-- cost per visit $18.45

No increase in personnel for additional 172 visits.
Increased cost for March, $517-- Increase in Malpractice Insurance 150%
(beginning January 1976)

As denoted above, the incremental increase in cost for each patient additionally accepted is small, and with each additonal patient and patient visit made, the overall cost per visit decreases.

SALARIES

Hospital Salaries			FULL TIME EQUIVALENTS	EMPLOYED
15000 - 27000	DIRECTOR/ ADMINISTRATOR	$23,400 .00	1.00	1
	MEDICAL DIRECTOR	12,500.00 (APPROX $40/HR)	0.25	1
11500 - 17500	NURSING SERVICE DIRECTOR	12,000.00	1.00	1
8600	STAFF NURSE	9,400.00	1.00	2
14000	PHYSICAL THERAPIST	16,000.00 *	1.00	2
4800	HOME HEALTH AIDE	5,200.00	1.00	4
	CLERICAL	VARIOUS		2

* At Salary due to supply / demand factor

BAY HOME HEALTH CARE AGENCY, INC.
1815 WEST 15TH STREET, SUITE 19
PANAMA CITY, FLORIDA 32401

J. C. PARMER JR.
DIRECTOR

Bay Home Health Care Agency, Inc., 1815 W. 15th St., Suite 19, Panama City Florida was incorporated in 1974. The Agency accepted its first patient on March 3, 1975, and during the fiscal year ending December 31, 1975, accepted a total of 130 patients, some 125 Medicare beneficiaries. The idea entered my mind to establish the agency following eight years as hospital administrator at one of the local hospitals. It was evident there was little followup on patients being discharged from the hospitals in the area. The readmission rate for the Medicare age group was considerably higher than for other groups. Much of this readmission problem was related to the lack of followup, post institutional care.

Our agency is a not-for-profit corporation. Subscribers to the corporation include myself as President, Dr. James A. Poyner, M.D., as Vice President and Medical Director and Rowlett W. Bryant, Attorney, as Secretary-Treasurer. In addition to the above, the Agency operates under an Advisory Board as required by the Department of Health, Education, and Welfare, and the State of Florida Division of Health. These advisors include members of the financial community, health related organizations and representatives from the various state and federal agencies coming into contact with persons in need of our services. Our Utilization Review Committee consists of myself as Administrator, our Medical Director, Nursing Service Administrator, and a community-health oriented nurse not employed by the agency.

Our schedule of charges is as follows:

Skilled Nursing Visit:	35.00
Physical Therapy Visit :	43.00
Home Health Aide Visit	20.00 per hour

These charges resulted in excess revenue of some $8,000 for the year ending December 31, 1975. Based on the Medicare Cost Reimbursement system, we are due to refund to Blue Cross of Florida, our Intermediary, in excess of $22,000 which resulted from a larger patient demand than expected. In accordance with this, our charges are being reduced effective June 1, 1976, to result in a lesser amount of surplus at the end of the current fiscal year. Charges are to be set at approximately $20.00 per visit, however, this level will still not allow us to accept Medicaid patients. Medicaid allows only $13.50 per visit maximum. Our cost presently is approximately $16.50 per visit. At such time as our patient load increase to reduce our cost below the $13.50 level, we will begin accepting Medicaid patients. We are presently accepting some private pay patients, however, I can not justify making the above charges to our private patients.

The question then arises, "how can I justify the charges on Medicare patients". My justification centers around the hypothesis that once collected from the private patient, refund to a large number of patients upon demonstration of lower costs would be impossible. With the Medicare Cost Reporting system, the amount can be determined without difficulty and refund can be made in one payment, one check, to cover any number of patients. For example, if the patient load of two hundred patients were equally divided between private and non-private, and it was determined our charges amounted to $11.20 per patient visit overcharge, we would have to compute amounts for each patient and write 100 checks for the private patients but only one check for the Medicare patients. The $22,000 refund previsouly mentioned relates to 125 Medicare patients, but will be written on one check against one account.

Examples of handbooks are enclosed, as are financial statements.

The only other element I can think of which might be stressed is the fact that a good many of our patients are located in remote areas, inaccessible to normal medical treatment channels. Numerous patients of this agency live over twnety-five miles from the nearest medical facility, as this section of Florida is primarily rural in nature. Many of these are illiterate and cannot follow the prescription directions on medicine containers. Our nursing personnel have to sort out their pills and tell them to take these today and those tommorrow. Many of our physical therapy patients are in a physical condition only slightly worse than their spouses, with neither able to drive an automobile.

The other area of concern in this region is the lack of institutional facilities. As opposed to the Sotuh Florida region, there are no empty nursing home beds in this area and little prospect of any being built. Medicaid reimbursement has made it impossible to treat the Medicaid patient in the nursing home, yet the reimbursement to Home Health Agency is such the Agency cannot accept them either. Hospital beds are much in the same situation. Both hospitals in the Bay County area are operating at rates in excess of 100% occupancy. This Agency has been able to relieve some of the pressure from both the hospitals and nursing homes.

While the cost of Home Health care is high, it represents the alternative to no care at all. Costs can be reduced by the changing of physician attitudes to one of increasing referals to the Agencies. Our census on December 31, 1975, was 36 patients. Today it is 51 patients.

GOLD COAST
HOME HEALTH SERVICES, INC.
A NON PROFIT AGENCY
SERVING BROWARD & PALM BEACH COUNTIES

4699 NORTH FEDERAL HIGHWAY • POMPANO BEACH, FLORIDA 33064
75 NORTHEAST 6TH AVENUE, SUITE 221 • DELRAY BEACH, FLORIDA 33444
IN BROWARD CALL: 785-2990 OR 522-6749
IN PALM BEACH CALL: 737-8180

May 4, 1976

Senator Lawton Chiles
Hialeah Opa-Locka Holiday Inn
1950 W. 49 Street
Hialeah, Florida

Dear Senator Chiles,

This is in reply to your letter of April 7, concerning the Government Operation Subcommittee on Federal Spending Practices, Efficiency and Open Government.

I will take the items one by one you requested.

Our agency was incorporated in 1970 as a non-profit, charitable and educational institution under the laws of Florida. It was founded by Dr. Richard Schultz who is a surgeon in this area, at this time approximately 40 years old. He heard about home health agencies at a medical meeting in New Orleans and realized that there was an insufficiency of services in Broward County. He investigated and talked with his colleagues and determined that there was a need in the county for such services and determined to establish one. At that time there was only the Visiting Nurses Association in Broward County that was working on a very limited budget with a very limited staff and highly restricted services (it should be of interest to you that the VNA of Broward County still has only telephone service from 8:00 - 4:00 or 4:30 with no weekend coverage by phone). Dr. Schultz hired a man for Executive Director, a Director of Nursing, who in turn hired an aide, and had contracts for physical therapy services at the opening of the agency in June of 1970. Medicare certification was not approved until December. In November of that year the Executive Director was dismissed and I was hired through an employment agency, having had 25 years administrative experience in medical industry . At the time I came, the agency made less than 500 visits a month. In March of 1976

we made 5,700 visits. Other notes of historical interest are that we have served in the past five years 6,300 patients, under orders from 955 MD's and DO's, who had been patients in 97 hospitals and 44 nursing homes.

The legal corporate body of the agency is the Board of Directors, consisting of Dr. Schultz as President, myself as Vice President, Mrs. Schultz, RN, as Secretary and Dr. Schultz as treasurer. However, as you probably know, home health agencies are required to have an additional Advisory Board consisting of professionals and consumers. Actions affecting the agency either fiscal or medical or legal are not approved by the Board of Directors without the prior approval of the Advisory Board. At the present time this board consists of a hospital credit manager, a cancer volunteer, an emergency room physician from a hospital, a Red Cross volunteer, two bankers, a retired medical school professor, a physical therapist, a psychiatric nurse, two practicing internist, a speech pathologist and a hospital director of nursing service. It should be noted that the three hospital personnel come from three different hospitals. This Advisory Board meets at least quarterly and does a complete annual Financial and Utilizational Review of selective cases to assure that the medical policies as printed and established in the agency policy manual are followed by the staff.

Since October 1, 1974, we have been under what is commonly called the PIP (periodic Interim Payment) Program for reimbursement purposes. This program lists all costs and divides by the number of visits and pays you at the average rate for which the year 1974 was $22.10 for nurses and other professionals and $17.37 per visit for aides. The aides visits may last from 1 - 4 hours. Those figures for 1974 have been audited by both an independent auditor and the intermediary's audit staff. An unaudited report for 1975 was submitted to the intermediary last week and shows that all the skilled visits were at a cost of $28.94 and aide visits at $22.61. Most of this increased cost for 1975 over 1974 is attributed to a considerable drop in the number of patient visits due to the competition as well as a very bad fall in the hospitals in this area. You may have recalled seeing in the paper that they were down to below 50% of capacity particularly in October and November. In addition, we separated the north and south part of the counties in the area independent operation as of the 1st of July and had 100 less patients July 4 than we had on June 30. We anticipate a slightly reduced charge of $27.83 for the next three months under the Periodic Interim Payment Program and are looking for ways to cut that for the balance of the year.

I have enclosed a copy of the booklet which gives detailed information which is handed out to physicians and the folder which is given to the general public. We have also cooperated with the Social Security Administration in distributing the blue Medicare handbook which is printed by them.

I have charted below for the years 1972-1975 the cost per visit and the number of visits for the skilled services and for aide services. You will note that we did very well through 1973 until all of the competition came into the county and the opening of many new agencies in combination with the price freeze removal; this meant higher salaries and increase in benefits which are the major increase in costs. This was first felt in 1973 in the cost of nursing salaries and additional benefits including a pension plan. Another factor was the necessity of hiring supervisors in the field as the number of visits and the size of staff increased.

I have also charted the principle employee's salaries from New Year's 1970 to 1975 as in comparison of the salary of an average staff nurse in that same period. Another considerable factor in the cost increase was the necessity of opening offices in Hollywood and in Delray, again to meet the competition of all the new agencies.

	Cost per Visit		Number of Visits
	Skilled	Aides	
1970	$21.09	$27.49	2,445
1971	$23.52	$20.86	8,754
1972	$16.96	$14.60	14,947
1973	$13.97	$15.16	40,069
1974	$22.10	$17.37	55,952
1975	$28.94	$22.61	63,967

Principle Employees Salaries

	Pres./Med.Dir	Dir. Professional Services (Nursing)	Vice Pres. Exec. Dir.	Average Staff Nurse
1970	18 months	$5,803(6months)	$6,000(6 mo)	$7,800
1971	accrued paid 1973 -$11,541	$7,200(7months) (10 mo. no director)	$13,750	$8,400
1972	$10,663	$6,245	$16,009	$8,970
1973	$11,196	$11,887	$17,774	$10,415
1974	$14,413	$21,589	$25,725	$11,150
1975	$16,207	$25,023	$28,268	$12,950

I should also like to note at this point that there is no family relationship or connection between the three principle employees and no members of any families on the Advisory Board. (Mrs. Schultz, Corporation Secretary, attends Advisory Board meetings but does not have a vote.) It also should be noted that neither the Director of Nurses or myself have any financial interest in the organization and have never had any.

Other items of importance, in my opinion, are the key to controlling costs rather than being punitive through retroactive denials. The Bureau of Health Insurance people have not been given either the guidelines or the weapons to keep them under control, they have only retroactive denials which must be settled through the appeals procedure or in the courts. This seems to be their only method of establishing reasonable costs and utilization. I know that they do have reasonable guidelines for utilization and they certainly shold have reasonable guidelines for reasonable costs. For example, when I found out that to remain competitive it would be necessary to install a pension plan, also the Board felt that in order to retain our staff during a period of increasing competition that a pension plan was necessary, they asked that the planner base the benefits and the cost on the Federal Retirement Program, and that is exactly what was done. With all the computer experience in individual cases and accumulation of visits and costs of agencies throughout the country it seems to me that they should be able to come up with a range that is understandable and acceptable. Whether they haven't thought it was necessary, I don't know. Hospitals have guidelines, nursing homes have guidelines - why can't the home health agencies have guidelines rather than punitive action.

Another problem, and I'm sure it's true in other states, is the provision of the Certificate of Need requirement through the health service agency and again some reasonable guidelines to those agencies so that you do not have 2,000 sets of rules or guidelines to determine their Certificate of Need.

I assume you are knowledgeable of the fact that the Division of Direct Reimbursement of BHI in Baltimore is running a study at the present time with a number of selected agencies in order to determine efficiency levels and perhaps reasonable cost levels. Certainly, this effort should be encouraged by the Congress.

There is one other point that I would like to refer to, the point was brought up in the hearing in Tampa that the private non-profit agencies are running out visits and then referring patients who needed care to VNA's or to public health agencies. In the past five years we have had over 6,300 patients and of these only 9 used maximum number of visits, none of these required a referral for further care. This record should make it clear that we are neither over-utilizing nor dumping people out on the street. On the other side, we have had numerous occasions where we have referred non-Medicare eligible persons to the VNA or to private for-profit agencies because they were Canadians or English or South Americans and did not have the eligibility in that way, or were in a geographical area where we did not cover.

A further point relative to the testimony in Tampa is that no one connected with this organization has any financial interest in any supplier and never has had. At the present time we have 4 different medical suppliers and the charges which we pay them are the equivalent to hospital prices and in the case of rental average 15-20% below that of what Medicare B allows them to charge patients.

I hope that this information will be useful to you and to your committee. I shall be glad to answer further questions if you desire.

Sincerely yours,

H. Benn Corwin

H. Benn Corwin, Jr.
Vice President/Executive
Director

Oliver J. Keller, Secretary
DIVISION OF HEALTH
POST OFFICE BOX 210 • JACKSONVILLE, FLORIDA 32201 • PHONE (904) 354-3961
E. Charlton Prather, M.D., M.P.H., Director
Reubin O'D Askew, Governor

February 4, 1975

MEMORANDUM

TO: Dr. E. Charlton Prather, Director, Division of Health
Dr. Malcolm Ford, Assistant Director

FROM: Dolores M. Wennlund, R.N., M.S., Administrator
Public Health Nursing Section

SUBJECT: POSITION PAPER ON HOME HEALTH SERVICES

PREAMBLE:

Chronic disease and long term illness is a major public health problem and the inclusion of services to those afflicted is properly part of public health services. These services should be part of basic programs provided by county health departments if not available through another agency.

Home Health Services can make a significant impact on the cost of health services and in selected cases offer a satisfactory alternative to nursing homes or extended care facilities.

The goal of home health services is to provide necessary nursing and therapeutic care to patients with chronic, subacute, or long term illnesses so that familiar surroundings and loved ones can hasten restoration to a healthful life or provide solace in terminal illness. They should be directed toward teaching and assisting patients and families toward independence and self help when possible. They should include counseling about health practices that will promote improved health and prevent complications of existing conditions. Pro-longed care of patients in their homes should be evaluated periodically (a minimum of every two months) to ascertain the feasibility of the care plan, welfare of the patient, and impact on the family. A utilization and case review committee should be responsible for determining continuation of care. The committee should be comprised of members of the medical and nursing professions and representatives of the rehabilitative team. At least two members should not be employees of the agency nor have a vested interest in the patients reviewed.

NON-PROFESSIONAL SERVICES:

Health services provided by non-professionals must be carefully and frequently monitored by a registered nurse. Such monitoring should include observation of the worker's performance of expected tasks, discussion with the patient and/or family of their expectations and reaction to the services, and evaluation of the patients progress. Frequency should be determined by the registered nurse

Over...

in compliance with medicare regulations when applicable. However, when not applicable, no interval should exceed two months.

Non-professional personnel should meet the training requirements specified in the Medicare regulations. Assignments of tasks should be in keeping with their training, the scope of potential impact, and the condition of the patient. For example, assisting a partially paralyzed patient out of bed may be a reasonable assignment since no untoward reactions would be anticipated. However, a patient with advanced osteoporosis may require very careful handling to avoid a spontaneous fracture while being assisted out of bed. In this instance, it would be inappropriate to assign this task to an aide. Patients and families must also be apprised of the aides limitations so that they do not make inappropriate demands nor entertain unrealistic expectations.

Administration of medications by non-licensed persons is presently being studied by the Attorney General. It would be premature to predict his opinion but it is safe to say that the foundation of the decision lies in the safety of the patient. Therefore, the factors to be considered are the patient's condition, the nature and effect of the medication, and the understanding of the one to administer it. For example, in one instance an alert self-directing patient having taken his pulse may request the homemaker to hand him a digitalis tablet. The patient is knowledgeable and assuming responsibility for the act. In another instance, a senile or confused patient could not assume this responsibility and there would be a need for careful professional direction and supervision of medication administered.

There must be a careful distinction between home health aide services and homemaker services. Home health aides are auxiliaries who provide sub-professional nursing care to the sick at home under nursing supervision. They may perform light housekeeping tasks for the patient. They are trained according to Medicare specifications. A curriculum guide for a 60 hour course is available in the Public Health Nursing Section. Homemakers, on the other hand, have a simpler shorter preparation to perform household tasks for patients or families who are unable to do so for themselves. This does not supplant health services.

HOME HEALTH AGENCIES:

Agencies who deliver home health services should receive a certificate of need and meet the following standards: **

1. Staffing patterns and ratios conform to regulations as established by the Division of Health, Public Health Nursing Section;
2. Services should be available to the public-at-large and not limited to those covered by third party payments;
3. Services should be available according to patient needs and not terminated when third party payments are exhausted;
4. The agency must be eligible for Medicare certification;
5. The administrator of such an agency must have completed formal education in one of the health fields;

6. Corporate boards of such agencies must be composed of at least seven members no more than two of which are relatives.
7. Funds for new agencies should cover expenses for at least six months of operation. Fiscal reports should be a matter of public record.
8. Referrals for service should come through professional channels. Solicitation for patients through direct contact is deplored.

**(See Appendix I)

ADMINISTRATION OF LICENSURE OF HOME HEALTH AGENCIES

In the event that licensure of home health agencies is deemed advisable, administration of the program should be vested in the Public Health Nursing Section. This section is already responsible for surveying agencies for Medicare certification, therefore a separate licensing agent would duplicate services. In addition, the section staff is well versed in the evaluation of home health services and delivery systems, nursing performance, goals, records, and reports. It would be anticipated that survey procedures for Medicare certification and state licensure would be telescoped into one operation which would constitute a considerable saving. Past estimates of $120 per survey visit or $300 for the average 2 1/2 visits and clerical support needed for a full certification process are largely born by Social Security Administration.

The enactment of a home health services licensure law would necessitate the appointment of a Home Health Agency Advisory Council to advise the Public Health Nursing Section in matters relating to regulations, standards of care, policies governing services, and expansion of home care programs in the state. Such a council would be comprised of a licensed physician, a registered nurse, a physical therapist, a speech pathologist or therapist, a medical social worker, an occupational therapist and three citizens who do not have financial interest in a home health agency.

DMW/br

cc: D. Hilderbrand
PHN Advisory Committee on Administration & Practice

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEALTH INSURANCE
50 7th Street, N.E., Room 250
Atlanta, Georgia 30323

May 11, 1976 Office of the Regional Representative

Honorable Lawton Chiles
United States Senator
Federal Building
Lakeland, Florida 33801

Dear Senator Chiles:

During the Miami HHA hearing last week, you questioned Mr. Dudley of Gulf Coast Home Health Agency about a $40,000 monthly repayment schedule. He responded to the effect that your information was incorrect and the repayment was about $20,000 monthly.

The actual amount of monthly repayment is $21,500. As the attachment indicates, $208,567 is in dispute. The issues (reasonableness of salaries and reasonableness of pension costs) have been heard by the Provider Reimbursement Review Board. I am awaiting the decision of the Board in this case with more than usual interest. Should the decision go against the government, our ability to cope with the all-Medicare HHA problem will be damaged.

As you probably know, this case represents one of the first efforts we've made to reduce what appeared to us to be "unreasonable" costs by basing our action on the specific language of the statute that compels us to pay only "reasonable" costs. We've gone into this knowing it will be difficult in the absence of specific guidelines. However, as I told you in Tampa, while I can't always say what is "reasonable", I can at times say with a fair degree of certainty what is not reasonable. And it did not and does not and will not seem reasonable to me to assume that a HHA operator has more responsibility and should receive more reimbursement (particularly from public funds) than the Mayor of Atlanta, the Commissioner of Social Security, or a United States Senator.

Because newspaper reports of my comments in Tampa and, I believe, your opening statement in Miami indicated I "did not wish to get involved in court cases because they would be costly", I would like (as a matter of personal pride, I suppose!) to offer this:

As a result of action by this office, the first termination in the country of a hospital's Medicare participation because of "bad medicine" took place. This was in Florida in or about 1970. There may have been

other terminations on that basis since but I'm not aware of them. The termination caused the hospital to go out of business, which was a blessing. The physician-owner was indicted, tried, convicted, and served time in a Federal institution.

Further, a case that has recently been turned down for review by the Supreme Court--a case involving Mt. Sinai Hospital at Miami Beach and some $6,300,000 in overpayments--came about as a result of action taken by this office. We haven't won that one yet (it's back in district court for hearing of other issues) and perhaps we won't win it. But I am compelled to believe that publicity resulting from our refund demands and the subsequent court action has had a strong and beneficial deterrent effect on other hospitals. Not enough, I'm sure, but certainly some.

Finally, in the Miami area alone we (BHI) are defendants in eight court cases, and plaintiffs in at least twelve others. This could hardly have come about had I been unwilling to take the kinds of action I took, knowing some cases would then wind up in court. I would add that Tom Tierney, Director of the Bureau of Health Insurance, has consistently supported my efforts, including my attempts to base action on the "reasonableness" provision of the statute, even in the absence of the precise regulations or guidelines that would be helpful.

I trust the above narration will not appear unseemly to you. I send it along, as I indicated, in part because I obviously did not express myself well on the subject in Tampa. More importantly, it is an attempt to show you that this Bureau does not act from a base of bureaucratic timidity but rather--considering the resources available to it and the magnitude of the program--from a base of administrative responsibility and stewardship.

Your hearings have been most beneficial, and I hope you will let me know whenever we can help you further with Medicare problems.

Sincerely yours,

Douglass M. Richard

Douglass M. Richard
Regional Representative

Status of the Overpayment of Gulf Coast HHA

The original overpayment for August 31, 1974 was $495,905.00. This amount was reduced to $474,049.92 on March 4, 1976 because a disallowance for salary costs was incorrectly based upon a calendar, rather than fiscal year.

The original overpayment on tentative settlement for August 31, 1975 was $227,781.00. This amount was increased to $346,363.00 as a result of disallowing pension costs.

The total overpayment, after revisions, for both years was $820,412.92; collections through April 1976 total $418,345.92, leaving a balance outstanding of $402,067.00.

As of January 26, 1976 the outstanding overpayment of Gulf Coast HHA for the period ending August 31, 1974 (revised final settlement) and August 31, 1975 (tentative settlement) was $142,059.08 and $346,363.00, respectively. At that time, the repayment schedule was established at $40,722.08 due February 24, 1976, and 11 payments of $40,700 with the final payment due January 24, 1977.

The payment due February 24, 1976 was not received. On March 4, 1976, as previously mentioned, the overpayment for August 31, 1974 was reduced. This reduction was based on further documentation received from the HHA. The total liability then was reduced from $488,422.08 to $466,567.00.

As a result of the pending hearing, Florida Blue Cross was instructed to collect the liability resulting from audit adjustments which were not in dispute. Those items in dispute (pension and salary adjustments) amounted to $208,567, leaving a balance of $258,000 (not in contention) to be collected over a 12-month period. This equated to $21,500 per month.

The payments due by the 29th of February, March and April in the amount of $21,500 each were received. Therefore, the total outstanding debt has been reduced to $402,067.00 to date. The uncontested amount remaining is $194,000.

UNITED STATES GOVERNMENT

Memorandum

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION IV — ATLANTA

TO : *Director, Bureau of Health Insurance* DATE: *May 21, 1976*

REFER TO:

FROM : *Regional Representative, HI, Atlanta*

SUBJECT: *Regional Bi-Weekly Highlight Report - Atlanta - for Two Weeks Ending May 22, 1976*

I. Contractor Operations

We hosted a meeting in Atlanta on May 19, 1976 for intermediary personnel, including DDR, involved in processing claims from Florida home health agencies. This was the second meeting in a two-part series for these intermediaries; the first having dealt with provider reimbursement problems on March 25, 1976.

The purposes of the May 19 meeting were to discuss approaches to HHA claims processing, examine difficult claims areas, and to encourage uniformity so that providers do not feel that they are (or can) get differential treatment from one intermediary at the expense of another. The meeting was successful in highlighting a number of problem areas and in encouraging uniformity. All participants agreed that the session was very productive. We plan similar meetings for the other intermediaries in the region both for claims processing and provider reimbursement personnel.

II. Program Integrity

A. On May 7, 1976 in the United States Court, Middle District of Florida, Orlando Division, Boyd D. Evans, President of Evans Respiratory Centers, Incorporated, was convicted of three (3) counts (18 U.S.C. 1001) of Medicare fraud. On May 13, 1976, Judge Reed sentenced Mr. Evans to three (3) years imprisonment, three (3) years probation, and fined him $10,000. All but four (4) months of the sentence were suspended.

B. On May 13, 1976 in United States Court, Middle District of Florida, Tampa Division, a 20 count indictment (1 conspiracy and 19 under 18 U.S.C. 1001) was returned on the following: Ernest Winkle, Leonardo Winkle, Jo DeStefano, Alan Colmar. A trial date has not been set, but this case is expected to go to trial in July. These individuals submitted fraudulent bills for a variety of services involving a hospital, an independent laboratory and chiropractic services.

HELP ELIMINATE WASTE HEW COST REDUCTION PROGRAM

C. On May 17, 1976 in the United States District Court for the Middle District of North Carolina (Winston-Salem Division), Roy T. Campbell (d/b/a Pulmonary Associates, Inc., Winston-Salem, North Carolina and Med-A-Rent, Columbia, South Carolina) pled guilty to three (3) counts (42 U.S.C. 1395nn(a)(1) misdemeanor) of Medicare fraud before Judge Gordon in Salisbury, North Carolina. The remaining counts (14) were dropped in accordance with plea negotiations. Judge Gordon sentenced Mr. Campbell to 12 months imprisonment and three years probation.

D. On April 4, 1976 in the United States District Court, Southern District of Florida, Harold N. Bernstein, D.P.M. entered a plea of guilty to fifteen (15) misdemeanor counts (42 U.S.C. 1395(nn). On May 20, 1976, Dr. Bernstein was sentenced to one year imprisonment, each count, to run concurrently. All of this was suspended except for 60 days, which he is to begin serving on June 17, 1976. Dr. Bernstein was placed on three years probation. There was no fine.

III. State Operations

With the amount of current interest in home health agencies in Region IV, it is interesting to note that Public Law 94-63, Section 602-A has made available $3 million to be used as seed money to facilitate the development of new home health agencies and the addition of new services to existing agencies. Region IV has been alloted about 40 percent of the available monies. The funding will not be limited to developing agencies in the rural areas but will be made available to any area that has a high density of over-65 population or a high density of medically indigents. Ed Sharpe, Chief, Provider Certification Branch, BQS, has been appointed Regional Office Coordinator for the grant project. He has recently notified State agencies of the availability of the funding.

IV. District Offices & Professional Groups

We participated in an Intra-Professional Faculty Seminar at Emory University here in Atlanta. The seminar lasted 2 1/2 hours and consisted of a presentation on Medicare, a presentation on Medicaid by the Georgia Medicaid Director, and physicians' views of both programs by a leading orthopedic surgeon. A question and answer period followed. This seminar is put on by the Schools of Nursing, Medicine, Law, Business and Theology, and was attended by about 40 members of the faculty and graduate schools.

Douglass M. Richard
Douglass M. Richard
Regional Representative

national league for nursing

Council of Home Health Agencies and Community Health Services

July 1, 1976

Honorable Lawton Chiles
United States Senator
Washington, D.C. 20510

Dear Senator Chiles:

The Council of Home Health Agencies and Community Health Services has been reading with interest the reports of your recent Florida hearings on home health services.

In response to one news item, the enclosed letter was sent to Mr. Gene Tischer, one of the persons testifying at the Tampa hearings. I think the letter is self-explanatory, but if you or any member of your staff wishes further information, we would like to hear from you.

CHHA/CHS is dedicated to achieving the goal of quality health care in the home and in community settings. To meet this goal, we cosponsor, with the American Public Health Association, a voluntary accreditation program for home health agencies and community nursing services. Other organizations participating in this program are, American Dietetic Association, American Occupational Therapy Association, American Physical Therapy Association, American Speech and Hearing Association, National Association of Social Workers, and National Council of Homemaker-Home Health Aide Services.

We believe that most home health agencies are providing good home health services and we earnestly hope that the abuses which have been identified in a few agencies will not be seen as characteristic of agencies in general. Home health services are an essential, economical part of the health care system and we cannot afford to have the further development of this sector stymied by fear of abuse. We know you are in agreement with this thinking.

ten columbus circle new york, new york 10019 212-582-1022

I have enclosed some brochures which describe CHHA/CHS and our programs. We would appreciate the opportunity to discuss this with you or one of your staff.

Sincerely,

Joan E Caserta

(Mrs.) Joan E. Caserta, Director
Department of Home Health Agencies
and Community Health Services

JEC:LB:cb
enclosures: This is CHHA/CHS
Somebody Still Makes Housecalls
The Community Health Nurse is Where you Need Her
Accreditation - Policies and Procedures
Criteria and Guide for Preparing Reports
Type, Length and Cost of Care fir Home Health Patients
Yearly Review - 1974
Proposed Models - for Home Health Care Benefits
for The Delivery of Home Health Services
CHHA/CHS Staff List

May 18, 1976

Mr. Gene Tischer, Director
Bay Area Home Health Services
85 West Miller Street
Suite 402
Orlando, Florida 32806

Dear Mr. Tischer:

In the March/April 1976 issue of Home Health Line, it is reported that during recent hearings held by Senator Lawton Chiles on home health agencies, your testimony included a statement saying that no salary guidelines are available and that such guidelines are needed.

The Council of Home Health Agencies and Community Health Services of the National League for Nursing, through our Yearly Review, has collected salary information in home and community health agencies since the 1920s. The Yearly Review is an annual survey of policies, practices and trends in home and community health agencies. The data are collected in April each year from a representative and largely identical sample of official and voluntary agencies of all sizes throughout the country. (The sample is not limited to CHHA/CHS member agencies.) Over the past few years private home health agencies have been included but the small number of returns and the incomplete nature of responses did not permit inclusion in the final survey results.

I am sure you are aware that salary guidelines are set on the basis of "what is"; therefore, the Yearly Review does, in fact, yield salary guidelines.

Also included in the annual survey is information on Cost and Charge for Home Care-of-Sick Services. A flyer for the CHHA/CHS publication with the 1974 survey results is enclosed. If you have any questions or need further information, please do not hesitate to contact us.

Sincerely,

(Mrs.) Joan E. Caserta, Director

Leah Brock, Statistician

JEC:LB:cb
encl.
cc: J. Rutherford

[Editorial from the Miami Herald, Apr. 14, 1976]

AS LONG AS FRAUDS CONTINUE, MEDICARE WILL BE UNHEALTHY

The latest chapter in the Medicare ripoff deals with windfalls of as much as $12.5 million that have landed in the private hands of persons operating home health agencies in Florida. Once again it is revealed that government's attempts to provide a social service the people desperately need wind up costing exorbitant sums because of inefficiency and unbridled greed.

As with Medicare in general, the home health aid program threatens to topple under its own financial weight, perhaps because the price paid to get the legislation through Congress was too high. The lawmakers had to tread gently around the medical profession, which is capable of throwing up numerous barricades to government programs that by any stretch of the imagination could be called "socialistic". Such programs that do get passed must be designed and executed on the assumption that all persons in health and medicine are honest and do not have to be watched very carefully. In all of Florida there are but two inspectors in the home health field.

Investigations by Herald Staff Writers James Savage and Andy Rosenblatt show that the taxpayer is being stuck for high salaries, kickbacks, free autos, plush furnishings and other non-essential costs like staff Christmas parties. As one federal official admitted to Florida Senator Lawton Chiles at a hearing Monday in Tampa, "There is little incentive for efficiency." More amazing documentation of the great throwaway is expected to be presented when Sen. Chiles moves the hearing to Miami May 5.

The entry of entrepreneurs more interested in easy money than in patient care also has threatened to undermine the long established, sincerely dedicated, more competent but less commercially aggressive community agencies like the Visiting Nurse Assn. Instead of getting more help to continue doing their good job, the traditional, truly non-profit home health care agencies are having to fight for their lives.

What the nation winds up with is programs exhibiting the worst features of both socialism and capitalism without any of the benefits of either system. If the system were truly "socialistic", and we certainly are not saying here that it should be, it at least would have the advantage of being better planned. If it were truly capitalistic, it would be fraught with so much competition that only the agencies which offered the best service at the lowest price would survive.

Many of its health programs the nation cannot long afford, regardless of what labels are put on them and regardless of whether they are response to real needs. If they are to survive they will have to be cleaned up. As a starter the home health mess could be improved by allowing the FBI to investigate the obvious fraud in it. The task was wrongly left to HEW and the U.S. Attorney.

Requiring more honesty is a good policy for any government program, and the least the taxpayers should expect.

[Editorials from the Tampa Tribune, Apr. 14, 1976]

GET MEDICARE'S HOUSE IN ORDER

The national ripoff in Medicare is scandalous enough. What's worse is that Congress is doing nothing about it.

Medicare is a creature of Congress—10 years ago. But Congress seems not to know of the soaring costs of treating Medicare patients, the wide disparity in Medicare charges and outright fraud in many instances.

A Tampa hearing into Medicare practices by Florida's U.S. Sen. Lawton Chiles produce some examples of what Congress should have been investigating years ago:

Home-care treatment agencies charge $36 for a home visit by nurses. The Hillsborough County Visiting Nurses Association charges $14.

Chiles reported that in New Jersey a wheelchair costing $168 was rented under Medicare for 72 months at a cost of $1,080.

Tribune reporters Charles Hendrick and Daniel Ruth testified they found evidence of kickbacks and doctor referral fees.

The reporters also said one medical laboratory's going rate for blood tests was $12.50, but it gave a $25 rebate to chiropractors for sending patients in for tests then billed Medicare $50 for the test.

The reporters also told of technicians from one laboratory who gave 50 respiratory tests, at a nursing home without a doctor's approval. Some of the patients were so senile the tube was taped to their mouths.

In just two years the homecare nursing treatment has mushroomed into a $2 billion business. There are two types of operations in this field—non-profit and those which operate for a profit. Chiles reported some non-profit organizations charge double and triple the fees paid nurses from community-sponsored organizations.

One St. Petersburg non-profit operation pays $40,000 in salaries to the operator and his wife, $9,000 to their daughter and $22,500 to a medical director who works four days a week.

What was so amazing about the testimony before Chiles was the indication that the Medicare administration doesn't know the intensity of the medical charge scandal, obviously doesn't care and is afraid to bring the ripoff operators into line.

One witness, Douglass Richard, who directs the Bureau of Health Insurance—which administers Medicare—in eight Southeastern States, said it is difficult to detect fraud or determine disparities in medical charges. Further, he has only six investigators under him.

Richard also admitted his agency is reluctant to take a wrongdoer to court because of the high cost of legal battles. The most telling admission from Richards was that his bureau has no guidelines for judging the efficiency of home-care operations.

If Congress can spend months investigating the FBI and the CIA, surely it can take the time to find why Medicare can't get its house in order and stop this disgraceful waste in treating the elderly.

[From the New York Times, Feb. 9, 1976]

MEDICARE AUDIT FINDS RENTAL COST DRAINING FUNDS

NEW YORK—Because of a loophole in the law, millions of dollars in public funds are being spent needlessly for renting medical equipment for sick and disabled beneficiaries of the Medicare program for the elderly.

Senior officials in the Social Security Administration confirm the excess expenditures, but they are powerless to stop it.

Under the law, they note, individual Medicare beneficiaries have the choice of renting or purchasing medical equipment prescribed for them by a physician and authorized by Medicare officials. This has led to such excesses as the following.

A wheel chair that cost $168 to purchase was rented for 72 months at a total cost of $1,080.

A hospital bed that cost $283.50 was rented for 58 months at a cost of $1,634.20.

A commode that cost $44 was rented for 22 months at a cost of $286.

A respirator that cost $396 was rented for 36 months for $1,932.

Federal Medicare funds paid for 80 percent of the rental cost and the beneficiaries paid the remaining 20 percent.

The rental charges, which exceeded the purchase prices on some cases by as much as 600 percent, were disclosed in audits of Medicare records in northern New Jersey and New York City.

Copies of the audits were obtained by The New York Times.

One big problem is that, although the law allows full, immediate reimbursement for equipment costing $50 or less, it requires installment reimbursements

for anything that costs more. For the Medicare beneficiaries who don't have sufficient capital for an outright purchase, the only choice is to rent.

Medicare officials in New Jersey and at Social Security Administration offices in New York City and Baltimore report that this is a difficulty for thousands of people across the country.

Initially, the Medicare law authorized only the rental of medical equipment. But Congress amended the law in 1968, giving beneficiaries the choice of renting or purchasing. No limit was established on rental charges, no matter how much they increased.

According to a contract specialist in the New York Social Security office, the law has been an "open invitation" to profiteering among medical suppliers. "Why sell something when you can rent it for a lot more money?" he said. "It's an example of fraud perpetrated within the loophole of the law."

Officials at the Social Security Administration's office of research and statistics in Baltimore agreed.

Peter Klein, an official in the program-experimentation branch of the division of health insurance studies, said the government "has been aware for a long time that there was a lot of waste, and we're trying to do something about it."

All told, $3.2 billion was paid to physicians and for medical supplies and expenses under Medicare in 1974. Of this, an estimated $100 million represented costs for wheel chairs, beds and other medical devices that the sick and disabled require at home.

Medicare officials said there was no way of accurately estimating the extent of waste involving excessive rental costs, but they said "it obviously involves millions and millions of dollars every year."

Dr. James Kaple, the head of the experimental branch, said the Social Security Administration was planning to conduct a series of pilot programs in five states this year to test new methods of eliminating abuses and waste.

In any event, officials anticipate that any major revisions will require new legislation.

According to officials in Kaple's office and to other Medicare experts, several factors compel beneficiaries to rent aside from the fact that they simply cannot afford to purchase.

The problem, the officials said, begins with the physicians who treat the Medicare patients and then prescribe the kind of medical equipment required at home. While the duration of some disabilities or diseases is relatively easy to determine, others are not, and the physicians can offer only an educated guess as to how long a bed or a wheel chair will be required.

In cases where there is an unexpected quick recovery, the physician can no longer authorize the equipment, and the government is required under the law to stop making monthly reimbursement payments, even though the patient has already paid in advance.

Moreover, most patients, except perhaps amputees or persons with similar permanent afflictions, psychologically tend to reject the permanence of their illnesses. To purchase a bed or wheel chair, they feel, is to confirm in their minds that they may never get out of them. Renting offers them a psychological advantage.

Finally, some equipment, such as respirators, requires continuous maintenance that can be guaranteed only if it is rented.

LETTER FROM HON. L. H. FOUNTAIN TO HON. F. DAVID MATHEWS

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., August 6, 1975.

Hon. F. DAVID MATHEWS,
Secretary-Designate, Department of Health, Education, and Welfare, Washington, D.C.

DEAR MR. SECRETARY: As I indicated in my letter of August 5, I am writing to call to your attention some specific problems in HEW's operations which appears to me to call for urgent remedial action.

As you may know, the Intergovernmental Relations and Human Resources Subcommittee is reviewing the resources and procedures utilized by the Department of Health, Education, and Welfare to prevent and detect fraud and abuse in its programs. In connection with this inquiry, the subcommittee requested background information in March of this year and held public hearings in April, May and June.

A formal report on the subcommittee's continuing investigation is now being prepared and is expected to be ready in the near future. It is also my expectation that the subcommittee will give consideration in the near future to the establishment of a statutory Office of Inspector General for the Department of Health, Education, and Welfare.

The report now being prepared will contain a detailed account of the subcommittee's findings, conclusions and recommendations. However, in view of very serious deficiencies disclosed by the subcommittee's investigation, I thought it advisable to write to you in advance of the report to urge that corrective action be initiated as soon as posible.

Since the subcommittee's report has not yet been completed, it would be inappropriate for me to try to speak for other members of the subcommitee at this time. However, in my judgment, the subcommittee's investigation clearly disclosed that:

1. Fraud and abuse in HEW programs are causing enormous losses and greatly reducing the effectiveness of HEW programs. Resources used to combat fraud and abuse are so inadequate and disorganized that HEW officials have little or no reliable information concerning the actual amount of such losses.

2. According to its charter, as published in the Federal Register, the Office of Investigations and Security has departmentwide responsibility and authority for policy direction, planning, coordination and management of investigations. However, HEW has not complied with this stated policy. Instead, there evidently is an unwritten agreement that OIS shall take no part in investigative matters involving the Social Security Administration, even though SSA programs account for more than 80% of all HEW expenditures.

3. The Office of Investigations and Security is responsible for reporting directly to the Secretary on fraud and abuse in HEW programs. However, even though HEW programs involve more than 129,000 employees and expenditure of $118 billion annually, OIS has only 10 investigators to investigate allegations of fraud. Five of HEW's ten regional offices do not have a single professional investigator assigned. When the subcommittee began its hearings in April, OIS had a four-year backlog of uninvestigated cases; that backlog has now grown to approximately ten years.

4. There are thirteen additional professional investigators working for HEW, who do not report to the Secretary. These investigators are assigned to the Investigations Branch of the Social Security Administration's Office of Administration, and work only on cases referred to them by SSA program units. These investigators currently have *no* backlog—primarily because very few cases are being referred to them.

5. There are also a number of quasi-investigative units which report to the administrators of some HEW programs. These units do not report to the Secretary, and apparently were established on an individual basis rather than as part of a coherent and coordinated overall plan to help provide the Secretary with information needed to combat fraud and abuse in HEW programs. There has been little or no coordination between units working on such closely related programs as Medicare and Medicaid.

The subcommittee's report will undoubtedly go into considerably more detail, but I am sure the above points are more than sufficient to illustrate the basis for my concern.

Pending issuance of the subcommittee's report, I want to urge that you give immediate personal attention to strengthening the procedures and resources used by HEW to prevent and detect fraud and program abuse, and to suggest specifically that:

1. Immediate action be taken to make the SSA Investigations Branch a part of OIS, thereby bringing HEW's investigative operations into compliance with the Department's stated policy. This would also make presently underutilized investigative resources available to meet the pressing needs of the Department.

2. An immediate review be made of personnel and resources being utilized for the prevention and detection of fraud and program abuse with a view to evaluating Departmental needs and available resources, and taking appropriate action to insure a high degree of cooperation and coordination among auditors, investigators and program managers.

3. Immediate action be taken to assign at least one qualified investigator to each regional office; if necessary, this could be accomplished by transferring qualified investigators from program units to OIS.

I hope these comments and suggestions will be helpful to you. If you would like any additional information concerning any of the matters discussed above, please feel free to have the appropriate member of your staff contact the subcommittee Counsel, Mr. Naughton.

Best personal regards.

Sincerely.

L. H. FOUNTAIN, *Chairman.*

○

END