ABUSE OF THE MEDICARE HOME HEALTH PROGRAM

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

FIRST SESSION

MIAMI, FLA.

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TUESDAY, AUGUST 28, 1979

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Miami, Fla.

The committee met, pursuant to notice, at 10:15 a.m., in the Dade County Courthouse, Miami, Fla., Senator Lawton Chiles, chairman, presiding.

Present: Senator Chiles.

Also present: E. Bentley Lipscomb, staff director; Kathleen M. Deignan and Helena Sims, professional staff members; Theresa M. Forster, financial clerk; and Sam Deramo, General Accounting Office.

OPENING STATEMENT BY SENATOR LAWTON CHILES, CHAIRMAN

Senator CHILES. Good morning. This morning's hearing is one I really wish we didn't have to hold. More than 3 years ago I held a hearing right here in Miami, right in this room, on the same subject—the efficiency of the medicare program in disbursing funds to home health agencies.

I said then that I fully supported the concept of home health care—that I believed care in the home was a valuable and needed service. I am even more convinced of that today. I also said then that I coudn't understand how the Congress could continue to encourage the development of home health programs while there were so many inefficiencies in the program and so many examples of outright abuse of the taxpayer's dollar.

We saw a rapid rise in the number of "medicare only" home health agencies here in Florida.

We saw medicare paying one home health agency $14 for a nurse's visit and paying another home health agency anywhere from two and a half to three times that amount for the identical visit.

We saw medicare being billed for parties, gifts, trips, high salaries and luxurious fringe benefits, and franchise fees.

It certainly was not the congressional intent that medicare be used to create a lucrative situation for enterprising businessmen and it was not our intent that the taxpayer's dollar be used for expenses totally unrelated to patient care.

I had hoped then, 3 years ago, that those hearings and others we have had in Washington would quickly result in much needed program changes. I am not able to come back to Miami today and

tell you that everything is working all right and that we can now take the next steps and expand this kind of care to more of those in need. Instead, we are here to find out why 11 years after the beginning of this program we are still hearing about the same old problems.

We have more than 130 medicare certified home health agencies in Florida. Many of them, however, serve the same people, locating in heavily populated areas, competing for patients and spending more on patient solicitation than on actual patient care. In contrast, there are other areas of the State where there are no home health agencies.

It becomes disturbingly clear that this same kind of proliferation of home health agencies is occurring now in other areas of the country. I am also disturbed when I find that some people who have clearly been ripping off the medicare system are still in business. That says a lot to anyone who wants to repeat this success in other areas and it makes me wonder about the adequacy of our prosecution efforts. This committee, for example, has been dealing with a case in California since early 1975 and that case is still not resolved.

What can I think when I see medicare cost reports with wide discrepancies in home health costs per visit?

When I hear of very high administrative fees?

And when we find home health agencies refusing to serve patients unless they can get quick, in-and-out visits as a way of keeping their reimbursement levels up?

Since our Florida hearings in early 1976, Congress has taken additional actions. A new law, the medicare and medicaid antifraud and abuse amendments, was passed to provide the Government with additional tools to detect and deter abusive payment practices in the medicare program, including home health.

I introduced a bill early this year to require specific cost guidelines for certain home health administrative costs—such as salaries, contract fees and fringe benefits—and to require designation of regional home health intermediaries to serve home health only. More recently, I introduced a bill to authorize civil money penalties for home health and other medicare providers who intentionally abuse the medicare program. I hope that this bill is going to afford some relief because where we cannot get prosecution or where that takes so long, I believe if we hit the abusers in the pocketbook and do it quickly it might help to clear up the abuses.

There is no doubt that home health is still growing. Medicare payments to home health agencies next year will total $849 million. This is almost double the amount medicare will pay to nursing homes—$488 million—and double the amount paid for home health in 1977—$457 million.

If this increase in payments directly represented an increase in the number of elderly persons in need receiving such services, I would not be as concerned as I am. If it represents, however, continuing and increased patterns of overutilization, padded costs and hidden profits by some providers, then we are very much in trouble. That is what we are here today to find out.

We will be asking those very questions today of representatives of three major Federal offices which have responsibility under the

law for administering this program and for elimination of abusive practices. I have also asked for comment from a representative of the Florida Association of Home Health Agencies.

I know that there are home health agencies that are very tired of me looking into this problem and hope that I would go away. I know some of those agencies are doing a creditable job and it is always bad when they have to be lumped with others because the news will always come out about the tremendous problems that are in the industry.

At the same time if we are going to use $800 million plus of the taxpayers money, we have got to have a program which we are running for the benefit of the people that it is supposed to be for. I am distressed as I can be, as I say, that 11 years after the program started we are still seeing these abuses and 3 years after we specifically held hearings on it in Florida.

Our opening witness today will be Richard Lowe who is a Deputy Inspector General of the U.S. Department of Health, Education, and Welfare in Washington. With Mr. Lowe is Arthur Friedman, Director of the Division of Special Assignments.

Deputy Inspector General Lowe, we are delighted to have you as our opening witness this morning.

STATEMENT OF RICHARD B. LOWE III, DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, WASHINGTON, D.C., ACCOMPANIED BY ARTHUR FRIEDMAN, DIRECTOR, DIVISION OF SPECIAL ASSIGNMENTS

Mr. LOWE. Thank you, Mr. Chairman.

It is a pleasure to have this opportunity to participate in this inquiry and to discuss with you abusive and fraudulent practices in the home health industry, as well as the role of the Inspector General in this field.

Many of the abuses which will be discussed today have been known for some time. Most of them came to light as a result of the earlier 1976 hearings on home health chaired by you, Senator Chiles. The continued existence of these self same abuses has been substantiated by the validation functions conducted by the Health Care Financing Administration—HCFA—the inquiries made by the audit and investigative staff of the Inspector General and, most recently, by the audit work of the General Accounting Office—GAO.

Frankly, we at HEW have not done all that we could have to address these problems and to correct the defects in the system. I recognize our failures, Mr. Chairman, and I do not come here to justify them. Rather, I feel it would be worthwhile to discuss the recent activity of the Inspector General and brief this committee on the headway the OIG is making in this area. I shall talk about investigations and prosecutions. Additionally, I think it would be useful to describe to you the obstacles which we have encountered in pursuing these investigations. We have profited from these experiences, and the lessons learned will help frame future endeavors.

As you know, Mr. Chairman, the Office of the Inspector General commenced operations in March 1977. Initially, there was a core group of auditors and a small staff of criminal investigators. Since that time, we have increased those staffs to a level that has en-

abled us to attack our current workload while at the same time allowing us the ability to direct small cadres of talented professionals toward new fraud and abuse initiatives and to address problems of systems design.

In this respect, we have just added a new legal and prosecutive dimension to our investigative staff. This new tool is the Division of Special Assignments, directed by Arthur Friedman, a former member of the staff of New York State Special Prosecutor Charles J. Hynes. Mr. Friedman, in collaboration with U.S. Attorney Jack Eskenazi, is currently directing one of our investigative efforts into Florida home health agencies. I will elaborate on this shortly.

Since its inception the Office of the Inspector General has initiated investigations involving approximately 43 home health agencies. Four cases have resulted in the lodging of criminal charges, with six convictions having already been obtained. Two of those convictions, one of which was in Florida, culminated in jail sentences for the defendants. Presently, three investigations are before the grand jury.

A key factor in our future fraud and abuse activities is our audit staff. We too often speak of investigations without paying due respect to the integral and important work of the auditors. Ordinarily our audit staff is not directly involved in the day-to-day auditing of home health agencies, or any other health care providers for that matter. That is the responsibility of the fiscal intermediaries. Normally our OIG auditors review the procedures and practices of the intermediaries, and their audits, as well as their settlement of provider cost reports.

In special situations, however, our auditors do perform provider audits. The most notable of this work in the home health field is the audit of the California operation of Flora Souza. This case has been referred to the Department of Justice for grand jury presentation and we are continuing our audit efforts in support of the grand jury investigation.

To be sure, our resources are insufficient and inadequate to cope with the ever burgeoning problems in the health care field, but with our full complement of auditors and investigators, our new initiatives, our new prosecutive dimension, program knowledge and expertise from HCFA, and help from the Department of Justice, we feel we will better those efforts.

I would now like to relate to you some of the problems in home health from our viewpoint.

Several abuses concern problems that we may call program deficiencies. In this category we have the reimbursement system in general and, more specifically, the difficulty of the Government collecting overpayments from nonprofit providers. There are also the tremendous discrepancies we find between the operational costs of similar agencies providing similar services.

Second, there is a category that goes beyond system abuse. This is illustrated by a scheme prevalent in institutional care whereby the provider seeks to circumvent medicare laws and regulations by establishing related entities which ostensibly supply such services as accounting and technical consulting to the provider. Employing deception and misrepresentation, unscrupulous individuals employ this device to defraud the medicare system of needed resources. I

say defraud because the true non-arm's length relationship between the provider and the entity supplying the service is disguised, thereby increasing the reimbursement to the provider.

It is also fraud to wilfully include personal nonpatient related expenses in the cost report. It is against this fraudulent activity that we are directing our most concerned efforts and substantial resources. There is a difference, however, Mr. Chairman, in describing fraudulent criminal conduct and proving it in a court of law.

Inquiries into the financial operation of home health agencies are classical white collar crime investigations; they are difficult to develop and difficult to prosecute.

Traditionally, the criminal justice system has not found a satisfactory way to deal with the white collar defendant. His schemes are complex, the investigation is costly, long, and tedious and, if convicted, he rarely gets a jail sentence. The public pressure has been to apprehend and prosecute the murderer, the drug dealer, the bank robber, and the mugger.

Most of the time no dispute exists as to what the facts are. The key to a successful prosecution is the proof of criminal intent; in other words, to show that the defendant had larceny in his heart. When the witnesses who possess the knowledge to pinpoint intent in these cases are insiders—insiders who usually have strong financial or social links with the defendant—necessary proof is practically impossible to uncover. However, sometimes this insider greed facilitates white-collar prosecution. Since there are usually multiple parties, rifts between the culprits occur and eventually someone turns to the authorities, but we cannot depend on these flukes of human nature.

At all levels of government we must take an active role in ferreting out the wrongdoers. Our efforts in this regard have been encouraging. The Department of Justice has also taken a lead role in directing more attention to white collar crime. They have been most receptive to our prosecution efforts and we look forward to very positive results.

A silent accomplice to the financial abuser and ultimate perpetrator of fraud is the laxity in the writing, interpretation, and enforcement of regulations. HEW programs, as envisioned by the Congress, and as pointed out by you, Mr. Chairman, were not directed toward helping profiteers but at providing services to people.

What has happened, however, is that we have tried to patch holes in the regulations that are often loosely constructed and afford insufficient guidance for effective monitoring. What has actually been created is a vehicle within which fraud and abuse can flourish. The result is a prosecutor's nightmare and an intermediary's frustration. A prime example is the regulatory maze that attempts to set out all of the details necessary to carry out the basic rule that only reasonable costs will be reimbursed.

Every discussion of the fraudulent or abusive problems with our institutional health system commences with a statement about our payment mechanism which allows for reimbursement based on reasonable cost. Without discussing the pros and cons, it can certainly be argued that, at a minimum, this system does not provide

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an incentive for holding down costs. The term reasonable cost itself is obviously open to various interpretations. At a maximum, it is an open invitation for intentional abuse.

The argument is often made that an intermediary must demonstrate that a cost is unreasonable. Obviously, that is not an easy task, particularly in light of the appeals process whereby the Federal Government must pay for the provider's attorney's fees, including appeals costs. While I am not ready to make a formal recommendation, I want to assure you that we are looking into possible improvements. One is to place the burden of proof for reasonable costs on the provider. Another is to establish a cutoff point where the Government is no longer required to pay for legal expenses. I do not want to dwell on these because they are quite controversial and these are substantive arguments that must be considered. However, we do see these as possible alternatives to help hold down medical costs and at the same time assisting the intermediaries with their jobs.

Until recently the intermediaries, seeking to run a cost-effective operation, focused their audits on large institutional providers such as hospitals where recovery potential is much higher. Recently this has been changed to some extent with the reprograming of audit funds toward home health agencies.

Keeping what I have just stated in mind, I want to briefly mention the magnitude of the problem. Home health expenses account for a very small, but increasing portion, of the total medicare budget. In 1976, home health represented only 1.6 percent; by 1978 it jumped to 2.5 percent. To talk in dollars, in 1978 this amounted to $607 million out of $24 billion. The figures indicate that this component is rising faster than the overall inflation of program costs. One can assume that as the amount of reimbursement rises, so does the magnitude of uncorrected program abuses.

I do not suggest that $607 million is an insignificant figure or that it does not deserve substantial investigative attention. However, as with all agencies, the Office of Inspector General has limited resources and the relative amount of Federal dollars involved enters into decisions of resource allocations. Even then it should be pointed out and noted that approximately 50 percent of our present investigative case load, or 227 cases, do deal with health care reimbursement.

I now want to summarize our present activities, please, Mr. Chairman.

In May of this year the Inspector General launched Project Integrity III which is a major investigative and audit initiative dealing with three classes of institutional health care providers—nursing homes, hospitals, and home health agencies. As such, it follows the earlier efforts of Project Integrity I and II. Home health agencies are the focus of the first phase of this initiative. These hearings have, quite frankly, caused us to accelerate our efforts and a three-pronged attack has been launched.

First of all, we, in cooperation with the Department of Justice, have deployed significant resources to come to grips with the most meritorious cases in Florida. Based on the experience we gain, we will then channel our future efforts toward problems in California, Texas, Louisiana, Illinois, Puerto Rico, and New York.

Under my direct supervision, all open cases have been evaluated. To date, we have identified four cases with little or no prosecutive merit. These will be referred to HCFA for appropriate administration action. I personally, as well as members of my staff, have consulted with Mr. Jack Eskenazi, the U.S. attorney for the Southern District of Florida, in order to facilitate the possible prosecution of the remaining cases. We have also met in Washington with representatives of the Department of Justice. The Department is aware of our present interest in home health and it has assured us that it will supply, subject to their own manpower limitations, the prosecutive assistance needed.

The present Florida effort involves three individual initiatives and nearly 30 individual home health agencies, comprising about one-quarter of all agencies in Florida. Almost all of those under investigation are the so-called nonprofit 100 percenters—those almost exclusively catering to a medicare clientele.

One of these initiatives involves OI investigators working with the Department of Justice on a group of cases based on evidence gathered by the Office of Investigations and Office of Program Integrity. The case is presently before a Florida grand jury.

The Inspector General has assigned another team comprised of three investigators and two auditors to support a second effort directed by the U.S. attorney for the Southern District of Florida.

We have also assigned an experienced trial attorney, two investigators, and two auditors to a third force which is working under the direct supervision of the Director, Division of Special Assignments, Mr. Friedman.

Our audit staff is likewise looking beyond the immediate concern for the investigative aspects of Project Integrity III. We have already reprogramed additional audit time in our 1980 work plan to give home health agencies priority attention. These audits will investigate the root causes that allow abuses to occur. They will focus on determinations as to whether or not medicare cost reimbursement procedures and guidelines adequately assure that only proper and reasonable payments are being made. In particular, because we know problems exist, emphasis will be given to the proprietary and the private nonprofit agencies. Matters for special audit consideration include salaries and fringe benefits, startup and consultant costs, fees for accounting and computer services, space costs, management agreements and double charging of costs.

I have tried to outline for you, Mr. Chairman, some of the key factors affecting the home health agency prosecution. My intuition tells me that these problems are pervasive. When I came to HEW several months ago, I looked forward to using my skills as a prosecutor to identify the fraud and abuse which steals money from vulnerable social service programs. Since I have been here, I have acquired an additional perspective. I now view our programs not just in terms of what is wrong with them but rather what is right about them. We have dedicated ourselves to insure that these programs will offer better and more accessible care while we strive to close loopholes that invite abuse.

The Office of Inspector General has steadily grown in 2½ years to a well balanced team under the able direction of Tom Morris. Admittedly, we are still beset with the typical staff limitations and

an ever burgeoning caseload, but we in partnership with the Health Care Financing Administration and the Department of Justice have begun to achieve what appears to be substantial progress and I believe that we will be able to come to grips with this problem in the future.

I thank you for this opportunity, Mr. Chairman.

Senator CHILES. Thank you, Mr. Lowe, for a very comprehensive statement.

You mentioned that the Office of Inspector General in HEW has been there now 2½ years. I recognize that, and I recognize even from the time in which the office was created originally, it didn't have the emphasis that it has now. Following the pattern from the creation of the Office of Inspector General in the HEW, as you know, we have now created Inspectors General in all of the major agencies of the Federal Government and I view this as really one of the most hopeful aspects that we have entered into in trying to deal with fraud and abuse and, more than that, trying to deal with the effective use of the taxpayers' dollars to see that that money is spent not only fraud free but also efficiently and effectively. The duties of the Office of Inspector General then go into much more than just fraud and abuse.

I say it is one of the most hopeful aspects, but at the same time I think it is almost the last hope, because if we cannot deal with the fraud and abuse, whether it is in the General Services Administration—and I have had the misfortune to have the oversight capacity in our programs there—in HEW, or in grain in Agriculture, or in food stamps, or anything else where we are losing so much of our credibility with the American public and with the taxpayers because we have not been able to run these programs so that we are not ripped off all the time and also so that they are run effectively and efficiently. So I think we are dealing with the last great hope and that we have got to make it work.

You mentioned resources. During the budget markup in the HEW appropriation bill, which I assume the President has now signed, we finished the conference report. Maybe we are still hung up on the abortion question, I guess we are. We never finished that question. We finished all the bill except that, I think. We have put in additional money.

Senator Eagleton and I sponsored a bill on the Senate side for additional money for the Office of Inspector General. If you or the Inspector General tell me you need so many more slots to be able to deal with this problem, we will get you the money because I think we have got to have the resources if we are going to have a credibility in the program.

Now I recognize that this is a small part of the overall budget of HEW and a small part of the overall problems that you all have to oversee and maybe right now you are putting a great deal of resources there but at the same time, as you pointed out in your statement, when you had these problems surfacing in 1976 and 1977 in committee hearings that I held and also in committee hearings that other people held on the House side as well, and we see the same kinds of problems continuing while a program that starts off in small dollars is beginning to double and you raised the figure of $600 some million in 1978—I cited the figure of $840

million in 1979 so we are seeing a doubling of that program from 1977 to 1979. It is going to continue to grow that way.

We are only finding some States just beginning to go into the area. As we try to broaden our whole range of home health services and home services and we are now pushing the administration to come up with a unified plan of how we really develop these services for our aging population, this program is going to run into billions of dollars and it will be very quickly. It is growing at a geometric rate right now and to have it grow while we still have the abuses, and they are almost pyramiding or the dollars that we are taking are pyramiding, too, is something that I think we have to be very concerned with.

I am delighted to see the stress that you place on the audit function of your office. On the Senate side, when we were dealing with the big Inspector General bill, the one covering all the agencies, we named the title Auditor and Inspector General. That changed a little bit in the conference, but the audit function, I think, can set up the procedures whereby you can prevent some of the fraud early on and not have it that you are around trying to catch it after it occurs.

So I think the audit function is tremendously important in our office. It also is tremendously important for HCFA to design it and for us to see that the intermediaries have the proper audit criteria that they are using in monitoring the agencies.

GAO identified some 5 organizations which assisted with establishing or providing assistance to at least 78 different home health agencies. Do you have any evidence that those organizations are all related to each other?

Mr. LOWE. There are indications, Mr. Chairman, but at the present juncture we don't have any hard facts to substantiate it.

Senator CHILES. Do you look to determine whether there is a relationship there?

Mr. LOWE. Mr. Chairman, with respect to your first question, some cases, as I said——

Senator CHILES. I am not asking you to speak of any specific case that is under prosecution.

Mr. LOWE. I understand, but I just wanted to point out that some of those very cases are under investigation and are before the grand jury. I apologize for not answering the followup question, sir.

Senator CHILES. I was saying what are the things that you look for in determining whether there is a connection, whether they in effect have a relationship with each other?

Mr. LOWE. The audit process, Mr. Chairman, looks behind the cost report. It goes into the ownership of the agency. It also looks at the board of directors, the subcontractors, and other supportive services and costs, including salaries and benefits and double charges. We try to identify the individuals or organizations where relationships might exist of less than arm's length. When we see a pattern or relationship, we try to follow them.

Senator CHILES. Would you please describe in detail the efforts that you plan to take under your project integrity III especially as it relates to the home health agencies? Feel free to let Mr. Friedman join in.

Mr. LOWE. Project integrity III is a joint effort by HCFA and the Office of Inspector General. What we have done on the investigative side is to identify those cases, and particularly those cases here in Florida, which are in need of investigation. A number of these cases were referred to us from HCFA. We have identified three groupings of cases here in Florida to which we have committed three separate investigative teams. HCFA, on the other hand, has established a plan of action to identify the problems with the system that allow these abuses to occur, as well as devoting additional resources. As problems on the investigative side are revealed that can help HCFA we will pass that information on to HCFA. HCFA passes its information on to us. So it is a joint effort, to attack not just the criminal aspects, but more importantly, what we feel are the system's problems, which we feel that HCFA will be able to come to grips with.

Senator CHILES. What are the manpower limitations you spoke of in the Justice Department, as you see them, as they relate to white-collar prosecution?

Mr. LOWE. Mr. Eskenazi will be testifying this morning, as you know, Senator Chiles. I believe that he can address that area better than I can. But as a former prosecutor, I can tell you that the area of white-collar crime is a difficult area in which to commit resources. It is difficult because the investigations are generally a very long and tedious process. When you have a prosecutor's office with a small cadre of prosecutors, a small staff, it is very difficult for the U.S. attorney to commit 2 or 3 members out of a staff of say 10 or 11 to cases that can take anywhere from 6 to 18 months to develop. Even then, you cannot be assured of success many times because of the problems with the law itself. So it is primarily the extent and the length of the investigations, and the total number of individual assistant U.S. attorneys that that office may have at a particular time.

Senator CHILES. Do you have an opinion on the bill that I was describing as I have introduced to provide for civil penalties as an expedited procedure in trying to deal with some of these cases?

Mr. LOWE. Yes, I do, Mr. Chairman. The civil money penalty bill affects many areas of the home health operation and it will obviously be of value in the gray area below provable criminal fraud. One of the problems of the prosecutor is that you may have the indications and even the facts but you cannot prove it in a court of law and yet you still know that abuses exist.

The quantum of proof in a court of law is a very severe one, it is proof beyond a reasonable doubt, as I am sure you are well aware, Senator. As an administrative hearing, the quantum of proof is different. The civil money penalty bill is one in which the quantum of proof is not as severe, it's the preponderance of the evidence as stated. The bill, however, is not a final solution in and of itself, particularly in home health. We anticipate problems in that area. One of the problems that we have with the home health industry is with the not-for-profits. When you have a home health agency that is not a profitmaking organization, collecting disallowances, much less civil money penalties, is like getting blood out of a stone, so to speak.

Senator CHILES. You have a judgment but there is no way to correct it, all the money is taken out of the salaries.

Mr. LOWE. Exactly.

Senator CHILES. That is a very good point.

Mr. LOWE. We are exploring some possibilities to correct this, but we have not come to the point where we are ready to make full recommendations. One area we are considering is to back the civil money penalty bill to require nonprofits to put up a bond before they go into business. Another is to make them personally liable. These are areas we are exploring, so that there will be some teeth in the bill itself, and will allow the Government to recover.

What happens when the Government identifies that there have been overpayments, or even fraudulent taking of money, but it is a not-for-profit organization? It is fine to say you can identify it and you owe us this money but if it is not a profitmaking organization, there is no profit or retained earnings to get that money back from. So as you can see, the bill is still not the final solution with respect to not-for-profit organizations.

Senator CHILES. I think you raised a very valid point in regard to that. I suggested bond before, and at that time HEW came back and said that that would be impossible. I would hope that HEW might look at that again, because I think having some kind of resources or requiring some kind of resources be there is very necessary because the so-called not-for-profits turn out to be very profitable for the people that have them and they don't exactly meet the concepts of many of our feelings of what was a not-for-profit like a visiting nursing association or something that was sponsored by some kind of a local group.

Mr. LOWE. Another suggestion, Mr. Chairman, has been to eliminate corporate ownership in home health agencies. One of the problems is, for example, if you can prove that the Government has been overbilled, or even fraudulently billed by a corporate entity, the personal liability of members of the corporation are limited only to that amount that they put in, unless you can pierce that corporate veil and show that it is just a shell. Of course, this is very difficult and it depends on various State laws.

Senator CHILES. You mentioned this and you mentioned other studies. When are we going to see some results from these suggestions? We have been dealing with this 11 years now. Our hearings were a long time ago and we are still talking about suggestions.

Mr. LOWE. I appreciate that, Mr. Chairman. I think one of the things that has to be considered, as you pointed out, is that there are a number of honest, sound, and dedicated people in the health care field. Unfortunately, as in any other area where you have a few abuses, a few profiteers so to speak, they make the situation bad for everyone. I am sure that the approach that is being taken by HEW is not to just go and to make sweeping changes that may ultimately cause undue harm to the people in the industry or that can produce other problems.

The intent and the desire is to provide the services and we must not get into an area of trying to shore up the holes and then—well, how do you say it—to inhibit the delivery of those services. So I think it is an approach that is taking time, but on the other hand I think that the abuses have now been recognized. One of the prob-

lems that you speak of is 11 years, sir, and that is very true. We admit that we have devoted attention to this area only recently. We have not done it for 11 years, we have just started to commit our attention and resources.

I think that you will see great improvement in the area. At least I hope that I don't have to come before you again and sing the same song.

Senator CHILES. I want to be sure I don't have to come back here again either.

Do you have direct access to records of home health management agencies, the so-called franchisers?

Mr. LOWE. The providers receiving payment must provide adequate cost data which can be verified by qualified auditors and a home health agency may be terminated from the program if it fails to supply information on the accuracy of its billings and payments. Obtaining provider records is usually pro forma. Our problem is obtaining records of the contractors or the suppliers of the provider. We do not have the authority under the law to just walk in and ask for their records, as we do with providers. We can, of course, use our administrative subpena and of course the Justice Department can use the grand jury subpena.

Senator CHILES. So you get it for the providers but the franchisers who are actually the ones that have set up the providers, you actually have to go and subpona those records?

Mr. LOWE. That is right. Of course there is an appellate process where they have the right to move to quash the subpena. Thus, you have that whole time period wherin the investigation is delayed until the appeals are resolved.

Senator CHILES. Should the medicare law be extended to cover access to records of the provider's contractors?

Mr. LOWE. It certainly would facilitate our operation. It would make it easier for us and it would make it easier to have oversight. There is no question about that.

Senator CHILES. That is not exactly a new precedent. The Department of Defense contracts have a clause stipulating access to subcontractors books, and the same clause is stipulated in subcontractors books, that you have access to the prime, so that is already a provision where we do the bulk of our procuring. That is where the bulk of our procurement dollars are spent.

On page 8 of your statement, you refer to a laxness in writing interpretation and enforcement of regulations. Who there is being lax? Your office is part of HEW. Are you in a position to evaluate the performance of the Medicare Bureau or the intermediaries who actually interpret and carry out the regulation?

Mr. LOWE. Well, Mr. Chairman, our key responsibility is the investigation of fraud and abuse. What we try to do all of the time when we recognize a problem in a particular regulation is to point out the problem to the administrating agency. Achieving regulatory change to correct abuses, however, is not an easy task. Although a regulation may create some problems in one area, it may well be sound in other important aspects of administering the program. We make recommendations and then work with HCFA to overcome the problem with the regulations.

Senator CHILES. In another place in your statement you say that there are 30 individual home health care agencies in Florida that are under scrutiny. What can you tell us about your findings there? How much money is involved? When can we expect those investigations to be resolved?

Mr. LOWE. The investigations are presently underway. There are three groupings. One is presently before the grand jury and two others are presently under investigation. I cannot at this stage, Mr. Chairman, give you a dollar figure. That will be determined by the audit process being conducted by HCFA and the intermediaries, concurrent with our investigation. In this connection, however, I believe one of the problems, and it is a problem with prosecution traditionally, is that the U.S. attorney will look at it from a resource point of view. He will ask what it is worth in terms of the dollar recovery? I can appreciate that. From our perspective that is the only basis upon which the need for investigation and prosecution should be viewed. As you said earlier, the dollar figure may be low today and it may proliferate into a huge amount tomorrow.

We want to recognize the abuses and attack them whether they are caused by system deficiencies or outright fraud. As far as the findings from our current cases, sir, I don't mean to beg the question, but I also don't think that I can discuss these cases, at this stage.

Senator CHILES. Fine. You have mentioned in your statement there are problems existing in the proprietary agencies as well as the profit and nonprofit. What type of problems do you see in the proprietary agencies?

Mr. LOWE. The inclusion of nonpatient-related cost, overutilization, and excessive administrative overhead, are some examples of the problems that exist with both proprietary and private nonprofits. The abuses are similar for the profits and the nonprofits when managed by private parties.

Senator CHILES. How many home health fraud cases have been referred to you by the Health Care Financing Administration? Are you dependent upon the Health Care Financing Administration particularly for referrals, and how many cases have you referred to U.S. attorneys for prosecution?

Mr. LOWE. Well, I don't have that exact figure here this morning, Mr. Chairman, but I will be glad to furnish that for the record, but HCFA refers those cases to us which go beyond the abuse status and have indications of criminality. Most of our health care cases stem from HCFA referrals. Others have come from the Tampa task force, the FBI, insider tips, and beneficiaries.

Senator CHILES. Can you tell me how many cases the U.S. attorneys have declined to prosecute and what the reasons have been for that?

Mr. LOWE. We have declined several, Mr. Chairman. I will furnish the exact number for the record. As I mentioned before, the declination by the U.S. attorney can be due to many reasons, including the prosecutive merit of the case, the dollar recovery, and the amount of resources that the particular office may have at the particular time. The prospects of success influence a great deal the decision of the U.S. attorney to decline to prosecute or to accept the case. They also look at the age of a case, how long the

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particular abuse that you are charging the individual with has been in existence. In addition, there is a problem of program knowledge. Many of these programs are new and regulations are subject to various interpretations. The U.S. attorneys are under pressure just like any other prosecutor's office, and they have to deal with those cases which have priority in their area. I am sure that Mr. Eskenazi will be able to give you a more complete answer, sir.

Senator CHILES. You were talking about the auditors that you have assigned to this effort. How many auditors do you now have assigned as opposed to prosecutors, and do your auditors have prior experience in home health?

Mr. LOWE. In the effort in Florida we have, six auditors—two for each of the three teams. All of them have experience in home health.

Senator CHILES. Now you mentioned in your statement that Florida is the focal point right now.

Mr. LOWE. That is because, as you know, Mr. Chairman, Florida has a great concentration of home health agencies. You also have here a large concentration of retired people and thus of medicare eligibles. That is why we are devoting our efforts here, so that we can use the lessons learned to attack the rest of the country.

Senator CHILES. The point I wish to make, and you did say in your statement that you would be moving from here into the other States, is that I am not just trying to bring grief on Florida companies here and that I am not going to be satisfied and I don't think the Congress is going to be to just have Florida problems attacked. We are talking about an industry that sort of took over here in Florida because of that concentration of retired people and certainly we want to see that it operates properly in Florida but we also want to see that it operates properly in the rest of the country and that all of the companies and organizations that enter into this industry are going to be held to the same accountability as we are going to try to require those in Florida to be held to.

Mr. LOWE. I am aware of that, Senator.

Senator CHILES. You mentioned that the Health Care Financing Administration is also conducting audits. Do you have a formal agreement with them and has any consideration been given to permitting their staff under program integrity to become more involved in the actual fraud investigations? In other words, should your staff and the Health Care Financing Administration's program integrity staff merge?

Mr. LOWE. Senator, we have a very cooperative working relationship with HCFA. In addition, in project integrity III, we have a joint action plan and we also have a memorandum of understanding between the two agencies, with using HCFA staff, their work papers, and program knowledge in our investigative effort.

We do not view combining the two staffs as necessary, now, Senator. We feel that the current situation is a more efficient way of operating now. HCFA has the oversight responsibility of health care providers, whether it be home health agencies, nursing homes, or hospitals.

The current relationship is that HCFA goes in first to validate program compliance. When they identify abuse, overutilization,

overcost, overbilling, and so forth, which in most instances do not amount to criminality, they work through administrative channels to correct the problem and make recoveries. When they identify that which appears to be criminal fraud, they refer it to us and then we take over.

While there is no need now to combine the two forces, there are occasions when we could do much better with more access to some of their highly skilled auditors and program specialists. What happens is that their significant work force develops a workload of health cases faster than we can absorb them. Our investigative staff covers the full range of HEW programs. But we do not want to get in the business of overseeing the programmatic aspects of the various programs. That is not a function that the Inspector General should assume. HCFA is involved with the programmatic aspects and in improving and carrying out the programs.

Senator CHILES. Can you give me any more specifics about the types of abuses that you have under probe in the 30 Florida cases that you are talking about?

Mr. LOWE. In my statement, Senator, I believe that I touched on some of the prevalent problems that exist, both generally and with these ongoing cases. I do not feel that I can be more specific about ongoing confidential investigations.

Senator CHILES. In our earlier hearings we were seeing promotion fees being paid. Is that still a problem that is out there? I am trying to find out the kinds of problems that you are seeing.

Mr. LOWE. That continues to exist. The gambit of costs that have been identified in the past are the very objectives of our concern now.

Senator CHILES. So these are not some new abuses that are coming about, we are talking about the same kinds of problems that existed before?

Mr. LOWE. The same kinds of problems. The one thing that may not have been mentioned back in 1976 were the discharge planners—those who steer the patients to home health agencies.

Senator CHILES. As I understand you have a situation where one parent or franchisee will set up a number of providers and then each one of them would have some kind of administrative plan—a "how to" manual. The cost of each of these manuals is billed to HEW as being a separate cost and expense of each one of those providers and maybe of the parent, too, where it is only really done once and after that time they just change the cover.

Mr. LOWE. That is in the area of startup costs, yes. That is correct. That whole non-arm's-length relationship is involved in the development of new home health agencies.

Senator CHILES. Do you have any idea what we are talking about in dollars and cents in these duplicate startup costs?

Mr. LOWE. I think probably HCFA would be in a better position, Senator, to answer that.

Senator CHILES. I notice that the General Accounting Office study was talking about the range of costs of $10,000 per manual.

Mr. LOWE. What happens is that there is a flat fee for startup assistance, including procedure manuals. It is usually around $10,000 to $12,000, but sometimes more. Thus, on top of that there

is a percentage of the overall yearly take, and this can be quite a substantial sum of money.

These outside contracts are for 25- to 35-year terms. These contracts represent some of the targets of the concern of both HCFA and OIG.

Senator CHILES. I understand you have been in this position some 7 months. In your statement you have taken a personal responsibility in this area in the direction of this. Based on the work that you are doing then you are going to make some recommendations of the changes that you see that need to be made in the regulations and in the law and in the way the program is administered, is that correct?

Mr. LOWE. Yes, sir. In addition, Mr. Chairman, I think it would be important for you to know of a letter from the Secretary to Senator Williams S. Cohen in regard to HEW's home health report that was rejected by the Congress because it failed to make the appropriate recommendations that were asked for.

Senator CHILES. I have heard something about that report.

Mr. LOWE. Senator Cohen had written a letter to the Secretary inquiring about the status of that, and I think that you would be interested in this and her response. It reads:

To the Honorable William S. Cohen.

Thank you for your letter of August 1 concerning the Department's report on home health and other in-home services. You enclosed a copy of Senate Resolution 169 which directs the Department to resubmit the report. Although I have not had the time to familiarize myself with the report that was submitted to the Congress, I have asked the Administrator of the Health Care Financing Administration and the Assistant Secretary for Planning and Evaluation for a thorough briefing on the report and on the home health care policy. Once I have received their report I will be able to tell you what additional information we can provide and within what time frame. I intend to be as responsive as possible to the Congress' desire in this important area.

Sincerely yours,

PATRICIA ROBERTS HARRIS.

We intend to make the recommendations and improvements in this area that has been asked for by the Congress.

Senator CHILES. I thank you for that. Because that has been brought up, maybe we should say that this is a report that the Congress asked HEW to make giving the Congress some policy recommendations as to what directions we should be taking in home health and in the home care area trying to work toward some kind of a coordinated policy where we would really be providing our elderly citizens with an ability to be able to remain in the home as long as they possibly could and not be shunted off to nursing homes or hospitals prior to the time that that would be necessary.

After the Department had had this request for a long time, we called for a report. After a considerably longer period than a year we got back what was to be a report which was simply sort of a restatement of the problems which we all knew existed. The Congress did reject the report as inadequate, something that I understand has only been done rarely since the War Between the States, and told HEW that we really meant what we said, that we wanted the policy recommendations in spite of the fact there are going to be some large costs and we recognize that.

We may not be able to start all of them right away but still Congress needed to know everything that the administration had, the experience they had, and their knowhow as to what directions that we should take. I am delighted to hear that Secretary Harris has said that that report is going to be forthcoming.

Now to expand on that just a little, you will be making some recommendations to the Department based on your experience and your personal direction of this. I would like to have a copy of the recommendations so that I can evaluate them. I think our committee would like to have those.

Mr. LOWE. Yes, sir.

Senator CHILES. I thank you very much for your attendance today and also Mr. Friedman. We look forward to working with you in this area.

Mr. LOWE. Thank you, Mr. Chairman.

[Subsequent to the hearing, Senator Chiles submitted a list of questions to Mr. Lowe. Those questions, with Mr. Lowe's response, follows:]

Question. In your statement, you talk about a category of program deficiencies that goes beyond system abuse. You mention a scheme prevalent in institutional care whereby providers seek to circumvent the medicare laws by establishing related entities which ostensibly supply such services as accounting and technical consulting to the provider. You go on to say, in part, that if this relationship is disguised and if the parties employ deception and misrepresentation, it is fraud. What are some of the deceptions and misrepresentations? How widespread are these practices? Have you documented them?

Response. What we have found is just a variation to the basic medicare fraud scheme: Occasionally, an individual or group of individuals who supply goods or services to medicare providers—in this case home health agencies—may themselves be instrumental in the creation of the agencies or the converse. Because of the "non-arms length" relationship between the supplier and agency, a problem is created when the agency pays for goods and services at a price fixed by the supplier. Of course, this price is then passed along to medicare.

Since the supplier and the provider agency are related by common ownership or control, regulations provide that medicare pay for only the cost incurred by the supplier or the charge to the agency, whichever is lower. When the agency fails to disclose the true nature of the relationship, medicare will pay for the goods or services at the invoiced price. Thus, the owner is in the position of being both the buyer and seller of a product that the Government will pay for in the end.

We say it is fraud if the parties employ deception and misrepresentation to hide this relationship. Although we have not completed our investigation into the magnitude of the problem, these problems exist in California, Texas, Louisiana, Illinois, New York, and Puerto Rico. When we finish our full-scale effort in Florida, we will redirect our resources to those other localities.

Question. On page 8, you refer to "laxness in writing, interpretation and enforcement of regulations." Who is being lax? Your office is part of HEW. Are you in a position to evaluate the performance of the Medicare Bureau? Or the intermediaries, who actually interpret and carry out the regulations?

Response. The initial writing of regulations are directed toward assuring that good care is provided. Oftentimes the creation process does not perceive or conceptualize the financial manipulations that may be worked into or around the intent of the system. Later on, in an attempt to correct earlier shortcomings, a "patching process" is grafted onto the system. Since these new rules are aimed at specific abuses, the sharp manipulator merely shifts his schemes. What is created then is a system of regulations dealing with existing situations—a reaction—rather than a comprehensive set of guidelines. In this regard, we believe a stronger joint effort is needed by both HCFA and the intermediaries. When an indication of a problem surfaces, HCFA and the intermediary should join forces to stop it. This may take the form of new policies, intermediary letters, new regulations, or even recommendations for legislative changes. The important thing is that it be a mutual and concentrated effort. The intermediaries are the first to see problems arising. When the guidelines are insufficient, they have a responsibility to go to HCFA. In turn,

HCFA has the responsibility to support the intermediary and get the deficiencies corrected. The other part of the same problem is a hesitance on the part of the intermediaries to make some tough calls. There is a natural tendency to say there are insufficient guidelines or clarification of an issue to make a disallowance. If the intermediaries take a tough position at the inception of a problem, we believe the providers will be less likely to try to slip through.

What must be remembered here is that intermediaries must feel their actions will be cost-efficient. As I referred to in my testimony, an intermediary's *financial* interest lies with big institutional recovery.

Question. On page 10, you say that you are looking at the possibility of placing the burden of proof for reasonable costs on the provider. You also mention the possibility of limiting legal payments. Can you explain these options further? How can that be done?

Response. The existing rule of law requires that all costs must be documented in order to be reimbursed. The law also states that only reasonable costs will be reimbursed. However, if intermediary determines that a cost is unreasonable and the provider appeals the disallowance to the Provider Reimbursement Board, it is the intermediary's responsibility to prove that the cost is unreasonable.

We want to extend the existing principle of law from simply documenting that a cost has been incurred to documenting that costs are reasonable in terms of competitive pricing for similar services and necessary for patient care. If the provider has no documentation, the cost should not be reimbursed. Closely related to this is the cost of appeals. Currently, if there is a challenge to a disallowance the medicare program pays in full for the provider's appeal when the provider is a 100 percenter. This often includes high priced legal and accounting talent. Obviously, if the provider does not have to pay a large portion of these costs (as is not the case with most providers), there is no incentive to settle, or negotiate regardless of the legitimacy of the legal position. We are looking at the possibility of a cut-off point in the appeals process or placing a dollar limit on the cost, even if all of the patients are Medicare beneficiaries.

Your may be interested in a recent court case that found attorney's fees incurred to defend a provider against charges of medicare overpayment or fraud are not reasonable expenses for rendering services to medicare patients. The court found that public policy would be violated if the public were required to pay for the defense of cases alleging fraud or overpayment, whether the defendant prevails or loses, or the case is settled.

Question. Your office has authority to issue administrative subpenas (section 205(a) of P.L. 95–505). How many have you issued for home health agencies? Have you encountered any problems in issuing subpenas?

Response. To date we have not issued any administrative subpenas for home health agencies; however, four are being prepared. In other health care areas, we have experienced delays up to 6 months, caused by motions to quash our subpenas. Because of these delays in a number of cases, we have chosen to use grand jury subpenas.

Question. What is the current staffing level of the OIG? How many full time equivalent personnel are involved in the investigation of medicare and medicaid fraud and abuse? How many in home health specifically? How many in Florida? How adequate is this level?

Response. The following table reflects total employment of the professionals and support personnel in the four operating components of the OIG:

EMPLOYMENT OF PROFESSIONAL AND SUPPORT PERSONNEL

	Budgeted positions	Employment ceiling	Onboard personnel
Executive management	25	25	22
Health care and systems review	40	40	32
Investigations	229	215	174
Audit	1,043	990	999
Total	1,337	1,270	1,227

There are 73 investigators, 4 attorneys, and 165 auditors involved in health care investigations and audits. There are also 10 professional program specialists working in the overall systems review and coordination of health care program activities. Within this group there are currently 11 investigators, 2 attorneys, 10 auditors, and

2 program specialists working on home health agencies. The audit agency will increase its commitment to 20 auditors in fiscal year 1980.

Out of this group—there are six investigators, two attorneys, six auditors, and two program specialists working on home health agency cases in Florida.

We are currently reviewing our personnel and budgetary requirements to deal with the actual workload after experience of 2½ years. This workload has been higher than anticipated and thus resulted in an ever-increasing backlog of cases. We have already identified a need for additional personnel to handle the backlog in our current caseload. More importantly, however, is the shortage of personnel to handle 696 actions which are under preliminary review but for which resources have not yet been considered.

Question. How many home health fraud cases have been referred to you by HCFA? Are you dependent on HCFA for referrals? How many cases have you referred to U.S. Attorneys for prosecution? How many cases have the U.S. Attorneys declined to prosecute and why? How much of a time lag exists between referral and investigation by OIG and Justice?

Response. HCFA has referred 27 cases to the Office of Investigations. While our entire caseload is not generated by HCFA, they are the principal source of referrals. Leads from intermediary audits are an excellent basis for referrals. They go to HCFA for the initial compliance review.

We also get cases from informants who come forward with information about the operation and billing practices of a provider. Such informants may come directly to the Office of Investigations, or to the SSA district office, the medicare intermediary, HCFA, FBI, the U.S. Attorney, or members of the Congress.

Of the 12 home health agency cases formally presented to the U.S. Attorneys, three cases have resulted in six convictions, while three cases were declined for lack of prosecutive merit. Presently pending with the U.S. Attorney are seven cases at various stages in the investigative and prosecutive process.

Regarding the time lag, a description of the process involved between the initial referral of a case and the investigation by OIG and Justice is the best answer I can give you right now. We do not have statistics on that type of data now.

A preliminary inquiry is initiated upon receipt of an allegation or referral. If the allegation appears meritorious, a case will be opened. Investigative and audit resources are then committed to a new case in accordance with a system of priorities. Depending upon the number and type of cases in the backlog of a given OIG field office (Investigations or Audit), the issues in a home health case will be resolved in 1 to 3 years by either a prosecution, an administrative recovery of an overpayment or by deciding that the allegation is unfounded and closing the case.

Question. Policy recommendations: Based on your work to date, what recommendations have you made to HCFA regarding changes needed in the program reimbursement policies? What action has HCFA taken on these suggestions?

Response. We have not made any formal recommendations yet. We are reviewing the entire reimbursement structure concurrently with our investigation. Some of the things we are looking at are access to suppliers records, requiring management to be personally liable for disallowances in the nonprofits, surety bonds, limiting legal payments, and placing the burden of proof for reasonable costs on the provider.

Senator CHILES. Our next witness is John Kennedy, Acting Director of the Bureau of Quality Control, Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, Washington, D.C.

Mr. Kennedy, I understand that your Bureau is responsible for all the auditing of the home health care agencies.

STATEMENT OF JOHN D. KENNEDY, ACTING DIRECTOR, BUREAU OF QUALITY CONTROL, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, WASHINGTON, D.C., ACCOMPANIED BY DON NICHOLSON AND JOHN JANSAK

Mr. KENNEDY. Good morning, Mr. Chairman.

My name is John Kennedy. I am the Acting Director of the Bureau of Quality Control within the Health Care Financing Administration. I have with me today a member of my staff, Don

Nicholson, and John Jansak, representing the Bureau of Operations within the Health Care Financing Administration.

We are pleased to be here today to discuss home health service provisions under the medicare program and some of the problems in the reimbursement of those services.

I would like to commend you and your committee for your continuing interest in this area. As you are well aware, there have been problems. We feel that progress is being made in addressing these problems. Through the hearings and discussions that we have with your committee and staff we believe that we can determine the most effective and cost efficient ways of dealing with these problems.

Mr. Chairman, people may lose sight of the fact that before medicare and medicaid providers of home health services did not fit into any uniform model of a home health agency. Before 1966, home care was provided chiefly through the patients physicians making house calls, through charitably funded visiting nurse associations, and public health departments. Other services were largely provided by relatives, neighbors, and church groups. Third-party payment for home health services, where available, followed no consistent pattern either in terms of benefits or reimbursement processes. Consequently, those organizations providing health services in the home typically had no great experience or expertise regarding cost accounting, cost allocation, or cost reporting.

With the advent of medicare, we had for the first time a standardized payment mechanism for basically a kind of service which the framers of the legislation intended as a less expensive alternative to institutional care.

As mentioned, the experience base that preceded the mid-1960's in paying through an insurance mechanism for physician and hospital care was not available in structuring a reimbursement system for home health. Furthermore, in the years since the mid-1960's, with home health benefits constituting less than 2 percent of the part A medicare dollar, the same attention has not been given in developing a home health reimbursement system as was the case for other provider types in the medicare program.

The level of sophistication that was built into the cost reporting process for HHA's was influenced by a recognition that those organizations providing home services did not approach the cost accounting expertise of institutional providers. Experience is showing that there appears to be those who are attempting to abuse the home health benefit by capitalizing on the absence of cost finding and reporting structures, which require a rigorous accounting of costs and apportionment methodologies.

As questionable practices on the part of some home health agencies became more and more apparent, we have found ourselves lacking in having all the needed solutions for dealing with these problems. Recognizing this, we have begun to focus a good deal of attention on home health reimbursement. What we are working to accomplish is the development of a total system that will insure the appropriateness of home health payments based on reasonable costs for services medically required.

Much of our stepped up activity is specific to Florida. We have asked the medicare intermediaries servicing Florida home health

agencies to develop audit work plans to intensify fiscal and utilization audits. We are providing over $100,000 of additional audit money to allow the intermediaries to fulfill these requirements. Plans for these intensified audits are nearly complete and actual field work will begin shortly. As a result, we expect that questionable utilization practices as well as questionable fiscal practices will be identified. We are asking each of the intermediaries associated with this project to keep records of the program benefits derived from this activity, and based on Florida results, we will examine possible other locations to launch similar approaches.

Based on our own analysis and the feedback received through the developed intermediary audit plans, we will focus our review activity into two broad areas: Utilization review or questioning the appropriateness of home health care being rendered and billed for by individual agencies; and detailed audits of recent years cost reports.

Inappropriate utilization.—We are requesting the intermediary to have nurses audit provider medical records and make home visits to verify that patients are homebound and that services being billed are medically required. As a general rule, when medical necessity is questionable, we have secured more documentation to support the billing but have seldom physically contacted the patient. We believe building this review process into the utilization control practices of the intermediary will reduce the number of questionable utilization situations.

Questionable cost reimbursement items.—In addition to intensifying our utilization screening activities, we will be requiring that the Florida intermediaries, through intensified cost report audits, focus close attention on specific areas of home health reimbursement including:

(a) personal expenses of owners; (b) organizational startup costs; (c) fees paid for adviser/director meetings; (d) contracted services including management/consultant contracts; (e) advertising; (f) rent; (g) travel and entertainment expenses; (h) legal and accounting services; (i) application of the prudent buyer concept to major purchases and rentals; (j) other related party arrangements such as where a home health agency owner also owns an interest in another concern doing business with the agency; (k) a review of the ratio of the administrative salaries of the agency to the total salaries of the agency to determine those agencies whose administrative salaries are substantially out of line; and (l) costs associated with soliciting patients which are generally not reimbursable under medicare.

Mr. Chairman, the intensified cost and utilization audits are being done to determine which home health agencies are defrauding or abusing the system. Through the course of conducting these reviews, if we find apparent attempts at fraud, we will immediately turn the matters over to the Inspector General for criminal investigation.

As I mentioned, these stepped up audit approaches will be followed in Florida. In addition, we have developed various other guides and instructions of a general nature which I would like to share with the committee:

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1. Section 223 cost limits.—Section 223 of Public Law 92-603 provides that regardless of the actual costs incurred by a provider, limits will be placed for purposes of medicare reimbursement based on the cost experience of similar providers. In applying the section 223 principle to home health reimbursement, we have begun placing cost limits on a per home health visit basis effective for cost reporting periods beginning on or after July 1, 1979. This new regulation should result in considerable medicare program savings. It will also promote greater efficiency on the part of home health agencies who will be operating with the knowledge that total costs may not be allowed depending on like costs of comparable agencies. Additionally, it will help us identify situations where aberrancies exist that could represent efforts to abuse the program.

2. New cost reporting system.—One problem associated with determining appropriate home health agency costs has to do with reporting requirements. Quite frankly, the cost report form in use now by home health agencies is not formated well to allow questionable areas to be easily pinpointed. We are in the process now of developing a revised home health agency cost report and expect this new cost report to be issued in 1980. The new reporting format will require Home Health Agencies to provide more detailed cost reporting than is currently the case and will more readily permit an intermediary to identify and question specific home health agency cost areas which may be abused.

3. Improved intermediary guidelines for determining medicare allowable HHA costs.—We have issued several new instructions to intermediaries, all focusing on ways to assure appropriate home health reimbursement:

a. Management fees and consultant contracts. We now require that each home health agency maintain documentation regarding the amounts paid for management fees and consultant services and the hours and nature of the services provided. The intensified audits include steps to determine whether these arrangements actually involve related parties, are franchise operations or involve other management service firms. We will expect the intermediary to carefully evaluate the costs of such services against the actual hours devoted to performing these services. Cost/benefit analysis for each home health agency under review will be done and decisions made on the allowability of such costs.

b. Patient solicitation. In some instances home health agency personnel have been used to visit hospitals for the purpose of recruiting medicare patients for their home health agency employer. We have provided instructions to the intermediaries that any costs incurred to increase patient utilization are unallowable for reimbursement purposes.

c. Administrative salaries. We have provided guidance for intermediary's use in determining the reasonableness of compensation paid to home health agency administrators and medical directors. These instructions require an intermediary to determine the fair market value of such services and compare that with the amounts actually paid. If the compensation paid, including fringe benefits, is substantially out of line with that being paid for similar work, it will be reduced. We intend to provide much more specific guidelines in the future. In addition we have reminded intermediaries

that the cost of items furnished to employees not commonly recognized as employee fringe benefits are not allowable.

d. Transportation costs. We have provided guidance to intermediaries for evaluating the reasonableness of provider incurred transportation costs. We have provided guidelines to assist intermediaries in judging the necessity of transportation costs incurred by supervisory or administrative personnel. These costs are to be compared to those of well established home health agencies to determine if they are reasonable.

These are several of the areas where we are moving now, Mr. Chairman, to improve the intermediary capacity and our own capacity to assure proper payments for home health services. Many of these actions have been taken to honor commitments made during testimony before this committee on earlier occasions.

We will be doing more than simply asking the intermediaries to do this job and then hope that they do it. I already mentioned that we are working with the Florida intermediaries to assure the implementation of an intensified audit approach.

In addition, we have routine monitoring programs which we will use to test intermediary adherence to home health agency reimbursement. Two such methods of monitoring intermediary performance by HCFA are the contractor inspection and evaluation program and the home health agency cost report evaluation program.

The contractor inspection and evaluation program consists of onsite reviews of contractor performance. The purpose of these reviews is to insure that the intermediary understands the responsibilities under the terms of the medicare contract and has the processes to meet those responsibilities. Inherent in this review is an evaluation of how well the intermediary is adhering to HCFA reimbursement principles including home health agency reimbursement.

The contractor inspection and evaluation program review will also be buttressed by the home health agency cost report evaluation program which is still in pilot stages and not yet fully implemented. This program enables us to review contractor handling of home health agency cost reports to insure these reports are being processed according to HCFA instructions. This review focuses more on results than process and involves an after-the-fact sampling and review of selected settled cost reports to evaluate the quality of the intermediary audit and the final cost settlement. Deviation from HCFA reimbursement principles will result in reopening of cost reports and recoupment of funds erroneously paid. We are just beginning these reviews for home health agencies through a pilot testing program and expect national implementation early next year.

Through the Office of Program Validation in the Bureau of Quality Control, reviews are being made of providers where statistical or other information pose questionable utilization or reimbursement practices. These reviews consist of monitoring program payments in an effort to detect abusive or even fraudulent billing practices. Personnel from this office have been and continue to be involved in reviewing the home health problems. It has been largely through their efforts that many of the home health agency

reimbursement problems before us today have been brought to our attention.

Mr. Chairman, let me summarize by saying that HCFA recognizes that there have been and continue to be problems in the payment for home health services under medicare. We have taken a number of steps to address these problems and as I have outlined here today we are intensifying our efforts in this area.

That concludes my formal testimony, Senator, if I could be permitted to make some closing remarks.

Senator CHILES. Yes, sir.

Mr. KENNEDY. I would like to echo the opening statement that you made, Senator, particularly with regard to the critical importance of the home health agency benefit. In and of itself, as well as an essential ingredient in the overall delivery system that was contemplated by the medicare legislation, it plays an extremely important role and we are extremely committed to making sure that that role not only continues but is protected from any unfortunate bad names or other implications that could flow from the practices that I have been discussing here today.

We want to make absolutely sure that in addressing these questions and designing solutions to these problems that people who have been in this business since the beginning providing a very valuable and a very critical service to the elderly and the poor are protected, as it were, and that any sort of strategy that we design to eliminate the bad actors from the program, that those strategies do not visit upon the people who have been providing this service over the years burdensome administrative requirements. That is the commitment that we are making to the home health agency benefit.

We would be more than happy to try to answer any questions that you have, Senator.

Senator CHILES. Mr. Kennedy, I understand that you have been in this job for just a few months as the head of the quality program in the area but you do speak for the Health Care Financing Administration and you speak for that Department. You say in your statement that the Health Care Financing Administration staff has been largely responsible to the Office of Program Evaluation for bringing these problems to your attention. I question that statement and if it is true I would like to know why you are just starting now to make this review.

In 1976, I held hearings in Tampa, and then we held hearings in Miami, and then we held hearings in Washington on the outright home health fraud in Florida and in California. We made a number of recommendations then and this is the first time that I have heard these problems officially acknowledged.

In 1977, I asked Mr. Derzon of the Health Care Financing Administration about these problems at another hearing in Washington and he said the Department was looking into them.

In 1978, Congressman Sam Gibbons held two hearings, one with HCFA and one with the intermediaries, in which the same problems were uncovered. The recommendations were again made and the Health Care Financing Administration promised to respond.

Now a few months ago, in May 1979, the General Accounting Office reports that the problem still exists and that authority given

by Congress to the Health Care Financing Administration to respond to these problems of fraud and abuse has not been adequately used. I am citing the General Accounting Office report.

Here we are now and you say that we are going to take another look. Are we going to have to do this again in another year, another 2 years, another 3 years? Are we going to be back in the same place or are we really going to do something about it?

Mr. KENNEDY. Senator, I did not mean to imply that we are now for the first time identifying these problems. The identification of the problems, as you just indicated, has a long history. I was attempting to suggest that through this capability we are attempting to come to grips with those problems in the context of individual cases or individual providers. While there is a long history of the identification of those problems, the ultimate solution of them in terms of providing the documentation, would permit a documented settlement. That would withstand challenge after a cost is allowed, or a decision in the context of an individual case is unallowed. A different kind of commitment is, in this case, oriented in the direction of providing the documentation upon which adverse determinations vis-a-vis an individual provider can be based. It was in this area that I was attempting to indicate that the activities that we are into now are providing that kind of documentation through these kinds of capabilities.

Senator, the problem is certainly not resolved. I would think, however, that it would not be appropriate to conclude that we are still talking in a mode of what is going to happen in the future. The process that I just alluded to of providing, acquiring, and validating the kind of information necessary to support determinations involving the disallowance of very substantial amounts of money, is a burdensome process and it is a significant responsibility. We feel that to do that in a fashion that will support scrutiny or be sustained on appeal is a considerable investment. That investment is continuing, and in fact, has in relationship to individual providers resulted already in some substantial disallowances of cost.

For example, in Florida we have already reached determinations with respect to individual providers that entailed disallowances for such items as pension costs in one instance over $18,000. The medical director's salary is almost $13,000 and then other incidental legal fees of almost $23,000 were disallowed. Exclusive consulting fees in excess of approximately $34,000 in another instance were denied. In another instance, $14,000 of undocumented startup costs were denied, $8,000 for unpaid expenses in another, $30,000 for pension expenses, $12,000 for controller's compensation, $10,000 of salaries paid to administrative assistants.

The point I am trying to make, Senator, is that we are, as it were, proceeding to address these generic problems in the context of individual providers. The investments, the time, and the resources are beginning to produce decisions with relationship to individual providers that are denying those costs. It was in that area that I was attempting to indicate to you, Senator, that we are moving ahead to make those tough decisions, and to acquire the documentation necessary to support them. It was in that sense that I was speaking.

Senator CHILES. Well, the point I am trying to make, Mr. Kennedy, is it seems like every time we are getting ready to hold one of these hearings we see a little flourish of activity, or something is going to be done. When Congressman Gibbons was holding his hearings in 1978 he was given all kinds of assurances of what was going to be done. I was told something in 1976, I was told more at my hearings in 1977, and now we find that 2 weeks ago these audit procedures are going into effect and you are talking of the 12 points of the audit procedure.

You are saying that it takes time to establish this framework to determine how we hold people accountable. It seems like to me, and these points look good to me, personal expense of owners. Did it take 11 years to determine that we ought to look at the personal expense of the owners when you make up one of these things and determine whether that is a valid charge in organizational startup costs?

It would seem to me that it shouldn't take from 1976, when we were talking about organizational startup costs, to now, when we find that that is being asked for in a uniform audit. Fees paid for advisors and directors meetings, contracting services including management consulting contracts—all of those were the things that came out in 1976, all of those were points that came out in 1978. They have been there since it finally started.

Now thank the Lord that they are now part of the audit procedure and that we are talking about them, but my whole concern is, is this something that is going to go away again? I hope Sam Gibbons is not going to go away and I want to try to hold hearings more than every 3 years on it to see that something is going to happen.

As we see a program mushrooming from $100 million to $400 million to $800 million to where it is going to go very quickly over $1 billion, I think that we are entitled to have some of these things go into effect and to have them actually working and not have it happen because we are holding another hearing. I have seen some of the memos about "Chiles is going to hold hearings in August and so prior to the time that those hearings are held we have got to have certain milestones—milestone 1, milestone 2, milestone 3."

That is very good but, gosh, I would hope that sometimes that would happen without the fact that somebody is holding hearings, that we could get something underway and say that we have got to have accountability for the program. Now I am glad to hear about these $8,000 and $14,000 fees, but again I am concerned. Are we talking about finding some costs or are we talking about changing a system? Are we talking about putting in some proper controls that are going to direct the system so that it is going to work properly?

Mr. KENNEDY. Senator, the ways that you have indicated, I cannot indicate to you today that these kinds of concern or these individual areas of concerns should not have been resolved earlier. I can indicate to you two things that have influenced our ability to resolve them within the timeframes that I think we would all agree to date have proven unsatisfactory.

When the kinds of concerns that you have referred to first came forward, as you indicated earlier, several years ago the availability

of guidelines in relationship to those particular areas were not that specific. The lack of specificity there did create a situation that gave us some concern, particularly where the absence of specificity resulted in different intermediaries in different parts of the country taking different postures with regard to the allowability a cost in essentially the same type of situation.

We felt that that was not the kind of a situation that was appropriate and we therefore felt the necessity to develop these more specific guidelines. That has progressed since 1976, where we had the basic instructions with respect to allowability, then some more specific instructions relating to certain of these items, three in 1978, and two in 1979, that we would have a better opportunity to achieve consistency in terms of these individual items.

Senator CHILES. But that is what HCFA was supposed to be doing, was it not, setting the guidelines for the health care financing responsibility? Did HCFA ever come to the Congress and say, "We think the law is too vague or we need to change the law?" No one has ever said that to me. I would welcome some kind of a statement that if the law is vague or we don't like reasonable charge we have got to have something different, tell us what it should be. It seems like the very thing that was there in 1976, that you are now talking about, was what was right, what HCFA was designed to do, and what they are set up to do.

Mr. KENNEDY. Well, Senator, as I indicated earlier, we are doing our best to build the kind of a guideline framework that would be necessary to achieve consistency in the application of decisionmaking or decisionmaking in these areas, but that does not imply that what has happened in the past is somehow water under the bridge or over the falls. We are, through the kind of activity that is ongoing here in Florida, attempting to design a standardized system to look at the sort of an audit expectation format that we would hope to use not only here but elsewhere. And in the use of that, Senator, having achieved a greater degree of consistency in the guidelines, they will be used and they will be applied retrospectively to those cost reports that have been settled. As I indicated already, we have made progress in the context of individual facilities, identifying those kinds of situations and take an action to disallow those costs.

Senator CHILES. How many home health providers have been investigated for possible fraud and abuse, and what have been the results of those reviews?

Mr. KENNEDY. The situation there, Senator, is a little complex. The stage at which a case reaches or ripens to the point where we feel a fraud investigation is required varies from situation to situation. We have in Florida, for example, worked very closely with the Inspector General's office, and I think they are looking at the instances that we are investigating.

I think we have perhaps two cases that have been referred in sort of a formal sense, but that is misleading in the sense that we have been jointly involved in a number of ongoing investigations or situations that we are trying to gather data about. So the mere statistics regarding formal referrals is somewhat misleading in the sense that we are involved in a number of individual situations.

Senator CHILES. How many home health providers are pending review for possible fraud or abuse?

Mr. KENNEDY. We have approximately 15 reviews underway at the current time.

Senator CHILES. The General Accounting Office turned over to you a number of home health providers for review because of possible fraud and abuse. You were to complete review of those providers during this year I take it. How many providers were heard from, and how many have you reviewed to date? Can you tell me something about what your review disclosed, again without identifying the providers, of which evaluations have been done? Will your review on all those providers be completed this year?

Mr. KENNEDY. Senator, in the context of the GAO report, there were a number of particular situations that were cited. My understanding is that those cited instances were in every case, instances of situations where the audit of that provider had not been completed in the normal way that audits are conducted. Certainly, in the context of the completion of those audits, the observations and points that were made in the GAO audit with regard to those individual providers will certainly be taken into account.

I cannot tell you today, Senator, whether or not in the specifics that were referenced in the GAO report, those cases have been adjusted to reflect those concerns that were expressed in the GAO report, but I do know that those instances, to the best of my knowledge, were not instances in which the areas cited had been subjected to a study by the intermediary.

Senator CHILES. Well, are you going to follow up on each one of those cases?

Mr. KENNEDY. We are going to follow up, Senator.

Senator CHILES. Is that going to be done and completed this year?

Mr. KENNEDY. We are going to be following up in terms of the audit aspect for every home health agency. The intermediaries, in addition to the guidelines that we have already provided, will be given additional materials, additional audit formats or audit plans that we hope to design, gaining from the experience here in Florida, to utilize in all situations that appear to represent the situations of abuse.

So the short answer, Senator, is that all home health agencies will be audited and we will do everything that we can to design an instructional framework that will point intermediaries in the direction of these potential abuse situations. And to the extent that that produces results we will reopen those cost reports and make whatever adjustments in them the facts warrant.

Senator CHILES. Well, based on your reviews, how many home health agencies employ people specifically to solicit patients?

Mr. KENNEDY. The pattern that seems to be emerging, Senator, is that those agencies that are primarily servicing medicare beneficiaries typically employ individuals in that capacity. I cannot say that in every instance that occurs but it certainly seems to be the pattern in those instances we have taken and that we are investigating to date. To the extent that those services and the costs associated with them are identified, there again, Senator, those costs will be disallowed on audit.

Senator CHILES. How do you determine if the activity is legitimate or not?

Mr. KENNEDY. That question, Senator, is the kind of question that we are attempting to address in the framework of these specialized audits that we are conducting here in Florida. We don't know all the answers to this, and what we are attempting to do is zero in on the situation here in Florida and develop the kinds of lead information that we can provide in a larger framework, so that when audits are conducted—whether they be in Florida, California, New York, or anywhere—the kinds of information necessary to make the decision as to whether or not they are legitimate is provided. That is what we are attempting to do here in Florida, Senator.

Senator CHILES. My understanding is that one of your reviews found that one of the agencies had three full-time nurses who billed the agency for 480 hours and yet the nurses only made five patient visits during that billing time or during that month and yet they called on the hospitals and the doctors that they were seeing at least once a day. Would that kind of a charge be a legitimate charge?

Mr. KENNEDY. Senator, in the context of the facts as you just represented them, I would have to conclude that they would not be allowable costs, and to the extent that that situation is documented, I have every reason to believe that those costs will be disallowed.

Senator CHILES. Do you have any estimate of the amount of money which may have been inappropriately paid by medicare for this kind of patient solicitation?

Mr. KENNEDY. Senator, I think that it would be inappropriate for me to extrapolate from the limited experience that we have had to date. I think the preferable approach, the more judicious approach, if you will, would be for us to not assume in every situation that we identify that we can leap to the conclusion that those are always unallowable costs.

So I think, Senator, it would be more appropriate for us to reach a pattern of conclusions, if you will, with reference to our investigation of these individual situations. Then if we can gain from that the kinds of signposts that would suggest these are unallowable kinds of situations, to the extent that those can be identified in other situations, we are in a much better position to make projections as to the amount of unallowable costs. I would prefer, Senator, to indicate that as we reach decisions in individual cases that involve these kinds of situations, we will make individual decisions as to allowability. Once those decisions are made, we will be in a position to give clear indications as to the amount of unallowable costs associated with those kinds of activities.

Senator CHILES. On what basis do you disallow expenditures in the area of patient solicitation?

Mr. KENNEDY. I am sorry, Senator.

Senator CHILES. What is your basis on which you operate to disallow expenditure if you feel it was a cost incurred on a patient solicitation as opposed to services direct?

Mr. KENNEDY. I think primarily, Senator, it is simply a question of reaching a conclusion that that is not a reimbursable, it is not a

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reasonable expense. There are certain activities that are permissible in relationship to advertising the availability and the existence of a home health agency which are not inappropriate but to the extent that those kinds of activities go beyond that——

Senator CHILES. You do have an intermediary letter 79-22 which allows cost incurred to increased patient utilization, don't you?

Mr. KENNEDY. Yes, sir. That is correct, sir.

Senator CHILES. That is the basis on which you would deny?

Mr. KENNEDY. The instruction is out there. I thought you were seeking the conceptual reimbursement principles that were involved that provide the basis for that. That principle is while we permit a certain level of advertising, to the extent that it goes beyond that, we reach the conclusion that those are unallowable costs because they are not related directly to patient care as patient care itself.

Senator CHILES. The HCFA Administrator Derzon told me in May 1977 that you were going to be considering ways to eliminate the 100 percent or medicare-only home health care providers. How many such agencies have you identified?

Mr. KENNEDY. I think there is clear indication that there are a very substantial percentage, upward of perhaps 77 percent here in Florida. Nationally, Senator, our information would indicate that there are approximately 650 out of a total of about 2,700 home health agencies. I think in Mr. Lowe's earlier testimony there were indications that there has been growth in that area.

Senator CHILES. When do you propose to deal with the 100 percent, or will they be eliminated?

Mr. KENNEDY. That question, Senator, is a very difficult one to answer. On the one hand, it can be argued that the mere fact an institution or an agency structures itself to provide as a 100 percenter is a sufficient reason to reach the conclusion, almost automatically, that it is a situation that is designed to capitalize or otherwise abuse the system. That is one line of argument.

There are others that would say that that is not necessarily true, and that in many instances it can be argued that in areas where others are not willing to provide the service, that proprietary or other kinds of institutions that are geared to provide services to medicare beneficiaries, provide a protection that otherwise would not simply exist in those areas.

So on the one hand, Senator, we are in the dilemma of addressing the situation that seems to be characteristic of that particular type of provider; but on the other hand we are reluctant to reach the conclusion that in every instance those kinds of situations are per se abusive. We think, Senator, that the kinds of things that I was alluding to earlier, if these areas of reimbursement practices that we have been discussing are identified, and the cost associated with them disallowed, and if that is in any sense characteristic of a large number of these kinds of organizations, we think that that in and of itself will tend to provide a basis of addressing the 100 percent situation.

Senator CHILES. Your answer reminds me a little bit of Harry Truman's dilemma in which he said he was going to get himself a one-armed economist. He said he was too tired of hearing economists saying on the one hand the problem may be so and so, but on the other it may be something else. I think maybe you need a one armed administrator of HCFA.

How then has the policy changed? Derzon told me as the Administrator, that we are going to be taking steps to eliminate the 100 percenters. Is that no longer the policy? Has that changed? Obviously nothing has been done to eliminate them. That was done in 1977. We are now in 1979 and there are no steps taken. Are you telling me today that the policy has changed, that that is not so?

Mr. KENNEDY. No, Senator. What I am trying to say is that there are two ways of looking at that solution.

Senator CHILES. Put one hand behind your back and tell me the answer.

Mr. KENNEDY. There is what might be called the more draconian approach and that is to say, by fiat, there shall be no more of these kinds of institutions. If there are those kinds of institutions and they are abusing the program, what we will do is identify those abuse situations and deny the reimbursement for those abuse situations. That in itself may be a legitimate way of addressing the problem, and perhaps the elimination of the problem 100 percent.

I don't mean to imply, Senator, that we have abandoned the former approach. We have asked our Office of General Counsel for an opinion as to the legality of that more, shall we say, draconian approach. They have not formally responded to us yet about the legal feasibility of that approach, but that does not mean that we have abandoned it. Second, it does not mean that we are not pursuing those costs and denying them to the extent that they are reflective of abusive situations.

Senator CHILES. Many of the 100 percenters are nonprofit providers and they are tax exempt. What are you doing to coordinate your activities with the IRS to insure that these are maintaining that tax-exempt status?

Mr. KENNEDY. We are already having some plans in that direction, Senator. Let me say a lot of people feel that the original granting of a 501 exemption status probably is something that should be reevaluated in the context of the kind of information that is being discussed here today. A series of discussions and meetings have already been held to see if a procedure on the process can't be worked out. There are some problems of confidentiality and other things that enter into that situation, but I feel confident that as a result of our meetings and discussions that that issue can get joined.

Senator CHILES. The GAO report said 5 organizations assisted with establishing or providing assistance to at least 78 different home health agencies. You identify those five organizations, I take it, or the report did.

Mr. KENNEDY. Correct.

Senator CHILES. The Unihealth in New Orleans with 23 agencies, Capitol in Florida with 20 agencies, National Health Delivery Systems in Chicago with 19 agencies, Medi-Patient Home Health Care Consultants in Chicago with 7 agencies. Have you identified any additional management organizations? How many additional provider agencies do they cover?

Mr. KENNEDY. I am not exactly sure of the precise number. My information is that approximately 8 to 10 other such organizations may be in a comparable business elsewhere in the country.

Senator CHILES. How does the home health agency enter into these contracts? Describe the types of services provided by the management funds. Does the billing permit the intermediary to determine the service and the amount of such service?

Mr. KENNEDY. Well, it is hard to say exactly what precisely they provide for. Oftentimes there are organizations that provide guidance development, manual billing procedure development, automatic data processing systems, provide consultation to these agencies in relationship to their ability to meet certain Federal standards relating to health and safety and other considerations. They often have an initial demand and then a percentage of the gross income facility, I forget the exact number, somewhere in the neighborhood of 6 or 7 percent on a continuing basis for those agencies for those continuing services. The problem there, of course, is the extent to which those consulting firms are related to the organization. The extent that it can be demonstrated that those organizations are related, and that the transaction occurred in a non-arm's length way or posture under the regulation, is to say that we will not recognize charges for those services, but that we will only recognize the cost associated with the service as provided by the consulting organization.

That means that we would have a right to access the information that is necessary to demonstrate what those costs were and to the extent that they are reasonable they would be allowable. To the extent that they are unreasonable, they would be denied and to the extent they are undocumented they will be denied.

Senator CHILES. GAO has said that management firms charged $10,000 to $20,000 to set up a home health agency. Does HCFA assist new agencies in setting up if they come to HCFA to seek assistance?

Mr. KENNEDY. Well, in the relationship to the kinds of organizational arrangements that are necessary to develop a home health agency, they are spelled out, the conditions of participation that these agencies must meet. The conditions of participation are available as public documents, and the availability of consultation or guidance as to the applicability and the intent of those regulations can be obtained from the certifying agency, which is the State health department.

Senator CHILES. Well, we have reports that medicare is paying a large startup cost for nothing more than a Xeroxed manual. Is that correct?

Mr. KENNEDY. I am sorry, Senator. Could you repeat the question?

Senator CHILES. We have reports that medicare has been charged and has paid large startup costs for nothing more than a Xeroxed manual. We see that in one review $10,000 was paid for each of nine agencies to one consulting firm for the same manual, $90,000.

Mr. KENNEDY. The facts as you discuss them indicate to me, Senator, that those costs would be disallowed on audit.

Senator CHILES. I have some other questions and I will probably submit them to you for the record.[1] Our time is running. We thank you for your statement.

Mr. KENNEDY. Yes, Senator.

Senator CHILES. One other thing I want to ask you. We have listened today about the potential of a focus by HCFA and the Office of the Inspector General and HEW to coordinate activities in trying to approach this problem not only from the audit function but also from the investigation function. You would change the course of direction and set some guidelines on this. Is HCFA sold on this program and are they going to cooperate with the Office of Inspector General in this regard? Or is this going to be another one of those things where we see some activity now and then it fades after a while?

Mr. KENNEDY. Well, Senator, I can speak from my side. I have had discussions with Mr. Morris. My staff has already had discussions with the staff of the Inspector General. It was my sincere belief, Senator, that the relationship that we have established is a good working relationship and it is one that will continue. I feel working together we have not only an obligation but a very good opportunity to capitalize on the experience that they have and make it work closely with the kinds of more indepth programmatic experience that we have, so that when we operate in our area, from a program standpoint, the case will be well developed and developed also with some sensitivity to the implications that it may also represent. At that point, the case is turned over to the Inspector General for the lead regarding those cases representing potential criminal fraud.

Senator CHILES. That kind of cooperative effort is only going to work if both sides are working hard to make it work because if people are looking for turf priority, credit, or one side is just dragging their feet as to whether they think the investigation should go forward or not, it will break down. What I want to know is whether everybody is committed and determined to make it work. Is everybody going to continue to work through problems that will arise when it comes to finding ways to make it work?

Mr. KENNEDY. I certainly am committed to that, Senator, and from my discussions with Mr. Morris I am confident that he is likewise committed to it.

Senator CHILES. Mr. Kennedy, I hope you will tell everybody else in your shop that I am committed to making it work, and that I hope it is going to continue in this regard. I hope that we don't hear from either HCFA or from the Office of Inspector General that there are any problems in turf or other problems of somebody dragging their feet.

Thank you.

Mr. KENNEDY. Yes, sir, Senator.

Senator CHILES. Now we will hear from Mr. Jack Eskenazi, the U.S. attorney for the Southern District of Florida, who is accompanied by Pat Sullivan, Chief of the Criminal Division, and Joel Rosenthal, Chief of the Fraud Section.

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[1] See appendix 1, item 2, page 59.

STATEMENT OF J. V. "JACK" ESKENAZI, U.S. ATTORNEY, SOUTHERN DISTRICT OF FLORIDA, ACCOMPANIED BY PAT SULLIVAN, CHIEF, CRIMINAL DIVISION, AND JOEL ROSENTHAL, CHIEF, FRAUD SECTION

Mr. ESKENAZI. Good afternoon.

Senator CHILES. Mr. Eskenazi, I don't know that we have ever had a chance to formally meet.

Mr. ESKENAZI. I am delighted to have the opportunity, Senator.

Senator CHILES. I had the opportunity to recommend you for the job in the Justice Department and Justice decided to go ahead with that recommendation. I am glad to have a chance to meet you.

Mr. ESKENAZI. I assure you it is a distinct pleasure for me to meet you as well.

Mr. Chairman, I appreciate the opportunity for myself and members of my staff to appear before you today and would like to take this opportunity to commend this committee's efforts to expose fraud and abuse in the home health care industry.

I think it might be appropriate for me to give you some perspective of the position of the U.S. attorney's office in the Southern District of Florida and to the extent that I am able to do so the Department of Justice with respect to these problems.

Senator CHILES. My understanding is that you are here today speaking not only on behalf of yourself as the U.S. attorney, Southern District of Florida, but also as the representative of the Justice Department, and to answer questions as far as you can about the Justice Department policy.

Mr. ESKENAZI. That is absolutely correct, Your Honor—Senator.

Senator CHILES. That is the first time I have been called Your Honor in a long, long time.

Mr. ESKENAZI. It is most deserved.

Senator CHILES. Note that for the record.

Mr. ESKENAZI. Let me begin by telling you a little bit about the U.S. attorney's office for the Southern District of Florida and the efforts of the Department of Justice and my office to address the problem of abuse in the home health care industry and what progress may realistically be expected in the future. It may be important to know what the U.S. attorney's office in this district consists of.

The U.S. attorney's office in the Southern District of Florida is composed of 39 assistant U.S. attorneys, of whom 12 are assigned to the Civil and Lands and Natural Resources Divisions and 24 are assigned in the Criminal Division, and of that 24, 4 have arrived on board within the past month, and 2 have arrived as recently as yesterday.

Senator CHILES. Have you been given any additional numbers yet because of the new judges that have been assigned to this area? Has anything gone forward for providing additional U.S. assistant attorneys?

Mr. ESKENAZI. The latter four positions, which I just mentioned, are essentially dedicated as a result of the increase in judge power in the district. We anticipate that we will receive——

Senator CHILES. You are getting fewer assistants than you are getting new judges.

Mr. ESKENAZI. I think it is in a sense the first installment. We anticipate that we will receive something in the order of magnitude of some six additional assistants after the judges take their place on the bench and we expect that allocation to be made, realistically, after the beginning of the next fiscal year across the Nation.

Senator CHILES. So you will be getting approximately two assistants per each additional new judge.

Mr. ESKENAZI. If I had to make a guesstimate, Senator, that would be my closest guess on the question.

Senator CHILES. All right.

Mr. ESKENAZI. In the Criminal Division responsibility for prosecution is allocated among the General Crimes Section, the Special Controlled Sustances Unit and the Fraud and Corruption Section. These 24 assistants are charged with the responsibility of prosecuting all Federal criminal violations within the district which extends from Fort Myers on the west coast and Fort Pierce on the east coast, south to Key West and the Dry Tortugas.

Accordingly, this office prosecutes all Federal narcotics cases, including importation and smuggling, boat cases, and other conspiracies involving cocaine, marijuana, heroin, quaaludes, and other dangerous drugs. Narcotics smuggling and sales are, as you know, Senator, a multibillion-dollar industry in Florida, and south Florida is the entry point for the bulk of this illicit traffic. Counterfeiting and the smuggling of illegal aliens are pervasive problems in this district as are frequent weapons violations, involving illegal sales, smuggling and interstate shipments.

Cases prosecuted in the frauds section include mail and wire frauds, some involving major international swindles, including so-called boiler room commodities frauds. We have presently under investigation or have indicted or successfully concluded prosecutions of mail fraud schemes involving franchise and land frauds, as well as false invoicing schemes of many different varieties.

Bank fraud and embezzlement cases are handled by the frauds section, including cases involving elaborate and sophisticated computer schemes and elaborate account manipulations. Bankruptcy frauds are within our exclusive jurisdiction and their proper investigation requires careful accounting work and thorough review.

With the advent of the Florida no-fault law in 1971, a whole new genre of insurance frauds was born, created by unscrupulous doctors and lawyers who jointly engaged in bilking insurance companies through false and inflated accident claims. Our frauds section has successfully prosecuted a number of these conspiracies, each of which takes months or years to investigate and anywhere from 2 weeks to 2 months of trial time. Other such conspiracies are presently under active grand jury investigation.

Our frauds section also prosecutes tax frauds in this district as well as cases involving labor law and agriculture violations. A large volume of cases are referred and prosecuted involving various kinds of frauds upon agencies of the United States. Thus, FHA and HUD refer numerous cases involving fraud by loan and mortgage recipients, and the Small Business Administration and the Veterans and Social Security Administrations refer cases involving frauds upon those agencies.

Cases involving CETA fraud, medicaid and medicare fraud, comprise the bulk of program fraud cases. The frauds unit is presently involved at one stage or another in investigations of a number of these cases. Some of these investigations involve allegations of false claims by single individuals while others involve allegations of widespread fraud and abuse involving voluminous files, numerous witnesses and many potential defendants. Additionally, the frauds section is charged with investigating and prosecuting cases involving official corruption and misconduct. These cases, frequently at the earliest investigatory level, require the close attention and participation of an assistant U.S. attorney because of their delicate and sensitive nature and their significance to the community.

Typically, an assistant in the frauds section has a caseload of between 30 and 75 cases at various stages from initial investigation through appeal in the court of appeals. Each assistant U.S. attorney is responsible for appeals in his own cases. And to put this all in perspective, there are but six assistant U.S. attorneys in our frauds section.

Our staff is assisted by Department of Justice attorneys from the Fraud and Tax Divisions, who periodically travel from Washington to Florida to assist my office in the investigation and trial of numerous cases. At one point this year, seven Department of Justice attorneys were simultaneously engaged in investigations or trials in this district.

Despite the volume of cases confronting our assistants, the volume of cases confronting the district judges is equally staggering. Recently the clerk of our district court calculated that as of September 1, 1979, the backlog of criminal cases in the court, based upon their estimated trial time, will take the judges of the court, sitting continuously, until nearly September 1, 1980, to try.

That is the present state of our office and our district court.

Recently the Department of Justice has created the Office of Economic Crime Enforcement. The Office of Economic Crime Enforcement currently has eight economic crime units in operation. Seven economic crime enforcement specialists presently staff those units. The office maintains an ongoing dialog with the 14 other U.S. attorney's offices that have their own fraud and corruption units, as does mine, in order to share information and ideas.

Senator CHILES. Does Miami have an office of that kind?

Mr. ESKENAZI. It does not, and I will speak to that in one moment.

In fiscal year 1980, the Department anticipates adding a minimum of six new units, beginning early in autumn. The south Florida area that has traditionally been identified with a high incidence of white collar crime activities will feel the impact of that expansion. However, the Federal judicial district data show that 55 percent of the population of the State lies within its middle district. If possible, the Department will create one office for the State, with two separate locations, in order to serve both areas. My closest guesstimate, Senator, is some time after the beginning of the year.

Let me read to you for just one moment a recent communication from the Department on this subject, and I quote:

While we anticipate going through the process of data gathering and assessment of existing patterns of fraud and corruption that is performed for any new location, a significant amount of work has already been accomplished by the three U.S. attorneys in Florida. They have already identified priority areas for investigation. Therefore, we should be able to quickly establish local priorities that are consistent with national ones, and so will be able to focus investigations on those priority areas with unusual speed.

Our method of operation will be to assemble a task force comprised of, in a home health care fraud, for example, investigators, auditors and program people from Health, Education, and Welfare, as well as criminal investigators from traditional law enforcement agencies such as the Federal Bureau of Investigation, Postal Inspection Service, et cetera. The efforts of all members of the task force would be guided by the economic crime enforcement specialist and/or an assistant U.S. attorney. This guidance would flow from a detailed investigative plan that would have been developed by the specialist and the assistant.

Our own review of the cases presently active in our office, and the cases which are under investigation by the various investigative agencies in which we play an active role, reveals that there are many priorities in this district and it is neither useful nor productive to assign a hierarchy to them. What we have in this district is an exceedingly high number of cases which by law enforcement standards, or in the eyes of one of the many constituencies in this district, have very high priority.

Among these cases are the overwhelming number of drug related offenses, bank frauds and mail fraud swindles, and the program fraud cases. Obviously, program fraud cases involving health care are priority cases in this district, if for no other reason than the fact that their impact upon the people in this district, both as victims and as taxpayers, is exceedingly great.

At present our office is actively participating with HEW investigators in a number of medicare fraud cases. Some of these involve home health care agencies.

Perhaps it might be helpful if I explained how a health care case is referred to our office and the manner in which the investigation is coordinated with the HEW. Typically, allegations of criminality will come to our attention or to HEW's attention through complaints of dissatisfied patients or former employees or principals, or through a referral from an auditing agency which may uncover irregularities or apparent criminality.

At this preliminary stage, the HEW investigators will conduct interviews or examine records. If, in their judgment, it appears that no crime has been committed, or the crime may not warrant prosecution, they will present their findings to the chief of the U.S. attorney's fraud section who will evaluate them and decline prosecution and terminate the investigation.

If, on the other hand, the agents believe that further investigation is warranted, or if the chief of the fraud section believes that an investigation should be conducted, further investigation will be authorized. At this stage, a file will be opened in our office and if necessary an assistant U.S. attorney will be assigned permanently to the case. Otherwise, Mr. Rosenthal, who is the chief of our fraud section, himself, will supervise the issuance of subpenas and assist the agents in the direction of their investigation until such time as it is appropriate to assign another assistant U.S. attorney the responsibility for taking substantive grand jury testimony or otherwise becoming actively involved in the case on a day-by-day basis.

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Some cases, because of their relatively straightforward nature and generally because they may only involve a single individual engaged in a pattern of fraud, are susceptible to investigation by the agents without the need for much involvement by an assistant U.S. attorney other than the issuance of grand jury subpenas to produce records.

In those cases, at the conclusion of their investigation, the agents generally prepare a written report for the prosecutor. This report will summarize all the testimony of witnesses and all the other evidence in the case. Based upon this report, the assistant U.S. attorney will then conduct grand jury proceedings and if appropriate seek an indictment.

Home health care cases, on the other hand, because of the size of the agencies involved, the number of potential targets of the investigation, the complexity of the regulatory scheme, and the accounting procedures involved, are not susceptible to a similar approach. There may be varying levels of criminality and key witnesses may need to be immunized in the course of such an investigation.

This is generally done through the grand jury in conjunction with field investigation by the agents and requires the active participation of an assistant U.S. attorney. Similarly, the grand jury subpena power to obtain live testimony frequently becomes necessary in these kinds of cases where witnesses may be reluctant to talk with an investigator. In these cases, because of the combination grand jury and interview investigative approach, prosecutive reports are generally not written which summarize the whole case or all the evidence. Thus, home health care cases are initially investigated with the active participation of a grand jury. Needless to say, this process is not a short or easy one.

I think it is fair to say that the investigators of the Department of HEW in this district must have complete access to the advice and assistance of the chief of our fraud section and the assistant U.S. attorneys who are assigned to particular cases. HEW investigators, like other investigators, must frequently consult with the prosecutors and seek advice and guidance. By the same token, Mr. Rosenthal advises me that he and his assistants need and have full access to the resources and assistance of these investigators. Necessarily, our successful investigation of program fraud cases requires the good will and active cooperation of our assistants and HEW's investigators. I believe that such cooperation presently exists between our staffs and that we can look forward to continuing in this relationship.

Prosecution of home health care frauds is a lengthy process. Only recently has HEW been accorded the resources which are a prerequisite to our staffing the kind of grand jury investigation necessary to a thorough, successful prosecution. Any grand jury investigation must be assisted and guided by a staff of experienced auditors and criminal investigators working as a team and capable of seeing such an investigation through the trial stage.

In this district we have seen that HEW, as its resources become available, is ready and eager to assign the manpower to investigate and prosecute those cases in this district which warrant investigation and prosecution. As HEW has supplied the investigative manpower, we have endeavored to supply a corresponding assistant U.S. attorney to conduct the investigation.

As Mr. Lowe may have explained, some of the HEW investigative teams are headed by attorneys, some of whom have prior Federal prosecutive experience. These individuals will be of great assistance to our staff and it is entirely conceivable that at an appropriate time such individuals could, if necessary, be given trial responsibility.

Successful prosecution of these cases requires experience, on the part of both the prosecutor and the investigators, both in the investigation of such cases and with the difficulties of proof and legal problems that develop during trial and upon appeal. Necessarily, then, experience in the first few cases is a prerequisite to creating a pattern for the investigations to follow and as a model and precedent for prosecution strategy. We are only just now reaching that stage.

As an example, the fifth circuit court of appeals recently reversed a medicare fraud prosecution arising in this district involving kickbacks in a laboratory scheme, finding that the particular kickback scheme which ultimately resulted in a greater cost to medicare and consequently to the taxpayer was not a crime. Cases like this necessarily must serve as guideposts to future prosecutions.

Another factor that contributes to the difficulty of prosecution and the delay in prosecution in many home health care cases is the complexity of the regulatory scheme. Violation of the law or regulations with which a potential defendant may be charged are usually not easily susceptible of proof. Specifically, for example, the Code of Federal Regulations requires that all payments to providers of services must be based on the "reasonable cost of such services" and it also requires that costs which are incurred must be "necessary and proper costs" which are "appropriate and help in developing and maintaining the operation of patient care facilities and activities."

Application of these standards in particular cases is not an easy matter, particularly where the Government must prove fraudulent intent, beyond a reasonable doubt, on the part of those charged with incurring or claiming reimbursement for particular expenditures. Many of the kinds of expenditures of this nature are detailed in the Comptroller General's report to Congress, issued in May of this year, with which I am sure you are familiar.

In this overall connection let me read to you part of a statement [1] from the Department of Justice Criminal Division concerning home health care investigations:

CRIMINAL DIVISION STATEMENT ON FRAUD IN HEW'S HOME HEALTH CARE FRAUD MATTERS

In 1976, the Senate Committee on Aging referred to the Department of Justice allegations of fraud in the home health care program in northern California. A very difficult joint HEW/FBI investigation has resulted recently in a guilty plea by the home health care agency's chief financial officer who was a former employee of the intermediary. That investigation and a second similar investigation in the same jurisdiction are continuing. Prosecutive staff are being supplied by both the U.S.

[1] The full statement appears in appendix 1, item 4, page 70.

attorney in the Northern District of California and the Fraud Section of the Criminal Division.

For the past two years, a second home health care investigation has been ongoing in the Southern District of Florida. That investigation, staffed jointly by the U.S. attorney's office and the fraud section is presently before a Federal grand jury. In addition, the U.S. attorney in Miami is staffing several other fraud investigations involving home health care. These investigations are the result of referrals from the Inspector General of HEW.

These experiences have given the Department of Justice a variety of insights into the home health care program structure, regulations, and procedures. There should be no doubt that simply due to the very nature of the program—health care services in the home—fraud investigations are very difficult. Further, due to the wide scope of the program, broadly worded regulations which are designed to insure program flexibility make the prosecution of these investigations most difficult. Finally, the key role of the intermediaries in the administration of the program complicate the investigations.

We are unable at this time to speak specifically about the pending investigations which are largely the source of our knowledge on the home health care program. The fraud section of the criminal division has assigned four attorneys to these cases and has made a broad commitment to the Inspector General of HEW to support his programs.

The Inspector General of HEW is very familiar with the difficulties in these investigations and the program weaknesses the investigations have revealed. We would defer to his observations in this regard.

The criminal division is committed to the success of the HEW Inspector General's investigation programs; health care and home health care fraud cases in particular are one of our highest priorities. As Senator Chiles is particularly aware, GSA and Defense Department matters also require high prosecution attention.

At the conclusion of the investigations presently staffed by the fraud section, the attorneys assigned will be made available to the staff of the committee to share, within permitted procedures, the results of the investigation.

Finally, let me say that I share your concern that the prosecutive process be speeded up.

Obviously, more prosecutors and more investigators would help. Equally important, however, we need a regulatory scheme which imposes clear requirements upon providers and operators of home health agencies so that it will be clear to all parties concerned what claims for reimbursement are simply not allowed and that any effort to make such claims would be fraudulent. Prosecutors and investigators would not, therefore, have to search for other evidence of fraudulent intent as they do now. Other controls which must be considered include setting maximum fee schedules for services and more frequent, thorough audits.

Clearly for prosecution to have a deterrent effect and to have an impact upon the activities of unscrupulous home health operators, prosecutions must be frequent and swift. If we had more prosecutors, more agents, and a better regulatory scheme, this would be accomplished to some degree. However, it will still take many months for the investigation and trial and still many more months thereafter after appeals before any defendant actually goes to jail. But we must remember, however, that the criminal investigative and prosecution process, no matter how swift, is not the whole answer. It is necessary to hit unscrupulous home health care providers equally hard in the pocketbook. To the extent that it is possible, this should be done administratively.

Home health care administrators and operators should be held personally liable for fraud and abuses which occur in their agencies. Reimbursements must not only be recovered but there must also be a punitive element as well. This can only be done with some concept of personal liability, since in the cases of those home

health care agencies which are 100 percent reimbursed by medicare any recovery will occur to the detriment of the Federal Treasury.

Once again let me thank you, Senator, for the opportunity to appear today. If the committee members have any questions, I or Patrick Sullivan, the Chief of my Criminal Division, or Joel Rosenthal, Chief of the Fraud Section, will be happy to respond.

With respect to some of the more particularized cases that you may be interested in, to the extent that response would not prejudice any ongoing grand jury investigation we will certainly try to be cooperative. I want to defer to the chief of my fraud section, Mr. Rosenthal, where it involves the interacting of representatives of HEW with our own office since he is most closely associated with what that relationship has been.

Senator CHILES. Thank you, sir.

Let me say at the outset that I don't want to impinge on any of your active investigations so if I touch into that area just feel free to tell me that we are in a dangerous area.

You cited that the present medicare program currently offers no incentives to control fraud or abuse and cited the difficulties in obtaining prosecution in many of these cases and going through with the prosecution. What is your opinion as to whether we need to have a civil penalty bill to try to address areas that fit into the fringe, or the borderline, as to outright criminal fraud and in areas where it is very difficult to obtain prosecution and conviction?

Mr. ESKENAZI. I think that Mr. Lowe articulated the very legitimate problem that this would pose with respect to the judgment proof nature of some of the targets involved but the concept, the attachment of personal liability, I think, is a matter that has to be considered very seriously. I know that the Department has given substantial consideration to the question of appropriate bonding in these instances.

Mr. Rosenthal, do you have any observations in this respect?

Mr. ROSENTHAL. I can only say one or two things based on my experience in New York medicare fraud a couple years ago and the fact that there was no real civil penalty provision in the manner in which reimbursements were made. The people who we prosecuted told us later on that they were encouraged because the worst they thought they would face was having to pay the money back, and the same notion could probably be attributed to people in home health. I am not saying that I would, but certainly where there is a lack of any kind of deep pocket theory that if you commit a fraud or an abuse, you are going to be personally responsible for it that that would create deterrence. As a practical matter it would amount to recoveries that are not possible now with 100 percenters in regard to getting money back that had been misspent.

Senator CHILES. You mentioned the necessity to convene a grand jury early on in a home health fraud case and you cited a lot of reasons for that. Would it be possible using the Office of Inspector General personnel, because they are now putting together teams in which they will have competent investigators and auditors, to initially try to short circuit, or not go before the grand jury that early?

I know the time delays you are going to be in. In other words, the Office of Inspector General has the subpena power administratively and otherwise to get information. So you could depend on them more to make the case as opposed to referring the case.

It would seem that with the workload that you are talking about, even if we get a civil fraud division in Florida, that you are still going to have a real problem of manpower in addition to your assistant district attorneys and investigators and it would seem that these people would know more of what you are looking for because they are more specialized.

We put together the strike forces in which we use people now from the Department of Labor; they are the most competent investigators. When we were about to lose those personnel, we worried about possible labor abuse problems which might come up if we lost this expertise and about the particular sort of subpena power that the Department of Labor had, or their right to go in and look at all records, as opposed to having to go through with everything. It seemed that that kind of approach might make sense and it would short-circuit the calling of the grand jury.

Mr. ESKENAZI. I think we have explored the possibility of making better utilization of the resources that could be provided through HEW attorney staffing and consider the possibility altogether feasible to have special assistant U.S. attorneys. We have not really considered that. I am aware of the creation of a separate task force in the sense that strike forces have been created across the country to deal with the problems of organized crime for various reasons. I think that perhaps the Department will have to speak to that issue itself but I do see a more cooperative utilization of those resources for the very purposes that you pointed out; namely, that they are the people with the expertise.

We do face some other problems. I know, Pat, you may have some thinking on this line and perhaps you can express it to the Senator.

Mr. SULLIVAN. The grand juries have always been active in this particular area. Without them, we probably could not prosecute most white-collar crimes. Recently, however, there have been certain, in my view, impediments placed in front of the grand jury investigations in this area. These investigations largely require the subpenaing of tons of records, sometimes from whatever the institution is that is being investigated.

Since the passing of the Financial Privacy Act, and certain grand jury procedural laws, they have not obstructed any investigation but they have certainly slowed it down when the grand jury is used and in the context of bank records which are always a very important tool. For any type of white-collar investigation there is a multitude of paperwork that has to be prepared.

Under the provisions of the Financial Privacy Act whenever any record that is subpenaed to a grand jury is turned over to the investigators of that particular investigation such as a home health investigator, any other type paperwork must be prepared to advise the courts just who has access to these grand jury subpenaed records. All of this tends to slow down the operation of the grand jury investigation.

Other Federal agencies do have subpena power. The DEA, Drug Enforcement Administration, does have an administrative subpena power. The IRS has an administrative subpena power. That subpena power is often used in their investigations and it circumvents these restrictions that have recently been placed on the grand jury. So a subpena power with the Inspector General's office could be well utilized in these investigations we are discussing today.

Senator CHILES. What do you think of the other cooperative team approach to having a special U.S. attorney made out of part of the team where he had prosecutive experience before?

Mr. SULLIVAN. I think our experience with those types of units has been fairly successful, Senator. We had such a unit that prosecuted the doctor/lawyer teams of ambulance chasers that still exist in this area made up of investigators from State and Federal agencies with several different assistant U.S. attorneys advising and guiding the prosecution.

Creation of such units I think would be of assistance to us in this area as well. There is always the problem of finding the qualified people for this type of investigation. You cannot hire anyone just off the street. It must be someone with several years of experience in Federal prosecution before they can proceed in this area. But the concept is a good one and we have always had good experience with it.

Senator CHILES. Well, I would hope that wearing your hat as a Justice Department spokesman, as well as the U.S. attorney for the Southern District of Florida, that this could be explored with the Justice Department not only with south Florida but also for the rest of the country with the hope of trying to put together the same problems that you are talking about that handicap you in Florida and handicap every U.S. attorney in trying to get any kind of priority to these cases and trying to see that successful prosecutions are going forward.

You stress the need to have a regulatory scheme which imposes clear requirements on providers and operators of home health agencies so that it would be clear to all parties concerned that claims for reimbursements are simply not allowed and that any effort to make such a claim would be fraudulent. I think that is one of the most important things and that is what we have been trying to have happen since we started this in 1976.

I think that the agencies are entitled to that—the providers. They are entitled to know clearly what the rules are. I think one of their biggest problems is that they are in an area where someone is legitimately trying to do the job properly. As long as you have the gray areas and someone can reasonably say, well, I think this is legitimate or someone could advise them or they could see that the other agency is doing it that way, then we have to do it that way to compete, then it just becomes a part of the system. I think where you can make the rules very clear, you can tell the people with white hats from the people with black hats, and it is a lot easier.

I know that that is not something that you all can do. I hope that that is something that we can get the Health Care Financing Administration and HEW to do. Congress, if necessary, has to step in and try to make the regulation.

I have some other questions and I may submit some of them. We are running over awful long in our hearing.

We thank you very much for your statement.

Mr. ESKENAZI. Thank you very much for allowing us to appear, Senator.

Senator CHILES. Our next witness will be Judith Travis who is the president of the Florida Association of Home Health Agencies and executive director of the Visiting Nurse Association of Hillsborough County, Inc., in Tampa, Fla.

It is nice to see you again.

Mrs. TRAVIS. Thank you.

Senator CHILES. You testified before me in 1976.

Mrs. TRAVIS. Yes, I did.

Senator CHILES. I understand you are kind of wearing two hats today.

Mrs. TRAVIS. Yes.

Senator CHILES. Proceed with your statement.

STATEMENT OF JUDITH M. TRAVIS, R.N., B.S.N., TAMPA, FLA., PRESIDENT, FLORIDA ASSOCIATION OF HOME HEALTH AGENCIES, AND EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION OF HILLSBOROUGH COUNTY, INC.

Mrs. TRAVIS. Thank you.

I would like to express appreciation to you for allowing me to participate in the hearing. I do really feel that by doing so you are giving an opportunity for some of the positive aspects of the program to be at least recognized and put into proper place.

The members of our association feel very appreciative of the fact that you have looked into this problem; that you are really interested in home health care, and that you feel that it is a very viable system and an important component of the health care delivery system. I would like to address some of the problems we see. I have seen many of the problems myself from a firsthand viewpoint.

Before I really get involved in the testimony I would like to refer back; I do have a copy of my presentation for you.

I have included with my statement some attachments[1] that I feel are very important to be at least reviewed and considered as far as the consideration of the whole testimony is concerned. I feel that in many cases there has been an attempt to add additional requirements, regulations, and so forth, without really recognizing what already is required.

For your information I have included a copy of a licensure application for the State of Florida. As you well know, Florida has a licensure law. I have also included a licensure survey form, which in many ways is duplicative of the medicare certification process.

I have also included a copy of the Federal home health agency survey report, a copy of the Florida minimum standards for home health agencies, and charts and forms used by one home health agency which are representative of those required that do meet the standards throughout the State.

I think you will see that there are certain requirements that must be included. Basically, these are universal, although each agency has its name at the top, generally speaking.

[1] All attachments, except the code of ethics, are retained in committee files.

Other attachments, of course, relate to the USHHAR study; and forms from the Florida Association of Home Health Agencies, which include the code of ethics,[2] the membership agency questionnaire, and the philosophy of home care.

With that, I will move into the meat of the presentation. One thing that we often hear is that we look at home care as an alternative for institutionalization. I think in many cases this is true, but so often I have heard people say, "Well, look at all the elderly that are in nursing homes that should not be there." But if you look at the specific elderly that are in these nursing homes, in many cases these are those who would fall into the area of custodial care and there is no way under the present system that that can be overcome. Medicare does not reimburse for custodial care. I think this is another area that I would like to address at a later time with you, because I do feel that this is something that is very important.

The complexities of providing care and continuing to meet standards are compounded by confusion, vascillation, and inconsistency in interpretation of guidelines, not only in the provision of care, but also in the area of reimbursement; and I am sure you have heard that before today. Retroactive disallowances of payments previously authorized and paid make it extremely difficult for agencies to continue to operate with stability and foresight.

One case in point is that of an agency which submitted its management consultant contract for review and approval in 1974. Not any of the contract fees were disallowed in 1975; however, in 1978, when audits were conducted for 1976 and 1977, 50.3 percent of the contract fees was disallowed. We talk about abuse but how can it be abuse when it has been previously authorized? I think this is something that really seriously needs to be considered.

This disallowance is presently being appealed. The appeal process in itself is a problem since it takes approximately a year for a hearing because of the provider reimbursement review board's backlog. In the meantime, the provider is faced with repayments pending the decision.

In order to deal with the fiscal intermediaries and the variance in interpretations, our State association established a liaison committee, made up of a person from the department of health and rehabilitative services and representatives of the intermediaries. In the past it has dealt not only with fiscal considerations and disallowances, but also in the area of coverage issues. It has appeared at times that denials of visits for patients with a particular diagnosis occur almost on a periodic basis.

As an example, focusing in on patients that have Foley catheters; for a while, all of the home health aide visits to Foley catheter patients were being denied, regardless of the severity of the patient's infirmities. I have had it mentioned to me on any number of occasions that denials seemed to increase near the close of the fiscal year. I have seen cases that in a 30-day billing period there would be, for example, 4 visits out of 13 denied but there was no attempt to identify which ones were denied; it was, just said that there were too many, That response, to me, does not seem rational.

[2] See appendix 2, page 76.

Agencies have been mandated to determine when a patient no longer meets the medicare criteria for care; so by extensive study, working with the liaison committee, and trial and error, they have become quite proficient and accurate in making these determinations resulting in a declining denial rate. Apparently they have done their job too well, since I understand that the observation has been made that there are not enough denials on visits as far as home health is concerned. Of course, when the home health denial rate goes above 2.5 percent, then the waiver of liability is lost and the agency is then responsible for visits they have made when, in essence, perhaps they did not really know that these visits would not be covered.

FAHHA members have worked with other State associations and national organizations in an effort to develop universal, consistent application of the guidelines and to expand the availability of home health services without an undue increase in cost to the medicare program. Many meetings have left the participants feeling disillusioned and angry and that attendance at the meetings had been an exercise in futility.

There has even been inconsistency in the interpretation of the guidelines on a geographic basis. Patients coming into Florida who have been under a home health program in another part of the country expect the same type of interpretation here because these are Federal guidelines, but they do vary in interpretation. I think the interpretation in Florida is much more stringent and much more conservative than it is in other areas of the country.

Last February, I attended a meeting in Atlanta sponsored by region IV of the National Association of Home Health Agencies to meet with representatives of the intermediaries and HCFA in an effort to solve some of the difficulties. In the morning, there was a panel which consisted of representatives from providers of various States, and we each discussed the problems that we encountered in our State. Those who were on the panel in the morning were in the audience in the afternoon.

The panel in the afternoon consisted of representatives of HCFA and the intermediaries. One of the comments I made that morning had to do with the fact that the nurses in my agency are making two to three less visits a day than they were 5 years ago, because of paperwork. The comment was made, "Prepare yourselves because more is coming."

It does not seem appropriate, or even rational, to require more layers of duplicative documentation without knowing what already exists and how the system works, from the initial referral right through to the receipt of payment for services. The intermediaries are involved in care, and I think have been extremely responsive to the problems that we have encountered, but they are between a rock and a hard place. I think they have been very receptive and have tried very hard to work with the providers. At this meeting, and at numerous others, it was suggested that representatives of HCFA and intermediaries go on visits with the nurse, go within the agency, asking questions, going actually from person to person, asking "Why are you doing this and what significance does it have?" I don't think HCFA really knows. I mean you can look and say these are the problems because "there is abuse here," or "I think there is fraud there," but they should really get down to see what control is going on, and then certainly more reasonable and consistent guidelines can come out from that.

As you know, the implementation of the uniform system for home health agency reporting has been a serious concern to all of us, and the particular agency with which I am affiliated was one of the test sites. I am not an accountant and I cannot speak with full knowledge of accounting principles, but I do know the result we saw—and we have not had the final report on the study as yet. The accountant that does the consulting for our agency and Ben Bailey, who is the chairman of the FAHHA finance committee were both present for the conference and both of them have written letters which are included in this presentation.

Initially, when cost caps came out, I thought that they were astronomical and I am sure there were some others who did in particular areas of the country, but then when our cost report was redone by the USHHAR system so much of the administrative cost was broken over into the contract services that our speech therapy went way up almost beyond the cost caps, and I think we have a pretty conservative agency. So if it can happen to one that has always been extremely conservative, it can happen to anybody. I think that this is something that really needs to be looked at because I think the USHHAR system needs some serious changes.

We do, I think, speak out very much in favor of the uniform system of cost reporting; I think it would be more meaningful to us, as well as to the reimbursement program, but I think there are many problems that should be resolved before this system can be implemented.

Then we get to consideration of the 100 percent agency. I have heard the definition of that and the definition that I am currently getting is that it is any agency that receives 85 percent or more of its reimbursement from the medicare program. This includes many health departments VNA's and whatever else, because medicare is the primary reimbursement source for most of the home health program, particularly in Florida.

One of the problems that we have seen is that we need to explore the reasons why there are so many 100 percent or nearly 100 percent medicare agencies in Florida and determine the validity of the criticism that has been levied because it is this way. I think that if you felt that there was an agency participating exclusively in the medicare program and it tended to abuse, or its costs were out of line, certainly this would be something that you would look at; but, on the other hand, there are many agencies that don't fit that pattern and there are legitimate reasons why we see this particular situation in Florida.

No agency can be expected to provide care without full reimbursement for the reasonable cost incurred; I think in most cases the agency could not long survive by doing so. The majority of people requiring home health services are elderly and medicare recipients; many are living with fixed incomes. Very few of these patients and few of the others requiring home health services could afford to pay for the full cost of care. FAHHA for several years has encouraged the inclusion of home health coverage in all medical insurance plans.

Another reason for a high medicare participation is the fact that many agencies cannot afford to participate in the medicaid program. So long as the medicaid reimbursement system fails to meet the home health agencies' expense for providing services there will remain a barrier to care for those patients who reside in areas where there are no home health agencies receiving community funding. Medicaid is paying $16 for a nursing visit and $9 for a home health aide visit. I don't think you can find service anywhere at that price. The Council of Home Health Agencies and Community Health Services of the National League for Nursing has recommended in testimony delivered before the Senate Finance Health Subcommittee that title XIX mandate cost-related prospective reimbursement.

In summary, we see at least three factors involved in there being a high percentage of medicare only providers in Florida: First, the financial limitations of the patient himself; second, nonavailability of insurance coverage; and third, the lack of adequate reimbursement under the medicaid program.

Recently I was called by a representative from the medicaid office in Tallahassee; she was interested in knowing which agencies happened to be medicaid providers and did I know when she gave me a list of agencies she had that had medicaid provider numbers I was amazed.

One of the first actions of FAHHA was to establish an ethics committee composed of representatives from each of the five regions in the State. The committee elected its own chairman. This committee, back in 1975, put together a code of ethics. Subsequently copies of the code have been sent out to various State and National organizations that were interested in the code of ethics. I think that it has been a very important committee and I would like to commend it for its activity.

However, the way it was designed was that it would process complaints that were brought to the committee; the committee does not go out and police. One thing that was just decided recently was that if complaints were found about an agency that was not a member of the State association and there were problems inherent in that agency that were obvious, then the complaint should be directed to the executive committee, as opposed to the ethics committee, because by the adjustment procedure of the ethics committee it was clothed in secrecy until actual resolution of the problem, so it seemed a problem to handicap the ethics committee with confidentiality about complaints that were already public knowledge.

In an effort to assure full compliance with FAHHA standards, the committee developed a form which would be completed by agencies applying for membership in the association and the applicant must also agree in writing to subscribe to the code of ethics and be reviewed and accepted by the board of directors.

Providers have long been concerned that decisions are made and requirements mandated without benefit of any contributions or comments by those actually involved in the delivery of care. There are two glaring examples, and I am sure you are familiar with both of them but I would like to have them included in the testimony. The first dealt with the directive concerning prefilling of insulin

syringes for the diabetic. Of course, many cannot see well enough to fill syringes, but they can give their daily injections and manage to function fairly independently.

For a long while medicare had been reimbursing for weekly visits by home health nurses to prefill seven syringes which could then be stored in the patient's refrigerator. The directive stated that this procedure was no longer considered a "skilled" service, keeping in mind of course that many of these elderly people lived at home alone or that their spouse was as blind or as visually impaired as they were.

After thousands of letters from National and State organizations, as well as individual agencies, the bureau then compromised and issued a new directive stating that payment would be made for the nurse to visit every 2 weeks to fill seven syringes. On alternate weeks payment would be made for a home health aide to fill seven syringes, incidentally, while she was in the home helping the patient with a bath.

Well, no thought had been given to the potential astronomical increase in the rates for liability coverage once the insurance carriers discovered that nonprofessionals were filling syringes, or the fact that filling syringes is not considered a legal responsibility or a legal procedure for an aide to do in most States—it certainly is against the Nurse Practice Act in the State of Florida—and the danger to patients because, of course as we know, insulin has to be measured very, very carefully and it is a very small syringe and it takes good eyesight and good knowledge. Ultimately, the issue was resolved and medicare is again covering the weekly visits by the nurse because of a vast letter writing campaign and intervention by concerned legislators such as you, Senator Chiles, and Congressman Pepper.

Medicare announced to oxygen suppliers—now this is the directive that concerned the oxygen issue—and I think that it was extremely significant because this was a directive that was included in the carrier's transmittal—and it just happened to be brought to our attention. This was something that really had no impact on home health agencies, but when we realized what impact it would have on patients, we were all extremely concerned.

The decision was made that after January 31, 1979, oxygen in the home would no longer be reimbursed under the medicare program unless the patient had an arterial blood gas study which reflected a hypoxic state, defined as a PO_2 level of 55 or below. The procedure for drawing the blood is costly and done only in hospitals in most areas of the country.

No consideration was given to the potential hazard for the patient, the expense of travel by ambulance for those not able to go by car to the hospital, nor to the distance involved. Not only was the requirement for this study a terrific burden for the patients needing oxygen but many pulmonary physicians felt that the arbitrary standard of a 55 PO_2 level was dangerously low. There were committees in many of the medical associations around the country standing ready to act on that directive.

Fortunately, at the 11th hour, a new directive came out saying this would not be implemented until it was published in the Federal Register, and then there would be opportunity for public com-

ment. I think if these things had been considered to begin with, the fear of the patients involved and the problem of having again to go to bat would never have occurred. In fact, I think these are two disasters that should never have happened.

We look at the patient, too. I think if you look at it in one way by income level, you would see that if he had the money, he would have paid for the oxygen rather than submit himself to the vigorous transportation to the hospital for the unpleasant arterial blood test. On the other hand, when the poor patient who could not afford to pay for the oxygen, got into pulmonary distress, he would have to be taken by ambulance to the hospital to be admitted, and that would have been costly to the program.

Florida passed its licensure law for home health agencies in July 1975 which included requirement for certificate of need from the health systems agency. Subsequently, through a misunderstanding, a letter was issued by the HSA giving a blanket certificate of need to approximately 12 agencies in a county which already had numerous agencies. I knew that schedules for licensure and certification surveys had already been made so I called HEW in Atlanta and inquired if something could not be done to delay the certification process because this delay would help prevent the escalation of cost which otherwise would surely result. I was told there was nothing they could do. Once the agencies met the State criteria, that was all they could do. They would have to accept it and go ahead and certify for medicare participation.

We are concerned about the cost caps. I mentioned that when I talked about USHHAR. It would seem that when a contract could be drawn, there would be incentive there for an economical system for reimbursement. I think that to say "OK anything up to this point is acceptable." I don't see that as a good mechanism that is cost-effective. Perhaps those more sophisticated in financial matters would find it so, I don't know

On August 14, 1979, a meeting on fraud and abuse was held in Atlanta attended by representatives of HCFA and the fiscal intermediaries. Considered at this meeting were 11 issues such as the use of hospital coordinators and administrative salaries. I have heard the issues mentioned in testimony earlier. On at least two occasions, one of the intermediary officials stated that he had heard "quality of care" mentioned not one time, but that the quality of care being delivered was very high. He was told there was no time to discuss that issue because they were there to discuss the bad things, not the good.

Since its inception, FAHHA has been vitally concerned with the quality of home health care being delivered. In March 1977 an ad hoc committee of quality assurance was appointed. The committee was changed from ad hoc status to that of a standing committee in August of that year. An agency can go back and read the nurses' notes and see what actually happened with the patient, what changes were involved with that patient because of the intervention of the health care team; if you don't measure up and you could recognize it yourself. This is not an end in itself but it shows the agency what areas of delivery of care need changing or need addressing.

The committee also developed a philosophy of home care which was adopted by the association and has drafted a home health patient's bill of rights. The nursing committee established outcome criteria for 19 disease processes. Currently the physical and speech therapists are working on outcome criteria for their respective disciplines. I have a copy of our quality assurance program which I would like to leave with you.

In a letter to Joan Buddi, current chairman of the quality assurance committee, from Joan Casserta, executive director, CHHA/CHS, National League for Nursing, the following statement was made:

> To sum it up, you have made an excellent beginning to a quality assurance plan which has implications for utilization and funding of home health care . . . Meanwhile we await further developments from your state with interest.

I would like to call attention again to the statement made by Mr. Lowe, where he said:

> We have dedicated ourselves to insure that these programs will offer better and more accessible care while we strive to close loopholes that invite abuse.

I don't want abuse and I am a taxpayer; we all are. I am very, very concerned where my tax dollars are going.

Fraud, I think, is a problem and since it is a problem, it has to be identified and taken care of. But in the same set of circumstances within testimony I would like to point out again the positive features of the home health delivery system. I think that there are some very, very good things that have been done in Florida and I feel that Florida in many ways has a potential and has served as a leader to many State associations.

I have attended meetings and I have been asked, "How does Florida deal with this?" "How do you cope?" Let me tell you, many copies of the code of ethics have been requested; this type of thing. I think we have worked very hard to enhance the program and to improve the quality of care that is delivered to our patients. We are very concerned about our patients.

I thank you again for the opportunity to be here, and I will try to answer any questions that you may have.

Senator CHILES. I thank you for your statement and I thank you for what you said in closing. You said in closing that you are concerned about the questions of abuse. Your statement really didn't address those questions.

Mrs. TRAVIS. That is true. Senator, did you see my letter? It was addressed to the administrator of the medicare home health care benefit, and that is what I geared it to, because I felt it was important to bring in the positive side of the program.

Senator CHILES. But I am glad that you are as concerned as I am that we still have these problems because I think that you agree that the worst thing that can happen to home health in Florida and in the Nation is to let these issues of fraud drag on without being resolved. That is all that anybody is ever going to talk to or report on every time you bring the program up. It even happens in the Congress now when we start talking about the dollars we are going to appropriate, how in the world are we going to go forward with national health insurance, for example, when we cannot get rid of the problems that we have in medicare and medicaid, when

we cannot deal effectively with those programs. When we cannot deal without fraud, how in the world can we conceive that we are going to open this up to treatment of everybody from infancy to the time that they die and that we are going to be able to afford the cost of that? There is just no way in the world.

Mrs. TRAVIS. If I may make a comment here, I think the points that you made are very well taken and I agree. However, I think it is important to recognize that many of the abuses that you are alluding to, in fact most, are some time back in the past and there has been a great deal of progress. I think there has been a great deal of guidance from the intermediaries, that you see very little overutilization as far as patient visits are concerned and this type of thing.

Senator CHILES. Well, we have not heard as much about overutilization this morning, and I hope that that is not the problem that it was before.

Mrs. TRAVIS. No.

Senator CHILES. A lot of the problems we talked about in 1976, a lot of the problems that Sam Gibbons talked about in 1978, are the same problems that we are talking about today—some of the ripoffs, some of the money charges that are made for startup costs, solicitation, all the double billing that goes on. Those things were the same things that existed before and they are still existing today. All we are doing is seeing more agencies, we are seeing a franchise that was set up where the parent is charging these excessive charges and getting away with it. We are seeing these direct tie-ins and operating between the operation. We are seeing again still today in Florida overutilization and expansion of services in certain areas, and no services provided in other parts of the State.

You point out that we have the Florida licensure law. Yes, we do, and I am glad we have it but it got there after the horse got out of the barn really. To come in and create one of them now with what was it you're supposed to have—potential 200, 300 patients? How many of those agencies today of the ones that we have in Florida have this potential right now? Many of them are grandfathered so they didn't come within that.

Mrs. TRAVIS. But, Senator, I think this is a very significant point. Federal legislation is not including certificate of need and this is where it began in Florida, was including the certificate of need. In the rural areas if there is not a sufficient clientele for an agency to survive, particularly in view of the fact they cannot participate in the medicaid program, I think this is a very important consideration.

Senator CHILES. I agree.

You are a member of the Hillsborough County Visiting Nurse Association. How many visiting nurse associations are there in the Florida association?

Mrs. TRAVIS. Four.

Senator CHILES. Does your association have proprietary agencies as well?

Mrs. TRAVIS. No, sir. There are proprietary associate members, businesses, but not as regular members.

Senator CHILES. You talked a little in your statement about your code of ethics. I have looked over the code and it seems to try to resolve many problems internally. Does that mean you want to report problems to medicare or other officials who might take action if those problems come to your attention?

Mrs. TRAVIS. No, sir, it does not. In fact, there have been cases where letters have been written to——

Senator CHILES. You have reported no unethical conduct on the part of your members?

Mrs. TRAVIS. There was one potential member who was reported.

Senator CHILES. Potential?

Mrs. TRAVIS. Yes.

Senator CHILES. How about a member situation?

Mrs. TRAVIS. The agencies that we came into contact with that would have been reported on the area as far as the fiscal abuse is concerned, we don't have knowledge of that. The areas in which we have dealt primarily with the members have been in the area of what we would consider unethical practices. Certainly we would not be adverse to notify the powers that be if we detected an element of abuse or suspected fraud.

The thing though that we have noticed is that there were agencies that were suspended from membership after indeed the Federal Government did make a move. Then we knew that these agencies were indeed operating in a way that we did not feel to be compatible with the code of ethics. Unless we were in the business of reviewing everyone's cost report and this type of thing, we don't really have the time or the authority to be a policing organization but certainly we will try to deal with anything that was brought to our attention.

I talked with Miss Deignan at one time and indicated some of the activities that we have done. There was a case where one of the physicians in an area of Florida was very concerned about home health care, but he was overly critical, and yet he would refer, he was still referring, and so I said, well, if you have specific complaints, if you will give documentation and bring it to the attention of the ethics committee, something will be done about it if they have that means.

The outcome was that the regional ethics committee member and I did go down and spend a couple of hours in a meeting with him and several other physicians and the social worker in the hospital and he was alluding to situations that had occurred 2 or 3 years before. I said these are areas that I think should be brought to the attention of the program integrity.

He said, "I don't know who to write," and I said, "I will tell you." When we got back to Tampa I sent him the information as to where the information should go and I strongly urged him to follow through with it.

One of the agencies about which he was complaining was not a home health agency at all, it was an equipment company. I think these are things that are important, too. I think sometimes anyone involved in a delivery of equipment or health care or anything else, as long as it is not in a hospital or nursing home automatically becomes a home health agency, and I don't think he realizes or recognizes the difference.

The social worker, incidentally, after that meeting said that she not only respected the home health agencies in her area, she felt they were doing a fine job, and that she frankly could not do her job so well without their help.

Senator CHILES. I understand that your association now requires all agencies to report members of boards of directors and advisory boards before they are accepted in the association. Why?

Mrs. TRAVIS. Well, there was an attempt to identify duplicative participation in the agencies by the same people. Well, let's see. It has only been this year that it was decided to do this. The form had been worked on. We had several variances of the form initially. This one was completed and accepted by the board of directors, and I believe that was in June of this year, and they were sent out, not only to be included in the membership application, but also to the existing members of the organization.

Senator CHILES. This is to detect interlocking?

Mrs. TRAVIS. It was an attempt to do so; yes.

Senator CHILES. Have you received those back yet and taken any action on those?

Mrs. TRAVIS. Most of those. I have not seen them because they went out with the billing to the existing members, membership fees.

Senator CHILES. Do you plan to look at those? Would that be your ethics committee?

Mrs. TRAVIS. One copy went to the treasurer. I guess two copies went back to the treasurer and one was to be filed with the ethics committee chairman. There has not been time to review them yet because, as I say, it was just implemented this year.

I might add that because of delay in getting some of them back there were suspicions involved and it was a matter of "I don't have time to fill it out," but it was very soon that the agencies did cooperate to get them back in. There was no effort not to return them and two originals were signed by the principal.

Senator CHILES. We thank you very much for your statement today. I agree wholeheartedly in what you say, that providers are entitled to clear regulations. Also, I think any time there is a problem, it seems that somebody thinks they can cure it with just a little more paperwork and I see that proliferated across all of the bureaucracy. That paperwork does not tend to be a very good policeman. If you are going to have to have some new reports, it looks like you will in this area if you are going to have to set some new procedures, then we ought to determine what paperwork we can get rid of that has not been working. I agree with you 100 percent.

Mrs. TRAVIS. Thank you very much.

Senator CHILES. Thank you.

Mrs. TRAVIS. I certainly appreciate it.

Senator CHILES. We are going to hear briefly from John Smith.

STATEMENT OF JOHN B. SMITH, MIAMI, FLA., GENERAL COUNSEL, MEDICAL PERSONNEL POOL, AND VICE CHAIRMAN, HOME HEALTH SERVICES ASSOCIATION

Mr. SMITH. Thank you, Senator.

I am general counsel for Medical Personnel Pool, which is a proprietary company headquartered in Fort Lauderdale. I am also vice chairman of the Home Health Services Association, which is the national organization of proprietary companies, equivalent to FAHHA at the State level. The association has seven members with approximately 624 offices throughout the country, of which I believe 12 in Florida are certified participants in the medicare program.

We are concerned also, Senator, about fraud and abuse not only in the abstract sense, but because we believe that proprietary agencies, certainly the ones represented by our association, are sometimes unfairly whitewashed by some of the charges we have heard brought up at these hearings. For example, I do regret——

Senator CHILES. I have heard of being unfairly tarred before but I have not heard of being unfairly whitewashed.

Mr. SMITH. Well, perhaps tarred is the better word.

I do regret, for example, Inspector General Lowe's comment that he finds all of the abuses applicable to proprietaries that he found applicable to nonprofits. I regret that that was not substantiated more. We do have some recommendations for dealing with fraud and abuse. As you may recall, we made some of these recommendations in the August 1976 hearings, so let me go over them briefly if I may.

We feel that provision should be made for regional designation of regional fiscal intermediaries and perhaps a single national intermediary for home health agencies. We believe that will result in more uniform audit standards, more uniform reporting controls and the opportunity to make better investigations of cost reports.

We also support the prohibition of the so-called 100 percent provider, perhaps with the exception of the county health departments and the bona fide visiting nurse association. At the same time, I think we need to avoid rigid quotas for any type of patients that might be applicable. We also support the improved audit activities that are presently undertaken by HEW and the intermediaries. We support the reasonable system of uniform cost accounting, which is presently in preparation, and representatives of our association are participating on the advisory committees of that group.

Perhaps, if I could digress for a moment on the question of consultants, my view is that Federal health care regulation is perhaps only slightly less complex now than the Internal Revenue Code and with the implementation of uniform cost accounting rules, I don't know that we can entirely eliminate the need for some type of consulting. The day may be approaching where a well-minded group of community citizens and community health nurses won't be able to organize a visiting nurse association without access to outside consultants, so I think you need to be careful that certain standards are developed that might still permit the use of these types of services.

Senator CHILES. I want to comment on the uniform cost reports. I have not had a chance to look into those in great detail and I hope to look into them further. I am glad to see that in this instance they are doing some experimentation work and they are going to the agencies themselves and getting their input before the regula-

tions are adopted and completed. It seems to me that it is a much better method than what is going on now where the hospitals are up in arms and have every reason to be up in arms when the first regulations came out. I think an awful lot of that was because HEW didn't get the proper input.

My understanding is, in the uniform cost standards that they are looking at in your industry, that HEW is requiring a cost benefit analysis. I think that is essential. I hope they are going to come up with something that is not going to be burdensome but will provide some kind of standards that can be used.

Mr. SMITH. We also support full access to financial records and to that extent our company, before we became involved in the medicare program, invited HEW's Division of Direct Reimbursement to come down and examine our records so we could become involved in it.

We support flexible guidelines for reviewing salaries, fringe benefits, service contracts and fees, and also guidelines in terms of percentage or numbers of administrative personnel. Obviously there has to be some room for reasonableness and variables, but perhaps these systems can work.

We also support patient or family verification of services provided. What my company does is for every visit that is made to a patient we secure a signed receipt, if you will, by the patient to establish the patient's authority that that visit was made, and that would help create an audit trail that would obviously not prevent forgery, but it would create something else that might be done.

I think we mentioned at your August 1976 hearings that the patients should receive perhaps some summary form of the agency's billing to their intermediary. Attached to that could be a statement of patient rights and a notice requesting the patient to advise the intermediary if they see anything improper in terms of number of visits or the type of service that was originally provided. This procedure might generate patient contact with the intermediary. Many home health recipients are not totally helpless and would provide some input into preventing fraud and abuse through that method.

Senator CHILES. I might say that in the bill that I sponsored before the Finance Committee, I provided that the patient would be able to receive the notification of what the billing was. There was such a howl from home health agencies—across the whole industry, private and the other—that the Finance Committee deleted that. I think a lot of times the patients look at this and they can tell you very quickly whether they received those kinds of services or not. Even though the Government is providing the payment, they don't like to see the Government ripped off any more than anyone else.

Mr. SMITH. That is right.

Senator CHILES. I think it is a provision that should be made.

Mr. SMITH. The taxpayers ultimately provide the funds.

Well, to provide a copy of the complete billing to every patient would be an undue burden but perhaps the cover page of the provider's billing to the intermediary, which shows the number of visits and the type of service or the type of medical problems that are being dealt with would be sufficient.

Something came to mind today when you were discussing civil penalties and the problem as to how to recover those civil penalties. You might be interested to know that the State of Michigan has proposed legislation whereby civil penalties can be imposed on home health agencies. The manner in which they intend to recoup those penalties is by deducting civil penalties from medicaid payments made by the State to the agencies. There may be some due process implications with that type of arrangement, but assuming that those could be satisfied, perhaps that might be something to look at in the medicare program as well.

I appreciate, Senator, the opportunity to make these brief remarks.

Senator CHILES. Thank you.

At this stage we are going to recess our hearings until further call of the Chair. I thank you all for your appearance and your attendance here today.

[Whereupon, at 1:50 p.m., the hearing adjourned.]

APPENDIXES

Appendix 1

CORRESPONDENCE RELATED TO HEARING

ITEM 1. LETTER FROM SENATOR LAWTON CHILES, TO LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED SEPTEMBER 6, 1979

DEAR MR. SCHAEFFER: I am writing to thank you and members of your staff for participation in the committee's hearings on "Abuse of the Medicare Home Health Program" in Miami on August 28, 1979.

I am encouraged by the Health Care Financing Administration's plans for focused home health audits under project integrity III, and I would like to be kept fully informed of audit progress and results. I have asked Kathleen Deignan of the committee staff to continue contact with your staff in this regard.

Attached are a number of additional questions which were not thoroughly discussed during the hearing. We plan to include most of the Department's responses in our hearing record, so would appreciate receiving your reply no later than October 1, 1979.

Sincerely,

LAWTON CHILES, *Chairman,*

ITEM 2. LETTER AND ENCLOSURE FROM LEONARD D. SCHAEFFER, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION,[1] DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, TO SENATOR LAWTON CHILES, DATED DECEMBER 19, 1979

DEAR MR. CHAIRMAN: This is in response to your request for information for the record of the committee's hearing on "Abuse of the Medicare Home Health Program."

As we discussed with your staff, we have divided our response into two categories: those items which are intended for publication in the record: and those items which are for committee use only. The latter items were separated from the rest because they involve ongoing investigative efforts. We are concerned that premature publication of some of this information could jeopardize these efforts.

I would like to thank you for providing us with the opportunity of testifying before your committee. You may be assured that we will continue to work closely with you in attempting to resolve the remaining problems in the area of home health abuse.

Sincerely yours,

LEONARD D. SCHAEFFER,
Administrator.

Enclosure.

Question 1. How many home health providers have been investigated by HCFA for possible fraud and abuse and what have been the results of those reviews?

In August 1978, Mr. Derzon testified before a House committee that HCFA regional office staff had investigated 239 home health agencies for possible criminal fraud and 75 for abuse. What have been the results of those investigations, how many additional inquiries have been made, and how many home health providers are not pending review for possible fraud and abuse?

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[1] John D. Kennedy, Acting Director, Bureau of Quality Control, Health Care Financing Administration, testified for the HCFA, see page 19.

Answer. The Health Care Financing Administration is currently in the process of developing a computerized system to track cases which have reached the status of full-scale fraud or abuse investigation. While we have total counts of initially substantiated complaints of potential fraud or abuse against HCFA programs, we do not compile statistical data by the type of provider. We do, however, track in detail those complaints that are determined to have substance; they are classified as full-scale investigations. On the basis of data on HCFA's full-scale investigations, 57 HHA cases have been referred to the HEW Office of Inspector General for further investigation and referral for prosecution, 51 HHA cases have been referred to U.S. Attorneys for prosecution, and 32 HHA cases are currently under active investigation by HCFA for fraud or abuse.

Question 2(A). GAO turned over to you a number of home health providers for review because of possible fraud and abuse. You were to complete review of these providers this year. How many providers were referred?

Answer. GAO referred 6 HHA's to HCFA for possible fraud and abuse on August 28, 1979.

Question 2(B). How many have you reviewed to date?

Answer. To date we have reviewed four of the six HHA's but have referred all six to the Office of the Inspector General (OIG) based on the GAO findings.

Question 2(C). What did your review disclose?

Answer. Our findings were very similar to those disclosed in the GAO report. However, we found additional evidence which would indicate that consulting firms and the agencies reviewed were related organizations.

Question 2(D). Will review of all providers be done this year?

Answer. The Bureau of Quality Control does not plan to review the other two HHA's. For one facility, Bay Area Home Health Services, Inc., the GAO adjustments were minimal. The FBI and OIG have reviewed the case and the intermediary has performed an audit of the books and records. The results of these reviews indicated no material audit adjustments and no indications of criminal fraud. In the other case, Home Health Services of Louisiana, Inc., the OIG has been reviewing the case for possible criminal fraud and the intermediary has proposed audit adjustments as follows: 1977, $71,057; 1978, $50,183. All GAO findings were considered in the audit adjustments by the intermediary.

Question 3. During your testimony, you point out that GAO did their audit prior to the intermediary settlement of the involved cost report. You expressed the opinion that the intermediary would have found most of these problems. Have you done anything to assure yourself that this is the case? (See page 17 of GAO's report). If such followup was done, what did you find? If not, why not?

Answer. We have been informed that all the HHA's discussed in the GAO report have either been audited or are in the process of being audited. The intermediaries have advised us that they have ensured that the points raised in the GAO report are being covered in these audits. For example, intermediary audit adjustments from one HHA have totaled $84,629 for the period ending May 31, 1977 and $78,763 for the period ending May 31, 1978.

Question 6. Mr. Kennedy's testimony indicated that approximately 650 of 2,700 medicare-certified home health agencies nationally are classified as "100-per-centers."

What is the Department's definition of a "100-percenter"? How many of these 2,700 agencies fall within the range of 90 percent to 100 percent medicare only? 80 percent to 90 percent? How many fall below 75 percent?

Answer. For purposes of selecting HHA's for further validation review by Federal employees of HCFA's Bureau of Quality Control, we have defined those HHA's whose medicare utilization exceeds 70 percent of all services provided as predominately medicare or "100 percenters." For purposes of directing intermediary audits, HCFA's Bureau of Program Operations has chosen to use a definition of 85 percent medicare utilization of total services provided in defining "100 percenters."

Our most recent data, based upon a review of 1,831 cost reports for the year 1977 shows that 334 HHA's have medicare utilization of between 90 and 100 percent and 234 have utilization between 80 and 90 percent. Thus a total of 568 HHA's, or 31 percent of the 1,831 reviewed to date have medicare utilization of 80 percent or more.

Question 7. Please submit, for the hearing record, information for each State, on: The number of medicare-certified home health agencies the percent of medicare-only agencies in 1975 and 1978.

Answer.

NUMBER OF PARTICIPATING HOME HEALTH AGENCIES

Region and State	July 1975	June 1978
All regions	2,242	2,605
Boston region	334	329
Connecticut	87	84
Maine	19	19
Massachusetts	159	150
New Hampshire	40	43
Rhode Island	13	14
Vermont	16	19
New York region	182	182
New Jersey	44	44
New York	124	117
Puerto Rico	13	20
Virgin Islands	1	1
Philadelphia region	253	213
Delaware	6	5
District of Columbia	3	5
Maryland	26	26
Pennsylvania	101	111
Virginia	99	45
West Virginia	18	21
Atlanta region	429	615
Alabama	70	79
Florida	42	122
Georgia	16	23
Kentucky	40	55
Mississippi	89	111
North Carolina	61	72
South Carolina	15	22
Tennessee	96	131
Chicago region	390	464
Illinois	81	110
Indiana	29	44
Michigan	48	55
Minnesota	61	70
Ohio	103	106
Wisconsin	68	79
Dallas region	257	311
Arkansas	78	79
Louisiana	74	80
New Mexico	7	12
Oklahoma	51	59
Texas	47	81
Kansas City region	144	185
Iowa	64	84
Kansas	34	42
Missouri	34	42
Nebraska	12	17
Denver region	89	108
Colorado	29	32
Montana	10	15
North Dakota	9	9
South Dakota	21	30

NUMBER OF PARTICIPATING HOME HEALTH AGENCIES—Continued

Region and State	July 1975	June 1978
Utah	9	9
Wyoming	11	13
San Francisco region	107	136
American Samoa		
Arizona	11	12
California	88	111
Guam	1	1
Hawaii	4	6
Nevada	3	6
Seattle region	57	62
Alaska	1	1
Idaho	9	11
Oregon	25	24
Washington	22	26

Our most recent data, based upon a review of 1,831 cost reports for 1977, shows 568 HHA's, or 31 percent, having medicare utilization of 80 percent or more. State-by-State data is not available.

Question 8. Many of the 100-percenters are private nonprofit providers and tax exempt. Please explain in detail what you have done and are going to do to coordinate your activities with the IRS to assure that these providers maintain their tax exempt status.

Answer. HCFA will prepare an instruction to medicare intermediaries requesting that any HHA's classified as private nonprofit which appear to violate the IRS requirements for maintaining tax exmpt status be identified in a quarterly submission to HCFA's Bureau of Quality Control. We expect to utilize this data as a referral mechanism to IRS and will confer with them on necessary actions to substantiate potential violations.

We have discussed the tax exempt status question with GAO and understand that GAO intends to initiate a major study of this area. We will cooperate with them in every way possible.

Question 10(A). Has the Department evaluated the validity and comparative effectiveness of the various management services provided by these organizations?

Answer. The Department has not evaluated the validity and comparative effectiveness of the various services provided by these organizations. However, the Department has instructed all intermediaries to reopen and examine the cost reports of those home health agencies with management contracts and to submit reports on their findings. Intermediaries have reviewed 49 of the 132 contracts and have disallowed a portion of the fees paid by 32 home health agencies to the management firms.

Question 10(B). Has the Department developed criteria for "reasonable" reimbursement for these management services?

Answer. As indicated in Mr. Kennedy's statement to the committee on August 28, HCFA has issued instructions to intermediaries which focus on assuring appropriate home health reimbursement with respect to costs incurred under management/consultant contracts. Intermediary letter No. 78-39 emphasizes that the portion of contract costs which represents unnecessary services as determined by the intermediary and the portion of costs which relates to necessary services but which are unreasonable in amount cannot be reimbursed. In its evaluation, the intermediary must consider the duration of the contract. It must also evaluate the relationship between the provider and contractor as a result of the terms of the contract to determine if the provider is under the control of the contractor.

Currently, a revision to the Provider Reimbursement Manual is being developed which will incorporate the instructions in IL No. 78-39. In addition, a proposed revision to regulations section 405.427 more clearly addresses the activities between providers and management companies with regard to relatedness, one of the problems that has surfaced with regard to home health agencies (see answer to question 13).

Question 10(C). Has the Department considered providing direct technical assistance to agencies for startup?

Answer. Intermediaries are not in a position to provide the full range of services with regard to the establishment, staffing, etc., of a new home health agency that can be provided by some management firms. However, intermediaries do furnish assistance to new providers in orienting them to the manner in which reasonable costs are determined under the medicare principles of reimbursement and to the necessity for documentation to support costs which are incurred. This assistance, as well as other assistance regarding billing, coverage, etc., is furnished not only when providers are new but on a continuing as-needed basis. However, assistance is primarily furnished to a provider after its certification into the medicare program since prior to that time, the agency is not a participating provider. While intermediaries can provide some general program information to an agency prior to certification, we believe it inappropriate to encourage this activity on a broad scale.

Question 11. Will either new regulations or additional instructions incorporate GAO's recommendation that prior intermediary approval for home health agency/management service contracts whose costs exceed a specified amount and/or whose terms exceed a specified period of time be approved in advance? The GAO reported to the committee that intermediary letter No. 78-39 does not provide sufficient instruction to intermediaries regarding prior approval.

Answer. We believe it would be inappropriate for HCFA (through its intermediaries) to approve contracts in advance. IL No. 78-39 was not intended to provide instructions with regard to intermediary prior approval of contracts nor do we plan any additional instructions in this regard. Such a procedure could place the intermediary in the position of disallowing contract costs based on a year-end cost report after having approved the contract at the beginning of the year since the prior approval of the contract could not provide a guarantee that the provider's costs resulting from the contract would be allowed. Such circumstances could result in provider perception of lack of credibility on the part of HCFA and the intermediary. Furthermore, without prior approval, a provider has an incentive to continually seek the lowest cost available. With prior approval, it may lack this incentive to act as a prudent buyer. Finally, we strongly believe that it is inappropriate for an intermediary to make decisions concerning the approval of contracts which should be made by the provider's management staff.

However, we believe that the intent to enter into certain long-term contracts may be indicative that a provider is not acting prudently and may, because of the contract, incur costs which will be found unreasonable by the intermediary. To evaluate such situations, we believe that the best approach is that stated in IL No. 78-39 which emphasizes that intermediaries must evaluate the terms and conditions of these contracts. As a part of this evaluation, it specifies that while contracts of less than 5 years' duration may be determined to be reimbursable based upon the intermediary's evaluation of the services offered and received, the cost incurred for services furnished after the fifth year of the contract should not be reimbursed (unless the intermediary is clearly satisfied that the services are necessary and proper and their costs reasonable in accordance with the instructions in effect when the services are rendered).

It is important that a provider's intent to enter into a long-term contract be brought to the attention of the intermediary, especially in light of the fact that a provider—particularly one with primarily 100 percent medicare utilization—could find itself legally liable for paying for the services provided but without the funds to satisfy its obligations. We have always stressed, most recently in IL No. 79-14, that a provider should never wait until the end of its cost reporting period to consult with its intermediary but rather should do so on a current basis regarding the allowability and reasonableness of costs that it plans to incur.

Question 12. Does HCFA have authority for direct access to the records of provider contractors? If not, do you believe such access is necessary?

Answer. HCFA has no direct relationship with contractors furnishing services under arrangements (contracts) with participating providers. Rather, HCFA's legal and contractual relationships are solely with providers of services, such as hospitals, skilled nursing facilities, and home health agencies. Therefore, evaluation of contractor costs and services can only be done indirectly, through the provider. There is no legal basis for requiring a contractor to make its records containing cost or other data available to the Secretary, and there is no legal authority for requiring contractors to enter into agreements with the Secretary as a condition of their furnishing services to Federal patients. These limitations have severely restricted HCFA's ability to determine reasonable costs in the medicare and medicaid programs, and

have prevented the establishment of a data base which could be used in future analyses of costs and utilization patterns.

Section 1861(v)(5) of the Social Security Act, for example, provides that guidelines will be established to determine the reasonable cost of therapy services and the services of other health related personnel (other than physicians) furnished under arrangements. Under the law, these guidelines shall not exceed an amount equal to the salary and other costs which would reasonably have been paid for such services in an employment relationship, plus the cost of such other expenses which a person furnishing such services under arrangements would normally be expected to incur. Under this provision, the intent of which is to control program expenditures and prevent abuse, specific guidelines have been developed for determining the reasonable costs of physical therapy and respiratory therapy services furnished under arrangements. Without knowing the actual costs incurred by the supplier in furnishing services, however, it has been difficult to determine the amount of reimbursement in addition to salaries which would be appropriate for these services.

Similar difficulties exist with respect to contract services, such as management and billing services, not included under section 1861(v)(5). Providers are reimbursed only for the costs of items or services that are necessary to their operations and then only to the extent that the costs are reasonable. Currently, to determine the reasonableness of contract management and billing services, intermediaries must review the amounts being charged in the market place for comparable services. While intermediaries can properly make reasonable cost determinations using this procedure, we believe that access to the actual cost data in contractor records would facilitate more accurate determinations.

In view of the above, HCFA believes that access to contractor records is necessary, and would support legislation to that effect. However, due to the extremely large number of suppliers and contractors, as well as the great diversity in the services they provide, HCFA recommends that the Secretary be given discretion in determining how or the extent to which such legislation is implemented.

Question 13. You have just proposed changes in your regulations concerning "related organizations." When will this be final? How will it differ from existing regulation?

Answer. HCFA anticipates that the proposed revision to regulations section 405.427, cost to related organizations, will be published in final form during the third quarter of fiscal year 1980.

The existing regulation treats a provider and a supplying organization as related if they are associated or affiliated "to a significant extent." The definitions of "common ownership" and "control" also use the terms "significant ownership" and "significantly" influence. We are proposing to revise these definitions to remove these subjective phrases.

The existing rule does not deal specifically with how the costs of a related supplying organization are to be determined. We are proposing that the supplier's allowable costs be determined in accordance with the general reimbursement principles of subpart D of the medicare regulations.

We are also proposing some clarifications and revisions in the existing criteria for granting an exception to the general principle.

The proposed revision to the regulation also applies the rule for related organizations to cases in which the provider and the supplying organization are unrelated prior to the execution of a contract, but common ownership or control is created at the same time by the nature of the contract or by other means.

Question 14. Several providers have terminated their contracts with management firms. Some intermediaries have allowed the contract termination fees as an allowable expense. Others do not. What is HCFA's policy on termination costs?

Answer. Contract termination costs are reviewed to determine if they are the result of a prudent business decision and to determine if the costs are reasonable. Under this policy, the costs may be fully disallowed, partially disallowed or allowed in full, based on the intermediary's evaluation of the facts and circumstances related to the contract termination. We agree that HCFA needs to clarify policy in the area and we plan to issue instructions in the Provider Reimbursement Manual on this area in the future.

Question 15(A). In Mr. Kennedy's statement, he indicated that HCFA plans to provide more specific guidelines to intermediaries on fringe benefits. What changes are you planning to make?

Answer. Section 2144 of the Provider Reimbursement Manual includes a number of fringe benefits recongized by the program and specifies that while other items not enumerated therein may represent fringe benefits they must be referred to the intermediaries for approval prior to being treated as fringe benefits. Intermediary

letter No. 79-14 emphasized these instructions and the necessity for providers to identify on the cost report all fringe benefit costs with other employee compensation to enable the intermediary to determine the reasonableness of total compensation. Since there apparently is still some misunderstanding of HCFA policy in this area, we plan to reevaluate existing instructions and issue clarifications where appropriate.

Question 15(B). Do you plan to eliminate intermediary authority to approve fringe benefits other than specifically stated in program policy?

Answer. We do not plan to alter intermediary authority in Provider Reimbursement Manual section 2144 to approve fringe benefits not specifically enumerated in that section. We believe the intermediary is in the best position to make these determinations.

Question 16(A). Based on HCFA's audit activities to date, what do you believe should be an appropriate ratio of agency administrative salaries to total personnel salaries?

Answer. HCFA has formulated no such ratio of administrative salaries to total personnel salaries. There are many factors which must be considered in developing a ratio, and we are not certain that any one ratio would suffice. For example, the type of services that an agency provides, the number of visits it provides, the extent to which it contracts for services, and whether it is hospital based vs. freestanding all affect the ratio. In addition, the same problems presently being encountered in analyzing administrative cost data from the cost report (see question 23) are also present in developing salary ratios from cost report data.

Question 16(B). Do you include fringe benefits in determining these ratios? If not, why not?

Answer. HCFA considers total employee compensation including salary and fringe benefits in determining the reasonableness of such costs. Therefore, if the ratios discussed above were to be developed, fringe benefits would be included.

Question 17. In one Provider Reimbursement Review Board decision (77-D32), the Board suggested "specific guidelines for prospective application in all major cost reimbursement areas of home health agencies serving only medicare beneficiaries. This could go as far as:

(A) Limitation on pension percentage.

(B) Limitation on each and every fringe benefit.

(C) Relationship of every job description to a specific civil service GS rating and salary with appropriate seniority and cost of living increases, since all are 100 percent compensated by the medicare program, etc.

In this regard, what has been done to respond to the concern raised by the Board? What are HCFA's views of these suggestions?

Answer. In PRRB decision No. 77-D32, the Board suggested that intermediaries provide specific cost guidelines in the major cost reimbursement areas for home health agencies serving only medicare beneficiaries. We expect intermediaries to employ any measures they believe necessary within the authority set forth in the law and implementing regulations to assure that providers are reimbursed only the reasonable cost of providing services. We also support actions taken by intermediaries to furnish guidance to providers in incurring only those costs which, in the opinion of the intermediary, are reasonable, thus minimizing year-end cost report adjustments. To assist intermediaries in making these reasonable cost determinations, we have issued several intermediary letters, including IL Nos. 78-16 and 78-39. Also, we have always stressed, most recently in IL 79-14, that a provider should never wait until the end of its cost reporting period to consult with its intermediary but rather should do so on a current basis regarding the allowability and reasonableness of costs that it plans to incur.

While an intermediary does not have the authority to apply its own cost limits in specific cost areas, we would encourage intermediaries to develop guidelines and to use other such tools in assisting them in determining reasonable costs. As you know, to supplement these intermediary activities, HCFA is already applying cost limits to control overall home health agency costs and has placed a high priority on developing limits to control administrative costs incurred by home health agencies.

Question 18. The committee is aware of instances where medical records (nursing notes) have been changed to make sure medicare reimbursement would continue, even though the patient may no longer need home care. (A) Is the Department reviewing nursing notes as part of a focused audit? (B) How prevalent is this problem? (C) Is HCFA considering medical audit guidelines which would routinely address such practices?

Answer. We do not have data on the extent of the problem of altered nursing notes. However, some intermediaries are now reviewing nursing notes as well as

visiting patients as part of an onsite medical audit of HHA services. We are currently preparing medical audit guidelines which would require all intermediaries serving HHA's to perform medical audits according to specific instructions.

Question 19. Are home health agencies required to carry out a formal program of utilization review as did hospitals prior to the professional standards review organization program? If not, why not?

Answer. Our regulations (405.1229(b)) require that, at least quarterly, appropriate health professionals of the home health agency review a sample of both active and closed clinical records to assure that established policies are followed in providing services. Also required is a continuing review of clinical records for each 60-day period that a patient receives services to determine adequacy of the plan of treatment and appropriateness of continuation of care.

Since the statute (1861(k)) specifically required utilization review of hospitals and skilled nursing facilities, but omitted home health agencies, the Department felt constrained to use the term in regulations in applying the clinical record review to home health agencies.

Question 20. You advised GAO that you planned to issue instructions to intermediaries to intensify review of medicare claims submitted by proprietary and private nonprofit home health agencies. Was this done? What have you learned from this intensified review?

Answer. Some intermediaries are now performing intensified review of proprietary and private nonprofit agencies. The medical records audits outlined in response to question 18 include a means of ranking HHA's to assure that the audits are performed in the most suspect HHA's. Generally, these will be proprietary and private nonprofit agencies because of their high medicare utilization, high average number of visits per patient and high denial rates.

Question 21. You issued home health limits on a per visit, aggregate basis 2 months ago. How much money will these limits save for the remainder of this year and next?

Answer. Home health agency cost limits were effective for cost reporting periods beginning on or after July 1, 1979. HCFA estimates that $2.5 million will be saved in the fiscal year ending September 30, 1979, and $20 million will be saved in the fiscal year ending September 30, 1980.

Question 22. What steps are you taking to develop cost limits by type of visit? Will you be able to set such limits?

Answer. The HHA cost limits effective July 1, 1979, were developed and published by type of visit. Separate limits were set for each of the six home health services reimbursed under medicare; skilled nursing care, physical therapy, speech therapy, occupational therapy, medical social services and home health aide services. However, the limits could not be applied directly to each type of service because many home health agencies use a method of cost finding which results in an average cost for all services. HCFA is planning to require HHA's to report costs on a per discipline basis which when effective will enable application of HHA cost limits by type of service. We anticipate the effective date for reporting costs by discipline to be cost reporting periods beginning on or after April 1, 1980.

Question 23. In response to GAO's report, HCFA stated that it would study the feasibility of setting administrative cost limits.

(A) What has your study revealed?

(B) Do you plan to develop administrative cost limits and for what type of expenses?

(C) When will these limits be proposed?

Answer. Analysis of administrative cost has been severely hampered by the lack of uniformity in the way home health agencies report costs under the medicare program. The multiple cost reporting methods used by home health agencies make it very difficult to draw reliable comparisons. Nevertheless, HCFA has extracted a large volume of administrative cost data from medicare cost reports to determine what expenses may warrant specific limits and how best to determine limits.

Although comparison of home health agency administrative costs based on currently available cost report data is difficult because of the variety of cost reporting methods used, HCFA is placing high priority on developing a means of controlling excessive home health agency administrative costs. However, we are unable at this point to predict when these limits will be proposed.

Question 24. In response to GAO's report you advised GAO that the uniform method of reporting cost would include specific reporting for employee salaries and fringe benefits. This recommendation was not adopted. Why not? How can an intermediary develop total compensation (wages and fringe benefits) per employee when such a reporting requirement does not exist?

Answer. The GAO recosmmendation in question was that HFW, "require that home health agencies provide specific reporting on the salaries and fringe benefits furnished to individual employees." We believe that requiring home health agencies to report the salaries and fringe benefits of each individual employee would be excessively burdensome, would be impractical and unnecessary and would constitute the creation of a system of records that would be covered under the Privacy Act. From a practical standpoint, the gathering of salary and fringe benefit information for each individual employee would produce more information than would be meaningful or useful. Rather, we think that gathering salary and fringe benefit data by functional cost center in the aggregate and individually for key employees, administrators and owners would be meaningful and useful. We believe this would be adequate as virtually all the abuses that have come to light involve only the key employees (administrators, medical directors, directors of nursing, etc.).

Revised cost reporting procedures under development will require the reporting of salary and fringe benefit information for each cost center. In addition, we are considering revising the reporting requirements to include the individual salaries and fringe benefits of key employees, administrators and owners.

Question 25. You said you would issue regulations to limit the number of cost finding methods to one, rather than four. When will this be done?

Answer. The proposed regulation for nonprovider based home health agencies which would allow only one method of cost finding and cost apportionment is currently scheduled to be issued in the near future. We plan to make this proposed regulation effective for cost reporting periods beginning on or after April 1, 1980.

Question 26(C). Will the draft home health reporting system be revised before proposal?

Answer. There are anticipated changes to be made to the draft home health reporting system; however, these discussions are still in progress.

Question 27(A). In Mr. Kennedy's testimony he pointed out that HCFA is developing a home health Cost Report Evaluation Program. How will this Cost Report Evaluation Program work?

Answer. Each HCFA regional office reviews a statistically representative sample of all HHA cost reports settled by intermediaries during the year. This is a review of the intermediaries' professional judgment made by accountants and reimbursement staff in reviewing and auditing cost reports and applying the medicare regulations on reasonable cost reimbursement. The home health agency cost report evaluation program (HHA–CREP) provides a uniform approach to measuring the quality of intermediary performence in cost report settlements, that will permit eventual ranking and comparisons of performance. CREP also leads to the discovery and appropriate adjustment of significant dollar errors in the cost reports.

Question 27(B). "Will this program attempt to assess the scope of the audit actually done?"

Answer. The methodology of CREP is to ask a series of objective type questions in order to rate each intermediary equally and uniformly. Therefore, through the series of questions the scope of the audit is reviewed. If the intermediary has not included an area for review in the scope of audit, the RO will give a negative score.

Question 27(C). How does the cost report evaluation program differ from your focused audits?

Answer. The HHA–CREP differs from the focused audit in two material aspects. First, the focused audit reviews approximately 12 specific problem areas, while the HHA–CREP looks at the entire audit and cost report settlement process. Second, the focused audit reviews only the 100 percent medicare providers. The HHA–CREP program is designed to review all types of HHA's, on a statistically valid sample basis.

Question 27(D). How many intermediaries have you reviewed, and what have you found?

Answer. At the present time HHA–CREP is only in the pretesting stages. We have commitments from the regions to look at 28 intermediaries and central office personnel will review one intermediary during pretesting. Pretesting is still in process and we anticipate results will be available January 1980.

Question 28(A). During previous hearings HCFA stated additional funds would be made available for home health audits. How much additional will be spent?

Answer. The incremental costs to perform intensive full scope audits in Florida is $144,270. Nationally, additional audit funds have been made available for HHA's.

Question 28(B). Are planned audits full scope or limited scope?

Answer. The planned audits in Florida will be full scope in most instances.

Question 29(A). Mr. Kennedy's testimony mentioned a program integrity special initiative to do focused audits of home health agencies in Florida. What other States will be included?

Answer. HCFA will do full scope audits in many instances of home health agencies in those States where the services of the home health agencies are primarily utilized by medicare/medicaid patients. We are currently discussing with the regions those areas necessitating special HCFA efforts.

Question 29(B). Is this part of HCFA's plan to do additional audits of home health agencies as referenced in Question 28, or is this an additional initiative?

Answer. This is an additional initiative.

Question 29(C). Please describe the scope of the audits planned.

Answer. The planned audits will be full scope in most instances.

Question 29(D). Why are these audits going to be monitored by program integrity rather than contractor operations?

Answer. These audits are under the director of the regional contractor operation staff and are going to be monitored both by program integrity and program operations.

Question 29(E). Will this effort replace or supplement areas to be audited that are developed as part of the desk review?

Answer. This audit effort will supplement areas to be audited that are developed as part of the desk review.

Question 30. GAO in its report recommended that your require intermediaries to routinely test provider adherence to the documentation requirement. Will this recommendation be implemented? When?

Answer. Effective November 1, 1978, HCFA included in its guidelines for provider audits (part A Intermediary Manual, section 2001) the "Standards for Audits of Governmental Organizations, Programs, Activities, and Functions" issued by the Comptroller General of the United States. Under the standards for examination of the provider's records, there appears the following:

E. ADEQUATE EVIDENCE MUST BE OBTAINED

1. *Sufficiency, Competence, and Relevance of Evidence.*—Evidence obtained to support conclusions and recommendations must be sufficient, competent, and relevant to afford a reasonable basis for the auditor's opinions, judgments, conclusions, and recommendations. Sufficiency of evidence is the presence of enough factual and convincing evidence to lead a prudent person to the same conclusion as the auditor. When there is conflicting evidence, the auditor must make a judgment as to what position is supported by the weight of the evidence. When appropriate, statistical methods should be used to establish sufficiency. Competent evidence is reliable evidence and the best attainable through the use of audit methods. The most competent evidence is that obtained directly through observation and examination, from original documents, and under a good system of internal control, Relevance means the evidence has a logical relationship to the issue involved.

2. *Types of Evidence.*—Regardless of the type, the evidence must meet the basic tests of this standard—sufficiency, competence, and relevance, Evidence needed to support audit findings may be:

a. Physical evidence obtained by observation, photograph, or similar means,

b. Testimonial evidence obtained by interviewing or taking statements from involved persons,

c. Documentary evidence consisting of letters, contracts, extracts from accounting records, etc., and

d. Analytical evidence secured by analysis of information obtained.

Question 31. GAO found that expenses they considered to be abusive are often found throughout the cost report. How will specific auditing of the 12 areas specified in Mr. Kennedy's testimony solve this kind of problem?

Answer. It is true that abusive practices may be concealed throughout a cost report. However, we believe that focusing our limited audit resources in those areas where abuse is most often found will produce the greatest benefit in controlling costs. For example, we anticipate that the audit adjustments relating to nurse coordinators in the State of Florida for 1 year will be about $3.1 million.

Our uniform audit program addresses approximately 12 audit areas where reviews should be intensified. To date this approach has been used on four reviews by the Bureau of Quality Control (BQC) and three reviews by Blue Cross. The BQC audit adjustments total approximately $387,000 and the Blue Cross audits have determined that $300,000 in costs should be disallowed. Previous audit adjustments to all seven of these HHA's were minimal.

Our audit effort is requiring intermediaries to conduct in depth audits similar to the audit effort in hospitals. Based on the three Blue Cross reviews conducted utilizing our focused audit approach, the cost benefit ratio of performing the audits was 30 to 1 compared to the normal cost benefit ratio of 5 to 1 for other HHA audits (current audits are uncovering $30 dollars in questionable costs for each dollar spent).

If this effort proves to be successful, as we believe it will based on preliminary results, we may expand the audit effort to require all intermediaries to utilize this focused approach. We would always encourage the intermediary to review other areas in the cost report, where it had reason, through complaints or other information, to believe that abusive practices were present in those areas for those providers.

Question 32. Deputy Inspector General Lowe testified that the Department is considering changes in legal fee payments. Currently medicare pays unlimited legal fees. This payment can be made even for legal expenses incurred for defense against a government action. (A) What appropriate action should be taken to limit such payments? (B) How much would the medicare program save?

Answer. Currently medicare policy does not provide for reimbursement of unlimited legal fees; rather, reimbursement is limited to those legal costs which are both necessary and proper to the delivery of patient care and reasonable in amount.

HCFA is presently reviewing its policy on the entire area of reimbursement of legal fees. The number of actions requiring legal expertise which are undertaken by home health agencies and other providers of medicare services is continually increasing. A major portion of such actions involve appeals on medicare issues. As a result, an increase is occurring not only in the cost of legal fees incurred by providers but for HCFA in defense of those cases. HCFA recognizes that definitive steps must be taken to discourage frivolous or unnecessary appeals by providers and to establish rules for evaluating the reasonableness of the fees incurred.

Question 33(A). Section 14 of Public Law 95-142 allows the Secretary to designate an intermediary to serve a class of providers to promote more effective and efficient administration of the program. Does HCFA feel there are differing levels of home health expertise among intermediaries? How can this expertise be evaluated?

Answer. Yes. These differing levels may be the result of a number of variables or combinations thereof. Among the factors which may influence these levels are:

(1) the number of HHA's serviced by the intermediaries;

(2) the percentage of total business with HHA's as compared to business with other types of providers;

(3) depth of review in the bill process; and

(4) management resources.

The expertise of intermediaries to service HHA's is evaluated through the contractor inspection and evaluation program which is conducted on an ongoing basis. Also, we have developed a structured HHA cost report review program similar to that developed for hospitals to assure consistent nationwide application of policy. The HHA cost report program is now being field tested in most regions. This report program is designed to objectively evaluate a sample of HHA reports and provide input into the annual contractor evaluation reports.

Question 33(B). What is the minimal number of home health providers an intermediary should serve to do a satisfactory job and develop the needed expertise in the area?

Answer. We doubt there is a particular number that points to success or failure in effectively reimbursing HHA's. The problem is for intermediaries to adjust their audit resources to more closely scrutinize problem type HHA's.

Question 33(C). Does HCFA consider it feasible to develop a separate intermediary system to serve home health only?

Answer. As we indicated in our response to 33(A) above, the issue revolves around intermediary expertise in processing HHA claims and determining appropriate costs. This may be accomplished by having an intermediary service HHAs and at the same time handle the workload being received from other provider types, or it may in some instances mean an intermediary servicing only HHA's. We are exploring the approaches to this issue and will study the results of the various approaches.

ITEM 3. LETTER FROM SENATOR LAWTON CHILES, TO J. V. ESKENAZI, U.S. ATTORNEY, SOUTHERN DISTRICT OF FLORIDA, DATED SEPTEMBER 7, 1979

DEAR JACK: I appreciate the time and effort you and your staff put into your appearance before the Committee on Aging on August 28.

I am encouraged by the activities undertaken by your office in regard to fraudulent activities in the medicare home health program. Your offer to have staff informally share investigative results with committee staff is much appreciated and I have asked Kathleen Deignan of the committee staff to keep in touch with your office.

In addition, I would appreciate it if you could provide the complete "Criminal Division Statement on Fraud in HEW's Home Health Care Fraud Matters" you referenced for our hearing record.

Once again, I appreciate your participation in our hearing and I look forward to working closely with you as you pursue your investigations.

Sincerely,

LAWTON CHILES, *Chairman.*

ITEM 4. LETTER AND ENCLOSURE FROM J. V. ESKENAZI,[1] U.S. ATTORNEY, SOUTHERN DISTRICT OF FLORIDA, TO SENATOR LAWTON CHILES, DATED OCTOBER 31, 1979

DEAR SENATOR CHILES: Please excuse the delay in responding to your letter of September 7, 1979, in which you requested the complete "Criminal Division Statement on Fraud in HEW's Home Health Care Fraud Matters" as referred to on page 10 of my prepared statement before the Senate Special Committee on Aging on August 28, 1979. The original text had been inadvertantly misplaced and it was necessary to obtain a copy from Department of Justice files.

The statement, the complete text of which is enclosed, was prepared by the Criminal Division of the Department of Justice for inclusion in my prepared statement before your committee.

If I can be of any further assistance to you in this matter, please do not hestitate to contact me.

Yours very sincerely,

J. V. ESKENAZI,
U.S. Attorney.

Enclosure.

CRIMINAL DIVISION STATEMENT ON FRAUD IN HEW'S HOME HEALTH CARE FRAUD MATTERS

In the past several years there have been significant increases in the numbers of investigations and prosecutions in connection with fraud in health care programs. This increase is due to special efforts by both the FBI and the Inspector General of HEW. In his last report, the Inspector General advised that over 66 percent of his manpower is devoted to health care investigations. The Bureau reports a total of 1,173 matters pertaining to frauds committed against the Department of Health, Education, and Welfare during the first three quarters of fiscal 1979, ending June 30, 1979. During that time frame a total of 152 convictions with such fraud matters was recorded by the FBI, consisting of 121 felony violations and 31 misdemeanors. As of June 30, 1979, the Bureau had a total of 793 such cases under investigation with a pending status.

In 1976, the Senate Committee on Aging referred to the Department of Justice allegations of fraud in the home health care program in Northern Carlifornia. A very difficult joint HEW/FBI investigation has resulted recently in a guilty plea by the home health care agency's chief financial officer, who was a former employee of the intermediary. That investigation and a second similar investigation in the same jurisdiction are continuing. Prosecutive staff are being supplied by both the U.S. Attorney in the Northern District of California and the Fraud Section of the Criminal Division.

For the past 2 years, a second home health care investigation has been ongoing in the Southern District of Florida. That investigation, staffed jointly by the USA's office and the Fraud Section is presently before a Federal grand jury. In addition, the U.S. Attorney in Miami is staffing several other fraud investigations involving home health care. These investigations are the result of referrals from the Inspector General of HEW.

These experiences have given the Department of Justice a variety of insights into the home health care program structure, regulations and procedures. There should be no doubt that simply due to the very nature of the program—health care services in the home—fraud investigations are very difficult. Further, due to the wide scope

[1] See statement, page 34.

of the program, broadly worded regulations which are designed to insure program flexibility make the prosecution of these investigations most difficult. Finally, the key role of the intermediaries in the administration of the program complicate the investigations.

We are unable at this time to speak specifically about the pending investigations which are largely the source of our knowledge on the home health care program. The Fraud Section of the Criminal Division has assigned four attorneys to these cases and has made a broad commitment to the Inspector General of HEW so support his programs.

The Inspector General of HEW is very familiar with the difficulties in these investigations and the program weaknesses the investigations have revealed. We would defer to his observations in this regard.

The Criminal Division is committed to the success of the HEW Inspector General's investigation programs; health care and home health care fraud cases in particular, are one of our highest priorities. As Senator Chiles is particularly aware, GSA and Defense Department matters also require high prosecution attention.

At the conclusion of the investigations presently staffed by the Fraud Section, the attorneys assigned will be made available to the staff of the committee to share, within permitted procedures, the results of the investigation.

ITEM 5. LETTER AND ENCLOSURE FROM HON. SAM M. GIBBONS, CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, TO SENATOR LAWTON CHILES, DATED SEPTEMBER 6, 1979

DEAR SENATOR CHILES: I thank you for the invitation to participate in the field hearings held by your Senate Special Committee on Aging on the administration of the medicare home health program, held August 28 in Miami. Mr. Byron S. Galloway, the staff member on the Ways and Means Subcommittee on Oversight responsible for medicare issues, did attend and advised me about the hearing.

At your suggestions, I have enclosed a statement of my views on the medicare home health program for inclusion in the hearing record. It appears that we are in substantial agreement on many of the changes needed to tighten up program administration in home health and I hope we can work together in the future to make home health a better and more efficient program.

Sincerely,

SAM M. GIBBONS.

Enclosure.

STATEMENT ON THE MEDICARE HOME HEALTH PROGRAM BY CONGRESSMAN SAM M. GIBBONS, CHAIRMAN, OVERSIGHT SUBCOMMITTEE, HOUSE WAYS AND MEANS COMMITTEE

The Oversight Subcommittee has been involved in monitoring the medicare home health program since 1976. We have been continually aware of the program's excellent potential. Because care is provided in the familiar surroundings of one's own home, home health can represent a humane alternative to institutional care. Because room and board is not involved, it can also be more cost effective. However, we have also seen this potential repeatedly undermined by certain providers. The program simply does not need providers who seem more motivated by opportunism than altruism, who play a cat and mouse game with the Government to see how much the program can yield in personal gain, and who have little or no motivation to operate on a sound and efficient basis. I am pleased to share with you what the Oversight Subcommittee has learned about how the program has been abused and what controls are needed to counteract that abuse. My comments are being submitted as my own views, since we have not had an opportunity to hold oversight hearings on all of the issues I wish to discuss.

At the outset let me commend this committee for its continuing efforts to improve the care provided to the elderly under medicare. Home health is, of course, an important part of the medicare program. I've heard repeatedly from constituents how much they value the opportunity to receive needed care in the home setting. Thus, I give a high priority to making sure that adequate and good quality home health care is available to all medicare beneficiaries. However, with present budget constraints we must also make sure that medicare home health funds aren't wasted in funding inefficient and—what is worse—unscrupulous providers. That only robs the intended beneficiaries and it robs the taxpayers.

Several Members of Congress have proposed liberalizing the medicare home health benefit in various ways. I am sympathetic with this general intent, but I am convinced that we must move very cautiously in this direction. Not simply because of the costs, but more particularly because of the abuse potential that some of the liberalizations involve. I am afraid that some of the proposed liberalizations involve too great a risk of fueling abuse for us to be able to consider them at this time. We need to realize that right now the medicare home health program is wide open to abuse. We must, therefore, think through proposed liberalizations with a clear awareness of the dangers. At the same time, we must begin to attack the abuse that bedevils the program so that we can end the waste of our increasingly limited health resources.

I would like to comment on the liberalizations that have been proposed; I will speak in support of some and in opposition to others. However, before taking these up, I would like to review for you, in some detail, the reforms that I believe must be made to the medicare home health program right now, if we are to begin to get at the abuse that exists in the program. These reforms fall into three areas: Changes in the standards for participation in the medicare program; Changes in current home health reimbursement practices; and controls on utilization.

CHANGES IN THE STANDARDS FOR PARTICIPATION IN THE MEDICARE PROGRAM

The first change that is needed in the present standards for participation in the medicare program is to require new home health agencies to obtain a certificate of need in order to qualify for medicare payments. Certain areas already have too many home health agencies. Parts of our home State of Florida are just such areas. These excess providers drive up what medicare must pay for home health care services. Because medicare pays cost, not price, the continual creation of more, ever smaller home health agencies gives us none of the advantages of competition and all of the diseconomies of multiple, small operations. More and more overhead is spread over fewer and fewer patients. The General Accounting Office tells us that the number of home health agencies continues to rise.[1] We need to prevent what has happened in certain parts of Florida from happening around the country. We can do this by requiring that new home health agencies get a certificate of need from either the local HSA or HCFA.

We must also change present standards so that home health agencies will not be allowed to participate in medicare if the agencies accept no patients other than medicare eligibles and discontinue serving patients when their medicare benefits run out. I've already alluded to the problems and improper incentives that are created by the system of cost reimbursement that medicare uses. However, for those agencies that service some nonmedicare patients, these problems are lessened to some extent, i.e., the nonmedicare portion of their business often depends on their being able to provide services at a certain price. In contrast, the medicare-only agencies, the so-called "100 percenters," have almost a blank check from the Federal Government, since we pay basically whatever their costs are. We should end this situation and we should also act to assure an adequate supply of home health services to individuals who either don't have or have exhausted medicare home health coverage. Both of these things can be done by not allowing medicare only providers in the medicare home health program. I was pleased to see that this principle, which was added by the House Ways and Means Committee to H.R. 13097 last year has been included in H.R. 3990. I think we need to strengthen H.R. 3990 by also providing that agencies must obtain specific, minimum levels of nonmedicare business in accordance with an established timetable.

We also need to change the standards of participation to make sure that home health agencies participating in Medicare are adequately capitalized. There are too many cases where agencies that owe the medicare program money simply go bankrupt, close up shop and the program never collects. In the past, too many agencies have had no money but the Government's. Very often, everything is leased and the Government makes the payments. Eliminating 100 percenters is a partial solution, but what is also needed is to get the sponsors' own money involved so they have a real commitment and it is not just a paper corporation. Along these same lines, we must make sure that HEW controls the amount of interest on agency indebtedness that medicare reimburses. Too many agencies pay back the Government for overcharges with a loan the trust fund services. HCFA needs to carefully police agency borrowing.

Finally, we must assure good quality care by changing the medicare participation standards regarding home health agency employees. The Oversight Subcommittee staff has found that some agencies make contracts with separate entities in order to arrange for home health aide services for their patients. The staff has found that in these cases, aides are generally not supervised by the agency nurses as medicare program rules require. This has led to erratic quality and a breakdown in important care related communication between the nurses and the aides. I think this problem is inherent in situations where an agency contracts out to provide some of its services. We should change the participation rules so that agencies which employ such contracts are denied participation in medicare unless the Secretary grants a specific exemption. We also need to make sure that HEW better supervises the qualifications of agency employees. The oversight staff has discovered occasions of home health aides being given as little as 8 hours of "observation training" before being sent out to render patient services on their own. Medicare beneficiaries need and deserve better care than this. HEW should be required to establish and enforce minimum standards for a participating agency's training program.

[1] A report by the Comptroller General: "Home Health Service—Tighter Fiscal Controls Needed."

CHANGES IN CURRENT MEDICARE HOME HEALTH REIMBURSEMENT PRACTICES

We also need changes in current medicare home health reimbursement practices. First and most basically, we need to do something about the high per visit rates that many home health providers are charging the trust funds. I think prospective reimbursement can help in this area. I generally support moving to a system of prospectively determined reimbursement in our federally funded health programs. More specifically, however, I think we should move toward prospective reimbursement in the home health area as rapidly as possible. The home health provider should be told up front how much the Government will pay. I think this will aid the responsible providers and I think it will help control program costs. I intend to explore with HEW how we can most productively start down the road to home health prospective reimbursement.

But we must also do something right now to combat high home health costs. I had hoped that limits adopted pursuant to section 223 of the 1972 amendments could help in this regard. I still think they can, but I've been very distressed by the great liberality of the limits HEW has issued. I'm afraid the high limits that have been proposed are going to start a gold rush, with the agencies that now have moderate costs contracting the ripoff fever certain others have had. To stop this HEW must promulgate, for general intermediary use, tough screens along the lines of those developed by its own Division of Direct Reimbursement. It also should go ahead, pursuant to section 223, with sublimits on specific items of cost, such as general overhead and administrative salaries, since these components of an agency's costs are particularly susceptible to abusive expansion.

In addition to taking these steps to hold down overall costs, attention must also be given to specific reimbursement areas that are persistent problems. The first involves the practice of some agencies to contract out for management or consulting services. Some of these arrangements with third parties have come about because franchisors have entered the home health services area. This is a problem we focused on in H.R. 13097 last year. The situation generally involves a management consulting firm that for its part promises advice on how to start and run a home health agency, if the agency-to-be will pay x dollars up front and a percentage of its billings over the duration of a long term contract. Even though the promised assistance is seldom worth the amount negotiated, the agency owner is told not to worry because no more will really be charged than the Government will pay, so long as the agency owner cooperates by trying to get all he can.

H.R. 13097 took the approach of giving the Secretary discretion to deny medicare participation to providers who entered into contracts that were too expensive or too long term. This moves us in the right direction, but I think we need to strengthen our approach by requiring HEW review of contracts with abuse potential on a prospective, before-signing basis, by prohibiting management or consulting contracts that determine costs on a percentage of billings basis and by giving HEW access to the books of contractors so that HEW can correctly ascertain the value of rendered services. HEW's Inspector General agrees that access to such books is necessary to counteract abuse. Access to a contractors books and records can also help with another type of contract for management consulting services, the contract to a related organization. The Oversight Subcommittee has observed a pattern of certain nonprofit home health agencies contracting for services with related, for-profit organizations. These situations, of course, have the danger of being sweetheart contracts. While Congress provided in Public Law 95-142 for disclosure of ownership interests, there are more indirect types of relatedness that also can lead to abuse. Access to books would permit detection of such indirect, but still significant relationship and would permit testing of compliance with existing disclosure rules.

HCFA also needs to improve its published guidelines on related organizations. These are the guidelines used by intermediaries in making reimbursement decisions, but the present guidelines are so vague and general that they do not really assist intermediaries, nor do they serve to guarantee uniformity of application. I have written to HEW on this and have made specific suggestions for improvement.

Another specific reimbursement area that has been subject to abuse and needs congressional attention is provider attorney fees. Presently when a provider litigates with the Government over whether it was properly reimbursed, its legal fees are treated as a reimbursable cost. If the agency is a medicare only agency, then medicare is reimbursing 100 percent of the agency's legal fees. This is true no matter how many times the agency appeals, and whether the agency wins or loses. In addition, agencies often hire the very best and brighest and the most expensive. Several Florida agencies hire the same New York lawyer. He merely flies down as the need arises, the Government pays the bills. Congress should allow routine reimbursement of attorney's fees only through the administrative phase. If the agency appeals to court, reimbursement should be allowed only if the agency prevails in significant part. Moreover, attorney's per hour charges and expenses should be limited to reasonable amounts with a fixed dollar ceiling on the total amount reimbursable. In cases where the Government is prosecuting someone for criminal fraud, medicare should not reimburse for attorney's fees at all. This is not an operating cost. Cumulatively, these changes would correct the present imbalance in this area.

CONTROLS IN UTILIZATION

New controls on utilization are also badly needed. This was another area where problems were recognized by provisions in H.R. 13097. GAO's work for the Oversight Subcommittee has made clear that some agencies routinely give each patient the maximum number of visits that can be passed off. Since present review is very limited and depends on the individual intermediary, in many places this means utilization is quite high. HCFA should be required to develop national utilization screens, as was called for in H.R. 13097. However, this should be backed up by required checks of patient medical records as well as actual sample visits to agency patients.

In addition we must stop wholesale patient solicitation by home health agencies. H.R. 13097 included and important step in this direction by prohibiting a physician from certifying a plan of home health treatment if the physician had an interest in the provider agency. It also called upon HEW to consider steps to end the control that certain home health agencies have over the discharge planning function of hospitals. I've instructed the staff of the Oversight Subcommittee to study whether some, very limited PSRO review might not help in this area. Some outside control seems necessary. At present there is nothing to stop very cozy, and thus very costly, relations between hospitals and home health agencies.

I also believe consideration needs to be given to reinstituting copayments for home health care. Utilization is always a difficult problem in situations where the consumer of health care has no incentive to hold down the amount of care consumed. Some very modest copayment could provide the patient and his family with some incentive not to accept excess care, without really amounting to a financial burden. To minimize the cumulative burden in serious, long-term cases, the copayment could phase down as the number of visits rose. In addition, if prospective budgeting for home health agencies were introduced it would be easy to provide a variable copayment that would require patients to pay more for services from the less efficient or abusive home health agencies that have high service costs.

These are the reforms that I believe are necessary. Some of them were contained in H.R. 13097 last year and have been retained in H.R. 3990.

As I've stated, reforms to prevent abuse must be given the highest priority. If we mandate such reforms, then I think we can consider certain modest liberalizations. However, some of the liberalizations that have been proposed should be rejected as too dangerous and too potentially wasteful for adoption at the present time.

First, the liberalizations that I support. I support removal of the three day prior hospitalization requirement for part A home health benefits.[2] This requirement does not have a significant prophylactic justification presently, and thus can be eliminated. This would benefit certain people who there seems little reason to disadvantage now.

I think we also can allow certain single service providers to enter the medicare home health program. In some nonmetropolitan areas, home health agencies pro-

[2] Elimination of this requirement would, of course, be coupled with elimination of the requirement that treatment received by beneficiaries be related to their hospital or skilled nursing facility stay.

vide only a single skilled service. They cannot participate in medicare because they don't satisfy medicare's two service rule. If an agency of this type is the only home health agency in the area, then that area has no medicare home health services. I think we can change this without engendering abuse problems, and thus achieve greater medicare services in currently underserved areas. These agencies should still be required to provide a skilled service, but the Secretary should have discretion to allow such nonmetropolitan agencies to participate in medicare even though it's only a single skilled service that they provide.

These are the liberalizations I support. Other liberalizations have been proposed that I cannot support, as I am convinced that the program cannot afford them at this time. I am opposed to the elimination of the homebound requirement. If a medicare beneficiary can visit an ambulatory center, then there is no need to spend the additional money it takes to bring the care to that person. The homebound standard is a rough-and-ready one, but it's one that medicare patients understand and that can prevent abuse by utilization-prone providers.

I am opposed to elimination of the skilled care requirement. From an abuse point of view, this one is very dangerous. It plays right into the hands of those agencies that presently give 8-hour home health aide visits three times a week. If such aide visits no longer have to be related to the provision of skilled care, I'm afraid the lid will be entirely off.

I am opposed to adding homemaker care services to medicare right now. If we're going to move in that direction, it should be through the merger of the various types of federally funded home care. To just add it to medicare without such a basic restructuring would merely create a disorganized and costly duplication of title XX services.

I strongly oppose the above changes. Further, I also question the advisability of eliminating the twin part A and B 100 visit limits. At the old-time home health agencies we've examined, there is generally no problem providing medicare beneficiaries with fully adequate care within these limits. However, at some of the new, fast-buck agencies that have entered the program in recent years, the limits are often hit for types of cases that traditionally have not required high utilization. At the same time, I'm very sympathetic to the fact that there may be occasional cases that really need more than 200 visits. Perhaps we should establish a lifetime reserve pool of extra visits that a beneficiary could draw from in exceptional circumstances. However, I am very reluctant to drop the basic, annual limits given the enfeebled status of existing mechanisms to control home health utilization.

Appendix 2

CODE OF ETHICS OF THE FLORIDA ASSOCIATION OF HOME HEALTH AGENCIES, INC.[1]

Preface

The code of ethics is administered by the ethics committee, which is elected by the general membership upon nomination by the nominating committee. It is composed of five members, one from each region in the State of Florida.

The ethics committee shall:

Create the initial code of ethics and standards of practice.

Create the procedures for disciplinary action.

Establish such further responsibilities as it deems proper for approval by the general membership.

The ethics committee creates and invokes the code of ethics under authority of the FAHHA by-laws, article II, membership, section 3.e, which states:

Membership shall be cancelled by a two-thirds vote of the entire membership for conduct detrimental to the association in accordance with applicable law and after an opportunity for a full and fair hearing.

Preamble

The most serious responsibility inherent in membership in the Florida Association of Home Health Agencies is that the members adhere to and comply with the highest ethical code of behavior in all personal and business conduct. For any member to do less is not only to place in jeopardy his own integrity and business operation; but, also that belonging to all his fellow association members.

The foregoing demands that each and every member of the Florida Association of Home Health Agencies continuously maintain self-surveillance that will identify potentially unethical behavior and self-discipline that will eliminate the possibility of engaging in any such conduct. It further demands that, if and when unethical behavior does occur, each member be prepared to take whatever action is necessary to eliminate the continuation of this behavior.

The FAHHA code of ethics is designed to minimize the opportunity for unethical behavior by:

Creating broad guidelines which establish a fixed base of ethical conduct;

Establishing certain specific acts which are considered unethical;

Applying these guidelines and restricted acts to individual members on a case-by-case basis; and

Holding accountable for unethical behavior the top-level management of the member against whom a meritorious complaint has been unfavorably adjudicated.

No member, regardless of any position held in FAHHA, is above this code. Members' dealings, whether internal or with one another, or with the multiplicity of institutions and agencies involved in home health care, are subject to being tested against the standards created in this code.

The Ethical Standards of Practice

I. GENERAL PRINCIPLES

1(a) Members shall place first loyalty to the patients whom they serve.

(b) Purpose.—The patient's welfare must be the primary motivation in our work. This means, for example, that (i) We strive to create an environment that is conducive to a speedy recovery and individually tailored to the needs of each patient; (ii) We acknowledge and respect the social practices, cultural heritage and religious beliefs of each patient; (iii) We respect, at all times, the patient's right to confidentiality in communication and medical records; (iv) We strive to develop and maintain health-care independence of the patient and his family to the greatest extent possible.

2(a) Members shall promote and support cooperation among all health providers and community agencies in the locality.

(b) Purpose.—As home health providers, we are a segment of an industry which must concern itself with the overall health status of all the citizens in the community. This concern can only be realized in a tangible manner if the various providers and community agencies aid one another in patient assessment, transfer and treatment.

3(a) Any report or communication to the public shall accurately and fairly state the facts relevant to the message conveyed. The member's public image shall reflect what in fact is the member's position.

(b) Purpose.—Public relations communications which are untrue or susceptible to being declared "inoperative" at some future date are self-destructive and injurious to the home health care program. All public utterances must merit the public's confidence. Thus, dissemination of false and/or misleading information by a home health agency regarding another agency or health care provider must be considered an unethical practice.

4(a) Members shall, in sum, exercise fairness, honesty and impartiality in all professional activities and relationships.

II. SPECIFIC ACTS

A. Internal Affairs

1(a) Members shall not compromise the home health care concept by payment to anyone that unjustifiably exceeds the compensation levels behind paid in the member's geographical area or by the reasonable medicare guidelines when issued, various institutions to employees of similar skills and/or whose jobs require similar effort and/or responsibility.

(b) Purpose.—(i) Excessively high levels of compensation are unfair to the home health program because it derives costs up; (ii) this in turn is unfair to the patient because the public comes to scorn the program which eventuates in the program's curtailment or perhaps, its abolishment; (iii) it is unfair to all other health providers in the area because it drains off the skilled and/or trained personnel pool they spent years developing.

2(a) Members shall deliver the appropriate level of care at the appropriate frequency—thus avoiding both overutilization and underutilization.

(b) Purpose.—(i) Overutilization results in promoting the dependence of the patient and/or family on the agency and, further, exhausts in a short period of time the coverage benefits of the patient, and this is to be avoided for the reasons cited above at 1(b), and (i); (ii) underutilization is unfair to the patient since he has the right to receive the full degree of medical care available to him under the program by virtue of which he receives treatment. To do less is to place institutional loyalty over patient loyalty.

3(a) Members shall maintain at all times adequate staffing, properly and continuously trained and supervised, to meet the reasonable needs of all the patients to whom they render care.

(b) Purpose.—Each member's reputation is built primarily on the conduct of its staff. A deficient staff, whether in quantity or quality, reflects poorly on the member itself directly and on all its fellow association members indirectly.

4(e) Members shall comply with all official applicable laws, rules and regulations.

(b) Purpose.—Each member's reputation is directly and adversely affected by its failure to adhere strictly to relevant governmental directives. This conduct, again, indirectly affects adversely the reputation of its fellow members.

5(a) Members shall not interfere with the operation of any other member agency by acts such as libel, slander, including employees to breach existing contracts, shall be subject to censure.

(b) Purpose.—Top-level management must be entrusted with a myriad of confidential information, the divulgence of which to a "friendly" competitor would unfairly and adversely affect the original employer. Thus, a contract designed to reasonably curtail the divulgence of this information should be honored by the membership.

6(a) Members shall not pay expenses for agency personnel for travel and entertainment that exceed the reasonable norm.

(b) Purpose.—See section 1, b, (i) and (ii) supra.

[1] Submitted by Judith M. Travis, whose statement appears on page 44.

7(a) No member shall, directly or indirectly, pay entertainment expenses on a regular and/or customary basis to or on behalf of any individual who is not a bona fide member of the agency's own personnel with the object of receiving preferential treatment and patient referrals.

(b) Purpose.—It is not in keeping with the philosophy of a nonprofit home health agency to incur and/or pay these entertainment expenses for nonagency personnel.

B. External Relationships

1(a) Members shall not engage in any course of conduct which involves interference or intrusion in the operation or affairs of any other agency so as to give it an unfair trade advantage or cause injury to such other agency; nor, shall any member engage in payment of any bribe, favor, inducement, or thing of value to any person engaged in health care the purpose or effect of which is to recieve referrals of patients; nor, shall any member obtain or seek to obtain any patient information from any health provider except in the normal course of business and shall further maintain the confidentiality of any patient information obtained.

(b) Purpose.—Conflict of interest arises whenever the individual involved in the decisionmaking process is faced with two or more contradictory loyalties. Such a situation is unfair to ther persons or institutions to whom the decisionmaker owes conflicting loyalties as well as unfair to the decisionmaker himself. In the health field such conflicts are even more unacceptable than is the case in other business since the patient inevitably suffers. The patient depends upon and is owed complete loyalty by the health provider charged with his care.

(c) Examples.—Specifically, conflicts of interest actually or potentially arise when a member:

(i) Pays compensation, in any form, to any social service or worker or discharge planner employed by a hospital, nursing home or state agency whether in an employment, contractual or consultant relationship to the member.

(ii) Involves a social service worker or discharge planner employed by a hospital, nursing home or state agency in the affairs of the member's business such as making said worker or planner a member of the member's Advisory Board even if no compensation is paid.

Exceptions.—Sections (i) and (ii) above do not preclude the use of any such worker or planner for an in-service to the member's personnel so long as there is no regularity to such use, the frequency of such use does not exceed more than one such in-service in 4 months, and the fee paid is that regularly and customarily paid to other in-service instructors.

In those geographical areas where qualified personnel are in short supply, sections i) and ii) above shall not apply.

(iii) Attempts to obtain and/or willingly receives business information about any other member from a common supplier.

(iv) Without disclosures as set forth below, contracts with, pays monies or grants anything of value to, or accepts gifts and/or services from any other business organization with and/or in whom the member's owners and/or top management personnel have a pecuniary interest. Such contracting, paying granting and/or accepting shall be done only after the member divulges said pecuniary interest to the ethics committee which shall file said information and make some available to any member who requests it.

(v) Receives information regarding patient admissions and/or discharges from therapists and/or other staff members of a hospital, nursing home, clinic and/or other health provider who are also employed by or under contract to the member agency. Divulgence and acceptance of such information is contrary to the principle of confidentiality of patient information, constitutes an unfair competitive practice and is unethical.

(vi) Visits patients in hospitals or nursing homes to solicit referrals to provide home health services on discharge with or without given or implied consent of administrative or other facility personnel. Visitation to such patients must be restricted to: (1) Visits made to a former patient of said agency; (2) visits made to provide predischarge planning for an individual patient on whom the agency has already received a physician's or social worker's or discharge planner's referral for home health care.

(vii) Visits and/or opens a patient record on a patient with knowledge that the patient has been referred to or is being seen by another home health agency.

2(a) Members shall, at all times, show respect and act temperately in their dealings with their fellow members.

(b) Purpose.—The Association shall be effective and worthwhile only to the extent each and every member cooperates one with another. Spreading gossip and arbitrarily refusing reasonable committee requests are actions which are unethical and self-destructive.

3(a) Members shall, at all times, show respect and act temperately in their dealings with the leadership of the Association and the leadership shall do likewise in dealing with the members.

(b) Purpose.—See section 2(b), supra.

4(a) Members shall promptly pay all monies owed the Association and they shall participate to the fullest extent possible, in a generous spirit, when assigned and/or/voluntarily undertake to perform tasks for the Association.

(b) Purpose.—The Association is simply a collection of members who have joined together for a common goal. Each member must contribute monies and talent if the Association is to succeed. It is not fair to those members who do contribute, if others get the benefits of their efforts and yet pay no price.

5(a) Members who have ethical complaints about other individuals shall adhere strictly to the complaint adjustment procedure.

(b) Purpose.—Ethical complaints must be resolved in an efficient and fair method. Complaining about another member's ethics outside the complaint adjustment procedure parameters is destructive and nonproductive.

6(a) Members shall not provide unnecessary and/or nonordered durable medical equipment.

(b) Purpose.—See section (A), (1), (b), (i), and (ii), above.

III. DISCLOSURE

The name and addresses of the member's owner, board of directors, excecutive officers, and resident agent shall be filed with the ethics committee and kept current.

IV. REPRISALS

Members shall not take reprisals against, nor adversely affect in any manner, anyone who files a complaint under the ethics complaint adjustment procedure.

Purpose.—The code of ethics will only be effective to the extent that potential complainants know they are protected by the code of ethics. Reprisals are simply intolerable.

V. DISTRIBUTION

A copy of the code of ethics must be placed in the agency's policy manual and made available to all agency personnel at all reasonable times.

Ethics Complaint Adjustment Procedure

I. THE COMPLAINT

(1) To be processed it must:

(A) Be in writing, signed and sworn to;

(B) Specifically allege and factually support the unethical conduct charge;

(C) Be filed with the regional ethics committee member (RECM) with seven (7) copies of it and supporting documentation, if any. If the person complained about is the RECM, the complaint shall be filed with the ethics committee chairman.

(2) Processing of the complaint:

(A) The RECM, after receipt of a valid complaint, shall within five (5) days:

(i) Forward copies of the complaint and any supporting documentation to the other six members of the ethics committee;

(ii) Forward, by certified mail, return receipt, a copy of the complaint and any supporting documentation, with the complainant's name deleted, to the respondent agency's administrator or executive director.

(B) If the RECM initially determines that the complaint and supporting documents lack the required specificity or any otherwise deficient, RECM shall, within three (3) working days, return the original complaint and any supporting documentation along with the seven copies to the complainant with a written statement setting forth the deficiencies. In this event, no further action shall be taken by RECM until:

(i) The complainant refiles all the papers with the deficiencies corrected within twenty (20) days; or

(ii) The complainant successfully appeals to the full ethics committee by mailing, within three (3) working days of receipt from the RECM, the complaint with any supporting documentation and the RECM's deficiency notice to each member of the ethics committee requesting that the committee find his complaint and supporting

documentation sufficient to be processed, and the committee, by majority vote, agrees with the complainant.

II. THE RESPONSE TO THE COMPLAINT

(1) To be processed it must:
(A) Be in writing, signed and sworn to;
(B) Specifically deny each factual allegation, if untrue, and specific allegations not denied shall be thereby deemed to be admitted as true (general denials are not accepted);
(C) Be filed with RECM with seven (7) copies of it and any supporting documentation within twenty (20) days of receipt of the complaint and any supporting documentation.
(2) Processing the response:
(A) The RECM, after receipt of a valid response, shall, within five (5) days:
(i) Forward copies of the response and any supporting documentation to the other six members of the ethics committee;
(ii) Forward, by certified mail, return receipt, a copy of the response and any supporting documentation to the complainant.

III. NOTICE TO PROCEED

Within five (5) working days of the receipt of the response papers, the complainant must notify the RECM in writing that he wishes to proceed with the charges. Failure to file timely this notice to proceed will result in the complaint being dismissed by the RECM.

IV. INFORMAL CONCILIATION STAGE OF PROCEEDINGS

(1) Within five (5) days after the RECM receives the notice to proceed, the RECM shall notify the respondent of the complainant's name and arrange for the complainant and respondent to meet informally with the RECM for an informal conciliation conference.
(2) The conciliation conference shall be held within twenty (20) days after receipt by the RECM of the Notice to Proceed. Only the parties and the RECM shall attend this conference, unless these participants all agree to invite any other individuals, and nothing said or submitted for consideration by any participant may be used as evidence in any subsequent proceeding. The conference may be adjourned from time to time, but it must be concluded within seventy-five (75) days from the date the RECM received the notice to proceed.
(3) Within ten (10) working days after the conclusion of the conference, the RECM shall prepare and mail to all members of the ethics committee and to the two parties a written report which states the following:
(A) The conference was successful in that:
(i) The complainant agreed to drop the charges; or
(ii) The respondent, without admitting guilt, agreed to acceptably modify his practices, conduct, etc., in the following particulars (specified); or
(iii) The complainant dropped some charges (specified) and the respondent agreed, without admitting guilt, to acceptably modify his practices, conduct, etc., with respect to the remaining charges; or
(B) The conference was unsuccessful and formal proceedings should be initiated; or
(C) The conference was unsuccessful because the complainant was unreasonable in his position and the RECM recommends the compromise offered by the respondent, which is set forth in the report, be accepted by the committee in spite of the complainant's failure to agree to the settlement. The committee, by majority vote, can accept, within ten (10) days, the RECM's recommendation and after notifying the complainant of its action, within five (5) days, the case will be closed; provided, however, the complainant can send to the committee members his written objections to the settlement within ten (10) days of recept of the notice of the committee's acceptance, and the committee may, within ten (10) days after receipt of these objections reopen the case and so notify the parties.

V. THE FORMAL STAGE OF THE PROCEEDINGS

Up to this point all action taken shall be handled in strictest confidence by the parties and the committee.
(1) If the RECM conference report states the conference was unsuccessful and formal proceedings should be instituted, or if the case is reopened after the complainant's objections to a settlement are reviewed, a notice of hearing shall be mailed by regular mail to the members of the ethics committee and by certified mail, return receipt, to the parties by the RECM within ten (10) days after the conference report is sent to the members and parties or within ten (10) days after the committee notifies the parties the case has been reopened, whichever be the case.

(A) This notice of hearing shall:
(1) Establish a date for the hearing which shall be no sooner than twenty-five (25) days nor more than forty-five (45) days from the date of the notice;
(2) Establish a time for the hearing to start;
(3) Establish a place within the respondent's region where the hearing will be held; and
(4) Inform the respondent of his right to be represented by counsel, to present oral and written evidence, to confront and cross-examine witnesses, to present argument and file briefs.
(2) The hearing shall be held before the ethics committee. If any interested party wishes to file a posthearing brief, he shall state so at the end of the hearing and send a copy of same to each member of the ethics committee within twenty-five (25) days after the hearing concludes. Within twenty-five (25) days after the hearing concludes, or, in the event briefs are filed, within twenty-five (25) days after the brief due date, the committee shall mail, certified, return receipt, to the parties and by regular mail to the board of directors, a detailed report of the proceedings with its recommendations. The committee may recommend various degrees of punishment, such as suspension for a time certain, the filing of periodic progress reports with the committee, and the like up to and including expulsion. Within twenty-five (25) days after receipt of the hearing report and recommendations, any party may send to the board of directors a statement in support of or in opposition to the recommendations.
(3) Within fifty (50) days after receipt of the hearing report, the board shall issue its decision accepting, modifying, or denying the ethics committee's recommendations. The board will notify the proper governmental authorities in those cases it deems this action appropriate. In all cases, except expulsion, its decision shall be final. In the case of expulsion, the board shall present a resolution of expulsion for adoption by the general membership at the next membership meeting. The decision of the membership shall be final in expulsion cases.

VI. EFFECTIVE DATE AND STATUTE OF LIMITATIONS

This code shall be effective as of September 20, 1975. Acts complained about must have occurred at least sixty (60) days after the effective date of this code, but not more than two (2) years prior to the date the complaint is filed.
BE IT KNOWN that on this, the 20th day of September, 1975, the board of directors of the Florida Association of Home Health Agencies, Inc., approved, adopted and endorsed this code of ethics and the ethics complaint adjustment procedure.
BE IT KNOWN that on this, the 7th day of May, 1976, the board of directors of the Florida Association of Home Health Agencies, Inc., approved, adopted and endorsed the amendments.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR CHILES: If there had been time for everyone to speak at the hearing on "Abuse of the Medicare Home Health Program," in Miami, Fla., on August 28, 1979, I would have said:

The following replies were received:

P. A. HEWETT, JACKSONVILLE, FLA.

Credit for public awareness for home health services available must go to those people who have worked so hard during the past 5 years. The large majority of these agency officials are simply earning a salary while providing quality patient care. I see nothing wrong with this.

PAUL MASS, FLORIDA HOME HEALTH SERVICES, INC., MIAMI, FLA.

(1) Yes, there are abuses, but I feel that they must be proven. Don't penalize a good industry for the abuse of some; some of which I could name.
(2) If abuse or fraud cannot be proven in a court of law, then get off our backs and expand home health coverage.
(3) I can cite more abuse and malfeasance from H.E.W. officials which is worse than what the agencies commit.
(4) No clear regulations have ever been enacted; morever, the providers can write better regulations that H.C.F.A.
(5) H.C.F.A.'s response to throw the baby out of the tub because there is some dirty water, is not the way to go. For example, an order to retroactively throw out coordinator's salaries will not stick up in court. The approach should be clear and concise regulations; not the vagueness of intermediary letter 78-16.
(6) Eliminating coordinators will not guarantee that hospitals will properly do discharge planning into the nursing home or home health. Home health is noninstitutional and; therefore, hospital people need to be educated. Who would pay for this?—Answer, H.E.W.
(7) I can show where a system of payoffs would be generated without coordinators.
(8) Closing down 100 percenters is unrealistic. We are contractors of services just like thousands of services provided to the Federal Government. Since most people who need home health care are medicare patients, why not allow us to contract for this service.
(9) Forcing agencies to close because Blue Cross of Florida received "marching orders" from H.C.F.A. will force the Government into defending many cases of "abandonment" which will be a national scandal.
(10) When, in the name of reason, will you get together with the providers and write title 21, a separate program for home health care?
(11) HCFA's lunacy on cost caps and USHHAR are shining examples of abuse that is greater than any committed by a home health agency. That abuse is public irresponsibility.
(12) If you go after 100 percenters, what about hospitals that are 92 percent, 71 percent, etc.; and what about the dollars that are poured out and the abuses of both hospitals and M.D.'s?

(13) What happens if home health is wiped out? The first day back into a hospital costs medicare $900 per day. Home health agencies could make 25 visits for that amount, or less.
(14) Senator Chiles, if you recall several years ago, Blue Cross had "marching orders" from region IV to cut down on covered services such as home health aides. After much agony and tremendous costs, Blue Cross was forced to admit that they were wrong and revised the policy. The point that I am making is that HCFA officials cannot go off on their own, but must work within existing regulations. Failure to do so may result in a large civil and criminal action against those officials for malfeasance.
As an attorney, you are well aware that we are a Nation of laws and not of men. A principle which I feel the Congress understands, as well as, the courts.
(15) Not meaning to introduce a "red herring", I would like to bring to your attention the fact that HEW is funding HMO's. I predict that within 5 years time, this will be a national scandal, far exceeding nursing homes, hospitals, and home health agencies. HEW not only pays administrative salaries, but pays for solicitation of people to enroll in HMO's. Who pays for the selling costs? Answer, HEW. Who pays for administrative salaries, cars, trips, etc.? Answer, HEW.
I call your attention to an article which appeared in a late August 1979, issue of Time Magazine regarding the colleges abusing grant funds from HEW without accountability.
(16) I again invite you or members of your staff to spend time in a large agency that has met every audit thrown our way. Come see what we do, and how we do it. The idiocy of redtape and how, if an agency wants to, can abuse the program.
(17) Dr. Roger Egeberg, Special Assistant of HEW, said to us that we are not any better or any worse than the population as a whole. Therefore, I reiterate, find those people who abuse the program and clean it up and don't penalize those who are not, who are in the vast majority.

MARY FAY VERVILLE, R.N., GOLD COAST HOME HEALTH SERVICES, POMPANO BEACH, FLA.

I would have agreed with those speakers who encouraged prospective denial of abuse. The guidelines as written are up for grabs on interpretation—they should be more definitive.

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